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INDEPENDENT
HEALTH AND SOCIAL CARE
REVIEW

Independent Review of the Isle of Man Health and Social Care System

FINAL REPORT

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18 April 2019

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Foreword

This Report should be seen as a catalyst for change. Several reviews of health and social care on the Isle of Man have been undertaken over recent years, identifying deep-seated problems in the way the services were organised and delivered. They made many good recommendations, which appeared to be accepted at the time but were not fully implemented – or, in some cases, not implemented at all. It would be extremely disappointing if the same were to occur with the recommendations in this Report, given that it has become very clear and widely recognised that the current system of health and care on the Island is both clinically and financially unsustainable.

In addition, the system cannot be shown to offer best value, either in terms of outcomes or costs. Therefore, now is the opportunity to make some fundamental changes to ensure that the service user is at the centre of the provision of services and that a clinically and financially sustainable system is secured for the people of the Island, now and for future generations.

Given my experience as a physician and a chief executive of leading NHS Trusts, I have considerable experience of managing major change programmes within the health and care environment. Since being asked to lead this important independent Review by the Council of Ministers last year, I have spent a considerable amount of time meeting people on the Island. I have gained an understanding of what health and care services mean to them, what challenges they find within the current system, what improvements are needed and at what cost. I found that the citizens of the Island want to see a comprehensive health and care service that is of the highest quality and delivered in a way which is efficient, effective and, whenever possible, provided on the Island. My Report has been informed by a combination of past experience and engagement with the lived experience of the people of the Isle of Man.

Above all I have learned about the talent, compassion and commitment of so many staff and volunteers, working across all sectors of health and care. I have heard very clearly their views about what changes they believe are needed to deliver better services. When in this Report I criticise the way services are organised, I recognise that the vast majority of staff are striving to deliver good care despite the system. However, patches of poor practice and behaviour do exist and, wherever they occur, they should be addressed.

No Government has unlimited budget. Whilst this Report does recommend increases in funding in the future, it also acknowledges that regular improvements in efficiency should be found to ensure that the increase in funding delivers the maximum benefit for the citizens of the Isle of Man. If the fore-casted increased funding levels and efficiencies are not secured, the range, accessibility and quality of services provided would need to be adjusted accordingly.

Given this situation, the degree of change required in health and care services on the Island is significant. This Report explains the need for legislative changes, organisational changes and service reconfiguration (which will determine what care is provided and how). I view health care and social care as equally vital components of the entire system and so my recommendations apply equally to health and care, except where specified. The changes I recommend will impact all aspects of the health and care system on the Island.

This Report also urges action to further embrace the technological advances, which can enable better care to be provided on-Island, reduce appointments off-Island and allow more accurate information to be gathered and used for performance management and planning purposes.

The programme to transform the provision of health and care on the Isle of Man will not be quick, without significant challenges or without some further costs. However, in my opinion, the recommendations in this Report are collectively essential to ensure that health and care services on the Island are focussed on the needs of the service user, safe, of high quality and get most value for taxpayers.

The Isle of Man Government and the Department of Health and Social Care (DHSC) have for some considerable time espoused a vision of a fully integrated health and care system for the Island. I fully support that vision, although I recognise that, as yet, limited progress has been made towards achieving it. I feel that the acceptance and, crucially, the implementation of the recommendations included in this Report will enable that vision to be realised.

I would encourage the Council of Ministers to strongly commend the recommendations contained in this Report to Tynwald and require the implementation of them as soon possible in order to provide a financially and clinically sustainable, high-quality health and care system for the Manx population.

I would like to conclude by expressing gratitude for the support shown to the Review by the public, service users, carers, clinicians, politicians, employers and others who work in the private and third sectors in the provision of health and care. They have all given their time, encouragement and thoughts, thus enabling the Review to consider the health and care system in its entirety. We owe it to the population of the Island to act now to achieve the improvements that can give them the services they deserve.

Sir Jonathan Michael

11 April 2019

Executive Summary

Section 1. Introduction

The Introduction to this Report explains that the Isle of Man is well placed to become a model of how to deliver a fully integrated health and care system. However, to achieve this aim, a fundamental rethink of the current arrangements is required.

The main objective of the Review was to obtain an independent opinion on the state of services as they stand and to identify options for delivering and funding a modern, fit-for-purpose and sustainable health and care system. Its Terms of Reference included examination of whether the Isle of Man is getting value for money for the sums currently being spent on health and care - and what is the likely increase in funding that will be needed to support those services by 2035-36. Core questions for the Review included asking whether the Isle of Man has the best possible organisational model for the delivery of health and care. Is the current health and care strategy still appropriate? What obstacles have limited progress and how should they be overcome in the future?

The independent Review was led by Sir Jonathan Michael, who was assisted by Isle of Man civil servants and external consultants. The Introduction explains the approach to taking evidence, including extensive engagement with the public, staff and service users. The Review was supported by an Advisory Panel of stakeholders and a Sponsor Group. Sir Jonathan greatly benefited from the views of the numerous contributors, but as this was an independent Review, he retained full editorial control of its conclusions.

The Report uses the term health and care to include health services, social services and others who deliver care within the Isle of Man health and care system.

Section 2. Current Costs and Models of Care

This Section looks at the growth in funding of health and care on the Isle of Man over recent years. It notes that budgets have tended to be overspent, predominantly due to overruns at Noble's Hospital. If changes are not made to the health and care system, costs are forecast to rise by 2.7% a year on average in real terms. This is due to demographic pressures, technological advance, rising public expectations and the tendency for healthcare costs to rise faster than general inflation.

If the 2.7% annual addition to costs were to persist until 2035-36, the annual cost of delivering current health and care services would rise to £433m at today's prices. This would require £156m more funding than is provided for health and care today – an apparently unsustainable proposition. These figures make it all the more important to make the system work more effectively.

The current service model is heavily focussed on delivering care from the main hospital site. Government policy since 2011 has been to shift services out of the hospital into the community, with an emphasis on the integration of services around the needs of the individual. However, although some progress has been made, integration remains limited.

The Review looked in turn at eight different sectors: public health; primary care; community services; social care (adults and children and families); third sector and private sector care; out-of-hours services; hospital-based services; mental health and learning disabilities. Each sector has its own set of issues.

Key points include:

1. **The Public Health** Directorate aims to protect and improve the health and well-being of the citizens of the Isle of Man as a whole. However, its ability to fully achieve this aim is

constrained due to a lack of key data from the health and care system and across Government, an inability to oversee key programmes delivering public health outcomes and a lack of resource to fully deliver on its remit.

2. **Primary care** on the Island relies heavily on GPs and by international standards makes relatively little use of practice nurses, nurse practitioners and pharmacists. However, there are fewer GPs per head of population on the Isle of Man than in England and their workload may be unsustainable. They also appear to refer more patients to other health services than in England.
3. **Community health services** (including community nurses, health visitors and a wide range of specialist therapists) are making progress towards formalised, integrated working with each other, but they are not yet able to integrate fully with other services, particularly with primary care and hospital-based services. This lack of wider collaboration results in greater pressure on hospitals and nursing/residential care, where costs are higher.
4. **Social care services** for adults are highly centralised. Services for people with more acute needs are predominantly provided in nursing and residential homes, rather than in their own homes. The benefit system encourages people to move into a care home instead of staying in their own home, where most people would prefer to be if sufficient support was available. Therefore, the Isle of Man gets the worst of both worlds from the system – higher cost and less satisfaction. Social care services for children and families have made progress in recent years and have undergone significant change, but structural fragmentation and limited integration pose risks to outcomes for some service users.
5. **Third sector and private sector organisations** can make a valuable contribution to the delivery of health and care services. They include charities, voluntary organisations, faith groups and care homes. However, partnership working between these organisations and the public sector is localised and not well developed.
6. **Out-of-hours** services depend on a "two-tier" system of GPs providing the Manx Emergency Doctor Service and Noble's Hospital providing an Accident and Emergency Department. There are in effect two fully staffed services and there is no single centre of emergency care. This model has not changed since 2016, when an earlier review into urgent care by the Island's Chief Ambulance Officer determined that it was unsustainable**.** A small number of emergency cases are diagnosed and stabilised in Noble's Hospital, and then transferred via the airport to specialist centres in England. The Review has been advised that enhanced medical air transfer facilities to those specialist centres would allow more patients in need of urgent emergency care to be transferred in a safe and timely manner.
7. **Hospital-based services** on the Isle of Man provide a higher proportion of planned care than in other healthcare systems. Evidence demonstrates this is the most expensive and least appropriate place to deliver some of these services. The high volume of hospital-based care also exacerbates long waiting times and breaches of specific quality targets. This, coupled with a historic high rate of delayed discharges, means that the patient journey through the current hospital system is longer and more costly than necessary. At present, 13 different organisations based in England are contracted to deliver specialised services for the population of the Isle of Man. There are some indications that these services may be less than ideal and there are question marks over whether Isle of Man patients in English hospitals are being given the appropriate priority.
8. **Mental health services** are currently going through a long-term process of welcome change. A Mental Health Strategy for the Island was published in 2015, which mirrors the approach being taken in other health and care systems, the aim being to prevent mental ill health, promote mental wellbeing and treat mental illness. Considerable work has gone into the implementation of the strategy and there are clear, credible plans to build on this progress. Despite this, some elements of a mental health service that would be considered 'best

practice' are not yet in place. There are also indications that elements of the system, as currently configured, are struggling to meet demand.
A Strategy for **Learning Disability services** on the Isle of Man was published in 2014 and a lot of effort has subsequently gone into its implementation. However, the Review process highlighted the need for greater medical input and improved integration, communication and education in order to support vulnerable people accessing care and navigating the system.

The Section proceeds to identify deficiencies in the governance of health and care, including a lack of data on quality and performance. There is not enough transparency about costs and spend. So it is not possible to judge whether, or to what degree, the spending of public money on health and care is appropriate or effective. There are insufficient processes or levers to hold to account the people with decision-making powers (whether clinical or non-clinical). There is also a lack of comprehensive, consistent quality regulation across health and care services. When inspectors do find fault, their recommendations are not consistently implemented.

There are a number of areas where the Isle of Man does not have legislation in force that is comparable to legislation covering the NHS in England, including lack of a clear framework against which clinicians can be held to account for the care provided. The current regulatory regime is not sufficiently robust to protect the public consistently and ensure that services are safe, relevant and of appropriate quality.

The health and care sector operates a multiplicity of IT systems that do not communicate well with each other and this inhibits relevant information sharing between providers of care. It is experiencing a variety of workforce challenges, including a high vacancy rate. The most recent comprehensive survey of the Department of Health and Social Care (DHSC) workforce highlights that the majority of its staff are committed to delivering a good customer service, but they do not feel encouraged to improve ways of working.

The section concludes by examining a number of cultural issues that may be standing in the way of progress.

Section 3. Principles of Health and Care

This Report is not suggesting any changes in fundamental principles. A motion passed by Tynwald on 20 March 2018 said:

> *"That Tynwald endorses and affirms the seven modern day core principles of the NHS [National Health Service]:*
> - *The NHS provides a comprehensive service, available to all;*
> - *Access to NHS services is based on clinical need, not an individual's ability to pay;*
> - *The NHS aspires to the highest standards of excellence and professionalism;*
> - *The NHS aspires to put patients at the heart of everything it does;*
> - *The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;*
> - *The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources;*
> - *The NHS is accountable to the public, communities and patients that it serves."*

The Review has taken these principles as given and has extended them to ensure that the values that have been clearly stated for health services should also apply in social care. It has also adopted an additional principle, based on the DHSC's current vision and strategy, that health and care services,

wherever possible, should be delivered on the Island and close to a person's home. They should be provided centrally only when clinically necessary (whether in an Isle of Man facility or off-Island).

Section 4. Case for Change

The Review heard very clearly about the sort of health and care system that people on the Island say they need. It is based on five key aspects:

- High quality, efficient services
- Best value
- Delivered as locally as appropriate
- Timely provision of services, which are both accessible and integrated with other aspects of the system
- Sustainable, both financially and clinically

This is achievable. The Island already possesses several of the components required to deliver a high-quality health and care system. They include a supportive population, a highly skilled health and care workforce, some good infrastructure, a supportive third sector and a strong economy. However, these benefits cannot yet be leveraged fully because of barriers to progress, which are described in Section 2.

A modern model of integrated health and care services is now required. It should be focussed on the service user, with the provision of care delivered locally whenever possible, either in the home or close to it. The need to receive care off-Island should be satisfied, but limited to those cases requiring specialist care that cannot safely be provided on-Island.

This Section sets out a vision of how services should develop, including improved communications and an increased emphasis on health and well-being, to improve the quality of people's lives and delay their need for access to health and care services for longer. Services should be delivered to an agreed high standard based on professional best practice, within an increased funding envelope and an annual efficiency target. They should be planned and delivered according to proven evidence of need. To achieve a satisfactory standard of emergency care there should be improved air links giving immediate access to a small number of specialist centres.

These changes will need to be underpinned by a fully delivered digital strategy, which exploits the current investment in technology services. There should be ubiquitous access, for those who have the right to it, to information which will help in the delivery of care, and systems that reduce travel for follow up appointments.

Costs and outcomes should be linked and measured; and the complete relevant information should be made available regularly to managers, clinicians, service users and those charged with making policy decisions. This will allow for the most informed decisions to be made. There should be regular, empowered inspection of services, with an aim to maintain and further drive up standards. Where failings are identified, there should be an agreed improvement plan and implementation timetable.

Section 5. Creating a Sustainable System

This Section sets out the model of health and care that the Review has designed to enable the delivery of a financially and clinically sustainable system. The first step is to ensure that patients and service users always come first. As a result, the first of the Report's recommendations is that the Council of Ministers formally adopt the principle that puts patients and service users at the heart of the planning and delivery of health and social care services. It must put this principle into action in social care as well as in health by ensuring that patients and service users are engaged at all stages in the planning and delivery of services.

New Governance Model

The second recommendation is for a fundamental change in the governance of health and care. At present, the DHSC sets the policy as well as taking responsibility for delivering and/or contracting others to deliver health and care services. This dual role is problematic. If policymakers become too involved in operational matters, it is almost certain to lead them to concentrate on apparently urgent day-to-day business at the expense of the really important strategic decisions.

The answer is to separate policy making from the delivery of services. The Report recommends that the officers of DHSC should focus on strategic policy, regulation, overall finances and supporting the Minister and Members. This would facilitate better analysis and more insightful policy development. Meanwhile health and care providers should be allowed to focus exclusively on the delivery of high quality, integrated care, based on clinical need, as opposed to any undue, external influence.

The recommendation is for the creation of a single public sector organisation, perhaps to be known as "Manx Care", which should be responsible for the delivery and/or commissioning from other providers of all required health and care services. Manx Care should be set up as an arm's length body and run by a Board appointed by Government and approved by Tynwald. However, importantly, it should be operationally independent of both Government and Tynwald.

A series of further recommendations are linked to the setting up of this new arm's length body. The services it provides directly or indirectly should be inspected regularly by independent, external quality regulators, with a report to the Manx Care Board and to the DHSC. To increase transparency, a publicly available annual report from Manx Care should be provided to DHSC and subsequently presented to Tynwald, summarising the delivery of the health and care services on the Island.

Other recommendations for improving the governance of health and care include:

- A new statutory duty of care, including a duty of confidentiality and a duty of candour;
- A transformation programme of health and care services;
- Progress reports on the transformation programme to the Council of Ministers and Tynwald; and
- Legislation to address weaknesses or gaps in the current system, enabling the implementation of recommendations in this Report, such as any necessary legislation to establish Manx Care.

New Service Model

Greater emphasis will need to be placed on the health and well-being of the population, so that people stay well for longer with less need. This will require health to be considered across Government policy-making and so those charged with providing expert guidance on public health matters should be placed at the centre of Government. The Review states that all Departments should be required to factor public health guidance into policy setting and legislation. To facilitate this, it recommends that the Public Health Directorate moves into the Cabinet Office.

The Public Health Directorate should be resourced to undertake a programme of health and care needs assessments to inform the development of clinical service delivery models. On an Island with a population of 85,000, the capability of health and care services is inevitably limited, but clearly people's needs must be met. A service-by-service review of health and care provision, in conjunction with the needs assessment, an analysis and implementation of care pathway design, should be undertaken. This should establish what services can, or should, or must be provided on- and off-Island, against defined standards. Where services cannot be provided safely or deliver best value by Island-based providers, the default position should be to seek services from third parties for delivery on-Island whenever possible and off-Island where necessary. Integrated care pathways must be designed,

agreed and delivered. At each point along the pathway, the provider(s) accountable for the service user should be clear. Work to establish the pathways should also incorporate the setting of quality standards.

Manx Care should deliver an enhanced 24/7 emergency air bridge, allowing for patients to be stabilised locally and moved quickly and safely to contracted specialist centres. This aviation solution (potentially using helicopters, fixed wing aircraft or both), with comprehensive in-flight emergency and critical care facilities, would transfer emergency activity to other specialist centres. The aim would be to provide a more reliable, faster and more comprehensive service than is currently in place in order to ensure access to timely and high quality, specialist emergency care. Enhanced emergency air transfer to off-Island specialist centres would alter the range of services that would need to be delivered on the Island.

Other recommendations for improving the service model include the establishment of a single, integrated out-of-hours service, deeper collaboration within primary care and removing disincentives to people requiring care and support remaining in their own home.

New Funding Model

Additional increases in day to day funding will be required going forward but must be linked to the achievement of annual efficiency targets. Evidence of progress against the targets should be outlined in the annual report to DHSC. The Review looked at how big an annual efficiency target would be appropriate to provide greater financial sustainability and concluded that a 1% target should be the standard measure, reviewed annually. Efficiency gains of 1% a year of the full costs of delivering health and care would still leave an additional funding gap of approximately £120m by 2035/36. The Review suggests savings that could be made without having a negative effect on the quality or availability of services.

The Review recommends a ring-fenced additional allocation to support the transformation programme, equal to 1.5% of health and care spend for up to five years of implementation (2019/20 to 2024/25.) This amount would be equivalent to £4.3m in 2019/20. It would include resources for a team of transformation professionals to lead on the significant change efforts required and for the delivery of this Report's recommendations.

Unless the Isle of Man decides to reduce the range of services offered, it will need to find a sustainable way to meet the remaining funding gap, even after efficiencies are made. This could be achieved in a number of ways including through making changes to the way health and care is funded and/or channeling Treasury income above inflationary rates. The Report includes an analysis of possible options.

The Review proposes that funding should move from the current annual budget allocation to a 3-5 years financial settlement. Predictable funding would enable those working in health and care to plan and deliver services more effectively.

Technology Enabled Transformation and Data

As the service is transformed through implementation of the recommendations proposed in this Report, reliance upon high quality digital systems will increase. To avoid delays in the delivery of health and care reforms, development of the Government-wide digital strategy needs to go further and faster. This would enable greater integration across the system, improved monitoring and enhanced delivery of quality and efficiency-related information.

One of the key aspects of the digital strategy is the delivery of the "Manx Care Record". The intention is to create a single overarching system that provides appropriate staff from all parts of health and care with access to all the key data from each relevant system used in the delivery of care. The Review considers this essential to the future clinical sustainability of care. Technology is not an add-on to delivery of care – it is an essential part of it for service users, staff, operational management and strategic planning.

A second important element of the digital strategy is the delivery of telemedicine services. By linking patients and their doctors to expert clinicians on and off the Island, the service can overcome many of the disadvantages of operating on a relatively small scale.

The Report calls for the collection of a core data set for the management and assessment of services. The systemic capture of accurate data should be a priority. Data sharing protocols and arrangements should be reviewed, agreed and implemented in accordance with the Information Commissioner's regulations and guidance.

New Workforce Model

Delivery of the recommendations in this Report requires a fit-for-purpose workforce. That demands solutions to a variety of issues including filling gaps in staffing, reducing duplication, easing recruitment difficulties, building career paths and improving morale. The answer is not as simple as hiring more staff. Increasing staff numbers only, at the same level of demand, would create unsustainable financial pressure, given that staff costs currently make up around 65% costs within the Island's health and care system. It will be critical to use the workforce more innovatively with new ways of working and increased use of technology to increase productivity, reduce unnecessary bureaucracy and enable more time to be spent delivering care. Such innovations are becoming especially important at a time of a growing international shortage of health and care staff.

A workforce skills audit should be conducted in order to objectively assess the ability of the current workforce to provide the services required. This should apply whether the services are to be delivered directly or indirectly by Manx Care. Any gaps in that ability will need to be addressed, e.g. through upskilling, recruitment or purchasing of those services from other providers.

Recruitment will need to focus more on appointing generalist clinicians, with suitable specialist skills delivered by other specialist providers both on and off Island, as required. The workforce model should include alternate approaches, such as contracting staff from off-Island specialist centres to deliver specific elements of care on-Island, linking in with professional networks and utilising telecare/ telemedicine solutions.

The Report notes the importance of the working culture of organisations. It is important to do everything possible to root out negative attitudes and develop policies that encourage staff retention and recruitment, including fair rewards and flexible arrangements to achieve an appropriate work-life balance.

Section 6. Implementation and Transformation

It is formally outside of the scope of the Review to consider implementation in detail. However, given the failure to implement the recommendations included in a number of previous reports, it was considered prudent to provide some advice, working on the assumption that the Recommendations within this Report are accepted and that there is a desire to press forward to implementation at pace. This section is intended to assist moving the Recommendations into actions and delivering change. It provides the outline of a transformation programme and describes the teams of people who will be needed to implement it.

Section 7. Recommendations

To make the recommendations stand out, they are presented prominently throughout the main body of the Report in bold italics. This section also lists all the Recommendations in the order that they appeared in this Report.

Section 8. Annexes

The Report is supported by a series of Annexes, including the Review's Terms of Reference and supplementary information.

1. Introduction

Since 2011, the Isle of Man Government has had a clear aim to provide a fully integrated health and care system for its people and, more recently, the DHSC has outlined its vision "to become the best small-island based health and care system"[i].

High quality, integrated care is a key theme across the developed world and the benefits of delivering on that vision are enormous in terms of direct outcomes for the people of the Isle of Man, both as tax-payers and potential users of services. There are also potential indirect gains through the Island becoming a more attractive place to live and work. It is apparent, however, that progress to deliver this vision has been limited.

As a self-governing jurisdiction with its own parliament, government and laws, the Isle of Man is well placed to make the changes required for its health and care system to become an exemplar of integrated health and care delivery and a model for others to follow. Indeed in terms of integration, the Island's size is a positive advantage. If it is not possible to integrate services for 85,000 people, surely it cannot be done anywhere.

In order to achieve this aim, a fundamental rethink of the current arrangements and a comprehensive, properly funded, transformation programme will be required in order to build on the recent work undertaken by the DHSC and others to address the current challenges facing the health and care system on the Island.

1.1 Terms of Reference

The main objective of the Review was to identify options on how to deliver and fund a modern, fit for purpose and sustainable health and care system for the Isle of Man.

Its Terms of Reference are at Annex 1, which, in summary, pose the following core questions:

- What is currently being spent on health and care, is it sufficient and does it represent value for money?
- What is the likely increase in funding required, projected to the end of the financial year 2035-36, and how might that be funded?
- Is the current organisational model for the delivery of health and care to the Isle of Man population optimal, now and for the future?
- Is the current health and care strategy still appropriate, or should it be amended and, if so, how? What obstacles have limited progress and how should they be overcome in the future?

The Terms of Reference required an interim statement to Tynwald in January 2019[ii] and a final report in May 2019.

As this was an independent Review, Sir Jonathan retained full editorial control of its conclusions.

1.2 Approach to the Review

In undertaking the Review, Sir Jonathan Michael was supported by a combination of Isle of Man civil servants, forming the Secretariat, and external consultants. The contents of this Report take into account the evidence, opinions and comparisons that the Review considered following extensive engagement on the Island. It reviewed health and care systems across the world, including analysis of best practice in the delivery of major change programmes. It also examined the progress already made on the Isle of Man in respect of its health and care strategy.

The Review undertook a large number of semi-structured conversations on a non-attributable basis with a variety of stakeholders – an established method in qualitative research. It also undertook a series of focus groups with stakeholders. The openness, honesty and time of all those individuals have been invaluable in ensuring a sound understanding of the current system and potential options for the future. A full list of stakeholders who met with the Review is included at Annex 2 and a summary of the focus groups is included at Annex 3.

The Review specifically sought to understand the views of the people of the Isle of Man about the current system and the desired future system. A substantial public engagement programme included consideration of public opinion gathered as part of the Review and through other means. A summary of the public opinion considered throughout the course of the Review is included at Annex 4.

The Review also considered desk-based reviews of materials obtained from the Island and elsewhere of similar health and care systems. It looked at what such systems need in order to deliver a change programme whilst maintaining essential health and care services. The most similar health system, and therefore the most frequent base for comparison used in this Report, is the NHS in England, which is where some patients from the Isle of Man go for more complex services that cannot be provided on the Island. This does not assume, in any way, that the NHS in England is the perfect model of care for the Isle of Man, but it does provide some comparative data points, which are credible and useful. It was a harder challenge to find a comparable social care system but, again, England was frequently used as a similar, but not the same, comparator. Other health and care systems from across the world (including the Channel Islands, Scottish Highlands and Islands, Ireland and New Zealand) with similarities to the Isle of Man have also been reviewed remotely and pertinent information included during the Review. Summaries of some key characteristics of certain other health and care systems are included at Annexes 5 and 6.

1.3 Advisory Panel

The Review was supported by an Advisory Panel, which provided advice on the set-up of services in the Island and guidance on any added complexities within the community. The Advisory Panel was made up of a wide cross section of local stakeholders whose details are included in Annex 2. Its Terms of Reference are in Annex 7.

1.4 Sponsor Group

The Review met with the Ministers and senior officers of the two sponsoring Isle of Man Government Departments on a regular basis to provide updates and seek resources where required. Members of the Sponsor Group are included in the full list of stakeholders who met with the Review, which is included at Annex 2.

2. Current Costs and Service Models of Care

2.1 Current Funding Model

The DHSC's 2018 Vision document warned that the Isle of Man '*cannot sustain the current proportion of expenditure that is currently spent on hospital services* [nor] *continue to afford, if the system were to remain unchanged, to fund the benefit support required for the projected future need*.'[iii]

The DHSC tends to overspend on its budget, as is illustrated in Figure 1 and detailed in Annex 12 B7.

Figure 1: DHSC budget, actual spend and overspend 2016/17 – 2018/19[iv]

Figure	2016/17	2017/18	2018/19
DHSC budget (£m)	198.4	210.0	215.4
DHSC actual spend (£m)	209.6	218.7	218.6
National Insurance (NI) contributions (£m)	37.4	38.5	39.7
Central shared costs (£m)	18.0	18.4	18.9
Total health and social care spend including NI contributions and central shared costs (£m)	265.0	275.6	277.2
DHSC overspend against DHSC budget (£m)	11.2	8.7	3.2

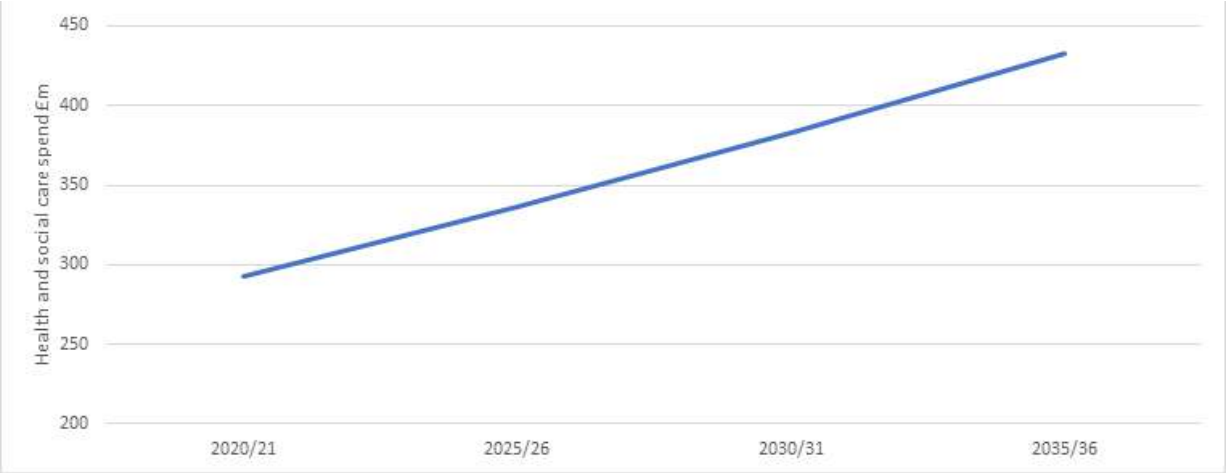
It is notable that the overspending predominantly derives from Noble's Hospital, which is also the largest component of the DHSC's budget. By contrast a number of other Directorates have underspent in recent years. This spending pattern does not appear to support the Isle of Man's vision for integrated health and care that is delivered closer to home[v].

Although the Review advises caution when dealing with high level comparisons, it is interesting to note that the Isle of Man spent approximately £3,300 per head on both health and care in 2017/18. This was approximately 10% more per head than Scotland; and approximately 28% more than England. Furthermore, compared to England, the earnings of medical consultants on the Island are 20-30% higher and the amount paid for pharmaceuticals is 33% higher, yet it is known the costs paid per individual type of drug is the same as in the north-west of England. Since England generally sees health and wellbeing outcomes that are comparable or better than the Isle of Man[vi], and given that that the Island's population is similar demographically to England's, these comparisons suggests that value for money could be improved. Although lack of data limits the Review's ability to fully assess value for money, there are several areas where it appears the Isle of Man could be doing things in a more cost-effective way.

Very few quantitative measures of efficiency and productivity were available for inclusion in the Review's analysis, and indeed there are a number of other areas including spending, capacity and activity where data collection could be significantly improved (see Annex 12 D1 and F for details). Without this information, it is much more difficult to make informed management and operational decisions. It is also difficult to understand whether existing services are delivering good value for money.

Assuming no changes to the health and care system and based on 2018/19 expenditure, costs are forecast to rise by 2.7% a year on average to £433m (in today's prices) by 2035/36. This would create a funding gap of £156m in real terms, as illustrated in Figure 2. This rise is due to demographic pressures (a growing and ageing population), non-demographic pressures (technological advancements and rising public expectations of health and care services), and the fact that healthcare costs are forecast to rise more rapidly than general inflation. Further detail on the work undertaken for this section is available in Annex 12.

Figure 2: Projected cost of providing DHSC services under a "no change" scenario



The vision for the future of health and care centres on balancing quality of care with sustainable expenditure. Only by balancing these elements can the Isle of Man achieve its vision of becoming *'the best small island-based health and care system'*[vii].

2.2 Current Service Model

The Isle of Man has made some limited progress towards achieving its vision of integrated health and care. However, the way in which services are currently structured and delivered is heavily focused on the main hospital site. The Island has not yet adopted an approach that has become accepted across the world over recent years – building services around the needs of the individual and providing them in the community whenever possible. As a result the Island has not made the most of opportunities to lower costs and to improve user satisfaction and outcomes. The current model is compounded by a lack of understanding of current demand for health and care services within the current arrangements, which makes it more difficult to proactively address people's needs. There have been attempts to consider and implement changes to the current model, through a number of different reviews, strategies and initiatives, which are included at Annex 9, but there has been limited success in implementing most of these.

To address these issues, the health and care system will need to understand local need and meet it through a predominantly community-based model of care, with increased focus on prevention and proactive care. This realisation is not new. Government policy on the Island since 2011 has reflected the need to shift services out of hospital, with an emphasis on the integration of services around the needs of the individual. However, although some progress has been made, integration remains limited and the proportion of the health and care budget spent on hospital services has continued to increase.

In addition, there exist opportunities and challenges within specific care settings, which are summarised below.

2.2.1 Public Health

The Public Health Directorate's overall aim is to protect and improve the health and well-being of the citizens of the Isle of Man as a whole, rather than provide treatment, as many other parts of the health and care system do.

This is best achieved by working across Government to improve the environment, improve lifestyles and reduce risk factors within the population which damage health. DHSC services can encourage lifestyle change, offer early intervention and provide screening programmes as well as treatment services. However, significant improvements in population health require a major focus on the wider

determinants of health. In short, the aim should be to create a wellness agenda rather than illness service.

To achieve its purpose, Public Health needs to provide system leadership, advice and guidance to Government and others, based on evidence, and determine the maximum impact that can be achieved within available budgets, against an agreed framework for prioritisation.

It is clear that several attempts to fulfil the Directorate's strategic remit have been made over recent years, but these have been hampered by a lack of key data from within the health and care system and, more worryingly, the fact that other parts of Government either do not collect or do not share data necessary to understand population wellbeing and inequalities in health. This is a frustration for those working within public health and a missed opportunity to influence systems and behaviours which may reduce longer term health and care needs and associated costs. Public Health has no remit to commission, or even have oversight of, key programmes delivering public health outcomes, including screening programs and the healthy child programme.

The lack of routine performance and outcome data across the health system hampers the identification of 'red flag' conditions and services, which should be priorities for the service and pathway review.

The Directorate could not manage the necessary increase in its workload without additional staff to either undertake that work and/or backfill for those from the Directorate who might undertake it.

2.2.2 Primary care

Primary care encompasses all the services that function as the usual entry point to the health system including general practice, community pharmacy, dental and optometry services. The current primary care service model relies disproportionately on General Practitioners (GPs), at the expense of other professional categories, such as practice nurses, nurse practitioners and pharmacists. This constrains effective capacity, reduces access to services for patients and makes general practice less attractive as a profession.

The Isle of Man has 12 GP practices on 14 sites. They are of varying sizes, some with only two GPs, and the Review heard some of them have financial difficulties. There are few standards defining what GP practices are expected to provide, resulting in varied practice and limited performance monitoring. There is no agreement between the DHSC and GPs for properly funded shared care arrangements when GPs take back care and prescribing for patients who remain under the observation of hospital consultants.

Whilst access to data to enable direct comparisons with other GP services was challenging, some information was available, which suggests that GPs on the Island have an increasingly unsustainable workload. There were 54 GPs (including 10 trainees) as of September 2018, which equates to approximately one GP for every 2,000 patients on the Isle of Man, compared to one GP for every 1,650 patients in England. There are fewer practice nurses and healthcare assistants (per head of population) to provide support and release capacity. GPs on the Island appear to refer more patients to other health services than GPs in England.

2.2.3 Community services

Community services delivered in or close to a person's home include community nurses, school nurses, health visitors, physiotherapists, podiatrists, occupational therapists and speech and language therapists. At present they are poorly integrated with other elements of the wider system. There is a lack of joint collaboration of primary and community care services resulting in greater pressures on

hospitals and nursing/residential care, which are amongst the highest cost settings in which to deliver services.

Community based care is also noticeably absent from the majority of the on-Island care pathways. (A pathway is a defined route through the different aspects of the health and care system, based on best practice and relevant to the particular condition(s) of the service user.) Even for the most common chronic conditions, the on-Island pathway tends to start with a GP referral to a hospital consultant, whereas international best practice would often start with a referral to community services, prior to consultant involvement. There are, however, some limited examples of joined up, locally-based models of care on the Island (e.g. the Integrated Care Pilot Project in the West) and of co-location of services (e.g. Thie Rosien). These are positive, if limited, advances to overcome the problems identified above.

Learning from other health systems[viii] demonstrates that a range of services (currently being delivered at the hospital site) can be delivered safely in the community, with greater access and reduced cost, including:

- Ambulatory Blood Pressure Monitoring;
- Phlebotomy (Blood tests);
- Pulmonary function testing (lung function); and
- Point-of-care testing e.g. Warfarin, Prostrate (PSA) testing etc.

2.2.4 Social Care for Adults

Social care services for adults on the Isle of Man are also highly centralised, with services for people with more acute needs predominantly being provided in nursing and residential homes, rather than in their own homes. As with other services, the current model is failing to leverage the strengths of its existing skills base. Learning from other health and care systems demonstrates the effectiveness of earlier interventions, delivered predominantly through the social care workforce, in delaying or arresting the progression or impact of illness and disability.

The key to delivering these benefits is to ensure that social care services are integrated with other frontline health and care services. There are some examples of effective multi-disciplinary working on the Island, but these are limited. It was noted that there are financial disincentives which discourage people from receiving care in their own homes. For example, the financial support available from social security to fund residential or nursing care is not allowed to be used flexibly in order to support a care package within a service user's own home. As a result, in some cases the only means of accessing appropriate care is to move into residential / nursing care in order to obtain financial support through social security benefits. The financial threshold for social care support to help people remain in their own homes, is higher than that for support for residential or nursing care.

This financial disincentive inevitably leads to increased use of institutional care, usually at higher cost, which might be avoided. On the whole individuals prefer to receive support and care in their own homes, which usually leads to maintenance of independence, better outcomes and is likely to be less expensive overall. This anomaly should be reviewed urgently, alongside the separate report into residential and nursing care provision which is shortly to be published.

Where provision of DHSC home care is provided, to those who qualify for income support, it is available seven days per week for existing service users (8am – 2pm and then 4.30pm – 10.00pm). However, the service is unable to pick up new cases out of hours or at weekends.

Many service users have needs outside of these specified hours, but no publicly funded service is available. As a result, the service user must fund their own care overnight and at weekends, or if they

are unable or unwilling to do so, must rely on members of their families or other carers for support, or move into residential care. This exacerbates the demand for institutional provision.

Due to a lack of capacity within the home care team run by social services, care is frequently outsourced to a range of suppliers. However, there are no agreed tariffs for the provision of the different types of care potentially required. There is some evidence that the prices charged increase when an urgent support is requested.

An agreed tariff, whereby all parties clearly understand the service to be provided at the required standard and cost, would substantially address this problem. These tariffs should be progressed as a high priority. This approach might also reduce the turnover of staff between service providers, since currently individuals move from one organisation to another seeking to improve their overall terms and conditions. This turnover of staff results in wage and cost inflation and reduces the continuity of carer for care recipients, which can be distressing.

The Review was also concerned that proposed legislative changes in support of social care provision, which have been discussed and considered over a number of years, remain undelivered.

In particular, the lack of comprehensive Capacity and Deprivation of Liberty Safeguards legislation means that there is no statutory basis on which a person is detained in their own best interests. Whilst the Review does not consider that those for whom care is provided for in this way is inappropriate, it does consider that the required legislative framework should be brought forward without delay, alongside the wider legislative changes necessary to ensure health and care services are provided in line with the recommendations.

2.2.5 Social Care for Children and Families

Social services for children and families on the Isle of Man are the responsibility of a separate Directorate within the DHSC. Integration with other children's services are in their infancy and, in common with health and care in general on the Island, the infrastructure for this is limited at a strategic level. Individual initiatives have had some success, but greater integration would further improve long-term outcomes and potential costs.

The Children and Families Directorate has, in recent years, undergone significant change to improve service delivery whilst achieving financial savings through a better understanding of the needs of the client groups. This is welcomed.

However, structural fragmentation within the existing health and care system poses risks to outcomes for children and families with complex health needs – despite some dedicated efforts by individuals working in this field.

It was reported that there was little integration or even joint working at a planning level between health and social care services. Staff report structural barriers resulting in delays in their ability to trigger, or even engage, other health care services for users. This appears to be exacerbated by a lack of clarity over accountability and the pathways of care.

Where integration between services does occur, it does so as a result of successful personal relationships and not because of strong strategic frameworks. This is not sufficiently robust or structured for such an important aspect of care.

The Review was advised (by those in the Children and Families Directorate and also others) that integrated working between Departments (e.g. DHSC, Department of Home Affairs (DHA), Department of

Education, Sport and Culture (DESC)) is also frustrated by structural Departmental budgetary constraints and the lack of a joint commissioning framework.

The formation of the Isle of Man Safeguarding Board into a statutory body under the Cabinet Office, which brings together DHSC, DESC and DHA, is a positive step towards overcoming the strategic barriers.

2.2.6 Third Sector, Private Sector and Carers

There are a range of third and private sector organisations in operation on the Isle of Man that make a welcomed contribution to the delivery of health and care services. They include charities, voluntary organisations, faith groups and care homes. At present, partnership working between these organisations and the health and care sector is predominantly on an individual basis and frequently covers specific services and/or specific geographies. The concept of a Third Sector Health and Care Alliance, which is in the early stages of formation, is welcomed as it should support a more strategic approach to the provision of care by these organisations.

Greater integration of local health and care services and close partnership with third and private sector organisations is currently being piloted in the west of the Island. However, the relatively small scale of the individual organisations in the third sector in particular, and the multitude of joint working arrangements this necessitates, are significant barriers within the current service model.

The Review acknowledged there are many committed carers on the Isle of Man who support others, usually relatives, in maintaining a level of independence. This benefits both the person being cared for and the taxpayer through the avoidance of heavy dependency on other health and care services. The level of support received by carers has been highlighted as an area requiring further consideration to maintain their valuable contribution to the system. The Review has been advised that a report on carers that examines this issue in more detail is pending release and should be considered once published[ix].

2.2.7 Out of Hours and Urgent Emergency Care

Out of Hours (OOH) and urgent emergency care services on the Isle of Man are currently provided via a "two-tier" system of GPs providing the Manx Emergency Doctor Service and the Accident and Emergency Department (AED) at Noble's Hospital. In addition, there is a Minor Injuries and Illness Unit, which operates between 8am and 8pm at Ramsey and District Cottage Hospital. The current arrangements rely on the existence of two fully staffed services and there is no single centre of emergency care. This model has not changed since 2016, when an earlier review into urgent care by the Island's Chief Ambulance Officer determined that it was unsustainable**.**

The Isle of Man Ambulance Service has 21 vehicles operating from three sites with 42 whole time equivalent (WTE) members of staff. The service has four ambulances on duty during the day (three at night), each crewed by a paramedic and an emergency medical technician/emergency care assistant. The service is also supported by three officers from its headquarters (paramedics) and a 24/7 duty officer.

A small number of emergency cases are diagnosed and stabilised in Noble's Hospital, and then transferred via the airport to specialist centres in England. The Review has been advised that enhanced medical air transfer facilities to those specialist centres would allow more patients in need of urgent emergency care to be transferred in a timely manner.

In parallel, there is an emergency response service for people with urgent mental health needs, provided at Manannan Court (on the Noble's Hospital site) and the adjacent Child and Adolescent Mental Health Service building.

2.2.8 Hospital Based Services

2.2.8.1 Secondary care services

At present, a high proportion of Isle of Man patients (relative to other health systems) receive planned care in a hospital setting. Evidence demonstrates this is the most expensive and least appropriate place to deliver some of these services.

The high volume of hospital-based care also exacerbates the long waiting times and breaches of specific quality targets. This, coupled with a historic high rate of delayed discharges, means that the patient journey through the current hospital system is longer and more costly than necessary. Individual initiatives to improve efficiency and quality often rely on the enthusiasm of individuals or teams and are difficult to sustain in the absence of a strategic quality improvement programme.

2.2.8.2 Integrated in and out of hospital services

Whilst there are elements of integration on existing care pathways, no pathways can be considered truly integrated due to the absence of shared accountability, including between in and out of hospital providers on the service user's journey. Current pathways demonstrate the transition between tiers of care, but not how providers can work together to deliver an end-to-end service.

Integration is enhanced through multi-disciplinary teams[x], joint appointments and co-location. There are some examples of these ways of working on the Isle of Man, which are either part of a pilot scheme which is yet to conclude or local initiatives not rolled out across the Island.

2.2.8.3 Tertiary and specialist services – services provided by off-Island providers

At present, 13 different organisations based in England are contracted to deliver specialised services for the population of the Isle of Man. There are some indications that these services may be less than ideal. For example, in some cancer services, delays by off-Island service providers result in cancer wait breaches for Isle of Man patients, even though those same providers are not breaching similar NHS England targets for patients resident in England. This *may* suggest that, in some cases, Isle of Man patients are not being given the appropriate priority. More stringent service arrangements (e.g. with appropriate Service Level Agreements) could potentially mitigate such issues.

Initiatives to provide improved specialist care and support from off-island providers seem to result from the enthusiasm and interest of individual clinical teams rather than any strategic approach.

There is inadequate integration and communication between care providers on and off the Island, about patients in receipt of specialist care and only rudimentary use of technology to reduce the need for travel. This can result in unnecessary visits to off-Island providers, increasing cost and inconvenience for patients. Poor communication complicates the process of planning and delivery of safe and effective on-going care.

2.2.9 Mental Health and Learning Disability Services

2.2.9.1 Mental Health Services

The interface between mental and physical health is an essential part of an integrated health and care system as there are numerous examples of physical health issues resulting in mental health care needs and vice versa. This interface is not fully developed on the Isle of Man. However, in 2018, responsibility for mental health services as well as community, social and primary care came under a single Directorate within the DHSC, which allows opportunities to make significant improvements.

Mental health services are currently going through a welcomed long-term process of change and development. A Mental Health Strategy for the Island was published in 2015[xi], which mirrors the approach being taken in other health and care systems, to prevent mental ill health, promote mental wellbeing and treat mental illness. Considerable work has gone into the implementation of the strategy and there are clear, credible plans to build on this progress. Despite this, some elements of a mental health service that would be considered 'best practice' are not yet in place.

In common with the other elements of the current service model, there is a limited understanding of needs on the Island and how these will be impacted by demographic and lifestyle factors. This makes it difficult to configure services appropriately and plan delivery proactively. There are also indicators that elements of the system, as currently configured, are struggling to meet demand.

2.2.9.2 Learning Disability Services

A Strategy for Learning Disability services on the Isle of Man was published in 2014 and a lot of effort has subsequently gone into its implementation. Learning disability services on the Island are predominantly focussed on social care, delivered by DHSC staff as well as the third sector. This is not dissimilar to the way services are provided in other health and care systems. However, the Review process highlighted the need for greater medical input, such as additional Learning Disability nurses, psychologists, psychiatry and, potentially, a specialist Consultant who could lead on the care for these individuals, educate their colleagues and raise awareness throughout the system. Some progress has been made through the creation of Local Enhanced Services for learning disability, to be delivered through primary care, but relatively simple initiatives, such as Attention Deficit Hyperactivity Disorder drug monitoring in the community, have not been implemented.

It was reported, in common with a number of other aspects of the health and care system, that communication between different services was limited and that care is not centred around the service user and their carer. In addition, meeting service user's needs that span budgetary or Departmental boundaries is challenging (including the availability and access to appropriate housing for vulnerable people). It was also reported that recent (last two years) changes in the management structures had led to an apparent reduction in the planning of services. The Review was told that the health sub-committee of the Learning Disability Partnership Board, which had previously brought together people from across the system, had not met for over a year. It was also reported that the current system is difficult to navigate and so presents additional challenges to vulnerable people. The apparent lack of sufficient focus around the needs of vulnerable people is particularly concerning.

2.3 Current Governance Model

Good governance ensures that organisations are run efficiently and effectively, with accountability to the people and stakeholders they serve for the work they do and the decisions they make.

There are a number of significant problems within the current model on the Isle of Man, which demonstrate a need for improvement. These include:

- The dearth of accessible, meaningful and published data on quality and performance, which means it is difficult for the DHSC, the public or other stakeholders to know how well any one body or organisation is discharging its core purpose and statutory and regulatory duties; how well led it is; or the degree to which risks are identified and well managed.
- The lack of data and transparency around costs and spend, meaning it is not possible to judge whether or to what degree health and care spending of public money is appropriate or effective.

- The lack of legislation defining the accountability and authority of those charged with providing services risks ineffective process to hold individuals with decision-making powers (whether clinical or non-clinical) to account for their actions
- The number of areas where there are legislative gaps or updates to existing legislation is required to support the delivery of safe health and care services for the Isle of Man.
- The lack of available data for performance monitoring and of legislative levers to enable proper oversight and governance has hampered effective management of health and care services. However, it is not clear that sufficient senior leadership attention has been given to identify and resolve those issues previously. Equally, despite the acknowledged constraints, it is considered that the leadership of staff and service delivery has not been as effective as it could have been and has been somewhat constrained by bureaucratic inertia. Individual improvements would sometimes appear to have been delivered despite, rather than because of, a corporate improvement culture. Thus, in addition to the increased availability of necessary data and defined authority to manage provided through legislation, enhanced leadership capacity and capability will be required in order to deliver improved health and care services across the Island.
- The lack of comprehensive, consistent quality regulation across health and care services.

2.3.1 Legislation

As the Review's Progress Report identified, there are a number of areas where the Isle of Man does not have legislation in force that is comparable to legislation covering the NHS in England. These include legislation on:

- clinical governance – a crucial piece of legislation that provides a clear framework of accountability against which both the organisation and clinicians can be held to account for the quality of care provided;
- duty of care – setting standards for care provided by professionals, including duty of confidentiality, duty to share information and duty of candour;
- mental capacity – including deprivation of liberty safeguards (DoLS);
- the extension of prescribing rights – to allow professionals, including therapists, dieticians, optometrists and midwives, to work to the top of their license and ease pressure on doctors;
- responsible pharmacist – to enable dispensers to run a pharmacy for a limited period when the responsible pharmacist is not present; and
- home of choice – to support service users being cared for in an appropriate care setting.

2.3.2 Regulation

In general, regulation of health and care services serves to protect the public from harm; provide confidence in the delivery of health and care services; promote good practice and education; and support a culture of continuous improvement. It is an essential element of all modern health and care systems.

On the Isle of Man, limited and separate provision has been made for the regulation of social care and healthcare services. Indications are that the current regulatory regime is not sufficiently robust to consistently protect the public and ensure that services are safe, relevant and of adequate quality. Whilst there is some inspection of aspects of social care by the DHSC's internal Registration and Inspection Unit, this does not cover all aspects of social care. For healthcare, non-regular inspections have taken place by invitation of the DHSC, but there remains no regular, systematic and comprehensive regulatory inspection regime, nor a comprehensive set of agreed standards against which such inspections can assess the services provided.

The inspections and reviews of clinical services that do occur are not consistently followed up; and any failings that they identify are not routinely dealt with and monitored. This is absolutely unacceptable. In some cases, it appears that no follow-up occurs at all – even when it has become common knowledge that services have been found to be inadequate. For example, an independent external review of vascular surgery in June 2016 advised that the current service needed major reform, but the Review did not find evidence that this had taken place.

Furthermore, inspections report back to the DHSC and so, in the case of some inspections by the Registration and Inspection Unit, reports are to the provider of services. Therefore, in those cases, the DHSC is inspecting and regulating itself, which is neither aligned to international best practice nor considered an objective assessment.

2.4 Other Aspects of the Current Model

2.4.1 Technology and Data

As with other health and care systems across the world, the vision of a fully integrated system has been the aspiration for some time, but has proven difficult to fully achieve.

On the Isle of Man there is a multiplicity of systems that do not communicate with each other and this inhibits relevant information sharing between providers of care. However, some progress has been made with important building blocks now in place within a number of the key elements of the total system.

A plan for the Manx Care Record (whereby all relevant systems can be accessed via a single on-line portal) is yet to be fully developed or funded. The lack of such an integrated care system is a substantial barrier to providing effective, integrated care as it affects communication, efficiency/productivity and presents risks to service users and providers. The Review noted the apparent lack of collaboration between the Integrated Care Pilot Project in the West and Government Technology Services and remains concerned, following representation from the Economic Policy Review Committee, that this issue appears not to have been addressed some months after being highlighted. The Review considers it vital that parties work together to ensure the maximum progress and benefits for the user are achieved on projects which rely on the use of technology.
The Review considers the approach currently being taken to make best use of the existing assets and to avoid technological “lock-in” to individual suppliers’ solutions appropriate for the Island but should be kept under review.

However, technology systems are perceived by users as inhibitors to change rather than enablers of it. This results in users working around the deployed system with little understanding of the impact that may have on the capture of data which others may need for planning and quality management. This siloed approach will take time to remove, but the integration of systems and services, greater joint working, high quality training and support and a rigorous and structured approach to implementation of new or updated services remains critical.

Within the current service model, there is a lack of accurate, comprehensive and timely operational data relating to activity, cost and quality across the system. Whilst there are some pockets of good practice, these are in the minority. Making informed, timely and accurate decisions as to the quality, efficiency and cost of health and care services on the Island requires information that is not routinely available at present.

2.4.2 Workforce

The Isle of Man, in common with health and care systems in the developed world, is experiencing a variety of workforce challenges (as outlined in Annex 8), including some which are common to smaller, geographically remote systems.

The Review has been made aware of certain gaps in the current workforce (including advanced nursing roles, physician associates and liaison psychiatry), creating longer waiting lists and de-skilling due to centralisation of some services (e.g. diabetic care where service delivery is highly focused on specialists).

The available data indicates that 2,452 staff worked in the DHSC as at 31 August 2018, but that the DHSC additionally had 516 vacant posts (a vacancy rate of 17%). The Review understands this data may not be completely accurate, but a new electronic Human Resource (HR) and Payroll system for the whole of Isle of Man Government (People Information Programme) is in the process of being deployed. In addition, these figures do not include others who provide health and care services that are not directly employed by the DHSC, such as those in primary care, third sector and tertiary centres or carers.

The most recent comprehensive survey of the DHSC workforce[xii] highlights that the majority of its staff are committed to delivering a good customer service and work beyond what is required to help the Department achieve its objectives. However, these staff also report that they do not feel encouraged to improve ways of working, that change is managed well or that the DHSC cares about their health and wellbeing.

In addition, throughout the Review, a number of concerns have been raised about negative and protectionist elements within the current culture of the Isle of Man health and care system. These challenges and an apparent lack of positive culture combine to suggest that the current workforce model may be unsustainable in the long-term.

2.4.3 Culture

It has been suggested to the Review that the culture on the Isle of Man has deep-seated reservations about, and resistance to, change. Whilst this could be argued to be outside of the Review's Terms of Reference, the importance of culture should be commented upon given its significance in any successful transformational change programme.

Currently and specifically, in health and care, there seems to be consensus around a culture rife with strategic visions and objectives, but with scant success in implementing planned or envisaged changes. There was no consensus as to whether this was due mainly to a lack of genuine belief in, and commitment to, the need for change, or rather due to a gap in the capacity and capability for driving and implementing change.

A number of other observations were made, including that:

- there is something about the health and care system on the Island that drives a culture where the service user is not at the centre – this is highly concerning and should change.
- there is a systemic lack of communication between the DHSC and the wider system, as well as within and between all health and care agencies and organisations within the system, and with the wider population, service users and carers. The people the Review spoke to called for more openness, transparency and dialogue, as well as clearer messaging.
- there is not an embedded culture of continuous improvement; rather, a tacit acceptance of mediocrity or even failure.

- the delivery of aspects of health and care and politics can become intertwined on the Isle of Man, with the associated risk of political interference with clinical decision-making.

A consistent theme of discussion throughout the Review is that staff at the front line feel disengaged and demotivated because they are not given the opportunity to influence how the services they provide are delivered. Engaging front-line staff and empowering them to improve services is critical to the quality of care and the user experience.

3. Principles of Health and Care

The Review's Terms of Reference encouraged radical thinking. Indeed, they went so far as to ask whether the principle of services being largely free of charge is still valid. This Report is not suggesting any changes in fundamental principles. The Review recognises the motion passed by Tynwald on 20 March 2018, which said:

"That Tynwald endorses and affirms the seven modern day core principles of the NHS [National Health Service]:

- *The NHS provides a comprehensive service, available to all;*
- *Access to NHS services is based on clinical need, not an individual's ability to pay;*
- *The NHS aspires to the highest standards of excellence and professionalism;*
- *The NHS aspires to put patients at the heart of everything it does;*
- *The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;*
- *The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources;*
- *The NHS is accountable to the public, communities and patients that it serves."*

The Review has taken these principles as given and has extended them to ensure that the values that have been clearly stated for health services should also apply in social care. In line with the original principles of the NHS, health care should remain available and provided on the basis of need and not the ability to pay. The same principle should apply to the provision of some aspects of social care in the service user's home. The appropriate use of co-payment and fair means testing in the provision of health and care services is compatible with the founding principles of the NHS and should remain available to support the funding of high-quality services to the population.

The Review has also adopted an additional principle, based on the DHSC's current vision and strategy, that health and care services, wherever possible, should be delivered on the Island and close to a person's home. They should be provided centrally only when clinically necessary (whether in an Isle of Man facility or off-Island).

4. Case for Change

The Review has heard very clearly about the sort of health and care system that people on the Island say they need, which is very much in line with the principles set out above. It is based on five key aspects:

- High quality, efficient services;
- Best value;
- Delivered as locally as appropriate;
- Timely provision of services, which are both accessible and integrated with other aspects of the system; and
- Sustainable, both financially and clinically.

This is achievable for all those who live on the Isle of Man and use its health and care services.

The Island already possesses several of the components required to deliver its vision of a high-quality, small-island, health and care system. It benefits from:

- A supportive population– who are ready to back credible reform;
- A highly skilled health and care workforce – who also bring skills and experience from other health and care systems – many of whom are desperate for change to enable them to deliver improved services;
- Some good elements of infrastructure – both in terms of estates and information technology;
- A supportive third sector; and
- A strong, stable economy.

However, these benefits cannot yet be leveraged fully as there are a number of barriers, mostly inherent to the current model of care, including:

- A hospital-centric model of care – which results in underinvestment in other service areas;
- Inadequate governance – which is needed to ensure that the system is operating within appropriate limits;
- A lack of sufficient and experienced transformational change leadership across many aspects of the health and care system, combined with a lack of committed follow-through on significant change initiatives;
- A culture which does not always place the service user first or at the centre of service planning and provision, leading to siloed delivery of care and working practices which are more difficult to change;
- Funding that is significant, but cannot be shown to provide the best value services; and
- A lack of communication within health and care services, between the providers of those services and the end users.

A modern model of integrated health and care services is now required.

Communication among providers and with the public should be open, transparent and frequent. As the service moves more closely towards full integration, staff, service users and carers should be kept informed about the changes and encouraged to share learnings and experiences.

The Review found the Island needs increased emphasis on health and well-being to improve the quality of people's lives and delay their need for access to health and care services for longer.

Care services should be delivered to an agreed high standard based on professional best practice, within an increased funding envelope and an annual efficiency target.

Services should be planned and delivered based on proven evidence of need. They should be well defined, integrated and measured, irrespective of where the journey through the health and care system begins or ends.

An enhanced, well-defined set of primary and community services should be available, with skilled staff and adequate funds, able increasingly to deliver services out of the hospital and in the community.

Health and care services should make best use of the available skills on the Island and allow clinicians and other health and care professionals to deliver the maximum range of services applicable to their skill set.

Emergency health services should be enhanced further by the provision of improved air links that provide immediate access to a small number of specialist centres where the provision of care applicable to patient's urgent needs can be best provided (except in exceptional circumstances such as the most adverse weather conditions).

These changes will be underpinned by a fully delivered Digital Strategy, which exploits the current investment in technology services. There should be ubiquitous access, for those who have the right of access, to information which will help in the delivery of care, and systems which reduce travel for follow up appointments.

Costs and outcomes should be linked and measured; and the complete relevant information should be made available regularly to managers, clinicians, service users and those charged with making policy decisions. This will allow for the most informed decisions to be made.

There should be regular, empowered inspection of services, with an aim to maintain and further drive up standards. Where failings are identified, there should be an agreed improvement plan put in place with a timetable for it to be implemented and re-inspection within a short period to confirm that appropriate remedial action has been undertaken.

5. Creating a Financially and Clinically Sustainable Health and Care System

This section sets out the intended model of health and care that the Review has designed to enable the delivery of a financially and clinically sustainable system. The Isle of Man is well placed to become an exemplar for what a truly integrated health and care system could look like, with all the associated benefits for its people. The intended model (unless specified) is relevant to all aspects of an integrated system, i.e. it applies equally to health care as much as social care, mental health as much as physical health and wellness and prevention as much as treatment and cure, and to all users, whether they are a baby, child, young person, adult or older person. The first step is to ensure an absolute commitment that patients and service users always come first.

Recommendation 1:
The Council of Ministers should formally adopt the principle that patients and service users are fully engaged in, and at the centre of, all aspects of planning and delivery of health and social care services.

The adoption of this principle will require a series of steps to ensure that service users are better considered, while policy and service models are developed in more detail. This work should include strengthened service user representation in all aspects of policy making and a clear, proactive communication programme with service users, wider stakeholders and the public as a whole.

5.1 New Governance Model

An effective governance structure is a fundamental requirement for any organisation, but particularly for those funded by, and providing services, to the public. Governance describes how organisations run themselves efficiently and effectively, with accountability to the people and stakeholders that they serve, for the work they do and the decisions they take. Good governance is essential to an organisation's responsible handling of public funds and its effective monitoring and management of risk. It also ensures that an organisation meets its legal and regulatory requirements.

In health in particular, a distinction is made between general organisational or corporate governance (which is concerned with how an organisation is led, directed and controlled) and clinical governance (which is concerned specifically with ensuring that standards of care are being met and quality continuously being improved by the establishment of clear lines of accountability and authority). Increasingly across the industrialised world, where the development of integrated care is driving transformation, there is also focus on system governance: the framework, rules and policies which ensure that a health and care system as a whole delivers high quality care, fair access to services, and value for money for the taxpayer.

All these areas of governance are critical for the Isle of Man, as it seeks to implement a vision of high quality, integrated care for its population.

At present, the DHSC sets the policy on health and care on the Island as well as taking responsibility for delivering and/or contracting others to deliver that care. There is a big advantage to be gained from freeing health and care providers to focus exclusively on the delivery of high quality, integrated care, based on clinical need, as opposed to any undue, external influence. This would enable them to provide the best possible care to individuals and also to take a longer-term, population health management perspective. The creation of a single delivery organisation would serve to bring a range of providers together, delivering care on the Island wherever appropriate with a focus on people and their care, and on making that care as cohesive, joined-up and accessible as possible.

Freeing the officers of the DHSC to focus on strategic policy, regulation, overall finances and supporting the Minister and Members would allow greater analysis of data, trends and the opportunity for more insightful policy development. If policymakers become too involved in operational matters, it is almost certain to lead them to concentrating on apparently urgent day-to-day business at the expense of the really important strategic decisions. Improved governance would allow the DHSC to focus on those high-level areas where it can add most value.

The DHSC would set priorities in an annual mandate to the delivery organisation, which would be held accountable for the expenditure and outcomes achieved. The delivery organisation would, in effect, be a 'prime contractor' in that it would hold a contract with the Department to deliver a set of services. It would deliver some services itself and, where appropriate, sub-contract delivery of others to a small number of other providers, with the same standard of care and outcomes required of them.

Recommendation 2:

The setting of priorities and the development of policy in both health and social care should be separate from the delivery of services. A comprehensive governance and accountability framework should be established aligned to agreed standards and underpinned, where necessary, by legislation. A single public sector organisation, perhaps to be known as "Manx Care", should be responsible for the delivery and/or commissioning from other providers of all required health and care services.

Manx Care should be set up as an arm's length body (perhaps a Statutory Board) and run by a Board appointed by Government and approved by Tynwald. However, importantly, it should be operationally independent of both Government and Tynwald.

Manx Care should deliver services, outcomes and efficiencies against a formal clear mandate set by the DHSC, within a funding envelope agreed with the DHSC and Treasury.

Manx Care would oversee the direct provision of services from its own resources, as well as collaboratively plan and purchase other necessary services from providers based on and off Island, including from the third sector and private sector.

Importantly, this approach differs from the current model in England whereby the commissioning and delivery of services are still separated by primary legislation. The NHS in England is now moving in the direction of bridging the gap between commissioning and provision to enable effective population health management and integrated care.

The recommendation is similar to that made the earlier Beamans[xiii] report and accepted by the Isle of Man Government, which suggested that Noble's Hospital be run at arm's length from the Government. Whilst the previous recommendation was not implemented, it is clear that the underlying reasons for it still stand and that it should apply more widely than the hospital only. Given the current situation, as outlined in section 2, many of the same issues are yet to be addressed and benefits of the separation are yet to be realised. The benefits cited that also apply to this recommendation include:

- Need for a structure that provides clarity on who is responsible and accountable for the provision of care;
- Need for the DHSC to adopt a more strategic (and less operational) role;
- Need for senior management to focus on service developments and enhancing levels of quality as opposed to day-to-day management issues; and
- Need for more leadership attention to strategic and operational planning and performance management.

As also outlined in section 2 and given the vision to achieve an integrated health and care system on the Island, it is imperative that Manx Care incorporates all aspects of delivery of health and care services on the Island. This means that its responsibilities should include those services delivered or commissioned by each of the current DHSC Directorates that deliver services – namely the Community Care Directorate (which includes adult social care, community health, mental health and primary care), the Children and Families Directorate and the Hospitals Directorate.

Manx Care should be led by a team that has experience in all aspects of health and care with appropriately skilled and proven resources, which can provide strategic, managerial and operational capabilities to deliver the mandate during a period of substantial change.

The DHSC should ensure that it is suitably staffed to deliver its responsibility as a Government Department including matters of policy, legislation, finances and oversight of Manx Care's delivery of the agreed mandate.

Figures 3 and 4 below illustrate how the separation of responsibilities, currently owned by the DHSC, will be achieved in the future, working with wider Government and reporting to Tynwald. An outline of the potential Manx Care Board is contained in Annex 10.

Figure 3: Position of Manx Care and DHSC in respect of the Isle of Man Government and Tynwald

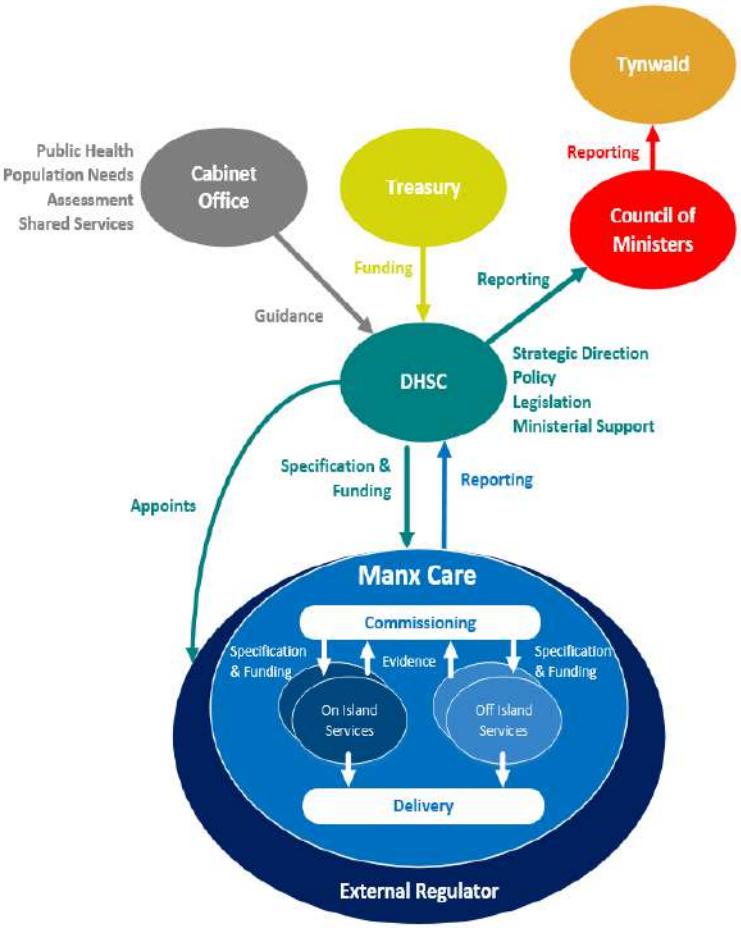


Figure 4: Summary of separation of responsibilities between Minister/Members, DHSC officers and Manx Care

Minister/Members	Department Officers	Manx Care
• Overall Policy Direction (with attention to public health advice) • Health and Care needs for the Island (with attention to public health advice) • Responsible to Tynwald for health and care Service on the Island • Appoints the Chair of Board of Manx Care	• Support for Minister and Members • Liaison with other Government Departments • Policy Development • Registration and Inspection[xiv] (including appointment of external inspection – see recommendation 3) • Creation of annual mandate • Agreement with Treasury and Manx Care of funding envelope • Maintenance and development of health and care legislation • Defining the agreed data set to be captured • Monitoring delivery of the annual mandate (including finances, quality, activity etc.)	• Delivers the overall mandate of health and social care required by the DHSC • Delivery of health and social care services (as currently delivered by or commissioned through the Community Care, Children and Families and Hospitals Directorates) • Delivery or commissioning of reconfigured primary care • Commissioning from, and management of, other providers of health and social care services (on and off island, including the private and third sector) of services Manx Care cannot provide itself • Development and management of integrated care pathways and services • Development and collection of data sets

Recommendation 3:
Services provided directly or indirectly by Manx Care should be inspected regularly by independent, external quality regulators, with a report to the Manx Care Board and to the DHSC.

Regulation of health and care services serves to protect the public from harm; provide confidence in the quality of services; promote good practice and education; and support a culture of continuous improvement. It can also serve to acknowledge good performance and ensure good practice is adhered to by every person involved in the system. It is an essential element of a modern health and care system.

The recommendation calls for independent regulation, akin to England's Care Quality Commission (CQC), to assess the quality of health and social care services against the agreed defined standards, provide assurance, require the enforcement of its recommendations and support a systematic approach to continuous improvement. There does not seem to be a single regulator that covers all areas of health and care providers available to the Isle of Man. As a result, it may be that the Island will need to contract with more than one regulator to provide the necessary comprehensive inspection regime.

In the event of failures being identified in the regulator's report, timescales to remedy should be agreed between Manx Care and the DHSC and subsequent re-inspection commissioned. Appropriate sanctions should be available to the DHSC in the event of a failure by Manx Care to improve poor services.

Recommendation 4:
A publicly available Annual Report from Manx Care should be provided to the DHSC and subsequently presented to Tynwald, summarising the delivery of the health and care services on the Island.

The recommendation calls for a report, produced annually, which would provide transparency on a variety of measures including, but not limited to, performance against the provided mandate and the range, quality, productivity and cost-effectiveness of services provided (directly or indirectly) by Manx Care. This will enable greater transparency concerning how public funds are being used by providers and the outcomes that are being achieved.

Recommendation 5:
A statutory duty of care (applicable to organisations and the individuals who deliver health or care services) should be agreed, implemented and maintained alongside the delivery of high value clinical governance, underpinned by legislation where necessary. The new statutory duty of care would include:

- ***A duty of confidentiality;***
- ***A duty to share information where appropriate to enable the delivery of safe optimal care; and***
- ***A duty of candour – a responsibility to disclose where breaches of safety standards or harm to individuals have occurred.***

All of the above apply in the NHS in England following legislation that was passed in 2008, 2012, 2014 and 2015 and building on existing legal precedent. Most recently the duty to share was introduced as a statutory obligation placed on the providers and commissioners of care in the Health and Social Care (Safety and Quality) Act 2015. On the Isle of Man, the duty of care would apply to all health and social care staff including those in agency or temporary roles and students/trainees and volunteers. From a patient or service user perspective, the duty of care should exist from the moment a decision is made to provide a health or care service.

The statutory duty of care would provide a basis for clinicians to be held to account for the care they provide. In the late 1990s, in response to the failure of governance in the Bristol paediatric cardiac surgery programme, the UK Government enacted a piece of seminal legislation that embedded the concept of clinical governance in the NHS. As a result, healthcare provider organisations were made legally accountable for the quality of the clinical care provided by their staff, rather than just for the finances of the organisation. Through the same legislation, clinicians were made directly accountable to their employing organisation for the quality of the care provided. For the Isle of Man, the introduction of enhanced clinical governance underpinned by a statutory duty of care is essential in ensuring the service user can have confidence in the care provided.

Recommendation 6:
The Council of Ministers should mandate the DHSC, Treasury and the Cabinet Office to ensure implementation of the agreed Transformation Programme of health and care services as set out in this Report, led by the Chief Secretary.

The Transformation Programme required to implement the recommendations of this Review, if accepted, should be co-owned by the relevant Isle of Man Government Departments to ensure suitable oversight from the key parties. The Departments should be held to account by the Council of Ministers for ensuring delivery of the Transformation Programme.

This approach should help ensure that the momentum of the necessary change programme is maintained and that the day-to-day delivery of services to citizens during the implementation period can continue.

Recommendation 7:
The Council of Ministers should receive a quarterly progress report on the Transformation Programme to understand the progress made and to identify any significant issues which need resolution. In addition, it is suggested that Tynwald should also receive an annual report on progress of the Transformation Programme.

In order to ensure delivery of the Transformation Programme, the Council of Ministers, Tynwald and, indeed, the people of the Isle of Man need to be able to hold those responsible to account. The recommended progress reports should be appropriate for the audience and include an overview of the progress achieved in delivering the transformation programme in addition to highlighting issues in order for them to be addressed.

Recommendation 8:
Primary and/or secondary legislation should be introduced as required, and included in the legislative programme as soon as possible, in order to form a modern, comprehensive legislative framework. This legislation should address weaknesses or gaps in the current system as well as enabling the implementation of the recommendations contained in this Report, such as any necessary legislation to establish Manx Care.

Legislation should be reviewed regularly and updated as necessary to ensure that it remains up to date and provides the necessary framework within which to develop and maintain a modern, high quality and efficient health and care system, including transparency and accountability for the people working in services, those using services and the wider public.

The Review has identified a number of areas where there are gaps in the law necessary to underpin a safe and responsible health and care service for the Isle of Man, for example around clinical governance and prescribing.

In addition, some of the recommendations outlined in this Report will require legislative changes to enable implementation, for example, new primary legislation will be required to establish “Manx Care” and amendments to legislation may be required following the decision on how to fund the increasing cost of the health and care service in the future.

An illustrative list of some of the recommended legislative reform is included at Annex 11. Given the volume of change required, it may be prudent for the Isle of Man Government to consider allocating suitable resource in order to replace the National Health Service Act 2001, the National Health and Care Service Act 2016 and the Regulation of Care Act 2013 with a new, modern and comprehensive Health and Care Act, incorporating the majority of the necessary changes.

The Review recognises that some of the issues raised in this Report are scheduled to be addressed, e.g. updates to prescribing and child and young person’s legislation have been considered and are already on the Government’s legislative programme. Other actions are pending, e.g. enactment of legislation for the protection of those with learning or physical disabilities through the Equality Act 2017, or would need to be considered and progressed separately, e.g. the basis for determining capacity and deprivation of liberty. All need to be in place in order to form a suitable legal framework.

5.2 New Service Model

The new approach to services outlined is intended to ensure that, in addition to the service user being at the centre of all planning and delivery of care, the care received is consistent with the principles identified in this Report and that the needs of the population are fully understood and planned for.

Furthermore, appropriate actions taken now will reduce the demands on the health and care system in the future. It is pivotal, therefore, that for the longer-term sustainability of the health and care system in the future that health and well-being is embedded within the system at every opportunity. The preventative steps that can and should be taken now on areas such as smoking, drugs, alcohol and fitness, amongst others, will reap significant rewards both for individuals and in lowering the demand and costs in the future for the health and care services.

It is for this reason that greater emphasis will need to be placed on health and well-being of the population, so that people stay well for longer with less need. This will require health to be considered across Government policy-making and that those charged with providing expert guidance on Public Health matters are placed at the centre of Government.

Recommendation 9:
The Public Health Directorate should be empowered to provide advice and guidance across Government, not solely to the DHSC. It should promote and co-ordinate health and wellbeing across the Island to help improve the quality of life and reduce the demand on health and care services in the future. All Departments should be required to factor public health guidance into policy setting and legislation. In order to facilitate this, the Public Health Directorate should be moved to a position in the Cabinet Office.

There are many wider determinants and influences on health and care and so it is more than those delivering, or managing/leading, health and care services who have a role to play in the health and well-being of the people of the Isle of Man. Those wider determinants include, but are not limited to:

- housing;
- education;
- sport;
- employment/economy;
- transport; and
- policing.

It is important that those wider determinants are understood and managed in order to improve health and well-being, both for the obvious benefit to the people of the Isle of Man and for easing current or future pressures on the health and care system.

The Public Health Directorate is a key function in assessing and helping to manage those wider determinants and so it needs to be able to work closely with other Government Departments and non-Government bodies so that it can inform policy in those areas. At present, the Review understands that Public Health faces some challenges in this regard, including obtaining data from those areas in order to assess need and consistent and comprehensive oversight/influence on relevant policies. These challenges should be overcome in order to improve the health and wellbeing of the population of the Isle of Man.

Therefore, means by which the Public Health Directorate can increase its influence and involvement in other areas of Government (as well as continuing its involvement in health and care) need to be considered. The Review considered whether this directorate should become an arm's length body, sepa-

rate from the Government departments that it needs to influence. However, in a small administration such separation does not seem appropriate. The Review therefore recommends that the Public Health Directorate should move into the Cabinet Office, where it would sit more centrally within Government alongside other shared and cross Government services and report to the Chief Secretary, who has responsibility for leading the entire Public Service and advising the Chief Minister and Council of Ministers.

Recommendation 10:
An on-going health and care needs assessment programme for the Isle of Man should be established and funded without delay. It is not possible to develop meaningful service delivery models and plans without establishing the current and future needs for health and care through this assessment. Many other recommendations in this report are predicated on the assumption that this programme will be established. The Public Health Directorate should be resourced to undertake the health and care needs assessment programme.

In the same way that a patient is assessed by a clinician for the totality of their potential needs, the same is true for the assessment of the needs of a population. An understanding of those needs is essential to the effective planning and purchasing of services and distributing health and care services in a way that will provide the greatest benefit. For these reasons a needs assessment is an essential step in defining the new service model.

Needs assessments can be undertaken at system, service or locality level. Current issues around the availability of data suggest that a service focused needs assessment (focused on care pathways) may be the best option in the short-term. The outputs expected are an understanding of:

- the level of need for health and care services;
- the amount of need that is currently unmet; and
- the pattern of supply.

Recommendation 11:
A service-by-service review of health and care provision, in conjunction with the needs assessment and an analysis of care pathway design, should be undertaken to establish what services can, should or must be provided on and off-Island, against defined standards. Where services cannot be provided safely or deliver best value by Island-based providers, the default position should be to seek services from third parties for delivery on-Island whenever possible and off-Island where necessary.

The service-by-service review will be an assessment of the capacity, capability, coverage and quality of services available. It will require an examination of all health and care services funded by the Government, irrespective of the setting (e.g. community) or location (on or off-Island) of delivery. The aim is to provide an understanding of the supply of health and care services under the current service model and determine where and by whom they are best delivered. The Review accepts there are a number of different considerations which impact decisions made about where services should and can be provided. On an Island with a population of 85,000, the capability of health and care services is inevitably limited, but clearly people's needs should be met.

There are well established guidelines around the volume of clinical procedures which a skilled clinician should perform annually, to both maintain professional competence and current knowledge and to ensure the services provided are clinically safe. It is for these reasons that, elsewhere, specialist services are often provided at centres of excellence, rather than at all locations.

As a result of a limited pool of potential need for each service on the Island, decisions have to be taken about how those services can be best provided. It is already acknowledged that some form of off-Island specialist hospital partnerships can support a more clinically and financially sustainable range of services, including the provision of certain services on-Island, by the partner hospital(s). Other important considerations include best value and public expectations. All of these factors need to be taken into account in determining how services are best provided.

Recommendation 12:
Service by service integrated care pathways should be designed, agreed and delivered. These should encompass both on and off-Island components of clinical service models.

The recommendation calls for the development of truly integrated care pathways for service users. There are a number of definitions of Integrated Care Pathways (ICPs) in operation internationally. For the purpose of this Review, ICPs are defined as an anticipatory plan of a person's journey through the health and care system (across and between settings of care). ICPs should span all service groups and should include services that are delivered both on- and off-Island.

At each point in the journey, the provider(s) accountable for the service user should be clear. At certain points in time multiple providers will have joint accountability. ICPs are effective in managing expectations, determining the contribution of individual partners and in enabling targeted quality improvement.

The creation of ICPs should involve all relevant clinicians/experts and should also incorporate the setting of quality standards, the establishment of performance management and the funding of effective shared care arrangements.

The Review noted that some work has started within the Public Health Directorate to lead the development of such pathways, which is to be welcomed and supported.

Recommendation 13:
Manx Care should deliver an enhanced 24/7 emergency air bridge, allowing for patients to be stabilised locally and moved quickly and safely to contracted specialist centres.

The emergency air bridge is a modern solution (potentially using helicopters, fixed wing aircraft or both), with comprehensive in-flight emergency and critical care facilities, aimed at transferring emergency activity to other specialist centres. Its aim is to provide a reliable, faster and more comprehensive service than is currently in place in order to ensure access to timely and high quality, specialist emergency care.

Enhanced emergency air transfer to off-Island specialist centres would enable highly specialised care that cannot be delivered safely on the Island to be available as part of an integrated clinical pathway between services on and off the Island.

The current rather slow transport arrangement can result in delayed emergency treatment and risks increased morbidity and indeed mortality. Rapid availability of emergency specialist care from off-Island providers would reduce the need for such services to form part of the portfolio of services provided on the Island (which is highlighted above and supports the need to ensure the highest quality provision of care). The previously mentioned off-Island specialist hospital partnerships could include the provision of highly specialised emergency care.

A full business case will need to examine options for enhanced air transfer provision including opportunities to utilise existing services (whether on or off-Island) to ensure that the investment necessary can be optimised to meet the needs of the Island. Note that such provision of an enhanced service will enable a greater range of urgent care to be treated more quickly at specialist centres and therefore consideration of this increased volume will need to be modelled as part of the business case created.

The availability of an enhanced 24/7 emergency air bridge would have a significant impact on the options available for service delivery models and so should be taken into account in all service by service reviews.

Recommendation 14:
A single, integrated out-of-hours service should be established to provide care in an efficient and appropriate manner outside normal working hours.

In order to provide care out of hours that is consistent with the principles identified in this Report, a more integrated service is required. The Review understands that the DHSC is looking at integrated urgent care and so this recommendation should be considered alongside that existing work. The new out-of-hours service should include a frontline telephone/online triage so that the service users can be directed to the most appropriate service for reassurance or care, which will also help ensure that certain services, such as Accident and Emergency, are not perceived to be a 'default' service. The professional groups that should be involved in the out-of-hours service include, but are not limited to:

- Primary care, including General Practitioners, nurses, pharmacists;
- Community care, including allied health professionals;
- Mental health practitioners;
- Social care staff; and
- Accident and Emergency staff, including Ambulance Services and enhanced air bridge services.

Recommendation 15:
The Isle of Man should establish a model for delivering primary care at scale, since further and deeper collaboration within primary care is necessary to deliver current services and provide additional local services.

This approach would allow for a range of service improvements and benefits, for those working within the service and those who rely upon it. This includes:

- standardisation of clinical treatment;
- opportunities to improve and enhance back office functions and patient facing services;
- the provision of a greater number of services in some locations;
- increased flexibility of access to services;
- sharing of specialist resources;
- increased clinical resilience during periods of absence; and
- broader mutual professional support.

Recently there have been some initial steps towards this goal with the establishment of the Community Care Contractors Advisory Group, which brings together, GPs, dentists, pharmacists and opticians. Furthermore, there has been some early work in establishing an Isle of Man GP Alliance. This is a welcome move forward acknowledging that the current model which exists within general practice is unsustainable.

There are three likely ways forward for general practice, each of which would enable increased flexibility regarding the locations of where services are best provided. These are:

a) GP alliances, also known as federations, networks, collaborations or joint ventures, are collaborative entities that enable the delivery of services across member practices, without a formal merger. In recent years the development of these groups of practices has been supported by the Royal College of General Practitioners and the British Medical Association. Networked arrangements of GPs should all be commissioned by Manx Care.
b) A single Island-wide primary care organisation could be established and contracted by Manx Care to deliver the services required.
c) A fully salaried GP service run by Manx Care could be established.

The particular model selected will require further engagement with the GPs and others on the Island. In all cases, enhanced collaboration in some form will improve resilience and sustainability. It will provide more opportunities to share learning and resource, improve efficiency and standardise care.

Recommendation 16

The provision of social care should be considered as part of the current review of future funding of nursing and residential care with the intention of removing disincentives to people requiring care and support remaining in their home. This consideration should specifically include equalisation of the current threshold of financial assistance, a more flexible approach to funding to enable joint commissioning of broader care arrangements in the interests of the service user and provision of 24/7 social care access.

As outlined earlier in this Report, the recommendations apply equally to social care as they do to health. However, the Review has been made aware of a number of issues specific to social care, which warrant particular attention.

The Review is aware of the separate review into future funding of nursing and residential care. The Review was often advised that the financial disincentives within the system drive behaviours which may not always be in the service users' best interests. The primary concern in addressing the issues highlighted in Section 2 of this Report is for the individual who may, if support were provided in their own home, prefer to stay there for longer, which would increase user satisfaction and decrease costs. It is suggested that this issue should be added to the terms of reference of the existing review or examined as a follow-on.

Similarly, comments were made to the Review regarding limited joint working between different parts of the health and care system and wider agencies and partners, due in part to the parochial view of who owns the specific budgets, rather than what is required to deliver for the individual. Delivery of integrated care relies upon joint working, and where necessary joint funding, in clear and accountable ways between all those involved in the care of an individual. Some limited progress has been made, but a strategic approach to building and funding jointly commissioned service provision is required.

The Review considers that all-hours access to emergency social care provision (likely on an on-call basis) is essential to ensure vulnerable people can have access to the care required, without having to rely on the goodwill or friends and relatives, as they do currently during certain hours and weekends.

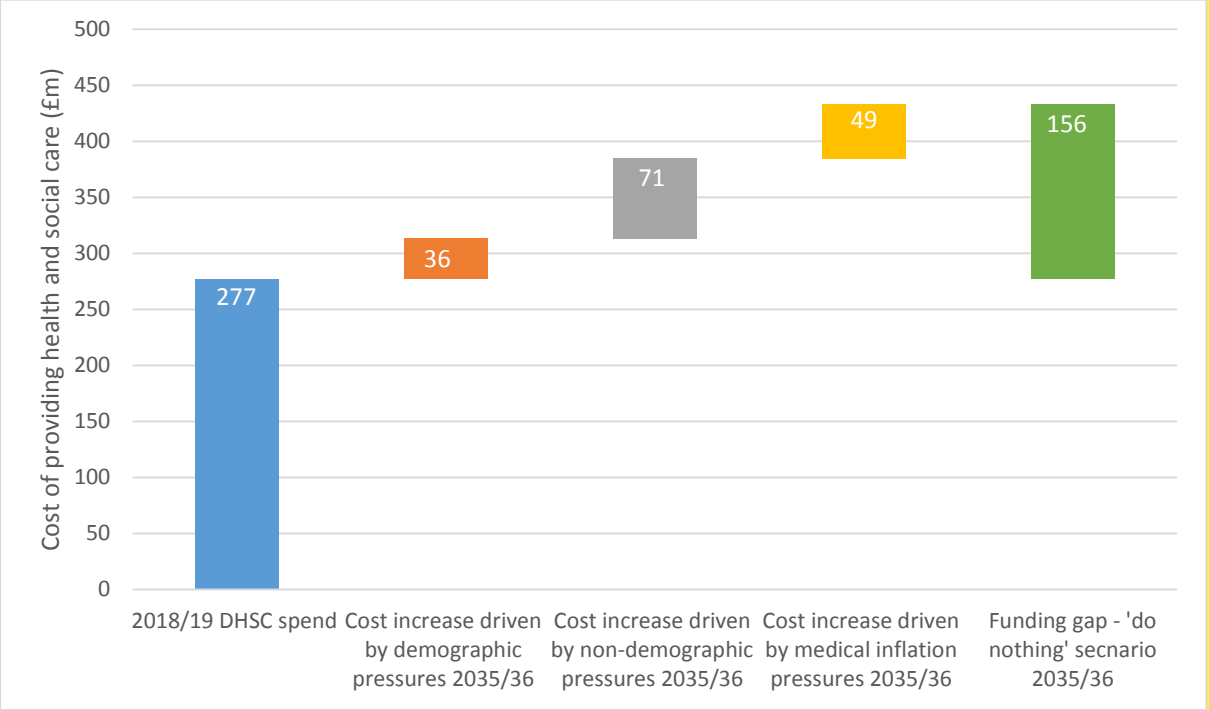
5.3 New Funding Model

The scale of the financial challenge facing health and care on the Isle of Man can be measured by calculating the annual "funding gap". That is the amount the health and care budget would have to grow to deliver the same range of high-quality services. A projected annual increase averaging 2.66% in real terms would be required to fund future services, which is a result of:

- 0.62% annual average growth from demographic pressures;
- 1.21% annual average growth from non-demographic pressures; and
- 0.83% annual average growth in healthcare-specific price pressures above Consumer Price Index (CPI) inflation.[xv]

The 2.66% average annual increase equates to an average additional funding gap of £9.2m each year (in real terms). By 2035/36 that would build up into a total funding gap of £156.0m.

Figure 5: Future health and care spend estimates – a 'no change' scenario



Given this forecast funding gap, it is essential to increase the efficiency of the ways services are delivered. Improving the efficiency of the current system is critical, particularly if more funding is requested from the public, directly or indirectly. However, it is inevitable that additional funding will be required to deliver the agreed transformation programme and support the implementation of the efficiencies outlined in this Report. Further detail on the work undertaken for this section is available in Annex 12.

Recommendation 17:
Increased funding should be linked to the achievement of annual efficiency targets.

The recommendation calls for increased funding for Manx Care to be linked to efficiency targets. It should also be underpinned by the health and care needs assessment, defined efficiency targets included in the mandate set by the DHSC and reports from the external quality regulators.

Evidence of progress against the targets should be outlined in the annual report to the DHSC. These targets would cover a range of areas relating to services provided (directly or indirectly) by Manx Care.

Improving the efficiency of the current system is critical, particularly if more funding into the DHSC is requested from either the public or the Treasury. Indeed, during the public engagement, a number of those involved relayed their views that the current health and care system was inefficient.

Although limited, the qualitative data available has indicated consistently that the current system is inefficient and that there are many opportunities to improve value for money (including reducing spend on agency staff and improving efficiency of theatre utilisation). Good value services are a cornerstone of the DHSC's vision.

The Review looked at how big an annual efficiencies target would be appropriate to provide greater financial sustainability and concluded that a 1% target should be the standard measure, reviewed annually. Efficiency gains of 1%[xvi] a year of the full costs of delivering health and care would still leave an additional funding gap of approximately £120m by 2035/36.

The DHSC has been given cost improvement targets in the past. For example, in 2017/18 and 2018/19 it was asked by Treasury to find £10m and £7m respectively. However, it struggled to meet these – as mentioned earlier, the DHSC tends to overspend its budget.

A 1% annual efficiencies target should be both achievable (given the opportunity on the Isle of Man and targets set and achieved by other health and care systems) and impactful without having a negative effect on the quality or availability of services. Instead, efficiencies should be identified that would in fact benefit the service user and adequate controls should ensure that their introduction is not detrimental to the quality or availability of services or the Transformational Programme.

In order to identify a series of suitable initiatives to achieve this efficiencies target, an implementation planning period would be required, including, where appropriate detailed businesses cases for each initiative suggested. The Review has, however, compiled an indicative list of efficiency initiatives (below) as well as an extended list of efficiencies for which good evidence of efficacy exists but require further modelling (see Annex 12 (D6)). These efficiencies are a combination of 'operational' (reducing 'waste', and 'doing things better'), and 'transactional' (reducing costs for a given output). The Review has also identified a range of transformational efficiencies (transforming care to make it more person centred and delivered closer to home where possible), which are detailed in Annex 12 (D3), although these in themselves would be unlikely to lead to cost reductions or efficiencies.

Figure 6: Examples of efficiency initiatives and their impact

Theme	Initiative	Annual forecast change in activity once implemented	Annual forecast gross saving in year of implementation (£m)	Annual forecast gross saving in year of implementation, assuming year of implementation is 2019/20 (% of forecast "no change" spend)
Operational	Cease 100% of activity related to procedures with limited clinical justification and/or limited clinical effectiveness	458 fewer day cases	£0.34m	0.12%
Operational	Programme to reduce referrals from all GP practices for seven common hospital specialties to the lowest level/practice seen currently in Isle of Man	4,628 fewer outpatient appointments in 2019/20 1.3 extra GP FTE required to deal with rise in community demand	£0.41m	0.14%
Operational	Improve theatre efficiencies in line with external recommendations	N/A	£0.50m - £2.25m	0.17% - 0.77%
Operational	Interventions to reduce delayed transfer of care and length of stay	1,811 fewer excess bed days	£0.63m	0.22%
Transactional	Reducing prescribing costs to match UK's per head costs through improved medicine management and cost controls	N/A	£4.32m	1.48%

The existing Healthcare Transformation Fund should be maintained and be available as now to help support agreed projects (e.g. the Integrated Care Pilot Project in the West) and achieve the efficiency target, including, where appropriate, through "invest to save" initiatives.

Recommendation 18:
Additional transformational funding and dedicated specialist resources, including proven change leadership, are required to deliver the transformational recommendations for them to be implemented successfully.

The principles and recommendations included in this Report will require skilled and specialist resource to implement the necessary Transformation Programme including for the backfill of existing resources who may be involved in delivery of the programme such that key staff can be released to assist and the important work they currently do can continue.

The Review suggests that this additional transformation funding (above that already available annually and mentioned above) is ring-fenced and that an allocation equal to 1.5% of health and care spend for up to five years of implementation (2019/20 to 2024/25) is made available.

This amount would be equivalent to £4.3m in 2019/20. This funding would be used to implement the recommendations set out in this Report and would include, for example, the establishment and running of a team of transformation professionals to lead on the significant change efforts required as

well as funding specific recommended initiatives to improve services (e.g. funding an enhanced air bridge as per recommendation 13).

For clarity, figure 7 below outlines the monetary amount and purpose of funding and efficiencies outlined in recommendations 17 and 18.

Figure 7: Funding, in addition to annual budget, and savings in relation to health and care

	Transformation Project Funding	Transformation Programme Funding	Efficiency Target
Amount	As determined by Treasury (generally up to £5m per annum)	1.5% of budget of DHSC (and Manx Care when established)	Suggested 1% of cost of health and care
Purpose	Existing pot of money (Healthcare Transformation Fund) to pay for agreed transformation projects, which may include projects to help achieve annual efficiency target	Specific funding for the delivery of the recommendations from Sir Jonathan Michael's Report	Annual savings targets to ensure drive towards more efficient service delivery

Recommendation 19:
Increases in funding for health and care services will be required to support the increased demands that will be placed on those services due to demographic changes, non-demographic changes and inflation.

Unless the Isle of Man decides to reduce the range of services offered, it will need to find a sustainable way to meet the remaining funding gap, even after efficiencies are made. This could be achieved in a number of ways including through making changes to the way health and care is funded and/or channeling Treasury income above inflationary rates.

To cover the gap entirely, receipts from existing Treasury income streams (such as general taxation) would have to increase by 2.13% above inflation (i.e. in real terms) year-on-year. This amount is higher than recent growth – from 2006/7 to 2017/18 income tax receipts have grown by approximately 1.2% in real terms year-on-year[xvii] and from 2010/11 to 2017/18 national insurance receipts have grown by approximately 0.7% in real terms year-on-year[xviii]. It would be unwise to rely solely on the possibility of increasing receipts and so the Isle of Man could consider the following options to raise additional funds in order to meet the funding gap in the future[xix].

The Review sets out a wide range of options for closing the funding gap in line with suggestions made in the Review's Terms of Reference, but the course of action will need to be considered alongside other priorities for the Isle of Man Government. The funding options set out in Figure 7 could be used in isolation or in combination to address all or part of the funding gap.

Figure 8: Summary of funding options to close the funding gap

Funding option	Summary description
General taxation	Changes to tax rates or thresholds, e.g. increases to income tax rates or reductions in the income tax personal allowance. Some or all the additional revenue could then be allocated to the DHSC.
National insurance	Rates could be increased, thresholds could be altered, and/or the allocation of national insurance to the DHSC could be increased as a % of the total collected.
Private insurance	Only people earning less than the income tax personal allowance would be eligible for "free at the point of use" health and social care. Others could pay at the point of use and/or pay for private healthcare insurance through an insurer.
Social insurance	All residents could be enrolled in compulsory government-administered insurance. Residents would pay premiums as a % of income, in addition to co-paying a % at point of use, with those earning less than the personal allowance exempt.
Charges	Charges could be levied for hospital outpatient appointments, hospital bed days, hospital meals, GP appointments, attendances at A&E and missed appointments. Current exemptions could be reduced so more people are eligible to pay a fee and more money could be raised from existing social care charges.
Hypothecated tax	An additional tax could be levied on income by increasing general taxation rates, the proceeds of which would be ring-fenced and entirely allocated to the DHSC's budget. This could include lifestyle taxes.
Reallocate funding from other Departments	Budgets of other Government Departments could be reduced and the funding reclaimed could be transferred to the DHSC to close the funding gap.

A number of other funding options were suggested to the Review team as part of the Review's research and engagement. These included means testing all government benefits and more generous tax deductions for people who choose to pay for private insurance. For a full list see Appendix E6. These options were not modelled in detail because the Review agreed that, currently, they would not be the most practical or effective options to close the funding gap. Once changes have been made in line with the Review's recommendations, however, these suggestions may merit further consideration in future.

Figure 9 below summarises the key financial and non-financial implications of implementing the main funding options considered in the Review.

Figure 9: Financial and non-financial implications of funding options by 2035/36

Option	To close £50m gap	To close £100m gap	To close £150m gap	Non-financial implications
Changes to general taxation	*For example, could adjust income tax:* • Lower personal allowance by £2,500 • Raise 10% rate to 13% • Raise 20% rate to 23%	*Assuming diminishing returns after raising rate more than 2%, and no gains after raising rates 5%, means this amount cannot be raised from general taxation alone*	*Assuming diminishing returns after raising rate more than 2%, and no gains after raising rates 5%, means this amount cannot be raised from general taxation alone*	• Affect Isle of Man's tax strategy • Increasing taxation may impact the desirability of the Isle of Man as a place to live and work • Simple to administer
Changes to national insurance	• 4% rise on both employer and employee rate, all proceeds to the DHSC	• 5% rise on both employer and employee rate, all proceeds to the DHSC • 5% rate on people earning under the lower threshold, all proceeds to the DHSC • Double current allocation to the DHSC	• 5% rise on both employer and employee rate, all proceeds to the DHSC • 5% rate on people earning under the lower threshold, all proceeds to the DHSC • 5% rate on people earning over the state pension age, all proceeds to the DHSC • Triple current allocation to the DHSC	• Depletes national insurance fund • Increasing taxation may impact the desirability of the Isle of Man as a place to live and work • Simple to administer • National insurance already considered to be 'for health' by many members of the public
Private insurance	• 16% of people pay for and are covered by private insurance	• 34% of people pay for and are covered by private insurance	• 50% of people pay for and are covered by private insurance	• Reduces accessibility of health and social care • Move away from NHS Model • Complex to administer
Social insurance	• 2.5% premiums on income paid by all earners • 2% co-payment for all service users at point of use	• 5% premiums on income paid by all earners • 2% co-payment for all service users at point of use	• 7% premiums on income paid by all earners • 7% co-payment for all service users at point of use	• Reduces accessibility of health and social care due to gap to co-pay costs • More responsive to need and ability to pay than private insurance

				• Move away from NHS Model • Complex to administer
Extend charges and reduce exemptions	• 25% increases in funding raised from social care charges; £10 charge for hospital meals; £100 charge per GP appointment, outpatient appointment, A&E attendance, hospital bed day, and missed appointment; reduce cost of exemptions to DHSC by 75%[xx]	*Assuming charges of higher than £100 cannot be levied, and that there will always be at least 25% of people unable to pay charges and therefore exempt, this amount cannot be raised from charges alone*	*Assuming charges of higher than £100 cannot be levied, and that there will always be at least 25% of people unable to pay charges and therefore exempt, this amount cannot be raised from charges alone*	• Reduces accessibility of health and care • Move away from NHS Model • Complex to administer
Hypothecated tax	• 2.5% tax on income for all earners	• 5% tax on income for all earners	• 8% tax on income for high earners, 7% for mid and low earners	• Affect Isle of Man's tax strategy • Increasing taxation may impact the desirability of the Isle of Man as a place to live and work • Simple to administer • Well received in public engagements
Reallocate funding from other departments	• 9% reallocation	• 18% reallocation	• 27% reallocation	• May have a negative impact on other vital government services • Simple to administer

As shown in Figure 9 above, each individual funding option in turn requires some very significant changes to be able to raise the sums of money which would be required to close the funding gap. The Review has therefore also modelled three potential scenarios in Figure 10 below which combine some of the funding options. This is not of course an exhaustive list, and in theory any combination of funding options could be implemented, although there would be challenges and opportunities for each. For example, the Republic of Ireland combines taxation, user charges and private insurance to pay for the healthcare needs of the population (a case study on the Republic of Ireland's healthcare funding model is included in Annex 12 (E5)).

Figure 10: Financial and non-financial implications of funding option scenarios combined to close a £100m funding gap in 2035/36

No.	Scenario of combined options	Financial Implications (by end of 2035/36)	Benefits	Challenges
1	Changes to general taxation and charges	• 5% additional on 10% and 20% rates of income tax, all proceeds allocated to DHSC • £100 charges for GP, outpatient and missed appointments, AED attendances and hospital bed days plus £10 charges for hospital meals • Increase funding raised from social care payments by 25% • Reduce current exemption criteria to increase funding raised by existing charges by 75%	• Raises substantial funds without huge changes to existing systems • Changes to general taxation are means-sensitive	• Increasing taxation may impact the desirability of the Isle of Man as a place to live and work • Charges have proved politically sensitive before • Charges are not means-sensitive and may deter people from accessing prevention, which is at odds with service model recommendations
2	Changes to national insurance and introduction of hypothecated tax	• 2% increase on national insurance rates for both employers and employees • 3% hypothecated tax on income for all earners	• Simple to administer • Surveys of public opinion indicate this might be a popular choice • Means-sensitive • Raises substantial funds without huge changes to existing systems • Retains 'free at the point of use'	• May have competitiveness implications • May be perceived as a "double charge" to change both national insurance and hypothecated taxes • Hypothecated taxes can be challenging to ring-fence in practice

			principle	
3	Social insurance and reallocating funding from other departments	• 4% premiums on income for all earners to support social insurance • 4% co-payment for all earners • 3% reallocation from other departments	• Raises substantial funds • Reallocation is simple to administer • Social insurance is means-sensitive and covers both health and social care for all	• A complex and significant change • Potential negative impacts for other determinants of health and wellbeing through reduced funding for other departments
4	Any other combination	• Should be modelled by the Isle of Man before implementation	• Options can be flexibly combined and phased in implementation in whichever way is preferred by the Isle of Man	• Some options when combined do create contradictions (e.g. private insurance and general taxation increases would likely appear to the public as “double paying”)

Recommendation 20:
Funding, based on agreed need, should, over time, move from the current annual budget allocation to a 3-5 years financial settlement for heath and care services for the Island.

Currently, the DHSC proposes business cases for additional budget that, if approved, are included in the Treasury's budget allocation to the DHSC in the following year as additional funding on top of the last year's budget.

The Review proposes that funding should move to a longer-term allocation process in which funding is agreed at regular intervals for the next 3-5 years. 'Predictable funding' is key to enabling those working in health and care to plan and deliver services effectively, especially at a time where efficiency savings and quality improvement are requirements[xxi]. This will be important as health and care services are commissioned from other providers, both on and off the Island, such that they can also plan and invest in the future longer-term delivery of services.

Therefore, it will be key to the longer-term sustainability and improvement of services on the Island for a more predictable, extended financial settlement. It would be helpful for those implementing the transformational changes recommended in this report to know that, in the future, longer term settlements will be provided so that plans and delivery can be made in that context.

5.4 Technology Enabled Transformation and Data

The integration of health and social care on the Island must be underpinned with high quality, future focussed technology. Increased use of, and access to, effective digital systems and reliable, shared information is not just an enabler for this integration; rather it is a critical component.

The current system, as with many health and care systems across the world, has been built incrementally over a number of years. It came together gradually as new solutions became available to meet the needs of separate parts of the health and care system, or as they were replaced when they reached the end of their contract term.

As a result, the current digital infrastructure further embeds a "siloed" delivery system on the Island, with the inherent risk of "trapping" data in a single part of the health and care system. This is not unusual, but it is recognised, including within the Isle of Man, that the appropriate sharing of data is an essential part of enabling the provision of higher quality services.

The Review welcomed the initial steps being taken to seek to address this within the Island, but much more needs to be done, in a structured way, whilst increasing the pace and level of change. As the service is transformed as a result of the implementation of the recommendations proposed in this Report, reliance upon high quality digital systems will increase. Modern digital technology will help enable and sustain the transformation required and therefore it needs to be planned as part of the outlined transformation programme and delivered in time for the operational need.

Whilst some health and care initiatives do have well-structured plans for the use of digital technology, as well as governance and user engagement that are in line with best practice, it is clear that this approach is not always adopted, with the consequence that the intended benefits of initiatives which rely on technology are not fully or at all realised.

Recommendation 21:
Ensure data sharing protocols and arrangements are reviewed, agreed and implemented in accordance with the Information Commissioner's regulations and guidance.

Most digital projects, particularly in health and care, require the capture, storage and sharing of data. The Review met with the Isle of Man's Information Commissioner who requires those responsible for relevant programmes to seek approval for data sharing initiatives as they develop their plans and before implementation.

The Information Commissioner is appointed to act as an independent authority responsible for upholding the public's information rights and promoting and enforcing compliance with the Island's information rights legislation. At a summary level this legislation requires that information is used only in accordance with the following principles:

- Lawfulness, fairness and transparency;
- Purpose limitation;
- Data minimisation;
- Accuracy;
- Storage limitation; and
- Integrity and confidentiality.

It is clear to the Review that there are genuine concerns amongst providers that regulations relating to information governance constrain their ability to share information with other service providers both on and off the Island. What is not clear is whether these concerns are well informed or based on misunderstanding, or some mix of the two. It was notable that the Information Commissioner reported he had not been approached by the DHSC with any Data Protection Impact Assessments (the required route for assessing proposals to change or create new data sharing systems.) This suggests a lack of understanding or lack of willingness to seek authoritative advice. In either event, that cannot be allowed to continue.

Clearly, as the health and care system develops further, it will be necessary to consider information rights legislation in all service design decisions and in any commissioned service agreements. System architects must, whenever necessary, consult the Island's Information Commissioner throughout the design and delivery processes to achieve the appropriate balance between privacy and efficient and timely provision of high-quality care. Proactive engagement will be much more efficient than seeking approval of a completed solution.

The ability and right to share data assume that the data exists in the first place. However, a core observation of this Review is that there is a lack of accurate, comprehensive, consistent and timely operational data relating to service inputs, outputs and quality across the system. There are some pockets of good practice but these are in the minority. Whilst the Review has not examined other Government Departments, it has frequently been advised by staff working in the DHSC, who interface with other Departments, that lack of data is endemic across Government. This is a major concern, which if proven to be accurate, needs to be addressed urgently since appropriate sharing of data must be enabled to allow better care to be delivered, or harm prevented. In any event, the systemic capture of accurate data must be a priority for the Island's health and care services.

Recommendation 22:
The development and delivery of the digital strategy should go further and faster to ensure the comprehensive capture, sharing and use of information. This would enable greater integration across the system, improved monitoring and enhanced delivery of quality and efficiency-related information.

The existing Government-wide digital strategy includes the Island's health and care services, with some key building blocks delivered already. This is welcomed. However, the funding necessary to implement the entire strategy in relation to health and care is yet to be made available and the

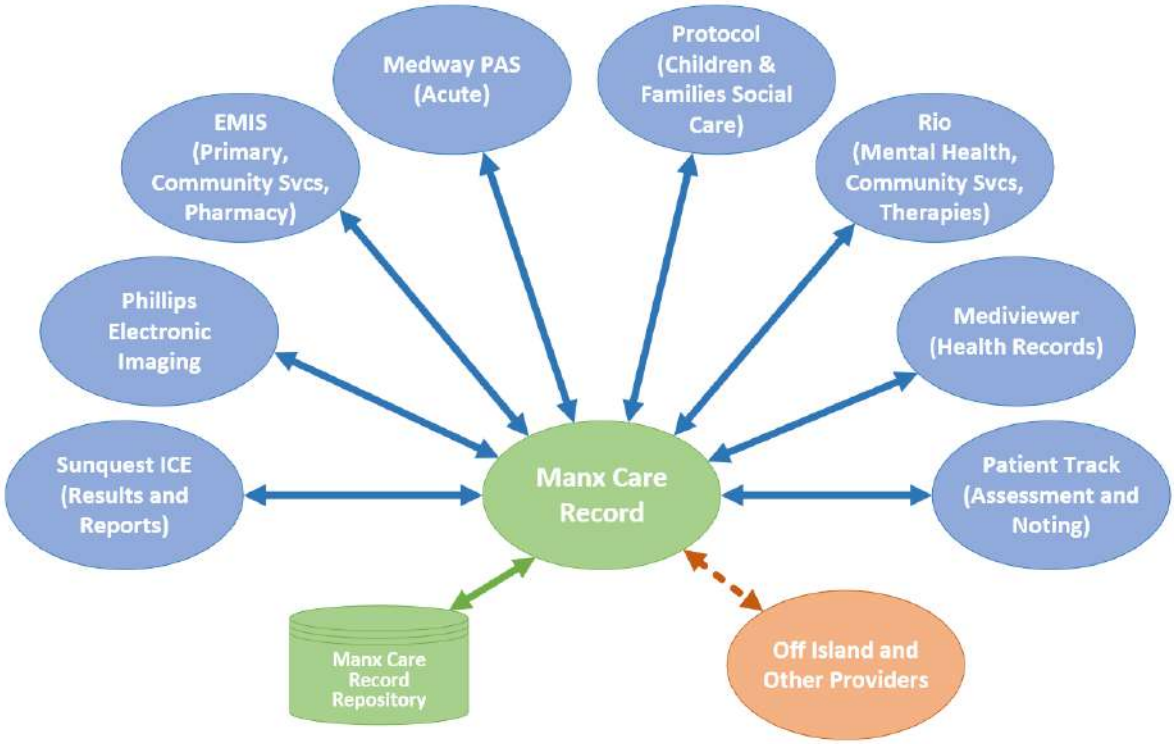
skilled resources allocated to its delivery are insufficient. This will result in delays in delivery and limitations as to what can be achieved. In the future, part of the assessment of payment for services, the measurement of the quality of those services for users and achievement of targets set, will be reliant upon the capture of data enabled by the digital strategy.

The Chief Clinical Information and Digital Officer in the DHSC has been working with Government Technology Services (GTS) to develop a proposal to implement a "Manx Care Record" conceived as a single overarching system to provide staff from all parts of health and care with access to key data from every major system used in the delivery of care. Achieving this end is a core element of the digital strategy.

The Review considers this capability to be essential to the future clinical sustainability of care. The risk for service users and, in some cases for those delivering care, of not sharing information from the current siloed systems is well known. Better care relies on the sharing of relevant data, fast access to it, and confidence in the information provided.

The Manx Care Record will provide a single system acting as an integrated repository of information, creating a view of an individual's key information from across the range of supported systems, as shown in Figure 11 below.

Figure 11: How Manx Care Record links to existing systems



Note: integration with the digital systems of "Off Island and Other Providers" as shown in the diagram are to be considered as a subsequent implementation phase of the Manx Care Record.

The Manx Care Record would not replace the existing systems that are necessary to support the detail of day to day activity in specific care settings, but it would enable key summary information to be made available readily and rapidly from one place. This will greatly help the process of creating a holistic view of an individual and their health and social care history from across a range of sources

and could be configured to support and monitor the individual's journey through the relevant integrated care pathway.

Whilst a programme of activity to progress the Manx Care Record does exist, the Review fears that unless a fully structured delivery programme is created, involving all necessary parties, the potential benefits may not be fully achieved or may be delayed. Therefore, it is suggested that a delivery programme should be initiated and funded to deliver the Manx Care Record as a matter of priority. This programme should follow good industry practice to ensure that it is focussed on the needs of service users and service providers and is achievable, affordable and prioritised. This programme should have clear and effective governance with appropriate controls and progress checkpoints.

A second important element of the digital strategy is the delivery of further telemedicine services.

The Island's local health and care system is constrained by the size of the population. In a larger geographic area with a greater population it is possible to organise and deliver services on a larger scale. This can optimise the service user's experience, service quality, safety and efficiency by delivering specialist services from nominated geographic hubs. It is not practical, or in many cases safe, to organise and deliver all services in this way on the Isle of Man.

For this reason, the practice of some health and care services being delivered by off-Island providers will need to continue in the future. Indeed, some services cannot be delivered on the Island at all.

Telemedicine could support a number of models of care, which would enhance services for the service users on the Isle of Man, including:

- Clinician and patient on the Island (housebound or remote) with link to an on-Island expert provider (reducing the need to travel to Noble's Hospital or other "hub" location for routine consultations);
- Expert provider and patient off the Island, linked with clinician in clinic on-Island (enabling upskilling and supporting transition of care back to the Island); and
- Domestic monitoring devices to monitor chronic diseases or specific conditions such as heart disease, diabetes and asthma – reporting information to a remote professional for assessment and intervention when required (reducing the need for visits for regular check-ups and potentially enabling any issues to be identified sooner).

Other elements of the current digital strategy and other aspects that may be considered in the future are outlined in Annex 13.

Recommendation 23:
A core data set is essential for the management and assessment of services and should be established without delay.

Without high quality data it is not possible to measure or reliably assess the efficiency or effectiveness of service provision to target and measure improvement or to assess value. Nor is it possible to make informed decisions or plan and review service delivery.

Working with the users and other key stakeholders (including Public Health) an agreed set of key data items, which must be captured and made available, should be established. Systems and use of these systems should be examined to ensure the information is being captured (or can be derived from that which is captured.) Also agreed methods and timescales should be established for the agreed data to become available. This may result in system or business process changes being required.

Processes and supporting systems must be designed so as to ensure that it is easy for service providers to collect accurate and useful information. There needs to be a culture within health and care on the Island that data and its accuracy are important and there needs to be a real commitment to achieve this aim.

An agreed core data set is essential for the management and assessment of services and needs to be established without delay. While the Review was able to obtain some metrics that should routinely be collected, that is not the case for all such information. An illustrative list of core data sets that should be collected is included at Annex 12 (F2).

The recommended changes to structural arrangements of the health and social care system should require and encourage the acquisition and reporting of appropriate, specified operational data. Similarly, any arrangements with other providers of care (whether on or off Island) should include equivalent provisions. Such arrangements must always be subject to the appropriate information governance regime and consultation with the Information Commissioner.

A realistic, potentially incremental, evidence-based plan for when the agreed data will be made available should be established.

Recommendation 24:
The systematic capture of accurate data should be a priority for the Island's health and care services

For the reasons outlined above, increased use of technology enables the accurate capture of data. Users' interaction with the technology solutions needs to be seamless, allowing information to be captured - automatically and validated where possible – in a single transaction and not endlessly repeated. Technology systems should be enhanced and/or implemented to ensure that necessary data can be acquired, recorded and collated with the absolute minimum of additional effort required from the user. It was clear to the Review that, within health and care, this was not always the case. Health and care data should not be viewed in isolation – it is clear that a number of other aspects of data from other Government sources are needed to plan and deliver care successfully. The health and care needs assessment, mentioned earlier, will require information from other parts of Government and will rely on that data to be fully comprehensive. It will be important that once the data needed is identified and defined, the sources of that data will need to provide or be enhanced to provide, accurate data in a timely manner.

5.5 New Workforce Model

In order to provide the health and care services required by the population of the Isle of Man to the desired level of quality, a fit-for-purpose workforce model needs to be defined and the staff to populate it, recruited (where necessary) and retained.

A fit-for-purpose workforce model would address a variety of issues including limited access to services, reducing gaps, reducing duplication, easing recruitment difficulties, enabling career paths for those that seek it and improving morale and culture – all of which support better outcomes for the service users.

Recommendation 25:
A fit for purpose workforce model needs to be developed to reflect the emerging needs of the new model of care. It should maximise the potential skills available within the workforce as well as the opportunity to recruit and retain high quality professionals. It will then increase the attractiveness of the Isle of Man as a career destination.

The solution is not as simple as hiring more staff. Increasing staff numbers only, at the same level of demand, would create unsustainable financial pressure, given that staff costs currently make up around 65% of costs within the Island's health and care system. It will be critical to use the workforce more innovatively with new ways of working and increased use of technology to increase productivity, reduce administration and enable more time to be spent delivering care. Such innovations are becoming especially important at a time of a growing international shortage of health and care staff. These international pressures have been well documented, including recently by the Chairman of KPMG's Global Health Practice[xxii] and the Nuffield Trust in collaboration with the Health Foundation and King's Fund[xxiii].

A workforce skills audit should be conducted in addition to earlier recommendations within this Report (the health and care needs assessment, pathway design, service-by-service reviews and, in time, within the mandate from the DHSC) in order to objectively assess the ability of the current workforce to provide the services required by the people of the Isle of Man. This should apply whether the services are to be delivered (directly or indirectly) by Manx Care. Any gaps in that ability will need to be addressed, e.g. through upskilling, recruitment or purchasing of those services from other providers etc.

Importantly, this approach seeks to address issues, experienced in recent years, through which the Island's secondary care (in particular), has aimed to deliver a full suite of District General Hospital-type services (which typically serve populations of 250,000) to a much smaller population of 85,000.

This approach has resulted in unsustainable pay inflation, professional isolation and challenges in maintaining professional competence due to low activity levels. It is a clear conclusion of the Nuffield Trust[xxiv] that trying to deliver such a broad service from small, geographically isolated acute centres (like the Isle of Man) is not sustainable.

In addition, in the future, recruitment activity will likely need to focus more on recruiting generalist clinicians, to ensure that there is a breadth of skills available to deliver against current and future demand; with suitable specialist skills delivered by other specialist providers both on and off-Island as required.

The workforce model should include innovative approaches, such as contracting staff from off-Island specialist centres to deliver specific elements of care on-Island, linking in with professional networks and utilising telecare/telemedicine solutions, such as Project ECHO (Extension for Community Healthcare Outcomes). It should also reflect the necessary new models of care (in terms of integration), such as facilitating multi-disciplinary team approaches (particularly for the most vulnerable service users) and shadowing/sharing knowledge among professionals in different settings.

It is important that the new workforce model has appropriate clinical leadership. The Review was surprised at the decision to remove the position of Chief Nurse, as all areas of clinical care require suitable leadership irrespective of where individuals are within the system or the professional services they deliver. The new workforce model should also reflect the principles of health and care,

including by ensuring adequate resource to enable care, wherever possible, to be delivered on the Island and close to a person's home.

More broadly in terms of recruitment, the Government encourages the growth of the Isle of Man's working population and it is recognised that various initiatives are ongoing to encourage such individuals to relocate to the Isle of Man. These include the 2018 Year of Our Island "A Special Place to Live and Work" and the recently announced National Insurance Holiday Scheme[xxv].

However, there remains more that can be done to ease the process of bringing skilled workers to the Island to work, such as reviewing Work Permit exemptions to ensure that they are adequate for the needs of the Isle of Man, which may require legislative change (see section 7.1 above). The Review heard that disincentives associated with transferring of pensions are an issue, although it is noted that this is due to a Government-wide policy decision to address public sector pensions and the Government has already sought to mitigate some of these concerns. The Isle of Man could learn from other health economies that have achieved success in this area, for example with comprehensive relocation packages.

These initiatives could help form a more attractive offer for professionals and others to the Island, which would help improve current arrangements, whereby premiums are paid to recruit and retain health and care staff[xxvi], which do not reflect best practice in pay policy and contribute to concerns over a lack of transparency and clarity and are unsustainable.

The Review recognises that the Isle of Man Government's HR function is necessarily a shared service (under the Cabinet Office) as opposed to having separate functions within each Department. However, it is necessary to have specialist HR support available to ensure that Manx Care and clinicians/professionals have adequate advice and support. This could be provided under the current shared service arrangement and, given that the DHSC is the largest employer on the Island, seems to the Review to be essential.

In order to retain staff, their needs should be met and their performance managed, as part of an overarching performance appraisal/management process, which has been created with the specific purpose of delivering the proposed service model. The current Organisational Development Plan references that the plans for implementation of the system have already been created; these may need to be updated to reflect the findings of the Review. Staff should, as a minimum, be able to maintain their skills on the Island, including through empowerment to work to the top of their licence, to ensure that the right professional is offering the right care in the right place, which may require legislative changes (see section 7.1). For example, a physiotherapist could prescribe, rather than always requiring a doctor to prescribe, and additional training for nurses could lead to more specialist nurse practitioners working in all care settings.

Successfully retaining staff will also aid recruitment, as professionals would be more likely to recommend the Isle of Man as a positive place to work to their colleagues further afield.

As mentioned previously, the workforce talked extensively about the cultural change as well as the organisational and operational changes needed within health and care on the Island.

The establishment of Manx Care gives an opportunity to make a step change in the culture and embrace the comprehensive changes that this Report recommends, and to deliver a more positive and fulfilling environment in which to work. It is well known that culture is also closely correlated with the likelihood of success in driving organisational change. An organisation can have a strong vision, solid leadership and a good idea of how to improve things, but a deeply embedded negative

culture can silently scupper all attempts at improvement and change. Understanding an organisational culture is therefore critically important for implementing successful transformation, as is developing an understanding of how change of culture might be achieved. International experience shows that workplaces can be blighted by negative behaviour and forms of prejudice. It is important to do everything possible to root out negative attitudes and develop policies that encourage staff retention and recruitment, including fair rewards and flexible arrangements to achieve an appropriate work-life balance.

Inevitably an effective cultural shift does not occur overnight as it takes time to build trust and create momentum. As Manx Care is formed, its leaders will need to consider how this can best be achieved, but it is clear that the change process should be driven by those at the top, and that many and consistent approaches to dealing with feedback are vital.

Clearly it will be for others outside of the Review to determine the best way forward but the Review considers the following four steps a useful starting point:

1. **Build buy-in across the organisation**. Work closely with senior leaders and staff at all levels and their representatives to articulate the case for change and the direction of travel.
2. **Consult and plan**. Map the key stakeholders, including staff representatives and engage them appropriately. Understand the needs of different parts of the business, and tailor interventions accordingly. Develop a comprehensive implementation plan, including timelines for delivery and key performance indicators.
3. **Communicate and engage all levels of the organisation**. Explain the purpose and objectives of the initiative and ensure that all levels of the organisation are represented and able to provide feedback on the initiative, *via* top–down and bottom–up engagement processes.
4. **Reinforce and embed the importance of culture through practices and policies**. Ensure that the values and behavioural norms defining the required culture are embedded in all processes.

6. Implementation and Transformation

Recommendation 26:
The Government should create a new, dedicated and skilled transformation programme group to oversee and support the implementation of the agreed Recommendations.

As outlined earlier in this report, the level of change needed to achieve transformation is substantial, requiring sustained effort in terms of time, skills and resources.

A portfolio of programmes and projects will have to be co-ordinated and planned, using a combination of on-Island expertise (and subject matter expertise in particular), supplemented by established external expertise in a wide range of specialisms. Where resources that are currently working in the DHSC or other parts of Government are utilised, backfilling as appropriate for their current posts will be required to ensure that essential services are maintained without compromising the transformation. A piecemeal approach to delivery will be sub-optimal and potentially take longer, at greater cost and for reduced benefit.

It is formally outside of the scope of the Review to consider implementation in detail, but given the failure to implement a number of previous reports it was considered prudent to provide some advice, working on the assumption that the Recommendations within this Report are accepted and that there is a desire to press forward to implementation at pace.

This section is intended to assist moving the recommendations into actions and delivering change. It is supplemented by a series of documents in Annex 14, which provide a high-level project plan and describe the individual programmes of work.

At this juncture in the process these materials can only be indicative, and they would require further detailed work to complete, review and approve. However, despite this, they are expected to provide a useful illustration now of some of the key work which needs to be undertaken.

A number of other deliverables will need to be developed subsequently and aligned to the materials listed above. These will include, by way of example:

- a communications plan;
- a stakeholder engagement plan;
- a staff consultation plan;
- a governance approach; and
- the reporting and escalation process.

To begin the transformation programme, resources will need to be allocated to create a project initiation document (PID) which outlines the work to be undertaken, the priorities, benefits, indicative cost and likely resources together with a more detailed plan. The overall approach to delivery of a programme of change should be aligned to a recognised programme methodology such as Prince2 or Managing Successful Projects (MSP).

Assuming that the PID is agreed and approved, detailed planning and execution of the transformation programme will follow.

It is vital to recognise that this is not simply a transactional process – it will require a very significant amount of on-going communication (with the public, the service and those who work within it, and with the Executive and other key stakeholders) and a change in mind set to accept the level of

change, be involved in its detailed definition, and then to enable and deliver the transformation itself.

6.1 Transformation Programme

Transformation is a deliberate, planned process that sets out an aspiration to make integrated radical changes to processes, behaviours and responsibilities that result in substantial, measurable improvement in outcomes. Transformation differs from smaller scale changes by:

- **Size –** involves a large number of people, often across more than one location and/or organisation.
- **Pervasiveness –** affects the whole system and not just a portion of it.
- **Depth –** affects ways of thinking as well as ways of working.

The following stages are recommended as the basis for successfully implementing transformational change.

Stage 1: Create the Ambition

This stage requires:

- **Designing the transformation** – involves understanding the internal and external context of the organisation and identifying enablers and barriers.
- **Building understanding of the changes required** – articulating clearly what the change will entail for individuals, from cultural and practical points of view.
- **Managing and leading change** – providing a suite of change management techniques used to implement changes.

Stage 2: Design the Transformation

This stage requires:

- **Rewriting the context** – evaluating the context to identify what will be enablers and the inevitable barriers to the transformation and putting in place initiatives and strategies to overcome them.
- **Aligning strategy and culture** – designing a roadmap, leading from the existing culture to the new one, in a way that feels consistent and meaningful.
- **Identifying opportunities** – building on existing smaller-scale change initiatives (such as the Integrated Care pilot in the West or existing digital strategy).

Stage 3: Build Shared Understanding of Change Required

This stage requires:

- **Disrupting the current position** – the status quo is challenged, to encourage everyone to think about what they need to do differently to move forward successfully.
- **Highly effective communications** – to clarify the new ambition and vision encouraging people to question, clarify and understand the direction of travel.
- **Dealing with resistance to change** – identifying champions to cascade the message through the organisation and ways to engage the sceptics.
- **Emotion, energy and momentum** – change is about hearts and minds, so emotional intelligence is key to taking people on the change journey and keeping them committed.

Stage 4: Connecting Culture Change to Transformation

Culture is closely correlated with the likelihood of success in achieving transformational change. An organisation can have a strong vision, solid leadership and a good idea of how to improve things, but a deeply embedded negative culture can silently scupper all attempts at improvement and change.

This is supported by evidence showing that better performance is achieved by repeatedly accumulating insights, improvements, and innovations, and putting them to good use. This means that the key source of improvement comes from people's behaviours[xxvii].

The Review has found many examples of strong leadership and potential "change agents" at all levels of the system. However, it has also found that these pockets of excellent practice and leadership exist in a wider context that does not support the spread of that practice. A significant change in culture will be required to work across current organisational divides to successfully achieve transformational change such that the attitude of demanding the highest quality and effective outcomes becomes standard practice.

6.2 Transformation Programme Group

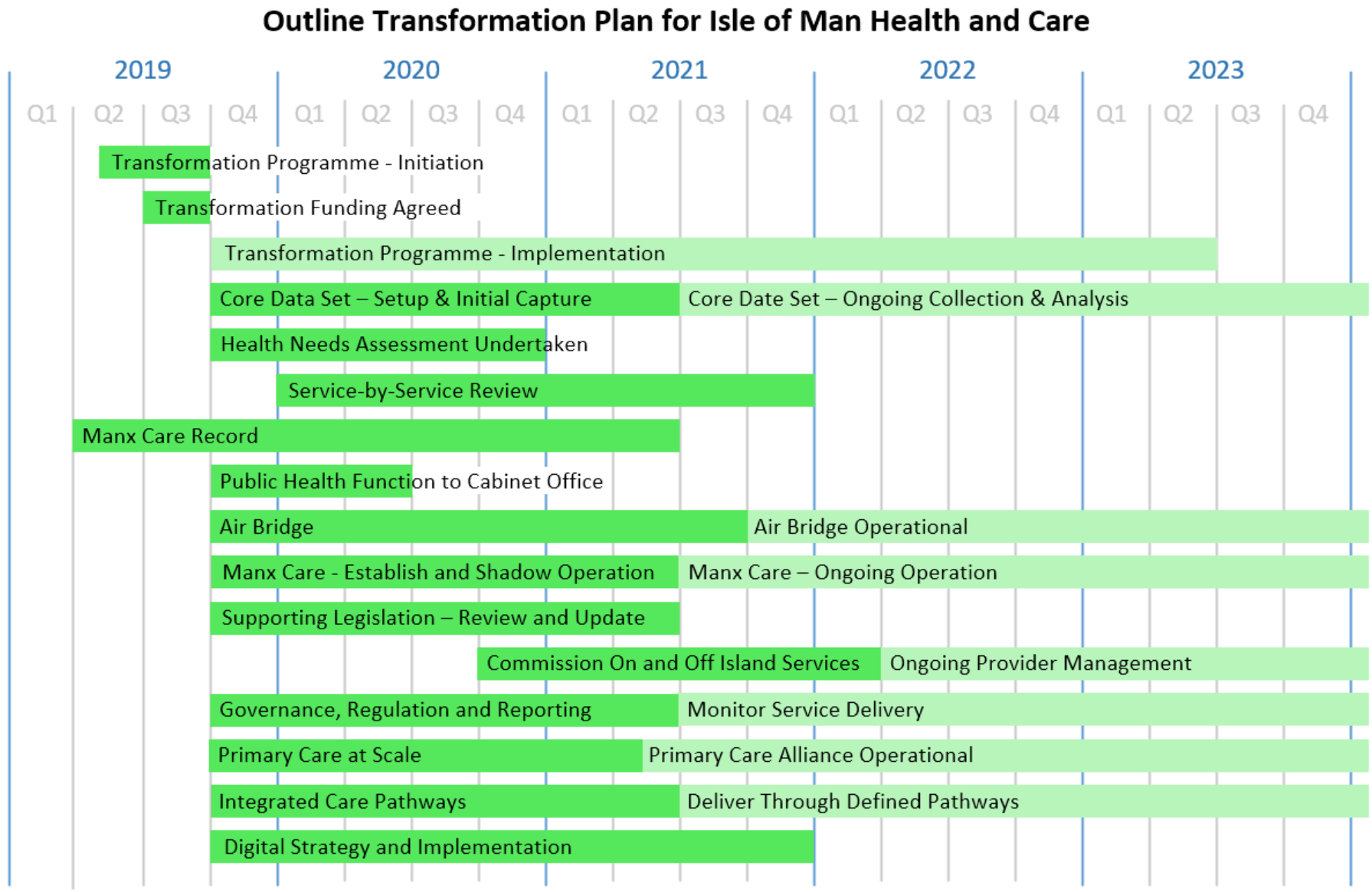
The transformation group needs to be seen as the engine room of the transformation programme. Reporting through the Treasury, DHSC and Cabinet Office, led by the Chief Secretary, this empowered "Delivery Unit" would be the source of the capability, energy and drive to take a transformational change forward. It requires a dedicated group of skilled individuals with the necessary experience, knowledge and personality working collaboratively with existing health and care specialists to define the approach to deliver the strategy and get the organisation behind the transformation process.

The Review is aware that there are individuals within the DHSC and Government Technology Service (and possibly elsewhere in Government or on the Island) with many of the necessary capabilities to form part of the engine room. However, given that the health and care sector is the largest single employer on the Island and its impact is so wide ranging, it is unlikely that there will be sufficient experienced staff to deliver this extensive programme of work. The Review believes that external support would be required in addition to those on the Island who have got the necessary skills. Those who are on the Island with those skills are consequently in high demand within the environments in which they work and contributors to the Review commented that previously necessary arrangements have not been made to enable people identified from the organisation to participate in projects and give the required time alongside their existing responsibilities. To be successful this should not be repeated.

The Review therefore suggests that a dedicated transformation team, supported by transformation funding, should be established to drive forward the recommendations from the Review building on the momentum achieved to date.

This transformation team can then drive forward the programme and deliver the new approach to radically improve the provision of health and care across the Island.

An outline transformation "plan on a page" is given below. More detail on the approach needed for the successful implementation of these changes is given in Annex 14.


Outline Transformation Plan for Isle of Man Health and Care
2019
2020
2021
2022
2023
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Transformation Programme - Initiation
Transformation Funding Agreed
Transformation Programme - Implementation
Core Data Set – Setup & Initial Capture
Core Date Set – Ongoing Collection & Analysis
Health Needs Assessment Undertaken
Service-by-Service Review
Manx Care Record
Public Health Function to Cabinet Office
Air Bridge
Air Bridge Operational
Manx Care - Establish and Shadow Operation
Manx Care – Ongoing Operation
Supporting Legislation – Review and Update
Commission On and Off Island Services
Ongoing Provider Management
Governance, Regulation and Reporting
Monitor Service Delivery
Primary Care at Scale
Primary Care Alliance Operational
Integrated Care Pathways
Deliver Through Defined Pathways
Digital Strategy and Implementation

7. Recommendations

The following list sets out the recommendations for actions required to deliver the desired sustainable, high quality, integrated health and care system on the Isle of Man:

Recommendation 1:
The Council of Ministers should formally adopt the principle that patients and service users are fully engaged in, and at the centre of, all aspects of planning and delivery of health and social care services.

Recommendation 2:
The setting of priorities and the development of policy in both health and social care should be separate from the delivery of services. A comprehensive governance and accountability framework should be established aligned to agreed standards and underpinned, where necessary, by legislation. A single public sector organisation, perhaps to be known as "Manx Care", should be responsible for the delivery and/or commissioning from other providers of all required health and care services.

Recommendation 3:
Services provided directly or indirectly by Manx Care should be inspected regularly by independent, external quality regulators, with a report to the Manx Care Board and to the DHSC.

Recommendation 4:
A publicly available Annual Report from Manx Care should be provided to the DHSC and subsequently presented to Tynwald, summarising the delivery of the health and care services on the Island.

Recommendation 5:
A statutory duty of care (applicable to organisations and the individuals who deliver health or care services) should be agreed, implemented and maintained alongside the delivery of high value clinical governance, underpinned by legislation where necessary. The new statutory duty of care would include:

- *A duty of confidentiality;*
- *A duty to share information where appropriate to enable the delivery of safe optimal care; and*
- *A duty of candour – a responsibility to disclose where breaches of safety standards or harm to individuals have occurred.*

Recommendation 6:
The Council of Ministers should mandate the DHSC, Treasury and the Cabinet Office to ensure implementation of the agreed Transformation Programme of health and care services as set out in this Report, led by the Chief Secretary.

Recommendation 7:
The Council of Ministers should receive a quarterly progress report on the Transformation Programme to understand the progress made and to identify any significant issues which need resolution. In addition, it is suggested that Tynwald should also receive an annual report on progress of the Transformation Programme.

Recommendation 8:
Primary and/or secondary legislation should be introduced as required, and included in the legislative programme as soon as possible, in order to form a modern, comprehensive legislative framework. This legislation should address weaknesses or gaps in the current system as well as enabling the im-

plementation of the recommendations contained in this Report, such as any necessary legislation to establish Manx Care.

Recommendation 9:
The Public Health Directorate should be empowered to provide advice and guidance across Government, not solely to the DHSC. It should promote and co-ordinate health and wellbeing across the Island to help improve the quality of life and reduce the demand on health and care services in the future. All Departments should be required to factor public health guidance into policy setting and legislation. In order to facilitate this, the Public Health Directorate should be moved to a position in the Cabinet Office.

Recommendation 10:
An on-going health and care needs assessment programme for the Isle of Man should be established and funded without delay. It is not possible to develop meaningful service delivery models and plans without establishing the current and future needs for health and care through this assessment. Many other recommendations in this report are predicated on the assumption that this programme will be established. The Public Health Directorate should be resourced to undertake the health and care needs assessment programme.

Recommendation 11:
A service-by-service review of health and care provision, in conjunction with the needs assessment and an analysis of care pathway design, should be undertaken to establish what services can, should or must be provided on and off-Island, against defined standards. Where services cannot be provided safely or deliver best value by Island-based providers, the default position should be to seek services from third parties for delivery on-Island whenever possible and off-Island where necessary.

Recommendation 12:
Service by service integrated care pathways should be designed, agreed and delivered. These should encompass both on and off-Island components of clinical service models.

Recommendation 13:
Manx Care should deliver an enhanced 24/7 emergency air bridge, allowing for patients to be stabilised locally and moved quickly and safely to contracted specialist centres.

Recommendation 14:
A single, integrated out-of-hours service should be established to provide care in an efficient and appropriate manner outside normal working hours.

Recommendation 15:
The Isle of Man should establish a model for delivering primary care at scale, since further and deeper collaboration within primary care is necessary to deliver current services and provide additional local services.

Recommendation 16:
The provision of social care should be considered as part of the current review of future funding of nursing and residential care with the intention of removing disincentives to people requiring care and support remaining in their home. This consideration should specifically include equalisation of the current threshold of financial assistance, a more flexible approach to funding to enable joint commissioning of broader care arrangements in the interests of the service user and provision of 24/7 social care access.

Recommendation 17:
Increased funding should be linked to the achievement of annual efficiency targets.

Recommendation 18:
Additional transformational funding and dedicated specialist resources, including proven change leadership, are required to deliver the transformational recommendations for them to be implemented successfully.

Recommendation 19:
Increases in funding for health and care services will be required to support the increased demands that will be placed on those services due to demographic changes, non-demographic changes and inflation.

Recommendation 20:
Funding, based on agreed need, should, over time, move from the current annual budget allocation to a 3-5 years financial settlement for heath and care services for the Island.

Recommendation 21:
Ensure data sharing protocols and arrangements are reviewed, agreed and implemented in accordance with the Information Commissioner's regulations and guidance.

Recommendation 22:
The development and delivery of the digital strategy should go further and faster to ensure the comprehensive capture, sharing and use of information. This would enable greater integration across the system, improved monitoring and enhanced delivery of quality and efficiency-related information.

Recommendation 23:
A core data set is essential for the management and assessment of services and should be established without delay.

Recommendation 24:
The systematic capture of accurate data should be a priority for the Island's health and care services

Recommendation 25:
A fit for purpose workforce model needs to be developed to reflect the emerging needs of the new model of care. It should maximise the potential skills available within the workforce as well as the opportunity to recruit and retain high quality professionals. It will then increase the attractiveness of the Isle of Man as a career destination.

Recommendation 26:
The Government should create a new, dedicated and skilled transformation programme group to oversee and support the implementation of the agreed Recommendations.

8. Annexes

Annex 1: Review Terms of Reference

COUNCIL OF MINISTERS'
INDEPENDENT REVIEW OF THE ISLE OF MAN HEALTHCARE SYSTEM

On 16 January 2018, Tynwald, the Isle of Man's parliament, approved the Treasury Minister's motion, which was as follows.

> *That Tynwald notes the financial pressures for the future delivery of Health and Social Care services, and supports:*
> *a) The Council of Ministers commissioning and receiving an independent review to determine change options for service delivery and funding to provide a modern, fit for purpose healthcare system for the Island; and*
> *b) That the Council of Ministers report to Tynwald by January 2019 with recommendations for the future of the Healthcare Service.*

Background

The continuing inability of the Department of Health and Social Care ("DHSC") to remain within its budget is of great concern: as the Isle of Man Government's five year financial plan and the availability of funding for services is dependent on the maintenance of strong cost controls. The continual exceeding of its budget each year by the DHSC restricts the funding available for other areas.

However, the DHSC cannot deliver services effectively for which it is not funded adequately. At present, there is insufficient evidence with which to determine whether the budget is too low or that our health and social care services are not appropriately designed and/or delivered.

The extent of this problem is not restricted simply to the short term requirement to manage within an annual budget; as with an ageing population, changes in technologies and increasing service user expectations, there are also significant long term implications.

While relating to funding in England, The Nuffield Trust, the Health Foundation and The King's Fund Joint Statement of 8 November 2017, said:

"We estimate total health spending in England will rise from £123.8 billion in 2017/18 to £128.4 billion by the end of this parliament in 2022/23. This is far below what is needed to maintain standards of care and meet rising demand. Based on projections from the Office for Budget Responsibility (OBR), we estimate that health spending would need to rise to approximately £153 billion by 2022/23."

If that basis, namely a 23% increase by 2022/23, is used to estimate future costs for the Isle of Man, it would equate approximately to an additional £60m: which is far in excess of what is currently allowed for in the five year financial plan.

It is acknowledged that the amount of work and 'fire-fighting' required to deliver services means inevitably that departmental management attention is focused on sustaining the service, which leaves little time for transformation. However, without some form of strategic intervention, the current system, at the current levels of funding, is becoming unsustainable.

DHSC funding presents two distinct challenges:

- firstly, in the short term, how best to deliver services, as they are configured currently, in the most effective, economical and efficient way; and,

- secondly, how to provide a sustainable health and social care system in the long term which meets the needs of the Isle of Man.

Addressing these challenges requires an independent review ("the Review").

Terms of reference

Objective

The objective of the review is to determine change options for service delivery and funding to provide a modern, fit for purpose healthcare system for the Island.

The Review will build upon previous work, including: Beamans (2013); West Midlands Quality Review Service reports (2015-2018); and, the Tynwald-approved Department of Health and Social Care five year strategy (2015).

Specifically, the Review will consider the goals of the strategy and make recommendations, as necessary, to ensure that they remain valid and current. In addition, the Review will assess progress in delivering the goals of the strategy, report on where and why progress has been difficult and recommend additional actions, as necessary, to enable successful implementation.

In forming these terms of reference regard has been taken of the debate on the motion in January Tynwald a summary of which is include as Annex 1 to these Terms of Reference.

Governance

The Review will be led by an independent Chairperson who will have full editorial rights over the final report that will be provided to the Council of Ministers. The Chairperson will be supported by a Panel of consisting a range of skills, experiences and representative stakeholders as follows:

- Clinical:
    - Doctor
    - Nursing
- Senior officers:
    - DHSC
    - Social Care
- Political:
    - MLC
    - MHK
- 2 x Patient Representatives
- General Practitioners Representative
- Secretariat Administrative Lead

In compiling the report evidence will be gathered from Government, service users, service providers, the wider public and will include consideration of the operation of systems other than the English NHS.

The Review will run for a period of 12 months from April 2018.

Secretariat support for the Review will be made available by the Treasury and DHSC, including project management, data collection and, the development of working documents, records keeping, facilitation of stakeholder engagement and other functions as required. Where key skills or research is required that is not within the skillset of the Secretariat, external consultancy support will be procured.

The secretariat and Panel will work under the direction of the Review chairperson.

Scope

To meet these challenges, the Review will cover a number of areas and address a number of questions.

Review areas

- The range, organisation and management of health and social care services provided by the DHSC or its contracted providers
- Management information, systems, governance and pace of change
- Workforce including recruitment & retention, culture, morale and balance of skills
- Quality and safety, including research & development and innovation
- Productivity including data and insight, digital and finance
- Interactions between health and social care services and other public services where relevant
- Essential and discretionary health services for an island population compared to those which cannot be provided and must therefore be commissioned elsewhere (mainly in England at present)
- The extent to which proven, evidence-based remote technology systems could be introduced so as to support or enhance essential and discretionary health services for an island population
- Comparisons with other healthcare systems in the British Isles (i.e. variants of the National Health Service) or overseas that have similar demands and geographical constraints but utilise different delivery models, organisational structures and approaches to involvement of the citizen

Review questions

- To what extent is the current funding provided for the range of DHSC services realistic?
- How might the funding requirement change over the next 15 years?
- How can primary, secondary and tertiary healthcare assets be used better, and what new investment in these areas might be needed?
- To what extent should partnership and co-production with other public services, local authorities, the charitable sector and the private sector play a part in the delivery of healthcare services in the Isle of Man?
- Is the principle that health services should largely be free of charge still valid, and what sort of alternative system might be appropriate for the Isle of Man?
- Should charges for services be extended in scope, or should free of charge services be made available on a means-tested basis?

- How would the introduction of a healthcare system other than the National Health Service affect the quality and the sustainability of services provided by the DHSC?

- How can financial stability and sustainability be ensured without compromising the quality of care?

- What system would help determine where money should best be spent: e.g., should the Isle of Man move towards an English commissioner - provider model or other forms of delegated financial management systems?

- Should changes be made to current funding and co-payment methods: e.g. a hypothecated health tax, increases in National Insurance Contribution rates, lifestyle ("sin") taxes etc.?

Reporting

Unless otherwise agreed in writing, an interim report will be presented to Tynwald in January 2019, with a final report for Tynwald in May 2019.

The final report will be a public document that will set out recommendations, policy options and a summary of the evidence that has been gathered in reaching these conclusions.

Approved by Council of Ministers
22 March 2018

Annex 1
Tynwald Debate – Jan 2018 – Review of Health and Social Care
Selected Political comments for TOR / Chair

Chris Robertshaw MHK

Given that if we agree that our role is very much one of being a policy director of an organisation, then clearly we should all be preoccupied with three key objectives: (1) a clear understanding of where we are going and why, and a commitment to promulgate that direction to those who put us here – we should not pretend we personally have the answers, but we should be very willing to admit it, that when we have not got them we need carefully to seek out the support and advice of those we believe can; (2) a determination to ensure we have the right executives in place to deliver on that vision; and (3) a data construction reporting system that accurately identifies progress, or indeed the lack of it.

So far, I have spoken about the lack of balance between the various elements of our health and social care system through our continued silo mentality, and perhaps – forgive me – some political egos as well. Our lack of data, our lack of a clear vision, a clumsy structure and an outdated political mind-set all play into this issue. Let me now address the motion at Item 5 more specifically
Means testing should play a significant role at the point of delivery of a range of peripheral Health and Social Care services, thus ensuring we are able to continue to protect that which we hold dear, namely our core Health Service provision, and that it remains free at the point of delivery. This must be kept simple via the application a dumb binary interrogation system using a range of personal cards and devices and readers. We need to get on with that. We need to get clear. (2) We will need to consider introducing a special employee NI contribution rate for those still working over the retirement age – something that would recognise a continued contribution to their health care but not to their pension which they would already be in receipt of. Let's be courageous, let's deal with these things. (3) Anonymised and aggregated data projected from the smart service framework led by the Minister for Policy and Reform, must, as quickly as possible – not five or seven years' down the line – allow for the development of much more sophisticated data leading to better and more highly targeted policy formation. This in turn would far better inform personalised needs assessments. Without it we will not get there. We are still running post-war clunky systems. It is laughable. (4) A growing willingness to accept that a small general hospital serving a modest island population cannot – cannot – be all things to all people

provide the highest possible standard of specialist care to our population, we review what we expect of Noble's and how we can further build up relations with specialist hospitals elsewhere, whatever their nature and wherever they are; then work out how this new arrangement should be delivered.

Claire Bettison MHK

The smaller divisions of DHSC cannot sustain further cuts while at the same time trying to work towards DHSC's fiveyear strategy of moving care delivery into the community with an integrated care approach. We should be steps ahead of our neighbours in the UK, who are only now recognising that acute care and social care should not be too separate entities run by two separate bodies but must operate cohesively and seamlessly, not for financial savings but in order to deliver true patient focused care. Cutting budgets while increasing level and quality of services are unlikely to ever go hand in hand – although if anyone knows the secret of this, I have got open ears. If we truly want to alleviate the pressure on our hospital services, we must first invest in our community services to increase capacity, improve service delivery and focus on a patient-centred service. We need more

community-provided services and we must recognise that those delivering community-based care are as much a part of our team as those on the front line in the Hospital

Juan Watterson SHK

Successive reviews have struggled with a lack of data. How, therefore, can it give well-informed options for the future of the healthcare service……
But we do need more than just this independent review. What we have found is a big disconnect between strategy and delivery, and creating new strategy will not actually solve the disconnect. Ultimately, we need a single strategic document that outlines prioritised goals, service provision, budget and expected outcomes. We need to know what success looks like. We need robust project management to ensure the policies actually get delivered on the ground. This includes articulating to staff what staff resources and what budget are allocated to delivery – and actually, this review will be no exception. It also needs to follow those basic precepts

Dr Alex Allinson MHK

Successive administrations have been happy for underspending in community services to be used to prop up the Hospital instead of asking why investment in primary care is not a priority. (A Member: Hear, hear.) This first report into overspending at Noble's documents how successive strategies have not been translated into operational plans but joined what has been described as an elephant's graveyard of well-intentioned documents. There is clear frustration in the Department that the urgent is always pushing aside the important and that this constant feeling of firefighting is becoming overwhelming. Now is the time to make the next bold step in the continuing evolution of the NHS and rather than rip up some of the core principles, we need to transfuse the service with democratic accountability. Staff represent 80% of the costs at Noble's, and yet these are the same staff whose commitment and passion offers part of the solution to the Hospital's long-term problems. Departments and groups of healthcare professionals need to be empowered to create better working practices and innovate to improve patient care. Management structures should become truly accountable both to the political representatives in the Department but also to the public. They must reaffirm the public process of decision-making. It is vital that clinicians are allowed to redesign services in the manner that are most needed to become sustainable, give stability and become far more democratic.

Bill Henderson MLC

We need to be looking at the core services of what an 85,000 population should be having; what we can do well and to a high standard; and not beat ourselves up over West Midlands inquiries and assessments and all the rest of it and the standards that we should be doing, because all that is doing is causing greater strain on the budgets, to try and aspire to those 2575 standards that we are being told to meet and the resources that are required to get to those standards – when, in fact, we should be looking at what an 85,000 population, in an island, what core services should look like. Those are the thorny issues, Eaghtyrane, and they are the thorny issues that we need to answer ultimately here some way down the line from the review, I believe, and what it is we should be reasonably be providing.

Bill Shimmins MHK

In terms of the review, we tend to look at the UK NHS model. I question, is this sensible? We all read the newspapers, we all switch on the television every night. Simon Stevens, the Chief Executive of the UK NHS said that it can no longer do what it is being asked to do. It feels misguided to operate a

smaller clone of a failing system. There are other models in Europe which are delivering better outcomes. As such, I would ask that these are explored by the review. The assumption that the Health Service is free has been mentioned a few times already today, and that is absolutely understandable – it is a very dearly held mantra by many people. I think we need to test that. Is it realistic, given the ever-increasing costs for drugs and treatments? It is not the case in Ireland, France and Germany, where patients who are able to do so make a contribution to the cost of their care. To be sustainable, I would suggest that the review needs to cover this point.

Daphne Caine MHK

New money is needed in Social Care: new money for extended care at home, new money for extra respite beds, more district nurses, and more money for nurses to manage long-term illnesses at home. All these services, I believe, are currently struggling for staff and resources. Once that has been remedied, then changes at the Hospital can be examined. Without the community services in place, discharges from hospital are delayed, or sometimes, because of bed pressure, sent home too soon. The result is a higher rate of return to hospital and A&E by patients who are either discharged too soon or who do not have help and care at home to keep them out of hospital. Sometimes these are simple things like urinary infection in older people, who are bouncing in and out of hospital on a regular basis when it can be managed at home with the right help. Money, staffing and resources are the key. Healthcare cannot be done on the cheap, but it can be less costly if people are given proper community care and kept out of hospital as long as possible.

Michael Coleman MLC

A long time ago the Merseyside Independent Audit Authority did a report – yet another report – not a well-known one, which basically concluded that what you have got to do for the Hospital is to determine what is going to be done at the Hospital and what is going to be done elsewhere. Whether the 'elsewhere' is Ramsey or it is saving up knee operations for a two-day specialist clinic with someone coming over who can do 10 every morning rather than someone who does two every month is a matter to be looked at, but it basically said your Hospital should be a triage where you work out what you have got: an A&E, an intensive care, a coronary unit, and neonatal – because you do not know when babies are going to come, so you have to have that. You need to stabilise people and then you need the regular type of clinics, and then you can decide where you are going to do them. Are you going to enter into agreements with hospital trusts in the UK who are specialised: Wrightington for hands and legs and feet? The point I am making is that until you know an acceptable model, it is difficult to work out the funding and vice versa. They have to be done together; they cannot be done individually.

Annex 2: Stakeholder Groups and Individuals in Contact with the Review

MEETINGS

Public

- Various (Tynwald Day)
- 72 participants at public workshops[xxviii]
- Chamber of Commerce°
- Positive Action Group
- Rotary Club

DHSC Leadership/Management

- Chief Executive*
- Executive Director of Health and Care °
- Director of Public Health°
- Director of Community Care
- Director of Children and Families
- Former Director of Hospitals
- Interim Director of Hospitals
- Interim Medical Director
- Finance Director
- Project Accountant, DHSC Corporate Services Division
- Director of Infrastructure
- Chief Information and Digital Officer/Chief Clinical Information Officer
- Communications Business Partner
- Human Resources Business Partner
- Head of Adult Social Work Services°
- Head of Adult Social Care Operations
- Head of Community Health Operations
- Programme Office Manager
- Finance Managers (Community Care and Hospitals Directorates)
- Pharmaceutical Adviser
- Patient Safety and Quality Managers (Community Care and Hospitals Directorates)
- Hospital Patient Safety and Quality Committee
- Interim Specialist HR Lead
- Service Planning and Engagement Lead (Community Care Directorate)
- Commissioning and Contracts Manager (Community Care Directorate)
- Contracts and Business Operations Manager (Children and Families Directorate)
- Business and Performance Manager (Women and Children's Division)
- Head of Commercial and Business Enterprise (Hospitals Directorate)
- Head of Primary Care Commissioning
- Community Care Contracts Advisory Group
- Hospital Operational Managers
- Hospital Performance Manager
- Hospital Therapies Manager
- Hospital Patient Flow Managers and Complex Discharger Coordinator
- Hospital Women's and Children's Care Group

- Integrated Care Pilot Project in the West Team °
- Integrated Care Pilot Project in the West – Executive Steering Group
- Manager, Family Practitioner Services
- Responsible Officers (medical revalidation)
- Lead Appraisers (acute care and GP)
- Former GP Adviser
- Manager, Drug and Alcohol Team and Children and Adolescent Mental Health Service
- Head of Information Management & Compliance
- Dental Services Business Manager
- Head of Research and Development
- Head of Legislation (former and current)
- Project Manager, Community Care Directorate
- General Manager for Scheduled Care (Hospitals Directorate)

Deliverers of Care

- Community Therapies (Physiotherapy, Occupational Therapy, Podiatry and Speech and Language Therapy)
- Thie Rosien Community Centre (including Southern Community Initiative, Thie Rosien Dental Clinic, Home Care, Reablement and Occupational Therapy, Bradda Resource Centre)
- Central Community Health Centre (including Salaried Dental Service, Continence Service, Community Adult Therapy, Paediatric Audiology, Long Term Conditions Coordinator, Older Persons Mental Health Service, Community Wellbeing Service, Community Mental Health Service for Adults)
- District Nurses°
- Health Visitors
- School Nurses
- Manannan Court
- Thie Meanagh
- Greenfield Park
- Adult Social Workers
- Generic Adult Social Work Team
- Adult Social Work Leads
- Service Lead for Older Persons Services
- Senior Practitioner for Adults Disabilities Team
- Learning Disabilities Liaison Nurse
- Public Health
- Senior Healthcare Public Health Practitioner
- Children and Families Directorate
- Ambulance Services
- Ramsey and District Cottage Hospital
- Former Clinical Directors
- New Board of Clinical Directors
- Associate Medical Directors°
- Hospital Consultants (various)°
- Medical Lead for Air Ambulance
- Director of Medical Education
- Hospital Nurses and Health Care Assistants (various)°
- Outpatient Nurses and Health Care Assistants
- Surgical Division

- Midwives
- Gynaecology Sister
- Obstetricians
- Diabetes Centre
- Hospital Therapies (Children's Therapy, Outpatient Physiotherapy, Dietetics and Acute Therapy)˚
- Stroke Unit
- Hospital Pharmacy
- General Practitioners˚ (various, Representatives of the GP Alliance, plus visits to Castletown Medical Centre, Palatine Group Practice, Finch Hill Health Centre, Kensington Group Practice, Ramsey Group Practice and Peel Medical Centre)
- Educational Psychologist
- Western Integrated Care Pilot Project – Implementation Team
- President, Isle of Man Medical Society
- Dentists
- Community Pharmacists
- Optometrists
- Brookfield Care Home˚
- Care Home Matrons Forum˚

Politicians

- Hon Howard Quayle MHK, Chief Minister
- Hon David Ashford MHK*
- Hon Alfred Cannan MHK*
- Hon Chris Thomas MHK
- Hon Ray Harmer MHK
- Hon Lawrence Skelly MHK
- Hon Bill Malarkey MHK
- Hon Juan Watterson SHK
- Mr Chris Robertshaw MHK˚
- Dr Alex Allinson MHK
- Mr Jason Moorhouse MHK
- Mrs Ann Corlett MHK
- Miss Clare Bettison MHK
- Mr Ralph Peake MHK
- Mr Rob Callister MHK
- Ms Julie Edge MHK
- Mr Lawrie Hooper MHK
- Mr Bill Shimmins MHK
- Mr Tim Baker MHK
- Mrs Jane Poole-Wilson MLC ˚
- Mr Bill Henderson MLC
- Mr David Cretney MLC
- Mrs Kate Lord-Brennan MLC
- Public Accounts Committee
- Various (Review launch and Tynwald Day)

Third Sector Organisations

- Chair, Council of Voluntary Organisations˚
- Griah
- Manx Deaf Society
- Disability Network
- Men in Sheds
- The Hub Club
- Isle of Man Health and Care Association
- Arthritis Care Isle of Man
- Bishops Chaplain and Diocese of Sodor and Man
- Coeliac Support Group
- Isle of Man Hospice
- Crossroads Care
- Mannin Sepsis
- Person Shaped Support
- Manx Cancer Help
- British Red Cross
- Motiv8 Addiction
- Southern Befrienders
- Live at Home
- Age Concern
- Isle of Man Parkinson's Disease Society
- McMillan Cancer
- Manx Swallows
- Isle of Man Cancer Services User Forum
- Bowel Cancer Isle of Man
- Manx Breast Cancer Support Group
- Quing
- Ellan Vannin Care Home
- Leonard Cheshire
- Motor Neurone Disease
- Children's Centre
- University of the Third Age
- Manx Asthma Association
- Corrin Memorial Home
- Care in Mann
- EPSA IOM
- Epilepsy Action
- Alzheimer's Society
- United Response

Other Stakeholders

- Hospital Patient Representatives and Volunteers˚
- Former Director of Primary Care
- Future funding of residential and nursing care team
- Members of Health Services Consultative Committee˚
- Mental Health Commission
- Health Services Independent Review Body
- His Excellency Sir Richard Gozney, Lieutenant Governor

- Chief Secretary, Isle of Man Government
- Chief Financial Officer (and former Financial Controller, Corporate Strategy Division), Treasury, Isle of Man Government*
- Executive Director, Office of Human Resource, Isle of Man Government
- Director of Learning, Education and Development, Office of Human Resource, Isle of Man Government
- HR Business Partner for DHSC, Office of Human Resource, Isle of Man Government
- Organisational Design Specialist, Office of Human Resource, Isle of Man Government
- Executive Director, Government Technology Services, Isle of Man Government˚
- Head of Core Operations, Government Technology Services, Isle of Man Government
- Programme Control Manager, Government Technology Services, Isle of Man Government
- Digital Transformation Team, Government Technology Services, Isle of Man Government
- Deputy Assessor of Income Tax, Treasury, Isle of Man Government
- Director of National Insurance, Treasury, Isle of Man Government
- Head of Economic Affairs, Cabinet Office, Isle of Man Government
- Collector, Customs & Excise Division, Treasury, Isle of Man Government
- Representatives of Department for Enterprise, Isle of Man Government
- Public Sector Housing Manager, Public Estates and Housing Division, Department of Infrastructure, Isle of Man Government
- University College, Isle of Man (Principal, Head of Education and Social Care, Principal Lecturer (at Keyll Darree) in Governance, Head of Special Needs Unit)
- Disability Employment Advisor
- Lay member for the Learning Disability Partnership Board
- Information Commissioner
- Representatives of Isle of Man Constabulary
- Third Clerk of Tynwald
- Others (Tynwald Day)

WRITTEN SUBMISSIONS[xxix]

- Mr Bill Henderson, MLC
- Miss Clare Bettison, MHK
- Economic Policy and Review Committee
- Royal College of Speech and Language Therapists
- Chair, Mersey Faculty Royal College of General Practitioners
- Eleven submissions from Third Sector organisations
- Sixteen submissions from members of the public
- Fourteen submissions from DHSC staff members

ONLINE HUB CONTRIBUTIONS

- 183 ideas
- 431 comments

Note those marked ˚represent one or more members of the Advisory Panel.

*Note those marked * are members of the Sponsor Group.*

Annex 3: Summary of Focus Groups

The Review Team (civil servants and external consultants) organised and facilitated six focus groups during November and December 2018 to test assumptions developed in the course of the work undertaken to that date, to identify further research requirements before completion of the Final Report and to consider/validate potential recommendations. The Focus Groups were as follows:

1. **Optimal Service Model –** What would be the optimal health and social care service model for the Isle of Man? Friday 23 November
2. **Integration of Services –** How could health, social care and other public services integrate more effectively? Friday 23 November
3. **Health and Care System Architecture and Governance** – How should the Island's health and social care system be structured and what governance should be in place to deliver safe, efficient, affordable and high-quality care? Thursday 29 November
4. **Funding** – How could additional funding for health and social care services in the future be raised? Tuesday 11 December
5. **Workforce –** How can the Isle of Man address the challenges in recruiting, retaining and developing a workforce to deliver excellent health and social care to the people of the Isle of Man? Tuesday 11 December
6. **Improvement and Efficiency** – How could the Island's health and social care services become more patient-centred, outcomes focused and efficient? Thursday 13 December

Every member of the Advisory Panel (AP) was invited to attend, or send a substitute, to each of the Focus Groups. Other key stakeholders were invited to specific Focus Groups as appropriate, including those on the advice of/recommendation from the AP. Therefore, through the Focus Groups, the Review Team was able to engage with a range of Advisory Panel members and other key stakeholders from across the health and care system.

Below is a summary of the Review Team's learnings from each of the Focus Groups. For each of the Focus Groups it was noted that attendance was good, with representation from every part of the health and care system (and more widely across and outside of Government) to provide the team with a clear understanding of needs on the Island.

Focus Group 1 - Optimal Service Model

Attendees at the first Focus Group recognised that the Isle of Man, in common with many other health economies, is facing a range of demographic challenges.

It was agreed that a shift from a reactive, acute-focused model of care to a more proactive, community-based model would improve quality, outcomes and value-for-money. It was understood however, that this would require fundamental changes in the way services are currently delivered.

The broad consensus within the group was that the system was currently trying to deliver too many services on the Isle of Man by Island staff. The general sense was that *'only services that can be delivered to a high-level of quality, or that are urgent should be delivered on Island by Island staff'.* It was discussed that other services, particularly those for which critical mass is a determinant of quality and outcomes, should either be delivered on Island by off Island providers or off Island.

The session was a useful forum in which to test ideas and the Review Team was able to move forward the future service model element significantly through feedback from the group exercises, which included:

- Confirmation that the principles presented for an optimal service model were fundamentally the right principles, but the language required tweaking in places to truly encapsulate the desired future service model.
- A challenge that rather than presenting principles we could use a mission, vision, values approach. Being more focused on this approach might *"avoid the need for another strategy in 5 years' time"*
- Three key criteria for success were raised:
    - Communication
    - Data
    - Culture change – it was noted that this is difficult but it has been done e.g. the IOM Constabulary. The cultural shift will be required for all stakeholders, starting with the public and including increasing accountability for DHSC staff.
- The overarching vision should be something along the lines of *"A health and care system that is a provider of contemporary services where people receive care aligned to high-quality, integrated care pathways which are constantly refined to reflect patient needs and experience through the measurement and reporting of relevant outcomes".*

Invitees:

Department/Relevance	Outcome
AP - General Practitioner Representative	Attended
AP - Private Care Representative	Unable to attend
AP - Senior Health and Social Care Representative	Attended
AP - Public Health Representative	Unable to attend
AP - Member of Legislative Council	Substitute attended
AP - Member of House of Keys	Attended
AP - Mental Health Representative	Unable to attend
AP - Allied Health Professional Representative	Attended
AP - Community Nursing Representative	Substitute attended
AP - Hospital Nursing Representative	Unable to attend
AP - Hospital Doctor Representative	Unable to attend
AP - Third Sector Representative	Attended
AP - Business Sector Representative	Attended
AP - Health Services Consultative Committee Representative	Attended
AP - Government Technology Services Representative	Substitute attended
AP - Social Care Representative	Attended
AP - Nobles' Patient Experience and Quality Committee Representative	Unable to attend
Commissioning	Attended
Commissioning	Attended
Ambulance Service	Attended
Interim Medical Director	Attended
General Practitioner	Attended

Focus Group 2 – Integration

The second Focus Group was held on the same day as the first and build upon the themes mentioned above.

It was felt that, despite limited progress against the 2011 and 2015 strategy documents, some progress had been made in integrating services and that this had translated to improved outcomes, with the following examples cited for the Review to be aware of:

- the Integrated Pilot Project in the West

- Joint patrols by police and mental health workers, which were felt to have been highly effective in supporting individuals in crisis
- Work to develop urgent care practitioners to reduce the amount of admissions to hospital
- Project ECHO – aiming to de-monopolise specialist knowledge

It was clear that, whilst the benefits of integration are understood, making it happen is more difficult. Some key barriers to delivering the new model of care were highlighted:

- the lack of GP capacity, which meant that opportunities were being lost at the point of first contact with the system
- Current funding arrangements - one central budget is required for health and social care and there needs to be greater investment in out of hospital settings
- The Island needs to develop expertise and capability in risk stratification

The following key enablers for successful integration were also highlighted:

- Changes in legislation to recognise and foster integration
- Greater efforts to learn from successes on Island and use the lessons learned to inform other change processes
- Mapping of service user journeys with a multi-disciplinary team to identify where integrated working across health, social care and the wider determinants can enable improvements in outcomes
- Allow professionals and staff more autonomy
- Myth busting regarding data protection - local Caldecott guardian/information commissioner could set out proper, practical guidelines on when and where information should and could be shared, noting a duty to share
- A unified, accessible health and care record
- Proper commissioning of third sector services, with longer-term contracts to allow the third sector to plan properly
- Addressing the culture of the organisation, including appointing/replacing staff with those with the right attitudes, behaviours and values
- Clear communications and change management to ensure awareness and accurate perception
- Visibility and connectivity between staff and leadership

Invitees:

Department/Relevance	Outcome
AP - General Practitioner Representative	Attended
AP - Private Care Representative	Unable to attend
AP - Senior Health and Social Care Representative	Attended
AP - Public Health Representative	Unable to attend
AP - Member of Legislative Council	Unable to attend
AP - Member of House of Keys	Attended
AP - Mental Health Representative	Attended
AP - Allied Health Professional Representative	Attended
AP - Community Nursing Representative	Attended
AP - Hospital Nursing Representative	Unable to attend
AP - Hospital Doctor Representative	Unable to attend
AP - Third Sector Representative	Attended
AP - Third Sector Representative	Attended
AP - Business Sector Representative	Attended
AP - Health Services Consultative Committee Representative	Substitute attended

AP - Government Technology Services Representative	Attended
AP - Social Care Representative	Attended
AP - Nobles' Patient Experience and Quality Committee Representative	Unable to attend
Ambulance Service	Attended
Fire Service	Unable to attend
Education	Unable to attend
Safeguarding	Unable to attend
Optometrists	Attended
Pharmacists	Unable to attend
Police	Attended
Future Funding of Nursing & Res. Care	Unable to attend
Live at Home	Unable to attend
St Christopher's - Wraparound Team	Unable to attend
Chief Executive Officer, Hospice Isle of Man	Attended
Adult Health Visitor for Vulnerable Adults	Unable to attend
Public Sector Housing Team	Attended
Interim Medical Director	Attended
Lead Nurse IPC	Attended
Emergency Services Joint Control Room Operations Manager	Unable to attend

Focus Group 3: System Governance and Architecture

This Focus Group was looking at a significant change to the structure of the health and care system. The facilitator gave some information to support how a purchaser and provider split might work on Island before asking for feedback from the participants.

Attendees identified serious failings within the current model of care in respect of corporate, system and clinical governance. The general consensus was that *"something needs to be done".*
There was agreement that greater transparency and accountability needed to be achieved in clinical practice, with recognition of and support for the need for increased regulation of both health and social care services.

There was broad agreement that the health and care service needs to be 'once removed' from politics on the island, and acceptance that this was likely to entail a split between purchaser and provider. In order to make this idea more palatable, it was agreed that it needed clearer terminology and exact definitions. It was clear that the term 'commissioning' was not favoured within the group as the term was not properly understood across the organisation, yet there was acceptance that some of the core commissioning capabilities and functions would be required for system transformation.

The following key enablers for the transformation were put forward:

- Actively get staff engaged with the idea and work with the positive and proactive people
- Strong leadership is required
- Focus on the positive of creating a better culture of evaluating against standards for patient safety
- Emphasise the need to make radical changes – lots of small changes can become disjointed and the individual changes will often fall by the wayside

The following barriers to achieving the change were also raised:

- Political barriers
- Lack of forward thinking and planning

- Lack of strong leadership and accountability
- Small number of people acting as 'blockers'
- Lack of useful evidence based data

There was a strong emphasis on the need for the Review to set out an outline implementation plan, with a staggered approach and an estimate of resource requirements.

Invitees:

Department/Relevance	Outcome
AP - General Practitioner Representative	Attended
AP - Private Care Representative	Attended
AP - Senior Health and Social Care Representative	Unable to attend
AP - Public Health Representative	Attended
AP - Member of Legislative Council	Attended
AP - Member of House of Keys	Attended
AP - Mental Health Representative	Attended
AP - Allied Health Professional Representative	Attended
AP - Community Nursing Representative	Unable to attend
AP - Hospital Nursing Representative	Unable to attend
AP - Hospital Doctor Representative	Unable to attend
AP - Third Sector Representative	Attended
AP - Third Sector Representative	Attended
AP - Business Sector Representative	Attended
AP - Health Services Consultative Committee Representative	Attended
AP - Government Technology Services Representative	Substitute attended
AP - Social Care Representative	Unable to attend
AP - Nobles' Patient Experience and Quality Committee Representative	Unable to attend
Chief Executive of DHSC	Attended
Hospital Consultant	Attended
Director of Children and Families	Attended
Associate Medical Director	Attended
Interim Medical Director	Attended
Executive Director of OHR	Attended

Focus Group 4: Funding

There were some strong, and often opposing, views within this Focus Group; however, this was expected given the feedback received from the public to date.

There was no consensus on there being a single, 'silver bullet' that would solve the funding gap; rather, that it would be a number of variations to existing mechanisms.

Within the group:

- people generally liked the idea of a hypothecated health and care tax (where everyone pays a percentage of earnings, specifically to pay for health and care services)
- introducing more charges on services (e.g. GP appointments), increasing charges (e.g. on prescriptions) or reducing exemptions (e.g. on prescriptions) was seen as politically very difficult to do, and it was noted that it had failed to be implemented before

- there was some discussion around amendments to National Insurance (NI) (making those above retirement age pay it, raising NI thresholds to UK rates) which could raise some funding.

It was clear that for any change (and perhaps irrespective of it), there needs to be honest communication about what 'deal' the public are currently getting for their money, and the fact that services have changed in the past couple of decades as people have got older and more unwell, and so there is more demand on the system. There needs to be a 'reset' in terms of people's expectations from the health and care system.
There was a very strong sense that people would expect quality of care, and outcomes, to improve if funding levels increase, so a close link to efficiency and productivity and the new service delivery model is needed.

The size of the funding gap (£290m with inflation) was accepted by the group and considered manageable, if action was taken.

There were some queries over the way that the funding gap is calculated:

- There was a view that the funding gap projection should ignore inflation - because tax receipts, NI etc. would also rise broadly in line with inflation and the gap may be overstated. Whilst the point was made that "health inflation" is typically higher than headline inflation (e.g. RPI) the Review Team will reconsider presentation of the funding gap excluding inflation.
- Most of the group supported the view that improving efficiency (value for money) is key because of the beneficial effect of applying the compounding cost increases over a number of years to a smaller initial figure. This action would reduce the size of the funding gap challenge as well as helping to justify any additional costs to the tax payer.

Invitees:

Department/Relevance	Outcome
AP - General Practitioner Representative	Attended
AP - Private Care Representative	Attended
AP- Senior Health and Social Care Representative	Attended
AP - Public Health Representative	Attended
AP - Member of Legislative Council	Attended
AP - Member of House of Keys	Attended
AP - Mental Health Representative	Unable to attend
AP - Allied Health Professional Representative	Attended
AP - Community Nursing Representative	Substitute attended
AP - Hospital Nursing Representative	Unable to attend
AP - Hospital Doctor Representative	Unable to attend
AP - Third Sector Representative	Attended
AP - Business Sector Representative	Attended
AP - Health Services Consultative Committee Representative	Attended
AP - Government Technology Services Representative	Attended
AP - Social Care Representative	Attended
AP- Nobles' Patient Experience and Quality Committee Representative	Unable to attend
Financial Controller - Treasury	Attended
Director of National Insurance	Attended
Deputy Assessor of Income Tax	Unable to attend
Collector – Customs & Excise	Attended

Economic Affairs	Attended
Department of Enterprise	Attended
Future Funding of Nursing & Res Care	Attended
Financial Director	Attended

Focus Group 5: Workforce

Participants in this Focus Group felt that there were serious workforce challenges on the Isle of Man, many of which were reflective of wider issues.

It was recognised that more could be done to attract talent to the Isle of Man (monetary and non-monetary incentives) and to develop the skills of existing staff. It was accepted that some disincentives originated outside of the control of DHSC (or the Isle of Man), e.g. ability of the Isle of Man Government to pay for university fees, and so focus should be on what can be addressed. Culture and behaviours were identified as being a major issue, both in terms of attracting talent and making the most of the talent already in the workplace.

It was agreed that the new workforce model would need to incorporate more generalist roles working across a range of settings, and that it would need to support individuals working to the top of their licence (e.g. therapists prescribing). It was understood that delivery of the new service model would necessitate workforce shifts and greater investment (number and skills) in community based staff. Some reductions in the acute workforce (under the new service model) were felt to be inevitable, however it was felt that a case could be made to the general public for how such changes could actually enhance the quality of care.

The following challenges that would be faced when moving from the current to the new service model were discussed:

- The new system will need to have individuals with specific and defined responsibilities and accountabilities related to the change
- There is a lack of effective communications and corporate (Human Resources, Technology etc.) support for the DHSC
- There is a need to engage with the workforce more and empower them
- Education has been used to build and develop the workforce more regularly over recent years, but changing the system might mean a need to change the education programmes, and it takes time to receive the benefits when using this approach
- It would require double running of the current model and the new model to complete the transformation, which could potentially lead to large costs so transformational funding is needed to kick start the change process.
- There is a limited talent pool
- Due to the health and care system being understaffed, change doesn't need to be seen as a threat to people and their jobs
- The Office of Human Resources (OHR) needs to have an understanding of who is needed to fill the vacancies. OHR and DHSC need to collaborate better
- Work permit rules should be specific to the Isle of Man so that they address local challenge (e.g. ease/aid recruitment of therapists).

Invitees:

Department/Relevance	Outcome
AP - General Practitioner Representative	Attended
AP - Private Care Representative	Attended
AP - Senior Health and Social Care Representative	Attended
AP - Public Health Representative	Unable to attend
AP - Member of Legislative Council	Unable to attend
AP - Member of House of Keys	Unable to attend
AP - Mental Health Representative	Unable to attend
AP - Allied Health Professional Representative	Substitute attended
AP - Community Nursing Representative	Substitute attended
AP - Hospital Nursing Representative	Unable to attend
AP - Hospital Doctor Representative	Unable to attend
AP - Third Sector Representative	Attended
AP - Third Sector Representative	Attended
AP - Business Sector Representative	Attended
AP - Health Services Consultative Committee Representative	Substitute attended
AP - Government Technology Services Representative	Unable to attend
AP - Social Care Representative	Unable to attend
AP- Nobles' Patient Experience and Quality Committee Representative	Unable to attend
Executive Director for Office of Human Resources (OHR)	Attended
Organisational Design Specialist, OHR	Attended
Head of Employment Services, OHR	Attended
Principal, University College Isle of Man (UCM)	Attended
Director of Medical Education	Unable to attend
Revalidation officer for GPs	Unable to attend
Revalidation officer for Acute Doctors	Attended
Head of Education and Social Care, UCM	Unable to attend
Principal Lecturer (Governance), UCM	Attended
HR Advisor	Attended

Focus Group 6: Improvements and efficiencies

The final Focus Group was seeking suggestions and opinions regarding how the Island's health and care services could become more service-user centred, outcome focused and efficient.

It was recognised that not all previous initiatives have delivered to their full potential. Some of the reasons cited were:

- A lack of identifiable 'cross-system' leadership
- Initiatives are not well implemented, with no clear strategy or communication plan
- Initiatives are very often Noble's focused and not across the whole health and care system, with few forums for meaningful interaction between staff groups (particularly across primary and secondary care)
- Political interference
- General lack of engagement with key stakeholders
- Lack of funding and additional resources
- Lack of performance management
- Lack of useful data collection

The following priorities to enable transformational change were highlighted:

- A focus on sharing knowledge and learning from successful change, including the ability to learn from past mistakes and use them positively and productively
- Time and funds to be made available to pilot new ideas.
- A fundamental change in culture and the behaviours that come with it – ensuring that there is oversight and answerability and being courageous enough to hold people to task
- Transparent decision-making to ensure that everyone understands and so can buy into the change
- Legislative changes are important, providing it is understood these changes would be a key enabler/gateway to make change and not enough change on its own
- Making use of digital enablers. Examples of this are: telemedicine, single integrated health and care record and tele-mentoring.

Suggestions for opportunities to improve efficiency and productivity on the island, centred around allowing professionals to work to the top of their licence, included:

- introducing the use of Advanced Nurse Practitioners or Physician Associates
- having nurse-led community services with input from off island specialists in a number of pathways
- making the maternity ward a midwifery-led service
- integrated community/secondary approach, as seen in the hospital audiology Department
- having a physiotherapy-led Botox service.

Invitees:

Department/Relevance	Outcome
AP - General Practitioner Representative	Attended
AP - Private Care Representative	Attended
AP- Senior Health and Social Care Representative	Attended
AP - Public Health Representative	Attended
AP - Member of Legislative Council	Attended
AP - Member of House of Keys	Unable to attend
AP - Mental Health Representative	Attended
AP - Allied Health Professional Representative	Substitute attended
AP - Community Nursing Representative	Attended
AP - Hospital Nursing Representative	Unable to attend
AP - Hospital Doctor Representative	Unable to attend
AP - Third Sector Representative	Attended
AP - Business Sector Representative	Attended
AP - Health Services Consultative Committee Representative	Substitute attended
AP - Government Technology Services Representative	Substitute attended
AP - Social Care Representative	Attended
AP - Nobles' Patient Experience and Quality Committee Representative	Unable to attend
Associate Medical Director	Unable to attend
Director of Community Care	Attended
Head of Care Quality and Safety, Hospitals	Substitutes attended
Head of Care Quality and Safety, Community	Attended
Chief Executive Officer, Hospice Isle of Man	Attended
Lead Nurse - Stroke	Attended

Annex 4: Public Engagement

1. Introduction

The process of public engagement – open, two way conversations that provided opportunities for mutual learning between the Review Team and members of the public – has been beneficial in the development of recommendations that are relevant to the population of the Isle of Man. The public engagement process has also helped to increase public awareness and understanding of the issues facing the health and care system.

As the result of the Review has the potential to affect all Island residents, and the Members of Tynwald representing the Island's residents will make the decision on the report, the public have acted as a useful sounding board for testing the acceptability of suggested ways forward. It is important that the public are supportive of the changes proposed and therefore can play a part in holding the politicians to account in terms of accepting the recommendations outlined within this Report and ensuring that implementation continues over the long term.

Initially a website was set up to publicise the Review, outline its remit (including the terms of reference and people involved with it) and begin the public engagement process. The Review then planned an initial, open public engagement programme to gauge public opinion on the current situation within the health and care system and options for the future of health and care services.

2. Online hub

The engagement programme began with an online hub[xxx] as a central point, which allowed for new ideas to be posted and current ideas to be commented upon and rated. Participation was encouraged by the use of anonymous submissions, press coverage, social media and the ability to access it offline by way of comment cards available from various DHSC buildings, other care delivery buildings and at a dedicated stand at Tynwald Day.

Feedback received through comment cards and other written submissions were anonymously uploaded, where permission was granted, by the Review Secretariat (civil servants) to the online hub.

The online hub was open between 26 June and 7 August 2018, following which the Secretariat uploaded all remaining submissions received by email, telephone and in writing.

The online hub was post-moderated by the Secretariat using the Government's dialogue moderation policy[xxxi] to ensure that:

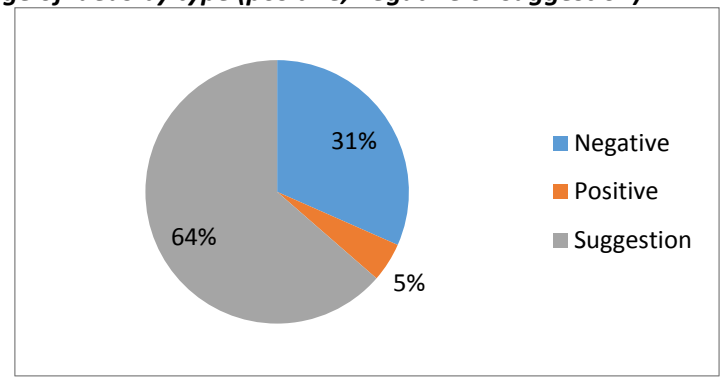
- similar comments were grouped (to maintain the thread of a discussion and build upon ideas),
- people were not identified within posts, and
- comments remained constructive (i.e. not threatening or obscene in line with the moderation policy).

The public were asked: What **is working** in the current health and social care system and **should be continued**? And what is **not working** and what **improvements** would you like to see?

2.1. Overview of responses

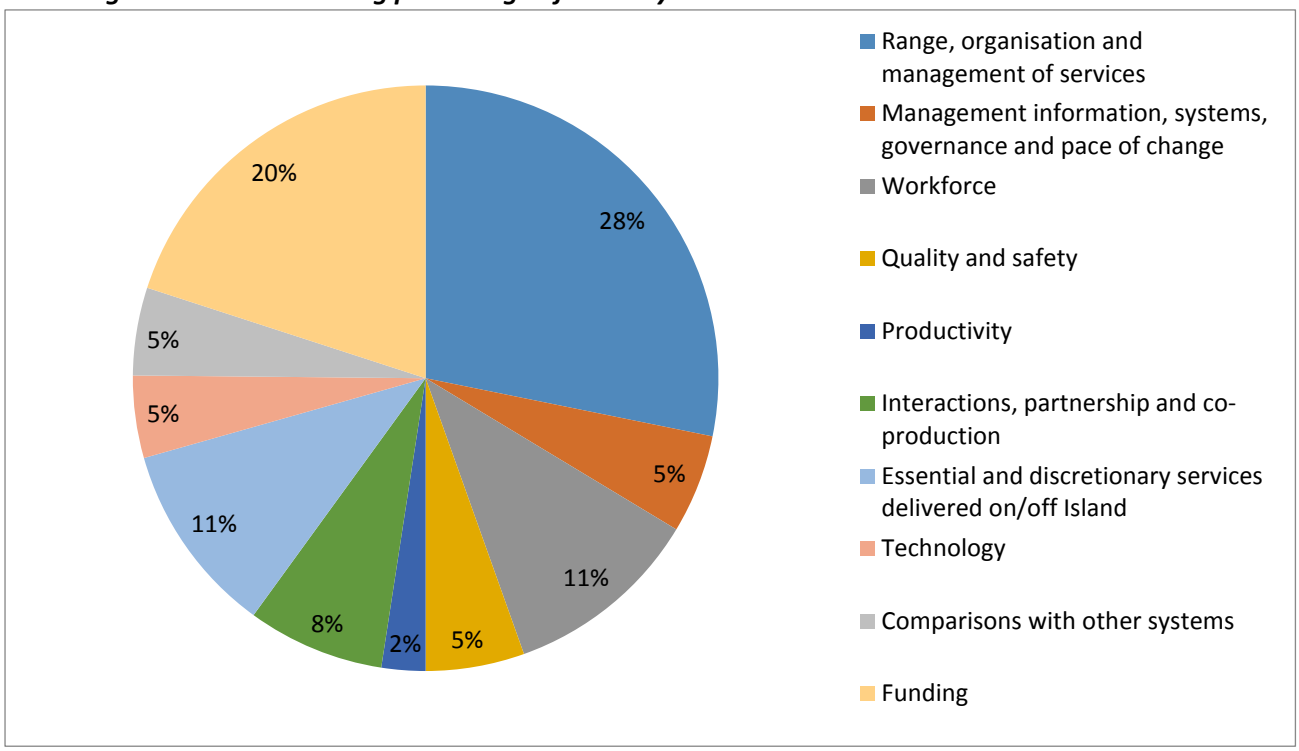
Overall, there were 183 ideas and 431 comments across the ideas posted. The chart below shows the split of comments received by type.

Figure 12: Percentage of ideas by type (positive, negative or suggestion)



The submissions were "tagged" to organise the debate into themes and allow the comments to be searched more easily. The tags were allocated by the Secretariat when moderating and used to group ideas into the review areas set out within the terms of reference. The below chart shows the split of comments received within each review area.

Figure 13: Chart showing percentage of ideas by review area



The members of public that engaged with this exercise were most interested in the:

- range, organisation and management of health and care services[xxxii], in particular improving access to services and delivery of services through the way that they are organised and managed;
- services at the hospital - these were most commented upon (58 ideas submitted) with services from GPs (26 ideas) and other community services (17 ideas) being the next most commented upon; and
- the funding of those services[xxxiii], which led to the most division of opinion.

2.1.1 Responses in relation to a revised service model

Figure 14: Summary[xxxiv] of public responses in relation to a shift from hospital to community based services gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"Integrated care hub" – Ramsey and District Cottage Hospital works well as an integrated care hub and it would be great to see more of this happening in different areas of the Island	5*	2	6 comments; mainly in agreement but some comment on whether RDCH worked better when it was run by the GP Practice rather than Nobles.
"Easy access to mental health facilities for young people"	5*	4	5 supportive comments
"Improved mental health access"	5*	8	7 supportive comments
"Access to GP's" – for working people	4.75*	4	4 supportive comments
"Introduce more flexible services" – access to appointments at evenings and weekends	5*	4	2 supportive comments
"Teach people how to use MEDS appropriately"	4.6*	5	2 supportive comments
"More home care provision"	5*	3	3 supportive comments
"Bring back convalescent services"	5*	2	3 comments focussed on the adequacy of RDCH
"Patients care to be delivered in the most appropriate place"	4.7*	6	5 supportive comments
"Assertive outreach approach" - Ensure those that need mental health support aren't missed or lost	5*	3	1 supportive comment
"Pre-emptive and preventative collaborations and therapies"	4.5*	2	0
"Define Wellness - The Current Model IS Geared To Upwards Only Sick Spending – National Wellness Service"	5*	2	0
"Exercise groups for patients who have reduced mobility"	4.5*	2	1 supportive comment

The following themes emerged from the ideas posted:

- care should be delivered in the most appropriate place, including increasing the number of step-up/step-down beds and amount of home care services, and educating people to use the Manx Emergency Doctor Service (MEDS) and pharmacies properly;
- more focus on pre-emptive and preventative collaborations and therapies; and
- better communication required between areas of health and care delivery.

Figure 15: Summary[xxxv] of public responses in relation to 'on'/'off' Island services gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
Essential services for the Island			
"Rheumatology Dept" - need to operate a full time service	4.5*	2	1 supportive comment
"Ensure adequate supply of NHS dentists"	4.8*	9	3 supportive comments
"Dental Care for Pregnant Women"	4.7*	3	0
"No Dermatology service at the moment - we need one"	5*	3	Update by DHSC to advise that there is a service. Discussion on waiting times and possibility of using telemedicine.
"More home care provision"	5*	3	3 supportive comments
"Review dental care for children"	5*	2	2 supportive comments
Off-Island services			
"Source off island healthcare from other places than Liverpool" – lack of acute mental health service for pregnant new mums.	4.5*	2	0

Twenty-two suggestions related to essential services for an Island population and eleven suggestions were put forward in relation to services being commissioned elsewhere.

The comments suggested a general understanding by the public that some services have to be provided off-Island, but some people thought that patients shouldn't always be sent to Liverpool as an "easy option". The DHSC needs to ensure efficiency (through a review of the services provided, service providers used, acquiring blocks of treatment, improving communication with off-Island providers etc.) and quality of the services being provided off-Island.
The majority of third sector responses suggested that more services could be provided on Island by working in partnership with the third sector.

Figure 16: Summary[xxxvi] of public responses in relation to integration of services gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"Value the work of psychologists"	5*	3	3 supportive comments emphasising that more psychologists are required.
"Better communication between departments"	5*	8	4 supportive comments, focus on lack of integrated computer system.
"Engage with alternative therapies more" – consideration of social prescribing and interactions with other services such as chiropractor	5*	3	3 comments – 2 supportive, 1 against
"Personal responsibility for own health and wellbeing to be encouraged" - system to have case workers/ information officers who have a working knowledge of services and benefits across the whole spectrum for ease of access.	4.5*	2	0
"Integrated care hub" – RDCH works well as an integrated care hub and it would be great to see more of this happening in different areas of the Island	5*	2	6 comments; mainly in agreement but some comment on whether RDCH worked better when it was run by the GP Practice rather than Nobles.
"Staff member who can liaise with off island hospitals"	5*	2	3 supportive comments

There were 24 ideas on the online hub relevant to current levels of integration within the system. The comments mainly focussed on the interactions between health and care services and the need for better communication and more integration across the system, both within and outside of the DHSC.

2.1.2 Responses in relation to governance

The ideas submitted by the public on the online hub did not often comment on the health and care service at this high level, instead focussing on anecdotal stories and personal experiences of care. Those ideas that were relevant to governance are summarised below:

Figure 17: Public responses in relation to governance gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"#voteGoogle" - Let google run the hospital services to optimise the way it is managed. The two important elements would be transparency and accountability	2.6*	9	4 comments – varied views
"Anonymous Management" – related to better decision making, better governance and transparency in the care of the patient which in turn leads to improved care.	4.6*	3	1 comment on the adequacy of hospital management
"Prioritise Public Health" – suggestion to establish public health as a separate body with wider representation than just health professionals, with accountability and a results based / commercial focus.	4*	3	4 supportive comments
"Political pressure" - Politicians need to give the health service time to breathe. There are constant questions asked about minutiae which means that staff are being taken away from duties to provide answers to those questions.	0	0	0
"Update and improve Social Care systems and policies"	5*	1	0

2.1.3 Responses in relation to funding options

Figure 18: Summary[xxxvii] of public responses around funding gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"Ring fence tax rise & NI to Health and Social Care"	5*	11	7 mainly supportive comments
"People to pay for treatment for self-induced problems"	5*	3	7 varied comments
"charges for wasted appointments"	3.6*	12	13 comments; mainly in agreement with the principle but noting the poor appointments system which would need fixing first.
"Introduce charge to see GP, ManDoc or receive treatment through A&E"	2.1*	14	13 varied comments
"Means tested contribution to social care for over 65s"	2*	8	12 varied comments

Twenty-six comments were made in relation to funding[xxxviii], with several different ideas put forward for raising additional funds, including: introducing charges (to be seen by a General Practitioner, at the Emergency Department or for not attending appointments, treatment for self–induced issues, car parking etc.); more use of means testing (social care for over 65's, credit for nursery placements, patient transfers for off-Island care etc.); and, tax or national insurance ('NI') rises.

This area of the Review prompted most discussion and disagreement amongst the public. All of the above ideas received some conflicting views but the most supported ideas related to introducing charges for people not attending appointments and increasing funding through tax/NI rises.

The third sector responses that commented on funding put forward the view that services should remain free at the point of delivery.

2.1.4 Responses in relation to other areas of the Review

2.1.4.1 Workforce

Figure 19: Summary[xxxix] of public responses around workforce gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"Create a mechanism for staff to create improvements"	4.5*	2	2 supportive comments
"Create a Medical HR division"	5*	3	0
"Management seem terrified of criticism"	5*	2	3 supportive comments
"Efficient admin support" - so that professionals/clinicians have time to spend with patients rather spending time on admin	5*	5	7 supportive comments and 1 disagreeing
"Value the work of psychologists"	5*	3	3 supportive comments emphasising that more psychologists are required.
"Doctors and other health professionals not to be recruited via an agency"	4.6*	9	4 varied comments – relating to substantive admin support, continuity of care, agency staff being cheaper in terms of pensions, and more training for staff on Island with the requirement to stay on Island for a minimum period afterwards
"Pension" – arrangements for transfer of UK NHS pensions	5*	2	4 varying comments mainly supportive
"Full staffing levels required to improve patient safety and care"	5*	2	2 supportive comments, noting problems with recruitment
"Caring Cadetships - clear entry and career paths" – one year	5*	2	1 supportive comment

covering all aspects of the care sector			
What is working - employees of the DHSC	4.8*	4	7 supportive comments

This review area received 34 ideas. The main themes emerging from the responses were:

- supportive comments for the frontline staff;
- recruitment issues – including the continued use of agency health professionals and temporary administration staff, the need for a specialist medical Human Resources (HR) division, arrangements for transfer of pensions from the United Kingdom (UK) and clearer entry and career paths for caring professions such as healthcare assistants and home carers; and
- the need for an avenue for staff to suggest and implement improvements.

2.1.4.2 Improvements and Efficiencies

Figure 20: Summary[xl] of public responses around improvements and efficiencies gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"Better communication between departments"	5*	8	4 supportive comments, focus on lack of integrated computer system.
"Skype Appointments"	4.7*	18	8 supportive comments
"Appointment efficiencies - Save money & time" – similar to above, use of phone/video call where appropriate.	4.8*	5	3 supportive comments
"Consultation Follow up Surveys"	5*	4	2 supportive, 1 conflicting comment
"Introduce more flexible services" – access to appointments at evenings and weekends	5*	4	2 supportive comments
"Add Hospital Records to Patient Access"	4.9*	9	4 supportive comments

In terms of improvements and efficiencies, themes emerging from the ideas posted focussed on making the most of the DHSC's assets (including staff, buildings and technology) to make the services more flexible. There were 15 ideas raised in relation to the use of technology to enhance services provided, predominantly around sharing patient records across one computer system, using technology for appointment bookings and utilising telephone/video calls to make appointments more efficient.

Figure 21: Summary[xli] of public responses around cost savings gathered from Review's online hub

Suggestion	Average rating (5* max.)	Number of ratings	Comments
"Cost of aftercare relating to mental health"	5*	5	0
"Small parking charges for visitors and staff"	1.2*	10	20 varied comments
"Reduce costs of waste from inferior or inadequate products"	5*	2	0
"Prescriptions for former Manx residents now overseas" – being collected and posted overseas	5*	4	3 comments focussed on prescription fraud
"Monitoring of lost meds/lost scripts"	4.8*	4	3 supportive comments
"Prescription" – to print the cost of the medicine of the chemists label to get the public to value it more and so reduce wastage	4.9*	7	3 varied comments
"When a prescription is not required" – adding information to a prescription informing patients that they could purchase the item	4.9*	7	1 comment disagreeing – stating it is the doctor's responsibility and prescriptions should not be given for those items.
"Reuse equipment"	4.7*	3	0

A recurring cost saving theme was in relation to prescriptions, with ideas including stronger controls to prevent prescription fraud and ideas for encouraging the public to value medicines being prescribed and take responsibility for purchasing their own over the counter medication.

2.1.5 Summary

The key themes that emerged from the written responses were:

- **Communication throughout the system;**
- **Integrated care** – This aspect was raised in comments from the public such as "*services need to be easier to access*", "*care should be delivered in the most appropriate place*" (including ensuring that services being provided are being utilised correctly and to their full potential), and "*I don't want to have to repeat my medical history several times to different people*"; as well as comments highlighting the need for shared computer systems across the DHSC and the positive effect of having a care co-ordinator;
- **Scope of services** – there was a consistent theme that there should be a greater focus on prevention (both public health and utilisation of pre-emptive/preventative services available). In terms of the split between on and off-Island services, there appeared to be an understanding from the public that some services have to be provided off-Island but people want to ensure the value and quality of services provided as well as feeling like that DHSC is ensuring efficiency in the way that this care is organised;
- **Efficiency** – common suggestions were to:
    - increase the amount of information available to improve effective decision making;
    - ensure that full use is being made of the DHSC's assets (services/people);
    - utilise technology to a greater extent; and
    - cut down on wastage (with a number of cost saving ideas put forward); and

- **Funding** – the overriding principle is that people want to feel that the system, including funding, is fair for all.

3. Face to Face Engagement

3.1 Tynwald Day

Sir Jonathan Michael was on the Island on Tynwald Day, which presented a useful opportunity for him to learn more about the Island's history and culture and meet with a large number of people who attend the Tynwald Day fair, in order to hear a variety of views that may otherwise have been challenging to obtain.

A table display was set up in the Manx Tent, which was colourful, informative and interactive for people of all ages, to increase public awareness of the Review and allow people to speak to Sir Jonathan Michael (and the Secretariat).

Photo: Independent Health and Social Care Stand, Manx Tent, Tynwald Fair, St John's, 5 July 2018

3.2 Public workshops

To continue the public engagement programme three open public workshops were organised for interested members of the public to share their views with the Review Team.

The three workshops took place during September and October 2018. Initially it was planned to hold these in three different locations across the Isle of Man (north, south and centrally) but there was limited uptake in the north and south of the Island so all three were held centrally at Keyll Darree on the Noble's Hospital site. The workshops were planned for various times in the day to enable as many people as possible to attend. There were 34 attendees across the three sessions, with the evening session being the most popular.

The sessions were publicised by following up relevant posts on the online hub with invitations to participate in the sessions, a general invitation on the Review's website, a Government news release, which was also highlighted on the Government's Facebook page and Twitter feed and led to an article in the Isle of Man Courier, the use of Eventbrite and invitations to various groups[xlii] as well as posters displayed in the family library, on the Government intranet site and sent to GP surgeries to be passed onto their patient groups and displayed in surgeries. The Advisory Panel supported efforts by encouraging participation and suggesting interested parties.

The workshops sought the public's views on:

- What is working well?
- What could be working better?
- How well are services joined up around individuals and communities?
- What should the future look like?

Below is a summary of the feedback gained during the sessions.

3.2.1 Responses in relation to what is working well

- Noble's Hospital is good in parts, examples given included: Accident and Emergency, Chronic Obstructive Pulmonary Disease clinics, Coronary Care Unit nursing, Special Care Baby Unit, Orthopaedics, Blood Clinic and Radiology (patient services and range of services especially) and Oncology;
- It is good to have access to Consultants specialising in medical conditions that are not covered by Consultants on the Isle of Man, who travel to Isle of Man on a sessional basis e.g. for Dry Macular Degeneration, Oncology, Dermatology;
- Community care – good services provided by rehabilitation, practice nurses, Cummal Mooar day centre, continence adviser and support services (such as home care workers and cancer charities offering psychological services);
- Spread of GP surgeries around the Island;
- It was noted that GP surgeries vary enormously in practice, but examples of good practice were cited as those that:
    - are proactive to remind people about appointments and medication reviews;
    - make appointments available online;
    - have nurse practitioners' clinics;
    - have specific nurses (i.e. for Asperger's); and
    - know patients personally.
- It is free at the point of use.
- Hospice care is excellent i.e. time given to patients, behavioural approach, real patient focus.

3.2.2 Responses in relation to what could be working better

- There is a need to build capacity for more care in the community;
- Location of services – they should be designed around the patient, bearing in mind that the transport infrastructure is geared around Douglas;
- Disparity of private/NHS waiting times;
- Better information is needed about what is available to utilise services more effectively;
- Waiting times are too long – specific examples were given in relation to GPs, hospital and mental health;
- There should be a joined up computer system to enable more efficient processes and improve communication;
- Communication – across all areas including professionals to patients/families, professionals across the system and across Government;
- Need shared care protocols;
- Good leadership/management is crucial;
- Social care funding – inequalities;
- DHSC should be accountable for money spent – look at investing in the right services (value vs cost);
- Eligibility criteria for free healthcare – there should be a review taking into account residency on Island, free prescriptions, ability to pay;
- There is an "Illness lottery" – some diseases (e.g. cancer) get great services but not all are equal in the service provided (e.g. stroke);

- Services are only available during standard working hours;
- Staffing pressures and morale;
- Implementation of reviews – nothing happens;
- Off-Island appointments are not efficient.

3.2.3 Responses in relation to how well services are joined up around individuals and communities

- Hospice is a great example of person centred care;
- Generally, services are not well joined up between GPs and mental health, and between GPs and the hospital;
- Positive experience given of multi-disciplinary team ('MDT') working (physiotherapy, occupational therapy, speech therapy, district nurse, GP) supported by a long term conditions co-ordinator as lead nurse. Monthly MDT meetings including the patient, family and private home carer. This was built on interpersonal relationships but shows that it is possible within the system;
- Co-ordinator role considered very important to put the person first;
- Interpersonal relationships between professionals are good but systems don't always align i.e. front line teams do work well together but 'management' can get stuck in silos over budget etc;
- Social care is continually overlooked.

3.2.4 Responses in relation to what the future should look like

It should:

- be based on a needs assessment to determine the needs of the population;
- be more efficient with resources – driven by data, accountability, transparency;
- use shared care protocols – be a single health service, with one set of notes accessible by everyone and one computer system;
- be part of a joined up Government:
    - To take into account how policies impact on the health and care services and vice versa (i.e. policy to grow the population – more working families, more children, more use of services); and
    - If the policy going forward is to keep people in their own homes for longer, consideration of who and how will that impact (i.e. may be useful to have a realistic Carers Allowance for anyone being prepared to give up a job to care for a loved one at home, which does not totally cease at 65);
- build on what is in the system currently:
    - utilise natural touch points with community – GP's receptionists, community nurses, employ local area co-ordinators;
    - more mental health services to be provided in GP surgeries;
    - close wards in Noble's and turn them into community facilities (based on the assumption that if you have the room in Noble's you will keep filling it and creating more capacity in the community should keep people out of hospital);
    - reopen step up, step down facility in south of Island;
    - utilise third sector as partners – for sustainable services need longer term contracts;
    - utilise more volunteers;
    - make Manx Emergency Doctors Service a 24/7 walk in clinic and refer non-emergencies through from A&E;
- focus on prevention:
    - increase education – again utilising natural touch points, give people knowledge to improve independence, GPs to give information and use social prescribing etc.;
    - Government to take lead (e.g. focus on local, good quality food to improve health in hospitals and primary schools);

- increase use of screening programmes;
- utilise data on GP referrals to target preventative work.

3.2.5 Summary

The feedback gained through the public engagement workshops was consistent with the key themes that emerged from the written engagement exercise:

- **Communication** – all aspects of communication were flagged as areas for improvement within the workshops.
- **Integrated care** – It became clear that the public like having services provided close to where they live and work. Workshop participants were asked for feedback on "local services", "hospital and speciality services" and "tertiary services" for ease of discussion with the group – one attendee commented that "*we should stop referring to different types of care and look at the services as a whole"* in order to become properly integrated. This highlights the change of mind-set that will be required to move more care into the community. Other factors highlighted in the workshops to improve integration were:
  - social care services and support services that are required for keeping people at home (i.e. carers, home care workers, meals on wheels etc.) should be recognised and more highly valued by other areas within the DHSC;
  - the care co-ordinator role is very important in putting the patient first and building care around that person;
  - there is a need to build more capacity to care in the community before the system can begin to move that way.
- **Scope of services** – there was a theme of utilising available data to ensure that the right services are being provided and a need for a greater focus on prevention (both public health and utilisation of pre-emptive/preventative services available)
- **Efficiency** – common suggestions were to:
  - increase the amount of data and management information to improve effective decision making;
  - ensure that full use is being made of the DHSC's assets (building, services and people);
  - increase oversight of prescriptions – to reduce errors, avoid wastage and stop people claiming for free prescriptions to which they are not entitled;
  - ensure that tertiary services are being used efficiently; and
  - consider value rather than cost of expenditure.
- **Funding** – this was mentioned in all workshops and, again, elicited diverse views with the groups split between those that thought that care should be free at the point of use and those that thought that charges for services should be extended.

3.3 Further public workshops

Two differently themed public workshops were held in January and February 2019, with each workshop held twice – in the afternoon and evening. Members of the public that had attended the sessions in the autumn were invited (along with any other interested members of the public) to meet with the Review Team again. The workshops were publicised in the same way as the first public workshops. At these follow up workshops, the team outlined Sir Jonathan's current thinking and discussed potential draft recommendations with the public to test the suitability for the Island. The workshops were held after the publication of the Review's Progress Report and so gave the public the opportunity to talk to the Review Team about issues raised in that report.

Workshop 1 focussed on the service model, governance and workforce and workshop 2 focussed on improvements, efficiencies and funding. There were 29 attendees across the two sessions of workshop 1 and 28 across the two sessions of workshop 2.

The majority of people attending the workshops had attended in September/October 2018, had a link with the Review (e.g. through the Advisory Panel) or were representatives from the third sector. The discussions around the topics presented during the workshops were engaged and lively. The Review Team was challenged in some areas but the direction of travel was generally positive and people were pleased to have been given the opportunity to contribute.

3.3.1 Feedback in relation to workshop 1

3.3.1.1 Integrated service model

During this workshop, the Review Team presented a model for integrated health and care, with the citizen and their friends and family at the core. Comments on this model included:

- Public health should be made more explicit to increase the focus on wellness and prevention and ensure that sufficient need resources are allocated to it;
- It is a disease focussed rather than societal model - it should also include the community and wellbeing;
- Ensure people are accessing the right level of care – those at Accident and Emergency should be assessed and re-signposted if it is not an emergency, educate the public to use pharmacies effectively;
- GP surgeries should merge to assist with some surgeries being short staffed and to save money on administration;
- Some residential and nursing care establishments should be run by Government to act as some form of regulation on the other establishments. There should also be regular unannounced spot inspections to ensure standards are kept high. Reference was made to UK models where people have their own flat in the grounds of care service providers and have more choice in the package of care provided;
- there needs to be a step up, step down facility between hospital and home;
- There is a major opportunity of cohesive communities on Island;
- The care co-coordinator role is important to pull the services around the person;
- A joined up Government approach to health improvement and delivery is required, including relationships with other areas that impact on health and care services, for example transport;
- There needs to be much greater service user engagement, because what makes sense clinically doesn't always make sense to the public;
- A fear that having so many different medical buildings/locations will make integration difficult – may have to commence integration using geographical splits (example: North/South/East/West) before integrating them into one large and local service.

3.3.1.2 Governance

The governance recommendations outlined for discussion within the workshop were: separate the policy and strategy setting body from the delivery organisation to drive accountability within the system; have an external independent regulator (including a question over whether this should be on or off Island?); clinical governance framework set out within legislation; and increase collection and utilisation of data and make it publicly accessible.

The public's comments on this section included:

- Currently there is some oversight of the healthcare system provided by the Health Service Independent Review Body and the Health Services Consultative Committee;
- Politicians need to be made more accountable;
- There needs to be a long term plan that cannot be derailed by politics. In order for this to happen, the NHS has to sit as separate business. There will also need to be a commitment from Government and management to stick with the NHS strategy;
- Disruptive/transformational change is required as step by step changes will never happen;

- We need to openly address GDPR and work out what is more important, the restrictions on sharing data or health. There needs to be easy and transparent methods for people to consent to sharing health related data.

3.3.1.3 Workforce

The public's comments on the need for a different workforce depending on the changes made to the health and care system included:

- A challenge that there would not be enough trained "generalist" doctors to implement the recommended model as doctors are not currently training this way in the UK. The Review Team advised that, although it might be difficult, it should be seen as an opportunity. Additionally, there is a global marketplace for recruitment that could be utilised;
- There is an opportunity to look at roles and focus on greater utilisation of professionals (nurses or occupational therapists) other than doctors;
- There should be a register of home carers and more oversight of their activities;
- The need for good leadership;
- Recruitment issues, particularly in relation to home carers. Having enough home carers is essential to implement the strategy to keep people at home longer;
- Medical Education Programmes are very useful at attracting junior doctors etc;
- Consider scrapping the requirement of UCAS points to get onto the nursing course. There are great, caring people who would make excellent nurses but are put off the idea because they can't attain the required UCAS points;
- The more dissimilar to the UK that the Isle of Man becomes (as an employer in Health and Care) the harder it will be for the Isle of Man to recruit. Being out of line with the UK health professional practice leads to a fear that professionals transferring to the Isle of Man will become de-skilled;
- The current culture stunts development of the workforce;
- Create an excellent working environment;
- An attractive job specification, pay and relocation package needs to be available but the differential in pay between the UK and Isle of Man Consultants is disproportionately high.

3.3.2 Feedback in relation to workshop 2

3.3.2.1 Improvements and Efficiencies

Some areas where the Review may highlight that improvements and efficiencies could be made, based on previous engagements, were outlined within this section of the workshop. Comments from the public included:

- Difficulties in getting clinicians to travel to the Isle of Man. It was noted that tendering would be more effective if the DHSC did an overview of what is required for the Island and then went out to tender with a bigger piece of work to attract higher quality care, focussing on outcomes based commissioning;
- The clinical culture should be to offer a good service with the public at the heart of it. Clinicians on the Isle of Man have different skills, and the Island offers opportunities to do additional things. A team ethos could be developed between Liverpool and Isle of Man where both parties could offer things to the other and share skills and experience;
- If a clinician is just "seeing" a patient there is no need for travel. Clinical culture/mindset needs to change in relation to follow ups. People need to think differently and utilise technology. Project ECHO was mentioned as a good example of this;
- It comes down to managers and leaders to implement changes. There needs to be a change of culture - front line staff need to supported adequately and not be bullied for raising concerns. Move away from the blame culture and look at finding solutions to what has gone wrong and what can be done to improve it;

- Political will may disappear after 5 years. There is a bigger conversation required involving the public. The public have a role in holding politicians to account;
- In the Isle of Man there is only a charter for the NHS[xliii] (rather than a constitution[xliv] as is the case in England). This needs to change. Everyone needs to know what to expect and what they are entitled to. Accountability should be clearly defined;
- The third sector has to deliver on their contracts or they don't get the money. Key performance indicators are monitored closely. However, different yard sticks are used for private social care than for social care offered by the DHSC. If there was the same approach across the board, greater consistency and better care would be achieved.
- The Island needs people with the skills and capability for driving change. There are people with capability but it cannot just be put on top of a clinical day job. The Isle of Man has got some really good people but they lack confidence. People need to be empowered to act to their full potential with stronger accountability to balance the associated risks.

3.3.2.2 Funding

The funding recommendations outlined for discussion were: focus on service improvements and efficiencies – including an efficiencies target for DHSC; if DHSC funding increases, there should be a requirement to evidence improved quality of care; both financial and non-financial factors need to be considered when deciding on what appropriate funding options are; data capture, validation and business intelligence should become systematic, standard and essential across DHSC; and payments to providers of health and care services to be linked to quality (or at the very least activity) to improve accountability.

The following comments were noted:

- Charities are willing to make capital investment. However, issues with the breast clinic in relation to too much charity involvement and interference were raised;
- People want to see significant improvements before they are willing to input more money;
- People's expectations are that there should be choice and intelligence online about the services provided to aid the decision making process. The current system is not transparent;
- The recommendations will be debated by politicians and so it will come down to what the politicians find acceptable;
- People are getting tired of what is offered – "being pumped full of pills". We need to be looking after ourselves so that illnesses caused by lifestyle factors are reduced. More prevention is required but it is difficult to demonstrate value for money;
- Loneliness is a big problem - community and caring for each other need to be invested in.
- The Isle of Man needs to consider whether services are needed. This requires more data. We could also use predictive data analytics;
- We need to look after carers to keep more people at home;
- Social care should outsource all services as commissioner. They have taken it all in house and cut services because the main focus is on price;
- More emphasis should be placed on the fact that people already pay for services through taxes.

3.3.3 Summary

The feedback gained from the public within these sessions continued to be consistent with the key themes outlined previously:

- Improved **communication** and transparency across the system is necessary;
- **Integrated care** should be the model used in the Isle of Man, focussing on more coordinated care with all parts of the system joined up around a person's needs and with the defining principle of the *"right care provided in the right place by the right person";*
- **Scope of services** – the theme of utilising data to ensure that the services provided are of high quality and right for the population of the Isle of Man, including completion of a needs

assessment and a greater focus on prevention (both public health and utilisation of pre-emptive/preventative services available);
- **Increased efficiency** must be looked at ahead of increases in funding to improve value for money; and
- **Funding** will be required to enable transformational change.

3.4 Other engagements

The Review feels that it is important that the public understands the problems facing the health and care system, the purpose of the Review and what the outcomes will mean for them personally so that people can truly understand why change is needed. Because of this, the Review attempted to reach as many members of society as possible, for example, news releases issued by the Review encouraged any groups of people that wanted to talk to Sir Jonathan to get in contact. As well as engagement with those people providing health and care services, which was ongoing throughout the course of the Review, specific engagement sessions were arranged with:

- third sector organisations, where discussions focussed on:
    - the importance of the "patient voice" being understood and respected,
    - lack of communication across the system,
    - the need for the third sector to work together,
    - lack of proper funding for third sector leads to challenges to plan ahead,
    - inequality of care/support and inconsistent services offered for different conditions,
    - silo working within DHSC (particularly within Noble's Hospital and between the hospital and GPs),
    - lack of data,
    - the need for a greater focus on social care, including more recognition of carers,
    - lack of mental health support, in particular psychiatric liaison service, and
    - increased focus on prevention;
- the Chamber of Commerce, where discussions focussed on:
    - the link between DHSC and the rest of the Isle of Man Government,
    - the political environment,
    - funding,
    - quality and regulation,
    - private care,
    - efficiency and productivity, and
    - data;
- the Rotary Club of Douglas, where discussions focussed on:
    - technology,
    - the political environment,
    - the importance of 3rd sector engagement,
    - previous reviews of the DHSC,
    - the need to use off-Island specialists, and
    - Regulation; and
- those who are homeless or in insecure accommodation at the Graih drop-in, where discussions focussed on the accessibility and consistency of services.

4. Previous and on-going engagement

Alongside the engagement programme carried out by the Review, other engagement activities have been carried out with the public which are of relevance to the Review and important to build upon. The outputs of the following engagement activities have been taken in to account as part of understanding the views of the public in relation to the health and care system.

4.1 Positive Action Group – Wellness: A New Health Model for the Isle of Man

A public meeting was organised by the Positive Action Group and held on 25 June 2018, where presentations were given by four speakers:

- General Counsel for Jurby Wellness, outlining the legal support for patient autonomy and fully informed consent, in order to help increase the feedback from the patient and to ensure that their concerns and voice is always acknowledged.
- Managing Director of Callin Wild Consulting, outlining the financial unsustainability of the current health model, focussing on public health and looking at Island 'food economics' opportunities.
- Founder of Jurby Wellness, focussing on 'wellness' instead of 'health' and highlighting how our body serves us, if we feed it well and avoid the toxins to which we are increasingly subject.
- Minister for Health and Social Care, with an update on the Island's Future Health Vison that focussed on a move from acute care to community care, the creation of a Manx service and highlighting work underway to achieve the aims of the DHSC.

4.2 The Health and Social Care Minister Roadshows for the 2015 Strategy

In 2016, a series of roadshows were held at the secondary schools around the Island to give the public an opportunity to learn about plans to develop the Island's health and care services over the next five years. The roadshows consisted of a presentation by the Minister and the DHSC's Chief Executive at the time. There was also an opportunity to talk to the Minister, political Members and senior officers of the DHSC around the key themes within the strategy: prevention, community care that works, acute care, safeguarding people and residential care.

During the sessions the public were asked to highlight the areas in which the DHSC should focus on over the next five years. The feedback covered a broad spectrum of services but there were consistent themes identified, including commissioning, waste reduction, utilisation of IT, integrated care and communication. These themes are consistent with the main areas of concern raised during the Review's engagement programme.

4.3 Southern Community Hub Project

Southern Community Initiatives was contracted by the DHSC to complete an engagement program with the community in the south of the Island to ascertain their understanding of health and wellbeing and integrated health and care and to identify any gaps in current services and the potential benefits of a community partnership in addressing such gaps.

A series of focus groups were held with the statutory sector, third sector, faith organisations, local authorities, community groups and young people's representatives in order to ascertain their understanding. Additionally, four public meetings were held in the south of the Island attended by 79 local residents.

A report was issued in March 2017, which outlined the following findings relevant to the Review:

- Understanding of integrated health and care: The overall understanding was that individuals should have access to timely and seamless services available from a range of providers working cohesively with central coordination. The provision of a combined package regardless of provider but of a consistent standard and utilising one-information source.
- The following issues were identified:
    - Isolation and loneliness is seen as a major challenge for society;
    - Lack of an effective community transport system;
    - Absence of a transparent and cohesive source of community information;

- Absence of joined up working, reflected in pharmacies not being used to maximum potential and community/Government assets not being used effectively; and
- Lack of understanding of emergency/urgent response resulting in a chronic bottle-neck of supporting services. Older people are frequently admitted to hospital for non-medical reasons leading to deterioration in both their physical and mental capacity.

Some of the above themes are common with the engagement programme, including coordination and integration of services, utilising the right services at the right time and communication. There are also some more specific issues for the southern community, which could reasonably be similar elsewhere on the Island.

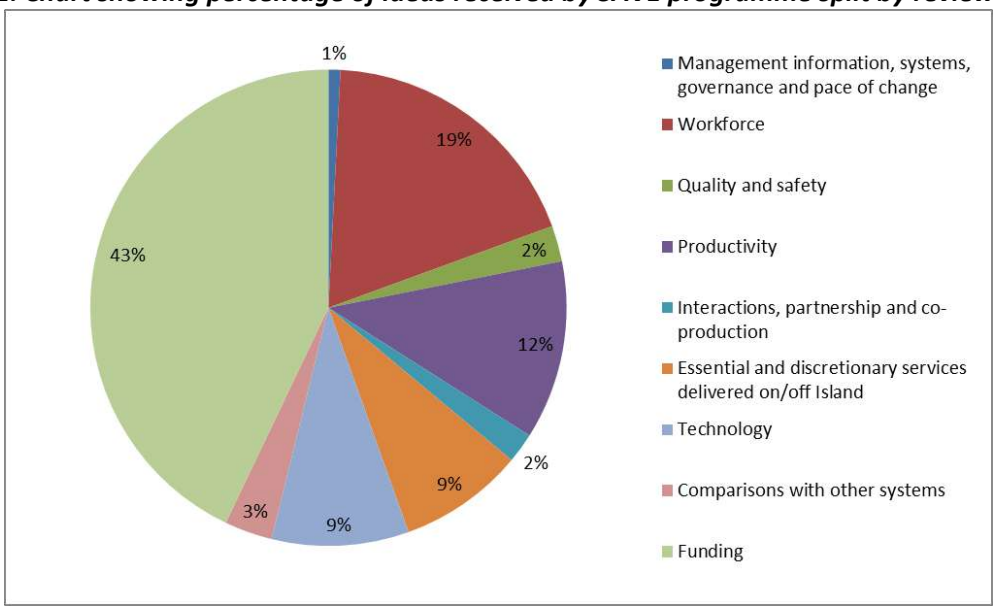
4.4 Isle of Man Government Securing Added Value and Efficiencies (SAVE) programme results relevant to the DHSC

In May 2017, the Isle of Man Government launched the SAVE programme. The main purpose was to encourage ideas about how government could streamline its services, cut waste or do things in new and innovative ways to reduce its revenue expenditure by £25million by 2021-22.

Ideas were submitted on an online ideas hub (similar to that set up for the Review), by forms in newspapers, postcards and via public drop-in sessions.

The SAVE Team has provided results relevant to the DHSC. Isle of Man Government staff put forward 20 ideas and 144 ideas were put forward by the public. The split of these ideas into the relevant areas of the Review are shown in figure 22 below.

Figure 22: Chart showing percentage of ideas received by SAVE programme split by review area



Unsurprisingly, due to the nature of the SAVE Programme, the majority of ideas put forward were for cost saving or funding ideas. The main themes arising from these were:

- Review the scope of services provided at Noble's and Ramsey and District Cottage Hospital – one relevant idea was to introduce state funded medical insurance services in UK, with only emergency medical care provided locally;
- Review funding arrangements – ideas included introducing a social security health card/residency similar to Jersey (to restrict health, social care and social security benefits to those who have been resident and working on the island for at least six months and encour-

age non-residents to take out Health Insurance), revised charging structure for GP appointments (similar to Jersey[xlv]) and looking into a direct payments model for social care;
- Review payments made for travelling off Island and only provide what is required (i.e. flight for patient);
- Increase the use of teleconferencing/technology for scheduling and carrying out all relevant appointments;
- Review services provided for free i.e. eye tests;
- Outsource catering facilities;
- Create prescribing formulary for the Island to encourage generic drugs to be prescribed and those that can be purchased over the counter not to be prescribed;
- Reduce the use of agency staff;
- Better management of repeat prescriptions;
- Review patient discharge within Noble's; and
- Focus on prevention rather than treatment – e.g., expand the Bone Densitometry Service and liaise with the local branch of the National Osteoporosis Society to help educate the population regarding good bone health.

All of the above themes were raised during the Review's engagement exercise.

4.5 Future Funding of Nursing and Residential Care Homes

In July 2018, a report was put to Tynwald on the Future Funding of Nursing and Residential Care[xlvi]. It was noted in this report that "*this investigation also sits alongside the fundamental review of the Review's Island's healthcare system which Sir Jonathan Michael heads*" and that the work is "*continuing in parallel*". The two teams are having regular meetings to keep up to date and ensure that there is consistency, but not duplication, within the work streams.

Between December 2017 and March 2018, six engagement and focus groups were held on this topic, inviting contribution from interested parties and members of the public. These sessions demonstrated that there is appetite for change, with a wide variety of alternative funding models suggested, and that the public are adamant that any system "must be fair".

Between October and December 2018 a series of 11 further focus groups were arranged designed to gather views and input from a wider sector of the community, based on the six funding options outlined within the report presented to Tynwald in July 2018. In each session, a presentation was delivered by members of the project team on the current scenario and the six options available. An exercise was then undertaken that enabled participants to review the six options and to cast three 'votes' on the option (or options) they favoured the most. The results of the voting exercise were shared with the Review Team in order to help inform the consideration of the funding options.
In seven focus groups option six (the mixed model[xlvii]) was the most popular, all but one of these focus groups were open public sessions held across the Island. Many of the participants in these sessions had had a personal experience of using residential or nursing care.

In the two public service focus groups options four (free social care provision at the point of access) and five (social insurance) had the most support.

The focus group held with students attending the Isle of Man College resulted in option four (free social care provision at the point of access) having the most support. Within this group option three (asset protection[xlviii]) was strongly supported as the second most popular option.

Participants at the focus groups were also asked to answer 3 key questions:

- **Who should pay?** The majority of comments indicated that everyone should pay, many indicating that this should be throughout working age
- **How should they pay?** The majority of comments indicated that this should be through some form of salaried contribution/tax
- **When should they pay?** The majority of comments indicated payment should be during working life

Other comments were also left which were outside of the scope of funding arrangements, including:

- "Larger investment in enabling effective home care and care in the community"
- "lifestyle changes" and other "preventable measures"
- "private nursing care at home"
- "increased carer's allowance", and
- additional care housing options, including thoughts on retirement and dementia villages.

The comments received align with some of the common themes elicited during the Review's engagement programme such as: the need for greater investment to enable integrated services to be provided locally, either at home or by care in the community; more focus on prevention; having a funding system that is perceived to be fair for all; and, consideration to be given to social care options that are aligned to the needs of the citizens of the Isle of Man.

4.6 Social Attitudes Survey 2018

The Social Attitudes Survey is carried out annually on the Isle of Man. In 2018, there were 1687 responses to the survey.

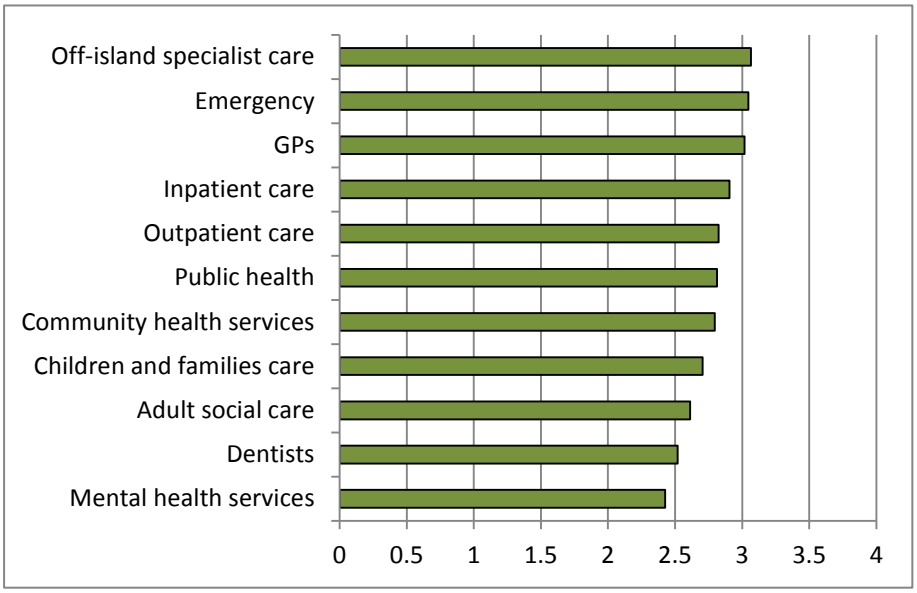
The survey included a number of questions in relation to health and care services that were tailored versions of questions included in the 2015 British Social Attitudes Survey ('BSA'). The survey reviews satisfaction with public services annually. Average satisfaction with health services and with social care services has remained consistent since 2016; health services fall in the middle of the public opinion rankings, and social care services fall somewhat lower.

Respondents who indicated that they were "satisfied/very satisfied" with current care provision generally cited factors that related to a direct experience of care as the reason for their level of satisfaction. "Attitudes/behaviour of staff" was identified by more than a quarter of the respondents as an influential factor in their response, closely followed by "free at point of use" and "quality of care". However, factors relating to availability of care (range of services and wait times) were not an influential factor in relation to these responses.

Respondents who indicated that they were "dissatisfied/very dissatisfied" mainly cited factors of availability, with long waiting times the most common factor.

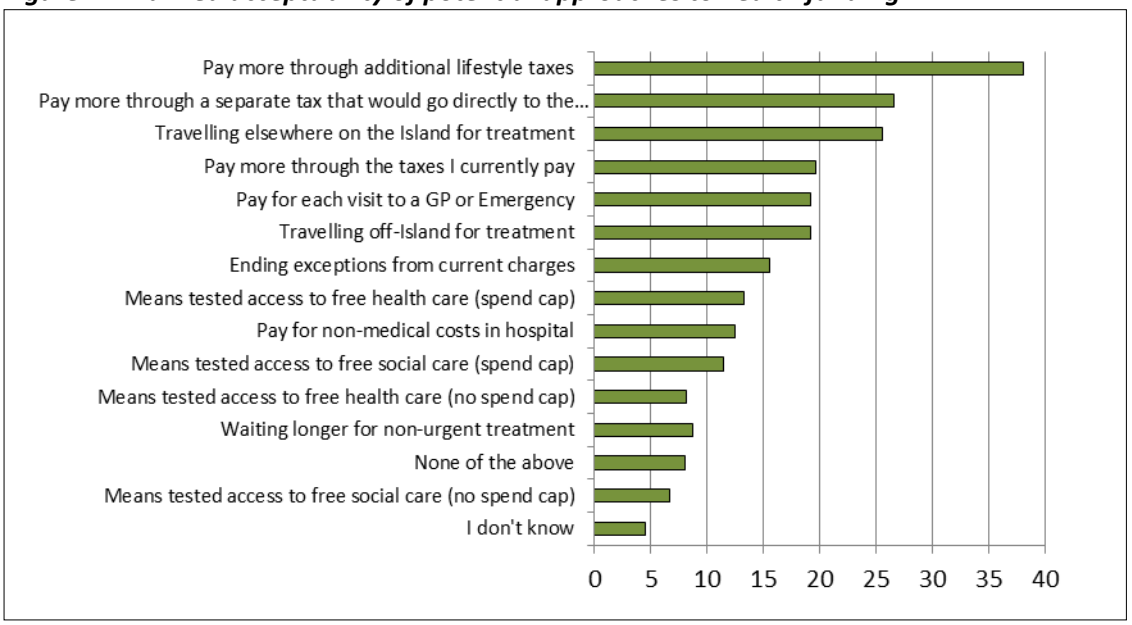
The most satisfactory element of the Island's health care system is reported to be off-Island care; this may be well-regarded either as a high-quality care alternative to the on-Island system, or as a highly valued privilege. Mental health services returned the lowest level of satisfaction with the general public, as can be seen in the chart below.

Figure 23: Ranked satisfaction with services and areas of care (max score = 4)



The survey also asked if more funding was required, what options would be acceptable. The below chart identifies the number of respondents who selected each choice (respondents had the ability to select more than one).

Figure 24: Ranked acceptability of potential approaches to health funding



Lifestyle taxes were the most widely supported possible measure, by a significant margin (38% of respondents supported the suggestion of lifestyle taxes, in contrast to the next most popular selection of a hypothecated tax, which attracted 27% of respondents). Both of these options were raised during the engagement programme, but the preference was vice versa between hypothecated tax and lifestyle taxes.

4.7 Crossroads Care survey

In June 2018 Crossroads Care launched a carer's survey to find out how they could help local carers on their caring journey. They asked all carers on the Island to take part in the survey to allow carers to help shape the services, policies, profile, events and opportunities of Crossroads Care. A total of 125 responses were received, although people responding were not obliged to respond to every question. The answers to relevant questions were shared with the Review Team.

A key finding in the survey is that 66% of people who took part in the survey feel that their own health has suffered as a consequence of their caring role. Of those who said that their health had suffered, 83% said their health had suffered emotionally, 72% said their health had suffered mentally, and 67% said their health had suffered physically. Other questions linked to this also showed that 84% of carers reported feelings of worry and anxiety because of the caring role and 56% rated their quality of life as less than good. The system should make it easy for carers to get access to health checks and ensure that they are able to avail themselves of services and treatment. Ensuring that carers are well looked after will help keep people at home for longer; however, the impact of caring on carers' health may impact upon their ability to provide long term, sustainable care for the future. This needs to be considered as part of the whole cost of the health and care system.

The survey reinforced a common theme encountered throughout the Review, which is a lack of good communications for and on behalf of the DHSC. The majority of carers (57%) reported that they were only aware of some of the services and support available to them as a carer and so there is a need for a directory of services or greater sign-posting to services. Also, 78% of carers were not aware of carer's assessments (which give carers the opportunity to access information, support and help and are available to carers under the Social Services Act 2011). Moreover, of the 21% of those who said they were aware of carer's assessments, 74% said they had not received an assessment. This is despite the Isle of Man having a Carer's Charter dated 2012 that states that "We will work with the Department of Social Care to implement the Social Services Act and to progress the completion of Carers Assessments and Carers Support Plans. This will be achieved through…widely publicising…the Carer's right to an assessment of their needs". An internet search did not show that carers' assessments are being publicised by the DHSC.

Additionally, the most recent Carer's Strategy published by the Government was for 2007 – 2010. There is no evidence that objectives and aims outlined in these documents have been reported on and therefore there is no way in which to measure their success. This is another example of a strategy that has not been fully implemented or monitored.

Additionally, over half of carers (52%) do not feel that the services that they have access to are meeting their care needs. Examples of gaps and issues highlighted in the survey include:

- Limited "free of charge" availability
- Lack of flexibility of services provided
- Not enough respite
- "There is nothing provided for me as a carer and no one to talk to about my situation"
- Shortage of services for parents with school age children to help throughout the school holidays
- Very little for high functioning autistic children

4.8 Quing Conference survey

Quing is a peer led community organisation that does not label or diagnose people by behaviour. As an organisation, they call for fewer services, and more strength based practice such as education, peer mentoring and geographical community building.

Quing is an advocate for Asset Based Community Development and has developed an accredited Peer Mentoring Training Programme on the Island. The ethos of Quing is that health, wellbeing, connectedness and long term change is done by the person.

On 6 December 2018, Quing held an International Conference, bringing the latest thinking and paradigms of wellbeing, active citizenship and abundant communities from a strength based practice approach to the Island.

At the end of the conference, attendees were asked to complete a questionnaire asking for their experience of current services and what they would like Quing to offer. The following questions were included at the request of the Review:

- What is it like for a new service user to initially access mental health services (Do you know where to go? How long does it take to get a referral? What happens next?)
- Where are the gaps in services?
- What would make the system work better for you?

Twenty-one questionnaires were received where attendees had completed the questions relevant to mental health services and 13 questionnaires were received where attendees had completed the questions relevant to social services.

The common theme emerging from the questionnaires was that access to services is an issue[xlix]. In terms of improvements, the respondents wanted to see:

- Earlier intervention;
- Less focus on medication;
- A more holistic people centred approach that considers the needs of the whole family;
- More empowerment of the individual to take responsibility for themselves; and
- Better links between organisations within the system.

4.9 Integrated Care Pilot Project in the West – Project Team

The Integrated Care Project Team has engaged with the public and service users at Peel Day Centre, Corrin Memorial Home, Westlands Sheltered Housing Scheme and Mylchreest Court; distributed feedback cards to service users with a freepost envelope (5 replies were received); held meetings with Commissioners at Peel, Kirk Michael, German, Patrick and Marown; and held a public engagement event attended by 39 members of the public.

Key themes from the feedback were identified and grouped together as follows:

- access to services :
    - extended service hours would be of benefit
    - a lack of awareness of what services are available
    - difficulties, or delays, in accessing GP services
    - more ability to self-refer to some services
    - a single point of access
    - people would like to be treated with respect
    - the community would like a bigger voice in service delivery
- resource issues:
    - some capacity issues
    - dealing with social isolation needs to be given a high priority
    - lack of respite provision
    - lack of clarity over charges
    - improvement in the provision of aids and adaptations (and more consistency in geographical provision)

    - the benefits system is complex and geared towards non community based care
    - transport is either lacking or inflexible
    - better use could be made of shared facilities and services
    - being introduced to services rather than referred would be of benefit
    - inefficiency regarding use of resources - resources need to be recycled
- person centred approach:
    - more flexibility built into service delivery
    - services that are co-ordinated and consistent
    - unnecessary appointments should be avoided
    - timing of appointments should take into account of service users' needs
    - support should be delivered with an emphasis on dignity and choice
    - people should be supported to remain in their own home, or as close to home, as possible
    - an emphasis on ageing well, promoting self-care and community consciousness
- staff culture and communication:
    - issues with hospital discharge with poor communication in both directions
    - issues to be addressed with regard to skill mix of the community workforce
    - practitioners should respect privacy
    - there is a fear of change
    - society has become more self-centred and less community spirited.

One area that stakeholders were unanimous in presenting was that services are generally felt to be good in the West and, whilst there are some issues with resources, generally people were not asking for more, but that what there is should function more efficiently and be better co-ordinated.

5. Summary

The engagement process was designed to consider and engage with interested stakeholders and was publicised widely to acknowledging that all Isle of Man residents are likely to be affected by changes to the health and care system and so should be given the chance to input to the process.

The Review Team has received feedback from the public through a variety of means both online and offline, in writing and face to face. The feedback has elicited common themes, which are set out below. They key themes are consistent with what was heard from current health and care staff from all sectors as well as previous and ongoing engagements with the public by other areas of Government and the third sector, which have also been considered as part of the Review.

Communication – from the Ministerial roadshows in 2015 through to the most recent engagements, improvement of communication across health and care has been raised consistently, with the following areas noted in particular:

- inter-professional communication;
- with service users and the public more widely;
- between DHSC leaders and policy makers and all staff groups;
- between the DHSC and other organisations offering care i.e. tertiary centres, third sector;
- across Government.

Integration – it is clear that a properly integrated health and care system based around the needs of the individual, rather than the organisations providing the services, is what is wanted. This would involve supporting and trusting people to help them lead independent lives and take control of their own health and care as well as providing more care in the community with all health and care providers working as part of a real partnership (as outlined in the DHSC's 2018 Vision).

Scope of services – this theme covers the grouping of the following three areas of concern raised by the public:

- greater utilisation of data to ensure that the services provided are of high quality and right for the population of the Isle of Man;
- the need for a greater focus on prevention (both public health and utilisation of pre-emptive/preventative services); and
- ensuring that the services provided off-Island are organised efficiently and offer value.

Efficiency – it is clear from the feedback gathered that the public want to see a health and care system that is efficient and effective before they are asked to provide increased funding for the system.

Funding – there was no clear message from the public in relation to how increases in funding should be found; however, the Review has worked to the principle that health, and some aspects of social, care should remain available and provided on the basis of need and not the ability to pay.

Annex 5: Summary of Health and Care System Key Characteristics

Measure	Unit	Isle of Man	Jersey	Guernsey	England	Scotland	Ireland
Population (total)	#	83,314	97,857	66,500	53,000,000	5,424,800	4,784,000
Av. age	Years	42.5	40.7	45.1	40.2 (UK)	40.2 (UK)	37.4
Population 65+ (%)	%	21	16	20	18	19	13
Population 85+ (%)	%	3	-	-	2	2	1.5
Life expectancy	Years	81.3	81.9	85.4	79.2	79.1	81.5
Rate of smoking	%	15	16	12.7	16	21	23
# with LTCs	%	-	27	21	28	40	-
% with diabetes	%	4.18	4.1	4.36	6.37	4	4.7
% with cancer	%	2.57 prevalence	1 incidence	1 incidence	2.26 prevalence	0.6 incidence	0.4 incidence
% with chronic heart disease	%	3.62	2.45	-	3.25	4.4	4.0
% with Chronic Obstructive Pulmonary Disease	%	1.52	-	-	1.82	-	-
% adult obesity	%	23	16	18.4	26	29	23
Emergency admission rate	/100,000	12,839	5,153	-	10,822	10,839	41,500
Elective admission rate	/100,000	11,093	-	-	17,594	11,060	-
Outpatient admission rate	/100,000	139,705	-	-	119,180	77,975	68,722
GPs	/100,000	65	92	63	79	91	52
% 65+ in care homes	%	3.5%	-	-	3.5%	3.2%	3.3%
Total spend on health and social care	£000	£275,529	£203,776	£118,528	£143,300,000	£16,236,000	£15,057,880
Spend per head on health and social care	£	£3,289	£1,956	£1,899	£2,576	£3,004	£3,148

Annex 6: Global Health and Care System Comparisons

Country	Health and Care System summary[i] [ii]	Rationale for use as comparator
Estonia	Health Care Estonia operates a single health insurance fund (single-payer model). Inpatient care involves a co-payment of EUR 1.60 per day, up to 10 days per episode. Outpatient care is free at the point of care for consultation, but there is a co-payment charge of EUR 3.20 for home visits and visits to a specialist contracted with the health insurance fund and with a GP referral. Visits without a GP referral are not reimbursed except for in certain specialities and specialists not contracted with health insurance determine their own fees. Clinical laboratory tests and diagnostic imaging are free at the point of care. There is a co-payment charge for general prescription medicines (which is reduced for prescription medicines for chronic diseases) and health insurance spending is capped at EUR 12 per prescription. People with certain conditions or disabilities are exempt from paying for medications. There is a small monetary benefit for some population groups e.g. older people and pregnant women. Dental care is not covered. Social Care The social care system in Estonia is predominantly contribution-based. It offers various benefits to those who have worked and paid contributions in Estonia. Subsistence level benefits are paid to those who have insufficient income and live below the subsistence level.	Relatively low-cost, insurance-based system, with healthcare free at the point of use. Useful comparator to explore suitability of insurance-based system.
New Zealand	Health Care The public healthcare system in New Zealand gives residents access to free or heavily-subsidised hospital care and emergency treatment. In addition to public hospitals, there are also private hospitals that can be accessed by people with healthcare insurance. For outpatient services and to see a GP, part-charges apply. Many medicines are subsidised by the public health system for adults and are free for children aged 13 years and under. Adults pay for dental treatment, but children receive free basic dental care until the age of 18. New Zealand's personal accident compensation scheme run by the Accident Compensation Corporation covers most of the costs of injuries from accidents. Social Care Publicly funded health and disability services, such as residential care, are available to people who are eligible (following a financial means assessment). Social welfare is primarily funded through general taxation.	Similar demographic profile with some remote areas. Have trialled and implemented Integrated Care Models in specific communities. Used as comparator to determine suitability of implementing similar system in IOM. New Zealand was ranked 4th out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017[1].
Australia	Health Care Australia has a national health system covering the country as a whole. Inpatient care is free at the point of care for patients treated as public patients in public hospitals. Patients treated as	Similar demographic profile, free at point of use with some co-payment for services

	private patients in public or private hospitals need to pay a share of the cost (often paid by their private health insurance). Outpatient care is free at the point of care when doctors accept direct payments from Medicare (approx. 80% of GP services in 2010/11). Otherwise, patients may have costs. Outpatient specialist consultations are fully covered when provided by the public hospital system and generally covered with co-payment when provided outside hospitals and financed by Medicare. Clinical laboratory tests and diagnostic imaging are free at the point of care when providers accept direct payments from Medicare. Pharmaceuticals are subject to co-payment of up to AUD 38.30 but this is reduced for patients with a concession card. There are exemptions in paying for drugs for certain medical conditions or disabilities and for those with income below a specific threshold. Dental care is not covered. <u>Social Care</u> Social care is means-tested government assistance funded by general taxation. Wealthier residents pay 'out of pocket'. Government assistance focuses on those with low incomes and charges are means-tested.	and treatments. Remoteness of certain regions and mechanism for providing health and care to them, make it a useful comparator. Australia was ranked 2nd out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017 and best for health care outcomes[1].
Canada	<u>Health Care</u> Canada operates a national health system covering the country as a whole. Inpatient and outpatient care is free at the point of care, including clinical laboratory tests and diagnostic imaging. Dental care is not usually covered, unless deemed medically necessary, but is at the discretion of the regions. <u>Social Care</u> Social assistance/income support is delivered in all provinces of Canada and provides monthly payments to eligible people with low income.	Similar demographic profile, remoteness of certain regions and mechanism for providing health and care to them, make it a useful comparator. Canada was ranked 9th out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017[1].
Sweden	<u>Health Care</u> The universal health system in Sweden provides access to publicly-financed healthcare services. However, there are small charges for many services (under 16s and vulnerable people are exempt from these charges). The average cost of an emergency department visit is approximately SEK 300 and a hospital stay is maximum SEK 100/day. Primary care incurs a charge of SEK 0-300 depending upon the council and specialist visits are maximum SEK 400. A patient never has to pay more than SEK 1100 for medical consultations in a 12-month period. Private healthcare is also available. Prescription medications incur a charge, but a patient does not pay more than SEK 2250 for medications in a given 12-month period. Dental care is not covered for adults but is free for children and	Similar demographic profile, limited, means-tested co-payment for services and treatments. Generally considered to be one of the best (clinically and financially) healthcare systems in the world. As a result, this makes it a useful comparator for IOM. Sweden was ranked 6th out of 11 in a

	teenagers up to the age of 20 and is subsidised for under 29s. <u>Social Care</u> There is universal social care via a National Long-Term Care Insurance funded by local taxation and government grants. Sweden provides universal and comprehensive coverage of social care to all citizens. Cost sharing is minimal. There are limits on the amount that individuals need to pay for their care needs and their co-payments are income-based.	Commonwealth Fund ranking of health systems in 'well off countries' in 2017 and was ranked 2nd for health care outcomes[1].
Germany	<u>Health Care</u> Germany operates multiple insurance funds or companies for healthcare. Inpatient care involves co-payment of EUR 10/day, limited to 28 days/year. Outpatient care, including specialist outpatient care, is free at the point of care for patients with statutory health insurance and selected PHI contracts. Clinical laboratory tests and diagnostic imaging is free at the point of care. Pharmaceuticals incur a co-payment charge of 10% of the cost (minimum EUR 5 and maximum EUR 10). Dental care is covered in form of in-kind for e.g. conservative treatment, surgical treatment and x-rays. There are exemptions in paying for drugs for certain medical conditions or disabilities. <u>Social Care</u> There is universal social care via Statutory Long-Term Care insurance which is funded by employer/employee and pensioner contributions. It covers basic needs and individuals are expected to contribute private funds or can apply for means-tested welfare payments. There is an option to take a private plan to fulfil the statutory requirement. Supplementary plans are available for costs not covered by statutory LTCI.	Similar demographic profile, insurance-based systems, limited means-tested co-payment for services and treatments. Generally considered to be one of the best (clinically and financially) healthcare systems in the world. As a result, this makes it a useful comparator for IOM. Germany was ranked 8th out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017[1].
Ireland	<u>Health Care</u> Ireland operates a national health system covering the country as a whole. Inpatient care is free at the point of care for medical card holders and certain other categories. There is a co-payment of EUR 75 per day for public patients, capped at EUR 750 in any period of 12 consecutive months. Patients attending an emergency department are subject to a EUR 100 charge (subject to a number of exemptions). Outpatient care is free at the point of care for approximately 40% of the population and the remainder of the population pays the full cost of a GP consultation as a private arrangement with their GP. Attendances at planned outpatient clinics in public hospitals are free at the point of care for public patients. Clinical laboratory tests and diagnostic imaging are free at the point of care for public patients in public hospitals. Pharmaceuticals for medical card holders require co-payment of EUR 2.50 per item (capped to EUR 20 per family per month). For other groups, costs are deductible by EUR 144 per family per month before full reimbursement. There are exemptions in paying for drugs for certain medical conditions or disabilities. Dental care is no cost-sharing on defined basic annual treatment package and	Similar demographic profile, geographical proximity. Limited co-payment for services. Possibility of 'buying in' tertiary service from Ireland make it a useful comparator.

	emergency dental treatment. Social Care Social care is provided via means-tested government assistance and funded by general taxation. Public health nursing is a universal service. Day services and outpatient care are generally provided free of charge.	
Switzerland	Health Care Switzerland operates multiple insurance funds or companies for healthcare. Inpatient care, clinical laboratory tests, diagnostic imaging and pharmaceuticals are subject to co-insurance of 10% after deductible costs and subject to an annual cap. Outpatient care and specialist care is 10% cost-sharing after general deductible costs and with an annual cap. Co-payment is increased to 20% for off-patent drugs with cheaper (generic) alternatives. Dental care is not covered, except when related to serious diseases. Social Care Social-security insurance provides annuities and pension allowances to senior citizens and other population groups.	Similar demographic profile. Multiple insurer-based model, with some co-payment. Being a relatively small country, making use of services provided by neighbours makes it a useful comparator. Switzerland was ranked 6th out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017[1].
Luxembourg	Health Care Luxembourg operates a single health insurance fund (single-payer model). Inpatient care requires a co-payment of EUR 20.93 per day for the first 30 days of hospitalisation per year. Outpatient care and specialist care is cost-sharing of 20% for a physician consultation and 12% for medical acts and services. Clinical laboratory tests and diagnostic imaging are free at the point of care. Tertiary care in Luxembourg is limited which means that the state pays for many specialist services to be provided abroad[2]. Emergency treatment in a neighbouring country such as Germany, Belgium or France may also qualify for reimbursement at the same rates as in Luxembourg. Pharmaceuticals require co-insurance of 0%, 20% or 60% depending on drug category (for example, 0% for drugs used for chronic diseases) and there are exemptions in paying for drugs for certain medical conditions or disabilities. Dental care is cost-sharing for the patient. Social Care There is an extensive social welfare system in Luxembourg which provides social security, health and pension funds via the social security system. If an individual is a member of a Luxembourg sickness insurance fund, they have nursing care insurance cover and would receive benefits in kind.	Similar demographic profile, small population with limited co-payment for services and pharmaceuticals. Being a relatively small country, making use of services provided by neighbours makes it a useful comparator.
Norway	Health Care Norway operates a national health system covering the country as a whole. Inpatient care is free at the point of care.	Similar demographic profile, limited, means-tested co-payment for services and

	Outpatient care incurs a co-payment of NOK 141 per visit up to an annual ceiling of NOK 2185 for all user charges. Clinical laboratory tests are variable and diagnostic imaging requires co-payment of NOK 228 with cost-sharing (on all outpatient care) capped to NOK 2185. Pharmaceuticals have a co-insurance rate of 38%, capped to NOK 520 per prescription. There are exemptions in paying for drugs for certain medical conditions or disabilities. Dental care is not generally covered, with exceptions for specific conditions. <u>Social Care</u> The Norwegian social welfare system includes social security, pensions, sickness benefits, surviving benefits and membership of the Norwegian National Insurance scheme. Cost-sharing for residential care is income-based.	treatments. Generally considered to be one of the best (clinically and financially) healthcare systems in the world. As a result, this makes it a useful comparator for IOM. Norway was ranked 4th out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017[1].
Slovenia	<u>Health Care</u> Slovenia operates a single health insurance fund (single-payer model). Inpatient care is via co-payment or co-insurance (from 10-30% of costs) and outpatient care is 20% cost-sharing. Clinical laboratory tests and diagnostic imaging are 10-30% cost-sharing, depending upon the procedure. Pharmaceuticals have co-insurance of 0%, 30% or 90% depending on the disease category and there are exemptions in paying for drugs for certain medical conditions and disabilities, as well as those with a low income. Dental care is covered with co-insurance of 20%. All of the aforementioned healthcare services are free at the point of care for certain high-risk groups and patients with certain diseases. <u>Social Care</u> Pension and disability insurance are compulsory in Slovenia. Social security is based on contributions paid by all employed and self-employed people into the social security scheme.	Relatively low-cost, insurance-based system, with healthcare free at the point of use with some co-payment for services and pharmaceuticals. Relatively low cost and quality of outcomes make it a useful comparator for IOM.
Scotland	<u>Health Care</u> NHS Scotland provides comprehensive free healthcare in Scotland. It covers inpatient treatment as well as outpatient services including clinic services, GP practice services, clinical laboratory tests and diagnostic imaging which are free at the point of care. Treatment by the emergency services is also free at the point of care and prescription medications are also free. Dental examinations are covered, but not dental treatments. NHS Scotland is made up of 14 Health Boards. NHS Highland provides healthcare and social care services in the Highland. NHS Orkney, NHS Shetland and NHS Western Isles provide services to the Scottish Islands. <u>Social Care</u> Persons entitled to social care services in Scotland may request full or partial exemption from payment depending upon their material position. NHS Highland runs Care Homes across Highland and commissions Care Home beds from voluntary and independent	Similar demographic profile, with health system that is free at point of use with some remote regions and increasing prevalence of lifestyle diseases. Proximity and possibility of 'buying in' services from Scotland, make it a useful comparator.

	sector providers.	
England	Health Care The NHS provides comprehensive free healthcare in England. It covers inpatient treatment as well as outpatient services including clinic services, GP practice services, clinical laboratory tests and diagnostic imaging which are free at the point of care. Treatment by the emergency services is also free at the point of care. In addition to public services, private healthcare is available at private hospitals. Prescription charges are £8.80 per item (to be increased to £9.00 per item from April 2019). Certain patients are exempt from paying for prescriptions, for example, pregnant women and children. Dental treatment is subsidised for adults and free for under18s). Social Care Social care is provided via means tested government assistance and is funded by general taxation. There is a very small Long-Term Care Insurance market (0.05% of over 40 population). Government assistance focuses on those with low incomes. Services are provided based on a needs assessment and charges are means-tested. Most adults receiving social care in England are expected to pay for it if they are able to. Means-tested financial assistance is available for people who are eligible.	Similar demographic profile, with health system that is free at point of use. Limited co-payment for pharmaceuticals and some elements of care. The UK was ranked the best out of 11 in a Commonwealth Fund ranking of health systems in 'well off countries' in 2017[1]. As the source of the majority of 'Off Island' workforce and specialist services provision, England is a useful comparator.
Wales	Health Care NHS Wales provides comprehensive free healthcare in Wales. It covers inpatient treatment as well as outpatient services including clinic services, GP practice services, clinical laboratory tests and diagnostic imaging which are free at the point of care. Treatment by the emergency services is also free at the point of care and prescription medications are also free. Dental treatment is subsidised. Social Care Social welfare is generally devolved in Wales. People with assets over a certain threshold pay the full cost of residential care. Those with assets less than the threshold are eligible for financial assistance.	Similar demographic profile, with health system that is free at point of use with some remote regions. Proximity and possibility of 'buying in' services from Wales, make it a useful comparator.
Jersey	Health Care Emergency treatment in Jersey is free at the point of care, as well as hospital treatment for eligible patients who have been living in Jersey for at least 12 months prior to treatment. GP services are not free at the point of care but is subsidised for those who hold a health card. An individual is entitled to a Social Security health card if they have been living in Jersey for six months or more and have paid any Social Security contributions that are due. Most prescription medicines from the GP are free to those who have a health card (although there are some exceptions). Dental care is not free but is subsidised for health card holders.	Similar demographic profile and status as small-island health system make it a useful comparator.

	<u>Social Care</u> Once assessed care costs reach the cap threshold, eligible people can claim the means-tested Long-Term Care benefit. In a residential home, the individual is responsible for paying the non-care costs (this is the co-payment).	
Guernsey	<u>Health Care</u> Certain secondary care and specialist services are free at the point of care but can only be accessed via a referral from a GP. All primary care is private and GP consultations, A&E visits, ambulance callouts and physiotherapy all incur a charge. Prescription medicines incur a charge of £3.80 per item (although some residents are exempt from charges). Dental care is private. <u>Social Care</u> Individuals make social security contribution payments in order to receive insurance protection under the Social Insurance Scheme.	Similar demographic profile and status as small-island health system make it a useful comparator.

Annex 7: Advisory Panel Terms of Reference

Terms of Reference

Independent Health and Social Care Review Advisory Panel

Objective

The objective of the Review is to determine change options for service delivery and funding to provide a modern, fit for purpose health and social care system for the Island. The Terms of Reference for the Review itself, which are applicable to the Chairperson, are included as **Annex 1** to these Terms of Reference and outline further detail on the objective, governance, scope and reporting requirements.

The objective of the Advisory Panel is to support the Chairperson in completing the overall objective of the review by considering and providing opinion and comment on information submitted to it.

In forming both sets of Terms of Reference, regard has been taken of the debate on the motion in January Tynwald; a summary of which is include as **Annex 2**[lii] to these Terms of Reference.

Advisory Panel Composition

The Advisory Panel responsible for supporting the Independent Chair in achieving the objective of the review will consist of a range of skills, experiences and representative stakeholders as follows:

- Health Care Professionals (nine)
    - Hospital Doctor (two)
    - Hospital Nurse
    - General Practitioner
    - Community Nurse
    - Mental Health clinician
    - Social Worker
    - Public Health clinician
    - Allied Health Professional
- Department of Health and Social Care senior officer
- Member of the Legislative Council (MLC)
- Member of the House of Keys (MHK)
- Third Sector representative
- Senior business employer representative
- Private Care Provider representative
- Health Services Consultative Committee representative (lay member)
- Noble's Patient Experience and Quality Committee representative (lay member)
- Government Technology Services representative
- Secretariat lead

Scope

The Advisory Panel is not an approval body but will provide support in the form of advice and opinion to the Chairperson, who will lead the Review and have full editorial rights over the final report.

The Advisory Panel will provide that support by absorbing information submitted to it in order to offer written and/or verbal opinion and advice, as well as any potential implications, to the Chairperson.

The Review's Secretariat and a Working Group will coordinate and undertake the research, stakeholder engagement, sourcing of specialist information and presentation of evidence throughout the course of the Review. The Working Group will be co-ordinated by the Head of Healthcare Review Secretariat and consist of internal and specialist consultancy support where necessary.

The output of the Secretariat and Working Group will be submitted to the Advisory Panel and Chairperson. The Advisory Panel will be required to consider these submissions, which will include relevant evidence, including that gathered from Government, service users, service providers, the wider public and relating to the operation of a variety of systems, on the review areas and questions included in **Annex 1** to these Terms of Reference in order to provide the required support to the Chairperson.

Timeframe

The Advisory Panel will be requested to provide support at the Chairperson's discretion. This support will, predominantly, consist of participating in meetings, which will, initially, consist of a half-day meeting on a monthly basis. Advisory Panel members will be required to read and assimilate the evidence and documentation submitted to them in order to provide advice to the Chairperson at these meetings.

The Review will run for a period of 12 months from April 2018.

Publicity

The names of Advisory Panel members will not be specifically announced but will be available to the public and included on the Review's website where consent is given.

Approved by Sir Jonathan Michael
Chairperson of the Independent Health and Social Care Review

Original: 18 May 2018
Updated: 18 September 2018
Updated: 13 March 2019

Annex 8: Workforce Challenges for the Isle of Man and other jurisdictions

Workforce issues are as major a challenge for the health and care system on the Isle of Man as enhancing service quality, improving outcomes and managing funding pressures. This is largely the case across all developed world health and care systems. The main driver is increasing demographic pressure (due to an increasing aged population) and increases in the prevalence of lifestyle diseases[liii]. This in turn has resulted in issues associated with capacity and an increasingly global marketplace for health and care roles, particularly in the developed world. Without timely intervention, it is widely understood that these trends will put unmanageable pressure on health and care systems. Whilst some additional capacity may be delivered by increasing staff numbers, this is only likely to provide minor improvements; a more sustainable solution is to implement new, innovative ways of using existing resources and driving maximum value from any new resources.

Several different approaches are being used worldwide, which may have some applicability to the Isle of Man; key approaches and specific examples can be summarised as follows:

Telecare/Telemedicine – technological improvements provide an opportunity to fundamentally change the way in which health and care services are delivered and, as a consequence, the workforce that delivers them. Telecare and telemedicine have reduced the need for geographic proximity and have allowed specialist expertise to be accessed from anywhere in the world. Combining generalist local resource with remotely-accessed specialist resource, can be a useful mechanism for reducing the need to have additional, highly-specialised staff members. In the Bronx, New York, the Montefiore Medical Centre has used remote patient monitoring to reduce costs associated with hospital admissions for the elderly by over 30%[liv].

Integrated care records and automation – by providing digital access to patients' records, the number of contacts, their duration and the nature of contact can be radically changed to enable better care delivery with fewer staff, albeit working in a more integrated way. It is estimated that up to 36% of health care tasks could be automated[lv], which could free up human resources to be deployed elsewhere.

Greater support for carers and third/voluntary sector – third/voluntary sector organisations often have a large and skilled workforce, who can be deployed flexibly to support health and care service delivery by statutory provider organisations. The flexibility and voluntary status of many of these staff means that they can be deployed when needed with minimal sunk costs. The 2016 Social Attitudes Survey in the Isle of Man showed that 13% of Islanders considered themselves to be a carer and 87% of these accessed no support or assistance from the Government or charity or other organisations. Providing financial support to carers has proven effective in some areas in freeing up workforce capacity. In Germany a scheme that allowed older patients to pay relatives or friends to become home carers[lvi], resulted in greater patient satisfaction and reduced hospital admissions.

New Models of Care – antiquated models of care do not often make the best, most productive use of services. New models of care which are more reflective of patient needs and ways of accessing services can be expected to drive improvements in productivity. However, it should be noted that a 'one size fits all approach' is unlikely to be successful; care models need to be aligned to the 'reality on the ground' in order to enable improvements in productivity. An integrated model of care in Clalit, Israel is delivering results by leveraging technology and enabling integrated primary and secondary care[lvii].

Activating and empowering patients – Patient Activation is a measure of the knowledge, skills and confidence a person has in managing their own health and care. More activated patients are more effective in managing their long-term conditions and achieve better outcomes. A positive correlation between patient activation and outcomes has been seen across a range of disease conditions.

Supporting staff to operate at the top of the licence – empowering staff to focus their efforts on the elements of their training that cannot be delivered appropriately by more junior grades, can ensure that capacity is used where it is most needed. The Buurtzorg model in the Netherlands allows nurses to extend their roles and has resulted in an improvement in unit productivity of nearly 30%[lviii].

However, the Isle of Man, in common with other smaller, geographically remote systems, faces an even greater challenge. The specific impact of these challenges in respect of workforce is that;

- Without changes in the composition of the workforce and ways of working, rising demand will require an equivalent increase in workforce numbers, which would be difficult to achieve in a small economy
- The workforce required to deliver the new service model will need additional knowledge and skills to be effective in their roles
- Different approaches to delivering services will need to be implemented (for example, improving patient involvement and activation).

There are other specific workforce challenges which need to be taken into account which are also impacting other health and care systems. These are:

- In this competitive environment, good candidates will choose where to work based not only on remuneration, but also on intangible benefits including the culture of the employer organisation and opportunities for personal and professional development.
- The impact of Brexit on the health and care labour market in the British Isles. Although the Isle of Man is not a member of the EU, as a result of the historic links between the Isle of Man and the UK, it is part of the wider labour market which is already being impacted by the UK's decision to withdraw from the EU. This is likely to continue to have an impact on the recruitment and retention of staff across the entire health and care services. These impacts are already being felt in the UK.
- Recruitment and retention of low-skilled, but vitally important staff, is also affected by the wider economy. Historically this group of staff has been relatively poorly paid, but applicability of their skills and experience to other sectors means that a growth in demand other parts of the economy can quickly impact on this element of the health and care workforce.

In addition to these general recruitment and retention challenges, there are challenges which are specific to the Isle of Man and to other small, geographically isolated health economies. These include:

- How to provide a comprehensive range of services to the population, some for 24 hours/7 days a week, balanced with the need to provide staff with an appropriate 'work/ life balance'
- At the same time, it is important that professional staff carry out sufficient specialist work to maintain their professional skills and expertise. This is more of a challenge when delivering services to resident population of only 85,000; there is an insufficient volume of specialist cases, to enable staff to maintain the relevant skillset. Not all clinical staff grades are as affected by this issue, but it does tend to affect the most highly skilled and specialist staff, where international competition for talent is the greatest.
- At present, staff define themselves primarily in terms of their professional category and their employer organisation. Key to delivering the new service model will be a culture of working across organisations and settings.

Annex 9: Current and Past Initiatives Relating to Isle of Man Health and Care

Date	Title	Author/Lead
Current	Integrated Care Pilot Project in the West	Department of Health and Social Care (DHSC)
Current	Tertiary Care Contracts	DHSC
Current	Organisational Development Plan 2018-2019	DHSC/Office of Human Resources, Cabinet Office
2018 - 2023	Island Plan for Integrated Palliative and End of Life Care https://www.hospice.org.im/assets/News/Content/863d8ea97c/Island-Plan-for-Integrated-Palliative-and-End-of-Life-Care.pdf	DHSC/Hospice/ Council of Voluntary Organisations
2015-2020	Five Year Plan for Health and Social Care 2015-2020 https://www.gov.im/media/1349186/health-and-social-care-in-the-isle-of-man-the-next-five-years-gdno20150052.pdf	DHSC
November 17 – 30 March 2019	Eye Care Strategy https://consult.gov.im/health-and-social-care/eye-care-strategy/supporting_documents/Eye%20Care%20Strategy%20.pdf	DHSC
March 2019	Inquiry into Overspending at Noble's Hospital (first and second reports from session 2018-19) http://www.tynwald.org.im/business/pp/Reports/2019-PP-0032.pdf http://www.tynwald.org.im/business/pp/Reports/2019-PP-0031.pdf	Public Accounts Committee
September 2018	DHSC Vision – Delivering Longer, Healthier Lives https://www.gov.im/media/1354840/programme-for-government-210917.pdf	DHSC
September 2018	Children and Families Action Plan (relates to Scottish Care Inspectorate and Social Affairs policy Review Committee entries)	DHSC
September 2018	Reaccreditation 2018	Cheshire and Mersey Major Trauma Network
September 2018	Review of Acute Care Pathway within Medicine	Professor Ian Sturgess
September 2018	Early Supported Discharge for Stroke Pilot	DHSC
July 2018	Noble's Draft Operational Structure	DHSC
July 2018	Review of Noble's Hospital Theatres and Opportunity Search	KM&T
July 2018	Future Funding Nursing and Residential Care (first report) http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020161820 18/2018-GD-0032.pdf	Isle of Man Government
June 2018	DHSC Service Delivery Plan 2018/19 https://www.gov.im/media/1361933/dhsc-service-delivery-plan-2018-19.pdf	DHSC
June 2018	Perinatal mortality report for 2016 births	Maternal, Newborn and Infant Clinical Outcome Review Programme

April 2013 to June 2018	Reviews 1-8 of Isle of Man Health Service http://www.wmqrs.nhs.uk/review-programmes/view/isle-of-man-health-services	West Midlands Quality Review Service
May 2018	Cervical Screening Audit Report	NHS Digital
May 2018	Learning Disabilities Respite Service Review https://www.gov.im/media/1362945/2018-respite-services.pdf	Care and Health Solution
April 2018	Prior Information Notice – Tertiary Services	DHSC
March 2018	Endoscopy Service Review https://www.gov.im/media/1363863/iom-dhsc-endoscopy-final-report-4-9-18.pdf	MIAA
January 2018	Inquiry into Overspending at Noble's Hospital (first report for session 2017-18) http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020161820 18/2018-PP-0004.pdf	Public Accounts Committee
January 2018	Data Summary Report for Noble's for 2017	National Neonatal Audit Programme
2018 – 2023	Hospice: Much More Than a Building 2018-2023 Strategy: https://www.hospice.org.im/assets/d525f5dcd6/2018-2023-Strategy-compressed.pdf	Hospice
2017-18	Consolidation of Endoscopy Services at Noble's	Tynwald Social Affairs Policy Review Committee
2017-18	Children and Families Division – Annual Report 2017/18 – Committed to Partnership Working to Respond Well to Children: https://www.gov.im/media/1362373/annual-report-children-and-families-division-2017-2018.pdf	DHSC
2017	Review of telemedicine in the Isle of Man	Henry Bloom Noble Healthcare Trust
November 2017	Assurance and Risk Workshop Report DHSC	Zurich
November 2017	Options for Integrated Acute Care provision in Noble's	Dr Jugnu Mahajan
November 2017	Report on General Surgery service at Noble's	Royal College of Surgeons of England
October 2017	Noble's Hospital Rheumatology Department Peer Review	North West and Mersey Regional Peer Review Committee, British Society for Rheumatology
August 2017	Community Nursing visit (press release only)	Queen's Nursing Institute
March 2017	Southern Community Project report	Southern Community Initiatives
January 2017	Home Care Review	Care and Health Solution
November 2016	Review of Therapy Services	Salford Royal (NHS) Foundation Trust
October	Organisational Development Programme proposals for 2016-20 and	Health Services

2016	comments from Health Services Consultative Committee https://www.gov.im/media/1361890/hscc-annual-report-2017-18.pdf	Consultative Committee
October 2016	Review of Breast Screening Programme	DHSC
July 2016	Review of Vascular Surgery	Chris Imray, Vascular Society
July 2016	Review of Salaried Dental Service Re-design	MIAA
June 2016	Progress Review of Services for Children and Young People http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020160218/2017-GD-0056.pdf	Scottish Care Inspectorate
2016	Urgent Care Review	DHSC
2015-16	Report of Children and Families Social Services http://www.tynwald.org.im/business/pp/Reports/2016-PP-0103.pdf	Social Affairs Policy Review Committee
2015-16	Report on the Funding of Nursing and Residential Care 2015-16 http://www.tynwald.org.im/business/pp/Reports/2016-PP-0120.pdf	Tynwald Select Committee
December 2015	Review of Clinical Administration	Rosalie Holmes
October 2015	Review of Bowel Cancer Screening Programme	Public Health
October 2015	Review of Cervical Screening Programme	Public Health
October 2015	Review of Diabetic Retinopathy	Public Health
August 2015	Visit to Blood Transfusion Service	Barbara Morris
June 2015	Out of Hours District Nurse Trial	Director of Community Nursing, DHSC
June 2015	Digital Strategy https://www.gov.im/media/1347695/digital-strategy-01.pdf	Government Technology Services, Cabinet Office
May 2015	Stroke Review	Stroke England, St Georges University Hospital, Royal Liverpool University Hospital and SCNs and senates Cheshire and Mersey
2015 – 2020	Strategic Plan for Mental Health and Wellbeing 2015-2020: https://www.gov.im/media/1353553/strategic-plan-for-mental-health-and-wellbeing-2015-2020.pdf	DHSC
2014/2015	Strategy for General Practice	Director of Primary Care, DHSC
August 2014	DHSC Leadership Blueprint	Former CEO, DHSC
July 2014	Tertiary Care Referral Process Review	Department of Health
April/May 2014	Clinical Coding Audit Report Noble's Hospital	Sue Eve-Jones
March 2014	Views on Dermatology Service	Dr Hepburn

February 2014	Report of Services for Children and Young People http://www.tynwald.org.im/business/opqp/sittings/20112014/2014-GD-0023.pdf	Scottish Care Inspectorate
February 2014	Quality Review of Colposcopy Service	Brady Medical Consultancy Ltd
January 2014 – 2019	Adult Learning Disability Service Strategy 2014-2019: https://www.gov.im/media/1013909/adult_learning_disability_service_strategy_2014_-_2019.pdf	Department of Social Care
December 2013	Review of Management Effectiveness Noble's Hospital https://www.gov.im/media/1027297/review_of_management_effectiveness_at_noble_s_hospital.pdf	Beaman's
December 2013	Francis Working Group Report	Department of Health
March 2013	Management Information Review	MIAA
November 2012	Report of Colorectal Surgery at Noble's	Steven George Stojkovic
April 2012	National Cancer Plan 2012-2022	Department of Health
2012 – 2017	Supporting people to live and die with dignity Hospice Strategy 2012 – 2017	Hospice
January 2011	A Strategy for the Future of Health Services in the Isle of Man http://www.tynwald.org.im/business/committee/PAC/Public%20Evidence/2011_A_Strategy_for_the_Future_of_Health_Services_in_the_Isle_of_Man.pdf?Mobile=1&Source=%2Fbusiness%2Fcommittee%2FPAC%2F_layouts%2Fmobile%2Fdispform%2Easpx%3FList%3D65364c59%252Da514%252D43d3%252Da716%252Da5fd7230a290%26View%3Df1795a00%252D4daa%252D48ef%252Da766%252D6d360b6720fe%26ID%3D15%26CurrentPage%3D1	Department of Health
Unknown	Anaesthetic and Critical Care Review	Dr David Yates

Annex 10: Outline of the make-up, responsibilities and governance for the Board of Manx Care

"Manx Care" is a statutory arm's length body acting as a prime contractor for health and social care services for the Isle of Man Government. Manx Care is responsible for planning, delivery and commissioning of health and care services for the citizens of the Isle of Man.

PRINCIPLES OF GOOD GOVERNANCE

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- The Isle of Man Government Corporate Governance Policies and standards of behaviours (Nolan Principles);
- the Tynwald approved principles for health and the principles in this Report for health and care;
- the Equality Act 2017.

ACCOUNTABILITY

Manx Care demonstrates its accountability to its members, local people, stakeholders and the DHSC in a number of ways, including by:

- appointing independent lay members and clinicians to the Board;
- consider holding meetings of its Board in public (except where Manx Care considers that it would not be in the public interest in relation to all or part of a meeting);
- publishing annually a commissioning plan;
- meeting annually in public to publish and present its annual report (which must be published) to DHSC and Tynwald;
- producing annual accounts in respect of each financial year which must be externally audited;
- having a published and clear complaints process;
- complying with the Freedom of Information Act 2015;
- providing information to the DHSC as required.

FUNCTIONS AND GENERAL DUTIES

Manx Care is responsible for the delivering and, where appropriate, commissioning of health and care services for the citizens of the Isle of Man that meet the reasonable needs of the annual Mandate as provided to it and agreed with the DHSC.

General Duties

In discharging its functions Manx Care will:

- Agree a communications strategy (which may be combined with the engagement strategy), helping to ensure that there is effective communication between service users, the wider public and the clinical commissioning group;
- Identify a lead for patient and public engagement;
- Ensure future commissioning decisions and related service plans follow best practice in consulting and engaging with the local community and key stakeholders;
- Ensure that service users, public and staff are engaged with commissioning decisions; from publicising information and individual involvement to support shared decision making to more formal consultation and engagement;
- Work with all providers of health and care to make sure that lessons are learnt from service users experience to improve the way services are delivered;

- Publish information about health and care services on the relevant website(s) and through other appropriate forms of media;
- Monitor performance against this responsibility and provide regular reports about performance to the DHSC;
- Provide services that respect and deliver the Tynwald approved principles for health and the principles in this Report for health and care;
- Act effectively, efficiently and economically;
- Act to secure continuous improvement to the quality of services;
- Promote the involvement of service users and their carers and representatives in decisions about their health and care by:
    - Acting with a view to enabling service users to make choices,
    - Obtaining appropriate advice from persons who, taken together, have a broad range of professional expertise in health and care and public health;
- Promote innovation, research and the use of research;
- Have regard to the need to promote education and training for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health and care service; and
- Act with a view to promoting integration of both health and care and other services where Manx Care or the DHSC considers that this would improve quality of services or reduce inequalities.

Financial Duties

Manx Care will perform its functions so as to:

- Ensure its expenditure does not exceed the funding envelope agreed by Treasury via DHSC; and
- Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by DHSC.

Other Relevant Regulations, Directions and Documents

Manx Care will:

- comply with all relevant regulations; and
- take account, as appropriate, of mandates, documents and requests issued by the DHSC.

THE BOARD

The Board must have a majority of Non-Executive Directors, no political representation and consist of:

- Non-Executive Chairperson
- 5 Non-Executive Directors
- Chief Executive
- Director of Finance
- Director of Operations
- Director of Social Care
- Director of Clinical Services
- Chief Information Office Health and Care (as part of GTS)

The Board may, at its discretion, invite other Directors to attend in a non-voting capacity. The Chairperson will be appointed by the Government and approved by Tynwald. The Non-Executive Directors will be appointed by the Government in consultation with the Chairperson. The Chief Executive will be appointed by the Chairperson and Non-Executive Directors in consultation with Government. The Executive Directors will be appointed by the Chief Executive in consultation with the Chairperson and Non-Executive Directors.

Annex 11: Legislative Changes

The below table provides an outline of some of the legislative changes that a) will be required to address gaps in the current legislative framework and/or b) will be required to implement the recommendations included in this Report.

Given the volume of change required, it may be sensible to replace the National Health Service Act 2001, the National Health and Care Service Act 2016 and the Regulation of Care Act 2013 with a new, modern and comprehensive Health and Care Act, incorporating the majority of the necessary changes. However, the Review recognises that some of the legislative changes suggested are scheduled to be addressed or would need to be considered separately.

The table indicates what action would be required to introduce these reforms but it is worth noting that most of these changes could be achieved through the introduction of a new Health and Care Act – those that would not be suitable to address in this way are clearly highlighted within the table.

Figure 25: Outline of some suggested legislative changes

Change	Action (New, Amend, Repeal or Enact Legislation)	Impact/Notes
Establish "Manx Care"	Amend Schedule 1 to Statutory Boards Act 1987	See recommendation 2
Clearly set out the functions of the DHSC/Manx Care	Amend/replace National Health and Care Service Act 2016	See recommendations 2 and 4
Establish clinical governance	New Primary legislation	See recommendation 2
Independent, external regulation of services provided and commissioned by Manx Care	New Primary legislation	See recommendation 3
Aim for consistency in internal audit and monitoring functions across all areas of health and care	Amend/replace Regulation of Care Act 2013	See recommendation 5
Establish duty of care to include: • **duty of confidentiality** • **duty to share information** • **duty of candour**	New Primary legislation	See recommendation 5
Relocate Public Health to Cabinet Office	Amend/replace National Health Service Act 2001 and new Transfer	See recommendation 9

	of Functions Order under Schedule 2 of the Government Departments Act 1987	
Define services to be provided	New Primary/Secondary legislation	See recommendation 11
Establish a duty for Government Departments to cooperate or to co-commission services for the benefit of the user	New/amend Government Departments Act 1987	A provision within a new Health and Care Act, or at a higher level applying to all Departments, would encourage multi-agency, integrated working and support the implementation of recommendation 12, which, at times, will require the cooperation of Departments other than the DHSC, e.g. the Department of Education, Sport and Culture in relation to services for children and young people.
Review child and young person specific legislation to implement the recommendations, ensure that it is fit for purpose and consider merging it into something similar to the UK's Children and Families Act 2014	Amend/replace Children and Young Persons Act 2001 and the Education Act 2001/Education Bill 2019	As above, to support the implementation of recommendation 12 and, in particular, more accountability and integrated working in relation to services for children and young people. Suggest not included in new Health and Care Act as its application will be wider than health and care services.
Update prescribing legislation	New/amend Medicines Act 2003 and its secondary legislation	To include a variety of areas of reform, including: • Establishing a "Responsible Pharmacist" responsible for the safe and effective operation of the pharmacy including for periods of absence. This will allow the pharmacist to be away from the pharmacy (i.e. to have a lunch break, have sessions working with other healthcare professionals in clinics, participate in commissioning and development of services or participate in continuing professional development) whilst allowing the sale and supply of medicines to continue; • Considering recognition of pharmacy technicians; • Extending prescribing rights (e.g. to include podiatrists, physiotherapists, therapeutic radiographers, paramedics, optometrists, dieticians, orthoptists and midwives) to improve the efficiency of these elements of services and reduce the demand on the doctors time; • Consider an update for electronic prescribing of controlled drugs and the mechanics of electronic prescribing.

		Suggest not included in new Health and Care Act as Medicines Act 2003 and subordinate legislation to be amended as part of a wider package of amendments that are already being considered by the DHSC.
Protection of those with learning or physical disabilities	Enact Equality Act 2017	To ensure legislative basis to provide equality, including vulnerable individuals. Suggest not included in new Health and Care Act as due to be enacted on 1 January 2020 through Equality Act 2017.
Basis for capacity/Deprivation of Liberty Safeguards	New Capacity Act	To provide legislative basis on which people who lack mental capacity are detained in institutional care in their own best interests. Suggest not included in new Health and Care Act as Mental Capacity Bill has been worked on by DHSC Legislation Team and should be progressed.
Discharge from hospital to care homes, supported by a "Home of Choice" policy	Enact/replace section 16 of the National Health and Care Service Act 2016	A Home of Choice policy aims to support people to transfer out of hospital at the appropriate time, by describing the process by which choice of discharge destination for an individual (particularly those who are unable to return to their usual place of residence) will be managed. The Review has heard that, on occasions, people decline the residential options that are available and continue to remain in hospital beyond the time that their care needs require. A home of choice policy, supported by the necessary legislative sanctions, makes the process more transparent and offers guidance and support for staff, the individual and their family.
Review work permit exemptions	Amend Schedule 1 to the Control of Employment Act 2014	In support of recommendation 25, consider extending the existing exemptions to requiring a work permit for health and care professionals within the Control of Employment Act 2014 to include, for example, Allied Health Professionals would remove any barriers to recruitment currently experienced as a result of the work permit requirements, including any delay to the recruitment process (although it is noted that the work permit application process has become more streamlined since work permit reforms made in 2018), additional administration and the perception of unstable employment, and so ease the recruitment of appropriately qualified staff.
Review the requirement for health and care professionals to be registered with a UK professional regulatory body	Amend the interpretations within the Health Care Professionals Act 2014	In support for recommendation 25, extending the requirement for various health and care professionals to be registered with a professional regulatory body in an acceptable jurisdiction, other than the UK, that applies appropriate standards of regulation (such as Eire) to open up the pool of professionals that could be attracted to work in the

		Island.
Review the appropriateness of the emergency preparedness, resilience and response (EPRR) framework and civil contingency legislation	Possibly amend the Emergency Powers Act 1936 and the Civil Defence Act 1954	To ensure that EPRR capacity planning, exercising, training and service delivery is fit for purpose and consistent with the enhanced emergency and out of hours care model. Suggest not included in new Health and Care Act as its application will be much wider than health and care services.

Note: Recommendation 19 states that increased funding will be required to support the new service model in the future and provides options on how this could be achieved. Depending on which option or combination of options is selected, there may be a requirement to amend legislation to enable funding to be raised through that or those means.

Annex 12: Funding and Data

A. Demography

A1. Summary

By understanding current demand for services in the Isle of Man, the Review can establish a baseline from which to predict increases in demand in the future. Future demand, alongside inflation, will be a key driver of future spend on health and care services. Demand for health and care services can be measured in two ways:

1. as the **need** in the population for health and care services (which includes unmet demand).
2. as the **usage** of health and care services by the population (which only measures demand that is met).

To understand how these two factors relate to each other in the Isle of Man, the Review has compared need and usage in the Isle of Man with need and usage in England (or the United Kingdom where England data has been unavailable).

The Review has chosen England as the system against which to compare usage because analysis indicates that the Isle of Man has a similar need for health and care services as England due to the similarity of underlying demographic factors.

Despite the similarities in population outlined below the Isle of Man appears to show a higher usage of acute services per head than England and lower usage per head for GP services. Better data on elective admissions off-Island would, however, improve this analysis.

A2. Current need for services

The sections below set out a range of proxy data for health and care need, including demographics (A2.1.), prevalence of Long Term Conditions (A2.2.) mortality rates (A2.3.), Public Health indicators (A2.4.), and deprivation and socio-economic status (A2.5.).

A2.1. Demographics

The size of the Isle of Man's population in 2016/17 (the date of the last census) was 83,314[lix].
Key drivers for need of health and care services in any population are deprivation, lifestyle and diet, long term conditions, and demographics, as older people will require more care and support.

The demographics of the Isle of Man's population are very comparable in terms of split by age band to England (using 2015/16 figures as these are the most recent available). The majority of the Isle of Man's population in 2016/17 was aged 16 – 65.

Figure 26: Isle of Man and England population demographics by age group 2016/17 (England data 2015/16)[lx]

Age group	Isle of Man numbers	England numbers	Isle of Man %	England %
0 - 15	13,346	9,792,438	16%	18%
16 - 65	52,763	35,282,317	63%	64%
66 - 75	9,653	5,285,755	12%	10%
76 - 85	5,284	3,130,528	6%	6%
85+	2,268	1,295,289	3%	2%
Total	**83,314**	**54,786,327**	**100%**	**100%**

The Isle of Man and England's demographics in terms of nationality in 2016/17 are shown in Figure 27 below. Due to differences in recording, the Review has included 'Non EU rest of world' nationalities in 'Other' for the UK's population %.

Figure 27: Population by place of birth in the UK and the Isle of Man, 2016/17[lxi]

Place of birth	Isle of Man (% population)	UK (% population)
Isle of Man	49.8	0.0[lxii]
British	40.0	90.8
European (EU)	4.8	5.5
European (non-EU)	0.5	0.1
Middle Eastern	0.1	0.4
Asian	2.0	1.7
African	1.6	0.7
North American	0.5	0.3
Central American	0.0	0.0
South American	0.1	0.1
Caribbean	0.3	0.1
Australasian	0.3	0.2
Other	0.0	0.0

The Review was not provided with data on ethnicity so a comparison of nationality was the best comparison available of ethnic diversity between the two countries.

The breakdown of the nationalities of residents in the UK and the Isle of Man are very similar. The vast majority of residents in both are British Citizens, with EU nationals and Asian nationals making up the next two largest nationality groups.

A2.2. Prevalence of Long Term Conditions

The three most common long term conditions in the Isle of Man in 2017/18 were hypertension, affecting 15.15% of the population, asthma, affecting 6.44% of the population, and diabetes, affecting 4.8% of the population[lxiii].

The profile of long term conditions prevalence on the Island is broadly similar to the profile of long term conditions prevalence in England.

Figure 28: Prevalence of long term conditions, England and the Isle of Man, 2015/16[lxiv]

Condition	Prevalence the Isle of Man as %	Prevalence England as %
Hypertension	15.00	13.79
Asthma	6.44	5.99
Diabetes	4.18	6.37
Cancer	2.57	2.26
Chronic Heart Disease	3.62	3.25
COPD	1.52	1.82
Dementia	0.48	0.74
Learning difficulties	0.38	0.44
Mental ill health	0.66	0.88
Stroke	1.97	1.73

A2.3. Mortality rates

Figure 29: Mortality rates for LTCs, the Isle of Man compared to England, 2013 - 2015[lxv]

LTC	Mortality rate the Isle of Man (per 100,000 people)	Mortality rate England (per 100,000 people)
Cardiovascular disease	69.7	74.6
Cancers	134.3	138.8

Figure 30: Preventable death statistics the Isle of Man and England in 2016/17[lxvi]

Preventable deaths from...	In the Isle of Man (per 100,000 pop)	In England (per 100,000 pop)
Cardiovascular disease	44.8	41.5
Liver disease	12.6	18.3
Cancer (under 75)	84.6	71.4
Respiratory disease	8.3	16.1

A2.4. Public Health indicators

Public health indicators are very similar between the United Kingdom and the Isle of Man, comparing 2016/17 data. In the Isle of Man, 22.6% of adults were obese, 14.5% of adults smoked and 72.6% of adults were active for more than 150 minutes a week in that year, compared to 25.8%, 15.5% and 61% respectively in the UK (see Figure 31 below for a full comparison).

Figure 31: Public health indicators in the UK and the Isle of Man, 2016/17[lxvii]

Measure	Isle of Man prevalence	UK prevalence
Obesity in adults	23%	26%
Obesity in children (9 year olds Isle of Man, 5 year olds UK)	9%	10%
Deaths from drug misuse	8.5/100,000	1%
Rate of smoking in adult population (18+)	15%	16%
Rate of smoking among pregnant women	11%	11%
Active more than 150mins per week	73%	61%
Low birthweight babies	1%	3%
Breastfed babies	70%	74%
Children under 5 free from dental decay	72%	77%
Teenagers who have had a drink	26%	44%
Abstain from alcohol	14%	19%

A2.5. Deprivation and socio-economic status

Some areas of the Isle of Man are more deprived than others. The area around Douglas has the highest crime rate. The top three areas for employment deprivation are located within the town of Douglas, followed by an area in Ramsey. The top three areas for income deprivation are within Ramsey, Douglas and Castletown. The Isle of Man therefore follows a pattern of urban deprivation, with rural areas generally being less deprived. Concentrations of deprivation are also seen in urban areas in England[lxviii]. There is also fairly high income inequality on the Island. The area with least deprivation, Kirk Michael, has an income deprivation score that is 79% lower than the next least deprived area in the Isle of Man.

The Isle of Man's Index of Multiple Deprivation is not calculated in a method comparable to England's so an absolute comparison cannot be made. The income domain within the Isle of Man

Index of Multiple Deprivation is made up of three separate indicators, in comparison to five indicators used within the United Kingdom index. The employment domain of the Isle of Man Index of Multiple Deprivation is constructed from three indicators. This is in comparison to the seven indicators used within the United Kingdom index[lxix].

Median weekly earnings in the Isle of Man were £558 in 2017[lxx]. This compares to £550 median weekly earnings in 2017 in England, indicating similar levels of average earnings with Isle of Man residents being slightly more affluent on average[lxxi]. National Readership Survey (NRS) or government grading of social class (NS-SEC) status comparisons between England and the Isle of Man are not possible, however, as the Isle of Man only records the sectors that people work in rather than the grade at which they work (e.g. manager, employee etc.).

A3. Current usage for services

The sections below set out a range of data for health and care usage. These include use of acute health services (A3.1.), use of GP services (A3.2.), use of primary care services (A3.3.), use of adult social care services (A3.4.) and use of children and families social care services (A3.5.).

A3.1. Use of acute health services

Figure 32: Use of acute health services 2017/18, Isle of Man compared to England[lxxii]

Service	Isle of Man/100,000	England/100,000
Emergency admission rate	12,759	10,822
Elective admission rate	11,093	17,594
Outpatient appointment rate	146,716	119,180

In 2017/18 the Isle of Man had higher emergency admission rates per 100,000 population, lower elective admission rates, and significantly higher outpatient appointment rates per 100,000 population across both hospitals on the Island than in England. These figures do not factor in tertiary activity off-Island. The Isle of Man therefore uses more acute healthcare per head than England. As per sections A1 and A2, need for health and care services should be similar between England and the Isle of Man, it is notable that usage is quite so different. This may reflect differences in the way health and care systems are accessed or set up, or in the way data is captured.

Notably, the activity data provided by off-Island providers only shows 29 elective procedures and 20 emergency procedures in 2017/18. This indicates that a number of procedures are not being recorded fully and that rates of procedures cannot be fully compared with the UK until off-Island reporting improves (see Figure 33 below).

Figure 33: Off-Island elective and non-elective hospital activity Isle of Man 2017/18[lxxiii]

Specialty	Elective	Non Elective Emergency	Non Elective Non-Emergency	Grand Total
Accident & emergency		1		1
Anaesthetics	1			1
Cardiology	13	2	3	18
Clinical oncology (previously radiotherapy)		1		1
Endocrinology			1	1
Gastroenterology		1		1
General medicine		4		4
General surgery		2		2
Geriatric medicine		3		3
Gynaecology	2			2
Obstetrics			1	1
Ophthalmology	1			1
Paediatrics			3	3
Respiratory medicine (also known as thoracic medicine)	4			4
Trauma & orthopaedics	8	2		10
Urology		4		4
Grand Total	29	20	8	57

A3.2. Use of GP services

In the Isle of Man, people use proportionally fewer GP appointments annually than people in England (comparing 2017/18 the Isle of Man estimates with 2013/14 England estimates, most recently available)[lxxiv].

Figure 34: GP appointments made per population[lxxv]

Location	Average appointments per year	Appointments per year per pop
Isle of Man	312,153	4
England	340,000,000	6

There is also high variation in the number of appointments per week provided by practices on the Isle of Man. This ranges from 40 appointments per week per 1,000 patients in Ramsey to 90 appointments per week per 1,000 patients in Palatine. GPs note, however that this is a crude measure of activity as it does not include home visits, phone calls and other GP tasks such as medicines management and requesting tests.

Figure 35: GP appointments per practice (as at September 2018)[lxxvi]

Practice	List size	Number of GPs	GPs WTE	F2s	GP trainees	Nurses	Notes on nurses	Health care assistants	Pharmacist / pharmacy tech	Practice Manager WTE	Admin WTE	Weekly clinical sessions	Patients per session	Apps pw per 1,000 patients
Palatine	9,467	7	6	1	2	2.00		0.00	0.00	1.00	7.40	53	16	89.57
Kensington	10,013	5	4	0	0	2.00	0.7 ANP	0.00	0.00	1.00	10.96	44	14	61.52
Snaefell	5,493	3	2.2	1	0	1.00	1 nurse 1 trainee ANP	0.00	0.00	1.00	6.20	28	14	71.36
Promenade	4,437	3	2	0	0	1.08		0.00	0.00	0.49	2.49	18	14	56.80
Hailwood	7,545	4	4	0	0	1.27	2 nurse pre-scribers	0.00	0.00	0.81	5.47	32	16	67.86
Finch Hill	4,597	1	1.8	3 locums, 1 GP registrar	1	1.00		0.00		0.85	3.00	18	15	58.30
Ramsey	14,099	7	6.4	0	0	2.00		2.00	0.00	1.00	9.20	40	14	39.72
Peel	8,468	7	5.2	0	2	1.33	1 nurse, 1 nurse pre-scriber	1.00	0.00	1.81	6.87	44	16	83.14
Laxey/Onchan	8,092	5	4.4	1	5	1.48	1.40	0.00	0.00	0.70	7.00	41	14	70.93
Ballasalla	4,549	3	2.6	1		0.69		0.53	0.00	0.70	3.49	23.33	15	76.93
Castletown	3,909	4	2.2	0	0	0.90		0.15	0.00	0.90	2.90	21	15	80.58
Southern	7,044	5	4.1	0	0	1.30		0.20	0.00	0.81	4.00	36	17	86.88
Totals	**87,713**	**54**	**44.9**	**3**	**10**	**16.05**		**3.88**	**0.00**	**11.07**	**68.98**	**398.33**	**180**	**843.60**

The Review has also been provided with some additional information about the capacity offered in different GP practices to inform the interpretation of the quantitative data provided in Figure 35 above. This information is summarised in Figure 36 below.

Figure 36: Additional detail regarding GP surgery capacity[lxxvii]

Practice	Additional comments
Snaefell	Urgents and telephone consultations available on the day F2 – appointments within 2 days, locum GP – within 10 days, regular GP – within 15 days (as at 13.08.18) 14 patients seen in a session plus 4 telephone consultations 28 face to face a day 4 telephone consultations per day 2 visits each 30-50 mon morning email consultations 25 per day medication requests
Palatine	Total WTE = 6 WTE For 9,409 1,568 per WTE GP Looking to increase 1650 to 1700 capitated patients The Practice routinely sees 12 patients per session then 4 extras on top per session. This is massively different for the VTs (Vocational Trainees) and F2s (Foundation Year 2 doctor)
Kensington	5 GPs 36 sessions /9 (WTE) = 4 4 GPs / 9309 = 2,327 patients per GP Adding NP into equation 4.8 / 9309 = 1,904 The NP is working as a front line clinician They are looking to replace 2 existing GPs (who will retire at some point) plus one more GP recruiting a clinical pharmacist
Promenade	Each GP has 12 scheduled appointments split into: Available to book via Patient Access 48 hours Unblock on the day Urgents GP unblock only The next available appointment was in 2 weeks' time. Urgent appointments were available on the day. In addition to this each GP has approximately 10 tasks per session plus 30 medicines management tasks per day.

	There was a discussion at the Practice about the high expectations that patients at the Prom had, particularly amongst the Eastern European patients.
Finch Hill	No additional information provided.
Hailwood	15 pre-bookable appointments to 10.45am. Rest of the morning = emergency. 13-14 pre-bookable afternoon, 1 GP on emergency. Urgents same day. Approx. 10 tasks / telephone calls to do per surgery in addition
Ramsey	Morning surgeries - 15 patient appointments Afternoon surgeries – 12 patient appointments Approximately 10 phone calls per surgery plus other tasks
Peel	14 per session plus 2 telephone. Urgents by duty doctor: no routine appointments all day. Telephone triage by the duty doctor. Waiting for pre-booked Mondays = 50 contacts for urgents, duty doctor manages. The maximum number of patients that one GP has seen in a day is 75. This includes telephone calls, triage, patients coming in, as well as blood result
Laxey	12 in morning sessions and 10 patients afternoon, plus extras of 2 and 8 in each clinic. Average 27 appointments per day and An average of (27*5*4.5WTE) – 607.5 Available appointments per week. Urgents seen same day but it's becoming unmanageable Telephone consultations on request but doesn't always code; stats may show lower consultations than other Practices
Ballasalla	12 pre booked per session plus 3 (2 in the afternoon) pre-booked telephone. Urgent appointments on top.
Castletown	12-15 per session. Plus each GP: 6 triage calls and 10 phone consultations per day. Work 10-11 hours a day with 30 minutes for lunch, non stop, multi tasking - very intense
Southern	17 appointments per morning session, 12 per afternoon session. 12 calls per GP each day plus visits. Working at pace 10 hours a day.

As shown in Figure 37 below, GPs in the Isle of Man also make proportionally more referrals per head of population than GPs in England, despite holding fewer appointments per head, which may indicate a higher reliance on acute services.

Figure 37: GP referrals made per population, 2013/14 - 2016/17[lxxviii]

Year	GP referrals per person Isle of Man	GP referrals per person England
2013/14	0.27	0.23
2014/15	0.27	0.24
2015/16	0.30	0.25
2016/17	0.30	0.25

GPs in the Isle of Man deliver on average 9 sessions a week, seeing on average 15 patients per session[lxxix]. This translates to an average of 27 patients seen per day per GP, compared to a UK average of 29 patients per day per GP[lxxx].

A3.3. Use of primary care services

In 2017/18 in the Isle of Man, community nurses had an average of 986 people on their caseloads each month and non-nursing community health services (including occupational health, safeguarding, prison health, adult speech and language therapy and podiatry referrals) made 58,045 contacts[lxxxi]. The Review cannot compare these caseloads to caseloads for community health practitioners in England, however, as it is advised that safe caseload levels for nursing vary depending on the set-up of the teams around them and the expectations of the role of a community nurse, which can vary from service to service[lxxxii].

A3.4. Use of adult social care services

Use of care homes in the UK and in the Isle of Man is very similar. In both, in 2017/18, 3.5% of the over-65 population were in residential care (see Figure 38 below). There appears to be slightly higher use of adult social care in the Isle of Man. In 2016/17 there were 0.3 referrals made per person in the UK, whereas in 2017/18 there were 0.4 referrals made per person in the Isle of Man (see Figure 39 below)[lxxxiii]. Adults aged 16 – 65 are referred to social services proportionally more in the Isle of Man than in England, however, although adults aged 65+ make up the bulk of referrals in both (see Figure 40 below).

Figure 38: Older people in care homes, UK compared to Isle of Man, 2017/18[lxxxiv]

Measure	Isle of Man	United Kingdom
Population over 65	17,460	11,989,322
Population in care homes	607	421,100
% of over 65s in care homes	3.5%	3.5%

Figure 39: Comparison of total England and Isle of Man social care referrals (Isle of Man 2017/18, England 2016/17)[lxxxv]

Country	Requests for support annually	Population	Requests per 1,000 pop
Isle of Man	3,264	83,770	39
England	1,800,000	55,619,400	32

Figure 40: Comparison England and Isle of Man social care activity per 1,000 population by age group (Isle of Man 2017/18, England 2016/17)[lxxxvi]

Social care activity	Isle of Man	England
All looked after children	1	1
Referrals to children's services	9	11
Aged 19 - 64 referrals	10	9
Aged 65+ referrals	28	24

The Isle of Man's social care use is therefore very comparable to use in England. In both areas, people aged 65 or over use far more social care resources.

A3.5. Use of children and families social care services

In 2017/18 there were 84 children in care in the Isle of Man, or 0.1% of the population[lxxxvii]. This is the same proportion of children in care as a % of the population in England (0.1%) in 2017/18[lxxxviii]. In the Isle of Man there were 775 referrals to family social care services, a drop from 989 referrals the previous year[lxxxix]. There were, however, 484 referrals in 2017/18 to the newly established Early Help and Support team[xc,xci].

B. Current spend on health and social care

B1. Isle of Man Budget spend 2018/19

Figure 41 below shows the expected spend in 2018/19 for the voted services of the Isle of Man (comprising Government Departments, and some Other Bodies). Spend for the DHSC is forecast to be £216.7m in 2018/19, however this is a net figure, lower than the gross spend prior to National Insurance contributions being considered. NI contributions to the DHSC are forecast to be £39.7m in 2018/19[xcii], and therefore the forecast the DHSC spend in 2018/19 is £256.4m.

Figure 41: 2018/19 Expenditure - Budget against probable[xciii]

Spend	Budget £,000	Probable £,000	Variance £,000	% of spend %
Government Departments				
Cabinet Office	30,449	30,442	7	4%
Enterprise	24	24	0	0%
Education, Sport & Culture	102,437	101,988	449	12%
Environment, Food & Agriculture	16,054	15,099	955	2%
Health & Social Care	216,107	216,726	(619)	26%
Home Affairs	33,255	34,320	(1,065)	4%
Infrastructure	63,229	63,227	2	8%
Treasury	361,370	358,451	2,919	43%
Sub-total	822,925	820,277	2,648	
Other Bodies				
Executive Government	10,467	10,467	0	1%
Manx Museum & National Trust	4,450	4,450	0	1%
Statutory Boards	90	90	0	0%
Sub-total	15,007	15,007	0	
Legislature	4,791	4,790	0	1%
Total Voted Services	842,723	840,074	2,648	100%

B2. DHSC spend

Figure 42: DHSC spend by Division, 2017/18 and 2018/19[xciv]

Division	Actual spend 2017/18 £,000	% of spend 2017/18 %	Probable spend 2018/19 £,000	% of spend 2018/19 %
Noble's Hospital	94,061	36.6%	108,627	42.1%
Tertiary Referrals	20,549	8.0%	20,141	7.8%
Adult Services	28,711	11.2%	29,432	11.4%
Children & Family Services	15,039	5.8%	14,860	5.8%
Primary Care Services	22,375	8.7%	11,213	4.3%
Mental Health	19,749	7.7%	21,752	8.4%
Public Health	1,247	0.5%	1,471	0.6%
Commissioning & Contracted Services	39,729	15.4%	38,701	15.0%
Corporate Services	11,706	4.6%	9,494	3.7%
Government Catering Services	3,032	1.2%	1,555	0.6%
Digital Transformation	972	0.4%	996	0.4%
Total	**257,169**	**100.0%**	**258,242**	**100.0%**
NI Contributions	-38,510	-14.97%	-39,665	-15.4%
Total (including NI Contributions)	**218,659**	**n/a**	**218,577**	**n/a**

B3. 'Central costs' spend

The central shared costs relate to services provided by Government Estates, Human Resources, Communications, Legal Support, Finance and Government Technology Services and from the Hospital Development Fund and spend on medical malpractice claims. These are government funded costs which apply to providing health and care services not covered by the DHSC budget, but which should be considered when assessing what the spend is. The overall spend quoted does not include expenditure by Treasury on funding care home placements through Social Security.

Figure 43: 'Central costs' estimated spend, 2017/18[xcv]

Budget area	Spend area	Estimated DHSC cost 17/18	Source
Estates	DOI expenditure in respect of the DHSC properties	£8.41m	Public Estates and Housing Division, Department of Infrastructure
Human Resources (HR) Support	HR costs covering HR advisory support, learning and development, and recruitment, payroll, employment administration & absence	£1.67m	Office of Human Resources, Cabinet Office
Communications	Cost for communications executive staff working on DHSC Communications	£0.06m	Government Communication Service, Cabinet Office
Medical malpractice	Costs to cover medical malpractice claims	£2.00m	The DHSC and Treasury estimate

claims			
Finance	Finance related costs	£0.65m	Treasury estimates
Government Technology Services	GTS estimates of infrastructure costs including mobile, desktop, service desk calls	£5.20m	GTS, Cabinet Office
Legal support	Staff costs from legal department working on the DHSC related issues	£0.38m	Attorney General's Chambers
Total		**£18.36m**	

For 2018/19, the Review have grown these costs by the expected 2018/19 demographic pressures (0.53%), non-demographic pressures (0.79%), and price pressures above general inflation (0.79%), to give a forecast 2018/19 spend of £18.93m.

B4. Health and care spend per head estimates

It may be helpful to consider the health and care spend per head for the Isle of Man compared to other geographies. **It should be noted that drawing conclusions from comparisons such as these should be done carefully, as there will always be differences between what health and care services are provided in one location compared to another**. For example, although Jersey spend per head is significantly lower than both England and the Isle of Man, this does not include GP spend as GPs are funded privately on Jersey. This is high level analysis, using the readily publicly available data. Whilst care has been taken to compare like with like, in some instances the most recent data in one area is a year or two different to in another area, and therefore comparisons need to be considered with caution.

Figure 44 below shows that the Isle of Man spend per head, at approximately £3,300 per head, is approximately 10% higher than spend per head in Scotland, and approximately 28% higher than in England. It is approximately 70% higher than Jersey and Guernsey, although the Review know that Jersey spend does not include spend on GPs.

Figure 44: Health and care spend per head high level comparison[xcvi]

Area	Health and care spend £,000	Population	Health and care spend per head £
Isle of Man	£275,529	83,770	£3,289
England	£144,400,000	55,619,400	£2,596
Jersey (excludes GPs)	£203,776	104,200	£1,956
Guernsey	£118,528	62,307	£1,902
Scotland	£17,217,000	5,404,700	£3,186

B5. Area specific spend comparisons between Isle of Man and England

There are a couple of areas where data does exist to be able to provide some specific comparisons on cost.

- **Hospital consultant pay**: analysis based on payroll data shows that the average hospital consultant pay in the Isle of Man in 2017/18 was £157,705[xcvii], 23.5% higher than the England average of £127,683[xcviii]. 14 of the 55 consultants were paid more than £200,000 in 2017/18. In 2018/19, the same analysis forecasts the average pay will increase to £169,129, 32.5% higher than the England average.
- **Pharmaceutical spend**: data provided by the DHSC (see Figure 45 below) shows that the Isle of Man spends 33.2% more per head on community pharmacy prescriptions[xcix] than in England. The Isle of Man spends a total of £17.1m on these items, at an average cost of £205

per population, whereas in England, they spend £8,507.5m on these items, at an average cost of £154 per population. The Isle of Man also uses 5.9% more items per population than in England, so this further demonstrates the difference in cost between the two.

Figure 45: IoM and England pharmaceutical item and spend comparison[c]

	No. of Items		Actual Cost		No. Items per 1000 Pop*		Cost per 1000 Pop		Variance from Eng. per 1000 pop		% Variance from Eng.	
	ENGLAND (1)	ISLE OF MAN (4)	ENGLAND (1)	ISLE OF MAN (4)	ENGLAND (1)	ISLE OF MAN (4)	ENGLAND (1)	ISLE OF MAN (4)	Items	Cost	Items	Cost
Gastro-Intestinal System (01)	98736360	134994	£441,414,542	£789,233	1786.50	1620.30	£7,986.79	£9,472.99	-166.19	£1,486.20	-9%	19%
Cardiovascular System (02)	320998237	397031	£1,029,084,260	£2,024,862	5808.02	4765.48	£18,619.86	£24,303.99	-1042.54	£5,684.13	-18%	31%
Respiratory System (03)	72554097	113802	£1,047,934,468	£2,046,124	1312.77	1365.94	£18,960.93	£24,559.18	53.17	£5,598.25	4%	30%
Central Nervous System (04)	207972454	349912	£1,703,661,664	£3,881,001	3762.97	4199.92	£30,825.41	£46,582.82	436.94	£15,757.41	12%	51%
Infections (05)	44918274	72865	£205,473,974	£392,452	812.73	874.58	£3,717.77	£4,710.51	61.85	£992.74	8%	27%
Endocrine System (06)	107625089	144381	£1,317,460,195	£2,440,763	1947.33	1732.97	£23,837.62	£29,295.95	-214.35	£5,458.33	-11%	23%
Obstetrics,Gynae+Urinary Tract Disorders (07)	29581051	42480	£324,254,911	£669,050	535.23	509.88	£5,866.95	£8,030.46	-25.35	£2,163.52	-5%	37%
Malignant Disease & Immunosuppression (08)	4468263	7073	£186,547,021	£464,820	80.85	84.90	£3,375.31	£5,579.14	4.05	£2,203.82	5%	65%
Nutrition And Blood (09)	59604195	86024	£607,825,428	£1,275,330	1078.46	1032.53	£10,997.76	£15,307.51	-45.93	£4,309.75	-4%	39%
Musculoskeletal & Joint Diseases (10)	33388382	55208	£185,394,116	£449,605	604.12	662.65	£3,354.45	£5,396.51	58.53	£2,042.06	10%	61%
Eye (11)	20039500	34839	£140,112,553	£312,519	362.59	418.17	£2,535.14	£3,751.10	55.58	£1,215.96	15%	48%
Ear, Nose And Oropharynx (12)	12350656	17327	£70,285,627	£119,765	223.47	207.97	£1,271.72	£1,437.51	-15.50	£165.79	-7%	13%
Skin (13)	37393768	57151	£278,043,729	£486,535	676.59	685.97	£5,030.82	£5,839.78	9.38	£808.96	1%	16%
Immunological Products & Vaccines (14)	13561508	344	£106,258,130	£103,568	245.38	4.13	£1,922.59	£1,243.10	-241.25	-£679.49	-98%	-35%
Anaesthesia (15)	1743901	3403	£25,752,081	£145,959	31.55	40.85	£465.95	£1,751.92	9.29	£1,285.97	29%	276%
Preparations used in Diagnosis (18)	65		£7,122		0.00		£0.13		0.00	-£0.13	-100%	-100%
Other Drugs And Preparations (19)	1292907	6421	£33,286,784	£157,546	23.39	77.07	£602.28	£1,891.00	53.68	£1,288.72	229%	214%
Dressings (20)	8654520	14719	£174,818,768	£370,203	156.59	176.67	£3,163.10	£4,443.47	20.08	£1,280.36	13%	40%
Appliances (21)	25652847	29106	£313,001,852	£468,804	464.15	349.35	£5,663.34	£5,626.95	-114.80	-£36.38	-25%	-1%
Incontinence Appliances (22)	2158573	2672	£51,567,521	£69,508	39.06	32.07	£933.04	£834.29	-6.98	-£98.75	-18%	-11%
Stoma Appliances (23)	5710980	7793	£265,332,109	£412,378	103.33	93.54	£4,800.82	£4,949.68	-9.79	£148.86	-9%	3%
Grand Total	**1108405627**	**1577545**	**£8,507,516,856**	**£17,080,025**	**20055.07**	**18934.93**	**£153,931.78**	**£205,007.86**	**-1120.14**	**£51,076.09**	**-6%**	**33%**

B6. Spend comparisons which cannot be made

However, the Review is still lacking data to enable it to make cost comparisons for some areas. For example:

- The Review understands patient-level costing is currently being developed at the specialty level for Noble's Hospital but has not yet been presented to management or used in operational decision making. While work is ongoing in this area, and progress is being made, comparisons cannot yet be made with Healthcare Resource Group (HRG) costs in the NHS in England[ci]. This means that, at the moment, information does not exist to be able to accurately compare the cost for specific procedures. If this could be done, the Isle of Man could assess where treatments are particularly cost ineffective (or effective), and mitigate accordingly,
- information on GP staffing costs to understand differences in General Practitioner costs, and
- unit costs of many items such as hourly carer rates, the cost of an outpatient stay.

B7. Overspend

Looking at the last three years, the DHSC has overspent against its projected budget every year from 2016/17 to 2018/19. During this period, however, several divisions have underspent in at least one year of the period. The Children and Families Division has underspent each year, Corporate Services underspent by £2m in 2018/19 and Primary Health Care services underspent by £1.4m in 2017/18. Whilst direct comparisons year on year are challenging without a deep dive into historic budgets due to accounting differences from year to year, an overview confirms that Noble's Hospital tends to drive the overspend for DHSC as a whole. This spending pattern does not support the Isle of Man's long-term strategy to move towards integrated and preventative health and care that is closer to home, as it encourages further investment into the hospital whilst reducing relative investment into other services[cii]. Discussions with stakeholders in the Isle of Man indicated that workforce planning challenges and a practice of relying on agency staff make cost controls in Noble's Hospital a particular area of difficulty.

The Isle of Man's 2017/18 review into overspend at Noble's Hospital commented: 'We noted that this problem [of overspending at Noble's Hospital] was not a new one; in the 1991 Strategy for

Health and Community Services on the Isle of Man it said: The team considered the current years' budgets for the hospital services and noted that the revenue outturn for 1989/90, while overall in balance, masked an overspending at Nobles hospital. This reflects the developing cost pressures within the acute service.'[ciii]

One contributing factor to overspend is the amount spent on agency staff. For example, agency spending at Noble's Hospital has increased from 7% of employee costs in 2012/13 to 12% of employee costs in 2017/18.[civ]

C. Future spend on health and care

C1. Vision for the future of health and care finances

The Review has been provided with several documents that set out goals, visions and aspirations for the future of health and care finances in the Isle of Man. A summary the relevant points raised in each is provided below.

Date	Author	Title	Key messages regarding a future vision for finances
August 2018	Isle of Man Government	Delivering longer, healthier lives	'We understand that the Review must change to address the scale of the financial challenge that is facing the Review's health and care economy. We cannot preserve the quality of services provided to the Review's residents if the Review continue to deliver them as the Review currently do. In order to maintain and improve the quality of services the Review must radically transform the system in which they are delivered. This means supporting people to be well and independent and building an integrated system of services that are targeted and preventative rather than unplanned and reactive.'
2018/19	the DHSC	Service Delivery Plan 2018/19	'We will work to ensure that everyone receives good value health and social care services.'
2017/18	Mike Quinn, Former Director of Hospitals	Isle of Man Hospitals Annual Report	'…despite some uplift in the budget for 2018/2019, the Review have undoubtedly further work to do in identifying and delivering the required savings in this coming year'
2016	Council of Ministers	Our Island: a special place to live and work, Programme for Government 2016 - 2021	'We are financially responsible while providing services that meet the needs of the Review's community.' 'We will demonstrate sustainable public finances with clear recognition of financial targets that support Government priorities.' 'We will maintain a stable tax and public revenue regime that meets the Review's fiscal, social and economic needs.' 'We will address the long term funding issues posed by an ageing population.'
August 2015	the DHSC	Health and social care in the Isle of Man - the next five years	'Integration is also good for the taxpayer because it reduces the apparently inexorable rise in the costs of care. The Isle of Man's health and social care service does not have to choose between providing better care and more efficient care. Integration is the key that unlocks both.' 'Our fifth strategic goal is to ensure that people receive good value health and social care. […] We will generate significant efficiency and productivity savings on a sustainable basis through better use of staffing, innovation and technology. We must become better at managing how the Review spend the budget which Tynwald gives us, and explain to the Review's community what the Review do with that money.'

In conclusion, no document yet produced by the Isle of Man sets out a standalone vision for health and care finances. Rather, the financial situation reached as a result of the Review's recommendations must support the Isle of Man's vision of integrated, good value and efficient care.

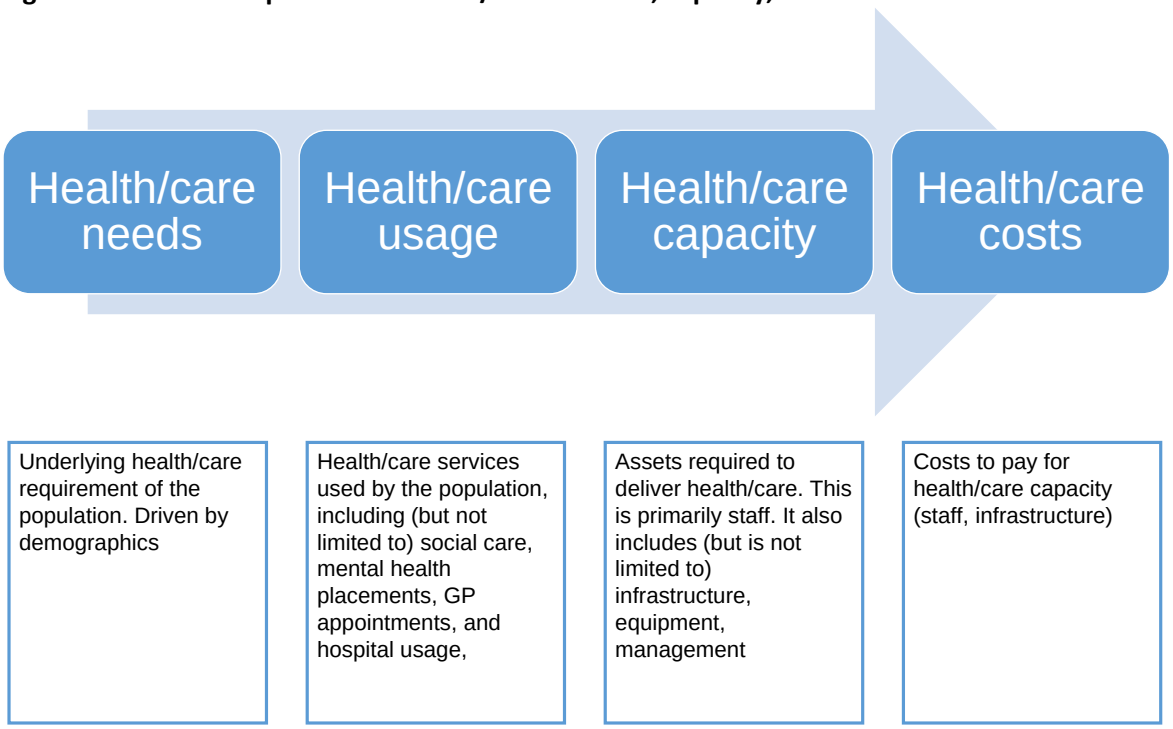
C2. Cost of health and care services in the future under 'do-nothing' scenario

This appendix sets out the methodology, results, and sensitivities of costing future health and care services in the 'do-nothing' scenario. In other words if no changes are made to the way services are delivered.

C2.1. Methodology

The Review has developed an economic model which estimates health and care costs by assessing health/care demand (split into need and usage), and health/care capacity. This relationship is summarised in Figure 46 below.

Figure 46: Relationship between health/care demand, capacity, and costs



When assessing how the cost of providing health and care in the Isle of Man changes, the Review therefore needs to assess what the future looks like in terms of:

1) Need – as populations grow, or become older, there is more need for health and care.
    a. In the 'do-nothing' scenario, the Review has modelled how the future population is expected to change in terms of absolute size (projected to increase) and in terms of age (projected to be an older population). Section C.2.2. sets out the projected demographic changes in the Isle of Man.
2) Usage – as need for health and care services increases due to demographic pressures, usage is also likely to increase. Depending on how the health and care system is structured, the extent to which this usage increases may change. Usage is also likely to increase due to non-demographic pressures (such as rising expectations).
    a. Demographic pressures: In the 'do-nothing' scenario, the Review applies the forecast 'do-nothing' need to usage using current relationships as a baseline. For example, if currently, 1,000 people means 1,000 A&E attendances a year, then in the future if there are 1,100 people, that will mean 1,100 A&E attendances. Section C.2.3. sets out the expected usage of services based on future forecast

demographic change. The Review adjusts this based on the need of those people. The population is forecast to get older than currently, and therefore the usage will increase at a rate of more than 1:1. This is done based on observed trends in England around how usage changes with age – explained in section C.2.4.

b. Non-demographic pressures: In the 'do-nothing' scenario, the forecast usage is modelled to increase due to non-demographic pressures. These include: increasing expectation and demand for healthcare services; improving access to care; changes in healthcare technology; medical practice; and changes in disease profile, etc. In absence of known forecasts for these pressures for the Isle of Man, the Review has taken the average six-year estimates of non-demographic pressures from the NHS England Five Year Forward View for 2015/16-2020/21, and assumed this same rate applies going forward in the Isle of Man. Section C.2.5. presents these assumptions.

3) Capacity – this covers the staff and assets required to deliver the health and care services to the Isle of Man population
    a. In the 'do-nothing' scenario, the Review is modelling the increase in capacity required to deliver the increased health usage modelled in 2). The model estimates the increased staffing numbers required at a rate proportional to the increases in demand.
4) Cost – this will be a function of the drivers above. As described previously, need drives usage, which in turn drives capacity, which in turn is what needs to be paid for.
    a. In the 'do-nothing' scenario, the Review modelled the cost pressures from increased usage of health and care services as coming from three areas. This is based on a similar methodology as that used in the Interim Lord Darzi Review of Health and social care[cv]. It is also based on a similar methodology as that used by NHS England in the 2016 Five Year Forward View looking at the 2020 funding gap[cvi]. Both methodologies use the following three drivers:
        i. Demographic pressures (more, and older people). Based on the 'do-nothing' estimates of changes to capacity mentioned above (which are in turn based on the increases in usage and need arising from demographic changes), the Review increases the costs at a proportional rate.
        ii. Non-demographic pressures. These include: increasing expectation and demand for healthcare services; improving access to care; changes in healthcare technology; medical practice; and changes in disease profile, etc. In absence of known forecasts for these pressures for the Isle of Man, the Review has taken the average six-year estimates of non-demographic pressures from the NHS England Five Year Forward View for 2015/16-2020/21, and assumed this same rate applies going forward in the Isle of Man.
        iii. Price pressures. The Review presents future costs in 'real terms' i.e. in today's (2018/19) prices. However historically, prices for health and care goods and services (including pay, drugs, and non-pay-non-drugs (e.g. devices, litigation)) have risen at a faster rate than 'general inflation' in the economy. The trend of health and care price rises above general inflation is expected to continue going forward. The Review therefore modelled how future costs need to rise over and above general inflation in order to present the funding gap in terms of what is needed to cover those above average price rises. Section C.2.6. sets out the Review's estimates of inflationary pressures.

C2.2. Future need of health and care services – i.e. population projections

Growth in future need for health and care services will be driven largely by an increase in prevalence of long term conditions, which will in turn be driven largely by a rise in the number of older people[cvii]. The impact of public health factors such as diet, exercise and smoking has not been separately accounted for but will be a driver for higher rates of long term conditions in older people. The Review has therefore based its predictions of future need for and usage of health and care services on the predicted ageing of the population.

The population of the Isle of Man is predicted to grow by 7.69% overall between 2016/17 and 2035/36, from 83,314 in 2016/17 to 89,721 in 2035/36. The age group that is predicted to increase the most over this period is the over 85s (by 46.74%). All the figures quoted in this section are based in the Isle of Man population growth forecast baseline assumption of 500 people p. a. net migration each year from 2016/17 to 2035/36 unless otherwise stated. This is the 'medium' population forecast (Figure 47 below), but Figures 48 and 49 below set out Isle of Man population projections under growth predictions based on the 'low' and 'high' population forecasts[cviii].

Figure 47: the Isle of Man % pop increase for 0-17, 18-65, 65-84, 85+, and the total growth for the 'medium' population forecast[cix]

Age range	2016/17	2035/36	Total growth	% increase
0 - 17	15,201	17,250	2,049	13.48%
18 - 64	50,908	49,958	-950	-1.87%
65 - 84	14,937	19,185	4,248	28.44%
85+	2,268	3,328	1,060	46.74%
All	**83,314**	**89,721**	**6,407**	**7.69%**

Figure 48: the Isle of Man % pop increase for 0-17, 18-65, 65-84, 85+, and the total growth for the 'low' population forecast[cx]

Age range	2016/17	2035/36	Total growth	% increase
0 - 17	15,201	12,634	-2,567	-16.89%
18 - 64	50,908	43,467	-7,441	-14.62%
65 - 84	14,937	18,780	3,843	25.73%
85+	2,268	3,427	1,159	51.11%
All	**83,314**	**78,309**	**-5,005**	**-6.01%**

Figure 49: the Isle of Man % pop increase for 0-17, 18-65, 65-84, 85+, and the total growth for the 'high' population forecast[cxi]

Age range	2016/17	2035/36	Total growth	% increase
0 - 17	15,201	21,187	5,986	39.4%
18 - 64	50,908	56,364	5,456	10.7%
65 - 84	14,937	19,590	4,653	31.2%
85+	2,268	3,210	942	41.5%
All	**83,314**	**100,352**	**17,038**	**20.5%**

C2.3. Future usage of health and care services

The future usage of services in the Isle of Man will vary depending on the rate of population growth. Assuming the Isle of Man 'medium' population forecast, demand for acute services will rise substantially. As explained in sections C.2.1. and C.2.4., forecast activity is modelled based on population changes both in terms of size and composition (ageing). Figure 50 below shows the forecast change to activity under the 'medium' population forecast). The greatest increase in volume

coming from outpatient appointments. The number of people needing care home placements is forecast to rise by 84% from 2017/18 to 2035/36 and 7% more GP appointments are forecast to be needed per year in 2035/36.If population growth rates are different to those forecast, then the activity will also change. Therefore the Review also present the forecast changes to activity under the 'low' and ''high' population forecasts, in Figure 51 and 52.

Figure 50: Forecast activity changes based on 'medium' population forecast[cxii]

Activity	2017/18*	2035/36	Total change	% change
A&E attendances	28,908	37,400	8,493	29.4%
Outpatient appointments	119,289	160,300	41,011	34.4%
Hospital admissions	20,174	27,590	7,416	36.8%
Adult social care referrals	3,264	5,497	2,233	68.4%
Number of people in care homes	607	1118	511	84.2%
Children in care	84	130	46	54.4%
Referrals to Early Help and Support	484	748	264	54.6%
Referrals to family care services	775	1198	423	54.6%
Total nursing referrals	6,409	10,141	3,732	58.2%
Total nursing caseload	8,581	13,577	4,996	58.2%
Total non-nursing referrals	3,776	5,975	2,199	58.2%
Total non-nursing contacts	43,364	68,614	25,250	58.2%
People with diagnosis from psychiatrist	3,450	4,417	967	28.0%
Referrals to MH services	694	889	195	28.0%
People on CPA	167	214	47	28.0%
People detained under MH Act	12	15	3	28.0%
Off-Island forensic placements	7	9	2	28.0%
Annual GP appointments[cxiii]	369,201	393,333	24,132	6.5%

Figure 51: Forecast activity changes based on 'low' population forecast[cxiv]

Activity	2017/18*	2035/36	Total change	% change
A&E attendances	28,562	30,562	2,001	7.0%
Outpatient appointments	118,142	133,081	14,939	12.6%
Hospital admissions	19,971	23,152	3,181	15.9%
Adult social care referrals	3,264	4,549	1,285	39.4%
Number of people in care homes	607	959	352	57.9%
Children in care	84	82	-2	-2.4%
Referrals to Early Help and Support	484	489	5	1.0%
Referrals to family care services	775	783	8	1.0%
Total nursing referrals	6,409	7,349	940	14.7%
Total nursing caseload	8,581	9,839	1,258	14.7%
Total non-nursing referrals	3,776	4,330	554	14.7%
Total non-nursing contacts	43,364	49,724	6,360	14.7%
People with diagnosis from psychiatrist	3,450	3,553	103	3.0%
Referrals to MH services	694	715	21	3.0%
People on CPA	167	172	5	3.0%
People detained under MH Act	12	12	0	3.0%
Off-Island forensic placements	7	7	0	3.0%
Annual GP appointments[cxv]	369,201	347,948	-21,254	-5.8%

Figure 52: Forecast activity changes based on 'high' population forecast[cxvi]

Activity	2017/18*	2035/36	Total change	% change
A&E attendances	29,220	44,818	15,599	53.4%
Outpatient appointments	120,385	190,583	70,198	58.3%
Hospital admissions	20,364	32,482	12,118	59.5%
Adult social care referrals	3,264	6,560	3,296	101.0%
Number of people in care homes	607	1298	691	113.9%
Children in care	84	185	101	120.8%
Referrals to Early Help and Support	484	1044	560	115.8%
Referrals to family care services	775	1672	897	115.8%
Total nursing referrals	6,409	13,613	7,204	112.4%
Total nursing caseload	8,581	18,226	9,645	112.4%
Total non-nursing referrals	3,776	8,021	4,245	112.4%
Total non-nursing contacts	43,364	92,109	48,745	112.4%
People with diagnosis from psychiatrist	3,450	5,356	1,906	55.3%
Referrals to MH services	694	1,077	383	55.3%
People on CPA	167	259	92	55.3%
People detained under MH Act	12	19	7	55.3%
Off-Island forensic placements	7	11	4	55.3%
Annual GP appointments[cxvii]	369,201	434,571	65,370	17.7%

C2.4. Methodology for calculating increases in usage

The Review has used the best data available in each case to calculate increases in usage due to demographic change at a service by service level. The Review then also forecast increases in usage due to non-demographic pressures. The methodologies below are what drive the activity forecasts in section C.2.3. above.

C2.5 Approach to acute hospital usage forecasts

In calculating demographic effects on changes in the numbers of A&E attendances, outpatient appointments and hospital admissions, the Review has been able to factor in an estimation of the impact of ageing in the Isle of Man population on service use due to data available from health services in England (as equivalent data is not available for the Isle of Man).

NHS England provides a breakdown of hospital care use by age group for A&E attendances, outpatient appointments and hospital admissions. A&E data is provided in Figure 53 below as an example – babies aged under 1 account for 2.8% of Accident & Emergency (A&E) attendances in England, and individuals aged 20-24 account for 7.8%.

Figure 53: Usage of A&E attendances in England by age group, 2016/17[cxviii]

England Population	2016-17	
Age group	Number of A&E attendances	Age group as % of England A&E attendances
Under 1	585,469	2.8%
1-4	1,514,599	7.3%
5-9	1,062,625	5.1%
10-14	1,113,889	5.3%
15	216,013	1.0%
16	208,872	1.0%

17	233,508	1.1%
18	285,862	1.4%
19	318,491	1.5%
20-24	1,636,799	7.8%
25-29	1,612,049	7.7%
30-34	1,383,698	6.6%
35-39	1,183,035	5.7%
40-44	1,089,862	5.2%
45-49	1,150,857	5.5%
50-54	1,131,095	5.4%
55-59	972,262	4.7%
60-64	833,885	4.0%
65-69	865,910	4.1%
70-74	824,493	3.9%
75-79	800,405	3.8%
80-84	778,146	3.7%
85-89	634,114	3.0%
90+	450,477	2.2%
Total	**20,886,411**	

By dividing the % of A&E attendances by the % of the overall population made up by that age group, the Review can arrive at an "age band ratio" for A&E attendance e.g. for babies aged under 1:
2.8%/1.2% = 231.6%

In absence of data in the Isle of Man, the Review assumes that this "age band ratio" is the same in the Isle of Man as in England. If one multiplies this "age band ratio" by the % of population made up of babies aged under 1 in the Isle of Man (0.94% of the population), one gets the percentage of A&E attendances that the Review expects this age group to take up:
231.6% * 0.94% = 2.19%

It is known from hospital reports that in 2016/17 there were 28,405 A&E attendances in the Isle of Man so the Review can estimate that 629 of these (or 2.19%) were taken up by babies aged under 1. This is less than the 2.8% taken up by babies aged under 1 in England, which reflects the fact that 1.2% of the English population is babies under 1, whereas in the Isle of Man, it is 0.94%. The Review then repeated this process to split out all A&E attendances by age group in the Isle of Man. The Review then grew these "attendance figures by age group" by the growth rates predicted for each age group in the 2016 census data available to the Review. Assuming the "age band ratio" stays the same over time, the forecast changing demographics of the Isle of Man drives the change in A&E activity over time. This provides a value for the demographic growth rate for activity.

The Review repeated this process for hospital admissions and hospital outpatient appointments. Once these forecasts of increased usage from demographic pressures were calculated, the Review added the forecast additional usage from non-demographic pressures (see section C2.5.).

C2.7. Approach to children's and families and social care usage forecasts

In forecasting usage of these services, the Review has assumed that demand for children and families services will be driven by demographic changes in the under 18 population, and that demand for social care will be driven by demographic changes in the over 65 population.

In forecasting the usage of children and families' services, the predicted growth rate of the population aged under 18 was calculated from the 2016 census data. The Review then applied this to 2017/18 data to obtain a year by year forecast, assuming that usage would grow in line with population.

Older people accounted for 71% of all adult social care referrals in 2017/18 so using the growth rate for this section of the population was likely to give a more accurate overall forecast that using the growth rate of the entire population[cxix]. The Review calculated the predicted growth rate of the population aged over 65 from the 2016 census data. This was then applied to 2017/18 data to obtain a year-by-year forecast, assuming that usage would grow in line with population.

Once these forecasts of increased usage from demographic pressures were calculated, the Review added the forecast additional usage from non-demographic pressures (see section C2.5.).

C2.8. Approach to usage forecasts for all other services

For all other services (mental health services, GPs, primary care services, tertiary services, and supporting the DHSC functions) the Review has assumed that usage will grow at the same rate as overall population growth. It calculated year on year predicted population growth based on the 2016 census forecasts. These are therefore the least detailed forecasts in terms of factoring in demographic effects.

Once these forecasts of increased usage from demographic pressures were calculated, the Review added the forecast additional usage from non-demographic pressures (see section C2.5.).

C2.9. Non-demographic pressures

As well as the direct impact on health and care services from increased numbers of people and an ageing population (demographic pressures), there are also non-demographic pressures which lead to increased usage of services. These include: increasing expectation and demand for healthcare services; improving access to care; changes in healthcare technology; medical practice; and changes in disease profile, etc.

In absence of known forecasts for these pressures for the Isle of Man, the Review has taken the average six-year estimates of non-demographic pressures from the NHS England Five Year Forward View for 2015/16-2020/21 and assumed this same rate applies going forward in the Isle of Man. Figure 54 below presents these assumptions – for example pressures on the acute sector are forecast to grow by 1.0% a year going forward, whereas pressures in other sectors are forecast to be much higher, at 3.4% a year.

Figure 54: Non-demographic pressures[cxx]

Service area	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Average
Acute	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
MH	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Community	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%
Continuing care	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Prescribing	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
Specialised	3.0%	3.0%	2.8%	2.9%	2.9%	2.9%	2.9%
GP	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

C2.10. Inflationary pressures

As discussed in section C2.1, the Review presents future costs in 'real terms' i.e. in today's (2018/19) prices. However, the Review needs to take into account the fact that prices for health and care goods and services (including pay, drugs, and non-pay-non-drugs (e.g. devices, litigation)) are forecast to rise at a faster rate than 'general inflation' in the economy which will incur a real terms cost to the DHSC over time.

In absence of known forecasts for these pressures for the Isle of Man, the Review has taken the average six-year estimates of price pressures from the NHS England Five Year Forward View for 2015/16-2020/21, and assumed this same rate applies going forward in the Isle of Man. Figure 55 below shows these forecasts.

Figure 55: Price pressures[cxxi]

Service area	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Average
Acute	2.3%	3.7%	2.8%	2.8%	2.9%	2.9%	2.9%
MH	2.3%	3.7%	2.8%	2.8%	2.9%	2.9%	2.9%
Community	2.3%	3.7%	2.8%	2.8%	2.9%	2.9%	2.9%
Continuing care	1.7%	3.6%	2.7%	2.7%	2.7%	2.7%	2.7%
Prescribing	1.5%	1.8%	1.7%	1.7%	2.0%	2.0%	1.8%
Specialised	2.7%	4.2%	3.6%	3.6%	3.6%	3.7%	3.6%
GP	1.7%	4.0%	3.0%	3.0%	3.0%	3.0%	3.0%

Using the price forecasts Figure 55 above, and the split of the DHSC costs by division, the weighted average inflationary pressures going forward are forecast to be 2.88%. In the absence of Consumer Price Index (CPI) forecasts for the Isle of Man, the Review has used the average of the Office for Budget Responsibility forecasts for CPI inflation between 2019 and 2022. This is 2.04%[cxxii], which means that the additional cost of providing health and care services above general inflation is forecast to be 0.84% a year on average.

C2.11. Funding gap under 'do-nothing' scenario

Taking demographic pressures, non-demographic pressures, and inflationary pressures into account, the Review has forecast what the funding gap will be between the current spend on health and care services, and what it is expected to cost in 2035/36 (in today's prices). Figure 56 below summarises the impact of the different pressures, and the funding gap by 2035/36, under a 'no change' scenario.

Figure 56: Components of health and care funding gap: funding gap under a 'no change' scenario

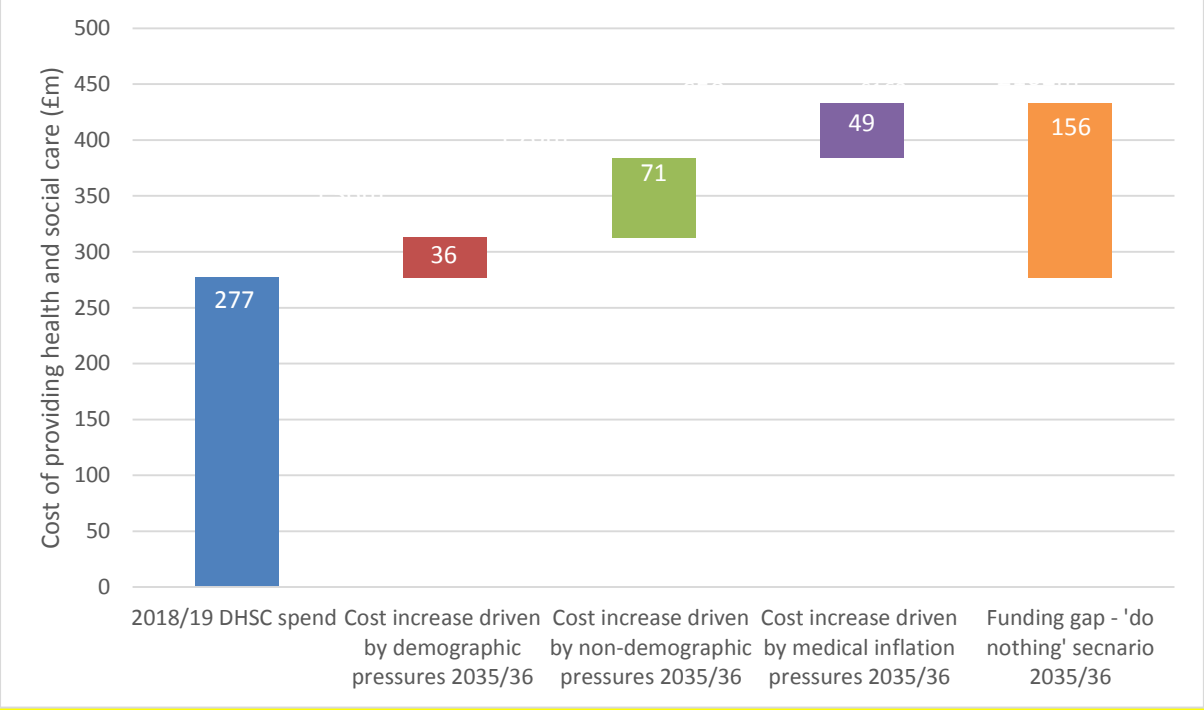


Figure 57 below summarises the impact of the different pressures, and the absolute values (in 2018/19 prices) which would be needed to meet the gap, under a 'no change' scenario.

Figure 57: Components of health and care funding gap

Increases in a "no change" scenario	Growth rate 2019/20–2035/36	Change 2019/20–2035/36
Increase from demographic pressures	0.62% a year (average)	£35.8m £2.1m a year average
Increase from non-demographic pressures	1.21% a year (average)	£71.3m £4.2m a year average
Increase from above general inflation price rises	0.83% a year (average)	£49.0m £2.9m a year average
Total required funding increase (2018/19 prices)	**2.66% a year (average)**	**£156.0m** **£9.2m a year average**

Figure 58 below presents the year-by-year forecast change of each pressure and the annual funding gap, under the 'do-nothing' scenario.

Figure 58: Future cost forecast broken down by % increase due to various components

Total cost - all in 2017/18 prices	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36
Current cost - the DHSC spend (£m)	257.2	258.2																	
Current cost - the DHSC share of 'central' costs (£m)	18.4	18.9																	
Current cost - the DHSC (£m)	275.5	277.2																	
Increase from de-mographic pres-sures			0.7%	0.7%	0.6%	0.8%	0.7%	0.8%	0.6%	0.7%	0.7%	0.6%	0.6%	0.5%	0.5%	0.7%	0.6%	0.4%	0.3%
Increase from non-demographic pres-sures			1.3%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
Increase from above general inflation price rises			0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
Total required fund-ing increase			2.8%	2.8%	2.7%	2.8%	2.8%	2.9%	2.7%	2.7%	2.7%	2.7%	2.7%	2.5%	2.6%	2.7%	2.6%	2.4%	2.3%
Future cost - 'no change' (£m)			285.0	293.0	301.0	309.5	318.1	327.2	335.9	345.0	354.3	363.8	373.5	382.8	392.6	403.2	413.5	423.3	433.2

Figure 59: Future cost forecast broken down by £m increase due to various components

Total cost - all in 2017/18 prices	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36
Current cost - the DHSC spend (£m)	257.2	258.2																	
Current cost - the DHSC share of 'central' costs (£m)	18.4	18.9																	
Current cost - the DHSC (£m)	275.5	277.2																	
Increase from de-mographic pres-sures (£m)			2.0	2.0	1.8	2.3	2.2	2.5	2.0	2.2	2.3	2.3	2.3	1.8	2.1	2.7	2.3	1.5	1.4
Increase from non-demographic pres-sures (£m)			3.5	3.6	3.7	3.7	3.8	3.9	4.0	4.1	4.2	4.3	4.4	4.5	4.5	4.6	4.8	4.9	4.9
Increase from above general inflation price rises (£m)(			2.3	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.9	2.9	3.0	3.1	3.2	3.2	3.3	3.4	3.5
Total increase - each year (£m)			7.8	8.0	7.9	8.5	8.6	9.1	8.7	9.1	9.3	9.5	9.7	9.3	9.8	10.6	10.3	9.8	9.9
Total increase – cumulative (£m)			7.8	15.9	23.8	32.3	40.9	50.0	58.7	67.8	77.1	86.6	96.3	105.6	115.4	126.0	136.3	146.1	156.0
Future cost - 'no change' (£m)			285.0	293.0	301.0	309.5	318.1	327.2	335.9	345.0	354.3	363.8	373.5	382.8	392.6	403.2	413.5	423.3	433.2

Figure 60: Sensitivities of the components of the funding gap

Factor	Mid scenario (baseline)	Low (optimistic) scenario	High (conservative) scenario
Increase from demographic pressures 2019/20 – 2035/36 (£m)	£35.8m	£4.4m	£68.1m
Average annual increase from demographic pressures 2019/20 – 2035/36 (%)	0.62%	0.09%	0.97%
Increase from non-demographic pressures 2019/20 – 2035/36 (£m)	£71.3m	£31.7m	£119.6m
Average annual increase from non-demographic pressures 2019/20 – 2035/36 (%)	1.21%	0.66%	1.69%
Increase from above general inflation 2019/20 – 2035/36 (£m)	£49.0m	-£28.7	£161.4m
Average annual increase from above general inflation 2019/20 – 2035/36 (%)	0.83%	-0.60%	2.24%
Funding gap in 2035/36 (£m)	**£156.0m**	**£7.5m**	**£349.0**
Average annual % growth in the funding gap 2019/20 – 2035/36	**2.66%**	**0.16%**	**4.90%**

The Review has used the mid scenario as the basis for further modelling. These sensitivities indicate that the Review's projections are only projections and cannot be perfectly accurate given the range of variables involved.

D. Efficiencies

D1. Current metrics on efficiencies and challenges

Efficiency metrics for health and care in the Isle of Man are limited. Efficiency and productivity are closely related and for the purposes of this Review the terms will be used interchangeably. The Centre for Health Economics defined productivity in healthcare as follows:

"*Productivity change is measured by comparing year-on-year growth in output against growth in inputs. Output comprises the total volume of services provided to all NHS patients treated in hospital, outpatient, accident & emergency, diagnostic, mental health, community, and primary care settings. The quality of care is measured by inpatient and outpatient waiting times, 30-day hospital survival rates, health outcomes and blood pressure control. Inputs include the staff, equipment and capital resources that contribute to the production of care*."[cxxiii]

Whereas the BMJ defines efficiency in healthcare as follows:

"Efficiency is concerned with the relation between resource inputs (costs, in the form of labour, capital, or equipment) and either intermediate outputs (numbers treated, waiting time, etc) or final health outcomes (lives saved, life years gained, quality adjusted life years (QALYs))."[cxxiv]

To conduct a full efficiency analysis, the Review would therefore expect to see the following data:

- Full activity data for all services (this would describe the 'volume of services')
- Meaningful and consistently measured quality and outcome measures for all services
- DHSC costs broken down by activity delivered and by full costs per staff member

Patient-level costing is currently being developed at the specialty level for Noble's Hospital but has not yet been presented to management or used in operational decision making. While work is ongoing in this area, and progress is being made, comparisons cannot yet be made with HRG costs in the NHS in England. Separately, accurate payroll information will not be available until the new digital system goes live, so it is difficult to analyse whether the DHSC spends money efficiently i.e. has a high ratio of outputs to inputs. Beyond activity measures, any analysis of efficiency would ideally measure the level of positive outcomes achieved for the financial input provided to the DHSC. Since outcome measures are sparse and sporadic the Review could not undertake an efficiency analysis of financial inputs against outcomes achieved.[cxxv]

The selection of metrics below is what the Review has been provided with from existing datasets. The Review is aware that this information by no means gives an overall picture of efficiency and productivity. These are also predominantly activity measures and may not be perfect comparisons with England data due to differences in the way measures are defined and/or collected.

Figure 61: 2018/19 efficiency measures available to the Review, compared to England[cxxvi]

Metric	Isle of Man	England
Social worker caseloads	14.4	22
Average GP sessions/week	9	8
Patient appointments per day per GP[cxxvii]	27	29
Outpatient DNA rates	10.4%	8.8%
Outpatient appointment average waiting times	25 weeks	18 weeks
Routine GP appointment average waiting times	5 days	13 days

D2. Efficiencies target

The Review recommends an annual 1% efficiencies target for the DHSC going forward. The Review believes achieving 1% productivity gains year-on-year is reasonable and achievable, when put in context to targets and achievements in the NHS in England[cxxviii]. Average historic productivity gains between 1995 and 2015 have been 0.8% per annum in the NHS in England[cxxix]. NHS England's Long Term Plan sets a minimum requirement of 1.1% efficiencies for the NHS in England per year for the next ten years[cxxx]. It also sets a stretch target of 1.6% annual efficiencies if localities wish to get access to Financial Recovery Fund funding.

It may well be achievable for the Isle of Man to make much greater efficiency savings given that, because few efficiency savings have been achieved in the past, there will be 'low-hanging fruit' available to target at least in the first few years.

The Review also notes that the SAVE programme may support in the achievement of these efficiency savings. This programme covers all areas of government, including the DHSC, and began in 2017. Savings will be incorporated from 2019/20 onwards[cxxxi].

D2.1 Previous efficiency targets

Over the last two years the DHSC has set efficiency targets but has not been able to fully realise them. The Isle of Man Government has followed a practice of providing part of the funding shortfall, requiring DHSC to make up the remaining projected shortfall for that year with cost improvements[cxxxii].

Figure 62: Previous Isle of Man DHSC efficiency targets[cxxxiii]

Budget figure	2016/17	2017/18	2018/19
DHSC budget (£m)	198.4	210.0	215.4
Revised DHSC budget (£m)	198.5	219.1	215.4
Cost improvement target (£m)	-	10	7
Cost improvement target (%)	-	4.8	3.2
DHSC actual spend (£m)	209.6	218.7	218.6
Overspend against DHSC budget (£m)	11.2	8.7	3.2
Cost improvement achieved (£m)	-	1.3	3.8

As the table above demonstrates, in 2018/19 the DHSC's spend for 2018/19 forecast as at end January 2019 against budget was expected to be overspent by £3.2m. This indicates that the additional funding received to make savings led to cost improvements which were £3.8m short of the £7m target.

Previously, in 2017/18 the DHSC received £11m of funding to make £10m of cost savings[cxxxiv]. Despite these commitments, and additional funding to achieve them, the DHSC overspent by £8.7m against budget, suggesting it achieved £1.3m in cost improvements, short of the £10m target.

The Isle of Man therefore has a previous history of struggling to use transformational funding to fully realise cost savings targets through efficiency. This only enhances the importance of the recommendations made elsewhere in this Review around implementation planning and around improving accountability, data oversight, governance, service delivery and benefits realisation. These recommendations will be essential to ensuring that the recommended efficiency target of 1% each year does not meet the same fate as previous cost saving targets.

D3. Themes of efficiencies

The Review has heard many recommendations on how to achieve efficiency gains, in addition to conducting best practice research. Our findings around possible efficiencies fall under the following key themes.

D3.1 Transactional

Transactional efficiencies are efficiencies focused on reducing the costs paid by the DHSC for goods and services. These include improving procurement and pricing processes to ensure that the Isle of Man receives the best value for money possible through measures such as medicines management and matching staff pay more closely to rates off-Island. These efficiencies are simple to administer and model[cxxxv]. Examples include[cxxxvi]:

- Reducing agency spend
- Improved use of properties and estates
- Consolidating procurement
- Medicines optimisation, including:
    - Increasing the ratio of prescribing pharmacists to total hospital pharmacists (the more time pharmacists spend on clinical services rather than infrastructure or back-office services, the more likely medicines use is optimised)
- Consolidating corporate and administrative costs
- Reducing prescription charge losses through fraud and error

D3.2 Operational

Operational efficiencies are changes to reduce the amount of waste in the DHSC procedures and processes. These include initiatives to reduce delayed discharge from hospital; reducing the DHSC reliance on agency staff; and bringing visiting consultants on-Island rather than paying for patients to

travel off-Island[cxxxvii]. They range in complexity. For example, reducing DNA appointments can be simply achieved by, for example, establishing a text reminder service for people who have booked appointments, whereas reducing delayed transfers of care can require reshaping out of hospital teams and ways of working. Examples include[cxxxviii]:

- Reducing unwarranted clinical variation
- Changing skill mix of staff
- Lean working - examples of this from one hospital trust in England include:
    - putting all items needed for steroid injections on a standard trolley. Previously, the items had all been in different places. The intervention cut the time it took to set up an injection from 85 seconds to 5 seconds
    - Improving processes for managing cases of diarrhoea which have cut diagnosis times from two days to six hours, reduced the time spent by nurses gathering supplies for personal care from 7.5 minutes to 1.5 minutes, cut the time taken to implement a treatment plan after diagnosis from 29 hours to 30 minutes and brought down the time needed for patients being put into an isolated room from over 20 hours to four hours
    - Using a computer on wheels during ward rounds for elderly care reduced "non-value-added time" spent with patients from 19 minutes to just under 12 and eliminated defects in reporting
    - Cutting set up times for ultrasound guided injections from 13 minutes to seven minutes per patient
- Improved workforce planning, including:
    - Improved rostering to ensure the right number of staff are available and to reduce the need for agency staff
- Improved people policies and practices (to reduce sickness absence and turnover and to improve productivity and staff wellbeing)
- Constraining increases to the number of consultations to the rate of population growth

D3.3 Transformational

Transformational change centres on changes to further integrate health and care services and to transform provision along the lines of patient-centred, closer-to-home approaches. The approach to transformational changes is informed by recent research completed by the Nuffield Trust assessing 'the realism of the narrative that moving care out of hospital will save money'. The report notes that '*demographic and other drivers create an imperative to shift the balance of care from hospital to community' but that 'NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care*'[cxxxix]. The Review has therefore followed the approach taken by NHS England's 2019 Long Term Plan and, while strongly recommending further integration, have not forecast cost reductions or efficiencies as a result of integration[cxl]. Transformational changes include[cxli]:

- Improved GP access to specialist expertise
- Ambulance/paramedic triage to the community
- Condition-specific rehabilitation
- Additional clinical support to people in nursing and care homes
- Improved end-of-life care in the community
- Remote monitoring of people with certain long-term conditions
- Support for self-care
- Patients experiencing GP continuity of care
- Extensivist model of care for high risk patients
- Social prescribing
- Senior assessment in A&E
- Rapid access clinics for urgent specialist assessment

- Peer review and audit of GP referrals
- Shared decision-making to support treatment choices
- Shared care models for the management of chronic disease
- Direct access to diagnostics for GPs
- Intermediate care: rapid response services
- Intermediate care: bed-based services
- Hospital at Home
- Case management and care coordination
- Virtual ward
- Extending GP opening hours
- A 111 access line
- Urgent care centres including minor injury units (not co-located with A&E)
- Consultant clinics in the community
- Specialist support from a GP with a special interest
- Referral management centres
- Integration of out of hospital care providers (GPs, community and social care)
- Pooling budgets (to get better value from collective resource)
- Further improvements in clinical pathways
- Effective working with partner organisations
- Prevention and community investment
- Digitisation and online technology
- Avoidance of unnecessary hospital admissions.

D4. Impact of efficiencies

By "an efficiencies target of 1%", the Review means "achieving the same output with a 1% reduction in the costs that were previously forecast as required to provide that output". The method used in the Review (and described in Annex 12 (C2) is to apply the forecast % change in activity to the % change in cost (also including an adjustment for medical inflation above general inflation). To model the effects of achieving a 1% improvement in efficiency, the Review has therefore reduced the forecast cost by 1% each year.

To calculate the impact of efficiencies, the Review has taken the mid-range forecast annual costs year on year up to 2035/36 as calculated in Annex 12 (C2), based on a 'no change' scenario, and have applied a % reduction to the overall cost figure each year. The methodology therefore equates to:

- previous year's cost + % demographic change + % non-demographic change + % medical inflation rise above general inflation - % efficiency saving = this year's cost.

The Review believes that the recommended target of 1% annual efficiency savings from 2019/20 onwards is, as discussed above, a reasonable target based on estimates and comparisons with historical efficiency achievements in the NHS in England. As this is an estimate and will in practice depend on many factors, the Review has added in a range of efficiency savings to demonstrate the impact of variance in efficiency achievements. For example it could be argued that the DHSC could find it more straightforward than the NHS in England to achieve efficiency savings in the next 15 years. There should be 'low-hanging fruit' available because the Isle of Man has not attempted efficiency initiatives previously, compared to the numerous initiatives that have taken place in the NHS in England. Alternatively, the lack of experience in obtaining efficiency savings may, however, mean that the Isle of Man could struggle to realise savings. The process and culture changes that will be required will be unfamiliar and may throw up unforeseen challenges.

Figures 63, 64 and 65 below show the funding gap each year between 2018/19 and 2035/36 if efficiency targets of 0.5%, 1.0%, and 1.5% respectively are achieved each year from 2019/20 onwards.

It is also possible that in practice efficiency achievements will be staggered. Either the DHSC will take time to work up to 1% efficiency savings per annum, saving more in the earlier years, or the DHSC will struggle to maintain savings of 1% per annum after tackling the simpler and more obvious options and the rate of savings per year will decline over time. In either case, the impact would be an increase in the future cost of providing services in 2035/36. As the Review cannot forecast which scenario would be most likely at this stage, the Review has not included scenarios in which staggering takes place in the Review's modelling.

Figure 63: Impact of 0.5% efficiency savings year-on-year

Year	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36
Future cost - 'no change' (£m)	276	277	285	293	301	309	318	327	336	345	354	364	373	383	393	403	414	423	433
Efficiencies target (%)			0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Total required funding increase after efficiencies (%)			2.3%	2.3%	2.2%	2.3%	2.3%	2.4%	2.2%	2.2%	2.2%	2.2%	2.2%	2.0%	2.1%	2.2%	2.1%	1.9%	1.8%
Efficiencies saved if 0.5% found - each year (£m)			1.4	1.4	1.5	1.5	1.5	1.6	1.6	1.7	1.7	1.8	1.8	1.9	1.9	2.0	2.0	2.1	2.1
Efficiencies saved if 0.5% found - cumula-tive (£m)			1.4	2.8	4.3	5.8	7.3	8.9	10.6	12.2	14.0	15.7	17.5	19.4	21.3	23.3	25.3	27.4	29.5
Total required funding increase after efficiencies - each year (£m)			6.5	6.6	6.5	7.0	7.1	7.5	7.1	7.4	7.6	7.7	7.9	7.4	7.8	8.6	8.3	7.7	7.8
Total required funding increase after efficiencies - cumulative (£m)			6.5	13.0	19.5	26.5	33.6	41.1	48.2	55.6	63.2	70.9	78.8	86.2	94.1	102.7	111.0	118.8	126.5
Future cost - 'with effi-ciencies' (£m)			284	290	297	304	311	318	325	333	340	348	356	363	371	380	388	396	404

Figure 64: Impact of 1% efficiency savings year-on-year

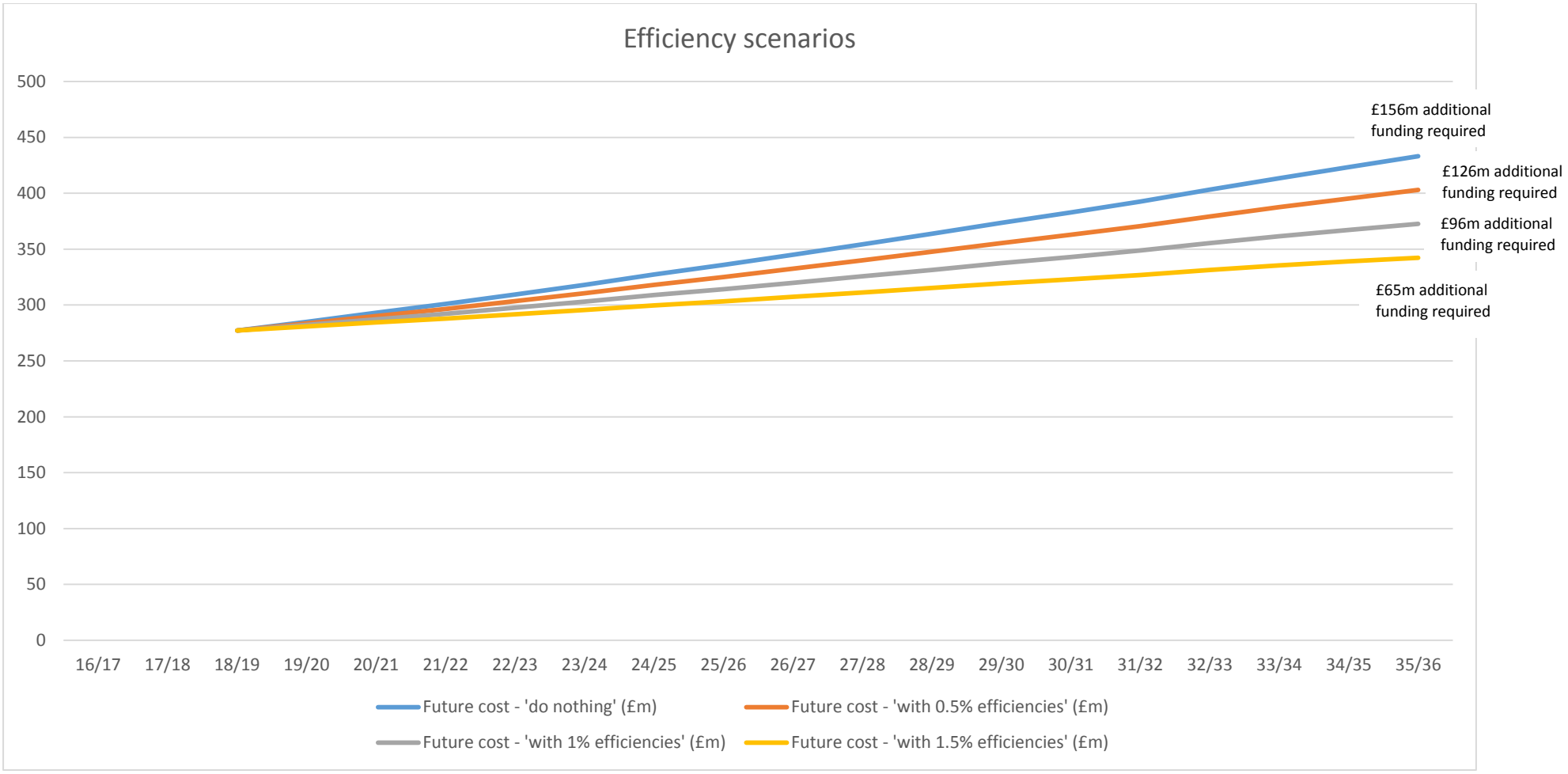
Year	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36
Future cost - 'no change' (£m)	276	277	285	293	301	309	318	327	336	345	354	364	373	383	393	403	414	423	433
Efficiencies target			1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Total required funding increase after efficiencies (£m)			1.8%	1.8%	1.7%	1.8%	1.8%	1.9%	1.7%	1.7%	1.7%	1.7%	1.7%	1.5%	1.6%	1.7%	1.6%	1.4%	1.3%
Efficiencies saved if 1% found - each year (£m)			2.8	2.9	2.9	3.0	3.1	3.2	3.3	3.4	3.5	3.5	3.6	3.7	3.8	3.9	4.0	4.1	4.2
Efficiencies saved if 1% found - cumulative (£m)			2.8	5.6	8.6	11.6	14.7	17.8	21.1	24.5	27.9	31.5	35.1	38.8	42.7	46.6	50.6	54.8	59.0
Total required funding increase after efficiencies - each year (£m)			5.1	5.2	5.0	5.5	5.5	5.9	5.4	5.7	5.8	5.9	6.1	5.6	5.9	6.7	6.3	5.7	5.6
Total required funding increase after efficiencies - cumulative (£m)			5.1	10.2	15.2	20.8	26.3	32.2	37.6	43.4	49.2	55.2	61.2	66.8	72.7	79.4	85.7	91.4	97.0
Future cost - 'with efficiencies' (£m)			282	287	292	298	303	309	315	321	326	332	338	344	350	357	363	369	374

Figure 65: Impact of 1.5% efficiency savings year-on-year

Year	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36
Future cost - 'no change' (£m)	276	277	285	293	301	309	318	327	336	345	354	364	373	383	393	403	414	423	433
Efficiencies target			1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Total required funding increase after efficiencies (%)			1.3%	1.3%	1.2%	1.3%	1.3%	1.4%	1.2%	1.2%	1.2%	1.2%	1.2%	1.0%	1.1%	1.2%	1.1%	0.9%	0.8%
Efficiencies saved if 1.5% found - each year (£m)			4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3	5.5	5.6	5.7	5.9	6.0	6.2	6.3
Efficiencies saved if 1.5% found - cumulative (£m)			4.2	8.4	12.8	17.3	22.0	26.8	31.7	36.7	41.9	47.2	52.6	58.3	64.0	69.9	75.9	82.1	88.5
Total required funding increase after efficiencies - each year (£m)			3.7	3.7	3.5	4.0	4.0	4.3	3.8	4.1	4.1	4.2	4.2	3.7	4.0	4.7	4.3	3.6	3.5
Total required funding increase after efficiencies - cumulative (£m)			3.7	7.4	11.0	15.0	19.0	23.3	27.1	31.1	35.2	39.4	43.7	47.4	51.4	56.1	60.4	64.0	67.5
Future cost - 'with efficiencies' (£m)			281	285	288	292	296	300	304	308	312	317	321	325	329	333	338	341	345

D5. Comparison of efficiency scenarios

If no efficiency savings are made, the funding gap in 2035/36 will be £433m, i.e. a funding gap of £156m. . If only 0.5% efficiencies are achieved year on year, the future cost in 2035/36 is forecast to be £404m, i.e. a funding gap of £127m. If 1.5% efficiencies are achieved year on year, the future cost in 2035/36 is forecast to be £345m, i.e. a funding gap of £68m. These figures compare to a future cost of £374m in 2035/36 under a 1% efficiency savings per year scenario i.e. a funding gap of £97m. These figures do not include the additional transformation funding required to implement efficiencies, which is described more in Annex 12 (D8).


Efficiency scenarios
500
450
400
350
300
250
200
150
100
50
0
16/17
17/18
18/19
19/20
20/21
21/22
22/23
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24/25
25/26
26/27
27/28
28/29
29/30
30/31
31/32
32/33
33/34
34/35
35/36
£156m additional funding required
£126m additional funding required
£96m additional funding required
£65m additional funding required
Future cost - 'do nothing' (£m)
Future cost - 'with 0.5% efficiencies' (£m)
Future cost - 'with 1% efficiencies' (£m)
Future cost - 'with 1.5% efficiencies' (£m)

D6. Examples of efficiencies to focus on

It is beyond the scope of this Review to model in full the service improvements and efficiencies required to achieve 1% efficiency savings. This would be best completed over an implementation planning period and would require detailed businesses cases for each initiative suggested. The Review has, however, researched and modelled a selection of the possible initiatives to give an indication of the scale of savings possible from various types of change programmes, in addition to the extensive list of possible efficiencies that have been shown to be effective elsewhere (provided above).

Figure 66: Examples of efficiencies to implement

Theme	Initiative	Modelling methodology	Assumed value of procedure	Annual forecast change in activity in year of implementation	Annual forecast gross saving in year of implementation
Operational	Cease 100% of activity related to procedures with limited clinical justification and/or limited clinical effectiveness	100% of activity related to procedures of limited clinical justification and effectiveness discontinued. These procedures are typically day case so the Review reduced the number of day cases rather than the overall figure for electives. Therefore number of day cases reduced by 6.23% (5.56%[cxlii] + 0.68%[cxliii]).	£742[cxliv]	458 fewer day cases	£0.34m
Operational	Programme to reduce referrals from all GP practices for seven common hospital specialties to the lowest level/practice seen currently in Isle of Man	For Dermatology, ENT, General Surgery, Gynaecology, Trauma and Orthopaedics, and Ophthalmology, estimated the reduction in referrals to Noble's from GPs that could be achieved if all GP surgeries matched the lowest referral/head rates per speciality from 2017/18 in 2019/20. Assumed that all referrals removed lead to an outpatient appointment avoided. For every outpatient appointment avoided, two extra GP appointments allowed to manage the issue in the community[cxlv].	£125 for an outpatient appointment ;[cxlvi] GP salary £87,000[cxlvii]	4,628 fewer outpatient appointments in 2019/20 1.3 extra GP WTE required to deal with rise in community demand	£0.41m (net saving)
Operational	Improve theatre efficiencies in line with KM&T recommendations	Increasing utilisation of theatres and making start times more efficient	N/A	2-10 additional sessions per week, all sessions starting at 9am	£0.50m to £2.25m[cxlviii]
Operational	Interventions to reduce delayed transfer of care (and length of stay)[cxlix]	Implementing a range of measures to reduce DTOC, which are assumed to reduce 50% of excess bed days	£346[cl]	1,811 bed days[cli]	£0.63m
Transactional	Reducing prescribing costs to match UK's per head costs through improved medicine management and cost controls		£17m for the DHSC 2017/18 prescriptions cost[clii]	N/A	£4.32m[cliii]

D7. Transformation funding

D7.1 Transformation funding in the Isle of Man prior to the Review

In the 2019/20 Budget the Isle of Man Government stated that:
'The Department of Health and Social Care (DHSC) remains a critical area of concern. We recognise that the forthcoming report from Sir Jonathan Michael could result in significant changes and we stand by with a Healthcare Transformation Fund of £5 million to act in accordance with Tynwald's decisions.'[cliv]

The Healthcare Transformation Fund began as the Health Inspection Fund in 2014, which was created to '*provide finance for the controlled implementation of project initiatives at Noble's Hospital, designed to address service shortfalls or underperformance, which were identified as a result of external reviews undertaken*.' [clv] This fund became the Healthcare Transformation Fund as of 1st April 2017, with the stated aim of supporting business cases for transformational change initiatives[clvi]. The terms of reference for the Healthcare Transformation Fund are set out in section D7.2. below.

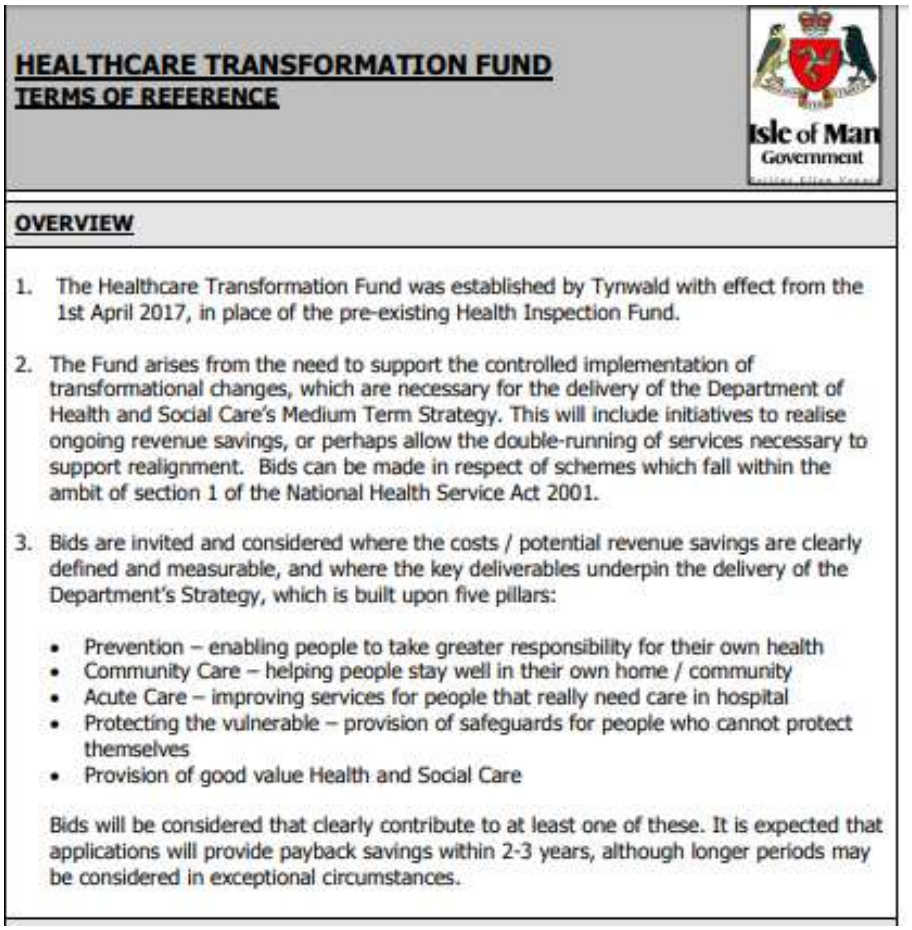
The size of the Healthcare Transformation Fund has varied over the last three years, depending both on the amount paid out to support business cases and on the amount paid in at the end of each year from increases in national insurance receipts[clvii]: Figure 67 below shows that between £1.7m and £3.3m is spent each year from the Healthcare Transformation Fund, although this figure has reduced over the last three years. The amounts are 'probable' because the exact NI contributions are not known at the time of the Budget.

Figure 67: Healthcare Transformation Fund over time

Year	Balance brought forward at the beginning of the year (£m)	Probable paid into the Fund (£m)	Probable spend from the Fund (£m)	Probable end of year value (£m)
2018/19	£5.05m	£1.00m contributed, £0.09m realised investment income	£1.70m transfer to revenue/capital accounts	£4.45m
2017/18	£3.81m	£1.00m contributed, £0.05m realised investment income	£2.29m transfer to revenue/capital accounts	£2.57m
2016/17	£4.16m	£0.80m contributed, £0.07m realised investment income	£3.34m transfer to revenues/capital accounts	£1.70m

As of the 2019/20 Budget, therefore, there is approximately £5m set aside for transformational funding on top of additional funding of £5.1m announced for DHSC[clviii].

D7.2 Terms of reference for Healthcare Transformation Fund[clix]



HEALTHCARE TRANSFORMATION FUND
TERMS OF REFERENCE

Isle of Man Government

OVERVIEW

1. The Healthcare Transformation Fund was established by Tynwald with effect from the 1st April 2017, in place of the pre-existing Health Inspection Fund.

2. The Fund arises from the need to support the controlled implementation of transformational changes, which are necessary for the delivery of the Department of Health and Social Care's Medium Term Strategy. This will include initiatives to realise ongoing revenue savings, or perhaps allow the double-running of services necessary to support realignment. Bids can be made in respect of schemes which fall within the ambit of section 1 of the National Health Service Act 2001.

3. Bids are invited and considered where the costs / potential revenue savings are clearly defined and measurable, and where the key deliverables underpin the delivery of the Department's Strategy, which is built upon five pillars:

   - Prevention – enabling people to take greater responsibility for their own health
   - Community Care – helping people stay well in their own home / community
   - Acute Care – improving services for people that really need care in hospital
   - Protecting the vulnerable – provision of safeguards for people who cannot protect themselves
   - Provision of good value Health and Social Care

   Bids will be considered that clearly contribute to at least one of these. It is expected that applications will provide payback savings within 2-3 years, although longer periods may be considered in exceptional circumstances.

7. Bids up to £50,000 are subject to sign off by the Chief Financial Officer or Financial Controller.

8. Bids between £50,000 and up to £100,000 require sign off by both the Financial Controller and Chief Financial Officer. In the event that agreement is not reached, or if the application is either politically sensitive or contentious, then the application requires approval by the Treasury.

9. Bids between £100,000 and up to £250,000 are considered and approved by the Treasury.

10. Any bids between £250,000 and £500,000 are considered and endorsed by the Treasury with the Council of Ministers then informed of the decision.

11. Any Treasury approved bids over £500,000 also require formal approval from the Council of Ministers.

12. A report on the activity of the Fund will be provided to the Treasury on a six monthly basis. This will include a breakdown of income and expenditure. This will also review the ongoing purpose of the Fund and ensure it is updated or amended accordingly.

ELIGIBILITY CRITERIA

13. All eligible projects must support the overall objectives of the Health Care Transformation Fund specifically;
    - It must be of a transformational or temporary nature or is self-sustainable from ongoing savings generated. Recurring or revenue expenditure is not eligible.
    - Savings may be applied to departmental revenue targets.
    - A business case must be produced and signed off by the sponsoring Department's Finance Officer which will include;
      v. Financial Benefits – Whether it is Capital or Revenue and a consideration of cashability
      vi. Social Benefits – Outcomes, intelligence, interventions and long term strategy
      vii. Economic Benefits – Productivity and competitiveness
      viii. All benefits will be assessed annually.
    - Contributes to the overall objectives of the fund and the benefits agreed must be committed within the 3 financial years following approval
    - VAT, inter-departmental and contingency costs should not be included

14. Departmental drawdowns from the Fund will only be made available after it has been demonstrated that the Department will not produce an underspend within the current financial year.

15. All bids will be time-limited and extensions will require formal approval in line with the governance framework outlined above. It is the responsibility of the Department to ensure this.

FPN B.04 Internal Funds

16. Approvals are not transferrable between projects and a new business case will be required for each new initiative.

Approved By:	**Treasury**
Last Updated:	**12.12.16**

D7.3 Scale of transformation funding required to support the Review's recommendations

Transformation funding will be essential to achieving efficiency and service design improvements. In 2015 The Kings Fund and The Health Foundation reviewed the transformation funding that would be needed for the NHS in England to achieve its twin aims of a 2% year on year efficiency saving and rolling out more effective integrated models of care to cover 20% of England's population in the next

five years. Their research advised additional transformation funding of between 1.3% and 1.8% of the 2015/16 budget in real terms every year for the next five years. Their calculations included backfill costs of staff to enable double running of services and additional work on efficiency and transformational improvements, and also considered a per head of population cost for improvements to IT and infrastructure[clx].

The Review suggests a 1% efficiency target for the Isle of Man rather than the 2% efficiency target used in the Kings Fund and Health Foundation research. Nevertheless, the Review recommends more extensive transformational change than the Kings Fund and Health Foundation research recommended, and the Isle of Man's transformational funding will also be required to cover the costs of establishing new organisations and changing governance structures. Given the smaller efficiency goals but broader aims of transformation funding in the Isle of Man, this figure provides useful context to the quantum of transformation funding which could be required on the Isle of Man. Assuming 1.3% to 1.8% of the 2019/20 projected cost would be required year on year for the next five years to support transformation, additional transformation funding of £19.6m to £27.1m would be required across the five years to 2023/24.

The Review has therefore modelled the impact of providing additional funding amounting to 1.5% of the DHSC's annual budget as transformation funding annually from 2019/20 to 2023/24.

It is notable that there is no history of transformation funding for social care in England to compare against but that the expectation of funding provided through the 2016/17 Sustainability and Transformation Fund was that it would support integrated care and therefore social care by extension. The Review has therefore applied this estimate to the forecast health and care spend, including central costs.
If 1.5% of health and care spend was supplied to DHSC for transformation funding each year from 2019/20 to 2023/24, the total additional amount required each year would be between approximately £4m and approximately £5m, as shown in Figure 68 below.

Figure 68: Estimated transformation funding required[clxi]

Funding required	2019/20	2020/21	2021/22	2022/23	2023/24
"No change" forecast spend including central costs (£m)	285.0	293.0	301.0	309.5	318.1
Transformation funding – 1.3% each year (£m)	3.7	3.8	3.9	4.0	4.1
Transformation funding – 1.3% cumulative (£m)	3.7	7.5	11.4	15.5	19.6
Transformation funding – 1.5% each year (£m)	4.3	4.4	4.5	4.6	4.8
Transformation funding – 1.5% cumulative (£m)	4.3	8.7	13.2	17.8	22.6
Transformation funding – 1.8% each year (£m)	5.1	5.3	5.4	5.6	5.7
Transformation funding – 1.8% cumulative (£m)	5.1	10.4	15.8	21.4	27.1

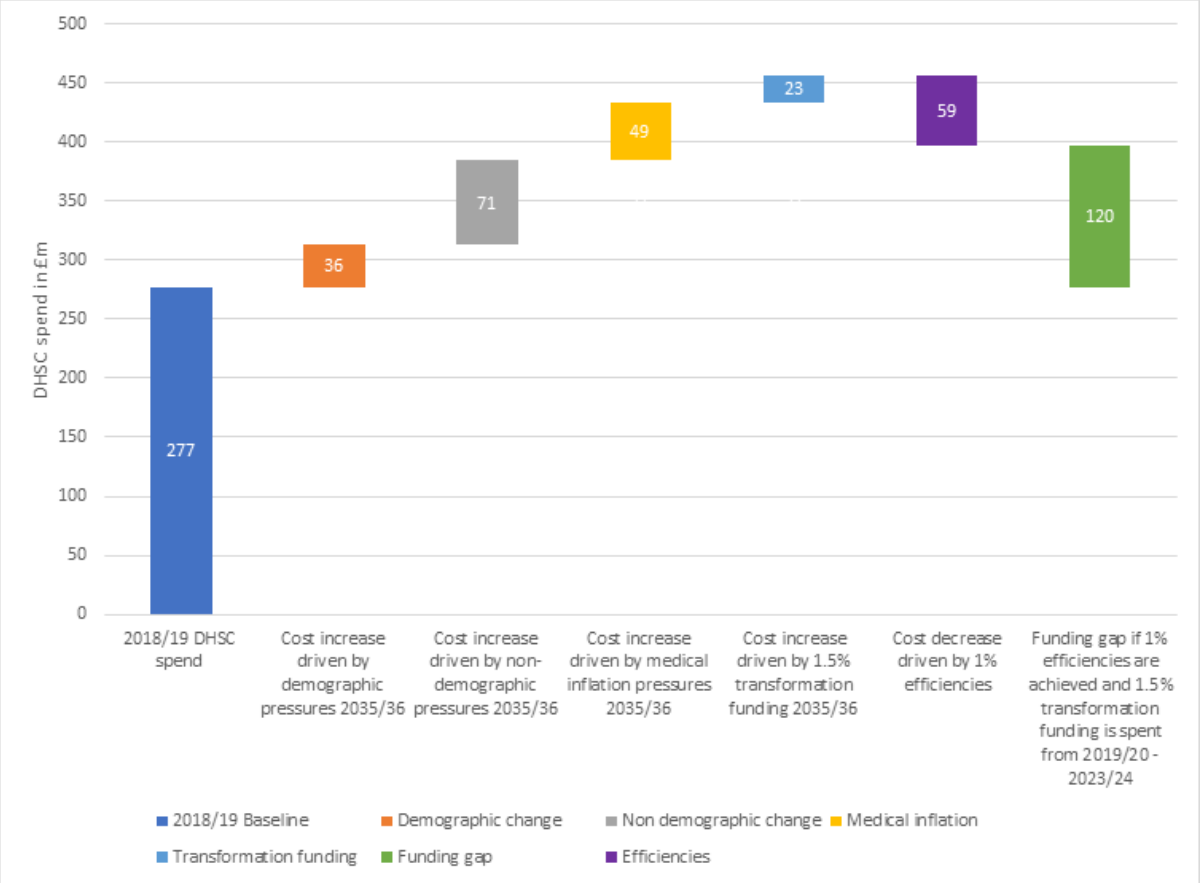
D7.4. Governance of transformation funding

The Healthcare Transformation Fund is overseen by Treasury, who approve any funding (see Terms of Reference above). The Review suggests that, going forward, the existing Healthcare Transformation Fund continues to be used to pay for the things it is currently being used for e.g.

transformational changes and improvements. It is expected the quantum of this spend is similar to in previous years, so in the region of £1.5m to £3.5m a year.

D8. Future impact of transformation funding and efficiencies

Figure 69: Funding gap including the impact of 1% efficiency savings and five years of transformation funding from 2019/20 – 2023/24



If efficiencies could be achieved without any injection of transformation funding, the funding gap in 2035/36 would be £97m. As the Review estimates that transformation funding to the value of 1.5% of health and care spend will be needed to achieve efficiencies, however, the projected funding gap in 2035/36 factoring in the impact of both efficiency savings and the transformation funding required to achieve them, is £119.6m.

Scenario	Projected funding gap in 2035/36 (£m)
"No change" scenario	£156.0m
1% efficiencies are achieved	£97.0m
1% efficiencies are achieved, and 1.5% transformation funding is provided from 2019/20 – 2023/24	£119.6m

E. Funding Options

E1. Treasury receipt increases scenario projections

In this section the Review summarises the potential effect of above inflationary Treasury receipts on the health and care spend funding gap. The Review makes the simplifying assumption that it is Treasury income (comprised of revenues from: Customs & Excise; Income Tax; NI Operating Account; and Other Treasury Income) which is the sole source of the DHSC and 'central cost' spend. In reality the picture is more complicated, but the Review has simplified it to provide an estimate of the scale at which Treasury income would need to grow to reduce the funding gap by varying

amounts. Figure 70 below shows that Treasury income in 2018/19 is projected to be £867.8m, 1.75% above the £852.9m expected.

Figure 70: Isle of Man Treasury Income 2018/19[clxii]

Income	Budget 2018/19 £,000	Probable 2018/19 £,000
CUSTOMS & EXCISE		
Shared Revenue		
Value Added Tax	276,836	277,136
Excise Duty	75,600	74,800
Customs Duty	6,500	6,500
Soft Drinks Industry Levy	0	0
Cost of Collection Adjustment	(1,200)	(1,300)
Non-Shared Revenue		
Gambling Duty	4,900	4,900
Air Passenger Duty	5,000	5,400
Lottery Duty	1,400	1,300
Non-Revenue Receipts	400	700
TOTAL CUSTOMS & EXCISE	**369,463**	**369,463**
INCOME TAX		
Resident Income Tax	191,550	201,450
Company Tax	12,500	12,380
Non-Resident Tax	19,150	18,900
TOTAL INCOME TAX	**223,200**	**232,730**
NI Operating Account	**250,948**	**256,543**
OTHER TREASURY INCOME		
Fines	750	600
Interest on Investments	8,000	8,000
Miscellaneous	83	33
IOMPO – Revenue Contribution	500	500
TOTAL OTHER TREASURY INCOME	**9,333**	**9,133**
TOTAL	**852,917**	**867,842**

DHSC and 'central costs' spend accounts for £277.7m, or 31.20% of Treasury income. Assuming this share of Treasury income spend stays constant going forward, if Treasury income were to increase by:

- 1% a year above inflation – this would require average annual Treasury income growth of £9.4m in real terms (rising from £8.7m in 2019/20[clxiii], to £10.2m in 2035/36), and would reduce the funding gap by 2035/36 from £119.6m to £68.5m;
- 2.13% a year above inflation – this would require average annual Treasury income growth of £22.0m in real terms (rising from £18.5m in 2019/20[clxiv], to £26.0m in 2035/36), and would reduce the funding gap by 2035/36 from £119.6m to zero; and
- 3% a year above inflation – this would require average annual Treasury income growth of £33.3m in real terms (rising from £26.0m in 2019/20[clxv], to £41.30m in 2035/36), and would reduce the funding gap by 2035/36 from £119.7m to a **surplus** of £61.3m.

An increase of 2.13% in Treasury income above inflation would therefore mean no funding gap in 2035/36. However, this should not be relied upon, which is why the following sections look at funding options to close the funding gap through other means than increased tax receipts from the growth of the economy.

E2. Explanation of funding options

E2.1 General taxation

General taxation changes would raise additional funds for the DHSC by requiring more tax to be paid by the Isle of Man public. General taxation is a common way of meeting the costs of universal health and care provision and is used in England, Scotland, and Canada among others[clxvi]. All countries that use general taxation do, however, supplement taxation with other means of raising funds such as charges or co-payment[clxvii].

There are several options available for the Isle of Man to raise more tax revenues from the public than at present. Options include widening the income tax base by lowering the personal allowance for income tax, lowering the income thresholds at which higher rates come into force or increasing the rates of tax paid at various thresholds of income. It is also important to note that, if the Isle of Man economy grows in the future, revenues from general taxation may increase without changes to rates or allowances but that this cannot be counted on as a certain future revenue stream.

Widely accepted economic theory holds that if taxes are raised past a certain point, they create disincentives for individuals to earn and companies to generate profits. This can actually drive down tax revenue collected as incomes cease to grow or even decline (a phenomenon known as the 'Laffer curve')[clxviii]. It is not known where the Isle of Man's current tax system lies on the Laffer curve but it is certainly true that raising taxes indefinitely would reduce the size and output of the Isle of Man's economy and result in decreasing tax revenues and less funding for the DHSC rather than more. Following discussions with the Isle of Man Treasury, the Review's modelling of the financial impact of tax-based funding options therefore includes diminishing returns for income tax raises of above 2% and does not explore income tax raises of higher than 5%.

It is also important to note the difference between general taxation and hypothecated tax. Unless the Treasury makes the decision to allocate the additional revenue raised by changes to general taxation to the DHSC, or unless the Treasury establishes a dedicated hypothecated tax, there is no guarantee that general taxation changes automatically translate into increased funding for the DHSC. General taxation raises funds for the Treasury, not the DHSC in particular[clxix].

Figure 71: Income tax rates in the Isle of Man, 2019/20 as at March 2019[clxx]

Income tax rates 2019/20	
Personal Allowances	
Single Person	£14,000
Jointly Assessed Couple	£28,000
Additional Personal Allowance	£6,400
Blind Person	£2,900
Disabled Person	£2,900
Income Tax rates	
Standard Rate	10%
Higher Rate	20%
Non-Resident Rate	20%
Standard rate tax thresholds	
Single Person	£6,500
Joint Assessed couple	£13,000
Balance taxable at	20%
Income Tax Cap amount	
Single Person	£175,000
Joint Assessed couple	£350,000

E2.2 National insurance

National insurance rates are based on earnings and are paid by both employers and employees. They are applied at thresholds of income and payments are capped above a high threshold for high earners on the Isle of Man. The Isle of Man's rates are, as of March 2019 from the information provided to the Review:

Figure 72: Isle of Man National Insurance Rates[clxxi]

Item (per week unless stated otherwise)	2018/19	2019/20
Lower Earnings Limit, Class 1 (LEL)	£116	£118
Upper Accrual Point (UAP)	£770	£770
Upper Earnings Limit, Class 1 (UEL)	£784	£784
Primary Threshold	£118	£125
Secondary Threshold	£118	£125
Prescribed annual equivalent of primary thresholds	£6,136	£6,500
Class 1 employees' primary rate of NI (between primary threshold and UEL)	11%	11%
Class 1 employees' additional rate of NI (above the UEL)	1%	1%
Class 1 employers' rate of NI (on all earnings above secondary threshold)	12.80%	12.80%
Employee's contracted-out rebate (COSR schemes only)	1.60%	N/A*
Employer's contracted-out rebate, salary related scheme (COSR)	3.70%	N/A*
Class 2 rate self-employed	£5.40	£5.40
Class 2 small earnings exception level (annual)	£6,136	£6,500
Class 2 rate for volunteer development workers	£5.80	£5.90
Class 2 for share fishermen	£6.70	£6.70
Class 3 voluntary contributions	£14.65	£15.00
Class 4 lower profits limit (annual)	£6,136	£6,500
Class 4 upper profits limit (annual)	£40,768	£40,768
Class 4 rate between the lower and upper limits	8%	8%
Class 4 rate above the upper limit	1%	1%

There are several options for the Isle of Man to raise more national insurance revenues from the public. Options include widening the income base by lowering the Lower Earnings Limit, increasing National Insurance rates, raising the threshold for which the Upper Earnings Limit applies, and/or lowering the thresholds at which higher rates apply.

It is important to note that the DHSC currently receives an allocation of National Insurance receipts (c. 20% in 2018/19)[clxxii]. The allocation could therefore also be increased to provide more funding to the DHSC. This would have two other consequences: an effective reduction in the National Insurance receipts available for spending in other Departments, and a reduction in the growth of the National Insurance Fund (used for pensions).

E2.3 Private insurance

Private insurance models are used to fund healthcare services in many countries, including the U.S.A. and Switzerland[clxxiii]. A number of residents in the Isle of Man use private health insurance alongside their access to free at the point of use public provision but full information was not available on the number of people who use private insurance, the amount they spend or the amount this "saves" the public sector each year.

Private for-profit health insurance companies offer insurance coverage in exchange for premia payments based on insurance policies. People are charged premia based on their health status and level of risk (premia can cover dependents as well) and employers usually contribute part of the premium. If a person requires healthcare, the private insurer will pay the costs either as a % or up to a certain amount. A "safety net" can be set up by the government to provide access for people who may not be able to afford market-rate insurance premia, such as retirees or those on low incomes. People may also have the option of not purchasing insurance cover and paying the full costs of healthcare upfront as and when they have need of it, although private cover can be mandated as in the case of Switzerland[clxxiv].

It is worth noting that, whilst private insurance is one of the most effective ways to reduce government spending on healthcare, it can increase the proportion of GDP spent on healthcare overall (both the U.S.A. and Switzerland spend more of their GDP on healthcare than the U.K., for instance)[clxxv].

It is important to note, however, that private insurance for social care has been explored by the Isle of Man previously and was rejected as no provider would be willing to provide this insurance due to the high risks and small population involved[clxxvi]. Private insurance, therefore, is strictly an option for funding health care rather than health and social care. The Review recommends that the Review into the Long-term Funding of Nursing and Residential Care is consulted in considering all social care funding options.

E2.4 Social insurance

Social insurance differs from private insurance in two key aspects:

- Premia are based on income rather than health status and risk
- Insurance is administered by the government or not-for-profit organisations rather than private for-profit insurers

Not-for-profit or government-owned companies offer insurance packages to the public, who may or may not have a choice of which organisation they sign up with. Social insurance can be made mandatory, or there can be options for wealthier people to opt out if they prefer to buy private insurance separately. Employers contribute part of a person's premium. If a person requires care, the social insurer will pay a % of the costs – for people with LTCs this can be set to 100% to protect them from high care costs. People with no or very low earnings can either be required to pay no premia or minimal premia as reductions from their welfare payments.

Social insurance is a viable model for funding both healthcare and social care, as policy in Japan has demonstrated[clxxvii]. The Review recommends that the findings from the 'Review into the future of funding for long-term residential and nursing care' are also considered when evaluating this option.

E2.5 Charges for services

The DHSC currently charges patients and service users for prescriptions, eye tests and glasses[clxxviii], dental treatment and residential and nursing social care unless they are exempt. Healthcare charges have exemption criteria based on income and health status. Around half of care home residents have an element of state funding in addition to universal non-means-tested benefit and the other half pay for their own care, topping up their state pension and any disability related benefits which they receive[clxxix].

There are multiple options available to the Isle of Man to raise further funds from charges. Charges could be extended in scope so that other the DHSC services (e.g. children and families social care visits, GP appointments), currently available for free at the point of use, were charged for.

Exemptions and voucher eligibility could be reduced in scope so that more people were eligible to pay charges (currently c. 90% of prescriptions are dispensed for free)[clxxx]. Finally, the fees for existing charges could be raised. The Review has not modelled removing prepaid vouchers for charges as these are necessary to protect people from extremely high care costs. All modelling for additional charges added on to other services includes a 'cap' where it is expected that 20% of costs would fall above the cap for individual payment and would be covered by the DHSC.

It is notable that raising the current charges and limiting the exemption criteria to include some people currently classed as 'chronic sick' were explored in detail in the National Health and Care Service (General) Scheme 2018. This was prepared and appeared on the Tynwald Order Paper for the April 2018 sitting but was not moved for approval and no Scheme has been brought in since[clxxxi]. After the 2018 General Scheme was not moved forward, it was concluded that the DHSC would progress with smaller, more manageable Schemes to sit under the 2016 Act. Each Scheme will deal with the services to be provided in one of the main service areas, i.e. community care, acute (hospital) care, mental health and public health. These schemes are currently being developed at time of writing[clxxxii].

As of March 2019 from the information provided to the Review, the charges are as follows:

Figure 73: Weekly fees for residential care[clxxxiii]

Resource Centre and EMI Services Charges	
Resource Centres (general – Cummal Mooar, Reayrt ny Baie and Southlands)	£449.82
Sweetbriar Unit (Thie Meanagh) and Langness Unit (Southlands)	£627.06
EMI Units (Thie Meanagh Units 1, Reayrt Skyal and Gansey Unit in Southlands)	£725.41

Figure 74: Prescription charges[clxxxiv]

Item	Charge
Item on a prescription form	£3.85
Item of elastic hosiery	£7.70

Figure 75: Opticians vouchers[clxxxv]

Type of optical voucher	Code	Historic the Isle of Man values (in 2004)	Historic English values (in 2004)	the Isle of Man Voucher Value (in 2012)	England Voucher Value (in 2012)	Current the Isle of Man Voucher value	Current English voucher value
Glasses with single vision lenses: a. 6 or less SPH or less CYL b. 2 or less SPH and over 2 to 4 CYL	A	£32.10	£32.10	£32.10	£37.10	£32.10	£39.10
Glasses with single vision lenses: a. 2 to 6 SPH and over 2 to 4 CYL b. Over 6 to less 10 SPH and 2 or less CYL	B	£48.80	£48.80	£48.80	£56.40	£48.80	£59.30
Glasses with single vision lenses: a. 10 to 20 inclusive SPH and 6 or less CYL b. 10 or less SPH and over 4 to 6 CYL c. Over 6 to less 10 SPH and over 2 to less 4 CYL	C	£71.30	£71.30	£71.30	£82.60	£71.30	£86.90
Glasses with single vision lenses: a. Over 20 SPH and any CYL power b. 20 or less SPH and over 6 CYL	D	£161.00	£161.00	£161.00	£186.50	£161.00	£196.00
Glasses with bifocal lenses: a. 6 or less than 10 SPH and 2 or less CYL b. 2 or less SPH and over 2 to 4 CYL	E	£55.40	£55.40	£55.40	£64.20	£55.40	£67.50
Glasses with bifocal lenses: a. Over 6 to less than 10 SPH and 2 or less CYL	F	£70.40	£70.40	£70.40	£81.60	£70.40	£85.60

b. Over 2 to 6 SPH and over 2 to 4 CYL							
Glasses with bifocal lenses: a. 10 to 14 SPH and 6 or less CYL b. Less than 10 SPH and over 4 to 6 CYL c. Over 6 to less 10 SPH and over 2 to 4 CYL	G	£91.30	£91.30	£91.30	£105.80	£91.30	£111.20
Glasses with prism-controlled bifocal lenses of any power or with bifocal lenses: a. Over 14 SPH and any CYL power b. 14 or less SPH and over 6 CYL	H	£177.00	£177.00	£177.00	£205.10	£177.00	£215.50
Glasses not falling with any of the above	I	£164.80	£164.90	£164.80	£191.00	£164.80	£200.80
Each single vision lens containing a necessary prism		£10.40	£12.10	£10.40	£12.10	£10.40	£12.60
Each other lens containing a necessary prism		£12.50	£10.40	£12.50	£14.60	£12.50	£15.40
Each necessary single vision tinted lens		£4.00	£3.50	£4.00	£4.10	£4.00	£4.40
Each necessary other tinted lens		£4.50	£4.00	£4.50	£4.60	£4.50	£4.90
Supply or replacement of the glasses or repair of the whole frame of small glasses		£52.80	£12.50	£52.80	£61.20	£52.80	£64.20
Frames to be specially manufactured on account of the patient's facial characteristics, voucher is issued/completed by the Department		£52.80	£4.00	£52.80	61.20	£52.80	£61.20
Complex appliance with single vision lenses only		£12.10	£12.10	£12.10	£14.00	£12.10	£14.60
Any other complex appliance		£30.50	£30.50	£30.50	£35.50	£30.50	£37.40

	Letter codes – Values								
Repair or Replacement of:	A	B	C	D	E	F	G	H	I
One lens	£10.00	£18.35	£29.60	£74.45	£21.65	£29.15	£39.60	£82.45	£76.40
Two Lenses	£20.00	£36.70	£59.20	£148.90	£43.30	£58.30	£79.20	£164.90	£152.80
The front of a frame	£10.25	£10.25	£10.25	£10.25	£10.25	£10.25	£10.25	£10.25	£10.25
A side of a frame	£6.10	£6.10	£6.10	£6.10	£6.10	£6.10	£6.10	£6.10	£6.10
The whole frame	£12.10	£12.10	£12.10	£12.10	£12.10	£12.10	£12.10	£12.10	£12.10

Figure 76: Dental charges[clxxxvi]

Band	Charge	Example treatments
Band 1	£18.50	Clinical examination, colour photographs, scaling and polishing
Band 2	£50.50	Tooth extraction, fillings, surgical treatment
Band 3	£219.00	Crowns, bridges, orthodontic treatment

Figure 77: Prescription charge exemption criteria[clxxxvii]

- Children under 16 years
- Full time students under 19 years
- Person of State Retirement age
- Persons in receipt of Income Support and their dependents
- Persons in receipt of Income Based Job Seekers Allowance
- Persons in receipt of Incapacity Benefit for a period in excess of six months
- Persons in receipt of Employed Persons Allowance
- Chronic sick, who have been in constant need of medical attention for six months or longer and who are not in substantial employment
- Persons suffering from the following conditions, irrespective of income or employment circumstances:
    - (i) Permanent fistula (including caecostomy, colostomy, laryngostomy or ileostomy) requiring continuous surgical dressing or an appliance
    - (ii) Forms of hypoadrenalism (including Addison's Disease) for which specific substitution therapy is essential
    - (iii) Diabetes insipidus and other forms of hypopituitarism
    - (iv) Diabetes mellitus except where treatment is by diet alone
    - (v) Hypoparathyroidism
    - (vi) Myasthenia gravis
    - (vii) Myxoedema
    - (viii) Epilepsy requiring continuous anti-convulsive therapy:
    - (ix) A continuing physical disability which prevents the patient from leaving his residence without the help of another person
- War Service Disablement Pensioners
- Registered Blind Persons
- Women who are pregnant
- Women who have given birth within the previous twelve months.

Figure 78: Opticians voucher eligibility criteria

- You are under 16
- You are under 19 and in full-time education
- You are, or are a member of the family of a person who is, in receipt of Income Support

- You are a war disablement pensioner
- You are registered blind

Figure 79: Dental charge exemption criteria[clxxxviii]

- You are under 16
- You are aged under 19 and in full-time education
- You are pregnant or have had a baby in the last 12 months
- You have reached state retirement age
- You, or your dependent, receive Income Support
- You receive Income Based Job Seekers Allowance or Employed Persons Allowance
- You are a war disablement pensioner
- You are registered blind

Figure 80 below shows how charges in the Isle of Man compare to charges in some other health and care systems. This comparison is by no means exhaustive, rather it gives some indication of the relative levels of charges in different systems.

Figure 80: Charges in the Isle of Man compared to other health and care systems[clxxxix]

Charge	Isle of Man	England	Ireland	Jersey
Prescription	£3.85 per item	£9 per item	At cost up to £118.41 (€134) per month per family, or £1.71 (€2) per item for medical card holders	£8 for emergency prescription items, £5 for a month's supply posted, £3 for a month's supply collected in person
GP appointment	£0	£0	£42.83 (€50)	£42
Highest dental charge levied	£219	£256.50	Prices set privately by each practice, discounts available to medical card holders	Prices set privately by each practice (can go up to £450 and above for bridges and crowns)
Highest optician charge levied	£177	£215.50	Prices set privately by each optician, glasses of value of £50.62 available to medical card holders (€59)	Prices set privately by each optician

The Isle of Man, England, the Republic of Ireland and many other health and care systems apply exemption criteria to charges levied. People who fall under exemption criteria do not have to pay charges to access services. While most systems include 'ability to pay' as a criterion for exemption, the criteria are often such that some people with the means to pay are still exempt. This includes people with the means to pay who are aged over 65 or (in the case of prescriptions) have certain conditions in the Isle of Man and England and children diagnosed with cancer in the Republic of Ireland[cxc]. The Isle of Man's exemption criteria are comparable to England's. In both systems, approximately 90% of prescriptions are dispensed for free, indicating that exemption criteria apply widely in both systems[cxci].

E2.6 Hypothecated tax

Hypothecation means earmarking tax revenues for specific, identified purposes. As with any other tax, the amount raised would depend on the rate and how many people would be liable to pay[cxcii]. The Isle of Man has already implemented a hypothecated tax on sugar, the proceeds of which will go towards the DHSC[cxciii]. Discussions with the Isle of Man tax departments have indicated that a reasonable approach for raising a further hypothecated tax would be a levy on income. Other

hypothecated lifestyle taxes (such as taxes on alcohol, salt or fat) have a potential public health benefit as they may deter people from engaging in behaviours that are harmful to their health. These taxes are impractical for the Isle of Man to levy independently given its duties sharing agreement with the United Kingdom[cxciv]. If the United Kingdom implement lifestyle taxes in future, however, then the Isle of Man may implement the same taxes (as occurred with the sugar tax in 2018/19). Hypothecated taxes can be used to top up spending on health and social or 'pure hypothecation' can be used to create a tax that becomes the only source of DHSC revenue.

E2.7 Reallocation of funds from other Departments

Reallocating funding removes the necessity of raising additional funding for the public purse and instead reduces the share of Government expenditure that other Departments receive in order to increase the share that the DHSC receives. This was done, alongside other changes, in England in 2010 when the UK government set out cuts to other government departments while ring-fencing the NHS budget[cxcv]. Reallocation necessitates reducing the funding in real terms allocated to other Government Departments, which would require efficiencies to be made in other areas. This could lead to financial struggles for other Departments and reduced quality of other Government services.

E3. Financial implications of funding options – year by year breakdown of funding raised

Each funding option is presented in this section and is modelled to close a £50m, a £100m or a £150m funding gap in 2035/36. The exception to this is for funding options that cannot close a £100m or greater gap without being combined with other options. In this case only an option to close a £50m gap has been presented. The Review has included charges and changes to general taxation in this category.

The Review has modelled the funding options to close a £50m, £100m and £150m funding gap as it is not within the Review's remit to recommend how much the Isle of Man should raise and whether elected representatives will decide to close the forecasted gap, leave some of the gap unfunded, or exceed the funding gap projection in order to provide further enhancements and improvements. This range covers from roughly 50% of the forecast funding gap (£109.4m) to 150% of the forecast gap.

The red 'Changes' bar underneath each projection indicates the change made (e.g. initiate charges of £100) and the year at which the change is made to achieve the additional revenue raised.
Each funding option is also presented in both 'staggered' and 'not staggered' projections.
In the 'staggered' projections, the modelling examines the impact of making changes progressively as the funding gap increases. Changes are only suggested at five-year intervals (2019/20, 2025/26, 2030/31, 2035/36). The Review has chosen five-year intervals as changing funding options that require high degrees of administration and communication with the public is not likely to be feasible if done more frequently than once every five years.

In the 'not staggered' projects, the modelling examines the impact of making the changes in 2019/20 that would be necessary to raise £50m, £100m or £150m in 2035/36. The approach has the advantage of being simpler to administer as there is only one year in which changes are made. The disadvantage of this approach is that it raises more funding than would be needed to close the funding gap in every year except 2035/36.

E3.1 General taxation

Figure 81: Closing a £50m gap with changes to general taxation (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/27	2027/ 28	2028/ 29	2029/ 30	2030 / 31	2031 / 32	2032 / 33	2033 / 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102. 0	108. 3	114.0	119.6
Rate change 1 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8
Rate change 2 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5
Lower PA (£m)	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2
New funding gap (£m)	-14.9	-5.3	4.2	14.4	24.7	30.6	11.8	17.5	23.3	29.3	35.3	40.9	46.9	53.5	59.8	65.5	71.2
Changes	*Lower PA by £2,500*						*3% on top rate of tax allocated all to health*										
							3% on lower rate of tax allocated all to health										

Figure 82: Closing a £50m gap with changes to general taxation (not staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Rate change 1 (£m)	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3	24.3
Lower PA (£m)	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2
New fund- ing gap (£m)	-39.1	-29.6	-20.0	-9.9	0.4	6.3	11.8	17.5	23.3	29.3	35.3	40.9	46.9	53.5	59.8	65.5	71.2
Changes	*Lower PA by £2,500*																
	3% on top rate of tax allocated all to health																
	3% on lower rate of tax allocated all to health																

E3.2 National insurance

Figure 83: Closing a £50m gap with changes to national insurance (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Rate change 1 (£m)	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0
Rate change 2 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	32.0	32.0	32.0	32.0	32.0	32.0
Rate change 3 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Funding gap remaining (£m)	-6.6	2.9	12.4	22.6	32.9	38.8	44.2	50.0	55.8	61.8	67.8	41.4	47.3	54.0	60.3	66.0	71.6
Changes	*1% on both employees and employers*											*4% on both employees and employers*					

Figure 84: Closing a £100m gap with changes to national insurance (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Rate change 1 (£m)	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0
Rate change 2 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0
Rate change 3 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.0	8.0	8.0	8.0	8.0	8.0
Rate change 4 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	7.0	7.0	7.0	7.0	7.0
Allocation change 1 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	38.5	38.5	38.5	38.5	38.5	38.5
Funding gap remaining (£m)	-22.6	-13.1	-3.6	6.6	16.9	22.8	12.2	18.0	23.8	29.8	35.8	-12.1	-6.2	0.5	6.8	12.5	18.1
Changes	*2% on both employees and employers*						*4% on both employees and employers*					*5% on both employers and employees*					
												5% on people earning under lower threshold					

Figure 85: Closing a £150m gap with changes to national insurance (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Allocation change 1 (£m)	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5
Rate change 1 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0
Rate change 2 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	7.0	7.0	7.0	7.0	7.0
Rate change 3 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.6	7.6	7.6	7.6	7.6	7.6
Allocation change 2 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	38.5	38.5	38.5	38.5	38.5	38.5
Rate change 4 (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1	1.1	1.1	1.1	1.1
Funding gap remaining (£m)	-29.1	-19.6	-10.1	0.1	10.4	16.3	-34.3	-28.5	-22.7	-16.7	-10.7	-59.3	-53.4	-46.7	-40.4	-34.7	-29.1
Changes	*Double allocation*						*5% on both employees and employers*					*5% on people earning under lower threshold*					
												5% on people earning above higher threshold					
												Add 5% to people over state pension age					
												Triple allocation					

Figure 86: Closing a £50m gap with changes to national insurance (not staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Rate change 1 (£m)	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0
Funding gap remaining (£m)	-38.6	-29.1	-19.6	-9.4	0.9	6.8	12.2	18.0	23.8	29.8	35.8	41.4	47.3	54.0	60.3	66.0	71.6
Changes	*4% on both employees and employers*																

Figure 87: Closing a £100m gap with changes to national insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Rate change 1 (£m)	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0
Rate change 2 (£m)	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Allocation change 1 (£m)	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5
Funding gap remaining (£m)	-92.1	-82.6	-73.1	-62.9	-52.6	-46.7	-41.3	-35.5	-29.7	-23.7	-17.7	-12.1	-6.2	0.5	6.8	12.5	18.1
Changes	*5% on both employers and employees, 5% on people earning under lower threshold, double allocation*																

Figure 88: Closing a £150m gap with changes to national insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/ 26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/ 35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Allocation change 1 (£m)	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5
Rate change 1 (£m)	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0	56.0
Rate change 2 (£m)	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Rate change 3 (£m)	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1
Allocation change 2 (£m)	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5	38.5
Rate change 4 (£m)	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6
Funding gap remaining (£m)	-139.4	-129.8	-120.3	-110.1	-99.8	-93.9	-88.5	-82.8	-76.9	-71.0	-64.9	-59.3	-53.4	-46.7	-40.4	-34.7	-29.1
Changes	*5% on people earning under lower threshold, 5% on people earning above higher threshold, Add 5% to people over state pension age, Triple allocation, 5% on both employees and employers*																

E3.3 Private insurance

Figure 89: Closing a £50m gap with changes to private insurance (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Amount raised by charging insurance (£m)	11.1	11.5	11.9	12.3	12.7	13.0	26.4	26.9	27.4	27.8	28.3	46.1	46.8	47.7	48.6	49.3	50.1
Funding gap remaining (£m)	-1.8	7.4	16.5	26.3	36.2	41.8	33.8	39.1	44.5	49.9	55.5	43.3	48.5	54.3	59.8	64.7	69.6
Changes	*5% of people are covered by insurance*						*10% of people are covered by insurance*					*16% of people are covered by insurance*					

Figure 90: Closing a £100m gap with changes to private insurance (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Amount raised by charging insurance (£m)	22.2	23.0	23.8	24.6	25.5	26.0	58.1	59.1	60.2	61.2	62.3	97.9	99.6	101.4	103.2	104.8	106.4
Funding gap remaining (£m)	-12.9	-4.1	4.6	14.0	23.4	28.9	2.1	6.8	11.6	16.5	21.5	-8.5	-4.2	0.6	5.1	9.2	13.3
Changes	*10% of people are covered by insurance*						*22% of people are covered by insurance*					*34% of people are covered by insurance*					

Figure 91: Closing a £150m gap with changes to private insurance (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Amount raised by charging insurance (£m)	22.2	23.0	23.8	24.6	25.5	26.0	58.1	59.1	60.2	61.2	62.3	144.0	146.4	149.1	151.7	154.1	156.4
Funding gap remaining (£m)	-12.9	-4.1	4.6	14.0	23.4	28.9	2.1	6.8	11.6	16.5	21.5	-54.6	-51.1	-47.1	-43.4	-40.1	-36.8
Changes	*10% of people are covered by insurance*						*22% of people are covered by insurance*					*50% of people are covered by insurance*					

Figure 92: Closing a £50m gap with changes to private insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Amount raised by charging insurance (£m)	35.6	36.8	38.1	39.4	40.8	41.5	42.2	43.0	43.8	44.5	45.3	46.1	46.8	47.7	48.6	49.3	50.1
Funding gap remaining (£m)	-26.2	-17.9	-9.6	-0.8	8.1	13.3	18.0	23.0	28.0	33.2	38.5	43.3	48.5	54.3	59.8	64.7	69.6
Changes	*16% of people are covered by insurance*																

Figure 93: Closing a £100m gap with changes to private insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Amount raised by charging insurance (£m)	75.6	78.2	80.9	83.7	86.6	88.3	89.8	91.4	93.0	94.6	96.3	97.9	99.6	101.4	103.2	104.8	106.4
Funding gap remaining (£m)	-66.2	-59.3	-52.5	-45.1	-37.7	-33.5	-29.5	-25.4	-21.2	-16.9	-12.5	-8.5	-4.2	0.6	5.1	9.2	13.3
Changes	*34% of people are covered by insurance*																

Figure 94: Closing a £150m gap with changes to private insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Amount raised by charging insurance (£m)	111.1	115.0	119.0	123.1	127.4	129.8	132.0	134.4	136.8	139.2	141.7	144.0	146.4	149.1	151.7	154.1	156.4
Funding gap remaining (£m)	-101.8	-96.1	-90.5	-84.5	-78.5	-75.0	-71.8	-68.4	-64.9	-61.4	-57.9	-54.6	-51.1	-47.1	-43.4	-40.1	-36.8
Changes	*50% of people are covered by insurance*																

E3.4 Social insurance

Figure 95: Closing a £50m gap with changes to social insurance (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Premia raise (£m)	18.9	19.0	19.1	19.2	19.3	19.4	19.5	19.5	19.6	19.7	19.8	49.5	49.7	49.8	49.9	50.1	50.1
Copayment raise (£m)	2.5	2.5	2.6	2.6	2.7	2.7	2.8	2.8	2.9	2.9	3.0	6.1	6.2	6.3	6.4	6.5	6.6
Funding gap re-maining (£m)	-12.0	-2.6	6.8	16.8	26.9	32.7	38.0	43.6	49.3	55.1	61.1	33.8	39.5	45.9	52.0	57.4	62.9
Changes	*1% premia, 1% copayment*											*2.5% premia, 2% copayment*					

Figure 96: Closing a £100m gap with changes to social insurance (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Premia raise (£m)	18.9	19.0	19.1	19.2	19.3	19.4	58.4	58.6	58.8	59.1	59.3	89.2	89.4	89.7	89.9	90.1	100.3
Copayment raise (£m)	2.5	2.5	2.6	2.6	2.7	2.7	2.8	2.8	2.9	2.9	3.0	6.0	6.1	6.3	6.4	6.5	6.6
Funding gap remaining (£m)	-12.0	-2.6	6.8	16.8	26.9	32.7	-0.9	4.5	10.1	15.8	21.6	-5.8	-0.3	6.1	12.0	17.4	12.8
Changes	*1% premia, 1% copayment*						*3% premia, 1% copayment*					*4.5% premia, 2% copayment*					*5% premia, 2% copay-ment*

Figure 97: Closing a £150m gap with changes to social insurance (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Premia raise (£m)	18.9	19.0	19.1	19.2	19.3	19.4	38.9	39.1	39.2	39.4	39.5	138.7	139.1	139.5	139.8	140.1	140.4
Copayment raise (£m)	2.5	2.5	2.6	2.7	2.8	2.8	5.8	5.9	6.0	6.1	6.2	21.9	22.3	22.7	23.1	23.4	23.7
Funding gap remaining (£m)	-12.0	-2.7	6.7	16.7	26.8	32.6	15.5	21.0	26.6	32.3	38.1	-71.3	-66.1	-60.2	-54.6	-49.5	-44.5
Changes	*1% premia, 1% copayment*						*2% premia, 2% copayment*					*7% premia, 7% copayment*					

Figure 98: Closing a £50m gap with changes to social insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Premia raise (£m)	47.3	47.6	47.8	48.0	48.2	48.4	48.6	48.8	49.0	49.2	49.4	49.5	49.7	49.8	49.9	50.1	50.1
Copayment raise (£m)	4.9	5.0	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	6.0	6.1	6.3	6.4	6.5	6.6
Funding gap remaining (£m)	-42.9	-33.7	-24.5	-14.6	-4.7	0.9	6.1	11.5	17.1	22.7	28.5	33.8	39.5	45.9	52.0	57.5	62.9
Changes	*2.5% premia, 2% copayment*																

Figure 99: Closing a £100m gap with changes to social insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Premia raise (£m)	94.6	95.1	95.6	96.0	96.4	96.9	97.3	97.7	98.1	98.4	98.8	99.1	99.4	99.7	99.9	100.1	100.3
Copayment raise (£m)	4.9	5.0	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	6.0	6.1	6.3	6.4	6.5	6.6
Funding gap remaining (£m)	-90.2	-81.2	-72.3	-62.6	-52.9	-47.5	-42.6	-37.3	-32.0	-26.5	-20.9	-15.7	-10.2	-3.9	2.1	7.4	12.8
Changes	*5% premia, 2% copayment*																

Figure 100: Closing a £150m gap with changes to social insurance (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Premia raise (£m)	132.5	133.1	133.8	134.4	135.0	135.6	136.2	136.7	137.3	137.8	138.3	138.7	139.1	139.5	139.8	140.1	140.4
Copayment raise (£m)	17.2	17.8	18.3	18.9	19.5	19.9	20.2	20.6	20.9	21.3	21.6	21.9	22.3	22.7	23.1	23.4	23.7
Funding gap remaining (£m)	-140.3	-132.0	-123.7	-114.7	-105.7	-100.7	-96.2	-91.3	-86.4	-81.3	-76.1	-71.3	-66.1	-60.2	-54.6	-49.5	-44.5
Changes	*7% premia, 7% copayment*																

E3.5 Charges for services

Figure 101: Closing a £50m gap with changes to charges for services (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Charges change 1 (£m)	12.9	13.1	13.3	13.5	13.8	14.0	14.2	14.5	14.7	15.0	15.2	29.2	29.6	30.1	30.6	31.1	31.5
Exemptions change 1 (£m)	12.3	12.4	12.5	12.7	12.8	12.9	13.1	13.2	13.3	13.4	13.6	13.7	13.8	14.0	14.1	14.2	14.4
Funding gap remaining (£m)	-15.8	-6.6	2.6	12.4	22.3	27.9	32.9	38.3	43.8	49.3	55.0	46.5	51.8	57.9	63.6	68.7	73.7
Changes	*£50 charges (£5 meals), raise 5% on more social care charges*											*£100 charges (£10meals), raise 25% more on social care services charges*					
	Reduce exemptions on dental, opticians and prescription charges by 75%																

Figure 102: Closing a £50m gap with changes to charges for services (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Charges change 1 (£m)	24.1	24.5	24.9	25.4	25.8	26.3	26.7	27.2	27.7	28.2	28.7	29.2	29.6	30.1	30.6	31.1	31.5
Exemptions change 1 (£m)	12.3	12.4	12.5	12.7	12.8	12.9	13.1	13.2	13.3	13.4	13.6	13.7	13.8	14.0	14.1	14.2	14.4
Funding gap remaining (£m)	-27.0	-18.1	-9.1	0.5	10.2	15.6	20.4	25.6	30.8	36.1	41.5	46.5	51.8	57.9	63.6	68.7	73.7
Changes	*£100 charges (£10 meals) for some health services, raise 25% more on social care services charges*																
	Reduce exemptions on dental, opticians and prescription charges by 75%																

E3.6 Hypothecated tax

Figure 103: Closing a £50m gap with changes to hypothecated tax (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Hypothecated tax raises (£m)	18.9	19.0	19.1	19.2	19.3	19.4	38.9	39.1	39.2	39.4	39.5	49.5	49.7	49.8	49.9	50.1	50.1
Funding gap remaining (£m)	-9.6	-0.1	9.3	19.4	29.6	35.4	21.3	26.9	32.6	38.4	44.3	39.8	45.6	52.2	58.4	63.9	69.5
Changes	*1% premia for all*						*2% premia for all*					*2.5% premia for all*					

Figure 104: Closing a £100m gap with changes to hypothecated tax (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Hypothecated tax raises (£m)	18.9	19.0	19.1	19.2	19.3	19.4	48.6	48.8	49.0	49.2	49.4	99.1	99.4	99.7	99.9	100.1	100.3
Funding gap remaining (£m)	-9.6	-0.1	9.3	19.4	29.6	35.4	11.6	17.1	22.8	28.5	34.4	-9.7	-4.1	2.3	8.4	13.9	19.3
Changes	*1% premia for all*						*2% premia for all*					*5% premia for all*					

Figure 105: Closing a £150m gap with changes to hypothecated tax (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Hypothecated tax raises (£m)	37.8	38.0	38.2	38.4	38.6	38.7	58.4	58.6	58.8	59.1	59.3	154.1	154.6	155.0	155.4	155.7	156.0
Funding gap remaining (£m)	-28.5	-19.1	-9.8	0.2	10.3	16.1	1.9	7.4	13.0	18.7	24.5	-64.7	-59.3	-53.0	-47.1	-41.7	-36.4
Changes	*2% premia for all*						*3% premia for all*					*8% premia for high earners, 7% for mid and low earners*					

Figure 106: Closing a £50m gap with changes to hypothecated tax (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Hypothecated tax raises (£m)	47.3	47.6	47.8	48.0	48.2	48.4	48.6	48.8	49.0	49.2	49.4	49.5	49.7	49.8	49.9	50.1	50.1
Funding gap remaining (£m)	-38.0	-28.7	-19.3	-9.4	0.7	6.4	11.6	17.1	22.8	28.5	34.4	39.8	45.6	52.2	58.4	63.9	69.5
Changes	*2.5% premia for all*																

Figure 107: Closing a £100m gap with changes to hypothecated tax (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Hypothecated tax raises (£m)	94.6	95.1	95.6	96.0	96.4	96.9	97.3	97.7	98.1	98.4	98.8	99.1	99.4	99.7	99.9	100.1	100.3
Funding gap remaining (£m)	-85.3	-76.2	-67.1	-57.4	-47.5	-42.1	-37.0	-31.7	-26.2	-20.7	-15.0	-9.7	-4.1	2.3	8.4	13.9	19.3
Changes	*5% premia for all*																

Figure 108: Closing a £150m gap with changes to hypothecated tax (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Hypothecated tax raises (£m)	147.2	147.9	148.6	149.3	150.0	150.7	151.3	151.9	152.5	153.1	153.6	154.1	154.6	155.0	155.4	155.7	156.0
Funding gap remaining (£m)	-137.8	-129.0	-120.2	-110.7	-101.1	-95.9	-91.1	-86.0	-80.7	-75.3	-69.8	-64.7	-59.3	-53.0	-47.1	-41.7	-36.4
Changes	*8% premia for high earners, 7% for mid and low earners*																

E3.7 Reallocation of funds from other Departments

Figure 109: Closing a £50m gap with changes to reallocation of funds from other Departments (staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Reallocation raises (£m)	17.6	17.6	17.6	17.6	17.6	17.6	41.2	41.2	41.2	41.2	41.2	52.9	52.9	52.9	52.9	52.9	52.9
Funding gap remaining (£m)	-8.3	1.3	10.8	21.0	31.3	37.2	19.1	24.8	30.7	36.6	42.7	36.5	42.4	49.1	55.4	61.1	66.7
Changes	*3% reallocation*						*7% reallocation*					*9% reallocation*					

Figure 110: Closing a £100m gap with changes to reallocation of funds from other Departments (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Reallocation raises (£m)	29.4	29.4	29.4	29.4	29.4	29.4	58.8	58.8	58.8	58.8	58.8	88.2	88.2	88.2	88.2	88.2	105.8
Funding gap remaining (£m)	-20.0	-10.5	-1.0	9.2	19.5	25.4	1.4	7.2	13.0	19.0	25.0	1.2	7.1	13.8	20.1	25.8	13.8
Changes	*5% reallocation*						*10% reallocation*					*15% reallocation*					*18% realloca-tion*

Figure 111: Closing a £150m gap with changes to reallocation of funds from other Departments (staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Reallocation raises (£m)	29.4	29.4	29.4	29.4	29.4	29.4	58.8	58.8	58.8	58.8	58.8	88.2	88.2	88.2	88.2	88.2	158.7
Funding gap remaining (£m)	-20.0	-10.5	-1.0	9.2	19.5	25.4	1.4	7.2	13.0	19.0	25.0	1.2	7.1	13.8	20.1	25.8	-39.1
Changes	*5% reallocation*						*10% reallocation*					*15% reallocation*					*27% realloca-tion*

Figure 112: Closing a £50m gap with changes to reallocation of funds from other D(not staggered)

	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34	2034/ 35	2035/ 36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Reallocation raises (£m)	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9	52.9
Funding gap remaining (£m)	-43.6	-34.0	-24.5	-14.3	-4.0	1.9	7.3	13.1	18.9	24.8	30.9	36.5	42.4	49.1	55.4	61.1	66.7
Changes	*9% reallocation*																

Figure 113: Closing a £100m gap with changes to reallocation of funds from other Departments (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Reallocation raises (£m)	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8	105.8
Funding gap remaining (£m)	-96.5	-86.9	-77.4	-67.2	-56.9	-51.0	-45.6	-39.9	-34.0	-28.1	-22.0	-16.4	-10.5	-3.8	2.5	8.2	13.8
Changes	*18% reallocation*																

Figure 114: Closing a £150m gap with changes to reallocation of funds from other Departments (not staggered)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Reallocation raises (£m)	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7	158.7
Funding gap remaining (£m)	-149.4	-139.8	-130.3	-120.1	-109.8	-103.9	-98.5	-92.8	-86.9	-81.0	-74.9	-69.3	-63.4	-56.7	-50.4	-44.7	-39.1
Changes	*27% reallocation*																

E4. Non-financial implications of funding options[cxcvi]

Funding option	Non-financial benefits	Non-financial disadvantages
General taxation	• General taxation is an efficient method of raising new funds, with low administration costs for the amount of money raised • General taxation is also often perceived to be equitable.	• Raising rates of general taxation and/or lowering thresholds taxation often proves unpopular with electorates and would contradict the Isle of Man's most recent budget announcement • Raising general taxation could negatively impact the Isle of Man's competitiveness as a place to do business
National insurance	• National insurance is an efficient method of raising new funds and national insurance is often perceived by the public as already being designated for health and care funding • Changing national insurance rates and allowances would not contradict the Isle of Man's existing tax strategy around fixed income tax rates	• Raising national insurance could negatively impact the Isle of Man's competitiveness as a place to do business • Reducing the earnings thresholds or changing rates of national insurance would contradict the Isle of Man's most recent budget announcement • National insurance can create the perception of an individual 'pot' of money available for each person after retirement, whereas in fact national insurance revenue is spent by Government on a variety of services
Private insurance	• Competition for patients as paying customers may drive up quality of care • People pay for the healthcare they personally require, rather than in a tax-based model where effectively the healthy subsidise the sick	• Private healthcare can have negative impacts on access to healthcare for people on low incomes, especially with regards to accessing non-urgent preventative care • Employer-based PHI schemes can make employees less likely to change employers and less able to be self-employed, leading some to argue that it makes countries less competitive
Social insurance	• Social insurance is often perceived as equitable since premia are based on a person's income rather than health status • Social insurance for social care offers people previously required to pay out of pocket a higher measure of financial protection and emotional reassurance against uncertain care costs in the future	• The element of copayment that most social insurance systems operate may discourage people on low incomes from accessing health and care • Social insurance schemes can result in effectively higher taxes on wages, since both employers and employees contribute to premia, which some argue negatively

		impacts a country's global competitiveness
User charges	• Charges can act as a deterrent for the overuse of health and care, the logic being that people will only use services when they really need them if they have to pay for use • Charges can be argued to be fairer than universal provision as, since exemptions are in place for those who cannot afford charges, free provision is restricted to those people who really need while those with means pay their own way	• Charges can be perceived as inequitable as they may limit access to health and care to those able to pay the fee • Charges can have negative impacts on health and wellbeing outcomes by deterring people from seeking preventative care until needs become urgent, and by increasing the risk that unwell people present to others in the community if they go untreated
Hypothecated tax	• The Isle of Man 2018 Social Attitudes Survey included a question on this issue – the answer indicated that hypothecated taxes in various forms were the first and second most popular means of raising more money for the DHSC • Taxes a relatively cost-efficient way to raise additional income, with a low administration burden	• 'Pure' hypothecation is likely unsuitable to health and care funding as the tax receipts would fluctuate in line with the economy rather than need for health and care • Additional taxes, particularly if established as a levy on income, may negatively impact the Isle of Man's competitiveness as a place to live and do business
Reallocation from other Departments	• Reallocation does not require raising further funding from the public and could therefore be perceived as the Government remaining within its means • Reallocation from other Departments may drive efficiency and cut out waste in other areas of Government	• Reducing the funding of other Departments may lead to unintended negative consequences for the wider determinants of health, as there would then be less funding for related fields such as the environment and education • Reducing the funding of other Government Departments may worsen the quality of other Government services that are also important to the Isle of Man

E4.1. 'Future funding: Nursing & Residential Care' Review

Concurrently to this Independent Review of Health and Social Care, a separate review focused specifically on the future funding of long-term nursing and residential care for the elderly of the Isle of Man is taking place. This Review is led by the Minister for Policy and Reform and put forward a report in July 2018 to the Council of Ministers. That review is due to publish its full findings in the summer of 2019.

The Future Funding of Nursing and Residential Care Review will provide a detailed breakdown of the residential and nursing care provision for elderly people, the current means by which people pay for their care, a range of options for funding care in the future and a summary of the public engagement responses to these options. The teams for both reviews have liaised and have agreed to publish independently but with awareness of the findings from both teams. Hence this Review suggests referencing the forthcoming findings of the Future Funding review for detailed information

regarding the current state of social care funding and for related recommendations that could be used to address one aspect of the funding gap in combination with the funding options laid out elsewhere in this Report. For instance:

- If the Future Funding Review recommends additional provision for social care in the future, the funding gap projected in this Review would increase if these recommendations were followed and the funding options should be considered in light of the larger funding gap.
- If the Future Funding Review recommends a particular funding model for long term social care, such as social insurance, then it might become more desirable to roll out a similar funding option across the whole of health and care rather than running two funding systems.

E5. Financial impact of scenarios

The scenarios below set out the impact of using two funding options in conjunction to close a £50m, a £100m and a £150m funding gap under each scenario. The Review has modelled three scenarios, combining options that could be used together without creating practical contradictions. The 'Changes' bar in red below each forecast indicates the change made in that year to increase the amount of funding raised.

The Review has modelled the funding options to close a £50m, £100m and £150m funding gap as it is not within the Review's remit to recommend how much the Isle of Man should raise and whether elected representatives will decide to close the forecasted gap, leave some of the gap unfunded, or exceed the funding gap projection in order to provide further enhancements and improvements. This range covers from roughly 50% of the forecast funding gap (£109.4m) to 150% of the forecast gap.

There are many other ways to combine two or more of the funding options than the three scenarios set out in this report. These should be debated by the Isle of Man's elected representatives as it is beyond the Review's remit to recommend a combination of options as preferred, or to model every combination and variation possible.

E5.1. Scenario A: Changes to general taxation and charges

Figure 115: Closing a £50m gap with changes to general taxation and charges (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through general taxation (£m)	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	24.2	24.2	24.2	24.2	24.2	24.2
Additional raised through charges (£m)	25.2	0.0	0.0	0.0	0.0	0.0	33.7	22.4	22.8	23.2	23.5	23.9	24.2	24.6	25.0	25.3	25.6
New funding gap (£m)	-25.5	9.2	18.7	28.9	39.2	45.1	16.8	33.8	39.3	44.9	50.6	41.3	46.8	53.2	59.1	64.5	69.8
Changes	*1% on both rates of income tax allocated to health*						*£100 charges (£10 on meals)*					*Lower personal allowance by £1,500*					

Figure 116: Closing a £100m gap with changes to general taxation and charges (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Funding raised through general taxation (£m)	19.4	19.4	19.4	19.4	19.4	19.4	19.4	19.4	19.4	19.4	19.4	58.2	58.2	58.2	58.2	58.2	58.2
Additional raised through exemptions (£m)	0.0	0.0	0.0	0.0	0.0	0.0	13.1	13.2	13.3	13.4	13.6	13.7	13.8	14.0	14.1	14.2	14.4
Additional raised through charges (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	23.9	24.2	24.6	25.0	25.3	25.6
New funding gap (£m)	-10.0	-0.5	9.0	19.2	29.5	35.4	27.8	33.4	39.1	44.9	50.8	-6.4	-0.9	5.3	11.1	16.3	21.5
Changes	*2% on both rates of income tax allocated to health*						*Reduce exemptions on dental, opticians and prescription charges by 75%*					*Lower personal allowance by £2,500*					
												5% on both rates of income tax allocated to health					
												£100 charges (£10 on meals)					

Combining charges with changes to general taxation cannot close a gap larger than £100m in real terms in 2035/36 due to diminishing returns.

E5.2. Scenario B: changes to national insurance and hypothecated tax

Figure 117: Closing a £50m gap with changes to national insurance and hypothecated tax (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through national insurance (£m)	16.0	16.0	16.0	16.0	16.0	16.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0
Additional raised through hypothecated tax (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.8	19.9	19.9	20.0	20.0	20.1
New funding gap (£m)	-6.6	2.9	12.4	22.6	32.9	38.8	28.2	34.0	39.8	45.8	51.8	37.6	43.4	50.1	56.3	62.0	67.6
Changes	*1% national insurance rate increase on both employees and employers*						*2% national insurance rate increase on both employees and employers*					*1% hypothecated tax on all income for all earners*					

Figure 118: Closing a £100m gap with changes to national insurance and hypothecated tax (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through national insurance (£m)	16.0	16.0	16.0	16.0	16.0	16.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0	32.0
Additional raised through hypothecated tax (£m)	0.0	0.0	0.0	0.0	0.0	0.0	19.5	19.5	19.6	19.7	19.8	59.5	59.6	59.8	59.9	60.1	60.2
New funding gap (£m)	-6.6	2.9	12.4	22.6	32.9	38.8	8.8	14.4	20.2	26.1	32.1	-2.1	3.7	10.2	16.4	21.9	27.4
Changes	*1% national insurance rate increase on both employees and employers*						*2% national insurance rate increase on both employees and employers*					*3% hypothecated tax on all income for all earners*					
							1% hypothecated tax on all income for all earners										

Figure 119: Closing a £150m gap with changes to national insurance and hypothecated tax (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through national insurance (£m)	16.0	16.0	16.0	16.0	16.0	16.0	32.0	32.0	32.0	32.0	32.0	62.2	62.2	62.2	62.2	62.2	62.2
Additional raised through hypothecated tax (£m)	0.0	0.0	0.0	0.0	0.0	0.0	19.5	19.5	19.6	19.7	19.8	99.1	99.4	99.7	99.9	100.1	100.3
New funding gap (£m)	-6.6	2.9	12.4	22.6	32.9	38.8	8.8	14.4	20.2	26.1	32.1	-71.9	-66.2	-59.8	-53.7	-48.3	-42.8
Changes	*1% national insurance rate increase on both employees and employers*						*2% national insurance rate increase on both employees and employers*					*Increase national insurance rate increase rate above upper earnings level by 1%*					
							1% hypothecated tax on all income for all earners					*Change national insurance rate below lower threshold from 0% to 2%*					
												5% hypothecated tax on all income for all earners					
												5% national insurance rate increase on both employers and employees					

E5.3. Scenario C: social insurance and reallocation from other departments

Figure 120: Closing a £50m gap with social insurance and reallocation from other Departments (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through social insurance (£m)	0.0	0.0	0.0	0.0	0.0	0.0	21.9	21.9	22.0	22.1	22.1	31.5	31.4	31.4	31.3	31.2	31.2
Additional raised through reallocation (£m)	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6
New funding gap (£m)	-8.3	1.3	10.8	21.0	31.3	37.2	20.7	26.4	32.2	38.1	44.1	40.2	46.2	53.0	59.4	65.1	70.8
Changes	*3% reallocation*						*1% premia, 1% copayment*					*1% premia, 5% copayment*					

Figure 121: Closing a £100m gap with social insurance and reallocation from other Departments (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through social insurance (£m)	0.0	0.0	0.0	0.0	0.0	0.0	21.9	21.9	22.0	22.1	22.1	88.6	88.8	88.9	89.0	89.1	89.1
Additional raised through reallocation (£m)	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6
New funding gap (£m)	-8.3	1.3	10.8	21.0	31.3	37.2	20.7	26.4	32.2	38.1	44.1	-16.9	-11.1	-4.5	1.7	7.3	12.9
Changes	*3% reallocation*						*1% premia, 1% copayment*					*4% premia, 4% copayment*					

Figure 122: Closing a £150m gap with social insurance and reallocation from other Departments (staggered)

Total cost	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
Funding gap - 'Efficiencies' scenario (£m)	9.4	18.9	28.4	38.6	48.9	54.8	60.2	66.0	71.8	77.8	83.8	89.4	95.3	102.0	108.3	114.0	119.6
Additional raised through social insurance (£m)	0.0	0.0	0.0	0.0	0.0	0.0	21.9	21.9	22.0	22.1	22.1	126.2	126.4	126.6	126.7	126.9	127.0
Additional raised through reallocation (£m)	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	17.6	35.3	35.3	35.3	35.3	35.3	35.3
New funding gap (£m)	-8.3	1.3	10.8	21.0	31.3	37.2	20.7	26.4	32.2	38.1	44.1	-72.1	-66.4	-59.9	-53.7	-48.2	-42.6
Changes	*3% reallocation*						*1% premia, 1% copayment*					*5% premia for low and mid earners, 6% premia for high earners, 6% copayment for all earners*					
												6% reallocation					

E5.4 Case study: The Republic of Ireland's mixed funding model for healthcare[cxcvii]

General taxation…

Public healthcare in Ireland is primarily funded through taxation. People who qualify for a Medical Card (around 37% of the population) can use almost all public medical services for free. Qualification criteria for a Medical Card include: financial situation, certain conditions such as side effects from Thalidomide and childhood cancers, living in foster care and living in direct provision. Additionally around 9% of people are eligible for free GP visits through a GP Visit Card.

Combined with charges…

Most people pay subsidised charges (i.e. not the full cost of the care provided) for aspects of their healthcare treatment. Charges include €100 for an A&E visit if not referred by a doctor and €50 for an outpatient appointment.

Combined with private insurance.

Around 40% of the population opt to take out private health insurance due to long waiting times and fees. Ireland has the highest % in Europe of people who are privately insured. The average annual fee paid for private insurance is €1,925 per

E6. Other funding options suggested that were not modelled by the Review

These suggestions arose during meetings, public engagement and focus groups:

- Expanding means testing across Government benefits with an expansion of the existing MiCard system
- Lifestyle taxes, the proceeds of which are ring-fenced for health and care
- More generous tax deductions for people who choose to pay for private health insurance
- Placing a cap on social care costs but including the value of a person's home in assessing their eligibility for free social care
- Stronger controls on prescription fraud and measures to encourage the public to appreciate the value of their prescriptions and the cost to the DHSC
- Introduce a health and care security card to restrict use of services to registered residents only
- Review the payment system for travel off-Island care and limit Government expenditure to essentials only
- Outsource catering services
- Better management of repeat prescriptions
- Government-led compulsory private social care insurance
- Parking charges for visitors and staff
- People to pay for treatment for self-induced problems
- Means tested contribution to social care for over 65s
- Removing all charges from services to save on administration costs[cxcviii]

These funding options have not been modelled in detail by the Review for one of three reasons:

1. Would not raise significant funds
2. Would not be practical to consider for reasons such as the current tax situation and data availability – for example:

(i) A paucity of data to give a true picture of a person's financial status at any given moments means that universal means testing of all benefits is not feasible for the Isle of Man at this time

(ii) Lifestyle taxes on alcoholic drinks or foods containing high levels of fat could not be levied on the Isle of Man due to the customs sharing arrangement with the United Kingdom

3. Are included as an aspect of funding options currently being modelled

Once the recommendations from the Review are in place, however, it may be worth revisiting these suggestions and reviewing their efficacy and practical considerations in the future, such as once data availability improves.

F. Data

F1. Available versus expected datasets

The following summary breaks down the availability of health and care data on the Isle of Man, as determined by the Review team during the processing of reviewing services. The RAG (Red Amber Green) rating and attached notes in the detailed tables below (which break down data into 'Activity', 'Capacity', 'Quality' and 'Financial' data) have been completed based on information gathered during stakeholder interviews and the Review team's experiences of requesting and reviewing data. The benchmark for the RAG rating is data availability in the NHS in England, which is not to say that this standard is itself a gold standard. Even areas rated 'green' could therefore be improved substantially to provide a full picture of the Isle of Man's health and care system for management, evaluation and improvement purposes.

It has not been possible for the Review to speak with every stakeholder involved in information management to or fully assess the quality and availability of every dataset on the Isle of Man related to health and care. Additionally, the analysis below only represents a snapshot completed in early 2019 so the situation may well change by the time of the Report's presentation in spring 2019 and beyond. The Review therefore recommends that the summary below is considered to be a best estimate rather than a full and verified representation of the true state of data availability. It may well be that the availability summary contains inaccuracies of which the Review could not feasibly have been made aware. As a result, further investigation should be carried out in a coordinated way across health and social care, and across other relevant parts of Government, possibly under the auspices of the transformation programme, before any decisions around changes and improvement are made.

Figure 123: Summary of health and care data availability on the Isle of Man

Service	Demand data	Capacity data	Quality data	Financial data
Hospitals				
Primary care				
GPs				
Mental Health				
Adult social care				
Off Island care				
Children and families social care				
Public health				

Key for Figure 123:

Colour	Data availability status
	Very little of the data the Review expected to see was available; compares very poorly to other areas including NHS in England
	Some of the data the Review expected to see was available but there were still significant gaps in availability and/or quality; compares poorly to other areas including NHS in England
	Most of the data the Review expected to see was available with no significant gaps and few quality issues; similar to availability in other areas including NHS in England

Figure 124: Detailed breakdown of activity data expected by the Review compared to the data available[cxcix]

Area	Expected data	Available data	RAG
Hospitals	• Numbers of appointments • Numbers of admissions • Hospital activity coded by specialty	• Numbers of appointments • Numbers of admissions	
Primary care	• Caseload numbers • Referral numbers	• Caseload numbers 2017/18 • Referral numbers 2017/18	
GPs	• Numbers of referrals • Numbers of registered patients • Numbers of appointments broken down by practitioner type (breakdown by appointment type not expected)	• Numbers of referrals • Numbers of registered patients (exceeds Isle of Man population due to ghost patients) • GP and nurse appointments only available as snapshot, would ideally be recorded historically, no appointment data for other practitioners available	
Mental health	• Numbers of referrals • Numbers of appointments • Caseloads • Number of off-Island placements	• Numbers of referrals • Numbers of appointments • Caseloads • Number of off-Island placements	
Off-Island care	• Activities undertaken off-Island last year, coded by specialty and attached to individual stays	• Activities undertaken off-Island last year, not coded by specialty or attached to individual stays	
Adult social care	• Caseload numbers • Referral numbers • Number of people in care homes • Visit/meeting numbers	• Caseload numbers • Referral numbers • Number of people in care homes	
Children and families social care	• Numbers of referrals • Numbers of looked after children • Visit/meeting numbers • Caseload numbers	• Numbers of referrals • Numbers of looked after children • Caseload numbers	

Figure 125: Detailed breakdown of capacity data expected by the Review compared to the data available

Area	Expected data	Available data[cc]	RAG
Hospitals	• WTE data • Vacancy data • Waiting times • Occupancy rates • Agency numbers and rates	• WTE data • Vacancy data (inaccurate) • Waiting times • Occupancy rates • Agency numbers and rates	
Primary care	• WTE data • Vacancy data • Agency numbers and rates	• WTE data • Vacancy data	
GPs	• WTE data • Numbers of sessions • Agency numbers and rates	• WTE data • Numbers of sessions	
Mental health	• WTE data • Vacancy data • Waiting times • Occupancy rates • Agency numbers and rates	• WTE data (inaccurate) • Vacancy data (inaccurate) • Occupancy rates	
Off-Island care	• N/A	• N/A	
Adult social care	• WTE data • Vacancy data • Waiting times • Occupancy rates • Agency numbers and rates • Caseload limits/targets	• WTE data (inaccurate) • Vacancy data (inaccurate) • Occupancy rates	
Children and families social care	• WTE data • Vacancy data • Waiting times • Agency numbers and rates • Caseload limits/targets	• WTE data (inaccurate) • Vacancy data (inaccurate)	
Public health	• WTE data • Vacancy data	• WTE data (inaccurate) • Vacancy data (inaccurate)	

Figure 126: Detailed breakdown of quality data expected by the Review compared to the data available

Area	Expected data	Available data	RAG
Hospitals	• Targets at overall hospital level • Targets at specialty level • Performance against targets • Patient satisfaction measures	• Some targets available (e.g. cancer waiting times) but not for all specialties • Performance against the targets available • Patient satisfaction measures	
Primary care	• Targets for service performance • Performance against targets • Patient satisfaction measures	• A couple of targets for community health services wait times and performance in a couple of periods	
GPs	• Targets for service performance • Performance against targets • Patient satisfaction measures	• No data received.	
Mental health	• Targets for service performance • Performance against targets • Patient satisfaction measures	• Numbers of people with risk management plans, numbers of people admitted to inpatient care – only a small number of the data points collected have targets associated with them, however	
Off-Island care	• Targets for service performance • Performance against targets • Patient satisfaction measures	• No data received.	
Adult social care	• Targets for service performance • Performance against targets • Patient satisfaction measures	• Targets for service performance • Performance against targets • Patient satisfaction measures • Comparison benchmarked against England	
Children and families social care	• Targets for service performance • Performance against targets • Patient satisfaction measures	• Targets for service performance • Performance against targets • Patient satisfaction measures • Outcome measures	
Public health[cci]	• Targets for service performance • Performance against targets • Full needs assessment of population	• Targets for service performance • Performance against targets	

Figure 127: Detailed breakdown of financial data expected by the Review compared to the data available

Area	Expected data	Available data	RAG
Hospitals	• Overall budget • Payscales • Agency spend • Payroll information for all staff	• Overall budget • Payscales • Agency spend • Consultant pay	
Primary care	• Overall budget • Payscales • Agency spend • Payroll information for all staff	• Overall budget • Payscales	
GPs	• Overall budget • Agency spend • Payroll information for all staff	• Overall budget • Payments per patient	
Mental health	• Overall budget • Payscales • Agency spend • Payroll information for all staff	• Overall budget • Payscales	
Off-Island care	• Overall budget • Spend by activity • Spend by provider • Spend by specialty	• Overall budget • Spend by provider	
Adult social care	• Overall budget • Payscales • Agency spend • Payroll information for all staff	• Overall budget • Payscales	
Children and families social care	• Overall budget • Payscales • Agency spend • Payroll information for all staff	• Overall budget • Payscales	
Public health	• Overall budget • Payscales • Agency spend • Payroll information for all staff	• Overall budget • Payscales	
System-level	• Overall budget over time • Expenditure from other Government Departments on health and care • Breakdown of costs for transport, pharmaceuticals and consumables • Cost of delivering specific procedures and treatments	• Overall budget over time • Expenditure from other Government Departments on health and care (some are estimates) • High level spend on transport and detailed breakdown of pharmaceuticals • Partial set of costs to deliver specific procedures and treatments[ccii]	

F2. Data gathering and reporting processes

F2.1. Positive progress made to date

From the discussions with stakeholders, and review of data and documents, the Review has identified that real progress has been made in a number of areas regarding data gathering and reporting processes:

- Mental health: Minimum Data Set created, including measures such as number of patients with a risk management plan and numbers of mental health patients who are admitted as emergency inpatients, where no data existed a couple of years ago. Processes set up to review division's spend, which have contributed to an improvement in financial position from a significant overspend to break even within two-three years.

- GPs: GPs use the EMIS data system, which is useful at the broader level to show what condition prevalences exist for a population, and some public health information such as those who have had vaccinations. However the Review understands this is not being used to provide more specific risk stratification of patient population to help with population health management
- Children and families social services: In 2014, this Directorate had no information systems. There is now a variety of processes including personalized data entry (target for assessments to be completed within 45 days), and budgetary controls (e.g. nothing can be spent if there is no budget line to put spend against). These have contributed to an improvement in financial position from a spend of approx. £20m a year in 2014/15 to approx. £16m in 2017/18. Payroll information for all staff, agency spend, accurate WTE and vacancy data and visit/meeting numbers are not yet available, however.
- Community: Until November 2018, there was a paper incident reporting system, with any 'red' incidents reported to senior leadership with a root cause analysis done. A new, electronic incident reporting system (Datex) has now been implemented in November.
- Public Health: Development of Public Health outcomes data, which did not exist three-four years ago. This has enabled analysis of public health of the Isle of Man, and comparators to be made with other areas.
- Finance: Two-three years ago, the DHSC had limited management information, and it was mainly paper based (with the exception of year-end). This is now much better, with management accounts issued to each division each month, and financial scrutiny meeting with division directors each month
- Off-Island acute: Until 12 months ago, there was no activity tracking at all of off-Island acute activity. In the last 12 months, the DHSC has worked with the Midlands and Lancashire Commissioning Support Unit to get access to SLAM and SUS data for Isle of Man patients. This is now starting to come through (although data is still incomplete)
- Patient records: digitisation of patient records has been implemented: millions of historic paper records have been scanned and digitised. Going forward all notes will be electronic and will be entered directly into a digital health record with appropriate patient information being made available to clinicians via a digital whiteboard on each ward.
- Acute: automated hospital activity dashboard has been developed within the last year, which has reduced need for some manual data reporting (although some of the metrics need targets)
- Acute: waiting time data is collected in a 'Patient Administration System' which allocates appointment based on the severity of a referral, whether it be routine, urgent, or two-week-wait.

F2.2. Key issues

Notwithstanding these successes, there are a number of things which still need to be improved:

- Community: limited data collected around outcomes
- Finance: there is no internal cost charging, or internal cost recharging. Without tariffs for certain procedures, there is limited understanding about what the drivers of costs are.
- Budgets are set on previous year's spend uplifted for additional funding requests, so there is no clear link to what the funding is delivering in terms of outcomes, or even in terms of activity
- Off-Island acute: a number of the off-Island providers are still coding activity to incorrect codes, meaning the data provided is incomplete
- Off-Island acute: no proper process for tracking and approving expenses reimbursement for travel
- Acute: quality of clinical coding is particularly poor. There are a large number of episodes which are not coded, and many episodes where the coding is inaccurate. A contributing

issue is that clinical coders are not fully qualified. Lack of quality means it is difficult to draw meaningful conclusions about activity and cost at a procedure level. Work to improve coding is underway but it has yet to contribute to patient level costing by making it possible to compare patient level costing with Healthcare Reference Group codes i.e. costs per procedure used in England.

- Acute: further investigation is required into how to deal with demand versus capacity (for example with utilisation of clinic space)
- Transferring between care settings: Different information systems used by different care settings can lead to inefficiencies. To take an example: GPs use EMIS so when they refer to hospital they have to send a manual email to the Patient Information Centre, and then when hospital refers back to GP, they send a referral letter back.
- Business intelligence: BI and information governance is currently done in silos, hindering openness and transparency. Perhaps with a single BI team the DHSC could use information more strategically and holistically
- A number of usual data collecting processes are missing which lead to significant variation in the quality of data collection across the health and care system (see Appendix F1 for an indication of the data missing that the Review would expect to see collected)
- The positive examples identified (e.g. the go-live of the digitisation of patient records) do not appear not to be part of a strategic approach to the collection and analysis of critical data but are localised initiatives to improve specific aspects.
- Since payments are not linked to outcomes or activity on the Island, there are limited consequences to providers of failure to collect and report basic quality, operational and financial data. For example, there are limited incentives for hospital staff to code clinical activity correctly.
- What is delivered, how well and with what result is not measured consistently or comprehensively. The resultant lack of clarity may be hiding excellent service and outcomes that offer superb value. Alternately it may mask poor service and outcomes along with inappropriate costs. Additionally, lack of data prevents like for like comparisons on cost in the NHS in England and elsewhere.

F2.3. Recommendations for improving data availability

Additional data the Review would recommend for future collection in the Isle of Man therefore includes:

- Hospital activity by speciality, fully coded so that activity could be matched to the condition the patient was treated for and to a cost for that type of care
- Off-Island activity by specialty, fully coded so that activity could be matched to the condition the patient was treated for and to a cost for that type of care
- Accurate WTE data across all teams at system level (the Oracle system covers all health and care teams but overestimates vacancies; however, it is noted that this is in the process of being replaced by a new electronic HR and Payroll system for the whole of Isle of Man Government (People Information Programme (PIP))[cciii]
- Key performance targets set up for all services covering activities completed, patient/service user satisfaction scores and outcomes for patients/service users
- Performance measured against targets mentioned above
- Numbers of appointments completed by GPs recorded centrally and consistently rather than through manual and ad-hoc data gathering exercises
- A consistent picture of WTE of agency staff employed across all health and care teams, ideally drawn from a system rather than reported ad hoc from teams
- A consistent picture of the costs of agency staff employed across all health and care teams, ideally drawn from a system rather than reported ad hoc from teams

- The population health measures that are well recorded in the 2016/17 PH report and 2013/14 JSNA would ideally also be available historically and in full for the last ten years
- Ready access through one system to complete payroll information for all staff employed by the DHSC (including expenses, pensions, NI, and salary)
- Records of the quality of care received off-Island, both through surveys of patient satisfaction and measurement of outcomes
- A focused data set or sets on conditions or areas of social care concern that are deemed to be of particular interest to the Island (e.g. NHS Digital in England collects a key data set on Neonatal critical care)

F2.4. Recommendations for improving data usage and management

Without further significant changes and a strategic approach to improvement of the quality and quantity of data gathered, it will continue to be difficult to make evidence-based assessments around the productivity, quality, and effectiveness of the quality of health and care provided on the Isle of Man. Data capture, validation and review should become a systematic, standard and essential building block of the modern health system in the Isle of Man. Its continued absence should not be tolerated further.

Improvements the Review has heard recommended from stakeholders for data usage and management in the Isle of Man therefore include:

- Reducing siloes between information systems
- Changing the culture around data management to encourage openness and data sharing and create an expectation of accountability for both clinicians and managers in the health and care system
- Establishing a single BI team across all directorates, which would encourage overview data analysis and insight
- Measuring DHSC social care provision by the same 'yard stick' as third sector and private social care providers, for whom KPIs are closely monitored and pay is tied to delivery against contracts
- Supporting the existing Regulation and Inspection Unit to better carry their function of supporting and advising
- Produce more management level data reporting to inform decisions
- Give patients access to their hospital records
- Implement follow-up surveys after patient consultations
- Develop detailed budget management accounts for all areas of DHSC, following the structure of the management accounts currently created for Noble's Hospital
- Improve data coding practices to match quality expected in the UK, either through automating more of the processes or through expanding and training up the coding team
- Include outpatients data in coding
- Pursue ongoing work to develop the integrated care record to support system integration
- Data sharing between off-Island providers and care providers in the Isle of Man should be improved and become part of a contracting expectation
- Develop patient level costing to the point where costs can be compared to Healthcare Reference Group costs in England and 'best case' costs can be compared to 'worst case' costs for the same procedure within the Isle of Man over time to inform programmes to improve consistency of care
- Improve the consistency of data recorded in surgical theatres to minimise data gaps and improve quality of records
- Report on data collected in all services –data should not be collected unless it is made available in reporting and used to drive behaviour

Annex 13: Digital Initiatives – Digital Strategy and Other Potentials

A number of initiatives under the banner "Digital Future" were announced by the Isle of Man Government in August 2016[cciv]. These were the following:

- **Scanning and Digitisation of Medical and Maternity Records** – making it faster, easier and more reliable for front-line medical staff to access patient records and has resulting in a considerable reduction in manual filing, tracking, searching and retrieving records.
- **Clinical Assessment and Noting** - a full range of digital templates, designed in conjunction with professional users, helping to reduce substantially the number of new paper records created every day.
- **Order Communications System** - the digital streamlining of test requests and result reporting increasing speed, efficiency and quality.
- **Electronic Prescribing and Medicines Administration** - an automated digital prescribing system, with a focus on driving down prescription wastage and medicine costs
- **E-Discharge** - using digital technology to ensure that a patient's stay in hospital is not unnecessarily extended.

Good progress has been made in the implementation of most of these solutions which are without question essential building blocks in the creation of integrated digital services across Health and Social Care and demonstrate progress along the maturity curve for digitisation. Work should continue to implement, enhance and embed these solutions to ensure that they make the greatest possible contribution to the system delivering to its objectives and to position for further improvements in service user experience, outcomes, quality and, not least, efficiency.

Telemedicine

Telemedicine is defined as "*The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities*."[ccv]

Because the Island's local Health and Social Care system is constrained by geography and by the size of the population telemedicine should be a fundamental element "designed in" to care pathways to ensure that care provided potentially across several settings or locations is seamless, coordinated and optimised to provide the most positive experience possible to the Island's population. This may apply to care provided remotely on Island (for example to reduce the need to travel for in-person diagnosis or treatment) or by off Island providers where necessary (for example for specialist support).

A year long study was undertaken in 2017 by DHSC and GTS, by a specialist funded by the Henry Bloom Noble Healthcare Trust looking at the potential for telemedicine on the Island. This review examined a number of potential telemedicine-related initiatives. These are set out in the table below together with a summary of current status as at March 2019.

	Potential Use of Telemedicine	Status
1	Out of hours Thrombolysis and Tele-stroke	Implemented
2	Tele-Dermatology	Following an options analysis, a face-to-face local service was implemented instead
3	Tele-Radiology	Implementation in progress
4	Digital Care Hub (Immedicare)	Piloted but not taken forward to implementation as not considered sufficiently beneficial currently
5	Tele-swallowing	Low demand (and therefore benefits) and dependent on the Digital Care Hub so not taken forward to implementation
6	Paediatric Neurology Tele-clinic	Implemented
7	Teleconsultations	This has a clear dependency on having a provider who is willing and able to participate and any necessary contractual rights and obligations being in place. Work on implementing Teleconsultations has recently commenced with Clatterbridge as the provider of specialist cancer care (off Island)
8	Digital Solutions in Mental Health Services	Manx e-Clinic to be implemented imminently
9	Tele-Pathology and Telemonitoring for long-term conditions	Activity in progress to secure funding

Potential Future Digital Initiatives

As part of this review the Review Team was asked to identify options to increase the use of digital technology to benefit the Island's health and social care system. The following potential initiatives were identified and were judged to be most worthy of further consideration.

a) Manx Care Record

A single overarching system that provides appropriate staff from all parts of health and care access to a key data from each relevant system used in the delivery of care. Better care relies on the sharing of relevant data, fast access to it, and confidence in the information provided.

Further information regarding the Manx Care Record is provided in the main body of the Report.

b) Data Warehouse and Reporting

A data warehouse would provide a holistic repository of data obtained from across the health and care system to enable in-depth analysis and reporting of achievement and trends for example relating to activity, quality, outcomes, costs and resources. Utilising this data to make build knowledge and inform decisions will help the integration of services, the prioritisation of change and underpin measurement as the basis of service improvement.

A data warehouse would provide a single source of trusted reporting data which could be utilised and queried by DHSC, Treasury, Manx Care and potentially regulators to create a shared view of service provision.

c) Integrated Access for Community-based services

Increased focus on the provision of health and care services in the community is core to the Island's vision as it will provide enhanced convenience for the service user, reduce delays and improve efficiency.

Using digital solutions hosted by mobile devices to make information and systems accessible from the field could enable community-based practitioners to undertake tasks such as seeking specialist support, making appointments for diagnoses or treatment and accessing and updating notes in real-time much more easily and quickly than current methods.

This would enable the practitioner to deliver a better service with more personal contact, less time completing administration and other follow-up tasks and would improve both their job satisfaction and the service user's experience.

d) Self-Triage

Self-triage is the provision of a gateway or "front door" to enable services users to determine the most appropriate route that they should follow to seek assistance for a range of potential concerns including mental and physical health, preventative steps and social care. The front door could be a website, a phone line, an app on a mobile device or some combination and could involve various degrees of sophistication such as diagnosis tools (perhaps supported by artificial intelligence) or the ability to contact a knowledgeable operator.

By directing the service user to the appropriate treatment quickly self-triage will improve the service user's experience and convenience. In addition it will avoid unnecessary demand on services such as A&E and GP surgeries by helping the service user to identify best source of care e.g. community nurse, pharmacist, ophthalmologist, third sector.

e) Chronic Disease Management Apps and Devices

Use of mobile device apps and measurement devices can enable service users suffering from diagnosed chronic conditions such as diabetes, hypertension, respiratory disease to actively manage those conditions.

This benefits the service user by helping them to maintain the best possible ongoing health on a day-to-day basis helping them to live a more satisfying and potentially longer life and reducing the risk of a condition worsening or the likelihood of associated complications occurring. It may also help to instil a sense of control over the condition in the service user.

It benefits the system by reducing the load on treatment services and the need for acute interventions. It can also provide useful additional information (such as a log of blood pressure readings between practitioner visits).

f) Performance Management Systems

A performance management system will enable regular reporting against key performance indicators such as re-admission rates, length of stay, mortality rates, resource usage and staffing levels. It will provide a regular and reliable system for the collection, analysis and reporting of data for assessment of the current state and the trend over time. This analysis will inform continuous improvement, the recognition of best practice and the prioritisation of change across the health and care system.

The performance management system will encompass measures of clinical performance and service efficiency and will enable performance to be assessed and benchmarked against other systems. It will also help to ensure that services as delivered align to the overall vision.

For the Island a performance management system could *additionally* be used to assess the strengths and weaknesses in the delivery of care on and off the Island by objectively measuring key attributes of care provided on and off the Island and determining if that is aligned to the agreed care pathways and defined services and thereby optimising the care provided.

The performance management system could be implemented as an application layer utilising the Data Warehouse described at (b) above.

g) Public Health Apps

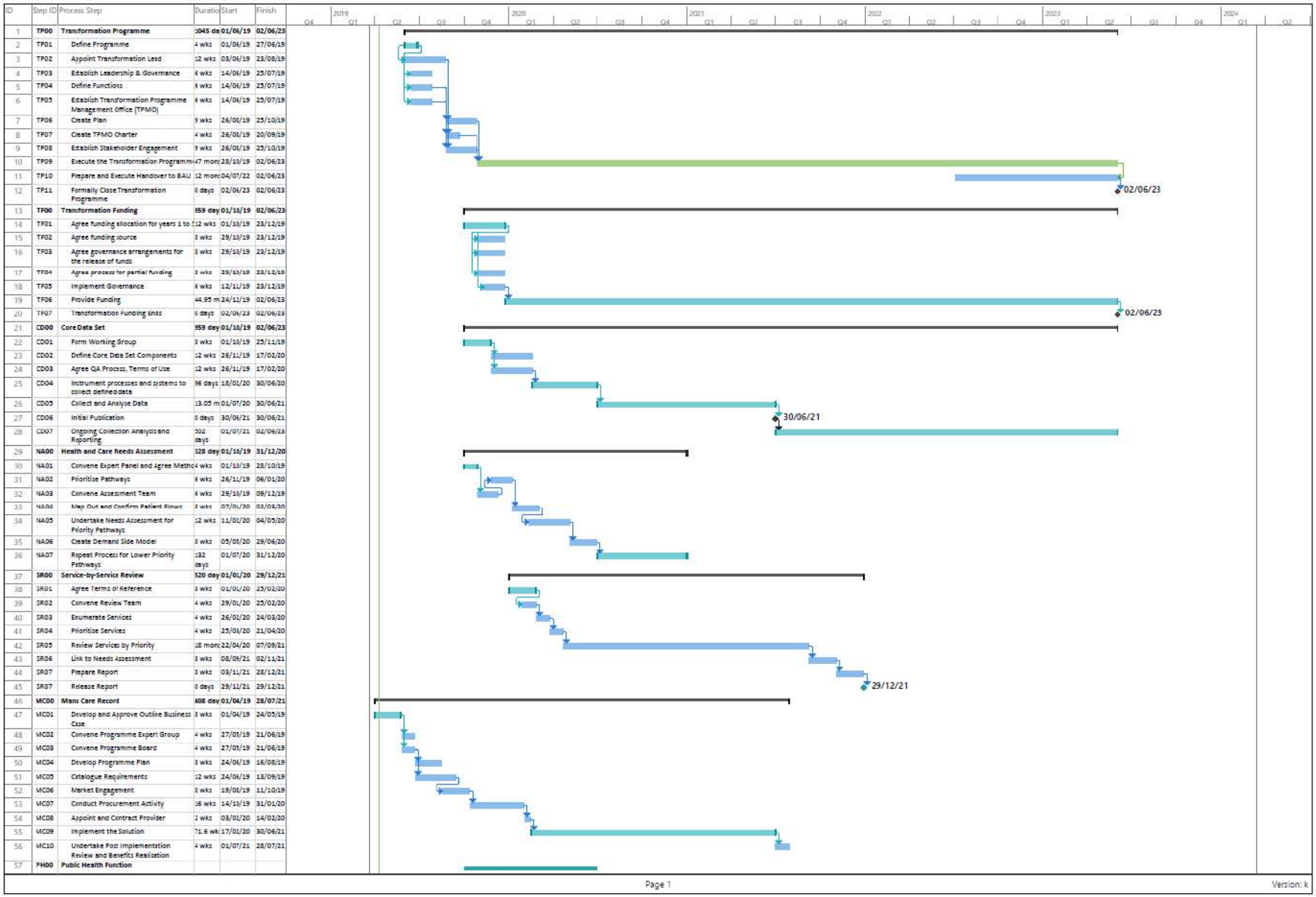
Although "*prevention is better than cure*" is not a new concept it remains a useful reference point. Today there is a proliferation of mobile device apps that enable or encourage people to improve their health by either doing more of activities that are beneficial such as exercise, sleep or addressing stress and minimising those that are negative such as poor diet choices, alcohol or smoking.

Clearly if the use of such apps were successful in increasing the beneficial and decreasing the negative this would improve service user's quality of life and reduce their reliance on health and care services. Of course, more work would be necessary to determine what types of apps might be sufficiently effective to justify their promotion or provision to the people of the Island.

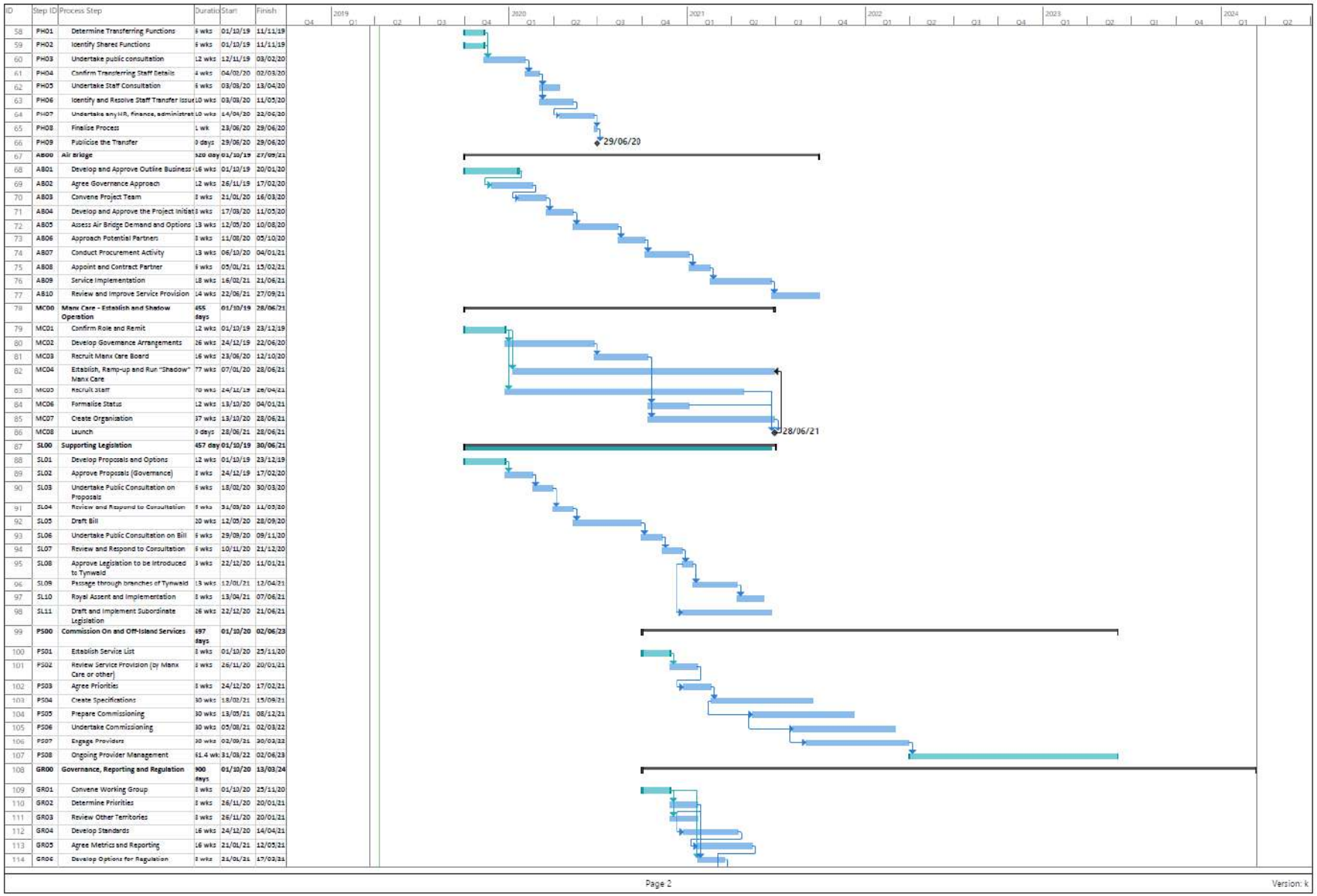
Any of the options above to be taken forward should be subject to programme and project management best practice such as clear governance, approved business case (cost and benefit identification with cost controls and realisation monitoring), stakeholder identification and implementation approach.

Annex 14: Transformation and Implementation

Section 1: Outline of Key Activities Project Plan



ID	Step ID	Process Step	Duration	Start	Finish
1	**TP00**	**Transformation Programme**	**1045 da**	**01/06/19**	**02/06/23**
2	TP01	Define Programme	4 wks	01/06/19	27/06/19
3	TP02	Appoint Transformation Lead	12 wks	03/06/19	23/08/19
4	TP03	Establish Leadership & Governance	6 wks	14/06/19	25/07/19
5	TP04	Define Functions	6 wks	14/06/19	25/07/19
6	TP05	Establish Transformation Programme Management Office (TPMO)	6 wks	14/06/19	25/07/19
7	TP06	Create Plan	5 wks	26/08/19	25/10/19
8	TP07	Create TPMO Charter	4 wks	26/08/19	20/09/19
9	TP08	Establish Stakeholder Engagement	9 wks	26/08/19	25/10/19
10	TP09	Execute the Transformation Programm	47 mon	28/10/19	02/06/23
11	TP10	Prepare and Execute Handover to BAU	12 mon	04/07/22	02/06/23
12	TP11	Formally Close Transformation Programme	0 days	02/06/23	02/06/23
13	**TF00**	**Transformation Funding**	**959 day**	**01/10/19**	**02/06/23**
14	TF01	Agree funding allocation for years 1 to 5	12 wks	01/10/19	23/12/19
15	TF02	Agree funding source	8 wks	29/10/19	23/12/19
16	TF03	Agree governance arrangements for the release of funds	8 wks	29/10/19	23/12/19
17	TF04	Agree process for partial funding	8 wks	29/10/19	23/12/19
18	TF05	Implement Governance	6 wks	12/11/19	23/12/19
19	TF06	Provide Funding	44.95 m	24/12/19	02/06/23
20	TF07	Transformation Funding Ends	0 days	02/06/23	02/06/23
21	**CD00**	**Core Data Set**	**959 day**	**01/10/19**	**02/06/23**
22	CD01	Form Working Group	8 wks	01/10/19	25/11/19
23	CD02	Define Core Data Set Components	12 wks	26/11/19	17/02/20
24	CD03	Agree QA Process, Terms of Use	12 wks	26/11/19	17/02/20
25	CD04	Instrument processes and systems to collect defined data	96 days	18/02/20	30/06/20
26	CD05	Collect and Analyse Data	13.05 m	01/07/20	30/06/21
27	CD06	Initial Publication	0 days	30/06/21	30/06/21
28	CD07	Ongoing Collection Analysis and Reporting	502 days	01/07/21	02/06/23
29	**NA00**	**Health and Care Needs Assessment**	**328 day**	**01/10/19**	**31/12/20**
30	NA01	Convene Expert Panel and Agree Metho	4 wks	01/10/19	28/10/19
31	NA02	Prioritise Pathways	6 wks	26/11/19	06/01/20
32	NA03	Convene Assessment Team	6 wks	29/10/19	09/12/19
33	NA04	Map Out and Confirm Patient Flows	8 wks	07/01/20	02/03/20
34	NA05	Undertake Needs Assessment for Priority Pathways	12 wks	11/02/20	04/05/20
35	NA06	Create Demand Side Model	8 wks	05/05/20	29/06/20
36	NA07	Repeat Process for Lower Priority Pathways	132 days	01/07/20	31/12/20
37	**SR00**	**Service-by-Service Review**	**520 day**	**01/01/20**	**29/12/21**
38	SR01	Agree Terms of Reference	8 wks	01/01/20	25/02/20
39	SR02	Convene Review Team	4 wks	29/01/20	25/02/20
40	SR03	Enumerate Services	4 wks	26/02/20	24/03/20
41	SR04	Prioritise Services	4 wks	25/03/20	21/04/20
42	SR05	Review Services by Priority	18 mon	22/04/20	07/09/21
43	SR06	Link to Needs Assessment	8 wks	08/09/21	02/11/21
44	SR07	Prepare Report	8 wks	03/11/21	28/12/21
45	SR07	Release Report	0 days	29/12/21	29/12/21
46	**MC00**	**Mans Care Record**	**608 day**	**01/04/19**	**28/07/21**
47	MC01	Develop and Approve Outline Business Case	8 wks	01/04/19	24/05/19
48	MC02	Convene Programme Expert Group	4 wks	27/05/19	21/06/19
49	MC03	Convene Programme Board	4 wks	27/05/19	21/06/19
50	MC04	Develop Programme Plan	8 wks	24/06/19	16/08/19
51	MC05	Catalogue Requirements	12 wks	24/06/19	13/09/19
52	MC06	Market Engagement	8 wks	19/08/19	11/10/19
53	MC07	Conduct Procurement Activity	16 wks	14/10/19	31/01/20
54	MC08	Appoint and Contract Provider	2 wks	03/02/20	14/02/20
55	MC09	Implement the Solution	71.6 wk	17/02/20	30/06/21
56	MC10	Undertake Post Implementation Review and Benefits Realisation	4 wks	01/07/21	28/07/21
57	**PH00**	**Public Health Function**			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2024
58 PH01 Determine Transferring Functions 6 wks 01/10/19 11/11/19
59 PH02 Icentify Shared Functions 6 wks 01/10/19 11/11/19
60 PH03 Undertake public consultation 12 wks 12/11/19 03/02/20
61 PH04 Confirm Transferring Staff Details 4 wks 04/02/20 02/03/20
62 PH05 Undertake Staff Consultation 6 wks 03/03/20 13/04/20
63 PH06 Identify and Resolve Staff Transfer Issue 10 wks 03/03/20 11/05/20
64 PH07 Undertake any HR, finance, administrat 10 wks 14/04/20 22/06/20
65 PH08 Finalise Process 1 wk 23/06/20 29/06/20
66 PH09 Publicise the Transfer 0 days 29/06/20 29/06/20
29/06/20
67 AB00 Air Bridge 320 day 01/10/19 27/09/21
68 AB01 Develop and Approve Outline Business 16 wks 01/10/19 20/01/20
69 AB02 Agree Governence Approach 12 wks 26/11/19 17/02/20
70 AB03 Convene Project Team 8 wks 21/01/20 16/03/20
71 AB04 Develop and Approve the Project Initiat 8 wks 17/03/20 11/05/20
72 AB05 Assess Air Bridge Demand and Options 13 wks 12/05/20 10/08/20
73 AB06 Approach Potential Partners 8 wks 11/08/20 05/10/20
74 AB07 Conduct Procurement Activity 13 wks 06/10/20 04/01/21
75 AB08 Appoint and Contract Partner 6 wks 05/01/21 15/02/21
76 AB09 Service Implementation 18 wks 16/02/21 21/06/21
77 AB10 Review and Improve Service Provision 14 wks 22/06/21 27/09/21
78 MC00 Manx Care - Establish and Shadow Operation 455 days 01/10/19 28/06/21
79 MC01 Confirm Role and Remit 12 wks 01/10/19 23/12/19
80 MC02 Develop Governance Arrangements 26 wks 24/12/19 22/06/20
81 MC03 Recruit Manx Care Board 16 wks 23/06/20 12/10/20
82 MC04 Establish, Ramp-up and Run "Shadow" Manx Care 77 wks 07/01/20 28/06/21
83 MC05 Recruit Staff 78 wks 24/12/19 28/04/21
84 MC06 Formalise Status 12 wks 13/10/20 04/01/21
85 MC07 Create Organisation 37 wks 13/10/20 28/06/21
86 MC08 Launch 0 days 28/06/21 28/06/21
28/06/21
87 SL00 Supporting Legislation 457 day 01/10/19 30/06/21
88 SL01 Develop Proposals and Options 12 wks 01/10/19 23/12/19
89 SL02 Approve Proposals (Governance) 8 wks 24/12/19 17/02/20
90 SL03 Undertake Public Consultation on Proposals 6 wks 18/02/20 30/03/20
91 SL04 Review and Respond to Consultation 6 wks 31/03/20 11/05/20
92 SL05 Draft Bill 20 wks 12/05/20 28/09/20
93 SL06 Undertake Public Consultation on Bill 6 wks 29/09/20 09/11/20
94 SL07 Review and Respond to Consultation 6 wks 10/11/20 21/12/20
95 SL08 Approve Legislation to be Introduced to Tynwald 3 wks 22/12/20 11/01/21
96 SL09 Passage through branches of Tynwald 13 wks 12/01/21 12/04/21
97 SL10 Royal Assent and Implementation 8 wks 13/04/21 07/06/21
98 SL11 Draft and Implement Subordinate Legislation 26 wks 22/12/20 21/06/21
99 PS00 Commission On and Off-Island Services 697 days 01/10/20 02/06/23
100 PS01 Establish Service List 8 wks 01/10/20 25/11/20
101 PS02 Review Service Provision (by Manx Care or other) 8 wks 26/11/20 20/01/21
102 PS03 Agree Priorities 8 wks 24/12/20 17/02/21
103 PS04 Create Specifications 30 wks 18/02/21 15/09/21
104 PS05 Prepare Commissioning 30 wks 13/05/21 08/12/21
105 PS06 Undertake Commissioning 30 wks 05/08/21 02/03/22
106 PS07 Engage Providers 30 wks 02/09/21 30/03/22
107 PS08 Ongoing Provider Management 61.4 wk 31/03/22 02/06/23
108 GR00 Governance, Reporting and Regulation 900 days 01/10/20 13/03/24
109 GR01 Convene Working Group 8 wks 01/10/20 25/11/20
110 GR02 Determine Priorities 8 wks 26/11/20 20/01/21
111 GR03 Review Other Territories 8 wks 26/11/20 20/01/21
112 GR04 Develop Standards 16 wks 24/12/20 14/04/21
113 GR05 Agree Metrics and Reporting 16 wks 21/01/21 12/05/21
114 GR06 Develop Options for Regulation 8 wks 21/01/21 17/02/21
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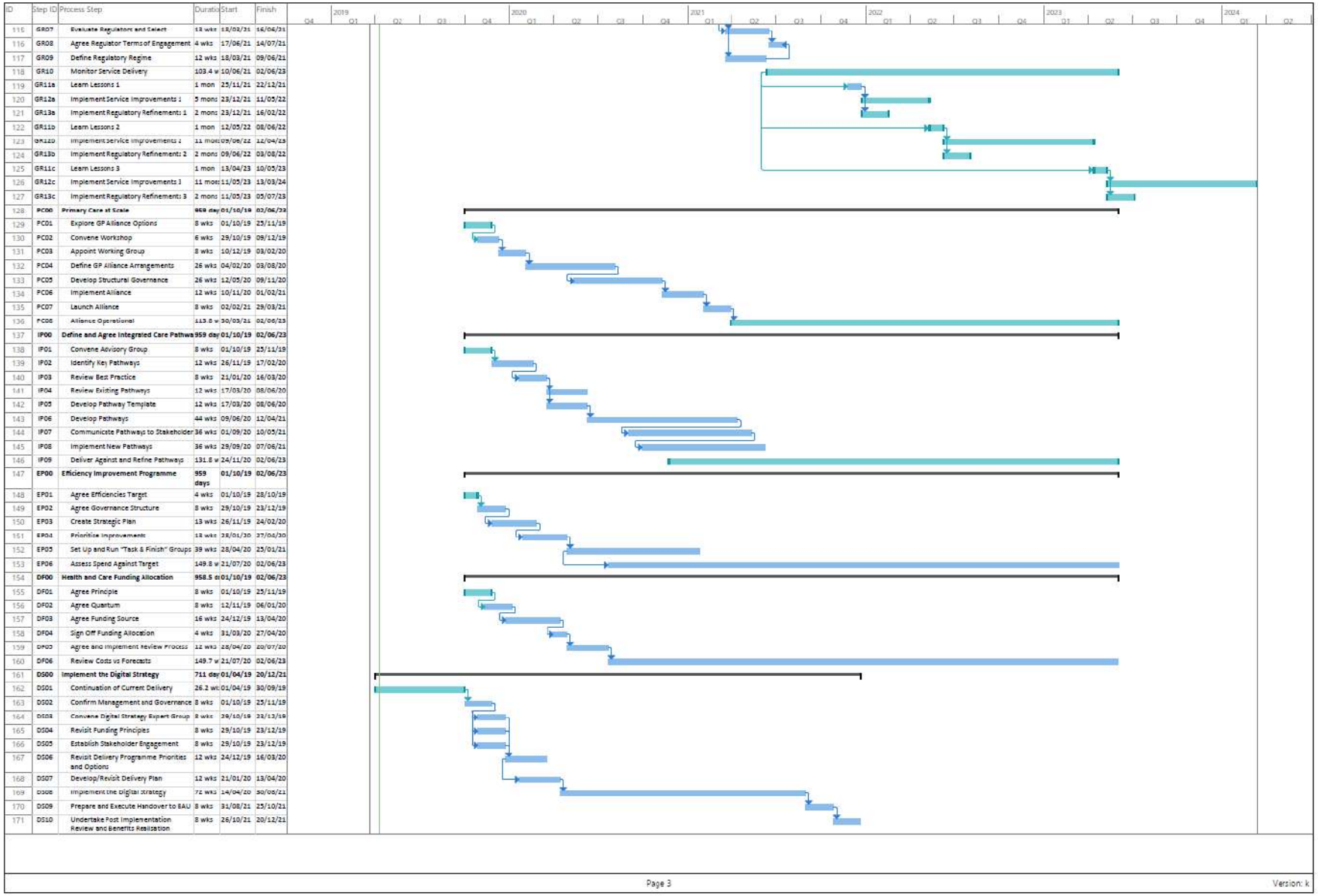

ID	Step ID	Process Step	Duration	Start	Finish
116	GR07	Evaluate Regulators and Select	12 wks	12/02/21	16/06/21
116	GR08	Agree Regulator Terms of Engagement	4 wks	17/06/21	14/07/21
117	GR09	Define Regulatory Regime	12 wks	18/03/21	09/06/21
118	GR10	Monitor Service Delivery	103.4 w	10/06/21	02/06/23
119	GR11a	Learn Lessons 1	1 mon	25/11/21	22/12/21
120	GR12a	Implement Service Improvements 1	5 mons	23/12/21	11/05/22
121	GR13a	Implement Regulatory Refinements 1	2 mons	23/12/21	16/02/22
122	GR11b	Learn Lessons 2	1 mon	12/05/22	08/06/22
123	GR12b	Implement Service Improvements 2	11 mons	09/06/22	12/04/23
124	GR13b	Implement Regulatory Refinements 2	2 mons	09/06/22	03/08/22
125	GR11c	Learn Lessons 3	1 mon	13/04/23	10/05/23
126	GR12c	Implement Service Improvements 3	11 mons	11/05/23	13/03/24
127	GR13c	Implement Regulatory Refinements 3	2 mons	11/05/23	05/07/23
128	**PC00**	**Primary Care at Scale**	**959 day**	**01/10/19**	**02/06/23**
129	PC01	Explore GP Alliance Options	8 wks	01/10/19	25/11/19
130	PC02	Convene Workshop	6 wks	29/10/19	09/12/19
131	PC03	Appoint Working Group	8 wks	10/12/19	03/02/20
132	PC04	Define GP Alliance Arrangements	26 wks	04/02/20	03/08/20
133	PC05	Develop Structural Governance	26 wks	12/05/20	09/11/20
134	PC06	Implement Alliance	12 wks	10/11/20	01/02/21
135	PC07	Launch Alliance	8 wks	02/02/21	29/03/21
136	PC08	Alliance Operational	113.8 w	30/03/21	02/06/23
137	**IP00**	**Define and Agree Integrated Care Pathwa**	**959 day**	**01/10/19**	**02/06/23**
138	IP01	Convene Advisory Group	8 wks	01/10/19	25/11/19
139	IP02	Identify Key Pathways	12 wks	26/11/19	17/02/20
140	IP03	Review Best Practice	8 wks	21/01/20	16/03/20
141	IP04	Review Existing Pathways	12 wks	17/03/20	08/06/20
142	IP05	Develop Pathway Template	12 wks	17/03/20	08/06/20
143	IP06	Develop Pathways	44 wks	09/06/20	12/04/21
144	IP07	Communicate Pathways to Stakeholder	36 wks	01/09/20	10/05/21
145	IP08	Implement New Pathways	36 wks	29/09/20	07/06/21
146	IP09	Deliver Against and Refine Pathways	131.8 w	24/11/20	02/06/23
147	**EP00**	**Efficiency Improvement Programme**	**959 days**	**01/10/19**	**02/06/23**
148	EP01	Agree Efficiencies Target	4 wks	01/10/19	28/10/19
149	EP02	Agree Governance Structure	8 wks	29/10/19	23/12/19
150	EP03	Create Strategic Plan	13 wks	26/11/19	24/02/20
151	EP04	Prioritise Improvements	13 wks	28/01/20	27/04/20
152	EP05	Set Up and Run "Task & Finish" Groups	39 wks	28/04/20	25/01/21
153	EP06	Assess Spend Against Target	149.8 w	21/07/20	02/06/23
154	**DF00**	**Health and Care Funding Allocation**	**958.5 d**	**01/10/19**	**02/06/23**
155	DF01	Agree Principle	8 wks	01/10/19	25/11/19
156	DF02	Agree Quantum	8 wks	12/11/19	06/01/20
157	DF03	Agree Funding Source	16 wks	24/12/19	13/04/20
158	DF04	Sign Off Funding Allocation	4 wks	31/03/20	27/04/20
159	DF05	Agree and Implement Review Process	12 wks	28/04/20	20/07/20
160	DF06	Review Costs vs Forecasts	149.7 w	21/07/20	02/06/23
161	**DS00**	**Implement the Digital Strategy**	**711 day**	**01/04/19**	**20/12/21**
162	DS01	Continuation of Current Delivery	26.2 wk	01/04/19	30/09/19
163	DS02	Confirm Management and Governance	8 wks	01/10/19	25/11/19
164	DS03	Convene Digital Strategy Expert Group	8 wks	29/10/19	23/12/19
165	DS04	Revisit Funding Principles	8 wks	29/10/19	23/12/19
166	DS05	Establish Stakeholder Engagement	8 wks	29/10/19	23/12/19
167	DS06	Revisit Delivery Programme Priorities and Options	12 wks	24/12/19	16/03/20
168	DS07	Develop/Revisit Delivery Plan	12 wks	21/01/20	13/04/20
169	DS08	Implement the Digital Strategy	72 wks	14/04/20	30/08/21
170	DS09	Prepare and Execute Handover to BAU	8 wks	31/08/21	25/10/21
171	DS10	Undertake Post Implementation Review and Benefits Realisation	8 wks	26/10/21	20/12/21

Section 2: Outline process steps for the Implementation of the Recommendations

Activity 1: Transformation Programme

Activity Description:

Implementing the leadership and programme management infrastructure required to deliver the transformation process. The key steps in this process will be the appointment of the Transformation Lead, creation of the Transformation Board and the setting-up of the Transformation Programme Management Office (TPMO).

Activity Steps

Step Number	Step	Description	Notes
TP00	(ACT01) Transformation Programme		
TP01	Define Programme	Define the aims, strategic objectives and priorities of the transformation programme with input from stakeholders.	Clarity is required on the programme's objectives to ensure that it can deliver against its remit. Input from stakeholders will help to support greater integration.
TP02	Appoint Transformation Lead	Appoint a Transformation Lead.	Strong, visible leadership will be key to the delivery of the programme and its aims.
TP03	Establish Leadership & Governance	Establish the Transformation Board in accordance with recommendation 6, define governance/reporting arrangements and associated documentation (e.g. Statements of Intent, Terms of Reference, Memoranda of Understanding etc.).	The Transformation Board will need to: • Sign-off the strategic objectives identified in step 1. • Provide the TPMO with authority to deliver the transformation process - given that it will impact several elements of the health system. To enable the delivery of the second bullet above, it is suggested that the Transformation Board includes senior leaders from health and care organisations on the Isle of Man.
TP04	Define Functions	Define, on the basis of the strategic objectives, the functions the programme will need to enable it to be effective – these will include all elements of good Project/ Programme Management (PPM) e.g. • Planning • Finances • Reporting • Quality assurance	The effectiveness of the TPMO in supporting transformation will be dependent (in part) on the fitness-for-purpose of these functions.

Step Number	Step	Description	Notes
		• Communication • Procurement • Resourcing	

TP05	Establish Transformation Programme Management Office	Establish a Transformation Programme Management Office (TPMO) to programme manage the transformation programme on behalf of the Transformation Board.	The Transformation Board will be primarily focused on strategy and providing oversight. The TPMO will be responsible for supporting the implementation of programmes of work corresponding to the review's recommendations.
			The TPMO must have the resources and functions needed to enable it to support the transformation process. Key considerations will include:
			• Office space
			• Equipment
			• Human resources
			  ○ Skillset
			  ○ Headcount

TP06	Create Plan	Create a detailed plan for implementation, with identified owners for responsibility of specific elements of delivery.	Creating detailed plans and sharing them with stakeholders will ensure that they know what is required and when it is expected. The overarching implementation plan is complex, with multiple co-dependencies, and slippage in any single elements could have ongoing, multi-year impacts.
TP07	Create TPMO Charter	Create a 'Transformation PMO' charter that is easily communicable to wider stakeholders.	The charter should be shared with all stakeholders and should include: • TPMO objectives • What the TPMO will/won't do • The organisational model (including roles and responsi-bilities) • Tools and processes • Reporting requirements
TP08	Establish Stakeholder	Engage and communicate with wider stakeholders (including service users) beyond the organisations	The scale and scope of the transformation signalled by the Review means that a range of different stakeholders will be

Step Number	Step	Description	Notes
	Engagement	with representation on the Transformation Board.	involved and will need to work in completely new ways. Communications and engagement will be key in preparing them for the change and assuring them that 'the end result' will be a much-improved health and care system. The communications process should make clear the role of the Transformation Lead, Board and TPMO in delivering this change.
TP09	Execute the Transformation Programme	Execute the Transformation Programme.	This should include: • Ongoing oversight from the Transformation Board • Regular internal lessons learned sessions to enable the approach to adjust to emerging needs • Regular reporting to all stakeholder groups.
TP10	Prepare and Execute Handover to business as usual ("BAU")	Hand over all programme deliverables, supporting information etc. to BAU organisations.	By definition a "programme" has a limited life and will be disbanded at completion of agreed deliverables and outcomes.
TP11	Formally Close Transformation Programme	Formally Close Transformation Programme	

Activity 2: Transformation Funding

Activity Description:

Agreeing and providing transformation funding to support Review recommendation: "*Additional transformational funding and dedicated specialist resources, including proven change leadership, are required to deliver the transformational recommendations for them to be implemented successfully.*"

Activity Steps

Step Number	Step	Description	Notes
TF00	(ACT02) Transformation Funding		
TF01	Agree funding allocation for years 1 to 5	Agree transformation funding allocation for years 1 to 5	Approve Review suggested figure of 1.5% of health and care spend (to include DHSC spend plus 'central costs') for first five years of implementation (2019/20 to 2024/25) (recommendation 18)
TF02	Agree funding source	Agree how transformation funding allocation is to be funded	Need significant engagement and discussions around how any additional funding is to be found. Firstly, to agree who is to be part of these discussions. Secondly to have those discussions, and cover: assessing funding options set out in the Review; longer term expectations of Treasury revenue streams (which impacts future funding requirements), expected future DHSC budget etc.
TF03	Agree governance arrangements for the release of funds	Agree governance arrangements under which transformation funding is held, distributed, and accounted for etc.	To include: • agree the terms of reference for what transformation funding is used for (e.g. implementing review recommendations) • agree process for requesting transformation funding • agree process for who approves funding requests • agree process for assessing impact of funding request
TF04	Agree process for partial funding	Agree process if requested transformation funding is not (fully) approved	While not recommended by the Review, if the Isle of Man did not approve levels of sufficient transformation funding, consideration needs to be given as to how to agree what quantity and quality of services would need to change

Step Number	Step	Description	Notes
TF05	Implement Governance	Set up agreed governance arrangements	
TF06	Provide Funding	Provide transformation funding in accordance with agreed governance	
TF07	Transformation Funding Ends	When transformation programme ends (expected to be at end of 2024/25), transformation funding stops	As per recommendation18, the 1.5% figure should stop (but the existing Healthcare Transformation Fund should continue).

Activity 3: Core Data Set

Activity Description:

Creation of a Core Data Set to support the review recommendation "*A core data set is essential for the management and assessment of services and should be established without delay.*"

Activity Steps

Step Number	Step	Description	Notes
CD00	(ACT03) Core Data Set		
CD01	Form Working Group	Form Data and Information Capture Working Group	Should include not only strategic representatives to agree purpose and usefulness of data, but also data representatives to discuss availability and practicality of data collection
CD02	Define Core Data Set Components	Define Core Data Set components and purpose	Core data set composition will be informed by the purpose of the information. Metrics should include, but not be limited to: • Operational metrics to assist with running of health and care services • Cost metrics to assess value for money and effective-ness • Outcomes metrics to assess impact As well as gathering data from different places into a single Core Data Set, the Working Group will want to consider how to make existing information more accurate and useful
CD03	Agree Quality Assurance (QA) Process, Terms of Use	Agree process for reporting, publication, and use of Core Data Set	For example regularity of publication, quality assurance of data provided (including process for sign off)
CD04	Instrument processes and systems to collect defined data	Commence collection of defined Core Data Set	This will involve gathering of a number of existing datasets. However, it may require changes to systems and processes to collect information that is not captured at present.
CD05	Collect and Analyse	Analysis of collected data and creating of Core Data	To include 'cleaning' of data, quality assurance, putting into

Step Number	Step	Description	Notes
	Data	Set	agreed reporting format/template for dissemination
CD06	Initial Publication	Publication of Core Data Set	Publication of Core Data Set having gone through necessary approvals and governance pre-publication
CD07	Ongoing Collection Analysis and Reporting	Annual refinement of Core Data Set	Annual review by the Working Group to agree whether the component data is all still required, or whether some can be removed, or additional metrics required

Activity 4: Health and Care Needs Assessment

Activity Description:

Implement recommendation 10: "*An on-going health and care needs assessment programme for the Isle of Man should be established and funded without delay. It is not possible to develop meaningful service delivery models and plans without establishing the current and future needs for health and care through this assessment. Many other recommendations in this report are predicated on the assumption that this programme will be established. The Public Health Directorate should be resourced to undertake the health and care needs assessment programme.*"

Activity Steps

Step Number	Step	Description	Notes
NA00	(ACT04) Health and Care Needs Assessment		
NA01	Convene Expert Panel and Agree Method	Convene an Expert Panel, made up of a range of key stakeholders from across the system including: service users, carers and health and care professionals, to agree the objectives and scope of the needs assessment.	The assessment is a critical step and will need to be delivered within a timeframe that enables the other elements of the transformation process to proceed.
NA02	Prioritise Pathways	Determine through workshops with the Expert Panel; priority pathways, with a focus on the highest prevalence disease conditions.	A pathway approach will support the development of Integrated Care Pathways and will enable a number of 'quick wins' (from a disease condition perspective e.g. diabetes) to be realised. Prioritisation may take into account factors including: • Volume of need • Outcomes delivered • Current cost of provision • Current societal impact
NA03	Convene Assessment Team	Convene an Assessment Team, led by the Public Health Directorate with analytical support and input from partners from across the health and care system.	The Assessment Team will deliver the assessment under the oversight of the Expert Panel. The Public Health Directorate is best placed to lead the assessment as some relevant information is already captured in the existing Joint Strategic Needs Assessment (JSNA). Data analysis will be needed to ensure that assessments are based on the best, most credible information.

Step Number	Step	Description	Notes
NA04	Map Out and Confirm Service User Flows	Map out the priority service user flows (pathways) with the Expert Panel to ensure that every stage and handoff in the person's journey is understood.	Bottlenecks in services often happen at the point of handoff. Understanding these processes will be key to ensuring that supply is appropriately matched to demand.
NA05	Undertake Needs Assessment for Priority Pathways	Commence a systematic needs assessment within the parameters defined in Step 1 and against the pathways mapped in Step 4.	The assessment at a pathway level will be used in subsequent phases of work to ensure that new integrated pathways appropriately address the need identified.
NA06	Create Demand Side Model	Create analytical (demand side) model for priority pathways.	To show the volume of demand (based on need) at each step and in each setting.
NA07	Repeat Process for Lower Priority Pathways	Run steps 3-6 again on pathways lower down on the prioritised list.	This will ensure that other transformation processes are not 'held up' unnecessarily.

Activity 5: Service-by-Service Review

Activity Description:

Implement Recommendation 11 - "*A service-by-service review of health and care provision, in conjunction with the needs assessment and an analysis of care pathway design, should be undertaken to establish what services can, should or must be provided on and off Island, against defined standards. Where services cannot be provided safely or deliver best value by Island-based providers, the default position should be to seek services from third parties for delivery on-Island whenever possible and off-Island where necessary*."

Activity Steps

Step Number	Step	Description	Notes
SR00	(ACT05) Service-by-Service Review		
SR01	Agree Terms of Reference	Agree the Terms of Reference for the Service-by-Service Review.	Clarity is required on the purpose, scope etc. of the review.
SR02	Convene Review Team	Convene a review team composed of clinicians and experts from across the health and care system, with a combination of those working within in the Isle of Man and (if needed) expert theoreticians and practitioners from other territories.	It is important that the team has wide representation from stakeholders from the Island, supplemented by knowledge of best practice and emerging thinking from elsewhere. This team would likely need to be adjusted to reflect the particular service being reviewed.
SR03	Enumerate Services	Establish a comprehensive list of the services to be assessed by the review.	This sets the scope and informs prioritisation
SR04	Prioritise Services	Prioritise the list of services for review.	Prioritisation may take into account factors including: • Volumes (frequency of use of the service) • Outcomes (does the service currently meet quality tar-gets/expectations)? • Cost (what is the budget for this service?)
SR05	Review Services by Priority	Review each service in order of priority (but with some achievable level of parallelism)	Evaluate the effectiveness of the service from the perspective of: • care and quality • health and wellbeing • finance and sustainability. Also consider interdependencies between services. Engage with

Step Number	Step	Description	Notes
			• service users • provider organisations • Government Departments • third sector and • other stakeholders to build a comprehensive view of the existing service
SR06	Link to Needs Assessment	Combine the findings of the review with the findings of the Needs Assessment	Provides an understanding of supply and demand at the pathway and service levels. This will be used to inform future integrated care pathway development work.
SR07	Report Findings (iterative)	Produce report(s), summarising findings at an individual service level and across pathways, identifying key improvement priorities	The report should clearly identify key improvement priorities. Note: steps 2 to 7 could be repeated as the review looks at each service.

Activity 6: Implement Manx Care Record

Activity Description:

Implement a Manx Care Record Programme to create a single overarching service that provides appropriate staff from all parts of health and care with access to all the key data from each relevant system used in the delivery of care.

Activity Steps

Step Number	Step	Description	Notes
MC00	(ACT06) Manx Care Record		
MC01	Develop and Approve Outline Business Case	Set out the core costs and benefits of the Manx Care Record	Outline of benefits realisation should be included
MC02	Convene Programme Expert Group	Expert Group to provide regular advice and guidance to the Manx Care Record Programme but not expected to be “hands-on”	Expert Group to include stakeholders from across health and care and service users as well as technical input.
MC03	Convene Programme Board	Programme Board to operate broadly in accordance with Managing Successful Programmes methodology	
MC04	Develop Programme Plan	The Programme Plan will define the key dependencies and resources to deliver the programme in accordance with the business case.	
MC05	Catalogue Requirements	Essential Functional and Non-functional requirements of the programme to be captured	
MC06	Market Engagement	Determine what solutions are available from the market to meet the requirements	It is suggested that specific solutions and more generic integration solutions are investigated and assessment made of relative costs for implementation and ongoing operation (including any licence and support costs). An “in-house” solution, possibly based on Open Source products could be considered but resource limitations could make this impractical.
MC07	Conduct Procurement Activity	A formal exercise to ensure that the Island is able to identify the most economically advantageous solution.	

Step Number	Step	Description	Notes
MC08	Appoint and Contract Provider	Create a robust and binding arrangement with the selected provider	
MC09	Implement the Solution	The rollout approach may be critical to the success of the programme and will require careful consideration.	Rollout should consider the possibilities to maximise early benefits but also be mindful of resource constraints at the ability of the organisation (in the widest sense) to accommodate change.
MC10	Undertake Post Implementation Review and Benefits Realisation	Post Implementation Review will allow the organisation to learn lessons as to what went well and what could have gone better for input to subsequent initiatives. Benefits Realisation enables the Business Case to be demonstrated and the funding provided to be justified.	

Activity 7: Public Health Function

Activity Description:

Transferring the public health function (and associated staff) from the Department of Health and Social Care to the Cabinet Office.

Activity Steps

Step Number	Step	Description	Notes
PH00	(ACT07) Public Health Function		
PH01	Determine Transferring Functions	Determine what public health functions should be transferred to Cabinet Office and which staff currently discharge these functions.	It should be determined whether it is appropriate to transfer all functions and staff currently within the Directorate.
PH02	Identify Shared Functions	Identify which functions are shared with other elements of DHSC. Identify how similar support could be provided within the Cabinet Office.	If some essential support functions cannot be delivered by the receiver organisation, it might make sense to transfer these functions also.
PH03	Undertake public consultation	Undertake public consultation.	It may be considered to be beneficial to put the proposed transfer to public consultation.
PH04	Confirm Transferring Staff Details	IDHSC/Office of Human Resources to confirm the details of individual staff to transfer to the Cabinet Office.	Absolute clarity is needed on the staff who it is proposed are transferred.
PH05	Undertake Staff Consultation	Support DHSC and the Cabinet Office in fulfilling their legal obligations, to inform and consult, with staff/staff representatives.	Any failure to follow obligations could result in legal challenge
PH06	Identify and Resolve Staff Transfer Issues	Support Cabinet Office to identify any organisation specific issues related to the transfer, e.g. specific pension provisions not covered by the core clauses and discuss these with staff.	Staff transfer regulations are likely to stipulate the need to transfer undertakings.
PH07	Undertake any HR, finance, administration or infrastructure processes	May include (for example) transferring budgets, amending organisation charts, updating public-facing web sites, undertaking office moves etc.	
PH08	Finalise Process	Support DHSC in finalising the decision to transfer.	Ratification will be needed before formal sign-off

Step Number	Step	Description	Notes
		Request the Cabinet Office formally confirm the transfer of staff to their organisation.	
PH09	Publicise the Transfer	Notify media organisations and update public-facing web sites.	

Activity 8: Air Bridge

Activity Description:

Implement an emergency Air Bridge – an aviation solution with comprehensive in-flight emergency and critical care facilities to transfer emergency cases to appropriate specialist centres. It will provide a reliable, faster and more comprehensive service than is currently in place in order to ensure access to timely and high quality, specialist emergency care.

Activity Steps

Step Number	Step	Description	Notes
AB00	(ACT08) Air Bridge		
AB01	Develop and Approve Outline Business Case	Set out the core costs and benefits of the Air Bridge.	Outline of benefits realisation should be included. The Business Case will not consider purely financial elements of the Air Bridge service but will also take into account factors such as outcomes, safety, quality and convenience for service users.
AB02	Agree Governance Approach	The governance and approvals approach should be capable of looking at the proposed service holistically, for example the consequent impacts to on Island acute care and off Island specialist services including commissioning arrangements.	Project governance to include stakeholders from across health and care and service users as well as technical input.
AB03	Convene Project Team	The Project Team should be set up broadly in accordance with robust, industry standard methodology such as Prince 2 or similar.	
AB04	Develop and Approve the Project Initiation Document	The Project Team will develop the Project Initiation Document (PID) to set out the key attributes of the project such as aims, objectives scope and reporting approach, aligning to the Business Case.	The PID will be approved via the agreed governance approach.
AB05	Assess Air Bridge Demand and Options	The Project (working closely with subject matter experts) should determine the options for the provision of the Air Bridge for example: • required capacity • cover for maintenance etc. • fixed wing and/or helicopter	Should be undertaken in conjunction with service-by-service review (Activity 5).

Step Number	Step	Description	Notes
		• cases to be supported • remote (off Island) locations to be supported (affects range and travel time) • requirements to stabilise critical patients prior to evacuation	
AB06	Approach Potential Partners	Approach existing providers and any other potential partners to determine what they are able to offer at what cost.	The appetite and capability of potential partners may require some changes to the scope of the service. There may be options to have a wholly in-house service, a fully externally provided managed service or a hybrid with (say) medical staff being provided in-house but aircraft and flight-deck crew provided by a partner.
AB07	Conduct Procurement Activity	If required, conduct a formal exercise to ensure that the Island is able to identify the most economically advantageous solution.	It may be that having approached potential partners and taken specialist advice the Project Team determines that a formal procurement activity is not required or appropriate.
AB08	Appoint and Contract Partner	Create a robust and binding arrangement with the selected provider.	The specification of the service to be provided and the nature of the selected partner may significantly influence the shape and nature of the contractual arrangements.
AB09	Service Implementation	Implementation will require consideration of: • changing arrangements on the Island to identify cases for transfer (quickly) and take necessary preparatory arrangements (in-cluding stabilisation) • ensuring that any remote providers are ready to receive cases • implementing arrangements for the transfer back of cases from remote providers on completion of immediate treatment – in-cluding notes, medication etc. • requirements of family members etc.	
AB10	Review and Improve Service Provision	Continuously assess the service provided including outcomes, safety and convenience for service users.	

Activity 9: Manx Care – Establish and Shadow Operation

Activity Description:

Establish an independent, arm's length body, perhaps known as "Manx Care", to be given the responsibility for the planning, coordination and delivery of high-quality services, as well as for contracting with a range of providers, both on and off the Island, as appropriate.

Activity Steps

Step Number	Step	Description	Notes
MC00	(ACT09) Manx Care – Establish and Shadow Operation		
MC01	Confirm Role and Remit	Confirm the role and remit of Manx Care with senior stakeholders.	Clarity of purpose will support engagement with wider stakeholders. Determining the purview of the organisation will ensure that it can be resourced and structured appropriately.
MC02	Develop Governance Arrangements	Develop governance arrangements and associated documentation (e.g. Statements of Intent, Terms of Reference, Memoranda of Understanding etc.).	
MC03	Recruit Manx Care Board	Recruit Manx Care Board in accordance with governance arrangements.	See Annex 10 for potential Board membership.
MC04	Establish, Ramp-up and Run "Shadow" Manx Care	Establish Manx Care in 'shadow form' i.e. enable the organisation to function before legislative change allows it to full discharge its statutory responsibilities.	This will enable Manx Care to establish ways of working and take on the gradual transfer of responsibility from the transformation programme before formal 'go live'. The shadow Manx Care should work closely with the Transformation Lead, Transformation Board and Transformation PMO.
MC05	Recruit Staff	Recruit Manx Care management and other staff, on the basis of the specific remit of the organisation (Step 7).	This may involve secondment or permanent transfers from other Isle of Man public sector organisations. Keeping expertise in-house, where possible, will be enable progress to be made in a relatively short space of time.
MC06	Formalise Status	Obtain approval, legislative cover and funding for	Manx Care should be empowered to monitor

Step Number	Step	Description	Notes
		Manx Care from the Treasury.	performance of its providers and: • require improvement plans or similar (across all providers delivering health and care services to the population of the Isle of Man) in the event of underperformance, which will set out the changes required from providers • Manage the contract fully, including any failings in line with agreed contract.
MC07	Create Organisation	Design organisational form and function, including: • Team/business unit structure • Leadership, management and general staff roles and responsibilities • Relationships/shared accountabilities with other health and care organisations	There should be a direct link between the remit of the organisation and how it is structured. Poor alignment can make it difficult for organisations to do straightforward things.
MC08	Launch	Launch Manx Care as a statutory organisation - when the required necessary legislative changes have been made.	This process should involve some double running with a gradual handover of responsibility from the Transformation Programme and DHSC. DHSC to strategically manage Manx Care's overall performance in line with mandate and arrange inspection reviews etc.

Activity 10: Prepare Supporting Legislation

Activity Description:

Primary and/or secondary legislation should be introduced as required, and included in the Legislative Programme as soon as possible, in order to form a modern, comprehensive legislative framework. This legislation should address weaknesses or gaps in the current system as well enabling the implementation of the recommendations contained in this Report, such as any necessary legislation to establish Manx Care.

Activity Steps

Step Number	Step	Description	Notes
SL00	(ACT10) Supporting Legislation		
SL01	Develop Proposals and Options	Using the table at Annex 11 as a starting point, develop and refine proposals to realise the recommendations of the Review, engaging with other parts of Government that may be part of delivering the proposals, or that are affected in another way by proposals, to help shape options.	There are a number of different ways the recommendations made could be actioned. Consultation with partners will be required to minimise the risk from unintended consequences. Initial discussions with the Attorney General's Chambers (AGC) have suggested that the majority of changes[ccvi] would be best progressed through a replacement Health and Care Act.
SL02	Approve Proposals (Governance)	Proposals agreed by the Department[ccvii] and the Council of Ministers (COMIN).	COMIN approval is required for a new Bill to be added to the Government's legislative programme and to give authority to the AGC to draft it.
SL03	Undertake Public Consultation on Proposals	Draft and issue a consultation paper to advise the public of amendments that are required to the legislation and to seek views on policy decisions.	It is important to directly engage with people who are affected by the proposals, to ensure that their views are represented. Whilst public engagement has been undertaken as part of the Review, a formal public consultation would be required. The standard period for consultation is 6 weeks but this can be extended to up to 12 weeks for significant consultations. A balance is needed between the urgency of the changes required and the need to enable everyone affected to get involved. It also provides an opportunity to make a case for why specific changes are needed and how it will impact service delivery. Invite comments on other proposed amendments concerning health and care services.
SL04	Review and Respond to Consultation	Review responses from the public to the consultation process.	To help build public trust a decision could be made to run the consultation longer than the statutory minimum.

Step Number	Step	Description	Notes
SL05	Draft Bill	Prepare drafting instructions and issue to the AGC to complete legislative drafting.	Any changes in policy following the consultation can be incorporated into the drafting instructions. The timescales for the AGC drafting a Bill vary depending on the number of clauses and the amount of discussion required between the AGC and the Department. A further consultation on the actual draft legislation *may* be required after this stage.
SL06	Undertake Public Consultation on Bill	Draft and issue a consultation paper to advise the public of amendments that are required to the legislation and to seek views on the legislation.	A further consultation on the actual draft legislation is likely to be required. To have two separate, but shorter, consultation periods may be more appropriate than one longer consultation period at the proposal stage.
SL07	Review and Respond to Consultation	Review responses from the public to the consultation process.	Any changes following the consultation can be incorporated into the Bill.
SL08	Approve Legislation to be introduced to Tynwald	Prepare Explanatory Notes, publish an Impact Assessment and prepare a submission for COMIN seeking approval to introduce it into the Branches of Tynwald.	
SL09	Passage through branches of Tynwald	Submit the Bill to COMIN for authority to introduce it into the Branches of Tynwald. Identify and support Members of Tynwald to take the Bill through the branches.	It typically takes 13 weeks to go through this process, and another eight weeks for Royal Assent to be granted, when a Bill becomes an Act.
SL10	Royal Assent and Implementation	The Bill is sent to the Ministry of Justice and Royal Assent is granted, usually by the Lieutenant Governor. The Act comes into operation when Royal Assent is announced in Tynwald or under the provisions of one or more Appointed Day Orders.	It can take up to 8 weeks for Royal Assent to be granted, when a Bill becomes an Act. By this stage the Department should have an implementation plan setting out the timescales for bringing into effect all clauses of the Bill.
SL11	Draft and Implement Subordinate Legislation	Once the Act has been passed (i.e. Royal Assent has been announced to Tynwald), progress subordinate legislation to fully realise the recommendations of the Review.	The process of implementing new secondary legislation involves policy development, drafting, consultation, review by the AGC, making of the legislation and submission to Tynwald. It is significantly shorter than the process of introducing primary legislation.

Activity 11: Commission On and Off-Island Services

Activity Description:

Manx Care will be required to deliver all health and care services and will need to either deliver them directly or procure/ commission them from suitably qualified providers, both on and off-Island.

Activity Steps

Step Number	Step	Description	Notes
PS00	(ACT11) Procure On and Off-Island Services		
PS01	Establish Service List	Determine what services need to be procured to meet the health and care needs of the population.	This process should be linked to the service-by-service review process and where possible run in parallel. Inputs could include: • The findings/recommendations of any reviews of any elements of the health and care system • The outputs of the needs assessment process • The outputs of any public and stakeholder consultation processes • Any information relevant to performance and quality i.e. waiting time breaches etc. • Service user complaints and serious incidents etc.
PS02	Review Service Provision (by Manx Care or other)	Review the service provision landscape on and off Island.	The aim of the process is to identify potential providers of specific services.
PS03	Agree Priorities	Agree procurement priorities with stakeholders i.e. key areas of focus for the year .	In future years this will be informed by Government's mandate
PS04	Create Specifications	Work with providers and their staff to create specifications for each service, including: • Timescale for implementation • Expected demand • Expected outcomes • How performance will be measured	These should be linked to the relevant Integrated Care Pathway, where it has been developed.
PS05	Prepare Commissioning	Share specifications with potential providers and issue Requests for Quotations (RFQs).	Onus is on the prospective provider to provide an estimate of how much it will cost to provide a service that meets the

Step Number	Step	Description	Notes
			specification.
PS06	Undertake Commissioning	Issue RFQs and review proposals.	Weightings can be applied to support improvements in specific areas e.g. service quality, patient outcomes, cost effectiveness.
PS07	Engage Providers	Formally contract successful providers.	The duration of the contract should be based on the needs of the specific service and the pre-existing relationship with the supplier. Provision for contract extensions, without a need for retendering, should be considered.
PS08	Ongoing Provider Management	Ongoing monitoring and contract management.	This will ensure maximum value is received for the contract.

Activity 12: Governance, Reporting and Regulation

Activity Description:

Specifying standards, establishing relevant reporting protocol and appointing regulator(s) to inspect and report on their delivery.

Activity Steps

Step Number	Step	Description	Notes
GR00	(ACT12) Governance, Reporting and Regulation		
GR01	Convene Working Group	Convene a Working Group composed of service users, carers, health and care professionals, and data leads.	Input relevant to standards should come from all elements of the system, particularly service users and carers.
GR02	Determine Priorities	Determine with Working Group key performance improvement priorities across health and care.	There are a multitude of things that can be measured and thus standards that can be implemented. The focus should be on the priority pathways to ensure that this activity drives the outcomes desired.
GR03	Review Other Territories	Review with the Working Group the regulatory regime in other nearby health systems, including Republic of Ireland, England, Scotland and Wales, to determine option(s).	The regulatory systems in England should not be chosen by default, other systems exist in neighbouring nearby health systems which may be fit-for-purpose.
GR04	Develop Standards	Translate improvement priorities into standards, which ensure that an acceptable level of performance is maintained.	Standards are a useful mechanism for focusing improvement activity in specific areas.
GR05	Agree Metrics and Reporting	Determine with the Working Group the most appropriate metrics (for determining performance), the reporting schedule and reporting process.	Standards should enable stretch, but should be achievable. Standards that are impossible to achieve will typically disincentivise performance.
GR06	Develop Options for Regulation	Conduct SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of the different regulation options, shortlist potential external regulator(s).	The merits of the different regulatory agencies and their applicability to the IOM health system, should be determined to ensure that the most appropriate system is put in place.
GR07	Evaluate Regulators and Select	Conduct options appraisal to identify preferred regulatory body.	An options appraisal will provide a transparent process, combining multiple inputs to enable the selection of the most appropriate option.

Step Number	Step	Description	Notes
GR08	Agree Regulator Terms of Engagement	Contact preferred regulatory body and agree terms of engagement and linkage to Manx Care.	Terms of engagement will determine how regulation is delivered.
GR09	Define Regulatory Regime	Co-develop with Working Group and preferred regulatory body regulatory regime with clear delineation of 'Manx Care delivered' and 'external regulator delivered' elements of process.	External regulars will not have enforcement powers on the Isle of Man. As a result, a shared understanding will be needed to enable these duties to be discharged by Manx Care.
GR10	Monitor Service Delivery	Monitor ongoing performance against agreed standards with regular reporting including (but not limited to) the Annual Report to DHSC.	Assessment of performance relative to standards will have to be ongoing to ensure that performance is being maintained.
GR11	Learn Lessons	Review outputs of the report with Working Group and determine (if required) changes are required to service delivery and to the regulatory process.	PDSA (Plan, Do, Study, Act) cycles could be used to deliver this.
GR12	Implement Service Improvements	Support providers in making service changes on the basis of the regulator's report.	Support for providers will be necessary and will provide an opportunity to monitor progress and support improvement in the identified priority areas.
GR13	Implement Regulatory Refinements	Implement any changes to the regulator's responsibilities identified from "Lessons Learned".	This will ensure that the next cycle is more effective.

Activity 13: Primary Care at Scale

Activity Description:

Implement recommendation 15: *The Isle of Man should establish a model for delivering primary care at scale, since further and deeper collaboration within primary care is necessary to deliver current services and provide additional local services.*

Note: all options should be considered but, for the purposes of this document, an outline of implementing the alliance option only is provided.

Creation of an alliance to enable the delivery of primary care at scale with the aim of decreasing fragmentation and supporting the delivery of integrated care with other health and care organisations.

Activity Steps

Step Number	Step	Description	Notes
PC00	(ACT13) Primary Care at Scale		
PC01	Explore GP Alliance Options	Schedule meetings with individual practices to explore alliance options and their suitability/ applicability on the Island.	There are many different models of general practice at scale in operation internationally, including: • Super-practices • Practice chains • Federations/ Networks The preferred model will have an impact on which arrangements are most suitable.
PC02	Convene Workshop	Convene 'all practice meeting' to test ideas and set a timeline/process for development.	Individual practices can opt in or opt out, as a result it will be important to make an early and consistent case for the creation of general practice at scale on the Isle of Man.
PC03	Appoint Working Group	Appoint a Working Group comprised of general practice staff from across a range of practices.	Participation needs to be widespread and representative of general practice on the Isle of Man as a whole.
PC04	Define GP Alliance Arrangements	Support the Working Group in determining the scope and key principles for the GP Alliance.	The scope will determine what services the Alliance aims to deliver in the short to medium term. The principles will be used to inform the choice of organisational form and the constitution.
PC05	Develop Structural Governance	Engage legal advisors to ensure that the principles are used to develop key documents including (as appropriate): shareholders agreements and articles of association	There is no requirement for this to be done by lawyers, however it provides impartiality and decreases the risk to the Alliance and its member practices Governance will be critical, if the Alliance is not felt to serve all

Step Number	Step	Description	Notes
		Develop, on the basis of the legal advice, governance and management structures ensuring fairness, accountability, responsibility, transparency and equity.	members equitably, there is a risk that it will fragment.
PC06	Implement Alliance	Deliver launch event to share the outputs of the working group, future plans and governance arrangements. Appoint a board of directors and a chair for the Alliance. Ask practices to formally sign-up.	The launch event should communicate the longer-term development ambitions of the Alliance. The board will be key and will represent the voice of primary care on the Island, it should include non-GPs as members. The Alliance, depending on the option chosen, may be a legal entity, as a result formal sign-up would be required of all members.
PC07	Launch Alliance	Instruct legal advisors to register the Alliance.	As a legal entity the Alliance will need to be registered.
PC08	Alliance Operational	Deliver the initial board meeting and disband the working group.	

Activity 14: Define and Agree Integrated Care Pathways

Activity Description:

Implementation of Integrated Cared Plans (ICPs). ICPs are defined as an anticipatory plan of the service user journey through the entire health and care system (across and between settings of care). ICPs span all service groups and include services that are delivered both on and off Island.

Activity Steps

Step Number	Step	Description	Notes
IP00	(ACT14) Define and Agree Integrated Care Pathways		
IP01	Convene Advisory Group	Convene Professional Advisory Group, led by Public Health, with input from partners from across the health and care system.	The Advisory Group needs to work in an integrated way to enable the development of truly integrated pathways.
IP02	Identify Key Pathways	Determine key pathways from an Isle of Man perspective with Advisory Group informed by available data.	Criteria should include: • Prevalence • Impact on quality-of-life, dignity or independence • Cost • Social impact
IP03	Review Best Practice	Review current 'best practice' pathways from e.g. NICE to determine their applicability to the Isle of Man.	The development of integrated pathways should build on up-to-date thinking from elsewhere.
IP04	Review Existing Pathways	Review existing pathways with professionals, service users and carers.	In the future professionals will be expected to use the pathways consistently, as a result their input is critical Integrated Care Pathways have the service user at their centre, which means that their input is critical. A separate session from the professional is likely to elicit more open and honest responses.
IP05	Develop Pathway Template	Develop standardised pathway template for all Integrated Care Pathways.	A standard format will make it easier for staff to locate key information and for patients to transition between pathways.
IP06	Develop Pathways	Convene pathway workshops to approve, update or redesign Integrated Care Pathways – ensure buy-in from all participants.	Workshop should provide clarity on: • The service user journey • Specific processes • Transition points

Step Number	Step	Description	Notes
			• Handoffs • The accountability of partners at specific points.
IP07	Communicate Pathways to Stakeholders	Communicate the updated pathways and signpost to patients and other relevant stakeholders, including (where relevant) off island providers.	For the ICPs to be effective, patients will need to be confident that they can access the elements of health and care they need, when they need it. Some of this will necessitate changes in patient/ service user behaviour.
IP08	Implement New Pathways	Implement the new pathways.	
IP09	Deliver Against and Refine Pathways	Monitor delivery against pathways and amend pathways as needed.	Ongoing monitoring will be needed to adjust pathways to be more reflective of patient/service user needs. PDSA (Plan, Do, Study, Act) cycles could be used to deliver this.

Activity 15: Efficiency Improvement Programme

Activity Description:

The agreement of an efficiencies target for health and care spend and a supporting programme of efficiency focused programmes to deliver health and care in a more cost effective way, whilst maintaining or improving quality.

Activity Steps

Step Number	Step	Description	Notes
EP00	(ACT15) Efficiency Improvement Programme		
EP01	Agree Efficiencies Target	Agreement of efficiencies target.	If not agreed as part of accepting recommendation 17. Likely to involve representatives from DHSC and Treasury. Suggestion and rationale for 1% efficiencies target set out in report under recommendation 17. What this means in practice is having a smaller allocation for health and care spend (by 1% each year) compared to if no efficiencies target.
EP02	Agree Governance Structure	Agree governance structure for overseeing, monitoring and implementing efficiency improvements.	Agreeing how funding for efficiencies (if 'spend to save' is required) should be approved. Implementation could be done by Task and Finish Groups (see Step 5).
EP03	Create Strategic Plan	Define and agree strategic plan for achieving efficiencies. This should also include agreeing what happens if the efficiencies target is not achieved.	Points to consider should be: • Quick wins to target (some of these interventions are set out in figure 6 of this Report) • Time period to implement efficiencies, and estimated time frame for benefits realisation • Should efficiency targets be overall or at Directorate level?
EP04	Prioritise Improvements	Prioritise efficiency improvement interventions.	This could involve a period of gathering business cases for specific interventions, with funding approved by the governance structure in place (see Step 2).
EP05	Set Up "Task & Finish" Groups	Set up Task and Finish Groups for efficiency improvement interventions, and commence implementation of interventions.	Membership of groups to include relevant operational stakeholders.

Step Number	Step	Description	Notes
EP06	Assess Spend Against Target	Assess health and care spend annually against expected efficiency targets.	

Activity 16: Health and Care Funding Allocation

Activity Description:

Agree funding allocation to meet review recommendation "*Funding, based on agreed need, should, over time, move from the current annual budget allocation to a 3-5 years financial settlement for heath and care services for the Island*."

Activity Steps

Step Number	Step	Description	Notes
DF00	(ACT16) Health and Care Funding Allocation		
DF01	Agree Principle	Agree the principle of moving from an annual budget allocation to a 3-5 year financial settlement for health and care services for the island.	If not agreed as part of accepting recommendation 20, likely to involve representatives from DHSC and Treasury. 'Predictable funding' is key to enabling those working in health and care to plan and deliver services effectively, especially at a time where efficiency savings and quality improvement are requirements.
DF02	Agree Quantum	Agree quantum of DHSC funding allocation, based on expected future costs, plus transformation funding, minus an efficiencies target.	This will involve accepting the Review's forecasts of future costs: • Agreement of expected rise in DHSC spend (if nothing changes) of 2.66% a year on average (see section 5.3) • Agreement of efficiencies target (see Activity 17) • Agreement of transformation funding of 1.5% for the first five years (see Activity 2)
DF03	Agree Funding Source	Agree where additional funding is to be found.	Detailed engagement process and discussion regarding how any additional funding is going to be achieved. This could be a combination of: • expecting Isle of Man revenue streams from existing sources to grow faster than inflation • expecting greater/less efficiencies to be achieved than the agreed target • considering the funding options set out in recommendation 19 of the Report (e.g. changes to direct taxes; changes to charges etc.)

Step Number	Step	Description	Notes
			As well as considering Treasury views about forecasts of future revenue streams, public engagement is crucial if funding option changes are expected.
DF04	Sign Off Funding Allocation	Sign off of DHSC funding allocation.	This is likely to involve representatives from DHSC and Treasury.
DF05	Agree and Implement Review Process	Agree process for review points for future funding.	For example, the process by which funding is reviewed if costs are significantly higher (or less) than forecast.
DF06	Review Costs vs Forecasts	Undertake ongoing review and report of actuals vs forecasts.	To include application of pre-agreed sanctions if delta between actuals and forecasts exceeds tolerance.

Activity 17: Digital Strategy Delivery

Activity Description:

Deliver the digital strategy to meet review recommendation "*The development and delivery of the digital strategy should go further and faster to ensure the comprehensive capture, sharing and use of information. This would enable greater integration across the system, improved monitoring and enhanced delivery of quality and efficiency-related information.*"

Clearly the implementation of the Digital Strategy has already begun and indeed has delivered some significant benefits, hence this activity "Digital Strategy Delivery" must recognise that this work is "in-flight" rather than starting from scratch. It will be useful though to reconsider and potentially re-set the existing programme of work to ensure the proper dovetailing of the future vision for the organisation and the system, the transformation programme to deliver the vision and the Digital Strategy to support and enable the transformation of services.

Activity Steps

Step Number	Step	Description	Notes
DS00	(ACT17) Implement the Digital Strategy		
DS01	Continuation of Current Delivery	"In-flight" initiatives should be continued pending the launch of the proposed Transformation Programme.	Assumes existing initiatives are subject to appropriate controls.
DS02	Confirm Management and Governance	Revisit the existing management, governance, reporting arrangements and documentation (Terms of Reference etc.) to ensure that the delivery of the Digital Strategy will support and work effectively with other elements of the Transformation Programme and adheres to established good practice such as the Managing Successful Programmes methodology.	The roles of: • Manx Care; • DHSC; and • GTS In the management and governance of the Digital Strategy and the relationships between them (in this context) needs to be clear to all parties and stakeholders.
DS03	Convene Digital Strategy Expert Group	Expert Group to provide regular advice and guidance to Digital Strategy Delivery but not expected to be "hands-on".	Consider whether Expert Group is necessary (i.e. is expected to add significant value) and convene only if so. If convened Expert Group to include stakeholders from across health and care and service users as well as a range technical input.
DS04	Revisit Funding Principles	If the Digital Strategy is to become a part of the wider Transformation Programme then the funding	Adequate, appropriate and controlled funding will be critical to achieving effective outcomes.

		principles, sources and approvals for the Digital Strategy should be aligned to and follow the standards required for Transformation Funding.	
DS05	Establish Stakeholder Engagement	Engage and communicate with wider stakeholders (including service users) to ensure that Digital Strategy delivery reflects their interests and concerns.	Communication and engagement will be key in preparing stakeholders for change prior to implementation as well as enabling them to contribute to shaping that change through the delivery lifecycle.
DS06	Revisit Delivery Programme Priorities and Options	Confirm the aims, strategic objectives and priorities of Digital Strategy Delivery with input from stakeholders including the Expert Group.	This is will be a critical step at which existing assumptions and decisions regarding the Digital Strategy are reconsidered to ensure that the initiatives being pursued will accrue the best possible improvements in health and care quality, safety and efficiency. This is likely to be influenced by other initiatives, for example wider use of Integrated Care Pathways will drive demand for improved (more integrated and accessible) digital solutions. Appropriate Management and Governance arrangements (see above) will be critical to ensuring that robust and auditable decisions are made for the right reasons.
DS07	Develop/Revisit Delivery Plan	The Delivery Plan will define the key dependencies and resources to deliver the Digital Strategy in accordance with the business case with identified owners for specific elements of delivery.	Maintaining a detailed Delivery Plan and sharing it with stakeholders will ensure that they know what is required and when it is expected.
DS08	Implement the Digital Strategy	Execute the Digital Strategy Delivery Programme in accordance with the agreed Delivery Plan and the Management and Governance arrangements (including reporting), The rollout approach will be critical to the success of the Digital Strategy and will require careful consideration.	This should include: • Ongoing oversight from the agreed Governance body • Regular internal lessons learned sessions to enable the approach to adjust to emerging needs • Regular reporting to all stakeholder groups. Rollout should consider the possibilities to maximise early benefits but also be mindful of resource constraints at the ability of the organisation (in the widest sense) to accommodate change.
DS09	Prepare and Execute Handover	Hand over all programme deliverables, supporting information etc. to “Business as Usual” owners to	By definition a “programme” has a limited life and will be disbanded at completion of agreed deliverables and outcomes.

	to BAU	leave a service that is sustainable for the medium and long term. Formally close the Digital Strategy Delivery programme.	
DS10	Undertake Post Implementation Review and Benefits Realisation	Post Implementation Review will allow the organisation to learn lessons as to what went well and what could have gone better for input to subsequent initiatives. Benefits Realisation enables the Business Case to be demonstrated and the funding provided to be justified.	Benefits Realisation will be undertaken on an initiative by initiative basis.

Annex 15: References

Below is a list of documents considered generally during the Review process with links, where available. This list does not include the initiatives already mentioned in Annex 9 nor does it include documents specifically referenced during this Report, which are included as endnotes to this Report.

2016 Isle of Man Census Report:
https://www.gov.im/media/1355784/2016-isle-of-man-census-report.pdf

Bercow: Ten Years On:
https://www.bercow10yearson.com/wp-content/uploads/2018/04/Bercow-Ten-Years-On-Summary-Report-.pdf

BMA England: Saving General Practice November 2017:
https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/influence/key%20negotiations/training%20and%20workforce/saving-general-practice.pdf?la=en

BMA England: Safe working in General Practice: https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/negotiating%20for%20the%20profession/general%20practitioners/20160684-gp-safe%20working-and-locality-hubs.pdf

Building capacity and capability for improvement: embedding quality improvement skills in NHS providers:
https://improvement.nhs.uk/documents/1660/01-NHS107-Dosing_Document-010917_K_1.pdf

Carers Strategy 2007 – 2010:
https://www.gov.im/media/72466/carersstrategy.pdf

Childrens and Young Persons Act 2001:
http://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2001/2001-0020/ChildrenandYoungPersonsAct2001_1.pdf

Civil Defence Act 1954:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/1936/1936-0001/EmergencyPowersAct1936_1.pdf

Closing the gap: Key areas for action on the health and care workforce:
https://www.nuffieldtrust.org.uk/research/closing-the-gap-key-areas-for-action-on-the-health-and-care-workforce

Consultation on the National Health and Care Service General Scheme 2017 -
https://consult.gov.im/health-and-social-care/nhcs-general-scheme-2017/

Continuing Evolution of the Isle of Man Government:
http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020162018/2017-GD-0030.pdf

Control of Employment Act 2014:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2014/2014-0011/ControlofEmploymentAct2014_11.pdf

Emergency Powers Act 1936:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/1936/1936-0001/EmergencyPowersAct1936_1.pdf

Equality Act 2017:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2017/2017-0005/EqualityAct2017_3.pdf

Extended Primary Integrated Care: Independent Pharmacist Prescriber:
https://www.kingsfund.org.uk/sites/default/files/media/Sue%20Oliver_extended%20primary%20integrated%20care_MCP.pdf

Fair Access to Care Services – Policy, Eligibility Framework and guidance:
https://www.gov.im/media/943492/facs_policy__eligibility_framework_and_guidance_feb_2014.pdf

Government Departments Act 1987:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/1987/1987-0013/GovernmentDepartmentsAct1987_6.pdf

Health Care Professionals Act 2014:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2014/2014-0009/HealthCareProfessionalsAct2014_1.pdf

Health Services Consultative Committee – Annual Report - 1 April 2017 to 31 March 2018:
https://www.gov.im/media/1361890/hscc-annual-report-2017-18.pdf

Hospice Annual Review 2017:
https://www.hospice.org.im/assets/About-Us/Resources/622c24c98b/Annual-Review-2017.pdf

Hospice Annual Report 2017:
https://www.hospice.org.im/assets/About-Us/Resources/b5674ab1ec/Annual-Reports-2017.pdf

Hospice Lymphoedema Service Review 2017

Human: Solving the global workforce crisis in healthcare:
https://global.oup.com/academic/product/human-solving-the-global-workforce-crisis-in-healthcare-9780198836520?cc=gb&lang=en&

Independent Nurse: The Challenges of Caring for an Island Community:
http://www.independentnurse.co.uk/blogs-article/the-challenges-of-caring-for-an-island-community/159754/

Independent Review Body Annual Reports (2010 – 2016):
https://www.gov.im/about-the-government/departments/health-and-social-care/complaints-and-compliments/

Isle of Man Carers' Charter:
https://www.gov.im/media/750345/carers_charter.pdf

Isle of Man Director of Public Health – Annual Report 2018 - Childhood Healthy Weight, The Road to a Better Future:
https://www.gov.im/media/1362465/ph03a-0818-dph-annual-report-2018-web-version.pdf

Isle of Man Government's Securing Added Value and Efficiencies (SAVE) Programme:
https://www.gov.im/about-the-government/government/the-council-of-ministers/save-programme/

Isle of Man Hospitals Annual Report 2017/2018:
https://www.gov.im/media/1363713/iom-hospitals-annual-report-2017-2018.pdf

Medicines Act 2003:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2003/2003-0004/MedicinesAct2003_5.pdf

Mental Health Act 1998:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/1998/1998-0008/MentalHealthAct1998_6.pdf

Mental Health Commission visit reports (various):
https://www.gov.im/about-the-government/departments/health-and-social-care/mental-health-service/isle-of-man-mental-health-commission/

Modernising Ministerial Government: Government as a Single Legal Entity:
http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020142016/2014-GD-0075.pdf

National Health and Care Service Act 2016:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2016/2016-0013/NationalHealthandCareServiceAct2016_1.pdf

National Health and Care Service Charter Consultation:
https://consult.gov.im/health-and-social-care/nhcs-service-general-charter/

National Health Service Act 2001:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2001/2001-0014/NationalHealthServiceAct2001_6.pdf

NH15 - Complaints Procedure for Health Services:
https://www.gov.im/media/78871/nh15-complaints-procedure-for-health-services.pdf

Patient Safety and Quality Committee Quarterly Reports Programme for Government 2016-21:
https://www.gov.im/media/1354840/programme-for-government-210917.pdf

Registration and Inspection Unit inspection reports (various):

https://www.gov.im/about-the-government/departments/health-and-social-care/registration-and-inspection-unit/inspection-reports/

Report to Tynwald on Health and Social Care Complaints 2016/17:
https://www.gov.im/media/1361026/report-to-tynwald-on-health-and-social-care-complaints-2016-17.pdf

Regulation of Care Act 2013:
https://www.gov.im/media/815765/regulation-of-care-act-2013v2.pdf

Safeguarding Act 2018:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2018/2018-0007/SafeguardingAct2018_3.pdf

Scally G, Donaldson LJ. Looking forward: clinical governance and the drive for quality improvement in the new NHS in England. BMJ1998;317: 61-5:
http://www.ihrdni.org/315-021.pdf

Social Attitudes Survey 2018:
https://www.gov.im/media/1363577/2018-10-09-social-attitudes-2018-report.pdf

Southern Community Initiatives: Southern Community Project Report 2017

Strategy development: a toolkit for NHS providers:
https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

Statutory Boards Act 1987:
https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/1987/1987-0014/StatutoryBoardsAct1987_3.pdf

The Regulation of Care (Jersey) Law 2014:
https://www.jerseylaw.je/laws/revised/Pages/20.820.aspx

Tynwald Public Accounts Committee – Inquiry into overspending at Noble's Hospital – Evidence from 9 May 2018:
http://www.tynwald.org.im/business/hansard/20002020/pachsc180509.pdf

Tynwald Public Accounts Committee – Inquiry into overspending at Noble's Hospital – Evidence from 28 November 2018:
http://www.tynwald.org.im/business/hansard/20002020/pachsc181128.pdf

Tynwald Public Accounts Committee – Inquiry into overspending at Noble's Hospital – Evidence from 13 February 2019:
http://www.tynwald.org.im/business/hansard/20002020/pachsc190213.pdf

Tynwald Public Accounts Committee First Report for the Session 2017 – 18 Overspending at Noble's Hospital – First Report:
http://www.tynwald.org.im/business/pp/Reports/2018-PP-0004.pdf

Tynwald Public Accounts Committee Second Report for the Session 2018 – 19: Overspending at Noble's Hospital – One Year On – 7 March 2019:
http://www.tynwald.org.im/business/pp/Reports/2019-PP-0031.pdf

Tynwald Public Accounts Committee First Report for the Session 2018 – 19: Overspending at Noble's Hospital – Staffing – 7 March 2019:
http://www.tynwald.org.im/business/pp/Reports/2019-PP-0032.pdf

[i] *'Delivering longer, healthier lives'*, DHSC, September 2018, found at: https://www.gov.im/media/1362838/integrated-care-vision.pdf.

[ii] A Progress Report was laid before Tynwald in January 2019, found at: https://www.gov.im/media/1364127/gd20180092-independent-health-and-social-care-review-progress-report.pdf

[iii] *'Delivering longer, healthier lives'*, DHSC, September 2018, found at: https://www.gov.im/media/1362838/integrated-care-vision.pdf.

[iv] DHSC Finance team management accounts (note 2018/19 'actual spend' figures in this table are estimates as at end January 2019); *Isle of Man Pink Book 2019/20'*, Isle of Man government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf, *Isle of Man Pink Book 2018/19'*, Isle of Man government, February 2018, found at: https://www.gov.im/media/1360554/pink-book-final-2018.pdf; *Isle of Man Pink Book 2017/18'*, Isle of Man government, February 2017, found at: https://www.gov.im/media/1355349/isle-of-man-budget-2017-18-v2.pdf; *Isle of Man Pink Book 2016/17'*, Isle of Man government, February 2016, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf; *'Explanatory memorandum to Tynwald's members'*, the DHSC, found at: http://www.tynwald.org.im/business/opqp/sittings/20182021/DHSC-SupplementaryVote-Mar19-MEMO.pdf.

[v] '*Overspending at Noble's Hospital – first report'*, Standing Committee of Tynwald on Public Accounts, January 2018, found at http://www.tynwald.org.im/business/pp/Reports/2018-PP-0004.pdf; *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf, *Isle of Man Pink Book 2018/19'*, Isle of Man government, February 2018, found at: https://www.gov.im/media/1360554/pink-book-final-2018.pdf; *Isle of Man Pink Book 2017/18'*, Isle of Man Government, February 2017, found at: https://www.gov.im/media/1355349/isle-of-man-budget-2017-18-v2.pdf; *Isle of Man Pink Book 2016/17'*, Isle of Man Government, February 2016, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf.

[vi] This finding is based on an overview of the metrics compared in the Isle of Man's 2017 Public Health report. Examples of where England has better outcomes than the Isle of Man include the % of babies that are breast-fed, the % of elderly people who receive a flu jab, the % of people who die at home and the proportion of deaths from drug misuse per 100,000 population. *'A healthy island?'*, Isle of Man Director of Public Health, 2017, found at: https://www.gov.im/media/1358936/ph03-dph-report-final-pdf.pdf.

[vii] *'Delivering longer, healthier lives'*, DHSC, September 2018, found at: https://www.gov.im/media/1362838/integrated-care-vision.pdf.

[viii] https://www.ncbi.nlm.nih.gov/pubmed/20375938

[ix] 'The State of Caring in the Isle of Man 2018-19', Crossroads Care, due for publication in spring 2019.

[x] https://www.sciencedirect.com/science/article/abs/pii/S0277953615302628

[xi] The Isle of Man Strategic Plan for Mental Health and Wellbeing, found at: https://www.gov.im/media/1353553/strategic-plan-for-mental-health-and-wellbeing-2015-2020.pdf

[xii] 2017 Have Your Say Survey Results for DHSC

[xiii] Beamans Review of Management Effectiveness at Noble's Hospital, found at: https://www.gov.im/media/1027297/review_of_management_effectiveness_at_noble_s_hospital.pdf

[xiv] The Review was made aware of a review of the Government Regulatory Framework that was taking place at the same time, but the final report and any resulting policy decision was not available at the time this Report was completed and so the work of the current Registration and Inspection Unit is identified in this table as resting with the DHSC. If, in the future, there is a decision to centralise regulatory functions, this position will need to be considered.

[xv] Numbers will not sum precisely due to rounding. See Annex 12 C2 for the full methodology and assumptions used to calculate the funding gap.

[xvi] 1% efficiency gains a year is equivalent to an average of £3.5m savings per year in real terms, starting at £2.8m in 2019/20, and rising to £4.2m in 2035/36. See Annex 12 for the methodology for how this was calculated

[xvii] Income tax receipts have increased on average 3.53% a year (*'Isle of Man Budget 2011/12',* Isle of Man Treasury, found at: https://www.gov.im/media/1352728/budget-2011-12.pdf; *'Isle of Man Budget 2012/13',* Isle of Man Treasury, found at: https://www.gov.im/media/1352729/budget-2012-13.pdf; *'Isle of Man Budget 2013/14'*, Isle of Man Treasury, found at: https://www.gov.im/media/1352730/budget-2013-14.pdf; *'Isle of Man Budget 2014/15',* Isle of Man Treasury, found at: https://www.gov.im/media/1352731/budget-2014-

15.pdf; *'Isle of Man Budget 2015/16',* Isle of Man Treasury, found at: http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020142016/2015-GD-0001.pdf, *'Isle of Man Budget 2016/17'*, Isle of Man Treasury, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf; *'Isle of Man Budget 2017/18'*, Isle of Man Treasury, found at: https://www.gov.im/about-the-government/departments/the-treasury/budget/2017-18-budget/). Isle of Man CPI inflation has increased on average 2.33% a year between January 2008 (latest data available, provided by Isle of Man Treasury) and December 2018 *('Isle of Man Inflation Historic Datasets'*, Economic Affairs, Cabinet Office, January 2019).

[xviii] National insurance tax receipts have increased on average 2.72% a year (data provided by Isle of Man Treasury), whereas Isle of Man CPI inflation has increased on average 2.05% a year between January 2010 and December 2018 (*'Isle of Man Inflation Historic Datasets'*, Economic Affairs, Cabinet Office, January 2019).

[xix] See Annex 12 E1 for how Treasury receipts increases would impact the amount of additional funding required under various scenarios.

[xx] Charges calculations assume that 25% of people will be exempt from paying charges due to criteria such as low income, and that a cap for charges is also put in place to protect people from paying very high costs for care (calculation estimates that 20% of activity charges will be waived due to being above an individual's annual cap).

[xxi] *'How to fix the funding of health and social care'*, Institute for Government, June 2018, found at: https://www.instituteforgovernment.org.uk/sites/default/files/publications/IFG_Funding_health_and_social_care_web.pdf.

[xxii] "Human: Solving the global workforce crisis in healthcare": https://global.oup.com/academic/product/human-solving-the-global-workforce-crisis-in-healthcare-9780198836520?cc=gb&lang=en&

[xxiii] "Closing the gap: key areas for action on the health and care workforce": https://www.nuffieldtrust.org.uk/research/closing-the-gap-key-areas-for-action-on-the-health-and-care-workforce

[xxiv] Publications: "Acute care in remote settings; challenges and potential solutions" and "Rethinking acute medical care in smaller hospitals"

[xxv] https://www.gov.im/media/1364409/pn-207-19-national-insurance-holiday-scheme-final.pdf

[xxvi] For hospital physicians the 'premium' is applied through additional Programmed Activities (PAs) and for allied health professionals and nursing grades, the 'premium' is applied through deliberately inflated staff grades relative to the NHS Agenda for Change pay scale.

[xxvii] Reinventing healthcare delivery, Steven Spear (2012), found at: https://qi.elft.nhs.uk/wp-content/uploads/2017/03/ReinventingHealthcareDelivery-Steven-Spear.pdf.

[xxviii] Some attended more than one workshop.
[xxix] Does not include submission of information, data and other evidence submitted by a multitude of sources thorough the course of the Review and is in addition to those included in the online hub.
[xxx] Using the Government's Dialogue system, which is a system designed to give public bodies a transparent, engaging way to involve citizens and stakeholders in decisions.
[xxxi] The Government's Dialogue moderation policy states that comments and user names which include any of the following may be deleted: Threats or incitements to violence, Use of obscenity, Duplicative or substantially duplicative postings by the same person or entity, Postings seeking employment or containing advertisements for a commercial product or service, Information posted in violation of law, including libel, condoning or encouraging illegal activity, revealing classified information, or infringing on a copyright or trademark.
[xxxii] This review area received the most responses, with 81 ideas submitted. Ten were in response to what is working, 38 were in response to what is not working, and 69 included suggestions for how things could be improved.
[xxxiii] There were 64 ideas received relating to cost savings and/or funding for the health and care system. Of those ideas, 26 related to funding and 40 related to cost saving, with two ideas being relevant to both funding and cost saving.
[xxxiv] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xxxv] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xxxvi] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xxxvii] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xxxviii] An additional 40 ideas were put forward for cost savings but these are included in the Improvements and Efficiencies section.
[xxxix] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xl] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xli] The most popular ideas (those that received an average rating of >4.5*) and those that promoted the most discussion (measured by the number of comments received being >8) are included
[xlii] Including all Island schools, Women's Institute, Rotary Club, Positive Action Group, IOM Freethinkers, a variety of sporting associations, the National Sports Centre, Local Authorities, the Scouting and Girl Guiding Associations and the Council of Voluntary Organisations requesting help to identify interested service users
[xliii] http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020162018/2018-GD-0018.pdf
[xliv] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
[xlv] Where there is a fee to see a GP and additional charges may be made for services like injections and blood tests. For the first six months after arriving in Jersey, the full cost of a visit to a GP is payable. After six months (and if Social Security contributions have been paid) you are entitled to a Social Security health card, which will give a discount of £20.00 off the fee.
[xlvi] *'Future funding: nursing and residential care'*, Future funding of nursing and residential care review, July 2018, found at: www.tynwald.org.im/business/opqp/sittings/Tynwald%2020162018/2018-GD-0032.pdf.
[xlvii] Achieved by combining other options; long term care benefit (available to meet the costs of care once care costs have been paid up to a care cost cap) and long term care support (means tested financial support to help meet care and living costs in a care home).
[xlviii] Individual's assets are valued at the time they first require care. Individuals are expected to self-fund until a set proportion of their assets have been exhausted. At the point that the cap is reached, government funded care would then be provided based on needs

[xlix] 70% of respondents answered that it is difficult to access mental health services on the Island and 60% of respondents stated that it takes months to get a referral.
[l] https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_jul_pdf_schneider_mirror_mirror_exhibits.pdf
[li] https://www.nhs.uk/using-the-nhs/healthcare-abroad/healthcare-when-travelling-abroad/healthcare-in-luxembourg/
[lii] See Annex 1 to this Report
[liii] https://www.telegraph.co.uk/news/0/mapped-global-epidemic-lifestyle-disease-charts/
[liv] https://medicalconnectivity.com/2006/01/13/montefiore-medical-center-expands-use-of-cardiocom-system/
[lv] https://medium.com/@cigen_rpa/overview-of-robotic-process-automation-in-the-healthcare-industry-b5c91069e6e0
[lvi] https://www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons/2005-Home-care/Germany
[lvii] https://www.ijic.org/articles/abstract/10.5334/ijic.1621/
[lviii] https://www.eelga.gov.uk/documents/publications/report%20on%20suffolk%20study%20visit%20on%20the%20buurtzorg%20model%20of%20care%20at%20home%20(final).pdf
[lix] '*2016 Census Population Projections'*, provided by Public Health Directorate.
[lx] '*2016 Census Population Projections'*, provided by Public Health Directorate; *'FOI – Population by age, gender and ethnicity',* Office for National Statistics, 10th January 2017, found at: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/populationbyagegenderandethnicity.
[lxi] *'Isle of Man in Numbers 2018',* Cabinet Office, May 2018, found at: https://www.gov.im/media/1361698/isle-of-man-in-numbers-2018-report-v2.pdf; *'Population of the UK by country of birth and nationality: individual country data',* Office for National Statistics, 29th November 2018.
[lxii] While there are people from the Isle of Man living in the UK, the number rounds to less than 0.05% of the UK population.
[lxiii] *'GP Performance Master 2018'* provided by Business Intelligence Team at DHSC.
[lxiv] *'GP Performance Master 2018'* provided by Business Intelligence Team at DHSC.
[lxv] *'Isle of Man in Numbers 2018',* Cabinet Office, May 2018, found at: https://www.gov.im/media/1361698/isle-of-man-in-numbers-2018-report-v2.pdf.
[lxvi] *'A healthy island?'*, Isle of Man Director of Public Health, 2017, found at: https://www.gov.im/media/1358936/ph03-dph-report-final-pdf.pdf; *'Avoidable mortality in the UK',* Office for National Statistics, 2016, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2016.
[lxvii] *'A healthy island?'*, Isle of Man Director of Public Health, 2017, found at: https://www.gov.im/media/1358936/ph03-dph-report-final-pdf.pdf; *'Statistics on drug misuse: England, 2017'*, Office for National Statistics, 28th February 2017, found at: http://webarchive.nationalarchives.gov.uk/20180328135520/http://digital.nhs.uk/catalogue/PUB23442, *'Statistics on smoking: England, 2017',* Office for National Statistics, 15th June 2017, found at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2017-pas; '*Maternity Services Monthly Statistics',* NHS Digital, 3rd January 2018, found at: https://files.digital.nhs.uk/publication/h/1/msms-aug17-exp-rep.pdf; *'Consumption: adult drinking in the UK',* Drink Aware, found at: https://www.drinkaware.co.uk/research/data/consumption-uk/; *'Consumption: underage drinking in the UK*:, Drink Aware, found at: https://www.drinkaware.co.uk/research/data/uk-underage-consumption/.
[lxviii] '*The English Indices of Deprivation 2015',* Department for Communities and Local Government, 30th September 2015, found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf.
[lxix] *'Joint Strategic Needs Assessment',* Isle of Man Government, June 2014, found at: https://www.gov.im/media/1345872/iom-government-joint-strategic-needs-assessment-2014.pdf.

[lxx] *'Isle of Man Earnings Survey Report 2017',* Cabinet Office, February 2018, found at: https://www.gov.im/media/1360610/2018-01-23-earnings-survey-2017-report-final.pdf.
[lxxi] *'Earnings and working hours',* Office for National Statistics, found at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours.
[lxxii] *'Briefing: Emergency hospital admissions in England: which may be avoidable and how?',* The Health Foundation, May 2018, found at: https://health.org.uk/sites/health/files/Briefing_Emergency%2520admissions_web_final.pdf; Medway data provided by the Hospital Performance Team at the DHSC; *'Quarterly Hospital Activity Data',* NHS England, found at: https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/quarterly-hospital-activity/qar-data/; *'UK population 2017',* Office for National Statistics, 20th July 2017, found at: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukpopulation2017; Medway data provided by the Hospital Performance Team at the DHSC.
[lxxiii] *'Isle of Man SUS data 2018'* provided by the Commercial and Business Enterprise team at the DHSC.
[lxxiv] The Review recognises that telephone and home consultations are an important part of GP workload but neither the BMA figures used for the comparison in England nor the GP appointment data available in the Isle of Man record anything other than face-to-face appointments consistently.
[lxxv] *'General practice in the UK – background briefing',* the BMA, April 2017, found at: https://www.bma.org.uk/-/media/files/pdfs/news%20views%20analysis/press%20briefings/general-practice.pdf ;*'Annual mid year population estimates, UK: 2013',* Office for National Statistics, 30th June 2013, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/2014-06-26; *'Data on patients seen per session'* provided by Primary Care Commissioned Services team.
[lxxvi] *'Comparison of WTE GPs, staff and patients'* provided by Primary Care and Commissioned Services team.
[lxxvii] *'Comparison of WTE GPs, staff and patients'* provided by Primary Care and Commissioned Services team.
[lxxviii] *'Hospital activity data',* NHS England, 2018, found at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/06/Annual-CSV-2017-18-up-to-Mar-incl-Revisions-published-June-18.zip; *;'Annual mid year population estimates, UK: 2013'*, Office for National Statistics, 30th June 2013, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/2014-06-26, '*Annual mid year population estimates, UK: 2014',* Office for National Statistics, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/2015-06-25; *'GP Performance Master 2018'* provided by Business Intelligence Team at DHSC.
[lxxix] *'Data on patients seen per session'* provided by Primary Care Commissioned Services team; '*Data on GP sessions and WTE by practice'* provided by Primary Care Commissioned Services team.
[lxxx] *'Exclusive: GPs in England deliver 1m appointments per week over 'safe limit'',* GP Online, 21st March 2017, found at: https://www.gponline.com/exclusive-gps-england-deliver-1m-appointments-per-week-safe-limit/article/1427972.
[lxxxi] '*Community Health Stats Apr 17 to Aug 18'* provided by the DHSC Community Health teams.
[lxxxii] '*Understanding safe caseloads in the District Nursing Service*', The Queen's Nursing Institute, found at: https://www.qni.org.uk/wp-content/uploads/2017/02/Understanding_Safe_Caseloads_in_District_Nursing_Service_V1.0.pdf.
[lxxxiii] These referral figures are for all referrals to adult social care services. The Review was not provided with a breakdown of referrals for particular types of care and data at that level of detail is not available for comparison.
[lxxxiv] *'2016 Census Population Projections*', provided by Public Health Directorate; '*Care Home Occupancy Data 2017/18'* provided by Adult Social Care team; *'Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland',* Office for National Statistics, 28th June 2018, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland; '*Later life in the United Kingdom',* Age UK, April 2018, found at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf.

[lxxxv] *'Adult Social Care Activity and Finance Report: Detailed Analysis',* NHS Digital, 25th October 2017, found at: https://files.digital.nhs.uk/pdf/2/m/adult_social_care_activity_and_finance_report.pdf; *'Population estimates',* Office for National Statistics, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates; '*Adult Social Care activity data 2017/18'* provided by Adult Social Care team.
[lxxxvi] '*Adult Social Care activity data 2017/18'* provided by Adult Social Care team; *'Population estimates',* Office for National Statistics, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates; *'2016 Census Population Projections'*, provided by Public Health Directorate; '*Characteristics of children in need: 2016 to 2017'*, Department for Education, 2nd November 2017, found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656395/SFR61-2017_Main_text.pdf; *'Children's social care in England'*, House of Commons Library, 8th October 2018, found at: http://researchbriefings.files.parliament.uk/documents/CDP-2018-0208/CDP-2018-0208.pdf, *'Community care statistics, social services activity, England 2015 – 16',* NHS Digital, 5th October 2016, found at: https://files.digital.nhs.uk/publicationimport/pub21xxx/pub21934/comm-care-stat-act-eng-2015-16-rep.pdf; *'Children and Families Division Annual Report 2017/18'* provided by Children and Families Services team.
[lxxxvii] *Children and Families Division Annual Report 2017/18'* provided by Children and Families Services team.
[lxxxviii] *'Fostering statistics'*, The Fostering Network, found at: https://www.thefosteringnetwork.org.uk/advice-information/all-about-fostering/fostering-statistics; *'UK population 2017',* Office for National Statistics, 20th July 2017, found at: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukpopulation2017; *'2016 Census Population Projections'*, provided by Public Health Directorate.
[lxxxix] *'Children and Families Division Annual Report 2017/18'* provided by Children and Families Services team.
[xc] *'Children and Families Division Annual Report 2017/18'* provided by Children and Families Services team.
[xci] These referral figures cannot be compared effectively to referral figures in England as England has a much greater range of services used to support children in need, which cannot be simply mapped on to provision in the Isle of Man.
[xcii] *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf.
[xciii] *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf.
[xciv] Source: DHSC management accounts provided by DHSC finance team. Spend is 'probable' for 2018/19, as using latest figures at time of writing – management accounts as at end of January 2018 (so 10 months of actual spend, two months of forecast spend)
[xcv] '*Central cost data'*, provided by Isle of Man Government Departments
[xcvi] *'Isle of Man Financial Report 2017/18*', provided by Isle of Man Treasury; '*Central cost data'*, provided by Isle of Man Government Departments; *'2016 Census Population Projections'*, provided by Public Health Directorate; *'Budget Statement 2016*', States of Jersey;, 2016, found at: https://www.gov.je/Government/PlanningPerformance/BudgetAccounts/Pages/Statements.aspx; *'Population characteristics',* Government of Jersey, found at: https://www.gov.je/Government/JerseyInFigures/Population/pages/populationstatistics.aspx; *'Autumn Budget 2017'*, HM Treasury, found at: https://www.gov.uk/government/publications/autumn-budget-2017-documents; *'Public Spending on Children in England: 2000 to 2020'*, Children's Commissioner and Institute for Fiscal Studies, June 2018, found at: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/06/Public-Spending-on-Children-in-England-CCO-JUNE-2018.pdf; *'Public spending on adult social care in England'*, Institute for Fiscal Studies, 2017, found at: https://www.ifs.org.uk/uploads/publications/bns/BN200.pdf; ; *'Estimates for the population for the UK, England, and Wales, Scotland and Northern Ireland',* Office for National Statistics, 28th June 2018, found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland; *'NHS in Scotland 2017*', Audit Scotland, October 2017, found at: http://www.audit-scotland.gov.uk/uploads/docs/report/2017/nr_171026_nhs_overview.pdf; *'Scottish local government financial statistics 2016-2017'*, Office for National Statistics, found at: https://www.gov.scot/binaries/content/documents/govscot/publications/statistics-

publication/2018/02/scottish-local-government-financial-statistics-2016-17/documents/00532038-pdf/00532038-pdf/govscot%3Adocument; *'Scotland's population 2017',* National Records of Scotland, found at: https://www.nrscotland.gov.uk/news/2018/scotlands-population-2017; *'2018 Budget: fair, innovative and confident'*, States of Guernsey, 9th October 2017, found at: https://www.gov.gg/article/162155/2018-Budget-fair-innovative-and-confident; *'Population, employment and earnings',* States of Guernsey, found at: https://www.gov.gg/population.

[xcvii] '*Consultant payroll analysis'*, July 2018, provided by Noble's Hospital.

[xcviii] *'Top women doctors lose out in NHS pay stakes'*, NHS Digital reported by BBC News, 16th February 2018, found at https://www.bbc.co.uk/news/health-43077465.

[xcix] Which includes GP prescriptions, dental prescriptions, and hospital out-patient prescriptions.

[c] Data provided by DHSC Pharmaceutical team.

[ci] Healthcare Reference Group costs are nationally measured costs produced by the NHS in England to create an average measure of what a procedure costs to deliver. Trusts are then recompensed according to HRG costs, creating an incentive to keep costs to the average or below.

[cii] *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf; '*Isle of Man Pink Book 2018/19'*, Isle of Man Government, February 2018, found at: https://www.gov.im/media/1360554/pink-book-final-2018.pdf; *Isle of Man Pink Book 2017/18'*, Isle of Man Government, February 2017, found at: https://www.gov.im/media/1355349/isle-of-man-budget-2017-18-v2.pdf; *Isle of Man Pink Book 2016/17'*, Isle of Man Government, February 2016, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf.; *'Isle of Man Budget 2015/16'*, Isle of Man Government, 2015, found at: http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020142016/2015-GD-0001.pdf.

[ciii] *Overspending at Noble's Hospital – first report'*, Standing Committee of Tynwald on Public Accounts, January 2018.

[civ] *'Overspending at Noble's Hospital – staffing'*, Standing Committee of Tynwald on Public Accounts, March 2019, found at: http://www.tynwald.org.im/business/opqp/sittings/20182021/2019-PP-0032.pdf.

[cv] *'The Lord Darzi Review of Health and social care: Interim Report,'* Institute for Public Policy Research, April 2018, found at: https://www.ippr.org/publications/darzi-review-interim-report.

[cvi] *'NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios'*, NHS England, May 2016, found at: https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf.

[cvii] There is a wealth of evidence indicating that as people age they are more likely to develop multiple long term conditions. In 2016 NICE estimated that 58% of people with an LTC in England are over 60 (and only 14% are under 40). *'Social care of older people with complex care needs and multiple long term conditions'*, NICE, found at: https://www.nice.org.uk/guidance/ng22/documents/social-care-of-older-people-with-complex-care-needs-and-multiple-longterm-conditions-equality-impact-assessment2. In 2013 the Kings Fund also reported that the prevalence of long-term conditions rises with age, affecting about 50% of people aged 50, and 80% of those aged 65 *('Delivering better services for people with long-term conditions*', The Kings Fund, October 2013, found at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf).

[cviii] *'2016 Census Population Projections'*, provided by Public Health Directorate.

[cix] *'2016 Census Population Projections'*, provided by Public Health Directorate.

[cx] *'2016 Census Population Projections'*, provided by Public Health Directorate.

[cxi] *'2016 Census Population Projections'*, provided by Public Health Directorate.

[cxii] *'2016 Census Population Projections'*, provided by the DHSC Public Health Directorate; Medway data provided by the Hospital Performance Team at the DHSC; '*Adult Social Care activity data 2017/18'* provided by Adult Social Care team; '*Care Home Occupancy Data 2017/18'* provided by Adult Social Care team; *'Children and Families Division Annual Report 2017/18'* provided by the DHSC Children and Families Services team; *'Community health activity data'*, provided by the DHSC Community Health Directorate, April 2017 to August 2018; *'Mental health minimum data set 2017/18'* provided by the DHSC Mental health services team; *'Mental health minimum data set 2018/19'* provided by the DHSC Mental health services team; '*Off-island forensic placements - 2018 snapshot'*, provided by the DHSC Adult Social Care team; *'Data on patients seen per session'* provided by the DHSC Primary Care Commissioned Services team.

[cxiii] 2018/19 for GP appointments, all others 2017/18. Annual GP appointments estimated by multiplying number of sessions per week by average number of appointments per session (data provided by DHSC).
[cxiv] *'2016 Census Population Projections'*, provided by the DHSC Public Health Directorate; Medway data provided by the Hospital Performance Team at the DHSC; '*Adult Social Care activity data 2017/18'* provided by Adult Social Care team; '*Care Home Occupancy Data 2017/18'* provided by Adult Social Care team; *'Children and Families Division Annual Report 2017/18'* provided by the DHSC Children and Families Services team; *'Community health activity data'*, provided by the DHSC Community Health Directorate, April 2017 to August 2018; *'Mental health minimum data set 2017/18'* provided by the DHSC Mental health services team; *'Mental health minimum data set 2018/19'* provided by the DHSC Mental health services team; '*Off-island forensic placements - 2018 snapshot'*, provided by the DHSC Adult Social Care team; *'Data on patients seen per session'* provided by the DHSC Primary Care Commissioned Services team.
[cxv] 2018/19 for GP appointments, all others 2017/18. Annual GP appointments estimated by multiplying number of sessions per week by average number of appointments per session (data provided by DHSC).
[cxvi] *'2016 Census Population Projections'*, provided by the DHSC Public Health Directorate; Medway data provided by the Hospital Performance Team at the DHSC; '*Adult Social Care activity data 2017/18'* provided by Adult Social Care team; '*Care Home Occupancy Data 2017/18'* provided by Adult Social Care team; *'Children and Families Division Annual Report 2017/18'* provided by the DHSC Children and Families Services team; *'Community health activity data'*, provided by the DHSC Community Health Directorate, April 2017 to August 2018; *'Mental health minimum data set 2017/18'* provided by the DHSC Mental health services team; *'Mental health minimum data set 2018/19'* provided by the DHSC Mental health services team; '*Off-island forensic placements - 2018 snapshot'*, provided by the DHSC Adult Social Care team; *'Data on patients seen per session'* provided by the DHSC Primary Care Commissioned Services team.
[cxvii] 2018/19 for GP appointments, all others 2017/18. Annual GP appointments estimated by multiplying number of sessions per week by average number of appointments per session (data provided by DHSC).
[cxviii] *'UK population 2017',* Office for National Statistics, 20th July 2017, found at: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukpopulation2017; Medway data provided by the DHSC Noble's hospital team; *'Hospital accident and emergency activity 2017 – 18*', NHS Digital, found at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2017-18.
[cxix] '*Adult Social Care activity data 2017/18'* provided by Adult Social Care team.
[cxx] *'NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios'*, NHS England, May 2016, found at: https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf.
[cxxi] *'NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios'*, NHS England, May 2016, found at: https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf.
[cxxii] *Economic and Fiscal Outlook - October 2018*', Office for Budget Responsibility, October 2018, found at: https://cdn.obr.uk/EFO_October-2018.pdf.
[cxxiii] *'NHS Productivity from 2004/5 to 2010/11'*, Centre for Health Economics, 2013, found at: http://eprints.whiterose.ac.uk/136291/.
[cxxiv] *'Definitions of efficiency',* BMJ, 24th April 1999, found at: https://www.bmj.com/content/318/7191/1136.
[cxxv] Efficiency analysis including quality outcomes was included in the *'NHS Productivity from 2004/5 to 2010/11'* study by the Centre for Health Economics, although it is not always achievable in the NHS in England either.
[cxxvi] '*Average GP waiting times remain at two weeks despite rescue measures'*, Pulse, 2nd June 2017, found at: http://www.pulsetoday.co.uk/your-practice/practice-topics/access/average-gp-waiting-times-remain-at-two-weeks-despite-rescue-measures/20034534.article; *'Waiting times for GP appointments',* FOI request of 22nd January, responded to on, 5th February 2019, found at: https://iom.icasework.com/servlet/servlets.getImg?ref=D340865&bin=Y&auth=0&db=ZVD1ZPdIGvo%3D&access_token=d-CIT7XAvC39i2kipf3HT5iEOd47VqLUVgp7Syldn2D3H0j1_srlvEnSZo4a2Bs1.VMAvuiNxiqQTgvnUrQhbtQ%3D%3D; *'Social work watch – inside an average day in social* work', Unison, 29th April 2014, found at: https://www.unison.org.uk/content/uploads/2014/06/TowebSocial-Work-Watch-final-report-PDF2.pdf; *'Adult Social Care Scorecard Graphs'* provided by the DHSC Adult Social Care team; *'Comparison of WTE GPs, staff and*

patients' provided by Primary Care and Commissioned Services team; *'General practice in the UK – background briefing',* the BMA, April 2017, found at: https://www.bma.org.uk/-/media/files/pdfs/news%20views%20analysis/press%20briefings/general-practice.pdf; Medway outpatients data provided by the DHSC Noble's BI team; *'NHS inpatient admission and outpatient referrals and attendances*', NHS England, 23rd Feb 2018, found at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/02/QAR-commentary-Q3-1718-78201-2.pdf; Waiting time data provided by the DHSC BI team; *'Treatment waiting times'*, Nuffield Trust, 16th August 2018, found at: http://www.qualitywatch.org.uk/indicator/treatment-waiting-times.

[cxxvii] Does not include telephone calls or nurse appointments at GP practices.

[cxxviii] Comparable statistics for social care in England are not available because budgets are set at local level and because over the last twenty years councils have been forced to cut budgets, rather than make efficiencies while preserving existing services.

[cxxix] *'The Lord Darzi Review of Health and social care: Interim Report,'* Institute for Public Policy Research, April 2018, found at: https://www.ippr.org/publications/darzi-review-interim-report.

[cxxx] *'The NHS Long Term Plan'*, NHS England, 2019, found at: https://www.england.nhs.uk/long-term-plan/.

[cxxxi] *'Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf.

[cxxxii] *'2018 Budget Speech',* Minister for the Treasury, 20th February 2018, found at: https://www.gov.im/media/1360560/budget-speech-2018-19-final.pdf.

[cxxxiii] DHSC Finance team management accounts (note 2018/19 'actual spend' figures in this table are estimates as at end January 2019); *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf, *Isle of Man Pink Book 2018/19'*, Isle of Man Government, February 2018, found at: https://www.gov.im/media/1360554/pink-book-final-2018.pdf; *Isle of Man Pink Book 2017/18'*, Isle of Man Government, February 2017, found at: https://www.gov.im/media/1355349/isle-of-man-budget-2017-18-v2.pdf; *Isle of Man Pink Book 2016/17'*, Isle of Man Government, February 2016, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf;

[cxxxiv] 'Clearly, if the Department is to effectively manage its budget and continue to provide these essential services then it must have a meaningful target to manage within; this level of continued overspending does not provide that. The Department estimates that the ongoing costs pressures amount to an extra £21 million for 2017/18. In recognition of this, but also to ensure that we impose strong cost controls where budget caps mean exactly that […] I am proposing that the DHSC's budget is increased by £11 million, which will help to address approximately half of the cost pressure. At the same time the Department will need to deliver reductions of £10 million to meet the remainder of the ongoing cost.' *'2017 Budget Speech',* Minister for the Treasury, 21st February 2017 found at: *https://www.gov.im/media/1355348/budget-speech-20170221-final.pdf. https://www.gov.im/media/1355348/budget-speech-20170221-final.pdf.*

[cxxxv] *'NHS financial sustainability'*, National Audit Office, 18 January 2019, found at: https://www.nao.org.uk/report/nhs-financial-sustainability/.

[cxxxvi] '*Making the most of the money: efficiency and the long-term plan',* NHS Providers, 2018, found at: https://nhsproviders.org/making-the-most-of-the-money-efficiency-and-the-long-term-plan/, *'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations'*¸ An independent report for the Department of Health by Lord Carter of Coles, 2016, found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf and *'NHS Financial Sustainability'*, National Audit Office, 18th January 2019, found at: https://www.nao.org.uk/wp-content/uploads/2019/01/NHS-financial-sustainability_.pdf.

[cxxxvii] *'Better value in the NHS: The role of changes in clinical practice'*, The Kings Fund, July 2015, found at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/better-value-nhs-Kings-Fund-July%202015.pdf.

[cxxxviii] *'Making the most of the money: efficiency and the long-term plan',* NHS Providers, 2018, found at: https://nhsproviders.org/making-the-most-of-the-money-efficiency-and-the-long-term-plan/,*'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations'*¸ An independent report for the Department of Health by Lord Carter of Coles, 2016, found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf and *'NHS Financial Sustainability'*, National Audit Office, 18th January 2019, found at: https://www.nao.org.uk/wp-content/uploads/2019/01/NHS-financial-sustainability_.pdf.

[cxxxix] *'Shifting the balance of care: Great expectations'*, The Nuffield Trust, March 2017, found at: https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf.
[cxl] *'The NHS Long Term Plan'*, NHS England, 2019, found at: https://www.england.nhs.uk/long-term-plan/.
[cxli] *'Shifting the balance of care: Great expectations'*, The Nuffield Trust, March 2017, found at: https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf and *Making the most of the money: efficiency and the long-term plan',* NHS Providers, 2018, found at: https://nhsproviders.org/making-the-most-of-the-money-efficiency-and-the-long-term-plan/
[cxlii] There has been recent guidance from NHS England on a number of clinically ineffective procedures and procedures to be performed only in specific circumstances. The NHS England Medical Advisory Group, comprising national clinical directors, supported the final list of seventeen interventions for consultation. The limitations of the Isle of Man data make granular analysis impossible. By applying relevant procedure names to data for theatres at Noble's Hospital for 2016/17, however, it can be determined that 5.6% of total recorded elective activity for that year fell into that category.
[cxliii] There has been guidance provided to NHS organisations in England regarding Procedures of Low or Limited Clinical Effectiveness (PoLCE). This guidance has resulted in some commissioning organisations in England discontinuing these procedures. It is noted that there is some overlap between the list of Procedures with Limited Clinical Justification and the list of Procedures of Low or Limited Clinical Effectiveness. Care has been taken in the Review's analysis to avoid double counting. By applying relevant procedure names to data for theatres at Noble's Hospital for 2016/17, it was determined that there approximately 0.675% of procedures delivered that fell into this category.
[cxliv] *'Reference costs 2017/18: highlights, analysis and introduction to the data'*, NHS Improvement, November 2018, found at: https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_201718.pdf.
[cxlv] Better management of referrals will reduce the number of patients referred inappropriately to Noble's. In addition to enabling a reduction in costs, it will also ensure that optimum use is made of community resources. Evidence comes from South Tyneside CCGs partnership with the University of Newcastle's Making Good Decisions In Consultation (MAGIC) on the Quality and Demand Management project, which aimed to improve the quality of referrals from primary to secondary care. Results from the project include a 30.9% reduction in referrals for General Surgery; an 18% reduction in referrals for Trauma and Orthopaedics; an 11.2% reduction in referrals for Gynaecology; improved confidence amongst local GPs in dealing with conditions; and savings of £530,000 in the year April 2012 to March 2013. Reductions were achieved through supporting primary care professionals to develop/ maintain their own professional skills, knowledge and experience; promoting the use of external resources/knowledge-bases to support primary care professionals in checking referral criteria or alternative treatment options e.g. National Guidance (e.g. NICE), Map of Medicine, local hospital protocols and Local/ national referral forms; developing processes for peer review by colleagues, facilitating the process whereby individuals can seek advice & guidance from more qualified clinician; and creating systems to facilitate requests for formal assessment/triage by a specialist clinicians.
[cxlvi] *'Reference costs 2017/18: highlights, analysis and introduction to the data'*, NHS Improvement, November 2018, found at: https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_201718.pdf.
[cxlvii] *'Pay guidance for salaried GPs',* BMA, 6th December 2018, found at: https://www.bma.org.uk/advice/employment/pay/general-practitioners-pay (highest point in the range used).
[cxlviii] Estimated £66,400 could be saved by having more efficient start time. Range based on range of utilisation improvements suggested by KM&T report, which ranges from 2 additional sessions per week (saving £436,800 pa) to 10 additional sessions per week (saving £2,184,000 pa). *'Isle of Man scoping day findings and next steps'* KM&T, August 2018.
[cxlix] DTOC/reducing LoS approaches are commonly used in other health and social care systems. They include: discharge to assess, improved collaboration between hospital and community services, virtual wards, domiciliary reablement, short term response teams in the community for elderly patients at risk of admission, providing expected discharge dates to patients on admission, charity teams of befrienders to support people who have recently been discharged to prevent readmission due to anxiety, rapid assessment units at A&E to prevent unnecessary admissions, discharge coordinator roles and seven day working (examples sourced from Nuffield Trust case studies of effective interventions). All have been proven to work, especially in combination. Discharge to Assess is now a national requirement in England and has been proven to deliver real benefits in areas such as Medway, Sheffield, South Warwickshire and South Gloucestershire. Results demonstrate that D2A improves outcomes for patients by reducing in-patient length of stay. In addition to delivering financial

benefits by moving people out of a hospital setting more quickly, D2A can also reduce on-going care requirements and associated costs. This is because extended hospital stays can permanently reduce a person's ability to live independently, resulting in a step change in the intensity of the long term care they require once they are discharged. Best practice evidence from Sheffield and North West London indicates that D2A reduces Length of Stay by an average of 4 days per referral. Evidence from South Gloucestershire indicates that D2A reduces Length of Stay by almost 12 days per referral.

[cl] *'Reference costs 2017/18: highlights, analysis and introduction to the data'*, NHS Improvement, November 2018, found at: https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_201718.pdf.

[cli] Half of the 3,623 2017/18 excess bed days – provided by Noble's Hospitals Performance Manager

[clii] Data provided by the DHSC Pharmaceutical team.

[cliii] Pharmaceutical cost per 1,000 population on the Isle of Man is £205,008 compared to £153,932 in England (data provided by DHSC Pharmaceutical Team). Bringing the cost down to the England figure would save £4.32m.

[cliv] *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf.

[clv] *Isle of Man Pink Book 2016/17'*, Isle of Man Government, February 2016, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf.

[clvi] *'The Isle of Man Government Financial Regulations'*, Government Office, 1st November 2018, found at: https://www.gov.im/media/1363501/iom-government-financial-regulations-november-2018-1-1.pdf.

[clvii] Discussions with Isle of Man Treasury and *Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf, *Isle of Man Pink Book 2018/19'*, Isle of Man Government, February 2018, found at: https://www.gov.im/media/1360554/pink-book-final-2018.pdf; *Isle of Man Pink Book 2017/18'*, Isle of Man Government, February 2017, found at: https://www.gov.im/media/1355349/isle-of-man-budget-2017-18-v2.pdf; *Isle of Man Pink Book 2016/17'*, Isle of Man Government, February 2016, found at: https://www.gov.im/media/1350454/pink-book-2016-17.pdf.

[clviii] *'Isle of Man Budget Speech 2019'*, Minister for the Treasury, 19th February 2019, found at: https://www.gov.im/media/1364401/budget-speech-2019.pdf.

[clix] *'The Isle of Man Government Financial Regulations'*, Government Office, 1st November 2018, found at: https://www.gov.im/media/1363501/iom-government-financial-regulations-november-2018-1-1.pdf.

[clx] '*Making change possible: a Transformation Fund for the NHS'*, The Kings Fund and The Health Foundation, July 2015, found at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-change-possible-a-transformation-fund-for-the-nhs-kingsfund-healthfdn-jul15.pdf.

[clxi] Calculated as 1.3%, 1.5% and 1.8% of DHSC spend (including central costs).

[clxii] *'Isle of Man Pink Book 2019/20'*, Isle of Man Government, 2019, found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf.

[clxiii] 1% * £867.8m = £8.7m

[clxiv] 2.13% * £867.8m = £18.5mm

[clxv] 3% * £867.8m = £26.0m

[clxvi] *Canada's healthcare system',* Government of Canada, found at: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html.

[clxvii] *'How healthcare is funded'*, The Kings Fund, 23rd March 2017, found at: https://www.kingsfund.org.uk/publications/how-health-care-is-funded.

[clxviii] *'The Laffer Curve'*, R. Hemming and J. A. Kay, The Journal of Applied Public Economics, Institute for Fiscal Studies, March 1980, found at: https://www.ifs.org.uk/publications/2870.

[clxix] Discussions with the Isle of Man Tax department.

[clxx] *Rates and allowances'*, Isle of Man government, found at: https://www.gov.im/categories/tax-vat-and-your-money/income-tax-and-national-insurance/individuals/residents/rates-and-allowances/.

[clxxi] *'Rates and allowances'*, Isle of Man government, found at: https://www.gov.im/categories/tax-vat-and-your-money/income-tax-and-national-insurance/individuals/residents/rates-and-allowances/.

[clxxii] Discussions with the Isle of Man Tax department.

[clxxiii] *'How healthcare is funded',* The Kings Fund, 23rd March 2017, found at: https://www.kingsfund.org.uk/publications/how-health-care-is-funded#private-health-insurance-phi .

[clxxiv] *How healthcare is funded',* The Kings Fund, 23rd March 2017, found at: https://www.kingsfund.org.uk/publications/how-health-care-is-funded#private-health-insurance-phi.

[clxxv] *'How healthcare is funded',* The Kings Fund, 23rd March 2017, found at: https://www.kingsfund.org.uk/publications/how-health-care-is-funded#private-health-insurance-phi.
[clxxvi] *'Report of the select committee on the funding of nursing and residential care'*, Mr C R Robertshaw MHK (Douglas East) (Chair), Mr P Karran MHK (Onchan), Hon J P Watterson MHK (Rushen), 2015/16.
[clxxvii] *'What can England learn from the long-term care system in Japan?'*, Nuffield Trust research report, May 2018, found at: https://www.nuffieldtrust.org.uk/files/2018-05/1525785625_learning-from-japan-final.pdf.
[clxxviii] These charges operate slightly differently as, rather than applying for exemptions from charges, people who are not eligible to pay for optician treatment apply for vouchers for treatment that are then reimbursed by the DHSC.
[clxxix] *Future funding Nursing & Residential Care'*, Future Funding Review team, July 2018.
[clxxx] Data provided by Primary Care Commissioned Services team.
[clxxxi] *'National Health and Care Service (General) Scheme 2018'*, Isle of Man government, 1st June 2018, found at: http://www.tynwald.org.im/business/opqp/sittings/Tynwald%2020162018/2018-SD-0104.pdf
[clxxxii] DHSC Head of Legislation.
[clxxxiii] *'Residential care',* Isle of Man government, found at: https://www.gov.im/categories/caring-and-support/adult-social-care/adult-services-for-older-people/residential-care/.
[clxxxiv] *'Prescription and appliance charges'*, Isle of Man government, found at: https://www.gov.im/categories/health-and-wellbeing/pharmacy/prescription-and-appliance-charges/.
[clxxxvclxxxv] '*Historical & Present Optical Voucher Codes'* provided by the DHSC Primary Care Commissioned Services team.
[clxxxvi] *'Dentists'*, Isle of Man government, found at: https://www.gov.im/categories/health-and-wellbeing/dentists/.
[clxxxvii] *'Prescription and appliance charges'*, Isle of Man government, found at: https://www.gov.im/categories/health-and-wellbeing/pharmacy/prescription-and-appliance-charges/
[clxxxviii] *'Dentists'*, Isle of Man government, found at: https://www.gov.im/categories/health-and-wellbeing/dentists/.
[clxxxix] *'What do I do to see a doctor in Ireland?',* Health Information and Advocacy Centre, 2007, found at: http://cairde.ie/wp-content/uploads/2013/02/GP-Final-doc1.pdf; *'Charges'*, Lido Medical Practice, found at: http://www.lidomedicalpractice.co.uk/making-appointments.aspx?t=3; *'How much will I pay for NHS dental treatment?'*, NHS, 10th October 2017, found at: https://www.nhs.uk/common-health-questions/dental-health/how-much-will-i-pay-for-nhs-dental-treatment/; *'Free glasses with medical card*', Specsavers, found at: https://www.specsavers.ie/offers/free-glasses-and-eye-test-with-medical-card; *'Prescription and appliance charges'*, Isle of Man government, found at: https://www.gov.im/categories/health-and-wellbeing/pharmacy/prescription-and-appliance-charges/; *'NHS prescription charges from April 2019',* Written Statement to Parliament, 21st February 2019, found at: https://www.gov.uk/government/speeches/nhs-prescription-charges-from-april-2019; *'Medical card application process',* Health Service Executive, found at: https://www2.hse.ie/services/medical-cards/medical-card-application-process/what-a-medical-card-covers.html; *'Prescription charges'*, Money Guide Ireland, found at: http://www.moneyguideireland.com/category/prescription-charges; *'NHS voucher values for glasses and lenses'*, NHS, 3rd July 2017, found at: https://www.nhs.uk/using-the-nhs/help-with-health-costs/nhs-voucher-values-for-glasses-and-lenses/; *'Treatment and prices'*, Little Grove Dental, found at: https://www.littlegrovedental.com/.
[cxc] *'Am I entitled to free prescriptions?'*, NHS, 1st April 2017, found at: https://www.nhs.uk/using-the-nhs/help-with-health-costs/get-help-with-prescription-costs/; *'Prescription and appliance charges'*, Isle of Man government, found at: https://www.gov.im/categories/health-and-wellbeing/pharmacy/prescription-and-appliance-charges/; *'Medical card application process',* Health Service Executive, found at: https://www2.hse.ie/services/medical-cards/medical-card-application-process/what-a-medical-card-covers.html.
[cxci] Discussions with Primary Care Commissioned Services team; *'NHS charges'*, House of Commons Briefing Paper, 12th September 2018, found at: http://researchbriefings.files.parliament.uk/documents/CBP-7227/CBP-7227.pdf.
[cxciicxcii] *'Securing the future: funding health and social care to the 2030s',* Institute for Fiscal Studies, 24th May 2018, found at: https://www.ifs.org.uk/publications/12994.

[cxciii] Oral answer to Parliamentary Question in Tynwald, week of 5th November 2019: 'The Treasury intends to introduce a soft drinks industry levy, or sugar tax, to the Island on 1st April 2019. A reasonable estimate for the Isle of Man receipts is currently £300,000 per annum. All income raised under this duty will be added to the DHSC budget and must be ring-fenced specifically to fund childhood health strategies. The fund was initially seeded with £100,000 from general revenue by Treasury in the 2018-19 Budget.'
[cxciv] Data provided by the Isle of Man Customs and Excise team.
[cxcv] '*Budget June 2010*', HM Treasury, 22nd June 2010, found at: https://www.gov.uk/government/publications/budget-june-2010.
[cxcvi] *'How healthcare is funded'*, the Kings Fund, 23rd March 2017, found at https://www.kingsfund.org.uk/publications/how-health-care-is-funded, *'Isle of Man Pink Book 2019/20'*, Isle of Man Government, 19th February 2019 found at: https://www.gov.im/media/1364400/2019-20-pink-book.pdf, *Securing the future: funding health and social care to the 2030s',* Institute for Fiscal Studies, 24th May 2018, found at: https://www.ifs.org.uk/publications/12994 and *'Isle of Man Social Attitudes Survey 2018'*, Cabinet Office, October 2018, found at: https://www.gov.im/media/1363577/2018-10-09-social-attitudes-2018-report.pdf.

[cxcvii] *'Healthcare in Ireland: A guide to the Irish healthcare system',* TransferWise, 9th November 2017, found at: https://transferwise.com/gb/blog/healthcare-system-in-ireland; '*Medical card application process'*, Health Service Executive, found at: https://www2.hse.ie/services/medical-cards/medical-card-application-process/what-a-medical-card-covers.html; '*Who can access health services in Ireland?',* Health Service Executive, found at: https://www.hse.ie/eng/services/find-a-service/eligibility.html; '*Hospital charges',* Health Service Executive, found at: https://www.hse.ie/eng/services/list/3/acutehospitals/hospitals/hospitalcharges.html.
[cxcviii] Prescription charges were abolished in Scotland in 2011 but this was shown to increase costs to government. *'Prescription charges: proposed phased abolition'*, Scottish Parliament Information Centre, 28th February 2008, found at: http://www.parliament.scot/search.aspx?terms=cost%20of%20scrapping%20prescription%20charges.
[cxcix] Public health activity data not included as the Review did not expect public health activity (e.g. consultation numbers, campaigns) to be recorded and did not inquire into this data.
[cc] Where data is noted as '(inaccurate)', this refers to data only being provided to the Review through Oracle, a data system which the Review has been informed is generally inaccurate regarding the number of posts and vacant posts. The Review notes that a new payroll system is due to replace Oracle and, once operational, is expected to provide accurate WTE and vacancy data. The Review has also been provided with capacity data at team level by some teams, indicating that individual teams have a view of their own capacity distinct from Oracle in some cases. An accurate overview for the DHSC that is consistently recorded is nevertheless a necessary improvement.
[cci] The Isle of Man has recently improved public health data collection significantly through the creation of the Public Health Outcomes Dataset. A full JSNA data set is still not available, however. *'A healthy island?'*, Isle of Man Director of Public Health, 2017, found at: https://www.gov.im/media/1358936/ph03-dph-report-final-pdf.pdf.
[ccii] This data has recently become available for Noble's Hospital through the creation of a patient-level costing data set. This data had not been launched to management teams at time of writing, however, and the system to support its collection and use long term was not yet in place.
[cciii] The Oracle System is the database used by the Isle of Man Government Office of Human Resources, within the Cabinet Office, to manage personnel matters.
[cciv] see https://www.gov.im/news/2016/aug/30/new-digital-initiatives-to-help-transform-care-at-nobles-hospital/
[ccv] see https://www.who.int/goe/publications/goe_telemedicine_2010.pdf
[ccvi] It was specifically noted that the Equality Act 2017, changes to the Medicines Act 2003, changes to the Children and Young Persons Act 2001 and drafting of a Capacity Bill should be progressed separately.
[ccvii] For most, but not all, of the legislative changes recommended the relevant Department will be the DHSC.

Sir Jonathan would like to thank all who contributed to this review