DEPARTMENT OF HEALTH

Rheynn Slaynt

Francis Working Group Report

December 2013

Isle of Man Government

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Executive Summary

Early in 2013 Robert Francis QC, at the invitation of the Secretary of State for Health in England, published a report of a Public Inquiry held under his chairmanship into failures of care at the Mid-Staffordshire NHS Foundation Trust.

The report contained 290 recommendations derived from a variety of "Themes".

The Minister for Health in the Isle of Man, Hon. David Anderson MHK, recognised that the Francis report represented one of the most significant documents of modern times relating to the delivery of NHS care. Accordingly, Minister Anderson determined that it was essential for the sentiments, conclusions and recommendations of Francis to be thoroughly considered in the local Isle of Man context. Minister Anderson therefore directed for the creation of a working group, the Terms of Reference and membership of which can be found on page 6 of this report, to undertake that work. The working group was chaired by Mr Mike Coleman, MLC , who, although a Tynwald member, is not part of the political make-up of the Department of Health.

It must of course be recognised that the Francis report was written in the context of the English NHS; not least it analysed, in the case of Mid Staffs, what is known as a "Foundation Trust" a concept which, along with many other structural elements of the English NHS, does not have a Manx equivalent. NHS Foundation Trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities.

Consequently, quite a number of the Francis recommendations are framed in a way which, eminently understandably, makes them applicable to the English context. This is particularly true when Francis examines the arrangements whereby NHS Trusts seek to become Foundation Trusts.

Nonetheless, the working group has been conscious of the direction from the Minister to pay attention to principles or practice which it would be remiss not to address, even where the "mechanics" of the recommendations are distinctly English in their composition.

The approach that the working group has taken has involved a narrative analysis in respect of each of the Francis "Themes", on a chapter by chapter basis, with that narrative preceding the commentary in respect of how each individual recommendation should be dealt with in the Isle of Man.

It has been noted by the working group that the full extent of the response to Francis, and the adoption of his recommendations, by the English NHS and indeed the English government remains presently unclear.

In framing this report the working group also had regard to the content and recommendations of the "Keogh report" published in July 2013 by Professor Sir Bruce Keogh KBE, National Medical Director for the NHS in England. That report, also at the instigation of the Secretary of State for Health, addressed matters in parallel to Francis in respect of 14 English NHS Trusts selected by Sir Bruce because they had been "outliers" in respect of patient mortality levels.

Incorporating the appendices that the working group has felt it valuable to include, this report to Minister Anderson is a fairly substantial document. Many of the recommendations made will require further analysis/action by the Island's Department of Health, which of course the Minister leads. Indeed, in certain areas we have expressly said that matters could also usefully embrace the Department of Social Care, a senior manager of which Department served on the working group.

Consequently, these key elements emerge from this report:

- a majority of the Francis recommendations are considered to have complete relevance and validity in the Isle of Man context. The working group has often proffered its own recommendation, or at least commentary, on how giving effect to such Francis recommendations might be taken forward here.

- by the same token, relatively few recommendations are identified as "not applicable to the Isle of Man". Where this does occur, it is because of the peculiarly unique English context of such recommendations.

- even in the case of some Francis recommendations that are not applicable to the Isle of Man, recommendations are forthcoming from the working group in terms of desirable actions that should be undertaken here, derived from the principle or sentiment of the Francis recommendation.

- Even where certain Francis recommendations are for implementation by English bodies - perhaps particularly the General Medical Council, Nursing and Midwifery Council and Royal Colleges, it is recognised that changes brought about by these agencies will ultimately impact upon the Island.

- The wide extent of the landscape addressed by Francis, and hence therefore by the working group, needs to be understood; whilst the working group does not of course advocate a lackadaisical approach, it is recognised that considering the implications of many recommendations and giving them effect will require some time. The working group is similarly aware that applying many of the recommendations will have quite profound effects.

- Many of the working group recommendations require to be considered and given effect by the Department of Health but the intentions and actions of other local bodies in response to Francis, in particular the Nursing and Midwifery Advisory Council, are noted.

Terms of Reference

The Francis Report commissioned by the United Kingdom Department of Health into failures of care at the Mid-Staffs NHS Acute Trust is one of the most significant documents of modern times relating to the delivery of NHS care.

The Department's Minister has determined that it is essential for the sentiments, conclusions and recommendations of Francis to be thoroughly considered in the local context. To that end he has directed that a working group be established to fulfil these Terms of Reference:

1. **To identify those recommendations of Francis which apply to the Isle of Man Health Service, both directly and indirectly. Attention must be paid to those recommendations which do not apply directly but have principles or practice which it would be remiss not to address;**

2. **To undertake an appraisal of where Isle of Man health services are in relation to those recommendations arising from 1 and to report accordingly to the Minister;**

3. **To identify areas which require further work, prioritise those areas, establish subgroups to work on the areas so identified and to report accordingly to the Minister;**

4. **To co-ordinate the work of the subgroups and report progress on a quarterly basis to the Minister.**

The Membership of the Working Group is:

Mr Mike Coleman MLC - Chair

David Killip - Department of Health Chief Executive

Mr Stephen Upsdell - Medical Director of Noble's Hospital

Mr Ian Wright Consultant Orthopaedic Surgeon - representing the Isle of Man Medical Society

Dr John Snelling General Practitioner - representing the Isle of Man Medical Society

Dr Tim Byrne – Clinical Lead for Mental Health Services

Bev Critchlow - Chief Nurse and Director of Nursing, Midwifery and Therapies

Barbara Scott – Noble's Hospital Manager

Sandra Pressley - representing the Royal College of Nursing - Isle of Man branch

Norman McGregor-Edwards - Department of Health Director of Health Care Delivery

Derek Legg - Health Services Consultative Committee Chairman

Margaret Simpson - Chief Executive of Hospice Isle of Man

Cath Hayhow – Director of Adult Services, Department of Social Care

Erica Humphries – Personal Secretary to Bev Critchlow - Clerk

The Minister anticipates that subgroups formed under paragraph 3 of the Terms of Reference are likely to include a wide range of other key personnel such as, for example, the Director of Public Health; Manager of Noble's hospital and the Primary Health Care Manager, together with "specialists".

1. Accountability for Implementation of the Recommendations

Francis makes it entirely clear that giving effect to the advances to be achieved by his recommendations is the responsibility of all those involved in the delivery of health care. He merges this with his passion for a "positive and universal culture".

He is clear that quality care begins on the frontline, as a consequence so therefore does accountability. The failure to empower frontline personnel is seen as a major past failing of the NHS. He believes that evidence of a positive safety culture also begins on the frontline in terms of ***"thorough and thoughtful information provided to patients".*** He is critical of the existing NHS culture of a defensive, inward looking organisation that tolerates poor practice. However, he does comment upon the adverse effects on organisational stability throughout the NHS occasioned by constant reorganisations, some of which he clearly feels were not merited, having the effect of almost certainly limiting the willingness and ability of the NHS to embrace change that actually benefits patients. Consequently, he frames a recommendation around this.

At board level ***"leaders"*** should contribute to the positive culture evinced by Francis such as open board meetings and personally listening to complaints - among other activities.

Francis paints a picture where accountability for the implementation of his recommendations is addressed across a very broad canvas and in many ways. The end goal is achieved by a diverse nexus of activities and attitudes. Indeed, a quote from Dame Christine Beasley, the former Chief Nursing Officer for England, which appears at paragraph 20.138, and clearly had resonance Francis, sums up just how broad a sweep the landscape of accountability is.

"Asked how cultural change could be brought about, Dame Christine Beasley, the former Chief Nursing Officer for England, wisely said:

I'd be very famous and rich, I suspect, if I had all the answers to that ... I mean, [in relation to changing attitudes about hospital infections] ***it's all the things we know. It was processes. It was performance management. It was how you trained and educated people. It's how you publish the data. All of that, I think, begins to drive the cultural shift that you need to make this sustainable across a whole organisation."***
Notwithstanding the large-scale nature of the task, the Francis comment/recommendations could be shown to be applicable in the Isle of Man context and that, from a size and organisational/structural perspective, applying them may be a less unwieldy task than that which faces England and Wales.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
1. Implementing the recommendations	It is recommended that: ● All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work. ● Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions. ● In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations. ● The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.	The principle of this recommendation - perhaps particularly the weight of the first bullet point - has arguably already been accepted by the Minister for Health through the act of creating the working group and its associated Terms of Reference. The other three bullet points reflect the particular English NHS context but the underlying principle(s) should also be accorded proper weight by the Department.
2.	The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: ● A common set of core values and standards shared throughout the system. ● Leadership at all levels from ward to the top of the	**This recommendation should be applied in full in the Isle of Man context** although the working group recognises that some commentators have questioned the value/validity/reliability of a "cultural barometer" as described in the concluding bullet point. It is recommended that the Department keeps a

	Department of Health, committed to and capable of involving all staff with those values and standards. ● A system which recognises and applies the values of transparency, honesty and candour. ● Freely available, useful, reliable and full information on attainment of the values and standards. ● A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	watching brief on the project being undertaken by the National Nursing Research Unit into the development and phased testing of a Cultural Barometer. http://www.kcl.ac.uk/nursing/research/nnru/research-programme/Organisations,environmentandwaysofworking/Cultural-barometer-project-summary-21-May-2013.pdfNNR Cultural Barometer Project It is recommended that a staff survey similar to that used by Hospice Isle of Man be developed and enhanced based upon the feedback.

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2. Putting the Patient First

> There are many statements of values in the healthcare system addressed to separate groups within it, but there needs to be a common statement of values to which all can commit together.
>
> The NHS Constitution is intended to be a common source of values and principles by which the NHS works, but has not yet had the impact it should. It should become the common reference point for all staff. Priority needs to be given in it to requirement of putting patients first in everything done and values associated with this. All staff should be required to commit to abiding by its values and principles.
>
> The system of standards in the NHS is in a state of evolution but there is evidence that essential standards are not yet effectively adopted on universal basis.

Francis Report, Chapter 21, Values and Standards. Extract from Key themes

This chapter of the report concerns itself with a range of recommendations relating to the setting, 'policing' and publishing a set of common standards and there is much herein which refers to structures and governance arrangements which do not apply on the Isle of Man. This section of the report does not comment on those areas, but is focussed on the matter of the common values espoused by Francis and the refreshed view of the NHS constitution.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
3.	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations, and obligations of patients.	There is no Isle of Man equivalent to the NHS constitution on the Isle of Man. The recommendation by Francis that there should be a single point where the system's common values and the rights, expectations and obligations of patients are laid out is accepted. It is for the Department review the appropriate form that this should take, but consideration should be given to the development of a constitution.
4.	The core values expressed in the NHS constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos	There is no equivalent to the NHS constitution on the Isle of Man. The recommendation by Francis that there should be a single point where the system's common values and the rights, expectations and obligations of patients are laid out is accepted. It is for the Department review the appropriate form that this should take, but consideration should be given to the development of a constitution.
5.	In reaching out to patients, consideration should be given to including expectations in the NHS constitution that: • Staff put patients before themselves • They will do everything in their power to protect patients from avoidable harm • They will be honest and open with patients regardless of the consequences for themselves • Where they are unable to provide the assurance a patient needs, they will direct them where possible to those who can do so • They will apply the NHS values in all their work.	NMAC has come together and considered the values of nursing and midwifery across the Isle of Man. "*We have developed a Nursing Declaration. This Declaration gives our commitment to patients and families and residents wherever they receive nursing care, and emphasises the values by which we would expect care to be delivered to them.* *This is a really positive step in placing the patient at the heart of all we do."* However, Francis specifically comments on the many different value statements addressed to distinct groups of healthcare staff. He acknowledges that they may have common themes but are expressed in different ways, and some groups do not have their own set of values. It is for this reason that he promotes the NHS Constitution values; giving them priority over those of professional groups . It is recommended that

		consideration be given to the development of a constitution or equivalent for the Isle of Man
6.	The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance	This recommendation assumes the existence of a constitution. The recommendation regarding an Isle of Man equivalent is made, above. Fundamentally, this recommendation relates to the availability of information about the core values expected of staff, and the core values of care which patients can reasonably expect. If the Department does decide to adopt the approach of developing a constitution, information about the values should be made widely available to both patients and staff.
7.	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	This recommendation assumes the existence of a constitution. The recommendation regarding an Isle of Man equivalent is made, above. If a constitution were in place this recommendation would be appropriate and relevant.
8.	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	This recommendation assumes the existence of a constitution. The recommendation regarding an Isle of Man equivalent is made, above. If a constitution were in place this recommendation would be appropriate and relevant.

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3. Fundamental Standards of Behaviour

Francis indicates that there should be commitment and responsibility for fundamental standards of care, and behaviour, by all who work within the healthcare system

He refers particularly to the part the NHS Constitution should play in making clear expectations of professionals, managers and staff with regard to following and complying with standards relevant to their work e.g. from the National Institute for Health & Clinical Excellence and the Care Quality Commission.

He focuses on the importance of healthcare professionals contributing to, and complying with, standard work procedures. It may be assumed that he includes other 'non-professional' workers in this section (e.g. support workers etc.).

Francis suggests that there should be '*necessary corrective action'* where staff members are affected by professional disagreements. This may be within the organisation or using external support. He also suggests that professional bodies should devise standard procedures, interventions & pathways based on up to date evidence.

His comments relating to the reporting of incidents regarding patient safety, compliance with standards or other requirement of the employer encourages organisations to insist on such reporting and to ensure staff receive feedback in relation to reports made by them, including action, or reasons for non action, taken.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
9.	It is recommended that: • The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound including the Code of Conduct for NHS Managers	• All Professional staff have codes of conduct in relation to their registering bodies, reference to adherence to these are generally included in job descriptions and / or contracts of employment; • Some areas have a code of conduct for non-registered staff e.g. Healthcare Assistants ; • There is no NHS constitution or equivalent on the island; • Although there is a Code of Conduct for Civil Servants there is no code of Conduct for NHS Managers as in the UK (ref: Department of Health (2002) *Code of Conduct for NHS Managers,* Crown Copyright); **Recommendations:** ▪ Consider adapting the current UK NHS Constitution to meet Island's needs or develop one in line with the values of the NHS; ▪ Adapt the current Code of Conduct for NHS Managers (2002) to meet island needs or develop one in line with agreed island values, reflecting the values of the NHS. ▪ Include reference to the above Code of Conduct for NHS Managers in the job descriptions / contracts of employments of all managers within the islands health service (discussion may be needed as to what levels this may include); ▪ Identify processes to monitor adherence to managers standards and methods of 'holding to account'; ▪ Agree and disseminate a Code of Conduct for non-registered staff island wide (including health & social care).

10.	• The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health & Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers	• There are Declarations on dignity & nursing expectations within some areas of health and social care; • There are standards indicating how the public should expect to be treated / dealt with (although not necessarily up to date); • NICE guidelines are often adopted as best practice; • There are clinical pathways, standard operating procedures & clinical protocols available in some areas (e.g. theatre checks, head injury management etc.); • There are competency packages available in some areas e.g. phlebotomy, ITU); • There is opportunity to increase the number of standard operating procedures, pathways, care bundles or protocols across all areas to ensure consistency in care delivery; • There is no legal requirement to comply with the Care Quality Commission or equivalent; • Policies & procedures are not always up to date, complied with or reviewed in light of recent evidence. Staff compliance with many policies is not audited / policed. **Recommendations:** • Consideration should be given to the utilisation of methods of staff engagement in order to gender agreement and commitment to the development of, and adherence to, standards etc.; • Current standards available to the public should be reviewed and updated in collaboration with patient representation; • Where possible procedures, processes & systems should be standardised to promote

		evidence based practice and reduce error; • Consideration should be given to developing robust systems and processes to ensure policies & procedures are complied with and up to date; • An environment that enables professionals to adhere to guidance and standards and to deliver effective care should be promoted. Those expected to deliver patient care should be given the time, resources & freedom to do so.
11.	• Healthcare Professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manage within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	• This expectation already exists to a certain extent by virtue of professional codes, current local declarations, job descriptions & contracts of employment and as part of appraisal / development forums; However not all staff contribute or comply with this consistently. • There are some Clinical & Patient experience indicators in existence that are audited and benchmarked against organisations in the UK • Standards, pathways etc. should reduce any professional disagreements regarding procedures and such, however it is likely that occasional professional disagreements will still occur both within and between different professional disciplines. Procedures currently available include grievance, mediation, disciplinary, peer review, specific external reviews, all of which are not immediate or timely and take time to arrange or undertake. • The current practice of managers to ensure that employees comply with these requirements is varied, inconsistent and often not perceived to be delivered in a way that is fair and equitable; **Recommendations:** • The utilisation of methods of staff engagement in order to gender agreement and commitment

		to the development of, and compliance with, standards etc. should be explored and discussed; • The development, and application, of managerial competencies should be considered in line with UK developments; • The RCN has set out a clear set of nursing values in the eight principles of nursing practice which could be used to underpin approaches to nursing quality measurement & practice improvement (ref:http://www.rcn.org.uk/development/practice/principles/principles_publications). This is the platform on which Noble's Hospital's Nursing Strategy, Nursing4Excellence, is based; • Further discussion needs to take place within the organisation as to how standards, pathways etc. may be further developed and integrated into practice. Discussions should include, and take advice from, clinicians, management & unions / professional bodies. Such formats should not detract from Professional judgement, but where such formats are not followed, there should be a clear indication of the judgement made. • How pathways & standards may be audited and monitored in a timely way should be explored – this could include considerable expansion, and development of focus, of the current clinical audit department to consider / oversee such monitoring across health; • Consideration should be given regarding guidance, or procedures, the organisation can produce to limit the effects of any professional disagreements in a timely way. The use of a key person who could be of accessed when required may be of use. Any discussions around

		this would benefit from the advice and input of professional bodies as to how the impact of professional disagreements may be lessened and any impact on patient care reduced.
12.	• Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	• There are incident reporting mechanisms available, although these vary across areas and include the use of forms or electronic reporting; • Not all staff (particularly in relation to electronic reporting) have access to reporting incidents and may have to rely on others to do this for them; • There is sometimes confusion as to what would constitute an 'incident of concern' and there are indications that, at times, staff are discouraged from reporting incidents as they are not relevant. • Feedback / outcomes / actions from incidents reported is inconsistent across areas. Some areas have a formalised way of sharing the incidents and actions / outcomes while others are less formal or consistent in their approach to feedback to staff. Where non-action is considered to be the outcome, the rationale / reasons for this are often not shared sufficiently, if at all. **Recommendations:** • Consideration could be given to a standardised incident reporting system across health and social care to enable trends and similar incidents to be shared across areas and acted on in a timely way; • Ensure all staff have access to incident reporting systems and aware of their responsibilities in relation to this; • Consideration should be given to providing

		definitions or examples of what would, and what would not, be considered to be an incident of concern, compliance with fundamental standards or a particular requirement of the organisation to assist staff in deciding whether or not to complete an incident report; • The current system of feedback to staff regarding actions or non-actions (and the reasons for these) should be reviewed to ensure greater, consistent information sharing across areas; • The originator of an incident should be kept updated with the progress of any actions / investigations. • Discussions could be held with staff, professional bodies and unions to determine what information from incidents clinicians would find useful and how this may be disseminated effectively to ensure lessons are learned; • Trends identified from incident reporting should be regularly identified and discussed appropriately (e.g. Clinical Governance / Health & Safety meetings); • There should be clear guidance on actions staff can take if they are unhappy with an incident report outcome;

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4. A Common Culture Made Real Throughout the System – an Integrated Hierarchy of Service

There are many statements of values in the healthcare system addressed to separate groups together.

The NHS Constitution is intended to be a common source of values and principles by which the NHS works, but it has not as yet had the impact it should. It should become the common reference point for all staff. Priority needs to be given in it to requirement of putting patients first in everything done and the values associated with this. All staff should be required to commit to abiding by its values and principles.

The system of standards in the NHS is in a state of evolution but there is evidence that essential standards are not yet effectively adopted on a universal basis.

The structure of standards should be provided with improved clarity of status and purpose by distinguishing between fundamental safety and essential care standards formulated by regulation, enhanced standards of quality formulated by the NHS Commissioning Board, and discretionary developmental standards formulated by commissioners and providers.

Persistent non compliance with fundamental standards should not be permitted and individual cases of non-compliance leading to serious harm should have serious consequences.

Indicators of compliance with fundamental standards should be set by CQC and NICE should be commissioned to formulate standard procedures and guidance designed to provide practical means of compliance.

Formulation of any standard needs to be "owned" by patients and front line professionals:
Full involvement of patient groups and professional bodies in the formulation of all standards as well as the methods and measurement of compliance is vital. Accurate information about compliance and non-compliance, capable of comparing individuals, services and providers, must be readily accessible to all.

"No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service.
Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable." Francis

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
13. The nature of standards	Standards should be divided into: ● Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; ● Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources; ● Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification	**This recommendation is both applicable and relevant.** The NHS for England and Wales are likely to be developing these standards. It is recommended that the IOM use these standards as minimum standards and enhance them accordingly.
14.	In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards.	**This recommendation is both applicable and relevant.** This recommendation encompasses healthcare delivery quality, governance structure and accurate information about compliance.
15.	All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working	**This recommendation is both applicable and relevant.**

	system but also a demonstration that it is being used to good effect.	
16. Responsibility for setting standards	The Government, through regulation, but after so far as possible achieving consensus between the public and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients who are accepted for treatment by a healthcare provider.	**This recommendation is both applicable and relevant.**
17.	The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	**This recommendation is both applicable and relevant.**
18.	It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance.	**This recommendation is both applicable and relevant.**

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5. Responsibility for, and Effectiveness of, Healthcare Standards

In England, the responsibility for, and for the effectiveness of, Health Care standards, is currently split between the Care Quality Commission (CQC) , the National Institute for Health and Clinical Excellence (NICE), hospital Trust Boards, Clinical Commissioning Groups (CCG s) and a number of other organisations such as the Royal Colleges.

Francis recommends that there should be a single regulator dealing with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts. Francis then makes further recommendations about the responsibilities of each of the bodies mentioned above.

Of the above bodies, the only ones which currently relate directly to the Isle of Man are NICE (whose assessments of clinical and cost effectiveness are extensively used, not least by the Clinical Recommendations Committee) and the Royal Colleges.

From the Autumn of 2013, however, we will have in place an independent review and inspection system using the West Midlands Quality Review Service. This will provide independent assessment of the quality of care provided by the whole Health Service, not just the acute hospitals. It will effectively assume the role of the English CQC albeit with a more comprehensive reporting regime than the CQC. In addition, the Isle of Man NHS has formal links with the Merseyside Internal Audit Agency (MIAA) and other English NHS organisations.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
19. Gaps between the understood functions of separate regulators	Single regulator to deal with corporate governance, financial competence, viability and patient safety and quality standards	In practical terms, this is not achievable in the Isle of Man. The Department should, however, determine how it can be shown that the various responsible organisations are together providing comprehensive assurance.
20. Responsibility for regulating and monitoring compliance	CQC should be responsible for monitoring fundamental standards	This will be discharged by an independent external review system, currently to be provided by the West Midlands Quality Review Service (WMQRS)
21.	Regulator should monitor accuracy of information disseminated by providers	This should be considered for inclusion in the independent external review system, currently to be provided by the West Midlands Quality Review Service (WMQRS), or other arrangements made.
22.	NICE should formulate fundamental standards	In general, the Department adheres to the standards published by NICE where it is practical and policy to do so.
23.	NICE-formulated standards should include suitability and competence of staff, and organisational culture	In general, the Department adheres to the standards published by NICE where it is practical and policy to do so.
24.	Compliance with fundamental standards should be capable of being assessed by the public and healthcare professionals	This relates to the 'understandability' and accessibility of performance information to non-clinical and non-specialist individuals.
25.	All specialty professional bodies , with NICE, should have a duty to develop measures of outcome and measurements of compliance.	In general, the Department adheres to the standards published by NICE and specialty professional bodies where it is practical and policy to do so.
26.	Direct interaction with patients, carers and staff should take priority over monitoring and audit of policies and procedures.	It is suggested that this is not a problem on the Isle of Man – not least because our difficulties with information retrieval and management make monitoring and audit more difficult than in equivalent English organisations. Nonetheless, the Department should seek assurance that neither internal nor external pressures for

		monitoring and audit information place undue pressures on clinical staff.
27.	Regulators should have low threshold of suspicion, zero tolerance of non-compliance with fundamental standards and allow no place for favourable assumptions.	The external independent review process by WMQRS should include such a low threshold towards non-compliance and the Department should include this in the briefing for the WMQRS team.
28. Sanctions and interventions for non-compliance	Services incapable of meeting fundamental standards should not be permitted to continue.	The Department suspends services which raise concerns over fundamental service standards but should also maintain continuous reviews of the sustainability of individual services.
29.	It should be an offence for death or serious injury to be caused to a patient by a breach of these regulatory requirements	This is a matter of policy for the Isle of Man Government to determine. It is unclear whether or not the UK is going to accept this recommendation.
30. Interim measures	Regulators must be free to require or recommend immediate objective steps where there is reasonable cause to suspect a breach of fundamental standards.	This is already the case with some bodies which regulate activity on the Isle of Man, such as the Royal Colleges , and there is clear evidence that the Isle of Man already complies with this recommendation.
31.	Regulators must have in place policies which ensure they constantly review if the need to protect patients requires use of their own powers of intervention	This is already in place but in addition the Department should ensure that information on potential areas of concern is escalated to the appropriate level, including beyond the Department if appropriate..
32.	Where patient safety is believed to be at risk, regulators should be obliged to take whatever action is necessary to protect patients' safety.	This is really a matter for the regulators concerned but the Department already complies *de facto* with this recommendation.
33.	The Department of Health should consider introduction of legislation to provide regulators with powers as required.	This is a matter for the Isle of Man Government to determine. It is unclear whether or not it is necessary or desirable for the Isle of Man to formally legislate to give external regulators the powers required.
34.	Where a provider is under regulatory investigation there should be some form of external performance management involvement to oversee any necessary arrangements for protecting the public.	This should be considered for inclusion in the independent external review system, currently to be provided by the West Midlands Quality Review Service (WMQRS), or other arrangements made.
35.	Sharing of intelligence between regulators should extend to all intelligence.	This does not apply directly to the Isle of Man because we do not have the same range of regulators or the

		same lack of clarity about their relative responsibilities.
36.	Coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real – time as possible.	The Department has an ongoing project, led by the Performance and Delivery Group, to increase the amount of performance information made available to the public. The first stage – making some of the iHub information available via the website, has recently been completed.
37. Use of information about compliance by regulator from : Quality accounts	Trust boards should provide, through quality accounts, in a consistent format, accurate information about the compliance with each standards which apply to them.	The Policy and Delivery Group could be tasked to consider compliance with fundamental standards as part of the framework for the publication of information.
38. Complaints	The CQC should ensure, as a matter of urgency, that there is reliable access to all useful complaints information relevant to compliance with fundamental standards.	The Department could be tasked to include complaints information within the framework for the publication of information.
39.	The CQC should introduce a mandated return from providers about patterns of complaints, how they were dealt with, and outcomes.	The Department is mandated to provide an annual return to Tynwald on complaints and should ensure that this information is included.
40.	It is important that great attention is paid to the narrative contained in, for instance, complaints data as well as to the numbers	The Department should seek to address this recommendation, insofar as it is possible to do so in such a relatively small community where maintaining anonymity can be particularly challenging.
41. Patient Safety Alerts	The CQC should have a clear responsibility to review decisions not to comply with patient safety alerts, and to oversee the effectiveness of any action required to implement them.	The monitoring of patient safety alerts and their implementation should be formally undertaken by the Department or an independent body (such as the HSCC?) and failures to comply reported at an appropriate level.
42. Serious untoward incidents	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the CQC.	This is not directly applicable to the Isle of Man, but the Department should adhere to the underlying principle that information on serious untoward incidents should be shared so that lessons can be learnt.
43. Media	Those charged with the oversight and regulatory rules of Health Care should monitor media reports about the organisations for which they have responsibility.	Media reports, including Internet forum activities, are regularly monitored.
44.	Any example of a serious incident or avoidable harm	This is not directly applicable to the Isle of Man as

	should trigger an examination by the CQC of how that was addressed by the provider . There should also be a requirement for the trust concerned to demonstrate that the learning derived has been successfully implemented.	there is no CQC or equivalent, but the Department should adhere to the underlying principle that information on serious untoward incidents should be shared so that lessons can be learnt. In addition, the Department should seek to demonstrate that the learning derived has been successfully implemented.
45. Inquests	The CQC should be notified directly upcoming Healthcare related inquests	This is not directly applicable to the Isle of Man, but the Department should adhere to the underlying principle that information on serious untoward incidents should be shared so that lessons can be learnt.
46. Quality and risk profiles	Quality and risk profiles should not be regarded as a potential substitute for active regulatory oversight by inspectors.	This is not directly applicable to the Isle of Man, but the Department, in conjunction with WMQRS, has embarked on a process of active regulatory oversight.
47. Foundation trust governors, scrutiny committees	The CQC should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board' events	This is not directly applicable to the Isle of Man, but the Department should consider the adoption of "sounding board" events to supplement existing methods of gathering "soft intelligence".
48.	The CQC should send a personal letter each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the CQC.	This is not directly applicable to the Isle of Man, but the Department may wish to consider issuing a similar letter from the most senior level to appropriate individuals.
49. Enhancement of monitoring and the importance of inspection	Routine and risk related monitoring, as opposed to acceptance of self-declarations of compliance, is essential.	This is not applicable to the Isle of Man as the Manx NHS is not party to the CQC self-declaration process.
50.	The CQC should retain an emphasis on inspection as the central method of monitoring non compliance	The Department has initiated a process of progressive external independent review and monitoring with WMQRS
51.	The CQC should develop a specialist cadre of inspectors-trained in the principles of hospital care and inspections should be led by such inspectors.	The peer review process used by WMQRS already adopts this approach.
52.	The CQC should consider whether inspections could be conducted in collaboration with other agencies and if they can take advantage of any peer review arrangements available.	The peer review process used by WMQRS already adopts this approach.
53. Care Quality Commission independence, strategy and	Any change to the CQC role should be by evolution.	**This is not applicable to the Isle of Man.**

culture		
54.	Where issues relating to regulatory actions are discussed between the CQC and other agencies, these discussions should be properly recorded to avoid any suggestion inappropriate interference in CQC statutory role.	**This is not applicable to the Isle of Man.**
55.	The CQC should review its processes as a whole to ensure that it is capable of delivering regulatory oversight and enforcement	**This is not applicable to the Isle of Man.**
56.	The leadership of the CQC should communicate clearly and persuasively its strategic direction to the public and to its staff	**This is not applicable to the Isle of Man.**
57.	The CQC should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving cause for concern at the trust described in the report	**This is not applicable to the Isle of Man.**
58.	Patients, through their user group representatives, should be integrated into the structure of the CQC	This is not directly applicable to the Isle of Man but the Department may wish to consider how user group representatives may become involved in the WMQRS peer review inspections.
59.	Consideration should be given to the appointment of nominated board members from representatives of the professions, nursing and Allied Health Care professionals, and patient representative groups.	This is not applicable to the Isle of Man as we do not have trust boards. The Department may wish to consider, however, the extent to which these groups are already, or should be, represented in Departmental performance monitoring processes.

6. Responsibility for, and Effectiveness of, Regulating Healthcare Systems Governance (Healthcare Systems Regulatory Functions)

Monitor is responsible for regulating the governance of Health Care providers and the fitness for purpose of directors, governors etc. Francis recommends merger of these functions with the CQC. As far as the regulation of governance is concerned Monitor's role is largely associated with the granting of Foundation Trust status which is irrelevant to the Isle of Man. There are, however, recommendations which are relevant, notably relating to the fitness of persons to act as directors and managers, their training, and their removal if found unfit to hold office.

Recommendations 60 – 73 (incl.) relate to Foundation Status and are therefore not applicable in the Isle of Man.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
74. Enhancement of role of governors	Monitor and the CQC should publish guidance for governors on the principles they expect them to follow in recognizing their obligation to counter to the public	**Not directly applicable to the Isle of Man** but the Department may wish to consider the formulation and issue of equivalent guidance.
75.	Foundation trust boards and councils of governors should consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations.	**Not applicable to the Isle of Man**
76.	Governors must be accountable not just to the media ownership but also to the public at large	**Not applicable to the Isle of Man**
77.	Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors	**This is not directly applicable to the Isle of Man** but the Department should review the resources and facilities made available for the training and development of, for example, members of the Health Services Consultative Committee and of any other monitoring bodies which may be established.
78.	The CQC and Monitor should consider how best to enable governors to have access to an advisory facility in relation to compliance with Health Care standards	This is not directly applicable to the Isle of Man but the Department should review how, for example, members of the Health Services Consultative Committee and of any other monitoring bodies which may be established could gain access to such information.
79. Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the CQC and Monitor are and remain fit and proper persons for the role	It is unclear whether or not the English NHS intends to pursue this recommendation. Whether it does or not, the Department may well wish to consider whether or not such assessment and/or action is necessary and practicable in the Isle of Man context.
80.	Those found not fit and proper on the grounds of serious misconduct or incompetence should be disqualified from participating in a foundation trust	It is unclear whether or not the English NHS wishes to pursue this recommendation. Whether it does or not, the Department may well wish to consider whether or not such action is necessary and practicable in the Isle of Man context.
81.	A minimum level of experience and all training should	It is unclear whether or not the English NHS intends to

	be included in the criteria for fitness	pursue this recommendation. Whether it does or not, the Department may well wish to consider whether or not such experience and training are necessary and practicable in the Isle of Man context.
82.	It should be possible for regulatory intervention to remove or suspend from office a person whom the regulator is satisfied is not fit and proper to hold office	It is unclear whether or not the English NHS is minded to pursue this recommendation. Whether it does or not, the Department may well wish to consider whether or not such action is necessary and practicable in the Isle of Man context.
83.	If they "fit and proper person test" is introduced them guidance on the principles on which the regulatory body would exercise its power to remove or suspend someone should be issued.	It is unclear whether or not the English NHS plans to pursue this recommendation. Whether it does or not, the Department may well wish to consider whether or not such action is necessary and practicable in the Isle of Man context.
84.	Executive or non executive directors removed as not fit or proper persons should be required to report the matter to Monitor, the CQC and the NHS Trust development authority.	It is unclear whether or not the English NHS intends to pursue this recommendation. Whether it does or not, the Department may well wish to consider whether or not such action is necessary and practicable in the Isle of Man context.
85.	Monitor and the CQC should produce guidance on procedures to be followed in the event of an executive or non executive director been found to have been guilty of serious failure in the performance of his or her office.	It is unclear whether or not the English NHS is intending to pursue this recommendation. Should it decide to do so, then the Department should review the guidance produced in order to assess whether or not it should be introduced here.
86. Requirement of training of directors	A requirement should be imposed on foundation trusts to have in place and adequate programme for the training and continued development of directors.	It is unclear whether or not the English NHS is intending to pursue this recommendation and, in any case, Foundation Trusts are not a feature of the Isle of Man NHS. Nonetheless, the Department may well wish to consider whether or not such a programme is necessary and practicable in the Isle of Man context and, if so, how it might be delivered.

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7. Responsibility for, and Effectiveness, of Regulating Healthcare Systems Governance (Health and Safety Executive Functions in Healthcare Settings)

Francis states clearly that the British Health and Safety Executive (HSE) should not be focusing on Healthcare and its responsibilities should be passed on to the CQC. Information contained in the legally required reports of injuries, diseases and dangerous occurrences made to the HSE should be made available to Healthcare regulators through the 'serious untoward incident' system.

The applicability of this recommendation required further study as it potentially overlaps with the responsibilities of the Manx Health and Safety Inspectorate (HSWI). In addition, the Isle of Man has no CQC or equivalent organisation. Initial discussions with Barbara O'Leary (Department of Health - Health & Safety Adviser) and Caron Palmer (Principal Health & Safety Adviser – Office of Human Resources) revealed significant complexities in the relationships and responsibilities between the DH, HSWI and the Isle of Man Constabulary. These reflect the broadly similar complexities seen in England.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
87. Ensuring the utility of a health and safety function	The Health and Safety Executive is clearly not the right organisation to be focusing on Health Care. Either the CQC should be given powers to prosecute offences or a new offence containing comparable provisions should be created under which the CQC has the power to launch a prosecution.	The Isle of Man has no CQC or equivalent organisation and it would seem impractical to create one. The complexity and lack of clarity around the relative roles of the Isle of Man Health and Safety inspectorate (HSI), the Department of Health and the Isle of Man Constabulary should be resolved by the creation of a mutually acceptable formal agreement defining roles, responsibilities and exchange of information in relation to healthcare.
88. Information sharing	The information contained in reports from RIDDOR should be made available to Healthcare regulators	This should be incorporated in any agreement created in response to Recommendation 87, particularly in relation to clarifying what is RIDDOR reportable and what is not. RIDDOR legislation on the Isle of Man is different from that in the UK.
89.	Reports from serious untoward incidents involving death or serious injury to patients or employees should be shared with the Health and Safety Executive.	This should be incorporated in any agreement created in response to Recommendation 87, particularly in relation to clarifying what is reportable and what is not and the definition of clinical incidents and events – for example in relation to normal clinical risks.
90. Assistance in deciding on prosecutions	In deciding on prosecutions, the Health and Safety Executive should obtain expert advice as is done in the field of healthcare litigation and fitness to practice proceedings.	This should be incorporated in any agreement created in response to Recommendation 87 and the Department should assist the HSI in identifying suitable expert assistance.

8. Enhancement of the Role of Supportive Agencies

This relates to be in NHS Litigation Authority, the National Patient Safety Agency, and the Health Protection Agency. The main recommendations relate to all these bodies being required to share information on providers' service failures with the CQC and other bodies. The Isle of Man is not linked to the NHS Litigation Authority as it self-funds successful claims. Whilst the Isle of Man Health Service does not have formal links with these organisations in the way that an English NHS organisation would, it would appear prudent to seek or develop informal links with them to provide intelligence on areas of concern in England which may apply equally here.

In addition, we should seek to develop robust links between complaints systems and any claims which are made through litigation.

Recommendations 94 – 100 (incl.) are not applicable to the Isle of Man.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
91. Improvement of risk management	All NHS providers should comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority	The Department may wish to consider reviewing these risk management standards to establish if they may and should be applied here. They are, however, likely to be based on the aggregation of information from many hospitals.
92.	Financial incentives should be adjusted to maximize the motivation to reach the highest risk management standards	Not directly applicable to the Isle of Man unless risk management performance is linked to financial incentives.
93.	The NHS Litigation authority should introduce requirements with regard to staffing levels, risk assessments and outcome based standards	The Department may wish to consider the reviewing these requirements to establish if they may and should be applied here. They are, however, likely to be based on the aggregation of information from many hospitals..
94. Evidence based assessment	As some form of running record of the evidence reviewed must be retained on each claim, the NHS Litigation authority should consider development of a simple database of evidence based assessment	**This is not applicable to the Isle of Man** as the information will be derived from the aggregation of information from many hospitals..
95. Information sharing	NHS litigation authority report should be made available to the CQC	**This is not applicable to the Isle of Man.**
96.	The NHS litigation authority should make more prominent in its publicity and explanation to the general public on the limitations of its standards assessments and of the reliance which can be placed upon them	**This is not applicable to the Isle of Man.**
97. National Patient Safety Agency functions	The National Patient Safety Agency's resources should be well protected and defined.	**This is not applicable to the Isle of Man.**
98.	All significant adverse incidents should be reported to the national reporting and learning system	**This is not applicable to the Isle of Man.** Nonetheless the Department should ensure that such incidents are reported at the appropriate level to ensure proper scrutiny and the maintenance of confidence.
99.	More information should be made available from the national reporting and learning system	**This is not applicable to the Isle of Man.** Nonetheless the Department should ensure that such incidents are reported at the appropriate level to ensure proper scrutiny and the maintenance of confidence.

100.	Individual reports of serious incidents which have not otherwise have been reported should be shared with the regulator for investigation as the receipt of such a report may be evidence that the mandatory system has not been complied with	**This is not applicable to the Isle of Man.**
101.	Mutual peer review inspections should be organised where possible.	The WMQRS approach is based on peer review.
102. Transparency, use and sharing of information	Data held by the National Patient Safety Agency should be open to analysis for a particular purpose or others facilitated in that task	**This is not applicable to the Isle of Man.** The Department may, however, seek to develop links enabling it to access information held by the Agency for benchmarking purposes.
103.	The National Patient Safety Agency should regularly share information with Monitor	**This is not applicable to the Isle of Man.**
104.	The CQC should be enabled to exploit safety information by the agency	**This is not applicable to the Isle of Man.**
105.	Consideration should be given to whether information from the incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.	We cannot currently calculate hospital standardised mortality ratios but the Department is actively seeking to correct this deficiency. It should be noted, however, that considerable doubt has been raised on the clinical value of mortality ratios.
106. Health Protection Agency Coordination and publication of providers' information on healthcare acquired infections	The Health Protection Agency should co-ordination collection, analysis and publication of information of each providers performance in relation to Health Care associated infections.	**This is not applicable to the Isle of Man.**
107. Sharing concern	If the Health Protection Agency becomes concerned about the providers management of Health Care Associated Infections it should immediately inform the NHS Commissioning Board, the CQC and Monitor.	**This is not applicable to the Isle of Man.** Nonetheless, the Department currently reacts proactively and rapidly to any indication of rising rates of Health Care Associated Infections
108. Support for other agencies	Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of Health Care providers infection control arrangements.	**This is not directly applicable to the Isle of Man.** Nonetheless, the Public Health staff contributors to the management of Health Care Associated Infections

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9. Effective Complaints Handling

The Isle of Man has a different Health Services complaints procedure from England – in simple terms the Manx system consists of three stages; informal resolution at or near the point of care delivery, if that is unsuccessful formal investigation and resolution, and if that is unsuccessful reference to the externally-appointed Independent Review Body.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
109.	Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients.	There are multiple gateways through which to make complaints and comments, including front-line staff, line managers, hospital management, Crookall House (Minister, Political Member, CEO, Directors), via Age Concern, and via third sector organisations with a interest in healthcare. The methods of making complaints are laid out in a comprehensive leaflet which is widely available through health service premises, libraries etc as well as on the IoM Government website. The Department should, however, conduct a review to confirm that these arrangements are readily understood and accessible.
110. Lowering barriers	Actual or intended litigation should not be a barrier to the processing were investigations of a complaint at any level.	Under Section 4 (f) of the NHS (Complaints) Regulations 2004 where a complainant has stated in writing that he/she intends to take legal proceedings, complaints processes are halted. Thus, historically the possibility of litigation has stopped the complaints procedure but a pragmatic view has been taken in informal and formal complaints processes where the possibility of litigation has arisen, but no definite intent has been declared. Legislation to repeal this Section would be required in order to comply with this Recommendation
111.	Provider organizations must constantly promote to the public their desire to receive and learn from comments and complaints	From induction onwards, staff are encouraged to promote the departments desire to receive and learn from complaints. Nonetheless there are anecdotal suggestions that some patients are reluctant to complain because they 'don't want to cause trouble' or fear retaliation. The Department should seek ways of ameliorating this problem and reassuring patients that such risks do not exist.
112.	Patient feedback which is not in the form of a complaint that which suggests cause for concern should be the subject of investigation and response of the same	The use of the PRISM and other reporting systems to capture such information is encouraged and feedback which suggests cause for concern is investigated fully.

	quality as a formal complaint.	
113. Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into the complaints at Mid Staffs should be reviewed and implemented in the NHS	The Patients' Association identified 12 standards for good complaints handling. These are to be incorporated in a guidance document to be used by the English NHS and is recommended that the Department similarly incorporates these in the revised guidance which it plans to issue following the implementation of the recommendations of the Francis report
114.	Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation	The Department already regards all such complaints and comments as grounds for the triggering of an investigation –there are several recent examples of Royal Colleges and others being called in to provide expert investigation of such concerns.
115. Investigations	Arms-length independent investigation of complaints should be initiated by the provider trust where the complaint amounts to an allegation of a serious untoward incident; subject matter which is not capable of resolution without an expert clinical opinion; a complaint raises substantive issues of professional misconduct or performance of senior managers; a complaint involves issues about the nature and extent of the services commissioned	As with the recommendation 114, the Department already regards all such complaints and comments as grounds for the triggering of an arms-length investigation –there are several recent examples of Royal Colleges and others – such as experts from UK Trusts - being called in to provide expert investigation of such concerns.
116. Support for complainants	Advocates and advice should be readily available to all complainants where meetings are held with providers	It should be noted that in this context the term "advocates" does not, as in the case of the Isle of Man, referred to legally qualified representatives but to lay friends and representatives who are able to assist complainants. These are readily available and are encouraged, with assistance in finding advocates and advisers where appropriate.
117.	A facility should be available to applicants and their clients for access to expert advice in complicated cases	Such a facility is available and complaints are encouraged to make use of such advice. The Department finds such a facility valuable in assisting complainants to frame their complaints and to understand the Department's responses.
118. Learning and information from complainants	Subject to anonymisation, a summary of each upheld a complaint should be made available on the provider's	This presents a particular problem for such a small and closely knit community but the Department should

	website	formally consider the possibility of making such information available.
119.	Overview and scrutiny committees and HealthWatch have access to detailed information about complaints	The Isle of Man does not have an organisation such as HealthWatch but instead relies upon the Patient Quality and Safety Forum to provide overall scrutiny. In addition, Health Service management receives detailed information and scrutinises responses. The Department should consider whether or not the Health Services Consultative Committee could fulfil a useful role in this area, possibly by expanding its role and size and providing it with greater independence.
120.	Commissioners should require access to all complaints information as and when complaints are made	The Isle of Man does not have a commissioning approach and therefore has no commissioners *per se.* The Department should consider providing this information to the Policy and Delivery Group as part of its normal reviews of Health Service performance.
121.	The CQC should have a means of ready access to information about the most serious complaints	The Isle of Man does not have an equivalent to the CQC but ready access to information about serious complaints is available to the Minister and to senior officers of the Department.
122. Handling large scale complaints	The primary responsibility for the causation of the activities of multiple organisations looking at large scale failures of clinical services should reside with the National Quality Board	The Isle of Man does not have an equivalent to the National Quality Board but as in the case of recommendations 114 and 115 seeks input from multiple organisations where there are concerns about large scale failures of clinical services. It should also be noted that the Department has recently entered a formal relationship with an external independent reviewer which has experience of extensive investigations and, depending on the circumstances, it might be appropriate to commission such an organisation to undertake a complex review.

10. Commissioning for Standards

The Isle of Man Health Service has not established a commissioning arrangement such as that in existence in England. The creation of a nascent Manx Commissioning Framework has been under discussion for some time and it will be important for this framework to take heed of the Francis recommendations. In particular:

- the monitoring role of GP's on behalf of their patients.
- the application of fundamental safety and quality standards in respect of each item of service provided, together with the monitoring of those standards and the establishment of infrastructure and support to enable proper scrutiny of providing services.
- the provision of the experience and resources necessary to procure complex and technical clinical services.
- a clear indication of what services should be provided, led by the Department rather than by providing clinicians.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
123. Responsibility for monitoring delivery of standards and quality	GP's needs to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services.	GP's could undertake this monitoring role despite there being no formal commissioning process. This would, however, require resources and the Department may wish to consider this against other priorities.
124. Duty to require and monitor delivery of fundamental standards	The commissioner is entitled to and should apply fundamental safety and quality standards in respect of each item of service it is commissioning.	**This would require the introduction of a formal commissioning framework.**
125. Responsibility for requiring and monitoring delivery of enhanced standards	Commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards.	**This would require the introduction of a formal commissioning framework.**
126. Preserving corporate memory	The NHS commissioning board and local commissioners should develop and oversee a code of practice for managing organisational transitions.	This recommendation is largely founded in the problems resulting from major reorganisation in the English NHS with a resultant loss in corporate memory, knowledge and skills. It does not apply directly to the Manx NHS but should nonetheless be considered in any future organisational transitions.
127. Resources for scrutiny	The NHS Commission board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of providing services.	**This would require the introduction of a formal commissioning framework.**
128. Expert support	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task.	**This would require the introduction of a formal commissioning framework.**
129. Ensuring assessment and enforcement of fundamental standards through contracts	The principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained.	**This would require the introduction of a formal commissioning framework.**
130. Relative position of commissioner and provider	Commissioners-not providers-should decide what they want to be provided.	**This would require the introduction of a formal commissioning framework.**
131. Development of alternative sources of provision	Commissioners need, wherever possible, to identify and make available alternative sources of provision .	**This would require the introduction of a formal commissioning framework** that is likely to be

		particularly challenging in the Isle of Man where the only alternative providers for acute services are off – Island.
132. Monitoring tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis.	**This would require the introduction of a formal commissioning framework.**
133. Role of commissioners in complaints	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient which appears to them that it is not being dealt with satisfactorily.	**This would require the introduction of a formal commissioning framework.**
134. Role of commissioners in provision of support for complaints	Consideration should be given to whether commissioners should be given responsibility for commissioning patient's advocate and support services for complaints against providers.	**This would require the introduction of a formal commissioning framework** as well as the introduction of an advocacy and support service similar to that available in England.
135. Public accountability of commissioners and public engagement	Commissioners should be accountable to the public for the scope and quality of services the commission.	**This would require the introduction of a formal commissioning framework.**
136.	Commissioners need to be recognisable public bodies, visit the acting on behalf of the public they serve and with a sufficient infrastructure of technical support.	**This would require the introduction of a formal commissioning framework.**
137. Intervention and sanctions for substandard or unsafe services	Commissioners should have powers of intervention were substandard will conceive services are being provided.	**This would require the introduction of a formal commissioning framework.**

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11. Local Scrutiny

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
138.	Commissioners should have contingency plans with regard to the protection of patients from harm where it is founders of the are at risk from substandard or unsafe services.	**This would require the introduction of a formal commissioning framework.**

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12. Performance Management and Strategic Oversight

Within the entire Francis report, whilst the issue of health care delivery performance management is of paramount interest on the Isle of Man, this chapter is the one which, arguably, has the most overtly English complexion. It addresses at some length the role of Strategic Health Authorities (specifically the SHA relevant in the case of Mid-Staffs - being Shropshire and Staffordshire SHA) and of course SHAs are not a feature of the healthcare structure in the Isle of Man and never have been. Nor is the recently created NHS Commissioning Board which is similarly addressed in this chapter.

Francis also examines in some detail a chronology of certain events linking the Mid-Staffs Trust and the SHA. However he does highlight that, regardless of the abolition of SHA's, ***"a performance management and strategic oversight function will reside somewhere in the system".*** This statement is weighty.

That said, the recommendations derived from the chapter are particularly telling. They highlight the importance of identifying fundamental patient safety and quality standards and of being able to demonstrate that they are met. Enshrined within this are what Francis describes as ***"unambiguous lines of referral and information flows".*** He speaks about the need to establish meaningful metrics, allowing outliers and poor performance to be identified and tackled.

Given the particularly Mid-Staffs and English structure/specific events focus of this chapter, the working group turned its attention to those elements such as "key themes"; "lessons for the future" and the recommendations themselves to inform its thinking. This is particularly so in respect of focus on relevant metrics; lines of reporting performance and the relationship between the hospital - and primary/community care - and the Department, in terms of reporting, evidencing, communicating and challenge in respect of performance management.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
139. The need to put patients first at all times	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	Until such time as there may be a formalised independent performance management organisation other than the Department of Health itself that is charged with responsibility for healthcare performance management, the Department should establish clear and unambiguous patient safety and quality standards in consultation with clinicians and other healthcare professionals. The Department should have regard to equivalent measures applied elsewhere. It is important to understand that such standards should embrace healthcare delivery beyond simply the hospital environment. In framing those standards consideration must be given to the regime of "convincing evidence" that will have to be made available to demonstrate compliance with such standards.
140. Performance managers working constructively with regulators	Where concerns are raised that such standards are not being completed with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	In the absence of a formalised regulator - but recognising that the Department will be using an external agency to review and publicly report upon healthcare delivery standards - where concerns are raised that performance standards are not being complied with, the Department has sought independent third-party audit of the relevant performance data with a particular emphasis upon the safety of patients.
141. Taking responsibility for quality	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	**Not applicable in the Isle of Man**
142. Clear lines of responsibility supported by good information	For an organisation to be effective in performance management, there must exist unambiguous lines of	**This recommendation should be applied in full in the Isle of Man context.**

flows	referral and information flows, so that the performance manager is not in ignorance of the reality.	
143. Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patients safety across the services, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	**This recommendation should be applied in full in the Isle of Man context.**
144. Need for ownership of quality metrics at a strategic level	The NHS Commission Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional officers, if appropriate.	A Recommendation reflecting a uniquely English structure although the Department of Health should have regard to the development in this area in England.

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13. Patient, Public and Local Scrutiny

The history of public and local involvement in the hospital in Mid-Staffordshire is quite complex because of changes made over a period of time involved around the crisis. However key themes recurring included:

- Involvement was ineffective
- Mechanisms relied upon enthusiastic but uninformed and untrained volunteers who were not representative of "the public"
- There was a clear lack of training resulting in ineffective challenges.
- Local media comment on quality issues should not be ignored.
- The complaints procedure was not heard or followed through.
- Local scrutiny, which may be ineffective, may however, give false comfort to others.

Community Health Councils had limited powers and functions (e.g. not involved with primary care), but were consulted on proposed changes to services. They had access to information from NHS, could enter and inspect hospitals, attend formal meetings with health authorities and make recommendations for change to the UK Secretary of State. CHCs ended in 2002.

These were replaced by Patient Forums, set up in 2002, creating a forum appointed under the Act for each hospital trust. Their role was to monitor and review the range and operation of services, inspection, obtain the views of patients and their carers and provide recommendations about services of the Trust. Most members were retired past patients as there were various exclusions to membership. Few were of ethnic groups and membership was not considered representative of the population. Specific comment is made about "conflict of interest" between patients whose lives were saved by operations within the hospital and other matters raised. However some believed this helped their judgement of certain situations.

Some members considered the function of the Patient forum should be more concentrated on the "monitoring of the hospital and its culture" than on trivial matters.
There was also an Overview and Scrutiny Committee, considered to be a more important committee but ineffectual.

Governance pre-occupation was on fractious disputes within organisations.
Both the Council and the County Council had scrutiny committees – some of which were effective in indication of problems before the Health Care Commission report. References made to Local MPs had been made but enquiries made by them were not followed up adequately.
Whenever aspects of the Health Services Act or regulations are changed, the Department have a mandatory list of consultees. Dependent on the subject matter, this would include:

- Tynwald members
- Attorney General
- Local authorities
- Chief Officers
- Chamber of Commerce
- Law Society
- Isle of Man Trade Union Council
- Any Island based professional organisation relevant to the legislation
- Any island based voluntary body where known relevant to the legislation
- HSCC

Health Services Consultative Committee (HSCC). This is the only totally independent Committee. Elected by the Appointments Commission, nine lay-members meet at least bi-monthly, and each attend other departmental meetings. ascertaining common threads and problems within DH and communicating these to the Senior Management Team of DH. However they are paid by DH and only report via the Senior Leadership team to the Minister.

The Department will also consult other organisations where they consider it relevant (shown on attachment to this report)
In September 2008, followed by another in June 2010 the local media advertised for volunteers to serve on hospital committees. Application forms were completed and a short-listing process followed. Those successful attended a one day induction training course that covered patient/public representation, confidentiality, date protection, equality and diversity.
Currently there are 13 public/patient volunteers working within the hospital as follows:

- Patient Safety & Quality Forum
- Patient Experience indicators
- Infection Control committee
- Clinical Audit Committee
- Nutrition Action Group
- Clinical Governance Committee
- Consultant Interview panels
- Clinical Recommendations Committee

Of these about half have been in post since 2008 and the remainder since 2010. Those who left resigned due to health, personal circumstances or job change.

Within wards of the hospital Patient Experience Indicators are checked for all wards and where possible 10 beds per week. The tick box questionnaire is simple. Results are analysed and will be included in the I-hub.

In Primary Care, bi-annual patient's surveys are carried out together with Patient Safety& Governance. Comments leaflets are being revamped at present.

There are also some 152 volunteers connected with the hospitals including dining companions, front desks, clinic guides, travellers with people off Island for appointments, audiology, translators etc. There are also external volunteers from Red Cross and Anti-cancer. Volunteer meetings are held every two months.

The Mental Health department have a Service Users Network (SUN) made up of past and present users for supporting each other.

Isle of Man Health Care Association has also recently been formed with the aim of identifying potential problems and obtaining early intervention to avoid problems.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
145. Structure of local Healthwatch	There should be a consistent basic structure for local Health Watch throughout the country, in accordance with the principles set out in Chapter 6:	**This is not relevant to the island but lessons can be learnt.** Health Watch, is effectively not relevant to the Isle of Man where such matters are dealt with on a more informal basis or through one of the many committees. The various Committees of DH and its structure should also be reviewed and re-organised to avoid overlaps and some Committees appear to continue seemingly through historic association. In the UK, as in the Appointments Commission, all members of the Interview panels for lay- members were not associated with the hospital and this was considered inappropriate. The method of appointment of public/local /patient representatives should be reviewed e.g. some very long outstanding members, HSCC appointed members appointed solely by Appointments Commission caused extreme problems.). Audit of function, role , membership and reporting structure of all DH Committees to ensure all areas are covered but overlap is at a minimum Review membership to ensure adequate and suitable membership, but take into account Appointment procedures suggested by Francis. Those with personal agendas should not be considered as members
146. Finance and oversight of Local Healthwatch	Local authorities should be required to pass over the centrally provided funds allocated to its Local Health Watch, whilst requiring the latter to account to it for its	**This is not relevant to the Isle of Man.** Not applicable as no funds from local authorities enter

	stewardship of the money. Transparent respect for the independence of Local HealthWatch should not be allowed to inhibit a responsible local authority – or HealthWatch England as appropriate – intervening.	the health service. However funding for some of the Health Committees should be reviewed Review basis of payment for official lay-representation on Committees.
147. Coordination of local public scrutiny bodies	Guidance should be given to promote the coordination and cooperation between Local HealthWatch, Health and Well-Being Boards, and local government scrutiny committees	**This is not relevant.** Liaison between bodies/committees in existence should be encouraged. See action on Recommendation 145 above.
148. Training	The complexities of the health service are such that proper training must be available to the leadership of Local Health Watch as well as, when the occasion arises, expert advice.	**This is not applicable to the Isle of Man but possibly UK training could be tapped.** Apart from induction training relating to all DH staff, no other training is given, apart from volunteers. Proper training for those involved in "scrutiny:" roles is lacking and needs action. Introduce training for Lay-representatives, especially those involved in scrutiny work. See also Recommendations 77 and 78.
149. Expert assistance	Scrutiny committees should be provided with appropriate support to enable them to carry out accessible guidance and benchmarks their scrutiny role, including easily	**This is both applicable and relevant to the Isle of Man.** The current lack of information to be able to benchmark with UK or other trusts is a present worry. Whereas the Department of Health are improving this area, without additional manpower diverted to it, this will continue to cause a problem for some time yet. Statistics and management information must be in a format that can be benchmarked with equivalent bodies in the UK.

150. Inspection Powers	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate rather than receiving reports without comment or suggestions for action.	**This is both applicable and relevant to the Isle of Man.** Agreed. Powers to inspect should be available to any official scrutinising committee, rather than relying on local patient structures or awaiting reports with comments and suggestions for actions.
151. Complaints to MPs	MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.	**The relevance of this is limited within the Isle of Man.** MHKs could adopt a system for recording complaints, comments and praise from constituents but this should take into account that the service is for all patients, not just for a particular constituent. We must accept that that with limited resources, treatment and investigations may be refused on an individual or group basis for the greater good of the rest of the patients. Input from MHK's should be recorded, and considered along with all other feedback.

See:
Appendix a – Health Services Consultative Committee Terms of Reference
Appendix b – Patient Experience Indicators

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14. Medical Training and Education

The quality assurance and management documentation seen by the Inquiry did not demonstrate an adequate recognition of the role medical education and training activity can play in safeguarding patients or of the importance of training taking place in environments not complying with minimum safety and quality standards.

Since the events at Stafford the General Medical Council (GMC) has taken encouraging steps to increase the focus on patient safety, including a specific question in its trainee survey, the creation of a response to concerns process and an audit of emergency department rotas.

The GMC has a justifiable concern in relation to the safety of patients that European Economic Area (EEA) practitioners do not have to demonstrate proficiency in English. There appears to be no reason why such a requirement could not be imposed on all candidates for registration.

The GMC's assessment of Approved Practice Settings relied on the results of the Healthcare Commission's (HCC's) Annual Health Check ratings.

The GMC's reaction to the HCC report on the Trust did not reflect the gravity of its findings. They may have been inhibited by the limited interventions available to them.

Training oversight is likely to have been diverted by the difficulties surrounding the failed introduction of the medical training application process (MTAS).

The Keele University Medical School's system of oversight at the relevant time did not have a sufficient focus on patient safety and care standards issues.

Surveys of the type administered by the Postgraduate Medical Education and Training Board (PMETB) suffered from a number of disadvantages resulting in it being less likely that concerns would be exposed, and they need development to exploit the information about standards of service likely to be known to trainers and trainees.

Self-assessments provided by the Trust to the Deanery failed to disclose the true state of affairs.

The system for reporting Deanery visits to the Trust did not give sufficient weight to concerns raised by trainees with regard to their relevance to patient safety.

The Deanery organised a degree of rigorous supervision in response to Dr Turner's complaints about the Trust's Accident and Emergency (A&E) but the Dean took no personal steps to liaise about these with the HCC after becoming aware of its investigation.

All these recommendations are for the Regulators (General Medical Council, Care Quality Commission) and Deaneries to put in place. A small number include actions to be taken by the healthcare providers, but only in response to the actions yet to be put into place by the Regulators etc.

When given the opportunity feedback is given to the organisations responsible for training in England and Wales.

Recommendations 152 – 172 are therefore omitted as not applicable in the Isle of Man.

15. Openness, Transparency and Candour

Openness, transparency and candour are necessary attributes of organisations providing healthcare services to the public. There is strong evidence based on the actions in particular of the Trust and the Care Quality Commission (CQC) that insufficient observance of these requirements has been prevalent.

The Trust made inaccurate statements about its mortality rates, information about serious concerns was not passed to the regulator, and a report critical of the care provided was not disclosed to the coroner. Frank and accurate information about the cause of death of patients was not universally conveyed to relatives. Exaggerated claims of success were made to the public.

The CQC made inappropriate use of non-disparagement clauses, and exhibited an inappropriately hostile reaction to communications of relevant concerns to the Inquiry – a reaction incompatible with its aspiration to be an open organisation welcoming and reflective of constructive criticism.

Insufficient openness, transparency and candour lead to delays in victims learning the truth,obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding.

There is a requirement not only for clinicians to be candid with patients about avoidable harm, but for safety concerns to be reported openly and truthfully, and for organisations to be accurate, candid and not provide misleading information to the public, regulators and commissioners.

Current requirements for openness, transparency and candour do not cover uniformly and consistently the areas in which these are needed.

Statutory duties should be created, supported by commensurate sanctions and remedies, creating obligations on healthcare providers believing or suspecting injury has been caused to patients to give them the information they require and on registered healthcare professionals who hold such a belief or suspicion to inform their employer. A further statutory duty should be imposed on directors of healthcare organisations to be truthful in any information required to be given personally or by their organisation to a regulator or commissioner in pursuance of a statutory obligation. There should be criminal liability for deliberately or recklessly made untruthful statements.

All relevant policies and guidance should be reviewed and amended to give effect to the requirements of openness, transparency and candour.

In the context of the Francis Report these terms have the following meanings;

Openness: the proactive provision of information about performance, negative as well as positive;

Transparency: the provision of facilities for all interested persons and organisations to see the information they need properly to meet their own legitimate needs in assessing the performance of a provider in the provision of services;

Candour: the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made.

Judging whether an organisation or individual has behaved with candour and in an open and transparent manner can be a highly subjective and extremely difficult to measure or assess but every effort should be made to instil a culture where the desire to be open and transparent and to act with candour should be the first reaction.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
173. Principles of openness, transparency and candour	Every Healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public.	This applies as much to the Isle of Man as it does to the UK. The difficulty for all health organizations will be in determining how to ensure that everyone working for them is honest, open and truthful in their dealings with patients and the public. The Department will have to consider how best to demonstrate this and may find it useful to learn from developments in England.
174. Candour about harm	Where death or serious harm has been caused to of patient by an act or omission of the organisation or its staff, the patient or their representatives should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	It is believed that this full and honest approach is routinely adopted by the NHS although it has to be accepted that it may not be readily accepted to be the case by those aggrieved by acts or omissions. The Department will have to consider how best to demonstrate compliance with this recommendation without compromising patient confidentiality and ensuring fairness to both patients and staff.
175.	Full and truthful answers must be given to any question reasonably ask about his or her past or intended treatment by patients or their personal representative.	It is believed that this full and honest approach is routinely adopted by the NHS although it has to be accepted that it may not be readily accepted to be the case by those aggrieved by what they believe to be poor treatment. The Department will have to consider how best to demonstrate compliance with this recommendation without compromising patient confidentiality.
176. Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	There is already a duty laid upon staff members at all levels to be completely truthful and honest in everything they say and do. This is normally enshrined in codes of conduct or similar guidelines, breaches of which may result in

		disciplinary sanctions. The Department may wish to consider whether existing codes and guidelines are adequate.
177. Openness in public statements	Any public statement made by a Health Care organization about its performance must be truthful and not misleading by omission	There is already a duty laid upon staff members at all levels to be completely truthful and honest in everything they say and do. This is normally enshrined in codes of conduct or similar guidelines, breaches of which may result in disciplinary sanctions. The Department may wish to consider whether existing codes and guidelines are adequate.
178. Implementation of the duty. Ensuring consistency of obligations under the duty of openness, transparency and candour	The NHS Constitution should be revised to reflect the changes recommended that regard to the duty of openness, transparency and candour.	This is not applicable to the Isle of Man as there is no NHS Constitution. Should such a Constitution or equivalent document be created then it would be appropriate to include this recommendation.
179. Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts for all Health Care organizations.	This is a matter which applies across Government and not solely to the Department of Health. It would therefore be appropriate to raise this recommendation in a wider setting.
180. Candour about incidents	Guidance and policies should be reviewed to ensure that they will comply with "Being Open" - the guidance published by the National Patient Safety Agency.	The Department should consider applying these guidelines and policies, even though they are not mandatory here.
181. Enforcement of the duty. Statutory duties of candour in relation to harm to patients.	A statutory obligation should be imposed to observe the duty of candour	There is already a duty laid upon staff members at all levels in Government to be completely truthful and honest in everything they say and do. This is normally enshrined in codes of conduct or similar guidelines, breaches of which may result in disciplinary sanctions. The Department may wish

		to raise this a pan-Departmental matter.
182. Statutory duty of openness and transparency	There should be a statutory duty on all directors of Healthcare organizations to be truthful in any information given to the Healthcare regulator or commissioner.	There is already a duty laid upon staff members at all levels in Government to be completely truthful and honest in everything they say and do. This is normally enshrined in codes of conduct or similar guidelines, breaches of which may result in disciplinary sanctions. The Department may wish to raise this a pan-Departmental matter.
183. Criminal liability	It should be made a criminal offence for any registered medical practitioner, nurse, allied health professional or director of an authorized or registered Healthcare organisation to obstruct another in the performance of their duties, provided misleading information, or dishonestly make an untruthful statement	There is already a duty laid upon staff members at all levels in Government to be completely truthful and honest in everything they say and do. This is normally enshrined in codes of conduct or similar guidelines, breaches of which may result in disciplinary sanctions. Whether or not this should be reinforced by legislation, and if so whether solely within Health Care or within other Government departments as well, could be a matter for discussion across Government. It is uncertain whether or not the UK is going to implement this recommendation.
184. Enforcement by the Care Quality Commission	Observance of the duty of candour should be policed by the CQC which should have powers to prosecute in cases of serial non-compliance or serious and wilful deception.	This is not applicable to the Isle of Man and, in any case, would depend upon implementation of Recommendation 183 above. If such a measure is adopted, then where the power to prosecute should lie will be an important matter to be resolved.

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16. Nursing

Given the role played by nurses and midwives in all aspects of patient care, it was inevitable that a large number of the recommendations arising from the Francis Report would touch on nursing and midwifery care on at least some level. There are very few of the 290 recommendations that nurses and midwives cannot learn lessons from. Whether this is from the perspective of the professional regulation with the NMC, from the professional body and union aspect with the Royal Colleges or from professional practice of the individual nurses and midwives themselves. It is critical that nurses on the Island continually strive to improve the care that we provide to our patients and their families.

It was with this in mind that the Island's Nursing and Midwifery Advisory Council (NMAC), led by the Chief Nurse, came together with Royal College of Nursing representation and membership from the Health Services Consultative Committee to consider the Francis Report and its recommendations. Whilst NMAC believe all professionals share responsibility for the failings at Mid-Staffordshire, we recognise that appalling care cannot be tolerated and we will do all that we can to learn the lessons and help prevent such care failings from happening here. NMAC believed that the Report and its recommendations provide a good base from which to assess the care provided at present and launch its strategic direction for the future. NMAC members used the recommendations within the Report to measure where we are now and what improvements can be made in all aspects of nursing and midwifery care.

Francis identified failings at Mid-Staffordshire, which can be summarised into the following key areas:

- Lack of openness to criticism;
- Lack of consideration to patients;
- Defensiveness;
- Looking inwards, not outwards;
- Secrecy;
- Misplaced assumptions about the judgements and actions of others;
- An acceptance of poor standards;
- A failure to put the patient first in everything that is done.

Francis goes on to provide us with a framework for improvement, stating 'to change this does not require radical reorganisation'. The themes from his recommendations include key aspects for the nursing profession:

- Readily accessible fundamental standards and means of compliance;
- No tolerance of non compliance and the rigorous policing of fundamental standards of nursing care, especially those that are older and vulnerable in our care;
- Openness, transparency and candour in all that we do;
- Strong leadership in nursing;
- Strong support for leadership roles;
- A level playing field for accountability;
- Regulation of Healthcare Support Workers;
- Better systems of regulation for the profession;
- Safe staffing levels.

With this in mind, NMAC responded to each recommendation, stating how the recommendation might be applicable in the Isle of Man, where we are in relation to that recommendation at the present time, and identifying key actions for the future. Those recommendations that offer us the opportunity for improvement in the future have been

condensed into an Action Plan, and assigned specific, measurable and achievable actions to ensure that they will be met within a reasonable time. The full document, complete with Action Plan, can be viewed as Appendix d in this document. Some of these actions have already been achieved. A Nursing and Midwifery Declaration has been developed and launched, and subsequently re-launched on 4th November during Nursing and Midwifery Awareness Week. Other actions, such as Value-Based Recruitment, are well under way. The recommendations included in this Chapter are those which Francis has identified as specifically within the gift of Nursing and the Nursing and Midwifery Council.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
185. Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: o Possession of the appropriate values, attitudes and behaviours; o Ability and motivation to enable them to put the welfare of others above their own interests; o Drive to maintain, develop and improve their own standards and abilities; o Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: o Recognition of achievement; o Regular, comprehensive feedback on performance and concerns; o Encouraging them to report concerns and to give priority to patient well-being.	Whilst NMAC already believes, with all good intention, that it is recruiting the right people into nursing, it will put more formal procedures and processes in place. NMAC will develop tools that will test this at all nursing levels within the organisation, including those applying for an entry in nurse training. **Recommendation:** NMAC will develop these tools. Underpinning our values, identified in our Nursing Declaration, NMAC will produce a document with the behaviours expected. Greater involvement at all levels of patient and public representation into the recruitment and education and training of nurses and midwives will be promoted and procedures put in place. In the next two years there will be a greater emphasis across the nursing and midwifery community in relation to building on our existing training which promotes the importance of a caring culture. NMAC recognises the importance of this. NMAC has already developed a number of things which promote this, including: • 5-day Care of the Elderly Training Programme; • Dedicated training for caring for vulnerable adults and a dedicated working group championing the needs of those who are most vulnerable when being cared for in Hospital, including the elderly, those with learning disabilities and those with mental illness;

		• A greater emphasis of our workforce training and development in the next two years will relate to caring for older people and those with dementia; • Academic Programmes promoting best practice in care standards up to Masters level have been implemented on the Island; • Leadership Programmes for all levels of Nursing and Midwifery staff have been developed within the Department of Health and it is recognised that these should be available more widely for those working in the independent and non statutory sections of nursing; • All Senior Nurses now have back to the floor responsibilities to work in clinical practice, supervising and monitoring standards of clinical care; • NMAC has reintroduced the Isle of Man Nursing and Midwifery badge, which will be used to recognise, reward and promote pride, passion and professionalism within Nursing and Midwifery; • The Hospital's Nursing Strategy, *Nursing4Excellence* and the Community Nursing Strategy *'Together for Health'* both promote the importance of a caring culture within Nursing and the importance of leadership at all levels. **Recommendation:** The principles discussed above will be built on and developed in key programmes and initiatives over the next two years, including wider awareness and roll-out of our Nursing Strategy principles and the

		implementation via a National Nurses' Day here on the Island in September this year. **Recommendation:** Following promotion, a formal system of coaching and mentorship will be put in place. **Recommendation:** Development of a process which enhances personal resilience, giving frontline nurses the tools and strategies to cope with their everyday work.
186. Practical hands-on training and experience	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.	The current nurse education curriculum delivered on the Isle of Man already has a strong focus on practice skills with two assessed practice themes running throughout the 3 year programme. Students in the new 2012 curriculum have two long placements per year allowing for an enhanced longitudinal assessment by the practice mentor. There is also a focus on gaining assessment information from a wider range of health professionals and patients/service users relating to the students skills in practice. The students also have the benefit of 2 fully equipped skills laboratories. The programme is supported by qualified committed mentors and the Island has a robust mentorship strategy. The programme is mapped to existing regulatory body standards for education including Essential Skills Clusters and at validation events we have received commendations by the NMC. The lecturers delivering the programme are cognisant of any national developments relating to practice skills and will continue to work in collaboration with Higher Education Institutions in the UK, contributing to curriculum development.

		Recommendation: NMAC will continue to foster the existing excellent links between service and education and continue to contribute to discussions regarding the future delivery of the pre registration nursing programme.
187.	There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.	There is continued national debate as to how this recommendation will or should be implemented. Health Education England will be leading a pilot which reflects the premise of the recommendation, commencing in September 2013. The initiative will place between 150 and 200 prospective student nurses in a placement area that provides direct patient care. The evaluation of this pilot will inform any proposed national implementation of this recommendation. Healthcare Assistant Training is already in place in many parts of the Island's health services. This is delivered in both a formal way, via the Qualifications Credit Framework (formerly NVQ) and informally via training programmes and workshops delivered via educationalists and Senior Nurses in practice. NMAC recognises the need to ensure that such programmes are available to all Healthcare Assistants who care for patients and their families. **Recommendation:** NMAC and the Department's health and social care teaching team and NMAC will ensure that they remain informed as to the progress of the pilot and follow any national implementation. **Recommendation:** Review the existing level and quality of training for

		Healthcare Assistants in an attempt to standardise it across the Island.
188. Aptitude test for compassion and caring	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	Locally, NMAC will promote a series of standardised recruitment procedures and questions to test attitude towards caring and compassion, and the values within the Nursing Declaration. At a national level, we will support and follow whatever is considered and implemented by the NMC. **Recommendation:** Develop a set of scenarios and questions which test attitudes towards caring, compassion and the Nursing Declaration values to be used in all areas of Nursing and Midwifery recruitment across the Island.
189. Consistent Training	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment / examination.	NMAC supports this principle and will follow national guidance if and when implemented.
190. National Standards	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care	NMAC supports this principle and will follow national guidance if and when implemented.
191. Recruitment for values and commitment	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	Locally, NMAC will promote a series of standardised recruitment procedures and questions to test attitude towards caring and compassion, and the values within the Nursing Declaration. NMAC will also be promoting the importance of patient representative involvement in the Nursing and Midwifery recruitment process. NMAC presently ensure patient representatives are involved in the recruitment process of Students to the pre-registration programme, and to more senior Nursing Leadership roles. However, NMAC will look at the feasibility of a greater level of

		involvement of the recruitment of all frontline Nursing and Midwifery staff. At a national level, NMAC will support and follow whatever is considered and implemented by the NMC. **Recommendation:** Develop a set of scenarios and questions which test attitudes towards caring, compassion and the Nursing Declaration values to be used in all areas of Nursing and Midwifery recruitment across the Island.
192. Strong Nursing voice	The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the Nursing and Midwifery Council.	The Isle of Man will follow whatever policy decisions are agreed nationally for implementation by the UK Department of Health and NMC. The Island has the Chief Nurse role which is accountable and the nursing voice to patients, families and government. Nurses are represented at all levels of the Isle of Man's Department of Health with the exception of the Department's Senior Leadership Team and the Department's meeting at Ministerial level. Nurses are at every other decision-making table. NMAC would welcome the opportunity for the Chief Nurse role to be included as a Department and Senior Leadership Team Meeting member. The Department of Health does not have non-executive members within its statutory structure, however there are patient and public representatives. Consideration will be given in the future to the engagement of ex and retired Nurses into these roles. **Recommendation:** Consideration for the Chief Nurse role to be included on the Department of Health Senior Leadership Team and

		Department Meeting.
193. Standards for appraisal and support	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.	The Isle of Man will follow whatever policy decisions are agreed nationally for implementation by the UK Department of Health and NMC.
194.	As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	NMAC already has an appraisal system which can be developed further to include an Isle of Man Nursing and Midwifery portfolio. This can evidence that Nursing and Midwifery practice is being complied with to an acceptable standard and that competencies are being achieved. There are some very good models in the Island in nursing where appraisals are being used very effectively as a performance measurement and development tool. NMAC will look at these, working closely with staff side, in a sub group and by March 2014, will have a robust system in place that can be adapted in any healthcare setting. The system will include feedback from patients and there will be patient representative input into the development. NMAC is also looking to implement a competency assessment framework called VITAL, which has been developed by the Heart of England Hospital Foundation Trust, and measures the fundamental aspects of care. This will be rolled out within the Department of Health as a mandatory framework for all Nurses to complete over the next two years. URL: http://www.nhst.co.uk/heftNursing/infoAboutVital.asp

		Recommendation: To develop a template portfolio and simplified appraisal system. Implementation of the VITAL competency framework to measure Nursing competence.
195. Nurse Leadership	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	Without additional resources, it will be difficult to achieve this on the Isle of Man. This recommendation relates primarily to Hospital ward based sisters and charge nurses, and the actions will relate primarily to Noble's Hospital and Ramsey Cottage Hospital. In most areas, the Ward Manager role has now been retitled Ward Sister / Charge Nurse. **Recommendation:** • NMAC will aim to achieve a standard whereby Ward Sisters will be working directly with patients, delivering and supervising care for at least three out of five shifts per week ward (where possible these will be supernumerary). NMAC will give a clear position whether this could be possible. • NMAC will undertake establishment reviews to see whether this is achievable. • Noble's Hospital will introduce a Ward Business Assistant role to support the administrative function of the ward sister – 1 WTE to be shared across 5 sisters. • NMAC will endeavour where possible to take out as much bureaucracy from nursing care as possible by undertaking a review of Nursing paperwork and assessment / care planning. • Nurse leaders at all levels in the organisation

		will have rostered duties back to the floor shifts, at least 2 per month.
196.	The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.	NMAC already has an appraisal system which can be developed further to include an Isle of Man Nursing and Midwifery portfolio. This can evidence that Nursing and Midwifery practice is being complied with to an acceptable standard and that competencies are being achieved. NMAC will ensure that these competencies prioritise all fundamental aspects of Nursing and Midwifery care, including Dignity, Respect, Kindness and Compassion – the values within our Nursing Declaration will be tested. There are some very good models in the Island in nursing where appraisals are being used very effectively as a performance measurement and development tool. NMAC will look at these, working closely with staff side, in a sub group and will have a robust system in place that can be adapted in any healthcare setting. The system will include feedback from patients and there will be patient representative input into the development. NMAC is also looking to implement a competency assessment framework called VITAL, which has been developed by the Heart of England Hospital Foundation Trust, and measures the fundamental aspects of care. This will be rolled out within the Department of Health as a mandatory framework for all Nurses to complete over the next two years. URL: http://www.nhst.co.uk/heftNursing/infoAboutVital.asp **Recommendation:** To develop a template portfolio and simplified appraisal

		system. Implementation of the VITAL competency framework to measure Nursing competence.
197.	Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	• Leadership Programmes for all levels of Nursing and Midwifery staff have been developed within the Department of Health and it is recognised that these should be available more widely for those working in the independent and non statutory sections of nursing; • NMAC will work closely with the Department's Health and Social Care Learning Team to ensure that Leadership Development is prioritised in curriculums from Student Nurse to the most senior Board level posts; • NMAC has already introduced a number of Leadership Programmes, including Making a Difference – a 2 Day Introduction for all staff, Aspiring Leaders for Band 5 / 6 staff nurses who have the potential to become leaders of the future, the RCN Leadership Programme for all Ward Sisters and Charge Nurses, Academic Leadership Programmes up to Masters level, and Leadership and Management Development from Intermediate to Advanced level. **Recommendation:** Commission research follow-up to evaluate success of our existing leadership programmes.
198. Measuring cultural health	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the	The culture of caring will be measured in a number of ways in the Isle of Man, including feedback from Nurses and Midwives in focus groups, Observations of Care carried out by Senior Nurses and patient

	experience and feedback of nursing staff using a robust methodology, such as the “cultural barometer”.	representatives, Patient Stories, Clinical Metrics and Senior Nurses working at the front line. Staff engagement will be critical to this process. **Recommendation:** The key action here will be to ensure that these systems are put in place in a consistent way throughout all healthcare settings, using a standardised quality monitoring framework. The above tools will be developed into a quality handbook for all healthcare settings to use.
199. Key Nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.	NMAC supports the principle of Key / Named Nurse allocation and will examine the feasibility of introducing this system **Recommendation:** NMAC will review systems of patient allocation and look at implementing a system which best suits patient care. NMAC will involve Nurses and patient representatives in a number of focus groups to explore the idea of the Named Nurse / key worker role.
200.	Consideration should be given to the creation of a status of Registered Older Person’s Nurse.	NMAC will support the consideration to the creation of a status of Registered Older Person’s Nurse if it becomes a national debate. However, this must not detract from the emphasis NMAC places on providing high standards of nursing care to older people in the meantime, and NMAC’s efforts will focus on ensuring the most vulnerable in nursing care are cared for and cared about. NMAC believe there should be consideration on whether there would be benefit in establishing an Older People’s Ward.

		Recommendation: Consider the feasibility of a Specialist Nurse for Older People.
201. Strengthen the nursing professional voice	The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls".	NMAC will engage in the debate about the role and responsibilities of the Royal College of Nursing. At the 2013 RCN Congress the recommendation was voted on and the large majority felt that the combined role brought greater benefit and the RCN should not divide.
202.	Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	**This recommendation is not applicable or relevant.**
203.	A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession.	Senior Nurses on the Island would welcome and support the development of a wider forum of Directors of Nursing nationally. NMAC has already developed key links with peers in a number of NHS UK and Channel Island Hospitals, and Healthcare Trusts, sharing best practice and information in relation to Nursing and Midwifery care. NMAC facilitates an annual conference between ourselves and the communities of Jersey, Guernsey and Gibraltar each year. NMAC has also been established to provide a consistent approach and standard of Nurse leadership and strategic development across the Isle of Man. NMAC is responsible for advising on all matters relating to Nursing and Midwifery, wherever care is delivered and has developed a website which promotes and advises on its role and responsibilities. URL: www.gov.im/health/services/nursing_midwifery

204.	All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	Nurses are represented at all levels of the Isle of Man's Department of Health with the exception of the Department's Senior Leadership Team and the Department's meeting at Ministerial level. Nurses are at every other decision-making table. NMAC would welcome the opportunity for the Chief Nurse role to be included as a Department and Senior Leadership Team Meeting member. The Department of Health does not have non-executive members within its statutory structure, however there are patient and public representatives. Consideration will be given in the future to the engagement of ex and retired Nurses into these roles. **Recommendation:** Consideration for the Chief Nurse role to be included on the Department of Health Senior Leadership Team and Department Meeting.
205.	Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact of the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	**This recommendation should be applied in full in the Isle of Man context.**
206.	The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.	NMAC will watch the development and effectiveness of the newly positioned office of the Chief Nursing Officer in the UK. The Island does, however, have its own Chief Nurse role - responsible for advising the Manx Department of Health and Government on all matters relating to Nursing and Midwifery. NMAC would support the role being given equivalent

		authority to that of the Medical Representatives within the Department. Nurses are represented at all levels of the Isle of Man's Department of Health with the exception of the Department's Senior Leadership Team and the Department's meeting at Ministerial level. Nurses are at every other decision-making table. NMAC would welcome the opportunity for the Chief Nurse role to be included as a Department and Senior Leadership Team Meeting member. The Department of Health does not have non-executive members within its statutory structure, however there are patient and public representatives. Consideration will be given in the future to the engagement of ex and retired Nurses into these roles. **Recommendation:** Consideration for the Chief Nurse role to be included on the Department of Health Senior Leadership Team and Department Meeting.
207. Strengthen identification of healthcare support workers and nurses	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	All Healthcare Assistants on the Isle of Man are called 'Healthcare Assistants' and do not use the term 'Nurse'. Wherever HCA's work, there are similar values, principles and role description. NMAC will ensure that this is consistent by undertaking a review of all such roles within the next year. **Recommendation:** Review the principles, values and role description of HCA's across the Island, assuring that there is an avoidance of confusion, and clarity with the relationship with Registered Nurses. Implement the Code of Conduct (presently introduced

		within the Department of Health) for all HCA's across the Isle of Man. Nursing and Midwifery Awareness Week will be used to promote and seek the opinions of nurses and midwives in relation to these important issues.
208.	Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse	This will be undertaken as part of the review, and confirm that all badges and uniforms clearly identify the role and responsibility of a HCA and are easily distinguishable from that of a Registered Nurse. **Recommendation:** Review the principles, values and role description of HCA's across the Island, assuring that there is an avoidance of confusion, and clarity with the relationship with Registered Nurses.
209. Registration of healthcare support workers	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)	NMAC is not discounting developing a local level registration for HCA's, however this would have to be underpinned by changes in legislation and would require Government support. It is feasible to do this here on the Isle of Man, whether a national registration system is brought in place or not. There would be resource requirements and a registrations office would have to be established, alternatively this could become a role undertaken by the Regulations and Inspections Unit within the Department of Social Care. **Recommendation:** NMAC to work with the Department of Health and the Department of Social Care to consider the feasibility of introducing a National Registration System for HCA's on the Isle of Man. NMAC will review the recommendations from the

		Cavendish Review to inform its way forward.
210. Code of conduct for healthcare support workers	There should be a national code of conduct for healthcare support workers.	NMAC is pleased to note that we have had a Code of Conduct for HCA's in place for around 5 years. This has been adopted in many areas and is in place within the Hospital and Ramsey Cottage Hospital. URL: http://www.gov.im/health/services/Nursing_Midwifery/PD_Preceptorship/healthcareassistantsdevelopmentprogramme.xml **Recommendation:** In light of the Francis Report, NMAC will review its existing code and relaunch it with emphasis on the values and principles set out in the Nursing Declaration. NMAC will make it mandatory across all statutory organisations for each HCA to sign up and work to this Code, and NMAC will be seeking the support of the Registrations and Inspections Unit to make it mandatory for HCA's within the independent sector.
211. Training standards for healthcare support workers	There should be a common set of national standards for the education and training of healthcare support workers	NMAC has introduced a 5 day training programme for HCA's at Noble's Hospital. This programme includes a competency portfolio which HCA's then work towards achieving in practice. Similar systems of learning and development are also in place in areas such as Community Nursing, Hospice and Mental Health Services. Many HCA's have achieved national standards of learning and training via the NVQ / QCF levels 2 and 3. **Recommendation:** NMAC will aim to review what is already in place for HCA's and bring these standards together, developing a common set of standards which can be used

		throughout the Island.
212.	The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.	NMAC will enter into the debate about the regulation, training and registration of HCA's nationally, however this will not detract from us developing standards and compliance here on the Island, as noted in Recommendations 209, 210 and 211.
213.	Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	NMAC is not discounting developing a local level registration for HCA's, however this would have to be underpinned by changes in legislation and would require Government support. It is feasible to do this here on the Isle of Man, whether a national registration system is brought in place or not. There would be resource requirements and a registrations office would have to be established, alternatively this could become a role undertaken by the Regulations and Inspections Unit within the Department of Social Care. **Recommendation:** NMAC to work with the Department of Health and the Department of Social Care to consider the feasibility of introducing a National Registration System for HCA's on the Isle of Man.

Nursing and Midwifery Council		
RECOMMENDATION NUMBER	**RECOMMENDATION**	**ISLE OF MAN COMMENTARY**
226. Investigation of systemic concerns	To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.
227.	The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.
228. Administrative reform	It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will

	danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.	extend to its registrants working on the Isle of Man.
229. Revalidation	It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.
230. Profile	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man. At a local level NMAC will enhance our website to ensure that the public is fully aware of us and our role and that of the NMC nationally We will develop leaflets and information for patients and will establish an annual Roadshow / Conference to promote awareness and understanding of the work of the NMC and NMAC. **Recommendation:** Continually develop and enhance the Island's Nursing and Midwifery website; Develop leaflet about NMC / NMAC; Run an annual road show / conference, Nursing and

		Midwifery Awareness Week will be the first of these.
231. Coordination with internal procedures	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.
232. Employment Liaison Officers	The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man. However, locally, NMAC already takes on the role and, as part of our Agenda, we do consider individual issues of Nursing and Midwifery competence and conduct, and give advice with regards to safety and regulatory matters. This role can be further promoted across the Island.
231, 233, 234 and 235.		Relate to NMC internal structures and are not actionable by the Isle of Man, although the nursing profession will watch closely at the changes and any regulatory and policy changes by the NMC will implemented as part of the regulation of nurses and midwives on the Isle of Man.

17. Leadership

Leadership issues are predominantly addressed by Francis in chapter 24 of his report. However, he separately addresses leadership specific to the UK Department of Health (among many other things) in the chapter devoted to that Department, being Chapter 19.

The chapter on leadership is a discursive narrative which addresses, at some points almost theoretically, leadership principles but it does try to tie those issues to leadership within the NHS. It compares and contrasts the availability of leadership training and exposure across a number of jurisdictions and public sector organisations but also considers the "***fit and proper person"*** tests often applied in the commercial environment and further reflects upon sanctions against individuals who might not be considered fit to hold office. It also speaks about accreditation in leadership skills and regulation thereof.

The chapter addresses leadership among Chief Executive/managerial personnel and medical professionals but also discusses matters in relation to leadership qualities on Boards and draws the distinction between Foundation and non-Foundation Trusts. Francis is also unequivocal that clinicians must be engaged to a far greater degree in leadership and management roles. ***"The gulf between clinicians and management needs to be closed"***. Seminars held in London and attended by a working group member endorsed this sentiment utterly, but expressed significant doubt – including by some senior clinicians themselves - at ever being able to persuade a sufficient volume of clinicians to recognise the value of organisational/management/leadership activity.

Tellingly, (in paragraph 24.105) Francis ***observes "in spite of the vital role NHS leaders and managers play in the running of the NHS and in healthcare generally, they are not held in high regard".*** The King's Fund report relating to NHS leadership and published in 2012 gave examples of this to which Francis referred.

When one looks at the significant range of issues, debating points and options set out in chapter 24 it is slightly surprising that it generates only eight recommendations. Further, a couple of the recommendations are options, one for another, and some are suggestive rather than binding, as it were. In this respect the chapter has a different complexion to most other elements of the report.

The first recommendation proposes the creation of a leadership staff College, or training system, to provide common professional training in management and leadership to senior NHS staff. Given the plethora of professional training available in the UK, including fairly substantial resources in the public sector, it is very interesting that Francis feels there should be a separate and distinct such faculty specifically for the NHS.

Again we must take proper cognizance of his recommendations, none of which can be illustrated to be completely outwith the Isle of Man context. Taking them forward will almost certainly involve seeking the professional views of HR colleagues elsewhere in government. With regard to the comments specific to UK Department of Health leadership these touch on a few areas but perhaps most pointedly address discussion about the Department of Health as a ***"cultural leader"***.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
214. Shared training	A leadership staff college or training system, whether centralised or regional, should be created to provide common professional training in management and leadership to potential senior staff, promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility by consideration for such roles, promote and research best practice in healthcare.	If implemented in the English context, even in a modified way, the outcome of this recommendation should be monitored by and, if relevant facilities are made available, embraced by the Isle of Man Department of Health. Independently, the Department should give consideration to whether any of these proposals could be effected in the local context, perhaps most particularly via the education and training facility at Keyll Darree.
215. Shared code of ethics	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	With necessary revision to reflect the local context, this recommendation should be applied in the Isle of Man.
216. Leadership framework	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	This recommendation should be given effect in the Isle of Man by the Department initially examining scope for augmenting the composition and role of existing Patient Safety and Quality Forum and attendant activities. It is also recognised that it would be useful to monitor the response to this recommendation undertaken by the English NHS.
217. Common selection criteria	A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.	A slightly nebulous recommendation in a way; the "list" would be subjective in the eyes of any particular individual who might be compiling it. It may also require finessing if it is a list of the competencies for clinical leadership as distinct from, for example, managerial leadership. In the context of the Chief Executive of the Department of Health the competencies required are those which the Civil Service Commission requires of all government Chief Executives. Nonetheless, the effect given to this

		recommendation in the English context should be considered by, and where relevant responded to, by the Department of Health.
218. Enforcement of standards and accountability	Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.	Having suggested in respect of recommendation 215 above that it should be applied, but reflecting the local context in doing so, it would be paradoxical not to accept this recommendation also. However, it too needs to be applied recognising the local context and the place of healthcare delivery/Department of Health in the wider public service environment, which differs greatly from that of the English NHS. Nonetheless, useful models may emerge in the England if this recommendation is taken forward there.
219. A regulator as an alternative	An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.	A recommendation which, if adopted, would surely be seen to have resonance throughout the much wider Isle of Man public service. It is therefore recommended that the Department of Health refer this recommendation, and the rationale and thinking giving rise to it, to the Office of Human Resources with an invitation for them to consider the issues raised and to respond.
220. Accreditation	A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initially, the objective should be to require all leadership posts to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.	The extent to which this recommendation is adopted in England is a further matter that the Department of Health should have regard to. It would also run the risk of "distortion" if it was adopted unilaterally by the Department of Health but not by other elements of the Isle of Man public service. It is a further matter on which the opinions of the office of human resources should be sought.

221. Ensuring common standards of competence and compliance	Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.	Common standards of competence and compliance is a principle that should be accepted; the distinction between foundation trusts and non-foundation trusts, which this recommendation expressly seeks to address, has no Manx context.

18. Professional Regulation of Fitness to Practise

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have been largely reactive to individual complaints against identifiable individuals which may suggest unfitness to practise on the part of unidentified doctors and nurses.

Stafford demonstrated a lack of referrals by professionals to their regulators when they have concerns.

The Trust failed to have a proper policy for referring clinicians to professional regulators.

Regulators should themselves refer or flag cases of concern with professional regulators, either by complying more properly with their current memoranda of understanding or by clarifying the terms of these.

The NMC and the GMC need to develop a close working relationship with the Care Quality Commission (CQC).

Patients are often not aware of the existence and procedure for complaining to the NMC and the GMC.

The NMC has failed properly to define its role or that of its representatives in the NHS.

Doctors have been reluctant to accept standard processes and to engage with team and management roles.

Recommendations 222 – 235 are all applicable and relevant.

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19. Caring for the Elderly

Recommendations 236 to 243 inclusive – approaches applicable to all patients but requiring special attention for the elderly

Key Themes:

- There should be clear identification of responsibility for each patient's care, led by a named consultant
- There should be clear nursing responsibilities for each patient's care and a clear dual responsibility at the point of handover
- The experience of Stafford demonstrates the importance of constantly ensuring that patients receive proper food and nutrition
- Teamwork is vital and the contribution of all individuals in the team needs to be recognised and encouraged
- There needs to be good communication with and about the patient, with appropriate sharing of information with relatives and supporters
- The importance of the involvement of patient families and carers should be recognised by those caring for patients

  Francis Report, Chapter 25, Common Culture Applied: the care of the elderly. Key themes.

In this Chapter, Francis lays out his expectation that examination of how the (health service) looks after elderly people is a true measure of effectiveness in delivery hospital care.

In giving consideration to these recommendations, discussions took place with representatives from a range of relevant services in both health and social care. It is worth noting that the narrative relates to care within hospital rather than a primary care setting, and have focussed on Nobles Hospital rather than Ramsey Cottage Hospital.

The recommendations from the Francis enquiry which relate to the care of older people have resonance for all care providers, who could all benefit from reviewing theirapproach to care in this context, and this is the basic premise on which recommendations are made.

Specifically, health colleagues expressed views which outlined significant progress in a range of areas consistent with the review recommendations, and commented on those areas where further work would be beneficial. All those asked expressed concerns that it is challenging to consistently embed change across areas, with some teams and individuals resistant to that change. The importance of strong professional leadership and visible managers was also echoed by all those who participated. The consistent expression of concern was in relation to the systems currently operated on medical wards, with the biggest impact being on older people. This largely appeared to be related to 4 key factors:

- Organisation of medical wards – with no allocation of consultants or firms to wards or beds resulting in multiple firms working on each ward

- Higher levels of sickness and reliance on bank staff on these wards than on other wards in the hospital. Perceived level of nursing staff and morale of those staff is lower than in other areas.
- Individual nature of these wards with senior nursing staff and AHPs operating an inconsistent approach to recording systems makes communication a challenge.
- Anecdotal evidence that less visible nursing leadership on medical wards than in other areas has also impacted negatively on morale.

These four issues were raised, in different ways, by all respondents. This is not unique to Nobles, with the busy and complex nature of medical wards representing a challenge in most acute hospitals. However, there are some key issues which may be worthy of particular note. Most particularly, for those patients where their nursing care needs outweigh their acute medical treatment needs, they may be better cared for in an older person's ward. This option does not currently exist within Nobles, and the Department may wish to review the option of reintroducing old age medicine as a specialty.

The detail attached makes a number of recommendations regarding audits of current arrangements. In all cases the Francis recommendations are both applicable and relevant. Much of the comments made in response to this section are based on perception and anecdote. It is recommended that the Department of Health considers undertaking a survey in addition to the current patient sample survey, post discharge, and including the views of relative and carers. It may be possible to undertake this with the support of a third party, for example Age Isle of Man. This would allow views of care in primary care to be included in a way that has not been possible to date.

Note: The review group gave time to the discussion of individuals in Nobles for whom acute medical care is no longer required, but where relatives and partners are unwilling to fund transition to residential or nursing home care. This issue is not within the remit of the Francis Review Working Group but the Department of Health and the Department of Social Care are jointly working on this matter as a separate piece of work.

NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
236. Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patients case, so that patients and their supporters are clear who is in overall control	**This recommendation is both applicable and relevant.** Discussions with colleagues highlighted a particular issue with regard to medical wards. Views were expressed that the pathways for older people admitted onto medical wards as Nobles was often complex and sometime fragmented because of the current allocation of consultants and beds to wards. This results in the movement of patients (sometimes 5-6 times in one admission) and is particularly the case in relation to infection control. Work is underway to address this and to formalise the allocation of consultant beds.
237. Teamwork	There needs to be effective teamwork between the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance and catering staff also needs to be recognised and valued	**This recommendation is both applicable and relevant.** The issues noted above in relation to medical wards means that the number and frequency of all multidisciplinary meetings on medical wards is significantly higher; and demands greater nursing and AHP investment as a result. The move to allocated beds on wards would allow the MDMs to be more focussed. Most positively, housekeeping staff are allocated to wards, and managed by nursing sisters. Arrangements are in place for protected mealtimes, together with dining companions.
238. Communication with and about patients.	*Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:* • *All staff need to be enabled to interact constructively in a helpful and friendly fashion with patients and visitors* • *Where possible, wards should have areas where more mobile patients and their visitors can meet in privacy and comfort*	**This recommendation is both applicable and relevant.** There remains some anecdotal evidence that discharge letter are, on occasion delayed. Audit of the production and coding of discharge letters should be considered.

	without disturbing other patients • *The NHS should develop a greater willingness to communicate by e-mail with relatives* • *The current common practice of summary discharge letter followed up some time later with more substantive ones should be reviewed* • *Information about an older patient's condition, progress and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled*	
239. Continuing responsibility for care	*The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the discharge destination*	**This recommendation is both applicable and relevant.** Review of the bed management policy would clarify and principles should also be applied to moves within the hospital.
240. Hygiene	*All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encourage to remind anyone however senior, of these.*	**This recommendation is both applicable and relevant.** There has been progress made in this area, particularly within the development and integration of the CARE rounds. Some concern has been expressed about consistent application across all wards, but this is now being audited on a regular basis. NMAC recommendations for a national hand washing day is supported. The most common cause for the movement of older patients

		between wards in Nobles is anecdotally recounted to be to manage infection risks; with infected patients moved together into bays where their needs may be more readily met and the risk of cross infection is reduced. This clearly has an impact on their experience of care.
241. Provision of food and drink	The arrangement and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation	**This recommendation is both applicable and relevant.** Significant progress has been made in this area including CARE rounds, protected mealtimes, dining companions, Nurse leadership of mealtimes. Some concern has been expressed about consistent application across all wards, but this is audited on a monthly basis
242. Medicines administration	In the absence of automatic checking and prompting, the process of administration of medication needs to be overseen by the nurse in charge of the ward, or his / her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	**This recommendation is both applicable and relevant.** NMAC recommendations for use of the VITAL competency framework is noted, as is the adoption of best practice in EMI and mental health services. Audits to ensure consistent use of a single recording system may be helpful, to make sure that comprehensive notes follow the patient on moves.
243. Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out	**This recommendation is both applicable and relevant.** Recent developments, including the Early Warning Scoring System, the development of Vital Pak proposals, and new arrangements for benchmarking practice with other hospitals are really positive, and may moderate the issues raised in terms of progress note recording. All wards should find these changes to be an incentive to moving to consistent use of the single recording system.

	and recorded.	

20. Information

The effective collection, analysis and dissemination of relevant information is essential for swift identification and prevention of substandard service, facilitating accountability, provision of accessible and relevant information to the public, and supporting patient choice of treatment.

There is a developed national system of governance of healthcare statistics and information. Consideration needs to be given to systems for accrediting their reliability and rendering them more readily useable by the public.

Reliable data, enabling comparison of treatment outcomes by reference to individual professionals (where appropriate), provider units and organisations, is an essential element of effective learning for improvement, performance monitoring, and patient choice. Healthcare professionals and organisations, individually and collectively, must commit themselves to identifying with patients and the public, and introducing measures that fairly reflect their performance.

Real time recording of treatment and medication management can assist decision making, reduce errors and assist performance and quality management.

Quality accounts provide a vehicle for the audited publication of consistent and comparable information about compliance with standards and other requirements, but there is room for improvement by attention to consistency of presentation, balance in reporting of positive and negative results, and rigorous auditing.

The Care Quality Commission's (CQC) Quality Risk Profile is an important and developing means of collecting information relevant to the assessment of standards compliance. Consideration needs to be given to how this information can effectively be shared with the public.

Real time and online means of allowing patients both during and after treatment episodes to feed back their experiences can enhance awareness of issues of concern and accountability.

It was generally accepted that failure to share relevant information lay at the heart of the failure of the system to detect the scale of the deficiencies at the Trust and that an effective overall system of information is essential.

Healthcare information recorded primarily for supporting the safe and effective care of individual patients should also be capable of being used to inform the statistics required for clinical audit, performance data, regulatory oversight and public information. The sharing of good quality information should be a powerful force for promotion of the required common culture. Properly maintained accessible patient records are vital to this process.

It was a key feature of the Stafford story that information that would have led to the much earlier appreciation of the problems of the Trust was either not collated, not analysed or not disseminated. The result was that commissioners, performance managers, regulators and the public remained unaware of the extent and significance of the issues for far too long. The importance of information in the provision of healthcare has been underlined in a number of subsequent reports and strategy documents.

Professor Ian Kennedy – Bristol Inquiry
"Without information patients and the public will remain disempowered. It is essential that they receive and can gain access to the information they need to participate fully at whatever level their contribution is sought"

Dr AC Enthoven – In pursuit of an improving NHS (2000)
"The importance of good information on quality and cost is not limited to market models. It is essential to any properly managed system.."

Rt Hon Andrew Lansley MP – UK Dept. of Health Information Strategy (2012)
"Information can encourage positive changes in the way we live our lives and also the way public resources are used on our behalf. Information also feeds the research that improves care services for us all and will play a key role in creating a public health system that is locally owned, locally led, and able to reflect the needs of the local population….
Information can bring enormous benefits. It is the lifeblood of good health and well-being and is pivotal to good quality care. It allows us to understand how to improve our own and our family's health, to know what care and treatment choices are and to assess for ourselves the quality of services and support available Information can also be used by regulators and by local organisations to head off issues before they become the next major incident."

Mersey Internal Audit Agency – Management Information Review (IOM June 2012)
"Information is the lifeblood of any organisation, without appropriate, timely information organisations cannot make informed decisions which impact upon their business or, in the case of the Department of Health and the service providing units within it, the health and care of the population…….Information requires the data to be interpreted. It should not only identify trends, outliers and anomalies etc., but should describe these in terms of potential impacts and/or causes"

Academy of Medical Royal Colleges – i-care

See http://www.aomrc.org.uk/publications/statements/doc_download/9725-i-care-information-communication-and-technology-in-the-nhs.html

These comments reflect that in any well run organisation there needs to be a repository of up to date accurate data sufficient for it to be interpreted to provide information. It is also essential that this information is made available in suitable formats to those tasked with clinical audit, performance data, regulatory oversight and public information. It is also essential for information to be considered at appropriate intervals. Information relating to patient safety needs to be reviewed on a more frequent basis than information relating to less critical issues.

One of the basic tenets of the ISO 9000 Quality Management System for business is "If you can't measure it you can't improve it". The measurement and consideration of healthcare information can provide signposts to ways of improving healthcare.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
244. Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: ●Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. ●Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. ●Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. ●Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	**This recommendation is both applicable and relevant.** To achieve this a high level of systems integration will be required. At 26.165 Francis describes an integrated system as needing - ● A foundation in information collected about individual patients and recorded by those clinically responsible for their care; ● Information and the method of storing it which must have the following characteristics: Immediate availability to those who need to have access to provide safe and effective care for the individual patient; Accessibility to patients as part of the information available to them about their condition and treatment; Responsibility taken by an identifiable professional for the accuracy of each piece of information; A facility to enable corrections to be recorded by both patients and professionals;

	Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	Minimisation of duplication of information and maximisation of its usability for patient care, performance management and regulatory oversight; ● Aggregation of information derived from individual patient care recorded for the purpose of auditing the performance of individuals and teams of healthcare professionals; ● Proportionate availability to patients and public of outcome results at individual, team, provider and national levels, together with full disclosure of the analytical methods; ● Responsibility for implementing and maintaining effective systems of recording, analysis and publication of local performance information to reside with provider boards *(Nobles)* monitored by the regulator *(IOM DH)*; ● Proportionately reported analysis of results in accordance with independently defined and authoritative statistical standards; ● Verification by external auditing of reported results; ● Regular review to ensure data and statistics produced are the most useful and evidence based available for the purposes for which they are collected;

		● Public accessibility via a common user-friendly information gateway; (Portal) ● Access to raw anonymised data to be made available to any organisation or individual intending in good faith to undertake their own analysis and having the competence to do so. Much emphasis is placed by Francis on real-time access by clinicians and current and past patients to their clinical records. To achieve this the move to a single patient record would seem a logical progression. Adoption of such an approach might also further progress towards achieving the goal of patient care systems being used to inform the statistics required for clinical audit, performance data, regulatory oversight and public information.
245. Board accountability	Each provider organisation should have a board level member with responsibility for information	**This recommendation is both applicable and relevant.** With the importance placed by Francis et al. on the provision of timely, accurate and available information there should be an individual responsible for information provision (Chief Information Officer) in place at “executive board level”. The Executive Board is responsible for ensuring the effective management of information necessary to provide assurance that there might be a problem within their organisation. This responsibility includes an obligation to – ● Ensure that proper patient record keeping systems

		are in place ● Require appropriate clinical and other audits to be conducted and that the information necessary to do so is made available by and to all relevant staff ● Prepare and publish accurate and reliable performance statistics in accordance with best practice, and the requirements imposed by their regulators (IOM DH) ● Supply the required information for collective statistical analysis (UK Trusts) in order to receive such information to use as a performance comparator. There may be no single way in which such obligations can be fulfilled and any general information requirements should not inhibit provision of more than the minimum information to patients, staff and the public: therefore innovation and development in the information field should be encouraged. The position of Chief Information Officer ensures that information matters are given their proper importance and there is a focus of accountability and line management for this function. One of the key functions of such a role would be to determine what information the Executive Board feels it requires to fulfil its obligations. In some areas this could be based upon recommendations from internal audits such as that done in June 2012 by the Mersey Internal Audit Agency. It could also be based upon general reports

		such as the Keogh Review commissioned in February 2013 into 14 NHS trusts that were persistent outliers on mortality indicators. It has since been confirmed that the new Chief Inspector of Hospitals will base reviews using the data packs used in the Keogh review. An example of such a pack is provided in Appendix 20.1.
246. Comparable quality accounts	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	**This recommendation is both applicable and relevant.** Francis 26.180 Quality Accounts, which were one of the innovations arising out of the work of Lord Darzi and *High Quality Care for All: NHS next Stage Review Final Report* have a huge potential for furthering the required common culture, transparency and openness regarding the quality of services, as well as being a vehicle for reinforcing the accountability of the Executive Board. To produce and publish comparable quality accounts as in England would provide useful data for benchmarking performance in relation to patient safety. There should be a section within the Quality Accounts where the individual ultimately responsible for the area signs a document much like the Statement of Internal Control, used elsewhere in Government, confirming such things as safety, conformance to recommended standards etc.
247. Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all	**This recommendation is both applicable and relevant**

	systems regulators	Quality accounts provide a quality surveillance mechanism and will require this or similar action such as lodging the QCA with the IOM DH, who if they did not agree with any part of the content they could issue a Statement of Correction. They should also be lodged with any external patient organisations equivalent to Local Healthwatch or Cure the NHS in the UK.
248-251.	Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	**This recommendation is both applicable and relevant** An independent source of scrutiny should be identified for safety and quality review. This could be achieved by peer to peer review with another care provider.
252. Access to data	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	**This recommendation is both applicable and relevant** Real time access by patients, ex-patients and clinicians is referred to in a number of Francis themes. Such data should be made available through a user friendly Portal, and as appropriate, to those monitoring safety, quality or even doing research. (A Portal is a single user friendly entry point into information held. By design it should lead the user through the usually myriad sets of information until the information required is found. Provision should be made for those who do not have internet capability.)
253. Access to quality and risk profile	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent	**This recommendation is both applicable and relevant**

	with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	The real-time portal should also provide access to Inspection and Audit reports within a "to be agreed" period following publication to facilitate formulated responses to also be available to provide proper balance. (Francis 26.191) All information relating to the patient experience should be available via the portal to further openness and transparency. Francis 26.81
254. Access for public and patient comments	While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.	**This recommendation is both applicable and relevant** The concept of live posting such feedback, and the responses to that feedback, on the hospital/DH website via the Portal would take this several steps further in providing openness and transparency. Birmingham Childrens Hospital has provided such a facility whereby comments and feedback are available real time or via an "app". See http://www.bch.nhs.uk/feedback/app/landing Such mechanisms should be extended to all patient/client areas within DH and DSC.
255. Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	**This recommendation is both applicable and relevant** A formal mechanism for utilising patient feedback

		should be implemented capable of being able to co-ordinate and focus on comments received in hospital, via patient surveys, follow-up surveys and if and when applicable web based comments. Analysis of this data should be made available real-time through the Portal and where applicable, support change.
256. Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	**This recommendation is applicable and relevant** A systematic method of following up patients shortly after discharge having given them the time to reflect on their experience and feeding their comments into a patient feedback system should be available.
257-259. Role of the HSCIC		**These recommendation are partially applicable and relevant** HSCIC provides national level metrics, that are used as comparators. Although not directly relevant care will need to be taken that if HSCIC is to be used as a comparator that changes made by HSCIC to their data are also reflected in locally provided comparison data.
260-261. Information Standards	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility	**This recommendation is both applicable and relevant** It is especially important that systems used to collect **all** incident data are user friendly and provide timely feedback. If this is not the case there will be a reluctance to use the system. Statistical information regarding serious untoward

		incidents should be made available real-time via the Portal.
262. Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	**This recommendation is both applicable and relevant** Effective collection, analysis and dissemination of relevant information is a necessary component of :- ● Ensuring, so far as possible, that any shortfall in service standards is brought to light as quickly as possible; ● Ideally, enabling deficiencies to be pre-empted ● Facilitating accountability for performance ● Providing the public with a full, accurate, and transparent picture of the performance of healthcare providers – both organisations and individuals ● Informing patients' choice of treatment. An increased provision of healthcare information can only enhance the above.

263.	It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties	**This recommendation is both applicable and relevant** Possibly using as a template the *UK The NHS Outcomes framework 2012-13* each healthcare area should define appropriate outcome criteria for assessing actual patient outcomes. Subsequent input of actual outcomes should be real-time and summary outcome statistics should be made available via the Portal.
264-267.		**These recommendations are not applicable or relevant (watching brief)** Although relating to central reviews by off-island organisations, the UK Department of Health, the Information Centre and the Care Quality Commission, consideration should be given to the statistics produced which should be available on-line with a view to including them in a local Statistics Pack as comparisons.
268. Resources	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	**This recommendation is both applicable and relevant** There should be sufficient resources to support the patient care systems and also to support the production of a Statistics Packs (MIAA KPI or Keogh) at appropriate frequencies depending upon their purpose. (eg. Weekly for QSG, monthly for Executive but to be determined) The concept of a Quality Support Group (QSG) should be revisited. A suggestion for a QSG within IOM healthcare is Appendix f.

269. Improving and assuring accuracy	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	**This recommendation is both applicable and relevant** At 26.87 Francis states that accuracy of data is vital if safe care is to be delivered to patients. Francis 26.88 In many cases the person most likely to detect inaccuracy is the patient, yet currently patients are given limited and, from observation, rarely contemporaneous access to their records…… In an electronic system, there is far less reason why a patient should not have access to his own medical history and treatment record. A patient could then identify inaccuracies in the record, or correct misunderstandings held by those attending him or her. Such a system as recommended by Francis might improve accuracy as far as the patient record is concerned but would be dependent on a single patient record. Where possible data entering a system should be subject to as much automatic checking as possible at the entry stage. (Limit checking, reasonableness checking, cross referencing et al.) Where automatic checking is not possible additional care must be taken to ensure accuracy. Depending on the implications of wrongly entering a data item the concept of “four eyes control” could be considered.

270-271.		**These recommendations are not applicable or relevant** These recommendations refer to the central publication of statistics for multiple UK Trusts.
272.	There is a demonstrable need for an accreditation system to be available for healthcare relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012, it should be used as soon as practicable.	**This recommendation is not applicable or relevant** This recommendation refers to the concept of UK trusts demonstrating conformance of their healthcare related statistical methodologies by having them accredited.

Current Status of Recommendations

In accordance with the second Term of Reference the current status of the recommendations is attached as Appendix e

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21. Coroner's Inquests

Francis paints a picture of a poor relationship with the Coroner and often a lack of openness and transparency.

The position on the Isle of Man is different – a good working relationship is apparent, with the desire from the Department of Health to ensure full cooperation in all cases to provide "an accurate record of the cause of death" with the intention of ensuring a family have all the facts. One area for improvement is the need for the provision of reports and evidence from the medical professionals to the Coroner of Inquests in a timely fashion. If necessary, actions will be taken to rectify any failures in systems of reporting and to ensure appropriate changes are made.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTS
273. Information to coroners	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.	The Coroners of Inquests expect all relevant information to be provided in a timely fashion so as to enable them to carry out their statutory function and indicate that there is no evidence of which they are aware indicating that this is not already happening in the Isle of Man. However, as with all of the recommendations we will monitor any developments in the UK and seek to implement changes as necessary.
274.	There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	The Coroners of Inquests would welcome the adoption of guidance issued to UK Trusts suitably adapted to conditions in the Isle of Man where appropriate.
275. Independent medical examiners	It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised.	There are no plans to introduce a medical examiner system in the Isle of Man presently. In respect of deaths reported to them the Coroners of Inquests independently instruct consultant pathologists (albeit in the main these individuals are also employed by the Department of Health) to carry out autopsies and additionally Home Office approved pathologists or other medical experts may be instructed from time to time. Although the Coroners of Inquests see some potential merit in the introduction of an independent medical examiner system, the costs of introducing such a system would be significant and it is suggested that observation and monitoring of the effectiveness of changes in the UK (which are due to come into effect there in 2014) take place prior to any proposals being made to introduce a new system in

		the Isle of Man.
276.	Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.	See answer to 275 above
277. Death certification	National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.	The Coroners of Inquests agree that following UK National Guidance should be routine for all practitioners on the Isle of Man. Once the National Guidance is produced it will be adopted on the Isle of Man.
278.	It should be a routine part of an independent medical examiners's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.	Aside from the absence of an independent medical examiner system in the Isle of Man, the Coroners of Inquests have confirmed that they now receive reports of serious or untoward incidents and would expect the co-operation received from the Patient Safety and Quality Team to continue.
279.	So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	The Coroners of Inquests agree that this recommendation should be adopted in the Isle of Man as soon as possible.
280. Appropriate and sensitive contact with bereaved families	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	The Coroners of Inquests have confirmed that the concerns of family, hospital staff and anyone else who raises any concerns regarding the death of a person are all taken into consideration when investigating a death. The Coroner's Officer plays a key role in ensuring this communication pathway is known and fully utilised.
281.	It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.	Training is currently provided to all those who deal with bereaved families and their ongoing support should an inquest be deemed to be appropriate. As ever we will keep this under review to ensure any new evidence supporting a change in practice is

		reviewed and adopted on the Isle of Man.
282. Information for, and from inquests	Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission.	The Coroners of Inquests have confirmed that the equivalent provision, being the production of reports under Rule 34 of the Coroners of Inquests Rules 1988, is applicable on the Isle of Man. The Coroners of Inquests are happy for Rule 34 reports to be forwarded to the WMQRS and a system will be set up in due course to enable this transmission.
283.	Guidance should be developed for coroners' offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient's family.	The Coroners of Inquests have confirmed that as a matter of course the Coroner's Officers speak to families about deaths reported to them. However, should new guidance be issued in the UK, this will be considered with a view to its being adapted for use in the Isle of Man.
284. Appointment of assistant deputy coroners	The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.	This recommendation does not apply to the Isle of Man due to the ex officio appointment of the High Bailiff and Deputy High Bailiff to the role of Coroner of Inquests.
285.	The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.	The office holders in the Isle of Man being members of the judiciary are acutely aware of the need to avoid the appearance of bias and are governed in that respect by the Code of Conduct for Members of the Judiciary of the Isle of Man.

22. English Department of Health Leadership

The unspoken implication behind all policy changes for the NHS has been that they should be implemented safely and without exposing patients to the risk of harm or unacceptable treatment. No reform considered in this report needed to have increased any such risk if implemented in a culture which put the safety of the patient first at all times. There is no evidence that any Minister received or ignored advice that would have led to safer outcomes.

No criticism of the conduct of any Minister is intended in this report's findings. In general the approach of this report is to consider the actions of the Department of Health (DH) collectively rather than on the basis of the responsibility of individual civil servants.

Over time there has been an increasing recognition of the importance of articulating and defining the requirements of quality and safety, but the shift in culture to make aspiration a reality has yet to be completed.

There has been recognition that there is a problem with the standard of nursing care but the problem persists in spite of various Department of Health (DH) initiatives.

The concept of commissioning services, first introduced in the 1990s and developed in various forms, was not turned into an effective process by 2008, in part because of the limited capacity of commissioners for assessment of quality. The aspiration of World Class Commissioning to drive quality improvements as a theoretical concept was implemented before the structure and resources were in place to make it an effective reality.

The definition of healthcare standards has evolved from combining minimum requirements and developmental standards to an attempt to identify universally required essential standards, and from process-based assessment to an attempt at assessing required outcomes. The story has been of a struggle between the rhetoric of improvement and the need for clear definition of what is acceptable.

A clear policy that healthcare organisations should cooperate failed to ensure effective communication between Monitor and the Healthcare Commission (HCC) about the Trust. The DH had been aware of inter-organisational relationship difficulties from 2006.

RECOMMENDATION NUMBER	RECOMMENDATION	ISLE OF MAN COMMENTARY
286. Impact assessments before structural change	Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues: ● What is the precise issue or concern in respect of which change is necessary? ● Can the policy objective identified be achieved by modifications within the existing structure? ● How are the successful aspects of the existing system to be incorporated and continued in the new system? ● How are the existing skills which are relevant to the new system to be transferred to it? ● How is the existing corporate and individual knowledge base to be preserved, transferred and exploited? ● How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change? ● How are necessary functions to be performed effectively during any transitional period? ● What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?	A recommendation framed from a very particular English perspective reflecting Francis's concerns at perpetual NHS organisational restructuring and the potential deleterious effects; consequently, of diminished relevance in the Isle of Man context but nonetheless is worthy of note.
287.	The Department of Health should together with healthcare systems regulators take the lead	**This recommendation should be applied in full in the Isle of Man context** but with

	in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards, as recommended in this report.	particular regard to the outcome, or emerging findings, of the equivalent recommendation in the English context.
288. Clinical input	The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.	**This recommendation should be applied in full the Isle of Man context.**
289. Experience on the front line	Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department.	**The principle of this recommendation needs to be applied in the Isle of Man context**, though it is noted that political figures and officials from the Isle of Man Department of Health do regularly undertake visits to healthcare delivery facilities and that service user representatives are involved in consultative forums.
290.	The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible.	**This recommendation should be applied in full in the Isle of Man context.**

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Appendices

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a. HSCC Terms of Reference

The Health Services Consultative Committee (HSCC), originally formed in 2004, has recently been reformed with enhanced role and change in representatives. Previously the Committee only provided a 2 way exchange of information for concerns and recommendations aimed at ensuring health service provision met the needs of the Island's health service. It consisted of 6 professional members involved with health and 6 lay members.

The Committee now provides independent scrutiny and advice on the operations, performance and effectiveness of the Service.

The all-lay membership of the Committee is:

Mr Derek M Legg (Chair)
Mrs Liz Godby
Mrs Sue Gowing
Mrs Dawn Kinnish
Ms Dawn Mayor
Mr Andrew Swithinbank
Mr J K Whitehouse

Members take responsibility for looking at allocated specific areas of Health Services activity, attending appropriate divisional meetings, receiving documents, offering advice and highlighting problem areas. Members report to the HSCC and through the HSCC to the Minister.

The objective of allocating specific areas of interest/responsibility is so that each member adopts responsibility for scrutiny of, and establishing a relationship, with a specific area of the Department of Health. This will enable members to become familiar with 'their' areas, develop an understanding of them, and be better able to provide objective scrutiny of their activities.

HSCC members will focus on monitoring the performance of services, quality of services and governance. Members will not become involved in matters of detail, in complaints, in staff matters, or in matters for which lay members of other organisations already provide a service – for example, the Patient Safety Forum or patient representatives.

The HSCC is an independent consultative body to the Department of Health with regard to all aspects of the provision of the National Health Service. Members are appointed by the Appointments Commission.

The HSCC is required to produce an Annual Report and copies are available on-line or in the Tynwald Library.

Further information about the Committee can be obtained from the Secretary.

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b. Patient Experience Indicators Questions

1	How clean is the ward (including toilets)?	Very clean	Fairly clean	Not very clean	Not at all clean
2	As far as you know do the staff wash or clean their hands between touching patients?	Yes always	Yes sometimes	No	Don't know / Can't remember
3	Do you feel informed about potential medication side effects?	I am not taking any medication	Yes	No	
4	Do you feel you have enough privacy when discussing your condition or treatment with staff?	Yes always	Yes sometimes	No	
5	Do you feel that you have been treated with respect and dignity while you are on this ward?	Yes always	Yes sometimes	No	
6	Do you feel involved in decisions about your treatment and care?	Yes always	Yes sometimes	No	
7	Have hospital staff been available to talk about any worries or concerns you have?	Yes always	Yes sometimes	No	
8	Do you get enough help from staff to eat your meals?	Yes always	Yes sometimes	No	I do not need any help with my meals
9	Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	Yes	No		
10	Do you think hospital staff do everything they can to help control your pain?	Yes definitely	Yes to some extent	No	
11	When you use the call buzzer is it answered?	Did not use buzzer	Answered promptly	Took too long	Not answered at all
12	Have staff talked to you about your discharge from hospital?	Yes	To some extent	Not at all	

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c. Acronyms and Abbreviations

Acronym	Explanation
A	
A&E	Accident and Emergency Department
ACAS	Advisory, Conciliation and Arbitration Service
ADL	Activities of Daily Life
AHA	Area Health Authority
AHC	Annual Health Check
ALB	Arms Length Body
APS	Approved Practice Setting
AvMA	Action against Medical Accidents
B	
BBCSHA	Birmingham and Black Country Strategic Health Authority
BLTPCT	Burntwood, Lichfield and Tamworth Primary Care Trust
BMA	British Medical Association
BMJ	British Medical Journal
C	
C. difficile	Clostridium difficile, a serious bacterial infection capable of causing severe gastrointestinal symptoms, frequently acquired in hospital
CCDC	Consultant in Communicable Disease Control
CCG	Clincial Commissioning Group
CCH	Cannock Chase Hospital
CCPCT	Cannock Chase Primary Care Trust
CDU	Clinical Decisions Unit
CEO	Chief Executive Officer
CfHCC	Connecting for Health Coding Clinic
CGG	Clinical Governance Groups

CHAI	Commission for Healthcare, Audit and Inspection
CHC	Community Health Council
CHI	Commission for Health Improvement
CHKS	A provider of comparative information and quality improvement services for healthcare professionals
CHRE	Council or Healthcare Regulatory Excellence (see also PSA)
CIP	Cost Improvement Plan
CNO	Chief Nursing Officer
CNST	Clinical Negligence Scheme for Trusts
CP	Core Participant
CPD	Continuing Professional Development
CQC	Care Quality Commission (from April 2009)
CQUIN	Commissioning for Quality and Innovation
CSCI	Commission for Social Inspection
CURE	Cure the NHS
D	
DFI	Dr Foster Intelligence
DFU	Dr Foster Unit
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
DNR	Do Not Resusitate
E	
EAU	Emergency Assessment Unit
ED	Emergency Department
EGG	Executive Governance Group
ESPCT	East Staffordshire Primary Care Trust

EWTD	European Working Time Directive
F	
FT	NHS Foundation Trust
G	
GMC	General Medical Committee
GP	General Practitioner
GRE	Glycopeptide Resistant Enterococci
H	
HA	Health Authority
HCAI	Healthcare Associated Infection
HCC	Healthcare Commission
HCPC	Health and Care Professions Council
HDD	Historical due diligence
HEE	Health Education England
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HPU	Health Protection Unit
HQIP	Health Select Committee
HSCA	Health and Social Care Act
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
I	
IBP	Integrated Business Plan
ICAS	Independent Complaints Advocacy Services
IHI	Institute of Healthcare Improvement

ICU	Intensive Care Unit
J	
JCI	Joint Commission International
K	
KPI	Key Performance Indicator
L	
LaRS	Local and Regional Services
LETB	Local Education and Training Board
LINk	Local Involvement Networks
LMC	Local Medical Committee
LREC	Local Research Ethics Committee
LTFM	Long Term Financial Model
M	
MHAC	Mental Health Act Commission
MCCD	Medical Certificate of Cause of Death
MEE	Medical Education England
MoU	Memorandum of Understanding
MP	Member of Parliament
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
N	
NALM	National Association of LINks Members
NAO	National Audit Office
NCAS	National Clinical Assessment Service
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NED	Non-Executive Director

NHS	National Health Service
NHSFT	National Health Service Foundation Trust
NHSIC	NHS Information Centre
NHSLA	NHS Litigation Authority
NHST	NHS Trust
NICE	National Institute for Health and Clinical Excellence (from April 2005)
NIGB	National Information Governance Board
NLC	National Leadership Council
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NQB	National Quality Board
NRLS	National Reporting and Learning System
NSF	National Service Framework
NSR	Next Stage Review
O	
OHPA	Office of the Health Professions Adjudicator
ONS	Office of National Statistics
ORP	Organsational Risk Profile (HCC)
OSC	Overview and Scrutiny Committee
P	
PA	Patients Association
PALS	Patient Advice and Liaison Service
PBC	Practice Based Commissioning
PbR	Payment by Results
PCG	Primary Care Group
PCT	Primary Care Trust
PEAT	Patient Environment Action Team

PEC	Professional Executive Committee
PHLS	Public Health Laboratory Service
PIAG	Patient Information Advisory Group
PMETB	Postgraduate Medical Education and Training Board
POhWER	Advocacy Service provider
PPIF	Public and Patient Involvement Forum
PROMS	Patient Reported Outcome Measures
PSA	The Professional Standards Authority for Health and Social Care (formerly the CHRE)
PSF	Patient Safety Forum
PWC	Price Waterhouse Coopers
Q	
QA	Quality Account
QI	Quality Information
QIPP	Quality, Innovation, Productivity and Prevention (A DH programme of work)
QRP	Quality and Risk Profile
R	
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RHA	Regional Health Authority
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RIEO	Regional Intelligence and Evidence Officer (CQC)
RO	Responsible Officer
ROCR	Review of Central Returns
S	
SaSSHA	Shropshire and Staffordshire SHA
SCTS	Society for Cardiothoracic Surgery

SGH	Stafford General Hospital
SHA	Strategic Health Authority
SHMI	Summary Hospital-Level Mortality Indicator
SMR	Standardised Mortality Rate
SSI	Surgical Site Infection
SSISS	Surgical Site Infection Surveillance Service
SSPCT	South Staffordshire PCT
SUI	Serious Untoward Incident
SWSPCT	South West Staffordhire PCT
T	
the Board	The Trust Board
the Hospital	Stafford Hospital
the Inquiry	This inquiry
the Trust	Mid-Staffordshire NHS Foundation Trust, formerly the Mid-Staffordshire NHS Trust
U	
UHB	University Hospitals of Birmingham NHS Foundations Trust
UHNS	University Hospital of North Staffordshire
UKSA	UK Statistics Authority
W	
WCC	World Class Commissioning
WMQI	West Midlands Quality Institute and Observatory
WM South PCT	West Midlands South Primary Care Trust
WMSHA	West Midlands Strategic Health Authority, or its predecessors (usually Shropshire and Staffordshire SHA)
WTEs	Whole time equivalent posts

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d. Nursing and Midwifery Advisory Council Response to Francis Recommendations

Isle of Man
Nursing and Midwifery Advisory Council

Recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry
Isle of Man Nursing and Midwifery Response and Actions for the future

Working Group:

Bev Critchlow	Chief Nurse
Cath Quilliam	Director of Community Nursing
Ginette Hattersley	Acting Hospital Manager Ramsey and District Cottage Hospital
Amanda Phillips	Lead Nurse Prison Healthcare
John Struthers	Nursing and Higher Education Manager
Tosh Cairney	Matron, Elder Grange Nursing Home
Jane Sloane	Head of Midwifery
Margaret Simpson	Chief Executive Hospice Isle of Man
Jackie Carter	Practice Nurse
Rosie McCaffrey	EMI Services Manager
Gary Reynolds	Clinical Governance Manager / Lead Nurse Mental Health Service
Sue Plant	Occupational Health Manager
Sandra Pressley	RCN Representative
Dawn Kinnish	HSCC Representative

Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.				
Number	**Recommendation**	**Isle of Man Nursing and Midwifery Response / Action**	**Progress**	**Red / Amber / Green**
5	In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: • Staff put patients before themselves; • They will do everything in their power to protect patients from avoidable harm;	NMAC has come together and considered the values of nursing and midwifery across the Isle of Man. We have developed a Nursing Declaration. This Declaration gives our commitment to patients and families and residents wherever they receive nursing care, and emphasises the values by which we would expect care to be delivered to		

	• They will be honest and open with patients regardless of the consequences for themselves; • Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; • They will apply the NHS values in all their work.	them. The emphasis of this Declaration is that patients will come first in all that we do. Throughout the next 6 months, this Nursing Declaration will be shared and embedded across the Island's nursing community and will become the principles underpinning all that we do. There is an acknowledgement by NMAC that within each of the specific nursing services, there are strategies in place which give a clear commitment to patients and quality care. However, NMAC recognises that leadership is critical and to have shared value statements across the whole Island is important.		

		Nursing Declaration Our Commitment to Care 'Working with our Heads, Hands and Heart' **We will:** • Put patients first in everything we do; • Treat everyone with compassion and kindness; • Do everything we can to protect you from avoidable harm; • Value each and every one as an individual; • Listen and respond; • Work with you to get your nursing care right first time; • Care about you as well as care for you; • Acknowledge and learn when things go wrong; • Be open and honest about what we can and cannot do; • Have pride, passion and enthusiasm in our work. **Key Action:** Develop and Launch		

		the Declaration as part of International Nurses' Week and to use it as the backdrop to our ongoing nursing quality developments. This will underpin Nursing and Midwifery Awareness Week in September and engage staff in delivering the Declaration. By November 2013.	Achieved Launched 12th May 2013	
Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.				
Number	**Recommendation**	**Isle of Man Nursing and Midwifery Response / Action**	**Progress**	**Red / Amber / Green**
12	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken	There are already incident reporting systems in place which nurses and midwives recognise their responsibility to adhere to. As part of NMAC's actions for the coming year, there will be great emphasis placed on the importance of reporting incidents, near misses, and episodes where care goes wrong. We will work with others to		

	or reasons for not acting.	ensure that effective feedback systems are put in place. We will build on our culture that it is important to know why there were failures and how those findings can help future practice. Ensuring nurses and midwives understand their responsibility and accountability in keeping patients safe, however we want nurses to feel supported and safe when reporting adverse incidents and patient safety outcomes. **Key Action:** Training and Education of all Staff in relation to Incident Reporting as part of a Mandatory Training Process. **Key Action:** Credible systems of Incident Reporting that are user-friendly, accessible and provide feedback across all areas needs to be introduced.		

Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.					
Number	**Theme**	**Recommendations**	**Isle of Man Nursing and Midwifery Response / Action**	**Progress**	**Red / Amber / Green**
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	Following a review of the Isle of Man Health Service's NHS Complaints Procedure to incorporate the recommendations from the Francis Report, nurses and midwives will be proactively involved in the local resolution of Complaints, whether these Complaints are made formally or informally. The Ward Sister / Charge Nurse or equivalent will be key to leading this. **Key Action:** Education, Training and Development of Ward Sisters and other key		

			nurse leaders in relation to the proactive involvement and resolution of local complaints about their service. Providing them with the appropriate support and skills. **Key Action:** Systems of dissemination of complaint themes and trends in relation to nursing and midwifery care, which can be accessed by all nurses and midwives, as an opportunity for sharing and learning information.		
Performance management and strategic oversight					
Number	**Theme**	**Recommendations**	**Isle of Man Nursing and Midwifery Response / Action**	**Progress**	**Red / Amber / Green**
143	Clear Metrics on Quality:	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to	Nursing and Midwifery community in the Isle of Man has already made great strides in introducing clinical quality		

		allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	indicators which measure the fundamental aspects and quality of nursing and midwifery care. These have been developed with other UK NHS providers, primarily the Heart of England Hospital in Birmingham, and will be able to be benchmarked across a cohort of around 25 UK Trusts. At this stage the indication is that we are able to set a higher benchmark parameter than others within the cohort. The clinical indicators not only measure the process of nursing, but also the patient experience and the outcome of nursing care given. These are currently being implemented at Noble's Hospital, in Community Nursing and at Ramsey District Cottage Hospital. The next phase of development will be to		

			introduce similar measures of quality into mental health services, the independent sector, the Department of Social Care where nursing care takes place, and in Prison Healthcare. The Isle of Man has built on these by developing further metrics to measure our care delivered to children and families in the Community and we will be sharing these with other NHS Trusts as examples of best practice. The early indicators in the metrics are that there are some excellent examples of nursing care, however we know that there are some areas that still need to be developed and standards of care improved. Using the indicators highlights these areas of priority to us. The results of the clinical indicators will, by September 2013, be available to the		

			public. Systems are being developed in some areas of the Independent Sector, eg Hospice. Examples of how we are measuring our nursing and midwifery care are enclosed. **Key Actions:** Metrics ready for sharing from Hospital and Community Nursing by March 2014. Introduce metrics into all other nursing areas by March 2014		
Openness, transparency and candour Openness: Enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency: Allowing information and the truth about performance and outcomes to be shared with staff, patients, the public and					

	regulators. Candour: Any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.				
Number	**Theme**	**Recommendations**	**Isle of Man Nursing and Midwifery Response / Action**	**Progress**	**Red / Amber / Green**
173	Principles of openness, transparency and candour	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	<u>Staff</u> The organisation presently has a number of policies and procedures which promote openness, honesty and transparency, and are useful and supportive tools for the professional groups. Nurses and midwives have access to: • Whistle Blowing Policy • Raising and Escalation of Concerns Policies and Procedures (as directed by NMC) • NMC: The Code – Standards of Conduct, Performance and Ethics for Nurses and Midwives		

			In turn, we as managers and leaders of nurses and midwives must also put in place standards which ensure we are open and transparent, and honest, with our teams and the staff that work with us. Also ensuring that our staff do not feel anxious and do not fear reprisal for openness and honesty about patient safety and patient care, but are actively encouraged to be honest about all aspects of work that they do. <u>Patients / Public</u> Honesty, openness and truthfulness is a value within our nursing declaration, which will be shared with all nurses and midwives on the Island. The principles will also be tested in our recruitment procedures, from nurse training up to senior leadership posts,		

			and it is a value that we will continue to promote. **Key Action:** Develop Nurse Standards for leaders of nurses. **Key Action:** Put in place awareness raising and training for all Nurses and Midwives which promotes the principles outlined here and the value we place upon it. **Key Action:** Develop Island-wide interview questions which will test values of openness, transparency and candour in all our recruitment procedures for Nurses and Midwives working in the Isle of Man, whether that be at pre-registration student level, up to the most senior leadership roles.		

Nursing					
Number	**Theme**	**Recommendations**	**Isle of Man Nursing and Midwifery Response / Action**	**Progress**	**Red / Amber / Green**
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: o Possession of the appropriate values, attitudes and behaviours; o Ability and motivation to enable them to put the welfare of others above their own interests; o Drive to maintain,	Whilst we already believe, with all good intention, that we are recruiting the right people into nursing, we will put more formal procedures and processes in place. We will develop tools that will test this at all nursing levels within the organisation, including those applying for an entry in nurse training. **Key Action:** NMAC will develop these tools by March 2014. Underpinning our values, identified in our Nursing Declaration, NMAC will produce a document with the		

		develop and improve their own standards and abilities; o Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: o Recognition of achievement; o Regular, comprehensive feedback on performance and concerns;	behaviours expected. Greater involvement at all levels of patient and public representation into the recruitment and education and training of nurses and midwives will be promoted and procedures put in place. In the next two years there will be a greater emphasis across the nursing and midwifery community in relation to building on our existing training which promotes the importance of a caring culture. NMAC recognises the importance of this. We have already developed a number of things which promote this, including: • 5-day Care of the Elderly Training Programme; • Dedicated training for caring for vulnerable adults and a dedicated working group		

		o Encouraging them to report concerns and to give priority to patient well-being.	championing the needs of those who are most vulnerable when being cared for in Hospital, including the elderly, those with learning disabilities and those with mental illness; • A greater emphasis of our workforce training and development in the next two years will relate to caring for older people and those with dementia; • Academic Programmes promoting best practice in care standards up to Masters level have been implemented on the Island; • Leadership Programmes for all levels of Nursing and Midwifery staff have been developed within the Department of Health and it is recognised that these should be available more widely for those working in the independent and non statutory sections of		

			nursing; • All Senior Nurses now have back to the floor responsibilities to work in clinical practice, supervising and monitoring standards of clinical care; • We have reintroduced the Isle of Man Nursing and Midwifery badge, which will be used to recognise, reward and promote pride, passion and professionalism within Nursing and Midwifery; • The Hospital's Nursing Strategy, *Nursing4Excellence* and the Community Nursing Strategy *'Together for Health'* both promote the importance of a caring culture within Nursing and the importance of leadership at all levels. **Key Action:** The principles discussed above		

			will be built on and developed in key programmes and initiatives over the next two years, including wider awareness and roll-out of our Nursing Strategy principles and the implementation via a National Nurses' Day here on the Island in September this year. **Key Action:** Following promotion, a formal system of coaching and mentorship will be put in place. **Key Action:** Development of a process which enhances personal resilience, giving frontline nurses the tools and strategies to cope with their everyday work.		
186	Practical hands-on training and experience	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a	The current nurse education curriculum delivered on the Isle of Man already has a strong focus on practice skills with two		

		consistent standard is achieved by all trainees throughout the country. This requires national standards.	assessed practice themes running throughout the 3 year programme. Students in the new 2012 curriculum have two long placements per year allowing for an enhanced longitudinal assessment by the practice mentor. There is also a focus on gaining assessment information from a wider range of health professionals and patients/service users relating to the students skills in practice. The students also have the benefit of 2 fully equipped skills laboratories. The programme is supported by qualified committed mentors and the Island has a robust mentorship strategy. The programme is mapped to existing regulatory body standards for education including Essential Skills Clusters and at validation events we have received commendations by the NMC. The lecturers delivering the		

			programme are cognisant of any national developments relating to practice skills and will continue to work in collaboration with Higher Education Institutions in the UK, contributing to curriculum development. **Key Action:** NMAC chaired by the Chief Nurse will continue to foster the existing excellent links between service and education and continue to contribute to discussions regarding the future delivery of the pre registration nursing programme.		
187		There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a	There is continued national debate as to how this recommendation will or should be implemented. Health Education England will be leading a pilot which reflects the premise of the		

		registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.	recommendation, commencing in September 2013. The initiative will place between 150 and 200 prospective student nurses in a placement area that provides direct patient care. The evaluation of this pilot will inform any proposed national implementation of this recommendation. Healthcare Assistant Training is already in place in many parts of the Island's health services. This is delivered in both a formal way, via the Qualifications Credit Framework (formerly NVQ) and informally via training programmes and workshops delivered via educationalists and Senior Nurses in practice. NMAC recognises the need to ensure that such programmes are available to all Healthcare Assistants who care for patients		

			and their families. **Key Action:** NMAC and the Department's health and social care teaching team and NMAC will ensure that they remain informed as to the progress of the pilot and follow any national implementation. **Key Action:** Review the existing level and quality of training for Healthcare Assistants in an attempt to standardise it across the Island.		
188	Aptitude test for compassion and caring	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession,	Locally, NMAC will be promoting a series of standardised recruitment procedures and questions to test attitude towards caring and compassion and the values within our own Nursing		

		exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	Declaration. At a national level, we will support and follow whatever is considered and implemented by the NMC. **Key Action:** Develop a set of scenarios and questions which test attitudes towards caring, compassion and the Nursing Declaration values to be used in all areas of Nursing and Midwifery recruitment across the Island. By March 2014.		
189	Consistent Training	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment / examination.	NMAC supports this principle and will follow national guidance if and when implemented.		
190	National	There should be national	NMAC supports this principle		

	Standards	training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care	and will follow national guidance if and when implemented.		
191	Recruitment for values and commitment	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	Locally, NMAC will be promoting a series of standardised recruitment procedures and questions to test attitude towards caring and compassion and the values within our own Nursing Declaration. We will also be promoting the importance of patient representative involvement in the Nursing and Midwifery recruitment process. We presently ensure patient representatives are involved in the recruitment process of Students to the pre-registration programme, and to more senior Nursing Leadership roles. However, we will look at		

			the feasibility of a greater level of involvement of the recruitment of all frontline Nursing and Midwifery staff. At a national level, we will support and follow whatever is considered and implemented by the NMC. **Key Action:** Develop a set of scenarios and questions which test attitudes towards caring, compassion and the Nursing Declaration values to be used in all areas of Nursing and Midwifery recruitment across the Island. By March 2014.		
192	Strong Nursing voice	The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed	IOM will follow whatever policy decisions are agreed nationally for implementation by the UK Department of Health and NMC.		

		by and accountable to, the Nursing and Midwifery Council.	IOM has Chief Nurse role, which is accountable and the nursing voice to patients, families and government. We have nurses represented at all levels of the Department of Health of the Isle of Man with the exception of the Department's Senior Leadership Team and the Department's meeting at Ministerial level. Nurses are at every other decision-making table. We would welcome the opportunity for the Chief Nurse role to be included as a Department and Senior Leadership Team Meeting member. The Department of Health does not have non-executive members within its statutory structure, however we do have patient and public		

			representatives. Consideration will be given in the future to the engagement of ex and retired Nurses into these roles. **Key Action:** Consideration for the Chief Nurse role to be included on the Department of Health Senior Leadership Team and Department Meeting.		
193	Standards for appraisal and support	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.	IOM will follow whatever policy decisions are agreed nationally for implementation by the UK Department of Health and NMC.		
194		As part of a mandatory annual performance appraisal, each	We already have an appraisal system, which can be		

		Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be	developed further to include an Isle of Man Nursing and Midwifery portfolio with evidence that Nursing and Midwifery practice is being complied with to an acceptable standard and that competencies are being achieved. There are some very good models in the Island in nursing where appraisals are being used very effectively as a performance measurement and development tool. NMAC will look at these, working closely with staff side, in a sub group and by March 2014, will have a robust system in place that can be adapted in any healthcare setting. The system will include feedback from patients and there will be patient representative input into the development. We are also looking to implement a competency assessment framework called VITAL, which has been developed by the		

		countersigned by their appraising manager as being such.	Heart of England Hospital Foundation Trust, and measures the fundamental aspects of care. This will be rolled out within the Department of Health as a mandatory framework for all Nurses to complete over the next two years. URL: http://www.nhst.co.uk/heftNursing/infoAboutVital.asp **Key Action:** To develop a template portfolio and simplified appraisal system by March 2014. Implementation of the VITAL competency framework to measure Nursing competence by March 2016.		
195	Nurse Leadership	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double	Without additional resources, that will be difficult to achieve on the Isle of Man.		

		up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	This recommendation relates primarily to Hospital ward based sisters and charge nurses, and the actions will relate primarily to Noble's Hospital and Ramsey Cottage Hospital. In most areas, the Ward Manager role has now been retitled Ward Sister / Charge Nurse. **Key Actions:** • We will aim to achieve a standard that Ward Sisters will be working directly with patients and delivering and supervising care for at least three out of five shifts per week ward – where possible these will be supernumerary. We will give a clear position by March 2014 whether this will be possible. • We will undertake		

			establishment reviews to see whether this is achievable. • In the Hospital, we will introduce a Ward Business Assistant role to support the administrative function of the ward sister – 1 WTE to be shared across 5 sisters. • We will endeavour where possible to take out as much bureaucracy from Nursing care as possible by undertaking a review of Nursing paperwork and assessment / care planning by March 2015. • Nurse leaders at all levels in the organisation will have rostered duties back to the floor shifts, at least 2 per month.		
196		The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses'	We already have an appraisal system, which can be developed further to include an Isle of Man Nursing and		

		demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.	Midwifery portfolio with evidence that Nursing and Midwifery practice is being complied with to an acceptable standard and that competencies are being achieved. We will ensure that these competencies prioritise all fundamental aspects of Nursing and Midwifery care, including Dignity, Respect, Kindness and Compassion – the values within our Nursing Declaration will be tested. There are some very good models in the Island in nursing where appraisals are being used very effectively as a performance measurement and development tool. NMAC will look at these, working closely with staff side, in a sub group and by March 2014, will have a robust system in place that can be adapted in any healthcare setting. The system will include feedback from patients and there will be		

			patient representative input into the development. We are also looking to implement a competency assessment framework called VITAL, which has been developed by the Heart of England Hospital Foundation Trust, and measures the fundamental aspects of care. This will be rolled out within the Department of Health as a mandatory framework for all Nurses to complete over the next two years. URL: http://www.nhst.co.uk/heftNursing/infoAboutVital.asp **Key Actions:** To develop a template portfolio and simplified appraisal system by March 2014. Implementation of the VITAL competency framework to measure Nursing competence		

			by March 2016.		
197		Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	• Leadership Programmes for all levels of Nursing and Midwifery staff have been developed within the Department of Health and it is recognised that these should be available more widely for those working in the independent and non statutory sections of nursing; • We will work closely with the Department's Health and Social Care Learning Team to ensure that Leadership Development is prioritised in our curriculums from Student Nurse to the most senior Board level posts; • We have already introduced a number of Leadership Programmes, including Making a Difference – a		

			2 Day Introduction for all staff, Aspiring Leaders for Band 5 / 6 staff nurses who have the potential to become leaders of the future, the RCN Leadership Programme for all Ward Sisters and Charge Nurses, Academic Leadership Programmes up to Masters level, and Leadership and Management Development from Intermediate to Advanced level. **Key Action:** Commission research follow-up to evaluate success by March 2015.		
198	Measuring cultural health	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line	The culture of caring will be measured in a number of ways in the Isle of Man, including feedback from Nurses and Midwives in focus groups,		

		nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the “cultural barometer”.	Observations of Care carried out by Senior Nurses and patient representatives, Patient Stories, Clinical Metrics and Senior Nurses working at the front line. Staff engagement will be critical to this process. **Key Action:** The key action here will be to ensure that these systems are put in place in a consistent way throughout all healthcare settings, using a standardised quality monitoring framework. The above tools will be developed into a quality handbook for all healthcare settings to use. March 2014		
199	Key Nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision	NMAC supports the principle of Key / Named Nurse allocation and will examine the feasibility		

		of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.	of introducing this system **Key Action:** NMAC will review systems of patient allocation and look at implementing a system which best suits patient care. We will involve Nurses and patient representatives in a number of focus groups to explore the idea of the Named Nurse / key worker role.		
200		Consideration should be given to the creation of a status of Registered Older Person's Nurse.	NMAC will support the consideration to the creation of a status of Registered Older Person's Nurse if it becomes a national debate. However, this must not detract from our emphasis in providing high standards of nursing care to older people in the meantime, and our efforts will focus on		

			ensuring the most vulnerable in our care are cared for and cared about. NMAC believe there should be consideration on whether there would be benefit in establishing an Older People's Ward. **Key Action:** Consider the feasibility of a Specialist Nurse for Older People.		
201	Strengthen the nursing professional voice	The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls".	NMAC will engage in the debate about the role and responsibilities of the Royal College of Nursing. At the 2013 RCN Congress the recommendation was voted on and the large majority felt that the combined role brought		

			greater benefit and the RCN should not divide.		
203		A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession.	Senior Nurses on the Island would welcome and support the development of a wider forum of Directors of Nursing nationally. We have already developed key links with peers in a number of NHS UK and Channel Island Hospitals, and Healthcare Trusts, sharing best practice and information in relation to Nursing and Midwifery care. NMAC facilitates an annual conference between ourselves and the communities of Jersey, Guernsey and Gibraltar each year. NMAC has also been established to provide a consistent approach and standard of Nurse leadership and strategic development across the Isle of Man. NMAC is responsible for		

			advising on all matters relating to Nursing and Midwifery, wherever care is delivered and we have developed a website which promotes and advises on our role and responsibilities. URL: www.gov.im/health/services/nursing_midwifery		
204		All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	We have nurses represented at all levels of the Department of Health of the Isle of Man with the exception of the Department's Senior Leadership Team and the Department's meeting at Ministerial level. Nurses are at every other decision-making table. We would welcome the opportunity for the Chief Nurse role to be included as a Department and Senior		

			Leadership Team Meeting member. The Department of Health does not have non-executive members within its statutory structure, however we do have patient and public representatives. Consideration will be given in the future to the engagement of ex and retired Nurses into these roles. **Key Action:** Consideration for the Chief Nurse role to be included on the Department of Health Senior Leadership Team and Department Meeting.		
206		The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole,	We will watch the development and effectiveness of the newly positioned office of the Chief Nursing Officer in the UK. However, here on the Island, we have our own Chief Nurse role, which is responsible for		

		able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.	advising the Manx Department of Health and Government on all matters relating to Nursing and Midwifery. We would support the role being given equivalent authority to that of the Medical Representatives within the Department. We have nurses represented at all levels of the Department of Health of the Isle of Man with the exception of the Department's Senior Leadership Team and the Department's meeting at Ministerial level. Nurses are at every other decision-making table. We would welcome the opportunity for the Chief Nurse role to be included as a Department and Senior Leadership Team Meeting member. The Department of Health does		

			not have non-executive members within its statutory structure, however we do have patient and public representatives. Consideration will be given in the future to the engagement of ex and retired Nurses into these roles. **Key Action:** Consideration for the Chief Nurse role to be included on the Department of Health Senior Leadership Team and Department Meeting.		
207	Strengthen identification of healthcare support workers and nurses	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	All Healthcare Assistants on the Isle of Man are called 'Healthcare Assistants' and do not use the term 'Nurse'. Wherever HCA's work, there are similar values, principles and role description. We will ensure that this is consistent by undertaking a review of all such roles within the next year.		

			Key Action: Review the principles, values and role description of HCA's across the Island, assuring that there is an avoidance of confusion, and clarity with the relationship with Registered Nurses. Implement the Code of Conduct (presently introduced within the Department of Health) for all HCA's across the Isle of Man. By September 2013 – Nursing and Midwifery Awareness Week.		
208		Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a	This will be undertaken as part of the review, and confirm that all badges and uniforms clearly identify the role and responsibility of a HCA and are easily distinguishable from that		

		registered nurse	of a Registered Nurse. **Key Action:** Review the principles, values and role description of HCA's across the Island, assuring that there is an avoidance of confusion, and clarity with the relationship with Registered Nurses.		
209	Registration of healthcare support workers	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they	NMAC is not discounting developing a local level registration for HCA's, however this would have to be underpinned by changes in legislation and would require Government support. It is feasible to do this here on the Isle of Man, whether a national registration system is brought in place or not. There would be resource requirements and a		

		are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)	registrations office would have to be established, alternatively this could become a role undertaken by the Regulations and Inspections Unit within the Department of Social Care. **Key Action:** NMAC to work with the Department of Health and the Department of Social Care to consider the feasibility of introducing a National Registration System for HCA's on the Isle of Man. November 2015 NMAC will await the outcomes and recommendations from the Cavendish Review to inform this.		
210	Code of conduct for healthcare	There should be a national code of conduct for healthcare support workers.	NMAC is pleased to note that we have had a Code of Conduct for HCA's in place for		

	support workers		around 5 years. This has been adopted in many areas and is in place within the Hospital and Ramsey Cottage Hospital. URL: http://www.gov.im/health/services/Nursing_Midwifery/PD_Preceptorship/healthcareassistantsdevelopmentprogramme.xml **Key Action:** In light of the Francis Report, NMAC will review our existing code by November 2013, and relaunch with emphasis on the values and principles in our Nursing Declaration. We will make it mandatory across all statutory organisations for each HCA to sign up and work to this Code, and we will be seeking the support of the Registrations and Inspections Unit to make it mandatory for HCA's within the		

			independent sector.		
211	Training standards for healthcare support workers	There should be a common set of national standards for the education and training of healthcare support workers	We have introduced at Noble's Hospital a 5 day training programme for HCA's. This programme includes a competency portfolio which HCA's then work towards achieving in practice. Similar systems of learning and development are also in place in areas such as Community Nursing, Hospice and Mental Health Services. We also have many HCA's who have achieved national standards of learning and training via the NVQ / QCF levels 2 and 3. **Key Action:** NMAC will aim to review what is already in place for HCA's and bring these standards		

			together, developing a common set of standards which can be used throughout the Island. September 2014		
212		The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.	We will enter into the debate about the regulation, training and registration of HCA's nationally, however this will not detract from us developing standards and compliance here on the Island, as noted in Recommendations 209, 210 and 211.		
213		Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect	NMAC is not discounting developing a local level registration for HCA's, however this would have to be underpinned by changes in legislation and would require Government support.		

		patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	It is feasible to do this here on the Isle of Man, whether a national registration system is brought in place or not. There would be resource requirements and a registrations office would have to be established, alternatively this could become a role undertaken by the Regulations and Inspections Unit within the Department of Social Care. **Key Action:** NMAC to work with the Department of Health and the Department of Social Care to consider the feasibility of introducing a National Registration System for HCA's on the Isle of Man. November 2015		
Nursing and Midwifery Council					

Number	Theme	Recommendations	Isle of Man Nursing and Midwifery Response / Action	Progress	Red / Amber / Green
226	Investigation of systemic concerns	To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.		
227		The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in		

		proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.	place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.		
228	Administrative reform	It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever		

		imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.	is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.		
229	Revalidation	It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. We would certainly support the principle of more robust systems of revalidation for all Nurses and Midwives. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.		
230	Profile	The profile of the Nursing and	NMAC will engage in the		

		Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man. At a local level NMAC will enhance our website to ensure that the public is fully aware of us and our role and that of the NMC nationally We will develop leaflets and information for patients and will establish an annual Roadshow / Conference to promote awareness and understanding of the work of the NMC and NMAC.		

			Key Actions: Continually develop and enhance the website; Develop leaflet about NMC / NMAC; Run an annual road show / conference, the first to be staged in September 2013		
231	Coordination with internal procedures	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	NMAC will engage in the debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man.		
232	Employment	The Nursing and Midwifery	NMAC will engage in the		

	Liaison Officers	Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.	debate with regards to the future role of the NMC and will support any recommendations put in place. It must be noted that whatever is agreed at a national level about the role and responsibilities of the NMC, will extend to its registrants working on the Isle of Man. However, locally, NMAC already takes on the role and, as part of our Agenda, we do consider individual issues of Nursing and Midwifery competence and conduct, and give advice with regards to safety and regulatory matters. This role can be further promoted across the Island.		
Caring for the Elderly Approaches applicable to all patients but requiring special attention for the elderly					

Number	Theme	Recommendations	Isle of Man Nursing and Midwifery Response / Action	Progress	Red / Amber / Green
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	NMAC would support the reintroduction of identifying a senior clinician who is in charge of each elderly patient's case. In theory, this is already in place with the role of the Consultant in charge, who has overall authority in relation to the planning and delivery of treatment and care, however the Island could consider the potential introduction of the role of a Key Worker system for older people across the Island, similar systems are already in place for example with other vulnerable adults in our society, including older prisoners, within the Mental health system and within Learning Disabilities. **Key Actions:** NMAC, on behalf of Nursing		

			and Midwifery and as part of a wider review and consultation, will be part of a feasibility study looking at clearer systems which identify who is responsible for the patient whilst in Hospital.		
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	NMAC recognises the importance of teamwork and would want this to be enhanced wherever possible. The development of clear standards for multi-disciplinary team meetings, the role of a key worker (as identified in 236) and the enhanced leadership ability of all ward sisters should all help to ensure that the collective care required by the elderly patient is recognised. Initiatives that have already been put in place such as the Vulnerable Adult working programme and champions,		

			the Leadership programme Making a Difference and our Elderly Persons 5 Day Education and Training programme all promote this. **Key Action:** NMAC will ensure that Nursing and Midwifery work together with other disciplines and services to develop clear standards which promote teamwork for older people, building on the work that has already been achieved.		
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a	Communication is seen as critical in all interventions and aspects of patient care. We have already introduced programmes of enhanced communication skills, CARE rounds (Communicate, Ask, Respond, Evaluate – these are undertaken every two hours		

		helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them,	where the patients are asked 5 key questions in relation to their care and comfort) and senior nurse 'surgeries'. These initiatives will be promoted and rolled out across the Island. All wards and departments have areas where mobile patients and their families can meet and chat. We would support the greater use of email with relatives and families, especially as many families may live remotely from the Island, and we recognise that getting appropriate and timely information may sometimes be difficult. NMAC think that the introduction of a generic email		

		who must be included in the therapeutic partnership to which all patients are entitled.	address for wards and departments so that patients and families can email directly for information from Ward Sisters, Senior Nurses and Specialist Nurses is a good one, and we will lead a feasibility study on seeing if this is possible in the future. We would support a review of how discharge information and discharge letters are formulated and disseminated. In recent years, considerable work has been done to introduce robust discharge procedures and planning at Noble's Hospital and this process is now measured in one of the questions in the care indicators. We know that considerable work still needs to be done in this area, and with the help of the Discharge and Transfer of Care Coordinator, we will review practice and aim		

			to enhance our standards and compliance even further. **Key Actions:** Investigate the feasibility of a generic email address for wards and departments by October 2013. Review audit results of the Discharge Policies and Procedures and enhanced training for all staff by September 2013.		
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge	NMAC will support a standard being put in place which states that no patient can be discharged from an inpatient ward area after 20:00 and this will be emphasised within the Bed Management Policy. We would also promote that no patient is transferred from one ward to another after 21:00.		

		areas in hospital need to be properly staffed and provide continued care to the patient.	**Key Action:** Review Bed Management Policy in relation to standard for limit on the time of discharge or transfer.		
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	Our Island-wide Prevention and Management of Infection team promote the importance of handwashing at all times. We have ongoing training for staff and regular audits. This is an integral question within our CARE indicators, where patients are asked on every ward, on a monthly basis, 'As far as you know, do the staff wash or clean their hands between touching patients?' **Key Action:** NMAC, together with the Infection Prevention and		

			Management team, will promote a national day of hand washing right across the Island, which will include awareness raising of staff and the public in April / May 2014.		
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	For the last 5 years, Noble's Hospital and Ramsey District Cottage Hospital, together with other areas of care within the Independent Sector, have promoted the importance of food and drink as a 'treatment' for our patients. Significant work has been undertaken to ensure that patients receive high quality food, sufficient nutrition and hydration, and the assistance they require whilst in all care settings. Noble's Hospital has introduced a Nutrition Action Group, which monitors and evaluates the care we provide with relation to food and drink. As part of these initiatives we have		

			introduced a number of practices, including: • Nurse in Charge must lead the delivery of meals at all times; • The role of the Housekeeper to support high quality and attractive preparation of food; • Protected mealtimes; • A red tray policy and improved food charts; • Dining Room Companions; • Seasonal menus; • Enhanced soft diet provision; • Snack boxes; • Food 24/7; • 30 minute observations of care by senior staff to observe and monitor the standards of mealtimes; • Patient Experience Indicators which ask about the quality of food and assistance provided to patients.		

			We will continue to develop this area and initiatives which have proved extremely successful within the acute Hospital settings will be rolled out elsewhere.		
242	Medicines Administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	The administration of medicines is seen as a critical part of the nursing care role and there are a number of ways we ensure that patients receive their medicines in a timely and safe way. This includes: • CARE Rounds • Audits • Safety Cross at Noble's Hospital as part of our Releasing Time to Care initiative • Patients are asked about their medication and its delivery as part of the patient experience indicators;		

			• It is recognised at Noble's Hospital that accidents occur when staff administering medicines are interrupted, and Noble's has therefore implemented a red tabard system for nurses administering medicines. We already have examples of good practice where this is done in Elderly Mentally Infirm Services and we need to review these and to consider their implementation across other care settings. In the future, NMAC will be using the VITAL competency framework to measure and test the competence of drug administration		

			Key Actions: Review examples of good practice in Mental Health and EMI services. Ensure that the safety cross at Noble's Hospital is used as a measure to test and audit drug administration in all areas. By April 2014		
243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	Routine observations are recorded as a minimum standard for all inpatients in Hospital twice daily. These are recorded on an Early Warning Scoring System and reported where variations exist which indicate that the patient's condition has deteriorated, or where the patient needs a review. Again, these are audited as part of our clinical care indicators on a monthly basis on all wards and standards are		

			monitored by ward leaders. At the present time, we have introduced a standard where ward sisters must check three charts per day, randomly on their wards, to ensure that standards are being maintained. A recent audit of the NEWS system (Noble's Early Warning Score) indicated that there is still considerable work to be done in relation to the response of junior doctors and medical teams, and the actions taken where observations give the nursing staff cause for concern. A considerable education programme, as part of our patient safety agenda, is being put into place at present.		

			Introduction of a new NEWS system. As part of the Patient Safety Programme at Noble's Hospital, we are presently looking at introducing a system called VitalPak or something similar, which will allow near-patient devices such as I-phone or tablets to record observations and for them to be monitored centrally. This will certainly enhance our ability to care for patients. However, it does depend on resources and funding as to whether such a system can be introduced. **Key Actions:** Support the introduction of Vital Pak and ensure nursing involvement in the choice and		

			procurement of a system. Review the recent NEWS audit and to enhance the training and development of staff within the Hospital. October 2013.		
		System of peer review	NMAC supports systems of peer review and are presently looking at setting up both external and internal systems where nursing care can be peer reviewed. We have already engaged with one or two Trusts in the UK to seek partnership working, and are presently developing systems and protocols with the Heart of England NHS Trust in the UK. **Key Action:** Sub group of NMAC will work to introduce systems of peer review for all Island healthcare		

			settings for introduction by April 2014.		

e. The Keogh review

On February 6 2013, the UK Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review.

Although the 14 hospital trusts covered by the review were selected using national mortality measures as a "warning sign" or "smoke-alarm" for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations. The review considered the performance of the hospitals across six key areas:

•mortality

•patient experience

•safety

•workforce

•clinical and operational effectiveness

•leadership and governance

Subsequently it has been confirmed that the new Chief Inspector of Hospitals will base reviews on the data packs used in Keogh. An example of which follows:-

Basildon and Thurrock NHS Foundation Trust

Data Pack

9th July, 2013

NHS

Overview

On 6th February the Prime Minister asked Professor Sir Bruce Keogh to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 trusts which fell within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital Mortality Index or the Hospital Standardised Mortality Ratio.

These two measures are being used as a 'smoke alarm' for identifying potential quality problems which warrant further review. No judgement about the actual quality of care being provided to patients is being made at this stage, or should be reached by looking at these measures in isolation.

The review will follow a three stage process:

Stage 1 – Information gathering and analysis

Stage 2 – Rapid Responsive Review

Stage 3 – Risk summit

This data pack forms one of the sources within the information gathering and analysis stage.

Information and data held across the NHS and other public bodies has been gathered and analysed and will be used to develop the Key Lines of Enquiry (KLOEs) for the individual reviews of each Trust. This analysis has included examining data relating to clinical quality and outcomes as well as patient and staff views and feedback. A full list of evidence sources can be found in the Appendix.

Sources of Information

Given the breadth and depth of information reviewed, this pack is intended to highlight only the exceptions noted within the evidence reviewed in order to inform Key Lines of Enquiry.

Slide 2

Basildon and Thurrock NHS Foundation Trust

Context

A brief overview of the Basildon and Thurrock area and Basildon and Thurrock NHS Foundation Trust. This section provides a profile of the area, outlines performance of local healthcare providers and gives a brief introduction to the Trust.

Mortality

An indication of the Trust's mortality data based on the HSMR and SHMI indicators. This section identifies the key areas within the Trust which are outliers.

Patient Experience

A summary of the Trust's patient experience feedback from a range of sources. This section takes data from the annual patient experience surveys.

Safety and Workforce

A summary of the Trust's safety record and workforce profile.

Clinical and Operational Effectiveness

A summary of the Trust's clinical and operational performance based on nationally recognised key performance indicators. This section compares the Trust's performance to other national trusts and targets and includes patient reported outcome measures (PROMs).

Leadership and Governance

An indication of the Trust's leadership and their governance procedures. This section identifies any recent changes in leadership, current top risks to quality and outcomes from external reviews.

Slide 3

Context

Slide 4

Context

Overview:

This section provides an introduction to the Trust, providing an overview, health profile and an understanding of why the Trust has been chosen for this review.

Review Areas:

To provide an overview of the Trust, we have reviewed the following areas.

- *Local area and market share;*
- *Health profile;*
- *Service overview; and*
- *Initial mortality analysis*

Data Sources:

- *Trust's Board of Directors meeting 31st Jan, 2013;*
- *Department of Health: Transparency Website, Dec 12;*
- *Healthcare Evaluation Data (HED);*
- *NHS Choices;*
- *Office of National Statistics, 2011 Census data;*
- *Index of Multiple Deprivation, 2011;*
- *© Google Maps;*
- *Public Health Observatories – Area health profiles; and*
- *Background to the remit and role of the national advisory group.*

All data and sources used are consistent across the packs for the 14 trusts included in this review.

Summary:

Basildon and Thurrock has a population of 400,000. 7% of Basildon's population belonging to non-White ethnic minorities. Childhood obesity is significantly more common, whilst breastfeeding is significantly less common than in the rest of England.

Relatively, it is a medium sized Trust for both inpatient and outpatient activity.

Basildon and Thurrock's health profile outlines that there are a number of aspects for which children's and young people's and adult's health is significantly lower than the national average. It also shows that in Basildon and Thurrock, male life expectancy is slightly lower than the national average.

The Trust has two hospital sites with the Essex Cardiothoracic Centre also located within the grounds of Basildon Hospital. Basildon and Thurrock became one of the first ten Foundations trusts in the country in 2004 and has a total of 667 beds. It has 66% market share of inpatient activity within a 5 mile radius of the Trust sites. However, the Trust's market share falls to 31% within a radius of 10 miles and 8% within a radius of 20 miles.

A review of ambulance response times showed that the East of England services were at national average.

Finally, Basildon and Thurrock's SHMI has been above the expected level for the last 2 years and was therefore selected for this review.

Slide 5

Trust Overview

Basildon and Thurrock became one of the first ten Foundations trusts in the country in 2004. Prior to this, in 2003, the Trust had gained University Hospital status. The Trust services a population of approximately 400,000 and has more than 10,000 public members as well as 3,700 staff. The Trust includes the Essex Cardiothoracic Centre, opened in 2007 and one of the most modern centres of its kind in the country. Heart attack victims from across the county are brought directly to the Essex Cardiothoracic Centre to have stents fitted to repair constricted coronary arteries, within just over two hours of the ambulance arriving at the scene. It also has 24 haemodialysis stations; this is the largest renal unit in Essex. The unit currently has over 130 patients receiving haemodialysis daily, six days a week.

Trust Status	Foundation Trust (2004)

Number of Beds and Bed Occupancy			(Oct12-Dec12)
	Beds Available	Percentage Occupied	National Average
Total	667	90%	86%
General and Acute	614	93.3%	86%
Maternity	53	51.3%	59%

Source: Department of Health Transparency Website

Basildon and Thurrock University Hospitals NHS Foundation Trust	
Acute Hospital	Basildon University Hospital
Outpatient Hospitals	Orsett Hospital
Diagnostic Services Unit	St. Andrew's Centre
Other Specialist Units	Essex Cardiothoracic Centre

Source: NHS Choices

Inpatient/Outpatient Activity			(Jan12-Dec12)
Inpatient Activity	Elective	57,595 (57%)	Day Case Rate: 87%
	Non Elective	44,124 (43%)	
	Total	101,719	
Outpatient Activity	Total	331,709	

Source: Healthcare Evaluation Data (HED)

Finance Information	
2012-13 Income	£254m
2012-13 Expenditure	£237m
2012-13 EBITDA	£17m
2012-13 Net surplus (deficit)	£124k
2013-14 Budgeted Income	£278m
2013-14 Budgeted Expenditure	£262m
2013-14 Budgeted EBITDA	£18m
2013-14 Budgeted Net surplus (deficit)	£100k

Source: Basildon and Thurrock University Hospitals NHS Foundation Trust, Board of Directors' Meeting, 31st March 2013, 'Proposed Budget and Financial Plan 2013/14 – Report of the Acting Director of Finance'
Maps of Basildon and Thurrock University Hospitals are included in the Appendix.

Departments and Services
Accident & Emergency, Breast Surgery, Cardiology, Children's and Adolescent Services, Dermatology, Diabetic Medicine, Diagnostic Imaging, Diagnostic Physiological Measurement, ENT, Endocrinology and Metabolic Medicine, Gastro Intestinal and Liver Services, General Medicine, General Surgery, Geriatric Medicine, Gynaecology, Haematology, Maternity Service, Minor Injuries Unit, Nephrology, Neurology, Oral and Maxillofacial Surgery, Orthopaedics, Pain Management, Respiratory Medicine, Rheumatology, Sleep Medicine, Urology, Vascular Surgery.

Source: NHS Choices

Slide 6

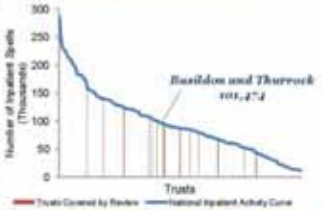
Trust Overview continued...

The graphs show the relative size of Basildon and Thurrock against national trusts in terms of inpatient and outpatient activity.

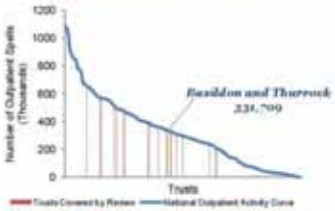
Basildon and Thurrock is a medium sized trust for inpatient activity, relative to both the 14 trusts selected for this review and the rest of England. However, the Trust is in the lower half of all those nationally for outpatient activity.

Nephrology and Gynaecology are the largest inpatient specialties while Trauma & Orthopaedics and Dermatology are the largest for outpatients.

Inpatient Activity by Trust



Outpatient Activity by Trust



Top 10 Inpatient Main Specialties as a % of Total Inpatient Activity	
Nephrology	24%
Gynaecology	15%
General Surgery	9%
General Medicine	8%
Paediatrics	7%
Cardiology	6%
Gastroenterology	5%
Trauma & Orthopaedics	5%
Urology	4%
Geriatric Medicine	4%

Bottom 10 Inpatient Main Specialties and Spells	
Accident & Emergency	6
Palliative Medicine	7
Radiology	233
Nursing episode	515
Oral Surgery	788
Respiratory Medicine	1024
Clinical Haematology	1283
Anaesthetics	1441
Ear, Nose and Throat	1465
Cardiothoracic Surgery	1629

Top 10 Outpatient Main Specialties as a % of Total Outpatient Activity	
Trauma & Orthopaedics	14%
Dermatology	13%
Gynaecology	9%
Haematology	7%
General Surgery	6%
General Medicine	6%
Cardiology	5%
Paediatrics	5%
Ear, Nose and Throat	4%
Midwifery	4%

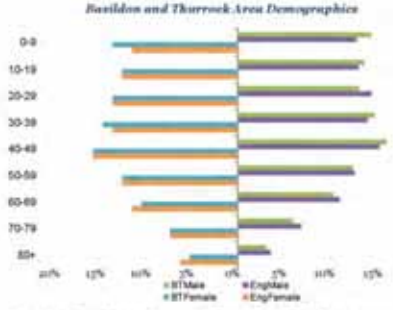
Source: [illegible]

Slide 7

Basildon and Thurrock Area Overview

Basildon and Thurrock is not a particularly deprived region of England. Over 65s constitute a lower proportion of the population in this region, compared to their proportion of the English population as a whole. However, obesity is a particular health concern in this region, just as postnatal care is below the national average on some measures. The ethnic composition of the population varies significantly between the two unitary authorities that comprise the region, with Thurrock being home to a higher percentage of Black Africans, Indians, and other ethnic minorities than Basildon.

Basildon and Thurrock Area Demographics



FACT BOX	
Population	400,000
The Royal College of Surgeons recommend that the "...catchment population size...for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000 - 500,000."	
IMD	Of 149 English unitary authorities, Essex is the 119th most deprived.
Ethnic diversity	In Basildon, 7% belong to non-white minorities, including 1.9% Black African and 1.2% Indian. In Thurrock, 14% belong to non-white minorities, including 6.2% African and 1.4% Indian.
Rural or Urban	Basildon and Thurrock is a rural-urban region
Obesity	Obesity among year-6 children in Thurrock is more common than almost anywhere else in England. Adult obesity in both Basildon and Thurrock is also more common than in England as a whole.
Postnatal care	Breastfeeding initiation is significantly lower than the national average in both Basildon and Thurrock.

Source: [illegible]

Slide 8

Basildon and Thurrock Geographic Overview

The map on the right shows the location of Basildon and Thurrock geographically. Basildon and Thurrock are suburban areas located in Essex, in the East of England. As shown by the map, Basildon and Thurrock is located outside of the M25 and is in proximity to a number of major roads and to the Thames estuary.

Market share analysis indicates from which GP practices the referrals that are being provided for by the Trust originate. High mortality may affect public confidence in a Trust, resulting in a reduced market share as patients may be referred to alternative providers.

Source: ©Google Maps

The wheel on the left shows the market share of Basildon and Thurrock University Hospitals NHS Trust. From the wheel it can be seen that Basildon and Thurrock has a 66% market share of inpatient activity within a 5 mile radius of the Trust.

As the size of the radius is increased, the market share falls to 31% within 10 miles and 8% within 20 miles.

The wheel shows that the main competitors in the local area are Southend University Hospitals NHS Trust, Mid Essex Hospital Service NHS Trust, Barking, Havering and Redbridge University Hospitals NHS Trust and Colchester Hospital University NHS Foundation Trust.

Source: Healthcare Evaluation Data (HED), Dec 11 – Nov 12

Basildon and Thurrock's Health Profile

Health Profiles, depicted on this slide and the following, are designed to help local government and health services identify problems in their areas and decide how to tackle these issues. They provide a snapshot of the overall health of the local population, and highlight potential differences against regional and national averages.

The graph shows the level of economic deprivation experienced in Basildon and Thurrock. Basildon has on average the same level of deprivation as England as a whole, whereas Thurrock is higher than the average.

The tables below outline Basildon and Thurrock's health profile information in comparison to the rest of England.

Deprivation by unitary authority area

1. *When reviewing Basildon and Thurrock's 'Communities Indicators', it is apparent that Basildon is statistically lower than the national average, especially concerning Children in Poverty, Homelessness and the Level of UCSBs urban red.*

2. *Thurrock has significantly more obese children than the national average, breast feeding is lower than the national average in both areas and teenage pregnancy is higher than the national average.*

Source: Public Health Observatories – area health profiles

Basildon and Thurrock's Health Profile

3 *Obesity is an issue for Basildon and Thurrock, as are smoking and being physically inactive*

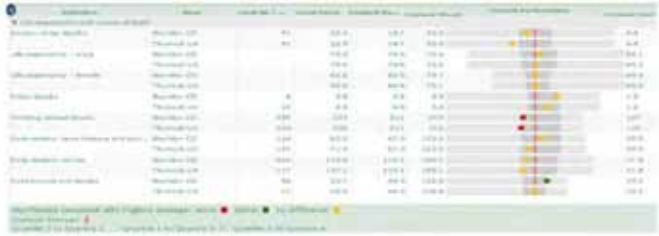
4 *Diabetes is more common in Basildon and Thurrock than in England as a whole*

Source: Public Health Observatories – area health profiles

Slide 11

Basildon and Thurrock's Health Profile

5 *In terms of life expectancy and causes of death, smoking related deaths is the only indicator statistically worse than national average*



Source: Public Health Observatories – area health profiles

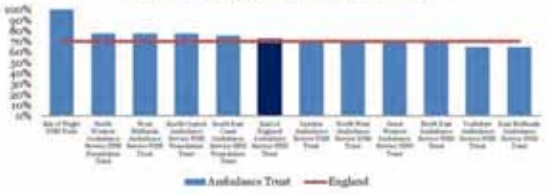
Slide 12

Performance of Local Healthcare Providers

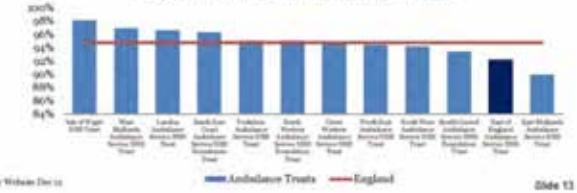
To give an informed view of the Trust's performance it is important to consider the service levels of non-acute local providers. For example, slow ambulance response times may increase the risk of mortality.

The graphs on the right represent some key performance indicators for England's Ambulance services. The East of England service is meeting its 8min response target but not the 19min target.

Proportion of calls responded to within 8 minutes



Proportion of calls responded to within 19 minutes



Source: Department of Health: Transparency Website Dec 11

Why was Basildon and Thurrock chosen for this review?

Based on the Summary Hospital level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR), 14 trusts were selected for this review. The table includes information on which trusts were selected. An explanation of each of these indicators is provided in the Mortality section. Where it does not include the SHMI for a trust, it is because the trust was selected due to a high HSMR as opposed to its SHMI. The SHMI for all 14 trusts can be found in the following pages.

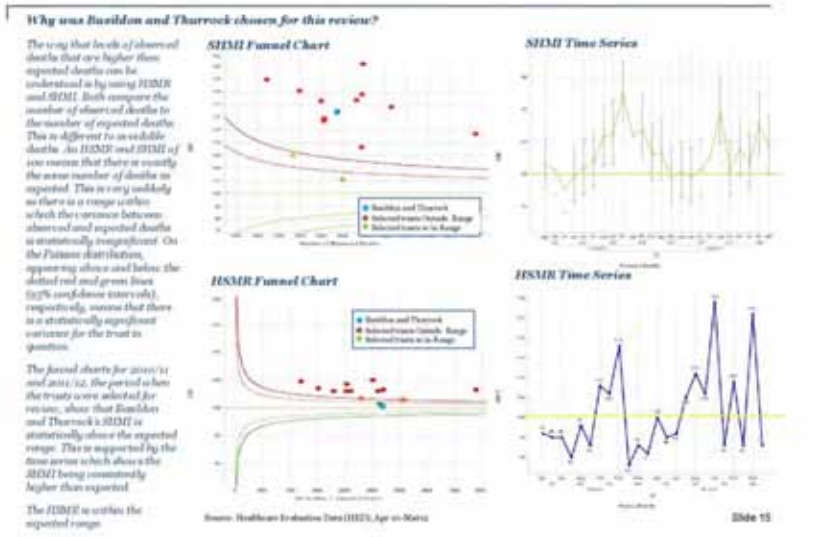
Initially, five hospital trusts were announced as falling within the scope of this investigation based on the fact that they had been outliers on SHMI for the last two years (SHMI data has only been published for the last two years).

Subsequent to these five hospital trusts being announced, Professor Sir Bruce Keogh took the decision that those hospital trusts that had also been outliers for the last two consecutive years on HSMR should also fall within the scope of his review. The rationale for this was that it had been HSMR that had provided the trigger for the Healthcare Commission's initial investigation into the quality of care provided at Mid Staffordshire Hospitals NHS Foundation Trust.

Basildon and Thurrock has been above the expected level for both SHMI and HSMR over the last 2 years and was therefore selected for this review.

Trust	SHMI 2011	SHMI 2012	HSMR FY 11	HSMR FY 12	Within Expected?
Basildon and Thurrock University Hospitals NHS Foundation Trust	1	1	99	103	Within expected
Blackpool Teaching Hospitals NHS Foundation Trust	1	1	112	114	Above expected
Buckinghamshire Healthcare NHS Trust			113	110	Above expected
Burton Hospitals NHS Foundation Trust			112	112	Above expected
Colchester Hospital University NHS Foundation Trust	1	1	107	102	Within expected
East Lancashire Hospitals NHS Trust	1	1	108	103	Within expected
George Eliot Hospital NHS Trust			117	120	Above expected
Medway NHS Foundation Trust			110	113	Above expected
North Cumbria University Hospitals NHS Trust			118	118	Above expected
Northern Lincolnshire And Goole Hospitals NHS Foundation Trust			118	115	Above expected
Sherwood Forest Hospitals NHS Foundation Trust			114	113	Above expected
Tameside Hospital NHS Foundation Trust	1	1	101	102	Within expected
The Dudley Group Of Hospitals NHS Foundation Trust			110	111	Above expected
United Lincolnshire Hospitals NHS Trust			113	111	Above expected

Source: Background to the review and role of the national advisory group Financial years



Mortality

Slide 16

Mortality

Overview:

This section focuses upon recent mortality data to provide an indication of the current position. All 14 trusts in the review have been analysed using consistent methodology.

The measures identified are being used as a 'smoke alarm' for highlighting potential quality issues. No judgement about the actual quality of care being provided to patients is being made at this stage, nor should it be reached by looking at these measures in isolation.

Review areas

To undertake a detailed analysis of the trust's mortality, it is necessary to look at the following areas:

- *Differences between the HSMR and SHMI;*
- *Elective and non-elective mortality;*
- *Specialty and Diagnostic groups; and*
- *Alerts and investigations*

Data sources

- *Healthcare Evaluation Data (HED);*
- *Health & Social Care Information Centre – SHMI and contextual indicators;*
- *Dr Foster – HSMR; and*
- *Care Quality Commission – alerts, correspondence and findings*

Summary:

The Trust has an overall SHMI of 112 for the last 12 months, meaning that the number of actual deaths is higher than the expected level.

Deeper analysis of this demonstrates that non-elective admissions are the primary contributing area to this figure, with a SHMI of 113, compared to a level of 97 for elective admissions.

Specialty-level analysis of SHMI results highlight some key diagnostic groups in non-elective admissions for further review: General Medicine, Palliative Medicine, and Geriatric Medicine.

The Trust has an overall HSMR of 105, which is above 100, however still within the expected range.

Similar to SHMI, non-elective admissions are seen to be contributing primarily to the overall Trust HSMR with 106, against 83 for elective admissions. In addition, Basildon and Thurrock are an outlier for weekend mortality.

Specialty-level analysis highlights areas for further review in non-elective admissions: Palliative Medicine, Cardiology, and Paediatrics.

Review by diagnostic group revealed further areas for further analysis. From the tree plot it is clear that the following areas should be considered: senility and organic mental disorders, cancer of bronchus; lung, cancer of colon, chronic obstructive pulmonary disease and bronchiectasis, deficiency and other anaemia, and coronary atherosclerosis and other heart disease.

All data and sources used are consistent across the packs for the 14 trusts included in this review.

Mortality Overview

The following overview provides a summary of the Trust's key mortality areas:

Mortality				
	Overall HSMR	●	*Elective mortality (SHMI and HSMR)*	●
	*Overall SHMI**	●	*Non-elective mortality (SHMI and HSMR)*	●
	Weekend or weekday mortality outliers	●	*Palliative care coding issues*	●
	Emergency specialty groups much worse than expected	●	*30-day mortality following specific surgery / admissions*	●
	Emergency specialty groups worse than expected	●	*Mortality among patients with diabetes*	●
	Diagnosis group alerts to CQC	●		
	Diagnosis group alerts followed up by CQC	●		

*SHMI**

- ● *Outside expected range of the HSCIC for Mar 11 – Sep 12*
- ● *Outside expected range based on Poisson distribution for Dec 11 – Nov 12*
- ● *Within expected range*

- ● *Outside expected range*
- ● *Within expected range*

**The detailed following analysis on SHMI is based upon a narrower set of confidence intervals compared to the Random effects model, which the HSCIC use to report whether the SHMI is within, below or above the expected range and was the range used to select the 14 trusts for this review. The narrower range is used here to increase the sensitivity to the data and serves to give an earlier warning for the purposes of this review.*

Source: Healthcare Evaluation Data (HED): Dec 11 – Nov 12
Health & Social Care Information Centre – SHMI and contextual indicators, Dr Foster – HSMR,
Care Quality Commission – alerts, correspondence and findings

HSMR Definition

What is the Hospital Standardised Mortality Ratio?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

How does HSMR work?

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific CCS groups, in a specified patient group. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

How should HSMR be interpreted?

Care is needed in interpreting these results. Although a score of 100 indicates that the observed number of deaths matched the expected number in order to identify if variation from this is significant confidence intervals are calculated. A Poisson distribution model is used to calculate 95% and 99.8% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

Slide 19

SHMI Definition

What is the Summary Hospital-level Mortality Indicator?

The Summary Hospital-level Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the general standardised mortality ratio, a measure based upon a nationally expected value. SHMI can be used as a potential smoke alarm for potential deviations away from regular practice.

How does SHMI work?

1. *Deaths up to 30 days post acute trust discharge are considered in the mortality indicator, utilising ONS data*
2. *The SHMI is the ratio of the Observed number of deaths in a Trust vs. Expected number of deaths over a period of time*
3. *The Indicator will utilise 5 factors to adjust mortality rates by*
   a. *The primary admitting diagnosis;*
   b. *The type of admission;*
   c. *A calculation of co-morbid complexity (Charlson Index of co-morbidities);*
   d. *Age; and*
   e. *Sex*
4. *All inpatient mortalities that occur within a Hospital are considered in the indicator*

How should SHMI be interpreted?

Due to the complexities of hospital care and the high variation in the statistical models used all deviations from the expected range are highlighted using a Random Effects funnel plot.

Slide 20

Some key differences between SHMI and HSMR

Indicator	HSMR	SHMI
Are all hospital deaths included?	No, around 80% of in hospital deaths are included, which varies significantly dependent upon the services provided by each hospital	Yes all deaths are included
When a patient dies how many times is this counted?	If a patient is transferred between hospitals within 2 days the death is counted multiple times	1 death is counted once, and if the patient is transferred the death is attached to the last acute/secondary care provider
Does the use of the palliative care code reduce the relative impact of a death on the indicator?	Yes	No
Does the indicator consider where deaths occur?	Only considers in-hospital deaths	Considers in-hospital deaths but also those up to 30 days post discharge anywhere too.
Is this applied to all health care providers?	Yes	No, does not apply to specialist hospitals

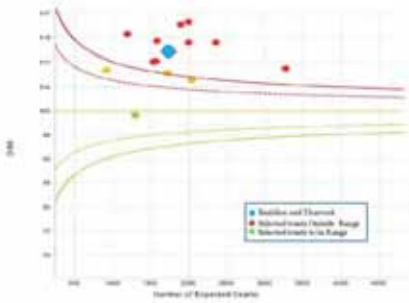
Slide 21

SHMI overview

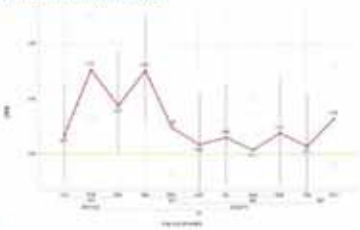
The Trust's SHMI level for the 12 months from Dec 11 to Nov 12 is 112, which means, as shown below, it is statistically above the expected range and so classified as an outlier, based on the 95% confidence interval of the Poisson distribution.

The time series show a general trend of decreasing SHMI both year-on-year and month-on-month, however the SHMI has been rising over the last 2 consecutive months

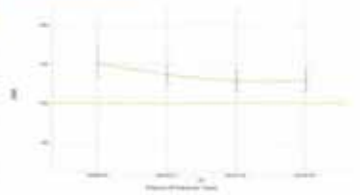
SHMI funnel chart –12 months



Month-on-month time series



Year-on-year time series



Source: Health Evaluation Data (HED) – Dec 2011 – Nov 2012

Slide 22

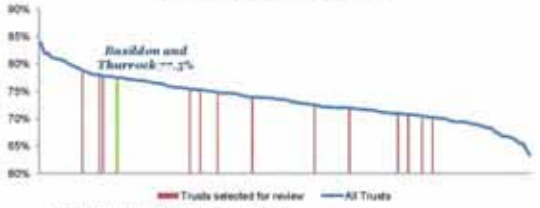
SHMI Statistics

This slide demonstrates the number of mortalities in and out of hospital for Basildon and Thurrock.

As SHMI includes mortalities that occur within the hospital and outside of it for up to 30 days following discharge, it is imperative to understand the percentage of deaths which happen inside the hospital compared to outside. This may contribute to differences in HSMR and SHMI outcomes.

The data shows that 77.5% of SHMI deaths occur in hospital, which is more than the national average of 73.3%.

Percentage of patient deaths in hospital



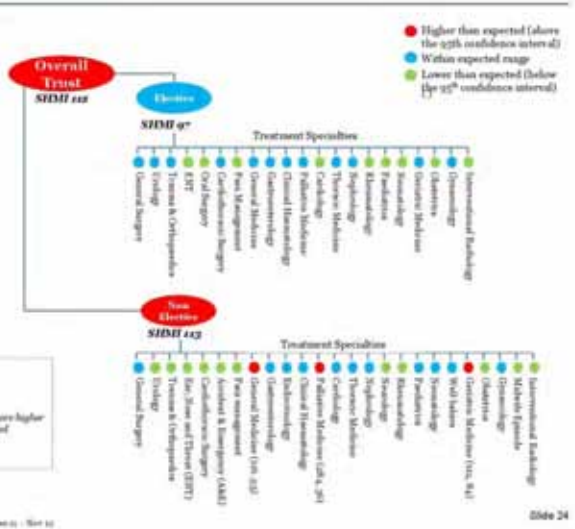
Source: Health Evaluation Data (HED) - Dec 2012 - Nov 2013

Slide 23

Mortality - SHMI Tree

Mortality from year ule is breakdown of SHMI into elective and non-elective admissions. The SHMI score for non-elective admissions has a greater impact on the overall indicator due to a higher number of expected deaths.

The tree shows that Basildon and Thurrock NHS Foundation Trust has a SHMI of 111.6 which is higher than expected. This is due to the number of observed deaths in non-elective admissions being higher than expected, with mortality significantly higher than expected in General Medicine, Palliative Medicine and Geriatric Medicine. These are potential areas for review.



Source: Healthcare Evaluation Data (HED) Dec 12 - Nov 13

Slide 24

SHMI sub-tree of specialties

The SHMI sub-tree highlights the specialties for elective and non-elective admissions with a statistically higher SHMI than expected and highlights the diagnostic groups with at least 5 more observed deaths than expected. When identifying areas to review, it is important to consider the number of deaths as well as the SHMI.

Geriatric Medicine has the highest number of greater than expected deaths with senility and organic mental disorders, urinary tract infections, and chronic obstructive pulmonary disease and bronchiectasis seen as the main diagnostic groups contributing to this.

- Higher than expected (above the 95th confidence interval)
- Within expected range
- Lower than expected (below the 95th confidence interval)

Treatment Specialties	General Medicine (116, 68)	Palliative Medicine (264, 36)	Geriatric Medicine (112, 84)
Diagnostic Groups	Acute and unspecified renal failure (112, 4) Acute cerebrovascular disease (126, 9) Cancer of stomach (347, 4) Cardiac arrest and ventricular fibrillation (143, 4) Dehiscence and other necrosis (196, 5) Gastrointestinal hemorrhage (128, 5) Other gastrointestinal disorders (300, 7) Pleurisy; pneumothorax; pulmonary collapse (127, 4) Residual codes, unclassified (381, 6) Skin and subcutaneous tissue infections (404, 5)	Pneumonia (except that caused by tuberculosis or sexually transmitted disease) (273, 4)	Aspiration pneumonitis; food/vomitus (128, 6) Chronic obstructive pulmonary disease and bronchiectasis (127, 7) Dehiscence and other necrosis (277, 5) Fluid and electrolyte disorders (133, 5) Gastrointestinal hemorrhage (128, 6) Intestinal infection (277, 5) Nausea and vomiting (264, 4) Open wounds of head, neck, and trunk (276, 4) Senility and organic mental disorders (287, 11) Skin and subcutaneous tissue infections (268, 5) Urinary tract infections (248, 8)

Key

Diagnostic Group : 4 / SHMI : Observed deaths that are higher than the expected

Source: Health Evaluation Data (HED) – Dec 2011 – Nov 2012

Slide 25

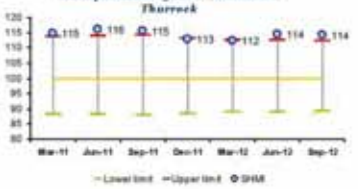
HSCIC SHMI overview

The Health and Social Care Information Centre (HSCIC) publish the SHMI quarterly. This official statistic covers a rolling 12 month reporting period using a model based on a 3-year dataset refreshed quarterly. The earliest publication was in October 2011, for the period from April 2010 to March 2011.

The HSCIC produce two sets of upper and lower limits. One set uses 99.8% control limits from an exact Poisson distribution based on the number of expected deaths. The other set uses a Random effects model applying a 10% trim for over-dispersion, based on the standardised Pearson residual for each provider excluding the top and bottom 10% of scores. This latter set is broader than the Poisson and is the one against which the HSCIC report whether the SHMI is within, below or above the expected range.

The SHMI for Basildon and Thurrock FT was 114 in the year to Sept-12 (England baseline = 100) and has been above the expected range for 3 of the 7 periods to date.

SHMI published by HSCIC, Basildon & Thurrock



Source: Health & Social Care Information Centre – SHMI

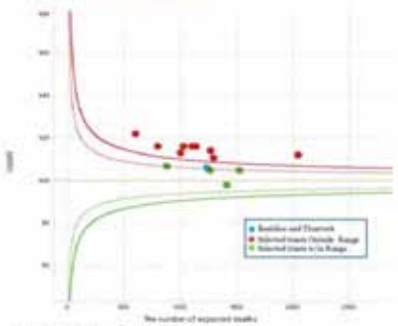
Slide 26

HSMR overview

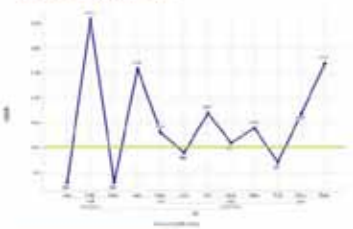
The Trust's HSMR level for the 12 months from Jan 12 – Dec 12 is 105, which means, as shown below, although it is above 100, it is within the expected range and so not classified as an outlier.

The time series show a general trend of decreasing HSMR year-on-year until fiscal year 2010/11 where it increases to 108, however the month on month time series shows an real trend, rising to 11th for the month of December 2012

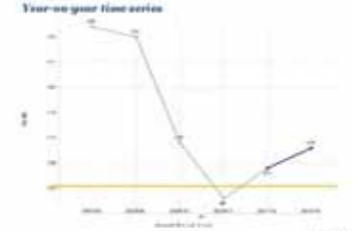
HSMR funnel plot – 12 months



Month-on-month time series



Year-on-year time series



Source: Health Evaluation Data (HED) – Jan 2012 – Dec 2012

Slide 27

HSMR Statistics

The table to the right shows Basildon and Thurrock's HSMR broken down by admission type.

The breakdown illustrates the overall HSMR is 105 which is within the expected range. The table identifies that non-elective weekend admissions have an HSMR higher than the expected range which has an impact on the overall weekend admissions, which is also higher than expected

HSMR	Weekend	Week	All
Elective	131	79	83
Non-elective	114	104	106
All	114	103	105

Source: Health Evaluation Data (HED) – Jan 2012 – Dec 2012

Key – colour by alert level:

Red – Higher than expected (above the 95% confidence interval)

Blue – Within expected range

Green – Lower than expected (below the 95% confidence interval)

Slide 28

HSMR CCS Diagnostic Group Overview

The darker colour boxes have the highest HSMR while the size of the boxes represent the number of observed deaths that are higher than the expected deaths. The larger and darker boxes within the tree plot will highlight potential areas for further review.

From this tree plot it is clear that the following areas have the greatest number of above expected deaths.

- *Senility and organic mental disorders (HSMR of 126, and 47 observed deaths that are higher than the expected);*
- *Cancer of bronchus, lung (137, 101);*
- *Cancer of colon (206, 111);*
- *Chronic obstructive pulmonary disease and bronchiectasis (115, 91);*
- *Deficiency and other anaemia (208, 93); and*
- *Coronary atherosclerosis and other heart disease (120, 87).*

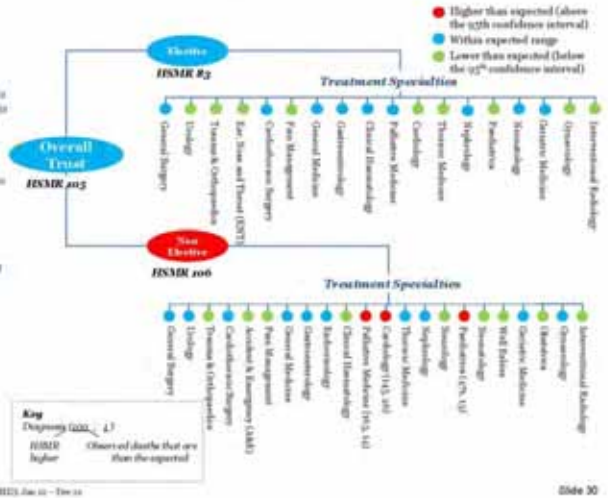
Source: Health Evaluation Data (HED) – Jan 2012 – Dec 2012

Slide 29

Mortality - HSMR Tree

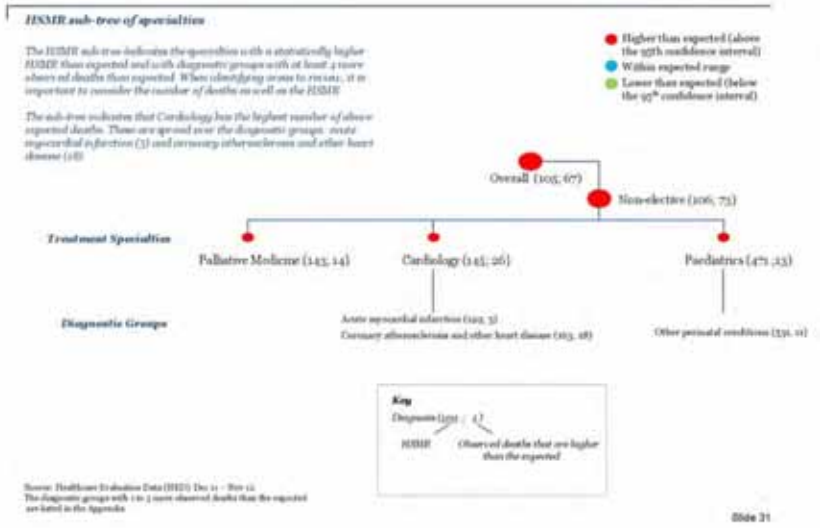
The tree shows that the HSMR for Basildon and Thurrock is 103 which is within expected range but close to the 97.5% confidence interval. When breaking this down by admission type, it is clear that it is driven by statistically higher than expected weekend admissions and the non elective admissions HSMR is also higher than expected.

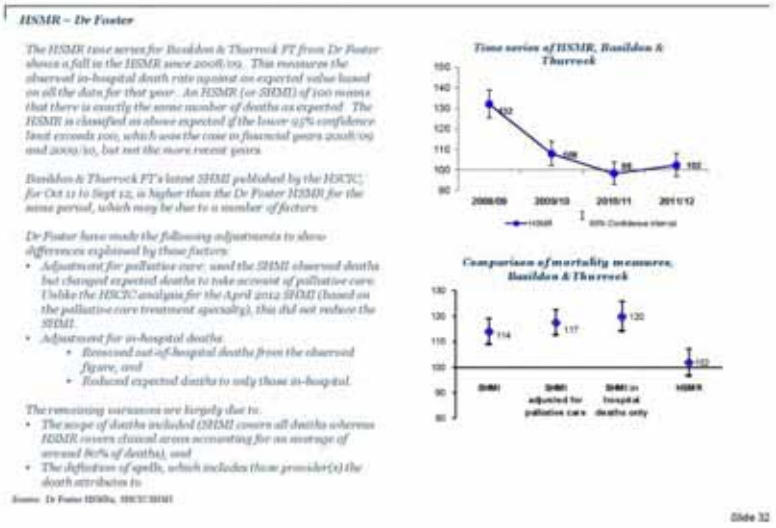
Within non-elective admissions, Palliative Medicine, Cardiology, and Paediatrics have the highest number of observed deaths that are higher than expected.



Source: Healthcare Evaluation Data (HED), Jan 12 – Dec 12

Slide 30


HSMR sub-tree of specialties
Higher than expected (above the 95th confidence interval)
Within expected range
Lower than expected (below the 95th confidence interval)
Overall (105, 67)
Non-elective (106, 75)
Treatment Specialties
Palliative Medicine (143, 14)
Cardiology (145, 26)
Paediatrics (471 ,23)
Diagnostic Groups
Acute myocardial infarction (129, 3)
Other perinatal conditions (330, 11)
Key
HSMR
Observed deaths that are higher than the expected
Slide 31

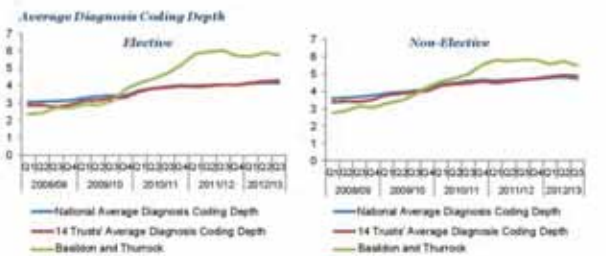

HSMR – Dr Foster
Time series of HSMR, Basildon & Thurrock
2008/09
2009/10
2010/11
2011/12
Comparison of mortality measures, Basildon & Thurrock
SHMI
SHMI adjusted for palliative care
SHMI in hospital deaths only
HSMR
Slide 32

Coding

Diagnosis coding depth has an impact on the expected number of deaths. A higher than average diagnosis coding depth is more likely to collect co-morbidity which will influence the expected mortality calculation.

When looking at the depth of coding for Basildon and Thurrock, it is clear that the Trust's average diagnosis coding depth is greater than the national average and greater than the average of the 13 other trusts covered by this review.

The elective and non elective graphs both show that Basildon and Thurrock was below the national average but since Q4 2009/10, the diagnosis coding depth has improved.



Source: Health Evaluation Data (HED) – Jan 2012 – Dec 2012

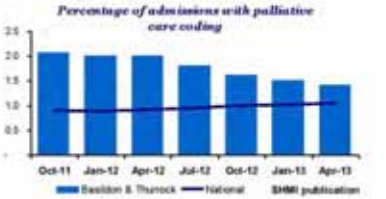
Slide 33

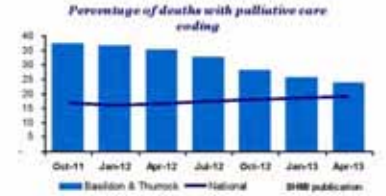
Palliative care

Accurate coding of palliative care is important for contextualising SHMI and HSMR. HSMR takes into account that a patient is receiving palliative care, but SHMI does not.

Basildon's SHMI would refuse to 'As expected' if the SHMI model accounted for treatment specialty use (Apr-12). However, the inconsistent use of these codes between providers led to the conclusion that the SHMI model is not improved by their inclusion.

Until recently, Basildon had the highest percentage use of the palliative care treatment specialty nationally, plus high use of palliative care diagnosis coding (72) (13). Basildon & Thurrock has a ward-based palliative care team and provides specialist inpatient palliative care at two charity-funded hospices (St Luke's and Fitzhaven).





Source: Health & Social Care Information Centre – HSMR unadjusted indicators

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Care Quality Commission findings

Care Quality Commission (CQC) reviews mortality alerts for each Trust on an ongoing basis. These alerts, which indicate observed deaths significantly above expected for specialties or diagnoses, come from different sources based on either HSMR or SHMI. Where these appear unexplained, CQC correspond with the Trust to agree any appropriate action.

For Basildon and Thurrock, the common themes that have arisen across the patient groups alerting since 2007 are Elderly Care and the Emergency care pathway.

The themes common to responses to the CQC are:

- *Accuracy of primary diagnosis;*
- *Coding;*
- *Lack of comprehensive medical assessment on admission;*
- *Failure to recognise a deteriorating patient; and*
- *Lack of sustainability of improvements implemented following an alert.*

The trust formed an action plan to implement recommendations following a review of mortality at the trust by West Midlands SHA. It has also been looking further at its clinical pathway for pneumonia patients.

Source: Care Quality Commission – alerts, correspondence and findings

Emergency specialty groups much worse than expected	
Sep 11 to Aug 12	2
	Endocrinology Dermatology
Emergency specialty groups worse than expected	
Sep 11 to Aug 12	4
	Other injuries due to external causes Musculoskeletal Cardiology Respiratory medicine
Diagnosis group alerts (2007 to date)	
Alerts to CQC	17
Alerts followed up by CQC	15

Source: Care Quality Commission – alerts, correspondence and findings

Recent diagnosis group alerts pursued by CQC
Acute myocardial infarction (Jun-11) Pneumonia (Feb-12)
Any related patient groups alerting more than once since 2007
Acute myocardial infarction Chronic ulcer of skin Intestinal obstruction without hernia Urinary tract infections

SMRs for Diagnostic and Procedure groups – Dr Foster

The standardised mortality ratio (SMR) is used to calculate the mortality rate for diagnosis and procedure groups. This is available for the 56 diagnosis groups that are included in the HSMR and the 56 procedure groups that are part of the Real Time Monitoring system.

SMRs are not yet remodelled for the year but are projected, rebased estimates. SMRs are classified as above expected if their lower 95% confidence limit exceeds 100 (excluding those with fewer than four more observed deaths than expected).

From Apr 12 to Mar 13, there were three diagnosis groups and no procedure groups with above expected SMRs in Basildon & Thurrock, which may highlight potential areas for review.

CUSUM alerts show how many early warning flags arose within the diagnosis and procedure groups during the year. These are based on cumulative sum statistical process control charts with 95% thresholds that trigger alerts once breached. The same groups may alert multiple times.

During the year, Basildon & Thurrock had three CUSUM alerts for diagnosis groups and one for a procedure group. However, none of these alerts were within groups that had a high SMR.

Apr 2012 to Mar 2013	Diagnosis groups	Procedure groups
SMRs above expected	3	0
CUSUM alerts	3	1

Diagnosis groups with SMRs above expected	SMR	Obs – Exp deaths
Cancer of stomach	372	4
Deficiency and other anaemia	219	10
Skin and subcutaneous tissue infections	172	8

Source: Dr Foster HSMR, SMRs, CUSUM alerts

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Mortality – other alerts

The Health and Social Care Information Centre publish 30-day mortality rates following certain types of surgery or admission to hospital. These are not casemix adjusted, but the rates may be compared over time.

Basildon and Thurrock had one rate improving substantially below the national average in the data to 2010-11 (published in Feb 2013).

This Trust had no other significant alerts.

30-day mortality following specific surgery / admissions
Stroke (high and improving 9% below national rate in 2010/11)

Source: Health & Social Care Information Centre (HSCIC) – HSMR and contextual indicators, Dr Foster – SHMI

Patient Experience

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Patient Experience

Overview:

The following section provides an insight into the Trust's patient experience.

Review Areas:

To undertake a detailed analysis of the Trust's Patient Experience it is necessary to review the following areas:

- Patient Experience; and
- Complaints

Data Sources:

- Patient Experience Survey;
- Cancer Patient Experience Survey;
- Peoples' Voice Summary; and
- Complaints data.

Summary:

Of the 9 measures reviewed within Patient Experience and Complaints there are three which are rated 'red': Cancer Survey, Patient Voice Comments and Complaints about Clinical Aspects.

Particular areas of concern from the cancer survey were diagnostic tests, deciding best treatment and Hospital doctors.

Of 144 individual comments from patients and public as part of the Patient Voice, 66 were negative (46%).

65% of complaints relating to clinical treatment (the average is 47%) were recorded. However, he Trust is A-rated by the Ombudsman for satisfactory remedies and low-risk of non-compliance.

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All data and scores used are consistent across the packs for the 14 trusts included in this review.

Patient Experience

This page shows the patient experience measures which are considered to be the most pertinent for this review. Further analysis, where relevant, is detailed in the following pages.

Patient Experience	Inpatient		PEAT: environment	
	Cancer survey		PEAT: food	
	PEAT: privacy and dignity		Friends and family test	
	Complaints about clinical aspects		Patient voice comments	
	Ombudsman's rating			

Outside expected range

Within expected range

Slide 40

Inpatient Experience Survey

Basildon & Thurrock scores below average on a range of survey questions including getting consistent answers from staff, involvement in decisions, obtaining information about medication side-effects, staff noise levels at night, cleanliness of wards, and the quality of food.

Arrival and Waiting	Overall	●	Length of time spent on waiting list	●
	Alteration of admission date by hospital	●	Length of time to be allocated a bed on a ward	●
Staff, Staff Quality, Cleanliness and Food	Overall	●	Delay of patient discharge	●
	Consistency of staff communication	●	Information provided on post-discharge danger signals	●
Patient Information, Choice, Voice	Overall	●	Staff communication on purpose of medication provided	●
	Patient involvement in decision-making	●	Staff communication on medication side-effects	●
Feelings, Treatment & Knowledge	Overall	●	Clarity of nurses' responses to important questions	●
	Clarity of doctors' responses to important questions	●	Language used by nurses in front of patients	●
	Language used by doctors in front of patients	●		
Pain, Cleanliness, Privacy, Plans to Leave	Overall	●	Hospital food	●
	Patient noise levels at night	●	Degree of privacy provided	●
	Staff noise levels at night	●	Level of respect shown by staff	●
	Hospital/ward cleanliness	●	Overall staff effort to ease pain	●

● Above expected range ● Within expected range ● Below expected range

Source: Patient Experience Survey 2012/13

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Patient experience and patient voice

Inpatient Survey

The national inpatient survey 2012 measures a wide range of aspects of patient experience. A composite 'overall measure' is calculated for use in the Outcomes Framework. This measure uses a pre-defined selection of 20 survey questions to rate the Trust on aspects including access to services, co-ordination of care, information & choice, relationship with staff and the quality of the clinical environment.

- *England Average: 76.3*
- *Basildon and Thurrock: 74.6 (within range)*

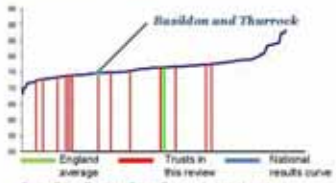
Cancer Survey

- *Of 58 questions, 37 were in the 'bottom 20%'.*
- *Particular areas of concern:*
  1. *Diagnostic tests;*
  2. *Deciding best treatment' and*
  3. *Hospital doctors'.*

Patient Voice

- *The quality risk profiles compiled by the Care Quality Commission collate comments from individuals and various sources. In the two years to 31st January 2013, there were 144 comments on Basildon and Thurrock of which 66 were negative (46%). Key themes included lack of, or patronising nature of, communication, some comments about neglect (soiled sheets for example), lack of privacy and dignity.*

Overall patient experience score: Inpatients 2012



Source: Patient Experience Survey, Cancer patient experience survey

Complaints Handling

- *Data returns to the Health and Social Care Information Centre showed 489 written complaints in 2011-12: the number of complaints is not always a good indicator, because stronger Trusts encourage comments from patients. However, central returns are categorised by subject matter against a list of 45 headings. For this Trust, 62% of complaints related to clinical treatment (compared to the national average of 47%).*
- *A separate report by the Ombudsman rates the Trust as 'A-rated for satisfactory remedies and low-risk of non-compliance.*

Slide 42

Safety and workforce

Slide 43

Safety and Workforce

Overview:

The following section will provide an insight into the Trust's workforce profile and safety record. This section outlines whether the Trust is adequately staffed and is safely operated

Review Areas:

To undertake a detailed analysis of the Trust's Safety and Workforce it is necessary to review the following areas:

- *General Safety;*
- *Staffing;*
- *Staff Survey;*
- *Litigation and Coroner; and*
- *Analysis of patient safety incident reporting*

Data Sources:

- *Acute Trust Quality Dashboard, Oct 2011 – Mar 2012;*
- *Safety Thermometer, Apr 12 – Mar 13;*
- *Litigation Authority Reports;*
- *CHC Evidence to Review 2013;*
- *National Staff Survey 2011, 2012;*
- *2011/12 Organisational Readiness Self-Assessment (ORSA);*
- *National Training Survey, 2012; and*
- *NHS Hospital & Community Health Service (HCHS), monthly workforce statistics*

All data and sources used are consistent across the peers for the 14 trusts included in this review

Summary:

Basildon and Thurrock is 'red rated' in four of the safety indicators: reporting of patient safety incidents, pressure ulcers, 'harm' for all four safety thermometer indicators, and clinical negligence scheme payments

The Trust recognises and reports patient safety incidents less fully and completely than similar trusts. It recorded 363 incidents reported as either moderate, severe or death between April 2011 and March 2012. Since 2009, seven 'never events' have occurred at Basildon and Thurrock, classified as that because they are incidents that are so serious they should never happen. On the other hand, Basildon and Thurrock has a rate of medication errors of 1.97, that is lower than the mean rate of 7.17 for all acute trusts.

Throughout the last 12 months, Basildon and Thurrock has been consistently below the national rate for new pressure ulcers, though it has breached this figure on three occasions. The prevalence rate of total pressure ulcers for Basildon and Thurrock has been above the national average for 10 of the last 12 months and is therefore an area for review.

The Trust's Clinical Negligence payments have exceeded contributions to the 'risk sharing scheme' over the last three years, and flagged twice in Rule 43 Coroner's reports.

Basildon and Thurrock is 'red rated' in nine of the workforce indicators. It notably has both a sickness absence rate for other staff and a consultant productivity rate above the national mean rate. For training of its doctors, it has a lower score on 'undertraining' that is lower than the national average. In addition, Basildon and Thurrock's joining and leaving rates are above the national average.

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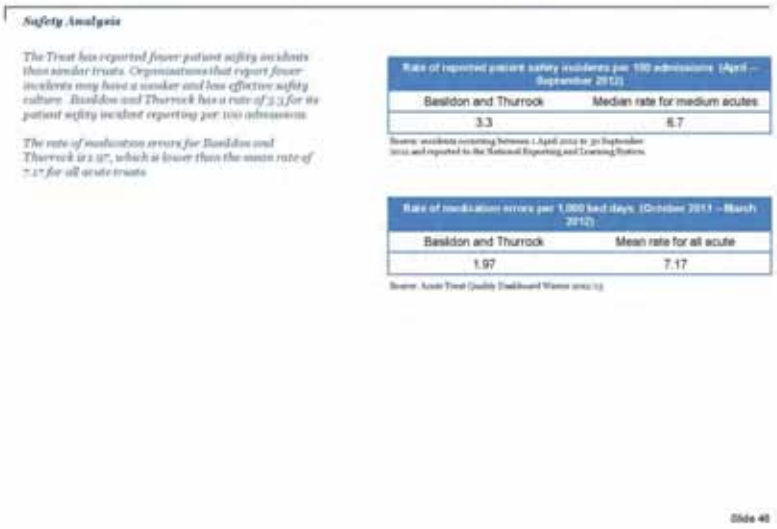
Safety
This page shows the workforce measures which are considered to be the most pertinent for this review, the items rated 'red' below are analysed in more detail in the following pages
General
Reporting of patient safety incidents
Number of harm incidents reported as 'moderate, severe or death' from April 11 to March 12
363
Number of 'never events' (2009-2012)
7
Specific Safety Measures
Medication error
MRSA
C diff
Pressure ulcers
"Harm" for all four Safety Thermometer Indicators
Litigation and Coroner
Clinical negligence scheme payments
Rule 43 coroner reports
Outside expected range
Within expected range
Slide 45


Safety Analysis
The Trust has reported fewer patient safety incidents than similar trusts. Organisations that report fewer incidents may have a weaker and less effective safety culture. Basildon and Thurrock has a rate of 3.3 for its patient safety incident reporting per 100 admissions
The rate of medication errors for Basildon and Thurrock is 1.97, which is lower than the mean rate of 7.17 for all acute trusts
Rate of reported patient safety incidents per 100 admissions (April – September 2012)
Basildon and Thurrock
Median rate for medium acutes
3.3
6.7
Rate of medication errors per 1,000 bed days (October 2011 – March 2012)
Basildon and Thurrock
Mean rate for all acute
1.97
7.17
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Safety Incident Breakdown

Since 2009, seven 'never events' have occurred at Basildon and Thurrock, classified as that because they are incidents that are so serious they should never happen.

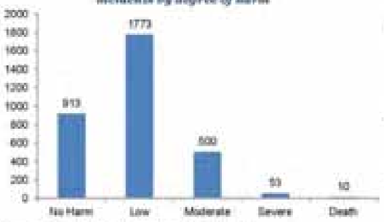
The patient safety incidents reported are broken down into five levels of harm below, ranging from 'no harm' to 'death'. 28% of incidents which have been reported at Basildon and Thurrock have been classed as 'no harm'; with 55% 'low', 15% 'moderate', 2% 'severe' and 10 occurrences classified as 'death'.

When broken down by category, the most regular occurrences of patient incident at Basildon and Thurrock are in 'patient accident' and 'implementation of care and ongoing monitoring / review'.

Never Events Breakdown (2009-2012)	
Misplaced naso or oro-gastric tubes	3
Maladministration of potassium containing solutions	1
Wrong site surgery	2
Retained foreign object post-operation	1
Total	7

Source: Freedom of information request, BBC - http://www.bbc.co.uk/news/health-[illegible]

Breakdown of patient incidents by degree of harm



Source: National Patient Safety Agency (NPSA) Apr 11 – Mar 12
A definition of serious harm is given in the Appendix

Breakdown of patient incidents by incident type

Source: National Patient Safety Agency (NPSA) Apr 11 – Mar 12

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Pressure Ulcers

This slide outlines the total number of pressure ulcers and the number of new pressure ulcers broken down by category for the last 12 months. Due to the effects of seasonality on hospital acquired pressured ulcer rates, the national rate has been included which allows a comparison that takes this in to account. This provides a comparison against the national rate as well as the 14 trusts selected for the review.

The Trust's new pressure ulcer rate was below the national rate for nine of the 12 months shown.

However, the total pressure ulcer prevalence rate has been higher than the national rate for ten months which may highlight an area for review.

New pressure ulcers prevalence

Total pressure ulcers prevalence

New pressure ulcer statistics	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of records submitted	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Trust new pressure ulcers	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Trust new pressure ulcer rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Selected 14 Trusts new pressure ulcer rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
National new pressure ulcer rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Total pressure ulcer prevalence percentage	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of records submitted	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Trust total pressure ulcers	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Trust total pressure ulcer rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Selected 14 Trusts total pressure ulcer rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
National total pressure ulcer rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Source: Safety Thermometer Apr 12 to Mar 13

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Litigation and Coroner

Clinical negligence scheme analysis

Basildon and Thurrock's Clinical Negligence payments have exceeded contributions to the 'risk sharing scheme' in each of the last 3 years.

Coroners' Rule

Coroners' rule 43 reports flagged two items:

- *Review of risk assessment, and*
- *Record keeping*

Clinical negligence payments

	2009/10	2010/11	2011/12
Payouts (£000s)	5,232	7,301	6,532
Contributions (£000s)	4,473	4,360	4,623
Variance between payouts and contributions (£000s)	759	2941	1909

Source: Litigation Authority Reports

Workforce

This page shows the workforce measures which are considered to be the most pertinent for this review. Further analysis, where relevant, is detailed in the following pages.

Workforce Indicators

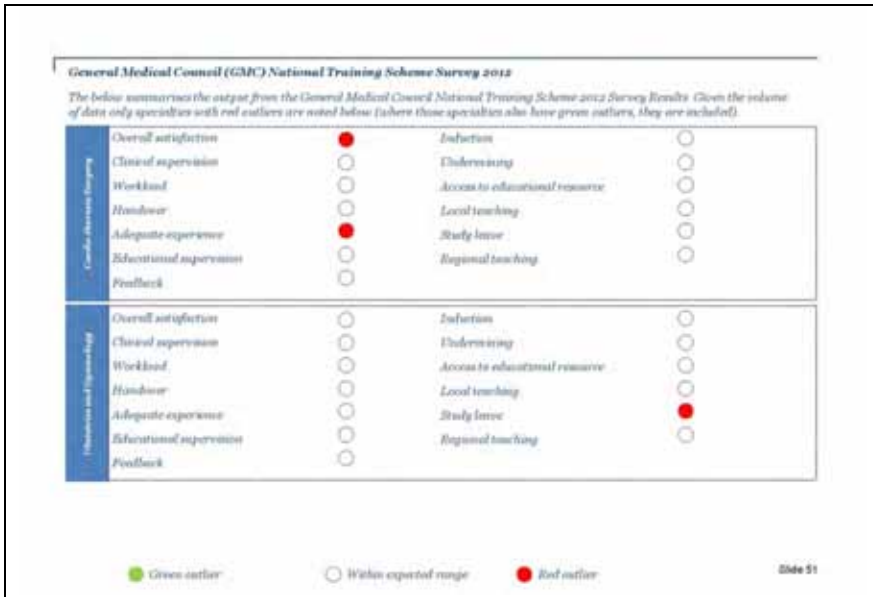
WTE nurses per bed day		*Sickness absence- Overall*		*Medical Staff to Consultant Ratio*	*4.64*
Spells per WTE staff		*Sickness absence- Medical*		*Nurse Staff to Qualified Staff Ratio*	*2.08*
Vacancies – medical		*Sickness absence -Nursing staff*		*Non-clinical Staff to Total Staff Ratio*	*0.33*
Vacancies - Non-medical		*Sickness absence - Other staff*		*Consultant Productivity (PTE/Bed Days)*	*364*
Consultant appraisal rates		*Staff leaving rates*		*Nurse Hours per Patient Bed Day*	*7.84*
Agency spend		*Staff joining rates*			

Staff Surveys and Intelligence

Response Rate from National Staff Survey 2012		*Overall Rate of Patient Safety Concerns*	
Staff Engagement from NSS 2012		*Care of patients / service users is my organisation's top priority*	
Training Doctors – "underlining" indicator		*I would recommend my organisation as a place to work*	
GMC monitoring under "response to concerns process"		*If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation*	

Outside expected range

Within expected range



General Medical Council (GMC) National Training Scheme Survey 2012

The below summarises the output from the General Medical Council National Training Scheme 2012 Survey Results. Given the volume of data only specialties with red outliers are noted below (where those specialties also have green outliers, they are included).

Cardio-thoracic Surgery	Overall satisfaction	Red	Induction	
	Clinical supervision		Undermining	
	Workload		Access to educational resource	
	Handover		Local teaching	
	Adequate experience	Red	Study leave	
	Educational supervision		Regional teaching	
	Feedback			
Obstetrics and Gynaecology	Overall satisfaction		Induction	
	Clinical supervision		Undermining	
	Workload		Access to educational resource	
	Handover		Local teaching	
	Adequate experience		Study leave	Red
	Educational supervision		Regional teaching	
	Feedback			

Green outlier Within expected range Red outlier

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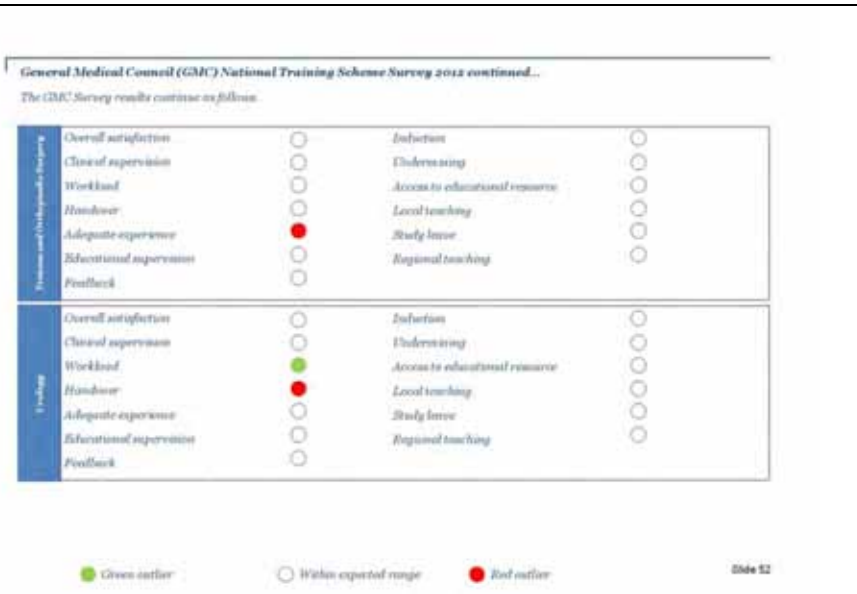

General Medical Council (GMC) National Training Scheme Survey 2012 continued...

The GMC Survey results continue as follows:

Trauma and Orthopaedic Surgery	Overall satisfaction		Induction	
	Clinical supervision		Undermining	
	Workload		Access to educational resource	
	Handover		Local teaching	
	Adequate experience	Red	Study leave	
	Educational supervision		Regional teaching	
	Feedback			
Urology	Overall satisfaction		Induction	
	Clinical supervision		Undermining	
	Workload	Green	Access to educational resource	
	Handover	Red	Local teaching	
	Adequate experience		Study leave	
	Educational supervision		Regional teaching	
	Feedback			

Green outlier Within expected range Red outlier

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Workforce Analysis

The Trust has a patient spell per whole time equivalent rate of 27, which is a slightly above average capacity in relation to the other trusts in this review and nationally.

The consultant appraisal rate of Basildon and Thurrock is 63% which is among the lowest of the trusts under review.

Basildon and Thurrock's staff leaving rate is 7.8% which is slightly higher than the median average of 7.6%. The joining rate of 8.4% is also slightly higher than the national average.

The data shows that the agency staff costs, as a percentage of total staff costs, is lower than the median within the region.

Number of FTEs (Dec 11-Nov 12 average)	3,720

Agency Staff (2011/12)		
Basildon Expenditure	Percentage of Total Staff Costs	Median within Region
£6.5m	3.9%	4.6%

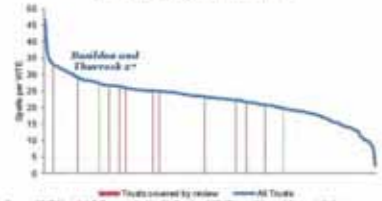
Staff Turnover	(Sep 11 – Sep 12)	
	Basildon	East of England SHA Median
Joining Rate	8.4%	8.1%
Leaving Rate	7.8%	7.6%

Source: Health and Social Care Information Centre (HSCIC)

WTE ratio's per bed day December 2012	
Basildon	National Average
1.79	1.96

Source: Acute Trust Quality Dashboard, Methods Insight

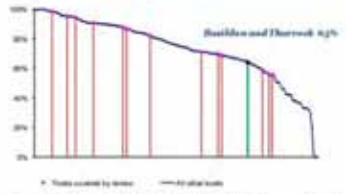
Spells per WTE for Acute Trusts



Trusts covered by review — All Trusts

Source: NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

Consultant appraisal rate 2012/13



Trusts covered by review — All other trusts

Source: 2012/13 Organisational Readiness Self-Assessment (ORSA)
Data based on the appraisal year from April 2012 to March 2013

Workforce Analysis continued…

Basildon and Thurrock's total sickness absence rate is lower than the East of England Strategic Health Authority average and the national average. At the more granular level, the Trust's medical staff sickness rate is below the national average, while the rate for other staff is above the average for all English trusts.

Basildon and Thurrock has a medical staff to consultant ratio above the national average, though its nurse staff to qualified staff ratio is below the average for all English trusts. The Trust's registered nurse hours to patient day ratio is also below the national mean.

The Trust's consultant productivity rate is above the national average.

Sickness Absence Rates			(2011-2012)
	Basildon and Thurrock	East of England SHA Average	National Average
All Staff	3.67%	4.03%	4.12%

Source: Health and Social Care Information Centre (HSCIC)

Sickness Absence Rates by Staff Category	(Dec 12)	
	Basildon and Thurrock	National Average
Medical Staff	1.0%	1.3%
Nursing Staff	4.8%	4.8%
Other Staff	4.9%	4.7%

Source: Acute Trust Quality Dashboard, Methods Insight

Staff Ratios		
	Basildon and Thurrock	National Average
Medical Staff to Consultant Ratio	2.64	2.59
Nurse Staff to Qualified Staff Ratio	2.08	2.50
Non-Clinical Staff to Total Staff Ratio	0.33	0.34
Registered Nurse Hours to Patient Day Ratio *	7.84	8.57

Source: Electronic Staff Record (ESR), Apr 12
* Patient Bed Days Data: Healthcare Evaluation Data Apr 12 – Mar 13

Staff Productivity		
	Basildon and Thurrock	National Average
Consultant Productivity (Spells/FTE)	564	492

Source: Electronic Staff Record (ESR), Apr 12

Workforce indicator calculations are listed in the Appendix

Workforce Analysis continued...

Basildon and Thurrock's response rate to the staff survey has fallen significantly below average from 2011 to 2012. In addition, the survey results have fallen significantly across all categories of questions over the same time period. Therefore ,Basildon and Thurrock is below average when compared with trusts of a similar type for overall staff engagement, percentage of staff who would be happy with the standard of care if a friend or relative needed treatment, recommending it as a place to work, as well care of patients / service users is the organisation's top priority.

National Staff Survey results				
	Basildon and Thurrock 2011	Average for all trusts 2011	Basildon and Thurrock 2012	Average for all trusts 2012
Response rate	52%	50%	36%	50%
Overall staff engagement	3.65	3.62	3.63	3.69
Care of patients/service users is my organisation's top priority	66%	69%	65%	63%
I would recommend my organisation a place to work	56%	52%	50%	55%
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	63%	62%	51%	60%

Source: National Staff Survey 2011, 2012

Source: GMC evidence to Review 2013

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Deanery

The trust has been under scrutiny from the GMC and the CQC for a number of years. Education concerns have related to training in Trauma and Orthopaedic Surgery, Anaesthetics and Obstetrics and Gynaecology, and Emergency Medicine. Significant improvement has been made in most of these areas since 2010, although the trust is still being monitored under our response to concerns process.

National Training Scheme (NTS) Outliers – Programme Groups by Trust/Board between 2010-12

Trauma and Orthopaedic Surgery and Anaesthetics were the programme groups with the most below outliers between 2010 and 2012. Paediatrics received the most above outliers during this period. Perceptions of doctors in training improved in 2012, with fewer below outliers reported compared to previous years.

NTS 2012 Patient Safety Comments

22 doctors in training commented, representing 6.13% of respondents. This was higher than the national average of 4.7%. Their concerns, which were raised in relation to specific training posts, and may apply to a single or multiple departments, related to:

- *Low staffing levels, especially at night;*
- *Shortage of beds resulting in patients being frequently moved, with poor patient tracking systems;*
- *Shortage of equipment (esp. clinical simulation area);*
- *Locum doctors of variable ability; and*
- *Not enough senior support.*

Deanery Reports

The Deanery returns for 2011 and 2012 identified the levels of non-Registrar middle grade support for doctors in training in the Emergency Department as being a concern. The substantial numbers of below outliers from Anaesthetic doctors in training of all grades from the NTS were also recorded as a concern.

Source: GMC evidence to Review 2013

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Monitored under the response to concerns process?

Yes, Basildon and Thurrock University Foundation Trust has been monitored through the response to concerns process since October 2009, when the CQC highlighted serious issues at this Trust including high mortality rates and issues around governance.

Deanery Action

- *The Deanery undertook a series of visits to the site to consider the general training experience at the Trust*
- *Issues were identified around the management of acute patients, handover, formal teaching, and supervision of F1 Doctors*
- *Action planning at the time indicated improvement*
- *In February 2011, the Deanery reported that a new Clinical Tutor had been appointed, that the Head of School for O&G was addressing 'Consultant undermining' that arose from the survey. Undermining is behaviour that subverts, weakens or unnerves young confidence*
- *In late 2011/2012, the Foundation School had a further positive visit, and an exceptional visit to Trauma and Orthopaedics was undertaken as a number of issues had been identified, some of which related to the interface of programmes with the London Deanery. The issue is complex as some of the foundation doctors in training come from London but the Rest of England Deanery manage the environment.*
- *The Deanery undertook a Paediatric School visit to the Trust in December 2012, which indicated that doctors in training were having a good educational experience, and no patient safety issues were identified.*
- *2012 survey results indicate improvement across all areas, and the site is not considered to be an outlier within the region, other than the slightly higher number of patient safety concerns raised by doctors in training.*
- *The Deanery is managing issues that arose during a Foundation school visit (28 February 2013) regarding supervision in the Emergency Department.*

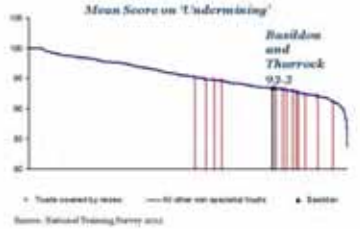
GMC Action

- *GMC have contributed to four risk summits on this Trust since September 2012, and*
- *GMC are monitoring annual deanery reports, Deanery visit reports, and Trust action plans.*

Source: GMC evidence to Review 2013

Undermining

For doctors undertaking training at Basildon, the Trust has a score on the National Training Survey on undermining of 93.3 which is below the national average of 94



Clinical and operational effectiveness

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Clinical and Operational Effectiveness

Overview:

The following section will provide an insight in to the Trust's clinical and operational performance based on nationally recognised key performance indicators.

Review Areas:

To undertake a detailed analysis of the Trust's clinical and operational performance it is necessary to review the following areas:

- *Clinical Effectiveness;*
- *Operational Effectiveness; and*
- *Patient Reported Outcome Measures (PROMs) for the review areas*

Data Sources:

- *Clinical Audit Data Trust, CQC Data Submission;*
- *Healthcare Evaluation Data (HED), Jan – Dec 2012;*
- *Department of Health;*
- *Cancer Waits Database, Q3, 2012-13; and*
- *PROMs Dashboard*

All data and sources used are consistent across the peaks for the 14 trusts included in this review

Summary:

With 92.3% of A&E patients seen within 4 hours, which is below the 95% target level, Basildon and Thurrock have one of the lowest percentages from the selected trusts in the review. In addition to this, the percentage of patients seen within 4 hours is falling. Similarly, a recent downturn means that only 80% of patients are seen within the 18 week target time (RTT) which is lower than the target level and places them as one of the lowest amongst the trusts being reviewed.

The Trust's crude readmission rate is the lowest readmission rate of all the trusts in the review. The readmission rate of 8.3% is in the upper quartile of the trusts covered by this review. Basildon and Thurrock also have the lowest standardised readmission rate of the 14 selected trusts and are shorter than the national mean average length of stay. The PROMS dashboard shows that Basildon and Thurrock is in line with the average across procedures covered by PROMS. The average health gain from Hip Replacement declined in each of the last two years, and the Trust is now close to the lower control limit (outcomes less good than average).

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Clinical and Operational Effectiveness
This page shows measures of clinical and operational effectiveness which are considered to be the most pertinent for this review. The items displayed below are analysed in more detail in the following pages where they are deemed to be relevant for this review.
Clinical effectiveness
Neonatal – women receiving steroids
Adult Critical care
Diabetes safety / effectiveness
PROMS safety / effectiveness
Joints – revision ratio
Coronary angioplasty
Peripheral vascular surgery
Carotid interventions
Acute MI
Acute stroke
Heart failure
Lung cancer
Bowel cancer
Hip fracture - mortality
Severe trauma
Elective Surgery
Operational Effectiveness
RTT Waiting Times
Emergency readmissions
Cancer Waits
A&E Waits
Cancelled Operations
PbR Coding Audit
PROMs Dashboard
Hip Replacement EQ-5D
Knee Replacement EQ-5D
Varicose Vein EQ-5D
Hip Replacement OHS
Knee Replacement OKS
Groin Hernia EQ-5D
Outside expected range
Within expected range
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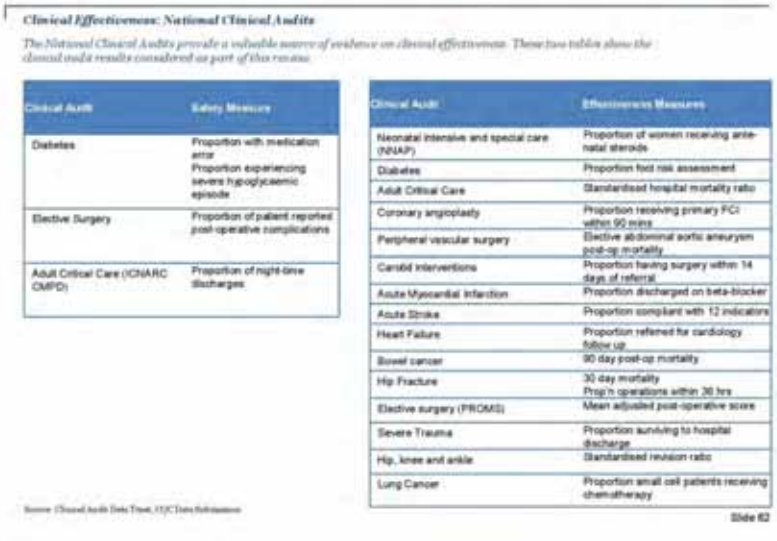
Clinical Effectiveness: National Clinical Audits
The National Clinical Audits provide a valuable source of evidence on clinical effectiveness. These two tables show the clinical audit results considered as part of this review.
Clinical Audit
Safety Measure
Diabetes
Proportion with medication error
Proportion experiencing severe hypoglycaemic episode
Elective Surgery
Proportion of patient reported post-operative complications
Adult Critical Care (ICNARC CMPD)
Proportion of night-time discharges
Clinical Audit
Effectiveness Measures
Neonatal intensive and special care (NNAP)
Proportion of women receiving ante-natal steroids
Diabetes
Proportion foot risk assessment
Adult Critical Care
Standardised hospital mortality ratio
Coronary angioplasty
Proportion receiving primary PCI within 90 mins
Peripheral vascular surgery
Elective abdominal aortic aneurysm post-op mortality
Carotid interventions
Proportion having surgery within 14 days of referral
Acute Myocardial Infarction
Proportion discharged on beta-blocker
Acute Stroke
Proportion compliant with 12 indicators
Heart Failure
Proportion referred for cardiology follow up
Bowel cancer
90 day post-op mortality
Hip Fracture
30 day mortality
Prop'n operations within 36 hrs
Elective surgery (PROMS)
Mean adjusted post-operative score
Severe Trauma
Proportion surviving to hospital discharge
Hip, knee and ankle
Standardised revision ratio
Lung Cancer
Proportion small cell patients receiving chemotherapy
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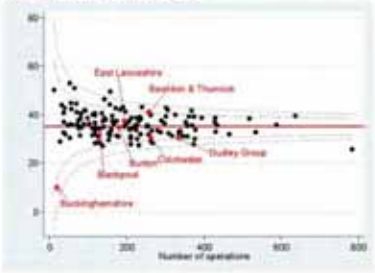
Clinical Effectiveness: Clinical Audits

The National PROMS programme measures outcomes, both in terms of health gain and also in relation to post-operative complications

For this review, we examined data on both aspects across all four treatment areas addressed by PROMS

Results for knee surgery show Basildon as an outlier for post-operative complications

Proportion of patients reporting post-operative complications – Knee Surgery



Source: National PROMs Programme, Apr 11 – Mar 12

Operational Effectiveness – A&E wait times and Referral to Treatment (RTT) times

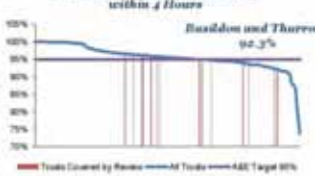
A&E wait times and RTT times may indicate the efficiency with which demand is managed.

Basildon and Thurrock saw 92.3% of A&E patients within 4 hours which is below the 95% target level. In addition to this the percentage of patients seen within 4 hours is falling.

89% of patients are seen within the 18 week target time which is below the target level. In addition to this, their percentage achieved is one of the lowest amongst the trusts being reviewed. However, the time series shows that Basildon and Thurrock were performing above the target runs until recently.

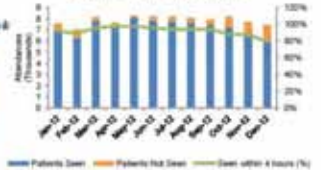
A&E Percentage of Patients Seen within 4 Hours

Basildon and Thurrock 92.3%



Source: Healthcare Evaluation Data (HED), Jan – Dec 12

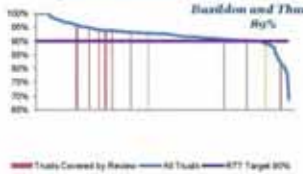
Basildon 4 Hour A&E Waits



Source: Healthcare Evaluation Data (HED), Jan – Dec 12

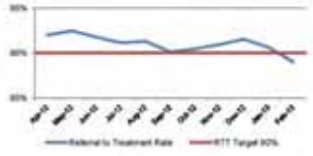
Referral to Treatment (Admitted)

Basildon and Thurrock 89%



Source: Department of Health, Feb 13

Basildon Referral to Treatment Performance



Source: Department of Health, Apr 12 – Feb 13

Operational Effectiveness – Emergency Re-admissions and Length of Stay

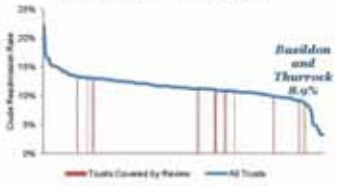
Readmission rates may indicate the appropriateness of treatment offered, whilst average length of stay may indicate the efficiency of treatment

Basildon and Thurrock's crude readmission rate is the lowest readmission rate of the trusts in the review at 8.9% and is in the upper quartile of trusts nationally

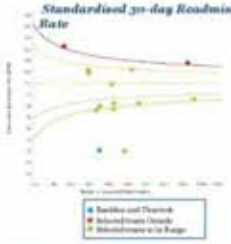
The standardised readmission rate most importantly accounts for the Trust's case mix and shows Basildon and Thurrock are statistically lower than expected having the lowest standardised readmission rate of the 14 selected trusts

Basildon and Thurrock's average length of stay is 4.6 days, which is shorter than the national mean average of 5.2 days

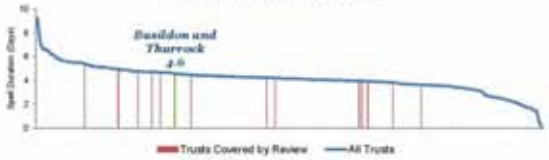
Crude Readmission Rate by Trust



Standardised 30-day Readmission Rate



Average Length of Stay by Trust



Source: Healthcare Evaluation Data (HED), Jan 12 – Dec 12

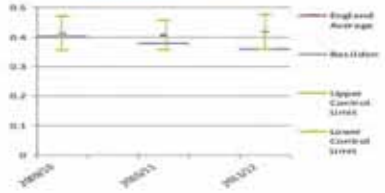
Slide 05

PROMs Dashboard

The PROMs dashboard shows that Basildon is in line with the average across procedures covered by PROMS

The average health gain from Hip Replacement declined in each of the last two years, and Basildon is now close to the lower control limit (outcomes less good than average)

Hip Replacement EQ-5D



Source: PROMs Dashboard and NHS Litigation Authority

Slide 06

Leadership and governance

Slide 07

Leadership and governance

Overview:

This section will provide an indication of the Trust's governance procedures

Review Areas:

To provide this indication of the Trust's leadership and governance procedures we have reviewed the following areas

- *Trust Board;*
- *Governance and clinical structure; and*
- *External reviews of quality*

Data Sources:

- *Board and quality subcommittee agendas, minutes and papers;*
- *Quality strategy;*
- *Reports from external agencies on quality;*
- *Board Assurance Framework and Trust Risk Register; and*
- *Organisational structures and CVs of Board members.*

All data and sources used are consistent across the packs for the 14 trusts included in this review.

Summary:

The Trust was deemed to be in significant breach by Monitor in 2013 as a result of concerns raised by the CQC. These concerns included high mortality rates, poor infection control and concerns regarding clinical leadership. Since this period the Trust continues to have a 'red' governance rating.

There have been a large number of changes to the Board over the last 18 months. Most recently, a new CEO was appointed in September 2015, and a new Medical Director in February 2015. However, all executive roles are permanent, except for the current Director of Estates (interim) and the current Finance Director (acting up). The Trust has recently established the Clinical Director role (1 April) as part of the new clinically led operational management structure.

The Trust has established a Hospital Mortality Review Group (HMRG) for specific consideration of mortality, and a Quality & Patient Safety subcommittee, which provides the Board with assurance on quality. The HMRG meets fortnightly and is chaired by the Medical Director; the subcommittee meets monthly and has a non-executive chair (David Halbert). The Board governance structure is being revised in line with best practice following a review by the CQC.

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Leadership and governance

This page shows the latest rating against regulatory standards, the items rated 'red' or 'amber' below are discussed in more detail in the following pages

Leadership and governance			
Monitor governance risk rating	🔴	CQC Outcome 16 - Moderate concern	🟡
Monitor finance rating	3	CQC Outcome 10 - Moderate concern	🟡
		CQC Outcome 4 - Minor concern	🟡
		CQC Outcome 8 - Minor concern	🟡

Governance risk rating
Red - Likely or actual significant breach of terms of authorisation
Amber-red - Material concerns surrounding terms of authorisation
Amber-green - Limited concerns surrounding terms of authorisation
Green - No material concerns

CQC Concerns
Red – Major concern
Amber – Minor or Moderate concern
Green – No concerns

Financial risk rating
rated 1-5, where 1 represents the highest risk and 5 the lowest

Leadership and governance

Trust Board

There have been a large number of changes to the Board over the last 18 months. Most recently, a new CEO was appointed in Sep 2012, and a new Medical Director in Feb 2013. All executive roles are permanent, except the Director of Estates (interim) and Finance Director (acting up).

Governance and clinical structures

The Trust is in a period of change with their operational and governance structures. On 1 April 2013 they moved to a new clinically led operational management structure. The Trust now has five clinical divisions; Women & Children's, Surgical Services, Acute Medicine, General Medicine and CTC, led by Clinical Directors (see Appendix A).

The Trust has established a Hospital Mortality Review Group (HMRG) for specific consideration of mortality, and a Quality & Patient Safety subcommittee, which provides the Board with assurance on quality. The HMRG meets fortnightly and is chaired by the Medical Director, the subcommittee meets monthly and has a non-executive chair (David Hulbert). The Board governance structure is being revised in line with best practice following a review by the GGI (see Appendix B for current structure)

External reviews

The Trust was placed in significant breach of the terms of their authorisation by Monitor in 2009, as a result of concerns raised by the CQC, high mortality rates, poor infection control (2009) and concerns regarding clinical leadership. At the time of the FRSs the Trust remains in significant breach with Monitor and has 2 minor concerns and 2 moderate concerns resulting from a CQC inspection in January 2013.

There have been a number of external reviews since this period, conducted by teams including PwC, McKinsey and Good Governance Institute (GGI) all resulting in action plans. However, the Trust continues to have a 'red' governance rating scoring 4 in March 2013.

A diagram of operational and trust executive structure as well as a table of the Board of Directors can be found in the Appendix.

Top risks to quality

The table includes the top risks to quality identified by the Trust on their corporate risk register, and other potential risks to quality identified through review of Trust Board papers.

Trust identified risks	Further risks for review
Access to emergency inpatient beds caused by prolonged period of demand exceeding supply, see further explanation below.*	Pressure ulcers – 46 out of 72 SUIs in 12/13 related to grade 3 and grade 4 pressure ulcers.
Failure to provide appropriate care to acutely unwell and deteriorating patients 24/7 caused by unavailability of appropriate staff. In particular out of hours senior availability of senior clinical staff.	Paediatric service – inadequate quality checking systems to manage risks to children who receive care (CQC moderate concern).
Failure to demonstrate a safe organisation caused by breach of regulatory requirements based on serious incident and risk management processes.	Never events recorded relating to a naso-gastric tube and wrong site surgery.

** The Trust has been experiencing unprecedented demand for emergency care, an action plan has been put in place to manage the emergency pressures including reducing the volume of elective work and implementing the internal major incident plan to manage capacity. The Trust is urgently reviewing alternative options to manage increased demand and discharge patients.*

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Leadership and governance – other areas for further review

External reviews

In January 2013 a CQC inspection resulted in a second warning notice being issued for Outcome 16: Assessing and monitoring the quality of service provision. The first warning notice was served by CQC on 14 November 2012 as the Trust did not have robust quality checking systems in place to manage risks to children who receive care. Although improvements have been made, there were not effective systems in place to identify, monitor and protect against identified risks at the time of the second inspection.

Following a number of serious incidents and the warning notice issued by the CQC, an external review of the operational and governance structures of paediatric services was commissioned. The review resulted in a number of immediate and medium term actions.

The two minor concerns that were raised related to Outcome 4: Care and welfare of people who use the services and Outcome 8: Cleanliness and infection control. For Outcome 4 it was identified that Children's assessment practices require development to ensure care and treatment is planned and delivered in a way that ensures their safety and welfare at all times. Following complaints from the public an inspection in relation to Outcome 8 identified that there were ineffective systems in place to reduce the risk and spread of infection.

In relation to Outcome 15, (Safety and Suitability of Premises), an inspection was undertaken to assess how the trust was managing the prevention and control of Legionella. The following was assessed:

The trust had taken acceptable actions to safely manage the prevention and control of hospital acquired Legionella, and

All relevant stakeholders in the process had concluded that the Trust is operating a water system that is under control and compliant and that the Trust has a robust system of assurance to monitor and mitigate any Legionella risk to patients, staff and visitors.

Further areas

A Quality and Safety turnaround programme is being implemented to sustainably improve the safety and quality of services provided by the Trust. Six workstreams had been set up, each clinically led, to look at the changes the Trust needs to make in high priority areas.

The Trust is in the lowest 25% of incident reporters compared to other medium acute Trusts. Actions are underway to strengthen the serious incident process in order to achieve compliance with the CQC regulatory framework, following a management review during January 2013.

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Trust Map

Basildon and Thurrock University Hospitals NHS

Welcome to **Basildon University Hospital**

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Trust Map Floor Plan

Basildon and Thurrock University Hospitals NHS

Welcome to **Basildon University Hospital**

Source: Basildon and Thurrock University Hospitals NHS Foundation Trust website

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Serious harm definition

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- *Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;*
- *Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);*
- *A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal, organisational information, damage to property, reputation or the environment, or IT failure;*
- *Allegations of abuse;*
- *Adverse media coverage or public concern about the organisation or the wider NHS; and*
- *One of the core set of "Never Events" as updated on an annual basis.*

Source: UK National Screening Committee

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Workforce indicator calculations

Indicator	Numerator / Denominator	Calculation	Source
WTE nurses per bed day	Numerator	Nurses FTE's	Acute Quality Dashboard
	Denominator	Total number of Bed Days	
Spells per WTE staff	Numerator	Total Number of Spells	HED ESR
	Denominator	Total number of WTE's	
Medical Staff to Consultant Ratio	Numerator	FTE whose job role is 'Consultant'	ESR
	Denominator	FTE in 'Medical and Dental' Staff Group	
Nurse Staff to Qualified Staff Ratio	Numerator	FTE in 'Nursing & Midwifery Registered' Staff Group	ESR
	Denominator	FTE of Additional Clinical Services – 65% of bands 2, 3 and 4	
Non-clinical Staff to Total Staff Ratio	Numerator	FTE not in 'Nursing and Midwifery Registered', 'Additional Clinical Services,' 'Allied Health Professionals' or 'Medical and Dental' staff groups	ESR
	Denominator	Sum of FTE for all staff groups	
Consultant Productivity (FTE/Bed Days)	Numerator	Consultant FTE's	ESR
	Denominator	Total Bed Days	
Nurse hours per patient day	Numerator	Nurse FTE's multiplied by 1522 (calculated number of hours per year which takes into account annual leave and sickness rates)	ESR
	Denominator	Total Bed Days	HED
Note: ESR Data only includes substantive staff			

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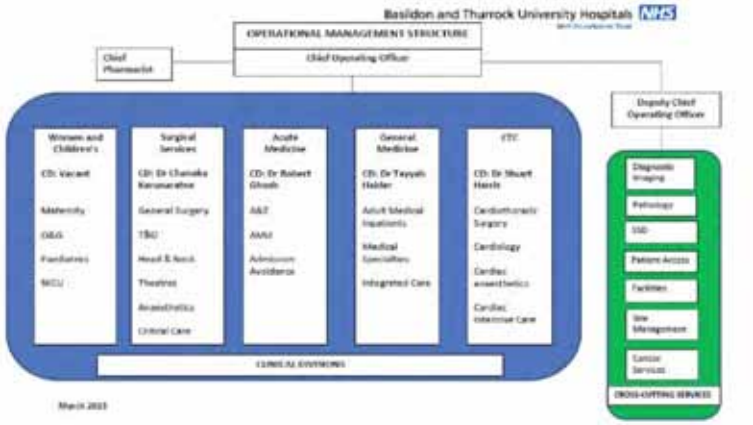
Operational structure



Source: Basildon and Thurrock University Hospitals NHS Foundation Trust – Information Request

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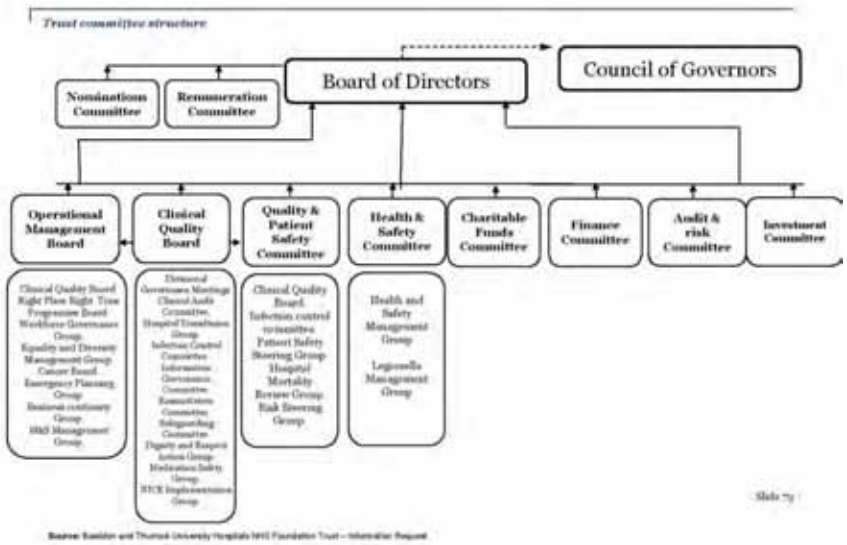

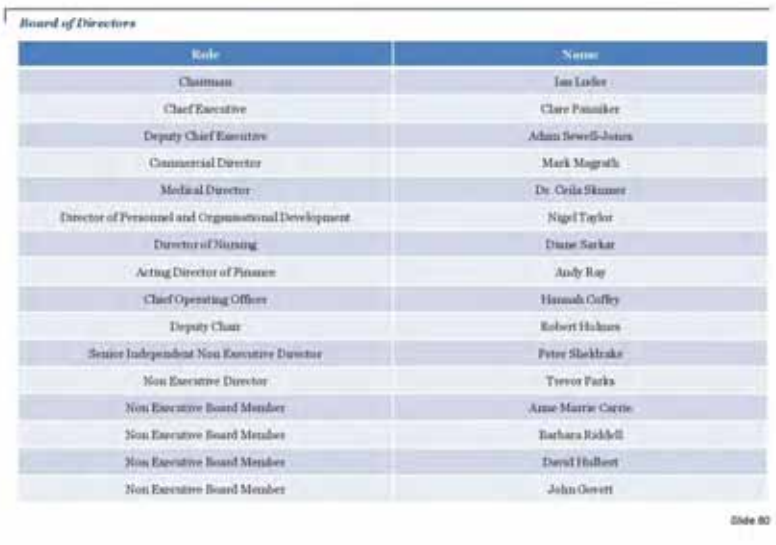

Role	Name
Chairman	Ian Lailer
Chief Executive	Clare Panniker
Deputy Chief Executive	Adam Sewell-Jones
Commercial Director	Mark Magrath
Medical Director	Dr. Ceila Skinner
Director of Personnel and Organisational Development	Nigel Taylor
Director of Nursing	Diane Sarkar
Acting Director of Finance	Andy Ray
Chief Operating Officer	Hannah Coffey
Deputy Chair	Robert Hulmes
Senior Independent Non Executive Director	Peter Sherbrake
Non Executive Director	Trevor Parks
Non Executive Board Member	Anne Marrie Carrie
Non Executive Board Member	Barbara Riddell
Non Executive Board Member	David Hulbert
Non Executive Board Member	John Govett


Data Sources
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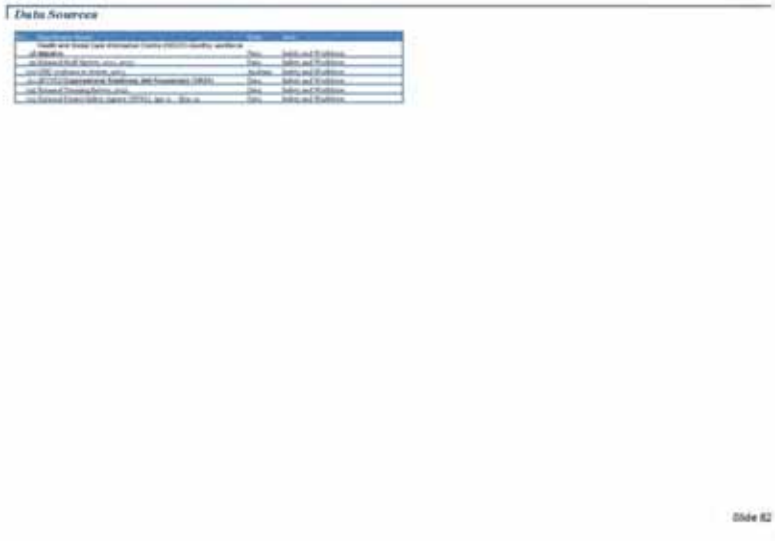
Data Sources
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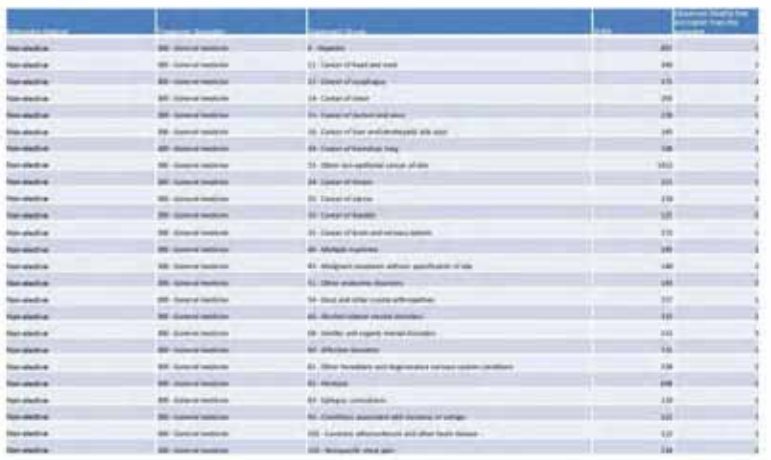
SHMI Appendix



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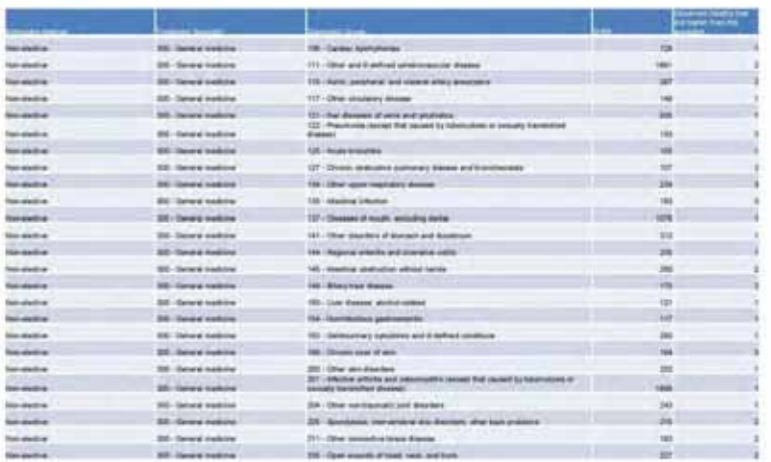
SHMI Appendix



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SHMI Appendix

Non-elective	630 - General medicine	237 - Complication of device, implant or graft	321	5
Non-elective	300 - General medicine	243 - Poisoning by other medications and drugs	216	1
Non-elective	300 - General medicine	245 - Syncope	331	2
Non-elective	630 - General medicine	250 - Nausea and vomiting	137	1
Non-elective	515 - Palliative medicine	2 - Septicaemia (except in labour)	395	1
Non-elective	515 - Palliative medicine	12 - Cancer of oesophagus	469	1
Non-elective	515 - Palliative medicine	15 - Cancer of rectum and anus	532	1
Non-elective	515 - Palliative medicine	19 - Cancer of bronchus, lung	189	1
Non-elective	515 - Palliative medicine	20 - Cancer, other respiratory and thoracic	211	1
Non-elective	515 - Palliative medicine	22 - Melanomas of skin	237	1
Non-elective	515 - Palliative medicine	24 - Cancer of breast	223	2
Non-elective	515 - Palliative medicine	29 - Cancer, of prostate	282	1
Non-elective	515 - Palliative medicine	36 - Leukemias	614	1
Non-elective	515 - Palliative medicine	42 - Secondary malignancies	338	1
Non-elective	515 - Palliative medicine	43 - Malignant neoplasm without specification of site	235	1
Non-elective	515 - Palliative medicine	95 - Other nervous system disorders	4274	1
Non-elective	515 - Palliative medicine	108 - Congestive heart failure, nonhypertensive	548	3
Non-elective	515 - Palliative medicine	109 - Acute cerebrovascular disease	481	2
Non-elective	515 - Palliative medicine	126 - Acute bronchitis	554	1
Non-elective	515 - Palliative medicine	127 - Chronic obstructive pulmonary disease and bronchiectasis	1280	3
Non-elective	515 - Palliative medicine	130 - Aspiration pneumonitis; food/vomitus	255	2
Non-elective	515 - Palliative medicine	133 - Pleurisy; pneumothorax; pulmonary collapse	646	2
Non-elective	515 - Palliative medicine	153 - Other lower respiratory disease	2462	1
Non-elective	515 - Palliative medicine	161 - Other liver diseases	708	1
Non-elective	515 - Palliative medicine	197 - Acute and unspecified renal failure	374	2

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SHMI Appendix

Non-elective	515 - Palliative medicine	199 - Chronic ulcer of skin	876	1
Non-elective	515 - Palliative medicine	233 - Intracranial injury	319	1
Non-elective	515 - Palliative medicine	245 - Syncope	1203	2
Non-elective	630 - Geriatric medicine	12 - Cancer of oesophagus	176	2
Non-elective	430 - Geriatric medicine	15 - Cancer of stomach	188	1
Non-elective	430 - Geriatric medicine	18 - Cancer of colon	184	1
Non-elective	430 - Geriatric medicine	19 - Cancer of trachea, lung	111	1
Non-elective	430 - Geriatric medicine	24 - Cancer of breast	141	1
Non-elective	430 - Geriatric medicine	36 - Multiple myeloma	382	1
Non-elective	430 - Geriatric medicine	53 - Other nutritional, endocrine, and metabolic disorders	208	1
Non-elective	430 - Geriatric medicine	63 - Diseases of white blood cells	215	1
Non-elective	430 - Geriatric medicine	69 - Affective disorders	874	1
Non-elective	430 - Geriatric medicine	71 - Other psychoses	139	1
Non-elective	430 - Geriatric medicine	78 - Parkinson's disease	197	2
Non-elective	430 - Geriatric medicine	84 - Headache, including migraine	409	1
Non-elective	430 - Geriatric medicine	85 - Conditions associated with dizziness or vertigo	249	1
Non-elective	430 - Geriatric medicine	94 - Other ear and sense organ disorders	10360	1
Non-elective	430 - Geriatric medicine	96 - Heart valve disorders	508	1
Non-elective	430 - Geriatric medicine	106 - Cardiac dysrhythmias	197	1
Non-elective	430 - Geriatric medicine	114 - Peripheral and visceral atherosclerosis	223	1
Non-elective	430 - Geriatric medicine	115 - Aortic, peripheral, and visceral artery aneurysms	151	1
Non-elective	430 - Geriatric medicine	125 - Acute bronchitis	126	1
Non-elective	430 - Geriatric medicine	153 - Other lower respiratory disease	139	1
Non-elective	430 - Geriatric medicine	154 - Other upper respiratory disease	150	1
Non-elective	430 - Geriatric medicine	157 - Diseases of mouth, excluding dental	223	1

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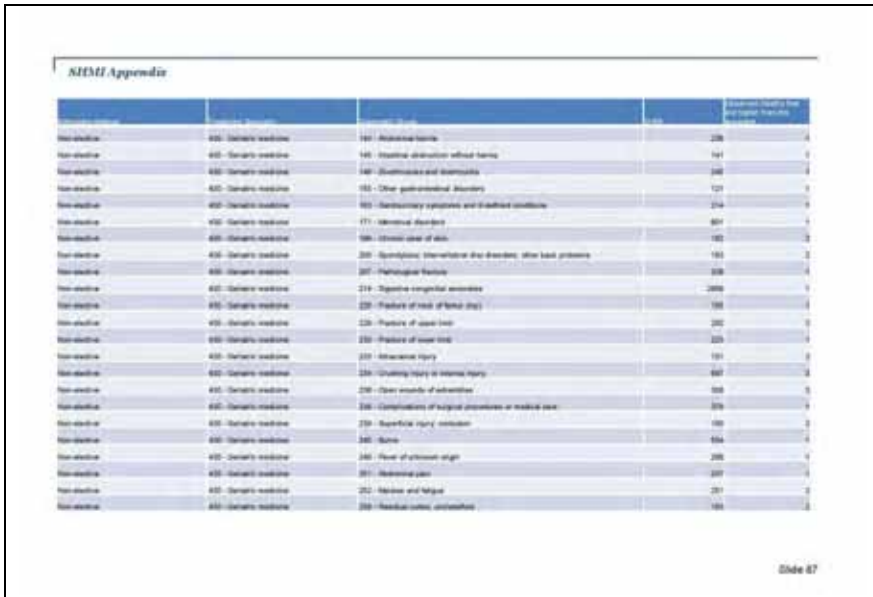

SHMI Appendix

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HSMR Appendix

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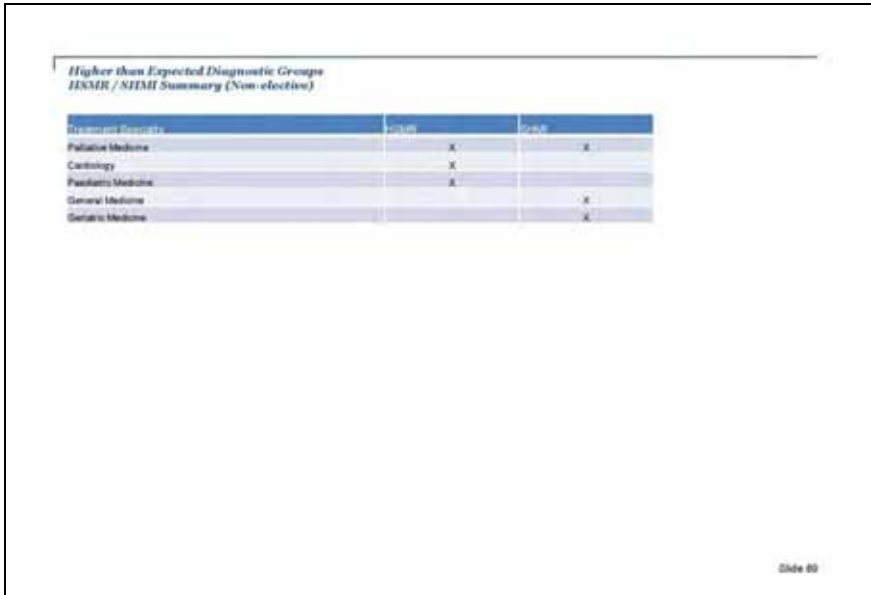
Higher than Expected Diagnostic Groups
IESMR / SHMI Summary (Non-elective)
Palliative Medicine
X
X
Cardiology
X
Paediatric Medicine
X
General Medicine
X
Geriatric Medicine
X
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f. Quality Surveillance Group

The need for a Quality Surveillance Group

Across the health economy, there is a wealth of information and intelligence, gathered formally and informally, about the providers of services to that population. Often the information that one party alone has will not cause concern. However, when combined with intelligence that, for example, a regulator may have, might point to a potential problem that should be investigated further.

Consideration should be given to the creation of a Quality Surveillance Group to co-ordinate quality assurance activities. It would be a proactive forum for collaboration, providing the health economy with:

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality; and
- opportunities to coordinate actions to drive improvement

The QSG will act as a virtual team across the health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, existing clinical governance, audit and regulatory activities. By collectively considering and triangulating information and intelligence, the QSG will work to safeguard the quality of care that people receive.

The scope of the QSG

QSG will look to answer questions such as:

- What does the data and soft intelligence we have tell us about where there might be concerns about the quality of services being provided to our community?
- Where are we most worried about the quality of services?
- Do we need to do more to address concerns, or collect information than we are already?
- Where is there a lack of information and so a need for further consideration and/or information gathering?
- How do our services measure up when compared to existing UK national quality standards (eg. NICE quality standards, National Cancer Audits etc)?

The aim is therefore, is not to supplant existing clinical governance, complaint and audit mechanisms but to ensure that there is a systematic approach to the quality in service delivery across all sections of the health economy.

Membership of the QSG

- External Chairman (Healthcare professional)
- The Medical leads from all major clinical disciplines
- Nursing leads from all three areas
- AHP leads from all three areas
- CCIO/Management Information team representative
- Clinical audit leads from the three areas
- Clinical Governance Leads from all three areas
- Director of Healthcare Delivery
- Director of Public Health
- Member of HSCC

For more information on Quality Surveillance Groups use the link below.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216996/Establishing-Quality-Surveillance-Groups.pdf

Information for patient safety – IOM & the Francis reports & Keogh reviews

August 2013

Dr Iain Kewley

Chief Clinical Information Officer
Department of Health

Background

Health Informatics provision within the Department has been underdeveloped over a considerable period. The CCSS project had the aim of delivering, "one patient, one record." In this, it did not succeed. It did replace a time-expired hospital patient administration system, centralise GP electronic records, and introduce some elements of an electronic record into mental health and community services (the latter with wildly varying success). In many ways the project delivered more than the UK's National Programme for IT but was of course, of a more limited scale.

The UK's purchaser-provider split in the NHS from 1990 onwards, led towards the introduction of its "Payment by Results" (PbR) scheme, whereby hospital income is dependent on both the volume and complexity of the work they undertake. Such a scheme inevitably requires large volumes of coded data in standardised forms and hospitals had to introduce the necessary infrastructure to produce it, in order to survive financially. The Isle of Man does not (for obvious reasons) have such a split. Consequently, it did not introduce the supporting infrastructure for a non-existent PbR scheme, and would probably have been soundly criticised if it had tried to do so. However, inevitably this means that the infrastructure support usually found is missing. Much of the data used to compare hospitals in terms of both efficiency and safety falls under what the Health & Social Care Information Centre (HSCIC) terms "secondary use services." In other words such uses are secondary uses of the data primarily collected to service the PbR scheme.

Given the lack of support infrastructure in the hospital it is not surprising that by comparison, the data is incomplete, inconsistent, or in some cases non-existent. Even where the data is both present and coded, a report by MIAA, has shown marked variation is coding practices between IOM and the UK. In short, until such time as the hospital is managed, structured, and financed in a manner that is directly comparable with a UK hospital, any information produced will not be on a sure, and comparable footing. In addition, many of the UK's metrics, especially around mortality, use information provided from elsewhere in the public sector, such as the Office for National Statistics, which is not available in the Isle of Man. Thus the underlying medical cause of death is not collected in any coded form in the island, and postcode level deprivation data is not available. Yet both of these are pre-requisites for the some of the complex mortality calculations being used to determine "high risk" hospitals in the UK.

Coders can only be as good as the information they are given. This information is provided by clinicians – and still mainly from paper notes. This means that there are a number of issues including (but not limited to):

- The date procedures are undertaken are not coded.
- Outpatient procedures may not be coded at all
- Complications are often not recorded or not coded as complications
- Readmissions under a different specialty (eg patient with DVT post-surgery) readmitted under medicine) will not be coded as readmissions
- Maternity admissions are not coded at all in Medway

- The use of the palliative care codes is very low compared to England

Despite the expenditure on Medway it did not deliver anything remotely resembling an electronic patient record for the hospital, and the whole project did not deliver the longitudinal electronic health record implied by the "one patient, one record" mantra. In these outcomes, CCSS mirrored some of the results from the NPfIT. It is equally clear that the best way to generate health management information, is to use an electronic patient record to capture data in real time, as part of the normal clinical workflows. It is this ambition that underpins the UKs latest move towards "paperless" hospitals to be implemented by 2018. It is clear that such an EPR would resolve many of the coding issues.

In addition to the data quality issues, it is clear that the business information (BI) tool introduced as part of the CCSS project is not fit for purpose. Information entered via the Patient Administration System (System C's Medway) is not reliably extracted by the Medway BI tool. Diagnoses are coded using the ICD-10 system. This allocates a code of up to 5 digits in length to each disorder. However the existing Medway BI system "ignores" all 5 digit codes but will report on those with 4 or fewer digits. An updated version of the system (Sigma BI) has been promised for a number of years, but has bogged down in a Bermudian triangle between the department, the suppliers, and ISD. A further attempt to establish the new version in the "DevLab" environment is immanent and hopes are high that the testing will go well, however, past experience urges a degree of caution onto such optimism.

The deficiencies in underlying data quality, and data extraction not withstanding, there have been issues with the delivery of management information to the Department. The Department established the Management Information & Technology directorate in 2011 with a brief to improve management information. However, although there was a reorganisation there was little additional resource. The information team from the hospital (2 wte) was augmented by the addition of a 0.8wte post, an ex-GP with experience/interest in health informatics. Management information, in theory, is only a component of the latter's role. Thus this small team was, in effect, charged with information provision from across secondary, primary, community, mental and public health services. In addition, it has to mirror some of the central services provided in the UK by HSCIC and the Dr Foster Organisation.

While information provision across the entire health economy from such a small team, presents challenges, these were not aided by the Department being uncertain which information is actually wanted. After the production of an initial set of Key Performance Indicators, by the senior team in the Department, the MI team then refined and converted these into a series of SMART metrics, and in so doing, serendipitously created an information/knowledge management system (iHub) which has become the Department's repository for management information but which has significant knowledge management potential.

The major single workstream for the MI team has remained the production of the monthly hospital information pack, a document some 70+ pages, which has been supplemented by the addition of benchmarking for 2 specialties per month. It is the MI team's hope that we will move to simply producing the information in iHub as it is updated rather than continuing to produce a monthly pack.

The creation of iHub has led, to quote the CEO, to shining a "light in dark corners." Almost all the information seen by the Department prior to this was process related – either the hospital monthly pack, or similar information in respect of primary care services. There was little patient safety information presented in a coherent and regular manner. That is not to say that the data was not collected. In some areas eg infection control, venous thrombo-embolism, incident reporting etc it was both collected and collated. However, reports went to the respective organisations' clinical governance committee but did not arrive at the Department. Equally, the hospital clinical audit committee oversaw a wide range of clinical audit, much of which is relevant to quality assurance, but did not report its findings to the executive team, and had no authority to ensure agreed action plans were implemented, or re-audits undertaken. Consequently, some audits, showing considerable problems did not always lead to service improvements. All such audits are now included in iHub, and thus considered by the Department's Performance & Delivery Group on, at least, a quarterly basis. However, it must be appreciated that such audits have been undertaken on a more or less ad-hoc basis, rather than on a prospective service wide basis, and offer poor levels of quality assurance in the absence of such wider studies. In general there has been little engagement with the numerous national clinical audits undertaken by the various Royal Colleges, nor any audits against national frameworks such as the NICE service guidelines. It was this situation that led to the MI&T proposal for the formation of a Quality Surveillance Group the need for which was agreed by the Department's Performance & Delivery Group. Unfortunately, as yet the proposal has not been implemented. While it is easy to criticise the clinical audit function within the hospital, it needs to be said that there is even less evidence of such audit (beyond the requirements of the Quality and Outcomes Framework for General Practice) beyond the hospital.

Patient experience information for the hospital, is limited to the newly introduced monthly impatient "survey," and the Department has not embraced Patient Recorded Outcome Measures (PROMS), and has eschewed the Friends & Family test introduced in the UK. There is a biennial survey of satisfaction of general practice patients, which is directly comparable with English performance. There is a biennial satisfaction survey for community service patients, but this does not use a standardised methodology, and it is unable to provide comparative data either between consecutive surveys or with external providers.

As result of the difficulties above, outcome information is even more sparse than in the UK. The NHS Outcomes framework 2012-13 established one framework defining how the NHS will be accountable for outcomes. It has Five domains articulating the responsibilities of the NHS, with Twelve overarching indicators covering the broad aims of each domain, Twenty-seven improvement areas looking in more detail at key areas within each domain. There are sixty indicators in total measuring overarching and improvement area outcomes. Of these we are able to produce less than 10 due to lack of underlying data either within the Department or from external sources. However, it must be restated that the information required by local health economies to populate their outcomes framework is collected collated, and analysed externally by agencies such as the ONS, and NHSCIC rather than by the local resources. Even if we had all the

underlying health data, lack of data from other departments, and lack of capacity means that producing similar statistics is unlikely.

Francis 1

In addition to specific relevant recommendations (shown below), throughout the report it is clear that there were significant problems in respect of information provision to the Mid-Staffs Board. The general themes that information provision needed to address were that information should be:

- **Timely**. The introduction of iHub has meant that the Department's Performance & Delivery Group now review all KPIs and related information on at least a quarterly basis. This does not mean that issues developing in the interim are not dealt with, but ensures that the Department is in a position to be aware of such developments. Quarterly reporting results from a balance between timeliness, potential information overload, provision capacity, and availability of comparator data.
- **Accurate & Comprehensive.** The adoption of iHub has led to a considerable increase in coverage. It is based on the concept of inputs and outputs. The inputs being effectiveness, efficiency, and prevention, with the outputs of Safe services, providing good outcomes, with good patient experience. However, there are areas, especially in respect of outcomes, where IOM remains relatively deficient, due to lack of underlying data, and in many cases, lack of supporting data from other Departments, and capacity within the department's information team.
- **Independent**. The hospital's performance is now measured by the MI&T directorate. This is not the case for primary, community mental, and public, health services, where the individual services continue to provide their own information. However, as part of the iHub process, any benchmarking is undertaken by the MI team. While the information may not be being provided independently, it is in general being scrutinised independently. Within the resources available, this may well be a reasonable compromise. While previously, all hospital, or primary care data was submitted and approved by the respective managers before onward transmission, this process has changed somewhat, in that although, from courtesy, those managers usually see "their" information first, any amendments are made in the light of their comments by the MI team, where those comments justify amendment.
- **Avoid Over-reliance on external assessments**
- **Quality** as well as quantity markers. There has been a marked increase in the "quality information" available to the department. However, there remain areas of concern, especially around prospective audit, and outcomes
- Mortality information remains elusive for all the reasons already given.

Francis 1 – specific relevant recommendations

Recommendation 5: "*The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis."*

The information team has undertaken some work with clinical audit, and incorporated the results of the audit into iHub as a way both to facilitate the dissemination of information, and to provide a platform to drive and performance manage the action plans that flow from such audits. However, the hospital audit committee neither has the resources, or indeed the authority to actually make this happen. While the information team will continue to do what it can within existing resources it is unable to address, in isolation, the wider issue in relation to audit. Reference has already been made for the need to participate in pro-active national audit and the possible role of the Quality Surveillance Group.

Recommendation 6: *The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it:*
• provides responses and resolutions to complaints which satisfy complainants;
• ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned all part of the recommendation
• minimises the risk of deficiencies exposed by the problems recurring; and
• makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.

As previously stated, although there has been an undertaking to provide this information for inclusion in iHub, this has not actually happened. It is likely that this delay is the result of the vacancy for the Risk Manager, and shortage of other resources.

Recommendation 12: *The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance*.

See comments on Francis 2 – recommendation 224 around electronic patient records.

Recommendation 15: *In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the*

process, and to assist hospitals in using such statistics as a prompt to examine particular areas of patient care.

There is considerable difficulty in producing either of the two mortality indicators presently in use. There are a number of reasons for this – some of which have already been described. Realistically we are still some considerable time from being able to produce these metrics, which are produced centrally in the UK. It is the MI team's view that we should explore links with HSCIC and/or the Dr Foster Organisation to assist in such functions.

Francis 2

Recommendation 244 *There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes.*

It is necessary to define terms here. For the purposes of this document an electronic patient record (EPR) is produced by a single provider, and/or documents a single episode or pathway of care. As such each patient may have multiple EPRs eg hospital, GP, specialty etc. The electronic health record (EHR) is a longitudinal "document" which tracks health, and healthcare from "cradle to grave" and may contain information from several EPRs. Superficially it would seem that one patient should have one record. However, this has proven, thus far, to be undeliverable for a number of reasons. Rehearsing the reasons for this is out-with the scope of this document, suffice to say, it remains an aim, rather than a reality. The practical way forward relates to ensuring that all the records are electronic, and ensuring inter-operability and data-sharing between systems where possible.

As already stated, the GP systems are comprehensive EPRs, which in turn can form the basis of an EHR. All practices in IOM use the same centrally hosted system, EMIS PCS. However, in practical terms there are 12 separate installations, and it is not possible to search across practices. At present the Department is considering its options around the next upgrade, as EMIS PCS is no longer being developed, with the company's resources being concentrated on EMIS Web. There are other options, such as TPP SystmOne which are being considered. All of these newer systems allow for cross practice auditing, meaning easier auditing. All of the newer GP systems can allow "sharing" to allow clinicians remote from the practice to view patient records. As part of EMIS PCS patients can view their own records, however this requires practices to "switch on" this capability and thus far, no Isle of Man practice has done so. The GP systems do meet most of the requirements of Francis 244.

However, the same cannot be said of the hospital. At present the hospital uses System C's Medway Patient Administration System. While at the time of installation this system did deliver the PAS functionality, it does not include anything that approaches the functionality of an EPR. By December 2014 System C will cease to support the present iteration of Medway. An indicative cost for the move to "new" Medway is around £2m. However, it is clear, that this sum will not deliver an EPR but merely upgrade the existing PAS functionality.

One option being explored, is the introduction of the GP system as the platform for some areas in the hospital to use as their EPR. These opportunities mainly relate to outpatient functions, where there are considerable parallels between primary care and outpatient functions, especially in IOM, where outpatient prescribing provision is via community pharmacies, and electronic transmission of prescriptions being undertaken in the community would be of additional benefit. Nonetheless, not

withstanding these developments, we are considerable distance (as are many UK hospitals) from meeting the Francis 244 standards. The UK's ambition for all hospitals to be paper-light and using EPRs by 2018 is seen by many as being optimistic. A similar timescale is likely to apply to the Isle of Man, and will depend on funding.

Care Pathways ensure that patients receive the right care, in the right place, by the right person, at the right time. Clinical pathways, also known as care pathways, critical pathways, integrated care pathways, or care maps, are one of the main tools used to manage the quality in healthcare concerning the standardization of care processes. It has been shown that their implementation reduces the variability in clinical practice and improves outcomes. Clinical pathways promote organized and efficient patient care based on evidence based practice. Clinical pathways optimize outcomes in the acute care and home care settings.

Generally clinical pathways refer to medical guidelines. However a single pathway may refer to guidelines on several topics in a well specified context. More than just a guideline or a protocol, a care pathway is typically crystallised in the development and use of a single all-encompassing bedside document, that will stand as an indicator of the care a patient is likely to be provided in the course of the pathway going forward; and ultimately as a single unified legal record of the care the patient has received, and the progress of their condition, as the pathway has been undertaken. An integrated care pathway includes the pathway within the clinical documentation, allowing early identification of patients deviating from the pathway allowing early intervention to return to optimal care. In addition they allow retrospective auditing of pathway concordance. ICPs represent an important step in patient safety and quality assurance. MI&T have been involved with establishing several such pathways within primary care but they need expansion to cross into secondary care. However, this too requires a secondary care EPR system capable of such functions.

Recommendation 245 *Each provider organisation should have a board level member with responsibility for information*

The Director of MI&T attends Nobles Executive Team meeting, and the CCIO attends the Department's performance and delivery group. The Director reports to the DCEO. The concern with this arrangement is that the Director is not directly involved in production/analysis of information and is therefore remote from the understanding of its interpretation. This limits to some degree the support given to the Nobles Executive Team. The Director has previously suggested that a member of the information team accompany him to the meetings but this has not been accepted by the hospital management.

Increasingly there is a move towards evidence based policy making in government. However, there remains no-one in a board level post with direct responsibility for information, and it is not inconceivable that the Senior Leadership team may receive conflicting information from different sources, and not be in a position to determine the relative validity of the interpretations. Equally, there is no clearly defined cross-department quality assurance system with a clear leader, whose only focus is on

the quality of the service being provided, who has sufficient authority to "get things done."

While it is an easy matter to add the role of responsibility to one of the existing senior team, doing so ensures that information management will remain subordinate to their "day job," rather than becoming an integral part of the business.

Recommendation 246 *Comparable quality accounts*

At present, neither the hospital, nor the department publish a document similar to the English "Quality accounts." (See http://www.medway.nhs.uk/about-the-trust/publications/quality-accounts/ for an example of Quality Accounts). Much of the information contained in such documents is available via iHub. If the recommendation to produce and publish comparable quality accounts in England comes to fruition then it will provide useful data for benchmarking our performance in relation to patient safety.

Recommendation 247 *Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators*

Any quality surveillance mechanism will require this or similar action – implying that there will be publication of our local quality account. Recent moves towards a public facing iHub are the first steps towards such publication

Recommendation 248 -251 *Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.*

By using a single source of information provision, sitting out-with the actual provider units the Department has taken reasonable steps to ensure validity. It must remain the information team's role to "speak truth unto power."

The lack of CQC/Monitor oversight does mean there is a weakness in external scrutiny. This was, at least in part, the impetus around the Quality Surveillance Group proposal

Recommendation 252 *Access to data*

We already ensure that properly anonymised data is available as required

Recommendation 253 *Access to quality and risk profile*

See previous comments re publication of public facing version of iHub which will have much of the information contained within Quality Accounts. However, the Department is not allowed to publish public-facing pages without working through PDMS, who have quoted in the region of £1800 for this single webpage. Given the

volume and frequency of information provision, at this frankly extortionate rate (where the work is already done) will prove expensive

Recommendation 254 *Access for public and patient comments*

We do not provide this at present. However it does not seem to be an overly onerous task

Recommendation 255 *Using patient feedback*

No formal mechanism in situ for this

Recommendation 256 *Follow up of patients*

A mechanism for this has been proposed to P&D – www.myclinicaloutcomes.co.uk – which would be free for us to use but there has been no decision to adopt such methodology

Recommendation 257-259 *Role of the HSCIC*

HSCIC provides national level metrics, that we use as comparators.

Recommendation 260 *The standards applied to statistical information about serious untoward incidents should be the same as for anyother healthcare information and in particular the principles around transparency and accessibility*

Although it is the Department's intent that information from its incident reporting system (PRISM) be reported via iHub this has not actually happened, despite the Hospital Manager's assurance that it would. The lack of both incident and complaint information may be the result of the current vacancy for the Risk Manager's role.

Recommendation 262 *Enhancing the use, analysis and dissemination of healthcare information*

Until the formation of the MI&T Directorate the Department has been significantly underperforming in this role. The production of operational data amounting to some 70-100 pages per month had been the focus of the hospital's information team, there was no attempt at benchmarking or comparisons with other providers/communities, and no attempt to collate information from across the health economy with data siting in silos, in the hospital, public health, primary care, and community services.

Following the formation of MI&T the information team increased from 2 wte to 2.8 wte – the difference being an ex-GP with health informatics interest/experience. This has allowed some of the previously noted deficiencies to be addressed. However, the team is too small for the potential demands, a fact acknowledged by the MIAA report. It not only attempts to replicate the information functions of a UK hospital Trust, but that of a PCT, and some of the functions of the HSCIC.

There remain issues with the underlying data. In short, until the hospital is managed and structured in a comparable manner to an English hospital trust, the data will remain incomplete at best, and in many areas, deficient. Analysis of such

data requires understanding of the weaknesses present, and findings are often not directly comparable with the UK. No amount of analytical input can make up for the current lack of data.

See previous comments relating to structured clinical audit

Recommendation 263 *It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.*

This has not been a noticeable problem locally

Recommendations 264-267

Relate to central reviews, which we can follow but have no direct influence over

Recommendation 268 *Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.*

It will be apparent from the foregoing that resources are a significant issue. The MIAA report (q.v.) recognised that the MI team was smaller than comparable organisations. If it is to meet the needs placed upon it, it will need expansion, especially in the CCIO is to be able to undertake the wider elements of such a role.

However, the resource issue is not confined to the MI team. As alluded to previously, there are issues with coding capacity, and management infrastructure that will also need to be addressed.

Recommendation 269 *The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.*

The MI team constantly reviews the data and information inputs and outputs. However, there really is no mechanism to audit the underlying data, or the quality of output.

Recommendations 270-272

Relate to central reviews, which we can follow but have no direct influence over

The Keogh review

On February 6 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review.

Although the 14 hospital trusts covered by the review were selected using national mortality measures as a "warning sign" or "smoke-alarm" for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations. The review considered the performance of the hospitals across six key areas:

- •mortality
- •patient experience
- •safety
- •workforce
- •clinical and operational effectiveness
- •leadership and governance

Subsequently it has been confirmed that the new Chief Inspector of Hospitals will base reviews on the data packs used in Keogh. An example of which can be found at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-basildon-and-thurrock-data-packs.pdf

Ideally we should be attempting to emulate such provision, and it is worth considering the contents of the packs. Using the example, it is salutatory to compare the main information pages, slide by slide.

Slide 6 – 7. We are likely to be able to populate these with relative ease

Slides 8 – 12. Fall within the Public Health function and is essentially a full public health profile. Although this profile exists http://www.nwph.net/applications/iom/iomprofile.aspx it is not updated in a regularly. It is deficient in a number of significant ways from the latest Public Health Outcomes Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226861/List_of_data_in_August_2013_update_FINAL2a.docx

Slide 13 – We already report these

Slides 14 – 37 Relate to mortality figures which have already been discussed

Slides 40-42 Patient experience and complaints – we do some of the surveys needed – but see previous comments re complaints

Slides 45-49 Patient Safety – we do something similar for most (although not all) of these areas

Slides 50-56 Workforce – mostly covered

Slide 62 Clinical Effectiveness: National Clinical Audits – of the 18 indicators we have data for perhaps 3 or 4

Slide 63 Clinical Effectiveness: Clinical Audits – PROMS – see previous comments re PROMS

Slide 64 Operational Effectiveness – A&E wait times and Referral to Treatment (RTT) times – we do not produce RTT information as the underlying data is not recorded – it should not be difficult to do, but requires the will to do so, and the clinical engagement to ensure it is done

Slide 64 Operational Effectiveness – Emergency Re-admissions and Length of Stay – we produce these and benchmark already

Conclusions

The position today is much better than it was 12 months ago, with the Department now having an agreed management information framework and system. However, there are still areas that need addressing:

- Information is a key business asset for the Department and requires the same leadership, and management as any other asset
    - Having adequate information is key pre-requisite for clinical quality assurance in the 21st century. Patient safety depends on information and patient safety assurance depends upon information systems.
    - The Department must decide what information it is actually going to collect for management and patient safety purposes and to allow comparisons – an information needs audit. If we are to compare our performance to England we must collect the data in the same way, which will require a similar infrastructure.
    - The Department has lacked an "information culture" and until recently an understanding of the potential power of information/informatics. Evidence based decision making has not been possible – due to lack of information.
    - Information leadership is key to progress and should be embraced at a senior level in the Department
- Information for quality assurance should be pro-actively sought not re-actively collected
    - While quality should be everyone's business, this may mean it's no one's business. There needs to be a clear leadership of the Quality and Safety agenda with sufficient credibility in both clinical and management domains, and sufficient authority to make things happen. There are considerable synergies between the leadership roles for quality assurance and information. The proposed Quality Surveillance Group would be a considerable step to filling this need
    - Clinical audit needs to be directed, with clear requirements to undertake the various national audits, with the information from these widely disseminated and action plans not only formulated but monitored.
    - The collection of "soft intelligence" to inform the Quality surveillance process, may be impeded by very hierarchical structures seen in the Department, which does not reflect the much flatter integrated structures that have emerged in clinical teams.
- Any information system is only as good as its data, and there are considerable gaps in our data.
    - A lack of both resources and clinical engagement has meant that much of the data that could/should be captured within the hospital as a by-product of routine clinical workflows is not.

    - Clinical information should be entered at the point of care and the systems must make clinicians jobs easier, and include early warning "flags" etc. It follows that the Department must adopt a full secondary care EPR. Double entry into a clinical record (paper or electronic) and a separate management information system (eg a coding form) is dangerous and to be avoided.
    - Coding coverage and quality must be enhanced
    - It remains the case, as already stated, that until such times as the hospital is managed, and structured in the same way as an UK hospital, there will be difficulties in comparing our data
- There is a need to enhance the capacity for analysis and interpretation of information within the Department
    - Interpretation, analysis, and presentation requires both knowledge of the data (and its weaknesses) and the clinical context. It is largely therefore a local function
    - There are insufficient resources within the present MI team to manage further significant expansion of information provision. This is acknowledged by the MIAA report, and further exacerbated by the fact that the CCIO is effectively working full time doing information management roles to the exclusion of other areas. The team is already exploring automation in terms of the data extraction and reporting processes, and the benchmarking process is considerably automated already
    - We lack data which in the UK would come from central sources such as the Office for National Statistics. This is particularly affecting our access to public health metrics, allowing population based comparisons.
    - Consideration should be given to "buying in" support from HSCIC etc to support the more complex analyses such as the Mortality indicators.
- Public accessibility is a major part of transparency within health quality assurance
    - The Department is moving towards publishing information, with explanations of how to interpret it
    - However, the complexity of the procedures (not to mention the expense) mitigates against such initiatives and the Department needs to consider whether it can influence/by-pass the central process

Background

- While both primary and secondary care have quality assurance mechanisms in place, there is no overarching mechanism for the Department to be assured that services are being delivered across sectors with an emphasis on quality
- There is much good work being done at all levels in the service, but co-ordination is at times lacking, and the approach to quality assurance tends to remain within organisational silos
- The modern healthcare environment, with increasing moves towards, patient empowerment, openness and transparency means that the Department must embrace such changes, to assure itself, and its stakeholders, of the quality of services it provides

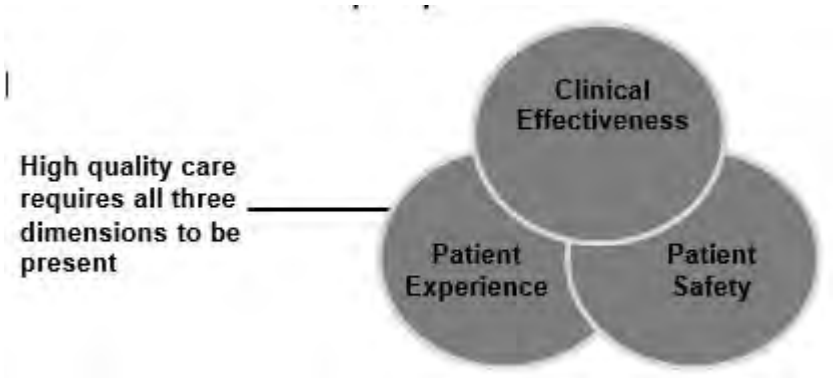
What is quality in health services?

A single definition of quality for the NHS was first set out in *High Quality Care for All* in 2008, following the NHS Next Stage Review led by Lord Darzi, and has since been embraced by staff throughout the NHS and by the Coalition Government.

This definition sets out three dimensions to quality, all three of which must be present in order to provide a high quality service:

- **clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- **safety** – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and
- **patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

FIGURE 1: Definition of quality



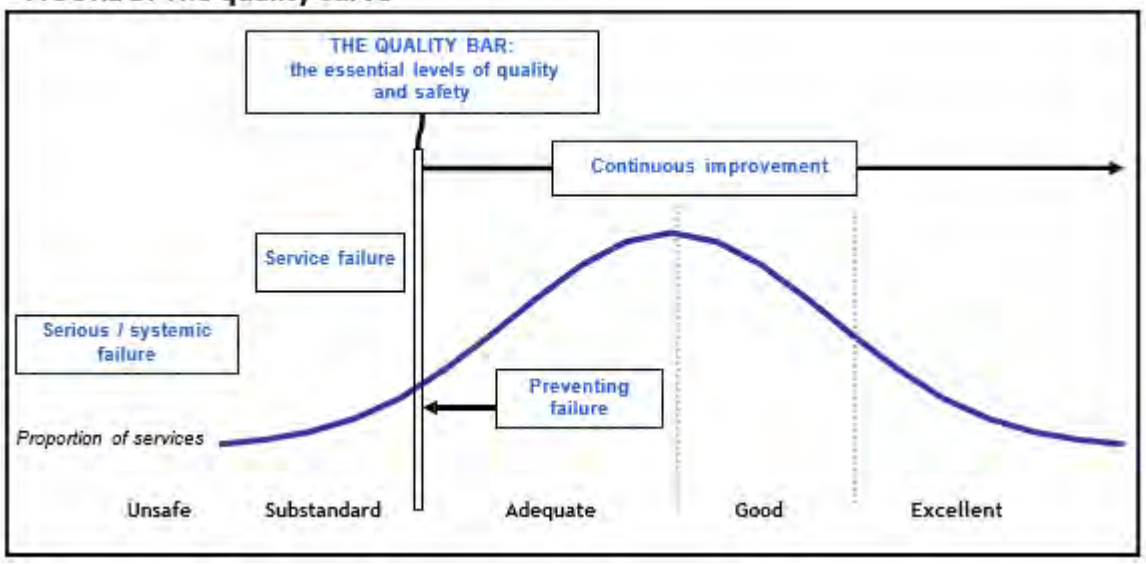
Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals, provider management, commissioning, professional regulators and the Department of Health. The system's collective objectives in relation to quality are to:

- ensure that the essential standards of quality and safety are maintained; and
- drive continuous improvement in quality and outcomes.

The quality curve illustrates the challenges:

1. To determine the level of the quality bar
2. To ensure that our services are uniformly above that level
3. Prevent subsequent failure
4. To foster continuous improvement

FIGURE 2: The quality curve



Whose line is it anyway?

- Individual health and care professionals, their ethos, behaviours and actions, are the first line of defence in maintaining quality.

- The leadership within provider organisations is ultimately responsible for the quality of care being provided by that organisation.

- The Department is responsible for ensuring services that meet the needs of the island's populations and must be assured of the quality of care

- The NHS in England has a number of regulators, including the CQC, and Monitor, which do not exist in the Isle of Man. This in turn increased the burden on the other components of the quality surveillance mechanisms

- All involved should share information and intelligence on the quality of services in an open and transparent way, and take coordinated action where appropriate in the event of an actual or potential quality failure.

The need for a Quality Surveillance Group

Across the health economy, there is a wealth of information and intelligence, gathered formally and informally, about the providers of services to that population. Often the information that one party alone has will not cause concern. However, when combined with intelligence that, for example, a regulator may have, might point to a potential problem that should be investigated further.

Such information has tended to be in silos. The Department has taken steps to ensure that management information is provided from a single source – the iHub, and it is proposed to extend this mechanism to include clinical quality. It is proposed that the Department establish a Quality Surveillance Group to co-ordinate the quality assurance activities in the island. It will be a proactive forum for collaboration, providing the health economy with:

o a shared view of risks to quality through sharing intelligence;

o an early warning mechanism of risk about poor quality; and

o opportunities to coordinate actions to drive improvement

The QSG will act as a virtual team across the health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, existing clinical governance, audit and regulatory activities. By collectively considering and triangulating information and intelligence, the QSG will work to safeguard the quality of care that people receive.

The scope of the QSG

QSG will look to answer questions such as:

- What does the data and soft intelligence we have tell us about where there might be concerns about the quality of services being provided to our community?
- Where are we most worried about the quality of services?
- Do we need to do more to address concerns, or collect information than we are already?
- Where is there a lack of information and so a need for further consideration and/or information gathering?
- How do our services measure up when compared to existing UK national quality standards (eg. NICE quality standards, National Cancer Audits etc)?

The aim is therefore, is not to supplant existing clinical governance, complaint and audit mechanisms but to ensure that there is a systematic approach to the quality in service delivery across all sections of the health economy.

Membership of the QSG

- The Medical leads from Nobles, Primary Care, and Mental Health
- Nursing leads from all three areas
- AHP leads from all three areas
- CCIO/Management Information team representative
- Clinical audit leads from the three areas
- Clinical Governance Leads from all three areas
- Director of Healthcare Delivery
- Director of Public Health
- Member of HSCC

The QSG's role – delivering The Quality framework

The work of the QSG is to deliver the quality framework across the Department.

1. Bring clarity to quality – there must be clear and accepted definitions of what high quality care looks like, which patients, and providers can unite around. The National Institute for Health and Care Excellence (NICE) produces **NICE Quality Standards** setting out what high quality care looks likes for a particular condition, pathway or patient group, covering the majority of care that the NHS provides. They will be aspirational, yet achievable, supporting the whole system in striving for excellence. As such, the Quality Standards of today will need to become the essential standards of tomorrow. The NHS Commissioning Board has agreed to extend the existing range of these for the UK NHS. The IOM QSG must localise these standards in order to achieve realistic service standards for our island.

2 & 3. Measure and publish quality – the system can only hope to improve what it measures. There must be robust, relevant and timely information transparently available on the quality of care being provided at every level of the system. This information should be used to drive quality improvement at the front line. The Department has developed its management information iHub, and this is to be expanded to include clinical governance and quality measures in a systematic manner. All directorates and their clinical teams should be drawing on the wealth of comparative quality indicators, including from **clinical audits**, to drive improvement across all services. All measures of quality at every level of the system, must be made transparently available. The QSG will produce an annual report, and provide a statement of assurance to the Department, and Minister, within it reasonable ability, that providers are meeting required quality standards.

4. Reward quality – the Department will develop mechanisms to reward quality service provision. Celebrating success, and replicating good practice are fundamental components of the quality agenda. The QSG and Department will explore in greater depth how to reward quality

5. Leadership for quality – leadership is essential for quality improvement to be embedded, encouraged and rewarded. The QSG brings together different parts of the system to provide leadership for quality, ensuring that there is alignment between how the different organisations carry out their responsibilities. The Clinical Recommendations committee's role in ensuring clinical effectiveness is a key ingredient for success. The Department has been increasing the level of clinical engagement in a number of areas, eg with respect to waiting times, and the QSG must consider the possible mechanisms to increase such engagement, such as Clinical Senates being former in the UK. Professional bodies and Royal Colleges have a critical role to play in supporting healthcare professionals in their pursuit of delivering high quality care and in setting standards for service delivery. Although there are clear mechanisms for clinical leadership in the hospital setting, these are far less clearly defined in primary and community services, due to their diverse nature. Nonetheless, clinical leadership must be fostered in these environments.

6. Innovate for quality – continuous quality improvement requires health services to search for and apply innovative approaches to delivering healthcare, consistently and comprehensively across the system. In addition, the unique circumstances of the island, offers both challenges and opportunities to innovate. Innovation requires some degree of controlled risk, and in such circumstances, failure is a necessary feature. Nonetheless, such innovation must be controlled in such a manner to ensure no reduction in existing quality or patient safety. The UK NHS is proposing **Academic Health Science Networks** to bring together the local NHS, universities, public health and social care to work with industry to identify and spread proven innovations and best practice to improve the quality and productivity of health care. The island has a number of features that makes it well suited to such approaches, and the Department should consider establishing itself, via the QSG, within such networks.

7. Safeguard quality – Any system that strives for quality improvement must, at the same time, ensure that the essential standards of safety and quality are maintained. In respect of individuals, the professional regulatory bodies already publish and regularly update clear standards of competence and conduct for regulated health and social care professionals. The QSG has a key role in preventing, identifying, and responding to quality failures. Each part of the system must fulfil their distinct roles and responsibilities in relation to quality, as well as working together in a culture of open and honest cooperation in the best interests of patients.

Recommendations / Conclusions

1. There is a need for a Department wide approach to clinical quality

2. There is both opportunity and challenge arising from the island's geographic and constitutional position

3. The Department will create and support, a clinically led Quality Surveillance Group

4. The QSG will lead the quality agenda, ensuring robust quality standards are set, monitored, and met

5. The QSG will produce an annual "statement of assurance" relating to the quality of services provided on-island.

DEPARTMENT OF HEALTH

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