Isle of Man Government
Reiltys Ellan Vannin

COUNCIL OF MINISTERS'

INDEPENDENT REVIEW OF THE ISLE OF MAN HEALTHCARE SYSTEM

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

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

Background

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

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

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

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

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

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

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

DHSC funding presents two distinct challenges:

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

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

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

Terms of reference

Objective

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

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

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

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

Governance

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

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

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

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

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

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

Scope

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

Review areas

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

Review questions

- To what extent is the current funding provided for the range of DHSC services realistic?
- How might the funding requirement change over the next 15 years?
- How can primary, secondary and tertiary healthcare assets be used better, and what new investment in these areas might be needed?
- To what extent should partnership and co-production with other public services, local authorities, the charitable sector and the private sector play a part in the delivery of healthcare services in the Isle of Man?
- Is the principle that health services should largely be free of charge still valid, and what sort of alternative system might be appropriate for the Isle of Man?
- Should charges for services be extended in scope, or should free of charge services be made available on a means-tested basis?
- How would the introduction of a healthcare system other than the National Health Service affect the quality and the sustainability of services provided by the DHSC?
- How can financial stability and sustainability be ensured without compromising the quality of care?
- What system would help determine where money should best be spent: e.g., should the Isle of Man move towards an English commissioner - provider model or other forms of delegated financial management systems?
- Should changes be made to current funding and co-payment methods: e.g. a hypothecated health tax, increases in National Insurance Contribution rates, lifestyle ("sin") taxes etc.?

Reporting

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

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

Approved by Council of Ministers
22 March 2018

Annex 1

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

Chris Robertshaw MHK

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

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

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

Clare Bettison MHK

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

Juan Watterson SHK

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

Dr Alex Allinson MHK

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

Bill Henderson MLC

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

Bill Shimmins MHK

In terms of the review, we tend to look at the UK NHS model. I question, is this sensible? We all read the newspapers, we all switch on the television every night. Simon Stevens, the Chief Executive of the UK NHS said that it can no longer do what it is being asked to do. It feels misguided to operate a smaller clone of a failing system. There are other models in Europe which are delivering better outcomes. As such, I would ask that these are explored by the review. The assumption that the Health Service is free has been mentioned a few times already today, and that is absolutely understandable – it is a very dearly held mantra by many people. I think we need to test that. Is it realistic, given the ever-increasing costs for drugs and treatments? It is not the case in Ireland, France and Germany, where patients who are able to do so make a contribution to the cost of their care. To be sustainable, I would suggest that the review needs to cover this point.

Daphne Caine MHK

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

Michael Coleman MLC

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