Health Services Consultative Committee Annual Report

1 April 2014 to 31 March 2015

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Chairman's Preface

This is the third Annual Report of the reconstituted Health Services Consultative Committee (HSCC) and covers the 12-month period from 1 April 2014 to 31 March 2015.

The previous HSCC annual report (2013-14) commented on the difficult period the former Department of Health was navigating its way through and the challenges that needed to be overcome. Whilst the challenges are in some cases different, the same could be said again this year. The Department has been completely restructured from 1 April 2014, taking back into the structure adult social care, children's and families services and housing services. These services fall outside the scope of the HSCC for comment, but we recognise that again the Department has been faced with significant challenge and change and that in taking on new service areas the focus on health services improvement has been diluted.

During the reporting period the Department has seen a large number of leadership changes, as many of the previous Senior Leadership team left, a new structure was implemented and a new team appointed. Whilst it is evident from our engagement with the new Senior Leadership team that progress is starting to be made, this has not been as quick as we could have reasonably expected. There is also minimal evidence that ongoing progress is visible to the Department's staff and patients, in particular with regard to the direction of the Health Services on the Isle of Man; the previous Health Strategy appears to have been put to one side and yet to be replaced by an alternative.

It is imperative that the Department and the Leadership team deliver on its promises so that the staff and patients can have confidence in the long term future of the Health Services provision. This must start with the new Strategic Vision for Health, originally expected at the end of this reporting period, and now planned for launch in the summer of 2015. Despite the strong commitment of staff it is items such as this that cause much frustration.

The provision of a sustainable Health Services for the Isle of Man must remain an area of high priority for the Manx Government, with the political intervention focused on policy issues and strategic direction, allowing clinicians to be free to make the clinical decisions necessary to deliver appropriate health care.

The changes within the Department during this period have had an impact on the HSCC and how it discharges its responsibilities. As a result a revised methodology with member links to Department officers will be employed during the period 2015-16. It is hoped that the revised approach will enable the HSCC to provide the Department with the best level of support, challenge and independent advice possible.

Set out within this Annual Report is the summary of the HSCC's work in 2014-15, along with a number of recommendations highlighted through our work with various committees and forums within the Department. The HSCC will review and monitor progress of these recommendations during 2015-16 and provide a summary of action against the recommendations in its annual report 2015/16.

With the Department's Senior Leadership Team now in place, Implementation of Quality Improvement Recommendations firmly on the agenda and with appropriate political support for change, it is hoped that 2015-16 results in a demonstrable and significant move forward for the Department. In discharging its role of independent challenge, advice and consultation, the HSCC look forward to working with the Department in supporting their progression in 2015-16.

As Chairman I would like to thank the outgoing Chairman, Derek Legg, for many years of service, members for their active involvement and contribution and Ms Nikki Sharpe, our long-serving secretary to the committee.

John Whitehouse, Chair – Health Services Consultative Committee
31st May 2015

Executive Summary

The purpose of this Annual Report is to provide Tynwald members and the Department of Health and Social Care with independent scrutiny and advice on the operation, performance and effectiveness of the Health Services. As a publicly appointed body under the National Health Services Act 2001, the nine lay members of the Health Services Consultative Committee (HSCC) are tasked under the Act with 'tendering to the Department views on any general matters relating to the Service. The Department shall have regard to any views given by the HSCC'.

The period covered in this report (April 2014 -March 2015) has seen significant changes to Senior Management and Departmental structures within the Health Services, combined with a strategic rethink of how services are to be provided on the Island. Added to these changes the Department received the first four West Midlands Quality Review Service Reports (WMQRS). New and existing senior staff have started in 2015 to address the findings of these Reports.

Whilst the HSCC appreciates and understands the need for this complete restructure, it has limited the ability of the HSCC to provide a detailed and regular level of scrutiny in some key areas. During any transitional period, it is vital to maintain a level of consistency and there have been times that the HSCC has felt that Health Services have struggled to do this.

Notwithstanding the changing face of the Health Services over the last year, the HSCC Annual Report includes: an outline of the work of the Committee in 2014-15 and intentions for 2015-16; detailed Member Reports provide accounts of areas of scrutiny; and recommendations to the Department for improvements. The following summarises the HSCC's view of the key areas of concerns and successes in the Health Services.

At the end of the period covered by this report, the strategic direction of the Health Services remains unclear. The ten-year Health Strategy (2011) appears to have been marginalised without an alternative taking its place, although a draft Strategic Vision has been drawn up for consultation. Even so, the HSCC still thinks that there has been too much of a strategic policy vacuum.

As with any large organisation, challenges exist in the Health Services with regard to the measuring and monitoring of performance and financial information, the volume of data and access to funding and its distribution. These are areas that the HSCC feels are affecting service levels, with no clear strategies to mitigate their impact.

The large number of Committees within Health Services is also an area that needs to be addressed, particularly their structure and to whom they report. With no clear structure, the HSCC representatives and the Health Services staff themselves who attend the various meetings are often unclear as to how the Department is coordinating its functions and activities. To further complicate matters, there is an increasing tendency for certain meetings to be ad hoc or cancelled and in some cases certain Committees seem to have been unofficially disbanded.

The stated intended transition from Acute to Community care has not yet materialised in practical service delivery. Known operational issues in areas such as recruitment and retention, bed blocking, waiting lists, housekeeping and porter services continue, although there is evidence of change to address some of these matters. Some new initiatives have tended to be short-term ones that have helped alleviate some immediate pressure on the above, but do not really offer any realistic long-term solution.

Despite underlying feelings of uncertainty, there has been a general positive attitude observed from most staff who have continued to work together and focus on their operational responsibilities. There have been notable areas of success such as; improved listening to the patient through the Patient Safety/Satisfaction Walks; the positive role model for provision of Intermediate care provided by the Ramsey Cottage Hospital; front line staff encouraged to identify, report and learn from incidents and complaints; a new drive to recruit nurses and encourage returnees/students to the Island; Mental Health services appearing to make strategic progress; the use of tools such as Clinical Audits and the establishment of an in Quality Improvement Programme Board chaired independently.

As the year unfolded, it became clear to the HSCC that its core work with Senior Officers and Committees was not happening because of staff changes and meetings being sporadic in many areas. This break in working practices meant that the HSCC's method of bi-monthly Escalation reporting to the Department on areas of concern would no longer work.

The HSCC as in previous years took the opportunity to review mid-year the way it had been working and its priorities. This review has resulted in the HSCC adopting a new, focused and strategic approach for the coming year. As from April 2015, the HSCC will view the Health Services through a number of Strategic Pathways and Enablers.

For Example:

- A Strategic Pathway such as a Strategy for Health that moves from a service focused on treatment of illness in hospital to one promoting good health and supporting patient's recovery in the community; and
- An Enabler such as Leadership that supports progress along the pathway setting the strategic direction, governance structure and accountability.

See Appendix A for further information

Key Recommendations:

The Health Services Consultative Committee offers a number of recommendations regarding delivery of health services to what is now the Department of Health and Social Care.

1. It should be explicitly and publically stated whether the 10 year Health Strategy from 2011 is still valid and active. If there is to be a new vision and strategy for the future shape of health in the Island it should be produced with patients, community groups and staff in an engaging consultation process and with the HSCC's involvement from the early stages.

2. The infrastructure of Primary Care must be sufficiently resourced and appropriately funded to enable it to deliver more services within the Community, and the transfer of services from Acute to Community Care must be done in an open and transparent manner.

3. Staff, patients and the public need to be fully involved in the new vision of integrated health and social care, with the idea of a collective ownership of health care being promoted to avoid undermining the motivation and morale of staff.

4. A broader range of methods including Patients Safety and Satisfaction Walks should become a structured part of engaging the patient and staff voice.

5. Recognition to be given to the importance of social, mental and spiritual wellbeing in the process of recovering from illness.

6. Acknowledge and act to mitigate the impact of change and uncertainty on the Health Services Staff and its potential impact on patient care.

7. Clarification of how Public Health will be able to fulfil its task in any new strategic vision for health services.

8. Business cases and funding for health improvement should be discussed with Treasury to facilitate the release of funds from the Health Improvement Fund. The health budget should be rebuilt using zero-based methods and the conditions of the £4.1m Health Improvement Fund reviewed.

9. Political intervention concerning Noble's Hospital should focus on policy issues and strategic direction of health services, leaving the clinicians free to make clinical decisions on patient care.

10. All initiatives coming from the West Midlands Quality Review Service reports should be communicated widely with the Department focusing on the management and tracking of these initiatives to ensure maximum benefit.

11. Ensure a comprehensive approach to health and wellbeing, and increase and improve collaborative working practices across health and other agencies.

12. Conduct an overhaul of Health based Committees and their meetings in the Department in order to determine their purpose and structure, streamline decision making, clarify accountability and avoid duplication and gaps.

Further recommendations are outlined within the HSCC Member Reports.

Role of the Heath Services Consultative Committee

What is the Health Services Consultative Committee (HSCC)?

Formed under the National Health Services Act 2001, and re-constituted under the Health Services Consultative Regulations 2012 that came into operation in August 2012, the HSCC is required to produce an Annual Report to the Department and to Members of Tynwald on the discharge of its functions under the Act and under the regulations.

The HSCC is a body of nine lay people appointed by the Appointments Commission to support the Isle of Man Health Services by providing independent scrutiny and advice on the operations, performance and effectiveness of the service. Vacancies on the committee are advertised and following interviews, successful members are elected for a three-year term up to maximum of nine years.

Members take responsibility for looking at specific areas of Health Services activity, attending appropriate Health Services meetings, reviewing documents, offering advice and highlighting problem areas. Members report to the HSCC monthly and, through the HSCC to the senior officers and Minister. The role is described as that of a 'critical friend'.

Membership

The following have served as members of the HSCC in the past 12 months:

- Derek Legg, Chair (completed service January 2015)
- John Whitehouse, Vice-Chair
- Colm Andrew (from February 2015)
- Liz Godby (to March 2015)
- Sue Gowing
- Diane Kelsey
- Dawn Kinnish (to August 2014)
- Linda McCauley (from February 2015)
- Dawn Mayor
- Malcolm Norris
- Andrew Swithinbank

HSCC Scope

Drawing upon the breadth and depth of its members' diverse knowledge and experience in business, public services and the community:

1. The HSCC will provide independent scrutiny of the performance of the management of the Department of Health.

2. The HSCC will provide the management of the Department of Health support, challenge and advice in the effective management of the Department.

3. The HSCC will represent the view of people of their community.

4. The HSCC will hold the organisation to account for decisions that the Department makes.

The HSCC should focus upon: WHAT the Department does, WHY it chooses certain strategic priorities and HOW the Department achieves these.

HSCC Out of Scope

The HSCC will not:

1. 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 Quality Forum or patient representatives.

2. Look to measure the performance of the clinical effectiveness of the Department as it is not qualified to do so.

Department of Health (DH) Committee representation

COMMITTEE or SERVICE AREA	HSCC representative	Alternative representative
Performance and Delivery Group	Derek Legg	Sue Gowing
Nobles Executive Team	Sue Gowing	Andrew Swithinbank
Nobles Patient Safety and Quality Committee	Dawn Mayor	
Primary Care Patient Safety	Andrew Swithinbank	Sue Gowing
Clinical Recommendations Committee	Diane Kelsey	John Whitehouse
Community Health Executive Team	Dawn Mayor	Derek Legg
Mental Health Services	Liz Godby	Malcolm Norris
Steering Group for Strategy for future of Health Services	Andrew Swithinbank	Sue Gowing
Nursing and Midwifery Advisory Council	Diane Kelsey	Dawn Mayor
Public Health	Malcolm Norris	
DH Audit Committee	John Whitehouse	Diane Kelsey
West Midlands Quality Review Service	John Whitehouse	Derek Legg
Oral Health Stakeholder Group	John Whitehouse	

Alternative representatives often attended a meeting if the main representative was unable to attend. Changes were made during the year to suit requirements and available time of the HSCC members. Committees have also changed and representation of the HSCC on any Committee can cease, if it is considered that our presence is not adding any value.

The HSCC have made repeated representations to the Department about the need for a review of its Committees because of duplication and overlap and because of extended attendance by senior management at those meetings. HSCC has also commented on the limited benefit of some of the meetings. Similar observations were made by both the Francis Committee and the Beamans Report. Action to speed the review was expected because of the re-organisation of the Department in April 2014 but we regret to report that whilst meeting structures have been dismantled in many areas, a new structure with clear inputs and outputs has yet to emerge.

As a result the HSCC is taking steps to alter methods of engagement with the Department. Whilst the increase in attendance by the CEO at the HSCC meetings was appreciated and improved two way verbal communication has taken place, this does not fully address our scrutiny role in specific Department areas. As most formal written communication has ceased, consultation on proposals continues to be lacking and needs greater attention if we are to perform our activities to an acceptable standard.

Health Services Consultative Committee Engagement

Meetings and communication April to October 2014

In 2013, after alternate monthly meetings, the HSCC provided the Department with an Escalation Report which highlighted areas which the HSCC found concerning and sought clarity and/or further exploration at senior level. This was sent to the Chief Executive and was circulated by him to all of the Senior Leadership Team including the political Member for Health, advising of its concerns and requesting explanations.

Following the regime change in April 2014 and the Interim CEO's arrival, the HSCC maintained cordial relations and continued to attend a wide range of Health Services committees until July 2014. However the hiatus in the Management structure soon began to reflect upon our ability to scrutinise across the wider range of Health committees. Members were communicating back their concerns about cancelled meetings, a sense of confusion and uncertainty amongst attendees when meetings were held, all affecting meeting performance/outputs.

After six months of observing reductions in frequency and quality of some meetings, the HSCC re-considered its method of working in order to become more effective in its scrutiny role. HSCC believed that some Committees now need urgent review. We adjusted to suit current changing circumstances by increasing the number of 1 to 1 communications already employed by our Nobles, Public Health and Mental Health representatives, and extended them into the Department itself. HSCC expected an outcome from a Review of Committee structures in September 2014 – disappointingly a review that still remains incomplete.

Part of our remit is to be consulted by the Department on proposed legislation and other matters and whilst we saw a draft Leadership Blueprint on new Senior Management Structure in August 2014 and a proposed revised "Our Plan on a Page Department Strategy", we have seen little in the way of actual legislation in its formative stages.

Mid-Year Review November 2014 and changes to the HSCC approach

When the HSCC formed it undertook to review periodically its own approach to ensure that it was able to continue to discharge its responsibilities. At no other time has the need to do so been more pressing than during this period. With the departure of the previous Senior Leadership Team, the gradual introduction of new senior posts and the resulting structure changes and the hiatus created as a result of standing meetings being cancelled, a different approach was most definitely needed.
Following a review of the HSCC Escalation reports covering the previous 18 months the main areas of concern for the HSCC were pulled out and summarised under the headings of Strategic Pathways and Enablers.

Strategic Pathways: areas of the Health Services where the HSCC has previously raised concerns that the HSCC feel more strategic action is needed to create a clear direction of travel from the current position to a future state

Enablers: largely operational functions that underpin the desired change and are required in order for the Department to move forward.

The full list of considered Strategic Pathways and Enablers are outlined in Appendix A.

The HSCC therefore:

- continued wherever possible it's input to committees and groups albeit several were disbanded or met infrequently in the period;

- stepped up alternative and additional ways to liaise with and influence Health Services by, for example, meeting 1:1 with key players with significant responsibility for operational and change management , and participating in visits to areas of Health Services provision to talk to front line staff about safety and to patients about their experience;

- Undertook a process of ranking Strategic Pathways and Enablers according to the areas of member concern identified in the mid- term review and listed below in Future ways of Working section. We ranked them according to the following criteria;
    - how we judged the importance of the issue to the delivery of an effective and high quality service;
    - where our individual and collective expertise and experience could best contribute;
    - where the HSCC could make the greatest impact.

The HSCC was pleased that during this period the Chief Executive and Executive Director of Health responded positively to every invitation to attend the HSCC. When attending they answered questions on current changes and intentions and shared with us a draft document Strategy on a Page and plans to form an effective management team and infrastructure to take the Department forward. In these sessions the HSCC seemed appreciated as a "critical friend" and the new strategic approach appeared to take into account many of the issues we had raised in the previous annual report (2013-14). However, we did not necessarily feel that we were involved at an early stage, and our diverse expertise and experience in the public, business and community optimised in the origins and evolution of a new vision and the plans taking shape during this period.

In operating primarily in this valued face to face dialogue with senior leaders the consequence has been an absence of written exchanges of the HSCC's highlighted concerns and Health Service's formal response.

FUTURE WAYS OF WORKING

During the reporting period there appeared to be a hiatus in substantive development of Health Services and almost all Senior Management Team members and roles changed. It is evident that a period of significant transition is going to start in 2015-16 and so it was felt important to re-evaluate how the HSCC will operate and what it will focus on.

The HSCC priorities for 2015-16

As indicated in the previous section, the HSCC reviewed our identified key issues and areas of concern in health at our midterm review. The HSCC is a public appointed lay committee that needs to prioritise its scrutiny. Therefore the HSCC determined it would focus on the six Strategic Pathways which members had prioritised to explore further in 2015-16 and the six Enablers, which would facilitate the desired direction of travel in those strategic pathways.

Strategic Pathways

The prioritised Strategic Pathways, selected by the HSCC, will help focus on continued progress in 2015-16:

A Strategic Vision for Health
- from a service focused on treatment of illness in hospital, to one promoting good health and supporting patient's recovery in their community.

Health and Wellbeing
- from piecemeal campaigns, to evidence of improvements in mental and physical health.

Integrated Treatment Approach
- from operating in silos, to multi-disciplinary team.

Engaging the Patient Voice
- from a defensive response to public criticism, to involving patients in the design of services.

Culture and Business Change
- from a de-motivating blame culture, to empowered decision making.

Scrutiny and Governance
- from prescribed external inspection, to embedded activity.

Enablers

The prioritised Enablers, selected by the HSCC, will help us help us focus on continued progress in 2015-16:

Managing the political process
- giving Tynwald the confidence to determine policy and to let managers manage.

Leadership
- setting strategic direction, determining governance structure and accountability.

Community Issues
- devolving provision to localised community facilities.

Human Resources
- tackling absence, recruitment & retention and professional training.

Learning and Performance
- managing and continuously improving performance and learning from reviews, complaints and praise.

Noble's Hospital
- changing the role and nature of the hospital, to facilitate a new strategic approach.

How the HSCC intend to operate in 2015-16

In the past, it has served the HSCC very well to nominate individuals to particular committees. This has allowed the HSCC to deploy its input around the different decision making and managerial levels of the Health Services hierarchical structure and across the breadth and depth of its services. Through this the HSCC has been able to bring fresh eyes and alternative perspectives to these groups and to understand the inner workings of the Department and to make suggestions for improvements.

Moving forward the HSCC believe it needs to continue the process of combining this approach with other methods of understanding, contributing to and influencing health provision.

So in 2015-16 the HSCC intend to:

- Assign each priority strategic pathway and each enabler to an individual HSCC member.
- Link HSCC members to a relevant lead officer within the health component of the Department of Health and Social Care (see table below).
- Attend both on-going and one off management meetings as appropriate.
- Join quality assurance visits to front line services.
- Respond to consultations, particularly encouraging the Department to share outline proposals at the earliest stage.
- Engage in multi-agency think tanks, networks, community consultation exercises, etc. which will be helping to formulate a new approach to health.

In this way the HSCC believes it will be able to focus on key issues and bring its wide expertise and experience gained from activity in the public, business and community to bear, to help Health Services to improve and tackle the changing health challenges.

HSCC Member Link to Officer

Strategic Pathways	HSCC member	Department link
Strategic Vision	Andrew Swithinbank	Amanda Craig Director Strategy and Performance
Health and Wellbeing	Malcolm Norris	Barbara Hurt Director Health and Wellbeing Angela Murray Interim Director of Mental Health
Engaging Patient Voice	Andrew Swithinbank	Linda Radcliffe Chief Nurse
Integrated Treatment	Dawn Mayor	Iain Kewley Executive Director for Integrated Care
Culture and Business Change	Sue Gowing	Tim Mansfield Director for Commissioning
Scrutiny and Governance	Diane Kelsey	Michaela Morris Executive Director of Health

Enablers	HSCC member	Department link
Managing Political Process	Linda McCauley	Brian Deadman Deputy CEO/Financial Controller
Leadership/ Governance	Diane Kelsey	Michaela Morris Executive Director of Health
Community Issues	Dawn Mayor	Cath Quilliam Head of Community Health Services
Human Resources	Colm Andrew	Susan Nwanze OHR Partner for Health
Learning and Performance	Linda McCauley	Jugnu Mahajan Medical Director
Nobles Hospital	Sue Gowing	Barbara Scott Hospital Manager

The Chair of the HSCC, John Whitehouse, will link with the Minister, and CEO of DHSC and provide the HSCC representation on the Quality Improvement Programme Board.

HSCC Member Reports

HSCC members have produced regular reports during the reporting period, the key points of which are summarised here.

HSCC MEMBER: Diane Kelsey
AREA OF SCRUTINY: Clinical Recommendations Committee
ACTIVITY NAME AND MEETING FREQUENCY: CRC scheduled monthly, regularly cancelled.
PURPOSE OF INTERACTION: Senior clinicians and advisors meeting to discuss and agree changes to clinical and drug treatment as they may or do affect the Island.
HIGHLIGHTS: • Wide-ranging, open and frank discussion.
LOWLIGHTS: • Loss of many key members without replacement.
MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES? Not always; however, it was often used as an information-sharing meeting with decisions made and policy being set as required.
STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? Mostly strategic but not sure what 'teeth' the CRC has in enforcing their strategy as there was evidence that recommendations not always followed. Being a bit more operationally in touch may be advisable.
EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? Some but not consistent.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? Mostly.
SUMMARY: Informative forum making key decisions and setting clinical policy and priorities. It has felt as if the DH and health community in general did not fully or properly support the CRC or policies. Key Concerns: Lack of GP representative for a whole year. Loss of key advisory member with no replacement and now no clear investigative process for new ideas from the international medical community and NICE. Lack of Lay 2nd member to give resilience to the Exceptions Panel (but recently resolved).
RECOMMENDATIONS TO THE DEPARTMENT: • The CRC or better still the DH Executive Team should decide what the value of the CRC is in its current guise, how often it needs to meet in person and what business would be better conducted through a virtual monthly meeting. The associated Exceptions Panels should continue to meet face to face as often as required.

HSCC MEMBER: Dawn Mayor
AREA OF SCRUTINY: Community Health Services Executive Team
ACTIVITY NAME AND MEETING FREQUENCY: With Community Health Services (CHS) providing a number of different clinical services on the IOM, membership encompasses assorted Community Service Leads, HR Advisor, Public Health Consultant, Community Nursing, Ambulance Service, Ramsey & District Cottage Hospital (RDCH), a Lay member and GP representative. DH staff and stakeholders are permitted to attend the CHSET meetings for specific cause.
PURPOSE OF INTERACTION: CHS adopts a patient focused holistic view of healthcare, whilst seeking to improve the health and well being of the community by fostering collaboration with stakeholders, whether they be patients, public, 3rd sector or other Health and Social Care divisions. The team ensures to deliver CHS that are congruent with the 'Strategy for Health Services'. Delivering high quality integrated care, closer to home, which meets individual need, is innovative, flexible sustainable and value for money. Producing safe and effective services simultaneously improving the patient experience through an embedded open and transparent learning culture.
HIGHLIGHTS: • Customer Service Excellence Award granted, putting RDCH in the top percentage of companies for customer service provision in the UK. RDCH is seen as a positive role model in the provision of intermediate care, in that it provides an integrated pathway of services between primary and secondary care. • WMQR. Positive feedback was received from reviewers regarding CHS although some corporate governance, organisational and integration issues were raised. There is an identified need for co-ordination and establishing responsibility for implementing the recommendations and action plans arising from the WMQR, which it is hoped that the recently formed Quality Improvements Board will undertake. The issue of additional implementation funding needs addressing along with the implications for public perception of the overall process. • Risk Register is rigorously monitored and reviewed quarterly by CHSET, with each service maintaining its own risk register. • Prison Health Care. An overall review of healthcare provision maybe required, with the GP services currently out to tender. HSCC member was invited on a PSW within the prison and was impressed by the excellence of the healthcare provision. • Patient story. Looking at patients' journeys through the health/social care experience is a constructive exercise and is undertaken at each CHSET meeting, thus improving the patient's experience in the care environment. An example of such a story involved the discharge of a long stay patient to residential care which highlighted the need for provision of intermediate care and potential legislation. There appears to be an increasing number of individuals who are in a state of 'limbo', awaiting discharge from hospital to suitable care within the community. • The use of Patient Safety/Satisfaction Walks provides a beneficial tool for listening to the consumer voice and leading to programmed improvement of services.

LOWLIGHTS:

- Frequent absence of External Contracts Manager/GP representative. The relationship and communication between CH and external contractors, e.g. GP practises needs to be more robust with focus on a more integrated working relationship.
- HR/staffing. Discussion took place regarding the absence statistics, the main point to note was the increase from last year. An improved staff awareness of this increase is needed. There was an overall satisfaction with e-recruitment, however an area of difficulty appeared to be a lack of information on the system following interview. Ongoing problems with recruitment panels and the length of time it took to fill a vacancy remained problematic. Some difficulty is apparent in recruitment in some specialities, e.g. podiatrists, dentists resulting in creative use of available resources by managers and prioritising of service provision. Concern was expressed regarding the HR response times, the effectiveness of JobTrain and overall performance of a centralised HR Department. Mandatory training attendance monitored and is currently on target.
- Public Health. Due to recent changes within Public Health there is currently no representation at Executive Team, which is of concern. It is believed that a review of Public Health and Occupational Health would be undertaken shortly.
- Community equipment loan store provides equipment for patients in a rather piecemeal way. Highlighting a lack of tracking system, lack of facilities, lead management, budget and volume of equipment and staffing issues. The increased demand for community equipment is outstripping supply and reflects the public's rising expectations regarding healthcare provision.
- Centralisation. On-going concerns with centralisation of services, e.g. portering and the cost implications involving the transferring of laundry services from Ramsey and District Cottage Hospital to Noble's Hospital. Lack of clarity regarding centralised services is apparent with budgets going to the shared area without the necessary service level agreements having been put in place. "It was not clear that centralised government functions always gave an appropriate level of priority to community Health Services" (from WMQR draft report).
- Out of hours service (MEDS). It was noted that GPs were struggling, especially in relation to staffing MEDS, with 90% of the doctors at present being agency locums. A plan was being progressed to secure two salaried doctors, with the possibility of also bringing in nurse practitioners.
- Finance/business cases. Confirmation of budgets was slow resulting in an uncertainty in planning future service. Some budget areas have been transferred to central services leading to a further lack of clarity as to the process of payments. Primary Care is approximately £200,000 overspent, a large part of which is due to expenditure on MEDS agency locums. An overall Department overspend of £7m was indicated. Lack of feedback and information regarding business case outcomes was apparent and concerning.
- The gross under use of Jurby Health Centre and RDCH facilities, for example the operating theatre.
- Outsourcing of CHS. Cleaning – poor audit results highlighted on-going issues with the sub standard service of external cleaning contractors. It is noted that the recently outsourced cleaning services should be put back under the service remit to alleviate inefficiencies. Cleaning in some areas is being undertaken by in-house cleaners but this is subject to budgetary and 'head count' restraints. Transfer of funding (£30,000) had commenced, but this would not be sufficient to resolve the issues. The Salaried Dental Service has also experienced out-sourcing of its services, in Ramsey and Hillside, the latter of which is being closely monitored due to performance and staffing issues.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES? YES

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? Strategic and operational issues are discussed.

EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE?

CHS are run by an enthusiastic, committed executive team who works collaboratively together and supports their front line staff. Leadership is strong and the team have vision, ambition and a potential to develop a wider range of services within the realms of Integrated Care.

The overall impression of CHSET is one of openness and transparency with members being encouraged to voice their opinions and concerns without trepidation.

DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? Yes.

SUMMARY:

In the light of numerous challenges and financial constraints CHSET consistently remains positive and collaborative. It is commendable in its openness, transparency and the ability to recognize and act upon omissions, thus strengthening its open learning culture. With the Health Services currently being in a state of flux, the Primary Care Director/Integrated Care Director and his managerial team have the capability to steer CHS through turbulent waters. The Department merger with Social Care, along with the revised leadership structure within the Health Services has had an impact on CHS, however an underlying ethos of integrated care appears central to the service and the outlook remains positive.

RECOMMENDATIONS TO THE DEPARTMENT:

- Recruitment and retention of staff throughout the Health Services needs attention.
- Better use of the under-utilised facilities at Jurby Health centre and RDCH.
- The infrastructure of Primary Care is not currently sufficiently resourced or robust enough to meet the demands and raised expectations to deliver services for which have not been formally agreed or planned. The transfer of services from Acute to Primary Care must not occur by stealth.
- Financial overspend at both Noble's Hospital and within CHS prompting an examination of overall funding of Health Services and how budgets are determined. Funding and structure of out of hours provision requires examination.
- In adopting an Integrated Care model the DH&SC is hopefully moving away from its main priority of driving down spending whilst maintaining a model of Health Services that is resource intensive and unsustainable.
- Involvement of staff and the public in the new vision of integrated health and social care is of paramount importance whether it be through leadership 'roadshows' or information sharing. Those working in primary and community care are going to be pivotal in the re-shaping of our Health Services following the well-publicised problems over the last year or so. Staff must be kept informed of proposed developments, helping shape, influence and drive these changes. A collective ownership of health care should be promoted to avoid a lack of motivation and low morale of staff and feeling of consumer powerlessness.

HSCC MEMBER: Andrew Swithinbank

AREA OF SCRUTINY: Community Health Services Patient Safety and Governance Committee

ACTIVITY NAME AND MEETING FREQUENCY:

1. Community Health Services Patient Safety and Governance Committee, alternate months.
2. Community Health Services Patient Safety and Satisfaction Walks, alternate months.

PURPOSE OF INTERACTION:

1. Meeting of managers of front line services and senior practitioners in all community based Health Services "to ensure that patients, clients, carers and users of Primary Health Care Services receive the safest high-quality care possible by overseeing the organization's systems and processes for monitoring and improving the quality of services".
2. To accompany managers, who are members of the committee, on visits to front line services to ascertain whether policy and practice ensuring the safety of patients is being implemented and improved. To talk directly to patients to hear their experience and views and to get a "snapshot" of their level of satisfaction and improvements they would like to see implemented.

HIGHLIGHTS:

- Frontline staff were encouraged to identify, report and learn from incidents and complaints and feel well supported by managers through the process even if they made mistakes.
- Staff were empowered to make improvements in the services they provide and propose change.
- Communication was crucial to the smooth transfer of patients from one service to another at a time when they are particularly vulnerable – risks occur when this communication is poor.
- The morale of dedicated staff was lifted when there is a clear way forward for their service.
- Safety improved when talented staff were retained through professional development opportunities.
- Patients generally felt safe, cared for, listened to and looked after by professional staff.
- Patients appreciated a local service, which was better for retaining their community support in an environment more conducive to recovery.

LOWLIGHTS:

- Standards were thought to deteriorate when services were short staffed and the future uncertain.
- Patients did not like being passed around doctors and liked their regular GPs who knew their medical history to coordinate their care.
- Medical staff needed to understand the whole person – their mental, spiritual as well as physical health.
- Patients were alarmed by the prospect of more services being centralised or privatized.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES?

After attending several committee meetings and making the inputs and suggestions as outlined in last year's annual report it was determined it was a better use of my time to attend the Patient Safety walkabouts and provide a different perspective to Health Service managers.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER?

Operational in terms of patient safety in current practice and short term improvements. Strategic in terms of staff and patient views (and confusion) about the direction the services are taking.

EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE?

All of 18 members seemed enthused and engaged by the work of the group. It was chaired in a very participatory way. Incidents and complaints were collated and ranked and there was a positive attitude to learning from them and improving practice. There was some reluctance to share publicly as it was thought this may be mis-interpreted. There was an open approach to inter service scrutiny but follow up to deficiencies could have been more robust.

DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES?

1. The Committee appeared to be effective in leading their service's patient safety and governance. All members appeared committed to promoting and raising awareness of safety issues including safe organizational and clinical practice. However there did not appear to be an explicit simple definition of governance to which everybody subscribed. The term seemed to have very expansive parameters in its subject matter.
2. Patient Safety Walkabouts visiting the various services in rotation pairing managers (from another service) with lay people delivered a look and listen approach which was helpfully complementary to the paper driven meetings. For visits to be successful they needed to be well introduced by the Lead officer to ensure staff and patients were aware of purpose and needed to provide the paperwork from the previous annual visit. They needed to be taken seriously and conducted in a professional manner with swift follow up otherwise they may have been seen as tokenistic.

SUMMARY:

Having joined patient safety and satisfaction walks to health visitors, community nurses, prison, Ramsey and District Cottage Hospital, community and special needs dental services, speech and language therapy and ambulance and paramedic services it appears that there was a positive attitude towards encouraging improvements in patient safety and continuous learning. Staff's ideas were not always implemented and reasons were not always given. Patients liked services to be delivered locally, and being dealt with in a personal and professional way, being seen as a person not a case and fear advancement of out sourcing.

RECOMMENDATIONS TO THE DEPARTMENT:

- Walkabouts should become a structured systematic part of engaging the patient and staff voice in improvements to current services to better meet the needs of patients.
- A clear process should be created and consistently used for reporting required improvements in patient safety, prioritising action, and feeding back on the rationale for decisions made.
- Walkabouts should be incorporated into consultative processes for planning the future shape of what, where, how and by whom health is promoted and illness treated and recovery supported.
- Further exploration should be undertaken to consider how patients always be considered holistically as unique individuals with complex combinations of needs to support their health.
- Recognition should be given the importance of supporting social, mental and spiritual needs in aiding recovery from, or ability to live with, illness.

HSCC MEMBER: Elizabeth Godby
AREA OF SCRUTINY: Mental Health Service
ACTIVITY NAME AND MEETING FREQUENCY: Mental Health Management Team/sporadic
PURPOSE OF INTERACTION: • To understand the structure and strategic direction of the Department. • To identify areas of positive action. • To identify areas under pressure from funding or staffing issues. • To look at complaints to the service. • To celebrate success.
HIGHLIGHTS: • At all interactions with the service I was made welcome and information and explanations were made without prompting. • My input was welcomed and questions answered. • A positive attitude was always displayed even in difficult circumstances. • The service appeared to be making progress strategically.
LOWLIGHTS: • Meetings were sporadic, frequently cancelled and then stopped altogether. • There was no continuity therefore it was difficult to judge actual progress.
MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES? Meetings I attended were well organized, actions followed up, outcomes recorded.
STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? Both
EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? From the few meetings I attended, there appeared to be strong bonds within the team members and they were able to disagree in a positive manner and discuss ways forward. The service appeared very positive in the direction they were going.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? YES The meetings achieved their purpose but did not achieve my purpose, as the HSCC representative.
SUMMARY: Unfortunately the year was unproductive despite efforts on both sides to make the relationship with the HSCC work. The significant changes within the Health Service as a whole impacted in the Mental Health Services ability to maintain their schedule of meetings that were appropriate for my attendance.

RECOMMENDATIONS TO THE DEPARTMENT:

- The over-riding concern with the Mental Health Service from my perspective was its ability to support the breadth of issues being presented to it. It did not seem to be sufficiently staffed and funded to work with the Hospital and Primary Care to tackle Mental Health issues early although it was starting to work with GPs to improve the quality of referrals to ensure the correct action was taken in a timely fashion to support patients.
- Resolve issues raised in supporting and equipping staff in dealing with enquiries into the death of patients with known mental health problems.

HSCC MEMBER: Sue Gowing

AREA OF SCRUTINY: Noble's Executive Team (NET)

ACTIVITY NAME AND MEETING FREQUENCY: Once a month. 11 meetings held, 10 meetings attended.

PURPOSE OF INTERACTION:

- Review operations and direct strategy to provide corporate leadership.
- Make executive decisions, information sharing, ratification of decisions.
- Planning developments monitoring progress and evaluating decisions made.
- Agree Corporate and Directorate Business Plans.
- Provide hospital wide Team Brief.

HIGHLIGHTS:

- Good attendance by all divisions.
- Acceptance of need for openness and transparency.
- Concise project reporting on progress of various I.T. projects.
- Communications with Department of Health slowly improving.
- Monthly performance days for Divisional Managers have started to reduce NET minutiae.
- Introduction of Service Improvement Plans.
- Nursing establishment increased by 28 followed by innovative recruitment drives.
- Complaint numbers levelled out after 2013 spike, more proactive response noted.
- A realistic pause in West Midlands visits to allow a procedure review.

LOWLIGHTS:

- Too much focus on operational issues to the detriment of strategic thinking
- Loss of continuity and experience. All five long serving Divisional Managers retired within 12 months.
- Recruitment and retention issues prevail throughout Noble's Hospital.
- OHR attendance erratic; staff absence stats remains high and reports without narrative or accuracy.
- Medical Division – locum overspend, bed blocking though delays in patient transfer to Social Care.
- Patient Safety - Patient Experience Indicators, now only limited completion by three wards.
- Diagnostic/Pharmacy Service - staff continuity issues, loss of innovative seven day working as no funding.
- Operations Division – Portering, Laundry and Housekeeping reviews have not translated into cost savings.
- Finance - AXAPTA budgetary system was unstable until July, discouraging attention to divisional financial performance assessments and consequently affecting performance reviews at NET.
- West Midlands peer review recommendations have been slow to progress for want of Action Plans and Treasury approval via appropriate business cases.

MEETINGS/ACTIVITIES WITH HEALTH SERVICE: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES?

Meet quality varied enormously. Some issues, though vital, should be resolved outside of NET, e.g. the manning of the Bank Office. Clear exception reporting is rare and focus on the big questions (strategy, financial loss mitigation, risk, service delivery, patient safety) is often lost in competing day to day divisional concerns.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER?

Very operational in content but latterly some improvement from initiatives brought in by short-term appointees and new Medical Director and Executive Director.

EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE?

Teamwork improving with the reformation of the Noble's Hospital structure, but early months of reporting period lost in Divisional Manager turnover and long awaited appointments throughout the management levels.

Transparency was much improved this year, and though a more positive culture shown at some meetings, an acceptance that staff morale remains low has not translated into any clear initiatives beyond pressure to close staff absences.

DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES?

Sadly most often no. Although with so many new attendees and no change on Terms of Reference or clarification in overall DH meeting structures, this response was almost inevitable.

Whilst input from Patient Safety is reported, very few Clinical Recommendations or Business Case presentations this year. Clear that selective NET extracts form Team Brief which is disseminated down throughout the hospital. It is unclear how output from NET feeds into Performance Delivery Group.

SUMMARY:

A more constructive year for NET despite a huge period of churn in senior posts. Day to day operations soldiered on within Nobles whilst Department of Health and Social Care spent three months in a holding pattern and a further six months developing a structure, which it has yet to convey clearly to the entire management and staff. Meanwhile, the public await consultation on the new Strategic Vision for Health.

RECOMMENDATIONS TO THE DEPARTMENT:

- Effect further change in Nobles Executive Team performance, through the Executive Director of Acute Care taking the Chair at monthly meetings and a revised Terms of Reference. Develop a focus on strategic matters at NET, maintain separate mid-month performance meetings with individual Clinical Divisions, and enforce clear reporting deadlines, and measurable targets that receive consistent review.
- Pursue long awaited business cases and funding through clear co-operation with Treasury. Facilitate by any means possible, the allocation from the long awaited Health Improvement Fund to agreed areas of priority.
- Help politicians to focus on policy issues and strategic direction, leaving clinicians to make clinical decisions. Well-meaning intervention can undermine the priority concerns for funding and potentially erode the willingness of staff at all levels, who continue working in the best interests of the patients, despite unclear strategic direction, and an ever evolving management structure.
- Rebuild Noble's Hospital budget using zero-based methods, as current budget appears based upon outdated foundations re: Deloittes October 2014 report. Challenge restrictive conditions of £4.1m Health Improvement Fund, which appears limited to one-off innovation without providing ongoing budget support for staffing costs.

HSCC MEMBER: Dawn Mayor

AREA OF SCRUTINY: Nobles Hospital Patient Safety and Quality Committee

ACTIVITY NAME AND MEETING FREQUENCY: Medical Director, Divisional Leads, Patient Representative, PSQC Manager, meet monthly and collectively.

PURPOSE OF INTERACTION

PSQC in being accountable to Noble's Executive Team (NET) 'is responsible for ensuring that patient safety and the concept or clinical governance is at the core of the Organisation's function. The committee as a strategic body, ensures that formal arrangements are in place to discharge its responsibility for continuous quality improvement and to ensure that patients are the main focus and priority of service delivery, and for monitoring that activity'.

In essence the committee seeks to provide assurance that effective patient safety and clinical effectiveness arrangements are in place that reflects national clinical quality initiatives.

The remit of the PS&QC is that of patient safety and clinical governance within Noble's Hospital. The committee is a framework through which the National Health Service is accountable for improving services and safeguarding standards by creating an environment in which clinical care excellence will flourish.

HIGHLIGHTS:

- Clarification and revision of the Terms of Reference.
- Patient Safety & Quality Reporting. In the light of managerial changes Divisional reporting has been revised, standardised and moved to an exception reporting style. PSQ reporting and recording of incidents appears more consistent and structured, largely due to the efforts of the PSQ Manager.
- Implementing of a weekly review of In-house hospital deaths to identify areas of concern and of good practise.
- The use of tools such as Clinical Audits, review of complaints and public involvement all contribute to a more productive service and working of the committee.
- The undertaking of Patient Safety Walks enable the identification of patient safety issues which in turn lead to greater collective understanding, and programmed improvement of the care environment.
- The inaugural Patient Safety Conference was well attended by a diverse audience and will be held as annual event.
- Ebola contingency plans are now in place.
- Clinical Audit committee. The number of clinical audit proposals is increasing annually, increasing collective intelligence. The committee performs well in comparison to the UK.
- SHAREPOINT. All divisions now have named administrators to manage the clinical local policies and protocols which go through the PSQC and are uploaded onto Sharepoint. The newly approved Electrolyte replacement guidance paper will be the first document to be uploaded onto the system.
- Paperless working/paper investigation results. A small working group is looking at the pros and cons of moving away from paper results for in-patients, however progress appears slow. Medical records currently consist of electronic and paper combination.
- Radiology/telemedicine Radiology provides a consultant led on call service for CT imaging out of hours. The demand figures have shown a substantial increase and it is felt additional support is need. The use of teleradiology/medicine and outsourcing was discussed; however this is decision outside the remit of this committee.

LOWLIGHTS:

- Budget overspend by Noble's Hospital.
- There appears to be a distinct lack of feedback with regard to submitted business cases and poor communication to divisions regarding formal outcomes. It was requested that the committee have access to the full list of submitted business cases.
- Slippage into divisional minutiae and a digression into operational matters on occasions.
- Bed movement within the hospital. Concern remains regarding the number of bed moves undertaken by patients during their stay at Noble's Hospital and subsequent discharge issues. An increase in the movement of patients between wards and bed shortages has affected continuity of care and is being looked into. Data provided compared that 25% of patients had one extra move compared to 9% the previous year, with 6% of patients having had two extra moves compared to 1% the previous year. This coupled with the need to trim the increasing emergency admissions (high in comparison to the UK) also needs addressing.
- Oncology service demand remains on the increase. In providing prescribed treatments within appropriate timeframes safely to patients, it is acknowledged that there is inadequate staffing to meet service demand and a business case for extra staff has been submitted.
- Risk register. In reviewing the hospital risk register the committee became slightly 'bogged down' by protocol issues and after some lengthy discussion it was suggested that the register should be reviewed by the Executive Directors in light of all of the changes in personnel.
- Staffing issues. Ubiquitous hospital recruitment and retention issues remain and are currently the focus of a small working group. There is an apparent failure to recruit appropriately and to appoint qualified healthcare professionals at all grades. Overall recruitment and retention of staff needs examining.
- Independent Review Body (IRB)/Complaints. There are approximately 21 IRB cases currently being monitored. There is a perceived feeling that the IRB is exceeding its remit in many cases and that a change of personnel within the committee had occurred. The new Corporate Governance Board will oversee IRB papers. Shared learning was evident and action plans developed regarding potential and highlighted failings within health and social care and external bodies. The number of complaints made has now levelled out. PSQC compliance to IRB recommendations is often a lengthy and complex process and involves considerable man power.
- Seven day working. The Microbiology Department proactively devised a method of providing a seven day service, initially as a six month trial which proved very successful. The staffing levels were insufficient to support this initiative long term, however the subsequent business case was rejected. Due to the need to provide increased patient safety at weekends the seven day working pattern has continued through locum service and a revised business case will be submitted.
- WMQR. Concern has been expressed regarding the compliance and implementation of recommendations from a staffing and funding perspective. In the region of 460 recommendations have arisen from the four WMQRs undertaken thus far. Co-ordination and monitoring of recommendations and subsequent action plans has been taken over by the newly formed Programme Board, whose scope is Health Service wide, as opposed to solely being based within acute care.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES? Generally yes. Constructive forum for information sharing and decision making.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? PSQC Terms of Reference discussed, clarified and accepted. The agenda for the PSQC, whilst addressing specific patient safety issues, must in essence concentrate on the strategic delivery of services. It must lead the strategic direction, with lead responsibility for day to day operational issues sitting with the divisional management teams. Subsequently the PSQC work programme should be structured in such a way to focus on broader strategic development. On occasions matters became operational in nature, but were swiftly referred back to Divisions for discussion and findings reported back at a later stage if necessary. Hierarchical reporting channels appeared clear with escalation of information to Noble's Executive Team (NET) being apparent.
EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? The attendance of the new Medical Director, other new committee members and the efforts of the PSQ Manger have had the ability of looking at the workings of the committee with 'new sets of eyes' which will hopefully lead to a rather more positive and dynamic direction in the future. The committee appears to support collaborative working with the group and other members are often co-opted to the committee for specific items, when required.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? Yes.
SUMMARY: The principle purpose of the PSQC is to consider and manage clinical risk within the acute hospital, however there are elements of working together across health, e.g. with Community Health Services on particular risk issues. The area remains under scrutiny, with interest from MHKs, social media, and the West Midlands Quality Review, nevertheless staff and divisional managers have remained proactive in the light of this analysis and have endeavoured to promote sound management and robust accountability with regard to patient safety within Noble's Hospital. They have done this in the light of managerial changes, financial constraints and staffing shortages and are to be commended for their commitment.
RECOMMENDATIONS TO THE DEPARTMENT: • Staffing issues. The R&R group whilst in its infancy highlights the need to maintain an active recruitment and retention programme, which could include looking at relocation packages, work permit issues, sub-contracting of services, key worker housing, etc. • Potential role of telemedicine within the Health Service. • The financial overspend at Noble's Hospital prompting an examination of overall funding of Health Services and how budgets are determined. • The Department merger with Social Care, along with the revised leadership structure within the Health Service has had an impact on the operation of Noble's Hospital and focused upon the growing need for more collaborative working within the Health and Welfare Service as a whole. • Increased public health care expectations, coupled with an increased life expectancy, means more frailty and subsequent increased use of health and social service resources, which needs addressing at governmental level.

HSCC MEMBER: Diane Kelsey
AREA OF SCRUTINY: Nursing and Midwifery Advisory Council
ACTIVITY NAME AND MEETING FREQUENCY: NMAC scheduled monthly, occasionally cancelled.
PURPOSE OF INTERACTION: Senior Management meeting of all areas of nursing on the Island.
HIGHLIGHTS: • Collegiate and collaborative approach from diverse/dispersed community. • Drive to recruit new nurses and encourage returnees/students to the Island.
LOWLIGHTS: Widespread concern and anxiety about the uncertainty (and apparent unfairness to nurses) of public sector pensions.
MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES? Yes: Despite the very wide area of interests covered by the members from the diverse nursing community, all meetings held are well attended and well run.
STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? Some of both – but long term planning is a major consideration (training, recruitment, retention, etc.). Very little tactical discussion takes place.
EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? Yes.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? Yes.
SUMMARY: NMAC is an excellent forum for the nursing community senior representatives to meet collectively, be updated on a wide range of points by the Chief Nurse, and to discuss and share ideas to support nursing in the Isle of Man. Morale is fragile, in part due to uncertainty and possible unfairness (to nurses) of proposed pension changes.
RECOMMENDATIONS TO THE DEPARTMENT: • Stability and certainty comes to the entire nursing community and that their senior leaders continue to work positively and professionally together.

HSCC MEMBER: John Whitehouse

AREA OF SCRUTINY: Oral Health Stakeholders Group

ACTIVITY NAME AND MEETING FREQUENCY: Half yearly.

PURPOSE OF INTERACTION:

The purpose of the Oral Health Stakeholder Group meeting is to hold to account the team responsible for the implementation of the Oral Health Strategy 2011 - 2016 and the resulting actions.

HIGHLIGHTS:

- Whilst there has been some changes in the attendees of this meeting the core group responsible have remained in place and committed to delivering against the strategy.
- Progress is monitored and reported at each meeting.
- Recent legislation changes put forward with regard charging for dental services will provide funding to support delivery of further Oral Heath Strategy actions.

LOWLIGHTS:

- The incubation period from inception of an idea/action to delivery takes too long, reducing the potential benefit that could be seen during the period of the strategy.
- There is evidence of a culture between the DHSC and other Departments thereby interactions seem to be at arms length rather than simply sitting down and discussing a particular matter.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES?

Each meeting of the OHSG met its objective effectively and communications are clear.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER?

The purpose of the meeting means that the subject level is largely operational.

EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? N/A

DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? YES

SUMMARY:

The OHSG meeting has been acknowledged by the HSCC previously as it is appears to stand-alone with regard focusing on implementation. This point is again reiterated by the HSCC**.**

RECOMMENDATIONS TO THE DEPARTMENT:

- As the Department puts in place mechanisms to ensure other areas of change are implemented the OHSG needs to adapt and should look to align as best it can to ensure an efficient implementation delivery.

HSCC MEMBER: Derek Legg, until January 2015. Temporary replacement by Sue Gowing.

AREA OF SCRUTINY: Performance and Delivery Group (PDG).

Political member, SMT members of NET, Mental Health, Public Health and partner agencies such as OHR.

ACTIVITY NAME AND MEETING FREQUENCY: Monthly meetings scheduled but some consecutive meetings cancelled in 2014 and 2015.

PURPOSE OF INTERACTION:

The group is chaired by the Member for Health and should look at the performance of the Health Service and at the delivery of services, as well as policies and financial decisions - for example on new drugs. The meeting primarily views performance via iHub, a computerized management tool providing a one stop basis for management statistics, comparisons, etc. relating to all aspects of health – from birth to death, both hospital and Community wide, including GP's, dentists, waiting lists and Departmental and other strategy matters.

HIGHLIGHTS:

- Initial meetings including pan wide iHub data provoked some good quality discussions and actions.
- Communication lines improved with the restart of individual Department of Health & Social Care liaison meetings after a substantial hiatus due to regime change.
- Noble's new hospital performance days for divisional accountability were well reported.
- Treasury took responsibility for compiling staff absence stats.
- Medway upgrade training reported as going well.
- Quality Improvement Program Board (QIPB) meetings were recently commenced.

LOWLIGHTS:

- The meetings until June, gave a detailed overview of the Department via iHub and could have been a useful tool to managers, but the information contained therein was only be of use if it was kept updated to monitor and improve the services and efficiency of the Department. Reduced manpower has permitted only limited input of Noble's Hospital data since Director moved to Primary Care.
- Take up of iHub usage throughout service remained low. HSCC lack of iHub access hinders scrutiny.
- Recruitment and retention issues increased despite closure of absences.
- Standing agenda items being removed such as MIAA report on inadequacy of management information and performance management and Beamans management structure reviews.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES?

From previous attendee notes, it would appear that meetings were not effective despite a relatively structured agenda. Cancelling consecutive meetings led to a lot of repetition of action points in meetings and yet follow up actions were often not achieved.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER?

More operational than strategic; a worryingly low quality and range of contribution; few actionable points raised from discussions and responses.

EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE?
Teamwork between attending members from Noble's Team was evident towards the end of reporting period. Political intervention in prioritising areas for improvement remained an issue, in respect of the differences between clinical-led decisions and politically acceptable decisions. Regurgitation of previous meeting action points without follow up has not created a positive can do culture.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES?
No, not during the HSCC attendances. The meeting neither performed nor delivered, and few action points were finalised.
SUMMARY:
There has been less meeting overlap compared to previous years, but mainly due to so many meeting cancellations in the loose structure that leads up PDG. Attendance in particular from Finance and OHR, has fluctuated. Whilst many of the more recent Nobles team members have shown increased understanding of the challenges faced by the many that have stayed in post, there was still a negative environment with overlap of functions of meetings and no one knowing where there discussion was being reported onto next!
RECOMMENDATIONS TO THE DEPARTMENT:
• As the next two meetings have been cancelled due to the lack of a political member to chair them, urgent action to ensure a positive format for this meeting, is required. • A long overdue overall review of meeting structures to clarify which meetings should continue within DH. • As PDG output is now a planned input to QIPB and given the political linkage, PDG may well continue to function, but if it to do so, it needs radical reform and fresh commitment to make it function effectively.

HSCC MEMBER: Malcolm Norris

AREA OF SCRUTINY: Public Health

ACTIVITY NAME AND MEETING FREQUENCY:

- Public Health Directorate: Informal Directorate meetings were scheduled alternate months, now monthly.
- Drugs, Alcohol and Sexual Health Committee, quarterly.
- Health Protection Committee, quarterly.

PURPOSE OF INTERACTION:

Directorate meetings: All members of the Directorate staff meeting to report progress, consider outcomes and offer each other assistance.

Drugs, Alcohol and Sexual Health Committee: Representatives from many parts of government, including the police, drug advice, nursing, and education, to discuss cooperative work to help solve problems.

Health Protection Committee: Again, representatives from many parts of Government, including the police, Department of Infrastructure, and Noble's Hospital. A good example was the "Festive Season", combining traffic, drink driving, sexual matters, and domestic violence around Christmas and the New Year.

HIGHLIGHTS:

- Initially it was very impressive to see a group of about 15 people, everyone of whom knew exactly what was expected of them, working to an agreed plan for the year, and getting on with their work with confidence and in support of each other.
- A wide range of activities was covered, including vaccinations, drug abuse and sexual health matters, smoking, obesity reduction, and how to deal with serious emergencies should they arise, such as bird flu and, most recently, what would happen if an Ebola case arose on the Isle of Man. In other words, it dealt with matters that were of concern to the health of the *public in general*, rather than *in particular*, the latter being the domain of the primary and secondary sections of the Health Service.
- Responsibility for formulation of strategies for treating major health problems, such as cancer, lies with Public Health.

LOWLIGHTS:

- The restructuring of the Health Service left Public Health drifting. Starting in August 2014, an assessment of their work was carried out by the Cabinet Office. The HSCC were not informed of the outcome of this work..
- Subsequently, two reviews of Public Health were conducted. The first, by the outgoing Chief Executive, was not adopted. The second one has now been completed and is awaiting approval by the Senior Management Team. The HSCC expects to see this review on completion.
- During this period, serious damage was done to staff morale, sense of direction and sense of purpose. Still having no clear indication of their future role, they were unable to produce their annual plan of activities, although, where they could, they continued to work on previously agreed activities.
- When the lack of a clear vision for Public Health was raised with him at a HSCC meeting, the CEO suggested that Occupational Health would be combined with Public Health. It appears that this may be happening, but the details are not yet clear.

- If the previous structure of Public Health can be judged against the structure and purpose of Public Health England (PHE), then its purpose was to oversee the Health and Wellbeing of the Manx nation as a whole. The Public Health Directorate recommended strategies, and oversaw policies such as vaccinations, drug abuse and sexual health matters, smoking, obesity reduction, and how to deal with the possible emergence of serious problems such as bird flu and, most recently, what would happen if an Ebola case arose on the Isle of Man. In other words, it dealt with matters that were of concern to the health *of the public in general*, rather than *in particular*, which latter is the domain of the primary and secondary care branches of the NHS.
- Apparently turning this upside down, Public Health now appears to be in a position subsidiary to Health and Wellbeing. Without a clear explanation of the logic behind this, it remains confusing. The status of the previous structure was reflected by fact that the Director of Public Health reported directly to the CEO. The reporting level is now at a significantly lower level.
- The loss of their previous Director was clearly deeply felt.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES?

In general, yes, although the implementation of strategies (such as the cancer strategy) sometimes left shortcomings.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? Both strategic and operational. For example, strategic in matters such as cancer, mental health and childhood obesity, and operational in matters such as smoking reduction, HPV vaccination and chair-borne exercises.

EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? See highlights above.

SUMMARY:

The year began very well, but deteriorated once the assessment and reviews started, exercises that, as of March 2015, have still not come to any final conclusion, leaving the staff still in a state of uncertainty.

RECOMMENDATIONS TO THE DEPARTMENT:

- How Public Health will be able to fulfil its task in the new structure needs to be clarified as early as possible.

HSCC MEMBER: Andrew Swithinbank

AREA OF SCRUTINY: Strategy for Health

ACTIVITY NAME AND MEETING FREQUENCY: Strategy for Health Steering Group. This group has not meet since July and the arrival of the new CEO.

PURPOSE OF INTERACTION:

Originally to devise and construct the strategy. Then to ensure its implementation, to prioritise areas for development and to monitor its effectiveness and review. Following this groups demise the purpose became to ascertain whether there was a new and different strategy.

HIGHLIGHTS:

- The original strategy was deliberately ambitious and far reaching in outlining the future shape of Health Services over a ten year period. It is good that the Strategy's two key messages on the direction of travel appear to be retained as the vision for health is updated:

  a) from an illness treatment service to the promotion of good health

  b) from hospital based to community delivered services

- The original strategy was being reviewed at the beginning of the reporting period after three years operation in the light of changed demands and resources.
- The new CEO saw the importance of revamping and revising a new vision and strategy.

LOWLIGHTS:

- HSCC raised concern that we saw and heard frustration around the lack of progress particularly on the transfer of resources from hospital to care at, or close to, the patients' home.
- The review of the overall strategy seemed to have got lost in the political and public interest and Departmental concern about external reviews. Progress on the original objectives and particularly to the key messages a) and b) above appeared to have not been thoroughly reviewed or reported on. HSCC had to alert the Department senior management that the level of awareness and understanding of the strategy and recognition of its progress amongst frontline services, patients and the public appeared limited.
- Throughout the year getting key positions filled has taken precedence over setting strategic direction.

MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES?

The strategy steering group as it existed before has not met for the majority of the year and many of the managers who were part of it either retired or changed position in the period. The work it had been doing was left hanging with lack of clarity as to whether this ten year strategy was still valid and active. The HSCC has emphasised the importance of keeping the public informed of the considerable progress on implementing the strategy and that the public deserve an explanation where intentions have been stalled or where changed and the reasons why.

Subsequently the HSCC encouraged the new CEO to share the evolving ideas for a new vision and the senior management team required to implement it. HSCC were able to comment on the various versions of the document called the Leadership Blueprint.

STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? Whereas the ten year strategy is strategic in some ways it appears to be an amalgamation of a long list of operational objectives not necessarily connected to the overall strategic goals. The new vision which emerged towards the end of the reporting period does appear to be more truly strategic however the blueprint was largely a plan for creating an appropriate senior management structure.
EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? At the beginning of the reporting period the steering group did not appear to be operating as a team but rather individual members who sponsored their own area of development. There was good transparency about some lack of progress and a will to rectify .It is difficult to tell how far the blueprint is the result of teamwork.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? As the Strategy steering group appeared to be disbanded the monthly meetings become the place where the HSCC were able to discuss strategy .The meetings with the CEO gave us a good insight into the evolving vision and enabled the HSCC to put forward concerns and ideas.
SUMMARY: Whereas within individual parts of the Health Services elements of the strategy continued to be implemented as planned others appeared to be on hold awaiting confirmation of the same direction or announcement of another. This has led to a hiatus in strategic direction**.**
RECOMMENDATIONS TO THE DEPARTMENT: • It should be explicitly and publically stated whether the 10 year strategy is still valid and active. • If there is to be a new vision and strategy for the future shape of health in the Island it should be produced with patients, community groups and staff in an engaging consultation process. • A new vision should be consistent with the positive overall objectives of the existing ten year strategy. • Progress on devising a new or revising and implementing an existing strategy should be accelerated now that key positions are filled. • The Department should work closely with the HSCC at the early stages of this process as the HSCC can be a key partner as a critical friend.

HSCC MEMBER: John Whitehouse
AREA OF SCRUTINY: West Midlands Quality Review Board
ACTIVITY NAME AND MEETING FREQUENCY: West Midlands Quality Review Board, quarterly.
PURPOSE OF INTERACTION: The purpose of the WMQRB was to set out the West Midlands Quality Review schedule, oversee the WMQRB process and review the review outcomes.
HIGHLIGHTS: None
LOWLIGHTS: • The Terms of Reference for the WMQRB did not assume responsibility or oversight for the implementation of recommendations from the individual reviews. • Planning felt rushed and reviews implemented prior to sufficient staff engagement or briefings. • Feedback from initial reviews was not acknowledged leaving individuals or groups unaware of whether their feedback was received, actioned or ignored.
MEETINGS/ACTIVITIES WITH HEALTH SERVICES: WERE THEY EFFECTIVE WITH CLEAR COMMUNICATION AND OUTCOMES? Communications from and for meetings was received in a formulaic manor, was usually clear but was not always sufficient timely to allow full review and comment prior to meetings.
STRATEGIC OR OPERATIONAL LEVEL SUBJECT MATTER? The meetings we largely strategic however given the nature of the review often missed the step between management of the activity and full engagement with those who were completing the operational side of the activities.
EVIDENCE OF TEAMWORK, TRANSPARENCY, LEARNING & POSITIVE CULTURE? There was little acknowledgement of feedback received following initial reviews having been taken into account for subsequent reviews, although this did start to change during the second half of this reporting period.
DID MEETINGS/ACTIVITIES ACHIEVE THEIR OBJECTIVES? Yes, although the HSCC believed that the objective was fundamentally flawed due to there being no focus on implementation.

SUMMARY:

The potential benefit of the West Midlands Quality Reviews is believed to be well understood, however seemingly rushed initiation of the reviews and limited acknowledgement of feedback has significantly impacted the potential benefit.

Furthermore management of the implementation of the review outcomes has been significantly lacking during the review period.

At the end of the report period a new Quality Improvement Programme Board has been formed. This board, among other activities, will manage the future West Midlands Quality Reviews and importantly the implementation of the identified recommendations.

The formation of the programme seems to address the main areas of concern identified by the HSCC. The HSCC will sit on the programme board and it is hoped that the lessons learned through the previous reviews can be addressed moving forward.

RECOMMENDATIONS TO THE DEPARTMENT:

- During the review period the Department has commenced a number of improvement initiatives. However, visibility and on occasion, such as with WMQRS, accountability for the implementation of those improvements has been lacking. It is therefore recommended that the Department focus more on the management and tracking of improvements to ensure maximum benefit from its initiatives.

APPENDIX

Appendix A

Outline of all Strategic Pathways and Enablers considered by the HSCC.

Strategic Pathways					
Acute priority provision	Set clear TFR priorities Objectives inline with health Strategy	TFR of budget & heads to community	Regional Health Centres		Appropriate community centred provision
Strategy for Health	Revised 2011	Reviewed Dec 13	Continue support or revise	50% review 2016	Rolling Programme of Strategic thinking
Treatment by SILO approach	Mental separate physical health				Multi Disciplinary Teams
Unlimited on demand full service range	Sole provider health service	Selecting / prioritising services Alternative service delivery			Charging for selected services Mixed economy, public private 3rd Sector
Peer to Peer Reviews **FRWG** **MIAA** **WMQRS**	Consult on Individual issues - reactive	Support pro-active approach	Regular Peer to Peer Reviews		Immediate in house reviews rather than crisis reactive approach. Internal learning
Appropriate Management Information	Reactive / selective response	Selective use of iHub Performance Data	Better narrative		Data-led decisions Performance judged Evidence based budgets
Engaging patient voice	Complaints Defensive Approach	Role Social media	Openness Transparency	Engagement in debate	Patient designated services
Mental illness	Mental Illness				Mental well being
Public Health	Piecemeal Campaigns	Numerous strategies No prioritisation	ID big risks to the nation		Evidenced improvement in the health of the nation / well being
Organisational Culture	Demoralised	Blame culture	Innovative creative Can do		Empowered
Scrutiny	Via committee attendances & escalation reports to DH	Critical friends welcomed			Embedded activity

Intended Direction of Travel →

Enablers	Short-term	Medium-term	Long-term
Leadership **Governance** **HSCC - DH**	Management structure & approach Piecemeal Lacks direction Overlapping committees	Able to challenge Avoid drops to detail Ownership defined Measurable targets	Goals: - Delivering - Against strategy - Financially viable - Patient safety - Recruit retain - Skilled staff - What public wants/needs
Issues **Community**	Piecemeal service	Individual Patient Budgets	
Info Management **Trend Analysis**	IHUB Data & Demographic		
Human Resources	High staff absence Slow recruitment Poor retention CPD Loss expertise Talent management Succession planning	Dedicated HR offices Values based recruitment E-Recruitment system	UK levels of staff absence or better Timely recruitment & improved retention levels
Public Health	Current management structure & programmes Piecemeal campaigns		
Mental Health		Development tiers MM to include social care, physio and occ therapy	
Nursing Issues	Difficult recruitment conditions Patient safety Volatile PEI & Nursing indicators		
Consulting **Change** **Management**	MIIA Francis WM QRS		
Financial Planning & Management	AXADTA budget issues No Mitigation plans	Hospital finance manager Prioritising services Contracting out services	
Nobles	Blame culture Terms of ref net Staff morale Overspent locum bank	Clarify structures	
Learning **Performance**	Data but no accountability PSW good Performance targets practice	Staff empowerment	
Managing **Political Process**	Demographic time bomb Prolific Tynwald Questions affect DH day to day working	Managing public expectations	Less interference/more confidence in operational matters