# Health Services Consultative Committee Annual Report

## 1 April 2015 to 31 March 2016

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# Chairperson Preface

The Health Services Consultative Committee has reported annually since it was reconstituted with solely lay members in December 2012. In each of those years the HSCC has commented on the uncertainty created by constant changes in senior personnel. This Report covers the 12 month period from 1 April 2015. During this period the Department has seen another leadership change, with the previous CEO leaving in June, another new structure implemented in October and amendments to the Executive Team appointments between July and December. Whilst it is evident from our engagement with the new structure, that real progress is starting to be made, it is essential that the deadlines outlined at Public Roadshows in January 2016 and Service Delivery Plans released in April 2016 are met. The analytical, open and transparent approach by the current CEO has set a good precedent; but analysis and actions must be delivered in equal part.

With the high level Department structure now largely recruited as substantive posts and meeting since November 2015 as The Board, we welcome the new stability that is beginning to permeate the Department, the significant changes that have taken place in the last twelve months, and those that are in gestation. During the year, substantial work has been carried out on a restructure and refocus of governance, the consultation on and subsequent publication of the 5-Year Health & Social Care Plan, the Strategic Plan for Mental Health and Wellbeing 2015-2020 and the new emphasis on Integrated Care with collaborative working across all Health provision. This work has contributed to a clear focus in direction and gradual increase in momentum.

There is however, little evidence that a genuine two way conversation between the Department and its staff, the public and patients has been established. The DHSC Communications Plan issued in April 2016 will hopefully address this issue. The validity of elements of the 2011 Health Strategy was acknowledged by the DHSC. Its long overdue replacement, the 5 Year Strategy for Health & Social Care was passed unanimously by Tynwald in November 2015, followed rapidly by unanimous approval for the Mental Health Strategy. Political intervention has rightly been focused on policy issues and strategic direction, but the provision of a sustainable Health Service for the Island must remain a high priority for the Manx Government. Further public engagement on prioritisation of services and third sector involvement and partnership working is vital if the goals of the 5-Year Strategy Plan are to be actioned. Pursuing value for money is laudable, but it is unlikely to resolve the issue that our current model of health is unsustainable in the longer term.

The HSCC has supplemented its one-to-one links with Senior Officers with workshop opportunities, annual Minister and quarterly CEO meetings, regular patient safety walks, monthly meetings, discussion of reports, strategy and legislation. This has enabled members of the HSCC to scrutinise all levels of the organisation. The HSCC intends to continue to adapt by adding attendance at Assurance Committees to its current methods of engagement in. We remain concerned at the pedestrian pace of progress, particularly within the workstreams established by the Quality Improvement Programme Board in March 2015 to translate WMQRS recommendations into action.

In discharging its role of independent challenge, advice and consultation, the HSCC look forward to working with the Department in supporting their progress in 2016-17. We would also acknowledge that the HSCC has seen many committed Health Service staff at all levels working long hours. Focus should be sharpened towards the creation of regional hubs, embracing telemedicine, the transformation of outdated practices and true collaborative working along clear pathways; all essential to improving outcomes for patients and the working lives of Health Service employees.

I would like to thank current and recently retired HSCC members for their active involvement and contribution, Ms Nikki Sharpe, our long-serving secretary for providing valuable continuity in ever-changing times and John Whitehouse the outgoing Chairman.

Sue Gowing, Chairperson May 2016

# Executive Summary HSSC engagement

- a synopsis of HSCC member engagements within the Health Services this year

Commissioning is a fairly new area within the IOM Health Service; however it has been highlighted that there is a lack of timely decision making adding pressures to an organisation already frustrated by long-known solutions not being put into action. There is a need for significant business transformation in many areas, particularly paper-light initiatives, to ensure the Health Service can meet the financial and demographic challenges ahead.

Community Health Services have been subjected to numerous challenges and constraints, whether financial, staffing issues or the seismic shift in the nature of healthcare. This coupled with the increase in volume in complex cases, general underfunding of the area and increased demand on services could potentially lead to crisis and run contrary to the current DHSC Strategy.

Engaging the Patient Voice is an important aspect of the Healthcare Service. Whilst there may be too many layers of committees in the activities around the patient voice, which may serve to dilute the original activity, the effectiveness of the Patient Safety Walks is less clear particularly when there are other committees in place involved in patient centred care. We need to see active progress and plans for engaging patient voice throughout the Health Service.

It is clear that Mental Health Care started 2015 from a very low point, striving to remove the stigma previously associated with mental illness. However, we feel that the staff all seem very dedicated to achieving this ambition, and have set about climbing this steep hill with commitment. We applaud the universal political approval of the Mental Health Strategy.

Nobles Executive Team observations reflect many HSCC members' concerns throughout the Health Service. Issues are repeatedly identified and solutions quantified, but remedial action is painfully slow despite divisional posts and overall Health Services structure being more stable in this reporting period. Until analysis translates into actions, the pervading feeling remains that necessary fundamental changes are still stuck in the pipeline, with consequences of continued low morale, disenfranchised, poorly motivated staff and high staff absence.

The Department merger with Social Care brings an increased need for more collaborative working within the Welfare Service as a whole which we hope will lead to a Pathways of Care sStrategy to promote the full integration of different teams across the service.

Revalidation for nurses and midwives is a concern. The current focus on recruitment and retention of nurses is very wise at a time of significant nurse shortages, although the unilateral withdrawal of the contractor for midwifery supervision needs addressing urgently.

The HSCC commented last year on the challenges concerning the measuring and monitoring of performance. Changes in OHR personnel have caused uncertainty and slowed some of the Human Resources progress. There has been a clear upturn in 2016 in terms of more direct interaction. Overall, however, too much time has been spent drawing up plans and strategies, rather than actually implementing short/medium term procedures which will have a more immediate effect. There needs to be a clear policy incorporating measures to encourage returning to work and on managing those returning to work following illness. The issue of sound workforce planning has not been fully addressed, although the NHS wide recruitment problem is acknowledged.

The notion to provide a modern Public Health Division ready to serve the demands of the new health plan, has seen a good recovery from the low point of mid-2015. The appointment of the current Director has revitalised this area of the Department that had experienced uncertainty. The HSCC welcomes the agreement to establish an Island-wide *Joint Strategic Needs Assessment* (JSNA) programme, and would like to see this progressed and properly resourced.

## 2015-16 Key Recommendations

The HSCC offers a number of recommendations regarding the Health Service to the Department for the year ahead which are expanded in the individual reports in the main body of the report.

1. Joint commissioning of services should be followed where clear benefits are identified, e.g. Eye Care Strategy.

2. Commissioned service contracts must have clear action plans with measurable outcomes, which are evidenced as good value for money.

3. The shift from Acute Services to Community and Integrated Hubs needs to be established with a reconfiguration of funding in line with the revised 5-Year Strategic Plan.

4. With the growing demand on Community Health Services the Department must determine what can be prioritised and afforded and this must be clearly articulated to the public.

5. Solutions need to be found for patient flow, bed management and delayed discharges at Noble's Hospital. This should include reviewing the provision of nursing homes.

6. Keep the public informed of the performance of the Stepped Care Programme, set out by the Mental Health Service and included in the Department's Annual Service Delivery Plan.

7. The notion of 'spend to save' needs to be qualified with a full explanation of what it is designed to achieve. The prioritisation of services and associated funding has to be clearly mapped out.

8. Urgently review nurse establishment levels to match demand to nursing resources.

9. Resolve flawed data and statistics across all areas of the Health Service.

10. Develop a cross cutting Dementia Strategy and Implementation Plan taking action to address the outcomes from the recent Dementia Audit.

11. Develop and deliver more targeted projects with the Office of Human Resources, to challenge the issue of higher staff absence levels within the Health Service.

12. The recommendations of the Patient Safety Walk Programme should always be followed up, actioned and publicised.

13. Public Health should continue to use, and expand upon the variety of outlets and methodologies to encourage and support people to look after their own health.

14. Create some targeted short term capacity to action the key deliverables of all of the work streams within the Quality Improvement Programme.

15. The delivery mechanisms for the 5-Year Strategic Plan should be developed by consulting with and utilising the skills and knowledge of the wider community, staff and the third sector.

16. Prioritise the development of new legislation to support the Goals and Objectives in the 5-Year Strategic Plan.

17. Develop and publish a Funding Strategy to support the 5-Year Strategic Plan.

## Review of 2014-15 Key Recommendations

In last year's Annual Report, the HSCC made Key Recommendations to the Department (see Appendix A). It has reviewed these against progress and actions undertaken during this year and the HSCC's view as to their current status is summarised below:

| **Summarised Recommendation:** | **Met, partly met or not met** | **Comment** |
|---|---|---|
| **Recommendation 1** 10-Year Strategy and engagement in consultation on new strategy | Part 1: Met<br><br>Part 2: Partly Met | There were two parts therein; one relating to the 2011 Strategy and re-engagement and consultation in any future Strategy. In regard to the 2011 Strategy, this was met.<br><br>Patients, Community Groups and staff were not extensively engaged in the consultation before the 5-Year Strategic Plan was approved by Tynwald, but public engagement has been sought following that approval. |
| **Recommendation 2** Transfer of services from acute to community | Not Met | Limited progress had been made on the transfer of services but not in a transparent manner. It is not clear that budget resource had followed the service. |
| **Recommendation 3** Staff, patients and public involved in the new vision and idea of collective ownership is promoted | Partly Met | The 5-Year Strategic Plan and the Roadshows have promulgated and reinforced involvement and collective ownership, which is welcomed. However there have been other factors, particularly continued poor internal communications and low staff morale that have worked against this approach. |
| **Recommendation 4** Broader range of methods for engaging patient and staff voice | Partly Met | Patient Safety and Satisfaction Walks remain a useful method of engaging, plus Staff Values sessions have been introduced. Worryingly, it appears that the QIPB work stream relating to engagement of patient and staff voice has not yet been delivered or actioned. |
| **Recommendation 5** Importance of social, mental and wellbeing in health | Met | The Mental Health Strategy, the additional human and capital resources in Mental Health and the inclusion of the Drug and Alcohol Strategy promoted the importance of these factors. |
| **Recommendation 6** Acknowledge and act to mitigate the impact of change and uncertainty on staff | Partly Met | The Workshops, presentations and Roadshows have gone some way to consult staff about business change. However, there is evidence that there is still work to be done with support staff as they take on new ways of working, particularly with the coordination of acute and community transitions. |

| | | |
|---|---|---|
| **Recommendation 7** How Public Health will fulfil tasks in new Vision | Met | The new Board Structure includes the Director of Public Health and the Public Health Strategy sets out how this Division will fulfil its tasks. |
| **Recommendation 8** Facilitation of funds from Health Improvement Fund (HIF) and rebuilding health budget using zero based methods | Partly Met | There has been a release of monies from the HIF to support the transition of Mental Health from funding of off-Island places to on-Island placements. Zero based accounting has not been introduced as yet. |
| **Recommendation 9** Political intervention limited to strategic direction | Partly Met | Universal political support on the 5-Year Strategic Plan and Mental Health. Unfortunate lack of opportunity for HSCC scrutiny of the political/clinical interface due to cessation of the Performance Delivery Group.<br>Some evidence that waiting list initiatives have not always arisen from clinical prioritisation. |
| **Recommendation 10** West Midlands Quality Review (WMQR) initiatives reported widely focusing on management and tracking | Partly Met | WMQRS recommendations are reported openly through the WMQRS website with workstreams communicated through the QIP Newsletter. However there is concern about the management and constructive tracking of the initiatives and lack of implementation plans with the vast majority of nearly 500 actions yet to achieve substantial progress. |
| **Recommendation 11** Comprehensive approach to health and wellbeing through collaborative working | Partly Met | There is evidence from the 5-Year Strategic Plan and the recent formation of the Department's Officer Board Structure that a more comprehensive approach to health and well-being is being moved forward. Unfortunately it is too early to evidence that this is occurring in practice at the work face. |
| **Recommendation 12** Overhaul Health Committees to streamline decision making, clarify accountability and avoid duplication and gaps | Partly Met | 2015-16 has been another one of change working with some of the existing internal meetings or Committees, either not meeting or meeting infrequently. Some new Committees have emerged but the Department has yet to establish a structure which ensures governance at all levels of management. |

# 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 Service Consultative Regulations 2012 which 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 the regulations.

The HSCC is a body of nine lay people appointed by the Appointments Commission to support the Isle of Man Health Service by providing independent scrutiny and advice on the operations, performance and effectiveness of the service. Members take responsibility for looking at specific areas of Health Services activity, attending appropriate Health Service meetings, reviewing documents, offering advice and highlighting problem areas. Members report to the HSCC and, through the HSCC to the senior officers and Minister. The role can be described as that of a 'critical friend' (see Appendix B).

The website for the Committee is found at:
http://www.gov.im/about-the-government/Departments/health-and-social-care/committees-and-groups/health-services-consultative-committee/

## Membership

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

- Sue Gowing, (appointed December 2012) Chairperson January 2016
- John Whitehouse, (appointed December 2012) Vice-Chair January 2016
- Colm Andrew (appointed February 2015)
- Derek Booth (appointed December 2015)
- Tracey Hellowell (appointed January 2016)
- Diane Kelsey (completed term November 2015)
- Linda McCauley (appointed February 2015)
- Dawn Mayor (appointed December 2012)
- Malcolm Norris (appointed July 2013)
- Andrew Swithinbank (completed term November 2015)
- David Trace (appointed December 2015)

## HSCC Scope – a reminder

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 reflect the view of people of their community.
4. The HSCC will hold the organisation to account for decisions that the Department makes.

The HSCC focuses upon WHAT the Department does, WHY it chooses strategic priorities and HOW the Department achieves this.

The HSCC does 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, e.g. the Patient Quality Forum.
2. Look to measure the performance of the clinical effectiveness of the Department as it is not qualified to do so.

## HSCC Engagement Methodology

In the three years since the newly constituted HSCC was appointed in December 2012 it has regularly reviewed and revised its methodology for providing scrutiny in response to the changing political and management climate within the Department of Health and Social Care. Initially members of the HSCC were nominated onto health service committees and submitted escalation reports to the Department outlining areas of concern.

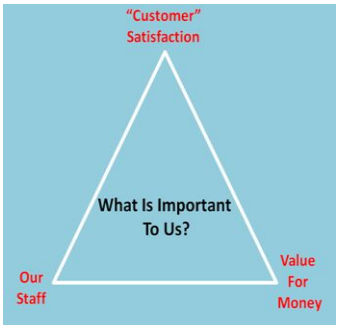
During 2014 service leads across the Health Service were invited to attend the HSCC. Out of these meetings the HSCC identified a number of Strategic Pathways and Enablers to base its guidance upon, in the vacuum created by the absence of a clear departmental strategic direction and during a period of significant turbulence and change in key senior personnel. Members continued to attend committee meetings in their nominated area and enhanced the insights these provided, with one-to-one meetings with Health Service leads (see Appendix B).

In early 2015, the reporting mechanism was restructured into a standardised Member matrix report highlighting areas discussed and identifying the relevance to specific Strategic Pathways and Enablers, thus ensuring all areas of concern received regular scrutiny (see Appendix C).

In keeping with each year's preparations for the HSCC Annual Report, the HSCC has recently undertaken an internal assessment of its current methodology. The components of this have therefore been formally reviewed to ensure continuing alignment with the Department's aims.

This internal review concluded that the HSCC roles and reporting methodology had been broadly effective in assessing the progress of change throughout 2015. Further analysis by members identified the ranking of importance of the given criteria and highlighted the resources that were being focused into specific areas by those levels of engagement and activity (see Figures 1 and 2).

In addition to this annual review, consideration was also given to new developments and announcements by the Department during the latter part of 2015 and early 2016.




The latest appointed Chief Executive has demonstrated in the public Roadshows in January 2016 that the three priorities for the Department can be represented diagrammatically shown here:

In August 2015 the Department of Health and Social Care published its 5 Year Strategic Plan 'Health and Social Care in the Isle of Man - the next 5 years', clearly setting out its five main goals for the Strategy, namely:

1. **For people to take greater responsibility for their own health.**
2. **To help people stay well in their own homes and communities, avoiding hospital or residential care whenever possible.**
3. **To improve services for people who really do need care in hospital.**
4. **To provide safeguards for people who cannot protect themselves.**
5. **To ensure people receive good value health and social care.**

In the HSCC's 2016 review an analysis of the current focus of scrutiny showed that there was a broad alignment of the Strategic Pathways & Enabler's criteria within each of these stated goals (see Figure 3). This demonstrates that the HSCC methodology to date has been supportive of the areas that generally fit with the DHSC's direction as it moves along the stated map of integration and change.

## Future Ways of Working

The HSCC noted in a recent written answer to Tynwald, the Department's intention to create seven Quality or Assurance committees to replace some of the large number of existing committees, working parties and groups within the DHSC. The Quality committees will be responsible for:

- Informatics
- Stakeholder engagement
- People
- Transformation
- Finance
- Commissioning
- Clinical Governance and Safety

Details of the membership of these Quality committees and terms of reference are now imminent. The HSCC anticipates that the inclusion of its members on these committees in a role similar to that of non-executive directors, will provide the next mechanism for the HSCC to fulfill its role. This will represent a further step in the HSCC's approach to its role. Specifically it will result in the HSCC examining how and to what extent, its observations and consultations contribute towards the achievement of the Department's five strategic goals both qualitatively and quantitatively, reporting within the context of the expected Service Delivery Plan.

Figure 1: HSCC members ranking of Priority of 2014 based on end of 2015 assessment of ways of future working.

| **Strategic Pathway** | **Priority ranking** |
|---|---|
| Culture Business Change | 1 |
| Public Health/Personal Responsibility | 2 |
| 10 year Health Strategy | 3 |
| Engaging Patient Voice | 4 |
| Business Intelligence/Data issues | 5 |
| SILO Treatment to Multi-Disciplinary Teams | 6 |

Figure 2: HSCC members ranking of Priority of 2014 Enablers based on end of 2015 assessment of ways of future working.

| **Enablers** | **Priority ranking** |
|---|---|
| Leadership Governance | 1 |
| Financial Planning and Management | 2 |
| Human Resources | 3 |
| Public Health | 4 |
| Community Issues | 5 joint |
| Consulting/Change Management | 5 joint |

Figure 3: Assessment of level of current HSCC activity and engagement in relation to the Departments Strategic Goals.

| **DHSC Goals outlined in 5-Year Strategic Plan** | **Main points of goal** | **Strategic pathways and enablers within each goal** |
|---|---|---|
| Goal 1 | People to take responsibility for own health | 15% |
| Goal 2 | Help people to stay at home | 21% |
| Goal 3 | Improve services for people on hospital | 11% |
| Goal 4 | Safeguards for vulnerable people | 11% |
| Goal 5 | Good value Health and Social Care | 42% |

**HSCC MEMBER:** Sue Gowing

**AREA OF SCRUTINY:** Commissioning - to secure services providing the best outcome at the lowest cost. The priority is the outcome and the appropriate access to services.

**ACTIVITY NAME AND MEETING FREQUENCY:** 1 to 1 Links to Officer, Tim Mansfield

**HIGHLIGHTS:**

- Extensive visit of 11 hospital trusts in November 2015 including oncology, cardiology, haematology & ophthalmology. Latter service has 30% more usage than in UK. Revised role of optometrists seems essential.
- Short term priority: the patient transfer service has been reduced by 1100 return trips in 2015.
- 2016 UK Hospital contracts will stipulate that the patient must have proven clinical benefit from a physical visit.
- Medium term: Telemedicine initiatives in Radiology, Dermatology (latter now out to tender).
- Ongoing: Management information (narrative not just numbers) and improved Business Intelligence, e.g. dashboard being trialled at Executive Board but challenging targets still needed.
- Acute Medical Unit 12 week pilot in Ward 6 has been trialling more collaborative working with entry and duration of patient stay. Gatekeeping & signposting of services has worked well, although the pilot has been completed and moved to being locum supported in the short term.
- Procurement via a North West buying group being actively pursued.

**LOWLIGHTS:**

- AMU pilot-business case presented at The Board, but not progressed to Treasury funding.
- Technology projects not progressing sufficiently to underpin vital business and cultural change.
- Waiting lists grow - screening initiatives trigger increasing demands upon the service.
- Staff absence and morale remain stubborn issues; recognition of need for quick wins, significant service decisions and improved recruitment timings.
- Further off-Island work is being commissioned where insufficient local volumes can have Patient Safety implications.
- WMQRS reports continue to feed recommendations into the Quality Improvement Programme, but unsure if this is adding value to the process of prioritising services.
- 5-Year Strategic Plan does not tackle sustainability issues, particularly in relation to political sensitivities in charging the public for services, e.g. prescription increases or health insurance.

**SUMMARY:**

Regarding Business Cases, there is a lack of timely decision making adding to pressures to an organisation already frustrated by the time being taken to put long-known solutions into action.

It is difficult to review progress on telemedicine initiatives and without acceptance of collaborative working with the UK, within Noble's Hospital and out in the wider community, initiatives may fail in the longer term. There is a need for significant business transformation in many areas, particularly paper-light initiatives, to ensure the Health Service can meet the financial and demographic challenges ahead.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Commissioning is in its infancy on Island. Detailed analysis of issues must be matched by prompt actions, with clear medium and long term action plans and measurable outcomes.
- Build upon this year's positive improvements in contract reviews and reduced patient transfers.
- Commissioning savings and service improvements in the short-term are commendable. In the long-term success depends upon co-operation across the Health Service and strong leadership.

**HSCC MEMBER:** Dawn Mayor

**AREA OF SCRUTINY:** Community Health Services and Primary Care

**ACTIVITY NAME AND MEETING FREQUENCY:** Primary Care Divisional Meeting (formerly Community Health Service Executive Team). Monthly meetings and occasional 1 to 2 meetings with Director of Primary Care and Director of Community Nursing to discuss strategic developments within Department of Health & Social Care, pertinent to Community Health (CHS).

**HIGHLIGHTS:**

- Areas of CHS have been externally audited by the WMQR and staff have worked diligently to review governance procedures and protocols. Mock inspections/reviews have been carried out by CHSET to pre-empt inspection and staff are engaged in the process.
- The appointment of a new, dynamic Contractor Services Manager has seen increased feedback and reporting of issues to CHSET, reflecting more integrated working.
- Trial of GP online services going well, e.g. online appointments. Six new GPs due.
- Review of salaried dental service currently underway. Fall in waiting list numbers and redefining of the service. Dentist led anaesthetic in the community going well.
- 'My Name Is' initiative up and running, which emphasises the importance of staff introducing themselves to patients.
- Ramsey & District Cottage Hospital (RDCH) an excellent example of Integrated Care Hub, to be used as a template for other community Hubs. Step up Step Down initiative praised
- Strategy for Children and Young People 2015-2020 ('every child will have the best possible opportunities in life') demonstrates a DHSC commitment to safeguarding children.
- Proposed setting up of a CHS based 'Geriatric Team', with a lead geriatrician and long term condition nurse (business Case currently being formulated). Identifying a need for a Community Frailty Service is an evolutionary process seeking to reduce hospital admissions.
- Patient Safety/Satisfaction Walks provide the opportunity for managers to engage with staff/public at the point of service delivery to gain qualitative and quantitative data.
- Nurse Practitioners now incorporated in MEDS service.
- Primary Care Patient Survey's aim was to gain valid and unprejudiced feedback from users of PC facilities, giving the opportunity to address areas of concern, ensure standards are being met and highlight good practise amongst practitioners. Overall feedback was positive.
- The intake of student nurses to be increased next year (to 14 from 10) - negotiations are underway with Chester University for the development of a Nurse Practitioner course.
- Ambulance Service recruitment & retention pathway 'Zero to Hero' – Paramedic training now fully Island based. Service Delivery Plan for the Ambulance Service presented, in line with 5-Year Strategy. Open, transparent discussions with managers and collaborative CTHS team work.

**LOWLIGHTS:**

- The movement to Integrated Care Hubs was presented with fanfare, but in reality it is apparent that healthcare is still predominantly Nobles focused. Consistent underutilisation of some CHS facilities, e.g. Jurby Health Centre and RDCH continues, not through lack of will but apparent historic favourable funding of Acute Care at the expense of Primary Care.
- Prison Healthcare financial overspend of 22% but new GP contract now finalised with Peel GPs.
- All Nursing Home provision is by the private sector and not matched to benefit level. The lack of direct Government provision and a lack of robust control could facilitate a cartel operation. Adult discharges are moving towards crisis point. The financial costs to both individuals and department needs addressing. The need for such provision will increase and prompts the developing of a more collaborative partnership with Nobles and Social care which overlaps with CHS.
- The archaic nature and anomalies within the Doctors' contract at Ramsey & District Cottage Hospital needs addressing and a contract template produced for proposed Integrated Hubs.
- The cleaning contracts run out shortly and there seems to be a 'blurring' of responsibilities between the Government Departments and CHS. The poor performance of the external cleaners highlights need to put the service back 'in house' to alleviate further inefficiencies.

- Recruitment and retention issues remain in particular areas, e.g. in MEDS. Overall shortage of personnel throughout CHS, Social Care and in private care homes, all fighting for a small pool of qualified staff. There is a significant gap in Nurse Practitioners.
- District Nursing demands exceeding capacity in some areas, due to lack of investment and rejected business cases.
- Infection control issues arising due to an increase in procedures taking place within the community. Prevention must be a priority, increased infection control, establishing robust procedures, improved education and more collaboration between Acute/CHS/Care Homes.
- Milk Scheme is to cease, with funds being diverted to education, 'failure to thrive' pathway, tackling the increase in childhood obesity and the like.
- Community Equipment Store still providing equipment for patients in a rather piecemeal way. The employment of cleaning assistants has helped alleviate the backlog, however lead management, budget and high demand for equipment remains.
- Ambulance Service experiencing a lack of investment, increased service demand and issues over staff terms & conditions and a proposed reduction in hours.
- MEDS service is reaching a crisis point, becoming increasingly difficult to staff particularly overnight and weekends, proving a costly service.
- Minor Ailment Scheme operational but needs greater publicity and public awareness.
- Financial over spend in CHS.

**SUMMARY:**

Throughout the year CHS have been subjected to numerous challenges and constraints, whether they be financial, staffing or the seismic shift in the nature of healthcare. This, plus the increase in volume of complex cases, general underfunding and increased demand on services will potentially lead to crisis and run contrary to the current DHSC Strategy.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- It is questionable as to whether the move to an Integrated Care Hub strategy is happening in a consistent and timely manner. Service transfer between areas appears haphazard, inadequately funded with roles and accountability 'blurred'. In increasing 'Care in the Community' senior management needs to understand that CHS cannot continue to absorb such work without commensurate funding and a concrete service transfer strategy.
- Priority need for shared records within the Department.
- Recruitment and retention of staff throughout the health service needs attention.
- The infrastructure of Primary Care is not sufficiently resourced or robust enough to meet the demand and raised expectations. There is a lack of linear progress towards CHS from Acute Services and a reconfiguration of funding is vital in line with the revised Strategy.
- Adult discharge issues, provision of nursing homes and the associated funding needs to be determined at government level. Overall discharge procedure requires examination.
- CHS are evolving and becoming more generic in nature. Increasing long term conditions and complex cases have obvious resource implications, particularly for Community Nursing. An evaluation of need and what a small Island community can provide needs to occur.
- Low staff morale with pockets of staff disengagement and dissatisfaction remain. A change in culture not just structure and leadership titles is needed to develop a collective ownership of healthcare needs with clinicians and stakeholders.
- Address lack of continuity; joined up services needed to promote Integrated Care.

**HSCC MEMBER:** Andrew Swithinbank and David Trace

**AREA OF SCRUTINY:** Engaging the Patient Voice

**ACTIVITY NAME & MEETING FREQUENCY:** meetings with Linda Radcliffe, Chief Nurse

**PURPOSE OF INTERACTION:** To feedback on the HSCC's observations on engaging the patient voice and why it is considered a priority. To gain an understanding of the role of the person nominated as the Link Officer on the Patient Voice and discuss how they may liaise with the HSCC. To consider the Link Officer's perspective on progress in and plans for engaging the patient voice.

**HIGHLIGHTS**

- Chief Nurse is aware of the value of Patient Safety and Satisfaction walks and is keen to expand to fortnightly in both Acute and Community services which involve nursing.
- She is also aware of the limitations of the action plans from the walks if they are not communicated with staff and implementation assured or lack of progress explained. That is now centrally monitored with a quarterly report indicating patterns and trends.
- Chief Nurse is very aware of the need to continuously review and experiment in new ways of listening to patients. She is well informed on methods in the UK and is introducing them here including 'I Want Great Care' a real time feedback system and 'Sit and See' observation of practice particularly the nursing care and communication culture.
- Staff are being trained as Quality Ambassadors on behalf of patients and 'Listening into Action' is encouraging staff to challenge bad nursing practice with patients.
- The Patient Safety Forum is now the Patient Experience & Quality Group. It meets monthly as a lay group and alternately with a Service Lead. It is recruiting to expand its current six representatives.
- Patient experience indicators are collected from ten patients per ward each month.
- The team are continuing to work on the QIP workstream and have written a Patient Experience and Involvement Strategy. This is in the final draft stage, as is the implementation plan for Noble's Hospital. A number of Sit and See observational reviews have been undertaken across clinical areas in line with the annual plan. There has been a continued focus on increasing the number of clinical areas undertake the patient experience indicators.
- The hospital utilises the Heartlands Patient Experience Indicators (PEI's). Recent compliance scores 95%, based on the seven surgical wards, three medical wards and two women and children's wards which is above the standards expected of compliance.

**LOWLIGHTS:**

- The Chief Nurse still appears unsure as to whether her role regarding the Patient Voice is for all patients/service users, or just Acute rather than Community patients.
- The idea of the Patient Voice is interpreted more about listening to immediate issues of current patients in their own treatment, rather than also the broader issue of engaging past, present and potential future patients in planning, managing delivery of service provision.
- Whereas multiple initiatives advance a patient's voice in their care they do not appear designed to engage and empower the Manx public to influence policy and practice.
- PEI's have improved since nurses rather than volunteers asked the questions.

**SUMMARY:**

The Chief Nurse is aware that listening to patients has immediate lessons for an individual's care and also, if all responses are collated and trends analysed, opportunities for improvement which can be replicated across services. New group patients who are seen as part of the team improving quality.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- The Department needs to ensure they monitor whether the multiple schemes being introduced deliver better patient engagement in their care.
- The Department needs to think more radically about engaging patients/public as key stakeholders in the design and delivery of good health.

**HSCC MEMBER:** Dr Malcolm Norris and Derek Booth

**AREA OF SCRUTINY:** Mental Health Directorate

**ACTIVITY NAME AND MEETING FREQUENCY**: Mental Health Management Board, monthly.

**PURPOSE OF INTERACTION:** Independently observe the Mental Health Directorate.

**HIGHLIGHTS:**

- Publication of Strategic Plan for Mental Health and Wellbeing 2015–2020, introducing five steps of care for mental health patients.
- Ratification of Care Planning Standards Policy for Mental Health Service.
- The building of Manannan Court, for use of Mental Health patients who need a high level of care, is 51% complete.
- Introduction of a Steps 1 and 2 pilot exercise in providing counselling and psychology in the Primary Care setting.
- Brunswick Gardens, which provides a tranquil atmosphere where patients can do some gardening, or just relax, and which is regarded as 'The Jewel in the Crown' of mental care in the Isle of Man, is having new buildings, financed by the Ballamona Trust.
- Director of Mental Health is now a substantive post.
- Wherever possible, more treatments are being provided on the Island, rather than in the UK, in order to provide better care at a substantially reduced cost. The savings will help to finance and improve the quality and scope of the local provision.
- On-Island staff are being trained to provide the above mentioned treatments locally.
- Development of a partnership approach, in particular with Social Care, especially between Elderly Care, Intellectual Difficulties and Autism.

**LOWLIGHTS:**

- Despite the steps being taken above, there is still a large budgetary deficit.
- Section 115 funding (after-care treatment in special cases) currently gives rise to considerable overspend, particularly due to the large population increase in recent decades. Ways of reducing this overspend are being explored.
- Delay in publishing the Strategic Plan for Mental Health and Wellbeing Man 2015–2020, a draft of which was available in February 2015.
- Death of a patient in acute care in 2014 presented staff with a difficult time. The inquest reached its final result in March 2016. The Coroner was satisfied with the steps taken to ameliorate risk in Grianagh Court and with the design of Manannan Court where such patients will soon be treated. The Coroner proposed no further action.

**SUMMARY:**

- Mental Health Care has started from a very low level, striving to remove the stigma previously associated with mental illness. Progress is being made.
- The staff all seem very dedicated to achieving this ambition, and have set about climbing this steep hill with commitment.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Keep the general public informed of progress, as it is made, with the steps set out for the Mental Health Service in the Department's Annual Service Delivery Plan 2016/2017.
- The 5-Year Strategic Plan emphasises the importance of mental health problems alongside physical health issues and the potential impact one has on the other. This calls for a truly integrated approach throughout all areas of the DHSC. Mental Health considerations need to be reflected in all developments and service changes

**HSCC MEMBER:** Dawn Mayor

**AREA OF SCRUTINY:** Nobles Patient Safety & Quality Committee (PSQC)

**ACTIVITY NAME AND MEETING FREQUENCY:** Monthly meeting with Medical Director, Divisional Leads, Patient Representative, PSQC Manager, and co-opted specialists.

**HIGHLIGHTS:**

- Patient Safety Conference was well attended and feedback positive.
- The 12 week trial for the acute medical hub is going well with staff engaged in the process. The status at the end of the pilot is questioned.
- Nobles successfully maintains competence in a small geographically isolated area in line with WMQR standards.
- Patient Safety Walks across Acute Services allows service users to be heard.
- The number of audit proposals through the Audit Committee is escalating annually, increasing collective intelligence. The committee performs well in comparison to the UK.
- An aspect in optimising patient safety is in the protection of the public from those who falsely represent themselves as registered nurses. Employers can check the registration status and ID numbers for nurses and midwives which is important for revalidation and an overall indemnity issue.
- Uniform Policy (incorporating bare below the elbows) complies with latest infection prevention control and also allows for easier identification of staff roles.
- All divisions now have named administrators to manage the clinical local policies and clinical guidelines protocols which go through the PSQC and are uploaded onto SharePoint.
- Risk Register reviewed bi-monthly by PSQC and escalated to NET. Divisional assurance exception reports produced quarterly. Improved governance reporting.
- The new PCR FilmArray system, which is one of only three in the region, is up and running. This piece of equipment was provided by the 'Friends' highlighting charitable involvement in Nobles.
- Service and Quality Delivery Plan for Acute Services presented and comments invited.
- New Business Case submitted for Datix, incident reporting system, as a replacement for PRISM.
- Trauma Coordinator has been appointed and is developing a local trauma course.
- Colorectal Surgery & Care Policy presented. Audit done following CR surgery being suspended in 2012 due to increased mortality. Action plans in place, protocol formalised, responsibilities outlined with CR surgery now fully operational on Island.
- Patient Experience & Quality Committee Report shows importance of Patient Voice and feedback.
- A more robust complaints procedure is in place at Nobles which has become more proactive in its approach to complaints. Under the lead of the PSQC Manager there is an improved structure, more vigorous framework of risk identification, reporting and profiling across the Divisions and effective escalation to Nobles Executive Team. 182 formal complaints have been received between April 2014 and March 2015, with 18 being referred to the IRB. The top 4 themes include – aspects of clinical treatment, communication issues, appointments/delays/cancellations and attitude of staff.

**LOWLIGHTS:**

- Weekly meeting to review all in-patient deaths at Nobles - 163 in-patient deaths occurred between April and December 2015. The gender split being almost 50/50, 55% of deaths were aged 80 or over. Due to the high number of patients clinically assessed as palliative, clinical teams should consider more proactive and timely decisions about ceilings of care, which could assist in reducing unnecessary and on occasions distressing interventions being undertaken. This situation has profound effects for other areas of DHSC, e.g. CHS. The Dementia Audit highlighted many areas of concern with Dementia care. Nobles had only 41% compliance of the vital standards needed to fulfil safety, rights, dignity and/or legal obligations.
- Despite a greater onus on public involvement, the recruitment drive yielded low take up and there is an overall shortage of lay representatives throughout the Health Service. Whilst initiatives such as the recently re-branded Patient Experience & Quality Group seek to advance the 'patient voice', it is questionable if greater engagement of the Manx public is occurring or influencing policy.
- The closure of Ward 20 in June 2015 had implications for bed management and discharge into the community. Clarification of the future status of Ward 20 has not been forthcoming.
- Concern expressed over the slow take up of monies from the Health Implementation Fund.
- Patient flow and bed management issues remain. The number of bed moves undertaken by patients during their stay at Nobles and subsequent discharge issues needs addressing. Delayed discharge of patients frequently occurs when neither residential care provision nor 'care in the community' is available leading to an increase in confused patients being treated in the hospital.
- Difficulty matching capacity and demand due to increase in activity across Renal services. A more effective utilisation of the facilities at Ramsey & District Cottage Hospital would remedy this.
- Inadequate Dermatology cover to meet the demands of the service. PUVA service recently suspended, following an incident, has highlighted staffing and training issues with a potential solution being outsourcing and/or telemedicine service and inclusion of a Dermatology Nurse.
- Financial overspend at Nobles should prompt examination of overall funding of health services and how budgets are determined. There appears to be a distinct lack of feedback with regard to submitted business cases and poor communication to divisions regarding formal outcomes.
- The recognition of the problem regarding delayed discharge letters has led to the secretarial backlog being examined and a review of the discharge pathway undertaken.
- Medical oncology demand remains high with an increase in activity of 34.2%. Recent audit on Cancer Service shows that the two week referral time is not always met.
- Failure to recruit and retain appropriately qualified healthcare professionals in all professional groups, for example the lack of substantive nursing staff in post in paediatrics. Difficulties arising from pension structure changes, being unable to recruit new personnel, rota issues and an over reliance on locums leads to lack of consistency and impacts on patient safety and staff morale. High levels of absences remain.
- Antimicrobial Policy ratified, MRSA policy operational. Lack of an antibiotic pharmacist is a worry.

**SUMMARY:** The remit of the PSQC is to manage clinical risk within the acute hospital, however there are elements of working together across health services on particular risk issues. Since the department merger with Social Care there is an increased need for a more collaborative working within the Welfare Service as whole, e.g. adult discharges from acute to community provision. Staff and divisional leads have remained proactive endeavouring to promote sound management and robust accountability concerning patient safety and governance within the hospital.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Timely structured and well-funded transfer of services to Community Services in line with the DHSC Strategy. Improved use of CHS facilities, e.g. Ramsey & District Cottage Hospital.
- Dementia Audit highlighted a number of areas of concern regarding Dementia care. The lack of a dementia care plan and lead clinician is of paramount importance. The ageing population and the statistic that one in three individuals will suffer dementia should be a catalyst for care. Gap Analysis is needed.
- Potential use of Telemedicine.
- Increase collaborative work with other areas for example Community & Social Care Services.
- Adult discharge issues, provision of nursing homes and the associated funding needs to be determined at governmental level. Overall discharge procedure requires examination.
- Involvement of staff and greater use of public participation and influence on service delivery and policy in the new vision of integrated health and social care is of paramount importance.

**HSCC MEMBER:** David Trace

**AREA OF SCRUTINY:** Nursing and Midwifery

**ACTIVITY NAME AND MEETING FREQUENCY:** Nursing and Midwifery Council (NMAC) monthly

**HIGHLIGHTS:**

- Increase in mental health nurse training due to appointment of new senior lecturer.
- New Nursing and Midwifery Strategy for acute care in gestation, link to new English strategy.
- Strong Midwifery training link with Salford University.
- Success of values based recruitment, resulting in zero attrition rate in last two years.
- Pro-active recruitment in Scotland.

**LOWLIGHTS:**

- Significant shortage of nurses, mental health failing to recruit, 36 vacancies in surgical. In total around 60 unfilled vacancies.
- Long waiting periods for DBS checks aggravates the shortages.
- High levels of sickness absence leading to inadequate cover in acute wards exacerbated by number of beds used for those awaiting a nursing home place.
- Staffing levels based on bed occupancy rather than demand (which is the standard practice in England). A number of wards have 100% occupancy and yet are only staffed for 70% occupancy. Recent and well-referenced UK statistics demonstrate that ward-based RN staffing is significantly associated with reduced mortality for medical patients.
- New medical appointments are not accompanied by funding for the nursing support that goes with it.
- Lack of 24 hours palliative community nursing (at home).
- Gaps in nursing home provision give rise to higher than expected hospital mortality rates.
- Business cases for specialist nursing posts are not seen as a priority and are rejected.

**SUMMARY:**

Monthly NMAC meetings of all senior nurse managers is good use of time enabling the Chief Nurse to give a clear lead on collegiality, be updated on concerns in the different areas and gain agreement on solutions to current issues. Revalidation for nurse and midwives is the current priority. Current sharp focus on recruitment and retention of nurses is very wise at a time of significant UK and Manx nurse shortages. New Return to Nursing campaign launched. Withdrawal of the LSA contract for midwifery supervision leaves a critical gap that needs addressing urgently.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Recognise the centrality of registered nurses to the Health Service and appreciate through actions that increases in specialist nurses are essential to, e.g. cancer care, district and community nursing and EMI care.
- Give greater scrutiny to business cases for specialist nurses.
- Department needs to be proactive in removing supervision of midwives from the legislative framework and in making new arrangements for their supervision.
- Give consideration to extending the good work in on-Island nurse recruitment and training to include training for care home nursing.

**HSCC MEMBER:** Sue Gowing

**AREA OF SCRUTINY:** Nobles Executive Team

**ACTIVITY NAME & MEETING FREQUENCY:** NET meets 2nd Wednesday each month

**HIGHLIGHTS:**

- Timed agenda, exception reporting & clear timetable for report submissions, with consistent attendance by Divisional Managers and Clinical Directors.
- Timely Management accounts with budget holder accountability and invoice verification.
- Service Improvement Plans – ongoing performance assessment now in place.
- Monthly Performance days for Divisional Managers are now embedded.
- Pilot scheme to form an Acute Medical Unit encouraged cross Nobles co-operation, improved outcomes for patients, positive staff engagement, reduction in bed occupancy.
- Number of incidents with harm has decreased; more transparency and Root Cause Analysis.
- A smaller number of WMQRS peer-to-peer reviews have ensured less disruption to NET participants and staffing this year from preparation for visits.
- Outsourcing initiative with clinical correspondence has improved a long-standing concern.
- Mixed results from this year's waiting list initiatives; endoscopy at RCDH very successful.

**LOWLIGHTS:**

- Business case and other presentations are long on clinical detail, but short on funding implications.
- Business case progression still not transparent, leading to demoralised sponsors and staff.
- Too much focus on operational issues to the detriment of strategic thinking.
- Recruitment and retention issues prevail at Nobles. Retirement demographics a concern.
- Staff absence remains high and OHR statistics lack narrative with ongoing accuracy issues.
- Complaints rising: earlier intervention noted but their complexity affects response times.
- Despite strenuous recruitment efforts, nursing vacancies are still in excess of 50 FTE.
- Ward 20 closure has increased pressure with some Medical wards on 100% capacity but 70% nurse establishment levels. UK statistics have shown that this can affect mortality rates.
- Increasing surgical and medical locum overspend; unfilled bank slots; increase in falls noted.
- Patient Experience Indicators are completed inconsistently. Discharge advice remains patchy.
- Diagnostic/Pharmacy Service-staff continuity issues. Seven day business case not successful
- Core Division-hard won cost savings, frustrated by lack of stock centralisation causing waste.
- Medway system unstable post August upgrade, waiting list accuracy affected.
- WMQRS report recommendations increasing following two further visits. Action Plans slow to progress despite formation of Quality Improvement Board in March 2015. Treasury approvals for funding appropriate business cases from £4.1m Health Inspection fund has been low with less than 20% spent although 60% has been earmarked against specific proposals.

**SUMMARY:**

NET reflects other members concerns that issues are repeatedly identified and solutions quantified, but remedial action is painfully slow despite Divisional Management and the overall Health Services structure being more stable in this reporting period.

Day to day operational matters continue to be managed within Nobles Management and staff, but until analysis translates into actions, the pervading feeling is that necessary fundamental changes are still stuck in the pipeline, with consequences of continued low morale and high staff absence.

There seemed to be no consequence for non-compliance with requested Cost Improvement Plans by some Divisions. With 80% of budget being payroll related, and the current staff shortages across the NHS forcing up locum rates and agency fees, it's perhaps understandable that Management and staff feel they have little ability to control these costs.

Nobles' budget, although built on outdated foundations, has received some reconstruction with further financial consultant support from Deloittes. Finally 60% of the £4.1m Health Improvement Fund has been earmarked for approved business cases, though initiatives remain limited to one-off innovation without continued financial budget support for any ongoing staffing costs.

**RECOMMENDATIONS:**

- The term Spend to Save, needs further explanation to provide a clear reminder that overall there is no additional funding available for ongoing costs. Disillusionment is setting in amongst staff preparing business cases that receive no feedback or funding.
- Clear direction on the prioritisation of services is needed in consultation with the clinicians and waiting list initiatives should be recognised as a sticking plaster rather than a solution. A focus upon Value for Money in the short term should not delay tackling the issue of sustainability.
- Noble's financial position continues to worsen despite negative budget setting. It seems demoralizing to set a budget which in 2015-16 was £5m less than the actual costs of 2014-15, without agreed Cost Improvement Plans in place. External upward pressure on locum and agency costs must be challenged and proposed solutions be communicated. Budget holders must feel they can exert influence and control, rather than a focus upon invoice coding.

**HSCC MEMBER:** Colm Andrew

**AREA OF SCRUTINY:** Office of Human Resources (OHR)

**ACTIVITY NAME AND MEETING FREQUENCY:** Monthly one-to-one meetings.

**HIGHLIGHTS:**

- New work permit regulations were introduced in Q4 2015. These made nurses, midwives and social workers exempt from requiring a work permit if they are not Isle of Man workers.
- A project looking specifically at staff absence at Nobles was started in Q1 2016 involving direct assistance from OHR and an aftercare plan to ensure new initiatives are continued.
- A Return To Practice programme has been heavily advertised, aimed at Nurses who have been away from practice for over three years, with the first of two six month courses due to commence in September 2016.
- A plan to actively recruit from Spain has been formulated in early 2016 and is expected to be ongoing from mid-2016.
- An Online Absence Reporting System is now operational which will facilitate the efficient reporting (and therefore analysis) of staff absence.

**LOWLIGHTS:**

- The Interim HR Director's contract finished at the end of 2015, but at the moment no discernible changes have been implemented as a result of the work she carried out.
- Statistics and data still have ongoing flaws which make their accuracy and interpretation less robust than it should be. All statistics also need to have clear target levels to determine and highlight any under-performance at an early stage.
- Active vacancies have increased significantly during the reporting year and despite the challenges of recruiting in an island environment, they remain a concern. Specialist posts are particularly difficult to recruit to and require smart solutions which are not cost heavy.
- Operational issues (such as absences not being closed for anything up to three months) need to have procedures in place to help Managers in the DHSC effectively deal with them. Without clear guidelines/deadlines for administrative work, the whole system becomes hit and miss with poor/inefficient performance becoming acceptable by default.
- Absence through sickness across the DHSC remains worryingly high.

**SUMMARY:**

An HR operation of a Health Service without issues will never be the case, but the approach to how they are tackled is key. If there is a weary acceptance of some issues, it is difficult to see how they will be turned around.

Changes in senior leadership over the reporting period have caused uncertainty and slowed some of the progress, but there has been a clear upturn in 2016 in terms of a positive approach and (just as importantly) a direct one. Overall however, too much time has been spent drawing up plans and strategies and thinking about things, rather than going in and actually implementing short/medium term procedures which will have a more immediate effect.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- The issue of flawed data, making analysis and decision-making sketchy at best, should be resolved and a system put in place which will provide accurate and timely information.
- There should be a targeted project purely to tackle culture change within the DHSC's middle management, to ensure that staff absence stops being an almost acceptable by-product of the working environment and its reporting an inconvenience. All the while this (albeit understandable) attitude is allowed to pervade, there is realistically no real chance of the issue turning around.
- Too much time and energy is spent on short-term firefighting, rather than medium-term solutions. Again, this is an understandable reaction when dealing with daily operational issues, but until the cycle is broken there is little chance of tangible change.

**HSCC MEMBER**: Tracey Hellowell

**AREA OF SCRUTINY**: Patient Safety Walk – Noble's Hospital

**ACTIVITY NAME AND MEETING FREQUENCY**: Patient Safety Walks at Nobles Hospital – monthly

**HIGHLIGHTS**:

- A thorough reporting structure is in place.
- Actions are clearly indicated and logged in the Chief Nurse's office.
- Patients feel that they are listened to.
- Managers appear to have bought in to the activity.
- Staff have an opportunity to discuss concerns they may have or suggestions of improvement to the overall running of the ward.
- Going forward it is agreed that quarterly reports are presented to the patient experience and quality committee, which again is chaired by a lay representative.

**LOWLIGHTS**:

- Still obvious dysfunctional activities in some wards.
- Although reporting procedures are carried out, it is difficult to see the results of actions.
- Too many layers in the amount of committees involved in the process.
- There is still a need for a change in overall culture and responsibility taken.

**SUMMARY**:

Due to a change in committee members part way through the year it is difficult to comment fully on the overall picture and the effectiveness of the activity. However, communication with the Interim Associate Chief Nurse confirmed that reporting is correctly carried out although there may be too many layers of committees in the activities around the patient voice. It is less clear regarding the effectiveness of the activity when there are other committees who are also in place to care for the patient centred care. There is the Patient Safety and Quality committee and the Patient Experience and Quality Committee and these multiple layers will only serve to dilute the original activity.

However, it is important that the HSCC should get down to the grass roots activities and understand the current culture in Nobles and be able to openly report on this and other findings and not just look at activities from this perspective.

**RECOMMENDATIONS TO THE DEPARTMENT**:

- To engage fully with the staff and understand the current culture and apathy which seems to be a key issue. This will also assist in retaining current staff and employment and retention of new staff members.
- Although reporting procedures seem to be working, ensure that this is not just a paper exercise and that the actual recommendations which are laid out, are understood and carried out.
- Streamline the patient voice committees so an understanding through the process is not diluted.

**HSCC MEMBER:** Dr Malcolm Norris

**AREA OF SCRUTINY:** Public Health Directorate

**ACTIVITY NAME AND MEETING FREQUENCY:**

Directorate Staff Meetings every four weeks to plan future actions, report progress. Health Protection Committee, approximately three per year. One to one with the Director, occasional.

**PURPOSE OF INTERACTION:** To independently observe and offer guidance to the Public Health Directorate

**HIGHLIGHTS:**

- The recovery of the morale and comradeship of the directorate staff, after the departure of the previous CEO who had stated publicly that he could not see the point of Public Health, and could think of better ways of using the money.
- The detailed preparation of a business plan that would carry out the basic level of the new plan for the Health Service by helping people to better look after their own health.
- Continuing to help reduce some of the major causes of ill-health, either directly (eg smoking) or strategically, such as in weight management (especially in children), vaccinations, alcohol and drugs, and sexual health. This has involved the dropping of some operational delivery that staff used to provide.
- The change in structure and culture following the appointment of the new CEO allowed the Public Health Directorate to increase the pace of change, providing the context against which much progress has been achieved.
- Creation of a health intelligence work stream that, for the first time, is routinely analysing data to get an accurate picture of health, ill health and mortality. The first set of indicators will be published shortly.
- Healthcare Public Health (evidence based decision making on what treatments etc, should be funded by the NHS) is now flourishing, as demonstrated by Public Health taking over the chairing of the Clinical Recommendations Committee.
- A formal arrangement for professional support from Public Health Scotland is helping Public Health to thrive.

**LOWLIGHTS:**

- The previous CEO set out to greatly reduce the Public Health staff, trying to halve their numbers by the time he retired in early June.
- Difficulty in the spring of 2015, of operating through a Director of Health and Wellbeing, the function of which was not clear. During this period the Directorate had to work on creating a modern Public Health Directorate without attracting too much attention.
- Difficulty reporting to the Director of Health and Wellbeing, and thence to the Director of Integrated Care. The reporting route was subsequently changed so as to be directly to the new CEO.
- The recurrent comment from the Public Health Directorate team is the possible loss of the current Director. The depth of vision and leadership of the current Director are greatly admired and respected by them, and they are nervous of the outcome if they lose her.

**SUMMARY:**

A commendable recovery from the low point reached in late May 2015, to provide a modern Public Health Directorate ready to serve the demands of the new health plan.

The HSCC welcomes the agreement to establish an Island-wide Joint Strategic Needs Assessment (JSNA) programme, and would like to see this progressed and properly resourced.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Need to establish clear cross-government working to improve health and wellbeing, as stated under Prevention on page eight of 'Health and social care in the Isle of Man – the next five years'.
- Make the position of Director substantive at the earliest opportunity, this being vital to the continuing good operation of the Public Health Directorate.
- Public Health Directorate to inspire and support the public to take steps to look after their own health, in keeping with the basic principle of the new strategy for the Health Service.

**HSCC MEMBER:** John Whitehouse

**AREA OF SCRUTINY:** Quality Improvement Programme

**ACTIVITY NAME AND MEETING FREQUENCY:** Quality Improvement Programme Board - every six weeks

**HIGHLIGHTS:**

- First evidence of true implementation planning and oversight for the delivery of significant change within the Health Services.
- Programme Scope clearly defined and focused on delivery of change following West Midlands Quality Reviews and Francis Report Action Planning.
- One single responsible manager for the delivery of the overall change portfolio with the ability to show clear line of sight from CEO to Change Area.

**LOWLIGHTS:**

- Progress of change from completion of initial project charters to project plans and evidence of change is moving at a pedestrian pace at best, in one example it taking over six months to outline and agree the scope of one work stream and unfortunately not an isolated example.
- Almost all projects/work streams are being managed and executed by existing staff without any reduction in their previous workload; this is contributing to the slow pace of progress.
- Professional Change Management controls lacking within many projects/work streams resulting in overly optimistic project plans and lack of true Risk and Issue identification, management and escalation.
- Little or no evidence of succession planning for coverage of augmented resource (contract resource) resulting in a continued need for contract resource.
- Non-delivery against key milestones passes largely without challenge or understanding of the support needed.
- Meeting used for review of monthly/six weekly reports, rather than to drive focus on the delivery of the change and review of key risks and issues.

**SUMMARY:**

The Quality Improvement Programme has a clearly defined scope and is arguably well placed to be able to deliver the changes that are within its scope. It is however, struggling to gain traction and has a significant volume of deliverables missed.

There is no evidence to suggest that this is as a result of lack of competence. Far from it, those working on the individual work streams have a clear grasp of what needs to be completed and how to deliver it.

The issue is therefore not competence but capacity. In almost all cases, the project activities for the various work streams are being managed and completed in addition to individuals' usual workloads.

The programme board also needs to step back from the minutia and focus on the deliverables and those risk and issues which are or may impede progress.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Consider creating short term capacity to support an accelerated delivery against key work streams/deliverables.
- Refresh the programme board approach to focus on deliverables achieved/missed and those risk and issued that may or are impacting progress, looking at the detail of individual projects or work stream by exception.

**HSCC MEMBER:** Andrew Swithinbank and Linda McCauley

**AREA OF SCRUTINY:** Strategy, Governance, Consultation and Legislation

**ACTIVITY NAME AND MEETING FREQUENCY:** 1:1s with the CEO, Deputy CEO, Director of Policy & Performance and the Minister and CEO; three Workshops and three consultations.

**HIGHLIGHTS: Strategy including 5-Year Strategic Plan**

- Moved from 'Vision for Health' in Spring 2015 to October 2015 Tynwald approved '5-Year Health and Social Care Plan'.
- 5-Year Strategic Plan is clear, concise and focused. It envisages moving forward with integration of Health and Social Care through shared goals and actions.
- Clearer understanding of the scale and complexity of a diverse Department focusing on the key problem area of the Hospital (lack of clarity on accountability, decision making & roles).
- Identifying priorities of 'Value for Money, Customer Satisfaction and our Staff' which will frame the move to more integrated services.
- Other Strategies for Tobacco and Mental Health have been published.

**HIGHTLIGHTS: Governance**

- A pyramid Governance with Department (Minister and Members), Senior Management Team ('The Board') established January 2016.
- Assurance Committees (Sub Committees of 'The Board') emerging.
- Director roles established as responsible across Department rather than just their Divisions.

**HIGHLIGHTS: Engagement by Department with the HSCC**

- Extensive and proactive engagement by the Department with the HSCC over the year.
- Meetings at all levels from Minister to front line staff.
- Extensive opportunities for questions and views of the HSCC to be taken account of in Workshops and by Senior Officers.

**HIGHLIGHTS: Published Consultations including Draft Strategy and Legislation**

- Draft 5-Year Strategic Plan – need to more fully integrate Health and Social Care
- Health and Social Care Bill – concern that it does not cover all the 'subjects' which require addressing in legislation. The Bill moves the Department towards:
  - Integrated care
  - Joint commissioning across services
  - Wider remit for the HSCC
  - a Charter for Health and Social Care
- Guidance on the meaning of Disability and Code of Practice to enact the Disability Discrimination Act.

**LOWLIGHTS: Strategy including 5-Year Strategic Plan**

- 5-Year Strategic Plan does not fully integrate all services e.g. Social Care appears as an add-on.
- Need for clearer plans as to the methods for involving non-government organisations, patients and public in the development of health promotion and regional hubs.
- Commitment to strategic change evident but some apparent reluctance to force through budget reallocation.
- Mental Health Strategy does not fully reflect the direction of travel of the Department towards integrated health and social care.

**LOWLIGHTS: Governance**

- A fully functioning Department Board of Senior officers has been lacking for most of the year which has resulted in the Department being unable to effectively embark on the Goals and objectives set by October 2015 Tynwald.
- The Assurance Committees which will drive Goals and Actions have yet to be established.
- There is an urgent need for profession lead officers, e.g. Nursing to embrace their widened roles which are crucial to enable strategic change.

- Dismantling the staffing legacy of previous Chief Officers is lengthy and time consuming.

**LOWLIGHTS: Engagement by the Department with the HSCC**

- The HSCC was invited at a late, rather than early, stage to comment on the 5-Year Strategic Plan.
- Some Workshops and the Regional presentations were about presenting what had been agreed by Tynwald rather than seeking input to an evolving Strategy.
- The skills and knowledge of the HSCC members in providing scrutiny and advice has not been fully utilised by the Department, e.g. the HSCC was not invited to engage in the development of the Health and Social Care Bill or to engage in the development of the 5-Year Strategic Plan.

**LOWLIGHTS: Published Consultations and Legislation**

- The Health and Social Care Bill is limited in supporting the 5-Year Strategic Plan. Additional Health and Social Care legislation will need to be introduced. It would have been helpful to have set out in the Bill the Secondary legislation intended to be brought forward. The content of the Bill needed to be more clearly communicated prior to its introduction into the Branches.
- The Government has a 'Code of Practice on Consultation' which is mandatory for primary legislation but it is also a best practice template for policy changes. The Department's reasons for not adhering to the Code in the consultation on the 5-Year Strategic Plan have not been published.

**Summary:**

The policy vacuum that existed in 2014/15 has now been filled by the 5-Year Health and Social Care Plan and partially by support given to the Plan by the Health & Social Care Bill. The Plan is focused and gives clear direction for further policy making, legislation, governance and financial control. The Department's new team is to be congratulated at the speed on which the policy was delivered. However, it is six months since the Plan was agreed and a Delivery Plan with outcomes, actions and performance measures has yet to be published although it is acknowledged that the Delivery or Service Plan will be published shortly. The Governance structure of the Department was effectively suspended in 2014 with few meetings of established Committees and a senior management team with changing and interim staff. The HSCC understood the need to step back and assess the effectiveness of the Committees that existed and is now satisfied to see a new Board established in the winter of 2015/16. In addition the emerging Assurance Committees with their themed and focused remits and reporting structure, will reinforce improved Governance. However, the hiatus of a Governance structure has taken its toll resulting in only a few actions and delivery progress over the last year. The Department is commended for its active work in reaching out to the HSCC and the community through Workshops, senior managers and regional presentations. This work has done much to convey and seek understanding of the problems of Health and Social Care and what can be done to resolve the problems. More could be done to engage with other bodies in order to use their skills, knowledge, experience and networks to raise points which might have been overlooked to add to the policy and delivery work being undertaken. Work has concentrated on getting an agreed message out which, whilst good, fails to truly engage with the public. More legislation will be required to fully support the 5-Year Strategic Plan.

**RECOMMENDATIONS TO THE DEPARTMENT:**

- Use the skills and knowledge of the HSCC and the wider community more effectively for development of the delivery mechanisms to roll out the 5-Year Strategic Plan. This can be achieved through an early, open approach before decisions have been taken.
- Continue the improved Governance structure to ensure that all Health and Social Care meetings have a clear remit and reporting structure with accountability for actions.
- Prioritise the development of new legislation to support the Goals and Objectives in the 5-Year Strategic Plan. Good legislation is the foundation for change.

**APPENDIX A**

# 2014-15 Key Recommendations

The Health Service Consultative Committee offered a number of recommendations regarding the Health Service to 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.

**APPENDIX B**

# Department of Health (DH) Committee Representation

| DH Committee | HSCC Representative | Meeting frequency |
|---|---|---|
| Performance and Delivery Group | Sue Gowing | Ceased April 2015 |
| Noble's Executive Team | Sue Gowing | Monthly |
| Noble's Patient Safety and Quality Committee | Dawn Mayor | Monthly |
| Primary Care and Community | Dawn Mayor | Monthly |
| Clinical Recommendations Committee | Diane Kelsey | No attendance |
| Mental Health Services | Malcolm Norris/Derek Booth | Monthly |
| Steering Group for Strategy.<br>Legislation Consultations Workshops | Andrew Swithinbank<br>Linda McCauley | Not met this period<br>As arises |
| Nursing and Midwifery Advisory Council | Diane Kelsey/David Trace | Monthly |
| Public Health | Malcolm Norris | Monthly |
| DH Audit Committee | - | Not met this period |
| Quality Improvement Board | John Whitehouse/Colm Andrew | Six weekly |
| Oral Health Stakeholder Group | John Whitehouse | Not met this period |

## HSCC meeting Health Service representatives

Health Service leads used to attend part of the meetings which were held in alternate months. Since monthly meetings have been commenced, alternate meetings were held as HSCC internal meetings or with invited guests. This has been increased to meeting senior members of the health service every month during 2015-16 in order for more intensive observations of a rapidly changing management structure.

**APPENDIX C**

# Strategic Pathways

The following prioritised Strategic Pathways, selected by the HSCC, helped 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 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 following prioritised Enablers, selected by the HSCC, helped 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 complements

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

**APPENDIX D**

# HSCC Member Links to Officers 2015-16

| | | |
|---|---|---|
| Strategic Vision | Linda McCauley | Amanda Craig, Director<br>Strategy and Performance |
| Health and Well Being | Malcolm Norris (Public Health)<br>Derek Booth (Mental Health) | Henrietta Ewart, Director (PH)<br>Angela Murray, Director (MH) |
| Engaging Patient Voice | Andrew Swithinbank<br>David Trace | Linda Radcliffe, Chief Nurse |
| Integrated Care | Dawn Mayor<br>Tracey Hellowell | Iain Kewley, Director Primary Care<br>Cath Quilliam, Head Community Health |
| Culture and<br>Business Change | Sue Gowing | Tim Mansfield,<br>Director Commissioning |
| Scrutiny/Governance | John Whitehouse | Michaela Morris,<br>Executive Director of Health |

| | | |
|---|---|---|
| Managing Political Process | John Whitehouse | Ralph Peake,<br>Department Member |
| Leadership Governance | Sue Gowing | Michaela Morris,<br>Executive Director of Health |
| Community Issues | Dawn Mayor | Cath Quilliam,<br>Head of Community Health |
| Human Resources | Colm Andrew | Anne Corkill,<br>OHR Partner for Health |
| Learning and Performance | Linda McCauley | Jugnu Mahajan, Medical Director |
| Noble's Hospital | Sue Gowing | Barbara Scott,<br>Director Operations (Acute) |