Health Services Consultative Committee
Annual Report

1 April 2016 to 31 March 2017

Contents page HSCC Annual Report 2016-17

Chairperson Preface HSCC Annual Report 2016-17

The Health Services Consultative Committee (HSCC) reports annually and for the last five years has commented in particular, on the adverse impact upon performance created by constant change in senior personnel.

During this reporting period, the Department has made more management and organisational structure changes, a significant reduction in full Board meeting frequency, and formed a 3-person Executive Leadership Team. The HSCC welcomed the introduction of 12 Service Delivery Plan (SDP) priorities and a new governance framework via the Quality Committee (QC) system. However early quarterly performance reporting on the priorities, whilst published, was both late and incomplete, and slippage was evident in almost all actions and reporting areas with exceptions of Mental and Public Health Directorates. The QC governance system has been partly effective, and an overview of all the QC's is provided within this report.

The HSCC consider that both strategic analysis and actions should be delivered. However, strategies have so far outweighed actions. In addition, HSCC had only prior consultation on 50% of these. There have been a number of strategies and Plans produced over the past 2 years. Each is a heavy tome: long on good ideas but often short on follow up action and implementation plans. Unfortunately, an Integrated Care (I/C) strategy is long overdue. This is a mainstay of the 5-yr Strategy and was a specific Ministerial promise at the Public Roadshows in January 2016. It has barely got off the starting blocks. The new emphasis on I/C, with collaborative working across all Health provision, appears to remain a pipe dream.

Political decision-making is always slow in an election year. However, difficult decisions are now urgent with respect to service prioritisation. It is essential to protect services that benefit the many, rather than those that shout loudest for their cause. The provision of a sustainable Health Service for the Island is only a little nearer fruition. Nobles budget deficits are increasing despite a well justified budget realignment of £10m. The current model of health is unsustainable in the longer term, and the public have a role to play in accepting some tough clinically based service rationalisation choices. The CEO found the Monthly Board format unproductive, the Quality Committees were variable in frequency, attendance, actions and outputs. The circles of communication throughout Health Services remain fragmented.

The Communication Strategy was weak, unimaginative and repetitive, with a limited range of mechanisms, particularly in social media. When controversial health issues of interest to the public have arisen, the PR response has been in our view lacking in preparation and often badly handled. Public and staff engagement has been limited. The Committee welcomes the long-awaited appointment of a dedicated Health Communications role and expects a dramatic quality improvement in PR output/management during the 2017-18 reporting period.

The HSCC has updated its ways of working. Its range of interactions at Minister, CEO, Lead officer and QC level, are described. Such engagement has enabled members of the HSCC to scrutinise most levels of the organisation. HSCC intends to continue to adapt to change by maintaining attendance at QC's but also by measuring performance against the new Programme for Government (PfG). We remain concerned at the lacklustre state of progress, particularly in legislation. The first scheme of Health & Social Care Act 2016 is now unlikely to reach Tynwald until October 2017.

In discharging its role of independent challenge, advice and consultation, the HSCC will maintain its intense schedule with the Department in 2017-18. The HSCC asked last year for focus to be sharpened towards the creation of regional hubs, embracing telemedicine, the transformation of outdated practices and true collaborative working along clear pathways. These are all essential to improving outcomes for patients and the working lives of Health Service employees. It is bitterly disappointing to note how few are the pockets of progression. Exceptions include Mental & Public Health Directorates and Digital Strategy projects; the latter were well-funded and largely externally managed.

Some things don't change, notably: a hardcore of long-serving health staff whose focus remains on the patient; high stress levels particularly within Nursing; a long recruitment process, and a constant struggle to maintain patient safety in the face of worldwide shortages within some specialisations and over reliance on agency and locums for filling the gaps.

Finally, my thanks to HSCC members and our long serving Secretary for their considerable commitment and to Health Service leads for accepting us as trusted critical friends who share their passion for improving healthcare.

Executive Summary

The purpose of the Health Services Consultative Committee's (HSCC) Annual Report is to provide Tynwald members and the Department with independent scrutiny and advice on the performance and effectiveness of Health Services. The HSCC is a publicly appointed body whose members are tasked under legislation 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.'

Over the last year, the HSCC has undertaken its work of challenging, advising and scrutinising Health Services through consideration of the Department's Delivery Plan priorities, emerging draft Strategies, attendance at divisional meetings and Quality Committees and 1:1 liaison meetings with Officers. Each member reports to the monthly Committee meetings where information is shared and matters discussed with attending Lead officers. The work culminates in the Annual Report and Key Recommendations are made to the Department.

During 2016-17, HSCC has seen the start of a transformation to Health Services. Led by the Health and Social Care 5-year Strategy, the Department has embarked on a new approach to health moving from an emphasis on acute care to supporting people to take more responsibility for their health and integrating hospital and community services.

The Department has made progress on the changes needed by setting itself priorities for work, timescales and reporting quarterly with progress. The work has focused on solid evidence gathering on health outcomes, waiting lists, and contracts. There has been strategic consideration of Recruitment and Retention, Quality Care, and Organisational Development. Governance has been improved through a Management Board and seven Quality Committees working on cross Department subjects such as Informatics and Care Quality.

There have been notable successes during the year including Digital projects, a Research & Development Group, Drugs and Alcohol Joint Strategic Needs Assessment, improved Mental Health provision and the establishment of a Patient/client services team.

Progress, however, has been slow and patchy. Evidence collection on which to set priorities has been held up due to other Government changes. Effective engagement with staff and public has been sparse. Communication has been confined to information through traditional media and press releases. Commissioning of services and the setting of contracts has started to improve but a contract catalogue is still incomplete. Medical Nurse staffing levels continue to be a source of concern. Timely, accurate staff absence data is lacking. A system is needed to monitor the operational impact arising from strategic changes, to ensure stakeholders are protected from unintended consequences.

At the end of the period covered by this report, the HSCC has serious concerns that the Department still has a huge amount of work if it is to transform Health Services within 5 years. In particular, work is directly needed to adopt change management principles; to introduce modern systems to manage Nobles; to integrate acute and community care (this urgently needs focus and resources); to bring the Department's finances into line using solid evidence of service priorities to set budgets which give the best value for money; and to introduce the Legislation passed by Tynwald in July 2016.

In the coming year the HSCC will monitor the Programme for Government as it relates to Health Services, the Health Service Delivery Plan 2017-18 and continue its attendance at Committees and Lead Officer meetings to scrutinise the management of Health Services.

The HSCC 2016-17 Key Recommendations are set out on the following page. They are based on the evidence contained in the Member Reports within the main Annual Report and the relevant Appendices.

Our previous Annual Reports, current membership and other information is available on the Government website at:

https://www.gov.im/about-the-government/departments/health-and-social-care/committees-and-groups/health-services-consultative-committee/

If you have any feedback or questions on this year's Annual Report please email us at hscc@manx.net.

HSCC Key Recommendations 2016-17

The HSCC recommend:

R1 2016-17	**Care Quality and Safety Committee**	that a supportive structure, pertinent funding and a clear definition of the Integrated Care model is created to facilitate the transfer of services and support Community Health Services in managing the increased workload
R2 2016-17	**Commissioning QC**	that DHSC complete the catalogue of contract management to allow them to exercise tighter control over the Health budget
R3 2016-17	**Finance QC**	that all Divisions should bring significant financial expenditure proposals for cross departmental scrutiny
R4 2016-17	**Informatics QC**	wider adoption of the change management principles as demonstrated by IQC for all areas that are not technology driven
R5 2016-17	**Mental Health Directorate**	that management of Manannan Court ensures a reduction in the numbers referred to the UK for treatment
R6 2016-17	**Nursing and Midwifery Advisory Council NMAC**	following 2017 establishment review, that nurse staffing levels are adjusted to meet individual ward occupancy, particularly in medical wards
R7 2016-17	**Nobles Executive Team/Senior Management Team**	that a wider and more modern and positive range of mechanisms are used to manage Nobles Hospital and Cost Improvement Plans are met
R8 2016-17	**Office of Human Resources QC**	that accurate staff absence data is produced monthly and Key Performance Indicators are drawn up which are reviewed quarterly at CEO level
R9 2016-17	**Primary Care Division**	that overall adult discharge procedures have improved collaborative working connecting Community Health Services (CHS), Social Care and Acute services
R10 2016-17	**Public Health Directorate**	that Public Health continue to develop Joint Strategic Needs Assessments (JSNA) in order to support the prioritisation of services
R11 2016-17	**Quality Improvement Programme QIP (now devolved to divisions)**	that the implementation of reasonable, relevant recommendations from the WMQRS should be reported via standing agenda items on QCs and divisional meetings
R12 2016-17	**Stakeholder Engagement QC**	development of a monitoring system to minimise negative operational impact of strategic developments upon stakeholders
R13 2016-17	**Transformation QC**	that legislation should be prioritised and accelerated to underpin progress on the 5-year strategy.

Further recommendations can be found in the HSCC Member Annual Reports section

HSCC Engagement - Current and Future Ways of Working

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 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, Mental Health Commission, Independent Review Body.
2. Look to measure the performance of the clinical effectiveness of the Department as it is not qualified to do so.

HSCC meeting format:

- Monthly meetings to scrutinize Health Service activity
- Itemised agenda with each member tasked to reports and actions
- Member reports of meetings circulated in advance
- Exception reporting and debate of current issues
- Bullet point summary of interest and concerns circulated to DHSC
- Individual DHSC officers invited to address meetings every other month
- Regular email correspondence to/from DHSC

Monitoring:

- DHSC related debates and questions in Tynwald
- Written and verbal Health related questions in HoK & Tynwald
- Consultations, Strategies, Policies and Legislation
- Contract management
- Communications Plan, Health PR & News Releases
- Regular 1:1 meetings with Link officers
- Annual Meet the Minister Q&A session
- Quarterly CEO meetings – with membership or Chair & Vice Chair
- New Bi-annual meeting with Minister and Department Member

Member attendance:

- 7 Quality Committees: i.e. Care Quality & Safety, Commissioning, Finance, Infomatics, OHR, Stakeholder and Transformation
- Eye Strategy Meetings
- Health Protection Committee
- Mental Health Management Board
- Nobles Executive Team
- Nursing and Midwifery Advisory Council
- Patient Safety Walks
- Primary Care Divisional Meetings
- Public Health Staff Meetings

Submissions:

- Public Account Committee
- Social Affairs Policy Review Committee

Annual Report:

- To Tynwald and available to the public via Government website.

A: Review of Previous HSCC Key Recommendations

The HSCC has combined its previous 2 years of key recommendations from 2014-15 and 2015-16 and rearranged them into three priority areas:

Strategic, Engagement and Finance/Commissioning.

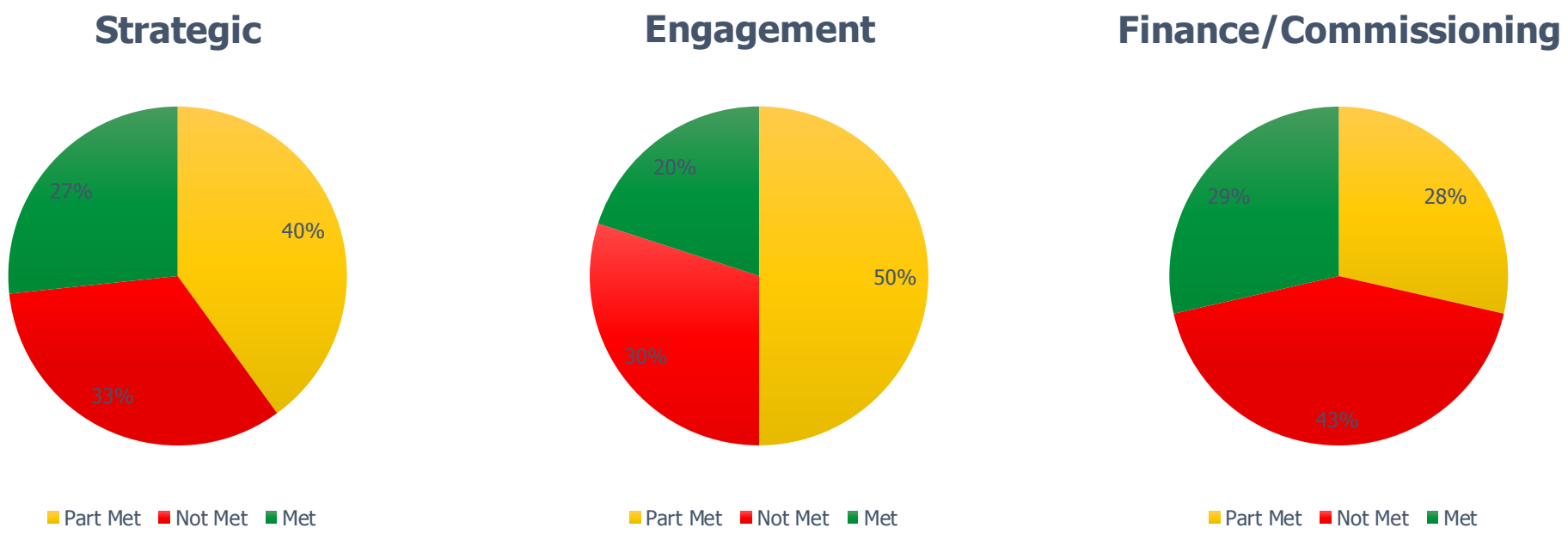
We had previously reported on 2014-15 progress in April 2016 within our last annual report.

However, the HSCC has now further reviewed these recommendations with those of 2015-16 and independently assessed progress against the same , based on the evidence it has available and observations made during the past year.

As is evident throughout our annual reporting, the HSCC feels that its recommendations have been largely accepted by the department.

However, it is the pace rather than the direction of change where we find progress unacceptably slow.

The HSCC performance assessment on delivery against our recommendations is set out in detail in appendix A and is illustrated in the charts below:



The HSCC feels progress in Finance and Commissioning has far to go whilst being pleased that many other recommendations are at least Part Met.

B: Quality Committees and Management structure changes - HSCC review

HSCC was pleased to see DHSC start April 2016 with a new Governance structure reflecting 2015 WMQR recommendations. A full Board in place chaired by CEO with all directors, business partners and professional leads, meeting monthly to address the key business of the Department, looking at Finance, Strategic Delivery, Performance and key operational decisions. Below the Board sat 7 Quality Committees (QC's), chaired by the relevant directors- to provide the overview needed by the Board on the activity and risk across each of the key areas of business in the Department.

Some QC's got off to a slow start as dates were difficult to set and Terms of Reference (TOR) and membership had to be agreed. The quality of any committee has much to do with both the TOR's and the motivation of the membership. As the table below indicates, some are very commendable and have met frequently with good attendance and performance. Others, however, have not met regularly and/or have had a number of meetings cancelled due to member unavailability. In addition, some have such poor TORs that they add little or no value to the Department. More details of QC meeting frequency, attendance and TORs can be found in Appendix B.

Quality Committee	Observation
Care Quality & Safety Committee	Open and frank discussion between service areas. Useful opportunity for sharing good practice between areas.
Commissioning QC	Original TOR a bit woolly, has not yet got commissioning under control. Now amalgamating with Finance QC.
Finance QC	FQC should bring significant expenditure proposals for support and scrutiny, but this does not happen on a regular basis.
Human Resources QC	Lacks incisiveness, resulting in progress being laboured with much discussion but few tangible results so far.
Informatics QC	The IQC is well attended and administered effectively. It provides a communication forum and most importantly provides a clear prioritisation of technology enabled change in Health.
Stakeholder Engagement QC	The SEQC has had some good presentations but some lack of attendance by some essential members.
Transformation QC	Noticeable absence from medical side at times. Agenda items majority strategic with lapses into operational matters.

This revised management structure included new interim Directors in Finance and Projects. In October, the Department created a new Division (Informatics Division) which reflects the growing impact of the Digital Strategy within DHSC. A further change to the management structure of the Department was proposed in October 2016 and finalised on 1st January,2017. This created the Executive Leadership Team (ELT), and moved the Board to meeting quarterly (except for when extra-ordinary meetings are required). Retirements in the last quarter in Estates and Primary Care have led to further changes in the structure; including GP contracts to Commissioning. Directors are grouped into two reporting areas to ELT – operational services for acute, community and social care services and all corporate services. Professional leads and Informatics now report directly to CEO.

Comment: The HSCC has advised that the absence of monthly Board meetings in general, and a clinical advice presence in particular, continues to be a concern. We would observe that communication to and from the Board has appeared to suffer as a result, with insufficient standing agenda items to ensure a circle of communication between it and QC's. From April 2017, the Board has reduced the number of monthly QC's as above.

The HSCC would now hope for a long period of stability in the management structure as constant refinements are confusing, time consuming and distracting for all, and do nothing to combat public perceptions that focus should be on action, service prioritisation and customer engagement, rather than repeated management reorganisation.

C: Service Delivery Plan (SDP) – Performance Comparisons

The Department has set out a Service Delivery Plan with 12 Priorities and over 50 actions. Against each Priority, they have completed a self-assessment of their progress. This is illustrated below and in detail in Appendix C:

However, before looking at the 12 Priorities, it is useful to take a wider view point and ask whether the 12 Priorities identified are the right ones to take Health forward to achieve the Vision and 5 Pillars set out in the 5 Year Strategy. Looking at Health from the HSCC perspective, the Committee has set its own 2016/17 recommendations which contained several finance/budget, integrated care and HR matters. It is therefore surprising that Finances/Budget is not a Strategy Priority. It could be argued that Finance underpins the Strategy but this could also be said for the Digital Priority.

There was no differentiation between the Priorities, they all have equal status. However, again, the HSCC from their discussion and recommendations have agreed that Integrated Care, HR, contract sorting and prioritising services through the JSNA are pivotal to the Strategy and should therefore have been given more focus. This lack of focus on important Priorities leaves increasing doubt as to whether the Strategy can be achieved in 5 years.

The relatively 'easy' Priorities such as the Patient Information Service and the Research and Development have been achieved, or close to it. The hard to do Priorities would appear to be just so, and have not been tackled in the robust manner which they require.

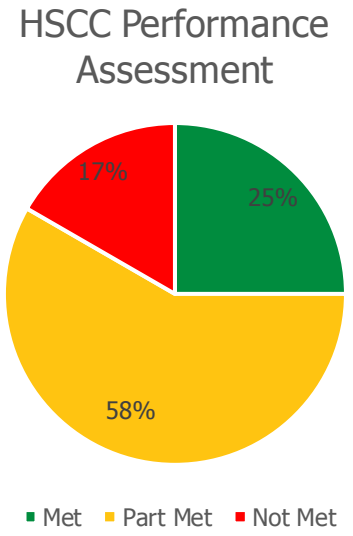
A good example of this is Integrated Care which languished for 6 months with little progression; it clearly suffered from the lack of a Project Plan. After 12 months of little action apart from Focus Groups and a Task and Finish group, it is still far from being moved forward and lacks even an agreed definition. This lack of focus is worrying because many of the other Priorities and Actions in the Strategy are dependent on a new approach to Integrated Care.

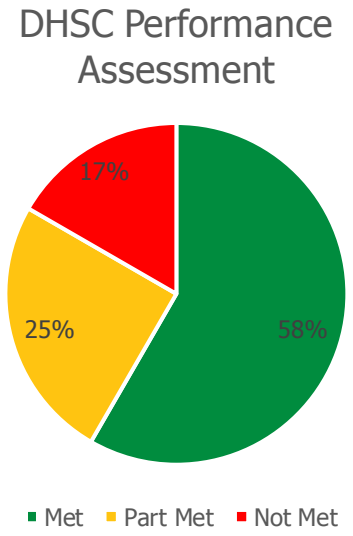
The HSCC has further reviewed the objectives and independently assessed progress against the same based on the evidence it has available and observations made. The HSCC assessment is set out below.

This clearly shows a less favourable picture than the Department's self-assessment. Fuller details of the Department's Assessment and that of the HSCC are set out in Appendix C.

The HSCC recognises that good progress has been made in some areas and the Department has a positive trajectory in others and this is reflected in our assessment.

However, care is needed to ensure that the Department is not overly optimistic in its own assessment of progress as this may damage staff and patient engagement.





D: DHSC Strategies and Plans 2015-17 – consultation, implementation, action – HSCC review

A large number of Strategies have been compiled during this reporting period. The HSCC welcome the strategic approach to policy formulation but has some concerns. Content of some of the Strategies is patchy, some Strategies have been compiled without consultation and engagement with staff, public and indeed the HSCC. Most importantly some Strategies have a lack of actions flowing from them. **Also see Appendix D**

Strategies & Plans	Observations
Digital Strategy Health Section Not consulted	Has received substantial funding to ensure success when many other health business cases have not had the same level of priority or funding.
5-Year Strategy Consulted	The Strategy sets out 5 clear areas for improvement, the pillars of the Strategy. However, it revealed some disjoint between Health and Social Care.
4 Domains of Public Health Consulted	The introduction of JSNAs to gather health intelligence is the first significant change to health intelligence, the results of which will help feed information to the other domains.
Strategic Plan for Mental Health and Wellbeing Consulted	The HSCC welcomes the introduction of a 6-stage structure, generally recognised in mental health in England as the most appropriate way to deal with mental illness.
Communications Strategy Consulted	Plan lacks key elements and detail, is full of rhetoric and little substance, resulting in a fairly meaningless document.
Eye Care Strategy Consulted	Progress is slower than anticipated although there is clear joined up working with the voluntary sector.

Strategies & Plans	Observations
Quality Strategy Not consulted	Puzzling as to how QS fits into the overall DHSC jigsaw. HSCC has no publication date and has not seen a final document.
Organisational Development Plan Programme 2016-20 Consulted	The ODP is one of the 12 priorities updated in the 5-year Strategy. The Plan is progressing with high level changes. No detailed updates have been received to date.
Recruitment and Retention Strategy Not consulted	This Strategy was developed to tackle the increasing number of hard to recruit posts within DHSC. Since launch there has been limited operational follow up on the ideas it put forward.
Integrated Care Not consulted	The HSCC understood that this strategy and a clear definition has been in progress for some time but shows no sign of fruition. The Southern Care Initiative (SCI) pilot was the latest reason for delay.
Programme for Government Centrally decided	The original document did not reflect the existing 5-Year Strategy 5 Strategic Aims, but following amendments in Tynwald it now does so.
Customer Experience & Engagement Strategy Not consulted	This was highlighted as required by the Francis Report and within the West Midlands Quality Review Service recommendations.

HSCC Member Annual Reports 2016-2017

Committee	New developments	Evidence of good practice	Issues causing concern	Outstanding issues from previous report	Evidence, justification or rationale for recommendations	Recommendations
Care Quality & Safety Committee (CQSC)	The CQSC includes the Directors from across the DHSC. The Committee shall be responsible for oversight of the services provided and commissioned by the department and the health and safety of our customers and the people providing those services.	Medical validation. Overall positive and compliant for both Doctors and Nurses. WMQR – Presentation of Action plans and comprehensive progress report for each area. Mortality group meets weekly to review all Nobles in-patient deaths Patient Safety Walks - Action plans & compliance good but staffing issues and need for consistency. Quarterly Partnership Board with Social Care & Mental Health Directors & reps from police & prison. Establishing of the Southern Community Partnership pilot, seeking to engage the community.	WMQR – Few of the recommendations can be met without additional investment. Lack of rehabilitation services resulting in poorer health outcomes since the closure of Ward 20. Reliance on agency & locum staff leads to lack of consistency & impacts on morale & patient safety. Dramatic increase in the number of GP referrals to Nobles consultants. Increase nursing establishment in Infection Control, lack of antimicrobial pharmacist. A&E - non-compliance of the built environment with the guidelines for this type of care.	There are distinct differences in approach and outcomes between the Health and Social Care services. However, the CQSC provides a forum for robust discussion between the various disciplines, promotes integrated working and shared learning and seeks to challenge silo mentality.	Procurement and Commissioning issues emphasize the need for increased transparency. Concern over lack of clinical arbitrator and decisions made by Commissioning or Finance, without full comprehension of clinical issues, outcomes or consequences. Business case information with clinical input submitted repeatedly, reflecting a discord between Treasury procurement and Commissioning, at the expense of patient safety.	1 Procurement & commissioning issues highlight the need for clear consistent framework. 2 Community Health Services struggle to manage complex patients without the necessary infrastructure and funding. 3 Yet again the transfer of services from Acute to PC is highlighted. PC is not sufficiently resourced to meet the demands of the 5-year Strategy. A supportive structure, pertinent funding and a clear definition of the Integrated Care model is urgently required.
Commissioning Quality Committee (CQC)	This committee has not met recently. There was a clear overlap with the Finance QC and as a result the two committees are becoming the Finance and Commissioning Committee (FCC).	The Clinical Recommendations Committee (CRC) now feeds into this committee so there is both clinical and financial oversight. CRC policy decisions are reviewed and recommendations made	Important developments are agreed but there is no funding to implement them. The consequent savings required in different divisions cannot be made so e.g. 7 day 24-hour Stroke Thrombolysis remains	Joint Commissioning of Services still not implemented. A comprehensive control list of all Department contracts is still outstanding, despite concerted efforts to complete it.	CRC TOR are out of date, and need to be aligned with Finance and Commissioning. Similarly, TOR for the Individual Funding Requests Panel (IFRP) must also be aligned to both CRC and FCC.	1 Need to have CRC and IFRP aligned with FCC with appropriate TORs. 2 Oversight and control of contract management is essential. 3 FCC needs to exercise

		to the Minister. Development of referral management centre to impose controls on tertiary commissioning.	unachieved. Strategic Commissioning and programme budgeting based on need should replace historic funding.			control over spending to free funds for commissioning.
Finance QC (FQC)	FQC should provide assurance regarding financial performance financial controls and management and business risk but excluding clinical risk. FQC merged in future with Commissioning.	Divisional financial reports, audit reports and capital plans were provided centrally for review. Some significant expenditure proposals were brought by Mental Health Social Care Adults, Children & families. Implementation of outstanding audit actions was pursued. Treasury attendance was useful.	Significant expenditure proposals were not widely brought for support and scrutiny on a regular basis. Opportunities for improving understanding on cross department financial issues and to debate solutions were rarely used. Monthly update on Nobles efficiency document required but not always provided.	Nobles Cost Improvement Plans continue to fail without consequence. Forensic cost analysis has not brought any improvements in the financial position.	Financial performance is provided centrally so there is a lack of individual accountability within some Divisions. Contribution by some Directors is limited to self-interest topics. Although on the TOR's the context of risk and expenditure decisions is not an integral part of each meeting.	1 All Divisions should bring significant financial expenditure proposals for cross departmental scrutiny. 2 A focus on analysis of department wide controllable expenditure rather than a protectionist attitude. 3 A regular risk register review is included.
Infomatics QC (IQC)	There has been a regular throughput of well thought out technology enabled changes, for example digitisation of the hospital patient records.	The IQC is well attended. Not all business cases have been approved, evidence that the challenge process is working where the business case has not been robust enough to pass the hurdle rake.	The IQC is working efficiently and a number of positive outcomes have been overseen by its associated processes and controls. The ability to deliver change through the IQC highlights that change can be delivered when managed and funded appropriately.	Change could be delivered but required dedicated resource to manage the change and avoid the notion of work being completed 'off the side of the desk'. It would therefore seem appropriate that the principles applied by IQC/GTS be more widely adopted through Health in areas where change is not being facilitated through new technology.	There is evidence that the IQC and Government Technology Services (GTS) are sharing their processes for success with other areas of Health but there is little evidence that Health, as a whole, are adopting the processes that have been seen to deliver change.	1 Wider adoption of the change management principles seen in IQC for all areas of Health where change is not being enabled through a technology enhancement.

Mental Health Directorate (MHD)	Problem of forensic patients - cost should not fall on MH. The opening of Manannan Court allows far more work to be done on the island. The training of more staff to carry out DBT, the reduction in the number of patients being treated in the UK and the employment of staff reduces the cost of off Island treatment.	Manannan Court is a good example of careful planning and implementation, providing a building with all the latest safety features in order to protect patients from hurting themselves.	(1) the situation of forensic patients and (2) that of patients discharged from hospital care. Those under (1) are referred to MH by the justice system. Since there is no way of calculating in advance how many there will be in a year, nor what level of treatment they will require, budgeting is virtually impossible. Those under (2) may be required by section 115 of the Mental Health Act to continue to be cared for by Mental Health: again precise advance calculation is almost impossible.	The issue raised last year was that of publicity. Overcoming the stigma attaching to mental illness is not easy. MH are making efforts to improve the situation and this has been helped by the increase in awareness of mental health, by the opening of Manannan Court and the invitation to the public to view it before any patients were admitted.	Mental Health has considerably reduced budgetary overspend this year and with this recommendation should be able to stay within budget in 2017-18. Manannan Court should bring a number of improvements to the effectiveness of Mental Health.	1 In order to continue to reduce overspend, obtain a political solution to the problems of forensic patients and that of Section 115 patients. 2 Mental Health and DHA to liaise more closely to resolve the issues associated with prisoners who have mental health issues. 3 Ensure that Manannan Court works effectively so reducing the numbers referred to the UK and by offering better treatment here.
Nursing and Midwifery Advisory Council (NMAC)	To date 81% of Department staff have participated in the HCA development programme. Associate Nurse - watching brief on UK developments. Urgent Care advanced training offered at Manchester Metropolitan University. IOM regulatory framework to be created.	Formal recognition of successful participants in HCA Development Programme Awards Evening. Task and Finish sub-groups created to define NMAC priorities following away day outcomes. Values based recruitment showing positive results. Appraisal replaced by 5 conversations but may take time to implement.	Lack of nursing representation on Quality Committees. Nursing and patients appear to be side lined throughout the organisation.	Staffing levels based on bed occupancy rather than on demand. Nobles use 70% bed occupancy to determine staffing levels. In reality, a number of Medical wards are in excess of 95% bed occupancy adding to staff pressures. 2016 nurse establishment review outcomes ignored.	High levels of sickness absence remain a major concern. Nurse recruitment is still a significant worry. There has been a halt in European recruitment and applicants since the Brexit referendum.	1 Ward staffing should be increased in line with 2017 review outcomes . 2 Nursing representation essential at all levels in the organisation, particularly Quality Committees. 3 A review of the Community nursing establishment should also be undertaken.

Nobles Executive Team (NET) now called Senior Management Team (SMT)	2 leadership changes since January 2016. Divisional managers in Surgical & Medical brought in to design & deliver significant cost improvement plans (CIP's). Attempt to streamline NET meetings by replacing Divisional reports with a single Power Point page. Digital Strategy progress on target; patient records scanning has commenced. Budget setting for 2017-18 reflects more recent actual costs and areas of expenditure.	Falls Audit brought in to satisfy H&S notice. Laudable attempts to widen the recruitment sources for both Doctors and Nurses. Performance meetings are identifying cost issues on a regular basis. E-roster rolled out to most wards, technology having a positive impact on outdated practices. Patient Experience Indicators now collected on regular & widespread basis. Improved reporting on cancer waiting times & activity. OHR support for managers regarding staff absence management.	Little evidence of any plan for transfer of services from acute to community. Further progress on WMQR recommendations rests with Divisions who are already overwhelmed with short and medium term challenges & have little capacity or power to address them. The time lapse between recruiting and starting in post is widening to as much as 7 months. Falls data reflects ongoing discharge issues. CIP has failed to make any visible impact on financial losses. Clear policies lack consistent enforcement e.g. use of taxis by staff. Lack of political support for clinical based decision-making on service prioritisation.	In the absence of clear service priority direction at a political level, and with UK wide health issues impacting upon the hospital, Nobles continues to struggle. Poor financial performance, low staff morale, high staff absence and lack of staff continuity, which in turn further impacts upon already weak lines of communication that are inherent throughout the whole of the Health Service organisation. Business case progression clarity remains poor.	Attend regular NET meetings and carry out 1:1's with lead officers both in Nobles and Crookall to follow up issues of concern. Observe the frustrations of well-intentioned knowledgeable employees at all levels that any proposals for redesign of services or teams cannot be enacted unless immediately cost neutral.	1 Enact difficult service prioritisation decisions to mitigate rising uncontrollable labour costs & continue to identify and enforce savings within controllable elements of the budget. 2 Establish a wider and more modern range of mechanisms to manage Nobles. 3 Communicate more effectively with both staff and public about the difficult choices ahead.
OHR Quality Committee	New Service Level Agreement being drawn up. Recruitment & Retention Strategy launched in Q3. Work Permit exemptions widened.	Realisation that firmer standards need to be adopted; clear appetite to make improvements; desire to put more radical ideas in place; move towards simplifying unwieldy processes and procedures wherever possible.	Absence continues on an upward trend; delays and inaccuracies in the figures mean Managers have little confidence in them. Pieces of work move forward at such a slow rate that time is wasted going over old ground and changes can be redundant before they are even launched. Inefficient record	Flawed and inaccurate data continues to be an issue. Culture change has started but is too uncoordinated and slow. When a new strategy doesn't work, the solution is usually to just start another one, instead of addressing the root causes.	Too much time is spent drawing up new plans and ideas, which are given little aftercare. Staff absence still doesn't have accurate figures and the data is often simply ignored as a result. Proposed new SLA drafted in June 2016 and is still not close to launch.	1 New strategies must be followed-up operationally, otherwise they have no real value. 2 Staff absence needs to have accurate data and be firmly managed. 3 New SLA should be prioritised to clarify responsibilities of the shared service as currently these are too

			keeping and poor administration is still causing operational issues.			blurred.
Primary Care Divisional Committee (PCDC)	The Community Health Services (CHS) Executive Team has become the Primary Care Divisional Committee. The PCDC is supported on an operational level by the CHS Managers meeting. Head of PC has new job title reflecting the sinuous changes within the service and in the movement towards Integrated Care. Further restructuring in March 2017 moved Contractor Services (GPs, etc) to a combined Finance & Commissioning Committee; new TORs still to be established.	3 long term condition nurses are operating at capacity. Step up/step down facility at Ramsey District Cottage Hospital (RDCH). Reduction in Dental waiting lists. RDCH is "dementia friendly". Enhanced retention & recruitment pathway for Paramedics, 'Zero to Hero' training on Island. Nurse Practitioner for MEDS. Patient Safety Walks provide feedback & clinical governance. New GP adviser working on Development Plans in GP Practices and trouble shooting in underperforming practices. Urgent Care project encompassing MIU, A&E, GPs, moving towards more integrated care. Regular patient stories highlighting incidents, prompting discussions, formulating action plans and reflecting shared learning. EMIS Community operational - positive impact on service delivery. GP online services now running, approx. 12%	Negative impact of closure of Ward 20, CHS struggling to manage patients with complex needs without necessary infrastructure or financial support. Possibility of utilising beds at Ramsey & District Cottage Hospital (RDCH) for rehabilitation. PCDC Service Delivery Plan progressing but lack of transformation funding. Legislative capacity hindering progress: e.g. prescribing by Pharmacists has no legal base. Demand for District Nursing outstripping resource, service at capacity. Increasing number of prisoners with Mental Health issues, Prison and CHS struggling to cope. Therapies deficit attributed to insufficient budget following transfer from acute services. Potential gap in Safeguarding Doctor role. A new prioritization system is being developed for respite care. Short term shortage of GPs. The	Adult discharge issues. MEDS service becoming increasingly difficult to staff and costly, particularly overnight and weekends. The infrastructure of PC is not sufficiently resourced or robust enough to meet the demands and raised expectations to deliver an increase in services, without pertinent planning or funding. DHSC Strategy, its implementation and its impact on PC and, ultimately, the community requires an implementation plan.	CHS absorbing a more complex caseload as services move into community without commensurate funding. The potential development of a 'single point of access' which encompasses both Social Care and Health services will create a more unified and efficient care service. An Integrated Care Lead would be beneficial. Looking ahead may see a complete overhaul in our NHS, with Nobles no longer being a General Hospital, focussing more on A&E cases, sending patients to the UK for specialist care and providing rehabilitation care upon the patients return.	1 Overall adult discharge procedure requires examination and improved collaborative working between CHS, Social Care and Acute services. 2 The lack of rehabilitation service and poorer health outcomes for patients following the closure of Ward 20 has increased demand on CHS and highlights the implications for Integrated Care. 3 GP contract - should practitioners be dissatisfied with the contract we may see a piecemeal reduction in their services.

		of population registered, SMS appointment reminders being piloted. RDCH GP contract under negotiation. Salaried Dental Services redundancy negotiations underway to meet 'spend to save'.	financial viability small GP practices is questioned. Long term conditions co-ordinated service is at capacity. Community Equipment Service transferred to central core services at Nobles. Clinical lead requirement recognised, 10% increased demand.			
Public Health Directorate (PH)	Director of PH confirmed as a substantive post. First JSNA survey completed. Awaiting analysis of the results. "Make Every Contact Count" (MECC), developed by PHE and HEE, under consideration in IOM. PH issued a description of what public health is about, clearly indicating its place in the health service. PH is planning a revolving 3 to 5 year business plan.	PH monthly management meetings include representatives from Mental Health, Occupational Health, Pharmacy, Education. PH run the Health Protection Committee where representatives from Police, Education, Occupational Health and Mental Health attend. - excellent inter/intra department cooperation within government. PH chairs the CRC, bringing together staff from different disciplines.	Partly by shedding certain treatments they were previously offering to more appropriate areas, PH are currently operating within budget. A major requirement of PH is that it is able to point the way to better and more efficient ways of treating customers: this it will continue to strive to do.	The uncertainty of having an interim director caused a lot of unease within the staff. Now this has been settled, the team spirit in PH (which was good anyway) has grown markedly. The leadership qualities of the director have been particularly noticeable.	The fact that PH has control over its finances, that it is planning and running JSNAs, that it creates cooperation through the HPC and the CRC, illustrate that is working well towards the aims of a modern PH directorate. The early consideration and planning for the possible use of MECC illustrate a will to try new ideas.	1 That PH continue to operate JSNAs in order to produce hard evidence for how to help the DHSC meet its objectives. 2 That PH continues to explore new ideas such as MECC, in order to help improve the health service in the Isle of Man.
Quality Improvement Programme (QIP)	QIP was disbanded in August 2016 with workstreams reallocated to QC's: 2 x workstreams to Care Quality and Safety Committee 1 x workstream to Stakeholder Engagement QC 1 x workstream to OHR QC 1 x workstream to	QIP structure allowed for clear line of sight of change activities and regular reporting of progress. This further allowed for risks and issues impacting the change to be highlighted and mitigating actions identified.	With QIP disbanded the plan was for the workstreams to remain active and report progress into the mapped Quality Committee. There has been little evidence of progress against the workstream being reviewed in the Quality Committees. Centre reporting of the	The workstreams rely on team members completing change activities in addition to a full workload. This allows for progress but that progress is slow in areas where it could be argued that change is needed more quickly and could be delivered faster.	Recent changes delivered via GTS with appropriate funding and resource provide evidence that supports the 2016-17 recommendation. Demonstrating that when change is needed it can be delivered cost effectively and in a timely manner supported by existing	1 The implementation of recommendations from the WMQRS should be reported via standing agenda items at the relevant QCs.

	Integrated Care 1 x workstream to Informatics QC		collective progress of the workstreams is now also limited and time consuming to collate.		team members but managed by team members whose role is to ensure delivery.	
Stakeholder Engagement Quality Committee (SEQC)	Pilot of Southern Community Initiative (SCI) to support and supplement agencies and volunteer groups. Review of Carers Charter. Customer Experience and Engagement Strategy. Customers and Staff Satisfaction feedback and review.	Visual Impairment Partnership lead and contribution to Eye Care Strategy. Learning Disability Partnership and Strategy 2014 - 2019. In House cross service auditing.	Integration of social and health care needs to encompass health but not be determined by it. Need for greater accountability in sharing of Customer Engagement activities across all services. Pilot for use of off island clinical support telephone system for residential care rather than GPs. Processes - Consultation is not Engagement.	Patient Reported Experience Measures and Patient Reported Outcome Measures. Proposal for "Neglect" Pathway. Proposal to re-establish Board for Children and Families corporate parenting group. Work now transferred to Transformation QC.	Outcome measures of medical staff not available. Key performance criteria and milestones - not routinely assessed, measured and monitored for operational impact.	1 All areas to have performance measured and published. 2 Develop a culture that does not compromise when improvement is necessary at all levels. 3 Monitor operational impact alongside strategic developments to ensure the customer will benefit.
Transformation Quality Committee (TQC)	Quarterly reporting on 12 health priorities from the Health and Social Care 5-year Strategy. Task and Finish Reporting. High level discussions and some decision making about top priorities. Urgent Care, Integrated Care and Integrated Pathways had some focus.	Directors engaging with each other and making some decisions. Focus of the Committee was on high level, strategic matters with ownership. Timetable for quarterly reporting was adhered to. Sign-off of some high level projects for Board agreement.	Little evidence of meeting the Committee's Terms of Reference of 'structured change management methodologies in pursuance of achieving value for money' and 'mechanism for prioritising change management projects, through which focus and delivery can be achieved'. Items considered by the Committee were reports or presentations with few or any options for change e.g. Urgent Care, Integrated Care and Organisational Development Plan.	Little visible movement from Acute Services to Community and on the development of Integrated Care with no visible reconfiguration of funding in line with the revised 5 Year Strategic Plan. The closure of Ward 20 has resulted in more pressure at the community level without the funding following. Little evidence of prioritising or mapping out of services e.g. no cogent plan for RDCH - how does it fit with the prioritisation of services/integrated care/why is it often at	No overarching plan for implementing the 5 year Strategy, only updates on the 12 priorities but how do these coordinate to deliver the Strategy? e.g. Is it right to fund new detailed contracts with service providers before the integrated care project and the JSNA have started? Published waiting lists but no apparent programme to address the problem. There have been Task and Finish, Integrated Pathways and Southern Communities Engagement Reports but still no clear, agreed	1 An overarching implementation plan for the delivery of the 5 year strategy should be produced as a high priority. The Plan will show how the 12 priorities coordinate and contribute to deliver the 5 pillars. 2 A Project Plan for Integrated Care should be produced to show how integrated care is to be defined, what the work strands are (urgent care, community care, contracted services, care pathways, etc.) how do the other priorities impact on it

			There appears to be inadequate resource management to address the change management needed. Due to historic problems of absence of reliable data and information there has had to be a focus on catching up e.g. contracts with UK and IOM providers; validation of waiting lists; health outcomes. This has resulted in little visible frameworks for moving forward.	75% capacity when Nobles is at 100%? Still no 5 year funding strategy, prioritisation of services and change management decisions re: funding have not been realised.	understanding of or Integrated Care Project Plan. Directors are rightly focused on their divisions but are also required to use their knowledge and skills to question the combined direction of the change management.	e.g. Digital Strategy, Communication Plan, and who is responsible for taking the project forward. 3 Legislation should be prioritised and accelerated