Review of HSCC past Key Recommendations for years 2014-2016 Appendix A

Recommendation Area: Strategic	HSCC 2014-2015 and 2015-2016 Annual Report comments	Met Part Met Not Met	HSCC comments on progress at 30 April 2017	Met Part Met Not Met
R1 2014-15 10-Year Strategy and engagement in consultation on new strategy	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. Patients, Community Groups and staff were not extensively engaged in the consultation before the 5-Year plan was approved by Tynwald, but public engagement has been sought following that approval.	Met Part Met	5YR Strategy released August 2015 - no further comment. Limited engagement with the public on progress since being superseded or at least amended by Programme for Government which was not extensively consulted on.	Met Part Met
R2 2014-15 Transfer of services from acute to community	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.	Not Met	Integrated health care strategy stalled. Primary Care (PC) Service Delivery Plan is progressing effectively but is hampered by the lack of transformation funding. The infrastructure of PC is not sufficiently resourced or robust enough to meet the increased demands and raised public expectations on its service.	Not Met
R5 2014-15 Importance of social, mental and wellbeing in health	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.	Met	Progress continues, with extra staff and the opening of Manannan Court. The Step Programme is developing, representing an important way forward.	Met
R7 2014-15 How Public Health will fulfill tasks in new Vision	The new Board Structure includes the Director of Public Health and the Public Health Strategy sets out how this Division will fulfill its tasks.	Met	Public Health (PH) has adopted a modern structure; has published details of its 4 domains: health improvement, health protection, and healthcare public health, all fed by the central role of health intelligence. Intelligence is gleaned through the Joint Strategic	Met

			Needs Assessment (JSNA) method of public surveys, the first of which is nearing publication, with two others planned. PH has dropped direct medical interventions such as immunisation and is moving to a 3 to 5 year rolling business plan, a simplified form of which will be available to the public; Morale has been transformed by the interim Director becoming made substantive. It is considering a new form of intelligence gathering known "Make Every Contact Count".	
R9 2014-15 Political intervention limited to strategic direction	Universal political support on the 5 Year Strategy and Mental Health. Unfortunate lack of opportunity for HSCC scrutiny of the political/clinical interface due to cessation of the Performance Delivery Group.	Part Met	Unfortunately, clinicians still await political decision making on Service Delivery priorities. In the face of financial deterioration tough decisions have not been made. HSCC does not support direct political intervention in clinical matters.	Part Met
R12 2014-15 Overhaul Health Committees to streamline decision making, clarify accountability and avoid duplication and gaps	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.	Part Met	Despite the implementation of Quality Committees, the fundamental route and branch review has not been completed. A Governance structure has been established but it varies in quality frequency and outcomes. See Appendix B.	Part Met
R3 2015-16 The shift from Acute Services to Community including Integrated Hubs needs to be established with a reconfiguration of funding in line with the revised 5-Year Plan	The movement to Integrated Care Hubs was presented with a fanfare, but in reality, healthcare remains predominately Nobles focused in terms of service delivery.	Not Met	A clear definition of the Integrated Care model is needed to facilitate the transfer of services and support CHS in managing the increased demand on its services, along with the commensurate funding. Emphasis and majority funding for Health appears to remain Nobles centric. The Task and Finish report on Integrated Care only touched the surface of this complex matter. There has been no visible reconfiguration of funding.	Not Met

R4 2015-16 With 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	There is a lack of linear progress towards Community Health Services from Acute Services. Service transfer between these areas appears haphazard, inadequately funded with roles and accountability blurred.	Not Met	A lack of integration and end to end patient pathway consideration resulting in an increased workload for CHS, needs addressing. For example, the gap in assurance from Therapies, which transferred to PC nearly two years ago, but has some services remaining in acute services. A review of Urgent Care Service has been undertaken. The work streams may be underway but they are moving very slowly and there is not a Project Plan to guide the work or a clear lead.	Not Met
R5 2015-16 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.	Adult discharge issues, provision of nursing homes and associated funding needs to be determined at Government level together with a complete review of discharge procedures.	Part Met	The purchase of Salisbury Street and the planning application for the Glen Side replacement are welcome. However, there is still no clear, agreed understanding/Integrated Care Project Plan of what is to be achieved and the implementation. The overall adult discharge procedure requires examination and improved collaborative working between CHS, Social Care and Acute services.	Part Met
R8 2015-16 Urgently review nurse establishment levels to match demand to nursing resources.	Staffing levels based on bed occupancy rather on demand. Nobles use 70% bed occupancy to determine staffing levels but in reality, a number of wards are at near 100% bed occupancy leading to staffing pressures.	Not Met	No action was taken following the establishment review in 2016. A further review was undertaken in Spring 2017 and the outcomes are awaited. District Nursing service is at capacity and is managing a more complex needs workload.	Not Met
R9 2015-16 Resolve flawed data and statistics across all areas of the Health Service	The lack of accurate data and statistics does not allow robust and well evidenced decision making.	Not Met	The Absence Statistics are still flawed and not produced on a regular basis – DHSC Managers have expressed the view that they have no confidence in their accuracy. Public Health are starting to address this problem.	Not Met

R10 2015-16 Develop a cross cutting Dementia Strategy and Implementation Plan	The ageing population and the statistic that one in three will suffer from dementia should be the catalyst for a review of this service area.	Met	Older Person's Mental Health Service (OPHMS) has been in operation since 1999, offering assessment, diagnosis, treatment and aftercare. It has an excellent Memory Clinic, and works collaboratively with the Alzheimer's Society (AS) and DECAF ("Dementia Café"). The OPHMS Manager has been seconded to lead a review, and develop a dementia strategy to link in with the Isle of Man Mental Health and Wellbeing Strategy. AS and DECAF are collaborating with the review and strategy development. Latest figures suggest that, at current average life expectancy of about 80, one in 10 may suffer from dementia.	Met
R14 2015-16 Create some targeted short-term capacity to action the key deliverables of all the work streams within the Quality Improvement Programme.	The Quality Improvement Programme has clearly defined scope and is arguably well placed to be able to deliver the changes that is within its scope. It is however, struggling to gain traction and has a significant number of deliverables missed.	Part Met	The formal programme has now been disbanded with responsibility for the workstreams transferred to various Quality Committees. Accountability for the progress of the workstreams is now unclear. Where change is being managed under the Informatics Quality Committee resource is being committed.	Part met
R16 2015-16 Prioritise the Development of new legislation to support the Goals and Objectives in the 5-Year Plan.	Good legislation is the foundation for change.	Part Met	Legislation has not been prioritised. Since the approval of the Health and Care Act in July 2016, the Act has yet to be enacted and will not be so for at least another six months.	Part Met

Recommendation Area: Engagement	HSCC 2014-2015 and 2015-2016 Annual Report comments	Met Part Met Not Met	HSCC comments on progress at 30 April 2017	Met Part Met Not Met
R3 2014-15 Staff, patients and public involved in the new vision and idea of collective ownership is promoted	The 5 Year 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.	Part Met	The January 2016 Public Roadshows raised public expectations for actions, particularly in the fields of integrated care with the then Minister promising physical hubs nearer to people's homes. Also, improved external and internal communications. Telemedicine reducing UK follow ups was another popular promise. All of this shows minimal progress.	Not Met
R4 2014-15 Broader range of methods for engaging patient and staff voice	Patient Safety and Satisfaction Walks remain a useful method of engaging, plus Staff Values sessions have been introduced. Worryingly, it appears that the QIP work stream relating to engagement of patient and staff voice has not yet been delivered or actioned.	Part Met	Patient Safety and Satisfaction Walks continue and remain useful. After a long period of gestation, the Patient Engagement & Patient Experience: Nothing about you without you, was published in March 2017.	Part Met
R6 2014-15 Acknowledge and act to mitigate the impact of change and uncertainty on staff	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.	Part Met	Whilst it is acknowledged that Digital projects have involved engagement and training, low staff morale particularly at Nobles is still evident and clear engagement very patchy. High staff absence, slow recruitment into post and locum/agency staff turnover is only making the situation more difficult. Consistent leadership appears lacking in many areas. Clear direction arises from difficult political decision making; now in urgent need of this.	Not Met
R10 2014-15 West Midlands Quality Review (WMQR) initiatives reported widely focusing on management and tracking	WMQR 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.	Part Met	Further WMQR reports have been issued in an open and transparent manner, however, the issue of management of QIP work streams and then lack of implementation plans is an ongoing concern. The majority of actions now reside with individual divisions, with exception reporting through the CQSC. The tracking of recommendations is no longer as visible on a regular basis.	Part Met

R11 2014-15 Comprehensive approach to health and wellbeing through collaborative working	There is evidence from the 5 Year 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.	Part Met	Repeated shuffling of management structure and responsibilities is unhelpful. A stable framework is required for forward momentum. QCs have revealed some evidence of some collaborative working but more needs to be done. There is still evidence of silo mentality particularly between acute and community.	Not Met
R6 2015-16 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	Progress is being made in removing the stigma associated with mental illness due to the determination and dedication of the staff.	Part Met	This is an uphill struggle. The 2015 Strategic Plan for Mental Health and Wellbeing introduced the six-step system (Steps 0 to 5) for the treatment of Mental Health. Step 0 (where the focus is on the promotion of positive mental health and wellbeing) to step 3 (moderate to severe, enduring recurrent mental health problems, substance abuse, requiring specialist intervention) are now in operation, with modifications continuing as experience is gained. The opening of Manannan Court on the Nobles Hospital estate is a significant step forward in mental health treatment. Offering conducted tours of the facility before any patients were admitted was a useful publicity opportunity. The Mental Health Directorate subscribing to Mental Health Awareness Week has offered further opportunities.	Part Met
R11 -2015-16 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.	High levels of sickness absence across the Department remains a major concern. This is exacerbated by poor management of absences with an inconsistent approach to back to work interviews.	Not Met	Fundamental issues still remain, with any initiatives that are eventually put in place proving ineffective and not rigorously followed up operationally. Procedures are confusing and open to interpretation, resulting is inconsistencies across the DHSC and poor direction overall. A high level of absence still appears to be an accepted norm, which isn't an approach likely to have any impact on the figures (which are unreliable anyway).	Part Met

R12 2015-16 The recommendations of the Patient Safety Walk Programme (PSW) should always be followed up, actioned and publicised.	Although reporting procedures are carried out it is still difficult to see the results of actions.	Part Met	There is a clear pathway for PSW recommendations and actions are communicated but not widely publicised. PSWs remain a useful tool in patient and staff engagement. Both Acute and CHS undertake regular PSWs and overall customer and staff feedback is positive. Reports are provided and supporting action plans and compliance monitored. Comments often highlight the need for consistency and staffing issues.	Met
R13 2015-16 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.	One of the key principles of Public Health as recognised in the Health Strategy is to inspire and support the public to take steps to look after and improve their own health and wellbeing.	Met	Work continues to achieve risk factor reduction (smoking, drugs & alcohol, overweight/obesity, sexual health, mental health & emotional resilience and oral health) through coordinated needs assessments and strategies with partners across government and the third sector. Design, promote and support campaigns to link with those in UK and/or local issues, usually in partnership with other departments (e.g. Festive Health Campaign, Stoptober, sepsis, antimicrobial prescribing, cancer screening, 'know your limits' alcohol guidelines). Delivery is provided by other parts of the health service. Vaccination and bowel screening programmes. Breast screening and cervical screening are dealt with through Nobles.	Met
R15 2015-16 The delivery mechanisms for the 5-year Plan should be developed by consulting with and utilising skills and knowledge of the wider community, staff and third sector.	A Delivery Plan with outcomes, actions and performance measures has yet to be published some 6 months after since being agreed.	Part Met	The work with Stakeholders and the public on the formulation of the 5-year Strategy was commendable but that was 15 months ago. This recommendation is about going forward to develop the delivery of the strategy. Some engagement is going on e.g. the Southern Community Initiative for Integrated Care but there needs to be more stakeholder involvement in all areas of the Strategy.	Part Met

Recommendation Area: Finance/Commissioning	HSCC 2014-2015 and 2015-2016 Annual Report comments	Met Part Met Not Met	HSCC comments on progress at 30 April 2017	Met Part Met Not Met
R8-2014-Facilitation of funds from Health Improvement Fund (HIF) and rebuilding health budget using zero based methods	There has been a release of monies from the HIF to support the transition of Mental Health patients from funding of off-Island to on-Island placements. True zero-based accounting has not been introduced as yet.	Part Met	Although the HIF is now largely spent, the balance has been transferred to a new fund for promoting money saving ideas. Gargantuan efforts have been made to rebuild budgets to reflect recent actual spend by area. An additional £10m was awarded by Treasury.	Met Met
R1 2015-16 Joint commissioning of services should be followed where clear benefits are identified	There is a lack of timely decision making adding to pressures on an organisation already frustrated by time delays in putting long-known solutions into action	Not Met	There has been no clear evidence of joint commissioning of services. Control of divisional commissioning is essential in order to identify clear savings that can be used to fund priorities.	Not Met
R2 2015-16 Commissioned service contracts must have clear action plans with measurable outcomes, which are evidenced as good value for money	There is a need to build on the positive improvements in contract reviews and short-term savings and service improvements. Long term success is dependant on strong leadership and cross cooperation across the Health Service.	Part Met	A contract must be in line with financial regulations but can be reviewed for value for money without having measurable health outcomes e.g. the contract for food and beverage at the hospital and at the NSC do not appear to have health outcomes. A comprehensive catalogue of all Department contracts is still incomplete, which makes this recommendation difficult to meet	Part Met
R7 2015-16 The notion of "spend to save" needs to qualify with a full explanation of what it is designed to achieve. The prioritisation of services and associated funding needs to be clearly mapped out.	Noble's financial position continues to worsen exacerbated by the demoralising effect of setting a budget for 2015-16 £5m less than 2014-15 without an agreed Cost Improvement Plans in place.	Part Met	Confusion remains re qualification criteria for Spend to Save. The prioritisation of services and associated funding needs to be clearly mapped out. This requires long overdue brave political decisions to be taken.	Part Met Not Met

R17 2015-17 Develop a funding Strategy to support the 5-year Plan	The Department's financial position continues to worsen. Costs must be challenged and solutions planned and implemented.	Not Met	The 5-yr strategy remains un-costed. Whilst some regular cost challenging is evident e.g. Nobles performance meetings, the high level political decision making to enable service prioritisation has not taken place. Further financial deterioration seems inevitable.	Not Met

Quality Committee Meetings 2016-17 Appendix B

Quality Committee Meetings Apr 2016 - Mar 2017	Overview	Membership Quorum Frequency	Record of meetings/attendance (less HSCC and Sec) *Red = no meeting	Observations
Care Quality and Safety Committee	CQSC is responsible for overseeing the services provided and commissioned by the DHSC and the health and safety of those receiving and providing these services.	9 members; Quorum Chair or Deputy Chair +4 Members; Meetings Monthly	06/16(8); 07/16(7); 08/16(8); 09/16(8); 10/16(7); 11/16(7) 12/16(7); 01/17(7).	The committee has proposed a Board Assurance Framework which should strengthen and improve risk management processes. Differing perspectives and approaches of Health and Social Care are evident; however, robust and open discussion between Divisions is promoted and shared learning evident.
Commissioning QC	CQC was established to enable the DHSC to commission services which meet the needs of the population of the Island and contribute to the overall aims and objectives of DHSC strategy and delivery plans.	13 members but variable; Chair Director of Finance. Quorum >50%; Meetings Monthly	04/16(7); 05/16(6); 06/16(0); 07/16(9); 08/16(0); 09/16(11); 10/16(7); 11/16(10); 12/16(0); 01/17(0); 02/17(13); 03/17(0).	Original TOR a bit woolly, has not yet got commissioning under control. No meetings March/April. Now amalgamating with Finance QC although not until May meeting.
Finance QC	FQC provides assurance on the Dept. performance on Finance, Finance controls and management and business risk.	12 members; Chair-Finance Director; Quorum 1 external stakeholders and 2 directors; Meetings monthly	05/16(12); 06/16(10); 07/16(10); 08/16(0); 09/16(8); 10/16(11); 11/16(9); 12/16(0); 01/17(0); 02/17(11); 03/17(10).	Although FQC was set up to bring significant expenditure proposals for support and scrutiny, this is not happening on a regular basis; substitutions helpful; but few directors contribute and collegiate discussion is rare.
Human Resources QC	HRQC support development of positive organizational cultures through people management.	7 Members including Chair: Quorum of 3 with min of 2 Dept rep and 1 HR rep; Meetings Monthly	05/16(6); 06/16(5); 07/16(6); 08/16(8); 09/16(10); 10/16(5); 11/16(0); 12/16(5); 01/17(6).	Lacks incisiveness, resulting in progress being laboured with much discussion but few tangible results so far.

Informatics QC	QC has been established to support the development and use of information and information communication technology (ICT) across the Department of Health and Social Care (DHSC). The establishment of the IQC was essential in part to ensure the delivery of the DHSC Strategy.	18 Members; Chair-Head of Digital Strategy; Quorum the Chair or Deputy Chair, a representative from Noble's Hospital and from Primary Care and a minimum of six members; Meetings Monthly	06/16(27); 07/16(22); 08/16(0); 09/16(26); 10/16(20); 11/16(18); 12/16(25); 01/17(21).	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	SEQC has been established by the Board of the Department of Health and Social Care with the purpose of assuring the Board of arrangements for Stakeholder engagement and communication.	10 Members (+ Sec) Chaired by Director of Adult Services; Quorum Chair (or Deputy) plus 4; Meetings - only bi-monthly	06/16(7); 08/16(7); 10/16(6); 12/16(0); 02/17(6).	Good quality presentations. Only met bi-monthly. Persistent lack of attendance by some essential members. Merging with Transformation QC.
Transformation QC	TQC has been established to facilitate the organizational transformation and the delivery of the Department's Strategy	8 Members (+ Sec); Chaired by Director of Policy and Strategy; Quorum-Chair (or deputy) plus 3; Meetings Monthly	08/16(7); 09/16(8); 10/16(7); 11/16(7); 12/16(8), 01/17(8); 02/17(7); 03/17(7)	Noticeable absence from medical side at times. Agenda items majority strategic with lapses into operational matters.

Other Committee Meetings Apr 2016 - Mar 2017	**Overview**	**Membership Quorum Frequency**	**Record of meetings/attendance (less HSCC and Sec) *Red = no meeting**	**Observations**
Health Protection Committee	Meeting of all the Agencies responsible for health protection including emergency services and DEFA Environmental Health. Discussing x-departmental health protection issues such as emergency preparedness and response.	The invited members to this meeting vary between 20-23. There is no Quorum. Meetings quarterly.	04/16(13); 07/16(16); 10/16(11); 01/17(16);	These meetings are not the best examples of good cross-governmental co-operation. Attendance by other Government departments is patchy.

Nobles Executive Team (now Senior Management Team)	Review operations & direct strategy to provide corporate leadership, make executive decisions, information sharing, ratify decisions, plan developments, monitor progress, evaluate decisions, agree corporate & directorate business plans provide content for communication in hospital team brief.	22 members including all Divisional Managers and Clinical Directors, strategic partner representatives from OHR Finance, GTS and Education.	04/16(19); 05/16(20); 06/16(18); 07/16(18); 08/16(18); 09/16(14); 10/16(16); 11/16(15); 12/16(15); 01/17(14); 02/17(17); 03/17(19).	NET has largely an excellent attendance and frequency record but given the large attendee list, it is not surprising that full engagement is an issue. Needs to be more strategic and focus on exception reporting. Slide presentation is improving focus.
Nursing and Midwifery Advisory Council	NMAC exists to enhance the professional delivery of nursing & midwifery services by x-departmental working, providing assurance and timely advice to colleagues, managers and Ministers.	14 members, chaired by Chief Nurse. NMAC are quorate when at least 50% of members are present. Meetings monthly.	04/16(9); 05/16(7); 06/16(0); 07/16(8); 08/16(8); 09/16(8); 10/16(0); 11/16(11); 12/16(0); 01/17(9); 02/17(0); 03/17(9).	NMAC has drawn up new, modern, Terms of Reference this year. It is planning a new Regulatory Framework to reduce reliance on the existing UK framework.
Primary Care Divisional Committee	Seeks to deliver high quality, integrated care within the community, working collaboratively with stakeholders and strives to be patient focused.	Monthly meeting chaired by PC director. Streamlined committee comprising PC divisional directors, political member and invited HSCC representative.	04/16(5); 05/16(5); 06/16(4); 07/16(6); 08/16(5); 09/16(4); 10/16(5); 11/16(6); 12/16(5); 01/17(5); 02/17(6); 03/17(7); Disbanded 01/04/17.	The meetings are open and transparent and the PCDC remain an enthusiastic, committed team who work collaboratively and support their front-line staff. Delivery of the strategic agenda being the primary role.
Public Health Staff Meeting	This a monthly meeting with key staff members to discuss corporate issues such as SDPs and Risk Registers; provide sectional updates and invited presenters.	The invited members to this meeting vary between 18-23. There is no Quorum	04/16(0); 05/16(8); 06/16(14); 07/16(12); 09/16(15); 09/16(19); 10/16(15); 11/16(0); 12/16(0); 01/17(16); 02/17(13); 03/17(16).	The Meetings are well attended, well managed and very positive. Open discussion with opinions being actively sought is the norm.
Mental Health Management Board Meeting	These meetings do not occur every 3rd month as there is a quarterly Partnership Board Meeting (PBM).	The invited members to this meeting vary between 14-16. There is no Quorum	04/16(10); 05/16(PBM); 06/16(12); 07/16(9); 08/16(PBM); 09/16(10); 10/16(11); 11/16(PBM); 12/16(9); 01/17(0); 02/17(PBM); 03/17(9).	Meetings are well attended, well managed and very positive. Open discussion with opinions being actively sought is the norm.

HSCC review of Service Delivery Plan priorities April 2016 – March 2017 **Appendix C**

This table compares the DHSC and HSCC overall assessment of Year 1 of the Service Delivery Plan.
The Plan contains 12 Priorities with 50+ Actions. This table deals only with the 12 Priorities.)

PRIORITY	MEASUREMENT	DHSC CURRENT POSITION AND THEIR RAG RATING	HSCC COMMENT AND OUR RAG RATING
PUBLIC HEALTH Agree a cross-government process for joint strategic needs assessment (JSNA) which, over time, will drive needs-led and evidence-based change to future health and social care services, as part of the overall approach to improving health and wellbeing.	By March 2017, the Department will: Achieve cross-government agreement on a process for JSNA to drive improvement in health and wellbeing; Agree a resourced work programme for JSNA into priority areas for health and wellbeing improvement to be carried out in 2017/18; Deliver a completed JSNA on drug and alcohol misuse, the results of which will drive strategic priorities for drug and alcohol treatment and rehabilitation service.	Agreeing the process, resources and work plan for the national JSNA Programme delayed to ensure fit with the Programme for Government and Cabinet Office policy committee arrangements. Phase 1 - Publication of the Public Health Outcomes Framework delayed until Summer 2017. Phase 2 - Governance/reporting through Social Policy and Children's Committee (SPCC) of the CoMin, supported by the Lead Officers' Group (LOG). Drug and Alcohol JSNA: the final report is due for publication in April 2017.Phase 3 - Resources/ work plan decided by SPCC/LOG once the revised arrangements for these.	Regrettably many of this priority's goals and progress have had to be delayed due to the Programme for Government and Governance reporting. The Public Health Outcomes Framework and JSNAs are one of the highest priorities for Government spend and yet are being held up due to changes in Governance reporting and the Programme for Government. The Health Outcomes Framework and the JSNAs would have helped to determine budget priorities but will not be in use for 18/19 budgeting. DHSC awarded Amber. HSCC agree Amber.
NOBLES Review UK NHS waiting list target times, commit to appropriate Manx targets and then monitor and publish performance data.	By October 2016, the Department will validate the current waiting list information it holds for health services provided locally. By March 2017, the Department will identify and publish realistic and comparable waiting list	We will report on those patients waiting less than 3 months for first out patient appointment and for those waiting less than 6 months for subsequent treatment. In addition, we will report on patients waiting longer than 52 weeks, as the standard would be that no one waits over 52 weeks for first treatment. Monitoring against '95% seen in under 4 hours' standard for the Emergency Department. We	It is not clear from the progress reporting whether all current waiting lists have been validated. How long is the wait for GP services? Weekly waiting list referral meetings set up in Feb 2017 to review the number of referrals added to the waiting lists and to understand the number of additions to the lists. Weekly review of referrals by GP practice and specialty. Completed 16-week analysis of GP referral trend by practice.

	targets using the UK NHS waiting list target times as a benchmark. It will publish its position against these targets on a quarterly basis from April 2017 onwards.	will report the numbers of patients waiting more than 4 hours. We will report the waiting time to see a specialist after referral for suspected cancer (England target 93% seen within 2 weeks: here - 89.2% in March 2017). We will report cancer treatment starting times (England target 96% within 31 days of diagnosis and 85% within 62 days of GP referral).	There is still some work to be done on waiting time targets and published on a quarterly basis from April 2017. DHSC awarded Green. HSCC assessment is Amber.
MENTAL HEALTH DIRECTORATE Publish all actions for 2016/17 under the Strategic Plan for Mental Health and Wellbeing 2015–2025.	Publish quarterly updates against the actions in July 2016, October 2016, January 2017, and April 2017.	The update reports will be published on the Mental Health and DHSC websites on a quarterly basis.	This Priority is not a Priority but an action. To meet the Priority only requires the publication of those parts of the Strategy that have been done. Fortunately, in reality the SMHW lead has undertaken a sensible approach to the actions being carried out. Hopefully a better priority will be included in the Framework for Government Programme. DHSC awarded Green. HSCC agree Green.
EXECUTIVE HEALTH DIRECTOR/PRIMARY CARE Carry out and publish initial planning in respect of delivering improved integrated care.	By November 2016, identify which initiatives could be implemented to help deliver more joined up services for customers as part of an integrated care strategy. By March 2017 publish the evaluation of the proposals and establish a number of pilot projects designed to link up services.	A 'task & finish' group worked on defining integrated care for the Isle of Man in December 2016. Additional elements of this work have started, including: • Integrated urgent care response team; • Discharge management across acute and primary services; • A pilot community partnership approach to the provision of health and care services in the South of the Island; • Telemedicine projects identified and in train; • Urgent care review implementation is delayed.	Another very important priority for saving money and improving services has fallen badly behind. This should have directed future budgeting. There has never been a Project plan for this work. Elements of the work have started but how they hang together is a not clear. Q1 work programmes identified Integrated Urgent Care Response Team and Integrated Discharge as additional to Integrated Care, this demonstrated a huge lack of understanding of integrated care. DHSC awarded Red. HSCC agree with Red.

DIGITAL STRATEGY In conjunction with Government Technology Services (GTS), publish details of all digital strategy projects for the DHSC in 2016/17, including their expected benefits.		**Acute Services** Digital Health Records (DHR): The digitisation of 100,000 general and maternity health records. Scanning of existing patient records will start early in 2017. Clinical Assessments & Noting (CAaN): Reduction of paper records with the development of acceptable e-alternatives to improve patient safety and increase clinical efficiency. Order Communications System (OCS): Digital streamlining and reporting of test requests and results. Roll out will commence in Q1 2017 with completion provisionally occurring Q4 2018. **Integrated Care** EMIS in Community: Health is a platform for a single source integrated care record for Primary and Community Care with key interfaces with newly developed Acute Services systems. Roll-out of Patient Access. Access to full health record and test results including online appointment booking now fully operational. Electronic Prescribing & Medicines Administration (EPMA): An automated prescribing system to reduce errors and unnecessary duplication. Planning, initiation & contract management on track. E-Discharge: The end-stage of the patient journey.	Yes, this priority has had significant progress and whilst this is essential, it is questionable whether the digital improvements are driving the priorities. The digital improvements are a service to achieve ends and it should be the JSNA and the Integrated Care that is driving the priority. DHSC awarded Green. HSCC agree Green.
STRATEGY & POLICY DIRECTOR Set up a research and development group to monitor research and		Board approved (18th May 2016) in principle establishing a R&D Unit in DHSC to support research applications which may involve academic research, medical or clinical trials in areas relating to health and social care.	On track and potential for revenue. DHSC awarded Green. HSCC agrees Green.

translate it to DHSC services (especially pathways) and to oversee novel research in the Isle of Man.		The R&D Unit will work in support of the Local Research Ethics Committee (LREC). Funding for the Research and Development Unit has now been approved for 12 months from 1st April, 2017. High-level deliverables have been agreed for 17/18 Joint departmental working with Economic Development has been agreed with regard to health and life sciences including BIOMED.	
NOBLES ACUTE Set up a patient/client services team within the acute health care setting that is responsible for public information about services, the management of appointments, the management of travelling for UK services and coordinating services for people (including at admission and discharge).		A project team has been in operation since April 16, making good progress with transformation of admin and clerical. The Patient Information Centre has moved into the former porters' lodge at Noble's Hospital. Options are being considered for integrating the patient transfers team. Initial workshop on the Patient Information Centre has taken place.	This has moved quickly and made operational improvements which should save time and money and be more efficient. Goals for next quarter are not goals but updates. Q1 Goals not achieved by time then times changed. Q2 goals also not achieved. DHSC awarded Green. HSCC assessment is Amber.
COMMISSIONING – UK SERVICES Put in place up-to-date contracts for all services commissioned from UK providers which specify exactly what will be delivered by the provider and what will be carried out in the Isle of Man.		The DHSC has agreements in place with 14 NW England hospitals. A plan for finance and activity has been agreed with all 14 hospitals. Work has started to formalise the agreement with hospitals which provide visiting services at Noble's Hospital. Draft service level agreements will be reviewed by Mar 2017.Form contract agreed with Attorney General's Chambers to ensure that they are meeting the needs of the Island. New arrangements for approval of referral to hospitals where DHSC does not have a contract will be in place by October 2017.	Same progress reported for each quarter. Measure has not been achieved. No update on SLAs. Contracts not agreed with AGs only the format. Q1 and Q2 Progress and Goals same. The progress Reports for this Priority do not seem to report coherently. It is not clear that all contracts have been dealt with. DHSC awarded Green. HSCC assessment is Amber.

COMMISSIONING – IOM SERVICES Put in place up-to-date contracts for all services commissioned from Isle of Man providers and develop further collaboration with the charitable and private sectors.		The DHSC is auditing all of its services from providers on Island to ensure that forward contracts are in place, approved by the Attorney General's Chambers, with review dates and regular partnership meetings, in accordance with financial regulations. The DHSC will work with partners across the public, private and charitable sectors on an Island wide recruitment and human resources campaign to increase the caring workforce across all sectors. DHSC Board has discussed a proposed framework agreement with the voluntary sector. This is currently being finalised.	Not achieved this priority in fact very much behind against a high spend area essential to integrated care. Could be argued that new contracts should not be in place until DHSC know what it wants to deliver for integrated care at the community level. DHSC awarded Red. HSCC agree Red.
COMMUNICATIONS Publish regular updates in newspapers, website and social media of progress against the strategic goals and performance data across the Department.		Additional comms capacity on track to be in place by June 2017. Visual identity created for comms relating to the strategy to help the public more readily identify related progress and announcements. Continue to demonstrate links to strategy in routine communications re: ongoing departmental activity (e.g. progress on Digital Future at Noble's Hospital, Health and Lifestyle Survey, Joint Strategic Needs Assessment, Healthy Workplace Toolkit Launch). Publicity of publication of Q3 update.	Very limited priority in that Communication is one sided whereas if the public are to enter into a positive relationship with DHSC the priority needs to be engagement. For a dedicated resource, there has been many gaps in the actions from the Communication Plan and instances of hyperlinks not working. DHSC awarded Amber. HSCC agree Amber.
HUMAN RESOURCES Develop and implement both a comprehensive recruitment and retention strategy and implementation plan for all parts of the Department.		Nursing recruitment plan in progress – delay in final version as a Nursing Establishment exercise completed in Noble's (March 2017). Pediatric recruitment plan completed. DHSC Relocation Policy has been reviewed and presented to the HR Committee. Specific retention measures have been agreed	On the surface, there has been a lot of work undertaken on 'recruitment and retention'. However, the Strategy was poor and failed to address significant points and has seen few actions achieved. Absence data and tackling absence has been inadequate. Clear lines of responsibility need to be identified to ensure accountability. The Q1 Goals never became progress Timescales

		and implemented: House hunting/schooling visits for candidates prior to taking up post. Refer a Friend £200 voucher reward – 12-month pilot for nurses. Two candidate welcome packs in final stages of production for 'hard to recruit' roles.	set have slipped. DHSC awarded Amber. HSCC agree Amber.
LEaD Put in place a comprehensive organisational development plan, in conjunction with OHR Learning and Development, concentrating on vision, values and behaviours.		The OD plan was agreed in November 2016. The structure of DHSC has been updated and an Executive Leadership Team (ELT) created on 1st January 2017. The OD plan was reviewed in January 2017 with a list of 26 priority projects scheduled for completion this quarter. The DHSC Induction has been reviewed and updated. Job descriptions across the Department have been reviewed. Roll out of CARE values has begun.	The ODP was not a full Plan and lost continuity in the last sections despite that it being agreed and resources put against it. It has resulted in some high-level changes but has failed to meet the measures set e.g. all service areas have not had workshops. DHSC awarded Green. HSCC assessment is Amber.

DHSC Strategies 2015-2017 Appendix D

Strategy	Overview	Published	HSCC comments on progress to 31st March 2017	HSCC Consulted
Digital Strategy DHSC	The 'Digital Future' programme includes a range of changes designed to increase efficiency and deliver enhanced care for all patients. Aim: to accelerate the use of digital services rather than paper and optimise existing complex systems to provide significant improvements to the delivery of joined up care, monitor information and early intervention. Direction: Digitise paper based records, electronic support for patient pathways Real-time working and reporting increase digital capability for staff and direct patient access to their care records, including share and control.	July 2015	DHSC has 50 areas (enablers) that they have identified as their way forward to fulfill the Digital Strategy. So far 10 have been completed and are currently working on digitising patient records. Milestones have been on target and progress updates are posted publicly and well-communicated to relevant stakeholders. It has received substantial funding to ensure success when many other general business cases have not had the same level of support. HSCC recognise the importance of this project and hope it will help lead the move to a genuine Integrated Health Care Service. Embracing Telehealth has been slow to progress.	No
5-Year Strategy	Sets out how DHSCC will improve the health and wellbeing of the people of the Isle of Man and how they will deal with emerging economic and demographic issues. 5 Strategic Goals: - 1-People take greater responsibility for their own health; 2-Help people stay well in their own homes and communities avoiding hospital or residential care whenever possible; 3-Improve services for people who really do need hospital care; 4-Provide safeguards for people who cannot protect themselves; 5-Ensure people receive good value health and social care.	August 2015	After a protracted consultation period and a change of CEO, this revised strategy, updated from the 2011 version, was finally launched. HSCC welcomed the opportunity to comment and responded that the Strategy set out 5 clear areas for improvement which became the pillars of the Strategy. Initial drafts were separated by style into divisions but there was a clear intention to work across divisions. However, the final versions still revealed some disjoint between Health and Social Care. The Department was commended on its public and stakeholder engagement.	Yes

4 Domains of Public Health	This document sets out four key areas of public health that the Department will focus on to improve health and wellbeing. 1-Health Intelligence; to inform actions and monitor outcomes 2-Health Improvement; increasing wellbeing and protecting the vulnerable 3-Health Protection; protecting the public from infectious disease and environmental hazards 4-Health Care; reduce premature mortality and reduce inequalities in health outcomes relating to healthcare interventions.	October 2015	The function of public health, as set out by the Faculty of Public Health, was not well understood outside of the Directorate. This document was produced to help clarify the public health function, and to justify the outsourcing of several areas where it was previously carrying out direct medical interventions, such as school immunisations. 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 domain.	Yes
Strategic Plan for Mental Health and Wellbeing	This is the first broadly owned Mental Health and Wellbeing plan for the Isle of Man. The Plan advocates a holistic approach to mental health and wellbeing and also sets out the strategic vision for the collective responsibility for mental health and wellbeing in the Isle of Man. With a defined set of objectives that are all encompassing, flexible and purposeful, the Plan will balance particular pockets of need while addressing the overall mental health and wellbeing of the population.	December 2015	The Mental Health Service is introducing a six-stage structure, generally recognised in mental health in England as the most appropriate way to deal with mental illness today. The structure ranges from stage 0, where common problems that family, friends and colleagues can help encourage the individual to overcome, to stage 5 where serious medical intervention is necessary, usually carried out in a specialist hospital. So far stages 0 to 3 are being developed with the cooperation of general practitioners and specialist nurses.	Yes
Communications Strategy	To improve DHSC Communication both within and outside the Department	January 2016	Appeared to be more of an internal action plan, rather than a strategy document - little substance, low-level and a lot of duplication gave a lazy impression and since launch, the strategy hasn't been followed up with any vigour and many actions are unachieved.	Yes
Eye Care Strategy	To Develop a Strategy for eye care with the public and voluntary sector which is developed using a robust evidence base and is line with the 5 year strategy.	March 2016	A good starting point for the development of this service but more work with Aintree need to minimise the number of patients needing to travel off Island. HSCC has been involved from the inception of this Committee and although progress is slower than	Yes

			anticipated there is clear joined up working with HSCC and the voluntary sector.	
Quality Strategy	Designed to develop continuous quality improvement, acknowledging the need for good quality care across DHSC.	August 2016	Puzzling as to how QS fits into the overall DHSC jigsaw. Very Nobles centric in its approach. Mis/overuse of the word 'Quality' which confuses the issues e.g.: Quality Committees; Quality Improvement Programmes; Quality Strategy. Difficult to perceive how all these are in any real way connected or interact together. HSCC has no date of publication.	No
Organisational Development Plan Programme 2016-20	This is a programme for developing Leadership, Practice and Motivation to create a high performing organisation.	October 2016	The ODP was presented to Transformation Committee and HSCC provided feedback retrospectively. 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 at Transformation QC.	Yes
Recruitment and Retention Strategy	This Strategy was developed to tackle the increasing number of "hard to recruit" posts within DHSC.	October 2016	Detailed and thorough. It lacks a coherent implementation route which may result in piecemeal progress. Without focus, any good ideas are likely to be lost in the excess of projects which rarely reach completion.	No
Integrated Care	Only Southern Care Initiative pilot working with the community has been commissioned.	December 2016	HSCC understood that the I/C strategy and definition has been in progress for some time.	No
Programme for Government Strategic Objective: An Inclusive and Caring Society	Produced by CoMin with little consultation with: 3 strategic objectives: 1-Inclusive and Caring Society 2-Island of Enterprise and Opportunity 3-Financially Responsible Government and 8 policy statements: 1-Continue to work towards the 5-year Health	January 2017	The original document did not reflect the existing 5-Year Strategy 5 Strategic Aims, but following amendments in Tynwald it now does. No further strategy docs should be needed from DHSC. PfG should be the ultimate set of objectives that we aim to comment about in 17-18 HSCC annual report.	CoMin imposed decision Neutral

Outcome Section: An Inclusive and Caring Island	and Social Care Strategy 2-Maximise efficiency of the service delivered through digital and tele-health care 3-Improve the way we communicate with the public about the way our health and care services are provided 4-Become an Employer of Choice in healthcare 5-Ensure we continue to improve mental health services and access 6-Address the long-term funding issues posed by an ageing population 7-Improve governance and accountability in the way we provide health and care 8-Explore opportunities for shared commissioning for safeguarding and early intervention services for those most at risk.		If the PfG has been aligned to 5-yr strategy then PfG is where our HSCC performance focus should be in 17-18. All funding should also be allocated with those 8 priorities in mind.	
Customer Experience and Engagement Strategy	Customers should feel confident and have the best experience possible while in our care. We will ensure this wherever possible by making decisions about care plans with the direct involvement of our customers. To ensure that customer service feedback is a continuous process and that relevant changes to service delivery meet customer needs. To achieve these goals, we need to help people let us know what it is like to use our service; listen to those experiences and where necessary make changes to improve customer experience.	March 2017	Improved Customer Engagement highlighted as required by both Francis and WMQRS reviews. It has 9 key principles and a framework for engagement. Though signed off by the CEO in August 2016 the HSCC only became aware of this strategy when brought to the Stakeholder Engagement QC in February 2017.	No

HSCC Member Links to Officers 2016-17 **Appendix E**

As at 31st March 2017	HSCC member	Department link	Scrutiny Area	HSCC member	Department link
Strategic Vision Transformation QC	Linda McCauley	Amanda Craig, Director Strategy and Performance	**Managing Political Process**	Bi Annual, ALL members	Minister
Health and Well Being	Martin Hall (Public Health) Malcolm Norris (Mental Health)	Henrietta Ewart, Director (PH) Angela Murray, Director (MH)	**Leadership Governance**	Sue Gowing David Trace	Malcolm Couch CEO
Nursing Services	David Trace	Linda Radcliffe, Chief Nurse	**Community Issues**	Dawn Mayor	Cath Quilliam, Head of Community Health
Integrated Care	Derek Booth Dawn Mayor	Iain Kewley, Director Primary Care Cath Quilliam, Head of Community Health	**Human Resources**	Colm Andrew	Anne Corkill, OHR Partner for Health
Commissioning	David Trace	Tim Mansfield, Director Commissioning	**Patient Safety CQSC**	Dawn Mayor	Jugnu Mahajan, Medical Director
Infomatics	John Whitehouse	Richard Wild, Interim Director, GTS	**Finance** **Noble's Hospital**	Sue Gowing	David Catlow Director Finance Mike Quinn Interim Hospitals Director

List of acronyms

Appendix F

5-YR (STRATEGY)	5-Year Strategy
CAN	Clinical Assessment and Noting
CHS	Community Health Service
CHSET	Community Health Service Executive Team
CIPs	Cost Improvement Plans
CQC	1. Care Quality Commission (UK); 2. Commissioning Quality Committee (IOM)
CQSC	Care Quality and Safety Committee
CS	Communications Strategy
DHR	Digital Health Records
DHSC	Department of Health and Social Care
ELT	Executive Leadership Team
EMI	Elderly Medical Infirm (Care Home)
EPMA	Electronic Prescribing and Medicines Administration
FQC	Finance Quality Committee

GMC	General Medical Council
GTS	Government Technology Services
HPA	Health Protection Agency (UK)
HRQC	Human Resources Quality Committee
HSCC	Health Services Consultative Committee
IQC	Informatics Quality Committee
JSNA	Joint Strategic Needs Assessment
LEaD	Learning, Education and Development
LREC	Local Research Ethics Committee
LSA	Local Supervising Authority (UK)
MHC	Mental Health Committee
MRSA	Methicillin-resistant Staphylococcus aureus
NET	Nobles Executive Team
NHCS	National Health and Care Service

NICE	National Institute for Health and Clinical Excellence (UK)
NMAC	IOM Nursing and Midwifery Advisory Council
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency (UK)
OD (STRATEGY)	Organisational Development
OHR	Office of Human Resource
PA	Patients Association
PAC	Public Accounts Commission
PC	Primary Care
PEIs	Patient Experience Indicators
PHC	Public Health Committee
PSF	Patient Safety Forum
PSQC	Patient Safety Quality Committee
PSW	Patient Safety Walks
QC	Quality Committee

QIP	Quality Improvement Programme Board
QS	Quality Strategy
R & R (STRATEGY)	Recruitment & Retention
RCN&M	Royal College of Nursing and Midwifery (UK)
RDCH	Ramsey and District Cottage Hospital
SAPRC	Social Affairs Policy Review Committee
SDP	Service Delivery Plan
SDPA	Service Delivery Plan Actions
SDPP	Service Delivery Plan Priorities
SEQC	Stakeholder Engagement Quality Committee
SLA	Service Level Agreement
TC	Tertiary Care
TOR	Terms of Reference
TQC	Transformation Quality Committee
WMQRS	West Midlands Quality Review Service