Health Services Consultative Committee
Annual Report

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1 April 2017 to 31 March 2018

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Chairperson Preface 2017-18 by Sue Gowing

The HSCC hoped to be reporting on genuine progress, particularly in the areas of clarification on service prioritisation, commissioning and Integrated Care Services. Instead, to quote the CEO *"the urgent often takes priority over the important".* To some extent, that admission casts light both upon the lack of management skills and experience within some parts of the organisation and the unique IOM working relationship between officers and politicians to achieve clinically evidenced but politically difficult service change.

It also alludes to the unintended consequences of the public and politicians, who mount intense campaigns re DHSC operational decisions and ask many wide-ranging Tynwald questions which require the priority attention of staff and management. These take the limited number of staff (many with dual frontline responsibilities) from the work of providing safe and appropriate healthcare to the local population. Some procurement decisions have seemed baffling, with minor savings and major upheaval for the vulnerable. The questions arise from genuine concerns, but the microscopic examination of decisions, needs to be tempered to permit progress on the big issues. The view of medical professionals needs to valued, (and retention rates would indicate otherwise) but also be balanced against the rightful eye on finances if health services are to truly modernise. Patient safety should always be the priority but demand led services are no longer a sustainable model. Clear definition and understanding of what can be delivered on the Island is long overdue.

Meeting healthcare quality standards, but in financial balance will be the central premise of the Independent Health Review (IHR) but there is real urgency to make progress whilst that is completed. The removal of significant high-level posts through MARS may bring short-term financial relief but risks the loss of organisational memory that can lead to past mistakes being repeated. Competent organisations manage what resources they have utilising existing manpower. Repeated restructures are costly, largely unproductive and morale sapping. The HSCC supports the Community Care Division amalgamation and Nobles hospital Divisions being combined into Care groups and hopes to report a consequent improvement in connectivity and benefits to service users in 2018-19. Succession planning is a concern, with service transformation reliant upon just a few key personnel.

To observe and interact with all levels of officers has been difficult this year. The failure to maintain the Governance structure of Quality Committees (QC's) after a promising start in 2016 is unacceptable. Proper transparent governance informs collaborative cross division working. Terms of Reference should be updated and QC attendance by Senior Leads be mandatory, or the DHSC governance framework will weaken further.

There is no doubt that some sections of the Health service have introduced changes, or made service enhancements, whilst managing to keep within budget. However, Nobles has made only minor impact upon its Cost Improvement Plans (CIP's), despite being given more funding and more autonomy. It has failed to get political, financial and moral support to modernise and streamline services. Whilst not underestimating the enormity of the task set, the outcome of failure to harness the existing staff talent and expertise, to lift morale, and to obtain genuine engagement of patients and staff, is reflected in the WMQRS 7 commentary - with common themes from its WMQRS-1 report three years ago being still as relevant today: *Outdated management techniques and service provision that is unfit for future needs.*

The HSCC members have observed, interacted, advised and listened, across the whole organisation. This has resulted in over 150 internal member reports, from which this Annual report is compiled. I thank the members for their effort. The HSCC has recently acquired new members. It also appreciated the summary scrutiny reports from members who had recently completed their terms of office. The HSCC thanks officers and staff from the Department for the unimpeded access to information and their largely candid and transparent approach to issues raised.

As the new reporting period starts the HSCC remains positive that change will happen with more urgency in 2018-19. This will require tough decisions, well communicated actions and a more enlightened approach to management change. The return to a published 2018-19 Service Delivery Plan is very welcome and should help everyone concerned to identify with the top strategic priorities and work to timed action plans to achieve them.

Continuity has given the HSCC strength and depth to its work since 2012. We hope to continue the role of critical friend to the Department in the future.

Executive Summary 2017-18

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 of nine lay members with skills and experience from business, public services and the voluntary sector. The 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.' The HSCC undertakes the work of advising and scrutinising Health Services as per the engagement paper that follows. Evidence for its views is contained within Member Annual Reports, and detailed in Appendix Tables A-D with each of those tables having a corresponding summary Main Body page A-D.

During 2017-18, the HSCC has been frustrated in its work by the apparent demise of good governance in Health Services. It has found that too often meetings have been cancelled or where they have taken place few, if any, senior officers have attended. Meetings are sometimes held without timely agendas or document distribution which inhibits challenge and debate. Executive Leadership Team (ELT) meetings are not minuted. Senior Officers have left at short notice leaving some Quality Committees unable to function. The consequences of inadequate governance are that decisions and actions seem to appear; rather than being grounded in open and transparent evidence.

The HSCC reviewed its previous Key Recommendations and is pleased to report an improvement in part Met ratings in all three areas of Strategic, Engagement and Finance/Commissioning sections. However, some recommendations have become Not Met, particularly in the Commissioning section.

The HSCC has undertaken its own assessment of the Health objectives ratings in the Programme for Government (PfG) based on its observations and meetings. Alarmingly, HSCC ratings vary significantly from those published for PfG. For example, PFG objective, 'Continue the external peer review process of the hospital and implement the recommendations' has been rated Green for 4 quarters. HSCC rate it Red because it is concerned that following the disbanding of the Quality Improvement Programme Board (QIPB) and the recent suspension of Care Quality and Safety Committee (CQSC) there is no proper governance or oversight of the WMQRS process and the implementation of its recommendations. It is noted that some of the Q3 PfG ratings have been retrospectively downgraded and a sense of realism applied to Q4 ratings.

The DHSC Strategy list came in for much criticism last year as the HSCC applauded the principles but despaired of how little implementation had occurred. Whilst long awaited progress has been noted in Integrated Care Strategy and Digital change continues, (and indeed actual implementation within the Eye strategy), the Recruitment & Retention Strategy and Organisation Development Plans have lacked sponsorship this year with the delayed PiP project dominating many agendas.

On a positive note, during 2017 HSCC is delighted to report on a range of good practice which include; the centralisation of Endoscopy, improvements to Eye Care through partnership working between acute, primary and voluntary sector, the introduction of Hot Boards in Wards, the digitisation of patient records; improvements in pharmaceutical working, improvement of care for long term conditions in the community, improvements in the effective Use of Resources - regular batches of policies from Clinical Recommendations Committee (CRC) for procedures of lower clinical value, a detailed Contract list for 2017-2018 compiled, a Nursing and Midwifery Professional Framework launched, the performance of 2 week wait cancer data has improved, MRI and Endoscopy waiting lists have dropped significantly, Manannan Court has established itself with Mental Health Services making strides forward for on-Island care through specialists and there is a consistent review of Monthly Financial performance by Nobles budget holders.

HSCC understands that there is a global shortage of doctors and nurses; it appreciates that clinical costs for drugs are rising exponentially. It is well aware that there is a need to balance the funding budget and to identify what a Health Service should and should not deliver. These are extremely tough challenges for all the politicians and staff in the Department and should not be underestimated nor the tough decisions required, be delayed any longer. There is a need for all to focus on the high priorities of Health and not get side-tracked into time consuming individual health matters.

HSCC Key Recommendations 2017-2018

The HSCC recommend that:

R1 2017-18	Cancer Strategy	DHSC carry out a mid-term review of The National Cancer Plan for the IOM 2012-2022 outcomes, resources, KPI's and accountabilities with a view to establishing a future costed Plan.
R2 2017-18	Care Quality and Safety Committee (CQSC)	Greater clarity, speed and efficiency in dealing with contract management and asset replacement matters e.g. replacement of laundry equipment, beds contract.
R3 2017-18	Community Health Services Executive Team (CHSET)	DHSC review the funding strategy to consider the urgent budget needs to support Integrated Care strategy.
R4 2017-18	Finance/Commissioning QC (FCC)	Better Financial and Commissioning Governance is required through a review of ToR's, membership and accountability.
R5 2017-18	Informatics QC (IQC)	The DHSC should involve itself at an earlier stage, in the rationale, scope and implementation of pan-Government projects such as PiP.
R6 2017-18	Mental Health Directorate (MHD)	The new Community Care Directorate structure provides a smoothly running system to care for people in the community by developing and funding an effective Integrated Care plan.
R7 2017-18	Nursing and Midwifery Advisory Council (NMAC)	Responsibility for Nursing and Health Care Assistant regulation is urgently re-established following the removal of Chief and Associate Chief Nurse posts, and NMAC itself.
R8 2017-18	Nobles Executive Team/SMT	Focus on gate keeping into Nobles and smooth discharge to the Community & Residential sector to ensure it fits with the Integrated Care Strategy and ensures patient safety.
R9 2017-18	Office of Human Resources QC	Systems are developed to overhaul all HR functions with DHSC with clear direction (via a new Service Level Agreement) for all future workforce planning and staff management processes.
R10 2017-18	Public Health Directorate (PHD)	DHSC ensure governance procedures for all screening services are improved and gain approval by the Director of Public Health as appropriate and adequate.
R11 2017-18	Transformation QC (TQC)	Within 6 months of the mid-point, DHSC carry out a review of the October 2015-2020 5-Year Strategy in the light of the Public Accounts Committee' findings and the broader aims of the PfG.
R12 2017-18	WMQRS Recommendations	DHSC urgently re-establish effective governance of Health services following the breakdown of the April 2016 governance system which currently fails to provide assurance to the CEO and Tynwald.

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 and 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.
- Bi-annual meeting with minister and Department Member.

Member attendance:

- 7 Quality Committees: i.e. Care Quality & Safety, Commissioning, Finance, Informatics, OHR, Stakeholder & 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 Accounts Committee
- Social Affairs Policy Review Committee
- Draft General Scheme and Charges

Annual Report:

- To Tynwald. Available to the public via Government website

The HSCC View – Progress on the Pathways to a modern Healthcare system 2015-2020

FROM	STRATEGIC PATHWAYS – a journey towards an appropriate healthcare system			TARGET
Acute priority provision	Set clear TFR priorities Objectives in line with health Strategy	Identify what services are provided on Island	Front load budgets to ensure services are transferred with budget	**Appropriate community centred provision**
10 year health strategy	Revised 2013 Reviewed Dec 2013	Replaced with 5-yr Strategy in Oct 2015	Mid-point review due in Summer 2018	**Rolling programme of strategic thinking**
Treatment by SILO approach	Barriers between different part of the system	Reorganise health structure to reflect changing priorities	Develop Care groups to meet co morbidity challenges	**Multi-disciplinary teams**
Unlimited demand-led Health Service	Sole provider health service	Work towards shared service delivery	Patient focused approach	**Mixed economy, public, private and 3rd sector**
Peer to Peer Reviews FRWG; MIAA; WMQRS	Consult on individual issues – reactive	Support pro-active approach MIAA	Francis Report WMQRS	**Regular external audit**
Engaging patient voice	Complaints Defensive approach	Widen engagement through Workshops & social media	Consult on evidence based planned service changes	**Patient designated services**
Mental Illness	Mental illness	Step up, step down		**Mental well-being**
Public Health	Piecemeal campaigns	Numerous strategies No prioritisation	JSNA Review of screening services	**Evidenced improvement in the health of the nation/wellbeing**
Organisational Culture	Demoralised Blame culture	Clearly communicate planned organisational change to all staff groups	Implement Recruitment and Retention Strategy	**Empowered staff** **Low turnover**
Scrutiny	Via committee attendances and escalation to CEO	Governance groups that challenge communicate and provide risk assurance	Fully transparent scrutiny access from Board to coal face encounters	**Stable governance system**

Intended Direction of Travel

A: Review of Past HSCC Key Recommendations

The HSCC has combined its previous 3 years of key recommendations and assigned them to three categories: Strategic, Engagement and Finance/Commissioning.

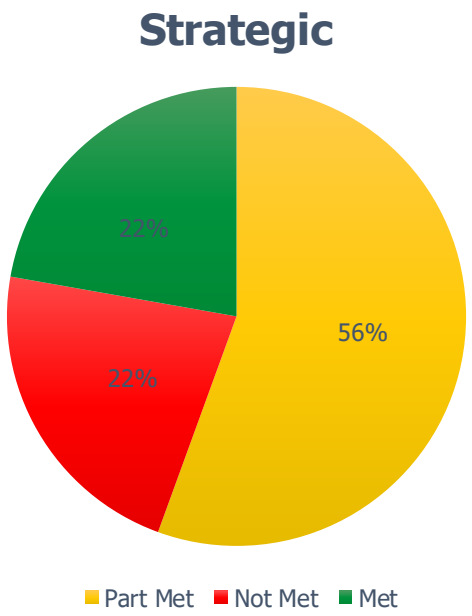
We had previously reported progress to April 2017 within our last annual report. However, the HSCC has now further reviewed 2014-16 recommendations with those of 2016-17 and independently assessed progress against the same based on the evidence it has available and observations made during the past year.

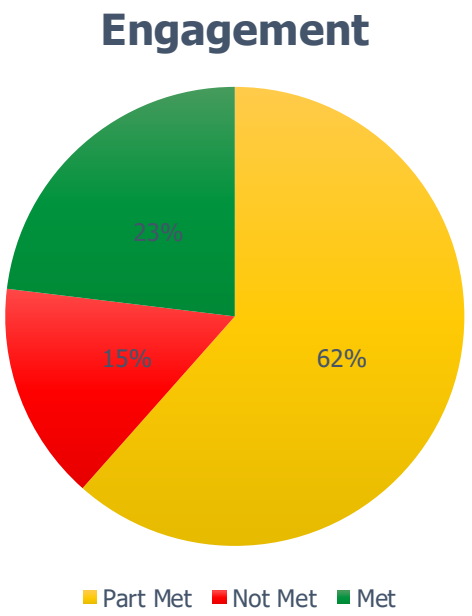
As is evident throughout our previous annual reporting, the HSCC feels that many of its recommendations are taken on board by the Department We are pleased to report an improvement in Part Met RAG rating in all three areas.

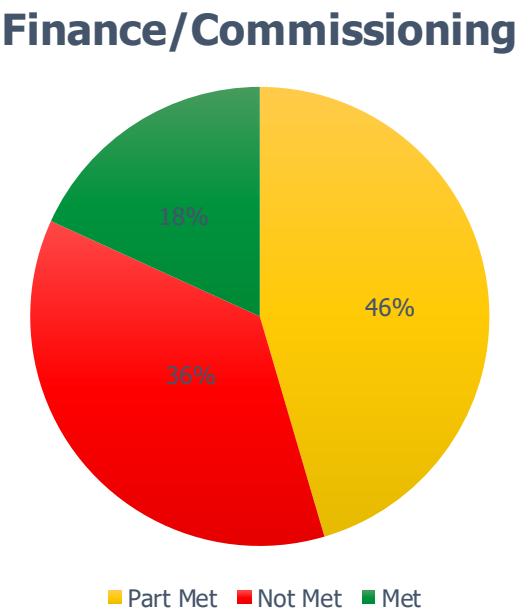
However some individual HSCC engagement recommendations have seen a backslide. It would seem that active public engagement will be vital in the year ahead, particularly to progress the Integrated Care agenda.

Again it is within the Finance and Commissioning category we find progress unacceptably slow. As before it is the pace rather than the direction of change where we are most critical. Finance has been well resourced this year further analysing known cost pressures. Commissioning resource has not increased and agreed strategic priorities from 2016-17 are still in slow progression as a result.

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







B: Governance: Quality Committees (QC's) & Management structure changes - HSCC 2017-18 review

As reported last year, following WMQRS 4 recommendations in 2016 a new Governance structure was introduced based around a full Board 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. These QC's were reduced to 5 in April 2017 with Finance merging with Commissioning (FCC) and Stakeholder with Transformation. In October 2017 the latter was replaced by a Programme Board, now a Programme Management Office (PMO)

The quality of any governance committee relies upon clear Terms of Reference (TOR) and the motivation of the membership. In this period only three QC's have met frequently (CQSC IQC and FCC) Repeated non-attendance by Senior leads has been an issue. Others, however, have not met regularly and/or have had a number of meetings cancelled due to member unavailability. Assurance is lacking across the DHSC. QC reform is now urgent.

Quality Committee	Observation
Care Quality & Safety Committee	Open and frank discussion between service areas. Useful opportunity for sharing good practice between areas.
Commissioning QC element	Good progress with PH on Policies & pathways & Contracts catalogue inc. Pharmaceutical Needs and Tertiary.
Finance & Commissioning QC (FCC)	Financials provided but Nobles non-attendance unhelpful to scrutiny. Few expenditure proposals for cross department scrutiny. Good oversight on the Capital programme.
Human Resources QC	Has limped through 2017 with very poor attendance. Much discussion. No clear actions or tangible results.
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	Merged into Transformation 04/17. Without regular communication, shared service attendance, no assurance or plan.
Transformation QC	Functioned until 10/17 when Programme Board proposed. Still await TOR's for a replacement governance option.

The Executive Leadership Team (ELT) continues to meet regularly; the Board meeting quarterly and the Department monthly. Directors are grouped into two reporting areas to ELT – operational services for acute, community and social care services and all corporate services. Professional leads such as Medical Director and Chief Nurse have been abolished. Public Health and Informatics report directly to CEO. Currently there is no Caldicott Guardian in post.

Commentary: The HSCC observe that communication to and from the Board has appeared to suffer as a result of ongoing upheaval. There is a lack of robust governance procedures throughout the DHSC. Limited standing agenda items prevent a circle of communication between ELT and QC's with the former lacking transparency, having no agenda or minutes taken.

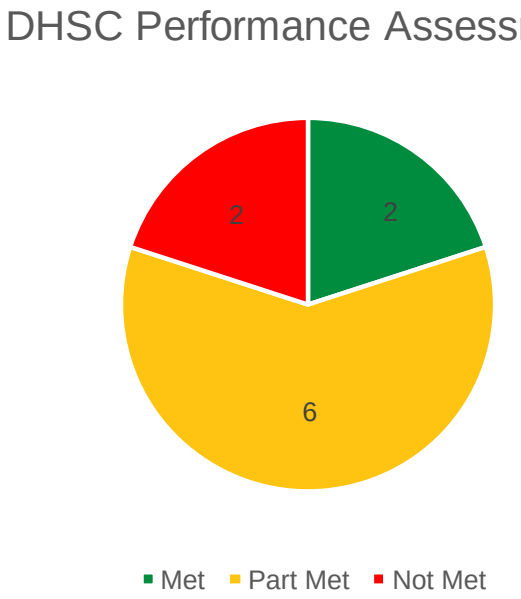
Whilst the HSCC fully supports the blending of Mental Health Community and Adult Social Care into the Community Care Division, and the forthcoming set up of Care Groups within Nobles to improve patient-centred care, it does not support more management restructures that are morale sapping, time consuming and a constant distraction from the important priorities. The public deserve progress on legislation, service prioritisation and location, genuine stakeholder engagement, and clear strategic priorities rather than repeated management reorganisation and abolition of posts that seem based more upon personality clashes than role performance or skills of the post holder. Neither WMQRS nor the Public Accounts committee has been complimentary about the quality of governance. A sound governance framework was put in place in April 2016, but as with many areas of HSCC reporting, the ongoing management of this framework has been inadequate with scant attention to TOR's and enforcement of senior lead attendance.

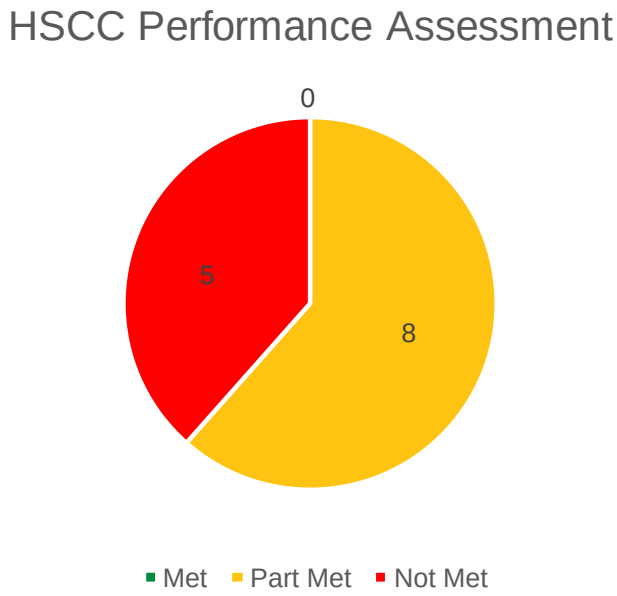
C: Programme for Government - Government Rating and HSCC rating 2017/18

We live longer, healthier lives, by MHK responsibility	Responsible MHK	PfG RAG rating				HSCC comment	HSCC RAG rating
		Q1	Q2	Q3	Q4		
Continue the external peer review process of the hospital and implement the recommendations	Clare Bettison	G	G	G	G	HSCC are concerned that following the disbanding of QIPB and the suspension of CQSC there is no proper governance or oversight of the peer review process and the implementation of recommendations. The Department is assembling a new project group which may alleviate some concerns but HSCC await to see the composition and TORs for this group.	A
Move more services from the hospital into the community so care is provided closer to peoples' homes	Ann Corlett	G	A	G	G	HSCC note that progress is slow with no clear implementation or communication plans. Areas needing addressing include funding, identification of pathways for patient care and case management in the community, engagement with key stakeholders including GPs.	A
Define the essential services always provided in health and social care and be clear about those that aren't	Jason Moorhouse	G	G	G	A	HSCC believe the Departments approach to health service provision must be flexible and responsive to changing needs at community and individual levels. The failure to bring forward the General Scheme illustrated the Department's confusion about what it should and should not be providing and at what cost.	A
Continue to digitally transform the hospital and health and care services more generally	David Ashford	G	A	A	A	HSCC welcome the move to digital records but recognises there is still much to do. In particular to balance ease of access of accurate and up to date records with concerns surrounding confidentiality, patient consent and safeguarding issues.	A
Define the services which will be provided on-Island and those which will be provided off-Island	Jason Moorhouse	G	A	A	A	HSCC would like to see full staff/public engagement in this process. Any changes should be evidence based and should have taken account of clinical guidelines. The Eye Care Strategy is a good example of how this can be taken forward,	R

Reduce waiting times for Operations	Clare Bettison	G	A	R	R	HSCC believes there should be a robust system for ongoing and continual waiting list validation with regular specific reporting to Tynwald. Each Consultant has to be held accountable for their own their own waiting list, based on agreed parameters and clinical evidence. Reasons for waiting lists growth should be made alongside plans for reductions and set against best practice.	R
Publish hospital waiting lists by April 2017	Clare Bettison	G	A	complete		HSCC believes that this is a continuous process and as such cannot be marked as complete	A
Implement the mental health services strategy	Ann Corlett	G	G	A	A	In general, very good progress is being made, although a few areas where more could be done – e.g. CAMHS, where waiting lists are growing due to increasingly heavy demand.	A
Consider and recommend funding options for residential and nursing care	TBA	G	G	to be revised for PfG2		HSCC would welcome the opportunity to be consulted and comment on this area which is key to moving health care from acute to community. This is marked as closed as the responsibility has gone to the Minister for Policy and Reform. HSCC have not been involved in the Focus Groups established to take this forward.	A
Improve the way we communicate with the public about the way we provide healthcare	Jason Moorhouse	G	A	A	A	2017 Communications is routine PR, reacting to events and firefighting. This was the same in 2016 with no obvious change. The recently appointed New Communications Executive with Responsibility for DHSC based in Government Office will create and work to a new overarching DHSC Communications Strategy and Plan which is clear, structured, measurable and deliverable.	R
Improve governance and accountability in the way we provide health & care services	Jason Moorhouse	G	A	A	A	HSCC has witnessed the erosion of governance and accountability over the past year as evidenced by the lack of attendance at Quality Committees by key staff, loss of the Transformation QC and NMAC. HSCC takes no confidence in yet another review of governance and management structures.	R

Become an employer of choice in healthcare	David Ashford	G	A	A	R	HSCC sees continuing HR problems as a major issue, not helped by very poor attendance at the OHR QC. In particular, poor data and management intervention on sickness absence remains an issue. There seems an over optimistic view that PiP will solve these problems. However, PiP is a system that will still rely on good management.	R
Address the long-term funding issues posed by an aging population	Ralph Peake	TBA	G	G	G	HSCC would like to see the Department Publish its plan for addressing this issue supported by evidence and key milestones. Q4 update did not include this indicator which seems to have been removed from the PfG.	A





A pattern is evident through ratings of PfG and previous 2016-17 Service Delivery Plan (appendix E): that is of optimistic views of progress which do not stand up to any detailed examination. Recent downgrading of Q4 PfG ratings are welcomed.

D: DHSC Strategies and Plans 2015-2018 –implementation, action – HSCC review

A large number of Strategies have been compiled since August 2015. The HSCC welcome the strategic approach to policy formulation but has some concerns. Content of some of Strategies is patchy. Some Strategies have been compiled without consultation and engagement with staff, public and indeed the HSCC. Most importantly most Strategies have not been followed up with detailed Implementation plans.

Also see Appendix D	Observations
Digital Strategy Health Section	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	The Strategy sets out five clear areas for improvement, the pillars of the Strategy. However, it revealed some disjoint between Health and Social Care.
4 Domains of Public Health	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	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	The 2016/2017 DHSC Communications Strategy document is out of date with no recent "Communications Plan Action Log" follow up.
Eye Care Strategy	The development and implementation of a visiting service has so far resulted in an 85% reduction in patients travelling off island for ARMD treatments.

Quality Committee	Observations
Quality Strategy	Puzzling as to how the Quality Strategy fits into the overall DHSC jigsaw. HSCC had no publication date and did not see a final document. Now integrated into the CARE project and never published as Quality Strategy.
Organisational Development Plan Programme 2016-20	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	This Strategy was developed to tackle the increasing number of "hard to recruit" posts within DHSC. There is mass slippage in this strategy.
Integrated Care	The draft I/C strategy (still to be published with relevant approvals) needs to be rapidly progressed into a solid action plan if any real change toward I/C is possible in the coming year.
Programme for Government	HSCC believes that although PfG now reflects the 5-Year Strategy and the 5-Year Plan it is a less accurate measure of the Department's performance than the Service Delivery Plan of 2016-17. HSCC would like to see the reinstatement of the Service Delivery Plan for 2018-19, which should be cross referenced to PfG2.
Customer Experience & Engagement Strategy	This was highlighted as required by the Francis Report and within the West Midlands Quality Review Service recommendations.

HSCC Member Annual Reports 2017-2018

Cancer	
New Developments	HSCC now has Cancer as a specific review subject. The Director of Hospitals in post since May 2017 has brought better focus to Cancer. Cancer services now report directly to the Director of Hospitals. Somerset Cancer Register now being used with comprehensive real time patient cancer data. Very recently linked to Medway. Now achieving waiting time targets.
Evidence of Good Practice	Weekly Friday PTM Cancer Patient Tracking Meeting with Director. Quarterly Cancer Strategy Group with good Terms of Reference. Cancer Operating Group (COG) meets every two months run by key Cancer MDT co-ordinators.
Issues Causing Concern	The National Cancer Plan for The Isle of Man 2012-2022 is a difficult read. Good on providing a range of ideas, visions, aspirations and challenges but has not had a progress report since 2014. Too many "priority" things to do without reference to resource required or accountability. Investment in service delivery and capital investment must be based on evidenced needs. The 2014 40-page Progress Report has pockets of data that are difficult to find among the text.
Recommendation 1	**Carry out a mid-term review of The National Cancer Plan for the IOM 2012-2022 outcomes, resources, KPI's and accountabilities with a view to establishing a future costed Plan.**
Recommendation 2	**Have a clear vision on what are the key priority areas and why.** **Define the role of competing Cancer champions (e.g. Macmillan, 3rd sector Cancer Charities)**
Recommendation 3	**Quantify what is going well and what is not.** **Be candid and concise including lack of data, facility, resource, money, expertise.**

Care Quality & Safety CQSC	
New Developments	Frank and open discussion occurs between departments; however a consistent lack of attendance from some divisions is an issue. CQSC has developed a Department Assurance Framework (DAF)
Evidence of Good Practice	Overall feedback positive from both CHS and Acute Patient Safety Walks. Health Roster operational in Noble's Hospital. Weekly Waiting List Assurance meeting, increasing transparency and highlighting capacity issues. All Senior leads seek to ensure WMQR reports containing recommendations summary and compliance.

	Implementation Plans for Adult Social Care, Primary Care and Mental Health presented, in line with Strategy document, in readiness to go into public domain.
Issues Causing Concern	24/7 Thrombolysis remains a priority and increased pressure for financial support is needed. Still no antimicrobial pharmacist for DHSC. Oversight of DHSC Risk Register remains an issue. A clear structure of escalation is required and it needs to be an integral part of developing a Department Assurance Framework (DAF). Adult discharge procedures. Improve links with CHS and Social Care. Efficacy of Immedicare; is its use in Nursing Homes is saving the DHSC time and money? Commissioning issues, particularly with asset management e.g. bed replacements, monitors, laundry equipment. Imminent replacement for PRISM (Incident Reporting System) planned for 9 years. Urgent replacement of outdated laundry machinery to improve patient safety and staff working environment. Current situation ongoing for over 12 months, contrary to H&S Act and infection control. Urgent Care review report completed 6 months ago, still awaiting feedback and action planning.
Recommendation 1	**Greater clarity, speed and efficiency is needed in dealing with contract management and asset replacement matters, e.g. replacement of laundry equipment, beds.**
Recommendation 2	**An increased commitment to Thrombolysis care and Rehabilitation services.**
Recommendation 3	**At a political level address the With the CHS, welfare, financial impacts and societal obligations needs generated by the forecast home care doubling in demand over the next decade.**

Community Health Services Executive Team CHSET	
New Developments	Bi-monthly CHS Divisional Managers meeting feeds back and supports the CHSET. CHS merged with Mental Health and Adult Social Care in forming the Community Care Directorate (CCD). CHSET meetings have ceased and a CCD organisation structure is anticipated. Contractor, Ambulance Services and Ramsey & District Cottage Hospital transferred out of Primary Care.
Evidence of Good Practice	Whole site at RDCH now Dementia friendly. Expansion of Long Term Conditions Team with additional staff member recruited to improve support for patients in the community. Self-care Nurse added to multidisciplinary team. Three District Nurses have completed their Specialist Community Practitioner training. Minimal complaints/IRB referrals, all dealt with within prompt timescales. Forecast CHS budget under spend, competent Managers working within budget and initiating savings. EMIS system now live in Children & Families and Adult Community Nursing.

	Improvements in Intermediate Care at RDCH, Step up/Down provision. New Geriatrician post advertised. Tissue Viability Nurse now in post, more equitable wound management now provided Island wide. Reduced waiting times for wheelchair service, due to reconfiguration of staff.
Issues Causing Concern	District Nurse services at capacity due to increased workload and an increase in complex cases. Need for transfer of nursing staff and budgets, in alignment with Integrated Care model. Smoother running of Community Equipment store, due to involvement of clinician. Larger items now tracked. However, questions remain regarding the property being fit for purpose, and budgeting is difficult due to it being a demand led service. Primary Care infrastructure remains on the corporate Risk Register. Ambulance services, inequalities in terms & conditions remain. Paramedic Services have seen a decline in response time targets with the 20-minute target being met only 50% of the time, on occasion. A pilot for an emergency transport vehicle is proposed. Occupational Therapy could work 'within the financial envelope' but this would necessitate cutting services, and re-evaluating the services offered, and no financial uplift for 10 years. Rehabilitation facilities – issues remain since closure of ward 20 in 2016. No dedicated facilities for either acute or 'slow stream' rehab within Nobles, resulting in cramped conditions, inappropriate use, longer stays in hospital and potential staff and patient safety issues. Matters may be resolved by moving slow stream rehab to RDCH. Hand surgery now undertaken on Island, however there is no capacity in Physiotherapy to absorb additional cases created by this surgery - lack of liaison with supporting services in service design. DBS checks not always redone after 3 years, will be costly to Department. HR issue. Note that Social Care re-checks annually. Decontamination suite at Community Care Health Centre (CCHC) not meeting standards.
Recommendation 1	**DHSC review the funding strategy to consider the urgent budget needs to support Integrated Care strategy.**
Recommendation 2	**Clarity on the proposed model of care at RDCH would be welcomed.**
Recommendation 3	**Major upheavals across the organisation have impacted on Primary Care finances and staff morale. In future advance consultation with staff and stakeholders should be automatic.**

Finance & Commissioning FCC	
New Developments	Pharmaceutical Needs Assessment completed. Proposal for a new model for community pharmacy payments and services for the Isle of Man. Proposals for 2018-19 General Medical Services Contract.
Evidence of Good Practice	Effective Use of Resources - regular batches of policies from Clinical Recommendations Committee (CRC) for procedures deemed to be of lower clinical value for consideration by FCC. Detailed Tender plan for 2017-2018 compiled.
Issues Causing Concern	FCC is not functioning as per its TOR's, which was to give assurance that FCC considered risks and provided assurance they were being managed effectively. Non-attendance of Directors of the two largest Divisions dilutes the work of this committee and renders objective discussion, particularly on financial performance, much less useful. Three main spending areas in need of an agreed management plan to ensure stronger controls - locum/bank staff usage, costs of pharmaceuticals and controlling access to tertiary treatment in England.
Recommendation 1	**Better Financial and Commissioning Governance is required through by review of ToRs, membership and accountability.**
Recommendation 2	**Increase staff resources to complete full contract catalogue and approve projects.**
Recommendation 3	**Continue work to clarify service delivery criteria re: what will be provided on/off Island.**

Informatics QC	
New Developments	The IQC continues to oversee the technology driven changes being delivered within the DHSC. It follows a standard change delivery operating rhythm which continues to see good delivery results.
Evidence of Good Practice	The IQC provides a good communications channel and visibility of change activates across the whole of health. This supports necessary prioritisation of resource supporting the deliveries that have been seen in this reporting year. The Departments establishment of its own PMO Office which will follow similar processes is welcomed by the HSCC and is consistent with previous recommendations made by the HSCC.
Issues Causing Concern	It is noted that some delivery tensions have been observed notably with delivery of PIP. This was raised in many of the meetings attended by HSCC members. It is interesting to also note that engagement from the Department for this project was reportedly slow to start. The limited engagement was noted and addressing actions taken.
Recommendation 1	**The DHSC should involve itself in rationale, scope and implementation of pan-Government projects such as PiP.**

Mental Health Directorate	
New Developments	Manannan Court. The purpose built £7.2m acute admission unit built to UK Department of Health Standards became fully operational in April 2017. Brunswick Gardens upgrading of this rest facility opened in August 2017. A good example of collaboration between Government, the local community and the third sector. The Mental Health Service has acquired the input of a dedicated Clinical Pharmacist. This development has been long overdue and is considered essential in terms of patient safety. MHS expenditure for 2017-2018 was within budget for most of the year, due to efforts made to replace bank and agency staff with substantive staff, including "specialist" doctors at greatly reduced cost, and the ability to return to the Island some patients who were being treated in the UK at considerable cost.
Evidence of Good Practice	The improving quality of the service Mental Health provides is supported by the cooperation and interplay between its many parts. The new MH Patient Quality and Safety committee is a good example. The Director of Mental Health has recently been appointed to lead the new Directorate of Community Care, replacing the practices and structures developed in the past three years.
Issues Causing Concern	Secure forensic patient placements, arising from the judicial system, can have an enormous impact on the otherwise careful budgeting of the Mental Health Directorate, has long been a matter of concern. The new financing system introduced by the Treasury should resolve this, but it needs to be watched with care, particularly over its first year, to check it works properly.
Recommendation 1	**The new Community Care Directorate structure provides a smoothly running system to care for people in the community by developing and funding an effective Integrated Care plan.**
Recommendation 2	**Minimise waiting times for Mental Health Services such as CAMHS and Clinical Psychology.**
Recommendation 3	**Increase further the provision of level 2 self-care across the population through the use of self-help guides and community teams.**

Nursing and Midwifery Advisory Council NMAC	
New Developments	Ward 5 closure should result in staff being redistributed to medical wards to cover long term shortages. Chief Nurse post has been removed from the management structure. NMAC ceased to exist in April 2018.
Evidence of Good Practice	A Nursing and Midwifery Professional Framework launched, based around the NMC Code, Standards and Revalidation for England, Scotland, Wales and NI form part of the actions required to meet the DHSC 5-yr strategy. Progress on Performance and Appraisal, known as CARE.
Issues Causing Concern	Appointments to specialist nurse posts are not all qualified even though they are experienced nurses. Who will speak for the profession and lead on nursing in the future? Who will regulate nurses, midwives and health care assistants? IOM will be the only GB Health Service provider without a Chief Nurse and an associated regulating body.
Recommendation 1	**Responsibility for Nursing and Health Care Assistant regulation is urgently re-established following the removal of Chief and Associate Chief Nurse posts and NMAC itself.**
Recommendation 2	**Ensure Nursing & Midwifery Professional Framework is the guiding tool for the profession.**
Recommendation 3	**Ensure all appointments to specialist nurse posts have appropriate training/qualifications.**

Nobles Executive Team NET	
New Developments	Endoscopy transfer from RDCH was predicated on waiting list issues but has ultimately succeeded albeit with an increase in costs but a decrease in waiting lists and risk reduction. Senior Nurses on ward shift weekly. Discharge lounge - where dispensing, discharge into the community and patient transfers can be monitored whilst freeing beds more quickly for incoming Acute patients.
Evidence of Good Practice	The maintenance and performance of two week wait cancer data has improved. PfG target met. MRI and Endoscopy waiting lists have dropped significantly. Consistent review of Monthly Financial performance by budget holders. Use of Hot boards on wards provides visible daily updates on staffing levels. Patient Experience indicators variable but improvements noted following drops in performance. Core Services, Pharmacy & Radiology – transparent evidence of performance and challenges faced.
Issues Causing Concern	Nobles Team is not functioning as per its TOR's, which were devised to ensure that risks were considered and provide assurance they were being managed. More challenge of top level decision making and increase in 2-way engagement needed. Patchy attendance of the shared services partners from GTS, OHR and Communications. Last minute reports reduce opportunity for considered review and objective discussion of issues. Business cases no longer come to NET for initial

	screening. Ward averaging statistics on patient falls may be disguising unacceptable high levels, particularly in Medical wards with average 96% ward occupancy. Delayed implementation of 24/7 Stroke Thrombolysis & Ward 5 reassignment is disappointing. Cost Improvement plans have had a very limited impact. Areas of success are often not well identified and applauded. External influences, upward pressures in demand, some unwillingness to engage in change, limited communication of priorities all contribute to this issue. With 82% spend on staffing, & rising pharmaceutical and UK tertiary treatment costs, long held implementation plans need political approval and manpower to reduce further Supplementary Vote requirements. Management of Patient Safety and Complaints has been diluted this year due to competing priorities. Core Services has had unacceptable levels of outstanding issues in certain specialities following the removal of the outsourcing initiative. The most recent in Cardio-Respiratory was flagged for urgent action by WMQRS in their recent peer to peer review.
Recommendation 1	**Focus on gate keeping into Nobles and smooth discharge to the Community & Residential sector to ensure it fits with an Integrated Care Strategy and ensures patient safety.**
Recommendation 2	**Genuine engagement with the workforce is made in order to improve morale & staff absence.**
Recommendation 3	**Continue root and branch review of Nobles structure to improve practices & procedures.**

Office of Human Resources QC	
New Developments	A new Service Level Agreement (SLA) between OHR and the DHSC has been under constant discussion since June 2016 and it still appears no nearer to fulfilment. The current lines of responsibility are far too blurred and the length of time that the proposed new SLA has been 'in discussion' is not easy to understand.
Evidence of Good Practice	The emphasis on the operational side should also be more prominent when existing strategy is deemed to be not working. The current answer always seems to be a long consultation period with yet another strategy being wheeled out – initially, it would be far more productive to simply look at how operationally things are being implemented
Issues Causing Concern	The Recruitment & Retention Strategy which launched in late 2016 was given little operational aftercare and seems to have been not much more than a paperwork exercise. The time and effort in writing a strategy, is largely wasted if its implementation isn't given close attention. Staff Absence figures continue to change up to 6 months later, until that changes they won't be taken seriously and the root cause of the issues will be lost in flawed data. Bearing in mind how much Staff Absence costs the Department each year, the fact that the figures are unreliable to the point that Managers have no confidence in them and are prone to ignore them, is impossible to justify (the soon to launch PiP has been cited as the solution to this issue, which should be stress-tested before launch).

	There is a lack of clarity surrounding the issues of Private Practice & Secondary Employment. This needs to be addressed to ensure lines aren't being crossed which could have operational and legal repercussions. OHR QC meetings have now been ongoing for over 18 months (with few tangible results or progress), the absence of a HR lead within the DHSC has become more apparent. OHR QC is the only official forum between OHR and the DHSC, but over the last 18 months it has steadily depreciated in value to the point that at the January meeting not one representative from the DHSC turned up.
Recommendation 1	**Systems are developed to overhaul all HR functions with DHSC with clear direction (via new SLA) for all future workforce planning and staff management processes.**
Recommendation 2	**Given the central role of HR to the Department determine the direction and focus of this QC.**
Recommendation 3	**Support managers in PiP implementation to ensure staff absences are effectively managed.**

Public Health Directorate	
New Developments	Monthly Public Health Meetings are well attended, with participants taking an active role. All required actions are monitored to be ensured work is being undertaken. Workshops have been undertaken with Government Departments and non-Governmental Organisations to explain the DPH Annual Report and develop pathways for the further development of Public Health joint working.
Evidence of Good Practice	Immediate review of the governance of Screening Services and appropriate action taken.
Issues Causing Concern	The Director of Public Health failed to get assurances and information on the all the Islands Screening Services to satisfy her that proper governance is in place and that these services are fit for purpose. The Department has entered this as red on the Risk Register.
Recommendation 1	**Ensure Governance Procedures for all screening services are improved and approved by the Director of Public Health as appropriate and adequate.**
Recommendation 2	**All Implementation plans for of the Drug and Alcohol Misuse Strategy are published for meaningful consultation.**
Recommendation 3	**Resources should be provided to ensure completed JSNA's are reviewed and maintained.**

Transformation QC	
New Developments	Consultation on the National Health and Social Care Service General Scheme which sets out the provision of Care and the realignment of charges and contributions and an NHS Charter were undertaken. Integrated Care partially moved forward through Southern Communities Initiative report and Peel Health Meeting. Some attempt to map out the components. Programme for Government Health, Milestones and KPIs linked to the 5-Year Health and Care Strategy. Eye Care Strategy - Draft Strategy agreed and launched. Positive feedback from consultation. Service improvements agreed and under action with better joined up services, improved customer support, possible improved outcomes for patients and possible cost savings.
Evidence of Good Practice	When it did meet, officers worked together and showed leadership. The PfG for Health was effectively linked to the 5-Year Strategy and Milestones were produced. Eye Care Strategy - Officers and voluntary sector worked together to produce a 'step change' Strategy for Eye Care. Clinical Officers were present at every meeting and contributed resulting in service changes which could be quickly implemented.
Issues Causing Concern	The General Scheme and Charter have suffered huge delays. Neither the options for inclusion in the draft Scheme or the draft General Scheme, the draft Scheme itself nor the Communication Plan were brought for consideration to the Transformation Quality Committee. The Scheme was poorly thought through from its content (the options for political consideration for the scheme were never made public), to its communication plan which resulted in an avalanche of queries. An FAQ had to be produced half way through the consultation to respond to concerns. The result of this hiatus in legislation leaves the Department with a 2016 Act which has yet to be implemented, despite extra in-house legislative resource being financed. The realignment of charges and contributions has yet to be resolved leaving another potential funding shortfall. In addition, the draft Scheme set out the purposes of the Department yet a Public Accounts Committee inquiry found it impossible to identify what the Department should be delivering on health. Integrated Care Strategy is still at draft stage, without a Project Plan to ensure transparency and measurement. The establishment of the Quality Committees in April 2016 should have improved governance but their subsequent working and reporting to ELT and ELTs relationship to the QCs was not clearly articulated to Directors and Officers leaving misunderstandings. The Dept has now restructured into two Divisions and governance needs to be restructured accordingly. 5-Year Health and Care Strategy set five main aims. The Department now need to review the Strategy both in the light of the PfG and with regard to the findings of the Public Accounts Committee. There is a need to get back to basics - what should the Department provide and at what cost. Only then can the Department know its priorities. The Department may argue that this work is left until after the Review of Health has reported but that will mean yet another year lost.
Recommendation 1	**Within 6 months of the mid-point, carry out a review of the October 2015-2020 5-Year Strategy in the light of the Public Accounts Committee' findings and the broader aims of the PfG.**
Recommendation 2	**Design and cost out a Project Plan for Integrated Care and progress its implementation.**

WMQRS	
New Developments	WMQRS 7 and 8 were completed in February 2018 although the final report on the latter is still awaited. WMQRS have now completed their 3-year Peer to Peer review programme.
Evidence of Good Practice	Consistent report formats. Clear list of immediate concerns for rectification. Common themes section linking all the reports together.
Issues Causing Concern	A lack of understanding of the legislative differences affecting some recommendations. The lack of progress on the recommendations since Quality Improvement Programme Board was suspended in August 2016. The recommendations now rest with individual Divisions with limited sponsorship or accountability for implementation.
Recommendation 1	**Urgently re-establish effective governance of Health services following the breakdown of the April 2016 governance system which currently fails to provide assurance to the CEO and Tynwald.**
Recommendation 2	**Establish effective arrangements for monitoring and follow up of recommendations. Publish items for immediate action. Allocate accepted recommendations to sponsored workstreams so decision making is clear and accountable and understood by all senior officers.**
Recommendation 3	**Establish the status of all recommendations including those not relevant due to legislative difference.**