Review of HSCC past Key Recommendations for years 2014-2017 Appendix A

Recommendation Area: Strategic	HSCC 2014-2015, 2015-2016 and 2016-2017 Annual Report comments	Met Part Met Not Met	HSCC updated comments on progress at 30 April 2018	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. Limited engagement with the public on progress since being superseded or at least amended by Programme for Government which was not extensively consulted on.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	5YR Strategy approved October 2015 – now at half way point with no review of progress. In 04/17 the PfG reporting introduced. Not as detailed as the DHSC SDP which had specific targets to measure against. Seen as a backward step by the HSCC. 03/19 Independent Health Review will inform the future direction for the next 5 Years. Advisory panel will include HSCC. Concerns re further delays to urgent modern service delivery implementation may occur.	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 is imminent. New Community Care Division (CCD) Service Delivery Plan expected. The infrastructure of PC remains insufficiently resourced to meet the increased demands and raised public expectations on its service.	Part 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. The Step programme is developing and mental health issues are becoming more understood by the general public.	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 a modern Public Health (PH) structure: 4 domains – health improvement, health protection, healthcare and public health, all fed by the central role of health intelligence. Intelligence is gleaned through the Joint Strategic Needs Assessment (JSNA) method of public surveys.	Met	First Annual Report from the Director of public Health was published in 2017	Met
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. Politicians need help to focus on policy issues and strategic direction.	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	A Governance structure was established in 2016 It has varied in quality frequency and outcomes. 2017 saw the demise of the Transformation QC which was to be replaced by a Programme Board. This Board has yet to be formally approved (TORs etc.) and has yet to meet. Over the year the number of Quality Committees has reduced from seven to five and of those only three meet regularly.	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 draft definition of Integrated Care is under discussion. It will need to facilitate the transfer of services and support CCD in managing the increased demand on its services, along with the commensurate funding. Integrated Care remains un-costed.	Part Met

R4 2015-16 With growing demand on Community Health Service 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. A lack of integration and end to end patient pathway consideration resulting in an increased workload for CHS, needs addressing.	Not Met	The creation of the Community Care Directorate (CCD) under an experienced Director should eventually lead to fulfillment of this recommendation. A review of Urgent Care has been undertaken but the results remain unpublished.	Part 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 The purchase of Salisbury Street and the planning application for the Glen Side replacement were 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	The opening of a discharge lounge at Nobles is a good initiative if well supervised. It is hoped Community Care Division will dovetail the patients' needs with Nobles staffing to ensure smooth discharge into the community. A draft Integrated Care Strategy document is in circulation but it is not expected to be introduced imminently. The delayed planning application for the replacement Glen Side remains outstanding but Salisbury Street has eventually reduced some stranded patient pressures.	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. A number of Medical wards are at near 100% bed occupancy. No action was taken following the establishment review in 2016. A further review was undertaken in Spring 2017. District Nursing service is at capacity and is managing a more complex needs workload.	Not Met	2017 Review - It is too early to know whether the closure of Ward 5 has resulted in the adequate redistribution of nursing staff to the Medical wards, as promised, or examine the success of increased usage of RDCH as a step up-step down facility, mainly for Older Adults. Senior Nurses struggle to provide professional lead because they are engaged in "Back to the Floor" initiative. Difficult to carry out essential "back to work" interviews as Ward Sisters are engaged in full time nursing roles. Rostering effectiveness and efficiency improved through the implementation and monitoring of Roster Perform in Health Roster.	Part 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. 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.	Not Met	Absence statistics continue to be flawed, when they are produced at all. PiP is expected to address this issue but implementation is delayed.	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. 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.	Met	Improvements in Intermediate Care at RDCH, Step up/Step down facility to be expanded and improved Rehab care. Long awaited Geriatrician post to be appointed.	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. (QIP)	QIP 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. In 08/16 QIP was disbanded. Responsibility for the workstreams transferred to various Quality Committees.	Part Met	Accountability for the progress of the workstreams is now unclear. QIP work streams were supposed to be taken up by Divisions and Quality Committees but there has been little reporting of progress. No evidence of QCs taking this up as a standing agenda item, other than at Patient Safety QC.	Not 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 in April 2018 withdrawn due to technical errors in drafting in the way it interacts with existing secondary legislation. Might go to June Tynwald with implementation in October 2018. The Charter was laid in April 2018 and has passed.	Part Met

R1 2016-2017 Care Quality and Safety Committee	That a supportive structure, pertinent funding and a clear definition of the Integrated Care model is provided to facilitate the transfer of services and support Community Health Services in managing the increased workload		There has been a slow movement towards Integrated Care and a distinct lack of clarity in its definition. Frontloading resources for CHS, is pertinent in the transfer of services.	Part Met
R8 2016-2017 Office of Human Resources QC	That accurate staff absence data is produced monthly and Key Performance Indicators are drawn up which are reviewed at CEO level quarterly		A worrying assumption that PiP is the magic bullet, disappointing that it is currently running 2 months late.	Not Met
R10 2016-2017 Public Health Directorate	That Public Health continue to develop Joint Strategic Needs Assessments (JSNA) in order to support the prioritisation of services		JSNAs require more finance to avoid delaying this vital activity.	Part Met
R13 2016-2017 Transformation QC	That legislation should be prioritized and accelerated to underpin progress on the 5-year strategy		Despite that, the first National Health and Care Service Scheme presentation to Tynwald is delayed to June 2018	Not Met

Recommendation Area: Engagement	**HSCC 2014-2015, 2015-2016 and 2016-2017 Annual Report comments**	**Met Part Met Not Met**	**HSCC comments on progress at 30 April 2018**	**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 Strategy and 2016 public Roadshows 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. The Roadshows raised public expectations for action, particularly in the field of integrated care with (now Chief) Minister citing physical hubs near to people's homes. Also Telemedicine to reduce UK visits.	Part Met	Still a public perception that this will result in new regional hub health centres NSE & West. Telemedicine remains in its infancy with only limited uses planned in Dermatology and Radiology	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	The Patient Engagement & Patient Experience: Nothing about you without you, was published in March 2017. However, there has been no action or implementation plans.	Not 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.	Part Met	Low staff morale particularly at Nobles is still evident and clear engagement very patchy. Consistent leadership appears lacking in many areas. Apparently, engagement workshops are planned for May 2018.	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	There is no longer evidence of any tracking of recommendations which now rest within the relevant Divisions.	Not 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. 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.	Part Met	Noble's Hospital representatives are conspicuous by their absence at QCs. This may be due to competing priorities and the lack of enforcement of the TOR's but nevertheless without representation accountability from the largest Budget holder, the QC's are not able to provide the required assurance to Executive Leadership Team (ELT)	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	The newly created Community Care Directorate consists of Community Health Services, Adult Social Services, and Mental Health Services. It is a significantly larger directorate but should be capable of bringing a more coherent set of services to this important area.	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 remain a major concern. This is exacerbated by poor management of absences with an inconsistent approach to back to work interviews.	Not Met	There appears to be a lack of Department engagement with OHR. A Service Level Agreement remains outstanding since 2016 compounding the issues of tracking and dealing with sickness absence.	Not 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. There is a clear pathway for PSW recommendations and actions are communicated but not widely publicized.	Part Met	The HSCC no longer attends in this area but is satisfied that the management of this mechanism is in place.	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. Work continues to achieve risk factor reduction. Screening programmes are dealt with through Noble's Hospital.	Met	Public Health has recently highlighted failings in governance and assurance of screening services resulting in them being added to the Department Risk Register as a red item.	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 & third sector.	A Delivery Plan with outcomes, actions and performance measures has yet to be published some six 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 27 months ago. This recommendation is about going forward to develop the delivery of the strategy. Initial work with stakeholders was good but now Integrated Care needs fully costing. Further engagement with staff and the wider community is now urgent	Part Met
R4 2016-2017 Informatics QC	Wider adoption of the change management principles as demonstrated by IQC for all areas that are not technology driven		The Department has not used this experience to spread the good practice to the divisions.	Not Met
R9 2016-2017 Primary Care Division	That overall adult discharge procedures have improved collaborative working connecting Community Health Services (CHS), Social Care and Acute services		Adult discharge procedures still need improving, however the increased bed space at RDCH and provision of benefit level beds at Salisbury Road Nursing Home have alleviated some discharge issues.	Part Met
R12 2016-2017 Stakeholder Engagement QC	Development of a system to minimize negative operational impact of strategic developments upon stakeholders		The lack of a monitoring system led directly to the communication problems associated with RDCH, Endoscopy and the closure of Ward 5.	Not Met

Recommendation Area: Finance/Commissioning	**HSCC 2014-2015, 2015-2016 and 2016-2017 Annual Report comments**	**Met Part Met Not Met**	**HSCC comments on progress at 30 April 2018**	**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. An additional £10m was awarded by Treasury in 2017.	Part Met	HIF has become the Health Transformation Fund. It is disappointing that this is planned to fund the Independent Review at least initially. A further £11m was awarded by Treasury in January 2018. Work to clarify budgeting has been achieved.	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. There has been no 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	Dermatology shows no sign of progress. The Eye Strategy implementation has been painfully slow. The lack of a joined-up approach is highlighted by the recent issues with screening.	Part 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 dependent on strong leadership and cross cooperation across the Health Service. A comprehensive catalogue of all Department contracts is still incomplete, which makes this recommendation difficult to meet.	Part Met	Things are improving. However, there are still a large number of FD8 waivers and a lack of decision making which has allowed contracts to lapse leading to sudden crisis e.g. laundry equipment 25+ years old and beds contract now 3 years past end date.	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. Confusion remains re qualification criteria for Spend to Save and a lack of progress.	Part Met	It is hoped that the new Programme Management Office will address the problems of Business case processes. The urgent prioritisation of services and associated funding is not progressing at the required rate. Commissioning is the key but this area remains under resourced and the political will seems weak.	Part 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-Year Strategy is at the half-way point. It remains un-costed and there has been no review of progress.	Not Met

R2 2016-2017 Commissioning QC	That DHSC complete the catalogue of contract management to allow them to exercise control over the Health budget		A Contract Database is nearing completion and a Contract Management Policy submitted. The Database will be kept up to date and managed to ensure it is robust and that contracts are delivering as per the specification. There are still some gaps which need to be filled.	Met
R3 2016-2017 Finance QC	That divisions should bring significant financial expenditure proposals for cross departmental scrutiny		Finance and Commissioning QC receives monthly divisional expenditure but there is little scrutiny. Programme Management should rationalize this.	Part Met
R5 2016-2017 Mental Health Directorate	That management of Manannan Court ensures a reduction in the numbers referred to the UK for treatment		There is no published data to demonstrate that this has been met but it is believed there has been some repatriation.	Part Met
R6 2016-2017 Nursing and Midwifery Council NMAC	Following 2017 establishment review we recommend that nurse staffing levels are increased to meet individual ward occupancy, particularly in medical wards		The delayed closure of Ward 5 and redistribution of nursing staff to other medical wards may help to fill vacancies and bring remaining wards up to recommended staffing levels but this is not yet evident and nursing vacancies have increased.	Not Met
R7 2016-2017 Nobles Executive Team / Senior Management Team	That a wider and more modern and positive range of mechanisms are used to manage Nobles Hospital and cost improvement plans are met		There is little evidence of improved engagement with clinicians or wider staffing and CIP's have had only limited success in Medicine and Nursing areas.	Not Met
R11 2016-2017 Quality Improvement Programme QIP (now devolved to divisions)	That the implementation of reasonable, relevant recommendations from the WMQRS should be reported via standing agenda items on QCs and divisional meetings		Implementation plans with designated leadership to facilitate reporting to QCs via standing agenda items. We have asked that the QC governance mechanism address this.	Not Met

Governance Structure- Quality Committee Meetings 2017-18 Appendix B

Quality Committee Meetings Apr 2017 - Mar 2018	Overview	Membership Quorum Frequency	Commentary APRIL 2018	Observations APRIL 2018
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.	Nine members; Chair: Medical Director; Quorum: Chair or Deputy Chair plus four members; Meetings: Monthly.	This committee had a Board Assurance Framework which strengthened and improved risk management processes. Differing perspectives and approaches of Health and Social Care are evident; Robust and open discussion between Divisions and shared learning was evident.	The ongoing suspension of the CQSC since December 2017 following the departure of the Medical Director, could have serious repercussions for patient safety and governance. The CQSC had proved a valuable conduit to the Executive Leadership Team and was a constructive forum for Department wide discussion.
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 variable; Chair: Finance Director Quorum: >50%; Meetings: Monthly.	Original TOR a bit woolly and has not yet got commissioning under control. Intermittent meetings. Amalgamated with Finance in April 2017.	New combined QC (FCC) has been variable. Good Public Health & CRC input on policies. Patchy consideration of Business Cases. Evidence that direct routing to ELT meetings has undermined what started out as a productive QC in 2016 with Department wide inputs. Few commissioning proposals received.

Finance QC	FQC provides assurance on the Dept. performance on Finance, Finance controls and management and business risk.	12 members; Chair: Director of Commissioning; Quorum: one external stakeholders and two directors; Meetings: monthly.	FQC was set up to bring significant expenditure proposals for support and scrutiny. This is not happening on a regular basis. Few directors contribute and collegiate discussion is rare.	Financials provided but Nobles non-attendance unhelpful to scrutiny and therefore assurance to ELT has not been possible. Few expenditure proposals for cross department scrutiny. Good oversight on the Capital programme.
Human Resources QC	HRQC support development of positive organizational cultures through people management.	Seven members; Chair: HR Partner; Quorum: three with minimum of two Dept reps and one HR rep; Meetings; monthly.	Lacks incisiveness, resulting in progress being laboured with much discussion but few tangible results so far.	Review of the strategic relationship and operational input to the DHSC and determine via an SLA the specific roles and responsibilities for all staffing issues - recruitment and retention, sickness absence, disciplinary and capability, use of qualitative and quantitative staff data for forecasting and workforce planning needs.
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: Chair/Deputy, representative from Noble's Hospital and Primary Care and a minimum of six members; Meetings: monthly.	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.	Continues to be a positive correlation between funding being made available and change delivery. The style of this QC is very performance status orientated and it communicates well via minutes and status logging.

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 (plus Sec); Chair: Director of Adult Services; Quorum: Chair/Deputy Chair plus four; Meetings: bi-monthly.	Good quality presentations. Only met bi-monthly. Persistent lack of attendance by some essential members. Merging with Transformation QC.	The abolition of this QC has meant there has been no oversight of Communications and Engagement strategies. Both areas have seen minimal impact this year beyond routine PR & firefighting, and no roadshow progress updates.
Transformation QC	TQC has been established to facilitate the organizational transformation and the delivery of the Department's Strategy	Eight Members (plus Secretary); Chair: Director of Policy and Strategy; Quorum: Chair/Deputy Chair plus three; Meetings: monthly.	Noticeable absence from medical side at times. Agenda items majority strategic with lapses into operational matters.	TQC to be changed to Change Programme Board. Apparently TQC not able to support current workstreams. ELT agreed CPB to be modelled on the Digital Programme Board with a wider remit including Communications. CPB has no TOR and has yet to meet.

Other Committee Meetings Apr 2017 - Mar 2018	**Overview**	**Membership Quorum Frequency**	**Observations**	**Current 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; Chair: Director of Public Health' There is no Quorum; Meetings: quarterly.	These meetings are examples of good cross-governmental co-operation.	This is a productive interagency meeting in which agreed actions are followed up. Unfortunately, due to lack of government-wide attendance it has been cancelled twice in the past 12 months.

Nobles Executive Team (NET now SMT)	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; Chair: Director of Hospitals; Meetings: monthly.	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.	NET SMT has experienced attendee churn and poor attendance by strategic partners in Communications Human Resource and GTS. As a result of this, and the one-sided meeting style now imposed, NET is not meeting its TOR's. Risk register reviews and strategic discussion are now less evident.
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; Chair: Chief Nurse. Quorum: 50% of members present; Meetings: monthly.	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.	NMAC was closed down in April 2018 with the Chief Nurse and Associated Chief Nurse posts removed from the DHSC management structure.
Primary Care Divisional Committee	Seeks to deliver high quality, integrated care within the community, working collaboratively with stakeholders and strives to be patient focused.	Streamlined committee comprising PC divisional directors, political member and HSCC representative; Chair: PC Head; Meetings: monthly.	The meetings are open and transparent. The PCDC is a committed team who work collaboratively and support their front-line staff. Delivery of the strategic agenda being the primary role.	Community Health Services Executive Team is no longer in existence, following the recent amalgamation of CHS with Mental Health and Adult Social Care. A Community Care Directorate governance structure is expected shortly.
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 Meetings: monthly.	The Meetings are well attended, well managed and very positive. Open discussion with opinions being actively sought is the norm.	These meetings are a beacon of how meetings should be: well attended, productive and all attendees get a chance to and are encouraged make input.

Mental Health Management Board (MHMB) **Mental Health Patient Safety and Quality Committee (MHPS&QC)**	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; Chair: Director of MH; There is no Quorum; Meetings: monthly.	Meetings are well attended, well managed and very positive. Open discussion with opinions being actively sought is the norm.	With the creation of CCD on 1 January 2018, the responsibilities of MHMB have been absorbed into CCD. It is too early to make meaningful observations, but CCD's development will be watched with great interest. MHPS&QC continues to meet monthly.

HSCC Assessment of Health Services Performance against Programme for Government (PfG) Appendix C

PfG Outcome for Health - We will live longer, healthier lives.

PfG Policy Statements for Health - We will

1 Continue to work towards the five-year health and social Care Strategy
2 Maximise efficiency of the services delivery through digital and tele-health care
3 Improve the way we communicate with the public about the way our health 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

PfG Policy Statements matched the five themes of the DHSC 5-Year Strategy

A Greater Responsibility (for own health) - PfG Policy Statements: 1 & 3
B More Care in the Community (integrated care) - PfG Policy Statements: 2 & 6
C Improved Hospital Care - PfG Policy Statement: 7
D Good Value Care (balancing budget) - PfG policy Statement: 4
E Protect Vulnerable People - PfG Policy Statement: 5

Note: In the table below a "RAG rating is used however "**N"** denotes that the Department has not RAG rated the KPI or SDP Measure.

HSCC Assessment of Health Services Performance against Programme for Government (PfG)

A: Greater Responsibility

SDP Measure: KPI: Actions/Outcome	DHSC RAG	HSCC Comment	HSCC RAG
SDP Measure: We will use modern ways of working and digital technology to help deliver services to people both in their own homes, at community health centres and in residential nursing care homes.	N	Slow progress. Residential home Immedicare pilot scheme has had patchy and inconsistent usage. Much more public engagement is required to kick start widespread understanding of the concept of personal responsibility across all demographics.	R
SDP Measure: Book and manage their own appointments and requests for prescriptions on line with GPs.	N	Slow progress and poor initial uptake against soft online access target.	A
KPI: Increase in eligible population registered with GP online services (target; 20%)	G	21% reached therefore target met; however, HSCC would like to see a more onerous target in the next Service Delivery Plan.	G
Actions/Outcome: Continue to digitally transform the hospital and health care services more generally	A	More smart indicators are needed to measure performance against this action.	A
SDP Measure: Develop a Public Health outcome dataset, to support the ongoing health needs of the Island	N	Progress in this measure is welcomed by the HSCC with the caveat that further outcome data is required and that existing datasets need to be maintained.	G
SDP Measure: Complete work on the Joint Strategic Health Assessment (JSNA) for drugs and alcohol and use the findings to identify priorities for a new Drugs and Alcohol Strategy.	N	JSNA completed and Strategy Approved by Tynwald.	G
SDP Measure: Encourage people to take part in screening and immunisation programmes.	N	Quality assurance for the Screening Programmes cannot be given and therefore it is inappropriate to encourage people to take part until such times as the proper assurances and governance can be demonstrated.	R

KPI: Maintain our adult screening programmes for Cervical (80%), Bowel (58%), and Breast (72%) Cancer at current levels.	G	Whereas uptake remains on target, significant concerns remain over quality assurance and governance. HSCC would like the Department to audit current standards and identify why different cancers have different uptake targets.	R
SDP Measure: Identify how we can help people take more exercise and choose healthier food and drink.	N	Public Health are currently working on indicators for physical activity, diet and obesity that are comparable with other areas of UK and Crown Dependencies with similar demographics. Also developing a weight management strategy based on healthy weight across all life stages. The lifestyle survey indicates that 72.6% of Adults achieve 150 minutes of physical activity per week.	A
SDP Measure: Support more people to stop smoking.	N	Cessation programme ongoing.	G
Action/Outcome: Improve the way we communicate with the public about the way we provide health care.	A	Poor communication continues to be an issue.	R

B: More Care in the Community

SDP Measure: KPI: Actions/Outcome	DHSC RAG	HSCC Comment	HSCC RAG
SDP Measure: We will improve the way in which people can access and receive emergency care from our services.	N	Progress slow and smart targets needed.	A
KPI: Reduce emergency admissions at Nobles for people with long term or chronic conditions where appropriate management in the community has shown to reduce the need for unplanned hospital admissions.	G	Target is from 16% to 13% by April 2019 Q4 shows No data available Q3 data showed only a marginal decrease to 15.7%. However, the wording this KPI should be revised to make it clearer as it is somewhat ambiguous at the moment.	A
SPD Measure: We will use modern ways of working and digital technology to help deliver services to people both in their own homes, at community health centres and in residential nursing care homes.	N	EMIS Community up and running. Increased use of computer booking system in GP Surgeries.	R

Actions/Outcomes: Move more services from the hospital into the community so care is provided closer to people's homes.	G	Slow progress and without commensurate funding. Effective Long-Term Coordinators Team working successfully within the community.	A

C: Improved Hospital Care

SDP Measure: KPI: Actions/Outcome	DHSC RAG	HSCC Comment	HSCC RAG
SDP Measure: We will use more beds in the community when people are ready to leave hospital but still need a bit of extra support.	N	Bed availability in the community still a major problem. More social workers require to be relocated to community services from hospital services.	R
KPI: Increase bed utilisation levels at RDCH.	G	Target 85-90% In Q4 level 86%; note changed RAG R-G.	G
SDP Measure: We will continue to deliver improvements from the WMQRS reviews and prepare for two more inspections in 2017/18.	N	WMQRS reviews now completed but no evidence of sustained pattern of implementing agreed recommendations.	G
Action/Outcome: Continue the external peer review process at the hospital and implement the recommendations.	G	No evidence of widespread implementation of WMQRS recommendations.	A
SDP Measure: We will repatriate from the UK as much patient activity as possible which can be delivered safely on the IOM.	N	more work needed on this with smart targets.	A
Action/Outcome: Define the services which will be provided on-Island and those that will be provided off-Island.	A	Despite efforts, little progress on clear evidence-based decision making within this politically sensitive but vital agreed Action.	R
SDP Measure: We will work towards reducing waiting times for A&E, outpatient appointments, diagnostic investigations and inpatient procedures.	N	Despite improvements in waiting list revalidation and acknowledged improvements in Endoscopy and MRI wait times, pressures on many demand led services are still increasing.	A
KPI: Reduce by 10% the number of patients travelling to the UK for follow up treatment and provide their care locally.	A	Q4 shows an increase of 36 patients travelling to the UK over base line which is 647 above the target number set.	R

Action/Outcome: Reduce waiting times for operations.	A	Almost 20% of patients waiting more than 52 weeks for elective surgery.	R
KPI: No Patient will wait >52 weeks for elective surgery by end of March 2018.	A	At Q4 13.2% waited more than 52 weeks. HSCC note this is an estimated figure due backlog in episode coding.	R
KPI: The hospital will achieve 85% aggregate performance for 2-week cancer waiting times by the end of March 2018, 93% by the end of March 2019.	G	At Q4 89.1% achieved (FY aggregate). Averaging can disguise poorer performance on individual sites.	G
Action/Outcome: Publish Hospital Waiting Lists by April 2017.	G	Achieved but HSCC believe this should be published annually.	A

D: Good Value Care

SDP Measure: KPI: Actions/Outcome	**DHSC RAG**	**HSCC Comment**	**HSCC RAG**
Action/Outcome: Consider and recommend funding options for residential and nursing acre.	G	Action has been abandoned.	A
Action/Outcome: Improve governance and accountability in the way we provide health and care services.	A	Governance issues remain to the fore e.g. screening services being added to the Red list in the risk register.	R
Action/Outcome: Become an employer of choice in healthcare.	A	This remains a significant problem.	R
Action/Outcome: Address the long-term funding issues posed by an ageing population.	G	HSCC have seen no evidence that this has been addressed.	A
SDP Measure: Reducing the reliance upon Agency and Locum staff.	N	Some attempt to do this but proved difficult to recruit to the large number of substantive posts to make sufficient impact.	A
SDP Measure: Reducing the level of sickness absence across the Department but with a special focus on supporting colleagues to manage their own health and well-being.	N	Sickness absence stats not available since October 2017 due to PiP implementation, which is now delayed. Trend remained upwards despite some targeted support plans.	R

SDP Measure: Delivering an effective programme of cost improvements across all areas to ensure that we get good value for the money we spend.	N	With 82% of budget being staffing cost, the impact upon cost improvement plans has been largely minimal in the Acute area. Many other Divisions have limited capacity to cut further.	A
SDP Measure: Reducing the overall number of visits we ask people to make to the UK for straightforward treatments and follow up visits which could be done here.	N	Despite recognizing this issue, only limited improvement made with Patient transfers and no evidence offered that unnecessary follow ups have been reduced on any consistent basis.	R
SDP Measure: Continuing to deliver the digital programme for Health and Social Care which will modernise the way we deliver services and make us more efficient. whilst at the same time enabling us to provide a better service to our customers.	N	Despite a more challenging year, the digital programme continues to be well managed. Engagement in digital change continues to be patchy. The delay to the PiP programme will impede any significant progress in staff absence and recruitment procedures in the medium term.	A
KPI: Maintain spend against Budget re Cost Improve Plans.	A	Year-end figures 4.3% overspend. Nobles CIP's remain unmet.	R

E: Protect Vulnerable People

SDP Measure: KPI: Actions/Outcome	**DHSC RAG**	**HSCC Comment**	**HSCC RAG**
SDP Measure: Continue to drive the delivery of year two of the Mental Health and Wellbeing Strategy.	N	On target.	G
Action/Outcome: Implement Mental health service strategy.	G	On target.	G
KPI: Reduce adult acute mental health bed occupancy.	A	In Q4 92%.	R
KPI: Increase in 5-day discharge follow-up rate by Mental Health Services.	A	90% in Q4.	A

DHSC Strategies 2015-2018 Appendix D

Strategy	Overview	HSCC comments on progress as at 31st March 2018
Digital Strategy DHSC July 2015	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.	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 slower to progress. The failure of deadlines for PiP will have a wide adverse impact on other areas such as staff absence.
5-Year Strategy August 2015	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.	After a protracted consultation period and a change of CEO, this revised strategy, updated from the 2011 version, was finally launched in October 2015. 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 version revealed some disjoint between Health and Social Care. Now 50% life point is reached, a midpoint progress review would seem useful.

Four Domains of Public Health October 2015	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.	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 domains.
Strategic Plan for Mental Health and Wellbeing December 2015	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. 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.	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.
Communications Strategy January 2016	To improve DHSC Communication both within and outside the Department	The "Communication Plan for Health and Social Care Strategy in 2016/2017" is now out of date. We look forward to the new well-structured and focused DHSC Communication Strategy and Plan with appropriate resources to back it up to deliver real value. With the recent appointment of a dedicated DHSC Communications Executive there has been a noticeable increase in communications but much of this has been driven by responding to various crises. This takes up management time away from addressing wider DHSC communication opportunities within the Health Arena.

Eye Care Strategy March 2016	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.	The development and implementation of a multi-agency and voluntary organisations Eye Care Strategy with a visiting service has so far resulted in an 85% reduction in patients travelling off island for ARMD treatments. There is now a procurement process being undertaken to deliver this service on island on a more permanent basis. Savings from the resulting travel costs reduction invested in further developments such as enabling Optometrists working in Opticians to provide a range of services for people with minor eye conditions, including stable glaucoma and follow-up appointments for people who have had cataract surgery. Other changes include enabling Optometrists to refer directly to Noble's without the patient having to go via their GP, increasing the interval for eye tests for most people to 2 years and considering how it can bring its processes in line with other parts of the British Isles in terms of creating a Certificate of Visual Impairment. The integration of services provided by RNIB and Manx Blind Welfare is also identified in ensuring people with impaired vision receive the support that they need.
Quality Strategy August 2016	Designed to develop continuous quality improvement, acknowledging the need for good quality care across DHSC.	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. It was never actually published and was subsumed into the CARE scheme in 2017-18.
Organisational Development Plan (ODP) 2016-20 October 2016	This is a programme for developing Leadership, Practice and Motivation to create a high performing organisation.	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 was progressing with high level changes. No detailed updates were received at Transformation QC. The officer tasked to the ODP was transferred to other duties in April 2017.

Recruitment and Retention Strategy October 2016	This Strategy was developed to tackle the increasing number of "hard to recruit" posts within DHSC.	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 clear sponsor or reported progress on this Strategy though piecemeal projects to fill hard to recruit posts by individual divisions is noted.
Integrated Care December 2016	Only Southern Care Initiative pilot working with the community has been commissioned during 2016-17. This was followed up with a very limited stakeholder engagement opportunity in September 2017 via Peel GP services.	The draft I/C strategy would mean a significant change in emphasis for health in future as well as a swift, effective shift in funding and services to Community Care Directorate and a rationalization of Noble's services. A commissioning review would also be required in order to effectively recommission or refocus on those services that should be provided from UK specialist centres.
Programme for Government Strategic Objective: An Inclusive and Caring Society Outcome Section: An Inclusive and Caring Island January 2017	Produced by CoMin with little consultation: 3 strategic objectives: 1 - Inclusive and Caring Society; 2 - Island of Enterprise and Opportunity; 3 - Financially Responsible Government; 8 policy statements: 1 - Continue to work towards the 5-Year Health 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 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 & early intervention services for those most at risk.	The original Programme for Government (PfG) document did not reflect the existing 5-Year Strategy 5 Strategic Aims but following amendments in Tynwald it now does. Including the 5 Strategic aims into PfG should have given continuity and the ability to comment against KPIs, actions and outcomes set out in PfG in a similar way we commented on the actions and out comes in the Service Delivery Plan supporting the 5-Year Strategy in 2016-17. However, the PfG has not "RAG" rated the KPIs, as was done in 2016-17 Service Delivery Plan and there is therefore no indication on how DHSC believes it is performing against the agreed KPIs. HSCC have however "RAG" rated the PfG KPIs and these can be found in Appendix C. HSCC believes that the Department should revert back to using a Service Delivery Plan in 2018-19 for measuring KPI's Actions and Outcomes.

Customer Experience and Engagement Strategy March 2017	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.	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. The CARE (Committed Appreciated Respect & Excellence) approach seems to been taken up as part of this. The proposed Charter was passed in Tynwald in April 2018.

HSCC review of DHSC SDP priorities April 2016 – March 2018 Appendix E

This table outlines HSCC overall assessment of Year 1 and 2 of the 5 Year Strategy, however DHSC have not updated this for year 2. The Strategy contains 12 Priorities with 50+ Actions. This table deals only with the 12 Priorities.

	Measurement and Department comment as at 2018	**DHSC RAG**	**HSCC RAG**	**HSCC COMMENT 2018**
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.	A	A	The Governance/reporting of JSNA is still to be agreed; this should be a priority to ensure the process is developed and maintained with agreed priorities and proper scrutiny. Publication of the Drug and Alcohol JSNA is welcomed, however, it is imperative that implementation plans are prepared and consulted on in a timely manner.

NOBLE'S HOSPITAL 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 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. We will report on those patients waiting less than three 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 four hours' standard for the Emergency Department. We 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 two 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).	G	A	HSCC believe waiting lists are an area that is fluid changing with time and should be kept under continuous review. There is still some work to be done on waiting time targets and published on a quarterly basis from April 17 has not happened.
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.	G	G	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 Senior Mental Health Worker lead has undertaken a sensible approach to the actions being carried out. Hopefully a better priority will be included in the Programme for Government.

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.	R	R	Another very important priority for saving money and improving services continues to fall badly behind in 2018. 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.

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.	G	G	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.

STRATEGY & POLICY DIRECTOR Set up a research and development group to monitor research and translate it to DHSC services (especially pathways) and to oversee novel research in the Isle of Man.	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. 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.	G	G	Director appointed Spring 2018.
NOBLE'S HOSPITAL 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.	G	A	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.

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 hospitals in the NW of England. 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 Contract form 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.	G	R	Measure has not been achieved. No update on SLAs. Contracts not agreed with AGs only the format. It is not clear that all contracts have been dealt with.
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.	R	R	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.

COMMUNICATIONS Publish regular updates in newspapers, website and social media of progress against the strategic goals and performance data across the Department.	Additional communications capacity on track to be in place by June 2017. Visual identity created for communications 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.	A	A	New dedicated DHSC Communications Executive now in place. It will soon become clear whether one head is sufficient resource to adequately cover the wide scope of DHSC Communications. There is huge opportunity to add real value to Health Care through well targeted messages within the overall DHSC organization; to the public about what DHSC programs are achieving; promoting two-way engagement with the public; and continuing to increase Health Education and knowledge of Healthy Lifestyles. Over many years insufficient priority and attention appears to have been given to well- structured Communications resulting in many good but random Communication initiatives, but this must be seen against the number of unwelcome fire-fighting Communications, some in the past often poorly thought through. Professional Communications are a vital part of Health Care and they need to be given full recognition and resource; not just a "nice to have" on call when needed. There remain many gaps in the actions from the Communication Plan and difficulties in accessing information.

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 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.	A	R	On the surface, there has been a lot of work undertaken on 'recruitment and retention' with a possibly overconfident reliance on the introduction of PiP. Training sessions have commenced with feedback from some Managers who report ease of use. However, full implementation is not now expected until November 2018, meaning accuracy for data remains compromised. This will continue to have an adverse effect on effective workforce planning. The need for a new Service Level Agreement is being considered to enable roles and responsibilities to be clarified. The new DHSC structures with so many different terms and conditions for a wide variety of staff and historical agreements will need an overhaul as the CCD becomes more integrated. Recruitment and retention problems appear to be reaching a critical stage. True vacancy figures are dynamic as need changes to due to ongoing Departmental re-organisation and as staffing requirements for the CCD start to become clearer.
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.	G	A	The ODP was not a full Plan and lost continuity in the last sections despite 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. In April 2017 the Officer leading this plan was seconded to Crookall with other tasks. Consequently, there has been little accountability for the numerous structure changes experienced this year. Last minute redundancy and MARS has lacked consideration and proved costly.

HSCC Member Links to Officers 2017-18 **Appendix F**

	HSCC member	Department link		HSCC member	Department link
Strategic Vision Transformation QC	Linda McCauley	Amanda Craig, Director Strategy and Performance	**Managing Political Process**	Bi Annual - All members	Minister
Mental Health	Malcolm Norris	Angela Murray, Director Mental Health	**Leadership Governance**	Sue Gowing David Trace	Malcolm Couch CEO Michaela Morris DCEO
Nursing Finance and Commissioning	David Trace	Linda Radcliffe, Chief Nurse Tim Mansfield Director Commissioning	**Community Issues**	Dawn Mayor	Cath Quilliam, Head Community Health
Integrated Care	Dawn Mayor	Cath Quilliam, Head Community Health	**Human Resources**	Colm Andrew	Anne Corkill, OHR Partner for Health
Informatics	John Whitehouse	Richard Wild, Interim Director, GTS	**Patient Safety CQSC**	Dawn Mayor	Jugnu Mahajan, Medical Director
Public Health	Martin Hall	Henrietta Ewart, Director Public Health	**Noble's Hospital**	Sue Gowing	David Catlow Director Finance Mike Quinn Director Hospitals

Alphabetical List of Acronyms

Appendix G

5-YR (STRATEGY)	5- YEAR STRATEGY
CCD	Community Care Directorate
CHS	Community Health Service
CHSET (now defunct)	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
DHSCCPB/(CPB)	DHSC Change Programme Board
DPB	Digital Programme Board
ELT	Executive Leadership Team
EMI	Elderly Medical Infirm (Care Home)
EPMA	Electronic Prescribing and Medicines Administration
FQC	Finance Quality Committee
GDPR	General Data Protection Legislation
GMC	General Medical Council
GTS	Government Technology Services
HPA	Health Protection Agency (UK)
HPC	Health Protection Committee
HRQC	Human Resources Quality Committee

HSCC	Health Services Consultative Committee
IHR	Independent Health Review
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 (now defunct)	Mental Health Committee
MHPSQC	Mental Health & Patient Safety Quality 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
PHSM	Public Health Staff meeting
PMO	Programme Management Office

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 (now Defunct)	Transformation Quality Committee
WMQRS	West Midlands Quality Review Service