**Review of HSCC past Key Recommendations for years 2014-2018** **Appendix A**

| Recommendation Area: STRATEGIC | HSCC between 2014-2018 Annual Report comments | DHSC rating | HSCC updated comments on progress at 30 April 2019 | HSCC rating |
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| R1 2014-15<br>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.<br>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.<br>Limited engagement with the public on progress since being superseded or at least amended by Programme for Government which was not extensively consulted on.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 | 5 Year Strategy approved October 2015 – progress reviewed April 2019<br>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.<br>03/19 Independent Health Review (IHR) 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<br>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 Care Vision now published.<br>Community Care Division (CCD) Service Delivery Plan incorporated into DHSC SDP 2019-2020.<br>The infrastructure of PC remains insufficiently resourced to meet the increased demands and raised public expectations on its service. | Part Met |
| R5 2014-15<br>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<br>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.<br>Intelligence is gleaned through the Joint Strategic Needs Assessment (JSNA) method of public surveys. | Met | Annual Reports from the Director of Public Health were published in 2017 and 2018 | Met |

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| R9 2014-15<br>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<br>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. Over the years the number of Quality Committees has reduced from seven to five and of those only three hold meetings and of those two have become quarterly. | Part Met |
| R3 2015-16<br>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 definition of Integrated Care was published in 2018. 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. A Business Case for Integrated Care has been prepared for Treasury. | Part Met |
| R4 2015-16<br>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.<br>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 under an experienced Director has led to fulfillment of this recommendation.<br>A review of Urgent Care was undertaken and the results published in September 2017. | Met |
| R5 2015-16<br>Solutions need to be found for patient flow, bed management and delayed discharges at Noble's Hospital. This should include | 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.<br>The purchase of Salisbury Street and the planning application for the Glen Side replacement were | Part Met | The discharge lounge at Nobles is a good initiative if consistently supervised and manned, which it is not. It is hoped Community Care Division can dovetail the patients' needs with Nobles staffing to ensure smooth discharge into the community. | Part Met |

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| reviewing the provision of Nursing homes. | 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. | | The Integrated Care Strategy document has been progressed through planning of the Western Integrated Care pilot.<br>The delayed planning application for the replacement Glen Side remains outstanding and Salisbury Street has not been without its issues. | |
| R8 2015-16<br>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.<br>No action was taken following the establishment review in 2016. A further review was undertaken in Spring 2017.<br>District Nursing service is at capacity and is managing a more complex needs workload. | Not Met | The closure of Ward 5 did not result in the redistribution of nursing staff to the Medical wards, bank costs actually increased. The business case was flawed. The success of increased usage of RDCH as a step up-step down facility, mainly for Older Adults is also subject to mixed opinion.<br>Rostering effectiveness and efficiency improved through the implementation and monitoring of Roster Perform in Health Roster. | Not Met |
| R9 2015-16<br>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 from Oracle continued to be flawed, until September 2018 when shut off.<br>Unfortunately, PiP was expected to address this issue, but it has been repeatedly delayed. DHSC implementation is not now expected until September 2019. Flawed data across healthcare continues to affect evidence-based decision making throughout the Department. | Not Met |
| R10 2015-16<br>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. A Geriatrician post remains vacant. Senior Nurses, therefore, exercise oversight of the hospital. | Part Met |
| R14 2015-16<br>Create some targeted short-term capacity to action the key deliverables of all the work streams within the | 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 | Part Met | Accountability for the progress of the workstreams has moved to the DCEO.<br>QIP work streams were moved to Divisions and Quality Committees but there was little interim reporting of progress. No evidence of QCs taking | Part Met |

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| Quality Improvement Programme. (QIP) | for the workstreams transferred to various Quality Committees. | | this up as a standing agenda item, other than at Patient Safety QC. A WMQRS update report to Tynwald is due in April 2019. | |
| R16 2015-16<br>Prioritise the Development of new legislation to support the Goals and Objectives in the 5-Yr 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, was expected at June or October 2018 Tynwald but is delayed indefinitely. | Not Met |
| R1 2016-2017<br>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 | Met | A definition for Integrated Care in the Isle of Man as proposed by the collective of Health & Care Directors in the DHSC was agreed at the Department meeting in June 2017. Frontloading resources for CCD, is still awaited. | Part Met |
| R8 2016-2017<br>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 | Not met | Real-time reporting system (People Improvement Programme system - PIP) is currently running 14 months late and does not function. | Not Met |
| R10 2016-2017<br>Public Health Directorate | That Public Health continue to develop Joint Strategic Needs Assessments (JSNA) in order to support the prioritisation of services | Part Met | JSNA process is not running as quickly or smoothly as was hoped. Partly due to other departments outside of DHSC control not giving the matter priority or the resources required. Moving PH to Cabinet Office may assist in the coordination and management the JSNA process. | Part Met |
| R13 2016-2017<br>Transformation QC | That legislation should be prioritized and accelerated to underpin progress on the 5-year strategy | Part Met | Despite that, the first National Health and Care Service Scheme presentation to Tynwald is delayed indefinitely. | Not Met |
| R1 2017-2018<br>Cancer | 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. | Met | The review was done and concluded the existing plan was outdated. A small team will scope the new cancer plan. | Met |

| R9 2017-18<br>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. | Part Met | Responsibility for nursing and midwifery is delegated to a variety of senior nurses in each division under the overall leadership of the DCEO | Part Met |
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| R10 2017-2018<br>Public Health Directorate | DHSC ensure governance procedures for all screening services are improved and gain approval by the Director of Public Health as appropriate and adequate. | Part Met | The audit of screening services has had to be brought in-house to Internal Audit as no suitable external contractors could be found. The initial audit fell short of the requirements and further work is now underway. | Part Met |
| R11 2017-2018<br>Transformation QC | 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. | Not Met | Review promised in July 2018 and published in April 2019 | Not Met |

| **Recommendation Area: ENGAGEMENT** | **HSCC between 2014-2018 Annual Report comments** | **DHSC rating** | **HSCC updated comments on progress at 30 April 2019** | **HSCC rating** |
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| R3 2014-15<br>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.<br>Telemedicine remains in its infancy with only limited uses in Dermatology and Radiology | Not Met |
| R4 2014-15<br>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 | The Workshops, presentations and Roadshows have gone some way to consult staff about business | Part Met | Low staff morale particularly at Nobles is still evident and clear engagement very patchy. | Not Met |

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| Acknowledge and act to mitigate the impact of change and uncertainty on staff | change. However, there is evidence that there is still work to be done with support staff as they take on new ways of working. | | Consistent leadership appears lacking in many areas. Engagement workshops were held in September 2018. | |
| R10 2014-15<br>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 | Report published for Tynwald April 2019. 739 standards remain unmet, of which 159 are deemed unable to be met in the context of current rural Island service provision. This leaves 580 of the original 2,931 for action to address. | 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)<br>Further instability in the DHSC management structure has been evident with 6 of 11 posts being changed with 4 of these dis-established. | Not Met |
| R6 2015-16<br>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 | Community Care Directorate consists of Community Health Services, Adult Social Services, and Mental Health Services. It is a significantly larger directorate and is bringing a more coherent set of services to this important area. | Met |
| R11 2015-16<br>Develop and deliver more targeted projects with the Office of Human Resources to challenge the issue of | 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 continues 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 |

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| high staff absence levels within the Health Service. | | | | |
| R12 2015-16<br>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.<br>There is a clear pathway for PSW recommendations and actions are communicated but not widely publicized. | Part Met | There are problems getting some doctors to undertake Patient Safety Walks with some walks being cancelled as no staff available. | Part Met |
| R13 2015-16<br>Public Health should continue to 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.<br>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. An audit is currently taking place. | Part Met |
| R15 2015-16<br>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. Further engagement with staff and the wider community has taken place and continues. | Part Met |
| R4 2016-2017<br>Informatics QC | Wider adoption of the change management principles as demonstrated by IQC for all areas that are not technology driven | Met | The Department has not used this experience to spread the good practice to the divisions. | Not Met |
| R9 2016-2017<br>Primary Care Division | That overall adult discharge procedures have improved collaborative working connecting Community Health Services (CHS), Social Care and Acute services | Met | Adult discharge procedures still need improving, however the increased bed space at RDCH and provision of benefit level beds at Salisbury Street Nursing Home have alleviated some discharge issues. Discharge lounge not consistently staffed. | Part Met |
| R12 2016-2017<br>Stakeholder Engagement QC | Development of a system to minimize negative operational impact of strategic developments upon stakeholders | Part Met | The lack of post implementation reviews led to the communication and confusion associated with RDCH, Endoscopy, Ward 5 and PPU closure. | Not Met |

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| R5 2017-2018<br>Informatics QC | The DHSC should involve itself at an earlier stage, in the rationale, scope and implementation of pan-Government projects such as PiP. | Part Met | PiP has, so far, completely failed leaving HR data un-collated. Establishment and absence data currently unavailable. | Part Met |
| R8 2017-2018<br>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. | Part Met | Combination of uneven approach to Nobles Governance meeting table discussion and debate, coupled with ongoing staffing shortages have resulted in decline in Nobles SMT performance. The August proposal for layout of Scheduled and Unscheduled Care resulted in a dysfunctional meeting. Thereafter the SMT has failed to meet in 5 out of the following 7 months. | Part Met |
| R9 2017-2018<br>OHR 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. | Not Met | Consistent attendance at these meetings by all the designated managers or representatives has not been evident (management changes notwithstanding). This hinders the process of obtaining agreed progress for the committee's workstreams. HSCC continues to express it's concern that work on a Service Level Agreement has not yet been completed. (discussion on this started in 2016). | Not Met |
| R12 2017-2018<br>WMQRS | 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. | Met | The CEO was adamant at PAC in February 2019 that good governance is in place but the poor attendance and cancellation rates of various governance meeting would suggest otherwise | Part Met |

| **Recommendation Area: Finance/Commissioning** | **HSCC between 2014-2018 Annual Report comments** | **DHSC rating** | **HSCC updated comments on progress at 30 April 2019** | **HSCC rating** |
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| R8-2014-15<br>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. | Met | HIF has become the Health Transformation Fund. It is disappointing that this is funding the Independent Health Review. A further £11m was awarded by Treasury in January 2018 and it will require a further top-up in 2019.<br>Work to clarify budgeting has been achieved. | Met |

| R1 2015-16<br>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. | Part Met | 16 provider contracts with NHS. Need to be realistic about what can be achieved at this stage of transformation. Clatterbridge and Liverpool Heart and Chest are CQC Outstanding - hospital commissioning looking at forming more of a partnership agreement with them. Also looking at feasibility of video consultations – clinician might not physically need to be on-Island. | Part Met |
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| R2 2015-16<br>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.<br>A comprehensive catalogue of all Department contracts is still incomplete, which makes this recommendation difficult to meet. | Part Met | Establishing what contracts DHSC have is the current concern. Starting with what has been paid, splitting it out into hospital directorate structure, see if it is being spent regularly, go back to budget holder to seek contract. There may be as many as 460 contracts or potential tenders in total. | Part Met |
| R7 2015-16<br>The notion of "spend to save" needs to qualify with a full explanation of what it is designed to achieve.<br>The prioritisation of services and associated funding needs to be clearly mapped out. | Noble's financial position continues to worsen exacerbated by the demoralizing 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 | The Programme Management Office has addressed the problems of Business Case processes.<br>However, 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. | Part Met |
| R17 2015-17<br>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 but there has been a review of progress in April 2019 | Part Met |
| R2 2016-2017<br>Commissioning QC | That DHSC complete the catalogue of contract management to allow them to exercise control over the Health budget | Met | Contract database being built up. 120 contracts fully detailed by April 2019. | Met |
| R3 2016-2017<br>Finance QC | That divisions should bring significant financial expenditure proposals for cross departmental scrutiny | Part Met | Commissioning Committee no longer receives monthly divisional expenditure and there is little apparent scrutiny. | Not Met |

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| R5 2016-2017<br>Mental Health Directorate | That management of Manannan Court ensures a reduction in the numbers referred to the UK for treatment | Met | There is no published data to demonstrate that this has been met but it is believed there has been some repatriation. | Part Met<br>MN update |
| R6 2016-2017<br>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 | Part Met | The closure of Ward 5 and redistribution of nursing staff to other medical wards did not help to fill vacancies. Wards are not staffed to the recommended safe staffing levels and nursing vacancies have increased. | Not Met |
| R7 2016-2017<br>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 | Part Met | There is little evidence of sustained closer engagement with clinicians or wider staffing and CIP's have had only limited success in Medicine Core services and Nursing areas. | Not Met |
| R11 2016-2017<br>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 | Part Met | Well laid out and welcome WMQRS Status Update Report presented to Tynwald April 2019. | Part Met |
| R2 2017-2018<br>Care Quality Committee CQSC | Greater clarity, speed and efficiency in dealing with contract management and asset replacement e.g. replacing laundry equipment, beds contract. | Met | CQSC abandoned April 2018. Resurrected April 2019 Chaired by CEO. Logistics and Hotel Services have attended to asset replacement. | Part met |
| R3 2017-2018<br>Community Health Services Executive Team (CHSET) | DHSC review the funding strategy to consider the urgent budget needs to support Integrated Care strategy. | Part Met | CHSET abandoned April 2018 with the formation of CCD. A Business Case for IC funding has been prepared for Treasury. | Part Met |
| R4 2017-2018<br>Finance/Commissioning QC | Better Financial and Commissioning Governance is required through a review of ToR's, membership and accountability. | Part Met | DHSC Commissioning Committee now meets quarterly. A sub-committee with representatives from each division meets monthly and feeds into the main committee. | Met |
| R6 2017-2018<br>Mental Health Directorate | 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. | Part Met | Integrated Care Vision and Plan is well developed but is yet to receive funding and the Business Case has to be resubmitted in April 2019. | Part Met |

**Governance Structure - Quality Committee (QC) & Other Governance Meetings 2016-19** **Appendix B**

| Quality Committee Meetings (STATUS) Apr 2016 - Apr 2019 | Overview -QC purpose | HSCC Commentary APRIL 2018 | HSCC Observations April 2019 |
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| **Care Quality and Safety Committee**<br><br>**(Revived in 2019)** | 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. | The ongoing suspension of the CQSC since December 2017 following the sudden departure of the Medical Director, could have serious repercussions for patient safety and governance.<br>The CQSC proved a valuable conduit to the Executive Leadership Team (ELT) and was a constructive forum for Department wide discussion. | After repeatedly advising its concerns to the CEO regarding the suspension of this QC, it was finally restarted in April 2019, chaired by the CEO himself and composed of Senior leads rather than Director level attendees.<br><br>The May 2019 CSQC meeting has now unfortunately already been cancelled due to the departure of the CEO on 3rd May. |
| **Commissioning QC**<br><br>**(Merged & moved to Quarterly basis)** | 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. | New 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. | FCC was just becoming an effective monthly QC when it was closed down by the CEO in April 2018. For some months this void was unfilled until a new Commissioning committee commenced quarterly meetings in October 2018. The new committee is fed by monthly meetings of a Commissioning sub-committee held by the relevant leads from Community, Hospitals and Public Health. |
| **Finance QC**<br><br>**(Merged with above)** | FQC provides assurance on the Dept. performance on Finance, Finance controls and management and business risk. | 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.<br>Good oversight on the Capital programme. | FQC was merged with FCC (above) in 2017 and closed down in 2018. There is now no apparent oversight of the management accounts or analysis of Cost Improvement Programme (CIP) performances but good oversight Commissioning and Contract Management remains. |

| **Human Resources QC**<br><br>**(survives but not thriving)** | HRQC support development of positive organizational cultures through people management. | 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. | This Quality Committee meeting has continued to exist but has rarely been quorate despite the best endeavors of the Chair and the HSSC representative.<br>A Service level Agreement which was initiated in 2016 between DHSC and OHR remains incomplete.<br>Following recent HSCC commentary, the QC has shown recent signs of improved attendance and content. |
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| **Informatics QC**<br><br>**(Survives but with financial challenges)** | 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. | Continues to be a positive correlation between funding being made available and change delivery.<br>The style of this QC is very performance status orientated and it communicates well via minutes and status logging. | The HSCC continues to monitor Infomatics QC through the Minutes supplied arising from its regular monthly meetings.<br>Whilst the efficient format and QC actions log continues, there are still significant issues with critical software that does not communicate with other systems. |
| **Stakeholder Engagement QC**<br><br>**(Abolished)** | 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. | 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. | There has been no further progress on DHSC Communications Plan.<br>The HSCC has not be given any evidence on progress with patient Engagement strategy. |
| **Transformation QC**<br><br>**(itself transformed)** | TQC has been established to facilitate the organizational transformation and the delivery of the Department's Strategy | 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. | The Change Programme Board was eventually set up as a Programme Management Office (PMO). Once properly resourced it has proved successful at managing the process of business cases as well as being responsible for organizing the DHSC PfG quarterly responses.<br>Continuity has brought effectiveness in this area. |

| **Other Committee Meetings (STATUS) Apr 2017 - Mar 2018** | **Overview- Other meetings purpose** | **Observations APRIL 2018** | **Observations April 2019** |
|---|---|---|---|
| **Health Protection Committee**<br><br>**(Continues)** | 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. | This is a productive interagency meeting in which agreed actions are followed up.<br>Unfortunately, due to lack of government-wide attendance it has been cancelled twice in the past 12 months | This committee has met quarterly in the past year. It is an important committee to ensure a multidisciplinary/multi departmental approach to tackling existing and emerging public health issues. |
| **Nobles Executive Team NET-then called SMT**<br><br>**Now renamed Nobles Clinical Board 03/19**<br><br>**(Not met 7 times in the reporting period including 5 consecutive months)** | 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. | 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.<br>Risk register reviews and strategic discussion are now less evident. | The absence of a genuine Nobles Executive SMT governance assurance across more than half of this reporting year is of serious concern.<br>The lack of report provision, consultation and the poor quality of debate and transparency has been alarming with few decisions made and no communication through the traditional channel of a hospital wide team brief.<br>Another Committee title, and a change of TOR's with a reduction in Senior lead representation has resulted in a change in focus towards largely clinical matters. |
| **Nursing and Midwifery Advisory Council**<br><br>**(dis-established April 2018)** | 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. | NMAC was closed down in April 2018 with the Chief Nurse and Associated Chief Nurse posts removed from the DHSC management structure. | Despite the roles and responsibilities of Chief Nurse being dispersed across three different post holders, the HSCC do not feel confident that the former standards of assurance, mediation and channels for advice have been maintained. |
| **Patient Experience & Quality Committee (PSQC)**<br><br>**(meeting very good governance standards** | The PSQC is accountable to the Nobles Board. It is responsible for ensuring the patient safety and the concept of clinical governance is at the core of the Organisations function<br>A strategic body, that ensures formal arrangements are in place across the | Not monitored in 2017-2018<br>Reporting period. | PSQC is a monthly Nobles - based governance meeting that is a good forum for many staff concerns. Its output should feed into the Nobles main governance board but this has not met in the latter half of this reporting period. |

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| **- has overcome initial poor attendance)** | Hospitals' Directorate to discharge its responsibility for continuous quality improvement. It ensures patients are the main focus and priority of service delivery, and monitors activity. | | This year PSQC has tackled some significant patient safety issues. Attendance is good and many reports result in actions and lessons being learned. The Chair is resolute in follow up and where necessary will escalate to Nobles SMT for action (if Nobles Governance is held). |
| **Primary Care Divisional Committee**<br><br>**(merged into CCD in April 2018)** | Seeks to deliver high quality, integrated care within the community, working collaboratively with stakeholders and strives to be patient focused. | Community Health Services Executive Team is no longer in existence, following the recent amalgamation of CHS with Mental Health and Adult Social Care.<br>It is hoped a CCD Governance structure will be put in place shortly. | A quarterly Clinical Card Directorate (CCD) was put in place which established good TOR's and similar format to the previous monthly versions.<br><br>Unfortunately, the cancellation of February and May 2019 governance has recently led to a dearth of reassurance and communications |
| **Public Health Staff Meeting**<br><br>**(good governance)** | This a monthly meeting with key staff members to discuss corporate issues such as SDPs and Risk Registers; provide sectional updates and invited presenters. | These meetings are a beacon of how meetings should be: well attended, productive and all attendees get a chance to and are encouraged to make input. | This meeting remains the standard to which all other DHSC governance meetings should aspire. Regular reviews of Service Delivery Plans and Risk Registers, with open communication and opportunity to keep well informed on issues. |
| **Mental Health Management Board/Mental Health Patient Safety and Quality Committee MHMB (MH PS&QC) (continues – but 2 recent cancellations)** | These meetings do not occur every 3rd month as there is a quarterly Partnership Board Meeting (PBM). | With the creation of CCD in January 2018, some responsibilities of MHMB have been passed to CCD governance. It is too early to make meaningful observations, but CCD's development will be watched with great interest. | MHPS&QC continues to meet regularly and retains a valuable oversight of Mental Health patient safety and quality standards.<br><br>CCD meetings, in common with some other committees, have suffered from recent cancellations, which should be rescheduled. |

| Programme for Government Outcomes 2018/19 | | | | | | | APPENDIX C |
|---|---|---|---|---|---|---|---|
| **Outcome** | **National Indicator(s)** | **Measure** | **Quarterly data/DHSC RAG where provided** | | | | **HSCC RAG/Comment** |
| **We Live Longer healthier Lives** | Reduce the time that people wait for residential or nursing care | Number of eligible people on the waiting list for residential or nursing care following needs assessment | Q1<br>66 | Q2<br>74 | Q3<br>53 | Q4<br>9 | G<br>Significant reduction in waiting lists |
| | Increase the number of people regularly undertaking physical exercise | The percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer Guidelines on physical activity | Q1<br>17/18<br>72.6% | Q2<br>See Q4 | Q3<br>See Q4 | Q4<br>Survey but no data | R<br>Survey in Q4 but no data published |
| | Reduce the number of people dying prematurely from preventable cancer | Under 75 mortality rates from cancers considered preventable | Q1<br>17/18<br>88.1/ 100,000 | Q2<br>See Q4 | Q3<br>See Q4 | Q4<br>As Q1 | R<br>No improvement apparent as no new data available |
| | Reduce the number of people dying prematurely from heart disease | Under 75 mortality rates from cardiovascular disease considered preventable | Q1<br>47.6/ 100,000 | Q2<br>No data | Q3<br>No data | Q4<br>No data | R<br>Q4 report refers back to Q1, presumably measure not undertaken |
| | Improve the health related quality of life of the population | Increase the average health status score of adults using survey responses to questions on mobility, self-care, usual activities, pain/discomfort, anxiety/depression | Q1<br>Annual measure | Q2<br>No data | Q3<br>76 out of 100 | Q4<br>76 out of 100 | G<br>Bench Mark for future years? |
| | Increase healthy life expectancy | Healthy life expectancy at birth as measured by Public Health | Q1<br>No data yet | Q2<br>No data yet | Q3<br>No data yet | Q4<br>No data yet | R<br>Data analysis not good enough for production of indicator |

| Programme for Government Key Performance Indicators | | | | | | | | | |
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| **Outcome** | **Policy Statements** | **KPI** | **Baseline** | **Target** | **Quarterly Data/DHSC RAG where provided** | | | | **HSCC RAG/Comment** |
| **We live longer, healthier lives** | We will help everyone to take greater responsibility for their own health, encouraging good life style choices | Maintain our uptake of adult screening programmes at current levels | Cervical: 80%<br>Bowel: 63%<br>Breast: 72% | Cervical: 80%<br>Bowel: 63%<br>Breast: 72% | Q1<br>80<br>60<br>70 | Q2<br>79<br>66<br>77 | Q3<br>80<br>56<br>66 | Q4<br>80<br>68<br>68 | A<br>Fairly constant uptake with only breast cancer below target |
| | | Maintain percentage of eligible population registered with GP online services | 21% | 21% | Q1<br>22 | Q2<br>25 | Q3<br>27 | Q4<br>27 | G<br>Slight improvement |
| | We will help people stay well in their own homes and communities, avoiding hospital and residential care wherever possible | Reduce emergency admissions at noble for people with long term or chronic conditions, where appropriate management in the community has been shown to reduce the need for unplanned hospital admissions | 16% | 13% by April 2019 | No data available | | | | R<br>No data due to coding issues<br>No date for resolution |
| | | Maintain bed utilisation/occupancy levels at Ramsey Cottage Hospital | 86% | 85%-90% | Q1<br>92 | Q2<br>81 | Q3<br>82 | Q4<br>89 | R<br>Below target |
| | | Reduce adult mental health bed occupancy | 92% | 85% | Q1<br>91 | Q2<br>92 | Q3<br>88 | Q4<br>92 | R<br>No overall improvement |
| | | Increase 5 day discharge follow-up rate by mental health Services | 90% | 100% | Q1<br>81 | Q2<br>87 | Q3<br>87 | Q4<br>94 | A<br>Just above baseline in Q4 |
| | | Older people will be transferred to community Social Work Team caseloads within 3 months of being on a Hospital Social Work Team caseload | 10% | 90% | No Data due to organisational re-design | | | | R<br>No Data due to organisational re-design |

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| | We will improve services for people who really need care in hospital | The hospital will achieve 93% aggregate performance for 2 week cancer waiting times | 89% | 93%-2019 | Q1<br>82 | Q2<br>77 | Q3<br>80 | Q4<br>80 | R<br>Percentage referrals with 2 weeks decreasing |
| | | No patient will wait >52 weeks for elective inpatient surgery by end of March 2019 | 13.2% | 0% | Q1<br>13 | Q2<br>11 | Q3<br>9 | Q4<br>7 | A<br>Target not reached but position improving |
| | | ED attendances less than 4 hours from arrival to admission, transfer or discharge | 79% | 85% | Q1<br>78 | Q2<br>80 | Q3<br>91 | Q4<br>80 | G<br>Performance is improving |
| | | ED attendances less than 6 hours from arrival to admission, transfer or discharge | 92.8% | 95% | Q1<br>93 | Q2<br>93 | Q3<br>91 | Q4<br>92 | R<br>No overall change in performance |
| | | Reduce ED mean working time | 156 minutes | 135 minutes | Q1<br>161 | Q2<br>153 | Q3<br>160 | Q4<br>159 | R<br>Performance poorer than baseline |
| | We will work to ensure that everyone receives good value health and social care services | Maintain spend against budget through delivery of cost improvement plan | 104 | 100 | Q1<br>100 | Q2<br>102 | Q3<br>104 | Q4<br>101 | A<br>Just over target |
| | | Reduce by 10% the number of patients travelling to the UK for outpatient first attendances and follow up treatment and provide care within appropriate locality | 7,299 | 6,569 | Q1<br>1.5k | Q2<br>1.5k | Q3<br>1.5k | Q4<br>1.5k | G<br>Circa 6000 for year therefore Below target |

| Programme for Government Actions | | | | | | | | |
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| **Outcome** | **Action** | **Political Sponsor** | **Target Delivery Date** | **Quarterly Data/DHSC RAG where provided** | | | | **HSCC RAG/Comment** |
| We have more responsive legislation and regulation | Embed a robust governance frame work for research and development activity, whilst improving the quality of research applications and associated outcomes | Jason Moorehouse MHK | Mar-20 | Q1 | Q2 | Q3 | Q4 | A |
| | | | | Due to finite resources, activity to progress the Integrated Ethics Portal and Research Management Software has been rescheduled for 2019/20; however, this has had no impact on the overall target delivery date.<br>The review of the Peer Review Network (PRN) is ongoing; part of this work has identified an opportunity to enhance the quality of research design from the outset therefore reducing the burden on the PRN | | | | HSCC is concerned that this important area is slipping |
| We have affordable and accessible housing which meets our social and economic needs | Investigate and report how to ensure we have accommodation that can meet the needs of an ageing population including "care" and "extra care" housing and nursing and residential homes | David Ashford MHK Minister | Dec-18 | Q1 | Q2 | Q3 | Q4 | A |
| | | | | The Social Policy and Children's Committee considered the paper at their February meeting and have requested further information be included; this is schedule for submission in June 2019. Accordingly, the target delivery date has been extended to July 2019 | | | | HSCC would like to see a detailed implementation Plan |
| We live longer healthier lives | Continue the external peer review process (WMQRS) of health services and implement recommendations | Clare Bettison MHK | Mar-19 | Q1 | Q2 | Q3 | Q4 | A |
| | | | | WMQRS Summary Paper is scheduled to be laid before Tynwald in April 2019; this action is now complete | | | | HSCC is concerned about delays in implementing regulations and about the removal of some of the recommended Quality Committees |

| We live longer healthier lives | Move more services from the hospital into the community so care is provided closer to people's homes | Ann Corlett MHK | Mar-21 | Q1 | Q2 | Q3 | Q4 | R |
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| | | | | No further progress has been made against scheduled milestones;<br>additional milestones to be agreed Q1 2019/20 | | | | HSCC acknowledge the Western Integrated Care Pilot is underway but a clear plan for moving further Acute services into the Community is not apparent |
| | Deliver clear legal frameworks for all Health and Social Care Services | Jason Moorehouse MHK | Mar 21 | Q1 | Q2 | Q3 | Q4 | R |
| | | | | Progress with the NHCGS has been put on hold following the publication of the Independent Review Progress Report in January 2019. The next steps to develop the General Scheme will be identifiable following the publication of the final Independent Review of the Island's Health and Social Care System which is scheduled to be laid before Tynwald in May 2019.<br>Regulations for a no deal Brexit were laid before the March 2019 sitting of Tynwald and approved; the regulations will come into operation if the United Kingdom leaves the EU without a deal in place. However, the Department now needs to consider the legislative changes that will be required if a deal is agreed between the UK and the EU is agreed and there is a transition period.<br>Activity to progress the Medicines Act has been put on hold until work on the Abortion Reform Act 2019 has been completed; the Abortion Reform Act 2019 (Appointed Day) Order 2019 was laid before the March 2019 sitting of Tynwald and the Access Zone Order, the Records and Notices Regulations and the Directions regarding disposal of the foetus following termination are to be laid before the May 2019 sitting of Tynwald for approval | | | | The DHSC position appears to be one of rearranging the deck chairs.<br>This work is urgently needed and a new legislative framework before the target of March 2021 is very unlikely |

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| We live longer healthier lives | Continue to digitally transform the hospital and health care services more generally | David Ashford MHK Minister | Mar 21 | Q1 | Q2 | Q3 | Q4 | R |
| | | | | User Acceptance Testing for Clinical Assessment and Noting has been signed off; deployment of the live upgrade is due to commence imminently. Contract changes with EMIS for the e-Prescribe solution have been agreed and the subsequent project plan is currently being finalised. OCS Reporting and Filing has now been incorporated into BAU. However, the roll out plan for DHSC Single Sign on remains in draft | | | | HSCC accept that some progress has been made but it is evident that programme has fallen significantly behind |
| | Define the services which will be provided on-Island and those which will be provided off-Island | Jason Moorehouse MHK | Mar 19 | Q1 | Q2 | Q3 | Q4 | R |
| | | | | The Department is now adopting a revised approach to its procurement strategy, through the development of strategic partnership relationships with NHS acute providers in the North West of England (many of whom are CQC rated outstanding). Planning and scoping activity is now progressing across a number of specialties.<br>It is important to recognise that when defining what is delivered on and off island that this cannot be done in all cases at speciality level. As we integrate our services, a particular specialty may have certain elements of a pathway that continue to be delivered on island, whereas other elements of the pathway may need to be provided off Island | | | | HSCC is concerned that this action was dropped from the 2018-19 PfG. It has been identified as an essential action by the Independent health review (IHR). However, the fact is this, target has not been achieved. The HSCC support the work with Clatterbridge as, if it is a successful model, it could define how we take our services forward |
| | Reduce waiting times for operations | Clare Bettison MHK | Mar 19 | Q1 | Q2 | Q3 | Q4 | R |
| | | | | The majority of the planned project activity is now complete, and we are now seeing significant improvement in waiting times. The next phase of activity will aim to deliver: benchmarking against UK HES data, detailed review of capacity and clinic Templates, and benchmarking of Diagnostic services to 6 week wait time. | | | | The HSCC is aware of the performance issues that require to be addressed and are encouraged that although this target is not met it remains a high priority for DHSC |

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| | Implement the Mental Health Wellbeing Strategy | Ann Corlett MHK | Dec-20 | Q1 | Q2 | Q3 | Q4 | A |
| | | | | A review of High Complex Cases at CAMHS is to take place by an external provider in May 2019. Based on the outcomes of this the Service Specification is expected to be written in Q2 of 2019/20.<br>The Service Specification for the Remodeling of Addiction Services has been completed. The Business Case & Options Paper is due to be completed in Q2 of 2019/20.<br>The pilot for the Forensic Pathway will be completed at the end of June 2019.<br>An Independent/external review of Manannan Court Inpatient Unit is taking place in April 2019. | | | | This remains incomplete but appears on target to be completed by the target delivery date |
| | Improve the way we communicate with the public about the way our health and care services are provided | Jason Moorehouse MHK | Mar 21 | Q1 | Q2 | Q3 | Q4 | R |
| | | | | Extensive engagement on social media, with 'digital first' becoming the standard approach, and posts designed to appeal to both the public and staff, generating coverage in diverse areas, from a hospital major incident exercise to health awareness campaigns. Drive continues to make Corporate Communications measurable for effectiveness with targets. Best practice in crisis communications understood and shared. Work commenced to update DHSC intranet and engage with staff on new model. This action will be removed in 2019/20 | | | | The Department intend to remove this action in 2019-20.<br>HSCC strongly disagrees with the proposal to remove this action as good communication is essential for the efficient and safe delivery of health services. |

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| | Become an employer of choice in health MHK Minister care | David Ashford | Mar 21 | Q1 | Q2 | Q3 | Q4 | R |
| | | | | The Organisational Development Plan has been reviewed by the Executive Leadership Team and priority areas for 2019/20 have been identified; these include:<br>• Embedding the CARE values across the DHSC<br>• Replacing the employee PDR process with the CARE performance framework<br>• Develop and implement a Making Every Contact Count (MECC) pilot project<br>• The ongoing activity to support this action has been incorporated within the Isle of Man Public Service People Strategy; as such, this action will be removed from the PfG | | | | The HSCC agree targeted and effective recruitment is important but feel the greater problem is the retention of quality staff once recruited, as highlighted by the high profile resignations and nursing retention rates in particular over the past year.<br>HSCC recommend that when staff resign an exit interview is undertaken by an independent body to see if significant retention issues can be recognised. |
| | Design and deliver a suite of core data sets to underpin the core work streams | David Ashford MHK Minister | Mar-21 | Q1 | Q2 | Q3 | Q4 | A |
| | | | | Work remains ongoing to develop the Core Data Sets and reporting timeline for the Substance Misuse JSNA. A series of workshops have taken place to strengthen data sharing agreements with multi-agency partners.<br>Work is being finalised to publish Public Health Outcomes Framework in Q1 of 2019/20; this data will be updated quarterly to include an annual report.<br>Public Health are working closely with Health Protection Nurses to complete an audit of Cover of Vaccination Evaluated Rapidly data to validate anomalies identified within data recorded in EMIS | | | | Lack of data remains an issue in many areas of DHSC. The HSCC would like to see HOF incorporated into the SDP or Annual Report.<br>The HSCC are aware that implementation plans, particularly where other departments and bodies are involved are not being met due to resource issues. |

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| | | | | | | | | The HSCC would like to see a cross Government responsible lead and a resource provision plan for all implementation plans |
| | Develop and implement the Integrated care Strategy | Ann Corlett MHK | Mar-21 | Q1 | Q2 | Q3 | Q4 | A |
| | | | | On 25th February 2019 the very first stages of a pilot for an operational model of Integrated Care in the West of the island was launched. Core Services now meet twice weekly at Peel Resource Centre. This is an opportunity to discuss ongoing complex cases where practitioners require supervision, support or intervention from other team members. The meetings will increase in frequency to discuss and allocate new contacts to the team once the new referral/contact | | | | The integrated care project in the West, has now been named the Western Wellbeing Partnership.<br>We await the implementation of the 42 recommendations and hope that the release of the IHR and recent changes in the senior management structure it would be given the financial support to see the project fully implemented |

| Service Delivery Plan Objectives | | | |
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| **Strategic Goal** | **Objective** | **Q4 Update** | **HSCC RAG/Comment** |
| Greater Responsibility | Ensure delivery of quality assurance and accountability review for all current screening programmes | The first report, a review of the Bowel Cancer Screening Programme, is now in draft. | A<br>This urgent work has been slow to progress |
| | Undertake review and refresh of children's oral health needs assessment and strategy | Research element of the Oral Health Needs Assessment complete. The final report will be completed by the end of Q1 2019. The contract between PHE and DHSC has been agreed. PHE are sending the contract to the Public Health Directorate for signing by the DPH | G<br>Good progress has been made here and is welcomed by HSCC |
| | Develop programmes aimed at reducing childhood obesity and improving children's oral health; drawing on funds from the Soft Drinks Industry Levy | Once COG has agreed the draft consultation strategy, this will go out for comment in Q1/2. The COG meeting for presentation has been put back to Q1 of 2019/20.<br>The draft children's weight management programme service specification is still with AGs office, and will be progressed as a matter of priority when it is returned. We aim to have the tender out by end of Q1 at the latest | A<br>Await Q1 but HSCC are aware of some further delays |
| More care in the Community | Complete Phase 1 of the Eastcliffe project; relocating Day Services for Adults with Learning Disabilities to the Noble's Complex | This action is complete. | This action is complete. |
| | Expand the scope of the Adult Social Work team to ensure care is not limited to those who have Learning Difficulties or Mental Health problems | This additional team is fully up and running enabling us to provide support to adults who have other support needs than Learning Disability or Mental Health problems.<br>This action is complete | This action is complete |

| Service Delivery Plan Objectives | | | |
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| Service Delivery Plan Objectives | | | |
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| | Continue to reshape Learning Disability Services in line with the Learning Disability Strategy 2014-2019 | Phase 2 of the day services build continues on target for new service users from September 2019. User engagement days are being completed to show progress and start preparing users and their parents for the move.<br>Respite recommendations report has been addressed where possible and discussions have taken place with regulations and inspections regarding the outstanding actions they are unable to complete and agreement has been made. The next phase of this project is to complete an improvement programme focused on medication, physical health support and documentation, in preparation for the completion of a capital project for a new respite building.<br>Strategy 2020-2025 planning is underway to capture outstanding plans from the current strategy and ideas to move into a new model from 2020 onwards. Presentation date is booked with J Carey and A Murray on the 8th April for first review of the next round of service redesign planning | A<br>In 2018 it was reported that the current Learning Disability Infrastructure may not meet future service demands and vulnerable adults may not be able to access services. Progress is questionable. Repeated cancellation of meetings demonstrates lack of leadership and governance |
| | Move appropriate paediatric activity from the hospital setting as an outreach service, provided in the community | This action is complete. | This action is complete |
| | Develop sustainable plan for GP out of hours services | The model of having a salaried GP undertaking a large proportion of the out of hours shifts is working well. Longer term plans are being considered, in liaison with the Emergency Department to broaden the provision of out of hours urgent care. The Department has been trialling the participation of Urgent Care Practitioners in the GP out of hours service setting. These Practitioners are able to deliver care in the GP out of hours centre and to patients in their home setting where necessary and have proved to be a useful asset to the Service. | GP Services is not within the HSCC remit |
| | Subject to full planning approval, commence development of the Summerhill View older persons care facility | Following the Appeal Hearing planning permission was granted in February 2019. The original design team has been re-appointed and it is intended to seek Tynwald approval by November 2019. | This matter is not within the HSCC remit |

| Service Delivery Plan Objectives | | | |
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| Improve Hospital Services | Develop and enhance quality management systems within the medical laboratory in pursuance of the 15189:2012 standard (recognises quality and level of competence in medical laboratories) | Discussions remain on-going with finance director to identify a funding source for 2019/20 budget. | A<br>Some signs that budget may be reinstated 2019-20 |
| | Redesign the chemotherapy clinic space to accommodate the increase in patients receiving treatment on the Island | The scheme has progressed to schedule and is planned for completion at the end of May, with commissioning to take place during June. | A<br>Building work is almost complete. However commissioning is well behind schedule |
| | Evaluate the introduction of Histopathology (the study of changes in tissues caused by disease) Telemedicine solutions | A Prior Information Notice has been produced and is due to be published on the Government portal imminently. | A<br>Await Q1 publication of notice |
| | Develop a high quality dermatology and skin service that ensures that all patients with skin complaints are seen and treated in accordance with clinical guidelines | Following the recent commencement of a Clinical Nurse Specialist in Dermatology, the dermatology service is now fully staffed and running to full capacity. There are further service developments in the pipeline, such as development of a photodynamic therapy service.<br>This action is complete. | This action is complete. |
| | Redesign the pathway for the admission of the acute medical patient from Emergency Department into hospital setting | The delivery of the recovery plan for the Emergency Department (ED) of acute admissions is well underway. The beginning of February saw the implementation of internal professional standards for the Emergency Department, which sets the timeframes by which patients are attended to within ED in order to ensure that are either admitted or discharged within four hours. Following initial feedback, we have introduced acute medical consultant cover into ED from midday to 6pm Monday to Friday to ensure there is a senior decision maker from acute medicine at the 'front door'. Given 75% of our admissions are into acute medicine, this new development | G<br>Successful Emergency Department Major Incident exercise conducted in Q4 |

| Service Delivery Plan Objectives | | | |
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| | | will have a significant impact on waiting times in ED and will reduce unnecessary admissions into hospital.<br>Monitoring of the internal professional standards and the development of the Urgent Care Hub is ongoing. | |
| | Improve access to radiology services through the implementation of sustainability plan | Charitable funding has been confirmed by three charities for the purchase of an MRI scanner and two CT scanners, fundraising for the CT scanners has begun. There is work being done to create a full diagnostic suite within the radiology department to best utilise the new equipment once installed and work to become part of the North West Cheshire and Merseyside Global Network has been initiated with Care Stream. Work has been on going to reduce the MRI and CT waiting lists which are now at a manageable level; preparation is being done to repatriate more services back to the Island once the new equipment is in place. | G<br>These developments are welcomed by HSCC |
| | Review the clinical model delivered by the ambulance service to ensure that it is at the forefront of modern urgent care delivery | The development of a pool of Urgent Care Practitioners (UCP) is ongoing with the commencement of a new UCP course at Keyll Darree on the 8th April – after 12 months this will increase the pool of practitioners by 20. UCP outreach trials (supplementing the ambulance service and MEDS) are ongoing however there is very positive feedback from ambulance service staff and MEDS GPs on the impact of UCPs. Their ability to treat patients in their own home, reducing transit to hospital, is also excellent, with 85% of<br>patients left at home after treatment.<br>Business Case for the 12 month trial of UCP outreach services will be submitted for ELT approval by the end of April. | A<br>The Urgent Care report was not published despite repeated requests by the HSCC |
| | Develop Ramsey Cottage Hospital into a vibrant community hospital with elderly care/rehabilitation facility, outpatient clinics and day case theatre | This action is complete. | This action is complete |

| Service Delivery Plan Objectives | | | |
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| Protect Vulnerable people | Development of an integrated (4 tier) Autism pathway | There were 2 problem statements raised during the first mapping session in the areas of appropriate diagnosis and also the complex link/ownership for early years, with educational psychology provided by the Department of Education, Sport and Culture. A further independent review of the current practice is planned for June 2019 by a specialist body. The aim is to allow independent assessment of our current caseload within Community Adolescent Mental Health Service and Learning Disabilities to provide information to support our future planning needs for Autism and other neurodevelopmental disorders. | A<br>The HSCC is concerned that a move to a dedicated Autism pathway is still outstanding and placing additional strain on CAMHS resources |
| | Work with colleagues in Department of Education, Sport and Culture to develop an integrated pathway for children with disabilities | The appointment of new service leads in both Departments will now enable this project to be taken forward in the next 12 months. | This matter is not within the HSCC remit |
| Value for money | Development of Directorate wide Commissioning process for Community Care | The work in developing the commissioning cycle continues. The cycle is a formal and staged process that underpins how we approach commissioning to source and secure services from external providers. A key aspect to this is contract management and the community care directorate are in the process of embedding a revised performance framework designed to improve contract management and importantly, to enable the acquisition of more relevant business intelligence and data from the services we commission. | A<br>These developments are welcomed by HSCC. HSCC is conscious of the amount of work still to be undertaken in this area. |
| | Improve the quality of financial information - Provide the Department with more detailed, timely financial information to aid the decision making processes and allocation of resources | An activity based costing exercise has been completed for Noble's Hospital, matching the current focus on patient level costing in the NHS. Management accounts continue to be issued monthly with forward looking forecasts. | A<br>Cessation of meetings to examine Nobles financial performance has reduced governance |

| Service Delivery Plan Objectives | | | |
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| | Develop and implement Medicines Optimisation Strategy which will deliver effective prescribing and cost improvement programme across the Department | The DHSC Medicines Strategy was presented in February, and a request was made for the strategy to be across both primary and secondary care.<br>An implementation plan from secondary care is required before the strategy is resubmitted. Recruitment has been completed (March 2019) and the pharmacy team will be 3 clinical pharmacists and 3 technicians from Q2 2019.<br>Spend on pharmaceuticals (Jan 2019) stands at £858k underspent. | A<br>These developments are welcomed by the HSCC. However, the enabling legislation has stalled, due, apparently, to Brexit |
| | Explore opportunities to generate a greater level of hospital income through commercial enterprise | A Private Patient Service Redesign group has been created, as has a detailed project plan to underpin delivery. The group's initial focus is a tender exercise to secure a strategic partnership with a third party provider and a public consultation to aid developments of the service once this partnership has been secured. A detailed service specification has been drafted and sent to the Attorney General's Chambers with a view for the ITT to be entered on the procurement portal in Q1, 2019/20. The public consultation is also planned to become live in Q1 2019/20. | A<br>The consultation has been, belatedly, published. However, according to the press release it is going out to tender before the consultation closes |
| | Deliver savings from the Tertiary Services budget through the implementation of Cost Improvement Plans | The 2018/19 year end accounts are not complete at the publication of this report, however we are expecting to be more overspent than what was previously forecast in Q3 due to high cost cancer drug charges with Clatterbridge Cancer Centre and further costs associated with high cost patients. | R<br>Overspend certain.<br>However, financial management, setting priorities and standards are improving but finances and processes need to be drawn together |
| | Explore opportunities to repatriate as much activity as possible from the UK to be delivered safely on island | The DHSC is currently working in partnership with Clatterbridge Cancer Centre to redesign service delivery models for oncology and haemato-oncology services. Phase 1 of the project is identifying digital solutions to aid delivery and a draft action plan is in place. Initial conversations have also taken place with Liverpool, Heart and Chest for the redesign of cardiology and respiratory services. | A<br>This is a long awaited initiative. However, it is only one of many repatriation opportunities that need to be grasped |

| Service Delivery Plan Objectives | | | |
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| | The DHSC is currently exploring models with UK providers to provide more 'in reach' services on Island where it is safe to do so rather than patients having to travel to the UK for treatment. | The DHSC is currently forging stronger partnerships with two of its main partners; Clatterbridge Cancer Centre to transform oncology and haemato-oncology services and Liverpool, Heart and Chest to transform cardiology and respiratory services. A draft initial action plan is in place and underway with Clatterbridge for phase 1 of the project and initial discussions have taken place with Liverpool, Heart and Chest. | A<br>HSCC welcomes this initiative which has been anticipated for at least twelve months and appears to be taking a long time to bring to fruition |
| Supporting Pillar | Establish a functional Programme Management Office to support delivery of the Department's objectives | Monthly project status reporting is now well-embedded, whilst governance controls, processes and procedures are continuously developed and refined on a monthly basis. | G<br>HSCC is pleased to see progress in this area |
| | Determine future commissioning arrangements for third sector organisations | Following the submission of the options paper, the Commissioning sub-committee is now developing a paper for Department consideration. | A<br>HSCC welcomes this progress which has been promised for at least two years |
| | To build a 'Pod', funded by Bridge the Gap Charity, on the Noble's site which will be jointly used by DESC and DHSC for support of young people with life limiting illnesses | This action is complete. | This action is complete |
| | Produce premises development plan for GPs - securing additional premises for Peel as a priority | The business case is in its final stages of production prior to approval by the Department and Treasury. The Planning Application has been submitted, the Release of the Covenant's for the land is being progressed with the Corrin Trustees and discussions are ongoing with P&WDHC to ensure good communication is maintained to ensure success in both projects. | A<br>Progress has been slow and a step up is required |
| | Ensure information across the business is delivered in a timely, accurate and consistent manner through the development of an information management strategy and implementation plan | The Information Management Strategy (IMS) has been approved by the ELT and Department; the document is waiting to be uploaded to the Department's website for public access. Activity is on track with the IMS schedule of work for key deliverables to begin reporting in Q1. | A<br>The DHSC has 8 different electronic patient record (EPR) systems with very little interface between them. Development of an integrated digital Manx Care Record is essential. |

| Service Delivery Plan Objectives | | | |
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| | Working with the Island's dentists to consider options for reforming the current dental contractual system by April 2019 | The Department is nearing completion of the draft dental strategy which will then be subject to consultation with both dental professionals and the public. | No longer under HSCC visibility since Finance and Commissioning Committee was disbanded in April 2018 |

**Integrated Care Overview- Timescale** **Appendix D**

## Integrated Care Events

**Jan 2016 – Sept 2018**
-Southern Community Partnership reformed
-Several committee groups at Nobles/Dept re Integrated Care work
-Initial thoughts/outline re the "Peel Pilot"

**Sept 2018 - Dec 2018**
-The Event in the Tent kicks off the full discussion around IC
-Dept launches its Vision document, citing method but NO targets or goals
-Updated ideas for the IC pilot in Peel.
-Gov't announce IHR to confirm which direction to travel

**Jan 2019-Apr 2019**
- Workshop activity around IHR identifies many issues/barriers to development of IC as part of a renewed NHS
-Newsletter circulated re IC pilot, followed by full project definition
- Western Pilot team update HSCC just before pilot due to begin.
- Southern Community recruit p/t co-ordinator to enact a Southern Hub

**Post April 2019**
Further upheaval in management changes, PPU consultation, IHR Report - all add additional issues and layers of complexity

## HSCC Comment

Lack of clarity around Integrated Care model to be adopted.
Contradictory statements.
September Event in The Tent was based on Buurtzorg model but now using Triple Aim model.

Event in the Tent CLEARLY identifies the need for transformational as opposed to step wise change.
IHR adds more complexity, not clarification. Focus on different issues. IC clearly a core service but many fundamental changes required beforehand.

IHR activity distracts from focus on the vision.
Western pilot fails to set out clinical pathways in advance.
Also, the numbers benefitting do not add up.
Objective data difficult to obtain?

## 2019 HSCC concerns and monitoring for 2019

-Evidence of transformational change required.
In particular, advance on the key foundations for Integrated Care (common record, data access, clinical pathways, co-working)
-There appears to be over-emphasis on Hospice activity in Western Pilot but not directly linked to objectives
-Pilot data needs to be shared regularly, particularly baseline v interims. Restrict anecdotal evidence
-Applicability of pilot to the wider Island community?
-Development of additional hubs critical to preparation without delay.
-Change management to be monitored. (How, when, objectives, etc).
-Appropriate development of clinical pathways. Not solely based on co-working relationships, successorship, appropriateness.

**Date Calendar of some associated Integrated Care meetings, briefings, workshops etc**

12th September 2017 developing and establishing a Southern Community Partnership which had gone quiet for a while whilst Peel / Western project being looked into.

9th July 2018 meeting for the reformed group, Southern Community Partnerships

3rd September 2018 HSCC representatives met with Paul Jackson and Margaret Swindlehurst who gave the presentation about the Peel project (now Western pilot)

10th September 2018 Event in the Tent 'Delivering longer healthier lives

11th September 2018 meeting of Northern Networking Group (an informal group who are also looking at integrated care)

5th December 2018 Southern Community Partnership meeting which identified a steering group to make terms of reference and identify objectives

17th December 2018 Informal meeting with the Integrated Care team to get an update of the project all on target

29th January 2019 Workshop about the Independent Health Review IHR being undertaken by Sir Johnathan Michaels and his team about the structure of the Island's health and social care structure, what we've learnt so far

February 2019 up-date newsletter from Integrated Care Pilot disseminated

20th February 2019 Paul Jackson gave an update to HSCC members including the 42 recommendations

27th February Northern Networking meeting

3rd April 2019 Southern Community Partnership meeting, now getting a part time admin person to assist the partnership and will liaise with Western Project and possibly be the next hub

| Independent Health Review Recommendations | HSCC 2014 – 2019 Key Recommendations |
|---|---|
| **Recommendation 1:**<br>The Council of Ministers should formally adopt the principle that patients and service users are fully engaged in, and at the centre of, all aspects of planning and delivery of health and social care services. | R3 2014-2015<br>Staff, patients and the public need to be fully involved in the new vision of integrated health and social care, with the idea of a collective ownership of Health care being promoted to avoid undermining the motivation and morale of staff.<br><br>R4 2014-2015<br>A broader range of methods including Patients Safety And Satisfaction Walks should become a structured part of engaging the patient and staff voice.<br><br>R13 2015-2016<br>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. |
| **Recommendation 2:**<br>The setting of priorities and the development of policy in both health and social care should be separate from the delivery of services. A comprehensive governance and accountability framework should be established aligned to agreed standards and underpinned, where necessary, by legislation. A single public sector organisation, perhaps to be known as "Manx Care", should be responsible for the delivery and/or commissioning from other providers of all required health and care services. | R9 2014-2015<br>Political intervention concerning Noble's Hospital should focus on policy issues and strategic direction of health services, leaving the clinicians free to make clinical decisions on patient care. |
| **Recommendation 3:**<br>Services provided directly or indirectly by Manx Care should be inspected regularly by independent, external quality regulators, with a report to the Manx Care Board and to the DHSC. | R10 2014-2015<br>All initiatives coming from the West Midlands Quality Review Service Reports (WMQRS) should be communicated widely with the Department focusing on the management and tracking of these initiatives to ensure maximum benefit.<br><br>R13 2018-2019<br>The Annual WMQRS update report to Tynwald continues, to ensure sustainability of the Priority Areas for Action 2019 and to encourage further compliance with remaining achievable quality standards. |
| **Recommendation 4:**<br>A publicly available Annual Report from Manx Care should be provided to DHSC and subsequently presented to Tynwald, summarising the delivery of the health and care services on the Island. | R11 2017-2018<br>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 5:**<br>A statutory duty of care (applicable to organisations and the individuals who deliver health or care services) should be agreed, implemented and maintained alongside the delivery of high value clinical governance, underpinned by legislation where necessary. The new statutory duty of care would include:<br>• A duty of confidentiality<br>• A duty to share information where appropriate to enable the delivery of safe optimal care<br>• A duty of candour – a responsibility to disclose where breaches of safety standards or harm to individuals have occurred | R6 2017-2018<br>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.<br><br>R8 2018-2019<br>An effective Nobles governance structure be re-established, that meets regularly and thereby provides a degree of transparency and accountability not currently evident.<br><br>R9 2018-2019<br>The Nursing and Midwifery Advisory Council is re-established to provide adequate checks and balances for professional conduct.<br><br>R10 2018-2019<br>That current shared service arrangements are reviewed by the ELT in light of organisational changes and recent PAC and SAPRC reports and to ensure all staff and managers are compliant with the CARE standards. |
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| **Recommendation 6:**<br>The Council of Ministers should mandate DHSC, Treasury and the Cabinet Office to ensure implementation of the agreed Transformation Programme of health and care services as set out in this Report, led by the Chief Secretary. | R16 2015-2016<br>Prioritise the Development of new legislation to support the Goals and Objectives in the 5-Year Plan.<br><br>R13 2016-2017<br>That legislation should be prioritized and accelerated to underpin progress on the 5-year strategy. |
| **Recommendation 7:**<br>Assuming the recommendations are accepted, the Council of Ministers should receive a quarterly progress report on the Transformation Programme to understand the progress made and to identify any significant issues which need resolution. In addition, it is suggested that Tynwald should also receive an annual report on progress of the Transformation Programme. | R10 2014-2015<br>All Initiatives coming from the West Midlands Quality Review Service Reports should be communicated widely with the Department focusing on the management and tracking of these initiatives to ensure maximum benefit.<br><br>R6 2015-2016<br>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. |

| **Recommendation 8:**<br>Primary and/or secondary legislation should be introduced as required, and included in the legislative programme as soon as possible, in order to form a modern, comprehensive legislative framework. This legislation should address weaknesses or gaps in the current system as well enabling the implementation of the recommendations contained in this Report, such as any necessary legislation to establish Manx Care. | R16 2015-2016<br>Prioritise the development of new legislation to support the Goals and Objectives in the 5-Year Strategic Plan.<br><br>R6 2018-2019<br>A full review of all heath related legislation be urgently commissioned, to include the IHR recommendations and to facilitate the Integrated Care Strategy. |
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| **Recommendation 9:**<br>The Public Health Directorate should be empowered to provide advice and guidance across Government, not solely to the DHSC. It should promote and co-ordinate health and wellbeing across the Island to help improve the quality of life and reduce the demand on health and care services in the future. All Departments should be required to factor public health guidance into policy setting and legislation. In order to facilitate this, it is recommended that the Public Health Directorate be moved to a position in the Cabinet Office. | R7 2014-2015<br>Clarification of how Public Health will be able to fulfil its task in any new strategic vision for health services.<br><br>R13 2015-2016<br>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. |
| **Recommendation 10:**<br>An on-going health and care needs assessment programme for the Isle of Man should be established and funded without delay. It is not possible to develop meaningful service delivery models and plans without establishing the current and future needs for health and care through this assessment. Many other recommendations in this report are predicated on the assumption that this programme will be established. The Public Health Directorate should be resourced to undertake the health and care needs assessment programme. | R10 2016-2017<br>That Public Health continue to develop Joint Strategic Needs Assessments (JSNA) in order to support the prioritisation of services.<br><br>R10 2017-2018<br>DHSC ensure governance procedures for all screening services are improved and gain approval by the Director of Public Health as appropriate and adequate.<br><br>R12 2018-2019<br>Specific resources and commitments to be agreed by Treasury and relevant Departments and Bodies through Social Policy Consultative Committee for all JSNA Delivery Plans before implementation is agreed. |
| **Recommendation 11:**<br>A service-by-service review of health and care provision, in conjunction with the needs assessment and an analysis of care pathway design, should be undertaken to establish what services can, should or must be provided on and off Island, against defined standards. Where services cannot be provided safely or deliver best value by Island-based providers, the default position should be to seek services from third parties for delivery on-Island whenever possible and off-Island where necessary. | R10 2014-2015<br>All Initiatives coming from the West Midlands Quality Review Service Reports should be communicated widely with the Department focusing on the management and tracking of these initiatives to ensure maximum benefit. |

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| **Recommendation 12:**<br>Service by service integrated care pathways should be designed, agreed and delivered. These should encompass both on- and off-Island components of clinical service models. | R2 2014-2015<br>The Infrastructure of Primary Care must be sufficiently resourced and appropriately funded to enable it to deliver more services within the Community, and the transfer of services from Acute to Community Care must be done in an open and transparent manner.<br><br>R3 2015-2016<br>The shift from Acute Services to Community and Integrated Hubs needs to be established with a reconfiguration of funding in line with the revised 5-Year Strategic Plan.<br><br>R3 2017-2018<br>Review the funding strategy to consider the urgent budget needs to support Integrated Care strategy.<br><br>R3 2018-2019<br>Evidence-based community care pathways are implemented, evidenced, audited and shared appropriately. |
| **Recommendation 13:**<br>Manx Care should deliver an enhanced 24/7 emergency air bridge, allowing for patients to be stabilised locally and moved quickly and safely to contracted specialist centres. | |
| **Recommendation 14:**<br>A single, integrated out-of-hours service should be established to provide care in an efficient and appropriate manner outside normal working hours. | |
| **Recommendation 15:**<br>The Isle of Man should establish a model for delivering primary care at scale, since further and deeper collaboration within primary care is necessary to deliver current services and provide additional local services. | R9 2016-2017<br>That overall adult discharge procedures improve collaborative working connecting Community Health Services (CHS), Social Care and Acute services. |

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| **Recommendation 16:**<br>The provision of social care should be considered as part of the current review of future funding of nursing and residential care with the intention of removing disincentives to people requiring care and support remaining in their home. This consideration should specifically include equalisation of the current threshold of financial assistance, a more flexible approach to funding to enable joint commissioning of broader care arrangements in the interests of the service user and provision of 24/7 social care access. | HSCC does not currently have a mandate to comment on Social Care.<br><br>R2 2016-2017<br>That DHSC complete the catalogue of contract management to allow them to exercise control over the DHSC budget.<br><br>R4 2017-2018<br>Better Financial and Commissioning Governance is required through a review of ToR's, membership and accountability. |
| **Recommendation 17:**<br>Increased funding should be linked to the achievement of annual efficiency targets. | R1 2015-2016<br>Joint commissioning of services should be followed where clear benefits are identified, e.g. Eye Care Strategy. |
| **Recommendation 18:**<br>Additional transformational funding and dedicated specialist resources, including proven transformational leadership, are required to deliver the proposed programme for it to be implemented successfully. | R2 2015-2016<br>Commissioned service contracts must have clear action plans with measurable outcomes, which are evidenced as good value for money.<br><br>R1 2018-2019<br>The Cancer Services Coordination Group must have strong leadership and senior management support to deliver a new IOM Cancer Strategy and implementation plan. |
| **Recommendation 19:**<br>Increases in funding for health and care services will be required to support the increased demands that will be placed on those services due to demographic changes, non- demographic changes and inflation. | R17 2015-2016<br>Develop and publish a Funding Strategy to support the 5-Year Strategic Plan. |
| **Recommendation 20:**<br>Funding, based on agreed need, should, over time, move from the current annual budget allocation to a 3-5 years financial settlement for heath and care services for the Island. | R4 2018-2019<br>Additional resource is provided to enable Nobles Commissioning to accelerate progress with contracts and compliance. |
| **Recommendation 21:**<br>Ensure data sharing protocols and arrangements are reviewed, agreed and implemented in accordance with the Information Commissioner's regulations and guidance. | R5 2017-2018<br>The DHSC should involve itself at an earlier stage, in the rationale, scope and implementation of pan-Government projects such as PiP. |

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| **Recommendation 22:**<br>The development and delivery of the digital strategy should go further and faster to ensure the comprehensive capture, sharing and use of information. This would enable greater integration across the system, improved monitoring and enhanced delivery of quality and efficiency-related information. | R4 2016-2017<br>Wider adoption of the change management principles as demonstrated by IQC for all areas that are not technology driven.<br><br>R5 2018-2019<br>Timely resources be made available to drive forward essential projects including the digital Manx Care record. |
| **Recommendation 23:**<br>A core data set is essential for the management and assessment of services and should be established without delay. | R9 2015-2016<br>Resolve flawed data and statistics across all areas of the Health Service. |
| **Recommendation 24:**<br>The systematic capture of accurate data should be a priority for the Island's health and care services. | R9 2015-16<br>Resolve flawed data and statistics across all areas of the Health Service. |
| **Recommendation 25:**<br>A fit for purpose workforce model needs to be developed to reflect the emerging needs of the new model of care. It should maximise the potential skills available within the workforce as well as the opportunity to recruit and retain high quality professionals. It will then increase the attractiveness of the Isle of Man as a career destination. | R9 2017-2018<br>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.<br><br>R10 2017-2018<br>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. |
| **Recommendation 26:**<br>The Government should create a new, dedicated and skilled transformation programme group to oversee and support the implementation of the agreed Recommendations. | R12 2014-15<br>Conduct an overhaul of Health based Committees and their meetings in the Department In order to determine their purpose and structure, streamline decision making, clarify accountability and avoid duplication and gaps.<br><br>R12 2017-2018<br>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. |

## HSCC Member Links to Officers 2018-19

## Appendix F

| | HSCC member | Department link | | HSCC member | Department link |
|---|---|---|---|---|---|
| **Strategic Vision** | Sue Gowing | Andrea Whitaker,<br>CEO Researcher | **Managing Political Process** | Annual - All members<br>1:2 Bi-Annual<br>Sue Gowing<br>David Trace | Minister |
| **Mental Health** | Malcolm Norris | Angela Murray,<br>Director CCD inc.<br>Mental Health | **Leadership Governance** | Sue Gowing<br>David Trace | Malcolm Couch, CEO<br>Michaela Morris, DCEO |
| **Nursing** | David Trace | Michaela Morris<br>Senior Nurse role<br>Leadership Regulation | **Community Partnerships Community Care Directorate** | Sharon Faragher<br>Dawn Mayor | Paul Jackson<br>Peel Pilot Project<br>Cath Quilliam,<br>Head CQ&S CCD |
| **Finance and Commissioning** | David Trace | Lara Swales - Nobles<br>Will McCann - Community<br>Tanya Hewitt - Nobles | **Human Resources** | Derek Booth | Anne Corkill,<br>OHR Partner for Health |
| **Integrated Care** | Andy Guy<br>Sue Gowing | Michaela Morris DCEO<br>Integrated Care Vision | **Patient Safety PQSC-Nobles** | Martin Hall | Chris Till<br>Patient Safety |
| **Cancer** | John Beckett<br>Malcolm Norris | Mike Quinn<br>Director of Hospitals | **Hospitals** | Sue Gowing | David Catlow<br>Director Finance<br>Mike Quinn<br>Director Hospitals |
| **Public Health** | Martin Hall | Henrietta Ewart, Director<br>Public Health | **Communications** | John Beckett | Marian Kenny<br>Comms partner for Health |

Informatics: Minutes received from IQC, Richard Wild, Interim Director, GTS

## Appendix G

| Alphabetical List of Acronyms | |
|---|---|
| 5-YR (STRATEGY) | 5- YEAR STRATEGY |
| AMU | Acute Medical Unit |
| CABO | Cabinet Office |
| CAMHS | Child and Adolescent Mental Health Service |
| CAN | Clinical Assessment and Noting |
| CARE | Care, Appreciative, Respectful, Excellent |
| CCD | Community Care Directorate |
| CHS | Community Health Service |
| CHSET (now defunct) | Community Health Service Executive Team |
| CIPs | Cost Improvement Plans |
| COG | Chief Officers Group |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPS | Crown Prosecution Service |
| CQC | 1. Care Quality Commission (UK);<br>2. Commissioning Quality Committee (IOM) |
| CQSC | Care Quality and Safety Committee |
| CRC | Clinical Recommendations Committee |
| CS | Communications Strategy |
| CSCG | Cancer Services Coordination Group |
| CSG | Cancer Strategy Group |
| CSST | Core Scrutiny Sub Team HSCC |

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| CWS | Community Well-being Service |
| DCEO | Deputy Chief Executive Officer |
| DEC | Department of Education Sport and Culture |
| DHA | Department of Home Affairs |
| DHR | Digital Health Records |
| DHSC | Department of Health and Social Care |
| DHSCCPB/(CPB) | DHSC Change Programme Board |
| DPA | Data Processing Agreement |
| DPB | Digital Programme Board |
| ED | Emergency Department |
| ELT | Executive Leadership Team |
| EMI | Elderly Medical Infirm |
| EMIS | Digital GP clinical web system |
| EPMA | Electronic Prescribing and Medicines Administration |
| FCC | Finance and Commissioning Committee |
| FG | Focus Group |
| FQC | Finance Quality Committee |
| FRWG | Francis Report Working Group |
| GDPR | General Data Protection Legislation |
| GMC | General Medical Council |
| GTS | Government Technology Services |
| HES | Hospital Episode Statistics |
| HIF | Health Improvement Fund |

| HPA | Health Protection Agency (UK) |
|---|---|
| HPC | Health Protection Committee |
| HOF | Health Outcomes Framework |
| HRQC | Human Resources Quality Committee |
| HSCC | Health Services Consultative Committee |
| ICT | Information Communications Technology |
| IDCR | Integrated Digital Care Record |
| IGSC | Information Governance Steering Group |
| IHR | Independent Health Review |
| IMS | Information Management Strategy |
| IQC | Informatics Quality Committee |
| JSNA | Joint Strategic Needs Assessment |
| KM&T | Health Consultancy |
| KPI | Key Performance Indicator |
| LEaD | Learning, Education and Development |
| LREC | Local Research Ethics Committee |
| LSA | Local Supervising Authority (UK) |
| MDT | Multi Disciplinary Team |
| MECC | Make Every Contact Count |
| MEDS | Manx Emergency Doctor Service |
| MHC (now defunct) | Mental Health Committee |
| MHD | Mental Health Directorate |
| MHPSQC | Mental Health & Patient Safety Quality Committee |

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|---|---|
| MHS | Mental Health Service |
| MIAA | Merseyside Internal Audit Agency |
| MRSA | Methicillin-resistant Staphylococcus aureus |
| NET | Nobles Executive Team – now Senior Management Team |
| NHCA | National Health Care Act |
| NHCS | National Health and Care Service |
| NHCGS | National Health and Care General Scheme |
| 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) |
| OAT | Out of Area Treatment |
| ODP | Organisational Development Plan |
| OHR | Office of Human Resource |
| OPMHS | Older Person's Mental Health Service |
| PA | Patients Association |
| PAC | Public Accounts Commission |
| PAS | Patient Administration System |
| PC | Primary Care |
| PEIs | Patient Experience Indicators |
| PH | Public Health |
| PHSM | Public Health Staff meeting |
| PIC | Patient Information Centre (at Noble's) |

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|---|---|
| PiP | People Information Programme |
| PMO | Programme Management Office (was Change Programme Board CPB) |
| PPU | Private Patients Unit |
| PRN | Peer Review Network |
| PSF | Patient Safety Forum |
| PSQC | Patient Safety Quality Committee |
| PSW | Patient Safety Walks |
| PTM | Patient Tracking Meeting |
| QC | Quality Committee |
| QIP | Quality Improvement Programme Board |
| QS | Quality Strategy |
| R & R (STRATEGY) | Recruitment & Retention |
| RAG | Red, Amber, Green rating system |
| RCN&M | Royal College of Nursing and Midwifery (UK) |
| RDCH / RCH | Ramsey and District Cottage Hospital / Ramsey Cottage Hospital |
| RSST | Resource Scrutiny Sub Team HSCC |
| 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 |
| SMT | Senior Management Team |

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|---|---|
| SPCC | Social Policy Consultative Committee |
| TC | Tertiary Care |
| TOR | Terms of Reference |
| TQC | Transformation Quality Committee |
| UCP | Urgent Care Practitioners |
| VFM | Value for Money |
| WMQRS | West Midlands Quality Review Service |