Health Services Consultative Committee
Annual Report

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1 April 2020 to 31 March 2021

Chairperson Preface: 01 April 2020 - 31st March 2021

During this reporting year two major themes coincided: preparation for Manx Care and the global pandemic COVID-19. The massive impact on ways of working and impedance of the latter in Q1 upon all aspects of delivery of Health Care for the Isle of Man is acknowledged. Nobles Hospital was configured to treat the expected influx of COVID-19 patients. In subsequent lockdowns improved arrangements for more business as usual were introduced. Routine services, appointments and operations were cancelled until restrictions were lifted and new ways of working in place. In parallel health centres, doctors' surgeries, dentists, and other support services had the same restrictions. Normal services are being reintroduced but the increased backlog is inevitable. Pre-pandemic waiting times were already at unacceptable levels. It remains of grave concern to all as to how the position can be recovered and improved from 2019.

There are over 2,500 FTE staff employed across health and social care in the IOM who have now been transferred to Manx Care. The HSCC is pleased to note the efforts of Manx Care in shadow senior management to proactively and positively engage with staff by sharing information and encouraging feedback. Staff should be the most valued asset and must be fully engaged in this process of change, fully motivated and given all necessary training. The implementation of the 2019 Recruitment & Retention strategy has become one of the many 'hot potatoes' passed on to Manx Care in an insufficiently progressed state.

In another mixed year in terms of performance and activity, the HSCC would like to commend Health Services in its continued Covid-19 response. The Minister, Interim CEO, COO, DCEO and Medical Director, together with an experienced Director of Public Health, all supported by a hard-working clinical and administrative team have demonstrated dedication (albeit with 2 notable undignified lapses regarding genomic testing, and the SPC inquiry), and difficult decisions taken are applauded. The pandemic has brought about permanent changes to ways of working in Health services. Whilst the goal of services wrapped around the patient is still a long way off, some silo mentality and rigid working practices have been overhauled. Pandemic communications have been regular, detailed and largely transparent, particularly on the Vaccine programme where Informatics funding for Business Intelligence solutions has been well employed.

Sadly, the HSCC is again disappointed to be reporting limited progress in the majority of its members' areas of health scrutiny. The strong common themes in members' annual reports and key recommendations: slow progress in clearly identified actions (Cancer, Comms, Legislation, HR, P4G), insufficient strategic and admin support (Cancer, Care Quality and Informatics), and single point of failure staffing (Cancer, Nobles Patient Safety, and Community). Treasury decision-making in business cases in general and asset replacement in particular leads to unnecessary duplication of effort, additional expense and intense frustration amongst many frontline staff who already have a difficult time juggling patient care and organisational functions, e.g. Integrated Care funding, and hospital pager replacement taking over 5 years.

The DHSC Minister continued to work hard within his brief and Political Members were more visible and involved, having been co-opted to serve on Transitional Governance Committees since September. Good transparent governance is still lacking across the estate but this new structure features appropriate agendas with clear standing items. The absence of core data sets contributes to a lack of timely and sound decision-making. Performance data is rarely challenged. The reality of a chaotic organisation with senior leads holding dual responsibilities, short timeframes for report preparation and analysis proved an eye opener for some Political Members. The largely unachieved specific P4G Actions and failed Cost Improvement Plans now transfer to Manx Care who are set a 1% CIP in its first year. The remaining DHSC structure numbers just 20 but nevertheless there is earnest recruitment to add another 16 DHSC posts, with concerning duplications at Senior executive levels between the DHSC and Manx Care structures.

The appointments of an experienced ICEO and a qualified Medical Director in January 20 proved timely for Covid-related activity decision-making, but limited progress on achieving long agreed operational priorities. There was no Service Delivery Plan planned for 20-21 with Transformation handed many partially achieved DHSC objectives to progress ahead of the April 2021 formal launch of Manx Care as an Arm's Length Body. Year 4: Q3 Programme for Government (P4G) and Q3 DHSC performance reporting were lacklustre with good progress in Integrated Care but lowlights such as the failed Patient Transfer service procurement in November 2020, which remains unresolved 6 months on.

Demand led services are no longer a sustainable model for the long term but yet the New Funding methods action is delayed to 2024. Evidenced observation of the success of the Community Care Division amalgamation, would suggest that capable leadership and engaged staffing can bring benefits, improve VFM and benefit service users. Nobles planned consolidation into Scheduled and Unscheduled Care groups has been through several more iterations with 9 Care groups each with a Triumvirate leadership team. Clear definition of essential health services and understanding of on/off Island clinical activity, are long overdue P4G actions. These have now been transferred to Transformation which has resulted in further delays on tough decisions and a lack of clear communication; both with the public and internally with staff.

The incoming CEO of Manx Care arrived in January 2021. Nobles as a unit, continues to be a financial challenge, ending the year £13.7m over budget and £7.5m increase in actual costs. Much of the overspend is employee costs. Tertiary spend to the UK is within budget only due to Covid restrictions. This backlog will place severe financial challenge on Manx Care.

The last WMQRS update report to Tynwald in January 2019 identified 579 achievable quality standards were still unmet. The P4G reporting action was removed in April 2019. The HSCC disagreed with this decision and suggested that ongoing reviews are vital to ensure that compliance with achieved standards remains monitored. We understand that Manx Care now has plans to employ CQC to do this, but this had been a DHSC action since April 2019 and CQC recommendations have no legal enforcement route in any event.

The HSCC members have observed, interacted, advised and listened, across the health estate. This has resulted in over 100 internal member reports, from which this Annual report is compiled. The HSCC members have been dedicated in their role as critical friends. The newer HSCC members have reinvigorated scrutiny areas with longer serving members providing useful long-term overviews of the HSCC journey alongside Integrated Care and the newly established Manx Care. Transformation progress towards Manx Care improved dramatically during 2020 with UK consultant-based projects less affected than the Island - based executive roles. The HSCC thanks DHSC officers and TPMO staff for the open access to information and their largely candid and patient approach to challenge.

Member continuity has given the HSCC strength and depth to its work for nearly 9 years. In this time, 4 Ministers, 5 CEO's and a plethora of executive managers have been employed to legislate, lay out strategic direction and lead a largely dedicated and hardworking workforce into updated ways of working, with patients at the centre of the process.

Despite best intentions and effort, progress has largely only been made by Transformation this year. Composing this Annual Report has been challenging. Ongoing relationships with Manx Care to allow the HSCC to fulfil its Tynwald regulations to scrutinise the performance and activity of health service post transfer to an ALB are yet to be clarified, despite requests for clarity since the DHSC ICEO arrived in January 2020. The Mandate between DHSC and Manx Care was completed just weeks prior to Manx Care's formal inception. There are concerns about day-to-day protocols between the 2 structures and role duplication, particularly in Patient Engagement and Commissioning. Plans to double the DHSC structure are in place.

The future still requires tough decisions, well communicated actions and a more transformative approach to service delivery. The Independent Health Review, Manx Care start up costs and Transformation team work has already cost over £5.1m in the 3 years since being commissioned. Visible results for this investment are essential. The first Transformation update report to Tynwald in July 2020 was limited in content and opaque in cost identification. Politicians have staked the future health of the nation on this scheme. Failure is not an option, despite the complexity of the 14 individual Critical and Enduring projects, many of which, it is acknowledged, have made good progress this year.

The role of critical friend to the Department and in particular the fulfilment of our HSCC Regulations is in jeopardy following the separation of Manx Care. The period between Health services establishing what should be done in 2016 and any significant progress on transforming those services in a meaningful way for the patient, has been too long and remains so far from the promised road map laid out by the then Health Minister, and now outgoing Chief Minister.

Any comments on the HSCC Annual report can be sent to hscc@gov.im.
Our previous reports can be seen at:
www.gov.im/about-the-government/departments/health-and-social-care/health-services-consultative-committee/

The Health Services Consultative Committee 31st May 2021

Executive Summary 2020 – 2021

The Health Services Consultative Committee (the HSCC) Annual Report provides Tynwald members and the Department of Health and Social Care (DHSC) with independent scrutiny and advice on the performance and effectiveness of Health Services. Members have well-established links with senior DHSC leads - see Appendix F for 2020-21 links including the NEDS now transferred to Manx Care.

Evidence for the Committee's views is based on over 100 internal member reports reviewing 13 scrutiny areas from April 2020 to March 2021 with member annual reports by scrutiny area provided on p21. The HSCC Key Recommendations itemise the priority issues. Main Body reports A-E overview the HSCC's past recommendations, DHSC governance and management structure, Programme for Government (P4G), with recent HSCC observations in Integrated Care and progress to the launch of Manx Care. Corresponding A-E appendices provide further detail and 5 year reviews.

The year has of course been dominated by the Covid-19 pandemic. As this topic is under intense scrutiny elsewhere the HSCC has reserved its focus for its usual scrutiny areas, some of which have been severely impacted. The dedicated staffing that has been stretched to contribute to Covid duties and maintain some BAU in their own roles, must be recognised. However, resource was provided to ensure that the journey to Manx Care continued during 2020. The HSCC was actively involved in the September launch of the Transitional Governance structure with political leads and appointed NEDs. This was a partial success, but exposed the flaws of an organisation with chronic unresolved issues to a wider political base.

The report is structured in a similar way to the past 2 years for ease of comparison.

Key HSCC Recommendations 2020-2021 by scrutiny area are on page 9.

Main A HSCC Past Recommendations See page 12
The HSCC continues to summarise its recommendations according to Strategic, Engagement and Finance/Commissioning categories. Whilst progress has been made in some areas the HSCC remains concerned about the pace of change. Some deterioration in strategic, slow progress in Finance and Commissioning and an improvement in Engagement has been noted.

Main B DHSC Governance and Management Structure See page 13
The HSCC has highlighted inadequate governance across DHSC over many years with meetings particularly poor in frequency, attendance, and transparency. In September 2020 7 new DHSC Transitional Governance Committees covering key areas were launched, chaired by political leads, with mixed success. Combining two pairs has reduced these to 5, adopted by Manx Care and chaired by their 5 Non Executive Directors (NEDs).

In November the Transformation Programme Office (TPMO) published the Governance and Accountability Project with associated TOR showing the proposed links between DHSC and Manx Care. Many new DHSC and Manx Care senior management appointments have been made both on and off Island. For Governance structures from 2017 - 2021, see Appendix B.

Main C Programme for Government (P4G) See page 15
Ends its 4-year duration with its 23 actions either closed down, transferred to other departments, or with deadlines repeatedly extended. HSCC v DHSC RAG progress ratings differ widely. Actions such as defining which services are carried out on or off Island remain WIP. Many incomplete P4G actions have been transferred to Manx Care. Whilst progress by Transformation on critical and enduring projects is acknowledged, many fundamental building blocks such as core data are unfinished.

Main D Integrated Care See page 16
Implementing the Integrated Health Care Structure is mandated for Manx Care with details in the Required Outcomes Framework (ROF). The central principle is for patients to access the right care at the right time in the right place with single point of contact for multiple Health services and multi-agency teams. Progress is being made on creating four Integrated Care Island Wellbeing Partnership Hubs (North, South, East, West). The Western unit based in Peel is fully operational. Next to follow is the South. The Integrated Care Partnership Board is responsible for shaping and implementing tiered locally based wide range Intermediate Care services including Community Frailty Services. Timely support from Treasury is key to success and this has not been consistently evident.

Main E Independent Health Review - TPMO - Manx Care See page 18
The IHR led to the implementation of Manx Care on 1 April 2021 for delivery of Health Services on the Isle of Man, as recommended by Sir Jonathan Michael in May 2019. Planned delivery comprised five Critical Restructuring Projects and ten Enduring Transformational Projects. The Pathfinder team identified seven top priority healthcare areas which have been developed into new pathways based on best practice and patient surveys. TPMO, shadow Manx Care and DHSC have developed their plans including the Mandate and its Required Outcomes Framework ROF. The DHSC and Manx Care must develop supportive and collaborative working relationships to deliver this ambitious mandated programme based upon previously under-achieved DHSC objectives. The quarterly Health and Care Partnership Board chaired by the DHSC Minister and the Mandate Assurance Meeting are set up as the primary oversight mechanisms.

The HSCC Member annual reports (see page 21)

Audit Provides assurance to DHSC and Executive regarding risk management and internal controls. It aims to move from a blame culture to one of ownership, accountability, clarity and learning, leading to improved patient safety. A new addition to the Governance structure. Key risk areas were quickly identified in hospital and community care, lack of predictive data, inconsistent incident reporting, analysis, review, and single points of failure. Risk log in place from February 2021.

Cancer The Cancer Strategy Steering Group lacked continuity of leadership. Face to face patient contact with clinicians was restricted by the pandemic but off-Island cancer treatment was maintained. Some services were brought on-Island. Donated CT and MRI scanners installed and operated by Nobles staff. 93% 2WW Compliance appointment target was unmet, breast cancer regularly failing. Radiologist and endoscopy capacity is a reoccurring concern for single point of failure and diagnostic delays. MC is mandated to implement wider and stronger waiting time compliance targets and implement new Pathways for Cancer Care. The Clatterbridge SLA is still a work in progress.

Care Quality (CQSC) Good leadership by the new Executive delivered a pro-active CQSC with meaningful reports, discussions and actions. Has established key reports e.g. Hospital and Community Care quarterly dashboards. Regular SMT reporting includes critical issues. A detailed Risk Register is reviewed. Obtaining full value from DATIX and failure to implement a single Core Data Set (IHR 21 & 24) remain an issue. Progress was made in recording mandatory training. Positively driven cultural shift from blame to learning is encouraged. Merging CQSC (inward facing for professionals) with PPUE (outward facing to public) is a concern.

Communications The HSCC noted a positive step change in communications driven by the COVID-19 pandemic, introduction of Manx Care, and DHSC ICEO who acknowledged internal and external communications to be an issue. Regular pandemic updates by Chief Minister, DHSC and Public Health team using radio and various media. Better coverage in written press this year. Manx Care Transformation Office and DHSC improved with frequent, structured, informative communications, newsletters, website updates, Director blogs, staff workshops and genuine encouragement re staff feedback. The HSCC looks forward to further improvements in operational communication across Manx Care.

Finance Performance Commissioning QC
TORs establish recognition of performance review as essential. Poor dashboard data has not yet made this a reality. Limited use of Private Patient Unit recommenced in November 2020. The Clatterbridge contract returned to DHSC in December 2020 after a long delay. Contract resource continues to lack admin support. The HSCC is concerned that well established governance remains after merger of finance with commissioning and that performance scorecard standardisation improves. The need to re-procure Patient Transfer is a serious issue that has yet to be resolved. Unmet cost improvement plans now transfer to Manx Care.

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Informatics QC Informatics Committee's purpose function, TORs, inward and outward reporting lines require review and clarification. Manx Care Record and core data sets lack progress. Good operational content with action log, managing and reviewing IQC risk register, pandemic informatics including testing, tracing, vaccinations. Pager replacement is finally actioned. Uncertain relationship with Change Portfolio Board.

Legislation Political Activity Manx Care Bill passed into statute in December 2020, surrounded by an active programme of associated regulatory legislation. Continued use of emergency powers and legislation for managing Coronavirus pandemic. Chief Minister and Health Minister in spotlight all year demonstrating leadership and agility in managing the pandemic. Public Health transferred into Cabinet Office. Another 12-to-24-month delay in Health and Social Care Reform Bill is expected. Independent external Health Quality Regulator not yet appointed.

Mental Health

MHS Clinical Director and MHS Matron appointed, joining the new head of MHS to complete the Mental Health Triumvirate. Good MHS (through PS&QC) monthly meetings to ensure governance oversight. Clinical Management Forum established following serious incident review. Serious incident panel established. MH service areas benchmarked against Royal College best practice. Training strengthened. MH Manx Care Pathfinders Project. MH have required outcomes in the Mandate. Resources and staffing for Mental Health services are a serious continuing issue.

Nursing and Midwifery Four Matrons appointed: Hospital, Community, Mental Health, Women and Children. Review of safer staffing levels in progress. Director of Nursing attends NHS NW meetings in UK. Year of Nurse and Midwife celebrated. Training strengthened. Nurse apprenticeships on hold due to cost. The HSCC are pleased to learn Nurse education will transfer from DESC to Manx Care from May 2021. A new personal development plan and appraisal system is being implemented. Quality dashboards being developed with patient and experience measures reinstated.

Office of Human Resources The new OHR Transitional Governance Committee with Political Chair was the last to launch in November 2020, agreed TORs and held just two subsequent meetings prior to Manx Care in April 2021. Lacked strategic outlook and good standing agenda items. Disappointingly there is now uncertainty about how this will develop. Clarity is needed on the future Process for OHR with DHSC. Workforce and Culture project implementation by Manx Care is essential. OHR operational issues remain with PiP implementation, eLearn Vannin, training records, staff absence, vacancies, locum arrangements, recruitment, mandatory training levels, high sickness absence. OHR workload re transfer of staff from DHSC entity over to Manx Care is acknowledged.

Patient Safety Quality Committee Lacked a permanent Chair at the date of this report. Implementing a streamlined membership. Meeting attendance has improved after Covid related hiatus. Patient complaints are well tracked. Need to have closure of incidents and overlap with IRB. The only committee actively following up WMQRS issues and outstanding recommendations. A strong voice for the need for appropriate staffing levels. Lack of clarity on accountability for resolving IT issues. Dashboard implementation lacks urgency.

Patient Stakeholder User Engagement (PPSUE) Transitional Governance Committee met in September 2020 to set up Patient and Stakeholder User Engagement for Manx Care as required by the IHR. TORs agreed and a plan for four user groups of two people from the public domain based NSE and W, with a member recruitment process. Selective participation at Manx Care Board level agreed. Subsequently DHSC implemented similar, for two public representatives. How the MC and DHSC PPSUE roles relate is unclear. The final structure is under review following recent public rep recruitment failure.

Quality Standards – WMQRS Reporting

Review of the recommendations made by the 2015-2018 West Midlands Quality Review Service is PSQC accountable. Many issues highlighted in the WMQRS report remain, with limited progress made. Updates reside with the individual Care Groups. There is progress in some areas, but lack of governance, commitment and staffing levels combine to impede progress and action. Reporting to Tynwald on implementing the WMQRS recommendations ceased in January 2019. An SLA with CQC to provide external quality standards was planned in early 2019 and is now being taken forward by Manx Care but will have no legal enforcement.

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HSCC Key Recommendations 2020 - 2021: The HSCC recommends that

R1	Audit	Essential cultural change regarding agreed audit methods be fully implemented in order to improve patient safety, e.g. all stakeholders committing to consistently using a system for serious incident reporting, risk scoring and prioritisation.
R2	Cancer	Adequate on Island cancer staffing is ensured to meet demand and quality standards.
R3	Care Quality and Safety Committee (CQSC)	Any cultural, organisational and resource barriers to care quality and safety are removed, e.g. full uptake of required essential training through effective messaging and more convenient access.
R4	Communications	The opportunity is taken to effectively embed operational communications across the health estate.
R5	Finance, Performance and Commissioning	There should be limited use of FD8 waiver fallback. Existing contracts under FD8 Waiver should be subject to competition where possible 6 months prior to the current contract term.
R6	Informatics QC (IQC)	The IQC continues to use its knowledge and expertise to argue for urgent progression of both the Manx Care Record and a core data set.
R7	Legislation and Political Activity	The DHSC Minister's and Department's political members should support the arms-length operation of Manx Care, ensuring that a sustainable model is developed and enabled by appropriate and timely legislation.
R8	Mental Health (MH)	The Department should ring fence financial support for the Crisis Referral Team to meet COVID based increases in demand.
R9	Nursing and Midwifery Advisory Council (NMAC)	Greater numbers of suitable applicants are attracted through student bursaries, financial staffing incentives and funding for enhanced Health Care Assistant roles.
R10	Office of Human Resources QC	DHSC ensure that Manx Care have structured and agreed OHR support from their OHR partners.
R11	Patient Safety and Quality Committee (PSQC)	Patient Safety impact is made more prominent, and is given more weight in business case submissions to Treasury.
R12	Patient Stakeholder User Engagement (PPSUE)	Patient engagement forums are actioned and implemented with realistic patient representative role profiles, structured training and the remit to make a measurable impact.
R13	Quality Standards - WMQRS Reporting	The annual WMQRS update report which identifies the priority areas for action, including outstanding recommendations from the original reporting, should continue to be implemented.

HSCC Engagement – Ways of Working 2020-21

HSCC Scope –

Drawing upon the breadth and depth of its members' diverse knowledge and experience in business, public services and the community:

1. The HSCC will provide independent scrutiny of the performance of the management of Isle of Man health services.
2. The HSCC will offer management support, challenge and advice in the effective management of the health service.
3. The HSCC will hold the organisation to account for its decisions.
4. Only comment and scrutinise matters concerning Health.

HSCC focuses upon WHAT (actions taken), WHY (reasons for priority order) and HOW (steps to achieve priorities) of health service provision.
The HSCC does not:

1. Become involved in matters of detail, in complaints, in staff matters, or in matters for which lay members of other organisations already provide a service, e.g. Mental Health Commission, Independent Review Body.
2. Look to measure the performance of the clinical effectiveness of the Department as it is not qualified to do so.

HSCC meeting approach:

- Monthly full meetings to scrutinise health services activity.
- Itemised agenda with each member tasked to reports and actions.
- Exception reporting and debate of current issues.
- Bullet point summary of interests and concerns circulated to DHSC.
- Health care officers invited to address meetings every other month.
- Regular email correspondence to/from DHSC.
- Meetings with individual service leaders on specific subjects.

Monitoring:

- Health related debates and questions in Tynwald.
- Written and verbal health related questions in House of Keys/Tynwald.
- Consultations, Strategies, Policies and Legislation.
- Contract Management.
- Service Delivery Plans, health PR and News Releases
- Regular 1:1 meeting with Link Officers
- Annual Meet the Minister Q&A session.
- Quarterly CEO meetings – with membership or Chair & Vice Chair.
- Bi-annual meeting with Minister and Department Members.

Member attendance:

- Quality Committees: Care, Finance and Commissioning, Informatics, Office of Human Resources, Patient Safety
- Audit and Risk committee
- Cancer Strategy Group
- Integrated Care PB & Community Partnerships
- Patient Safety and Quality Committee (MHS)
- Nursing and Midwifery Advisory Committee
- Patient Stakeholder User Engagement

Consultation submissions:

- Complaints Policy
- Medicines regulations (prescription only)
- Duty of Candour regulations
- Capacity regulations

Annual Report (July):

- To Tynwald. Available to the public via Government website

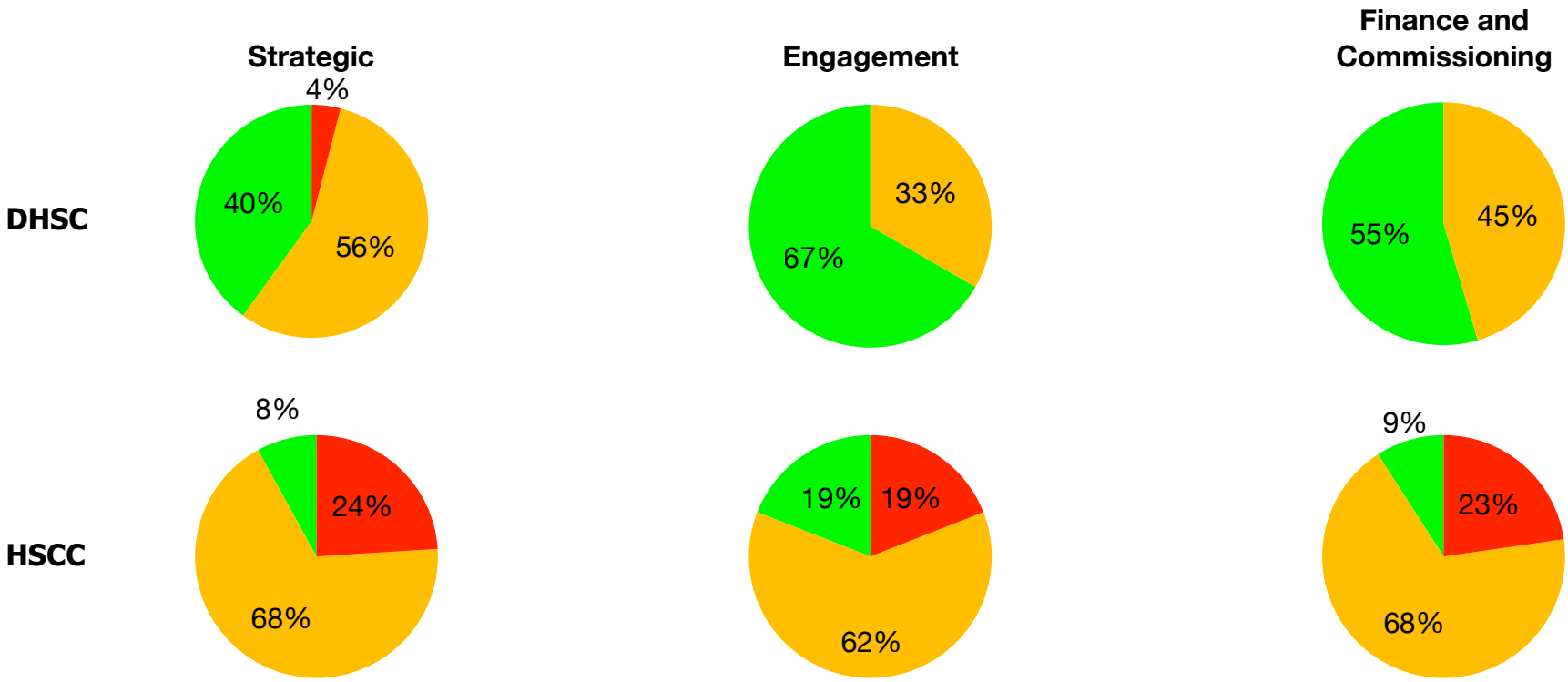
FROM	STRATEGIC PATHWAYS – journey towards a better health care system			TO
Acute priority provision	Set clear TFR priorities Objectives in line with 5-year Strategy	Identify what services are provided on and off Island	Front load budgets to ensure services are transferred with budget	Appropriate community centred provision
10-year health strategy	Revised 2013 Reviewed Dec 2013	Replaced with 5-yr Strategy in Oct 2015	Review due Autumn 2018 completed April 2019	Rolling programme of strategic thinking informs dynamic plans
Treatment by SILO approach	Barriers between different part of the system	Reorganise health structure to reflect changing priorities	Develop Care groups to meet co-morbidity challenges	Multi-disciplinary teams Agility, collaboration
Unlimited demand-led Health Service	Sole provider health service	Work towards shared service delivery	Patient focused approach	Mixed economy, public, private and 3rd sector
Peer to Peer Reviews FRWG MIAA WMQRS CQC	Consult on individual issues – reactive not proactive	Support pro-active approach MIAA	Francis Report WMQRS Lacks CQC SLA	Regular external audit Continuous peer audit, including Public Health
Engaging patient voice	Complaints Defensive approach	Widen engagement through Workshops & social media	Consult re evidence based planned service changes	Patient designed services
Mental Illness to Mental Wellbeing	Mental illness	Step up, step down system	MECC – make every contact count CAMHS capacity	Mental well-being
Public Health	Piecemeal campaigns	Numerous strategies No prioritisation	JSNA Review of screening services	Evidenced improvement in the health of the nation / well being
Organisational Culture	Demoralised workforce Blame culture	Clearly communicate planned organisational change to all staff groups	Effective recruitment and retention strategy	Empowered staff Low turnover
Scrutiny	Via committee attendances and escalation to CEO	Governance groups that challenge communicate and provide risk assurance	Fully transparent scrutiny access from Board to coal face encounters	Stable governance system

A: Past HSCC Key Recommendations reviewed against DHSC ratings 2019-20

The HSCC has again combined its previous 5 years of key recommendations and assigned them to three categories of development: Strategic, Engagement, Finance/Commissioning. Areas that have moved into new areas of responsibility, e.g. Transformation Programme, Cabinet Office, have been tracked through. As far as possible DHSC assessments have been compared with HSCC assessments using publicly available information. The broad picture is reflected in the charts below and is set out in detail in Appendix A, page 28.

HSCC Comment

It is clear that HSCC recommendations are often aligned to the Department's priorities and that some progress has been made. The HSCC hopes that its recommendations are not only seen as valuable due to the detailed scrutiny behind them, but that they are also of some value in expediting necessary actions. Taking MET and PART MET recommendations together it is most encouraging to see that Engagement priorities had moved forward significantly at 81% compared with 32% in 2018-19. However, Strategic and Finance/Commissioning had both slowed by 8% and 13% respectively. It is also disappointing to note the high proportion of part-met actions in all three areas.



B: Governance-HSCC overview 2016-21: Management restructures & Transitional Governance Committees (TGC's)

DHSC has a poor history re maintaining Management and Governance structures to address the key business of the Department – looking at Finance, Service Delivery, Performance and key operational decisions. In April 2016, 7 Quality Committees (QC's) chaired by the relevant Directors, were structured to provide the overview needed by the Board on the activity and risk across each of the key areas of business within the Department. Within a year Stakeholder Engagement & Finance ceased & the Programme Management Office (PMO) was introduced. By April 2018 Care Quality and NMAC were also suspended. The HSCC made repeated representations to the CEO in the 2018-19 Annual Report and both were reinstated in 2019 and have thrived under the leadership of the Director of Nursing.

Following the departure of the CEO in May 2019, a temporary interim CEO was internally appointed from Mental Health. This led to some continuity in 2019, albeit with many high-level posts throughout Health services being held on an interim basis. Closer co-operation between Acute and Community Care was forged by the Interim CEO using a DCEO structure in Operations, Nursing, People and Governance. The monthly Executive Leadership Team (ELT) continued, adding extended ELT meetings fortnightly as required to involve relevant areas such as Programme Management Office.

The incoming ICEO in January 2020 acknowledged the mixed governance picture and placed particular emphasis on Stakeholder engagement. This was re-enforced by the incoming Chair and CEO of Manx Care in shadow form. Both organisations (DHSC and Manx Care) now have revised Governance structures (See Appendix B on page 35) which acknowledge the importance of transparency in governance. Public Patient Involvement (PPI) opportunities are integral to future plans in both organisations.

The quality of any committee relies upon clear Terms of Reference (TOR) and the motivation of the membership. In the past year some QC's have continued despite a significant pause for Covid related priorities (CQSC, IQC and PSQC). However, some DHSC governance arrangements have faltered and/or have had a number of meetings cancelled due to member unavailability (HR, PSQC). The new governance structure commenced in September 2020 bears a remarkable similarity to the 2016 format. The Transitional Governance Committees (TGC's) were chaired by political leads, and this affected meeting regularity in some domains. However, strict adherence to agenda items, appropriate attendees and well-prepared Executive Leads, did ensure that the structure was fit for transfer to Manx Care Non Executive Directors.

Tynwald requested in an Independent Health Review (IHR) in March 2018. The report was accepted in July 2019, but this inevitably caused stasis in DHSC's strategic priorities. The role of Transformation (TPMO) until the formal creation of the Arm's Length Body (ALB) was complex, taking three years from the commission of the IHR in April 2018 to Manx Care, which has run in shadow since September 2020 and launched on time in April 2021. The Manx Care Bill arrived post public consultation at June 2020 Keys but was finally approved in December 2020, with Manx Care being formed as an ALB under the Statutory Boards Act in March 2021.

HSCC Comment: The HSCC has repeatedly drawn attention to the breakdown of the governance structures over the past five years, providing regular observations and evidence to the 4 CEOs and 3 Ministers and making submissions to the Public Accounts Committee. In 2020-21 the HSCC has supported the development of a new governance structure which bears close similarity to that in place in 2016. HSCC Members have attended all Transitional Governance Committees (TGC's) to date. The HSCC has recognised the improvements in the structure of the Transitional Governance Committees, although robust challenge is not yet evident in many meetings and performance data is intermittent and inconsistent. The focus should be on actions, service prioritisation and stakeholder engagement, rather than repeated management reorganisation. Management restructure costs have expended millions that could have been invested in service improvement. Our current concern is about role clarity and avoidance of duplication now the two organisations have split, with rapid increase in new posts evident within the DHSC structure, in particular.

The HSCC attendee's observations are listed in the table below:

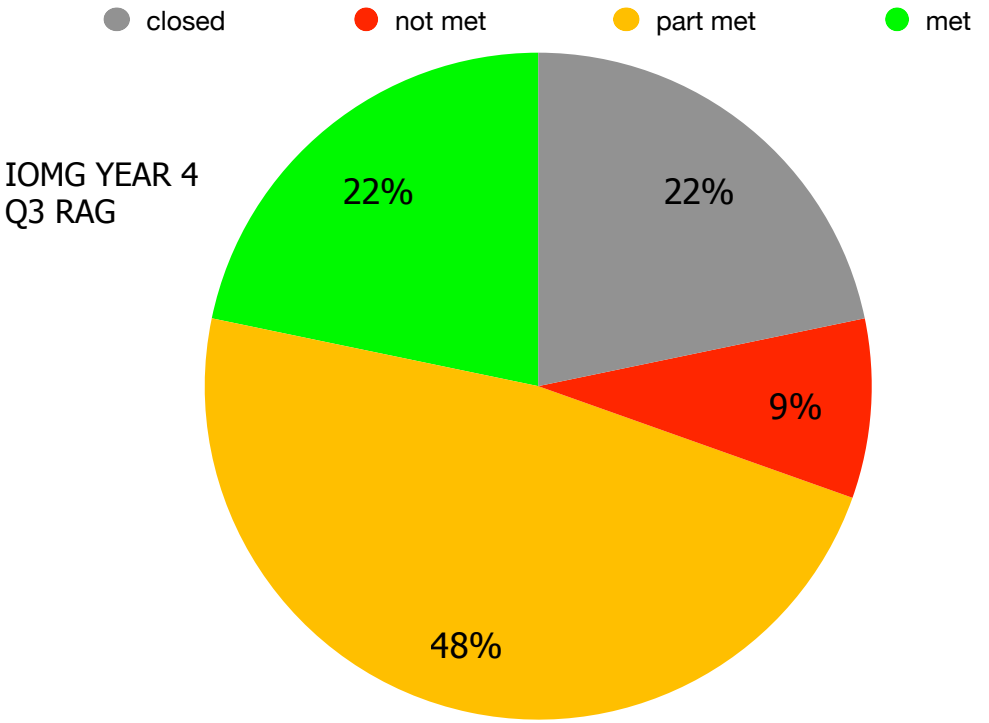
Governance	Frequency	Oversight	HSCC member observations. See Appendix B for DHSC and Manx Care (MC) Governance structure diagrams
Audit Committee	Monthly	Manx Care	New in September 20. Appropriate level of membership. Lacked momentum but clear on future direction.
Care Quality & Safety	Restored Sept 19	Manx Care & DHSC	Well led by Nursing Director with clear report expectations; risk registers reviewed. Moved to MC but DHSC also plan quarterly CQS with Regulation, Engagement & Mandate Assurance reporting lines. Clarity to avoid duplication.
Commissioning QC Finance & Performance	Monthly QC now TGC	Manx Care & DHSC	Commissioning is to be split into Strategic and Tactical Commissioning with DHSC and MC respectively. Shadow TGC since September 20 with good attendance but little challenge. Commissioning catalogue handed to MC incomplete. Clarity on how expanding structures will dovetail rather than duplicate required.
Execs was ELT COO led SMT Now Execs EMC	Fortnightly	Manx Care & DHSC	EMC is now held twice monthly, split into operational and corporate based service reporting. Minutes show largely operational content, less governance fundamentals e.g. staff absence, service delivery, patient safety, CIP's etc. This is now a Manx Care operational Care Group Governance meeting to reflect its content.
Human Resources QC now TGC	Sporadic. TGC from Nov 2020	Manx Care & DHSC	HR struggled to fulfil its TOR and was unstructured and largely operational in content. As a TGC it was last to start and only met twice prior to MC move. HR is included on both DHSC & MC structures with little clarity on functions.
Informatics QC now TGC	Monthly	Manx Care operational	The IQC is well attended and administered effectively. It provides a forum for project status and importantly provides clear prioritisation of technology enabled change. Lost momentum in Q1 & Q2 due to Covid reassignments.
Stakeholder Engagement QC	Merged Apr 17	Manx Care & DHSC	Public Patient involvement given high priority by DHSC ICEO & MC CEO. Restored Sept 20 as PPSUE with clear priorities to recruit Patient reps and an Engagement structure. Recruitment plans have struggled.
Transformation QC	Merged Apr 17	Now Manx Care	Programme Management Office well established since 2018-collates Service Delivery performance and P4G info, and tracks Business case progression with Treasury. Post-holder continuity has ensured strong performance.
Nursing NMAC	Restored Aug 19	Monthly Now Manx Care	Led efficiently. Reviews Nursing Strategy on regular basis and provides an overview of nursing and workforce developments, education, sharing best practice and ratification of key policies. Good standing agenda items, attendance, contribution and challenge. Postholder continuity has ensured strong performance.
Nobles PSQC	Monthly	Manx Care operational	Forum for clinical concerns, clear work plan and action logs. Previously robust reporting workplan. Lost momentum due to Covid reassignments. Attendance post Covid has been poor. Associate PS lead not yet replaced.
Integrated Care Partnership Board	Bi-monthly	Now Manx Care	Integrated Care Exec Steering group migrated to Integrated Care Partnership Board. New sub-committees for Local Area Coordinators Intermediate Care & Frailty service. Plans to incorporate Social Care under MC leadership.
MH Board MH (PS&QC)	Continues	Manx Care	MH-PS&QC meets regularly; retains valuable oversight of Mental Health Patient Safety & Quality standards.

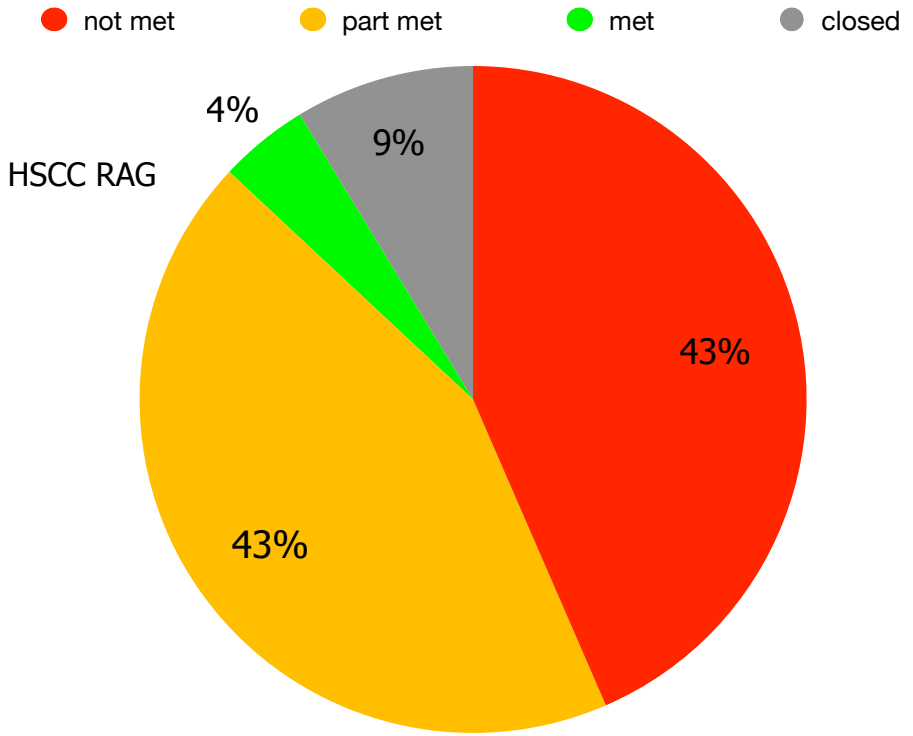
C: Programme for Government actions: Year 4 Q3 HSCC review of IOMG RAG ratings

The HSCC has maintained longitudinal scrutiny of the actions specified in 'We live longer healthier lives' section of the Programme for Government, P4G. Appendix C (page 39) itemises all these actions between Year 1 April 2017 Q1 until Year 4 January 2021 Q3. Due to the global pandemic Year 4 Q1, Q2 & Q4 were not completed. There are 23 actions including 3 new Year 4 actions. 5 actions were closed in previous years. N.B. Percentage figures in the summary charts are rounded to the nearest whole number so may not tally to exactly 100%.

Removal of 20% of the actions from the P4G has made tracking more difficult. It has led to some discrepancies between what appears to have been achieved and what has actually happened. In some cases, actions were shut down but the HSCC continue to RAG, e.g. 18:1 Continue to report WMQRS external peer review process. Some actions were re-started elsewhere in Government without cross reference to P4G, e.g. 18:3 audit of essential services ongoing now within the Transformation Programme and Manx Care under the Mandate. The expanded commentary in App C should therefore be treated with caution in places because Government reports only on P4G performance.

HSCC Comment
The HSCC would like to have seen P4G concluded properly, with transparency, continuity and handover to the next administration in order to facilitate good audit trails. It has been too easy to 'lose', or transfer difficult actions or to repeatedly delay achievement dates. Good proactive planning has been replaced over the 4 years by defensive accountability in many actions, e.g. 18:15 establishment of core data sets.





D: Integrated Care Progress 2020 - 2021

The second pillar of the DHSC Strategy 2015-20 was moving Health Services into the community. Implementing a strong Integrated Care structure on the Isle of Man was also an important element of the 2019 Independent Health Review. The IHR proposal for Health Care development included putting appropriate Healthcare back into the community whilst having Nobles Hospital focusing on those patients requiring hospital care and its range of specialist services. Progress has been made, albeit not as comprehensively or as fast as wished for by all partners.

Future:
Objectives 3 and 9 of The Manx Care Mandate call for an Integrated Care structure within Isle of Man Health Care.
The Required Outcomes Framework (ROF) in section 4.7 Integrated Community Services provides further details on the operation and services of the Wellbeing Partnerships with an implementation timeline by end 2022.

The central principle of Integrated Care is service users should be able to access the right care at the right time, delivered by the right team in the right place. Evidenced in the IHR report, healthcare delivery on the Isle of Man is focused on Nobles' hospital, both in terms of inpatient and outpatient services, with many service users with chronic conditions receiving care centrally. This is because many of the tiers of health and care delivery that should enable access to care on a locality basis on island are either uncoordinated or missing, resulting in chronic conditions, including conditions associated with frailty, escalating unchecked until an acute admission.

Integrated Care is moving the appropriate care and services back into the Community locality around "hubs" the first of which has been up and running since February 2020, based in Peel and known as The Western Wellbeing Centre.

Integrated care Management and Accountability:
The Integrated Care Partnership Board (ICPB) was implemented in June 2020 with agreed Terms of Reference and a detailed framework for implementation and Governance. Meetings are held quarterly, the first of which took place on 19 August 2020. The Executive Director of Social Care appointed in March 2021, who has direct experience of Integrated Care, together with Manx Care Director of Operations will chair the ICPB meetings.

The ICPB is responsible for overseeing operational developments within the Integrated Community Care Group. ICPB holds a crucial role in the shaping of integrated care provision across the island through provision of operational direction and guidance to managers and clinicians working within the services. ICPB works collaboratively with other governmental and third sector bodies to help develop a truly inter-agency integrated health and care system. ICPB produced a progress update in November 2020, also updating "Integrated Car Wellbeing Partnership – Operational Guidance".

Funding and Structure for Integrated Care:
Initial funding was agreed by Treasury for 3 Wellbeing Partnerships Local Area Coordinator Leads (LAC), who have now been appointed. One will lead the established Western Wellbeing Centre. The others will lead South and North areas. An existing project team member will lead the Eastern Wellbeing Centre. A Consultant Geriatrician has been appointed to set up and lead Community Frailty Service.
The HSCC stresses that ongoing, timely and secure funding from Treasury is essential to maintain the momentum for Integrated Care.

Service Provision:
The Western Wellbeing Partnership Team is established at the in Peel. There is single point contact, single documentation for patients for referral access, with locality based multi-agency teams delivering the "right care at the right time, closer to home." Operational Guidance Documentation and Information Sharing Agreements are in place; and for patient users the Consent to share personal data form is in use.

The tiered structure for Integrated Care is being phased in.
Main headings and entry points for Integrated Care include:
Tiers 1 and 2: Locally Based Services Tier 2.5: Community Frailty Services Tiers 3 and 3.5 Intermediate Care Services, which are a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission (with timely discharge) and premature admission to long-term residential care. The overall aim is to maximise independent living.

Implementation Timing for Integrated Care:
With the Western Wellbeing Partnership now well established in Peel, the target date for implementation of the "Southern Wellbeing Partnership" was originally March 2021, and 2021-2022 for the Northern and Eastern Wellbeing Partnerships. Clearly, there have been delays caused by the pandemic, but the commitment and planning have steadily moving forward, despite the demands of Covid facing duties.

Stakeholder Involvement:
Three awareness open sessions were held in the South in September 2020 explaining the objectives of Integrated Care and to gather public response and ideas. Questions and input were meaningful, and the process was well received. As IC expands further similar sessions will be implemented in the South, North and East areas. These will include explanation of the Community Frailty Services.
Wide Stakeholder involvement is an essential part of Integrated Care implementation process and over the past 5 years approximately 3,700 people and 253 organisations have been involved. Obviously, the programme of stakeholders' engagement in the South and later in the North and East has been interrupted due to the pandemic and meeting restrictions, but the HSCC hopes these will recommence as soon as possible. Stakeholder engagement sessions and timelines for phased Integrated Care implementation are under constant review.

HSCC Comment:
The HSCC has been on a journey of observation since the DHSC "The next five years strategy" started. See Appendix D timeline in this report, page 45.
The HSCC strongly commends action to join up care closer to community. Though slow in coming, Integrated Care has had clear continuity of leadership, the retiring COO and Project Lead being crucial to its success. The issue of Social Return on Investment (SROI) remains and we remain skeptical about cost saving claims made. Appropriate health services with the patient at the centre requires further progress, especially in terms of the single Integrated Care Record.
In summary we believe that with correct levels of timely financial support and good governance, together with strong ongoing leadership, Integrated Care will continue to develop successfully on its current positive trajectory. Manx Care future plans to widen the integration, to encompass more Social Care aspects is broadly welcomed.

E: The HSCC Journey: observations from the Independent Health Review - Transformation - Manx Care

Background:
Since 2013 when the HSCC was reconstituted, it was evident that the IOM Health Services Structure and Governance required fundamental overhaul. Health Care is continually advancing and the cost and pace of change will only increase. The Isle of Man must adapt to meet new demographics and local population expectations. Through various media the public has increased awareness of new fast-moving sophisticated health technology and health systems, in which it can justifiably expect to partake.

IOM Government commissioned various Health Care external reviews and reports into aspects of Health Care on the Isle of Man. Health Care external reviews into Isle of Man Health Care included Beamans 2013 and 2015, West Midlands Quality Reviews WMQRS 2015-2018.
Numerous internal strategy documents were produced from the various Directorates. The Hospital Directorate produced the first Nobles Hospital Annual Report in 2018 but failed to repeat it due to postholder departure until January 2021. DHSC Health Services had already been reviewed many times over the last decade with little or no effective action. This has been expensive and inevitably demoralising for stakeholders, particularly staff as they have been required to engage in piecemeal changes without clear and costed implementation plans.

Few recommendations were fully achieved or implemented for a number of reasons, in our view, including: -

- Multiple changes to DHSC Senior Management structure leading to lack of report ownership.
- Lack of Political will and understanding, with repeated Supplementary votes to cover escalating costs
- Ministerial change within a complex Department
- Lack of transparent accountability and clear communication
- Lack of ambition – tacit acceptance of mediocrity
- Setting unachievable objectives, expecting Senior leads to drive change whilst combining operational and leadership roles
- Numerous internal restructurings leading to confusion and inertia
- Deep seated negativity and resistance to much needed cultural change

Gaining traction with DHSC and IOM Government for the Sir Jonathan Michael's (SJM) Independent Health Review

Following Tynwald debate in January 2018, Tynwald commissioned the Independent Health Review (IHR). The first detailed interactions and scoping meetings took place during mid 2018 and thereafter rapidly gained traction. SJM and the ASE consultants hired, began with fundamentals: demographics, health needs, structure, funding looking forward 10-20 years, information. Sir Jonathan was forthright in his views that the report must be actioned and should have teeth.
By May 2019, the Independent Health Review had been published. Section 1 of the IHR report is clear on the scope and methodology for the report compilation. It was given full political backing by Tynwald to implement all recommendations. All 26 recommendations were to be implemented in full leading to fundamental changes. The Health and Care Transformation Political Board issued a detailed plan which included updates for each key part of the programme, and regular communication with stakeholders, DHSC and Tynwald.

Stakeholder Engagement and Publication of The Independent Health Review
Numerous Stakeholder workshops and meetings took place to ascertain public and professional opinions to inform the IHR. These were well constructed and covered a wide spectrum.

Transformation Management Office Co-Chairs issued informative short newsletters every month to all DHSC staff on the progress of Manx Care and the various projects – these are excellent and have continued after the launch of Manx Care.
Associated with this is the publication of traffic light progress charts of all the Critical Restructuring and Enduring Transformation Projects..
HSCC have produced their own summary reports tracking progress RAG (red - not achieved, amber - partly achieved and green - achieved) ratings on the projects.

The Transformation Team, Creation of the Practical Way Forward and The Mandate

Health and Care Transformation Programme Terms of Reference were issued at the end of November 2019 and work immediately commenced.
Transformation Political Board and Transformation Board were established. The Governance and Accountability project was approved in detail.
Detailed organograms of the new boards and structures were issued showing who was responsible for what.
The Transformation Programme Management Office with both on and off Island personnel working on Transformation. The Programme and Projects were broken down into Critical and Enduring Projects related to the 26 IHR Report Recommendations. Each one has a named Project Leader and Project Manager – important for improving accountability.

Critical Restructuring Projects:

Improve Legislative Framework
Establish Arms-Length Delivery of Health Care Services
Governance and Accountability Framework
New Funding Arrangements
Transfer of Public Health Directorate to Cabinet Office

Enduring Transformational Projects:

Design and Implement Care Pathways
Undertake Needs Assessment
Undertake Service by Service Review
Implement Air Bridge
Implement Single Integrated Out of Hours Service
Primary Care at Scale
Data, Information and Knowledge
Digital Strategy
Workforce and Culture
Implement External Quality Regulation

The FAQ paper from the Transformation Team in January 2021 explains in simple form the key elements past, present and future.
The Pathfinder Project has 7 priority health areas being developed using stakeholder engagement sessions.
These 7 are all well progressed with regular very good one page updates issued for each project. Initial focus was on the new pathways for:
Diabetes, Cardiovascular (Cardiology, Vascular, Stroke) Cancer, Autism, Eye Care, Urgent and Emergency Integrated Care

Restructuring DHSC and Manx Care – The Mandate and Required Outcomes Framework

Manx Care commenced as an arms length body with its own Board and 2,500 FTE employees on 1st April 2021. The vast majority of DHSC personnel were reassigned to Manx Care as their employer, with all the necessary legal formalities. A detailed programme of communications was established to ensure all staff were informed of the changes. A residual body of approx. 20 DHSC employees remains, with significant additional recruitment in progress.
Manx Care is operationally responsible for the delivery of Health Care Services as Mandated by DHSC.
DHSC responsibilities include strategy, commissioning, finance, and parliamentary liaison with IOM Government.
The Mandate to Manx Care and its related Required Outcomes Framework ((ROF) 2020-2021 for delivery of Health Services are detailed and clear.

HSCC Comment

The HSCC has participated in all stages of the three year journey, summarised as a timeline at Appendix E on page 46. It supported the TOR's which asked the core questions:

- What is being spent, is it sufficient and does it represent VFM?
- What long term funding increase is required up to 2036 and how might it be funded?
- Is the current service model for delivery of IOM Health and social care optimal now and for the future?

The HSCC has attended Advisory group meetings, met the ASE consultants driving the programme, attended workshops and focus groups testing out learning and developed proposals. It held 1:2 Team lead meetings with the Executives leading the Critical and Enduring projects. It has tracked and recorded and fed back to DHSC its views on this major investment in health and care services in the Isle of Man. Detailed evidence of how and what has been tracked can be found in previous years' annual reports at **https://www.gov.im/about-the-government/departments/health-and-social-care/health-services-consultative-committee/** , particularly in the 2019-20 report which has a carefully considered 5 year review of the DHSC's 5 Year Strategy; Health and Care content of the Programme for Government; Integrated Care; The Independent Health Review; and the Transformation Programme.

The HSCC believes all of the IHR's recommendations should be fully implemented. The high quality of scoping work carried out mainly by the Transformation Programme team is widely acknowledged. Of particular note are the conclusions drawn from Restructuring, Transformational and Pathfinder projects. Urgent need for an efficient organisational structure to enable delivery of service improvement is paramount.

Set against this potential are some serious concerns about the inherited estate; the transfer to Manx Care under The Mandate of some incomplete or failed projects that are no longer the responsibility of DHSC. The absence of long promised SLA's, further delays in the legislative framework, digital strategy, data/information and knowledge; and cancer pathways are some specific and crucial concerns.
In conclusion, the HSCC hopes to see rapid progress on the established roadmap, supported by courageous Manx Care leadership. Political priorities should not impede progress in areas where DHSC have previously failed, e.g. The expedited Complaints legislation may slow the long delayed core Health Care Reform Bill due June 2021 but now further delayed to June 2023.