# STANDING COMMITTEE
## OF
# TYNWALD COURT
# OFFICIAL REPORT

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# PUBLIC ACCOUNTS COMMITTEE

## Health and Social Care – Noble's Hospital

**HANSARD**

**Douglas, Wednesday, 28th November 2018**

**PP2018/0179** **PAC-HSC, No. 4/2018-19**

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## Members Present:

*Chairman:* Hon. J P Watterson SHK
Mr T M Crookall MLC
Mr D C Cretney MLC
Mrs J P Poole-Wilson MLC
Mr R E Callister MHK
Mr C R Robertshaw MHK

*Clerk:*
Mrs J Corkish

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# Standing Committee of Tynwald on Public Accounts

## Health and Social Care – Noble's Hospital

*The Committee sat in public at 2.30 p.m.*
*in the Legislative Council Chamber,*
*Legislative Buildings, Douglas*

[MR SPEAKER *in the Chair*]

**Procedural**

**The Chairman (Mr Speaker):** Good afternoon and welcome everyone to this public meeting of the Public Accounts Committee which is a Standing Committee of Tynwald. My name is Juan Watterson. I am the Speaker of the House of Keys and I chair this Committee. With me are Mr Tim Crookall MLC, the Vice-Chair; Mr David Cretney MLC; Mrs Jane Poole-Wilson MLC; Mr Rob Callister MHK; and Mr Chris Robertshaw MHK.

If we could all ensure that our mobile phones are silent or off, so we do not have any interruptions; and for the purposes of *Hansard* I will be ensuring that we do not have two people speaking at once.

This is the fourth public evidence session in our inquiry into overspending at Noble's Hospital and today we will be largely focusing on staffing matters. Today we are joined by Dr Malcolm Couch, Chief Executive of the Department of Health and Social Care, and Mr Mike Quinn, Director of Hospital Services; and we welcome you both back.

**EVIDENCE OF**
**Dr Malcolm Couch, Chief Executive Officer, and**
**Mr Mike Quinn, Director of Hospital Services,**
**Department of Health and Social Care**

**Q413. The Chairman:** I suppose as a starter for 10 the burning question we are all dying to know is are you going to come in on budget this year? Dr Couch.

***Dr Couch:*** He hesitates …

Our current projections are mixed. There seems to be quite a lot of variation month by month on expenditure and I would say that by explaining sometimes with public finances, and as most members of the Committee will recall my previous roles, it is somewhat difficult to predict with great accuracy, even at this distance from the end of the year. However, our September figures indicated that we were looking as if we would come in on budget; our October figures were quite negative and we are a little bit concerned we are over again; and there is some indication from November run rates so far that the sawtooth has gone down again. Our Minister, political Members and all senior executives in the Department are committed to trying to come in on budget.

**The Speaker:** Okay. We will start with Mr Robertshaw, please.

**Q414. Mr Robertshaw:** Good afternoon, both. Mr Quinn, if I can start with you, sir. We have obviously seen the new structure inside the Hospital. How will it be an improvement and how will you be able to measure those improvements?

***Mr Quinn:*** The new structure is based around a care group ethos which very much joins up, or connects, the various elements of service across a hospital. The structure is developed around pathways. The previous structure was based around divisions; and I think maybe I have said this here before that my view of divisions, by definition, is that they can be quite divisive and encourage silo working. What we need to be looking at is the broader picture across the entire organisation and not just across the hospital, but how we relate outside of the organisation as well – so out of hospital is as important as in hospital.

The key clinical care groups will be 'Scheduled Care', which is anything that is planned; and 'Unscheduled Care' which is anything that results from an emergency attendance at hospital. Those services will be supported by a number of other care groups, in particular 'Diagnostic Services' which provides services across all specialty areas, and it is probably one of the primary and most key elements of service provision because, without it, nothing else can really function.

Equally the care group pathways should provide greater efficiencies around how we utilise our resource and avoid duplication, and what we want to arrive at, and I think it is important for patients that we arrive at quicker decision-making around their treatment and the treatment plans and the delivery of those treatments. When you work in silos there can often be problems associated with repeating investigations, for instance, and that increases cost. So what you want to do is to get to a decision-making process faster – it is far more beneficial for the patient and certainly provides a much more cost-effective way of operating the Hospital.

**Q415. Mr Robertshaw:** Are you satisfied that the structure wraps around the patient sufficiently so that if there is transference horizontally in terms of requirements for that patient, that will be achieved without re-adopting verticality and the famous silos, which I seem unable to avoid mentioning at some stage in every conversation these days that I have?

***Mr Quinn:*** Sure. Well, I think if you look at the common threads and how the structure has been designed, it is with that in mind. It is for how does a patient move across, move up, move down, move across an organisation seamlessly. I think that goes back to the point of saying you only need to do it once rather than on multiple occasions. If you look at the clinical service support across the patient, so when we focus on patient experience, care and quality that is united across the entire organisation, so there is only a single – one version of the truth, as I would describe it – and this is the way we will do it, irrespective of where the patient happens to be in the organisation.

**Q416. Mr Robertshaw:** Is your technology capable of keeping up with that aspiration in terms of not having different systems?

***Mr Quinn:*** I think there are improvements to be made, as with any technology. What I would say is it is not necessarily the technology itself, it is how we apply it. We need to be better at applying the technology that we have at our disposal. Things can always be better and I think as we move towards a much more integrated health economy, integrated technologies are going to be a thing that we will come to expect. Again it goes back to, if you can avoid a person having to repeat over and over – so there is a single patient record, for instance, whether that patient be in community, in hospital or being referred onward, then that is going to be of huge benefit to patients, service users and service workers, and it will drive cost efficiency.

**Q417. Mr Robertshaw:** I am not really competent to comment on the vertical groups that you have got, but I am just curious to know why, in the chart that you have very kindly given us, that retail and staff accommodation do not sit with the other hotel issues at the right-hand side, and why they sit with commerce and business and tertiary services. That just seems strange to me. There must be a sensible reason; I am just curious.

***Mr Quinn:*** It is simply around the whole remit of the commercial part of the business, and that is to generate income. The tertiary element to that role is very much about our relationship with off-Island providers and making sure we are getting the best value for money where we are expending money outside of the Isle of Man. But it is about bringing all of the elements of our income generation under one manager. That is why retail would sit there and accommodation would sit there, at present, because there is income that is received from accommodation. We will move towards the retail side of catering going under that role as well – the staff restaurant, and those sorts of things.

**Q418. Mr Robertshaw:** Oh, so that is why I see a sort of dotted box? (***Mr Quinn:*** Yes.) Oh, I get that now. Thank you very much for that.

How many people, then, will report directly to the Director of Hospital Services –?

***Mr Quinn:*** It will be each of the general managers, or 'heads of', within those respective care groups. So it is no more than currently do, and that is seven.

**Q419. Mr Robertshaw:** Right. And in terms of the senior person in each group, and each area where it is appropriate has the three competencies, (***Mr Quinn:*** Yes.) is there a prime leader in that triumvirate?

***Mr Quinn:*** Well, what we want to move towards, and one of the ambitions that we have with this restructure, is that we absolutely move toward becoming a clinically led organisation. So from a governance perspective we will be establishing a clinical grouping, or a clinical committee, so to speak – a clinical board. Therefore the clinician has to have a very strong voice within how the organisation operates, but that voice also has to take with it a huge amount of responsibility because it is not just about the quality of clinical care that is being delivered it is again ensuring, and being assured, that it is delivered in a very cost-efficient way.

Now, you would have a triumvirate made up of a lead doctor, a lead nurse or other clinician, and a general manager. They will each bring their own strengths and therefore the expectation is they should each complement; each should be in a position to become a natural leader, depending on what the issue of the day happens to be; and there will be an expectation of deputisation as well. So what it should not be is that we have got a team of three and only one voice is heard.

**Q420. Mr Robertshaw:** And rather the reverse of a previous question about how many report to the Director of Hospitals, is that some of the spans are quite big in terms of responsibility. Are you confident and comfortable that is not going to be too big for a triumvirate or a particular group to satisfactorily manage, direct and concern themselves with –?

***Mr Quinn:*** I think there will be a process of evaluation once we kick-start the reorganisation in the true sense and we expect that is going to be from early January, and that is when the clinical board will be established.

There will be an element of trial and error because I think for some, on paper, it would look as though it is a significant sized portfolio, but you have to understand what the additional support is that you have within the care group over and above the triumvirate. So it is not the fact that the people are the three, and only the people at the top of the tree operate that care

group, they have a relationship with other managers and other senior clinicians in that care group to deliver on their behalf also.

**Mr Robertshaw:** Thank you very much, Chair.

**Q421. The Chairman:** Before we move on, can I just have two supplementaries on that please?

Firstly, with this triumvirate model is there not a danger of watering down the accountability that they are not actually really clear who is the person who is going to be held accountable, or held responsible, for the clinical outcomes or any other outcome?

***Mr Quinn:*** One of the key differences I think with introducing the clinical model, is that the accountability … And that is why I say when we are looking at the clinical leadership of the organisation going forward, there is a process whereby you ensure we recruit into those clinical lead roles those people that meet the criteria to undertake those respective roles; and with that comes the responsibility around the delivery of their care group. So in essence if it is the clinical director, if that is the title we go with, they are the people you would be expecting to provide the assurance around both the quality and the cost effectiveness of their operation.

**Q422. The Chairman:** So is this a model that you have seen working well somewhere else? Is this something that is a 'Mike Quinnism', or is it –?

***Mr Quinn:*** No, no, not at all! It is quite standard in the NHS in the UK. (**The Chairman:** Okay.) They will call it different things, but how I have described it is very similar.

**The Chairman:** Okay, thank you. Mr Callister.

**Q423. Mr Callister:** Yes, Dr Couch, I was wondering if we can carry on the theme of leadership and structure and maybe just focus a little bit about the changes that have taken place within the executive team over the last four years. Could you maybe outline how you are ensuring even with these changes that accountability is still being maintained at the highest level?

***Dr Couch:*** The way to ensure accountability is to make clear to each senior executive, or anybody in the organisation, what the requirements of their role are, and I think that would range from a cook in our kitchens through to an executive director of health and care. There have been some changes and we have had some structural changes at departmental level, if you will. So, for example, in January we fused mental health services with community health and with adult social care and that is now Community Care; and that now has a single leader where there were three leaders before.

However, the accountabilities within that leadership echelon, if you will, come together in that person and their objectives are managed by their line manager which in that case is the Executive Director of Health and Care, the Deputy Chief Executive. So accountability comes from people having clarity of the responsibilities and obligations of their role; and with those obligations may come targets on a short-term basis or an annual basis, therefore there is delivery against those targets. The functions of the Department overall of course in that period have not particularly changed. We are trying to find the best way to have the Minister and the departmental political team's policy initiatives etc., or policy wishes – the functions of the Department – delivered in the most effective way possible.

Of course the other issue – and I think Mr Quinn would echo this, and in fact I think he alluded to it in a way, in terms of recruiting clinical directors – is that there needs to be a particular skillset in people that they are prepared to acknowledge and accept accountability for

the whole organisation, to be effective. And in a general sense some of the changes in people that we have had at senior level are designed to get people with the correct competency set in those executive roles so that they understand accountability, they understand the need to deliver objectives effectively and constantly, etc. to make the organisation as effective as possible.

**Q424. Mr Callister:** I was wondering if I could possibly continue that particular theme, because how do managers receive feedback on their overall performance? Can you give an example of how their performance is assessed and what mechanisms you use? Do you use something like a 360 degree or a peer review mechanism, or do you use a different type of mechanism in order to feed information back down on their overall performance? I know you have highlighted it slightly there, but I was wondering if you could give us an overview on that.

***Dr Couch:*** There is actually a plural approach to people management in the Department, as there is across the public sector in the Isle of Man Government. For example, the people I manage will be performance managed through the Performance and Development Review System which is common to the Civil Service in the Isle of Man. That is actually a documentary approach where you will be saying what the person's business objectives – and I mean that in the most general sense –for the forthcoming year are and how they will be assessed; what their development objectives are, which are based often on their own needs – and we will be monitoring those as they go along. If you look at people's contracts of employment and their job descriptions, if they are in that system – so for my line reports, it says that I will have regular discussions with them about performance during the year, we will have a target-setting meeting each year, and then we will have a formal wrap-up review for that year just gone. Then they are graded against certain categories and we talk about where somebody's performance is – it is either on the mark, it is higher than expected or lower than expected – and what the development needs are going forward.

In other staff there is not so formal an approach. So, for example, National Joint Council staff, which is like former Whitley staff, that is much more an immediate day-to-day task-orientated system.

But again I think we would both agree that the key to it is to have people who are, or wish to be managers and leaders, committed to the theme of engaging with the people that they manage. And I would much rather see a day-to-day gentle hand on the tiller, if that is an appropriate metaphor, helping people keep their performance good rather than the clunky annual, 'We are now going to sit down for your performance review'. And indeed without breaking any particular confidence, within the Office of Human Resources and the Chief Officer Group we are discussing whether or not to recommend a movement away from the PDR system – because it is rather formal, it is rather paper-based – into something that is much more dynamic and based on a concept called 'conversations' where you are asking people, 'What are your objectives? What are your skills? How do you want to develop those skills?' etc.

**Q425. Mr Callister:** And you do, as an organisation, push to produce the leaders for tomorrow within the Department – the future managers, the leaders within this section – so there is always a programme there for them to develop themselves professionally?

***Dr Couch:*** There is a split in actual fact, and I will be frank with you, as I always am. We have clearly some people who are developing leaders, and across the Isle of Man Government as a whole and through further and higher education there are leadership development programmes that that person can draw to themselves on the basis of a personal development plan and the organisational support. So, for example, we sponsor a Master's Degree Programme in Professional Practice – that would be largely nurses but it could be allied health professionals

who say, 'I would like to become more specialist in leadership, or in clinical skills'; and, sponsored by Manchester Metropolitan University, we will facilitate people doing that.

There is the Middle Management Development Programme and the Senior Leadership Development Programme of the Government and all of our staff can take part in that if they wish. But the reason I was saying, and the frank point is, that I think there are gaps and there is not at this point, even since 2014 – as Mr Robertshaw remembers in one of his former ministerial roles – I think there is still somewhat of a sense of different entities that came together. So I would rather – and again we are working on this – actively have a comprehensive 'prospectus', if that is the right word, to say for any colleague at any level in any place in the Department they should be able to look at this prospectus and say, 'I would like to advance leadership, professional research and development, etc.; what can I find that the Department will assist me with?' And then push that on. I think by doing that on a comprehensive basis, getting the organisation fired up and enthusiastic about that, then we should be able to grow all of our own timber as leadership of the future –

**Q426. Mr Callister:** And this is at all levels?

***Dr Couch:*** Yes, of course. Because to my mind a Civil Service administrative assistant or a registered nurse, or a social worker should be able to come to me and say, 'I'd like to be the Chief Executive in the future'. And I should be able to say, 'Fine, let's talk about it; you need a development plan; let's look at the support that we can give you; here's the brochure', etc. At the moment that brochure, which could be virtual rather than a physical thing, is not there but it is an active piece of work and we are collaborating with UCM on how best to pull that together. The Nursing School is now part of University College Isle of Man, and they deliver excellent education for a number of people in a number of areas, but they are quite restricted and I want to broaden it out.

**Mr Callister:** Excellent.

**Q427. Mr Robertshaw:** I recognise and share your concerns about PDR; I think that dissatisfaction is really growing across the system.

If I can, though, ask Mr Quinn to just share his thoughts on this in terms of Mr Couch mentioned the engagement with HR and trying to rethink this, and I think he used the words 'a system of conversation'. Is migrating to a new system within the Civil Service as a whole, do you think, going to be the right model for trying to improve personal development in a hospital environment? Have you experience of successful systems that have worked inside hospitals that staff respond well to?

***Mr Quinn:*** I think staff respond far better if there is a two-way exchange – so I like the notion of conversations because that involves two parties, rather than a PDR process that people I think see it almost as, 'Something I have to do once a year; I am not really prepared for it. What do I get out of it? What is the person on the other side of the desk getting out of it? Is the organisation going to deliver its objectives simply because I have a PDR once a year?'

I think there has to be an ongoing process and that is why the two-way exchange is so important. I think it is also important for the organisation to recognise talent early on and to demonstrate its belief in talent. So whilst an individual may say, 'I have an ambition and I would like to come and discuss it with you', I think the organisation has a responsibility to equally recognise talent when it sees it and to take the appropriate measures to encourage, develop and retain that talent.

I think it is a travesty that talent is perhaps leaked, because we have not in a timely fashion done what we could do to keep people interested and on board.

**Mr Robertshaw:** Thank you.

**Q428. Mr Callister:** Can I just … you mentioned before, Dr Couch, with regard to the Deputy Chief Executive: I was wondering if you could possibly outline some of the responsibilities of the Deputy Chief Executive along with the Interim Medical Director, just to give us an overview of actually what their responsibilities and their day-to-day duties are, etc.?

***Dr Couch:*** Of course.

The Deputy Chief Executive is Mrs Michaela Morris; her alternative title is Executive Director, Health and Care. I would say the first of her primary accountabilities is to be line manager of the Director of Hospitals, the Director of Community Care and the Director of the Children and Families Social Care Division. So that is the key part of what she concentrates on. And in a sense, if you forgive me the management jargon, that is a 'span breaker' – so she takes some of the pressure off me of managing the whole of the executive team, by managing those three people. So there is that.

She is overall now our professional lead for nursing – obviously the Chief Nurse left the organisation earlier in the year. Mrs Morris is a registered nurse and midwife by profession and she has maintained her nursing registration, so another incredibly important aspect of her role is to be fully cognisant of all requirements of the Nursing and Midwifery Council for the maintenance of registration of nurses in the Isle of Man. She liaises therefore with that organisation which is the UK regulator. We oblige all of our nurses in the Isle of Man to be registered with the NMC, etc.

She is also the DHSC, at least, national safeguarding lead. So there are a number of activities which most members of the Committee will be aware of in the safeguarding arena. There is, for example, an action plan which Minister Thomas brought to Tynwald recently from the Social Policy and Children's Committee of the Council of Ministers, about children's services. So all of the aspects that affect DHSC services contributing to that action plan, Mrs Morris oversees and drives all of our people, but she links with all the other agencies on that.

And then I suppose the other key aspect of her role at this point is – and of course roles change as tasks change – she is leading the whole of the Community Integrated Care Strategy. So effectively, that is the second goal of our five-year strategy which is to deliver more care close to where people live. I think most of you will be aware that we are starting a pilot of integration in the West of the Island in Peel, Michael and Patrick. That is part of our future and it is part of our sustainability. That means of course that in terms of sustainability of Noble's, part of the five-year strategy means that to a relative extent we have to disinvest somewhat in the Hospital and invest more in the community. But again she is part of that so she leads the strategy group – and, interestingly enough, I am a member of the strategy group, but in the context of that she chairs it and I work to her. So there is a range of accountabilities there.

What was the second one, forgive me, Mr Callister?

**Q429. Mr Callister:** Well, I think you have outlined it, it was mainly the Deputy Chief Executive which you have outlined fantastically, and the Interim Director and Medical Director.

***Dr Couch:*** A medical director again, as you would imagine, is a critical role. Mr Quinn has outlined in terms of operational management of a hospital, in particular, that a lead doctor in a care group or a division is vital as part of the senior three. The medical director's role is about leadership of doctors – and again, forgive the jargon – but I guess most of us will understand, it is often on a 'matrix basis'. So, for example, in the hospital's directorates I would expect Mr Quinn to be the director of all services vertically, if you will, so he has to set the objectives for all of the different care groups right through to bedside care standards. The medical director on a matrix basis will be managing into the doctors, helping them with standards, etc.

And as I said for Mrs Morris and her close links with the Nursing and Midwifery Council, one of the key aspects of a medical director is the liaison with the General Medical Council. All of our doctors in the Isle of Man have to be registrants of the General Medical Council in the UK, in law, therefore we need to have a very strong liaison with that body. Doctors have to be appraised regularly, they need to be revalidated regularly to maintain their registration, and the medical director oversees that.

Working with the Interim Medical Director are two associate medical directors who specialise in what is called 'responsible officer duties' and that again is all set out in UK regulations which we adopt in the Isle of Man, about how doctors should be managed professionally rather than operationally. That is vitally important. An aspect of the role of the Medical Director is what again is often called 'doctors in distress'; and this can be doctors who are ill, either physically ill or mentally unwell, where there are concerns about the quality of their practice, where we might need to be investigating. That all needs to be discussed in real time with the General Medical Council because of its importance. So again the Medical Director manages that.

Also, linked to the overall medical leadership – and there is a group of people doing this and all of them are doctors – are associate medical directors who concentrate on education. So there is an associate medical director for education – it is a 'he' at the moment – and he concentrates, for example, on trainee doctors coming to the Isle of Man, medical students who occasionally come here, and the higher education for doctors who are involved in what are called 'core medical training programmes'. There is an associate medical director who concentrates on patient safety; there is an associate medical director who concentrates on quality. So again what you have there is the locking-in, really, of governance where you have operational leadership saying, 'This is what this piece of the organisation needs to be achieving on a day-to-day basis' – which could be as simple as patients attend, patients are cared for, patients are made well, patients are discharged. But across that you have got the professional lines and the Medical Director for Doctors is managing all of those horizontal lines – so do we have good doctors who are also developing professionally, maintaining their professionalism, and their continuing professional education, etc.?

**Q430. Mr Callister:** Fantastic, thank you.

I suppose the last question from myself in this section relates to yourself. I think we all acknowledge it is a big Department and you have outlined just two roles which are very detailed, very complex, so I suppose it comes down to how much of your own time, what sort of proportion of your time is dealing with the Hospital? How much of the executive's time is dealing with the Hospital? How often do you meet Mr Quinn and other the members of the Hospital yourself, as the Chief Executive and that of the executive?

***Dr Couch:*** Without even being tongue in cheek – and this gentleman to my right will confirm this – we probably correspond every hour of every working day. We meet physically at least once a week, if not more. We talk on the telephone frequently.

Noble's Hospital in budgetary terms, in staffing terms, in importance terms is probably 40% to 45% of all of the workload in the Department – if not a little bit more. Therefore that means that in terms of my senior stewardship of the Department, my time needs to be reflected appropriately; and that means that I am supporting, I am signing off the most senior executive decisions and I am giving advice, not only to Mr Quinn but other senior leaders in the Hospital, on a daily basis. Sadly, if we make mistakes from time to time I also need to be aware constantly of medico-legal cases where people might be taking action against the Department. So yes, that is constant.

Community Care is our other big directorate and again my time is split that way, but it is not simply in terms of the functions of the Department because of course I need to support the Minister closely, and the Members who from time to time will need my support, supporting Committees like yours.

**Q431. Mr Callister:** Is it because of the budgetary concerns within the Department? Is that why your focus is having to be so much on the Hospital? Or is that normal within any hospital that the chief executive would spend, say, 40% to 50% of his or her time within the hospital?

***Dr Couch:*** It is difficult to answer that question directly without perhaps talking about our Manx context – we are not like NHS England. If Mr Quinn was working in an NHS hospital trust or an NHS foundation trust – especially a foundation trust – that would be largely autonomous. It would have its own board with a Chair usually appointed by or very close to the Secretary of State; a chief executive for operational things; some non-executive directors; clinical directors of various kinds, etc.; and HR, finance. The chance of an NHS foundation chief executive talking every hour with the chief executive of NHS England I would suggest is remote. So we are different.

If we did not have budgetary concerns about Noble's Hospital, or any other concerns, would my application of time and support be different? Perhaps, but I am not sure, because we do run a rather different model. I think as you will realise as a Member of Keys, the link between a constituency Member of Keys in the Isle of Man and their constituents I suggest is far more intimate, in a professional way, *(Interjection by the Speaker)* than a Member of Parliament is in the UK. And I think it is similar in terms of the way some of our Government Departments work.

I think as well, to give the support that Mr Quinn needs with a *very* difficult role indeed at this point in the Hospital Directorate's history, it is appropriate that I bring my experience and support to the piece to help him.

**The Speaker:** Mr Crookall.

**Q432. Mr Crookall:** Just following on from that, and in view of the information you have just given us, would you be physically better off being positioned up at the Hospital, bearing in mind the percentage of time you have said you spend in talking to Mr Quinn or emailing, or whatever, and the other staff members up there, and everything else that is going on with your Department at the moment? Would you and other members of staff, and probably the Minister at times, be better off being based up at the Hospital?

***Dr Couch:*** I have thought about it many times, Mr Crookall. The reason I do not do it is that if I did, I suspect that large numbers of my colleagues in the Hospital and probably a number of our patients, would default to talking to me, seeking decisions from me and seeking my advice on a daily basis. We have a Director of Hospitals – that role is very important – it leads and manages the operations of the Hospital. So there is an argument for doing that, there is an argument for putting additional senior resource into the Hospital's Directorate to help it manage some of its capacity difficulties, I think, to get through some of the things at the moment.

I think if I was there I would rapidly become overloaded, because I think everybody would default to me. So there is a balance to strike.

**Q433. Mr Crookall:** You never feel the need to, as Mr Quinn described one time, just to be part of that 'morning huddle' – and I dare say you do meet at times, but I think you said you meet most mornings – ?

***Mr Quinn:*** At eight o'clock.

***Dr Couch:*** I would love it. I am very proud of this role and I am very cognisant of its importance, and Mr Quinn sometimes feels that there is maybe too much focus on Noble's Hospital from the Minister and Members and senior executives – but I do not think I should be partial. The staff running our learning disabilities facilities, to me, are as important as our hospital staff.

We have got to be careful that although there are challenges which seem to be sometimes disproportionate – that Noble's may seem to have more challenges than other parts – that is only at this point in its history, and I do not know next week or next month whether an issue could come very rapidly to the fore in Communities or Public Health or whatever, that I would then need to swing some of my resource to support that team.

**Q434. The Chairman:** You made the point earlier that one of the key points in terms of accountability is making sure that everybody knows how the organisation works, where everyone sits and their role in it. However, we have been through about as many staff structures as we have had years, in the last three or four. The moving target is getting harder to hit, but will we now see a period of stability in terms of the structure going forward?

Is that something that you feel the organisation can commit to?

***Dr Couch:*** I think in terms of the major architecture of the Department I do not, as Chief Executive; and I certainly do not think my Minister would see any need to be reconsidering that for a period now. So I think stability in terms of the directorates that we have and stability in terms of leadership, would be ideal I think to do the transformational changes that we need to achieve. That is assuming we all have good skills and I think that is for Committees like yourselves to consider, but assuming that we all have good skills the stability in the senior leadership team will also be ideal, because then that will keep the same messages and same approaches pulsing into the organisation.

**Q435. The Chairman:** And how have staff at middle or lower levels reacted to the new structure?

***Dr Couch:*** Well, again I need to be honest with the Committee: it varies. I think that if we look at Community Care, for example, there are some people and there are some teams that are thriving in a new environment, because again there is a different form of integration by creating that directorate. I think there are others who feel threatened. I think, as you immortally said in either a Keys or a Tynwald sitting, that people often do not like change, but they do not like what they have now, so there is always a tension. We were a very large organisation with whatever it is, 2,500 FTEs – but in terms of the people we employ it is probably over 3,000.

So I think some people are thriving; some people are very enthusiastic about change. In September we had what we called our 'Events in the Tent' where we were talking about a number of aspects of the future for integrated care and for how we want to manage and enthuse people in the organisation, and people were very enthusiastic indeed and they would go out from those meetings and become champions elsewhere. However, I am not naive enough to assume that everybody is happy and my job is done. There are some pockets of poor morale – they change from time to time depending on issues and, again, I need to support my senior intermediate managers to get through those things.

**Q436. The Chairman:** And how are you managing to focus that, firstly identifying and then secondly focus the right sort of support into some of those areas?

***Dr Couch:*** It is very difficult because again, as is a theme of our conversation today, it is a very large organisation, it is covering an enormous plurality of services. We are working, I think, from over 100 premises in the Isle of Man, plus we need to manage all of our interaction with hospitals and services in the UK. So I think in a way it is almost like if somebody comes into the Emergency Department, the first thing is triage – you need to assess somebody and determine a priority. So in terms of *my* work, my phone is turned on to silent but as we all know there have probably been 50 emails since I sat down, and when I look at them later it is assessing what is the most important to look at first, get on and give the support that I need to do as Chief

Executive – and then the others come later. And that is the same across the different aspects of the Department.

**Q437. The Chairman:** I suppose what I am looking for is some sort of confidence that the system is working in terms of identifying where the problems are, and that the right support and the right reassurance and the right management – senior management or high-level support – is going in there to make sure that the organisation is not leaving teams, groups, individuals behind, albeit you have to prioritise the resource available for that. I just want to try and test your understanding of how that is working.

***Dr Couch:*** I am confident that I know all of the problems that I need to know as Chief Executive; and I probably know most of the middle-order problems that my directors talk to me about and seek advice on. There would probably be lots of things going on at levels that I do not need to know about – sometimes I wish I knew about them, but again it is the Donald Rumsfeld 'unknown unknowns' isn't it, then? I have to live with that.

So I am happy that I know what is going on; I am happy that my senior leaders are committed people with integrity who want to deal with those problems. Can we deploy enough of the right type of support? Sometimes that is a challenge, and I have to be honest, so our capacity to do certain things is limited. For example, we have had to, as we have moved on an almost constant basis for several years in a financial set of difficulties. We have had to reduce some areas of staffing, but we have said explicitly that we would protect the front line – so these people actually delivering services to people that they need – and that means, for example, where you might want to deploy HR specialists, or project managers, or lean process engineers, or whatever; there is a whole series of support people you could put into difficult areas, but we might not have them at any particular time. So that is sometimes difficult, and I think what we have to do then almost – and I am smiling internally because it is not as simple as tea and sympathy; but sometimes we need to just say to teams, 'We know there is an issue; we will support you as much as we can, but at this point we cannot deliver the exact right support for it'.

**The Chairman:** Mrs Poole-Wilson.

**Q438. Mrs Poole-Wilson:** Yes, just building on that, where there is that lack of capacity, whether it is HR turnaround teams, there is a business case surely, isn't there, to be made to put that support in? Because the tea and sympathy, if it is not really addressing the problem and making a real difference to outcomes for the staff and for the patients affected, there is a serious consequence to that, potentially. So how are you making the business case when you are struggling with that capacity?

***Dr Couch:*** Well, to a degree, I suppose you hit the problem there which is that you need capacity to develop the business cases to submit to Treasury and elsewhere, and sometimes that is limited. But we do do that, there is a Healthcare Transformation Fund which is held centrally – its gatekeeper, if you will, is the Treasury – and we can make bids to that. Largely the ethos applied to that fund, or the National Contingency Fund, is that if you draw down from it you should be saying that you want to spend to save. So that means that some of the business cases, some of the transformation that we want to do does not naturally fit into that set of rules, if you will. But we do make bids to it and we have been successful in a number of bids, and we have deployed resource as a result of those successes to various things. So we are always trying to get the right resource in the right places to do the right things.

Sometimes the organisation, sometimes Mr Quinn, is frustrated that that seems to take some time. But again I suppose on the triage basis that I mentioned earlier, I am fairly sure if not completely sure, that the Department will always be focusing on the big issues immediately. The

difficulty then is that some issues which, for particular teams, are always important are coming behind in the queue.

I will give you an example: my community physiotherapy team is low on resource at the moment because of some sickness absences, etc. Because of our financial constraints and because boosting that team – even though there may be a social good in that they deal with people who can self-refer for musculoskeletal complaints, fix them and get them back to work, so there is a social and economic good, it is not possible immediately to give them that resource. So that can swing from a major issue, for example, when we had to review 1,200 breast care cases a few months ago, down to a smaller issue but still very important for that team. But we cannot do all of them.

**Q439. Mrs Poole-Wilson:** I understand what you are saying. I suppose in that example you have just given do you track, for instance, the fact that when community resource is unavailable in that way, how many people then ultimately arrive in the Hospital with more serious problems? Or, you talked about the social good and it is perfectly possible that there is a public finance issue there as well, because if a proportion of those people are paid by public money and they are not able to work ... So I suppose it is interesting to hear you talk about the 'spend to save' and how difficult it is to make the case, but it strikes me just from the example that you have given that it should be possible to say that if we are not addressing these things there are going to be serious consequences socially and financially.

***Dr Couch:*** I could not agree with you more. I think that what you set out in the question – and I do not say this in any negative sense, and I am sure you will understand it – is utopian. I would love that we could have that system, and it almost goes back to one of Mr Robertshaw's comments earlier that to have a well-integrated IT system where we could track things like that would be great. But we do not. So the problem therefore that DHSC has is many of our activities do not easily lend themselves to statistical analysis – and of course I am a former Treasury official, so we love things like that –that you can then present the cases.

So where we were talking about social policy issues and social good, we could say in a perfect world that the application of musculoskeletal community physiotherapy services helped 10 people to get back to work and therefore there was an economic good. At this point in terms of the data that Government collects and how it can be analysed, we cannot make that case even though we feel instinctively it must be there; and therefore it might not reach the threshold of convincing the Treasury Minister and Members to give us some additional funding to get extra capacity to fix it.

**Q440. The Chairman:** But certainly you have known about that issue and that demand for data for the last two years that I can recall, because it came up I think at our first session that this is the sort of thing you would want to track, and we still appear to be no closer to tracking it. Is that –?

***Dr Couch:*** It is a fair comment. However, I think as Committee members will be aware there is a national digital strategy and within that national digital strategy there is a sequential series of projects and we are moving little by little, or sometimes in quite large chunks, towards a far better future. So, for example in Mr Quinn's directorates, we digitised all paper records in less time than we expected and at less cost than we expected. So that means all those storerooms full of paper are no longer necessary because it is all on a computer screen – and that makes things better.

We are moving further and further towards that stage. The challenge then we have, and forgive me for going slightly on a tangent, but I think it is actually pertinent to what you asked, the issue then is that our services and Government as a whole has a number of databases in different applications. So as I think the Committee will be aware, in our case we have the

Medway patient system in the Hospital, we have the EMIS patient system largely in general practice and community partly in the Hospital, we have the RiO system largely in social care, but partially elsewhere – and each of them are different databases. So again to track well and to analyse well, somehow you need to look into each of those databases with another application which does not exist yet, and collate the information and review it.

So even in terms of our practitioners who might want to see what we are calling at the moment 'an integrated healthcare record', that needs to be built. And for my Department – and it is similar to my discussions with Treasury – but from my discussions with GTS and the Cabinet Office I need to make a bid for the priority of the digital strategy programmes affecting our Department and say, 'Can we have that earlier than' – I do not know – 'the latest version of the Company Registry's software?' – if you see what I mean. So it is prioritisation, constantly.

But we are moving to a better place. And then of course we also have the challenge which is a cultural one, which is that one may have *really* well-designed digital systems and we then need to bring our people with it, because again it is all very well having the boxes with the blinking lights in the corner, you need to be adding the entries and coding them correctly, so that you can then do the analyses to make the cases for further investment.

**Q441. The Chairman:** You have mentioned a few times in that last part there about the relationship with Treasury. I think again, thinking back to when you sat alongside Mrs Beecroft and you said about an improving relationship with Treasury; and we spoke to the Treasury Minister in January and he said that Treasury was supporting DHSC with your financial challenges. Can you give us a flavour as to what this practical support from Treasury looks like and feels like to you and the DHSC? Does it feel warm, nurturing and understanding, or is it the monitoring and a big stick approach?

***Dr Couch:*** It is the former, Chair, (**The Chairman:** Good!) I can say that quite sincerely. At officer level we have taken the approach that certainly on financial things we operate on a basis of no surprises with the Treasury. David Catlow, our Finance Director, will talk very frequently with either the Chief Financial Officer or the Financial Controller, explaining things. We are showing them our monthly accounts regularly. So I think there is an understanding, there is a supportive, collegiate approach – notwithstanding that Tynwald each year votes a budget that we have to live with. I think at political level, Ministers and Members understand each other and are supportive. But that support clearly if we go through our national budgeting process, in February you will assemble in Tynwald, you will consider the Treasury Minister's Budget and you will vote on that, and that sets our parameters, largely.

I suppose that Treasury *ought* to be saying to us that if they have done their job properly in each cycle, and that you as Members of Tynwald have scrutinised that Budget appropriately and voted it through, then largely we should have the resources to deal with what we have to deal with. And I suppose that is our challenge. The 'extra-ordinary' in any organisation that I have worked in in the past would be covered by – and you would not need a big one, necessarily – a contingency of some kind. I think that because the Department has been running hot in terms of its Budget, in actual fact it does not really have any contingency, and that is why I think we have this issue with needing to talk to Treasury more regularly than I would wish, where the financial resource or the physical people resource is not sufficient at the point of a particular crisis to address it well enough and get through. But the relationship is good.

**Q442. The Chairman:** It still strikes me as a tea and sympathy relationship rather than a practical assistance relationship – so you are getting the understanding and awareness rather practical and tangible support.

***Dr Couch:*** I am not necessarily going to agree with you, Chair, because I am not sure what support my colleagues or Minister Ashford's colleagues politically in Treasury could give us. The

reserve funds – and there are a variety – are there for particular reasons, they have particular rules which Tynwald has seen and approved. And that support is sort of saying that they will act as a four-eyes review system of our bids, rather than just allow us to spend all of those reserves immediately. So I think there is quite a lot of support, and Tynwald supports each year additional funding being put into the Healthcare Transformation Fund, for example, which is for our exclusive use. So I think the support is there. (**The Chairman:** Okay.) And of course it helps – if we felt that there was an oppositional relationship with the Treasury, I think that would make my life harder and make my Minister's life harder. But it does not feel like that.

**Q443. The Chairman:** Taking a slight sideward step, one of the other things that have come out of this reorganisation is bringing the ambulance service into the Hospital portfolio. What difference has that had to the overall system?

***Mr Quinn:*** I think at a personal level – or the personnel that work within the service have welcomed that move. I think they feel they can properly now identify in a way that perhaps they have not identified previously. I think they felt as though the service was slightly out on a limb and there is a natural connectivity with the Hospital, particularly from the emergency side of service. But also again, patients who are being discharged from Hospital on the patient transport service side of things too, there is a natural link with the Hospital.

In essence, though, the ambulance service should be and is a prime example of an integrated service, because it does not just belong to the Hospital, it sits within the family that is the Hospital's Directorate but it provides services across the entire Island wherever a person may be. There is a big piece of work that we are carrying out at the moment which is reviewing our urgent care provision and a lot of that focus is around what we call our 'out of hospital' experience. And that, in essence, is very much around how we support more people to stay at home and not require to be brought into hospital.

Some of the interesting conversations I have had with the senior personnel of the ambulance service is asking fundamental questions of why do we measure what we measure. There are standards in the UK that I think we have adopted, but I do not know that there is any demonstration of improvement to patients, simply because we have adopted the standards – and one would be the 'eight-minute standard'. That to me, on a small Island, tells me how quickly somebody might drive, but it does not necessarily tell me what the end result for that person that they are attending to is. And I would sooner – and I can remember having similar conversations with ambulance paramedics in the UK who were extremely frustrated because they were highly skilled practitioners in their own right. They were attending a scene and felt as though what they had to do in order to keep within the clock was to 'scoop and run'. And not in any way wanting to be disrespectful, I said, 'Well, you know, a man with an ice-cream van could do that, couldn't he?' Because what I want is a trained practitioner delivering care, and if the correct thing to do is to stabilise and keep somebody at home, then that is okay.

One of the measures that I introduced when I was at Portsmouth, and one that I have asked that we introduce here on the Island, is if you look at the conveyance rates – so, how many people are brought to A&E by ambulance and what percentage of those patients are then admitted into hospital. That is a useful indicator to understand the quality of those conveyances. I think what it does is demonstrates further – or what I have just described is, if what is happening is that we are responding to, simply because that is what the standard says, rather than understanding the outcome for the individual, it seems a very expensive way to ferry somebody into hospital who may then be turned around in the A&E department and go home.

**Q444. The Chairman:** So your view is that there is sufficient capacity, it is perhaps just not being used most effectively?

***Mr Quinn:*** Yes, part of our role is: how do we ensure that we deploy the emergency service and focus on it remaining as an emergency service? And then you separate out what would be your patient transfer service, away from a paramedic-based service. It is important that we differentiate so you can deploy your appropriately qualified and trained personnel to those people who need them most.

**Q445. The Chairman:** Do you think there is a gap in the system though, that in terms of the dispatching there is no qualified medical practitioner within the ESJCR to make some of those decisions about whether they bring that person in, or whether they go and get the person that has broken their leg down the road? Or are they making hot clinical decisions in real time when you have only got potentially, say, three ambulances in deployment at any one time?

***Mr Quinn:*** You raise a very valid point and I think we would want to build on some of the good work that has happened in Mental Health, where they have actually deployed a practitioner within the control centre where they *can* offer that advice and where they can properly evaluate a situation and respond accordingly. One of the advantages we have got here on the Isle of Man and we have to take full advantage of it of course as part of our urgent care – and I talked about the 'out of hospital' element and that would include the control centre – is that we have as the clinical lead for that Dr Gareth Davies who is a senior A&E physician, but is also the Medical Director of the London Air Ambulance Service. He works the majority of his time now on the Isle of Man and is using his skill set to bring about some of those changes needed at the front end.

**The Chairman:** Okay, thank you. We will move on. I am conscious that we are perhaps not making the level of speedy progress that we had hoped for as a Committee, but certainly it is really useful to get these answers.

Mr Crookall.

**Q446. Mr Crookall:** Okay, moving on to activity up at the Hospital to start with. We have noticed over the last 30 years the population of the Island has grown by about 30% and yet activity up at the Hospital has grown disproportionately by about 80%. Any idea what has accounted for that?

***Mr Quinn:*** I would like to see those figures, just to understand if it has grown by 80% compared to it, but what I would say is that there *is* evidence that activity has grown in certain parts of the organisation. There is also evidence to show that we have also got a reducing level of activity and my concern is that we have got the balance the wrong way round.

And I can explain to you – for instance, we have got an ageing population on the Isle of Man and you have mentioned the size of the population. In terms of the percentage of patients over the age of 60, who therefore are going to have a higher dependency on health services, that is significant and is growing and that will put an added burden and strain on hospital services, in particular the likes of the A&E Department.

I can tell you that between 2013-14 to date we have seen an increase of about 30% in the numbers of people attending the A&E Department – and that difference is over 10,000 between those two years. That is a significant increase. The positive thing associated though with that is that we are seeing a reduction in our conversion to admission. So we are not admitting as many people as we were doing before, as a conversion ratio, from attendance to admission. So that is positive and that is a really useful indicator for us to keep looking at on an ongoing basis.

The other thing we have seen, which is important, is that over a period of time our average length of stay in the Hospital has reduced. So whilst we might be admitting more people into the Hospital they are staying for shorter periods, therefore that suggests we are getting improved throughput and flow across the Hospital. I will give you just some examples of that: in 2013-14

across the entire Hospital – and this will vary depending on specialty – the average length of stay was 5.32 days. In 2018-19 our average length of stay has reduced down to 4.4 days, and that is a further reduction of a half day on average per admission compared to this time last year. That is extremely positive.

That is also on the backdrop that we have reduced our bed capacity because we decommissioned a ward, as you know, at the end of March; so we are getting improved flow, more patients are being admitted and discharged, with fewer beds. That is a really positive indicator.

The average length of stay in England for interest, in 2015-16, was seven days – so you have got an average length of stay in Noble's Hospital that is better than the average length of stay across NHS England. Again, if we are doing some comparisons, and I think it is important we have to understand how we compare – and where we are comparing positively let's celebrate it. But where we compare negatively we have to put in place appropriate actions to reverse that. It is important for the people working at the coalface at the Hospital that we share the positive news as well as highlight the things that we need to improve, because it has an immediate impact on morale if all we ever talk about is the things that we are not getting right. Those are just some headlines I think that are important to hear around what does seem to be working.

The area I do personally have concern around is our outpatient activity. The vast majority of activity that you would undertake in any acute hospital is outpatient-based – it does not require beds, it is outpatient-based. What you should be seeing and what you would need to see as a positive indicator is more outpatient activity being delivered, and that your new to follow-up ratios reduce. So you are seeing more people but you do not need to see them as often. And when we do benchmark with our colleagues across, we are seeing people on a frequent basis in the Hospital. Our new to follow-up ratios are outwith what you would expect to see if you are benchmarked against NHS England and that varies by specialty; and we have to, again, describe that in real terms.

I think what is evident to demonstrate our new to follow-up ratios are out of kilter, is our 'do not attend' (DNA) rates. So we have got high DNA rates and it is increasing year on year. I think it is multifactorial why a number of people may not be attending their outpatient appointments, but I would not be surprised if for some it is because, 'Not again; you are seeing me too frequently and something else has come up and I am very happy to go to that appointment instead'. We have to focus on those things and get them better. Outpatient appointments have reduced this year compared to 2013-14 by 4,500 – so we expect to see 4,500 less people in outpatients this year than we did in 2013-14, which is a reduction of about 3½% –

**Mr Crookall:** Okay, thank you – sorry, Mike, I think Mr Cretney wants to come in.

**Q447. Mr Cretney:** Yes, it was just to take you back for a moment, if I can, to admissions into A&E. I just wondered whether any exercise has been carried out to see whether people are choosing to go to A&E because of difficulties in terms of getting a GP appointment?

***Dr Couch:*** I think we could do that and it is probably quite important, because in terms of the activity through the door at the Emergency Department almost by definition even if it is a 999 call, it is a self-referral – so the person has decided that they need to attend the ED. I think if we look at any of the component nations of the UK or elsewhere, the load on emergency departments is going up and up, even on the basis of *per capita* population. So, as Mr Crookall said, populations may grow but that load is going higher which must indicate that, for whatever reason, society is changing in its expectation of its health service. We do not have those answers at this point but I think almost an opinion poll could be very useful, or maybe the Social Attitudes Survey could have some additional questions about why people behave that way.

But beyond that in terms of managing demand, as Mr Quinn was saying, we then have other streams coming in – so to outpatients largely that would be a referral from another professional,

such as a general practitioner, and even there we are seeing *very* significant shifts in activity in referral rates. And then other ones which might not go to an outpatient clinic, let's say going to a diagnostic procedure, like an X-ray or an MRI, or something, again we are seeing *very* big changes in the activity there. So you almost want to have somebody from outside – it is almost like an academic study – to try to work out what is going on there, and then we would need to think how we could manage those better.

**Q448. The Chairman:** Just to add to that, you talked about decreasing the number of outpatients, increasing the number of 'do not attends' and decreasing the length of average stay in the hospital, but what you have not mentioned so far is readmission rates. So again we are back to the quality of the service that is being provided – it would be quick to get people in, spin them round and send them right back out the revolving door, but in terms of making sure that you are measuring the quality of that.

Is that something that you are actually measuring?

***Mr Quinn:*** We are measuring that and that is a new report we have started to run, but there is nothing at this moment in time that is causing concern. If you look at the standard that we would apply which is equivalent to across, it is looking at the readmission rate within *x* number of days of discharge from hospital, 28 to 30 days. It is also important to understand whether somebody is being readmitted associated with the initial reason for admission, or whether it is a completely separate event.

**Q449. The Chairman:** We used to have the same statistic with the prison service as well. *(Laughter)*

But just wondering, then, when you say you are not finding anything unusual, what is the standard there that you are looking at in terms of the UK standard?

***Mr Quinn:*** The UK standard is readmission within 30 days of discharge.

**Q450. The Chairman:** What proportions of people are getting readmitted within 30 days of discharge?

***Mr Quinn:*** Within the Hospital? (**The Chairman:** Yes.) I have not got the answer with me, but I can share that with you after the event.

**Q451. The Chairman:** I presume there is a UK benchmark?

***Mr Quinn:*** It is a UK benchmark. And in the UK it also has a financial penalty attached because any readmission within 30 days associated with the primary reason prior to discharge will not be funded. So the cost burden is taken by the organisation directly.

**Q452. The Chairman:** Which obviously would not apply in the Isle of Man.

***Mr Quinn:*** No, we would just incur a cost.

**Q453. Mr Crookall:** Could it be that when the GP out-of-hours service stopped and Manndoc took up, could that have helped to increase the numbers? Or is that separate from the Hospital numbers as such?

***Dr Couch:*** I think it could, Mr Crookall, but with many of these things there is a range of factors that contribute to the position you see. It is hard to know often in terms of people's

behaviour what is causation and correlation – you cannot say, 'Because of *that* people acted differently', or is it a range of things?

But, yes, I think Mr Cretney's challenge is perfectly fair. If people perceived, (a) that they are poorly, and (b) needed to see a doctor, but they perceive they could not easily see their community doctor, they will seek to see a doctor somewhere else. Now, that could be through MEDS or it could be the Emergency Department, but at the moment we do not have that information. We might *suppose* that is the case, but we do not have the information to prove it.

**Q454. Mr Crookall:** So we would not know whether that was a retrograde step or not, and whether we should have kept it locally rather than basing Manndoc up at the Hospital?

***Dr Couch:*** No, but again what we did there was we essentially mirrored a significant change in the NHS in the UK, where all GPs at a certain date stopped doing their out-of-hours cover and came into various forms of co-operative in cities or districts where it was essentially the equivalent of MEDS. And that is normal now.

**Q455. Mr Crookall:** Could it be said that GPs are over-referring, or referring too early to the Hospital?

***Dr Couch:*** Again, that becomes a research project. I think there are questions that we could ask and we would need to study. I think as you will realise in terms of the nature of this hearing our people probably would not have any spare time to do that sort of studying. But I think it would be very valid.

**The Chairman:** Mrs Poole-Wilson

**Q456. Mrs Poole-Wilson:** You have mentioned the need to research it properly, but how easy would it be when people present at A&E or MEDS, (**Mr Cretney:** Ask them!) to capture simply from what they tell you about why they are there, whether this is a true emergency situation that they have had to come out of hours right there and then, or present to the A&E Department as opposed to a community facility, or not? Most people when they arrive, explain exactly why they are there. So is that not captured and how easily could you just capture that data point?

***Dr Couch:*** I think it is straightforward but there is probably an ethical overlay. Forgive me, I am not putting words into your mouth but you are sort of saying, 'Are you really poorly?'

There is a challenge with that, but I think we *could* do that. But again I suppose to make that work well – it is not like a Government consultation – but I would probably want to do a public information programme beforehand and say, 'We want to try to understand better and therefore you should expect, if you attend for certain types of things, we will ask you two or three extra questions'. I think that would be okay, if people were prepared to answer them; and I would guess in the Isle of Man they would – but we have not done it before.

**Q457. Mr Cretney:** Before we go off the subject, you have given a number of comparisons in terms of the Isle of Man compared with the UK, Mr Quinn, and I was just wondering – it is not strictly relevant, so I apologise, Chairman – but are there any stats in terms of people whilst they are in hospital picking up bugs, or whatever, on the IoM compared with the UK?

***Mr Quinn:*** I do not have them but I am sure we could get information. These are hospital-acquired infections you are talking about? (**Mr Cretney:** Yes.) So we will be able, through our infection control service and our microbiologist, to provide you with data based on the number

of admissions into hospital, what the hospital-acquired infection rate is and how that compares with NHS England. Yes, we can certainly get that response to you.

**Mr Cretney:** I think it is just around the efficiency, the organisation –
Thank you.

**Q458. Mr Crookall:** The step-up, step-down facility up at Ramsey: does that work? What sort of effect has that had on … Obviously, hopefully it has worked, but what sort of effect has that had on the activity at Noble's?

***Mr Quinn:*** Well, I think if it was not for the fact that we commissioned 10 extra beds at Ramsey whilst at the same time decommissioning 21 beds at Noble's, if those beds were not working or were not being utilised we would not be seeing the improvement in flow that we are seeing today. I think I have mentioned it before and it is an important point that one of the key barometers of safety of any hospital – and I do not say this tongue-in-cheek, because it is a serious statement – that if you start your day with empty medical beds then you are in an extremely positive position. The vast majority of NHS organisations across are starting their day in a negative bed position, with an A&E department that may be full with people sitting on trolleys waiting to be admitted. That is a *serious* issue that is well publicised and documented.

Since we started measuring our bed capacity from 14th April this year, the average number of empty beds we have in medicine – and the reason why it is important to look at medicine, is because over 80% of your emergency admissions coming through A&E are medical and you need beds to admit those patients into. So on average since 14th April we have 11 empty medical beds at Noble's; and overnight, at 10 o'clock – because we did the measurement at 10 o'clock as well – the average number is 17. So that is important too because we carry on admitting throughout the night – we are a 24/7 business and we need that capacity.

So it is a positive news story for the Island that you have capacity at the points in the day when you need it. And I think having introduced the discharge lounge into the Hospital has also assisted with flow, because we can transfer people safely to the discharge lounge awaiting their transport to go home, whereas previously they would have been occupying an acute bed whilst waiting, say, for a relative to come and collect them.

**Q459. Mr Callister:** Can I just ask a question on the discharge? Have you actually changed that service, because I know of a few examples where people were being discharged at an inconvenient time, say seven o'clock at night? I know that from a previous conversation. Has that been reviewed and are people being discharged at a suitable time?

***Mr Quinn:*** I would suggest that even seven o'clock actually is a suitable time. If you look at the 'SAFER discharge bundle' that was introduced in the NHS in England a number of years ago – something which we are slowly adopting here on the Island – it requires 100% of your discharges to have occurred by seven o'clock. So I would be concerned if we had got people who are being discharged certainly from ward beds, not A&E – because I think discharging from A&E is very different. But if we had people being discharged at nine o'clock and 10 o'clock at night I would be concerned about that and we would want to understand why that has happened.

It may be a choice issue. It may well be that somebody has said, 'My son, or daughter, is coming to meet me and take me home'. The discharge lounge closes at six o'clock so it would not be appropriate for them to sit on the ground floor of the Hospital, alone. So that is why they may have been discharged late in the evening.

**Q460. Mr Callister:** It was more about the joined-up, because I was aware of, for example, older persons' complexes were not accepting admissions after, say, seven o'clock. So there was some confusion about actually getting the two services to match up and somebody being

discharged, as you rightly said, from a ward and going into an older person's care home that there are actually facilities available to accept that patient.

***Mr Quinn:*** Well, even at seven o'clock at night I would suggest most care homes on the Island would not support us transferring a patient that late in the evening. So part of the discharge planning process is to ensure that we do line up with the organisation that is going to play host to that patient.

The other thing that we have got improved advantage over is that we have now moved our patient transfer service to a different provider and we are not obligated only to discharge at two points in a day – it is across the day. It used to be that you had to be discharged either at eleven o'clock or at two o'clock, and inevitably those discharges were sometimes delayed. We are discharging patients throughout the entire period of the day now.

***Dr Couch:*** I think as a little bit of addition, Mr Callister, we will slip up occasionally, I can guarantee that, but I think in terms of our discharge planning for people we are far better than we were. And I think the other thing is to change the opinions of our colleagues in the Hospital in actual fact, and actually try to convince them that most people do not want to be in Hospital!

**Q461. Mr Robertshaw:** I will try and make this quick because the Chair has been kind in letting me ask this question now, because we are running a bit behind. But focusing on the positive, as you have asked us to, I have to say I was surprised at the difference between the average length of stay in our Hospital and across. If you were trying to capture it quickly in bullet points what would the top three reasons for that be?

***Mr Quinn:*** I would say probably the primary reason is that if you are looking at the basket of cases, we serve a very different population. So the acuity of our patients is very different.

If you are doing a comparison with NHS England – even our very sick patients on the Island are transferred to England. So no-one is suggesting we are cherry-picking, but what we are doing on the Island is we are managing a reasonably healthy cohort of patients, healthier than what you would expect to see within an NHS acute trust across. So that is likely to be contributing to their longer length of stay.

**Q462. Mr Robertshaw:** And a couple of other reasons why it is –?

***Mr Quinn:*** I would say they have perhaps not put the focus of attention that we have put in locally to improving our flow around the Hospital. And certainly I think one of the biggest challenges faced by the NHS across is the separation between Health and Social Care; and even though they are talking about Health and Social Care as a combined entity, they are still operated as very different services and reliant on Social Care. And there has been funding withdrawn from services across, that has made it very difficult for people or their care to be transferred to other agencies in a timely fashion. That is not through any fault of Adult Social Care in the UK, I think it is a victim of circumstance.

I know there is a huge amount of work happening daily to try to improve that and there are what they call 'DTOC reports' that happen daily where you look at delayed discharges of patients into the community, and understanding the reasons why that might happen. We have on the Island what people talk about as 'complex discharges'; I would suggest what we have are 'complicated' discharges, not necessarily complex. We can make them so.

**Mr Robertshaw:** Thank you.

**Q463. Mr Cretney:** Can I just again, sorry, ask about A&E? From time to time people contact us and say, 'I was waiting for *hours* in A&E'. I just wonder, is there a comparison – I know there is

obviously triage when people go into A&E to assess the order of priority, but is there an exercise carried out to see whether we do compare favourably?

***Mr Quinn:*** Yes, we look at the four-hour standard every day and we look at the six-hour standard. So certainly a significantly higher percentage of patients are seen, diagnosed, treated, discharged, admitted within six hours than there are four. The standard for the four-hour is 95% of patients attending A&E. Our aggregate performance at the moment is 79.4%. And what I have done, and I do – because I think it is important and it is a standard that you can accurately benchmark against your neighbours across the water.

Our 79.4% was nowhere near being the best and is nowhere near the worst, and if I tell you that organisations like King's College Hospital in London and Portsmouth Hospital – both hospitals I have worked at – have a worse performance around four-hour standard than the Isle of Man … There are about 12 hospitals sitting below the Isle of Man in the UK, in NHS England, that have worse performances. The worst performance I think in one trust is 65.2% against the 95% standard.

***Dr Couch:*** Forgive me – can I, Chair?

I think one of the challenges we are going to face in terms of financial sustainability is you have got the *quantity* of what you can provide and the *quality* of what you can provide. (**Mr Cretney:** Yes.) Again, I think it is incumbent on us to be better at communicating with the public that, for example, if you attend the Emergency Department while we guarantee you will be seen by good professionals who will give you the right treatment, there may be somewhat of a wait.

And I think even in the lounge of the ED, we could probably be better at letting people know. (**Mr Quinn:** Yes.). We are trying that, and maybe even taking them a cup of tea if it is appropriate to have a cup of tea, rather than just have somebody sitting on the plastic chair waiting and waiting. But ultimately we will have to decide I think, as an Island, what quality we want to have because to have a much higher quality we would have to expend more on staff in the Emergency Department, which would cost more. There is always a question about the effectiveness of how the number of staff we have work, but ultimately to really push some of those timescales down you need more people.

**The Chairman:** We could talk about whether the bottleneck is staff or space at A&E in the Isle of Man, but we will park that one for now.

Mr Crookall.

**Q464. Mr Crookall:** Just finally from me for now regarding the staffing levels: how do you verify the adequacy of the staffing levels at any point in time? And what factors do you consider for doing that?

***Mr Quinn:*** It is good practice to undertake regular establishment reviews. There are a number of tools one can use to understand that. I think I have shared previously what helped inform our decision around the decommissioning of a ward earlier this year was just that: we did a review of our nursing establishment and what the tool suggested was that we would need a significant financial investment to bring our staffing levels to the levels required to make it safer.

Now, given that we already were sitting with a funded vacancy factor, if I had put a bid and received additional monies for investment for more nurses it would have just simply contributed to a higher funded vacancy factor. So in reverse what we looked at was how many beds can we safely operate with the establishment we have? And that came out with the equation that we needed to reduce our beds by 20 – that was the equivalent of a ward. So our wards, in terms of our staffing numbers are at the level where we need them to be.

**Q465. The Chairman:** But in terms of responsiveness at any one point in time rather than in the global scale of things: how do you deal with that?

***Mr Quinn:*** There is a daily staffroom meeting and one of the key questions asked at the eight o'clock safety huddle is around staffing: where might we be challenged? And it is how you redeploy your staff in real time – that is the important thing. And what you cannot allow is for one part of the organisation to feel very satisfied with their lot while another half of the organisation is struggling because 10% or 20% of their staff have not turned up for shift due to illness, or whatever.

So it is about redeploying people in real time. It is not always well received because people are very comfortable working on the ward that they know. But you know – and as a nurse myself it is something that you become accustomed to – it happens, it is required, where you have to deploy people to maintain safety across the hospital.

**The Chairman:** Okay.

Mr Cretney, shall we move on to staff engagement?

**Q466. Mr Cretney:** Yes. When we met in May you mentioned that staff sessions to follow up the Have Your Say survey would be taking place. Can you tell us how that has gone?

***Mr Quinn:*** I would say that is ongoing. I think the important thing is that rather than see this as an event that might happen every two years and we get people in a room and give them feedback, it is about saying, 'Let's just have continual dialogue with staff'. And speaking to my managers they have all taken a very different approach because they have adopted an approach that works better for their respective teams – so we are not being prescriptive. And it is still important to note, isn't it, that our overall staff engagement response improved by eight percentage points in 2017 compared to 2015, and we continue to build upon that?

***Dr Couch:*** We also found – Mr Cretney, forgive me – I was referring earlier to when we erected our marquee near the rugby club car park in September and had five days of events. We did some immediate polling of people attending those and we asked the same sort of questions, and the scores compared to the Have Your Say survey were *far* better. (***Mr Quinn:*** It was, yes.) So I think again that tells us that direct engagement with people and talking about things that matter to them is important.

Part of the programme of work we did there was, for example, an exercise called 'My Job Matters', where we got people to share what their role was, because often they did not know – there would be people sitting around the table from all over our services. And now we have put posters and banners around different parts of our workplace showing people who were happy to have their photograph taken for 'My Job Matters' – a podiatrist, a ward sister, etc. There is a range of things.

***Mr Quinn:*** Yes, lots.

**Q467. Mr Cretney:** Okay. Have you noticed any changes resulting from the sessions you ran earlier in the year focusing on culture and behaviours?

***Mr Quinn:*** I think, yes, there have been changes inasmuch as a large number of people are really positive that as an organisation we are prepared to challenge unacceptable behaviours, and I think that is what has come out loud and clear. So I think from that perspective it has been extremely positive because staff now feel that they are being listened to. And if we are putting the standards in place we expect people to adhere to those standards; and if they fail to, appropriate action will be taken.

**The Chairman:** Mrs Poole-Wilson.

**Q468. Mrs Poole-Wilson:** Thank you.

Specifically on the Have Your Say survey, I think the areas where the Hospital differed most – this is the 2017 results, and I hear that you polled and you have got significantly better results. But going back to what we were talking about in the beginning – the importance of leadership, the importance of people, managers and supervisors who understand their responsibilities for culture and leadership – the four areas where Noble's differed most were: my manager/supervisor tells me when I have done a good job; my manager/supervisor communicates effectively; my team is well managed; and, I have the opportunity to discuss my learning and development opportunities with my supervisor and manager. So those four areas are where Noble's polled significantly lower, which seemed to go right back to what you were talking about at the beginning. I wondered what work has been done specifically around improving and holding managers to account, and particularly in order to address those concerns.

***Mr Quinn:*** The restructure in itself I think will help address a number of those shortcomings. There have been a number of management changes as part of the restructure and certainly the feedback in response to some of those changes has been quite positive from various quarters.

Fairly recently, with the support from LEaD, we undertook a number of developmental centres and really it was around, again, observations and listening to feedback, where some people feel as though they have been put into leadership roles but do not necessarily have the requisite skill set to deliver what we are expecting them to deliver. I think what has then happened is those individuals have been penalised for not delivering what is expected, when in reality we have to take responsibility for not supporting them to gain that skill set. So the initial assessment centre has thrown out a number of really good items for us to start to work on. We had our second follow-up meeting yesterday with some of the lead sisters, with LEaD, to talk about how those improvements are coming about – and we *are* starting to see. We are empowering people, we are giving them support. We will hold people to account for delivery, but it is giving them the opportunity to start to develop in a way that perhaps they feel they have not.

One of the other initiatives that we put in place early this year was the 'Back to the Floor' scheme, where we put senior managers back to the floor to work alongside their colleagues so that they could see in the raw what the issues of the day are, and start to work with the team to put appropriate change mechanisms in place. And on one of our wards in particular is a big focus at this moment in time around the culture change that is needed around leadership and development.

**Q469. Mrs Poole-Wilson:** Okay, and just on that, how much autonomy do you think there is for staff, where they do see perhaps sometimes straightforward things that could be changed that would make a real difference either to their working lives or to outcomes for patients? So how much autonomy do you think there is for innovation now and to make change proactively in the Hospital?

***Mr Quinn:*** I think, as we have alluded to, that there have to be some control mechanisms in place because clearly what you cannot do is just allow people to go off and *do*, and you end up with a bill.

The 'Freedom to Flourish' is very much around encouraging innovation and ideas and sharing – and let's sit down together to understand what does that mean and what is the impact on the rest of the organisation? Is it an enabler to drive cost efficiency? Does it require investment? Does it become a cost pressure? We start to look at all of those things with the individual and I think that in itself acts and serves as a very good coaching methodology, so they can begin to understand next time what they might have to think about before they come

forward *with*. So I would say it is not totally autonomous because there has to be an element of oversight, but it is encouraging people to come and share those views and ideas with us.

**Q470. Mrs Poole-Wilson:** And can you describe for me a little bit about that sharing, and where does that go to in terms of the level in the Hospital? How high up does it have to go and how do you ensure the feedback loop is closed?

***Mr Quinn:*** An individual would take it to their associate line manager in the first instance, who may then want to discuss it with the general manager, say, within their respective care group. Those ideas might be formulated on paper and brought into the Operations Management Team and there is a weekly meeting every Wednesday so they can be received. What I would like to be able to assure you is we would reassure the Chief Executive that the level of interrogation that happens at a local level happens because we will not be prepared to send anything upwards for consideration, without having tried and tested it first. And then, if we get the support that we could make that change happen and the development is going to proceed, the individual that may have raised the idea in the first place will be met with and will be advised accordingly.

**Q471. The Chairman:** Can I just ask, then, what the criteria are for escalating these ideas? I presume most of them can come up to maybe your level, Mr Quinn, and you would be happy to sanction them as change management programmes. What are the criteria for them going to the Department in terms of trying to get that political buy-in? When is that perhaps the key and – I suppose this is perhaps one for the Chief Executive – how would you then define the political appetite for taking on some of these challenges? So there is a question there I suppose for both of you.

***Dr Couch:*** Yes, from my perspective I think sometimes you say to colleagues, 'Why haven't you done it already?' And then they are a little bit disarmed.

I think within the boundaries of good practice and appropriate infection control and all those sorts of things that we need to have, getting on and fixing things make sense. Sometimes there are parts of the organisation that say, 'No, thou shalt not, because this is the way we do things', etc. and then that tends to be escalated. Usually, if something gets to my level I still say, 'What's the common-sense position with this?'

To take something into a departmental meeting, as you will recall from your time as a Minister, it really ought to have a very broad application and probably a very broad price ticket attached to it – if that is the right word. But I think we should be trying to help people.

I sense that at this time the organisation is probably not focused enough on continuous improvement, and the three things I tend to concentrate on are: the experience of the people who use our services; the experience of my colleagues; and our financial environment. And I think we still need to make significant advances on the latter two. I think virtually all of my colleagues will be very much focused on giving care to the best of their ability; but in terms of how we manage the workplace with each other, and finances, they are not thinking of suggestions to make that better. Although, as Mr Quinn was saying, little by little people now are talking more freely and they are applying peer pressure where they see behaviours that could be better. (***Mr Quinn:*** Yes.) So even that is improving.

**Q472. The Chairman:** I suppose in the first instance I am trying to ensure that politicians are not being asked to make clinical judgements on any matters. (***Dr Couch:*** No; never.) Secondly, also to try and work out in what sort of circumstances they are turning down ideas that are coming up from below?

***Dr Couch:*** I do not think that happens very often. One of the things we are working on at the moment with GTS – who we are going to ask to build this for us – is that we have seen some approaches in other organisations across where you can now have almost a web-based suggestion scheme on an intranet rather than necessarily openly on the web. So GTS at the moment are working on something for us for DHSC and we think we want to have something which would be the 'Suggestions Portal', possibly with some form of forum where colleagues can discuss ideas and refine them and improve them. And the Minister is fully supportive of that. So again it would be allowing people to feed ideas in.

Our medical director told us that at the last place he worked, teams were almost asked to do like a *Dragon's Den* and it became a very exciting thing in the hospital where they would think of ideas that needed some funding to make them work, and then they would go in and pitch them to colleagues. That is one approach; and there are myriad. I think if good suggestions do come up to executive level, or political level, they will nearly always be acted on, but it is how we facilitate that best.

***Mr Quinn:*** And an example of where we have taken the ground floor-up approach is the discharge lounge. That was a suggestion that came to us from people who were looking after patients every day about making things better – and we got on and did it. We did not need to come and seek permission; we did it.

**Q473. Mr Robertshaw:** Just one question, very quickly – and perhaps this is slightly unfair because, Mr Quinn, you were not here then and Dr Couch was in a different role. But scrolling back to about four or five years ago there was at that time quite a lot of well-recognised anxiety in the throughput or activity in the operating theatres, and at that time there was a determination to increase the staffing levels. I do not know the terminology here, I think is it pre-scrub anaesthetics and recovery afterwards? As I understood it, thinking back to that time, there was a determination to do it. I think it happened. Did it deliver, do you think in terms of –?

***Dr Couch:*** I will start and then hand over to Mr Quinn.

I think in a general sense – and it always sounds as if it is a strange word to use in the context of caring services – our *productivity* could be far better in many areas. I think that would not necessarily affect financial sustainability in that the same number of people might need to be employed, etc. but it would certainly affect things like waiting lists and waiting time for various things. The theatres are an example of that. If we compare to the most reasonable comparators we can find in England, our throughput on a daily basis in operating sessions is not as good as in England. We have tried over the last few years to improve that and it has reached a sort of *impasse*, if you will.

We have had a review done this year almost on a pathfinder basis – and I think it is public knowledge as it has been in the media – by an organisation called KM&T who came in specifically to look at the theatre suite and were saying, 'You are not managing the actual underlying process well enough'. So, for example – forgive me for giving you a little bit more detail – for an operation you are largely going to have a person on a ward, let's say you are the first on the list in the morning: you need to move that person from the ward to the arrival lounge; then you need to go into the anaesthetic room; then into theatre; then into recovery; and then back.

The theatre suite team needs to be ready to receive that person and it is good to go – the anaesthetics, the medical team, the doctors need to be scrubbed, etc. – and we were getting all of that in a rather disjointed way. So what we have done – and interestingly enough this is an application for Health Care Transformation Fund money, which has been successful within the last few days. We have said we have had that pathfinder study done that says probably with a little bit of process re-engineering, a little bit of change in culture and approach in the team, we

could be *far* better. But again we are going to need to bring in a little bit of capacity to make that work. We have put the case to Treasury and that will be starting, I would guess, in the New Year.
I think if we can show that is successful by adding some extra capacity to get over the hump of what needs to be done, I would like to do that in lots of different places. We run far too many 'business as usual' processes without challenging them and saying, 'Could we do this better?'

**Mr Robertshaw:** Thank you very much.

**Q474. Mr Callister:** I was wondering if we could possibly move on to incident reporting. I think, Mr Quinn, in your opening remarks on 9th May 2018 you talked about Prism and I think answering a question, you actually said you were confident that people raising their concerns using Prism was the right approach and you had confidence in that.
I was wondering if you can possibly confirm if it has been replaced by – I think it is called (***Mr Quinn*:** Datix.) Datix, thank you. Has it been replaced?

***Mr Quinn:*** Datix comes online next week (**Mr Callister:** Okay.) but what has been happening behind the scenes is all the training that is required so people become familiar with how to report through Datix. We have taken the decision that Prism will be closed down as Datix is launched and we do not want to run parallel systems because people will tend to refer to the system that they are familiar with using. So that is why the training upfront was important. So, as I say, that becomes live next week

**Q475. Mr Callister:** I do not know if it is a question that you want and I would welcome both of your inputs really, because in May you clearly said you had confidence in that system and you felt it was a good system when staff were reporting through that, but it has been replaced. Can I ask why it has been replaced?

***Dr Couch:*** I think it is simply that Prism is an old system. We considered replacing, we had a specification for replacement, we went out to the market – I think it was a procurement exercise (***Mr Quinn:*** It was, yes.) and we have decided to use Datix. It is a standard system and it is used in *many* care environments in the UK.

**Q476. Mr Callister:** And will staff have access to this new system as well?

***Dr Couch:*** Yes, everybody.

***Mr Quinn:*** It is all staff that currently have access to Prism who have been trained in using Datix as a replacement system, yes. So it is open reporting.

***Dr Couch:*** And clearly part of the leadership's role must be to encourage people to report incidents. It is only by reporting everything that we will learn and make things better.

**Q477. Mrs Poole-Wilson:** Just a short follow-up. I think in May you talked about Datix being more robust and being a good way to close the feedback loop. What is it that is different?

***Mr Quinn:*** I think by comparison Prism is an old system and it is much more cumbersome, whereas Datix provides you with a significant number of prompts which enables you to … it will not allow you to not complete the reporting cycle. And what we are saying culturally – and that is why the training has been so important – it is not just that the system closes a loop, but part of the closing of the loop is that we feed back to the individuals who have raised the incident in the first place, or been party to it, and that we identify the learning that is coming from that. It is

pointless having an incident reporting system if you do not take away the learning opportunities and improve services going forward.

What I am confident in, and further commented that we have a high reporting culture and that is extremely positive. Some people see a high number of incidents being reported as negative, but a low number is the negative because you are concerned that people are not telling you what you really need to know. What we did see last year in terms of red incidents – and those are fairly serious incidents, I suppose, by comparison. There were 26 incidents that were coded as red last year and this year, to date, we are forecasting there will be about 20 when we close this year down. But it is still against the backdrop of a high reporting culture.

**Q478. Mrs Poole-Wilson:** And does that mean when you say 'the learning opportunities', the follow-up, that Datix will hold the learning opportunities and what has been actioned? (***Mr Quinn*:** Yes.) So if there was an audit you would be able to show exactly what had come along – any themes, trends and exactly what had been done?

***Mr Quinn:*** Yes, absolutely. And if in six months down the line you start getting a repeat incident, it would flag it because it is so similar. That gives you then the opportunity to say: 'Why has the learning not been translated into practice? What did we miss? Why has there been a repeat?' It is about trying to minimise the risk of recurrence. I think that is what we have to get better at understanding: what are we learning from what people are telling us?

Themes do come up and if we do not grasp those themes and act on them, then we are doing a complete disservice to service users and to the staff themselves.

***Dr Couch:*** This is quite a new theme, however – forgive me, Chair. There is a very good book called *Black Box Thinking* by an author called Matthew Syed and it compares safety environments in Health and the airline industry. The airline industry now, all people involved in the industry know that they can report anything without fear and it has made it far safer and far better. I think health services are coming somewhat behind that, but we are getting better, aren't we?

***Mr Quinn:*** Yes.

**Mr Robertshaw:** Everybody should read that book. I have read it and it is brilliant. *(Interjections)*

**Q479. Mr Callister:** Mr Quinn, you were saying that there were high numbers of reporting. Could I possibly ask what improvements are being made to the process where individuals hear exactly what has happened as a result of their report or their submission?

***Mr Quinn:*** What will they hear?

**Q480. Mr Callister:** Yes, what will they hear back from the process? Once they have logged their submission and everything else, is there a timeline, are there any times they should hear back by? Are there stages? Could you go through the process of somebody making a submission to the point of when it is considered closed?

***Mr Quinn:*** Okay, so in terms of time it depends on the nature of the incident, because these are separate to complaints – these are things that may well have resulted in harm to an individual. The timeline will vary case by case and all of these incidents will require a root-cause analysis to be undertaken. The individual who has raised the concern will be invited to participate in that root-cause analysis because they are the key witness, they flagged the

concern in the first instance, so they have to be part of the understanding from the off. They will help inform those discussions.

What I would not want to do is to say that we would have to complete and close down an incident within *x* number of days, because you may apply a hurried approach that results in you missing something, and again it becomes a target for target's sake. I think what we have to be driving is improvement and allowing sufficient time in which to properly investigate, understand the learning and put the changes into practice.

**Q481. Mr Callister:** Brilliant, thank you. Just a final question on this from myself, and possibly to you, Dr Couch: how are you ensuring that everybody is using this system throughout the Department? You said there is high reporting, so how are you making everyone aware that this system is there and it is available for everyone to use within the organisation?

***Dr Couch:*** There is a carefully planned project plan that involves training. I mean, for example, I know this morning I was walking along the first floor of Crookall House and there was a board saying 'Datix training inside'. So it is cascaded through teams and there is no sort of message saying that 'Tomorrow thou shalt use Datix'. People have been made aware that the system is changing and they have been given the training. There are champions around the place and there will be technical experts who can help them if they have got any issues. So it is all in the project plan.

**Mr Callister:** Thank you.

**Q482. The Chairman:** I think we are at a good point to move on to the slightly less controversial area of consultants and their pay. *(Laughter)*

Who plans and agrees consultants' job plans?

***Dr Couch:*** Largely – I will jump in first – within either the care groups or the divisions that were there before, that should be the responsibility of the clinical director working in conjunction with the business manager or clinical directors. It would largely be the role of the medical director working in conjunction with the director of hospitals, and it will be the equivalent for mental health services and community care, etc.

**Q483. The Chairman:** What monitoring is there of consultant workload and productivity?

***Mr Quinn:*** Do you want me to answer that?

I would say more now than perhaps there has been, and the only way that we will begin to understand whether or not we are getting value for money is by having a monitoring process and looking at output and productivity.

Job plans, by definition, only tell you often where somebody is. It does not necessarily tell you what they are doing and so therefore we have to marry up expectations around output along with the job-planning process. I think if we divorce the two then we will just continue with a job plan that says one thing and we will not see the improvements in our productivity that we need to see, particularly with some of the key challenges. The Department has committed to delivering RTT at 18 weeks within the next five years. So that has to require a significant amount of change.

The first thing we need to demonstrate before we even begin to think about do we need more, is 'Are we getting enough out of what we already have?'

**Q484. The Chairman:** So in terms of the monitoring that is being done more now than it has been done previously, are you finding that those with the higher workload are proportionately more productive?

***Dr Couch:*** Forgive me: the challenge is whether the workload is higher. The job plan is one thing and I think, as Mr Quinn is saying, what people are doing is different. So we actually need to understand genuinely what the workload is to then do the next job-planning exercise. It is a loop.

**Q485. The Chairman:** I completely understand that and I suppose in the first instances are we happy that we have got the right information on success and performance in the present job planning cycle, in order to then be able to adjust it and refine it into the next cycle?

***Dr Couch:*** No, we are not content.

**Q486. The Chairman:** So effectively, having come out of one process blind you are potentially walking into the next one blind as well?

***Dr Couch:*** I accept there is a risk of that but I think what we are embarking on now is a comprehensive, supported and – I was going to use the adjective 'assertive', but I do not think it is quite assertive – but 'a more professional approach' to job planning. And I think the question, coming back to your challenge is that if a hospital consultant has 15 programmed activities, are they genuinely in some way working 60 hours?

**Q487. The Chairman:** Yes; and also are they delivering the outputs that are associated with that job plan, and are they delivering them to a high enough quality? And what I am hearing is that you do not know.

***Dr Couch:*** I think the issue is that at hospital management level Mr Quinn can gather all sorts of reports from the IT systems we have, etc. so we can often filter those down to individual consultants. So we can see operating theatre activity – as we were just talking with Mr Robertshaw about – we can see outpatient activity and we can see where, for example, the agreement is that certain programmed activities are for private work, etc.

I think what we suspect, and maybe this is hinted at in your question, is that heretofore that information was not brought into the job-planning exercise comprehensively. (***Mr Quinn:*** Yes.)

I am not saying it was never done, but it was probably not brought in comprehensively for all consultants; nor was the job-planning exercise, which is expected to be largely on an annual basis, done with that frequency. So you can have a situation where there has been drift, there have been agreements in the past, etc. And, if nothing else, we want to have a transparent system in the Hospital where people know which process is being followed – that it will be followed equitably for all; that there will be a general understanding of the baseline expectation of a contract; and that if you are going to get additional payments what exactly will it be for, so that you can show it to all of your colleagues; and how do we manage on-call rotas and the payments for being on call, etc.?

So that is a significant area of cultural change that I think we need to effect.

***Mr Quinn:*** I think too one of the other changes that is required – because again, if you compare how we operate here with across in the UK, a consultant by and large knows what is required of them because the hospital knows what it needs to deliver. I think we need to get to a point where the consultant becomes aware of what is required from them in order for us to deliver what we set out to achieve. And I think that is a significant shift.

**Q488. The Chairman:** Yes, you talked about sort of triangulating the programme of activities for that activity and quality, even to the extent that are we ensuring within the system that the quality is in line with, say, Royal College guidelines and we are monitoring and measuring

successful operations or outcomes and things like that? And are we looking at the activity in terms of, for example, comparing their productivity in private practice with that in NHS practice?

***Mr Quinn:*** Well, there is an expectation that our practice is in line with Royal College guidance and that should form part of any review with an individual practitioner. We have been subjected to a small number of peer reviews which have all been received extremely positively – most recently last week, where we had a haematology review. These are *peer* reviews and culturally they are things that people do not see as draconian in any way; certainly in the UK they are seen as a very supportive type of review because they *are* peer review. And because in a way we are working with a number of our specialties, who are single-handed practitioners, it is probably more important on the Island that we have a peer review undertaken, because if you are working in the UK and you are one of 10 cardiologists, there is inbuilt peer review within that service – and we do not have that.

**Q489. The Chairman:** Are they contractually required?

***Mr Quinn:*** Contractually required –?

**The Chairman:** Yes, within the consultant's contract, these peer reviews?

***Mr Quinn:*** No, they are not. It is good practice but it is not contractually required; nor is it contractually required in the UK.

**The Chairman:** Okay.

***Dr Couch:*** The issues in terms of standards are that at the moment I think we have one leg when we need to have two, in terms of driving up the standards. And I will explain that briefly.

All doctors, as I was saying earlier, have to be registered with the General Medical Council and there is an expectation – the code is called 'Good Medical Practice' – of how you should operate as a doctor, and that includes keeping up to date, following best practice, etc. And again, the ultimate Hippocratic Oath of 'do no harm' has to be the key.

In the UK – and this has actually been pointed out to us by Sir Jonathan Michael as part of his discussions with us carrying out his review – significant legal changes were made at national level in Health and Social Care Acts that changed the duties incumbent upon the Secretary of State, which we have not done. So in the 1946 UK Act which brought in the NHS, the duty in section 1 was to provide a national health service; and if you look at our 2001 NHS Act that is the duty that the Department, aka the Minister, has to deliver.

In the UK now there are many more duties that the Secretary of State has to deliver – for example, continuous improvement – and that flows through the system of hospitals right through to consultants and practitioners and back again, because they are held accountable in their part for delivering the duties of the Secretary of State. So I think Sir Jonathan has said to us that we probably should be – and we will see whether he makes the recommendation his report – considering legislative reform to bring in those quite sensible changes to make it easier for us to manage with our medical colleagues.

**Q490. The Chairman:** There is more to life than legislation – and that is perhaps not a quote that you would expect to hear from the Speaker of the House of Keys. But there is more than one way to skin a cat on that one.

The other point that I made in that question was about being able to compare productivity between NHS practice and private practice and whether that is something you are measuring and whether you are finding congruity there between how it works.

***Dr Couch:*** There is a challenge with that, Chair, in that consultants – and again this was part of Nye Bevan's great compromise in the 1940s – are permitted to do some work outside the NHS. That is normal and we accept it and we have no problem with it. Some of that private work may be on our premises with our equipment, etc. – so, for example, surgical operations are a classic example. Some may be completely outwith, so a physician could have consulting rooms in Douglas or Port Erin, or wherever, and be seeing patients privately, prescribing for them and caring for them.

Of those things that we do see then I think there are potentially some challenges. So we have seen in terms of the KM&T initial review of the theatres' activity that there is a challenge where it seems that productivity in private sessions is higher than in NHS sessions. I do not know the reason for that necessarily because what it does is it triggers further questions, and that will be part of the work which as I was explaining earlier will commence shortly.

**Q491. The Chairman:** I suppose the layman might interpret that as people working harder when they are getting paid privately than they do when they are being paid by the taxpayer?

***Dr Couch:*** The layman might, but in a way if you think about what Mr Quinn said earlier that if you look at our activity versus a major hospital in the UK, the balance of patients may be different. So, for example, it may be that more complicated procedures are coming into the theatre on an NHS list than on private lists. However, if it was the same procedure and we saw a difference in productivity, then there are questions to ask.

**The Chairman:** Okay.

Mrs Poole-Wilson.

**Q492. Mrs Poole-Wilson:** Just a point of clarification, really.

When you were talking before about job planning and it tells you what you can find out is that you can pull various reports that show activity, I am mindful that before you talked about the fact that we have considerably more outpatient appointments. So it might show you what activity is going on but are we measuring or checking whether all of that activity is required or is appropriate?

***Dr Couch:*** The challenge is that if we were working in the English NHS at the moment – and again I think everybody in the Committee will have heard this word – 'pathways' tend to become the default. So for a particular condition the deal is that with the providing organisation and the patient, both of them will know … And let me make one up: I have got pain in my chest, what happens next? What timescale should I expect? Which practitioners should I expect to see? In a general sense what treatment might I expect and how long will it take? So that sort of pathway is there. I think this is where the challenge is, that we could do more of that here to make a lot of things clearer.

So in terms of an outpatient clinic you would have a range of people on either condition pathways or specialty pathways, and it would say, for example, that largely for condition A in England it might be managed by general practitioners under what is called 'shared care', and you might have an annual review in the hospital. What we see with some things here is – and I will just use this as an illustrative example – they might be seen four times a year in our outpatient clinic and never by the GP. So the activity is an interesting statistic to look at but again it is how we manage the whole system and pathway which will then ultimately, when we get to the next proper job-planning session for the consultant in that specialty, you would say, 'By applying this pathway, this is the activity we expect of the ones that should genuinely be coming to hospital.

Is that fair?

***Mr Quinn:*** That is fair.

I think in terms of the other measures you can look at and benchmark with other jurisdictions it is very much around things like new to follow-up ratios within Outpatients. So it is about that frequency of follow-up attendance and how do we compare? Again, we do not have a commissioning system here on the Island as you would expect to see across, but a pathway is what determines the remuneration. If you want to work outside of the pathway then you do so at your own risk and the commissioner is not going to fund you anything in addition. So if you want to see that, if the pathway says 'In this particular condition the patient is seen twice as a follow-up', and you want to see them a third, fourth and fifth time, those additional follow-ups are at the expense and the cost of the organisation, not the commissioner.

***Dr Couch:*** The other issue of course is – and maybe this question would have come up in any case – if we are not following what would be orthodox pathways in England, which is our nearest comparator, and let's say, if I use the phrase advisedly, 'We are clogging up clinics with patients who would not normally be in clinics in England', that is pushing back the people who need to come in for the first appointment (***Mr Quinn:*** Yes.) to have their diagnosis and maybe primary treatment kicked off. So waiting lists are profoundly affected by how we manage clinics.

So again I think we need to pull together all of that information and say to our employees, our consultant physicians, or anybody else, and it comes back to what Mr Quinn was saying: 'This is what we require of the system' – so, for example, it might be that we will follow *these* pathways for *these* clinics – 'we want to have waiting lists of no longer than *x, y* and *z* and you, our employee, will play your part in delivering that pathway'.

A much older model would be that, in a hospital, professionals would be trusted to be professional and that was enough. 'Professional autonomy' as it might be described, I think.

**Q493. Mr Cretney:** I recall now the Chief Minister, Mr Quayle when he became Health Minister, expressing concern that as he came from a business background and in terms of assisting budget determination, that he was not able to be informed how much a particular procedure would cost here whereas in the UK, for example, that is something that was a norm.

Has anything improved in that regard?

***Dr Couch:*** It is improving very rapidly, but I do not think it is in a position where either of us feels completely comfortable. The issue comes to the old computing nostrum: 'rubbish in, rubbish out'. So to get a good understanding, we would need to take our principal accounting system – the Government has Microsoft Dynamics AX – and in theory *all* expenditure will be going into there, and in theory you could get that down to a blood-mopping swab. The question then is: what was that swab used for? So it needs to have a different code attached to it.

Now, if we were working – and Mr Quinn has worked in private medicine in the UK – I am sure that a BUPA or a Spire, or whoever, would know what every swab was used for because it would have a code (***Mr Quinn:*** Yes.) that would then track through the system. It would have a third code that if Mr Cretney was coming for a procedure, we would see, 'We have spent on a swab, it was used for this, for Mr Cretney, because we are going to bill you for it ultimately, either through yourself or your insurer.'

At the moment we do not have those other additions, so we are building that up. We have done some pilot exercises and our challenge is that for aggregate services – so, particular specialties – we appear to be more expensive than we would expect, were we to be in England. So we now need to start drilling down much more into those individual costing lines and then start coming back up again.

**Q494. The Chairman:** Is it policy that consultants can cover their own leave as a locum? Is this cost-effective, and how do you monitor the other effects of this?

***Mr Quinn:*** It is policy currently that a consultant can cover their own annual leave as a locum but that has to be agreed in advance. I think the key thing is though we also have a duty of the individual's welfare. So we will want to monitor how often that is happening, because if it is happening all the time, when is that respective individual getting time to rest and have a bit of time with their family, etc.? So it is something that is permissible, but within reason.

**Q495. The Chairman:** So in terms of how do you monitor those secondary effects, you are keeping an eye on how many days they are 'cashing-in', for want of a better expression? But how are you then checking that there are not any of these secondary effects in terms of performance and concentration, etc.?

***Mr Quinn:*** You would be looking at performance; you would be looking at complaints; you would be looking at sickness records – there is a whole host of things you could look at.

***Dr Couch:*** In an ideal world – and some of our teams actually do this – you would have an appropriate number of doctors where their rotas covered each other. So obviously 'locum' in its simple meaning, derived from the Latin, is just 'in the place of'. We often mean now that you bring in an external person at a much higher cost to be the locum. So you could have internal cover where, let's say you have 10 doctors in a team, and even when they are on annual leave the other team members will cover them and that would be normal. We are a little bit different from that in some parts of the Hospital, but not all.

So again, part of our transformation – if that is the right word – and part of our sustainability and reducing the cost of external agency locums has to be to ask how many doctors in a particular specialty team do you need to give that cross-cover level? And then in theory, barring more than one person being ill, you would not really need to use external locums at all.

***Mr Quinn:*** Yes, that is correct.

**Q496. The Chairman:** And I presume that is also then part of the contract coming in, in terms of that, because it effectively means that where self-rostering may work, it may *not* also; and there needs to be the ability to say 'Well, actually, Dr So and So, you are going to have to cover a locum shift in this two weeks here'? Yes.

What is the policy relating to a waiting list initiative or waiting list incentive payments? How are these used and how successful have they been?

***Mr Quinn:*** I personally do not support them. I think we need to understand why a waiting list initiative has come about. And the reason I do not – and I have never supported them in the NHS in the UK either – is because often we would end up paying somebody twice for the same work. So if it is because a backlog has occurred for no specific fault of the individual practitioner, but there is a requirement to reduce that backlog, then there are other ways in which you can request the support of those individuals to deliver additional activity. But if you are paying them a premium rate for doing it, what it can result in is a perverse incentive for people to slow down and artificially inflate a waiting list.

**Q497. The Chairman:** Would you not say that given the sorts of comments earlier about productivity, that we are seeing evidence of this?

***Mr Quinn:*** I do not know that I would want to comment on that at this stage but I think that as always, human nature being what it is, if you put an opportunity in somebody's way they may grasp it. What I think we need to be better at doing is not putting the opportunity out there.

***Dr Couch:*** And I think the question – picking up, I think, on your challenge, Chair – is that if we have a waiting list that appears to be unacceptable, what we need to do first as leaders is to understand why that waiting list is long. Then if we are going to apply additional resource of some kind to improve the waiting list, it would be applied in the right place.

***Mr Quinn:*** Yes.

**Q498. The Chairman:** My understanding is that that exercise has been done because the solution as identified by the Department was to increase the number of consultants from 44 in 2016-17 to 56 in 2017-18. But as far as we can see, there does not seem to have been a corresponding effect on waiting lists. Why is that?

***Mr Quinn:*** And in areas perhaps where we have seen that additional investment – and I think that is what we would have to look at – if you look at just total numbers, it may in the overall aggregate position, say, we have not seen any reduction. If you focus on the areas where the additional resource has been brought in and compare their activity levels and performance with those where we have not put the additional resource, it will be interesting. I am happy to do that comparison.

**Q499. The Chairman:** So do we measure waiting-list figures on the Isle of Man in the same way as NHS England do? Do we use the same methodology?

***Mr Quinn:*** No, we do not.

Referral to Treatment (RTT) was brought in in the UK in 2000. It took eight years for them to deliver to an 18-week standard.

The difficulty that we operate here: we have a patient information system called Medway that has a module built in within it called RTT. But we are operating two separate waiting lists. We have an outpatient waiting list and then we have an inpatient waiting list for those coming in for surgery. The reality is, and the ideal is that you have a single waiting list and that is where the 18-week pathway comes about – from point of referral from a GP into service, to when the first definitive treatment is initiated. That is what the Minister has recently committed to, that we will work toward delivering RTT at 18 weeks over the next five years.

But I have just begun to share with you that it actually took eight years in the UK because it was a very phased approach and it was not introduced as a blanket standard across every specialty. It started off in orthopaedics and gradually, over a period of time, was rolled out across all the other specialty areas.

What we need to understand in the first instance is if we utilise the capacity we have at our disposal currently, how much of the existing backlog we could reduce by. The assumption is you need significant investment to get from where we are today to where we need to get to. Undoubtedly we will require some investment at some point. And again I shared with the Minister when the NHS introduced its ambition to get to 18 weeks it also had to employ 7,500 extra consultants who had to enter into a concordat with the private sector to get increased capacity; it built 100 new hospitals; it employed 22,500 new nurses and 6,500 therapists. I am not suggesting that is what we need to do –

**The Chairman:** There might be an element of scale in that, yes! *(Laughter)*

***Mr Quinn:*** I think what we need to ask in the first instance is: are we getting a sufficient return on our current capacity? And utilise it better.

**Q500. The Chairman:** Would it surprise you to learn that there are about as many people missing the 18-week RTT target in the Isle of Man as there are in all of England?

***Mr Quinn:*** Yes. Nobody is hitting the 18-week RTT on the Isle of Man.

**Q501. The Chairman:** No, whereas I think the number in the UK that are missing that target is around about 3,000, which is pretty much the entire Isle of Man caseload.

***Mr Quinn:*** It is yes, although I would just point out the NHS is not delivering at 18 weeks currently in *all* areas.

**Q502. The Chairman:** There has also been a recent decision to suspend private practice. Could you just give us the reason why that is please?

***Dr Couch:*** There was a media release on 8th October, we had informed doctors and members of staff a little before then, that our current private medical services offering that is, if you will, *sponsored* by the Department … So again as I was explaining to Mrs Poole-Wilson earlier, that you can have private activity within our precincts and private activity outside, but the bits that we control, the income from it, seems to be falling steadily year by year. The private patient unit which was commissioned when new Noble's opened 15 years ago – no, not 15 years – yes, 15 years –

**The Chairman:** Yes, doesn't time fly when you are having fun!

***Dr Couch:*** – is now somewhat degraded and it has not had a significant refurbishment since it was opened. And again some of our protocols have drifted into – and again this will change now because of what Mr Quinn was saying about bed management – but we had been using the Private Patient Unit a little bit for overspill with patients from the Hospital. So the brand, if you will, of Isle of Man DHSC Private Medical Services is somewhat degraded, the unit is degraded, some of our policies in our operations and charters I think with doctors, the management and patients need to be upgraded. So we said all of those things need to be fixed.

Our ambition is to have a far better service that will deliver something far better for people who want to use private medicine – which is fine. It should deliver a better environment for the practitioners; it should be attractive for doctors wanting to come here, who want to do some private work; it would be a better offering for the economy because a number of people working in certain sectors, certainly here, wish to use private medical services and they want to have an excellent, immediate service; and it will deliver more income to the Department which we can use to subsidise other services and make it more sustainable.

So we have made all of that clear. Part of kicking that off is to close the private patient unit initially, for a period to be determined, because it needs to be refurbished, etc. and that means that primarily the services affected are those where you would need to be an inpatient in the unit. That is largely going to be surgical procedures, so for a period they will be suspended. We will continue to allow private diagnostic work; we will continue to allow the use of the consulting rooms, etc. So part of it needs to close to do the refurbishment and then what we also announced in the media release at the beginning of October was that it may be that a partner organisation from elsewhere could come in and help us run the private patient offering. So again we did a prior information notice. That has been done and we have had I think six parties who have sent their thoughts in. We are just at this point planning to meet them and hear more detailed presentations.

So it may be that I can give you an example: the Clatterbridge Hospital near Liverpool, a major cancer centre, has a private patient unit and it is in a partnership with an Irish hospital group to run that private patient unit. And again by doing that, you might have the people who are specialists in that form of medicine doing a really slick service.

**Q503. The Chairman:** So how is it run at the moment, or how was it run until early October?

***Dr Couch:*** There is administration but I think it is largely fused with the hospital system; and then partly apart, isn't it? (***Mr Quinn:*** It is.) And I think one of the things we have been concerned about is that as we have seen income falling off – and it almost goes back to 'Can we track the swab'? – we felt that is another area that we need to upgrade, so people could be self-payers, they could be insured with private health insurance, they would have a relationship with a doctor here who would work out their care plan that might involve coming through the private patient unit into operating theatres.

I think we have been a little bit concerned that we have not been able to track well enough at the billing side, as the provider, to make sure that we get proper recovery for what we have been doing. Now, that does not necessarily mean that *anybody* has abused the system but I do not think we are were content with the control environment around the system. So that is another part of the upgrade that needs doing – the accounting system, the billing system, if you will.

**Q504. The Chairman:** So is one of the ambitions then of this new system, to avoid publicly having to fund a facility that is supposed to be paid for by its users, which are on the whole not NHS users?

***Dr Couch:*** Yes, I think the deal ought to be – and in many places in the UK now private medicine has moved completely away from NHS facilities so that there are private hospitals and consulting rooms. (**The Chairman:** Yes.) There *are* still private patient units in the UK and some of them are very successful indeed, but the deal has to be in terms of: 'I do not work for private medical services; I work for the NHCS and for the people of the Isle of Man.' The deal has to be that that should subsidise the NHCS not the other way around, which I think is what you are hinting at?

**Q505. The Chairman:** Yes. And have we not had a slight problem here that there has been a slight conflict of interest that because of the fusion with the Hospital management, the people who have been overseeing and governing it from a clinical management perspective are also the same people that are using it and billing for it?

***Dr Couch:*** I think there are potential conflicts of interest, yes.

**Q506. The Chairman:** There is obviously the rather high profile issue recently about the high salaries of the consultants at Noble's and some of the highest paid being 75% more than the UK average. I suppose it would be remiss if I did not ask you if you think the Manx taxpayer is getting value for money, especially those at the top end of the pay bracket?

***Dr Couch:*** I think, to answer that question without hesitating for too long, we need to do the studies which we have covered in this session. We need to understand the activity; we need to understand the job planning; we need in terms of our employees, who are consultant doctors, to be able to say to them what is required and they need to say what they are delivering. Then, if you call us back to the Committee, let's say in six months or a year, I think I could answer that question better.

Our pay arrangements are what they are, they have built up over a period and we can see decisions that have been taken that have led us to our particular position. Our wish is to move forward, as I said earlier, on a much more transparent basis that everybody understands. And then as part of my job as accountable officer for the Department I should be able to say to this Committee or to Tynwald or to the public, it *is* value for money. We are still doing the studies to understand that better.

**Q507. The Chairman:** Obviously we had hoped that at any point in time there was a real grasp, but if we look at the figures that are out there it looks on the face of it that if they were brought more in line to a UK average that there is a million pounds to be saved just on the salaries of 40 to 60 staff. And what you are telling us basically at the moment is that the Department does not know whether it is getting value for money from that rather large sum of money.

***Dr Couch:*** I think my initial response, Chair, is that we accept your analysis – we can do the same analysis. However, we have a group of employees who are doctors who are paid in a certain way at this point. We cannot simply change that overnight. We need to negotiate with people, we need to do the job planning exercises, etc.; and it may be that in a reasonably expeditious timescale that cost profile changes.

**Q508. The Chairman:** I think there was the opportunity … The point was made in the earlier session that this job-planning exercise would have been commissioned by the autumn, so I presume that we are well into that?

***Dr Couch:*** Yes, actually we have an exercise that has started now.

**The Chairman:** Mr Robertshaw.

**Q509. Mr Robertshaw:** Thank you; and some of the answers given to you, Chair, have already answered some of the points I was going to make. But if I could just make one particular point before I return to the clearly non-controversial matter of consultants' pay, and that is to perhaps take the opportunity to emphasise that those of us who are on the panel for Sir Jonathan Michael, that he has made very specific reference to the importance he attaches to the point that Dr Couch has just made with regard to changes in legislation to determine a changed relationship between the consultant and his or her employer. And I think it is important that we make that. It is not for me or Jane to pre-empt in any way Sir Jonathan's report, but we are sure that he will want to address that.

Dr Couch, how long have we known about the discrepancy in consultants' pay, when you compare our rates here with the UK? When did it first become obvious, I suppose is the right way to ask the question?

***Dr Couch:*** I think that is hard to answer. I think that certainly Mr Quinn and I have been aware for probably over a year that there is a disparity. I think often it depends how one compares. So we could say our average or our high pay as compared to UK averages, and there is a lot of interleaving. (***Mr Quinn:*** Yes.) So there are very highly paid doctors in the UK and there are doctors paid an average amount, and the average amount seems to be lower than our average amount. But we also have an understanding, I think, that it is likely that an Island health economy, like the Isle of Man and I think it is similar for our counterparts in Jersey and Guernsey, might need to pay a premium compared to average or absolute UK rates to attract people to work here. So it is complex.

I think we have known that if you look at some gross statistics – if that is the right phrase to use – we seem to be completely or significantly out of line with the UK, but it is more subtle than that. But I think we will find this as we go through, we are doing a job-planning audit now and then we will move on to a job-planning exercise with the consultants and we will see what filters out of that.

**Q510. Mr Robertshaw:** I appreciate you want to come back to us on this, and we welcome that and look forward to it. But are there a couple of pointers that you would be willing to

address at this stage to say it might be something associated with consultants that have been with us for some time, or is there some other factor which jumps out and bites you?

***Dr Couch:*** Could you forgive me, Chair, in terms of timing, but I have another commitment. Do we know when the Committee will close?

**The Chairman:** I would hope that we would rise at about half past five.

***Dr Couch:*** I need to leave before then, I apologise.

**The Chairman:** Okay, if it would be possible to get through to the end of this sub-section and then we will –

***Dr Couch:*** Yes, I have got my phone on silent but I am expecting a call and I need to collect somebody, if I could be excused then.

**The Chairman:** Okay.

**Q511. Mr Robertshaw:** I will make this my last question, Chair.

Dr Couch, we have seen an advertisement recently for a speciality doctor in Paediatrics which says the post attracts 10 PAs with a possible addition of 5.5 PAs, with the additional PAs being subject to change and job plan review. Why are posts still being advertised in this way?

***Mr Quinn:*** I am happy to –

**Mr Robertshaw:** I beg your pardon.

***Mr Quinn:*** It is okay. All contracts are based on a 10 PA job plan and that is in line with the UK. I think the particular post that you have described, because of the number of middle-grade doctors in paediatrics, in order to ensure that we have what we call a compatible roster – so, a safe roster – the numbers of PAs that those respective doctors have to work is in excess of the 10. If we kept them to work in 10 there would be significant gaps during the week, and certainly overnight where we would not have middle-grade doctor cover in paediatrics.

**Q512. The Chairman:** Okay, given the commitments, I am conscious that we have been sitting for two and a half hours, and perhaps I am letting my enthusiasm for the topic run away with me. *(Laughter)* It has been known. We are also conscious as a Committee that you are never too far away and we may well have a fifth session on this particular subject at some point in the future.

***Dr Couch:*** Chair, you can take our assurance that we are happy to come back if you want to reconvene.

**The Chairman:** Absolutely. But for today what I will propose to do to the Committee is if we suspend the public sitting at that point and the Committee will continue to meet in private if that is okay.

In which case can I thank our guests today, Dr Malcolm Couch and Mr Mike Quinn, for coming in and for your evidence today. Thank you very much.

***Mr Quinn:*** Thanks very much.

*The Committee sat in private at 5.06 p.m.*