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PUBLIC ACCOUNTS COMMITTEE

Health and Social Care: Overspending at Noble's Hospital

HANSARD

Douglas, Wednesday, 13th February 2019

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Members Present:

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

Clerk:
Mrs J Corkish

Contents

Procedural 173

EVIDENCE OF Dr Malcolm Couch, Chief Executive Officer, and
Mrs Michaela Morris, Deputy Chief Executive Officer,
Department of Health and Social Care 173

The Committee sat in private at 4.57 p.m. 214

Standing Committee of Tynwald on Public Accounts

Health and Social Care: Overspending at 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): Welcome to this public meeting of the Public Accounts Committee which is a Standing Committee of Tynwald. I am Juan Watterson, Speaker of the House of Keys and I chair the Committee. With me are Mr Tim Crookall MLC, the Vice-Chair, Mr David Cretney MLC, Mr Chris Robertshaw MHK, Mr Rob Callister MHK and Mrs Jane Poole-Wilson MLC.

If we could all ensure that our mobile phones are on silent or off, so that 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 fifth public evidence session in our Inquiry into overspending at Noble's Hospital and we are now one year on from our first Report, so I will be returning to the strategy, planning and budgetary matters raised in that Report to discuss progress with the recommendations.

Today, we welcome back Dr Malcolm Couch, Chief Executive and for the first time we welcome Mrs Michaela Morris, the Deputy Chief Executive.

EVIDENCE OF
Dr Malcolm Couch, Chief Executive Officer, and
Mrs Michaela Morris, Deputy Chief Executive Officer,
Department of Health and Social Care

Q513. The Chairman: Welcome, and I am wondering if you have an opening statement which you would like to appraise us of our progress one year on?

Dr Couch: No, Chair, we will just take your questions.

Q514. The Chairman: Okay, no problem.

So, as I said, we have based our questions around the Committee's first Report for this Inquiry, and we will start with some connected questions to that.

In the October 2018 update on the first recommendation about a single strategy, the Department said that the goals from the 2015 strategy had been 'largely' reflected in the Programme for Government.

What is not reflected and what has been dropped?

Dr Couch: Forgive my hesitation. I do not think … Yes, maybe I used a loose phrase; I think it is all there, basically.

Mrs Morris: I think so.

Q515. The Chairman: Okay, nothing has been dropped?

Dr Couch: No.

Mrs Morris: No, not to my knowledge.

Dr Couch: So, in other words there is nothing from the 2015 Strategy that we are not trying to achieve.

Q516. The Chairman: Okay, that is great.
The Tynwald Policy Decisions Report Update in 2018 also noted that:

> aspects of the recommendation are contingent upon the findings and recommendations of the Sir Jonathan Michael Review …

So is some of the work on hold, pending Sir Jonathan Michael's Review?

Mrs Morris: No, I do not think so. I think Sir Jonathan has always been clear that nothing that he is doing should hold us up within the Department, so from that perspective we are continuing in that way. I think it probably refers to the aspect of the budget, because obviously the Independent Health Care Review was initially based on finance, but obviously it is wider. So I think it was around that aspect. That is my take on it.

Dr Couch: Also, Chair, clearly it is a fundamental review of the Health and Social Care system.
At this point we are not sure what the recommendations might be, so the Department is anticipating perhaps a need both with Tynwald and the public to revisit the strategy perhaps once the final report comes to the May Tynwald.

Q517. The Chairman: But it has been full steam ahead on the 2015 strategy until now?

Dr Couch: Yes.

The Chairman: Okay, great. Thank you.
Mr Cretney.

Q518. Mr Cretney: What do you think are the biggest concerns highlighted in the Interim Healthcare Review?

Dr Couch: I think the Review is continuing, so we do not have any final outcomes or recommendations. But clearly Sir Jonathan said it was a progress report to Tynwald and he highlighted themes emerging. I think my summary would be that in terms of the hearings of this Committee and this particular study, we had probably covered most of those things already.
So the concerns are things that I have said to the Committee that DHSC Ministers have said in public. It is things like our cost profile compared, for example, to benchmarking in England on certain themes – the culture. I think new themes have emerged which perhaps, because we are so concentrated on the operations of the Isle of Man DHSC and National Health and Care Service, maybe we had not spotted, if that is the right word – so, for example, the fact that in

the UK and in particular for the English NHS, significant legal changes have been made over the last two decades that have not been reflected in Manx law. Particular things which in our case, in our law we would use the phrase 'the Department' and in a UK context it will often say 'the Secretary of State'.

So if you look at Health and Care Acts in the United Kingdom, the duties of the Secretary of State to do certain things, to foster certain things, there is a range of those that we do not yet have in law. So Sir Jonathan, I think, is saying that one of the themes he is seeing is that our law is out of step with some things that make it easier to run a national health system in the UK. So that is not a concern but it is an observation, I think.

Q519. Mr Callister: Mr Chairman, can I just ask a question?
Could I ask Dr Couch why the Isle of Man is out of step with this legislation?

Dr Couch: I genuinely do not know the answer, Mr Callister.

It is because, if we go back – forgive me – to 1948, Tynwald made an Act to create a National Health Service. The UK had done one in 1946 and brought in the system in 1948, but we did a 1948 Act, I think, which *very* largely mirrored the UK NHS Act.

Over the years, *largely* we have tracked changes in UK law, but not always. So my supposition would be – obviously I was not around when the 2001 Act was created; and in actual fact I was not really involved the 2006 National Health and Care Service Act, it had already been developed and was starting to move into the Branches when I became Chief Executive. Decisions must have been taken with each of our updates about which UK updates we would import into Manx law, and which we would not. The reasons for that, I am not sure.

Q520. Mr Callister: So it did not come down to a lack of legal draftsmen or something?

Dr Couch: No, I think there must have been purposive decisions to bring in certain aspects of changes in the UK and not others. And of course if we think about very big changes in the UK, for example, in 2012 what are often called the 'Lansley Reforms', almost none of that came into the Isle of Man because that brought in things like clinical commissioning groups and purchaser provider, etc. – a radically new system that I think the Isle of Man would not have wanted and does not want now.

Q521. Mr Cretney: One of the things that have been raised here before, and which I do not think we have had a definitive response on, is things such as medical consultant salaries which have been identified in the Report as being 20% to 30% higher. What is happening about those?

Dr Couch: As I have said previously in evidence, the contracts that we have mirror those in England and they are based on a concept of Programmed Activities (PAs). So the assumption is that the basic PA is half a day's work. Over the years, a number of our consultants both for additional duties and for particular clinical responsibilities have built up contracts of more than 10 PAs per week. Some of them are quite significantly more than 10 PAs. In addition, our base salary for consultants is significantly higher than the base salary in the UK. So if you add those two things together you get a potentiation of the salary difference between some of our consultants and some of those that we might see in England.

Q522. Mr Robertshaw: What was that word you used then? Potentiation?

Dr Couch: Yes, building up.

Mr Robertshaw: Right, thank you.

Dr Couch: Forgive me. So, what are we doing about it? Well, we are aware that there is a significant disparity between our base salaries and the UK base salaries and what is called in the process is related to consultants' 'Job Planning'. You are meant to have each year a job planning session with your boss where there is a determination about the clinical activities you will be performing, the administrative activities and any other duties you might have, and then there should be an annual agreement of what your total of PAs should be.

We have, I think, uncovered that the system – the rolling system of each year doing a review with each consultant – in some cases has been done scrupulously and in other cases has not. So at the moment what we are doing is a review of the job planning system itself and then, over the next few months, each of the doctors who needs to have a job planning review will have one. We shall be settling for a new tally, if that is the right thing, and we expect that will actually drive out savings.

Q523. Mr Cretney: Okay, in terms of pharmaceuticals, he identified that we are paying 33% higher here than the UK. Anything about that?

Dr Couch: We are already seeing … There are various ways of approaching this, Mr Cretney, and I think one of them is that in England, for example, there might be a system called a 'Common Formulary'. A formulary is basically the list of medicines that doctors can prescribe, or other prescribers for that matter. That is very common now in England both in the general practice world and in the hospital world, that there will be an agreed formulary which restricts the list of medicines. You could have medicines that are brand new that are covered by the copyright, etc. and they are very expensive, and there might be other ones which are generic medicines which are far cheaper. So the formulary tries to restrict things to appropriate medicines to treat people well, but to get the best cost profile.

So we are moving into that world and what we have seen is also that the investment by the Department in the number of pharmacists has been limited – and pharmacists are a very powerful professional group in terms of the control of medicines, which is not surprising. What we have seen is that – and with the support of Treasury we actually drew some money down from the Health Care Transformation Fund – we have brought some additional pharmacists into the community and we are starting to drive out formulary practices and already the costs are starting to fall.

In the Hospital it is somewhat different. We need, I think, to put more effort in there. In effect, I think there is a challenge for management saying, 'Here is a list of instructions' and professionals sometimes challenging us saying, 'Well, we are doctors' – or other forms of prescribers – 'we should be prescribing what is best for our patients'. And at the cutting edge of new medicines that is always a challenge. So, for example, some of the medicines for autoimmune diseases or various arthritis are brand new, *incredibly* expensive medicines.

I think patients will often approach doctors and say, 'I have read about this in the media somewhere and I need to have that', and doctors will immediately prescribe it. And there is no issue with that. However, the Department also needs to decide what its resources are and whether we should go immediately with that, whether we should delay it in some way or whether we should be looking to where there are similar approaches. So that clearly is a concern, it is something we are managing, but as I say we are seeing progress now.

So in the community pharmaceuticals budget that has actually been reduced somewhat, but the Hospital is still running hot.

The Chairman: Mrs Poole-Wilson.

Q524. Mrs Poole-Wilson: Yes, you have talked about the Job Planning Review in terms of the cost profile, but I think Sir Jonathan Michael also talks about the fact that the productivity that

we have at the Hospital is relatively low for the cost that we put in; and I think specifically he talks about the fact that:

> waiting times at Noble's Hospital are relatively long, targets … for cancer referrals and treatment … are not being met and utilisation rates of Theatres at Noble's Hospital are lower than average across the NHS in England despite comparatively high medical consultant salaries.

So what is the bigger picture about how we are looking to get better value for the cost that is going in?

Dr Couch: I think at this point our approach is to go through sequentially with a number of projects, based on information that we have already had from reviews that have been carried out. So, for example, last year there was a pilot review of the management of the operating theatre suite, and that showed us quite clearly that productivity was a challenge there. So I think we need to go through that sequentially.

We need to do the Job Planning Review. The job planning to an extent I think has to say to doctors, 'This is an expected productivity level for the clinical activities that we do' – and I do not think that has been done in the past. We need to be thinking about how the Hospital flows – how things run. For example, to have the most effective operating theatre suite you need to have the patients there at the right time, moving into the preparation area at the right time, the anaesthetist preparing them to go into theatre at the right time and them moving into recovery at the right time. And ideally you need to have the next patient probably coming in to preparation at the time somebody is going out to recovery. So all of those things are almost like time and motion studies and they are commencing now.

But again I will come back to things that I have said to the Committee a number of times before. Our challenge as leaders in terms of supporting our colleagues to change, is that the culture at this point is – maybe the word I would use is 'relaxed' – and we need to be putting more pressure on whilst respecting the needs of our staff to adapt to those changes.

Q525. The Chairman: So just to build on that, you did say that the job planning process and the review of it is expected to drive some savings. Where do you expect those savings to come from? Will they have any impact on service?

And, to pick up on your last comment, what do you expect activity to look like in terms of driving that performance that you have talked about in terms of moving from a less relaxed culture?

So, each of those three elements.

Dr Couch: I think obviously in our services we would not normally use this phrase, but I mean some of the aspects of what you have just said, Chair, are about industrial relations. I think I said previously in evidence – and I have said again today – that if we have currently a series of contractual arrangements, let's say, with our senior doctors as an example, and we want to move that, we have to be sensitive and we have to explain what that is about. We have to explain what the process will be to effect the change and we have to do that over a reasonable period; we have to give people some notice that these things are happening, but moving towards a point where that is revised.

It is the same across the Hospital, across our services I would say in general, that if we are comparing, let's say, to a similar population size or a similar hospital size in England and we can see that generally they would achieve far more with what they have than what we have, there is a hearts and minds exercise of explaining to people that we want to move to something better. We should be setting milestones, we should have a project plan in place, etc. And if one of the themes that you mentioned, or Mrs Poole-Wilson may have mentioned, is around some of the English targets for things like a referral to treatment or cancer waiting times, or more generally waiting times for outpatients or operations, again we need to do that steadily by targeting, I

think almost with milestones, that by such-and-such a date we will move it from there to there, to there, to there.

But I think there is a risk of our colleagues challenging … Our colleagues may say, 'Well, there are not enough staff members to do *a*, *b* and *c*'. So that is why I say 'industrial relations'. I think that a change programme as big as what we anticipate – it *needs* to be achieved, but it will be difficult to achieve.

Q526. The Chairman: At the moment, we do not see the framework for what that performance management system or that performance drive is going to look like. When will we start to get a picture for that?

Mrs Morris: If I may, since we have had Mr John Coleman join us in the organisation at Noble's – he has got a lot of experience from the UK and he has worked in numerous other organisations, because he does usually six months to a year in interim roles. In the last fortnight he has introduced, and is just about getting to conclusion and agreement from the different aspects of the Hospital service areas, a performance standard document which they are discussing. It is a sort of standard one that would be used elsewhere, but they are discussing it to ensure that people are comfortable with it here. So it is not going to be taken away exactly from the UK, but it is pretty close from the ones I have seen so far.

The idea will be that that will be signed by the Operational Manager, the Hospital Director and the Lead Clinician for each service area. And I think John was only explaining to me last week that all the members of staff of that particular service will be issued with a copy, but there will be one actually on the wall that people can see so that will be instantly available for people to understand. I think that is a good new indication that things will be different.

The Chairman: Excellent, thank you.
Mr Callister.

Q527. Mr Callister: Yes, it was just to carry on the theme with regard to reducing costs, with regard to pharmaceuticals, and looking at one particular area that I have asked about in the past which was prescriptions. Have we actually started to implement policy and change with regard to ensuring those who *should* pay at the counter do actually pay?

Dr Couch: We have issued, I think, general instructions to community pharmacists that those things should be checked. Certainly when I have been, in the last six months, in to my local pharmacy for family medicines there is always a check. And I think there is actually on the desk, 'Are you sure that you are exempt?

But generally I think with our system at the moment very many people are exempt from prescription charges for a variety of reasons, which we have covered before. The question should be, and this was discussed last year, and I think we may be coming on to this in terms of the schemes under the NHSC Act: should we update our prescription system generally? That is a much bigger debate. For example, some of the exemptions are *very* old fashioned. So if you have an illness which is largely related, for example, to a hormone deficiency such as diabetes or hypothyroidism, the old rules which we imported from the UK say that you therefore are exempt from all medical charges for anything that you might need; whereas there are other chronic conditions that you will suffer from for life where you will need medicines and they are not exempt.

The challenge we always have I think in that policy area is that when you try to move to a more objective and fair system, it is a little bit – if I say slightly tongue-in-cheek – about rating reform for Tynwald in general. You know from the outset that some people in a general sense will be winners and some will be losers, and therefore that is a quite challenging policy to bring in. But in general I think the system as it is at the moment is operating well, that the checks and

balances are there. The question is: is the system appropriate for the Isle of Man at this point? And of course across the UK components, the four countries of the UK, they have now gone in terms of prescription charges to completely different places.

Q528. The Chairman: But it is an honesty-based system. If the box is ticked that they are exempt and the pharmacist does not check it – which they may or may not do; they are under no legal obligation to – then you cannot withhold funding from them because that person does not have a pre-payment certificate. Am I right?

Dr Couch: That is correct.

Q529. The Chairman: So there is no risk for the pharmacist in not checking, but there is a great financial risk on the Department.

Dr Couch: I think that is a fair comment.

The Chairman: Mrs Poole-Wilson.

Q530. Mrs Poole-Wilson: Yes, sorry, just coming back to the productivity issue and moving from, as you describe it, the culture being relaxed to perhaps making some real improvements in productivity and you talked about it being potentially an industrial relations issue and perhaps numbers of staff available to do certain things, but the Minister in his Written Answer to Tynwald in September about the KM&T report into the efficiency of the operating theatres talked very much about problems being absence of clear accountabilities for theatre performance and procedures, lack of quality assurance processes, no clear team vision and lack of clearly defined roles and responsibilities. So how much of this really is about the lack of these fundamental processes and frameworks, as opposed to the number of staff available?

Mrs Morris: The numbers of staff are definitely an issue, but I think that the framework around it is also very key. For instance, there has been the designation of a lead for theatres in Dr Chris Till, who is an intensivist and does a lot of work in ITU, right next to the theatres, and is an anaesthetist by trade. He is a very strong leader within the organisation, so that again will have a big influence on theatres. He has the remit for the Associate Medical Director for Patient Safety and Quality as well – so a highly respected individual who has a real conviction for bringing change about. I think that will be a big influence in the theatre environment. But again I refer to these performance standards that I just talked about that John Coleman is introducing. Again, that will be applied within the theatre environment as well.

Q531. The Chairman: Could I just pick you up on the staffing issue there? I understand that Noble's is staffed for 85% capacity but it actually runs at 65% bed occupancy, so surely there should be some slack in the system there.

Mrs Morris: No.

Q532. The Chairman: No?

Mrs Morris: Sorry, no. Usually the capacity is way over the 85%. Previously it has been as high as up to 95% occupancy, so certainly it is more likely to be over than it is under.

The Chairman: Right, okay, that is interesting. Thank you.

Q533. Mr Cretney: Just back to some of the issues that were raised by the interim report, one of the other ones was in terms of our spend in relation to agency staff: 13% compared with 6% in the UK. Any comment about that? Anything you are doing to try and reduce that?

Dr Couch: This largely will relate to, again, issues that we have discussed with the Committee around recruitment. In the medical science lingo at the moment we are considered to be a remote and rural place, but we are also an island, which makes it even worse, so recruiting is a challenge.

I think again I have said to the Committee previously that there have been some very big shifts in the way that a number of healthcare professionals in particular, but it is probably going to become social care too, manage their careers. They do not want to have the approach to their careers that people had previously. The challenge, therefore, is that we may have vacancies that are in areas where that service is essential, so you need to have the person delivering the service and we cannot recruit to them and therefore we are needing to use agencies. Although it is still very difficult for some places in the UK now, I think it is easier for a large body of land such as Great Britain in terms of recruiting people than it is for us.

So I think at first blush that will be the reason for the disparity, that it is harder to recruit here. Probably, when we see any final recommendations – and I think it may be a recommendation to look at that area – we might need to do a study just to ensure that the agency rates per hour that we are paying match what we are seeing in England, which I think they do but we might need to study that and our management of those.

Mrs Morris: I know that from April we are just about to bring in a new framework for the agencies that we work with, and that should have an effect on reducing the costs. There is an awful lot of commission that is made by the actual agencies that really tops up the amount that one pays for these locums. There was one instance recently that I was being asked to look at and it had a 17% uplift for commission, which is vast.

Q534. The Chairman: Thanks to the good offices of our Clerk, who has pulled out the piece of paper that I had remembered but could not quite reference at the time.

I talked about 'staffed for 85% capacity and operated at 65% capacity'. These figures come from a Tynwald Question on 11th December 2018 which has midday bed occupancy between 62% and 66% over the last four years and the midnight bed occupancy between 62% and 65%. That is where those figures have come from – but the Hospital staffed for 85%.

Mrs Morris: Yes, that is the normal across the whole of the NHS.

Q535. The Chairman: Yes, but then occupancy rates are 65%, so there should be some slack there – there should be headroom, rather than staff shortage.

Mrs Morris: There should be. I was not involved in answering that Question, I am sorry, but yes.

I know there were questions around the bed availability that were asked because I know Mr Quinn has spoken, I think, at this forum before in relation to the capacity meetings that are held at eight o'clock every morning and that the Hospital has a big handle on what is available and what is not, which is different from how it was before. So I am sorry, but from my understanding it has been very much the case in recent times – maybe not in December – that capacity has been such that we have been over.

Q536. Mr Robertshaw: So that Answer is right and your answer is wrong, or the other way around?

Mrs Morris: Well, I cannot –

Q537. The Chairman: This is about three full years – but, Mr Callister, it was your Question, so I will give you –

Q538. Mr Callister: And that was because of correspondence I received with regard to concerns raised, so once I read the Answer … But based on what you have said this afternoon, would you have a look and see if that Answer is correct, if it is detailed, and maybe advise the Committee?

I was surprised when I got that, because I received correspondence over a couple of months' period from individuals who actually conflicted that, who actually said that the figure was a lot higher, and you have actually said that today. One of the correspondents clearly showed me that the figure was towards 100% at times, and that excludes TT and whatever else.

Q539. The Chairman: I think, in fairness, it was in part on medical wards and that might be where the difference is.

Mrs Morris: Ah, that may well be the differentiation then, yes.

Dr Couch: And this is the challenge. If you look at a hospital as a dynamic organism, it has wildly different activity levels and also even areas that may be busy today may not be the next day; but the medical wards, which will largely be the route certainly from admissions from the community or admissions through the emergency department, do tend to be very busy. Some of the others may balance.

I think maybe one of the themes is – and we recognise this – that largely the Hospital management system is configured around wards and the ward manager will be aware that her or his staffing complement is for that ward. I think we have got to move to a world where there is much more flexibility around that and balancing out. Certainly our Minister has said to us that we need to do a study quite quickly to determine what the appropriate staffing is in different circumstances and make sure that is flexible, because again if you are a ward manager where … I will make up a figure to illustrate it, but let's say you have a staff complement of 40 and two people go off sick, you might think, 'I need to have two people in to keep my complement at 40.' If I think of an extreme example, your ward might be empty. So we have got to push on that.

Q540. Mr Cretney: Just a final one from the interim report – from me, anyway – and that is about why we are not using UK guidelines and pathways. The report says:

> The absence of a formal commitment to follow advice from organisations such as the National Institute for Health and Care Excellence (NICE) means that the citizens of the Isle of Man do not benefit from a consistent approach to evidence based quality standards, medical technology appraisals or best practice clinical guidelines and procedures, as is the norm in the NHS in England.

Any comment about that?

Mrs Morris: I will comment, if I may. I have been doing a lot of work recently on the West Midlands, all of the reviews there, and one of the things that kept coming up with the West Midlands was that we did not have specific, locally adapted guidelines, and yet our response to that was that we were using the NICE guidelines. So we are using the NICE guidelines but we have not got those formal pathways documented. The clinicians will definitely confirm that they are following the NICE guidelines and not locally adapted ones, but there is a disparity at the moment with regard to the pathways for care because we have not been strong in having shared care arrangements with our primary care practitioners and our consultants, and that is what we need to get together to do more clearly. We have now got our Interim Medical Director

to encourage leading on the pathways work, so that should improve; but it is long in the coming, I do agree.

Dr Couch: Pathways, Mr Cretney, is another aspect of integration, which no doubt we are going to come on to, I am sure, this afternoon – that you have got to be saying that for a person and understanding their needs, we as a Department will bring the array of services needed to meet those needs. That means that the different professional groups, whether they are in the community or the Hospital, or even in England, need to be able to see how those needs will be met. I think, again, it is another area of reform and improvement that absolutely we need to bring in, and I think hitherto not enough attention has been paid to that.

Mrs Morris: We do have examples of pathways being followed quite well in Mental Health Services, but they are more the exception than the rule, I am afraid, at the current time.

The Chairman: Yes. Mr Crookall.

Q541. Mr Crookall: Thank you.

You mentioned earlier Mr Coleman, the new member of staff, and that he had worked in several locations across, usually for six or 12 months. His contract here is something similar, is it, for the time being?

Mrs Morris: He has been engaged currently for a period of six months. We were able to achieve transformational funding because interims are usually paid at a higher rate – on a daily rate – than a substantive member of staff. So we are obviously offsetting the position that Mike Quinn held, the money, against his reimbursement, but it will be more than six months of the designated pay for that role, so the Treasury allowed us to access the health transformation funding for the Interim Director of Hospital Services and for a transformation lead for HR.

Q542. Mr Crookall: Thank you. Good old Treasury!

Can I ask: will the Department come in on budget for 2018-19?

The Chairman: Don't tell me you were not expecting the question!

Dr Couch: Our current financial situation is that we genuinely feel our performance is better than last year. If I look across the different directorates and divisions in the Department, some of them are doing remarkably well compared to their budget. So, if I look at Corporate Services, Public Health, Children and Family Services, Community Commission Services, etc., they are actually in the black in terms of spending against what was expected.

We still have challenges with Government Catering Services. We have actually integrated those into the Hospitals Directorate now, so that they are worse than we expect them to be but, if this does not sound like a paradox, they are better than they were last year.

Our problem continues to be Noble's Hospital, which is overspending currently about 10% versus its budget, but that is enough to tip the Department into the red.

Q543. Mr Robertshaw: Ten per cent is what, though? What amount?

The Chairman: Nearly £10 million.

Dr Couch: It is almost in millions. The 10% variance is not far off £10 million.

Q544. Mr Callister: Can I intervene there? It is –?

The Chairman: Sorry, that is on top of the £10 million additional that the Department was given last year?

Dr Couch: I am giving you figures there of our current performance against this year's budget.

Q545. Mr Crookall: So it will be?

The Chairman: It will be, yes.

Dr Couch: Yes, but bear in mind, Chair, that the Treasury Minister said in his Budget speech last February that notwithstanding that we were being given an additional funding element, there was still a £7 million efficiency target in our budget.

Q546. Mr Callister: Can I just elaborate on that, just to be very clear for *Hansard*: last year you received an extra £10 million in your budget and expected to make a £7 million saving. I think it was something on those … £7½ million savings. But you also received a supplementary payment as well, so realistically you started on a very positive figure at the start the financial year. You are saying by the end of this financial year you are going to still be around £10 million –

Dr Couch: I did not say that, Mr Callister, no.

Q547. Mr Callister: Okay, so how do you think –?

Dr Couch: I said Noble's Hospital has a significant overspend.

Mr Callister: Okay, and that –

Dr Couch: Other divisions and directorates are underspent, so where we are looking at the moment is that our outturn is … It varies, and it is very difficult – I used to say this when I was CFO looking at the whole of the Government's expenditure – to see exactly where we will be at the year end. At the moment we are looking like we are overspending on an annualised basis at about £3.5 million. However, not all of that is related to performance.

I am sure that Members will be aware that the Treasury allowance for salary increases in this year's Budget is 1%. So far, the Public Service Commission's employees have been awarded effectively a 3% pay award. It is a pence-per-hour pay award but it comes out at about 3%. We have not, for 2018-19, yet settled with our Manx Pay, Terms and Conditions National Joint Council group of staff, which is all of our nurses and allied health professionals and what might be called manual workers; nor have we settled with our doctors. The issue, therefore, is that if we have a 3% settlement against a 1% allowance, a very large part of that £3.5 million forecast is down to pay awards beyond what we were allowed. We negotiate with and MPTC and with doctors, so the Department is a stationed employer for those people. We as a leadership team, or my Minister as a politician, are not involved in the negotiation of PSC pay awards, so there is always that sort of contingency around that.

Q548. The Chairman: PSC?

Dr Couch: PSC, yes.

Q549. Mr Crookall: So, if parts of the Department are doing very well and obviously some are overspending, are you scaling back or cutting back some of the services that you are providing, to try and come in closer to budget? And if so, which way are you cutting back, scaling back?

Mrs Morris: I think we submitted a cost-improvement programme for you to have a look at in advance, so you may have seen that already, but the schemes that we have for the last quarter – so, from January until the end of March – are listed on that spreadsheet and there are 15 aspects of those.

One of the largest areas is a rescheduling of non-urgent, elective tertiary referrals for the last quarter.

We have made impact by not having a backfill of a diabetic specialty area; similarly, with rheumatology. We have had no backfill for the locum that we had in place for the Ramsey geriatric consultant; we are having that covered by doctors that are already in our system.

We have had conversion of two agency specialty doctors that worked in the A&E department, and not the consultant level, the middle-grade doctors that are there all the time. We have converted two of those people and they have joined us on the bank, which is significantly less for us to pay.

We have, as a result of the closure of the PPU, been able to redistribute the nursing and administrative staff in those areas to other parts of the Hospital. Most of those nurses have been moved to other wards, obviously, because their specialty has been ward activity rather than specialist activity, so we have allocated those to vacancies and other areas in the Hospital.

We also have a plan to reduce agency staffing in theatres completely from the end of this month. We have only got one person there, but we will reduce that from this month because he is joining us substantially as well. And we have had some reductions in consumables in theatres etc.

One of the big hitters is actually going back to the discussion about drugs. I am not sure of the technicalities – I am sorry, I am not a pharmacy person by background – but one of the big drug spends that we have had is on drugs that are technically termed as biologics, which are for rheumatology and various other high-cost areas. In the pharmaceutical industry they have adapted drugs so that they are now called biosimilars and they are much cheaper but they still have the same effect, so we have been able to swap patients from the biologics to biosimilars, and again on our spreadsheet that is predicted to … Well, we know that we have already saved £60,000 a month, so it is predicted to save nearly £200,000 in the last quarter, a significant amount.

Dr Couch: But again, Mr Crookall, we are doing all that we can to avoid reducing services to our communities. (***Mrs Morris:*** Yes.) If you think about earlier discussions about Sir Jonathan's observations about efficiency etc. that is perfectly appropriate.

You recall that we had the MARS programme; that reduced some of our staffing complement without any effect on services. Certainly from our level we have quite assertively reduced the number of senior people. So again annualised savings there, of not that far short of a million pounds. So we are doing what we can to reduce the super stretch of the organisation, to reduce back office people, to protect the frontline etc.

Then of course we are expecting that one of the key features of Sir Jonathan's report, which is part of the terms of reference, is actually to assess the funding settlement for the Department as a whole and to whatever information they can gather to say, 'Does that look as if the DHSC is getting too much, too little, or is it Goldilocks and just about right?'

Q550. Mr Crookall: It certainly sounds from the list that Mrs Morris has just given us that extensive work is going on to try to make those savings and not make cuts on the services, but inevitably in the community and things, it sounds as though there have been some cuts and lists will grow slightly, by the sounds of it.

When those decisions are being made are politicians involved in those at any time? (***Mrs Morris:*** Yes.) They are?

Mrs Morris: Absolutely.

Dr Couch: Always.

Q551. Mr Crookall: The whole of the Department is aware?

Mrs Morris: Yes.

Q552. Mr Crookall: Is it just the Minister or the whole of the Department is aware? Those decisions are made at departmental meetings?

Dr Couch: All of my primary briefings will be to my Minister, but we have a departmental meeting on the first Friday of every month, where all of these things will be aired for the Members; and I think the Minister – I cannot remember if it is every week but it is certainly very regularly – meets all the Members to brief those on things too.

Q553. Mr Robertshaw: Good afternoon.

Just going back to this issue about staffing costs, at the start of this administration the Treasury forecast coming forward for the whole of Government was 1% increase per year and at the get-go I said, 'No, I do not agree with that. It should be more than that because there are going to be areas where wage costs are going to exceed that,' and I particularly made mention of your Department.

It has now moved up, I think, to 2%. You are now saying it is, in reality, 3%. Are you actually saying that you are not going to be able to meet those Treasury general targets, or that others elsewhere are going to have to compensate for the fact that you are going to find it *very* difficult to live within a 2% bracket, in light of all the evidence that exists right across Western Europe that this is a really tense area?

Dr Couch: Yes, I think it does make it very difficult. (**Mr Robertshaw:** Thank you.)

We are a Department where a very significant percentage of our overall costs is people costs. If the allowance from Treasury, as approved by Tynwald in the February Budget, is for 1% increase in pay then the consequence of that is that to manage a pay award above that we should be reducing the staff complement. The challenge then almost comes back to Mr Crookall's question: does that therefore lead to reductions in services? It could do in some areas, theoretically.

So, yes, that is one of our big challenges. The people costs line, pay awards, recognising that people in any form of occupation will want to see pay rises and at least keep them in real terms meeting inflation, is a challenge. We now have a three-year pay award agreed with the PSC, which, if I remember correctly, comes out at about 3% for this year, then I think it is 2.75%, 2.5%. Each of those years is beyond what Treasury said in its medium-term forecast would be allowed. So the pressure on us therefore is enormous.

As I said earlier, for 2018-19 the Department also has a £7 million efficiency target built into its budget. So although we were given more money this year, the Treasury Minister said that there is still ... So we have got £5.5 million more this year. In essence, I think we were asking for £12.5 million, but we have got a £7 million savings target. So that is one of our key challenge areas.

The Chairman: David.

Q554. Mr Cretney: Yes, I was just seeking a little clarification on the biosimilars. Acknowledging that it is not your area of expertise, I just wondered is there an analogy where generic prescribing takes place, because you said the end result was the same, that it helps? So is that what it is – it is just like a generic prescription? No?

Dr Couch: It is similar. Standard medicines development will be that a pharmaceutical company will do its research and development, it will ideally find a medicine that is approved for use in humans for certain purposes. It then will – obviously it is a business – try to make a profit and it will try to recoup those R&D costs. So the initial costs of a new medicine are very high. (**Mr Cretney:** Yes.) Usually that will then run in copyright for a period, the copyright ends and then other people can make that formula of medicine, if they wish. So that is generic.

What has happened with the biological medicine stream is that other scientists very quickly realised that you could do similar things without breaking the patent of the original one, but delivering an equivalent effect before the end of the patent period. So the biosimilars, I think, is a new class of medicine that does something very similar to the brand new expensive ones, but came in much more quickly than you would have expected. (**Mr Cretney:** Okay, thank you.)

Therefore our challenge is to talk to our prescribing doctors and to our patients, of course, and say, 'You may have been started on that wonderful new medicine for your particular condition but we actually have an equally good medicine now which will say something different on the box but it works as well, but for the Department is far cheaper.'

Mr Cretney: Thank you.

The Chairman: Mrs Poole-Wilson.

Q555. Mrs Poole-Wilson: Yes, going back to the overall budget, and you mentioned that other parts of the Department are in the black, I just wondered is the Department then in fact scaling back or stopping certain services in other areas in order to try and balance the books or support the overspend in Noble's?

Mrs Morris: We are not stopping services in other areas but we certainly have a cease on all discretionary spend across the whole of the Department. So things like that, people may have decided they want to send somebody on a study day or whatever for this last quarter, they will not be sent unless it is absolutely essential. So a discretionary spend is absolutely ceased for the whole Department.

Q556. Mrs Poole-Wilson: So if we look at, for example, just Children and Families, they have a particular challenge, I know, at the moment of having to deal with the fostering service. (***Dr Couch:*** Yes.) (***Mrs Morris:*** They do.) How confident are you that there is adequate resource available to support just an area like that, that does need major support?

Dr Couch: I am confident. We have an extremely good director. She is on top of that job. Bringing in adoption and fostering has not been without its challenges, but she is on top of that. I think that the budget for the division overall is adequate.

Q557. Mr Robertshaw: If it is the case that you are not a huge distance away – listening to what you said earlier – from your anticipated budget for the year, not a huge distance away, but that the acute service at Noble's is overspent by something in the region of 10% and therefore we are somewhere in the £9 million, to £11 million, £12 million bracket, from what you say, then that means that probably £10 million has come out of other services in community care, primary care *et al*.

Michaela has just mentioned one particular thing; I cannot equate what she said with a saving in those areas, if I have understood you correctly, of about £10 million. Where has the money come out of? Primary care, community care, adult and elderly, children and families? Where has it come from and how?

Mrs Morris: One example would be we have had the amalgamation of a number of divisions since the beginning of January 2018 where we have brought mental health, adult social care, community health and, in the middle of the year, the primary care aspects all together under the one director. As a result of that, there have been significant savings because they have realigned their management structures and so forth. So there have been significant changes there.

Q558. Mr Robertshaw: So are your corporate costs going up, down or staying the same; the corporate as described in budgetary forecasts, in the light of what you have just said?

Dr Couch: Corporate costs are running in the black so they are doing well. But it is difficult. If you look at the Pink Book tables or even the Government's accounts it seems as though corporate costs are very high, but that is because we reserve certain global DHSC expenditure at the corporate level. We have also tried to manage this year by retaining a contingency at the corporate level, whilst obliging our directors to accept cost improvement targets built into this year's budget; which is actually interesting because that means that as I look at the table of where we are, some divisions have done really well with those targets.

Mr Robertshaw: Thank you.

Q559. Mr Crookall: Can I just pick up, we were told a minute ago about decisions on savings or cost cuttings that have been taken to the Minister and the political Members and you said they were always told; how often do they overturn an idea that you come up with or that has come from the Department? Is it regularly or not at all? Have they, I suppose is …? Yes.

Mrs Morris: There certainly have been things that have been put forward that have not been agreed. Usually those are things that are more affecting of the patients or waiting lists or something like that, that are felt to be not something that actually is palatable really.

Q560. Mr Crookall: Have you got an example?

Dr Couch: In the last budgetary cycle we were running in the red and one of the things that we could do to save money would be, for example, to have planned operations – so these are not emergency operations – parked for a period. That would reduce activity, it would reduce the cost of the actual equipment you use, etc. Officers proposed that as a savings idea because that is actually now reasonably frequently seen in England and other parts of the UK; and politicians said – and they have a different focus than we have, *you* have a different focus than we have, that is how it should be – 'That is not going to work.' So the idea was rejected. We then go back and try to find other ways of saving money.

It comes back to what I was saying earlier, Mr Crookall, we would not want to reduce services to the people of the Isle of Man unless there was absolutely a necessity to do that. But again we do recognise that we are a corporate player in the Isle of Man Government and that the Treasury has an overall budget envelope that we are part of.

Mr Crookall: Okay, thank you.

The Chairman: We will move on to integrated care at this point.
Mr Robertshaw.

Q561. Mr Robertshaw: The Chairman has asked me to kick off the inquiry this afternoon into this document, for *Hansard*, 'Delivering Longer, Healthier Lives'.

If I can precis my remarks by expressing a certain amount of cynicism which is borne out of a long life on the Isle of Man, both in Government and in the private sector, in dealing with

Government issues, that I have over that long period seen endless reports coming in, with particular regard to health, that have been full of good intentions and determination to improve things, that have progressively either fallen by the wayside, been forgotten or left on a dusty shelf.

So you can understand my cynicism in asking you why is this one, this document, going to be different this time? Can you persuade me that this is going to be a document that is actioned?

Mrs Morris: I would like to persuade you by saying that it is a document that means a lot to a lot of people in the Department and across the Island itself.

I think that the reason it took quite a little while in coming about is initially the thoughts were around having a more medicalised model for integration. That was the direction that things were going in and certainly when I was given the delegation of looking after integrated care when I was designated as Deputy Chief Executive from the beginning of January 2017, I had a lot of meetings with a cross-section of the directors and staff within the organisation to understand that. Having done lots of literature searching and reading around models that have been more successful, it was, for me and the people in those discussions, about people, not medicalised models. So there was some thought originally around having things around the GP model and them being the centre of everything. GPs have to be very involved in all of this work of course, but actually this is about people and place-based services.

That is what I think people bought into across the Department around this issue. Certainly, I believe that is why – because it is not about just the medical profession delivering something differently. We have got a lot of people that work in the Department, obviously, that cover lots of different professions and different areas of health and care; and they are very much bought into this philosophy of doing it for the person that is at the centre of everything, rather than it being what the medical team might ordain is the right thing to do. So that, for me, was a very strong perspective on why it took a little while.

It was being led initially by the previous Director of Primary Care who has a background as being a GP, so you can understand his mindset might have been on that model and we shifted it from the time that I was designated to look after this area. It takes time for people to understand a buy-in, and the document did take a little while in being brought about.

But certainly when the Minister launched it in September 2018, there was quite a lot – well, a huge amount – of enthusiasm for it and very much a commitment to bring it about this time. Nobody wants to let the people of the Island down and as a group of directors – there must have been five, six, seven directors that stood in front of the people that attended the events in the tent in September; we had a week's worth of events – we spoke, each one of us, with conviction about not wanting to stand in front of them and offer them something or suggest that something is not possible. I think we noticed – didn't we, Malcolm? – from the comments that we had from the floor, the questions that were asked, that people were pleased to see that we had that conviction and we were determined not to make it a dusty copy.

Q562. Mr Robertshaw: Good to hear and I share, along with many other people, the importance of this.

Unless I have missed something and had a senior moment, why wasn't such an important document then given the opportunity to exercise itself on the floor of Tynwald? If it came out in September 2018, it is now February, and we have not even debated it yet?

Mrs Morris: That is very remiss. I am not sure why we did not take the opportunity to do so. It certainly was not suggested to me to put it forward. So I am sorry that that was not the case.

Q563. Mr Robertshaw: Okay. Move on.

It is something we are going to have to debate and discuss. It is *very* important. So I look forward to that opportunity in the future.

Turning to this important document, I am a bit confused about its timescale, when it starts and when it will be delivered. On page 21 of your document it says:

> This will be an economy-wide programme to deliver this change in a phased way over the lifetime of this strategy.

What is the lifetime of the strategy?

Mrs Morris: Because it is part of the overall strategy for the Department, the DHSC, which although was unanimously agreed by Tynwald in 2015, runs from April 2016 to March 2021, so it is until March 2021.

Q564. Mr Robertshaw: But you are not suggesting that a lot of this stuff … because most of it starts, 'We will' and 'We want to' and 'It is our intention to'; it is not 'We have started', 'We are doing'. What is the timescale for this, in all honesty?

Mrs Morris: I know you have read around integrated care, (**Mr Robertshaw:** Yes, I have.) as have I, and it is something that is an evolution; it is not something that is going to happen overnight and certainly it will not be completed by March 2021. But we wanted to tie it in with the timescale of the overall strategy. So that is why it is written in that way for here. But it is certainly not anticipated that everything will be achieved within that timescale, no.

Q565. Mr Robertshaw: Would it be unreasonable to say if it is a five-year ambition? I mean if it is going to work, back to my original point about reports ending up as aspirational rather than deliverable, (***Mrs Morris:*** Yes.) you would accept that at some stage, and particularly when it comes to Tynwald, you will want to put some sort of timescale on it? (***Mrs Morris:*** Yes.) Otherwise you can never really analyse your performance against it.

Mrs Morris: No, well, we have some of our implementation plans around one particular aspect of integration pertaining to the pilot in the west that you may have heard of, I know you will have heard of, from us discussing it at the Jonathan Michael Review Steering Committee. And certainly the implementation plans for that range from some short-term issues, that can be achieved within six to nine months, to the whole duration of 21 and more, depending on how quickly we are able to access funding to do some of these things. I think Sir Jonathan has certainly suggested, and we all believe working on this area, that there may well be a need for some pump priming to be able to make things work. The idea is that we reduce the costs in the Hospital and eventually that money can be removed from the Hospital to be able to facilitate more of this care happening in the community setting. But to have two things running in parallel you are going to need some pump priming to do that.

Q566. Mr Robertshaw: Fine. But we are agreed then that it does need a timescale attached to it at some stage that is measurable, for those watching with great interest how this enfolds?

Mrs Morris: Yes.

Q567. Mr Robertshaw: Thank you very much.
Who was actually involved – I know you were leading it – in putting it together and how?

Mrs Morris: Well, I was the main author of the document but there was one particular chapter that has been written from our third sector partners, so that was a combination of the Chief Executive of the Hospice, the Chief Executive of Crossroads and David Gawne, in his many guises across the third sector. So that chapter was specifically written by them and contributed to it.

The various iterations of the draft, as they were being developed, were shared at Department meetings a couple of times so directors certainly had more access to it and all of the Department members had access to it in its formulation. And changes were made as a result of comments etc. that were given to me.

Q568. Mr Robertshaw: Thank you.
On page 30, 9.2, Governance, you say:

> Transparent and efficient governance is essential to delivering this transformational change. A DHSC Programme Board chaired by the DHSC Chief Executive has been established to ensure the planning, prioritisation and implementation project streams are coordinated, monitored and reported…

Actually it says to the Board, so it is sort of reporting to itself there, but:

> Minister and delegated political members.

How is that going?

Mrs Morris: The project board is in place and it covers a wide range of topics and there is also an Integrated Care Project Board that also reports into what we described ourselves as the Executive Leadership Team rather than the board. It is effectively the board of directors.

We have had our first integrated steering group that reported to ELT this this month and the programme board has been established since, I think, December of last year or January of this year, so it is relatively new.

But, for instance, the pilot in the west, because it was recognised it was going to have a lot of interest because it is hopefully going to be a model that is replicated across the Island, rather than just isolated to the west, had been set up with its own governance structure. Again, I chair the Executive Group but it has a range of people on that including MHKs from the west, so Minister Harmer is on that, we have Mrs Corlett and Miss Bettison from our Department on it, we have a representative of the CVOs, so Jackie Betteridge is on that Executive Steering Group for that pilot, we have got David Catlow, Henrietta Ewart, myself, Angela Murray, it is a very large group for steering that particular project because we recognise how important it is. And that feeds in to the integrated governance arrangements which I was describing before.

Mr Robertshaw: Thank you very much.
We come back to funding because –

Q569. The Chairman: Sorry, can I just – (**Mr Robertshaw:** Yes, indeed.) That is a very high level group of individuals, how many people are actually delivering that on the ground?

Mrs Morris: I have not got it in front of me, but it is a very complex pilot and so it has a number of people that are at a sort of management level that are the … forgive me, I am not sure if I have got the correct terminology, there is a delivery group and an operational group below it. It is certainly not just people within the Department, because a lot of this success will be by reaching out to community leaders and organisations that are working in the community around the west. I know that those groups meet every fortnight and I think it is almost a range of about 70 people, so it really is very broad. I can provide that detail if you would like me to.

The Chairman: That is great, thank you.

Q570. Mr Robertshaw: Moving on to the funding issue. In some respects we have started to touch on this already in some of your answers to some of the questions from the rest of the Committee, but on page 2 of your Report you say:

> These plans will require large-scale transformation of the way that care is delivered in the Isle of Man, and include a significant shift of resources out of the hospital setting to care provided in the community setting…

So that is a very important statement that you make there. As things stand, we all recognise the fact that funding is migrating away from primary and community care into acute care, it is going on, as I understand it, as we speak. So in other words, funding is going as it were north and our intentions and desires are going, as it were, south or the other way round, whichever way you want to look at it. Does that not worry you?

Mrs Morris: I can see why you would be asking that question. What the concern is, I think, is how we can stop people accessing services that are currently delivered in the Hospital that they may not really need to access in that way. We need to change the mind-set of the people and obviously our clinicians and the people that work in the acute setting as well, so that they only do in the hospital setting what is actually really required of those professions to deliver there.

And that is the big thing that we need to change in culture, and that is the big move that is going to take … As we know, culture is something that takes time to change. And we want to be delivering to the highest quality what we absolutely need to in the hospital setting, but the majority of people should be able to have their care provided perfectly safely and adequately in a setting close to their home or in their home in the community.

Q571. The Chairman: And this will be reflected in the job planning process that you are undergoing at the moment, about pushing that down to shared care and things?

Mrs Morris: It probably will not be in the first iteration of the job plans but job plans are definitely to be done every year, so it will be more and more as far as the time progresses and the changes shift from hospital to community.

Q572. Mr Robertshaw: Okay, thank you.

Back to funding again, this issue of the budget is staying reasonably close to balance, by projections anyway, because of these huge swings from primary and community into acute care. You accept it has got to go the other way but we do agree, don't we, that in any attempt or determination to achieve improved efficiency or productivity it always costs money? (***Dr Couch:*** Yes.) And so do you feel you have got satisfactory apportionment of funding to enable that at this stage, or maybe it is something you are going to deal with later, to drive those massive changes forward?

Dr Couch: At this point the Department has no reserve in its Tynwald vote to do significant transformation projects. So the pilot in the west, as an example, we are largely trying to do that with internal resources to see how it will run.

Q573. Mr Robertshaw: But is that wise?

Dr Couch: Well there is the Healthcare Transformation Fund which Treasury, with the approval of Tynwald, has topped up each year. And that is explicitly designed as a reserve that our Department can draw upon on the basis of spend to save. So we should be saying that if we want to do this with this money the end point is *x*. So that will give us some funding for transformation projects once we have determined the best ones to use to draw those funds down for.

Going back to Mr Cretney's questions earlier about Sir Jonathan's progress report, Sir Jonathan also highlights the need for some form of transformational funding to get us over this hump of running the day-to-day services whilst needing to transform. Our Finance Director

often uses the analogy that it is like trying to change a wheel whilst driving on the motorway. It is an enormous challenge.

So I think that this will be an issue for the Department clearly in terms of leading the transformation in all of its facets. Including, as the Chair was just saying, the need to integrate the contracts that GPs work under, the contracts that our hospital staff work under, how they interact with each other, how the referral system works etc. So there is the Department, there is the Treasury as the guardian of the public finances and then, of course, there is Tynwald, both in terms of the annual review of the whole of Government expenditure in the budget debates and then from time to time there may be other things that come up that need to be taken care of. But yes, there is a need for transformational funding.

Q574. Mr Robertshaw: So is Peel then a pilot or a determination to go in a particular direction that you are comfortable with? I am a bit confused because if you are going to apportion transitionary funding to the determined new model, how can you achieve that determination without investing in a pilot? I am confused.

Mrs Morris: We are investing in the pilot, in that there are a number of cases that have been built now that will go to request transformation funding. So going back to the pilot, the foundation for the integrated care document that came to the Executive Steering Group for Integrated Care for the pilot on 20th December, were again all of the recommendations in this document that were agreed by those of us and the membership of the Committee were all there for that meeting. So there are 42 recommendations that were unanimously agreed as the right way forward to go and a number of those will require cases to be made to the transformation budget funding, so that is very much anticipated.

We are not trying to do it on a shoestring because it has to be done well.

Q575. Mr Robertshaw: It would fail.

Mrs Morris: It would fail! And we do not want anything to fail because we really believe this is the right way to go.

Dr Couch: One aspect which will be critical is probably going to be a very expensive aspect to the project and that is – and again I think Mrs Corkish mentioned it in some of the themes for today's meeting, digital transformation etc. At the moment all of us in this room will have some parts of our health and care record in different places, it is inevitable. So, again, to have a good, functional, integrated care system in the community we need to have an integrated care record. So again that is another project which is now starting which will drive us towards that.

Q576. Mr Robertshaw: Okay, let's go over today to data then. I am trying to sort of lock timing into budgets and investment in data issues. My understanding, right or wrong, and you have touched on it, Malcolm, is that effectively you cannot do integrated care without a strong supporting data system, I think that is fair. What is the timescale to achieve a usable data system?

Mrs Morris: When I took on integrated care, in January 2017, I set up a working group to be able to look at the things that needed to happen around the integrated record and the multidisciplinary working group, that was led with project management input, they identified that there were certain aspects that could be done without the records being completely digitalised but obviously that was the right solution. So we introduced the concept to our colleagues in GTS in the middle of 2017 and they went away to try and identify whether or not there were connections that could be made within the systems that we already have working across Social Care, the Hospital and the community so systems like RiO, EMIS and Medway and

that is where they have been trying to progress things to see whether or not there could be connections made.

So what is happening currently is that requests have been made from the managers and the project team in the pilot in the west so that the people working in the team in the west have access to … So, for instance, if you are working in the community you would currently have access to the EMIS system if you are a district nurse, and you want that professional to be able to see what the social care system is saying as well. So they have requested additional licenses for people to be able to see both systems. You will not be able to document in one record at the present time but you can see what has been going on in both aspects so that you will have an overall picture of things. So that is how we propose to temporarily move things on so that people can actually work in the new system without having the integrated care record brought about.

We have had a strategy, or a vision document as it has been renamed again, for the integrated digital care record that has been produced with our Clinical Chief Information Officer and with help from GTS as well. Certainly we have workstreams going on to ensure that it is not just a technical solution, that we have complete buy-in from all the service inputters. And so there is a service input committee that is just about to be established and obviously terms of reference and so forth around that whole project area, but there will be a requirement to go out for a PIN, and to try and understand what are the systems out there that we could potentially purchase.

Q577. Mr Robertshaw: Okay, so what is the timescale?

Mrs Morris: Initially this document that we received suggested it was 2021 before we would have one in place. Apparently it is possible before then, in a year or so, but –

Q578. Mr Robertshaw: The Council of Ministers then, bearing in mind the amount of money and the importance of all this, do they now see this as a priority as far as GTS is concerned? Is it at the top of their list of things to get delivered?

Dr Couch: I am not aware of that because at the moment we are building the case that will go to Treasury and then to the Council of Ministers as part of the digital strategy.

I think, as Mrs Morris was saying, we have a stop gap solution which is clunky. So if I think of an example to try and make things simple, it is hard, but let's say we have Mrs Qualtrough living in Castletown, she will have some parts of her record in the local GP surgery, she might have a social worker who has some record in the social work system, she might have an occupational therapist at Noble's and she might have been an inpatient last week so there will be a Noble's patient record. Our stop gap is that a care worker going to see her at home or in the community, I think as Michaela was saying, could have multiple screens that they can open on an iPad or on their computer so they could open the Hospital Medway system, they could open the doctors' GP system etc. to see. But that would not easily tell them that Mrs Qualtrough last week was in Noble's with a urinary tract infection, was treated in such and such a way and has gone out etc.

So our ambition is to have a system floating above that which can present to the worker the key details, the key immediate details, of this person and their needs. That is the one that would take longer to build because it is a massive project and it will be expensive.

Q579. The Chairman: How does patient consent work around that, in terms of data protection?

Dr Couch: We need to ask them for their consent.

Q580. The Chairman: You need to ask every single patient for their consent for each of the systems to feed into this umbrella system?

Dr Couch: Yes.

Mrs Morris: Yes.

Q581. Mr Robertshaw: So that would create bureaucracy, no?

Dr Couch: It could do.

Q582. Mr Robertshaw: Fine, okay.

If you compare what we are trying to do here with say what they do in France, and you touched on RiO, Medway and EMIS just a few moments ago, we in the Isle of Man, and in the UK, have a single health and social care system – well, certainly in the Isle of Man – that is not able to successfully communicate within its systems for the benefit of the patient as things stand. If you compare us to France, for example, they do not have an integrated care system; they have a range of different independent providers but, following the Chairman's report, through the provision of an authority code called Vitale, a patient takes the authority to the provider and it instantly accesses the information that they require.

We are saying we are clunky – by your own admission, you are saying that we are moving towards bureaucracy in terms of trying to achieve, as the Chairman has asked, this authority from the patient and yet right the way through this strategy here you keep putting the patient first. Isn't the answer here to put the patient first and have the patient give the service provider the authority? Isn't that the way forward?

Dr Couch: Yes.

Q583. Mr Robertshaw: So what are we doing about it?

Dr Couch: Are we still talking about the integrated care record?

Mr Robertshaw: Yes.

Dr Couch: Well, that has to be an aspect of the project because, of course, as part of the project workstream we have to consider data protection, we have to consider where the person's information is and we have to consider how to activate access to that information with the person's knowledge and permission.

Q584. Mr Robertshaw: Yes, but I asked all those questions of the Information Commissioner and he said that the Vitale system works well and would pass his examination – because you are placing the authority in the hands of the patient, which is something you keep repeating you have got to do. I could bore you with about eight references right through your document 'putting the patient first'. You do not seem to be doing that. You seem to be saying, 'Actually, the system is going to be in control of the patient rather than the patient in control of their care.' That conflicts with your own vision.

Dr Couch: I find it hard to accept that interpretation, Mr Robertshaw.

Q585. Mr Robertshaw: Okay. Fine. So shall we say there is a difference of opinion.

We touched on pathways before and obviously you have indicated, as we all understand, the importance of developing these pathways. How will the pathway system, which can be different

for each patient and problem that a patient has, how is that going to integrate, as you see it, in your visionary sense with the development of proper data and access to it, for the benefit of the patient?

I am sort of troubled. If it was the fact that you had some sort of authority for the patient to access, with the patient's permission, RiO, Medway and EMIS, isn't that a way of enabling a pathway system to start working?

Dr Couch: Yes, I agree.

Mrs Morris: Yes, absolutely.

Q586. Mr Robertshaw: Okay, so you are agreeing with me right the way through, but you actually do not agree with me. I am a bit confused now. Explain it.

Dr Couch: The bit I do not agree with – forgive me, Mr Robertshaw – was saying that the system will drive it. We are not saying that and the reason I am agreeing with you just now is that the citizen has needs. We need to explain through public information that at the moment their information might be in a variety of places. To meet their needs well we will need to ask them at some point in this project course to be aware of that and to give permission so that the portal, or something which allows the person to activate that, is the key. They should have control of that.

In the early days of the development of online services, which I was involved in from the Treasury side, we envisaged a virtual hallway that the person can walk into through their computer. They would see different doors to online tax services or whatever they needed and go through. So they had complete control of that.

So in some ways, yes, I can envisage a system whereby Mrs Qualtrough comes in to see a care worker or a care worker comes to see her, and she has, let's say, recently been diagnosed as having type 2 diabetes and at that point can say, 'I give you access to my hallway of information.' So I think it can be very much driven by the person.

Q587. Mr Robertshaw: Michaela knows where I am coming from here, because although there are different interpretations – the French have got one, the Dutch have another and they have been incredibly successful with their Buurtzorg system, but from the get-go it was built on the capacity for the service provider to be able to engage with the patient or client successfully because the data was there.

You can understand the concerns that the Committee would have, in the sense that we have embarked on the right vision but behind that, *way* behind that, is no sense of priority about driving the data. You are saying, 'It is going to be clunky, it is going to be bureaucratic. It can fail if we let this go on.'

Dr Couch: Forgive me, but we did not say that, we said that at the moment we can envisage a stop-gap which will be clunky; we want to have a smooth, integrated system at the end of this particular project.

Mr Robertshaw: Okay.

Mrs Morris: Absolutely, I would totally agree there.

We recently had the Information Management Strategy that has been developed in the Department, at the Department meeting at the beginning of this month, and throughout it there is reference to delivering longer, healthier lives throughout etc. It is really emphasised throughout the document that it is absolutely to be an enabler for what we want to achieve in our vision for integrated care.

Q588. Mr Robertshaw: Going back to a point I have made – and I will close on this particular area with just this last question.

Given – and I am to some extent repeating myself – the huge importance of health to every member of our society, given the cost escalation that has been going on and the drive that now is engaging to change things, do you agree that it is important you ask the Council of Ministers to prioritise data issues with GTS as far as your Department is concerned?

Mrs Morris: I would agree.

Mr Robertshaw: Thank you. Okay, I will move on then, unless anybody has got any –? (**The Chairman:** Sorry –) Sorry, Jane.

Q589. Mrs Poole-Wilson: I just wanted to ask, it is really to build on this: you talked about a project steering board and so on, but in terms of the interdependencies and the sequences and the actual detailed implementation planning, and which comes first and how that is being organised and then timelines to deliver, has that been worked up, does that sort of document exist?

Mrs Morris: I have an example of it here. But I have got so many papers on my desk now. I can share it with you afterwards because I have it here.

Yes. For those 42 recommendations from the pilot in the west, absolutely, we have a Gantt chart with timelines against all those 42 recommendations.

Q590. Mr Robertshaw: Okay. Can I continue?

Earlier on you used an analogy that I think the Finance Director used about – I think it was him, you said – that it is difficult to change the way while you are driving down the road. You are embarking on a very significant change here. Are you going to be able to, as the drivers of this, change the wheel as well?

Dr Couch: I think we can. I think we have talked already to the Committee about the need for certain funding streams to do some parallel running. We are potentially lacking in certain skills that we might need to hire in or outsource. There is potentially – and I think I accept this as an accounting officer – a need to have scrutiny, which can be from my Minister and our political team, it could be from Tynwald or Council. Almost like you are doing in the Committee, saying, 'What is the project plan? What are the milestones? Have you achieved them, Malcolm, Michaela, Department etc.?' So there is that.

But I think we can achieve it. There is an enormous enthusiasm in significant parts of the Department for change, and this goes right back to the debate in October 2015 that Michaela was referring to. Tynwald universally, unanimously, approved the strategy. So what we have been talking about here is the actual iteration of the delivery of goal 2, which is to deliver care closer to where people live.

Q591. Mr Robertshaw: Thank you. If I can move on, on page 8 in this document you talk about telemedicine; telehealth, I think, is the phrase you use. How is that going?

Mrs Morris: We have examples of it in use in our stroke service in the Hospital. We access that service for patients that need thrombolysis and that service. So we have it working within the Department. We do not yet have it working in the community setting.

Q592. Mr Robertshaw: Is that your ambition?

Mrs Morris: Yes.

Q593. Mr Robertshaw: What is the timescale for that?

Mrs Morris: I cannot specify at the present time.

Mr Robertshaw: Alright. Okay. So moving on again –

Q594. Mr Cretney: Mr Robertshaw, could I just ask? (**Mr Robertshaw:** By all means.)
In relation to the telemedicine and telehealth, it is a long time since I was a Minister but when I was a Minister I went to the British-Irish Council and at that time we were leading on telemedicine. Is that still the case? We were supposed to be leading a workstream at the British-Irish Council in that regard.

Dr Couch: I am not aware that that workstream still exists, Mr Cretney, but I can check. I have not been involved in it, no. (**Mr Robertshaw:** Okay.)
The big challenge, interestingly enough, I think genuinely is data protection, because those partners that we would want to engage with will not be in the Isle of Man. So we talked earlier about the citizen controlling access to their information. To then share that with other professionals who might want to look at certain aspects of information elsewhere and give an opinion back, we have got to clear that through. I think, again, as all members of the Committee will be aware, as GDPR has come in, the stakes of infringing against data protection law are of a completely different order than they were previously.

Q595. Mrs Poole-Wilson: On that particular point though, isn't it the case at the moment that scans and documents and notes are frequently exchanged with certain hospitals in the United Kingdom?

Mrs Morris: Yes.

Q596. Mrs Poole-Wilson: So it is not entirely clear to me why telemedicine creates an additional layer of challenge from a data protection –

Dr Couch: Because with each one we need to go through the whole process again.

Q597. Mrs Poole-Wilson: Well, aren't you doing that now?

Dr Couch: We are. I am just saying that genuinely is a challenge. (**Mr Robertshaw:** Okay, can I –?)
It can go the other way. I may have said to the Committee previously but, we obviously commission an enormous amount of specialist care from the UK, which in our jargon is tertiary care. It was only within the last six months or so that we actually gained access to what is called the SLAM data. I do not even know what that acronym stands for. But that is the core of information of what is happening in English trust hospitals. That is freely available in the NHS England, but we were not able to get into it.
So it goes both ways and I suppose really all I am trying to articulate, perhaps not very well, is that often data protection is thrown in as a sort of blocker. We do not want it to be and I think, as Mr Robertshaw was saying, if we discussed these things with the Information Commissioner he does not want them to be either. But you need to be absolutely scrupulous that you follow the steps because not to do so causes a big problem.

Q598. Mrs Poole-Wilson: Sorry, just on that, this transdata, I think you said, (***Dr Couch:*** SLAM.) is that personal data or statistics?

Dr Couch: Yes, because what that shows is that for a person in the system it will show all of the interactions in the tertiary centre. So we might have sent you to have an operation on your shoulder and it will show all the steps in that piece of the pathway in the English trust hospital. It is very important to us to ensure that when we are receiving charges from that hospital we can monitor the activity and just double check that everything is okay.

Q599. Mrs Poole-Wilson: So individuals in the UK give consent for data to be shared freely within the whole of the NHS IT system?

Dr Couch: Forgive me, I am not aware of what happens with English patients but it is shared, yes.

Q600. Mrs Poole-Wilson: But it is do-able if it is happening there.

Dr Couch: Yes.

Mr Robertshaw: Can I continue?

Mrs Morris: Sorry, just to clarify it is done by their patient number, obviously, but not by name.

Mrs Poole-Wilson: Yes.

Q601. Mr Robertshaw: If I can just go back for a moment to an area we have sort of closed down, but I forgot to ask about why you decided to do the first proper full trial in the west rather than the south, because your document talks about the south and then you flip over to the west? Why was that?

Mrs Morris: The document is informed by the community partnership that was a pilot in the south from January to the end of March in 2017, but then we wanted to try and have a place where we could take forward the ideas from Buurtzorg; and when we discussed how we would do that – we were open to any area, at that point – the west came up because it has one GP surgery there and it has a population of one tenth of the Island. It just seemed to us, after we had done a lot of analysis of the data, etc. that that was a good place to do it in and it did not have a base, such as we know that there is one in Thie Rosien in the south and Ramsey Cottage Hospital in the north. The west did not have anything, so we thought that actually it would be good to do something there and to have that. So when we say 'one GP surgery' we are participating with the people that are using that GP surgery or are signed up to that. So that is our catchment and that is our sample, if you see what I am saying.

Q602. The Chairman: Having been through this twice with my constituency hat on, firstly in 2010 and then in 2017, you have at least twice had a complete data set about what was needed in the south; it would have seemed the natural place to have rolled it out, and almost, from what you are saying, easier to roll it out in the south because there is a community facility there, there is the GP surgery right opposite the sheltered housing, right next to the residential home in a compact area.

Have you made a rod for your own back, I suppose is the first thing, by doing it in the west; but why didn't you push that more open door in the south?

Mrs Morris: I am struggling to think exactly what it was that required us to find the right sample set to do it in, but certainly the west was the one that was identified because of the size

of the population. We hope that the whole thing will be rolled out across all areas of the Island as quickly as possible and certainly the south are very keen and ready to get very much involved.

But I guess the complications around there are that there are very many more GP sites etc. there and I think they thought that there was already a provision of a bit of a hub and something going on there anyway. It was the west that did not have anything in that regard so they thought it was probably important to move in an area that did not have that sort of a hub, rather than other areas that did.

Q603. The Chairman: So the west is the *first*, rather than the pilot? It is not a model that you will try to move on from, you are going to roll it out and then you are going to roll it out in the north and the south and the east?

Mrs Morris: What is important to understand around this, and why it has been so key to the engagement and development in the pilot in the west so far, is that each community is quite bespoke. It may be that although it is not particularly far away in the south from the west, they will have their own bespoke needs. So it is a model that should be able to be replicated in the round, but it is not going to be something that you can pick up from the west and put in the south.

So generally speaking, hopefully it will work well, but actually each community has to have their own bespoke kind of way of doing things. (**Mr Robertshaw:** Gosh.) That is really how we want it to be: people-centred and community-centred, place-based. So although the Island is not huge, as we know, we believe that there may be differences in the south, in the north, in the east, in the west.

Q604. Mr Robertshaw: What do you see those differences as being? I mean there are huge dangers in this – having a system which you cannot roll out across the whole of the Isle of Man because then you end up with pockets of difference. Do tell me more.

Mrs Morris: I think generally it will be rolled. We just do not want to say that it is something that if it works in the west it has to be replicated exactly the same way in each of the other pockets. That is what I am trying to say. It has got to be something that works. I think it will generically work in most areas, if not all areas, but we just do not want to be held to that because –

Q605. Mr Robertshaw: Advise me to the contrary; I do not know of any jurisdiction that says actually we are going to roll out a whole load of different systems because that is what people –

Mrs Morris: No, I do not mean different systems, Mr Robertshaw, I am sorry. What I am saying is that what we want is it to be bespoke to the population and the person at the centre of it, and there may be some things that are different in different aspects of the Island. That is all I am saying – probably not very different by any means.

Q606. Mr Robertshaw: I would hope your last statement is true because I hope we do not find a situation where the south or the north or the east, whatever, say, 'Oh, well, actually that won't work because the people that are engaged in the west don't share a philosophy that we've got,' and that runs you into all sorts of difficulties, doesn't it? Okay.

This is a bit of a personal thing and that is: in my time, which is going back a bit, we pushed hard to get the development of Joint Strategic Needs Assessments (JSNA) into the system and it was brought to Tynwald, I think it was 2015 or something, and it was a mapping, as you know, of a pretty decent level – although we all accepted at that time it was just a start.

You refer to JSNA on page 18. You say:

A designated subcommittee of the Council of Ministers, the Social Policy and Children's Committee will decide …

– *will* decide –

… on the prioritisation of the programme for future Joint Strategic Needs Assessments (JSNA).

So have we started yet?

Dr Couch: Yes, substance misuse was based on that Island JSNA. A Joint Strategic Needs Assessment, for other members of the Committee, can be done at the whole of the community level. So we will say, 'Do we know what the health and care needs are of the whole of the Isle of Man?' As Mr Robertshaw was saying, we had a version of that a few years ago –

Mr Robertshaw: Starting a version, yes.

Dr Couch: Or you can look thematically at what we have called in our internal discourse chapters – so you look at particular areas of need and map those out carefully, think of a strategy to meet and then move on.

So we are doing them. Again, there was no internal expertise so we have needed to hire consultants to work with us on the initial work. If we did a comprehensive whole Island one it would be, I think, a relatively expensive exercise, but very valuable. Our Director of Public Health is absolutely committed and advises us constantly that that is needed at some time.

The challenge that we then have – and all of these things are a complicated matrix, as I think all Committee members will accept – is that you get people who will come in and work with us on a needs assessment and they will sort of say, 'Well, where is that information? We need that. And where is that? We need that.' So you almost chase your tail to an extent and they then give you their best guess, because often they will be working in England which is now data rich on all of the things that you need for needs assessments; we are still not in a number of areas.

So, again, I agree with you completely. We need to have a comprehensive needs assessment because without a needs assessment you cannot decide the services you need, you cannot then decide the number of people delivering those services and you cannot decide the costs.

Q607. Mr Robertshaw: Therefore it is not expensive, is it, to do it? It is quite the contrary, isn't it? It is expensive not to.

Dr Couch: I can see your drift. Yes.

Mr Robertshaw: Okay, thanks.

Right, my last question, if I may, Chair?

On page 18 of your document, you talk about listening and working with the Island residents and understanding the population but I think the Committee was a little bit concerned that a lot of the references, which had been personalised to the Isle of Man in terms of names, were actually cut-and-paste commentary from residents in Wigan. And I just wonder whether you think that was appropriate?

If we are personalising care to our people in the west and the south and the north, etc. why are we referencing commentaries made by people in Wigan?

Mrs Morris: Because they actually resounded with the commentaries that we had found from the Island ourselves. Certainly in the pilot in the west, since it started in April, we have had lots of engagement going on, and I think just referring to the document in front of me here, there is a statistic – sorry, I will have it shortly – that the project team have engaged and consulted with over 836 people and 98 organisations in the west. So we have had all of that, and although those –

Q608. Mr Robertshaw: So if you have done all that work – and I do not doubt you for one moment (***Mrs Morris:*** Absolutely.) and I congratulate you on it – but why did we not then use the references from the local people? Why did we transplant commentary from another jurisdiction altogether? That just seemed *strange* to the Committee.

There sort of is not an answer there.

Chair, that is the end of my questions.

Q609. The Chairman: No, I will just pick up on that theme, because it is not just the examples which are word for word what Wigan had in their examples, with the names changed and of course they live in Douglas rather than the outskirts of Wigan, but it is the whole document! Over half of this document is a copy, cut and paste, word for word what Wigan produced in 2014.

I mean, all the bits in yellow in this document are word for word what Wigan put in their strategy. This is not a Manx strategy, is it? This is the Wigan strategy that has been brought to bear on the Isle of Man.

Mrs Morris: Certainly, and I acknowledged that and in the back of the document there is acknowledgment to Wigan Council for having access to it and using it. And certainly when the vision document was being discussed first in the Department, the Minister asked for a number of examples to be brought so that he could see how they were put together and what styles they were in, and I brought three examples to the Department. The Wigan example was the one that people felt was the best style.

Q610. The Chairman: It does not say … It does not give them credit for writing it, because it does say the text is by yourself. But it does give a passing thanks – 'with special thanks to Wigan Council', in the scheme of everybody else.

But would you not agree that it is slightly deceiving to say that this is an Isle of Man vision? This is Wigan's vision with an Isle of Man title on it, is it not?

Mrs Morris: It is very much the vision that fits well for the Island. It is absolutely very similar to one in Wigan, but certainly the visions for integrated care are very similar across the whole world. This particular integration vision is about the people on the Island and so it is very much … Certainly all the work that we are doing in the pilot for it is all about the local population and the engagement with them, and the organisations that we are working with. So it is very much bespoke to the Island, although based on something that –

Q611. The Chairman: And we cannot even come up with Manx examples of people, we have literally just drawn them off.

What would concern the Committee here is that we say we understand the issue, we have brought a Manx solution; but it is not a Manx document. I just do not understand how … I mean, it is either we are such a similarity to Wigan, which has a population of 300,000 people that live on the edge of Greater Manchester and have very poor health outcomes, from what I have read about Wigan in the last couple of weeks – or it is just laziness. And I am not sure which it is.

Why Wigan?

Dr Couch: I do not think it is laziness. It is very similar to discussions earlier in today's session where many people would accept, or expect, the DHSC to bring in NICE guidelines.

Q612. The Chairman: I think we are at least open and honest about that, and I do not think we have been about this. You are comfortable that we have transplanted the Wigan document to the Isle of Man without –?

Dr Couch: Our document is based on the Wigan document, yes, but again that is looking around for what we considered to be good practice elsewhere and relying on it. So, rather than creating a completely Manx wheel, using –

Q613. Mr Callister: Would you say the Wigan model has been successful then?

Mrs Morris: It has, actually, yes. I think there has been a recent publication – and Wigan are often asked to speak at conferences on integration.

Q614. The Chairman: I mean, just to give you the credit for an area that has been changed from the Wigan document: the Wigan document has in its section 10 'Outcomes', and what they intend to achieve roughly by what. We have removed that and put in a whole page about what an outcome is, so our vision does not even have outcomes in it that we are going to hold ourselves to. I mean, that waters it down somewhat. We have not even got our aims and ambitions for what we are trying to achieve, whereas at least Wigan did try in a somewhat awkward way to put something in.

Why is that?

Mrs Morris: Because we wanted to be able to specify those in relation to the pilot first and that is what we have in the implementation plans and the work around the pilot. The pilot in the west is the most tangible aspect of the delivering of this vision and so we wanted to base it on that, and that is what the Foundations for Integrated Care document –

Q615. The Chairman: But you say we cannot roll out the pilot in the west around the whole of the Island because needs are subtly different from the west, the north and the south. Well, surely they are going to be massively different between Wigan and the Isle of Man, so why have we taken the strategy and the vision from Wigan?

Why Wigan?

Mrs Morris: I think perhaps I have not put it across particularly well, around the pilot in the west being something that … I believe it is bespoke to the west, but what I am trying to convey is that we want the integrated model to be right for each area in the community for the Island. So when I say that it may not be replicable in other areas I do not mean that in a generalism. I think it can possibly be, but all I am trying to say is you should not pick something off the shelf and say it will work in one area and work exactly the same in another.

Q616. The Chairman: That is what we have done though, isn't it?

Mrs Morris: Not particularly, no. Because generally this is a general vision, but the bespoke part is what goes on in the west around this document about foundations for integrated care pertinent to the people in the west, and we will learn from that to know whether it is –

Q617. The Chairman: So can I just ask one more, if I can, before I bring the others in?

The Wigan document was written in 2014, so they have now five years of putting that into practice. Apart from speaking at conferences, what is it that makes us think that they are on the right road and they are actually achieving success? What is the evidence that they are doing that?

Mrs Morris: I have not got the update on that in front of me to be able to share with you, but I know that it has been based on work that has been led by the local authority which is why it is something that works particularly well for place-based integration. And that is why, again, we

chose to go down that route rather than it to be particularly all about the medical profession and health particularly, because it is about the whole system working well together.

Q618. The Chairman: So it has been picked by the way it has been put together and what sort of feels it fits, rather than any evidence-based solutions that are coming out of Wigan to show that this is working?

Dr Couch: Well, yes, I mean this is a description of an integrated care approach. What we have in the Isle of Man will be a Manx system. If you think about Mr Robertshaw's references earlier to Buurtzorg, I think they feel that the optimal population catchment is probably in the 20,000 to 30,000 region.

Mr Robertshaw: It is 15,000 to 22,000 actually.

Dr Couch: Yes. So we could have, let's say, four regions in the Isle of Man. Our challenge then comes, and we need to test this on the ground, because in the south – *part* of the south, of course, because people in Castletown may not agree that Port Erin is all of the south – we have a cluster of buildings and a cluster of services as we do in Ramsey, and not everybody would agree that Ramsey is the whole of the north, as we do in Douglas. But if we have let's say four regions, part of our thinking then has to be should we have a central facility in those regions to dispatch people from and to draw people into, etc.?

So I do not think any of these things will have a defined end point and I go back to the concept of the duties of the Secretary of State in the UK. One of those duties is to foster continuous improvement.

The Chairman: Mr Callister.

Q619. Mr Callister: Yes, can I just ask two questions, if possible, Mr Chairman?

Firstly, Michaela, can I ask that maybe the Department provides the evidence to the Committee to show how successful the Wigan programme has been over the last five years, just so we can measure the successes if we are taking that as being the benchmark?

Secondly, could I just ask, possibly Dr Couch or yourself, with regard to the Minister and the political Members. Were they actually aware of how much our vision has actually been copied and pasted from Wigan?

Mrs Morris: I can confirm that certainly the Minister, and I would imagine all of the Members, did. I will have to confirm that. But as I say, the Wigan document was presented to the Department meeting in its entirety –

Q620. Mr Callister: But were they made aware that this was a copy and paste from the Wigan model?

Mrs Morris: They have seen both versions.

The Chairman: Mr Robertshaw.

Q621. Mr Robertshaw: Back to this timeline thing, this capturing programmes that have to deliver by certain dates: do you think therefore that Wigan was wrong in saying their Integrated Health Care Strategy – which you have taken a lot from – was 2014 to 2019? If they can put a package of activity within a particular timescale, why can't we?

The reason I ask that is that I am, frankly, thoroughly lost now as to how we are going to achieve an integrated health care strategy across the Isle of Man within a reasonable timescale,

and integrated with a data system that complies with the Information Commissioner's requirements, because the whole thing seems to be incredibly fluid.

Are you not setting yourselves up for a fail if you do not tighten this all down and give it timescales?

I take your point that the Secretary of State for Health in the UK, of which Wigan is part, said that it is a continuing process – they have put dates, or target time periods on theirs. Do you not think we should, here? Surely?

Mrs Morris: Yes, I think we should. And as I said earlier I think the way it was put, because it is part of the overarching strategy which is 2016 to 2021, I was asked to contain it within that period initially –

Q622. Mr Robertshaw: But you know full well that this programme –

Mrs Morris: Will take longer –

Q623. Mr Robertshaw: Far longer; but no time, effectively, defined at all. It is a huge worry, this.

Chairman, has Rob already asked for the evidence from where Wigan is up to? I think he did. (**The Chairman:** Yes.) I do apologise.

Thank you, that is all.

The Chairman: Right, we will move on.

Mrs Poole-Wilson.

Q624. Mrs Poole-Wilson: If we could come on to leadership and governance, because I think this really does pick up on what we have just been talking about, about the reality of good implementation.

The DHSC Governance Policy was updated, I think, and published in October 2018. What would you say has improved as a result of that?

Dr Couch: We have a smaller, more committed group of senior people. We have coalesced three of the original six divisions of the Department into one. We have a shared values and behaviours framework which we expect senior people to adhere to and be role examples for. Our Quality Assurance Committees working to the Executive Leadership Team are now mature and doing better than they did.

I think on the flip side, before you ask me the question, we still have some issues in terms of information. Certainly, if we were working in certain areas of the UK, leaders would have dashboards of performance figures, etc. more easily available to them than we have. But, no, things feel more effective and things feel much more aligned to the Programme for Government and much more aligned to our strategy than they were.

Q625. Mrs Poole-Wilson: Okay, so that is in some respects about structure.

In their 2017-18 report the Healthcare Services Consultative Committee reported some frustration with the demise of good governance. Would you accept that what they expressed was valid?

Dr Couch: No.

Q626. Mrs Poole-Wilson: Okay. I mean, specifically, the HSCC said:

> … that too often meetings have been cancelled or where they have taken place few, if any, senior officers have attended. Meetings are sometimes held without timely agendas or document distribution which inhibits challenge and debate. Executive Leadership Team (ELT) meetings are not minuted. Senior Officers have left at short notice leaving some Quality Committees unable to function. The consequences of inadequate governance are that decisions and actions seem to appear; rather than being grounded in open and transparent evidence.

So which parts of that would you disagree with?

Dr Couch: The HSCC is a scrutiny body. Its chair and members say that they will try to be our critical friends, and they make a number of comments from time to time that we do not necessarily agree with.

Q627. Mrs Poole-Wilson: Okay, so were Executive Leadership Team meetings minuted?

Dr Couch: Yes, they were.

Mrs Morris: Yes, I think this pertains to when the ELT were a group of three and we used to have bullet points rather than full minutes, but they certainly were … There were outputs from those meetings available, certainly. Now they are more substantive, because we have a wider group. We have the whole of the directors on the ELT. It has now been widened to everybody and there is more narrative covered in those, yes.

Q628. Mrs Poole-Wilson: And the Quality Committees, the lack of attendance and lack of meetings?

Mrs Morris: I think probably that refers to the HR Committee and we have had reports that that is something that people have not always been able to prioritise to go to, and they may have sent more junior people to than the original membership of it, and some of those meetings may have been cancelled.

Dr Couch: We have actually discussed that within the last few weeks, interestingly, because again I certainly, as Chief Executive, do not want that situation to happen.

Q629. Mrs Poole-Wilson: Yes; and which is germane given that we have talked about the importance of staffing, the amount of budget, the culture and so on.

I think the Department said in response to that feedback, all of the elements of clinical governance and quality safety are in place in the DHSC although not all at the same level of effectiveness or maturity. And then in particular I was struck by this comment:

> Research shows that people and customs (culture) in an organisation can confound governance. In health and care, for example, long-standing rivalries between professional groups and personalities need to be managed: and deeply entrenched cultural systems and customs of practice ('business as usual') have to be broken down and rebuilt.

I am interested – we talked before about contracts and job planning reviews. This seems a lot more fundamental in terms of culture, this comment. So is it your view that the culture of the DHSC has and still confounds good governance? And, if so, what is being done to address it?

Dr Couch: I think we have to be honest with the Committee and say that there are still aspects of culture that can confound governance. I think again it is alluded to in Sir Jonathan's Progress Report and certainly he has mentioned to me in meetings I have had with him that some of the challenges we have may need to be addressed actually through legislation.

And this comes again – I mentioned earlier the duties of the Secretary of State in the UK through changes in UK law, the Secretary of State has duties which are then passed on almost

directly to Trust chief executives and chairs and then are almost passed on directly to clinicians. They *must* adhere to them.

Because we have an old-fashioned legal system, often people will cite 'professional autonomy' as a reason for not following a policy that has been mandated by the Department. So that is the 'confounding' point I think that is referred to in that response.

Q630. Mrs Poole-Wilson: So are you saying that we have staff in the DHSC who will refuse to follow – if we have all of these implementation plans and so on – to deliver real change?

Dr Couch: Yes, of course.

Q631. Mrs Poole-Wilson: That, as things stand, we will have people blocking them?

Dr Couch: Yes, of course.

Mrs Morris: Yes, most definitely.

Q632. The Chairman: I do not suppose you think that naming them here would help, do you? You are resisting the temptation – okay, you had your chance!

Q633. Mrs Poole-Wilson: Just going back to the new governance policy that you have published, I am just interested as to why what was previously there – which you then referred to as the board, whereas now I understand it is the ELT – the requirement to 'undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors' was actually removed from your governance policy.

Dr Couch: Again, I think largely that the first document that we had was significantly based on common documents that would be in NHS trusts and to a degree there was not so much of a focus on social care in that, so we have updated it partly because of that.

There was a period where the board, as we called it, became fairly dysfunctional. That was the reason for a period … As Mrs Morris was saying, we took the three most senior people onto weekly meetings to get through some of the decision-making that needed to be done. Then a number of those board members have moved on, and of course DHSC monitors that – some of them some left quite quickly – and we move on to a new point.

That document will evolve. I think it is almost like Mr Robertshaw's point, the evolution etc. I suppose maybe we realised that we had picked up some language from templates elsewhere that at this point it is difficult for us to know … and it is almost again like a point Mr Robertshaw said: can we do it ourselves; are we the people to assess our own work like that? I think that is the reason it was taken out.

Q634. Mrs Poole-Wilson: Your point before, when talking specifically about the effective implementation of integrated care, was that you would need to be open to scrutiny. (***Dr Couch:*** Yes.) So who should be providing the scrutiny of the Executive Leadership Team and the effectiveness of your leadership and governance?

Dr Couch: I think that is a much broader question than for DHSC and I am not quite sure how to answer. I am an accounting – or accountable officer in the new language. I answer to my Minister, so I think the primary point of scrutiny for my performance and effectiveness is my Minister, supported by the political Members of the Department. I also have a line of reporting to the Chief Secretary. So, again, in terms of my performance and effectiveness the Chief Secretary has an interest. I am an employee of the Public Services Commission, so again they

have that. I think in terms of the work of the Department, in terms of policies, operations etc., the Standing Committees of Tynwald, such as this one, as scrutiny bodies …

In terms of that close reporting, if we were, for example, working in a UK trust, often the board meetings are held in public, so there is very direct scrutiny of actions and then there is a separation between – it is like a board of directors – the executives who are running the hospital on a day-to-day basis, the chairman or chairwoman and non-executives watching, etc.

So there are different ways of doing things, but one could say the same for all leadership teams in any Department or Board of Government at this point.

Q635. The Chairman: Can I just say that one of the actions in the Programme for Government was about developing an independent health regulator: is that still an ambition?

Dr Couch: Yes, it is; that is proceeding.

Q636. The Chairman: Okay, so when do we expect that that will be up and running?

Dr Couch: When that target came into the Programme for Government and Mrs Beecroft, who was our Minister then, was very keen on it, we contacted all of the regulators in the British Isles who could cover health and care services, including children's services, which is somewhat different. The children and families division in regulators in the UK will often be also wrapped in with education services. We contacted all of them and we said, 'Are you able legally to do any regulatory oversight in the Isle of Man; and if so, are you willing?' What we have got to now is a situation where, in terms of the bulk of the work of the DHSC, the only regulator that was able and willing is the Care Quality Commission (CQC). We have had detailed discussions with them. We now have a paper ready to go to Treasury, because again we will need some transformational funding. It has been agreed by our Department that we will ask the CQC to come in and do an exercise which will create a bespoke regulatory programme for the Isle of Man, and if that works we then commission them to do it more regularly.

I think there is a challenge – that as an external regulator in the UK context they have teeth, they can order certain things to happen – but nevertheless we can live with that. And forgive me, Chair, but one of the things that they will look at when they are reviewing one of their regulated bodies … The first question is: is it well led? They will gather information, they will go and watch activities etc. And again, they have the five key lines of questioning: is it well led, is it safe, etc.? They then give gradings, ratings, against each of those and if you get inadequate on more than two, I think, they probably recommend that you go into special measures. So that is a form of regulation.

Again, the challenge would be, I think, at the broader Isle of Man Government level, the effectiveness of the DHSC leadership team at officer level. Is it appropriate that we are more or less reviewed than any other parts of Government? That is not for me to determine, but I throw it out as an interesting debate.

Q637. The Chairman: What was the timescale for implementation?

Dr Couch: I think the CQC are ready to come in and start the approving work –

Q638. The Chairman: I just need the date.

Dr Couch: We just need to establish the funding line first, because there will be a cost of that first exercise.

Q639. The Chairman: So, it is not the legislation; it is just the funding?

Dr Couch: I do not think there is legislation, actually, no.

Q640. The Chairman: At the moment, then, all the other areas of social care are parked, in terms of independent regulation?

Dr Couch: No, forgive me –

The Chairman: Sorry, that is okay, just checking.

Dr Couch: CQC can cover almost all of our services, apart from Children and Families.

The Chairman: Thank you.

Q641. Mrs Poole-Wilson: Just another observation from the … something that is not in the 2018 version of the governance policy, which is a comment that:

> The Board commits to having in place arrangements which allow staff of the DHSC, and other individuals where relevant, to raise, in confidence, concerns … Such processes will enable individuals ... to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are addressed promptly.

Again, why has that come about?

Dr Couch: Because we have realised that there was a pan-Government policy, that there was no need to say that specifically for DHSC; it is for all Government employees.

Q642. Mrs Poole-Wilson: I see. Is that a reference that all the Government have a whistleblowing policy?

Dr Couch and Mrs Morris: Yes.

Q643. Mrs Poole-Wilson: Just in terms of the DHSC, though, how well do you think that aspect of governance, that ability to receive concerns and then address valid concerns appropriately, is working?

Dr Couch: I think it is mixed. You can register concerns through incident reporting. You may see an incident of potential harm or problem – that can be recorded in our … There is a computerised incident reporting system. For other things, you can approach your manager or your manager's manager, and then there is the confidential whistleblowing system, where that goes to the departmental whistleblowing officer, who will do an investigation and decide what to do with that.

The quality of incident reporting designed to improve things often rests upon the quality of the people hearing the complaint. I am sure that we have teams where there is a general view of an enormous attention to quality and excellence etc., where people will identify things to try to improve and everybody says, 'That's great, we're glad to hear it.' There will probably be other teams where middle managers etc. do not like to hear such things and therefore would want to damp them down. But certainly from the executive leadership level – and I go back to values and behaviours – we will be radiating constantly that this organisation is about continuous improvement. We do want to hear where things have slipped up, so that we can fix them and make things better.

Q644. Mrs Poole-Wilson: So, to your point about if there are pockets where these things are not being listened to – and, in fact, over the last year we have had two reports highlighting that

things have been raised and there are concerns about communication channels … I referred before to the Minister's September 2018 Written Tynwald Answer stating the significant findings of the KM&T report into the operating theatres includes people's perception that communication structures do not work, lack of faith in escalation processes and lack of quality assurance processes. And then of course we had the MIAA March 2018 report into endoscopy services that really highlights some serious problems, including that numerous concerns were raised by email which raised obvious alarm bells, that they present missed opportunities to delve deeper and ask searching questions to establish actual risk to patients, individuals were of the view that concerns expressed had not been acted upon and they had little confidence in the system to act when expressing concerns, and there is no evidence of any action plans having been formally compiled, communicated or progressed.

I am not sure – but correct me if I am wrong – that we need legislation to address management behaviours that are not taking seriously concerns that are being raised and then dealing with them. So, what is being done where clearly there have been pockets where people have not been listened to?

Dr Couch: I think the key challenge for leaders in an organisation as large as ours is to know where those pockets are that need dealing with. I think we can have a rolling programme both of internal audit or of specialist reviews like that and then we need to deal with each of those as we come to them. We do need to take very seriously certainly when people bring in whistleblowing complaints, because they will be people who feel that it is either not safe or they will not be listened to in their area. But yes, of course we have systemic problems.

Q645. Mrs Poole-Wilson: How senior did some of this reporting get to, do you know?

Dr Couch: It was not to Executive Leadership Team level. I had a meeting with the MIAA team before they finalised that report and they said it reached a position in the system and then the message almost changed. Again, this is a problem of leadership. I am overall accountable for over 3,000 people. I cannot know what is going on with every single one of them on every single day, so the challenge then is how do we get that dynamic sense of what is happening in our Department to the level of the people who genuinely can make executive decisions to change.

Q646. The Chairman: And I will put that question back to you: how do you do that? Rightly, that is the challenge. What is being done?

Dr Couch: We have an organisational development programme which is done in collaboration with the Office of Human Resources. Part of that is to improve management capability and skills, because a lot of this is how managers deport themselves. I repeat that the care values and behaviours framework, which has been developed collaboratively with people, needs to be pushed out because a key part of that is speaking up when you see an issue that needs to be dealt with. The challenge is that we do not want to be on people's backs, watching them all the time as if trying to catch them out and trip them up, so there is a challenge. The Quality Assurance Committees that work to the ELT, their remit in essence is to look at the quality on a day-to-day basis in the Department of the areas for those committees.

Some of the things you can do remotely. We can look at the number of incidents reported into our incident reporting system and we can see if there are hotspots in particular parts of the Department and go and look at those. I think it is a combination of human factors, management factors and information, and all of those need continuous improvement, and I do not think we are content that we are in as good a position as we could be.

Mrs Morris: If I may just add to that – thank you – the care values are something that are not being pushed out. They have been pushed out, they have had workshops for staff to come and

understand what all of that is about for those that were not participating in the generation of them. It is something that I speak about at every induction for 15 minutes or so at the end of the corporate induction. The care values are now part of our framework for PDR and all of the work that we do in developing staff. So, it is definitely a way of doing things – 'This is how we do things here now', the concept of that.

Certainly, speaking from my own experience when I was at Noble's, for a period of time I had 'Meet Michaela' sessions where anyone from any level in the organisation could come and meet with me as a group or on a personal basis. I used to change the time of those. They were advertised across the whole Hospital. I know that when Mike succeeded me – I was only doing that for a few months, based at Noble's – Mike has a very open-door policy at Noble's and very much people would come and see him and talk to him freely. It is about the visibility of leaders, so that you can go around and you can see people in their working environment and they can get to know you.

Malcolm was only commenting to me the other day that, for instance, I have a skill set of being very personable and very easy to talk to and people openly speak to me about all sorts of things, anybody in any sort of a role, so if I am visible they will say things to me or whatever. I certainly remember a situation where some housekeepers came to see me one evening. They were on an evening shift and they had an issue. I spent time with them then, I went back a few days later, I went to them in the evening to talk to their colleagues. It is about the managers taking that responsibility to act in that way.

So, for me, it is about role modelling that. I certainly saw it when I was working with Mike and I am very much seeing it now I am working with John Coleman. He is really visible in the organisation. I am specific about Noble's at the moment because that is where I am based at the moment and I see that more often.

The Chairman: Thank you.

Q647. Mrs Poole-Wilson: Just to finish on that, all of that sounds wonderful, but would you agree that if there are one or two managers who fail to behave in the way that is desired, it causes huge problems?

Mrs Morris: It does.

Dr Couch: Yes, of course.

Q648. Mrs Poole-Wilson: And I suppose the question I have is how are you holding them to account? Having done all of this, having provided information, training, opportunities for development, if people are not walking the walk how are you holding them to account?

Dr Couch: Ultimately you move into capability and disciplinary procedures or in some cases, where you have major issues, you may simply ask somebody to leave.

Q649. The Chairman: And do you feel that the Government systems and practices, as they are, help in that or don't they work? Do they or don't they? It is an open question.

Dr Couch: Forgive me, Chairman, I think the Government systems are perfectly appropriate. The test is in their application.

The Chairman: Indeed, thank you.
Mr Robertshaw.

Q650. Mr Robertshaw: I feel I should know the answer to this before I ask it but I am asking out of ignorance: is the whistleblowing system completely within the Department or has the officer responsible for receiving whistleblowing observations or complaints got some sort of departmental external authority that enables that officer to feel that he or she is not simply reporting internally?

Dr Couch: There is a national policy and at departmental level it devolves down to a departmental whistleblowing officer.

Q651. Mr Robertshaw: So that officer reports completely within the organisation and is not authorised by Government at all – authorised by overarching Government process, but has not got an authority outside of the Department. Would you not think that would be helpful and appropriate and would help people to be reassured if they wanted to engage in a whistleblowing process?

Mrs Morris: I am not sure if I am going to answer your question but to me it sounds like, and I will not go into the detail, clearly, but there is a process going on at the moment that I have asked for the Internal Audit – is that the right term for it? – to help investigate so that it can be can be looked at independently. So that is reaching out beyond the Department to get it looked at and that process is still going on. So I felt perfectly able to ask for an independent agency to help with that.

Dr Couch: I think there is a challenge. We are following national policy, and I suppose the policy has evolved because the people most likely to be able to fix a departmental problem that has been flagged up are the Department's executive leaders.

Mr Robertshaw: You get my point.

Dr Couch: I do.

Mrs Poole-Wilson: Do not worry; there is a Whistleblowing Select Committee. *(Interjection and laughter)*

The Chairman: Mr Callister, we will move on.

Q652. Mr Callister: Thank you, I am conscious of the time.

I was wondering if I can just ask you a quick question on information and data: Dr Couch, when you first came before this Committee in October 2017, you said that the information environment within the Department Health and Social Care was poor when you joined back in June 2015. With regard to the Department developing an information management strategy do you feel you have all the information you need to implement strategic decisions needed to make or to implement those actual processes?

Dr Couch: Things are far better than they were when I made that comment and I think that is a combination of the continuing rollout of the Digital Strategy – the DHSC is a big component of the national Digital Strategy. We have more of our services now in a digital environment than a paper environment, so you can draw reports from that. So we are better with that. The Hospital is now essentially paperless; it is not paperless but we have now digitised all of the paper records that are available. We have moved into a lot of things where we can draw that information so we have got far more information.

The challenge then is: you have got lots of information; you then need to make it into something comprehensible that allows you to draw inferences and make decisions. And we are getting better at that too.

We are moving to an information management strategy in the Department. Again, that will help us to do things. But there is still a way to go, without any doubt at all. When I was making the comments earlier to Mr Robertshaw about joint strategic needs assessments, there are some data sets still that one would expect to see absolutely standard in England that we do not have in yet. Part of it is comparing and contrasting, understanding what would normally be elsewhere and then mandating our people to do it.

You then chase your tail because you then need to have the system to put that information into and the people to put the information into the system, but we are moving forward steadily and it is far better than it was.

Q653. Mr Callister: I suppose that leads on quite nicely, have we got the DATIX system in place yet?

Dr Couch: Yes.

Mrs Morris: Yes, we have.

Q654. Mr Callister: It is fully operational is it?

Dr Couch and Mrs Morris: Yes.

Mr Callister: Wonderful.
Thank you.

Q655. The Chairman: And what results, changes, are we seeing? Are we seeing a greater level of reporting as a result of that? Have we changed the culture of reporting with the system or is it just a matter of changing an electronic system and not changing the culture?

Dr Couch: It is early days but it is a fair challenge, Chair.

What we will need to do is compare and contrast. We had a system in the Hospital called PRISM; we have now got DATIX. We will need to compare the level of reporting. It certainly seems an easier system to use.

Mrs Morris: It is easier.

Dr Couch: And I can go in as a super user and I can draw reports from it, which seems to be far easier than it was. But, yes, we will need to compare and see whether the uptake is better. But again, part of it is pushing out on the culture thing. Use it, report everything, because that will help us to learn and improve things.

Mrs Morris: And if I may, DATIX is now across the whole of the Department, whereas PRISM was only in the Hospital, so you cannot compare it like for like because it was not as wide.

But it is a system I am used to using in the UK from the past, and it does have a lot more functionality than the old system that we had at Noble's.

Q656. The Chairman: It is important not to take an electronic system that is garbage in and replace it with a new electronic system that is still garbage in, garbage out.

Mrs Morris: True.

Dr Couch: We have to be courageous because if I say to my colleagues across the Department, 'Use this system, use it frequently, report everything you see', and they take that message on board, another observer might say, 'Oh there is something dreadful, the reports have gone up times 10.' But that might actually be a very positive thing because we were moving into a continuous improvement environment.

The Chairman: Absolutely.

Q657. Mr Callister: I have got two general, very quick ones if I can. One relates to the National Health and Care Service General Scheme. Have we got any update on that?

Dr Couch: Yes, I think we are in the final stages now of getting things ready to bring to Tynwald.

The genesis of that piece of law was that the primary Act, the NHCS Act 2016, was meant to be the framework for schemes which would describe the services that we deliver. Also because some of those services might change from time to time it would allow the schemes to be updated relatively frequently with them being secondary legislation.

When we started to develop the general scheme it became a gargantuan thing that started to look remarkably like the 2001 Act. Also, as we had put it on an Order Paper for Tynwald and Members were scrutinising it, we started to get some comments about saying some things do not quite hang together etc. so we withdrew that and went to have a look at things.

What that has uncovered is that in terms of our legislative environment we realised that cross-references were not in place – and this would cover any Department that any of you work in. We have primary Manx law, we have secondary Manx law, we have Acts of Parliament which have been given application in the Isle of Man through order, and we have some secondary UK legislation which has given effect in the Isle of Man. There needs to be a really carefully balanced machine that watches all of those changes in the UK to check that we are up to date here. I think in our case we found that that was not scrutinised as well as it could be. I do not know how well it is scrutinised elsewhere in Government.

So the answer to your question is that the schemes are probably going to be more than one. We will start to come this year, without any doubt at all, and then they will set out the blocks of services that we deliver.

Q658. The Chairman: Just to challenge that, you have got a legislative team of four, I think. But there has been one piece of legislation in the past two years that has been bought to Tynwald.

Dr Couch: Yes, but forgive me, at the moment significant amounts of time are being spent on, for example, the Abortion Reform Act, which was not a departmental piece of law but clearly we deal with that. The legislation team is actually two people plus a temp at the moment, so it is not four. They are also giving an enormous amount of support to Sir Jonathan Michael's Review because lots of questions are coming about our law; and they are also spending an enormous amount of time preparing for Brexit.

So, absolutely, one would expect a certain amount of throughput from a legislative team, but it almost comes back to Mr Robertshaw's points about prioritisation, sometimes the urgent is pushing aside the important. *They* would like to do more, because we have got some very big pieces of law: we need to update the Children and Young Persons Act, we need to bring in a Capacity Act, Deprivation of Liberty law – there is a long list and –

Q659. The Chairman: If there is one thing we concluded last time it was that the urgent perpetually outweighs the important in the Department, and the Department does not seem to

have ever found the right mechanisms to stop that from happening – and I am not greatly reassured from the answer that that has yet been found!

Dr Couch: I think, at least, the urgent things are being done.

Q660. The Chairman: Okay. But we will wait and see, because of course we do not know yet.

But it does still appear though that the DHSC, by what you have said today, is still in many areas in a state of inefficiency. There are a lot of areas which you have said today should be better. It is still out of budgetary control and it still seems unable to define a clear future with stated outcomes and timescales. That has not changed, it has not changed at all – never mind over the last year, but in the last two years, three years and before that.

Dr Couch: I acknowledge your comments, Chair; I am not necessarily agreeing with them.

Q661. The Chairman: Well, give me the evidence to rebut them, because that is what I think we need to hear today.

Dr Couch: I think we have covered today lots of things that are improving, lots of things are on a track of improvement. Do you ever say that you have got there with a continuous improvement programme? Probably not. And maybe part of the role of a Chief Executive is to be eternally dissatisfied.

We are being frank with you about the issues that we see. We scrupulously, and with great energy, try to deal – well, we do not try to deal; we *deal* with the things that come up. If we have a legacy when we move away from the Department it should be that it was better than when we took over.

The Chairman: Any other questions around the table? No?

In which case, on this occasion, we will actually get you out before five o'clock today! That concludes the public session for today.

Thank you very much, Dr Couch and Mrs Morris, for your contributions today. The Committee will now sit in private.

The Committee sat in private at 4.57 p.m.