PP 2021/0127

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

SECOND REPORT FOR THE SESSION 2020-21

Mental health and suicide follow-up report

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MENTAL HEALTH AND SUICIDE FOLLOW-UP REPORT

There shall be three Policy Review Committees which shall be Standing Committees of the Court. Subject to Standing Order 5.6(3) they may scrutinise the established (but not emergent) policies, as deemed necessary by each Committee, of the Departments and Offices indicated in this paragraph together with the associated Statutory Boards and other bodies:

- *Social Affairs Committee: Department of Health and Social Care; Department of Education, Sport and Culture; and Department of Home Affairs.*

Each Policy Review Committee shall in addition be entitled to take evidence from witnesses, whether representing a Department, Office, Statutory Board or other organisation within its remit or not, in cases where the subject matter cuts across different areas of responsibility of different Departments, Offices, Statutory Boards or other organisations. The Policy Review Committees may also hold joint sittings for deliberative purposes or to take evidence. The Chairmen of the Policy Review Committees shall agree on the scope of a Policy Review Committee's inquiry where the subject cuts across the respective boundaries of the Policy Review Committees' remits.

Each Policy Review Committee shall have:

(a) a Chairman elected by Tynwald,
(b) two other Members.

Members of Tynwald shall not be eligible for membership of the Committee, if, for the time being, they hold any of the following offices: President of Tynwald, member of the Council of Ministers, member of the Treasury Department referred to in section 1(2)(b) of the Government Departments Act 1987.

The Policy Review Committees shall be authorised to require the attendance of Ministers for the purpose of assisting the Committee (or Committees, if sitting jointly).

Should the need arise in relation to a particular matter, such as a conflict of interest, Tynwald may elect an alternate member for the purpose and duration of a Policy Review Committee's consideration of that matter. A conflicted member so replaced shall continue to serve as a member of the Committee for all other purposes.

The powers, privileges and immunities relating to the work of a committee of Tynwald include those conferred by the Tynwald Proceedings Act 1876, the Privileges of Tynwald (Publications) Act 1973, the Tynwald Proceedings Act 1984, and by the Standing Orders of Tynwald Court.

Committee Membership

Ms Julie Edge MHK (Chairman)

Mr Martyn Perkins MHK (Garff)

Mr Peter Greenhill MLC

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All correspondence with regard to this Report should be addressed to the Clerk of Tynwald, Legislative Buildings, Finch Road, Douglas, Isle of Man, IM1 3PW.

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To: The Hon Stephen C Rodan OBE MLC, President of Tynwald,

and the Hon Council and Keys in Tynwald assembled

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE
SECOND REPORT FOR THE SESSION 2020-21
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I. INTRODUCTION

1. Our report on mental health was laid before Tynwald in November 2018 and debated in January 2019.[1] Our report on suicide was laid before Tynwald in November 2019 and debated in January 2020, the debate concluding with a combined vote in February 2020.[2] In this report we present further evidence and discussion of these two related topics; and we look back at action taken since the January 2020 debate.

2. As we acknowledged in our November 2019 report, the two topics are related but not the same.[3] Whilst the link between suicide and mental health issues is well established, there are numerous other factors which can lead to someone taking their own life. Combatting suicide therefore needs a broad public health approach; and it is for this reason that lead responsibility in Government for suicide prevention lies with the Public Health Directorate and not with the Mental Health Service. Nevertheless, because a link does exist, we consider it appropriate to cover the two topics in this one follow-up report.

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[1] PP 2018/0151

[2] PP 2019/0142

[3] See PP 2019/0142, paragraphs 51 to 53

3. On 18th February 2020 Tynwald approved the Transfer of Public Health Functions Order 2020, moving the Public Health Directorate from the Department of Health and Social Care to the Cabinet Office with effect from 1st April 2020.[4] Between June and December 2020 the Manx Care Bill passed through the Branches, achieving Royal Assent in March 2021 and going live on 1st April 2021. It is to be hoped that these structural changes will soon lead to improvements on the ground.

4. We would like to recognise at the outset the deeply personal nature of the evidence which has been provided to us by patients, service users and their families, and the genuine vigour and care shown by professionals. From our scrutiny perspective we would wish to see developments which build on what is already readily available within the Manx community and on the good work already being done.

5. We acknowledge at the outset also that since March 2020 a global pandemic has been placing unprecedented demands on both the Public Health Directorate and the Department of Health and Social Care.

We conclude that the pandemic makes it even more important and even more urgent for Tynwald to pay attention to mental health and suicide prevention.

II. MENTAL HEALTH

Before the pandemic

6. The cross-cutting impact of mental health was recognised in the Isle of Man Government's Strategic Plan for Mental Health and Wellbeing 2015-2020[5], approved by Tynwald in December 2015, which provided the following points:

    - Mental health issues are responsible for 22.8% of burden of disease; for comparison, the figure for cardiovascular disease is 16.2% and for cancer 15.9%. No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact.

[4] SD No 2020/0066

[5] https://www.gov.im/media/1353553/strategic-plan-for-mental-health-and-wellbeing-2015-2020.pdf

- A key reason for the size of impact is that mental health issues start early, with 50% of lifetime mental illness (excluding dementia) starting by age 14 and 75% starting by the mid-20s.

- Mental health issues start at an early age and can have lifetime consequences.

- Mental wellbeing is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and anti-social behaviour.

- Improved mental wellbeing and reduced mental disorder are associated with better physical health and quality of life; longer life expectancy; reduced inequalities; healthier lifestyles and improved social functioning.

- People with severe mental illness are estimated to die an average 20 years earlier than the general population, largely due to physical health problems.

Having acknowledged the depth of the issue, the Mental Health Strategy 2015-2020 stated that "improving Mental Health is everybody's business".[6]

7. In April 2018 Angela Murray, then Director of Community Care, explained to us the stepped care model then in use as follows:

> *The Stepped Care Model is based on the tiered model that is common throughout the UK, except we have additional steps in it. So I will start from the top. The highest step is Step 5, which is actually reserved for off-Island placements, and now will go forward and include forensic specialist placements as well. Below that we have the on-Island inpatient service, which is now Manannan Court, that is at Step 4.*
>
> *At Step 3 we have the Community Mental Health team providing, as you would expect, all the step-down services from somebody coming out of an inpatient bed or maintaining people in the community, rather than placing people in an inpatient bed, and it also does an awful lot of outreach work with other services.*
>
> *Below that you have Step 2, which is a wide community service now which deals with anxiety, depression, that sort of level of lower intervention. But you also*

[6] GD 2015/0070

have to remember that people step up and down and sometimes people will be accessing more than one step at any given time, depending upon their diagnosis.

And then below that, which is a step we are only just bringing in this year in a much more robust way, is about the self-help, self-care aspect of mental health.[7]

8. Our 2018 report concluded, among other things, that:

the waiting lists for mental health services are too long, particularly for lower intensity services which would alleviate demand for more intensive treatment…

the lack of a clearly defined pathway from education into the mental health services may be leading to the deterioration of issues suffered by children…

there is a lack of care in the community and at the lower level, especially for young persons…

while of excellent design and intent, the Mental Health and Wellbeing Strategy is not adequately resourced. There are not enough schemes or resources available at lower levels and this stretches the service…

the aims of the Mental Health and Wellbeing Strategy will only be reached if further care provision is made available outside of in-patient services. We are aware that this will require additional resources being allocated to the Mental Health Service…[8]

9. On 13th September 2019, the Department of Health and Social Care published an independent report by Dr Tommy Dickinson on provision at the Island's acute mental health in-patient facility, Manannan Court.[9] We heard oral evidence on the implementation of Dr Dickinson's recommendations from the Minister and Interim Chief Executive in February 2020. We heard more about this topic in July 2020, on which occasion the Minister and Interim Chief Executive were joined by the Chief Operating Officer (in post since January 2020) and the Acting Head of the Mental Health Service (in post since November 2019). This evidence is included as part of this Report.[10]

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[7] PP2018/0151, Q 166

[8] PP2018/0151, paragraphs 165 to 174

[9] https://www.gov.im/news/2019/sep/13/report-published-on-care-and-provision-at-manannan-court/ (accessed 19 April 2021)

[10] Hansard 3rd February 2020 QQ93 to 1010 and 13th July 2020 QQ167 and 191 to 196

During the pandemic

10. The past eighteen months has seen a period of unprecedented social isolation, restriction of movement and reduction in face-to-face services. Coupled with increased unemployment,[11] financial pressure and school closures, the coronavirus pandemic has magnified both the importance and fragility of mental health. Tangible markers of rising pressure are evidenced throughout the community. For example, in July 2020 the BBC reported a 21% increase in domestic violence in the Island during the first lockdown period.[12]

11. As we are experiencing a public health crisis, it is natural to expect significant reallocation of resources, time and attention on meeting the immediate physical health needs of the community. That this has been happening was confirmed to us by the Minister for Health and Social Care, Mr Ashford, giving evidence in July 2020:

> *There is going to be an impact; I have been quite clear about that the whole way along. There is no way there cannot be. We had to repurpose staff from across the Department into other roles, such as contact tracing, manning the 111 line and also the testing itself. However, the Committee has taken repeated evidence demonstrating the impact of the pandemic on mental health.*[13]

12. However, Mr Ashford also said on the same occasion:

> *mental health is one of my priorities as Minister. It has been since the day I became Minister and it will continue to be. If you do not have your mental health then what do you have?*[14]

13. During the pandemic, the usual services available to support vulnerable people have been restricted. Not only does this minimize opportunities for early intervention support, it also places a heavy pressure on staff themselves, as described to us in November 2020 by Debbie Brayshaw, Director of Children and Families Services:

> *…there has been a trend upwards in the number of referrals into the Department, so we are outstripping where we thought we should be at this point in time … Our group challenge is staff … managing their resilience through their*

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[11] https://www.gov.im/news/2021/mar/16/labour-market-report-for-february-2021/

[12] https://www.bbc.co.uk/news/world-europe-isle-of-man-53370612

[13] https://www.tynwald.org.im/business/hansard/20002020/saprchsc200713.pdf Q 168

[14] https://www.tynwald.org.im/business/hansard/20002020/saprchsc200713.pdf Q 220

own personal circumstances and then managing the impact of service provision as well.[15]

14. From a patient or service user perspective, the wide-reaching impact of the pandemic on mental health was succinctly summed up by a service user from Quing whose words were reported to us by Mr Graham Clucas in his oral evidence in December 2020:

> *This year has been really tough and COVID brought home how isolated you can become. Since lockdown has lifted, finding work has been really hard. Everything going online has been really stressful and the pressure to get a job, even when it has been really hard to get one, has had a profound effect on my mental health.*[16]

15. Beyond the "adult" pressures of employment and finance, children and young people have been isolated from their peers and experienced reduced access to education. Despite best efforts of parents and teachers to maintain home education, it is not yet known what impact social isolation may have on child and adolescent development.

Waiting times

16. With increased awareness of mental health comes increased referral. This naturally leads to increased waiting times, over burden of resources, staff fatigue and financial cost. Moreover, desire to help and concern over potential for harm places a heavy weight on professionals which in term can lead to over-referral. As a GP reported to us in oral evidence in June 2017:

> *As a GP, say, at five o'clock on a Friday afternoon a woman comes to me and she is distraught. Her husband has left, the house is being repossessed and she is in a terrible state. The only doors open to me are mental health. The woman is not mentally ill. But we have medicalised so many of life's events – you are not allowed to be 'unhappy' any more, you are 'depressed'.*[17]

17. However, quick referral does not mean quick access to services. In 2018, information provided to the Committee by the Department of Health and Social Care showed that:

- The Community Wellbeing Service had a caseload of 578 patients, with 172 awaiting allocation

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[15] https://www.tynwald.org.im/business/hansard/20002020/saprchsc201109.pdf QQ 40–41
[16] https://www.tynwald.org.im/business/hansard/20002020/saprcmh201207.pdf Q 80
[17] PP2018/0151, Q49

- Low Intensity Therapy – waiting list of 11
- Healthy4Life – waiting list of 29
- As of 20th May 2018, the Community Mental Health Service had a caseload of 1,691. Of these, 51 patients were awaiting psychology treatment and 58 for adult Cognitive Behavioural Therapy (CBT). Eighteen were awaiting allocation.[18]

18. Long waiting lists impact three key areas. Firstly, a person in need does not access appropriate care. Lack of low-level mental health care or early intervention can enable concerns to ferment and escalate. Ultimately, this may lead to a vulnerable person either deteriorating or attempting to end their life. As the Mental Health Commission, which oversees the conditions of those who have been detained under the Mental Health Act 1998, told us in January 2018:

> *It may well be that some of the people who end up having to be detained under the Mental Health Act might have avoided that extreme outcome had they been able to access service in the community earlier and more speedily.*[19]

19. Secondly, long waiting lists place a burden on wider professionals, as evidenced by Isle of Man Government Staff Welfare who told us in January 2019:

> *We are quite often supporting now people who are on the waiting list for mental health or psychological therapies. So there is lots there; I mean they are still seeing somebody, so they are getting some support, and I hope that we would be responsive if they were suicidal and we would do what we could to support them, of course we would. But if we can only see them every two or three weeks then it is quite a space in between. So we are doing things that we would not necessarily normally do: we are checking in more with people and that sort of thing and obviously we are putting them in touch with the crisis response team, who I think are very busy from what I understand. (The Chairman: Yes.) But it also means when people are not getting the service that they need, and they know that the only way they are really going to get the service is if they are in crisis, it leaves them just without that sense of a safety net, which is going to increase their anxiety and make them are likely to move into a crisis.*[20]

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[18] PP2018/0151, paragraphs 46–47 and Appendix 2

[19] PP2018/0151 , Q 135

[20] PP2019/0142, Q 81

20. Incidentally, comments made to us by the Minister for Health and Social Care to us in September 2019 show an understanding of this pressure. He said at that time:

> *We should not be putting police officers through having to become mental health workers and make assessments of people on the ground.*[21]

21. Thirdly, delayed access to regulated statutory provision means that many vulnerable people seek support from Third Sector or private organisations. This can be a double-edged sword. Freedom from statutory restraints can enable Third Sector bodies to offer alternative methods of support, as illustrated by Quing, who told us on 7th December 2020:

> *Quing is a very modern expression of mental healthcare. We do not actually describe ourselves as a mental health charity because instead of siloing problems we look for people's strengths, and if you look for people's strengths … you do not see the problems and the problems fall away… we are a peer-led community, which basically means people learn they have a safe space to experiment and get it wrong, in their aim of getting it right in the future.*[22]

However, not all organisations are created equal and not all practitioners have the skills to safely and effectively respond to serious mental health concerns. Concerns have been raised both by organisations within the sector on issues such as regulation, safety and joint working practices.[23] Similar concerns were aired by some Members during the January 2020 debate on our report on suicide.

22. From an Answer given in the House of Keys in October 2020, it is clear that by that time the Department for Health and Social Care had not taken clear steps to monitor and publish accessible data on mental health waiting times.[24]

We are concerned that waiting times for mental health services are still too long. We conclude that the continuing lack of data on waiting times for mental health services is unacceptable and must be addressed as a matter of urgency by the new administration, in co-operation with Manx Care.

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[21] PP 2019/0142, Q 192

[22] https://www.tynwald.org.im/business/hansard/20002020/saprcmh201207.pdf Q 2

[23] Appendix 1

[24] Keys Question 1.11 of 27th October 2020

III. SUICIDE

23. Whilst many people live with or recover from mental health issues, the ultimate risk is that a person in crisis ends their life.

24. It can be difficult to accurately measure rates of suicide. This is for two main reasons. Firstly, due to the legal definition and burden of proof required by the Coroner's Court. Secondly, suicide verdicts are organised by the year in which the inquest was concluded, not the year of death. Nonetheless, evidence provided to the Committee following press reports in early 2021 shows an increase in suicide verdicts, as summarised in the following table.[25]

Year	Number of Suicide Verdicts Recorded
2017	5
2018	10
2019	6
2020	22

We conclude that the high number of suicide verdicts in 2020 is cause for alarm.

IV. IMPLEMENTATION OF PREVIOUS RECOMMENDATIONS

25. Our previous reports led to two lengthy Tynwald resolutions. The resolution of 15th January 2019 based on our report on mental health contained seven recommendations.

26. The resolution of 18th February 2020 based on our report on suicide contained 13 recommendations. However, the fifth of these 13 recommendations was a reaffirmation (i.e., a duplicate) of the seven recommendations in the mental health report from a year earlier.

27. The seven recommendations of the January 2019 resolution were reported on in the Tynwald Policy Decisions Report laid in October 2019 and again in the Tynwald Policy

[25] Appendix 2

Decisions Report laid in October 2020.[26] Because of the duplication referred to above, some of the seven recommendations appear twice in the 2020 Tynwald Policy Decisions Report.

28. The 12 unique recommendations of the February 2020 resolution were reported on in the October 2020 Tynwald Policy Decisions Report.

29. Relevant entries of the October 2020 Tynwald Policy Decisions Report are reproduced as an Appendix to this Report.[27]

January 2019 resolution (mental health)

30. Three recommendations are still outstanding from our 2018 report on mental health despite having been approved by Tynwald in January 2019. They are Recommendations 3 (support for carers), 6 (mental capacity legislation) and 7 (annual progress reports on the 2015 strategy, to include a focus on waiting times).

We acknowledge and welcome the work that has been done since the January 2019 debate on our report on mental health. However, the lack of progress on three of our recommendations is of concern. The lack of any mental capacity legislation remains a serious gap in the Island's law.

February 2020 resolution (suicide)

31. This resolution contains 12 unique recommendations in this resolution (that is, Recommendations 1 to 13 excluding Recommendation 5, which duplicates the January 2019 resolution). Of the 12 unique recommendations, none has been completed, although many have been started.

32. The principal recommendation in this report was Recommendation 1, which was:

> *That a Joint Strategic Needs Assessment on suicide prevention, leading to an evidence based achievable strategy and a timed, costed and accountable delivery plan, will be delivered by the Director of Public Health no later than March 2021, and that information and data on suicide should be included in future Public Health annual reports to Tynwald as soon as practical.*

[26] GD 2019/0054 and GD 2020/0056

[27] Appendix 3

33. This has not been done. The reason given is:

> *The capacity, resources and supporting structures to enable the delivery of a prioritised and ultimately comprehensive Joint Strategic Needs Assessment Programme (led by Public Health) are being taken forward through the Transformation Programme following the Sir Jonathan Michael Report. Until this work has completed, Public Health is unable to set out a schedule for future JSNAs or to undertake the scoping work to determine content of future JSNAs.*[28]

34. With reference to Recommendation 10 (which relates to the type of information which should feed into the Joint Strategic Needs Analysis) it is stated:

> *As stated above (87/19), Public Health is unable to give any time commitment for completion of any JSNA.*[29]

35. The statement at 87/19 which is referred here states:

> *Prior to March 2020 (and the onset of the COVID-19 pandemic), links had been established with PHE, LGA and the Association of Directors of Public Health in relation to developing metrics for social and economic inequalities in remote, rural and island communities. Unfortunately, COVID-19 has meant that this work is currently suspended due to lack of capacity both in PHD here and in partner organisations across.*[30]

We conclude that significant resolutions of Tynwald based on our previous reports on mental health and suicide have not been implemented. While we acknowledge that the pandemic has placed extraordinary burdens on the Department of Health and Social Care and the Public Health Directorate, we expect that the pandemic will also have had severe adverse effects on mental health and suicide risk. Resources must be found to progress the approved recommendations of our mental health and suicide reports as a matter of urgency by the next administration, working in partnership with Manx Care.

V. A HOLISTIC APPROACH

36. There is a clear link between mental ill health and need. Maslow's Hierarchy of Needs dictates that a human's basic needs (food, shelter, warmth, safety) must be met

[28] GD 2020/0056 at ref 54/19
[29] GD 2020/0056 at ref 16/20
[30] GD 2020/0056 at ref 87/19

before other needs (psychological or self-fulfilment) can be addressed.[31] In Tynwald in December 2019, Mr Henderson explained the link to mental health during a debate on poverty:

> *Abraham Maslow … studied human needs and put them into a hierarchy from the basic needs up to your social community and the higher self-actualisation needs, and if you are not meeting those as well that is causing mental health issues – it is causing stress.*[32]

37. The need to consider mental health and wellbeing in its wider social context is well understood in Tynwald. For example, in the Strategic Plan for Mental Health and Wellbeing approved by Tynwald in 2015, the Chief Minister's foreword says:

> *We must all work in partnership and recognise that mental health … is not just a health concern but a major social issue which requires a coordinated approach across all parts of the public, private and third sectors.*[33]

38. The Strategic Plan itself says:

> *A priority of this Plan is to modernise mental health provision for the Isle of Man by increasing the availability of primary and community based services. This involves a collaborative approach including the third sector. Increasing primary and community provision will support early intervention, community treatment, support and a reduction in the use of secondary care services.*[34]

39. Mr Michael Manning of Graih told us in written evidence in April 2017:

> *Mental health cannot be viewed in isolation. It is intrinsically linked to the environments that people live in and the sort of activities they are involved in. Many of the guys we see live in insecure boarding houses where they are exploited by landlords, who provide very little in terms of cooking or sanitation facilities, tenancy agreements or privacy. Deposits are routinely withheld, leading people into further poverty. All of this exacerbates mental ill health.*

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[31] See diagram at Annex 1

[32] 10th December 2019, 3922–3924. See also PP 2019/0122, Appendix 3

[33] GD 2015/0070, page 3

[34] GD 2015/0070, page 19

The lack of supported accommodation options on the island increases vulnerable people's isolation and the likelihood that their mental health will deteriorate. This is another area that needs development.[35]

40. In oral evidence in June 2017 Mr Manning said:

the environment that people live in is so important to maintaining stability, to recovery, to reintegration back into society. When that is not there, it is a colossal waste of everyone's time, effort and money to do a lot of wonderful, specialist work with them, whether that is in the community, whether that is in an in-patient facility, when actually they are living in atrocious environments.[36]

41. Speaking in December 2020, Mr Graham Clucas explained to us the approach taken by Quing as follows:

You build five things into people's lives: one is social capital, which is healthy relationships. The next one is cultural capital, which is an understanding of the culture we live in; that is the dominant culture. The next one is personal capital which is emotional intelligence, education levels and those personal attributes. The next one is material capital, which is the physical resources you have, which is housing, which is the food that you can afford and which is access to transport. The last one is what we call political capital, which is how much you feel you are in control of your environment, and what choices do you have. If you build that into someone's life they will change and they will heal naturally. That is what we specialise in.[37]

42. Previous reports have explored mental health provision on the Isle of Man as recently as 2020, with a general acknowledgement that there is wealth of skill, energy and enthusiasm across both statutory services and the Third Sector.

43. Joint working between mental health services and the Police has been a particular success story. The Chief Constable's Annual Report for 2019/20, laid before Tynwald in October 2020, states:

How we address mental health issues in the community has continued to have great importance. Last year I wrote about the pilot scheme that involved the deployment of mental health professionals to Police Headquarters. During the

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[35] PP 2018/0151, Appendix 27

[36] PP 2018/0151, Q 14

[37] https://www.tynwald.org.im/business/hansard/20002020/saprcmh201207.pdf Q 16

year the number of professionals increased from two to three and, towards the end of the year, Treasury provided funding to place the scheme onto a permanent and more sustainable footing. The scheme makes a real difference; the professionals involved in it make a real difference to vulnerable people and, whilst demands faced by the police in terms of mental health in the community, are still high and increasing, they are now managed in a better way, so those who are in crisis and who need help the most are able to get it.[38]

44. Moreover, the opportunities afforded by a comparatively small community could lead to the production of streamlined mental health provision. As Maggie Mellon, then Vice Chair of the British Association of Social Workers, remarked to our predecessors on this Committee in 2015:

> *It seems to me that the Isle of Man is a really human size of a population and that you have an enormous opportunity to not make the mistakes and go down the routes of… for instance, in England and in Scotland… There are lots of opportunities for building on strengths and social solidarity, rather than on treating people as individuals. We are all individuals of course, but build on the good social strengths and social systems you have got.*[39]

A holistic approach to wellbeing requires clear and adept inter-agency working, Third Sector support and, where appropriate, personal accountability.

However, despite the planned focus on joint working highlighted in Government strategy, evidence provided to the Committee indicates that lack of cohesion between services is having a negative impact on service users and on professionals. Increased awareness has led to increased referrals and subsequently increased pressure on services. Not only does this place pressure on staff and lengthen waiting lists it means that people in desperate need of support are not able to access it. Lack of early intervention has been shown to increase the risk of further deterioration of mental health. Not only can this impact quality of life – it could be linked to increased risk of suicide.

We note the successful joint working between the mental health service and the police. Similar joint working is needed between the mental health service and GPs.

Whilst we recognise the care and commitment show by so many professionals within Mental Health, coronavirus is non-discriminatory and impacts us all. Staff

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[38] GD 2020/0020, page 7

[39] PP 2016/0103, Q 101

pressures may ultimately – and unintentionally – increase the likelihood of human error or compromise quality of care. Support to the workforce as a whole – both Government and Third Sector – is vital.

VI. OVERALL CONCLUSIONS AND RECOMMENDATIONS

Building on the extensive evidence gained through previous reports and evidence sessions, we conclude that an amalgamation of the following general themes would enhance the overall mental health of the Isle of Man:

- Tynwald to adopt the maxim 'mental health is everyone's business'.
- The 'stepped care' model to be adequately resourced at every level, with clearly signposted pathways allowing service users to step up and down according to their need.
- Public Health to carry out a Joint Strategic Needs Assessment as previously recommended.
- A co-ordinated approach to statutory services (health, police, education etc.) and third sector to agree remit, working practices, referrals, information sharing pathways etc.
- Appropriate training, support and advice to third sector/non-mental health specialists.
- A co-ordinated approach to GDPR and information sharing.
- A culture of mutual professional respect, providing the client with information of all available resources at each stage of their care – including recognition of the value/impact of wider support such as housing, finances, food, health, education and community participation.
- Targeted support for workers.
- Targeted support for carers.
- Considerate use of buildings and locations.

Recommendation 1

That Tynwald is of the opinion that mental health is everyone's business; and notes that pressures on the mental health of the Island, which were already severe, have been made worse by the pandemic.

Recommendation 2

That the Department of Health and Social Care, working with Manx Care, should ensure that awareness of mental health issues is raised and that clear information is provided to the public on how to seek help.

Recommendation 3

That the stepped care model of mental health support should be adequately resourced at every level, with pathways allowing service users to step up and down according to their need; and that this should be a high priority for the Department of Health and Social Care and Manx Care.

Recommendation 4

That resources must be found as a matter of urgency to implement in full the Tynwald resolutions of January 2019 and February 2020 relating to mental health and suicide.

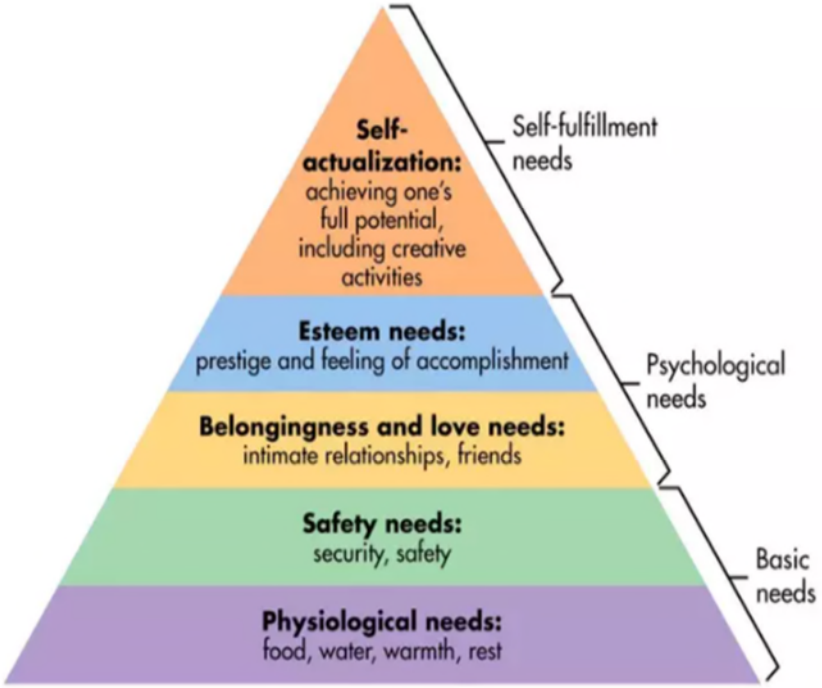
J M Edge (Chairman)

M J Perkins

P A Greenhill

May 2021

ANNEX 1: MASLOW'S HIERARCHY OF NEEDS



ORAL EVIDENCE

3rd February 2020

Evidence of

Hon. David Ashford MHK, Minister,

and Ms Kathryn Magson,

Interim Chief Executive Officer,

Department of Health and Social Care

S T A N D I N G C O M M I T T E E
O F
T Y N W A L D C O U R T
O F F I C I A L R E P O R T

R E C O R T Y S O I K O I L
B I N G V E A Y N T I N V A A L

P R O C E E D I N G S
D A A L T Y N

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

DEPARTMENT OF HEALTH AND SOCIAL CARE

HANSARD

Douglas, Monday, 3rd February 2020

PP2020/0025 **SAPRC-HSC, No. 1/19-20**

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Members Present:

Chairman: Mr D C Cretney MLC
Mr M J Perkins MHK
Ms J M Edge MHK

Clerk:
Mr J D C King

Assistant Clerk:
Ms I Perry

Contents

Standing Committee of Tynwald on Social Affairs Policy Review

Health and Social Care

The Committee sat in public at 10.30 a.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MR CRETNEY *in the Chair*]

Procedural

The Chairman (Mr Cretney): Welcome to this public meeting of the Social Affairs Policy Review Committee which is a Standing Committee of Tynwald.

I am David Cretney MLC and I chair this Committee. With me today are Ms Julie Edge, MHK, and Mr Martyn Perkins, MHK.

If we can please ensure all our mobile phones are off or on silent 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.

The remit of the Social Affairs Policy Review Committee is to scrutinise the established but not emergent policies as deemed necessary by the Committee of the Department of Health and Social Care, the Department of Education, Sport and Culture, and the Department of Home Affairs.

Today we welcome back the Minister of the Department of Health and Social Care who was last before us for a general oral evidence hearing in July 2018. He was also here more recently in September 2019 in the context of our inquiry into suicide. He is accompanied today by the Interim Chief Executive Officer.

EVIDENCE OF
Hon. David Ashford MHK, Minister, and
Ms Kathryn Magson, Interim Chief Executive Officer,
Department of Health and Social Care

Q1. The Chairman: For the record, I would like to begin by asking you to please state your name and job title and how long you have been in that role.

The Minister for Health and Social Care (Mr Ashford): David Ashford, Minister for Health and Social Care, and I took on the post on 8th January 2018.

The Chairman: So the honeymoon period is over!

The Minister: Well and truly, Mr Chairman!

Ms Magson: I am Kathryn Magson. I am the Interim Chief Executive Officer and I started on 8th January, which is a complete coincidence, in 2020. So this is my fifth week.

Q2. The Chairman: Thank you.

There has been some restructuring of late in your Department. For the record could you please explain what has happened with the role of Chief Executive Officer since our last meeting in July 2018?

The Minister: The last time we met, Mr Chairman, obviously the CEO at the time was Mr Couch. Mr Couch left in May 2019. At that point there were conversations and we appointed Angela Murray as Interim Chief Executive. Angela served as Interim Chief Executive from May in 2019 until January of this year. Now Kathryn has taken up post for the two-year interim position up until such time as Manx Care and everything is up and running with the Transformation, when obviously the Department and the way it operates is going to look very different.

Q3. The Chairman: Okay and what is Angela Murray doing now?

The Minister: Angela has become Chief Operating Officer for the Department. She took up that post on 8th January.

The Chairman: Thank you. Yes.

Q4. Ms Edge: To the Minister, you just said that the Department is going to operate very differently; could you put a bit more depth into that as to what you –?

The Minister: I most certainly can.

Obviously the way it is going to work is in line with what was approved by Tynwald and the Sir Jonathan Michael Review. So the Department will become focused purely on policy and the mandates that flow down to Manx Care; the service delivery on the ground and obviously the responsibilities that go with that will sit with Manx Care which will be a separate independent legal structure. So it will be a much more focused mandated position than it is now where everything is driven from the centre by the Department.

Q5. The Chairman: When and why was it decided to add the role of Chief Operating Officer to the Department and could you please explain the functions of the new role and how this has impacted the role and responsibilities of the Chief Executive Officer?

Ms Magson: So actually, clearly that is a new role starting from the last few weeks. I think at the moment it is still in its early stages but predominantly it is about transitioning to the move between provision and the commissioning and the regulation with the Department. So Angela has maintained her operational responsibilities around mental health and in the community but has also added the operational responsibilities around Noble's Hospital. So it is to ensure that we have got the right people in the right places and enough of the senior focus and making sure that we are driving the Transformation forward ultimately.

At this early stage that is where we are and that will develop and evolve as we go along in the next few weeks and months.

Q6. Ms Edge: Were you actually involved in the creation of that post? Obviously it only started on 8th January and clearly that post has been announced around a similar time. Were you actually involved in the creation of … you felt that role was required or was it a decision that was taken before you started?

Ms Magson: Yes, it was before I arrived and I know the Minister was involved as well with the Cabinet Office. But clearly that actual role is quite standard, it is quite normal to have a chief operating officer in structures of this sort, particularly also when you are in large provider

organisations that are involved in the provision of care. As I said, it really makes sure that you have got the focus around provision, and strategy and policy setting which is going to be so important and in line with the direction of travel around Sir Jonathan Michael's Report.

The Minister: Can I just say, Mr Chairman, it is an absolutely crucial role because it is that link between the Department and the Transformation which is absolutely key, because one of the risks of course whenever you are doing a review of this kind and you have got a separate Transformation team based in Cabinet Office, driving that forward, is the Department has got to be in sync with what is happening with the Transformation team. It is absolutely crucial you do not have the Department day-to-day doing something that is completely out of line with what the Transformation is going to be doing. So you have that link from myself chairing the political board of the Transformation but equally with the Chief Operating Officer within the Department there is actually that link as well to ensure that the two are joined up.

Q7. Ms Edge: That nicely leads on to the fact that the post was not advertised, so clearly there is some reason why that did not happen because normally every post within our services, whichever Department you are in, has to be.

The Minister: Yes, there is indeed.

Q8. Ms Edge: I am sure you have probably just answered that a little bit, saying about the Transformation and operations, but clearly policy was not followed with the advertising of the post. Can you explain why that decision was taken?

The Minister: I most certainly can. Because it will be at the moment an interim role, because obviously once Manx Care is up and running Manx Care people's responsibilities will be divided, because the Department will be becoming effectively a policy hub where we mandate Manx Care; delivery on the ground will be delivered by Manx Care. So a chief operating officer is likely to sit within Manx Care and that post would then obviously have to go out for advertisement.

Q9. Mr Perkins: Last time you informed us that the political Members had been given delegated responsibilities. Is this the case? Has it happened? How well is that working?

The Minister: Yes, the Members have had delegated responsibility since the day I became Minister. For instance, Mrs Sharpe has Children and Families, Mrs Barber actually has the Peel pilot project and also I intend very shortly to give her the delegated responsibility around culture within the Department. I need to sign that delegation yet but she will be taking that on. Mrs Corlett has Mental Health and Mr Moorhouse has Corporate Services.

From what I gather in the conversations I have very regularly with them, and I meet them once a week for Members' and Minister's meetings, they seem happy with their roles and they are content with the delegations that they hold.

Q10. Mr Perkins: How involved with the Transformation team are they?

The Minister: In terms of the Transformation team there are going to be regular reports to Members but they are not involved in the day-to-day. That was one of the crucial things with the Sir Jonathan Michael Review and one of the key recommendations: that the Transformation should be split off from the Department of Health, so the Department of Health and Social Care concentrates on the day-to-day and the Transformation team be based in Cabinet Office under the Chief Secretary. So the political Members in the Department are not involved in the day-to-day because the Transformation is being driven from Cabinet Office. But they have already had

one presentation from the Transformation team explaining where we are up to with things and those will continue on a regular basis going forward.

Q11. Mr Perkins: So they have got no strategic input at all?

The Minister: Well they have got strategic input via the presentations, so there will be communications. But you have got to remember Tynwald voted to ensure that the Transformation was done completely separately outside of the Department of Health and Social Care. The link with me as Minister is I chair the overarching political board which consists of myself, the Minister for Policy and Reform, Chris Thomas, and the Treasury Minister, Alf Cannan. But obviously the main Transformation board is chaired by the Chief Secretary as per the Sir Jonathan recommendations.

Mr Perkins: Okay, thank you.

Q12. The Chairman: Just on that, do you think that is working successfully inasmuch as the Chief Secretary is already a fairly busy person? In practical terms is that working okay?

The Minister: I believe it is. He has got a very good team in terms of the Transformation team. The people within it are working exceptionally hard. The first seven projects and project lines are up and running and it is underway. Certainly from my oversight on the political board we are moving things forward and we are on time for those projects that we need to get in early on.

Q13. Ms Edge: I believe that there have been secondments from the current management of the Hospital in the Unscheduled Care to the Transformation team. Is this leaving gaps with the services and the support mechanisms that were in place? The Unscheduled Care Manager, I believe, has gone to the Transformation team so what impact is that going to have on the Hospital?

Ms Magson: I can only answer from early days at this moment in time, but I am aware of there are a few people actually who have been nominated to transfer and it is all as part of the thinking around, quite rightly so, that actually Transformation cannot be done at arm's length. It is being managed and overseen at arm's length, but actually fundamentally it is about the whole system engaging in that Transformation itself. A lot of our best people who know that really well and how these things work, or the example that you gave in Unscheduled Care, actually need to be at the heart of the thinking around how this is going to work in the future and working alongside the external resource that has been brought in.

So a number of people – I think there are, to my knowledge, two or three that I am aware of – have been identified to go and work, who are in the business. But some will be moving over completely, some will be moving over completely for a short period of time, a longer period of time and some will be doing a blend of their existing roles.

So at this stage it is too early to say. I cannot give you any more views but what I can say is I do believe that direction of travel is correct because it brings the people that are responsible for delivering the services at the heart of what we are trying to transform and they ultimately are the people that are going to be able to take it forward and make sure it is a sustainable position.

The Minister: If you are going to be redesigning clinical areas and clinical pathways you have got to involve the clinicians on the ground. That was one of the fundamental things that came out of the Transformation Report as well, that if you are going to be doing that it has got to be led by clinicians. So it is only right and proper that those clinicians are involved in the Transformation going forward.

Q14. Ms Edge: So a number of these people that you are talking about are quite new in their roles as well and obviously we have had major issues within many areas. So is it right – and I suppose I will ask the new CEO … How are you going to manage if you then find that perhaps some of the people that are moving over are not going to be able to work within that new system?

Ms Magson: On a day-to-day basis we are always going to have to be fluid in how we operate and determine the needs of the business but also the need to transform. Both can run simultaneously. Actually what is really important is we give – however new people are in their post – the ability to grow and develop. So my understanding is that is the approach that has been taken and I would support it. I think it is the right thing to do.

The Minister: I think the other thing to add is, although we have people who may be new in their post, in a lot of cases these are people with wide-ranging experience, long experience around healthcare and having worked in other systems elsewhere I think can actually be a benefit because it brings new thinking, new ideas and also an understanding of how things work elsewhere that I think will actually benefit the Transformation team.

Q15. Ms Edge: So I suppose going back to my original question, there are going to be gaps within areas where you are seconding people to Transformation teams and that, so how are you going to fill those gaps – (***Ms Magson:*** At this moment –) and experience because you said it is the experience you are looking for? So there is clearly going to be possibly an issue.

Ms Magson: Yes, at this moment in time I am not aware of that being the case and I know Angela and the team were looking to bring people up also as well to fill some of the gaps and think about how things are done slightly differently depending on the individual that is involved.

Another individual, for instance, there are actually already gaps in that team as well itself and it is part of the wider Transformation Programme – bringing extra resource into it, it has already identified of that need.

So we will need to release people as we go along and feel the right way and make sure it works for the day-to-day as well as it does for the Transformation, but ultimately maximise the opportunities and the skills for those individuals.

Q16. Ms Edge: Once Sir Jonathan Michael's Report was announced there was an interim structure put in place, so is that getting pulled apart now?

The Minister: Are we talking about the interim structure in terms of Departments?

Q17. Ms Edge: Two structures appear to have been put in place or certainly another layer of management appeared to have been put in place when Sir Jonathan Michael's Report was announced. Then there was a new interim structure for the Department, for the Hospital. So is that now changing; and the future structure, can that be published to the Committee?

The Minister: I assume, is this referring to the split off of the Deputy CEO role where the Deputy CEO role was split three ways?

Q18. Ms Edge: There certainly seems to be in a lot of Transformation team roles announced prior to the Transformation full Sir Jonathan Michael team. So it looks to the people of the Island that there are two structures: there is a structure within the current system and there is now going to be this new structure. (***Ms Magson:*** In Transformation?) In Transformation, yes.

Ms Magson: Okay, but ultimately my understanding is that it was really clear in what was agreed at Tynwald that Transformation would be managed separately and there would be a structure around that and appropriate senior appointments and that is what I understood is in place and is the case. So I think that split and that way of working had already been brought in some months ago.

The Minister: In fact it was one of the key recommendations of the Sir Jonathan Michael Review that there must be dedicated Transformation resource in terms of management of the Transformation Programme – and I think I stated very clearly in my speech in Tynwald when the Sir Jonathan Michael Review went through – it is only my personal view, some people might share it, some people might not, but – one of the fundamental reasons I felt that review after review of the Health Service has always failed is what we used to do was we used to get to the end and say what wonderful recommendations have been approved and then we shove it on the already busy people in the Department and go, 'When you have got time would you mind just managing to implement this as well?' And with the best will in the world, while they are very good professionals on the ground and they know what they are doing, they are not project managers and they do not necessarily have that project management experience. The difference this time is we are building a proper project management base within the Cabinet Office for the Transformation, supported by the clinicians feeding into that.

Q19. Ms Edge: So to go back two or three steps, a minute ago you said you are going to be using some of the people that are already in the system for the Transformation team but, Minister, you have just said that the recommendation is a dedicated team so –

The Minister: The dedicated team is there, Mr Chairman. The dedicated team is there in the Cabinet Office. Sir Jonathan is quite clear, if you go into his Report, that there needs to be a dedicated Transformation team with clinical support from the Department and that is precisely the model that is there.

Q20. Ms Edge: When I have just asked you about the secondment the answer that I was given was that there will be a mix of people, that they might continue in some of their –

Ms Magson: Some of them are doing a blend of roles, yes, definitely.

Q21. Ms Edge: So that is not dedicated, is it?

Ms Magson: They will spend a dedicated amount of their time in the week focusing on the programme management in Transformation. So a good example is – and I think the Minister was talking about it already – the development of the initial project initiation documents (PIDs). They are clear in what resource is needed in each of those programmes. Most of that is coming from an external resource, it is sitting in the Cabinet Office, but also some of it will be for opportunities for people in the business to take up those roles either part time or full time, and they are the opportunities that we were talking about earlier.

Ms Edge: Thank you.

Q22. Mr Perkins: What is the ratio between the management and the people actually working with patients?

The Minister: In terms of across Health and Social Care?

Q23. Mr Perkins: Yes, where I am coming from is is it any different to the UK? Have we got more managers per patient than they have in the UK, or are we better, are we about the same?

Ms Magson: I do not know the answer to that. It is too early days. We can give you that ratio but it varies where they are in the UK depending on the split of the organisations. So when you have got splits of commissioner and provision, if you are in a commissioner it is meant to be less than 1% of the total spend that you commission. But if you are in a provider then clearly there is a larger management structure because you are managing hundreds and thousands of people.

So in reality we can get that information for you and share that with the Committee so you can get a feel for what those numbers look like, but ultimately that is going to change. We will need to think about as part of this process futureproofing the organisation in Manx Care and also futureproofing what the Department looks like. Actually in reality that will just be really the *status quo* rather than what it is going to look like as we go into shadow form into October and then ultimately April next year.

Q24. Mr Perkins: Okay. The reason I am asking the question is because the public have a perception out there that there are too many chiefs and not enough Indians. (***Ms Magson:*** Yes.) I think you have got a bit of a job to do to persuade them otherwise and you couple that with the increased waiting lists and you have got a job to do. So I am glad you are under way with it and we would like the information if possible.

Ms Magson: Yes, I am very happy to do that. I think that is always a challenge, isn't it? But ultimately I can assure you that I have not seen any opportunity yet where the management team are not busy, hard at work and adding value to frontline patient care ultimately. Actually the delivery of care is a blend of clinicians and managers, it is not one or the other, you have to have both in order to be able to make it work.

The Minister: Can I just come in there, Mr Chairman, because waiting lists are something that keeps getting raised and there is a lot of misconception around waiting lists. For instance, if we take a two-year comparator since I became Minister, going to the most recent data we have, which is the end of October 2019, in a lot of cases waiting lists are actually coming down. So if you look at the surgical lists, for instance, if you take something like ophthalmology, when I became Minister there were 831 on the waiting list, there are now 302. That is quite a lot across surgical. There is definitely some work we need to do around the medical aspect of waiting lists which have seen increases, but in terms of surgical and Women and Children's, the waiting lists in most cases are coming down.

So we need to actually have that balanced out. There is a lot to do around the medical side but in terms of surgical and Women and Children's numbers are decreasing.

Q25. Mr Perkins: I am very surprised to hear that. That is not the information I am getting on the replacement hips and knees and things.

The Minister: To give another example there, oral surgery, when I became Minister: 1,087 on the list; 722 now.

Q26. Mr Perkins: I would be interested to know how you arrive at those statistics because I have come across several people in my constituency who have been waiting for knee ops and hip ops for quite some time and they have been put back and put back. I do not know how you actually gather all your information but again I think the Department, if that is right, have got to get the message out there –

The Minister: That is a like-for-like comparison. In fact just referring to the hip operations, that is one area in surgical, we do need to look at the waiting list around the orthopaedics. That is one of the ones in surgical that has not come down, but most of the surgical areas such as, for instance, breast surgery, general surgery, oral surgery, orthodontics, paediatrics, pain management plastic surgery have all come down in the last two years. So it is important we do not just generalise and say that waiting lists are all going up. There are things to do around the medical side and certainly orthopaedics within the surgery side, but it is not a completely bleak picture where all these lists are continuously going up.

Mr Perkins: Thank you.

Q27. Ms Edge: I, as well, have got a number of constituents contacting me because they have had letters from the Health Department, from the Hospital, asking do they still want to remain on a waiting list. Some of these are elderly, some are younger and obviously we can make our lists look reduced if we give people a two-week turnaround to respond, people might be on holiday. So are they automatically taken off these lists so that the figures look that way? I think it is wrong to be asking individuals to make a clinical decision as to whether they need to be on a waiting list. These letters have gone out. There are still people not happy. There have been people who have been able to actually respond but there will be people who have not.

So I am just a little bit concerned you are saying waiting lists are coming down but we are also doing this alongside to try to –

Ms Magson: Okay. So again I know a little bit of it but only a very little bit. So again we could probably share with you more detail of the process being undertaken. I think I may say that a few times today bearing in mind it is week five, so I apologise for that but that is not because we do not want to know.

But in reality what the Minister was talking about, what we do not have here – and actually, funnily enough, this is quite a managerial function or an administrative function actually – is the infrastructure that exists around what you would call patient tracker listing (PTL) and the way that the infrastructure or the architecture of how we manage patient waiting lists should be constructed.

It is all linked to … you will be familiar with what happens in the UK, around 18 weeks and RTT waiting – referral to treatment times – for how long people have been waiting for their hip operations, how long have they been waiting for outpatients, how long have they been waiting for surgery and so forth. As we know, in Sir Jonathan Michael's … it is not new, everybody knows that actually the data, the reporting, the infrastructure is lacking here and that is one of the things that we need to improve, and quite a lot of access to the Transformation Fund is about how do we do that, how do we look to use infrastructure that is already there, but also how do we look to build on that and enhance it? And also leapfrog what happens elsewhere so that it could be suitable for the Isle of Man.

One of the ways that actually is quite common practice, so this is not unusual to receive letters of that sort, is what they call a validation exercise. So quite often – and I talk from a UK perspective – actually you would validate your waiting lists and if you have got in a particular instance a backlog or a large number or a position that had led you to be worried about the data you would validate in that way.

One of the methods in order to be able to do that is to write to patients. We are not asking them to make a clinical decision. I do not know the letters that went out but it is quite common practice to say, 'Have you been seen elsewhere?' because some people do, 'Has the pain gone away?' because also that can be the case and actually it does not mean in my experience, but again I cannot tell you whether that happens here yet at this moment, that you will be taken off the list because that would have to be a clinical decision. But actually things do change for people and it is only right that we should ask so it is quite a common practice. It is not unusual.

Whether it is two weeks or … I would expect it to be slightly longer but I do not know the circumstances of what that was and it may well be that these patients have been on there many years ago and that was right. But I am sure all of that was looked at at the time. So what you are describing is a way of validating the patient list.

Going back to my original point, what you ultimately should do is if you have got the systems and infrastructure in place, that validation happens all the time and that is the utopia of where we need to get to. But it is quite manual, it is quite heavy and it is not as sophisticated as you would expect in today's age, but ultimately things do happen, people are not fit for surgery and therefore actually have to be put back on the waiting list. There are all sorts of different dynamics that go behind what is effectively the engine room behind surgery and how that is managed, and that is where we need to get to.

Q28. The Chairman: So in terms of the publication of waiting lists, does a consultant in that particular area or a speciality, does he or she confirm that the figures are actually accurate or is that done by someone else within the organisation?

Ms Magson: So what I am aware of at the moment is the waiting list and the information that we do have are only really a proxy for the reasons I have said; they are not validated, I can confirm that for you. It is an enormous exercise that would take many years to do and it is on a journey around how we move to that place.

Again, it is good practice when you get to a certain point where a clinician would be involved in deciding whether that patient needed to remain on the waiting list. Quite what the infrastructure is here at the moment, I do not know, but it is clear that the team are already starting to think that way and are moving in that thinking.

Again, I would need to look at what the processes were in the work that they did, but my understanding, when the team have been talking about it, it was done in quite a carefully managed way and I would expect the clinicians to be involved in the final decisions, yes.

Q29. Ms Edge: The system appears to have gone backwards from the many years ago that I worked – the consultants kept their own lists – because we have gone centralised. Do you think that is a hindrance to being able to … The consultants could track their patients and they knew exactly how many they had on their list, but obviously it is a centralised system now.

Do you think that has impacted?

The Minister: I think with centralisation of systems, it is because it is important data is recorded in the same way.

This Committee has heard several times from Dr Hewitt when she has appeared with me as Director of Public Health. One of the problems we have had in the past, not necessarily just talking about waiting lists, but where things have not been collected centrally things have not been done in a comparative format. So I think when you are collecting data, like waiting lists and everything else, it is important it is done centrally to make sure that the actual data is able to be validated and it is the same across all specialities.

If you have not got that and you have got different sections doing it individually, you end up with exactly what Dr Hewitt said when we came to give evidence around the suicide issue: a set of statistics that you cannot be absolutely certain are the same, year in year out, and you have got no trend data that you can identify.

Q30. Ms Edge: So, to be clear then, the data is possibly there, it has just not all being gathered into the centre?

Ms Magson: My understanding – again, it is very early days – is that it is being gathered, because that is what the Minister refers to, but it needs to be consistently reported, validated

and actually, just to partly answer your question as well, really, the focus should be around clinicians and the use of their clinical time, not the administrative time. So I would support it centralised. I think it is absolutely right thing to do.

Q31. Ms Edge: They do not have individual secretaries now that they can have support from.

Ms Magson: Well, again, a lot of those would be centralised and working in the same way and they are a pooled resource. Because ultimately you are making sure, going back to the point of your clinical time and managerial and administrative time, you are making the most efficient use of as much administration staff as you do.

Q32. Mr Perkins: One of the problems is with all this that GDPR … the doctors surgery cannot talk to the central database. Is there anything we politicians can do to change that? The Caldicott thing is nobody has ever died from having too much information or people have died if they have not had the correct information on people. (***Ms Magson:*** Yes.) Is there anything we politicians can do to help that process along? Could we pass some law whereby medically the information could be transformed from one to the other?

Ms Magson: Do you want me to partly answer? Okay.

So, I have to be honest, in my introduction meetings I have yet to have time with the GTS team. So I think you ought to be directing a lot of your questions at the Information Commissioner, clearly. But again, from my experience, there is a way, with patient consent – and that is the key – that you can share information with an integrated care record. We are moving toward that here. It is definitely on the digital roadmap and my understanding is it is actually quite far on in the delivery of that and they are looking at options. But again, it is early days; I do not know the full detail.

So with a patient's consent, the ability would be able to exist. Then it is a read and write access, and who can write in the individual records – that is also another thing that needs to be worked through. But I have just come from a system where, actually, if you turn up to emergency care (ED), they actually can see the GP record; the GP can see the community care record and *vice versa*. But it depends on the patient sitting in front of them giving consent at that time and saying, 'May I access your record?' and that is the way …

But I understand there are different rules here in relation to GDPR which would need to be worked through.

The Minister: If I can come on that, Mr Chairman, just to say my layman's understanding is that it is more to do with systems than GDPR. There is a lot of myths that go around with GDPR and the sharing of data.

When I was a Member of the Cabinet Office, it was me that assisted Minister Thomas in taking that wonderful voluminous piece of legislation through Keys, as you will remember well, Mr Perkins. I can actually say the simplest way of defining the change between data protection and GDPR is that the only fundamental really that has changed is that instead of 'implied' consent it is 'active' consent that you now need to seek under GDPR.

So it is more around, my understanding, the technical systems that the GPs use in the Hospital, but data-sharing does go on between the GPs and the Hospital. I know certainly in my own case as a patient a few years ago, when I had a blood clot, there was data shared between the GPs and the Hospital without any problem whatsoever.

Q33. Mr Perkins: And you were asked for that or that just happened?

The Minister: It just happened.

Q34. Mr Perkins: Yes. One of the other things I have heard is that people go across for examinations or whatever and the doctor across cannot get the information from the Island. Surely that needs to be streamlined?

The Minister: Yes. Well, again, it comes down mainly to systems and the interface between our systems and the UK.

Obviously there are rules around security of data being transferred electronically as well. I know there have been instances that I have looked into where paper records have had to be sent and there have been claims that they have not arrived in time at the receiving hospital. The one I did look into, that was raised by a constituent of mine, it turned out it had been received by the receiving hospital but had been in their post room for five days.

So what we need to do is – as all members the Committee will know, I am very much digitally minded –we need to get to a digital utopia where everything is transferred electronically. But in doing so, it is important that we have systems here that can securely interface with the systems that are there in the UK.

Mr Perkins: Thank you.

Q35. The Chairman: Okay, we are jumping around a little bit here. I have got a couple of questions back to things we have spoken about already.

We have spoken about the Director of Public Health. Has the transfer to the Cabinet Office happened yet and if not, do you have a time for when it will happen?

The Minister: It is very good timing, Mr Chairman, because I have literally, before coming in here, signed the motion to Tynwald for the transfer. (**The Chairman:** Good.) So the Transfer Order will be coming, hopefully, to the next sitting of Tynwald.

Q36. The Chairman: Okay. And then onto the Transformation Programme, it will require primary legislation to meet the 2021 date. How are we getting on with that?

The Minister: It is being drawn up in the Attorney General's Chambers. We will be going out to public consultation on it in the spring and then I will be proceeding with it through the Branches so that we can get Manx Care set up in shadow format and it is on time to be live the next year.

Q37. The Chairman: Okay. In terms of the Transformation Programme Management Office's 14 key projects, how many of them have entered the implementation phase?

The Minister: At the moment, my understanding is it is seven. You cannot just activate every single programme because some are dependent on other things being done. So it has been broken down, as you say, into 14 overall projects to implement all the recommendations, and the first seven that need to happen to drive forward the next seven are already up and running and work is going on, on the ground.

Q38. The Chairman: Okay. In response to a Written Question in Tynwald the last month, the Chief Minister confirmed the Health and Care Transformation Director had resigned. Could you explain that? How has this risk resignation impacted the implementation of the projects and when will a successor be appointed?

The Minister: Yes. In terms of the Transformation Director, it is exceptionally unfortunate that the Director of Transformation has left. He has moved back to the UK. I cannot go into the

details as to why because I do not have any permission with him to share his personal information here at the Committee.

What we are looking at is, rather than going for another Director of Transformation, the Cabinet Office is looking at the existing resource that has been appointed – because we have a Project Manager for Transformation – to be able to utilise that in a better way.

If there was a good time for the Transformation Director to go, and I am not sure there ever is a good time, it was probably the most ideal time because he had already set up the first seven projects and they already had leads appointed for the projects to be able to move forward. So if ever there was a semi-good time to go, that was probably it.

Q39. Mr Perkins: Did he take a look at it and see it was an insurmountable –?

The Minister: Right, I have heard all these myths and rumours, and obviously I am not going to start going through a list, but I would say that the wonderful social media world that said he took one look and went, 'Oh God, this is a basket case, I do not want to touch it!' – completely and utterly not true whatsoever.

Mr Perkins: I am glad to hear it. Thank you for that.

The Minister: And he was enjoying the job as well, I would make a point of.

Q40. Ms Edge: So he was appointed to a specific role, and you have just said that you are looking in the Cabinet Office to existing resources to carry out that role now. We have problems with the budget in Health, and clearly there is a resource there that perhaps can just be utilised?

The Minister: Well, hang on. I need to be clear, Mr Chairman, this is not coming out of the Department of Health's budget. The Transformation team is being run by the Transformation Fund. I need to be absolutely specifically clear on that: it is not coming out of the day-to-day DHSC budget.

Q41. Ms Edge: So the question is then that you said there is a resource that you might be able to identify. So is that somebody that is already doing a role somewhere else within the Transformation team?

The Minister: From a political level, I am not driving the Transformation. Again, I need to point out the Sir Jonathan Michael Review did the separation. So the Transformation is being driven by the Cabinet Office, not by the DHSC Department.

Ms Magson: I know the Cabinet Office are definitely looking in order to be able to respond to your question. So at this moment in time we do not know, but obviously we are part of those discussions and dialogues.

Q42. The Chairman: Okay. You mentioned in Tynwald last month that the Island is suffering from a shortage of nurses and that efforts were already being made to increase recruitment. Have you seen any significant increase in recruitment since introducing some of these methods and do you foresee the Island becoming ever more dependent on agency and bank staff?

The Minister: I will let the CEO come in in a moment, but certainly from my point of view, when you go out for recruitment it can be a long lead-in time. Certainly we have done some very successful things. Members will probably have seen the social media video that went out last year, in terms of people talking about their jobs – that got very high profile responses. Nurses: there is a shortage in the UK as well. The vacancy rate in the UK is about 12% in relation to

nursing staff. We have 75 vacancies in nursing staff, which equally is just under the 12% ratio. So we are very similar across the two jurisdictions.

I know there have been conversations from Cath Quilliam, the Director of Nursing, and a company that looks to recruit full-time nurses, not bank nurses. They look to position full-time people and I believe that conversation has gone very well.

Q43. The Chairman: So you will have made an assessment as to why this problem exists, if it exists here and it exists in the UK. What are the principal reasons why people are not wishing to get involved in nursing?

The Minister: I think it is a mixture. Obviously demand has increased over the years, both in the UK and here in the Island. With a different hat on, from my days in the private sector where I did used to look to recruit to various different posts, people now do not tend to have a career for life. They tend to move.

Also with nursing, whereas you had in the old days, a nurse would join the hospital at, say, age 20, they would finish at the hospital at age 65, nursing is now much wider than that. There are, much wider, prescribing nurses out in GP areas, there is nursing out in the community as well, and what you tend to find is people will change over the years much more than they have in the past.

Q44. The Chairman: So specifically, in terms of your Answer in Tynwald last month, do you think the morale among nursing staff is about the same, better or worse than it has been?

The Minister: I think it is mixed on the ground; I will be perfectly honest with that. Certainly I know a lot of nurses that I speak to on a personal level; they feel very heartened about the Sir Jonathan Michael Review the transformation. I think they will feel more heartened when they actually see the results on the ground, because some people feel like they have been reviewed to death over the years and they want to actually see some form of outcome.

So I think once they start seeing the outcomes on the ground that will improve. I mentioned at the start of this sitting that one of the things the Department has acknowledged in the past is around culture and improving the culture. I mentioned at the very start of the sitting I will be giving Mrs Barber a delegated power in relation to culture across the Department.

Q45. The Chairman: Yes, I wondered what you meant in relation to 'culture'. So you are talking about the culture of the organisation as such?

The Minister: The culture of the organisation. Because there are projects underway around culture I think it is important that there is oversight. With the best will in the world, as Minister I have got a broad oversight, but my time is taken up with a lot of different things and I think it is important to send that message out there: that there is someone who has a dedicated delegation in that area. I think that Mrs Barber is the ideal person and I am delighted to say – I am not saying anything out of turn – she has accepted to take it on before I have mentioned it here today.

The Chairman: Good. Just one more from me and then I will hand over to Ms Edge.

The Clerk: Do you want to let Ms Magson comment on that?

The Chairman: Sorry.

Ms Magson: Shall I just add a bit on the nursing, is that all right? Yes.

The Chairman: Yes, it was about nursing I was going to ask –

Ms Magson: Yes, you go ahead then.

The Chairman: – so perhaps you can wait until I do mine –

Ms Magson: Yes, of course.

Q46. The Chairman: – and then you can feedback, because it may be that from a professional perspective it might be helpful.

How about nurse training on the Island? Could we not do more of that?

Ms Magson: Yes, that is exactly what I was going to say. It was on my – (**The Chairman**: Yes.) So you are right. At the end of the day, I would expect *always* to be having a conversation about recruitment, because it is a continuous challenge. And as you have talked about it, it is affecting the UK, but is it affecting all parts of the profession wherever.

So it is not unusual and we have got to constantly look at innovative ways in order to be able to attract, retain and also develop. One of the opportunities of doing that, of course, is the integrated care pilots and people working in different types of nursing roles. So there are all sorts of different opportunities that we can do.

You have touched on education: that is absolutely key. Back in the UK, with the bursary changes, that was a real difficulty in their shortage of workforce around nursing. They have obviously reversed that decision. But my understanding here is that the bursar remained in place and actually I think that has been quite key in managing to keep the numbers where we are.

We should not underestimate, though, how much work has been going on. So I am aware there is a nursing strategy that has been developed from the bottom up. In fact, it went to the departmental meeting, the first one I went to – last month, in fact, now, because we are in February! That has been produced from the nurses themselves. So it has been quite a long time in the making but it is here and will be published. It is in line with the year of nursing and midwifery, which is also 2020 – you may have heard about some of those things that are happening.

But ultimately the culture is what is going to make the difference, isn't it? The reason why there is a culture Project Initiation Document (PID) in the Transformation because that is – you have picked it out, but it is so important – about the sustainability of the delivery of services and everything we have touched on today in bringing people with us on that journey.

So the Minister and I talked about it: how do we make sure it has got the right resource within the Department to make this work? There is already resource set aside in the Transformation team to focus on culture. We have just had the staff survey results as well, there is a diagnostic underway and we have got support from some of the Shared Services team, to really motor on with this wider organisational development plan. It is not just the nursing workforce.

But ultimately, there is a lot going on in this space and I think over time we will be able to talk to you, you will be able to feel that down on the ground and ultimately make a difference to the feedback that you might be receiving.

Q47. Mr Perkins: Just going back to nurse training, are you involving University College Isle of Man?

Ms Magson: Yes, I have already raised it with my counterpart in the Department of Education and actually I am meeting with the principal on 20th February, along with Cath Quilliam, who has also similar, similar to Angela, taken on the responsibility for nursing across

the piece; also Rosalind Ranson, who is the Medical Director, who started this last week. It is one of the key areas that we have already identified as a priority. We need to work closely with the University and I have spoken to Ronald accordingly.

So yes, that is already in train.

Q48. Mr Perkins: Do you think it is necessary for nurses to have a degree qualification?

Ms Magson: Yes I do. I would encourage –

Q49. Mr Perkins: Do you think they are better than the ones that do not?

Ms Magson: Sorry?

Mr Perkins: Do you think they are better than the ones that do not have a degree?

Ms Magson: Not at all, because people can come up through the ranks in different ways, can't they? And it is always going to be a blend of their experience as well. So no, we would encourage everybody, whatever route they wish to take.

There are different parts of the Department where there are different ways of recruiting and also taking through the professional degrees. I know we are talking about nursing, but in the social care social worker we have been growing our own in that space as well. So there are lots of different ways that we can work towards the same aim and every profession will need a multitude of different approaches.

The Minister: From a slightly different angle, just on that point, Mr Chairman, as Minister, I think it is very important that when we talk about – because there has always been this talk before – should the Isle of Man break away and say, 'We do not need nurses with a degree and we have different criteria.' As I was mentioning before, people move on in their career and it is important that those people, if they do choose and decide they want to go into the UK, can do so. If you have not got that equivalence you may get to a point where the UK will no longer recognise periods served in nursing on the Island. It is an extreme situation, but they will not recognise that period served on the Island as service.

So it is important we do not do anything that actually could have a reverse effect on recruitment, where people think that their service over here will not be recognised if they move elsewhere.

Q50. Mr Perkins: Do you think there is an opportunity to bring trainee nurses in from the UK and train them here?

Ms Magson: Yes. All of those things we should be looking at, and as I said, I am going to be meeting with the University and the relevant colleagues. There is a medic as well at Noble's, who I have yet to meet, but who has also been involved in all this.

So yes, it is definitely in train.

Q51. Ms Edge: So I will start with the degree part first. I have got about four questions on this particular topic of nurses. The UK about a year ago did mention that they might be getting rid of the degree. A lot of our very experienced nurses now did not have degrees when they took up their training. If the UK did take that route, would we follow in the Island to ensure that we have frontline services sustainable for the future?

Is it right that staff at 65 are being made to retire and the Equality Act is not getting applied to nurses who reach 65?

And are nurses in training … I am not sure how many it is per year, but a number of them were not offered jobs. They were told to go to agencies if they wanted a job. Why, if we are training our own on Island, are we not offering every single one of them a job at the end of their training?

The Minister: Just to come in on a couple of the points, my understanding is since the Equality Act provisions came in that that has not applied in relation to the 65. But if you have any evidence to the contrary, obviously please share it with me.

Q52. The Clerk: Do you mean the Act has not applied or – ?

The Minister: No, no, the provision that they are forced to retire, outside of the Equality Act. But if you have any individual cases where you think that the Act has been breached, please do share them with me.

In relation to a nursing degree and the UK talking about it, I think the key emphasis is the 'might'. As someone who has been following politics quite closely in the UK, I seem to remember it being discussed as a 'might' since the Blair government in the late 1990s. There have been a few Secretaries of State since then. So I will believe it when I actually see it.

But like I said, the important point for me is that we keep some form of equivalence regardless of what we do; that we do not go to a position where we might hamper recruitment by doing something that is so different from the UK that service …

If the UK does go down that path and they make a firm commitment, then it is something we would have to look at.

Q53. Ms Edge: Can I just ask on that then, because when people get a degree qualification for nursing the frontline services can be affected because they can go into management roles. Do you think that has impacted on that since the degree was introduced?

The Minister: Personally, I would not say so. Certainly I have seen no evidence of that. It is people's choice as to what they want their career to be. You cannot box someone in and say, 'You shall forever be a nurse'. If they wish to move on and go into a management sort of function then that is their individual choice.

The other point I just wanted to make was in relation to the nurses in training and being referred to agencies. In my understanding, that was an issue that emerged last year and I believe it has been corrected – is my understanding.

Q54. Ms Edge: So can you confirm that everybody that went through training and successfully completed it last year got a job on Island –

The Minister: I will get that confirmed for you.

Ms Edge: Thank you.

Q55. The Chairman: Just as a rolling up in terms of that, do you have a particular preference? Would your preference be for people to be trained wherever possible on Island and able to take up jobs or would you think that agency provision is equally appropriate?

The Minister: My personal preference is that people would be trained on Island – but this is my utopian politician vision, isn't it? We might get more of a reality check in a moment – but my utopian politician vision would be that people would be trained on Island and then take up jobs, because one of the things that shows when you do look at various jurisdictions, not just UK/Isle

of Man but wider afield, those nurses that have lived locally, trained locally, tend to actually stay longer in the role; those who already have a connection.

Living on an Island is a very different way of life to even if you are in a rural part of the UK, where you can get on a train and, say, be in the centre of Liverpool in 20 minutes or something like that. That is my personal utopian politician vision, but I think we are probably just about to have a reality check now.

Ms Magson: My honest answer would be is it going to be a blend of lots of different things that will … And as I said right at beginning, recruitment will be a constant challenge that we have to think of and we have to be innovative and that the best way is to maximise the opportunities that exist in the Isle of Man to attract us for all professions.

So it is going to be a blend of different things. Ultimately, this is not 'one size fits all' and one approach is going to work. We welcome lots of different ideas. That will also come from the staff. The staff will be quite important in resourcing this. It is a journey we need to go on and it is constant – will never stop. Whatever profession, in reality, whether it is the nurses or many of the other disciplines in the Department, it is a constant challenge.

So even now we have already started to pick up, trying to maximise some more of the Locate theme, picking up on some key areas that we could really target them on to try and to deliver for us. Again, there is more we can do across Government in making this work.

So yes, we are going to try lots of different things with the aim to obviously attract as many people as we can.

Q56. The Chairman: One of the things we were told previously in relation to innovation on the Island was the potential opportunity for our services linking with specialist services in the UK. Is that still something that is on the boil?

Ms Magson: Yes, and actually that is another example of where you gain from recruitment. So networks, as I would normally describe them, particularly around … Well, they can be complex tertiary services and specialist services you talk about, but actually they can be many different ways of providing networks in more innovative solutions, in the way we deliver outpatients, for instance, and how staff rotate. Now, we do have some of that at the moment, but actually not as much as we are going to need to have.

So only last week I was in a meeting discussing how we would work around further developing our cancer networks with Clatterbridge. Ultimately, we are going to have to look at a number of these services in that way and they will, as a result, not only upscale our existing staff, but also attract people to the opportunities of having a diverse workplace and of the rotation in and out of the UK or otherwise. So yes, we are going to see more and more of that.

Q57. The Chairman: That was what was spoken of and it just seemed at the time to be something that may be successful.

Ms Magson: Yes, I think you are right.

Q58. Ms Edge: Is that not part of the training; that they do have a placement outside of the Island?

Ms Magson: Yes.

Q59. Ms Edge: It is currently? So any of our trained nurses will have had a placement in a UK hospital; Clatterbridge?

Ms Magson: Well, I do not know the full extent of all of that at the moment, to be honest. But you would expect, on a rotation, absolutely. And it is a good thing to do. It enhances the skills that people bring back to the Island when they come back as well.

Q60. Ms Edge: It certainly used to be in place in the old Noble's training. (***Ms Magson:*** Okay.) It used to take place.

The Minister: It should not just be during a training period, it should be ongoing.

Ms Edge: Continuous, yes.

The Minister: People have the opportunity … And I think one of the things we are lucky with here in the Island is geographically the north-west of England does have lots of centres of excellence around a various amount of specialties. So we have on our doorstep, or whatever you can class as a doorstep as an Island, access to a lot of different high quality providers.

What is important is we get the service level agreements right with those providers to ensure we are delivering it and we are delivering access to patients.

Q61. The Chairman: Okay, anything else on recruitment?

Then we move on to Adult Social Care. What is the latest progress update on the Adult Social Care Outcomes Framework that was due to have commenced in the second quarter of 2019?

Ms Magson: So at this stage my understanding is we have not actually reported in line with the Framework since 2015, but actually, the review which is being done UK-wide we will follow, work with and are connected in. That has just started. There is a document that we can send you, if that helps. It shows how it is kicking off. But I know the team are heavily involved and we would want to learn from and be party to the work that is being done over there. But we are just all deciding on how we are going to report here.

Q62. The Chairman: What measures have been taken by the Department to improve Adult Social Care services and are there any plans, without giving away budget secrets, for additional funding for improving Adult Social Care services?

The Minister: I have got to be careful, obviously, what I say, Mr Chairman, in relation to Adult Social Care. Adult Social Care is one of those things that feeds into the wider picture. So again, it is not something that can be just looked at in isolation, because health departments tend to have this thing where we divide off adult social care from children's social care and then if you are not careful a chasm starts developing between the two.

What we need to do is ensure that everything is joined up and it feeds into the wider community programme as well. That is why we have a community division to try and drive things forward. Certainly the Department has been developing business cases, is what I can say, around Adult Social Care and the services we provide. But ahead of February I think I need to leave it there.

Q63. Ms Edge: So with regards to Adult Social Care and our elderly, we have a demographic that are living longer; they are living in the communities longer. (***Ms Magson:*** Yes.) Do you feel the service offered in the community is adequate for our elderly at present? If there is something in the Budget, great news! Obviously I know you cannot say, but –

The Minister: What I would say is – and I am going to expand the question a bit if I may, Mr Chairman – that I think the services we are offering now are adequate to the base level.

Obviously there is always room for improvement, but what we have got to be doing is looking to the future.

As, Ms Edge, you have just said there our demographic is changing. So we have got to make sure we are proactive, not reactive, when it comes to things like this. That is the important point. Even if we had a utopian system now, which I am not saying we do by any means, but even if we did the important point is we have got to look over that next 15-20-year period at what is going to change and what the demand is doing. That is exactly what the Department is doing around Adult Social Care.

So we are not just focused on what the provision is now, we are focusing on what the provision needs to be in the next 15 to 20 years.

Q64. Ms Edge: I totally agree with the word 'proactive'. What is the Department doing to do additional services in communities?

Ms Magson: Okay, so again, it is very early days, but I have sighted a little bit about what they have been doing. I have not had my deep dive on Adult Social Care yet, but they have actually had a programme schedule of redesign – in my understanding it was agreed in 2018 in the summer – and have been working through that. A number of those strategies actually came through to the departmental meeting that we had only last week.

So some of them you will be familiar with, around the eye care strategy. These are more broadly the community, because obviously we are looking at it as a whole. We are doing some work also around the autism strategy, which is also part of the Transformation PIDs; the Mental Health and Wellbeing Strategy.

So all of these things are part of the Adult Social Care and community integrated, tiered approach. Actually, what the team quite rightly have designed, and I would expect to see, is a tiering where patients flow up and down the pathway as needed in and out of social care and health needs in a proactive way. And where they need to access health provision and particular crisis provision, then that will be there for them as well.

So from what I can see so far, the team are very much working in that direction, have a plan in the initial stages to develop that, have started to deliver on some of those products and clearly the integrated pilot is one of those. It is a really good example of where they have energised a community in order to try and work in that way and are obviously developing that further into its second pilot.

So all of these things are part of that transformation around Adult Social Care.

Q65. The Chairman: Yesterday I was invited to go to the south of our Island to meet some people in their home. Two elderly people, one caring for the other. I just wonder how you think we are doing in relation to carers and the inevitable consequences of somebody being potentially worn down by taking on the caring role, and whether you think that is adequately funded etc. at the moment?

The Minister: To be perfectly honest, we have got a long way to go in that regard, in relation to carers, particularly around making sure there is adequate respite care available. There are respite services. I gave an answer, to you I think, Ms Edge, in Keys I think it was, not too long ago, where, very helpfully as well, I managed to get the numbers out there for people to be able to contact to try and access. But again, that is a service that as we get an ageing population we will get more and more people wanting to stay at home, partners wanting to care for their loved ones, which is quite natural, and it is important that we adapt the support mechanisms to ensure that they can get respite and help that is required there.

This again is – and I think we have talked about this before when I have appeared before the Committee – the whole point of the community aspect. When I talk about moving things from

an acute setting into a community setting, this feeds exactly into that; in ensuring that people are supported to be able to stay where they want to stay.

If you go back to the 1990s – and again, it is only my personal opinion but – it was a very regimented system, wasn't it? You could be admitted to hospital, then you would go into residential care, then you go into nursing care and there you would stay. In fact, they made a comedy series about it, *Waiting for God*, I seem to remember, in the 1990s. But now more and more people are saying, 'No, I want the ability to stay in my own home' and it is important we adapt to that new world and the demands that the people in our community have.

Ms Magson: I think the best thing we can all do is to encourage people to have the relevant care assessments, which we do have here. It is a constant challenge clearly, and I have read the Crossroads report – I am going to see them next week; that is on my schedule. So we cannot underestimate it, because clearly, as we know, carer breakdown also means there are implications for Health and Social Care.

So we need to encourage people in a language as best as we can to have the care assessments as they are commissioned on the Island.

Q66. The Chairman: Yes. The specific case that I will not mention any more, other than in the case I went to, it was a sister caring for a younger sister, and it just seemed to me that the amount of financial support available (**Ms Edge:** Minimal.) precluded the younger sister obtaining external support because it is pretty limited.

The Minister: Obviously, in terms of Carer's Allowance and everything else, that sits with Treasury and not with DHSC.

The Chairman: I will take it up with them.

The Minister: But I was just going to say, on that individual case, obviously you do not want to mention too much here in a public forum, Mr Chairman, (**The Chairman:** Yes.) but if you feel behind the scenes there is something we can talk about there, then as always I am more than happy to have that chat.

Q67. Mr Perkins: I think it is important to understand that we do need to look after carers because they are actually saving the Health Service an awful lot of money. And to give them a week's break by taking the patient into hospital, or wherever, saves us money in the long run.

The Minister: I have got friends who are carers, and full-time carers at that, that I have had to give up work. So I know just how much they actually do. It is phenomenal and most of them do it without complaint; without even highlighting it to anyone. They just get on and do it. So I do not think we should ever underestimate the amount of work that carers undertake.

Q68. Ms Edge: Is it a statistic that you have? Do you know how many people are caring for people, for their own relatives, in the community? Is it something that you need to have on your radar, because there is no way in the future you are going to be able to bring an effective balance forward?

The Minister: We do have low-level statistics, obviously those that have engaged with Adult Social Care, and I have seen those before. But it was a while ago and I am not even going to try off the top of my head to remember the figure. But what I would say is I would take that figure with a huge pinch of salt, because of the fact that you have many people, and I know carers, who do not engage with Adult Social Care at all. They have just got on and done it.

I know someone who is looking after their elderly father, them and the brother, and they have never actually contacted or sought help from anyone. They just see it as their duty … and doing it in shifts. So I think it is very hard to get an exact figure out there in the community.

Ms Magson: But what I can tell you, rather than the numbers, is how many hours we provide, I think it was part of a Tynwald Question that came through: 7,000 hours.

You probably will also be familiar with the residential care homes where we offer respite and the Dementia Care and Support Services that offer respite in the short term. So I am not saying there is not more to do, but actually, what is already commissioned is quite a significant out there that people can access – again, if they have had that assessment and they are going through the appropriate routes, starting with their GP or any other professional that they know.

So there are a number of other things that we can offer that we provide and we commission across Health and Social Care: day centres, either dementia or otherwise for older people. Again, we are happy to share all that information and encourage people to ask. That is the key: ask for help. Yes.

The Chairman: Absolutely. Thank you.

Q69. Ms Edge: You mentioned there had been a redesign of your strategy for social care. Is it possible to share that policy? And I have not heard the words 'social exclusion' mentioned at all. I am just wondering how you are going to address people in the communities where services perhaps get reduced – we do have a lot of elderly people in the communities – how are you addressing that? Obviously you have had your pilot, but what partners have you engaged with?

The Minister: Do you want to – ?

Ms Magson: So when I was talking specifically about the plan, what the team came up with is a programme plan, rather than necessarily a strategy itself. So it looked at a number of different things. Learning disabilities was in there, mental health was in there – it was a whole end-to-end community Health and Social Care area focus on a programme plan over the next 12 to 18 months. That was started in July 2018. They have delivered some of those things. I think we may come on to Manannan Court later, that was another one of the things that was sitting in the programme.

But ultimately, the strategy really was about the tiered structure and patients would flow up and down as they needed and ultimately, if people were needing crisis intervention, then they access the relevant specialist services as needed. So at this stage that is my understanding of where we sit in the programme. The team have shared that and I will be working with them to understand that further.

The Minister: I think one of the key points, particularly on the community thing, what we are wanting to do is join up the services in the community and that is exactly what the Peel pilot is doing. Because although vulnerable people might not engage with all of the services, and some of the services they need, they will engage with some. So it might be the GPs, for instance. They might attend the GPs'. The GPs might see something that they feel needs to be looked at elsewhere and it is about having all those services communicating with each other to deliver the services on the ground.

Certainly from what I have seen so far of the Peel project, I have been greatly encouraged.

Q70. Ms Edge: Are you going to roll it out further and have you got a date?

Ms Magson: So it is on a phased basis, and it will need to be, because again, it is about cultural engagement and bringing people with you on the journey. So obviously a second pilot is

being planned at the moment, and absolutely, the intention is we will move us as quickly as we can.

The Minister: I think what is important to stress at this point is it is not a 'one model fits all' either. (***Ms Magson:*** No.) Although we are technically a small Island, we have very different communities depending upon where you look. So the model that is being rolled out in the west of the Island, whether the Peel pilot … might not be 100% suitable for what we acquire in the north of the Island.

So it is important to stress that the Peel pilot is not just going to develop a model that we pick up and plonk around the other three regions. That is not going to be the case. The different services provided will adapt to the populations in the different areas and that is the whole point of integrated care.

Q71. The Chairman: Prior to your appointment there was some work done in the south of the Island in relation to this. Is it planned that the south of the Island will be the next area that will receive this attention?

The Minister: Prior to my appointment – and of course I was on the Committee with you on the other side of the table at that point, Mr Chairman! – I seem to remember us being told that there had been some spec work done in the south. At that time it had not gone that far, is my understanding.

Ms Magson: But the staff engagement started this week. So my understanding is 'yes' is the answer to your question.

The Minister: But the south of the Island is potentially the next big project.

Q72. The Chairman: Okay. Another thing that I have been keen on for a long time, and when I was a Minister this was talked about at the British-Irish Council in terms of the Isle of Man and telemedicine. Have any further advancements been made in the use of telemedicine to allow easier access to help for the elderly or less mobile people?

Ms Magson: Okay. So at this stage my understanding is no, but there was a pilot done in a number of care homes and residential homes. Actually, it did not complete its pilot. There were a number of issues, some of which we have talked about today, around IT and GDPR. I think it is also a good example of where we need to spend time on the culture and the engagement and getting all of this right. How you are bringing all of these different ways of working and bringing the people with us in these different journeys ahead; and pathways?

So that pilot was stopped. It was a third party – you probably know more than I would – but ultimately, again, we should be looking at whatever opportunities there are to work as digitally as we can in a safe way that works for the Island. In that instance, there was clear evidence that it was not working and we needed to reset it. So the decision was taken at that time to stop that pilot.

The Minister: I think as I mentioned in our last evidence session, the annual evidence session, the problem with telemedicine is it is this concept of: people think it is just a case of, you plug a TV in, you connect up and off you go. It is not as simple as that, because there are obviously security implications around data again. It is ensuring that whoever you are communicating with actually has the same ability as the person on the other side.

Particularly telemedicine, one of the things I have always been keen on as Minister, where I feel it has the greatest benefit, is to stop people having to travel to the UK for consultations, where it is one of those where they fly out, the consultant just says, 'How are you?' and then

they are waiting to fly back again. That is where I see the greatest benefit. But in order to do that we have got to ensure, again, that our contractual arrangements with our third-party tertiary providers are correct, the data control is correct as well, and that we have the same technology, obviously, for it to be able to work.

So that is not a small undertaking in any way. Although it might seem simple, telemedicine, that you just plug a cable in and off you go, unfortunately, as with most of these things, it does not turn out to be the case.

Q73. The Chairman: Any plans to introduce new schemes or policies to improve the help and care given to patients suffering with advanced dementia?

Ms Magson: At this early stage I cannot comment. It is too early days. But clearly we can take that back. As I have talked about, there is a lot of provision already in place around dementia; it is a constant challenge. Clearly there is an enormous growth in need. So at this moment in time I am not familiar with where we are with needs assessment and what all the services in place are, but I am happy to talk to you about that at a later date.

The Chairman: Thank you.

The Minister: Again, just to say on that, any provision the Department provides obviously has to be tiered, because different people with different levels of dementia have different needs. So it needs to be very much a person-focused approach that the Department takes in relation to that.

Q74. Ms Edge: How many spaces do you have for people with advanced dementia on the Island and do you only have one area that they can be in or is it across the Island? How many dementia patient secure beds do you have?

Ms Magson: Yes, so I can tell you that exactly, actually. So the Dementia Care and Support Services short-term care – in that instance there are four residential and one emergency respite room at sites in Douglas, Ramsey and Port St Mary.

Q75. Ms Edge: What about long term?

Ms Magson: Beyond that, I do not know. They clearly have the Dementia Care and Support Services around day centres and longer term … and we offer 15 places per day in those centres. But beyond that I do not have any of the other statistics with me today.

Q76. Ms Edge: So are people with dementia are having to mix in normal residential … Are they going to normal residential homes? And then there is a management issue, so we do not have –

Ms Magson: Again, I am afraid I do not know.

Q77. Ms Edge: Does the Minister?

The Minister: What I would say is, again, if you have any evidence of that, please share it with me. I have been out to see several of the residential homes and it is not something that has been raised with me when I have been out to them.

Q78. Ms Edge: It just seems four residential beds, when we are very aware of a dementia … Because people are living longer with dementia, but –

Ms Magson: Yes, okay. So those are respite beds. Those are respite beds, yes.

Q79. Ms Edge: Right, okay, so what is normal – ?

Ms Magson: I do not know the answer to that. (**Ms Edge:** Okay.) We can definitely provide that.

The Minister: We can get that figure and provide it to you.

Ms Edge: Thank you.

Ms Magson: And actually, I would expect it to vary, because I suppose many of the nursing homes and residential homes will be looking at their blend and how their bed base looks. Most of them are looking at what the future holds in relation to the dementia care provision. So I will get, though, for you the current position, as much as we know.

The Chairman: Yes. I obviously acknowledge that you are new –

Ms Magson: Yes, absolutely.

Q80. The Chairman: – in position. But I can tell you that having worked with people wishing to obtain suitable accommodation for relations with dementia, it is not always the easiest.

Anyway, we will move on to suicide and mental health now. Do you think that we have the model for mental health services right?

The Minister: Obviously, in terms of mental health service, we have had several reviews now into the mental health provision on the Island. I think obviously we have got work to do, but that work is ongoing. I think the models that we are undertaking are the way forward. They are going to provide a much better situation than we have had in the past and I think, again, there is acknowledgement that there needs to be a proper tiered service in place, which is the model we are now working towards.

Q81. The Chairman: And early intervention?

The Minister: Well, early intervention comes as part of that. Mr Chairman, you know my personal feelings on that. Early intervention is the key to anything, but particularly in mental health.

Q82. The Chairman: And in terms of the Chief Executive –

Ms Magson: Yes, it might just link back to one of the other points you were talking about earlier around networking, clinical rotation and staffing. Again, workforce in mental health is also challenging – increasingly so – for all the reasons we talked about earlier. I know last week the team were talking about using different mental health trusts in the UK – actually, they were in the south in that instance – to think about the same sort of thing around clinical rotation, reciprocal rotation, in order to support training and ultimately the workforce challenge.

Q83. Mr Perkins: Just coming on to the Crisis Team, I know that you have had a mental health worker with the Police and that has worked pretty well. Are you going to extend that? How is that panning out?

The Minister: Yes, we are working with the Police to ensure that that can continue. Again, I cannot say much ahead of the Budget in February, but what I would say is from my point of view as Minister I think it has been an exceptional success. Members will know from the Chief Constable's Report as well, Mr Chairman, the Chief Constable highly praised it.

It is sensible to have that, again, early intervention and someone there who is a mental health professional to assist the Police. Because for far too long, and again, my views are on public record, police officers who are not, with the best will in the world, trained to deal with all of those sorts of situations, were being left to be the first port of call. That is not only problematic for the Police; it can also be problematic for the individual that they are trying to deal with.

Q84. Mr Perkins: Did the idea for that come from England; where did we come up with that idea to have them accompanying the Police?

Ms Magson: I do not know where the idea came from but it is a very –

Mr Perkins: It is a good idea, yes.

Ms Magson: It is a model that is absolutely used in the UK, yes. And normally as a combined funding arrangement, which I think is here as well. My understanding is we are awaiting response from the Treasury around the additional funding for ongoing … But in reality, yes, it is a model that is used and increasingly used, for the reasons the Minister talks about, successfully.

Q85. Mr Perkins: Is that 24 hours a day or is it just normal working hours?

The Minister: Well again, I have got to be very careful what I say ahead of any Budget presentation in February –

The Chairman: We are aware that business plans have been submitted, because Angela Murray has told us at previous –

The Minister: Yes. So what I would say is this there is a business case to ensure –

Mr Perkins: It is ongoing?

The Minister: – that we can continue as it is.

Q86. Mr Perkins: One of the other comments we had when we did the suicide investigation was that the staff kept changing and the people that were using the service did not know which member of staff would be dealing with them next. Is there anything being done about that?

The Minister: Obviously, in terms of crisis response, we operate crisis response 24/7, 365 days a year. So it has to work on a rota system. You could not do it otherwise. But in order to mitigate that for the needs of patients, to stop them having to repeatedly describe their history and experiences, the Mental Health Service does utilise a handover process and a care programme approach so that there should be information in place to make sure that it is recorded; so that if it is someone who has previously had contact with the Service, whoever is on-duty with the Crisis team should be able to access that information so the person is not just continuously regurgitating the same thing over and over again.

Q87. Mr Perkins: Again, one of the comments we had was that the initial Crisis handling was good, but then the patients were told, 'It's going to be another 12 weeks before we can get you to see somebody'.

The Minister: Again, obviously – and I have answered Questions about this in Tynwald and Keys as well – it depends upon how the patient has been rated. So it works, again, on a tiered system. It depends how the patient is presenting. So in some cases, if it is low-level crisis tiering, then yes, it would be about 12 weeks.

Q88. Mr Perkins: How does our system measure up to the UK?

Ms Magson: So it is the same challenge and demand. It is about the focus on early intervention and the focus on crisis management and ultimately specialist care that we would need to access also off the Island here for us. So it is a constant challenge around workforce and the growing demand.

But also I do know that the team, in the way that they are working and the plans that they have got, it is about keeping as many people closer to home and care in the community, as many professionals, and that does not necessarily mean to see a psychiatrist. It can be many other different supports that are in place.

So it is about that early intervention and the access, as quick as they can, the clinical view, and that is a multidisciplinary view – you would expect that to be the case – and that happens here as well, is my understanding; and then determine what the next steps are.

But there is a huge role for lots of different players here and that includes the voluntary sector. (**The Chairman:** Absolutely.) So what I am hearing and what I have seen so far is that that is very much part of the strategy, the method and the approach that we have had here, actually, for quite some time, and is developing accordingly.

Q89. Mr Perkins: Of course, one of the vital things is to make sure we support the relatives of people.

Ms Magson: Yes, absolutely. Yes.

The Minister: Well, family support and family networking is very important, particularly when you have got someone who is under Crisis.

Q90. Ms Edge: Going back to the mental health support with the Police, which I campaigned for since 2017, is it your intention – I am aware that the Crisis Team do turn people away if they are under the influence of drink or drug – that perhaps there could be a triage with a mental health nurse that would support those people in that crisis, rather than them going back out to wherever? They have arrived at the door and they want help and they do not receive it. Obviously, third sector are not necessarily open at midnight.

So I am just wondering what support mechanism … Obviously there is a policy in place that you do not accept people if they are under the influence, what happens to these people at midnight?

The Minister: My understanding is the Police will take them normally to a secure place if there is an issue –

Q91. Ms Edge: What if there is no Police involvement and they just arrive themselves for help?

The Minister: Obviously with drink and drugs it is *very* hard to do an assessment on someone; when they are under the influence of something else. So it is *very* difficult to assess how that person is. One of the things we have got to remember as well is, depending on how the person is acting, it is *very* hard for the team to be able to engage and actually understand what sort of support and help that person needs when they are under the influence to that extent.

Q92. Ms Edge: Okay. What about when people have perhaps been involved with the services and go back out into the community; the level of support that is out there for them?

I hear many issues with constituents that the support that they have had whilst they are in the system is great and then they are put back out into the community and that is very limited – the support mechanism going forward. Obviously I know it is difficult recruiting in these areas, but should somebody be completely left on their own once they go back out into the community, into perhaps a place that they have never lived in before? They get located to, perhaps, a premises that they are not even familiar with, and then they have no support for … I think it is about five days there is a gap – there is a big gap.

Ms Magson: Okay. So again, early days for me and I have not spent time in these services yet, but my understanding is that is not how the team are planning to operate and clearly if there are individual circumstances then the Minister would be happy to look at those with the team. But actually, the tiered structure and the way that they manage care plans as people flow up and down the requirements would be the approach that they are trying to take.

They are in the process also of going out to permanent recruitments of some more staff in the community. Ultimately that will help try and manage demand into the service and to manage out. We focus just as much on transition in Mental Health Services as we would do the care in the actual service itself. So my understanding is the way that the team work is that that is absolutely their approach.

Q93. The Chairman: Okay. We are going to move onto Manannan Court next.

In September 2019 Dr Tommy Dickinson published key findings and recommendations of the nursing care and service provision on Manannan Court's Harbour Suite. It revealed that he found the care plans to be poor, that they did not seem to be evidence-based or developed in collaboration with a patient. And when that report was issued, Minister, you were very frank in terms of your concern in relation to issues that had been raised.

Have you ever been able to make any progress?

The Minister: One of the first things I should raise is obviously the Dr Dickinson report came out due to certain allegations that were made in the media. So we commissioned it as an independent report because Dr Dickinson had reviewed our services previously, so he knew the baseline we were starting from.

I think one of the important things to emphasise is in a lot of areas, as you will see from Dr Dickinson's report, he actually said things had moved on quite a lot from when he was originally commissioned to report. Obviously that was referred straight in to the Department after he had done it and there has been work going on.

For instance, there has been work around the implementation of the 'Safewards Model', which was a very key point of Dr Dickinson's report. We are also looking around the way that the managerial clinical leadership functions are operating. Obviously, we have had a recent resignation of the Manannan Court Service Manager, which is very unfortunate, but it has given us the opportunity to look at the way we deliver things.

For instance, the previous service manager role included both clinical and managerial responsibilities and that really led to a blurring of roles. That was identified by Dr Dickinson. So we are allowing for the introduction of a modern matron role, and also an inpatient manager

will allow focus on managerial leadership and particularly focus on performance management, resource management and also managerial supervision of the services.

So both roles ... There have been job descriptions now written and they have undergone evaluation and training and it is anticipated both of those roles will be advertised in the next few days.

Q94. The Chairman: Are there plans to make physical health care plans a routine consideration for Harbour Suite patients?

The Minister: So physical health assessment … A registered general nurse has been recruited to undertake physical health screening and assessment within Manannan Court, and this also includes access to ECG and phlebotomy. This approach also supplements the existing mental health assessment undertaken at the point of admission by nursing and medical staff. In addition to the above, patients are offered smoking cessation as well by an in-reach specialist and ward staff are supported through access to a dedicated specialist mental health pharmacist; and also a visiting mental health dietician now as well.

Q95. The Chairman: One of the things that seemed to me to be of most concern in the report was that some issues seemed to be facing problems receiving access to independent advocates, which is …

The Minister: Obviously, that was very concerning within the Dr Dickinson report, and again, that is something that obviously is trying to be moved forward within the team, because it is absolutely critical that people do have access to that.

Ms Magson: It will be part of the managerial and the clinical responsibilities with the new structures and the way of working. So yes, you are quite right; absolutely.

The Minister: I think part of why I just referred to previously about the role that was there before, where it was both managerial and clinical, and the blurring of lines, that is one of the things that got caught up in there, whereas the separation now will allow that to be much more clear and for patients to be able to gain that access.

Q96. The Chairman: I mean, it is a legal requirement.

The Minister: It most certainly is and that is why, as I said, it was exceptionally concerning and it was certainly the one that I think I said in a previous hearing immediately flagged with me when I saw it.

Q97. Ms Edge: Can that not be implemented as of today, rather than waiting for plans and people to arrive?

Ms Magson: Yes, it may well have done, Ms Edge; again, I can find out. But I know the team have been doing a lot of extensive work in this space, rebuilding in line with the action plan. But clearly, ultimately, the sustainability of the culture that we are all talking about is going to be done with the recruitment of these two people, focused around the clinician and also the managerial lead.

Again, I can check for you.

Q98. Ms Edge: Obviously there are a number of people that are inpatients in the secure area of Manannan Court and there was going to be development … that the ward next door would be

developed so that they could move into supported care before going out into the community, and that does not seem to have happened.

Is that still going to happen or is there bed-blocking because you have not got that facility which is available in other jurisdictions?

The Minister: In specific point of that, I am not actually sure where that is up to at the moment. But, again, I will seek an update and get that information to you. Certainly that was a proposal that was on the table to try and allow more of a step down before people enter the community.

Q99. The Chairman: In terms of the provision that is available, have you made an assessment at any time whether that is adequate in terms of the numbers of beds that are available?

The Minister: So in terms of bed occupancy, obviously, in light of the Dr Dickinson report, it has been looked at. I can say that bed occupancy levels do continue to exceed the target of 85% – because that is what we operate off. We operate on a target of 85% and we are employing a variety of strategies to allow more effective patient flow.

To give examples, for instance, there is a review of the existing round process to support multidisciplinary decision-making and there is also restructuring of the existing Crisis Response and Home Treatment service, which enables of greater focus on home treatment and being a viable alternative to psychiatric admission.

Again, this is one of those where – not to again bang on about community but – sometimes in the past there has been a rush to admit people into psychiatric admission when perhaps they do not potentially need that. They need the support in the community. This links back to what we were discussing, Ms Edge, a few moments ago, about ensuring we build up that support in the community to enable people to be there so they do not end up in the psychiatric admission.

Ms Magson: I do know a little bit about the building work. So they are starting the building work to commence at this quarter, before the end of the financial year, for the three 'step down' beds that you were talking about. So yes, that is planned to commence. That is as much as I know, but that is where they are.

Q100. Ms Edge: Okay, and with the mental health independent monitoring board and the future of that … and obviously we mentioned about care plans being done in collaboration with the patient, but also families should be involved. (***Ms Magson:*** Yes.) Can you ensure that that is progressing, but particularly the independent monitoring board and the role of it in the future?

The Minister: Obviously the structure and the way the Department reviews services is going to change with the advent of Manx Care. I do not want to pre-empt Questions I am taking in Keys tomorrow, but the Department is committed to independent review of its services, and that is across all the services. That is one of the things we have been working on and looking at; so organisations such as HSCC, such as the Mental Health Commission.

I attend the meetings with the Mental Health Commission, I think it is twice a year – it might even be quarterly, actually – that I go along to meet with them to discuss issues. I think they are an important body as it stands now, because we have not got that independent review. But we will have to see from the development of Sir Jonathan Michael pathways where we go with independent regulation.

Ms Magson: But for the time being we can give you assurance that the inpatient care plan … Those plans are being reviewed by the care team out in the community. That is part of the transition that was talking about earlier. So that is part of the model and that is what the team are focusing on currently.

The Chairman: I would not like to keep your diary, Minister. *(Laughter)*

Q101. Mr Perkins: Just going back one step, if I may, Chairman. (**The Chairman:** Yes.)

One of the things that came out of our inquiry into mental health and suicide was that with Manannan Court the relatives felt that they were not being given the full story in all cases and they were *very* frustrated with some of the staff.

Have any steps been made since our recommendations on that?

The Minister: Again, I know that the team have been working very much around the Committee's recommendations. One of the things that I remember … I do not know if I was still on that side of the table when that first all started; I lose track now as to which investigations were ongoing when I switched around. But I do remember when I was that side of the table people say and there was not much engagement.

From my point of view, obviously engagement is key, the family are there, but the limit of course is – one of the big limits – the patient still has the right to what data is shared and sometimes you can have a difficult situation, and I am aware of a couple of these, where the patient has expressly said, 'I do not want my family to know anything about this'.

Then it is a difficult situation, because you have got a family who think they are coming from the best of intentions and they want to help the individual, they want to be involved, they want to support them out in the community, and you have got the patient saying, 'Under no circumstances are you to share any of my information with the family' and we have got to respect that decision of the patient.

So although it may look to the family like we are blocking, we are doing so because the patient in those situations has said they do not wish it.

Q102. Ms Edge: What if the individual does not have the mental capacity? And obviously we need to know when that legislation is coming forward! *(Laughter)*

The Minister: Well, obviously mental capacity is another issue as to whether or not … We obviously at the moment use best practice to assess that. Although we do not have the physical Act at the moment in place we do use obviously the guidelines etc. But for those patients who are assessed to have mental capacity and be able to make that decision for themselves, it is a difficult situation if they turn around and say, and in some cases they do, 'We do not want our family to know'.

Ms Magson: I think the only other thing I would just make the point of – we have not publicised this, because it has just come out and action plan is being developed but – clearly the patients themselves in their survey … it is done on a regular basis, we have just had the 2019 results, so the team are working on it, but actually, in comparison to NHS England, the results were better. Clearly there is room to improve. There always is and there will be, and how do we use that as the next stage on a journey?

But just to give you some examples, I have not got a wider answer around the family and their wider network, but if the patients themselves … Were they given enough time to discuss their needs and treatment? This is significantly different. In England it is 57%; and it is 68% in the Isle of Man.

Not so much of a difference, but again better, did the person or people you saw understand how your mental health affects other areas of your life? In England it is 52%; in the Isle of Man it is 55%.

And the last question: did the person or people you saw appear to be aware of your treatment history? So again, about the continuity piece you were raising earlier, in England it is 52%; in the Isle of Man it is 60%.

So there is a difference there which … clearly the service and the steps they are taking are having an impact. Again, all of that will come out as a wider response to the survey and the action plan that the teams will be working on currently.

Q103. The Chairman: I think one final question on the Manannan Court situation: you indicated, Minister, that the Dr Dickinson report came about as a result of your initiative and because of whistleblowing or one thing or another. Have you noticed any steps that have been taken to improve attitudes and morale within the organisation?

The Minister: Well, in terms of morale, the first thing we need to comment is of course with whistleblowing in relation to this. The people who made the allegations did not go down the whistleblowing route; they just went straight to the papers.

I think one of the things we need to do … It is a whole cultural piece across the Department. I know there were some staff who were unhappy with the rota system, which was one of the big things that came out, and when Dr Dickinson spoke to the staff, that seemed to be the one that actually stood out. Well, the staff have been engaged with and they have been asked to come up with ideas as to how the rota system could work differently. So there has been engagement on that line. In relation to a lot of the allegations that were made in the newspapers from the individuals, you will see from Dr Dickinson's report that he found no evidence to substantiate quite a few of them.

Q104. The Chairman: But the point you made just in answering my question there, you referred to the Department. I think it is a wider question. There is a Government-wide –

The Minister: I apologise for slipping into silo mentality, Mr Chairman, particularly since I am someone who is very keen for cross-Government working. But it most certainly is. Culture does not just stop and start in the Department of Health and Social Care, it expands right across Government. I know that, certainly from my time when I was Member for the Cabinet Office, that is something that is both the Chief Secretary and Chief Minister share.

Ms Magson: But practically, down on the ground, the teams will recognise … The tiering approach between the services in those different divisions will mean a lot to them in the way that they work. That is alternately how we are going to have the biggest impact with the professionals out in the community and so forth.

Q105. Ms Edge: You have got a new 'culture' politician, so it is going to be across the Department is it?

Ms Magson and the Minister: Yes.

Q106. The Chairman: Good. Okay, we will move on to bowel screening.

Has the Department reconsidered how much funding is allocated to bowel screening?

The Minister: In terms of funding, at the moment I would say not particularly, and the reason is … Obviously Public Health has been leading on the analysis of data. You will have seen from an Answer I gave to Mr Hooper in written form, I think it was last week, there is not a lot of data around. The data has only been really properly collected since 2018. Public Health at the moment is trying to format it into a usable format so that they can actually compare it to the Public Health Outcomes Framework in Public Health England, so that they can actually come up with precisely what Mr Hooper was asking for: instances by age quartile etc.

As with a lot of the data we hold, we are a long way off that, to be perfectly frank. There is a lot of work that needs to be done and, again, it ties in to this creating a Public Health hub in the

Cabinet Office where the data is collected in the same format year after year so you can build up trend data.

Q107. The Chairman: Are prisoners and other potentially hard to reach patients receiving adequate access to screening?

The Minister: I have not, certainly from my point of view as Minister, had any issues raised with me. But –

Ms Magson: No, in fact, quite the opposite. I was told that the services that were available in Prison were … I was given good feedback in the introduction meetings that I have had.

Q108. The Chairman: Well, I can confirm that is also the case in relation to mental health issues in the Prison too.

Ms Magson: Yes, very much so. That was specifically what we were talking about actually. Yes.

Q109. Ms Edge: The bowel screening programme on the Island is different to the UK. They do it at a younger age in the UK. Is there an intention to implement that?

The Minister: Well, in terms of the UK we have got to be careful, because it is different between Scotland and England, is my understanding. So there is actually not a one size fits all system in the UK. Also, the English model I believe is currently under review as to what they actually are doing in terms of the age etc.

Q110. Ms Edge: Now, obviously the sooner you diagnose anything with any patient, it can have savings further down the line. So is there any intention from the Department to implement bowel screening at an earlier age than currently?

The Minister: Well obviously it is being looked at by Public Health. But again, one of the things I would actually say is that our model at the moment … there is not, I believe, any immediate change.

Q111. The Chairman: Okay. We will move on to rehabilitation. Do you believe that conditions for those returning from drug rehabilitation are up to standard and do they give vulnerable people the support they need to stay clean? What measures are taken to provide people who have returned to the Island with further rehabilitation and assistance?

Ms Magson: I am going to have to defer that question, because I do not know those services at the moment. So I am happy to obviously come back and talk to you about those accordingly, but I am not familiar with them as it stands here.

Q112. The Chairman: I think the point also would be, when giving such consideration, that perhaps you consider there may be mental health issues involved in that as well, (***Ms Magson:*** Yes.) and as such they may not be in the best position to make decisions in terms of engaging.

Ms Magson: Yes. And the point you were making earlier about what happens at the point of request – okay, absolutely.

Mr Perkins: There are things like finding accommodation for them, that sort of support as well.

Ms Magson: Okay, yes.

Q113. Ms Edge: What is the access for patients? Do you have so many beds available for a specialist unit? Is there a contract in place for specialist units for individuals?

Ms Magson: Again, I think it is probably best, bearing in mind my fifth week in, that we … As you can see, I am trying to pick up lots of lots of services and reading and digesting. So we will probably come back with … and happy to take questions accordingly then; yes.

Q114. The Chairman: Poverty: what policies and strategies have been put in place, or do you propose to put in place, in order to tackle poverty?

The Minister: Well, again, Mr Chairman, this is something where it is not just a silo issue for DHSC. This is one where, again, it stretches across the whole of Government.

You will probably have seen the Council of Ministers response document in relation to poverty. It is very important that we actually take a joined up approach; the DHSC does not just go off and do its own thing outside of that. There is a Council of Ministers' action plan that has actually been worked up in relation to poverty, with key steps. I do not know, again … I think that is a public document that has been shared. But it is being driven from the centre, and it is important that it is, and it links in obviously to the Social Policy and Children's Review Committee of the Council of Ministers as well.

Q115. The Chairman: And are there any provisions that have been put in place to help veterans facing poverty or help rehabilitate veterans suffering from post-traumatic stress disorder?

The Minister: Veteran's services … obviously there is a wide range of services offered in the UK. There have been, recently, issues with Manx veterans being able to access that. So I have been in contact with the UK in relation to that, because Manx veterans obviously serve in the British military in the same way as veterans do in the UK. So there should not be any difference in their access to services.

Again, particularly around things like post-traumatic stress, it can be a very complicated and technical area and with the best will in the world, as a small Island, we are limited in the services and the level of services that we can provide. But there are services offered by the Ministry of Defence for veterans. My personal view is that Manx veterans should be able to access those services on an equal level to any other that I have served in the British Army.

Q116. The Chairman: Good.

Children's Champion: the Children's Champion's Annual Report, which we debated last month, highlighted concerns which we have also raised about fostering and adoption services. How is it going with the recruitment of foster carers?

The Minister: My understanding in relation to fostering is, in terms of recruitment, we will be looking to recruit and go out. I think as I explained in the Tynwald debate, it was decided to pause that recruitment while we tried to ascertain the services. Being blunt, the service came back in-house and while we anticipated a certain level of issues, it was not in the best of states when it came back in-house and there has been a lot of work going on around that.

For me, one of the important things around fostering, and one of the things I found most concerning and the Children's Champion's Report, was obviously the trust of the foster carers themselves in the system and feeling they were engaged with and they had a service that they could rely on.

So I know there has been lots of action points developed around that to ensure that we engage with foster carers and obviously the forum that the Children's Champion is involved with as well has been absolutely instrumental in that. Mr Baker has been an absolutely excellent Children's Champion in the way that he has engaged with the services.

But in terms of fostering, we are moving it forward now in various stages to ensure that we can actually engage with fosterers and get people back into fostering.

Ms Magson: Just to add a little bit, I have to spend some time on this one. The new contract has been signed, is my understanding, as well, and actually, recruitment and staffing has improved in the current service. The managerial one was more of the issue, is my understanding, but they have been working around that.

Q117. The Clerk: Sorry to interrupt Mr Chairman. Could I ask, when you say a contract has been signed, who is that between; who are the parties of that contract?

Ms Magson: I am not familiar with all of the details at the moment, but it is in line with the strategy that they have had in place. So –

Q118. The Clerk: We were told that the Family Placement Service had it brought in-house as part of the Department.

Ms Magson: Yes, it was. They have been working on a new model, and the aim of the action plan and everything else on the back of that was to have a new contract which, in my understanding, has been signed in January of this year. So I do not know any more detail other than that at the moment.

The Clerk: Is the Department contracting with itself?

Ms Magson: Sorry?

Q119. The Clerk: Has it entered into a contract with itself?

Ms Magson: No, I do not think. It is with a third party.

So I do not know any more of the details at the moment. All I know is that. They do have an action plan, but then they have been hosting workshops with families, specifically to talk about, as most of the actions seem to be progressing, policy, procedures, the way safeguarding reporting and the way they work at the moment … The audit showed improvements. There is some way to go to continue to embed that, but ultimately their focus was very much around working with families. They have been doing a number of workshops, so they are just trying to translate those into some outputs at the moment for wider sharing. But I can take your point around the contract *per se*.

The Minister: Yes, and we will share any information with the Committee.

Q120. Ms Edge: Obviously there has been a lot of concern from a number of families that I am aware of across the Island about Children and Families services and children that perhaps are under care plans etc., and the lack of consistent social workers working with these families. (***Ms Magson:*** Yes.) I am aware that perhaps you have settled down a little bit in that area, but what about the families that have been impacted during that period and the young people that perhaps will have had an adverse reaction, which the Chief Constable continually says … it is about adverse reactions in young people that create problems in the future?

So what are you doing to ensure that there is progress made in that area?

The Minister: Well, the point for me is that consistency is key and people building up a relationship. That was one of the problems when it came back in house. There was a quite a big turnover of staff. I have got a constituent who I know had three different social workers in the space of about six months. That has now settled down, as you rightly say, Ms Edge, and in fact my understanding is there is now only one vacant post to be filled; that all the other vacant posts … my understanding to date, is that they have now been filled.

I think what is important is that we maintain that consistency. We cannot help if people decide to move on. You cannot prevent it. If I could lock the doors and stop people I would, but you cannot. But I think the important thing is that we try to maintain that consistency and that we ensure that people have got that point of contact. And that builds up trust. I think that is one of the problems as well. If you have got someone continuously turning around and having to change over then you have not got that bank of trust built up with the person.

So the stability is absolutely key and I know that there has been a lot of work going on around the team to ensure that stability can be in place.

Q121. Ms Edge: One of the other concerns is around the documentation, in keeping it and informing the people upfront before meetings and access to their own data, really. (***Ms Magson:*** Yes.) That seems to have been quite weak for the individuals involved during the period of having all these social workers swapping in and out. So, is that – ?

Ms Magson: Yes, you are quite right. So that was one of the areas in the action plan, is my understanding. They have been auditing those and improvements have been seen. There has been a lot of training, devising of policies, training of the staff and so forth. In my understanding, they are making good progress. There is still more to be done though.

The Minister: Yes. It has been 18 months of upheaval. I stated that again on the floor of Tynwald when speaking to the Children's Champion's Report. I think the key important thing is that next year, within the Children's Champion report, Mr Baker can report that we have moved forward and that is a much more stable system in place.

Q122. Ms Edge: Obviously you said it is consistency of approach. What are you doing to try and retain these people? Have you got a good, strong retention policy to try and encourage people to keep that consistent?

The Minister: Well again –

Ms Magson: So I do think they have made good progress. As I mentioned earlier, in my understanding they have had a good suite of recruitment and clearly all of these policies, the procedures, the training, the culture, and everything we are trying to do, is all about retaining and developing people. So the gap was around the managerial lead, but again, the progress has been made.

So yes, from what I hear, they have really stabilised and knitted into the corporate parenting and all of the strategy that is involved with the Children's Champion.

The Minister: I think one of the key points as well is around stability of leadership within the team. (***Ms Magson:*** Yes.) So there is now a permanent adoption lead that has been appointed. The team leader for quite a while was an interim agency worker and there is now a permanent team leader in post as well.

So it is about having that high-level consistency as well, because if you have continual churn at the top then it can obviously have an impact further down. So it is about having that continuation of leadership as well.

Q123. Ms Edge: Okay.

I have not heard you talk much outside of your own Department, but how are you working, with the Department of Education, with the Police, around young people and obviously children that are under child protection plans? Because there was a change, was there not, in the policy for Home Affairs of the Youth Justice team. How has that impacted and how are you filling any gaps?

Ms Magson: So with both of those key Departments where you would expect us to work, the feedback has been that we are doing exactly that. I have had introductory meetings with both my equivalents there and they say that it is working well. So my understanding is that they are very much working in that way.

The Minister: Certainly in the conversations I have had with the Police around this they have been quite content. I know quite a few magistrates as well who … particularly, you mentioned around the Youth Justice team, and I had concerns expressed by several magistrates that they were worried and they were starting to see issues where there were certain things going through the courts again and they were seeing an uptick. The feedback I have had from those particular magistrates is things have settled down again and they, from a court side, are quite happy with what they seeing.

Q124. The Chairman: Okay. Prescription charges next.

In our last general oral evidence session in July 2018, new prescription charges and eligibility criteria were being discussed after being put forward by the previous Minister along with the consultation on the new Health and Care Service (General) Scheme 2018. But this does not seem to have happened yet.

Are there still plans for these increases in charges and eligibility criteria changes, and what has happened to that scheme?

The Minister: In terms of prescription charges, they feed in with the Sir Jonathan Michael Review. It is mentioned in the Sir Jonathan Michael Review about the whole way we do it, so it will feed into the various workstreams that are ongoing there.

In terms of the Scheme, the Scheme was put on hold, because obviously we are having a fundamental rethink of the entire legislation of the Department. The Scheme, if you remember, Mr Chairman, was in order to get the National Health Service Act activated –

The Clerk: Health and Care Service.

The Minister: Health and Care Service – thank you to the Clerk – Act 2016 that needed a Scheme to actually come forward in order for it to be active, or certain provisions of it to be active. That is now being subsumed in the wider review of the legislation that will need to change under the Sir Jonathan Michael Review. But prescription charges and so on will fall in that.

Members will remember that under my predecessor when it did come forward, it did not find favour with Tynwald. There were questions around why eligibility for free prescriptions is being matched with the age for free TV licences etc. So it was pretty clear that in that current form it certainly was not going to get through the floor of a Tynwald. But it is something that is now tied up in the Sir Jonathan Michael Review.

Q125. The Chairman: So if there are any new proposals, they will be subject to public consultation as well?

The Minister: We will go out, if it differs, obviously, from what is there, we will go out beforehand so that the public can have their input.

The Chairman: Did you have something you wish to – ?

Q126. The Clerk: I just wanted to make a point about the fostering, because it has come at the very end of a very long meeting, but it is something that this Committee heard a lot about over the last few years, (***Ms Magson:*** Okay.) including I think when Mr Ashford was on the Committee. It is in the nature of the business that we talk in terms of management structures and contracts and then when MHKs raise individual cases, you cannot talk about individual case. (***Ms Magson:*** No.) But I would just like to play back to you an impression that I have picked up attending upon this Committee over a lot of years, and that is that people who wish to be foster parents feel that they are under the intensive scrutiny of the social workers, and that sense of partnership is a sense which does not always emerge.

In other words, do you recognise this and what are doing about it?

The Minister: That is why one of the very first points I made when we moved on to the topic of fostering here was around the interaction between the service and the foster carers, and building up trust, because that is what it has got to be. Obviously when a foster carer starts out there is going to be more intensive scrutiny to make sure, not just for the child's benefit, but also for the foster carer's benefit, to make sure that everything is going to plan.

But I think, again, it comes down to this building up of trust and if you have got a constant churn of social workers and faces and who you are dealing with, then it probably would build up an impression that, 'Here comes another one' so to speak, 'who does not know my situation, who is asking the same questions over and over again.' Again, that is where stability is key; and that we have got to remember the Department needs to work in partnership with the foster carers. Because both parties are wanting exactly the same thing: they are wanting the best for the child.

The Chairman: Thank you.

Q127. Mr Perkins: Just coming back to prescriptions, if I may. (**The Chairman:** *Yes.*)

We had some publicity Island-wide about the idea of people obtaining free prescriptions and we are making chemists aware that they must produce the ID. How is that going? Has that produced benefits?

The Minister: I have not had the full feedback. I have had second-hand comment that the audit and everything else that we have been doing has paid off; that there has been some. But I have not had any formal feedback yet on what the results of that are.

In relation to prescriptions and free prescriptions, there is a lot of work to be done around that. I know I am keen to try and work with the Post Office on a solution. I did have, in fact, a meeting booked with the Chairman – who is across from me – *(Laughter)* of the Post Office which I had to at short notice cancel. But we will get that rearranged, because again, with my digital hat on, I think there are digital solutions we can be doing on Island as to how we identify people who are entitled to free prescriptions.

Mr Perkins: What about alternative drugs prescribing – ?

Q128. The Chairman: Generic?

The Minister: Generic? Well obviously … Do you want to – ?

Ms Magson: So overall I have done a bit of work on that prescribing. Clearly our spend overall is being managed, actually, quite well. The team in the Department have a strong set of policies. Most of the GPs … There is one community that do not engage in that work at the moment, but we would hope that they would and I know they will continue to work with them accordingly to support them. But in reality, the impact that they have had in investing in the community pharmacists and working with general practices really helps support and manage that spend; and some of that is around the work around generics and otherwise.

Our issue is generally, at the moment, financially in the cost pressures with specialist drugs and cancer drugs. That is where we are seeing the biggest pressure. But it is a constant thing; a constant way that we would need to work and make sure all our formularies are up to date and in line with clinical guidance.

Q129. The Chairman: In terms of repeated prescriptions, where there has been instances where people have sadly passed away, and when they go to the cupboard the cupboard is full, has there been any improvements in terms of – ?

The Minister: There was a big piece of work undertaken last year, as I am sure Members of Committee will remember, by Maria Bell, our pharmacist advisor, and myself as well trying to promote … I think one of the big myths which we have tried to dispel with repeat prescriptions is people think if they do not order it every time it will just disappear and they will never get it again. So I know the pharmacists over here have been very actively engaged in that process of chatting to patients about the medication that they are on and actually saying, 'Do you need any more?'

I am aware of someone who – in a similar situation you just mentioned there, Mr Chairman – passed away and when their family came to clear it out there was drawers and drawers of the stuff. In fact, they were trying to find a way to dispose of it all. He had it in the boot of his car and was worried he was going to get pulled over and people were going to ask why he had all these drugs on him! But I think we have seen progress from that and certainly the feedback I have had from the pharmacists is those conversations have cut down an awful lot.

Also at the moment I think, as I made clear my supplementary vote speech, the overall drugs budget this year is actually underspent, (***Ms Magson:*** Yes.) or is predicted to be underspent, which is not normal for the Department in that sense. So there has been a lot of work going on around the control of drugs.

Q130. Mr Perkins: Just picking up on that, with these local pharmacists knowing the patient, when the doctor stops prescribing that particular drug and they have got boxes and boxes of the drugs in their drawer, it is just a shame that they cannot take the complete box back that is unopened and we can use it for somewhere else. (***The Minister:*** Yes.)

Has any work been done on that?

The Minister: It is a clinical safety matter once it leaves the pharmacy, and that is why last year we engaged with the pharmacists so they have the conversations in the pharmacy, because the moment you step out that door –

Mr Perkins: That is it.

The Minister: – that is it. And I think, to be perfectly honest, certainly from what I have seen, from a clinical point of view that is only right and proper. Although it can generate a large amount of waste, you do not know what atmosphere that drug has been kept in. There are various different destabilising factors that could have an impact if we allow people to just return boxes.

Ms Magson: One of the things that I have tried elsewhere is where you have an 'open the bag' scheme, where you actually encourage people – it sounds simple, but – to open their bag in the pharmacies, because then you can deal with it. That was just some of the language that was used to try and encourage people, for the same reasons you have been talking about – and it did work.

Ms Edge: So, opposite to that, because I know that system is working, there are a number of patients who are saying that they are on a long-term drug, that the GPs can only actually issue for two months now – that is a restriction that is been put on by the Department – and therefore the bureaucracy and paperwork around getting another prescription … I had a conversation myself with a GP surgery last week –

The Minister: I need to clarify … Sorry.

Q131. Ms Edge: Okay. But I have had patients come to me, some people are immobile, they cannot get out, and so they rely on relatives to do it. I get the policy and I understand why it has been implemented. It is just the length of time that it takes to actually get the prescription, and that is taken up perhaps a medical professional's time to be able to do it … Are you reviewing it? Are you going to a complete review to make sure – ?

The Minister: Well, there are several points that I would come in on that. The first one is, in my understanding, it is a discretionary policy. So if the GP … For instance, if someone is going away for three months off Island, the GP can prescribe longer. So it is not a case of they can only prescribe for the two months, it is a discretionary policy. It is best practice. It is used in other jurisdictions very successfully as well to limit waste.

But on your other points around the GP and is it the best use of a GP's time, that is why we need to get to a model of primary care that is radically different, so you have a model based around pharmacists potentially in GP practices, you would have prescribing nurses etc. – it is that kind of model, because at the moment we have a very old fashioned primary care model.

And it is about culture change with the public as well, to be honest: the turning up to a GP surgery, depending what is wrong with you, you may not automatically see a GP; you may see the practice nurse; you might see the practice pharmacist. It is that kind of model. So that comes in all around the changes we are planning on making to primary care.

Q132. Ms Edge: Okay. Just one other on prescriptions. Accepting UK prescription: so not health tourism, but people coming over from the UK with their UK prescriptions and going to pharmacies, they have to be accepted, apparently. Is that correct?

The Minister: I honestly –

Ms Edge: It would be interested to know how many UK prescriptions have been prescribed through our pharmacies; our charges are quite cheap.

The Minister: I would say I do not know the answer, but I will find it out for you. But I would imagine it is correct and I know certainly someone who has been in the UK with a Manx prescription and it has been acceptable, because I assume there is reciprocity between the two jurisdictions. I personally do not see that as a huge problem. The problem I would potentially see is if we do not do that and the movement of people between the Island and the UK.

So I would not imagine it is a massive problem, but certainly, I will find out the information for you.

Q133. Ms Edge: So to receive Health Service services on the Isle of Man, you do not have to have a Manx address?

The Minister: Well, no, it depends what services you are accessing. Emergency care, you most certainly do not. Obviously, GP –

Q134. Ms Edge: But continued care?

The Minister: In terms of GPs you can have a temporary registration, but after that you do have to (***Ms Magson:*** To register.) register via a Manx address. So it differs depending on which service you are –

Q135. Ms Edge: You might be tracking people going the other way, but if you are under a consultant, for instance, and people decide they have moved away from the Island but they come back every three months for their consultant, how do you track that?

The Minister: Well in relation to that, they should have a Manx registered address –

Ms Edge: Thank you.

The Minister: – is my understanding.

Q136. The Chairman: But there was some abuse of that going on and my understanding was that there was a joint Government initiative to try and minimise –

The Minister: I believe it was the records were looked up to see who was valid and who was where they said they were. (**The Chairman:** Yes.) I do not think you are ever going to remove it completely, Mr Chairman, because you will probably have people who will register at their mother's address or something such as that.

But also, to be perfectly honest, I do not necessarily see what benefit people would potentially get by then having to travel backwards and forwards to the Island to be under a consultant. I would have thought it would actually be of more benefit to them to be registered with the consultant in the UK.

Q137. The Chairman: Except that some of them may now live in Thailand or somewhere else, (***The Minister:*** Yes.) and those are cases that I brought to Government's attention where it seemed to me to be something of an abuse: that they were then normally resident in Thailand but would come back. Yes, they would use their mother's address and be eligible to.

The Minister: Yes, that would potentially work obviously for someone who only needs to be seen once a year or twice a year, but it would very quickly get expensive if it was someone under –

Q138. Ms Edge: The reciprocal agreement is only with the UK, isn't it?

The Chairman: Yes.

The Minister: Yes, it is.

Ms Magson: Yes.

Q139. Ms Edge: So if you are outside of the UK which … a lot of people do go to Spain, Thailand to work and things.

Ms Magson: Exactly, yes. I do not know the answer, to be honest, but I am with the Minister. It has not been raised as an issue. There are a lot bigger issues around our drug spend that we really should probably be focusing our attention on.

The Minister: One thing I should point out is we do actively pursue treatment costs where people outside of the UK have been treated where it is not emergency care. I know of several cases, in particular one where we have pursued someone who is in the United States of America for the cost.

Q140. The Chairman: Okay. So last Friday, at 11 o'clock, the bell bonged. *(Laughter)* Any comments in relation to the concerns that people had in relation to Brexit and the obtaining of drugs, etc.? Is that still a live issue or are you – ?

The Minister: Well, the pre-recorded bell bonged at 11 o'clock on Friday, *(Laughter)* but one of the things I would say is obviously we are still in the transition period at the moment. (***Ms Magson:*** Exactly.) We have seen that the Prime Minister has put out what he wants from a free trade agreement, Europe will obviously have themselves what they want, so we still do not know what the final outcome will be. It is still possible that there may be no trade deal. We may get to the end of December, because it is now written in law – unless they change the Act – to say that, 'That is it. That is the date by which a free trade agreement must be agreed.'

Certainly, I think I have mentioned before when I have been here, I have been in very close contact with my counterparts in the UK. I have been down to Westminster to speak to them and there were lots of contingency plans in place depending upon any form of disruption: from low-level disruption to high-level. Obviously we have had the team here in the Island as well with very close contact both with the Department of Health and the Ministry of Justice.

We, as I think I have said before as well, are slightly more insulated, because being an Island we hold a higher stock than you would in the hospitals around the UK. But certainly there has been no complacency and we will have to reassess as we get towards the end of the year depending upon what the system is. We may end up with the utopia of a complete free trade area or it may be a no deal, but we will react accordingly and our plans, if necessary, will be reactivated.

Ms Magson: I have looked at the plans. That is one of the first questions you ask when you are in, where we have … bearing in mind … actually in the unknown. So we cannot manage the unknown unknown at this moment, but actually the contingency arrangements seem quite strong. The key will be around workforce as well, particularly some of the care sectors. So that is one to watch. But looking at the stocks and supplies – it is not just medicines, there is oxygen and all of those sorts of things – the team, particularly in the hospitals, had that spent a lot of time working to do what they needed. As you said, because we are an Island, we already have a lot of those contingency plans in place; so extending those where needed.

So we will continue to assess as it goes along. That is where we will need to be over the next 11 months.

The Minister: One of the things I want to put on record, Mr Chairman, is the UK has been very engaging with the Island at all levels. (***Ms Magson:*** Yes.) The Department of Health and my political counterparts in the UK … we have had a very good relationship and they have shared a lot of information on a trust basis, and I believe that is across Government. So the UK has been exceptionally engaged with the Island and very helpful in all eventuality planning.

Q141. The Chairman: So, for example, I was contacted, and I am sure others were, by consultants at the Hospital in the early days, and I guess the arrangements that apply in the United Kingdom to consultants who have lived and worked here for some time will be the same. Is that – ?

The Minister: Yes. Our immigration rules in the Island will mirror whatever the UK's are, because obviously we have free movement between the Isle of Man and the UK, so we need, in terms of immigration, to mirror that. I know that from my days as Member for the Cabinet Office.

The Chairman: Anything else you have got?

Q142. Mr Perkins: Yes. If I may ask about the monitoring of diabetes type 1, how is that going on? I know we have had monitors for kids, it has been *very* successful, and I think it was discussed that we may extend this to adults. Again, bearing in mind early intervention, it is a financial trade-off, isn't it? How far have we got with that?

The Minister: What I can say, Mr Chairman, is I am hoping there will be an announcement this week at some point. At the moment it is on my news management grid for this week, but we have obviously been engaging with the Diabetes Centre as to how we move this forward, because it is absolutely crucial that it is done in a proper clinical way.

But there will be an announcement imminently.

Mr Perkins: I shall await that with interest, in that case. Thank you.

The Minister: I will build up the anticipation.

Q143. Mr Perkins: Okay. I have got one other question, if I may? Post-viral illnesses, ME, MS, chronic fatigue syndrome, that type of illness, I think the last Minister had ringfenced some money and was going to put in specialist consultants to actually deal with this. And one of the things was they were going to have the opportunity go out to these people's homes, because obviously they cannot sometimes come into hospital. How far have we got with that?

The Minister: Several of the appointments have been recruited to, in terms of the ME service, and there is now access availability in terms of them going out to people's homes. I do not know where we are up to with that, but certainly the development of the service and the initial service is now up and running. That was several months ago and I think I answered a Tynwald Question around that as well several months ago. But the initial first few posts have been recruited to be able to support.

It is something I have been very keen on as Minister as well, because for a long time unfortunately ME sufferers were seen as, 'It was all in their head'. That was around for decades and they have not had the support that they need to have. I have engaged with the ME charity and certainly they are normally pretty quick to tell me if things are not working right, but I have not heard anything from them recently. But certainly the first few posts have now been recruited into.

Q144. Mr Perkins: So that is still in mind to be followed up?

The Minister: Well, it will be an evolving service. It will be a continuously evolving service. I cannot see it being one of those services that will reach a point where you are saying, 'We have got the utopia' and we stop. As with all our services they need to be kept under continuous review.

Q145. Mr Perkins: And finally for me: endoscopy; the fact that we are not able to perform capsule endoscopies that you mentioned in the House the other day. Where we are going with that?

The Minister: Well in terms of capsule endoscopy, I was being a bit pessimistic in my Answer, because in my Answer I suggested we would have it re-opened in April. I did get advice from the team afterwards that they are hoping to be able to do capsule endoscopies again from this month.

One of the issues that obviously they have had is the technical part of capsule endoscopy. While the process itself seems quite simple – you give the person the capsule, they go about their daily business – it is the reading of it. And we have had, again, bringing back digital in, issues with having the ability to put them into a digital format where we could send them over to the UK to be read. As I said in my Answer, we were limited to one person who was able to read them, which has caused a backlog. So it was sensible at that point for them to suspend the service. But my understanding is that they will be up and running, or they are working to be up and running, again this month and they have also got a plan to tackle the backlog as well. So that is in relation to capsule endoscopy.

Mr Perkins: Okay, thank you.

Ms Edge: I have got about four questions, apologies. *(Laughter)*

The Chairman: I am sure the Minister will be very happy to answer them.

Q146. Ms Edge: Follow up on diabetes … Obviously the motion on the type 2 diabetes and there was some commitment to do some media around it. I have not seen any of that, so an update on that and obviously it is within the programme, possibly linking in with the type 1.

The Minister: Just before I bring Kathryn in, type 2 obviously links in with the Health and Wellbeing agenda within the Department. So it is built into that. I seem to remember there was some media around the type 2. I do not know how widely reported it was, I certainly did do a piece myself around it.

Ms Magson: That was what I was going to say. *(Laughter)*

Q147. Ms Edge: I think it was more publicity … You could walk around the Island and not see very much about type 2 diabetes, which helps support the Department further down the line doesn't it? (***Ms Magson:*** Yes.) So I think I have seen it in one pharmacy when I have been in there –

The Minister: Again, I think it is something that needs to build into the wider Public Health remit. It is not just, again, a DHSC problem, although it is medical. Again, it is important we do not start silo-ing things and say, 'Well that is a problem for Health and Social Care'. It is a wider problem for that and it is about education across the whole piste of Government.

Q148. Ms Edge: I think the commitment was that you would work with Public Health on it.

Ms Magson: Yes, so the transfer into the Cabinet Office will be key for that, won't it? And my understanding of the reason behind it is it becomes a thread throughout everything that we do. So that should be the approach, yes.

The Chairman: I declare an interest. *(Laughter)*

Ms Edge: He is a fine model, an example, of what happened.

The Chairman: That can be taken both ways! *(Laughter)*

The Minister: I think that was meant to be positive, Mr Chairman!

Q149. Ms Edge: It was positive! It was yes.

Okay. Primary care: we had an announcement last week – and these are quite key to the people of the Island – about Promenade Medical Centre. Do we have other GP surgeries that still have open lists so anybody can transfer to them? I do not think the media that has gone out to the individuals has given that option. So are there any GP practices with open lists to take these patients?

The Minister: There are practices with open lists, but what we are trying to do is do this in a managed way. The last thing we want to do is to have 4,300 people panic, suddenly try to find their own GP surgeries and just inundate the other GP surgeries. It will be done in a managed way.

We have gone out to the other practices to see if there is anyone who would take it on on a managed basis, but at the moment I believe it has not been a positive response from the other practices wanting to take it on. A lot of the patients, actually, that are down at the Promenade surgery do not actually live within the catchment area. They are spread quite a way across the Island. But I know there are obviously a lot of people, because it is a small practice, who are very much invested in that practice. I have spoken to constituents up in North Douglas that operate at the practice and are deeply concerned, because of that relationship they have had with it, about the future.

So the Department is looking at options. Obviously, the Department itself will look, if necessary, to run the practice until June so all those options can be explored. So it is not a case of: the practice has handed in its notice and it is going to shut instantaneously. There is a whole range of options that the Department is exploring and it is only if those options are exhausted that obviously then the decision will have to be made to close it.

Ms Edge: Okay.

Ms Magson: So I think what we will do is … The key here is actually not for people to – *(Interjection by Ms Edge)* Yes exactly. That is why the message has gone out as it is.

So we have agreed, I think, to write to everybody again before the end of this month with a further update. It is absolutely getting a lot of care and attention to make sure that is a managed process. And ultimately it is really important to do that so that you look after the vulnerable who naturally would not necessarily think about doing something now for continuity of their care. So yes, we are comfortable that we can have an approach. We will have to deal with it really carefully and we should do it in a proactive way with patients.

We have already arranged a couple of sessions to come and talk to people, so we will get those out and help people answer some questions as we go along. I think in the last comms, we suggested that people could phone the Department if they needed to ask questions. But really the message at the moment is stay as you are until we just work through the options and the managed process.

Q150. Ms Edge: So obviously there is a crisis with GP recruitment as well. (***Ms Magson:*** Yes, exactly.) Obviously 4,000 patients is … You have offered it out to other GPs and it does not sound like you have much of an uptake, obviously because they are stretched already. So I am just coming from a few patients' point of view, and they are concerned as to where could they go if –

The Minister: I think the important point to make with the GPs though is of course ultimately GPs operate in many ways like a private business and, of course, we would be asking them to take on effectively another mini-business. So it is not so much about them being stretched, but also it is a large undertaking for someone else to take on, because they will be operating off two sites. I think there is one GP that already does that on Island, because Onchan and Laxey are the same practice.

It is a large undertaking to ask, but I think it is an important thing that we did go out and ask, because the Department recognises how wedded to that practice a lot of the patients are. They have been there a long time, so we thought it was important that all options were looked at.

Q151. Ms Edge: Okay. Another one that is an Island-wide concern: Patient Transfer. Obviously around Flybe there are concerns that have come about. Have you got a contingency depending on … you might get notification … You are in contract, I assume, with the provider, so you must – ?

Ms Magson: Yes, so we do – that was my first week – have contingency arrangements in place and options, which we work closely with the Department of Infrastructure on. That contract, I believe, is up for renewal at the early part of next year. So as we go through that process we will need to look at all options.

But again, we have also got to remember that there is as much on-Island care as we can deliver and different ways of delivering care. This has all got to be wrapped around the whole Transformation agenda and options to deliver services in a different way.

So yes, we will be looking at a number of options as we go through this financial year.

Q152. Ms Edge: And you know a lot of patients are ending up on the Manchester flight and then there is quite a big shift. Depending on your circumstances, it is quite a long journey –

Ms Magson: Yes, on the other end.

Ms Edge: – to get to Liverpool, because most of our services are in Liverpool.

Ms Magson: Yes.

Q153. Ms Edge: So there are a few contracts there.

But the other concern that I have got is obviously Clatterbridge is moving and the strategy going forward for the Island of how are we going … and the Minister is aware I have asked this question: what sort of strategy is in place for patients from the Island using Clatterbridge services once they move into the heart of Liverpool?

Ms Magson: So I think I referred to it a little bit earlier. We had an initial discussion, the team have been to see them, I had an initial meeting with them last week, they have put a proposal forward, we now need to work with them on that – it is just the first stages – and then it will be a networked model. It will be trying to make sure we have got the IT in place … some of the points that were raised earlier, that has also been an issue that has come up. And actually, they do have a solution that is workable, that is possible, actually, with limited changes at our end.

So there is a lot that we can do here and now and then there is also working through what will be quite a careful programme to look at the future, which is going to take some time. So I have got an initial meeting with the Chief Executive there next week, I think, or the week after, just to follow on those initial conversations.

So those agendas are definitely starting, the thinking is happening: what is the demand coming; how do we deal with some of the issues that we have got currently whilst we plan for the future? They are our main alliance partner around cancer, and actually, we would want to

gain the benefit of their solutions and their opportunities that they are getting in the north-west, making sure that all networked in and our patients ultimately gain high quality care as result.

Yes, there is a big journey to go on in this space, but the journey has started.

Q154. Ms Edge: Good to hear.

One of the other concerns, having just been a cancer patient through Clatterbridge, is the access to accommodation. Obviously the Minister did react last year and you increased the allowance to people, but as this is going to be in the heart of Liverpool, where there is difficulty getting accommodation at times, has any consideration been given, with third sector or with providers, for accommodation blocks for the Manx people within your strategy?

The Minister: I know there have been conversations in the past around this. How far those conversations have gone, I am not too sure. But also the other side to it is although you mention about being in the centre of Liverpool, there is a lot more accommodation available in the centre of Liverpool for people to access. There is a much wider selection.

We did up the allowances last year, because I took a look at the allowances and I did not feel that they were reasonable given the circumstances and, obviously, depending upon need we do look at the allowances, because I have actually introduced since then that we should be assessing the allowances on an annual basis. I think it was, off memory, 10 to 12 years since they had been looked at before I undertook the review last year.

Q155. Ms Edge: Okay. One last question: Private Patient Unit. Obviously it was discussed last week and we have seen the business case that has been proposed. Has work actually started?

The Minister: There is work being undertaken, as I stated in Keys, in relation to drainage, electrics and obviously some of the issues around the shower rooms. The work that is being undertaken is to get it up to infection control standard.

Q156. Ms Edge: So obviously the service specification –

The Minister: And I think, as –

Ms Edge: – is out of date. There is no date on it, actually, which is –

The Minister: Well, specification was the case it went to Treasury. I think the Committee has been told that there is a further paper that is coming to the Department meeting on Friday and we are happy to share that with the Committee after it has been to the Department meeting.

Q157. Ms Edge: Okay. Do you know when this went to Treasury? There is no date on it.

The Minister: I can actually, if you bear with me –

Ms Edge: It is just there is a document, but there are no dates on it so we cannot relate it to anything.

The Minister: My wonderful electronic … I have a feeling, and I do not why it has just come to me, I think it was the middle of May last year.

Ms Edge: Thank you.

The Minister: But again, I will have to confirm.

Q158. Ms Edge: I think when the unit … Obviously in this specification it states that the unit will be closing for a period of at least 12 months. We are at 12 months. How much longer are you expecting before you go out … ? I assume you have not even gone out to contract yet?

The Minister: We are still obviously speaking to the Attorney General's office, who lead the procurement exercise. The expectation, as I said in Keys, was we would be looking to go out in March.

Q159. Ms Edge: For the specification, but when would you expect patients to be able to access facilities on Island?

The Minister: June.

Q160. Ms Edge: So they can get a unit that is just a shell ready by June?

The Minister: June is when we are looking to have the unit open, as I stated in Keys, and I can give, Ms Edge, the exact date. I was not the far off, in fact I was pretty much spot on. That paper went to Treasury on Wednesday, 22nd May.

Q161. Ms Edge: So you have not gone out procurement yet, you are giving them a shell with drainage and clinical specification, how on earth are you going to get a unit ready within that short space of time? If you are only going through the procurement process in March, surely there has to be about six weeks there?

The Minister: Well, it depends how –

Ms Edge: It is very tight.

The Minister: – we engage with the third party. We have already gone out for expressions of interest –

Ms Edge: Prior to the –

The Minister – we had a very good response in the expressions of interest; there has been engagement with those –

Ms Magson: Site visits.

The Minister: Yes, there have been site visits even, as well. So we have an idea of what is actually wanted out of the unit. So again, we are aiming to have a unit ready to be used in June.

Q162. Ms Edge: I am concerned, under financial regulations, that what you have gone out with … obviously this document is not a complete document –

The Minister: Well, as I said, the finalised version is going to the Department on Friday and we will share that with the Committee after it has been there.

Ms Magson: It is all part of the discussion that we are having on Friday in the Department, yes.

Q163. Ms Edge: The other one that none of us have asked about is budget (***Ms Magson:*** Budget?) and overspend. Obviously we are aware … And none of us want to see any money

withheld from Health; we know it is a costly exercise. But what plans … I know you have not been there very long as the CEO, (***Ms Magson:*** Yes.) but what financial management processes are going to change? Clearly it has gone on and on, and it seems that other areas have achieved financial savings through processes, and it seems there is one big pot of money and we will divvy it out, rather than actual financial control within each division.

Ms Magson: So it is early days, but I have started the process already, actually. So one that I absolutely feel is my responsibility is obviously around duty of care for the patients, but also we are working within the maximum affordable envelope.

Now, clearly within that there may be some difficult decisions that need to be made of what can or cannot be provided within that envelope, but that is part of the Transformation work that is being undertaken in the finance PID.

So there is a whole suite of things that needs to look about what is affordable, but also what is the funding in place at the moment and whether that is under or over. That conversation needs to happen and in the work that is happening over the summer, the costing model and the future planning, you would do that more than a one-year basis and a five-year … All of these things will play out, and as part of the thinking.

But for the here and now I have already started some deep-dive work on the finances. I have spent some time with the team on Friday, that was the first one – I have got a couple of others to go at the moment – to try and get a feel for how things are managed; how decisions are made; how people understand what are their decisions.

But it is multifactorial, isn't it? So it will take time, but ultimately that will be working very closely with our colleagues in Treasury. We are already in a position where we are in a Shared Services function and those appointments are made. There is more that we can do to try and work holistically together to improve those controls that you are talking about. But we are on a journey towards a new system that is Sir Jonathan Michael's proposal. All those recommendations were agreed; absolutely all of those are key in order to be able to have a sustainable Health and Social Care system for the Island, and there is numbers of years' worth of work to get through and a number of stages of that journey.

So we are going to go through different things and different processes as we go along and my aim will be to have regular updates and to be as open and transparent with people, as best as we can, to tell everybody where we are in this journey.

The Minister: I think from my point of view, as I emphasised in Tynwald, we have been recruiting into posts, particularly consultant posts, that in the past have been *very* difficult to recruit into. So we have managed to fill some substantive posts. It is about how we manage the bank and agency staffing arrangements as well, up at the Hospital.

But also this year, as I stated, we have seen overspends in relation to treatment. So the £4.4 million on tertiary overspend with providers off Island, the important thing is that as we move forward we ensure that we have got a base budget for the Department for Manx Care that we can actually work with; to be able to go to Treasury and say, 'This is the base we are working from'. But it is also important, as the Sir Jonathan Michael Review pointed out, that there is cost-saving built into that system. In the UK I think it is about it is about 2% to 3%, isn't it, a year?

Ms Magson: Yes, normally we would do 2.5% a year every year; yes. But then you are also in a position where you have an arm's-length organisation as well. So it is going to be a blend of all of those actions on all those recommendations being implemented. So the journey is set, isn't it?

The Minister: That is one of the two things with Manx Care: it will be a commissioned model. So it be mandates from the Department feeding into Manx Care as to what services are

provided. So it will be a much more regimented system then everything at the moment just being driven in the Department itself.

Q164. Ms Edge: So from what you have said, I am quite certain that you did not think the cost improvement plan presented to Tynwald was adequate from a Department which has such financial responsibility. The cost improvement plan was an A4 sheet of a few savings that were going to be made in various areas.

So from what you have said you are doing a full review and you have started digging deep?

Ms Magson: I am, yes. But again, all of the work that we have talked about has to be done around what is the true, accurate funding of what is currently being provided and what is sustainable? So until all that is completed, there is no point in making a decision or a judgement on that position. But we need to be able to look at everything and determine what is the right approach. So yes, we will do that and I have started that work.

Q165. Ms Edge: Do you have good financial management? Do you have a Department that is able to deal with your finances, I suppose is the question?

Ms Magson: Yes. So again, I have referred to working with the Treasury. They have an infrastructure; we are already in that shared service approach with finance. I think there is more that we could do to make sure that that is working as it was meant to set up. So we have started that process already.

It is not just about though finance, and Sir Jonathan Michael obviously talks about this. Actually, contracting, commissioning, business intelligence, data; you cannot have one without the other. So all of those cogs in the wheel are important in order to be able to make this a success.

The Minister: Just on the cost improvement plan, Mr Chairman, it is important we constantly keep it under review, as we do with any programme, but there have been some successes within the cost improvement plan. For instance, the improved locum booking practices is this year forecast to have saved £202,115, the switch to generic drugs £600,000, the chemistry profile review is a bit of a smaller saving at £10,000, but still fairly substantial.

So there is a lot going on within the cost improvement programme that is releasing savings that if we had not done, the Department would have been an even worse position than the one I had to present to Tynwald.

Ms Edge: Thank you.

Q166. The Chairman: I have got one last one – please do not be offended by this. All morning we have been talking about the significant challenges presenting themselves to the Department and to the Chief Executive and to the Minister. Are you confident that they can be progressed in terms of you not being permanently resident on the Island?

Ms Magson: Absolutely, yes – completely.

So I am here on a two-year secondment. I bring with me a wealth of experience that I would like to evidence that we can make a huge difference on your journey. It is not going to be finished in two years. This is a *multi*-year programme. We have talked a lot about culture here, have we not, as well? But I have already met and spent a lot of time with people who really understand the journey that has got to go ahead and my job is to try and enable that to happen through lots of different ways, with lots of different people. And that will not just be the people in the Department, but it will be everybody; the politicians and everybody out in the community.

So yes, I will be here, normally on a Wednesday, Thursday and Friday, but ultimately I work full time and I will be working with a technology that we are also looking forward to bringing in: a future-proof service. So yes, absolutely; I am confident we can make a big difference in that period of time.

The Minister: I would just come in, Mr Chairman, I am going to embarrass the new CEO now, in the fact that I think we are exceptionally lucky to have Kathryn. The very fact that her previous employer has allowed it to be as a secondment for the two years, I think actually shows just how much they value her and the experience that she has.

I think we are very lucky to have her.

The Chairman: Okay.

Mr Perkins: I hope you have pretty thick skin, because the Manx public love Facebook and there is a lot of misinformation out there; so good luck to you.

Ms Magson: Thank you, yes.

The Chairman: Well, I would like to thank you again for –

Ms Magson: No, thank you.

The Chairman: – being so frank and so open again at today's sitting. It will be the last one I have with you and hopefully at your next one you will have the same Chief Executive. *(Laughter)*

The Minister: I will try and get two in a row, Mr Chairman.

The Chairman: So once again, thank you very much for you openness.

Ms Magson: No, thank you. That has been really helpful.

The Minister: Can I just add, Mr Chairman, on that note, it is my chance to embarrass you now, because I have sat both sides of this table; I have sat on the Policy Review Committee and also this side of the table. I would like to take the opportunity to thank you, because I assume this is your last hearing with the Social Affairs Policy Review Committee, for all the work that you have put in, but also the passion you have shown.

I think we have broadly the same views on many social issues and I know that you have worked exceptionally hard since the day you came into Tynwald – which was 1985, I think, wasn't it? – (**The Chairman:** It was.) on all of those social issues. So from my point of view, as someone who has worked with you on both sides of the table, I want to put on record my thanks to you and I hope you have a peaceful, good retirement, because if anyone has deserved it is it you.

The Chairman: Thank you very much. That brings our public hearing to a close this morning Thank you.

Ms Edge: Thank you.

The Committee sat in private at 1.11 p.m.

13th July 2020

Evidence of

Hon. David Ashford MHK, Minister, Ms Kathryn Magson, Interim Chief Executive Officer; Ms Angela Murray, Chief Operating Officer; and Mr Ross Bailey, Acting Head of the Mental Health Service, Department of Health and Social Care

STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

DEPARTMENT OF HEALTH AND SOCIAL CARE

HANSARD

Douglas, Monday, 13th July 2020

PP2020/0165 **SAPRC-HSC, No. 2/19-20**

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Members Present:

Chairman: Ms J M Edge MHK
Mr P Greenhill MLC
Mr M J Perkins MHK

Clerk:
Mr J D C King

Assistant Clerk:
Ms I Perry

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Standing Committee of Tynwald on Social Affairs Policy Review

Health and Social Care

The Committee sat in public at 4 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MS EDGE *in the Chair*]

Procedural

The Chairman (Ms Edge): Okay. Welcome to this public meeting of Social Affairs Policy Review Committee, a Standing Committee of Tynwald. I am Julie Edge MHK and I chair the Committee. With me today are Mr Martyn Perkins MHK and Mr Greenhill MLC.

Please can we all ensure our mobile phones are off or on silent so that we do not have any interruptions. For the purposes of *Hansard*, I will be ensuring that we do not have two people speaking at once.

The remit of the Social Affairs Policy Review Committee is to scrutinise the established but non-emergent policies, as deemed necessary by the Committee, of the Department of Health and Social Care, the Department of Education, Sport and Culture and the Department of Home Affairs.

Today we welcome back the Minister and Interim Chief Executive Officer of the Department of Health and Social Care, along with the Chief Operating Officer and Acting Head of the Mental Health Service. The Interim Chief Executive Officer is off the Island at the moment and joins us by video conference.

This meeting was originally planned to focus on mental health and we will come to that later. However, given that we are living through a health emergency, we will just spend some time on that first.

EVIDENCE OF
Hon. David Ashford MHK, Minister;
Ms Kathryn Magson, Interim Chief Executive Officer;
Ms Angela Murray, Chief Operating Officer; and
Mr Ross Bailey, Acting Head of the Mental Health Service,
Department of Health and Social Care

Q167. The Chairman: For the record, I would like to begin by asking each of you to please state your name, job title and how long you have been in that role.

The Minister for Health and Social Care (Mr Ashford): I will start off, Madam Chairman: David Ashford, Minister for Health and Social Care. I have been in the role since January 2018 – it feels like a lifetime now, but January 2018 – and of course prior to that I was a member of the Committee alongside yourself.

Ms Murray: Yes, Angela Murray, Chief Operating Officer. I have been in post since January 2020.

Mr Bailey: Ross Bailey, Acting Head of Mental Health. I have been in post since November 2019.

Ms Magson: Kathryn Magson, Interim Chief Executive Officer. I have been in post since 8th January.

Q168. The Chairman: Okay, thank you. Thank you for that.
I would like to start with: what will the effect – to the Minister or to the Chief Executive Officer – of the pandemic be on waiting times?

The Minister: Well, I will come in first, if I may. There is going to be an impact; I have been quite clear about that the whole way along. There is no way there cannot be. We had to repurpose staff from across the Department into other roles, such as contact tracing, manning the 111 line and also the testing itself.
We are still working through all the lists to see what the exact impact is across all the different specialities. In some cases we may have to look at innovative ways to try and bring those lists down, but there is no getting away from the fact that there is going to be quite a substantial impact on our waiting list.

Q169. The Chairman: And is that impact assessment something that you will publish at a later date?

The Minister: Well, we publish our waiting lists, so people will be able to actually see when the next set of data goes up precisely what the impact has been across all of the different specialties.

Q170. The Chairman: Okay, thank you.
So how have the staff coped with the changes in their working environment; and now you are coming out of COVID, have you seen any impact?

The Minister: I will bring Kathryn in in a minute, if we may, but from my point of view the staff have done exceptionally well, I have got to say.
We have turned everything on its head, really. The duties that people have been undertaking have been completely different to what they would normally expect. I have spoken to an awful lot of staff across various different areas and I think, personally, they have coped exceptionally well with that change. The important thing now is to get the services back up and running; and that is, as I said from the very beginning, harder than turning things off. You turn things off by shouting, 'Stop! Do not do that anymore', but the problem then comes in turning things back on and also at the same time keeping certain elements of the COVID response that we still need to have. So we still need to be doing some elements of testing, we still need to obviously have a certain resilience in terms of contact tracing and also manning of 111 and other things. That is that balancing act now about getting people back where they should be but also keeping that resilience at the same time.

Q171. Mr Perkins: Does a member of your staff have to do the contact tracing or could somebody else in Government do that? Because I know there is –

The Minister: Well, that is generally what has now happened. As we have started repurposing our staff back, other people have become involved in the team. But also, of course

we have got to remember there were huge changes up at Noble's as well. So we doubled our ICU capacity, so that used up one of the theatre areas; that had to all be reversed back. Then also we had obviously the COVID wards as well that we repurposed, so that all has to be changed as well.

So it is not just staffing changes, there are actual physical changes that need to be unwound too.

Q172. Mr Perkins: And also, bearing in the back of your mind we may have another spike, so – ?

The Minister: And we have got to keep that resilience – I think I am getting known for my cautious nature. I think we have got to keep that set of resilience within DHSC.

I do not know if Kathryn wants to add to that?

Ms Magson: Can you hear me?

The Minister: Yes, we can hear you, Kathryn.

Ms Magson: Yes, it is a bit difficult to hear one side to the other, but the question about … It might be useful for Ms Edge to just repeat the question to make sure I am on track about … My understanding of what we have got to do, what we have got to change, how are the different working practices … What is going to happen differently in the future? So in reality, we are in a position where we have had to transition back out of our COVID services while still keeping one eye on being able to escalate them back in if we need.

From a risk perspective, yes, we are going to be cautious, as you would expect. But actually, a lot of staff have been repurposed into an extraordinary number of new roles as part of this process and we have had to extricate them back in to their day to day, and as a consequence that has been challenging and has been a transition over a number of weeks. We are about five/six weeks on, just coming into our sixth week, and actually, as we enter into this week now and really get into the position where pretty much everything will be switched back on into its normal place.

We have had to almost turn the Hospital back round, for example, to where it used to be. So the surgical wards now, wards 11 and 12 now will be free and fit for purpose to go back to their original activity. And that is just to name one example itself. We have had social workers in children's teams, for example, working in the ED department. We could go on and on because there are all sorts of teams in all sorts of different places, but in reality we have had to clinically and safely move those individuals back out and in back to their day-to-day roles; and doing that in a safe way that ensures that patients and service users are safe.

So I understand it may have seemed a little bit slower than people would have expected, but actually, we have been clear up front: just please be patient with us while we transition back out, while close things down safely and re-open up accordingly. At the same time, we have got this one eye on: what happens if we get another case? How do we enact our testing and our tracing to make sure that we continue to be fleet a foot and managing that risk as it occurs? Undoubtedly, it is not a matter of *if*, it will be *when* – we are quite clear on that – and how do we make sure that that capacity that we built at the front end when in February and March time we are able to reuse if we need.

So that is very much what our thoughts are, in a very balanced, careful way, whilst accepting there are a lot of people that need services to get back to business as usual. We are very focused on doing that as quickly as we can.

Q173. Mr Greenhill: Yes. Just to pick up on the point of using the 111 number, that has been effectively brought in during this pandemic. I am just interested about whether you are planning

to carry that forward in a different format to deal with – perhaps as it used across as well – people who are needing a different approach than queuing up outside their own general practitioners, for example.

The Minister: We almost certainly are. As I have said at the very start of this, there would be many things that came out of the changes with COVID-19 we want to keep and we want to keep resilience – 111 is definitely one of those. I would like to put on record my thanks to GTS who have basically built the 111 line pretty much from scratch in a *very* short space of time. I think it is actually the fastest anyone has ever produced one of these lines. So I want to put credit to them for that.

But yes, it most certainly is something and I think it is something we can repurpose and it is something that hopefully we will be able to keep around for a *long* time to come. I see it now as quite an integral part of our health services moving forward.

Mr Greenhill: Thank you.

Q174. The Chairman: If I could just ask Ms Murray, obviously you said that you have only been the Chief Operating Officer since 2020, what difference is it in the role to what you had before? What have you added to …?

Ms Murray: Well, last year, if you remember, I was Interim Chief Executive, which was only ever to fill that role until a Chief Executive was appointed. So the difference is obviously that the Chief Executive deals a great deal with the strategies and the policy and the politicians and all that goes along with that, and my role is operational. I run the operations and that is my focus; and transformation being key in all of that.

So we have the day-to-day operations to manage which, of course, we have a senior management team under my leadership doing that, and I drive forward the transformation agenda. So I am, if you like, that link between operations *as are* and the transformation agenda that we are working to.

If I could just come in around the 111, it is very much part of the development of the urgent and emergency care piece, as a result of the Transformation Programme. So a lot of consideration is being given as to the best place to place the 111. It is not off the agenda; it is actually central to a lot of what we will be doing going forward.

The Chairman: Okay. Thank you.

So we will move on to the report that the Committee wrote and –

The Clerk: Sorry, Ms Edge, can I just say Kathryn is having some difficulty hearing, so I think everybody just needs to speak up (**The Chairman:** Speak up.) as much as possible.

Q175. The Chairman: Okay, thank you.

So we want to go back on the recommendations on the Mental Health Report which this Committee made in 2018 and debated in January 2019. Our first and second recommendations concerned the confidentiality of patient records. Has GDPR had any impact on the ability to share patient information with family members?

Ms Murray: We have actually made considerable changes, which I will let Ross outline because he is actually running in the Mental Health Services now. But as a result of your recommendations and some of Dr Dickinson's recommendations and work that was ongoing at the time, there has been quite a lot done, particularly at ward level, around changing how ward rounds are run to include relatives. So if it is okay, I think Ross can expand on that.

Mr Bailey: Clearly there was, as Angela was candid about at the last sitting for the purposes of these recommendations, there clearly have been issues and problems in terms of – and there were some shortfalls in – the way we shared information with carers. That was recognised and there has been an awful lot of work focused in the inpatient area to try and develop a much more cohesive information-sharing platform as a multidisciplinary team. So we effectively split the ward round so there is a meeting with the doctor and the patient and then there is a wider MDT that tries to bring in all the other kind of agencies who are involved in that individual's care.

I think in fairness there is still some further education that needs to happen in terms of how practitioners, when and how, they share information. I think there is still a great deal of anxiety around sharing information and it is quite an emotive subject because often people, patients, do not want their information shared and if they have the capacity to make that decision then it is only right and reasonable that that is not shared. There are some caveats to that around risk and I think sometimes that is where the issues have lay; where the gravitas of the risk where information should have been shared and has not been shared, and that is down to individual clinical decisions. You cannot really devise a policy for those incidents. That is about individual clinicians making those decisions.

So there are some practical measures that have been undertaken, but clearly there is still work to be done.

Q176. Mr Perkins: And the Caldicott Principles for when there is a crisis …

Mr Bailey: Well, principle 7 and reinforcing principle 7: that we have got a duty to share information that is as important as the duty to withhold; and that is a struggle for some clinicians. It is a struggle for some professionals and there has been quite a lot, I think historically, of defensiveness in terms of using the principles of Caldicott not to share information where its whole kind of system is there *to* share and *to* enable. I think if you read any serious incident report, it talks about the lack of information sharing, and that is a common theme right across serious incidents.

So we do need to improve and I think a lot of that is around education.

Ms Murray: It is also a balance between the capacity of someone to make the decision they do not want their information sharing. We do actually have significant numbers of people who do not want their information sharing and previously … I mean capacity is back on the legislation programme, which is good. It is quite key to what we do going forward; that if somebody has the capacity to choose not to have their information shared it is then the balance of risk for the professional to take forward, really.

Q177. Mr Perkins: I think it came out in the juvenile crisis police relationship with the social services and that that was a problem. So we are working on it then presumably, yes?

Ms Murray: Yes.

Mr Bailey: There is. So there is quite a lot of work in terms of data sharing between the different organisations, the key stakeholders. So ourselves and DHA, for instance, ourselves and even other areas within the Department. But those information-sharing agreements are key, because it is only with those in place that we have got a consistent approach.

Ms Murray: It is also for us about, within DHSC, the electronic systems that support the sharing of data. (***Mr Bailey:*** Yes, absolutely.) We work with three or four – in Mental Health – different systems that do not talk to each other. So it is really key that, for example, if there is somebody in the Prison then the Prison's healthcare staff have to access four different pieces,

four different databases if you like, about the one person to gather all the information together. (***Mr Bailey:*** Yes.) And that is something that is high on the agenda and being worked; and GTS have been working, pre-COVID, quite hard to look at …

The Chairman: So we –

Ms Murray: Words that fail for me to understand, all these platforms that they talk about, but that is what they are trying to do, is ensure that you can access the data; *quickly*, is the key.

Q178. The Chairman: So we know there are issues with obviously the platform – (***Ms Murray:*** Sorry?) We know there are issues with the platforms and there are various systems that need to talk to individuals. But what is the actual … You said it is about capacity and sharing information. Who decides at what point that person has not got the capacity to share the information with relatives?

Mr Bailey: Well, that is a clinical decision based upon a capacity assessment. The fact is, however, that we do not –

Q179. The Chairman: So the clinicians decide they have got the capacity to say no?

Mr Bailey: A clinician would make that judgement, but it should be founded on a statutory footing, it should be founded on legislation, and we have not got it at the moment. We have not got that legislation. So I understand the second draft has been prepared, I know the Minister is very keen and has been driving that forward, so we are pushing ahead with that. But it is a clear and significant shortfall locally in terms of our legislative framework.

Q180. The Chairman: So from a relative's point of view, if the individuals perhaps have had a difficulty just before they have gone into the care of the Department that that might not be a full picture. Obviously you mentioned, and the Dickinson Report, about families being involved with the care plans, and it seems from what you have just said there the families would not be involved in the initial care plan, they would come in at a later stage?

Mr Bailey: No. The family should absolutely be key to the care plan and, again, historically that has not been as good as it should have been. There is no point glazing over that – that is the case and that needs to improve. I think it has improved; it needs to improve further. But carers and families are the ones with the information. They are the ones that are bringing the information in terms of, they know the patients best, typically; and they should inform the risk assessment, but then the clinician would build upon that risk assessment. So an example might be if there were some really quite risky incidents happening in terms of self-harm or potentially harm to others and the patient said, 'I don't want you to share any information', or the clinician might make a judgement based on that risk that they will override that decision. Now, they are few and far between – very few and far between. But professionals do have the ability to share that information even if someone says, 'I don't want it shared', purely based on the presenting risk at that point in time.

Q181. Mr Greenhill: Are the clinicians actually being trained in what to do in those circumstances, how to … when to share, when not to share, when to ask for information?

Mr Bailey: I think it is *very* difficult to give a kind of generic training. We can train people in terms of the capacity legislation and the framework, the common law framework, that underpins it at the moment – and it is a common law framework – but it is understanding the

principles of the seventh principle of Caldicott and really reinforce that. That is, relatively speaking, quite new. It was only added in the last few years.

So what we are trying to do at the moment in the Mental Health Service is be a much more proactive, reflective, learning organisation. So we have developed different forums where we look at incidents, we look at complaints, we use our Datix system and we draw learning points out and then we disseminate those to the respective teams; and there are standing items on each individual team's business agenda, so they can reflect and we can learn as an organisation. So information sharing is key to that.

Q182. The Chairman: So how are you going to monitor the effectiveness of what you are saying with your learning in that? How are you relating that back to, obviously, improve support to carers of the individuals that have then become into your care?

Mr Bailey: Well, we need to … We have got an audit process in place where we can audit the care plans to make sure that it is explicitly cited within the care plan that the care team has liaised proactively with the family. If it is not within the care plan it should be picked up by the audit and we would be asking the questions why.

Ms Murray: Can I just come in here?

I think there has been an improvement. I think when GDPR came in there was a lot of angst, and not just amongst health and social care professionals – amongst lots of professions. And it has taken us quite a while to really get people to understand you will not be hung, drawn and quartered under GDPR and about the risk management; because there was a lot of anxiety around sharing information if somebody said, 'No, I don't want to share it' and quite vehemently said, 'I don't want to share it'. As Ross said, it has been about giving the staff the training, confidence and the management to actually say, 'You can still share without it being punitive'.

The Minister: If I could just come in on the legislation front as well, because one of the common things around this is, as Ross just said, about common law. At the moment it is common law principles being applied; the capacity legislation is absolute key to this. As the members of the Committee will know, it is one of my big passions as well that we need modern, up-to-date capacity legislation in place. I know it has been talked about for, as far as I can remember, back about nine years now I think it has been talked about. We do have basically the drafts with the Attorney General's at the moment. Obviously the most important thing is going to be the public consultation around this. We are not just going to try and bring something into the Branches, we want a proper, full and frank public consultation and we are hoping to do that over the summer recess so that when we come back with the next session in October, shortly afterwards we should be in a position for me to actually bring a Bill into the Branches.

Q183. The Chairman: That is good to hear – it is.

We have also noted that the complaints procedure has been modified within the Department since we wrote our Report. So what steps have been taken to make the complaints procedure more accessible with regards to Mental Health Services specifically?

Ms Murray: Right. Well, first of all the complaints process is now tracked and we have the Datix system that is in, auditable and trackable, and that system also reports up to senior management level. So, for example, I get, 'You need to check this; you need to see this; you need …' it is a … lost the word now – a reminder service, if you like, on the audits that are required. And of course that all feeds into our care quality and safety committee through our patient safety groups which are held in all the different services and then all feed into the care quality and safety committee. So that is reported on all the time.

Now, that includes mental health. Mental health is no longer treated any differently than all the services. So it has taken quite a long time, probably around about 18 months, to draw all of this together because what we had were different systems; and we still do not have the Noble's system right. But the Mental Health Service is quite efficient now.

Q184. The Chairman: Okay.

Have Mental Health Services' policies and guidance been reviewed and converted into a more accessible, user-friendly electronic files for … Do they form part of the eLearn Vannin training courses?

Mr Bailey: All of our policies certainly over the last three years our policies all have been reviewed. We have got an established policy group which consists of several senior clinicians and some managers when we review the policies on a monthly basis. So we have had a schedule of policy review to make sure, to ensure, they are consistent with best practice and NICE guidance.

So I am really very confident that our policy schedule is up to date. It is now available on SharePoint systems, there are some training links via LEaD, but again we are looking at the platforms; some of the platforms at the moment where the electronic training platforms are not as good as they should be. So they are not very accessible, so it means some bits of training are dotted around a little bit fragmented. So eLearn Vannin, some sit in the Safeguarding Board area. So we need to pull those together to make them accessible. But in terms of our policies, they are up to date. I think there might be some lag, some might be slightly overdue as a result of COVID, but they have all been reviewed in the last 12 months.

Q185. The Chairman: So you have got your policies up there, how are you monitoring whether they are actually getting accessed and individuals are up to speed with the current policy?

Mr Bailey: Well, the policy schedule is thoroughly undertaken as part of the induction process. So there is a session on key policies within the induction. We operate a read-and-sign version using Outlook so people can acknowledge they have read and understood the policies so we can keep track of who has read and signed. But again, it is going back to the induction. It is really laid out very coherently during the induction process what the expectations are in terms of the key policies that people should have access and read and then they are distributed as they are updated. So we –

Q186. The Chairman: How do you check, as the leaders of the Service, to make sure that people have done that? What process of audit have you got to say that, 'Ross Bailey has gone in and he's actually done this training on the latest up-to-date policy'?

Mr Bailey: We have because it is done via … We used to historically have a sheet of paper with loads of people's names on, they used to read it and sign it. What we do now is do electronic read-and-sign so the people are acknowledging. So we can keep an audit trail because it is done electronically.

Ms Murray: And that also links into the care quality and safety that do spot audits, they do regular audits, there is a whole audit schedule, and spot audits as well, and then they report back to the senior management team.

Q187. Mr Greenhill: Expanding a bit off the induction side and then looking at the staffing side in terms of vacancies and recruitment (***Mr Bailey:*** Yes.) in this area and how that again

might affect the number of people you have and the effect that has on waiting times for people. Could you expand on that for us, please?

Mr Bailey: Our vacancies: we have quite a few vacancies in Mental Health, particularly for psychotherapists and nursing staff. It is a really challenging environment because the market is so incredibly hot, if you like. These are highly skilled professionals that are hugely sought after. We are competing not just on a local … or indeed with our neighbouring jurisdictions: we are competing internationally for staff now. So it is a real challenge. We are fortunate enough in recent, I think, weeks, or last month, we can now advertise via NHS Jobs, which is a major step forward for us. But it is a *very* competitive market and we are thinking much more laterally I think in where and how we recruit and we have been a bit more savvy in the way we try and recruit staff because of how competitive the marketplace is.

But it is a real challenge. It is really –

Mr Greenhill: I mean, in terms of the number of vacancies that you have –

Ms Murray: The waiting times issue is in two particular areas. One is in CAMHS – and I will come on to that in a minute – and one is in the Community Wellbeing Service that we know as Tier 2 services.

When I have appeared here previously, I have explained that actually there was no funding at all for Tier 2 services. When I first came here there were no Tier 2 services and they were introduced from efficiencies from within the Mental Health Service themselves, but at a *very* thin level. We have put several business cases in requesting funding that we can increase the staffing; and it is not just about nursing staffing in there, it is across the board professionals, because what happens if you do not actually get your Tier 2 services robust enough is things escalate and people end up in Tier 3/Tier 4. Okay. So your biggest waiting times are within our Tier 2 services, because it was created out of the existing budget.

Then you have the issue of CAMHS which has huge waiting lists because within CAMHS you have autism. There is no autism pathway yet on the Island and has never been. So what happens is that children or young people, anybody really, in the right age group diagnosed with autism is dealt with by a community mental health service – the CAMHS service. And that creates its own waiting list, because somebody who has autism is then treated perhaps with medication, that medication then has to be reviewed monthly, usually, so they keep coming back. So therefore, as the new people come on, your waiting list goes up and up because there is not an autism service.

What we spent last year doing was analysing and working with an external organisation to really look at the caseloads in CAMHS, because what CAMHS should be is a child and adolescent mental health service and there should be an autism pathway. To that end, it is actually a pathfinder on the Transformation Programme. So we have already started the work on how you would design and develop an autism pathway which, again, will need funding, but that is all under the Transformation Programme; because you cannot actually get the CAMHS service right until you are actually dealing with the autism issue, if that makes sense.

The Chairman: What is the split in numbers for waiting times for autism and the rest on the CAMHS list?

Ms Murray: Sorry?

Q188. The Chairman: What is the split? Is it 50% autism and 50% –?

Ms Murray: No, it is actually more than that. We have the waiting that goes on for the CAMHS services, 70% of that roughly (**The Chairman:** Is autism?) is for autism. It is not just

autism diagnosis, it is about outpatient appointments to come back to have your medication reviewed to … because this is medication that is long term. You do not come off this medication, but it needs reviewing. There are several pieces to this jigsaw which are really important and that is the issue of shared care with primary care, for example, because some of the people who are actually on the autism caseload could actually, as we work towards having shared care with GPs, receive their medication from GPs. But, quite understandably, GPs want support from the services in order to support them to deliver that.

So it is a complex picture, but that is where the main waiting lists sit.

Q189. Mr Perkins: What about the carers? Do we give them support, to the carers?

Ms Murray: Okay, we have got a problem. We have got a problem with carers. Again, I do not want to labour the whole funding thing, but we were looking and we had made a lot of inroads into advocacy and carer strategy – okay – with no funding. The only funding we actually have is £50,000 that was ring-fenced for advocacy and we were making quite a lot of progress with that before COVID, then COVID happened, and that was because we cannot get off Island to speak to the people that were coming to actually look at the delivery of the service *etc*.

Carers are … all we can do at this moment in time is work with our third sector providers and try and work up a carer strategy, but that again will be subject to a bid for finance because it is quite intensive work that you need to do with carers and it definitely is a hole in the service, without a shadow of a doubt. That is why when Ross is talking about what we try to do at a ward level, which is obvious … the Tier 4 services where somebody is really acute, is about all we can do at this moment in time.

But we are aware and we are working with third sector providers to look at a carer strategy.

Q190. The Chairman: Can I just jump back to your changes to your complaints procedure: is it correct that you will not respond to emails from anybody, either an individual or services, in that new process?

Mr Bailey: No.

Q191. The Chairman: Okay, thank you.

Okay, we move on to the Tommy Dickinson Report. Obviously we spoke a little bit about that in February, in to Manannan Court. The Minister advised that work had already been done on one of the key recommendations concerning the Safewards Model. To what extent has the model now been implemented in Manannan Court and has someone been nominated to lead the implementation?

Mr Bailey: There has; there has been a great deal of work in terms of implementation of the Safewards Model. It is going to be driven forward by a newly developed post that is purely on delivering on the quality agenda within Manannan Court. So that is going to be their focus. They are hoping to get that individual into post within the next four to six weeks. So that individual is going to be driving the Safeward. We have got a variety of working groups that have been established to implement the Safeward process; and Safewards is not just one, it is various elements that contrive to increase the safety of the ward environment.

There has been a significant reduction, thankfully, in the level of observations that we have seen on the wards over the last 12 months. So the observations, the high levels of observations that we had at the time that Dr Dickinson did his review, has significantly reduced. So we no longer have those high levels of observations, yet we still have the *really* high staffing ratios on the ward. So what that has enabled the staff to do is to focus much more on care and less on the constraints of the one-to-one observations that were happening.

We regularly review the incidents that occur on the ward and they are directed through the care safety and quality panel along with other incidents and complaints.

So absolutely, Safewards is very much on the agenda. It is going to continue to be driven forward. It is going to be an evolution – it is not going to finish. We are always going to be striving to increase and improve the safety on our inpatient area.

Q192. The Chairman: So this new role that is coming in four to six weeks, is that the person that will be the lead on this or is there somebody in senior management leading?

Ms Murray: There has been a lead on it, but again, what we have done is create more posts because actually everybody cannot be spread too thin. So this is a new post and the totality of that post will be improving the quality and dealing with the Safewards issue, and being amongst that.

Q193. The Chairman: Is that a replacement for the Manannan Court Service Manager? Has that been …?

Mr Bailey: It is more, I think, it is –

The Chairman: Or is that separate?

Mr Bailey: It is separate, and as you will see in other parts of Dr Dickinson's recommendations he focuses on what was historically the challenge of having a unit manager who was responsible for both the quality and the line management and other management functions, the performance management. So we have separated those two tasks. We have got a unit manager we have gone out for an advert for – though we did have someone who accepted the post but unfortunately last week they withdrew. So we need to re-advertise that.

The advert is out at the moment for the other post which is purely focused on the quality and driving the quality and the Safewards agenda within Manannan Court; so really splitting those two functions and creating two pathways – so an adult pathway and an older person's pathway. So really seeing the patient journey as a system as opposed to individual services. So we had the community Mental Health Service for adults, if you like, and then the Harbour side which is the adult inpatient area. The management structure has been defined to see that much more of a system as opposed to individual siloed, if you like, services. It is much more of a systemic approach to patient care and that is reflected in the hierarchy now.

Q194. The Chairman: Okay.

So with regards to the step-down approach, which I think we did talk about when you were in front of us last year, has that been developed any further? So for individuals that perhaps do not need intensive care of Manannan Court, has that step-down model been developed?

Ms Murray: Yes, right. We have the tiered model, which we have gone through here before. So if we take Tier 4, which is Manannan, they are about to actually start the refurbishment of what was Geddyn Reesht and within that will be four CAMHS beds dedicated to short-term intervention, crisis intervention only, because at the moment if a child is in crisis they go on to the paediatric ward, which is inappropriate. But that is not a long-term four beds. They will either return home with the wraparound team that works in CAMHS with them or they will actually end up in an off-Island placement because their condition is so acute.

Alongside that, there are going to be three beds for step down into supported beds. So you come from Manannan, rather than come out of an acute ward and straight into the community, which might be appropriate for some people; for other people it would not be. There will be three beds that will be staffed to support people to get back into the community appropriately.

That might be that they actually go from there to other supported living beds but in the community and usually for quite a long time, maybe 12/18 months before then, on to more independent living if that is appropriate. That is a piece of the jigsaw that has been missing for a *long* time.

So then if you actually look at the Tier 3 services and somebody that does come out of Manannan Court and does not need to go into the three supported living beds, then they will step down and be supported by Tier 3, and then eventually be discharged or supported in a different way. So it is very much a step up, step down.

The difficulty, as I said before, is the fact that we do not have enough of Tier 2 and that that is where a waiting list builds up and then sometimes people end up in Tier 3 just by the fact that they were not seen quick enough.

Mr Bailey: On top of that, we have currently got five supported living beds from a contracted provider and we are going through a commissioning process at the moment to increase that to 14 in totality. So the three beds in, which will be the River Suite which Angela has just referred to, plus another six additional supported living beds in the community. So it is really a significant increase in the available of supporting living beds that is going to be happening over the next few months, and *much* needed.

The Chairman: Alright, okay.

Just to go back to advocacy, has access for patients to advocates improved? You mentioned £50,000 and that due to COVID you could not (***Ms Murray:*** For advocacy ...) go across to speak to people.

Ms Murray: Yes, that was the –

Q195. The Chairman: Can that not be done over electronic means?

Ms Murray: That was the only funding we had – that was the only funding we ever had – for advocacy, and we actually got experienced people – from the Island, actually – to look at what system we could have, and they were essentially looking at a volunteer system for advocacy. However, they went across to Ireland and they went across to the UK to have a look at how volunteer systems work there *etc.* and were at the stage of reporting back to us around the time that … just before COVID, actually, and it was not feeling robust enough for me. It was not feeling robust enough.

So a business case was going to be put together to apply for more funding for advocacy, because we need a solid advocacy service. What we have had in the past has fallen apart because it has been one person, single point of failure. So that has to be addressed. We are still in the process of that. COVID held a lot up because, again, we were looking at whether we would be able to commission that from an external provider, whether that was here or the UK. But it has to be a service, not a person.

Q196. The Chairman: So in the report from Dr Dickinson, it reported that improvements had been made, but ensuring that staff at all levels are periodically rotated into different clinical settings: has that happened?

Ms Murray: Yes, okay. We have a provider in the UK who we had made arrangements that rotation would start, and a lot of the staff were quite keen on that. They are a partner organisation to us, and also I had been talking to St George's and St George's had come over to see us. We were arranging, again, the rotational programmes at staff nurse level, so we were at the stage where actually St George's were looking at how they can have their staff; as we send somebody over there, somebody comes back.

So again, it is work in progress. It has been slowed up since everything went on hold, but we have made significant inroads into it. I am expecting by the end of the year we would probably – all things being equal and we never get COVID again – that we should be able to start rotating staff. And there were about four or five staff from Manannan Court who had said they would really appreciate that. So it was not as if we were struggling to get people to go.

Q197. The Chairman: Specifically in his report, though, he said that people have been on the same ward, they were not even rotating within there. You seem to talk a lot about, 'reliant on services from the UK', this is specific to within Manannan Court.

Mr Bailey: Yes, absolutely. So that, what Angela has referred to, is one *really* important … So it is tapping into an external, huge provider of mental health services in the NHS, a Foundation Trust in the UK. So they have got lots of skills and experiences that our staff would not have, lots of training opportunities they would not have. But also, importantly, is the development of the pathways, and that is much more of a focus on staff rotating within the pathway; so moving patients so staff, not just from the inpatient area, but also to work in the Community team, to work in the Crisis team.

So that focus on it not being an individual service area, but as a pathway, because effectively the inpatient area is an intervention. It is an intervention that is part of a patient's journey, potentially. So the development of those pathways and the hierarchy within those pathways will certainly enable us to rotate what the staff bring with them. Also, as new staff come on board, we change the job descriptions to reflect the fact that they are pathways. So they work for the Mental Health Service, or they work for the Department. Historically, they were working for that service within the Mental Health Service. So even going down to the job descriptions and the way we advertise for posts reflects that you may work anywhere within the Mental Health Service, not just in one individual service area.

Ms Murray: And that has left us with a position where I think we are left with three individuals who have a contract to work, that was given to them years ago, fixed days on a contract in that place. And that is very difficult to unpick, even.

The Chairman: Okay.

Q198. Mr Perkins: One of the pathways you mentioned last time you came was the personality disorder pathway and I know you are doing some work on that. How has gone?

Mr Bailey: We are looking at … we are just revisiting all of our clinical pathways at the moment. So there are two different things, really. They have got the clear clinical pathways which is the evidence base in terms of how we should treat people with a certain condition – the evidence base for that. So that has taken information/advice from what NICE say. Then we have got our service pathways: the way we realise that locally.

So there is still some considerable work. If we would look at the tiered-care approach, we are now in a position where we offer a specialist evidence-based programme, DBT, and their waiting list for DBT would be the envy of many of our neighbouring jurisdictions. So we can get people on to that programme *very* quickly. It is a huge commitment; it is a 12-month programme, up to twice a week, for individuals. We need to be very cautious in terms of which individuals undertake that programme. So that is more of the higher end of the tier. We have got commissioning arrangements for block beds for where inpatient care is needed to be delivered with DBT. So we have got that arrangement with our colleagues at St Andrew's and Cygnet as well. So that is four, and step three, if we move down the tiers, we are also rolling out DBT skills training. So not the full DBT programme, but DBT skills, so we can try and assist people in terms

of developing their resilience, and we are looking at rolling that in step two and also that programme within CAMHS and the Drug and Alcohol Team as well.

So the approach is very much mirroring the tiered-care approach.

Ms Murray: We did say originally it would take us about five years to get people trained up and spread across the service in order to handle the sheer numbers of personality disorders that we deal with.

I think it is also worth mentioning the impact that having our staff working with the Police has and capturing at the front end of things – *very* skilled people working with the Police. The impact of that is actually there has been a 27% reduction in section 132s, which are significant resources for both, but more than that we are actually dealing with people from the front end appropriately as opposed to, again, a system that it all just escalates to the point where there could be an admission – unnecessary admission.

Mr Perkins: And the staff have embraced this training?

Ms Murray: Sorry?

Mr Perkins: The staff have embraced the training or are they reluctant in certain areas?

Ms Murray: For?

Q199. Mr Perkins: Embraced this training for communicating with the Police and taking things forward, particularly with the personality disorders?

Ms Murray: Yes, they are part of the Crisis Response Team, but there are three individuals who have been … they are the individuals that originally I asked to set it up and when we were working with the Police to see how this worked. But they are part of the crisis response and the idea is, of course, we do not want to create more single points of failure where one of them may go off sick and nobody else is trained up, if you like. And it is not that it is any specific training, but it is a lot of knowledge – it is a lot of knowledge. So we are looking to create a rotation within that, that more members of the Crisis team actually work in a rotation to support the Police.

Q200. Mr Perkins: So you have got somebody on call 24 hours a day then have you, or how does that work?

Ms Murray: Yes.

Mr Bailey: Yes, 24/7.

The Chairman: Okay.

Mr Bailey: I think just going back, it is a point that I would really like to stress, is that the Mental Health Service is but one cog in the wheel here. If we are speaking about the mental health and wellbeing of our community, particularly in terms of things like DBT, so people struggling with emotionally unstable personality disorders, that is as a result of trauma; that is typically associated with childhood trauma. So until such time as we work in a more cohesive, systemic manner to look at poverty, to look at homelessness, to look at how we treat and deal with the young people and the most vulnerable in our community, the same pictures … we are literally going to be in the same situation because we are treating the symptoms of childhood trauma.

So it is really looking at this as a system. We are one, albeit intrinsic, cog in the wheel, but until we to start work – and we are – in a much more integrated, systemic approach, things are not going to change.

Ms Murray: That links to the whole CAMHS issue because we are not capturing quickly enough – because of the reasons I said earlier – and it reaches a crisis, really.

Q201. The Chairman: And has the education psychology service improved? Are you working closer with them?

Mr Bailey: Well, there has been a great deal of work, certainly in the last few months, to work much more closely and we are just looking at a pathway, that systemic pathway, for CAMHS; so working much more closely with our colleagues in Children and Families Services, much more closely with school nursing, much more closely with Education, upskilling some of the key team members with things like DBT skills to support children in terms of their own emotional resilience.

So yes, we are working in a much more – and plan to work in a much more – unified, collective way with some of the key stakeholders there, not just within the Department, but outside the Department. Education are a key stakeholder in that.

The Chairman: I am hearing an awful lot about training and what you are doing; I am not hearing a lot about people at the moment! So a little bit concerning, really.

But Dr Dickinson emphasised in his Report that the ratification of version 5 of the Therapeutic Engagement and Observation Policy which requires registered nurses to develop a risk management care plan should be fast tracked. Has this been successfully introduced?

Ms Murray: Ross?

Mr Bailey: Yes, sorry, could you just repeat that? Sorry.

Q202. The Chairman: Yes. So Dr Dickinson ratified version 5 of the Therapeutic Engagement and Observation Policy which requires a registered nurse to develop a risk management care plan, and he stated it should be fast-tracked. Has this been successfully introduced?

Mr Bailey: They have; it was incorporated into version 5 of the updated policy on therapeutic engagement and observation. That was signed off and it is available on SharePoint; it was available on 15th April 2019. All registered professionals within the Mental Health Service have also undertaken the DICES risk assessment training and that is … I think out of the few hundred staff we have there is literally a handful of registered staff who have not undertaken the two-day DICES risk assessment training. So yes, to answer your question: yes it has and that has been followed up with a *very* thorough training programme around risk assessment.

Q203. The Chairman: Okay.

He also noted that the 'zonal engagement and observation' model had not been implemented in the Harbour Suite despite the layout of the facility 'lending itself' to such a system. Has consideration been given to using this model now?

Mr Bailey: In my understanding, that has been applied. Hence we have seen, as I alluded to previously, the significant reduction in the higher level of observations that were in place when Dr Dickinson undertook the report. I mean, it is a significant … I am quite happy to provide you with the data to support that in terms of what percentage reduction we have seen in those

higher level observations; those one-to-ones, those within arm's-length observations. So I am quite happy to provide you with the data to support that statement.

Q204. The Chairman: And has there been any inspection from the care quality review of any of this that you can provide to the Committee?

Mr Bailey: Yes, the Care Safety and Quality team undertake audits. Recently, about two weeks ago, they undertook the ligature audit, which is a significant piece of work. They routinely and regularly undertake audits around the application of the risk assessments, around the application of the therapeutic observation policy, the application of the seclusion policy. That information is fed back through the care safety and quality agenda, any action plans arising to that are then disseminated – as I spoke to earlier – to the teams so we can ensure that each component of the service is learning from each other, which was not historically always the case.

Ms Murray: Would it be helpful to share the audit programme with you? We can send it on.

The Chairman: Yes, it would be useful. Thank you. Okay.

Q205. Mr Perkins: Just going back to your staffing problems, we noted that you have a lot of agency staff and I think it was touched on that they were not perhaps as fully qualified as they should be. Has that changed now? Are we making sure that the agency staff are well qualified, if you are using them?

Mr Bailey: The volume of agency staff that we are using has reduced and that is certainly the case, that we want to recruit into substantive posts and we are doing that at every opportunity. There is a real push that … I was not aware that we recruited agency staff that did not have the relevant qualifications. We would expect every qualified member of agency staff to be registered. We would expect and we would see their names on the NMC register. But certainly our strategy is to reduce the reliance on agency staff and fill our substantive posts because, with all the best will in the world, locum and agency staff are not enmeshed within the system.

Ms Murray: We try to keep them longer term, so it is not like, 'This agency this week, that agency the next'. There are occasions where somebody will say, 'Well, I'm going back to the UK, I don't want to be …'. But in the main, if we have an agency filling a vacancy it is longer term while we recruit into it.

Mr Greenhill: And do you know how those –

Ms Murray: And sometimes – sorry – it is the agency worker who applies.

Mr Bailey: It is.

Q206. Mr Perkins: For the job?

Ms Murray: Yes.

Mr Bailey: Yes. That has happened on a number of occasions.

Ms Murray: Yes.

Q207. Mr Greenhill: Do you know how those numbers have changed over the recent periods; the number of agency staff percentage wise, how that has dropped?

Mr Bailey: I have not got that information to hand. Again, I am quite happy to provide information should you wish to have it.

Mr Greenhill: Thank you.

Q208. The Chairman: So you indicated there that you employ qualified mental health employees, so do you have practitioners working in the Service that are not fully qualified as RMN or whatever?

Mr Bailey: We have –

Ms Murray: We have students.

Mr Bailey: Yes, and we have unqualified members of staff (***Ms Murray:*** Yes.) who are there and who are working in a supportive capacity, so community support workers, but they might not have a formal qualification in terms of a registered qualification. But they will have other qualification, City & Guilds health and safety qualifications. But, yes.

Ms Murray: They are not inappropriately working. (***Mr Bailey:*** *No*.) They are actually in as part of the multidisciplinary team.

Mr Bailey: Yes. So they cannot … The policy is very clear in terms of what functions they can undertake. So they could not act in the care coordinator function.

Q209. Mr Perkins: One of the things that was outlined in the Dickinson Report was the Harbour Suite, he felt, that the staff should collaborate more with the patients on their plan. Has that gone forward or how have you made inroads into that?

Mr Bailey: It is the same as I alluded to in terms of the relationship and the collaborative working with the families: it is explicit within the care planning policy. Again, that has been revisited; it has been made even *more* explicit. There is an expectation that patients are proactively engaged and family members are proactively engaged in terms of the development of care plans. Again, that is subject to an audit process, and that again is a recently developed audit process so we can see explicitly when that has occurred. So –

Q210. Mr Perkins: Are the family – sorry to interrupt – included in that? Obviously that is very important as well.

Mr Bailey: In terms of the care … *absolutely*, yes. They absolutely should be. There has been no … Unless someone who has capacity says, 'I do not want my family involved' and there is no presenting risk that would stop that happening, absolutely they should be involved. I am confident that happens 100% of the time? No. I think there is absolutely still work to be done in that regard, but the situation is we can now audit and see when that is occurring. But clearly there is progress to be made.

Ms Murray: I think in relation as well to the Glen Suite, the social workers – because you are talking about people who perhaps do lack capacity or capacity comes and goes – are *very* involved, because you are often talking about a placement then in a residential home or a nursing home. They also provide a very strong link to families and previous carers about their needs, because that is intrinsic in the work that they do. They are part of that multidisciplinary team in that area.

Mr Perkins: Right, thank you.

Q211. The Chairman: Okay, we will move on to COVID-19 response and outcomes. So with regards to, I am sure everybody suspected that COVID could have an impact on mental health, have you seen any impact on the Island of COVID and the effects?

Ms Murray: I think we are starting to now; (***Mr Bailey:*** We are.) and this is where the Tier 2 services will have bigger waiting lists if we are not very careful.

Often in these situations it is not the immediacy that creates it, it is when, as we are expecting there is going to be, more people out of work, there are going to be people under financial pressure *etc*. and that does not necessarily blow up overnight. That is something that incubates itself – doesn't it? – as the pressures become worse. And it is the Tier 2 services that need to cope with that; with the anxiety and the depression *etc*.

Q212. The Chairman: So that is new things that are emerging. What about the people that were current, under your care, when COVID broke out and the services stopped quite quickly for them and perhaps they were not receiving support –?

Ms Murray: Well, they did not stop; they were delivered in a different way. So the Tier 2 and Tier 3 services were actually using technology; and that is not perfect, we know for some people, but actually it was the best we could do at –

Q213. The Chairman: So the face-to-face contact that some patients do rely on, perhaps weekly or monthly, ceased, and that perhaps could have had a bigger impact on them now. (***Ms Murray:*** Yes.) So how are you going to deal with that to try and bring those people back to the level that they were at perhaps before COVID?

Mr Bailey: As Angela has alluded to, certainly the mode of contact changed, and there was nothing to stop face-to-face contact happening with the appropriate use of PPE, and on lots of occasions that did happen. But you are absolutely right that what would have been routinely face-to-face contact changed into, typically, telephone contact. For our existing base of patients, contact was maintained like I said by telephone and on occasion, if required, on a face-to-face using PPE. I think we did not see the spike in referrals during the COVID epidemic that we anticipated. I think what we are now, we are certainly starting to see an increased surge in referrals and if we do not get the funding right, we do not secure the appropriate funding, then there is every potential that our step 3 services will become overwhelmed.

Q214. The Chairman: So – sorry – the individuals that were in your care, (***Mr Bailey:*** Yes.) and perhaps did not get that face-to-face, have you seen any detriment to them? How are you going to bring … If there was a patient that has suffered during COVID, surely they need to be dealt with quite quickly? You are talking about new patients coming on line.

Ms Murray: Well, the issue is one and the same, actually. You are talking about an escalation in somebody's recognised condition and the key to it is to get to it as quickly as possible. We have to actually, with the numbers that are starting to come through, have a system of prioritising and risk management of the individuals, but we are … Well, actually, we had discussions last week and you had discussions earlier today – didn't you? – around what services are there out in the community that can also, if you like, be commissioned for a period of time to support, to get people through quickly. We are trying to be quite innovative about the speed at which we do things, because if it continues as it is starting to ramp up now, then we need more therapists quickly, basically, and we can do that by commissioning from local providers

that do not work within the DHSC. But again, that is the subject of a business case to be able to get that going quickly.

Q215. Mr Greenhill: In terms of those having issues created by the pandemic, I am thinking in terms of two types of those: one, those people who are forced effectively to stay at home to be locked down, and seeing certain pressures on them because of that; but also there might be some people who are now being asked or told or looked on to go back in to work, and that might be the critical element to them. Are you experiencing both of those? It sounds like you are.

Mr Bailey: Yes, we are.

Q216. Mr Greenhill: But how can we respond to those?

Mr Bailey: Well, for existing patients, I think undoubtedly, the entire population, it had a huge effect and some people who are more vulnerable, absolutely, it was an enormous effect on their daily living and they did not have the same potential level of support and face-to-face contact that they might have done under normal circumstances. We are seeing an increase in referrals to our step 2 services, and indeed CAMHS services, and we can expect that trend to continue, particularly as some of the financial implications of what has happened start to kick in.

So until such time as we can proactively recruit into the CBTs and certified therapists and the counsellors and psychologists, we are not going to be in the position to deliver the service we want to at that step 2; so those kind of low to moderate, if you like, mental health problems. We call them low to moderate in terms of stepped care approach, but still have an absolutely profound impact on people's lives. Until such time as we can proactively recruit to those positions with an allocated budget, we are really going to struggle. There is only so much you can do to create a service out of the existing budget line, and until such time … We applied last year to Treasury and unfortunately that was refused, turned down. We are redoing the business case to reflect how we have made some more savings and we reinvested it again within our existing provision to create more step 2 services. But it is still, relatively speaking, in its embryonic stages.

Q217. The Chairman: So you talked about the third sector and how you think they can support, they can support you in your step 2 as well. But you talked therapists and … Are there no other services that you can support people with, other than your sort of clinical view of it? There must be –

Mr Bailey: Yes, absolutely and I think again this comes back to this stepped care approach. So at step 0: how do we create, how do we work to create, a population, a community that is able to proactively self-help, self-treat, is more resilient, can tap into the existing resources? That is really step 0 stuff.

Step 1 is about our interface with General Practice and our shared care arrangements and we are working very proactively with Public Health at the moment. The Mental Health Service is working proactively with Public Health to say how we can get these messages out there, how we can build individuals' resilience, build people's awareness about how to access self-help materials; because there is a huge range of information and self-help material out there, but it is almost getting it in one cohesive repository, one place and then marketing that and saying, 'Look, here's where it is, here's where you can access information to self-treat/to self-help'. But again, that is a work in progress.

Q218. Mr Perkins: It is making patients aware of it as well, isn't it? (***Mr Bailey:*** Absolutely.) *(Interjections)* I cannot remember the name of the other organisation that offers counselling.

Mr Bailey: Yes, and they are one element. There has been a lot of work during COVID I spoke about in front of the press. But there is a lot of information, a lot of self-help information, a lot of *really* good quality, evidence-based stuff that people can actively engage in without coming anywhere near the secondary Mental Health Service or even their GPs. But it is about making that accessible for people and then promoting it, proactively promoting it, and marketing the availability of it.

Q219. The Chairman: Okay, those are some deficiencies that you have found in the Service during COVID. Is there anything else that you have noticed where, particularly in mental health, that the Service … something has to light that you had not thought about before COVID?

Ms Magson: I think from my perspective, the domestic violence agenda. Working with DHA, we need to do a lot more together around the whole domestic violence agenda. They have noticed significant increase. I am sure you have all read the reports and the Chief Constable's report, and that is going to be an ongoing piece of work because, again, the more … And if we have a second wave, how do we actually deal with that? If in lockdown, once this has flared up and you are locked down again, if that is what happens.

I think there are significant pieces of work around that and, as Ross said, one of the key things is education for the population about how actually you access help. And that is why I go back to: there are private therapists on the Island doing a good job and we need them working with the DHSC. So we will put a business case in because that is the quickest way to actually get trained therapists working with the population and we should be doing more of that anyway, and in that way, because there is always the tendency to say, 'DHSC needs more'. Okay, well, that is not necessarily true because DHSC already has vacancies, as you have spoken about, and training up, where there are people who work on this Island in private businesses providing therapy that we could access quickly and efficiently and they provide a good service.

Q220. The Chairman: So when are you hoping to have that on line? Minister? *(Laughter)*

The Minister: In relation to that funnily enough, I actually met with an organisation this morning and who offer some services – that I have not had a chance to speak to Ross and Angela about yet – that I think would fit in very nicely with this. But mental health is one of my priorities as Minister. It has been since the day I became Minister and it will continue to be. If you do not have your mental health then what do you have?

So I am keen to see it driving forward as quickly as possible.

Q221. The Chairman: And is the triage coming down towards the community, to the doctors, now that they would be able to refer, so that people can get that help quicker? Because it is –

Ms Murray: I think the work that we did in the west of the Island has actually proved so beneficial in COVID to give us the information that we need actually to … I know we had to virtually kind of dismantle everything very rapidly, but *really* interesting to see how the GPs in the west of the Island work *very* cohesively with multidisciplinary teams there that we want to roll out in the integrated care programme across all the Island.

Q222. The Chairman: So where is your next place? *(Laughter)*

Ms Murray: Where's next!

The Chairman: Where's next!

Ms Murray: Yes, coming to a quadrant near you, shortly. *(Laughter)* But you are talking then about a team who have become more and more aware. So the district nurses are involved in working with the mental health leads – everybody in that team is *far* more aware. And yes, I know you mentioned training and we talk about training a lot, but it is the key to it because for years and years and years there was not enough training. So you have got this kind of backlog that you are trying to catch up with.

So if you look at mental health first aid, you do not have to be a mental health professional to deliver mental health first aid, for example. But the Mental Health Services had to pick it up to train people to do it and that takes time, doesn't it? But if you look at what was done in the west of the Island in the integrated care and you have got the Community Wellbeing Service there, and the GPs are very much part of that, I am hopeful, as we get that rolled out across the Island, there is much more community cohesiveness about the support that is needed.

Then on top of that, in COVID we introduced the two teams – I am sure you have heard of the chat team and the chart team – that actually dealt with individuals and dealt with nursing homes. So again, in terms of mental health, it would only need in either of those teams one mental health worker to be working with the teams to be identifying things at the coalface, really, because those are teams that we are not going to lose outside of COVID. We are just working out how that actually works to keep people at home, not just in terms of mental health, but you cannot exclude mental health if somebody is in their home and we want to keep them there longer – it has to be a holistic approach to it.

So there are significant things being done that take mental health out of the silo of mental health.

Q223. The Chairman: So you are feeling positive that the services to the Island are going to get much better and the waiting lists will be down with some intervention from …?

The Minister: If I could add in there, Chairman, I think we have got a huge opportunity actually. I think, as I say, there are lots of dreadful things that came with COVID, but I think there are some good things as well and the way that – you have heard many times bang on about silo working; it is one of my absolute pet hates – I think a lot of the silos have disappeared because they *had* to disappear overnight, to be frank. I think certainly we have got a huge opportunity to drive forward the mental health agenda and a lot of the other agendas across DHSC that in normal times we would have perhaps been talking years, rather than weeks or months.

The Chairman: Okay, thank you very much. Thank you for coming along today and we will now sit in private.

Mr Greenhill: Thank you.

The Committee sat in private at 5.26 p.m.

9th November 2020

Evidence of

Ms Deborah Brayshaw, Director of Children and Families Services, Department of Health and Social Care

and

Evidence of

Hon. David Ashford MHK, Minister and Ms Kathryn Magson, Interim Executive Officer, Department of Health and Social Care

STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Children and Families Services;
Department of Health and Social Care

HANSARD

Douglas, Monday, 9th November 2020

PP2020/0245 **SAPRC-HSC, No. 1/20-21**

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Members Present:

Chairman: Ms J M Edge MHK
Mr P Greenhill MLC
Mr M J Perkins MHK

Clerk:
Mr J D C King

Assistant Clerk:
Ms G Phillips

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Standing Committee of Tynwald on Social Affairs Policy Review

Children and Families Services

The Committee sat in public at 10.38 a.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MS EDGE *in the Chair*]

Procedural

The Chairman (Ms Edge): Welcome to this public meeting of the Social Affairs Policy Review Committee, a Standing Committee of Tynwald. I am Julie Edge MHK and I chair this Committee. With me today are Martyn Perkins MHK and Peter Greenhill MLC.

Please can we all ensure our mobile phones are off or on silent, so that we do not have any interruptions. For the purposes of *Hansard*, I will be ensuring that we do not have two people speaking at once.

The remit of the Social Affairs Policy Review Committee is to scrutinise the established but not emergent policies, as deemed necessary by the Committee, of the Department of Health and Social Care, the Department of Education, Sport and Culture and the Department of Home Affairs.

EVIDENCE OF
Ms Deborah Brayshaw,
Director of Children and Families Services
(appearing virtually)

Q1. The Chairman: Today, we welcome the Director of Children and Families Services, Debbie Brayshaw. For the record. I would like to begin by asking you to please state your name, job title and how long you have been in this role?

***Ms Brayshaw*:** Yes, I am Debbie Bradshaw. I am Director of Children and Families Services in the Department of Health and Social Care, and I have held the role since August 2014.

Q2. The Chairman: Thank you. Would you like to make an opening statement?

***Ms Brayshaw*:** I had not prepared an initial statement. I am happy to take any questions based on the information that was provided by the Department; I can make a statement on that, should you wish me to do so.

The Chairman: Yes, please.

***Ms Brayshaw*:** Okay, so the Committee asked for a submission on the updated progress of the Children and Families Social Services, in particular the response to the Committee's Report on the Children and Families Service in 2016. Just to update the position, the Council of Ministers

responded to that Committee Report. The Department accepted the learning from the findings and the recommendations of them.

Since 2017, the findings of that Report are being collated with the recommendations of the last inspection report progress we had in June 2016, and the Tynwald investigation, which was a report into allegations relating to the management of case files. So all of those have then combined together in what is known as a combined action plan, which has been managed through the Cabinet Office and Social Policy and Children's Committee, and an update has been laid before Tynwald each October; I think the last one went last month in October this year as well.

Most of the recommendations are complete and there are a number of strategic recommendations overall that are outstanding from that combined plan, but in relation to the learning and the recommendations specific to the Report of this Committee, the Department has completed most of those recommendations.

Would you like me to make a statement in detail of those recommendations?

Q3. The Chairman: Yes, please.

***Ms Brayshaw*:** Okay. The recommendation is that we should produce a training policy to ensure the statutory aim of keeping families together is reflected in the policy and the working practices of the Department. That policy position is set out and defined in the Children and Young Persons Act and is now present in all policies and procedures introduced to the Department. All policies and procedures have been reviewed over the past few years and are up to date. All of that information is established through discussion with staff, and we have a more robust induction process that is now in place.

We believe from the performance information that we have got, that we are performing quite well on that situation, insofar as the number of looked-after children that we have is within an agreed, optimum range that we would expect for the Island and the demography of the Island, and that is benchmarked against the position in the UK as well.

We also have increased the number of extended family members or friends that we use in situations where children cannot stay with their own families, whether that is for a short period of time in an emergency or a longer period of time.

The second recommendation is that we should make every effort to ensure that social workers are competent and are seen as competent, and that they communicate positively and not negatively, and that they become … with practical or emotional help and do not give the impression that any withholding of consent will be held against the family. The service now has a robust system for induction and supervision and decision-making for managers. We have a delegated scheme of decision-making so social workers know when they can make a decision, or when they need to escalate that decision to a more senior manager to make that. The matter of consent has been subject to specific training right across the service, and we have reviewed all of the consent material and the documentation that we use with families, and all staff have been inducted with the use of that information … *[Inaudible]* … through case file audits as well, so we believe there is improved performance on that matter.

The third recommendation was that we undertake public education with the aim of ensuring the way social services and related agencies behave on the doorstep is adequately communicated, so that people can talk about any concerns that they have and feel confident that they will receive help. There has been an ongoing piece of work to provide public information leaflets to families at different points of the service. They are currently being reviewed again and should be out in circulation with families at the end of December. We have also begun an initiative to look at a handbook that can also be shared with families, but that is not yet complete; it is still in the process of being built up into a draft form for consultation.

We were asked that the legislation to place the Safeguarding Children Board on a statutory footing should be introduced to the House of Keys before the end of 2016-17. That happened, so you will be aware the Safeguarding Act 2018 is now established and the Safeguarding Board

operates on a statutory footing. Its first statutory annual report has been laid before Tynwald as well.

The final one was in relation to the inspection of Children and Families Services. The Committee recommendation specifically named Ofsted, and there was a request for an amendment that it was a regulatory body and not necessarily specifically Ofsted, and that occurred. The recommendation has not yet been realised, and it now forms part of the Transformation work of the big piece of work of the establishment of Manx Care and will be established in the mandate between the Department and Manx Care. The negotiations, and how that will be commissioned, are an ongoing piece of work jointly with the Transformation team to achieve that.

So the last time Children's Services – and that's Children's Services across all Departments – was inspected towards the review of inspection by the Scottish Inspectorate in 2016 which reported in 2017. Earlier this year, we had begun again negotiations with the Scottish Inspectorate to ask if they would come back and do another full inspection and obviously the global position with regards to the COVID pandemic has had to put that on hold.

So at the moment we may or may not resume those negotiations, depending on the position, particularly in the UK, with regard to COVID, or it may be that the requirements that are agreed in the establishment of Manx Care establish how and who that regulatory body may be, before that becomes a reality.

We were also asked that the Department should be required to produce a statutory annual children in need census to include the same standards statistical data required by the Department of Education in Whitehall and include any other statistical data, as specified by Tynwald. The Department does not operate exactly the same framework as the Child in Need Census would in the UK, so we did consider how that would be best used in the Department. We do report every quarter to the Safeguarding Board, and we report and record against the Child in Need categories that they do use in their census, so we always have a position with regard to those, and it does enable us to categorise referrals that are coming in. As you will see from this submission, at the end of the year 2020, which was the end of March 2020, 93% of referrals were categorised either as abuse and neglect, or family stress and family dysfunction. That is consistent with the thresholds for statutory intervention and are the consistent categories that I would anticipate to be used in that census to demonstrate that the right sort of referrals are coming into the Department to be dealt with.

Recommendation 7 was that the Department and Children and Families Division should encourage and welcome complaints from families and should deal with them positively, so that lessons can be learnt and grievances resolved. We have done a significant amount of work around our … *[Audio interference]* …

Q4. The Clerk: Sorry, excuse me, Debbie. Your connection broke up a moment ago. We started to lose bits.

Shall we just wait and see if it comes back? I think it was just after you started speaking about complaints.

Mr Perkins: The video has come back now.

***Ms Brayshaw*:** Okay, is it back now? Thank you.

So we have changed our management arrangements and the response to complaints, and that is specifically so that we can capture the learning from them. The information that has been provided over the past three years is far more detailed than at any other previous time, and it has been really rich for us in understanding, firstly, how complaints are made – and you will see from some of the information that is provided, rarely do we get one complaint; our complaints are complex and we get lots of areas of complaint within one complaint that we need to break down, and we track those better now, as well.

So again, in the year up to the end of March 2020, there were 67 complaints, but there were 180 elements within those 67 complaints, which demonstrates the complexity of what we are managing. We now track them right through to conclusion, and we track them through to which go on to stage 2 and which go on to stage 3, which is an independent position, and how many were upheld. So the 57 complaints that were completed within that year, and 134 elements that were concluded, 49% were upheld or partially upheld at stage 1; 60% were upheld at stage 2; and 50% were upheld at stage 3.

What we have done with regard to the learning from those is we have two staff development days internally over the course of each year, and at least at one of those days we look at the learning that comes through from the complaints, and that is used to change practice in real time for workers and also from a policy or a procedural position for the Division as well.

I know that the complaints process is another area that has been looked at through the Transformation work, because we have different parts of the Department that operate different complaints processes. So there is a big piece of work to look at standardising the complaints process across the whole of the Department as well. The interim Chief Executive, Kathryn Magson, I know she has recently completed a three-year review of all the complaints processes across the Department, which should be available to Members.

The Tynwald Commissioner for Administration was appointed. That was not an action for our Department but it was a recommendation from the Committee's Report. We have not, to date, had any complaints that have been dealt with by the Commissioner. However, one complainant had approached the Commissioner and it was ruled that they had not exhausted all their available options in the procedure prior to the Commissioner taking up that complaint. I do believe that position was laid before Tynwald by the Commissioner as well, in respect of that position.

Then the core national policies in respect of children should not be introduced, amended or abandoned without the express approval of Tynwald. The position with regard to children and the Division is that all of our policy decisions are made in accordance with the established process of the Department. Where it is an intra-departmental process where we would use the Social Policy and Children's Committee, and I am a member of the Lead Officers' Group that feeds in to that bigger Committee with the Ministers present as well.

So the big areas of current … *[Technical interference]* … were followed by a major change to the Children and Young Persons Act, which is for the next administration, and the areas that are being looked at in the Children and Young Persons Act are to the duties and powers in relation to care leavers, the established statutory powers for the independent … *[Technical interference]* … care proceedings around which we have a consent.

Q5. The Clerk: Sorry, Debbie, we have lost another bit – are still there? Can you hear me?

Please could you go back to the bit about the proposals to amend the Children and Young Persons Act?

***Ms Brayshaw*:** Yes, so the key areas of the Children and Young Persons Act will be extending duties and powers, particularly for care leavers and strengthening the support services for them. There will be changes in relation to establishing on a statutory footing the role of the independent review officers and the quality assurance processes within the Division, and there will be an amendment that will link with the adoption legislation to introduce what we call placement orders, and we would also like to address the timeliness of care proceedings through the judicial process.

Q6. The Chairman: Thank you.

Just to start, we are going to ask a few questions for you to explain your services, so could you explain the role of Children's and Families on the Isle of Man, including the different tiers of support available?

Ms Brayshaw: Yes, so the Children and Families Service is primarily a statutory service, so it undertakes the statutory functions under the Children and Young Persons Act 2001. We broadly split that into two, so we have services that are of a support nature which are primarily voluntary, and that is provided in the first instance. We have an early help and support service, which is the first point of contact. That is a service that was introduced a few years ago and is jointly funded with the Education Department as well.

We also provide, under section 23 of the Children and Young Persons Act, we can statutorily provide assessments to certain groups of families with their consent and about a third of the work of the Department is based on working with consent. The rest of that work is in relation to the statutory functions for children who may be at risk of neglect and abuse, children who have been abused or neglected, and children who have been subject to care proceedings, are unable to live with their birth families and therefore we have to make alternative arrangements and are looked after by the Department or have left care and are still receiving support from us under the key statutory powers we have for care leavers at the moment.

So I would describe primarily is a statutory service.

Q7. The Chairman: Okay, so could you explain what the pathways for referral and the journey of a client is with the Department?

***Ms Brayshaw*:** Pathways for referral for what, sorry? I didn't catch that.

The Chairman: So, just from your whole structure, what would the pathway be for a referral for a client?

If you want to use one of your examples, a section 23 referral, what would the pathway be for the individual?

***Ms Brayshaw*:** Okay, so all referrals come into our Initial Response team; so that is the service that operates to receive all new referrals, whether it be a member of the community or from another professional or agency, and that is where they are received. All that information is screened and it is determined what sort of referral it should be; whether, in the first instance, there is a *prima facie* case to look at it from a section 46 child protection perspective and make inquiries around any child or children, or from a section 23, which is in essence a request for support, and any request for support, even if it comes from another agent, only proceeds if the family give their consent for that to happen.

Separately, referrals are made into the Early Help and Support Service, so that is a first tier, which is managed within the Initial Response. But the referrals do not go from the Initial Response team to Early Help and Support; they have a direct route through, whether that be from families themselves or from professionals, primarily education establishments and health visitors, using the referral rate through the Early Help and Support system.

Q8. The Chairman: So with regard to a referral, obviously you said that they could come from numerous directions. At what point would a family know if they were then to move into a complaints process? Is that referral classed as a complaint from other services fed into you?

***Ms Brayshaw*:** Sorry, I am not understanding the connection with the complaint?

The Chairman: You are saying that you get referrals from various bodies, so at what point would that … if that referral starts and a process starts and you commented about section 23, or it could be section 46, at what point would that referral be recorded that it could possibly become a complaint in the future? I am trying to link up the process and the pathway for an individual.

***Ms Brayshaw*:** Okay, well, it would not be recorded as a complaint until the complaint had been received. We do not regard a referral as a complaint about a family. So a referral is a referral for service or for assessment of a family. If it is a referral under section 23 for support, we would anticipate that if that referral has come from an agency, they are making that referral with the agreement of the family concerned, because it is primarily for support and should have consent for it.

If it is a child protection referral, consent is not needed for that referral, although we regard it as best practice that families are informed that a child protection referral is being made and the requirement of the Department is to make contact with the family within the 24-hour period after the receipt of a referral that is categorised as a child protection referral.

Does that answer the question that you are asking, sorry?

The Chairman: It is fine, we will follow up.

Q9. Mr Perkins: Can I just jump in there? Is there any difference between a child-led complaint and an adult-led complaint?

Ms Brayshaw: Are we talking complaint or referral? I am a little confused.

Mr Perkins: Yes, this is once a complaint has been initiated. What is the difference between … is there a difference? Are they dealt with in the same manner, or how does it work?

***Ms Brayshaw*:** A complaint is an administrative process. A referral is a service process, so they are not the same thing at all. So a complaint would go through a completely different process to a referral.

The complaints procedure is a three-level process, so stage 1 would seek to try and resolve that at an informal level with the manager of the service. If that was not satisfactory to the complainant, then it would be escalated to stage 2, where a more senior manager would look at that complaint, and if that was not satisfactory, then via the Chief Executive, an independent investigator would be brought in to look at stage 3. But complaints are very separate from referrals.

Mr Perkins: Right okay, thank you.

Q10. The Chairman: So just to follow up on referrals, and you keep saying that it is with consent, do you record within your statistics that consent has been received? Is that standard process?

***Ms Brayshaw*:** It is a standard process. We have revised forms that we use to establish that consent has been given to the services that are being provided under a support mechanism. In the area of Child Protection, consent is not required because we have a duty to the child. It is best if we can work in partnership with the families, but our duty is to protect the child, so if a family is not consenting to a child protection intervention or service, we do have the power to provide that service directly to a child without the family's consent.

Q11. Mr Greenhill: If I could just go back to the complaints side of things, at stage 3 when it becomes an independent review, how is the person chosen to run that side of things? Is that decision is made by the Chief Executive or by the Minister?

***Ms Brayshaw*:** That decision is made by the Chief Executive, and it would be usual for the Chief Executive to have either a number of independent individuals or a number of independent

agencies that they can make contact with to engage somebody with the relevant knowledge and experience to undertake such an investigation.

Q12. Mr Greenhill: And when we use the word 'independent' there, do we mean that person is outside the Department completely, always?

Ms Brayshaw: Yes, at that level yes.

Mr Greenhill: Okay, thank you.

Q13. Mr Perkins: And would they be from across in the UK, or would they be Island-based people?

***Ms Brayshaw*:** It could be either. I think the last couple that we have had have been somebody from across but with a working knowledge of the Island.

Mr Perkins: Thank you.

Q14. The Chairman: I think it would be helpful if you could explain your current complaints procedure.

***Ms Brayshaw*:** I didn't catch the end of that …

The Chairman: Okay, I think it would be helpful if you could explain the current complaints procedure for your Department.

***Ms Brayshaw*:** Yes, as I said there are a number of complaints procedures for the Department, but for the Children and Families Service it is a three-stage process. So stage 1 is what we would call an attempt at seeking informal resolution between the family and the manager of the team that they are involved with; stage 2, it would escalate to a more senior manager, that could be the group manager of the service or the Head of Statutory Social Work Services or myself; and level 3 would then be the independent investigator that we have just spoken of.

Q15. The Chairman: Could you explain your staffing structure within Children and Families?

***Ms Brayshaw*:** Sorry, I didn't catch that; it was broken up.

The Chairman: Could you explain your staffing structure within Children and Families?

***Ms Brayshaw*:** Yes, I can do. So the services are primarily established at this … I don't know whether to start at the top or start at the bottom; I will start at the top. So there is myself as the Director of the Service. There is a Head of Statutory Social Work Services who is responsible for two areas of work: the Initial Response services, so everything that comes through the front door, and that includes the Early Help and Support and includes Youth Justice within that; and then there is the longer-term, what we call Care Management, who manage cases on a longer-term basis after assessments and plans are put in place. So that is the statutory operational part of the service.

There is a Senior Independent Reviewing Officer that is responsible for the safeguarding and quality assurance processes in the Department, and that person reports directly to myself as the Director. There is a Head of Business and Contracts. You will appreciate that some of our work is contracted out, so the support services in the Early Help and Support Services are contracted out to an external agency and our residential and after-care services are contracted out to

St Christopher's, who have been on the Island for many years. So there is a senior manager responsible for that and I have a senior manager who then is responsible for Business Planning and Service Development, building back that learning loop back into the service and undertaking some of the work and producing the performance report that informs how well we may or may not be doing.

The service areas themselves: Care Management is three teams and they can carry cases that are either child in need cases, which are the section 23 support cases. They can be carrying child protection cases, where a child may be subject to a child protection plan, or they can be carrying looked-after children, where a child is in care and the plans for them.

The Initial Response services are our first response to all referral that come in. That includes the … *[Technical interference]* … so the 24-hour … operate and the Early … and the response to the complaints as well.

We also now … have the Family Placement Service that was in the … and the Family Placement Service is led by a manager who currently is reporting directly to … *[Technical interference]* …

The Chairman: It has frozen again.

Mr Greenhill: We have got another freeze. Can you hear us at all?

Q16. Mr Perkins: We have lost the connection completely, I think.

We are back on again. Could you just go back one, please, because we lost about 30 seconds of what you were saying?

***Ms Brayshaw*:** Okay, so for the services within the Department, there is Care Management and the Initial Response services, there is the Early Help and Support services and there is the Family Placement Service that are the key parts of the work that we deliver. Safeguarding and Quality Assurance that oversee things like child protection conferences and review meetings for children that are looked after, and then we have services that are externally contracted with St Christopher's and Family Action, as the two organisations providing those.

Q17. Mr Greenhill: You mentioned that some services are contracted out, but in terms of overall, what proportion of the staff are actually agency workers?

***Ms Brayshaw*:** Okay, so agency staff within the statutory services at the moment is at an all-time low, and so we currently have six agency workers working across the social work teams at the moment; proportionately that is less than 15%.

If I tell you that when I came into the Island seven years ago, the level of agency staff was at 44%, so we have made significant shifts in bringing that down. Primarily, that is through investment in a scheme that we call 'Grow Your Own Social Worker', so we have been investing in that for the last four or five years. Last year was the first year that we saw our first return of a worker qualifying through that scheme, and there will be three or four returning this year, and then every year subsequent to next five or six years there will be two or three returning every year. That has enabled us to succession plan for social work posts across the system, so the majority of the workers in the system are permanent workers.

Q18. The Clerk: Can I just ask you when you talk about people returning under the scheme, does that mean that part of the scheme involves them training away off the Island?

***Ms Brayshaw*:** No, I use the term 'returning' to mean coming back qualified as opposed to being a student. What the course actually entails, it is a work-placed social work degree, so they do most of their placement with the Department, but the relationship is with Robert Gordon University in Aberdeen, and there are key points where they would go to the university to

undertake some of the learning that is required. Obviously, this year because of COVID that has all now moved to a virtual position and is done online.

The Clerk: Thank you.

Q19. Mr Perkins: The agency workers that you have got, how long can they stay with the Department or do you review their appointment after a year or so?

***Ms Brayshaw*:** Sorry, is that in relation to agency workers or permanent workers?

Mr Perkins: Yes, agency workers. Have you got any permanent agency workers or do they have to …?

***Ms Brayshaw*:** We do not have permanent agency workers; we have got agency workers that are … *[Technical interference]* …

Mr Greenhill: Sorry, could you answer that question again? We have gone into freeze again. If you can hear us.

***Ms Brayshaw*:** So we do not have permanent … *[Technical interference]* … had somebody in that position is five years.

Q20. Mr Perkins: You have had somebody in there for five years?

***Ms Brayshaw*:** Yes, where they have renewed their contract.

Q21. Mr Perkins: Right, okay. And is that the longest one?

***Ms Brayshaw*:** … *[Technical interference]* …

Mr Perkins: We are just going to try and take you off video so that we can hear you better, see if that works.

There was some technical discussion.

Q22. The Clerk: Okay. We were just talking about the maximum length of service of an agency worker. Can you confirm that the five years was the highest agency length of service?

***Ms Brayshaw*:** Yes, but we cannot contract for that length of time; we contract for up to 12 months to achieve consistency and continuity, or up to six months if we know that we are recruiting into a post in a short period of time.

Q23. Mr Perkins: And how do they continue with the case? I think it is important to have one social worker maintaining a case. Do they ever get taken off halfway through a case?

Ms Brayshaw: We do try to maintain continuity; that is not always possible for lots of different reasons, be they personal or professional for individuals, but we do attempt continuity of worker.

Mr Perkins: Thank you.

Q24. Mr Greenhill: If we could take a wider view, perhaps of your area, could you describe the culture and the morale of the Children and Families for us, please?

***Ms Brayshaw*:** Can you just repeat the start of the question, sorry. I caught the end of it in respect of culture and morale, but can you just repeat the start of it?

Mr Greenhill: It is really just giving a flavour of the whole Department, of the whole area, from your perspective; describe that culture for us and how that might have changed over time? So it is the culture and the morale of the Children and Families.

***Ms Brayshaw*:** Okay, I think over the past five or six years we have done a lot of work to establish what I would call a 'safe' service, and that is to ensure not only that staff feel safe in order to give the best that they can, but that then translates into providing what I would consider to be a safe service for families. By safe, I mean that we have got proper governance about what happens; so improved policies and procedures, improved decision-making processes, the right level of management support across the board for people and at different levels of hierarchy as well, that we have performance information that tells us how well we are doing and there is communication around that as well.

So for example, we hold a monthly staff briefing with all staff across the service, and that is to bring staff up-to-date with departmental and service issues, and also for staff to highlight or bring into play anything they want to in that process.

My view at the moment is that I think it is performing reasonably well as a service, there is always room for improvement and there are always things that you can do differently and new trends and themes of issues and problems that we need to adapt to and respond to, such as the COVID situation, which has been a real challenge for everybody, both on an individual, personal and professional level as well.

So I think we are performing quite well, I think the governance that we have got within the service is as strong as it can be at the moment. Again, there are areas for improvement, and I think some of the changes that may come through the Transformation and the move to Manx Care will assist with that, and the legislation changes that are happening.

I do believe that the morale generally is relatively good within the service.

Q25. Mr Greenhill: That was the point I was going to go on to. It is one thing looking at performance and that should, if it is improving, lead to an improvement in morale as well, but have you have seen any specific cases where morale is improving or areas where you need to take some action?

Ms Brayshaw: I think morale generally is okay. The performance that we look at with regard to supporting staff is to look at their caseloads and the workload. At the moment it is pressurised from the point of workload, and that is partly because of movement of staff and agency workers, some of which have gone back to the UK because of the prolonged period of time of the restrictions on COVID, so we are having to manage that workload. It is workload that really impacts on the resilience of individuals. I would hope that most staff, if they were asked, would say that they are valued for the work that they do within the service and have the opportunity to raise any issues or communicate any ideas equally to improving the service.

Q26. Mr Greenhill: And can you give us an idea of the average caseload that each person is coping with at the moment?

Ms Brayshaw: Yes, the average caseload: it is anticipated, it should be anything between 13 and 18 as an average caseload, depending on the experience of the individual. We have a small number of workers who are particularly experienced in key areas of work that do exceed that, so there are some pinch points within that, and caseloads have been as high as 20 and 23 for some individuals.

Mr Greenhill: Sorry, could you repeat that answer with the numbers please?

***Ms Brayshaw*:** Yes, so the established framework requires a caseload of between 13 and 18, depending on the experience of the worker. The average usually is at the top end of that, usually 17 or 18. We have a small number of staff that exceed that and have had caseloads as high as 22 or 23, and there is always a management action plan when that is identified, to bring that back down.

Mr Greenhill: Okay, thank you.

Q27. Mr Perkins: How many staff have you got signed off with stress or related problems at the moment?

Ms Brayshaw: I do not have that information to hand at the moment. I would need to provide that to you. My understanding is that it is a small number, less than five, but I am happy to check that specifically for you.

Mr Perkins: That would be useful, thank you.

Q28. The Chairman: Can you confirm that all of your staff are registered? Obviously there is a database in different jurisdictions, there is an English database for social workers, I believe there is a Scottish, a Welsh, and possibly an Irish one. Are all your staff registered on one of those registers, or do you hold a Manx register that could be published?

Ms Brayshaw: No, they would need to be registered with an equivalent or with Social Work England. We have a memorandum of understanding with Social Work England that any of our staff who are not registered will register with them.

Q29. The Chairman: And is that published anywhere within your own website?

Ms Brayshaw: No, it is not, but any individual can … on the Social Work England register. We keep a checklist on everybody's individual supervision file to know that they are up to date with that and up to date with their enhanced DBS check and police check as well.

The Chairman: Thank you.

Q30. Mr Perkins: How is your relationship with the other agencies, for example, the Police and Department of Education? Are they fully co-operating

***Ms Brayshaw*:** Are they what, sorry?

Mr Perkins: Are they fully co-operating with your requirements?

***Ms Brayshaw*:** Yes, I think we work very closely with other agencies and Departments. We constructively use the Lead Officers' Group, we constructively use the Safeguarding Board where we need to come together and develop areas of work.

That does not mean to say it is not without tensions, but I do believe we have a good process of resolution where there is disagreement.

Q31. Mr Perkins: Would you say the early intervention plans are working well?

***Ms Brayshaw*:** The early intervention service, the Early Help and Support service?

Mr Perkins: Yes.

Ms Brayshaw: Yes, I would believe it is working well. It is regularly evaluated, and the Department of Education contributes to that –

Mr Perkins: Thank you.

Q32. The Chairman: With regard to Youth Justice, it is not the Youth Justice team as it was known, you have got a new name for that, is it PEAT or something like that?

***Ms Brayshaw*:** No, the Youth Justice team is based within the Initial Response team. The Police Early Action Team (PEAT) service is an early intervention that the Police operate.

Q33. The Chairman: Do you have any representation on that?

***Ms Brayshaw*:** No, we do not. The difference is that the Youth Justice team and Initial Response team are a statutory response to court ordered requirements for young offenders, and the PEAT service is pre-offending, so PEAT would engage with young people and children prior to any court intervention or actual charge with individuals.

Q34. The Chairman: Okay, thanks for that clarification. So with regard to the Youth Justice team, do any of your staff have criminal justice qualifications?

***Ms Brayshaw*:** None of the staff currently do have that qualification, and we are currently reviewing that position as well, but they are qualified to be representatives in the court.

Q35. The Chairman: And when you say you are reviewing that, have you got a deadline for that review to ensure that there is a good service there for the youth?

***Ms Brayshaw*:** Yes, we are hoping to have reached a position on that by the end of this year in December.

Q36. The Chairman: Thank you. Obviously, one of the disposals for the court is fines or probation orders rather than reparation orders or interventions. They focus far more on rehabilitation and diversion from offending behaviours. Do you have anything to say with regard to that and the way it is operating at the present time?

***Ms Brayshaw*:** Yes, that is part of the review that we are doing. We are hoping to have a far more comprehensive menu of interventions by the end of December that can be delivered as alternatives.

Q37. The Chairman: Will that be published?

***Ms Brayshaw*:** It will be published at some point, yes it will. Once we have done it all and it has all gone through due process in the Department, then what we determine as the service at the end of that would be available for publication, yes.

Q38. The Chairman: Can you make sure the Committee receive a copy of that work?

***Ms Brayshaw*:** Yes, we can do that.

Q39. The Chairman. Thank you.

Just with regard to inspection, obviously you have spoken about it and you have a section that deals with inspection, your last independent inspection was 2017, and you are not sure whether you will be continuing with that because of the COVID restrictions. Do you feel that there is an opportunity to do an inspection despite COVID, there are opportunities for reviews to take place, or is that not something that you would like to see? Obviously, we have seen through COVID that we have actually passed legislation to do online independent … well, not independent reviews, but we can do online services. Is that something that you think could be adhered to, bearing in mind you have not had an independent inspection since 2017?

***Ms Brayshaw*:** I think it is a possibility. I think the difficulty at the moment is that we were negotiating with the Scottish inspectorate earlier in the year; we are now at a position where the requirements under the new mandate will be established from 1st April, as we move into Manx Care, and I think it is a balance between capacity and ability, both to get us to where we need to be by 1st April, as well as servicing and reviewing what we have got at the moment, so it may be pragmatic that we wait until the mandate position is established and then commission that, whether it be virtually or in person, from wherever that comes from, but I am not against the suggestion that you have made at all.

Q40. The Chairman: Okay, thank you.

We are going to move on to the COVID-19 response from Children and Families and if you have the information with you, the number of referrals that Children and Families have received?

***Ms Brayshaw*:** I do not have that information with me from the last quarter or through the COVID period specifically. What I can tell you generally is that there has been a trend upwards in the number of referrals into the Department, so we are outstripping where we thought we should be at this point in time.

Q41. Mr Greenhill: Perhaps I can take that a bit wider, if we may, to how COVID-19 has actually impacted the work of the Children and Families?

***Ms Brayshaw*:** Okay, so obviously we had the challenges when we first went into lockdown with all the emergency measures in March of establishing how we undertake our critical statutory functions whilst fulfilling our duty of care to staff, so we had to be very innovative very quickly in what we did with that. A lot of services went virtual for a period of time to do that and for some families there was not any face-to-face contact with them, although every situation was subject to a risk assessment, so if face-to-face contact was required, that was given.

We maintained a response to all telephone referrals and information so that we continued to undertake child protection inquiries through the COVID period. From May onwards, we started bringing services back online again and we went back up to resuming services as normal at this point in time. Our group challenge is staff, in terms of being able to sustain the resilience of those permanent and agency staff. Even permanent staff have key family members who are across and not on the Island, and so managing their resilience through their own personal circumstances and then managing the impact of service provision as well, so we are continually looking at that on a very regular basis.

At the moment, I think for families, we have seen an increase in the number of children moving through the child protection system. We also have a better understanding of the levels of support that families are wanting on a consenting basis. Right at the … beginning of COVID, we did make very practical arrangements for families that needed access to food, where money was an issue for them, then we were able to provide food vouchers, and we have more recently just agreed the criteria of 'hardship' with the Department of Education, where a family may get access to emergency support through Children and Families, should that be required.

Q42. Mr Greenhill: And were there particular types of problems that you were seeing increasing because of COVID?

***Ms Brayshaw*:** There are not any particular types of problems, no. It is the same problems that we see on a regular basis. We are talking about families that are in stress anyway, so that is always an issue. As I have said, there has been an increase in the Child Protection referrals and the investigations that have been undertaken and the number of children that have been made subject to a Child Protection plan.

Underlying issues like drug dependency, domestic violence, they are often contributory factors to some of the circumstances that we are working with anyway. And yes, whilst you would anticipate that the stress the families are spending a lot of time together when they were in lockdown, that will have a knock-on effect on some of the families we have been working with.

Q43. Mr Perkins: COVID-19 obviously presents certain risks that are not normally encountered or higher risks levelled at vulnerable families. How did the Department go about trying to mitigate those risks?

***Ms Brayshaw*:** Well, as I have said, the position that we put in place was that we continued to provide a response to every referral that was given so we continued to fulfil our statutory duty on that. We maintained weekly contact with families that we could not see face-to-face, and where there was an urgent circumstance or circumstances with particular high risk, a risk assessment informed whether we need to make face-to-face contact with those families. Out-of-hours emergencies were responded to, as they always are, and if face-to-face engagement with families was made during active hours in critical emergency circumstances.

Q44. Mr Perkins: Yes, and how long would the response take from the initial referral? If it was an emergency.

***Ms Brayshaw*:** It would be no different to what it normally is, so if it was a child protection issue, then there would be a position and a response within a 24-hour turnaround.

Mr Perkins: Thank you.

Q45. The Chairman: So, looking forward, do you anticipate more families are going to need Early Help and Support? You have indicated that you have seen an increase. Have you had a chance to do any analysis of that as to the level of support, or has it just been a COVID-19 response due to more people reporting in a different manner to you during COVID-19?

***Ms Brayshaw*:** No, it has been the same response and the services have always been available to provide, so it is the same services and interventions, and the analysis of the services and interventions through Early Help and Support do demonstrate that they are very effective with the families that we are working with and they continue to be effective for those families.

When Family Action, who provide that structured intervention in Early Help and Support, were providing face-to-face support, they were providing a telephone helpline to families that they could use, and there was quite a good take-up of that, and practical support was always available as an emergency when that was required.

Q46. The Chairman: Okay so you are talking about, obviously, families that you already are aware of. How many new referrals did you get during COVID? Clearly the schools were closed, I am sure you usually get some referrals from schools, so did you see an increase in new referrals?

***Ms Brayshaw*:** I would need to go back to the data and check that for you, as that would be in the quarter that we have not yet analysed. That data is coming through with COVID, so I would need to provide that to you.

Our primary referrer is the Police, and from that point of view the referrals were still coming through regularly from the Police from a child protection point of view. The request for Early Help and Support did reduce during the COVID period, because the schools *were* providing a service to vulnerable families that were known and they were providing a response to key worker families as well, so the referrals for Early Help and Support during the COVID period did reduce.

Q47. The Chairman: During the period that, obviously with the time constraints that you have with some of your services with regard to the different sections that you have to report to within the Children and Families Act, do you feel any of the times were extended and perhaps have caused a longer delay for some families, or do you feel confident that all of your times …?

So say, if you had a referral and you have got to respond within 48 hours, do you feel that was still happening, or if you had to respond within 14 days, are you confident that all of the targets were met?

Ms Brayshaw: I can say that the timescales were not changed, so I can say that the expectation was that the target hours that we set in procedures should have been maintained. Until I have analysed the data I cannot tell you exactly what the performance against those timescales was, but I am happy to provide that for you.

Q48. The Chairman: Thank you. Okay, so I am moving on now to the combined action plan for children and young people. What impact has the introduction of mandatory chronologies had on both DHSC staff and young people?

Ms Brayshaw: So the requirement for the mandatory chronologies; first of all, from a staff point of view, it is a task that enables a staff member to be fully up to speed with the background and the current position of a case, so it gives a better understanding from a professional perspective. From a family's perspective, it should enable them to contribute to that, so that we are identifying and not missing any key events or key people, key services, key supports that a family feels are important to them as well.

Q49. The Chairman: Okay, and what is your timescale for completion of the joint strategic needs assessment for children with disabilities, and how is that project developing?

Ms Brayshaw: There is no timescale on that, at the moment. It is currently awaiting Public Health capacity in order to do the strategic needs assessment, and as you can appreciate Public Health have had significant capacity issues, particularly in response to the COVID situation, which is ongoing as well. So it is our forward plan of the Lead Officers' Group and the Social Policy and Children's Committee, but an absolute timescale cannot be put on it until that capacity can be considered.

Q50. Mr Perkins: The other thing, of course, is the Equality Act 2017 that is now coming in. How does that affect your services with disabled children?

***Ms Brayshaw*:** Well, we have to ensure that our services are compliant with the Equality Act, and procedures and processes are compliant with the Equality Act as well. So waiting for the JSNA does not stop us starting to look at that … *[Technical interference]* … services that we need to proved. As it is at the moment, individuals are invited to an assessment, carers are entitled to a carer's assessment and we fulfil those requirements. What we also need to look at is how we provide … *[Technical interference]*

The Chairman: Sorry, you were breaking up for about the last 30 seconds there. Can you repeat that?

Sorry, we still cannot hear you.

Mr Perkins: I think we have lost you altogether. Can you hear us?

The Clerk: I think a telephone number would be really useful.

Mr Greenhill: If you can hear us, we are now trying to get a telephone number so that we can call you, as an alternative.

There was some technical discussion.

The Chairman: Okay, we will just suspend the sitting for five minutes whilst we get a better connection.

The Committee adjourned at 11.42 a.m.
and resumed its hearing at 11.48 a.m.

Q51. The Chairman: The Social Affairs Policy Review Committee, speaking to Deborah Brayshaw, Children and Families – we are back on air. Thank you.

Can you just repeat – you were running through various comments and we lost you, so could you just repeat the last response you have given to the Committee?

***Ms Brayshaw*:** That was in relation to the chronologies, yes?

The Chairman: That is right, yes.

***Ms Brayshaw*:** Yes, so the chronologies are undertaken. The benefit for the worker is that they get a better and more rounded understanding of the family situation that they are working on, and it is an ongoing document, it does not end, so the chronology is always kept up to date. It should be done in partnership with families, so that families can also contribute key events into that chronology and challenge anything if they believe that is not correct in the chronology.

Q52. The Chairman: So the provision is within the current residential children's homes and/or foster placements for children with disabilities to be accommodated; should they become looked-after children?

***Ms Brayshaw*:** We have a procedural permission with regard to children with disabilities becoming looked after, and it is determined by the number of nights over the course of the year as to whether they become looked after or not. So, most families can have in excess of 75 nights per year before a child would become looked after.

Q53. Mr Perkins: What impact has the review of the Safeguarding Children's Board training had on the professionals, and by extension the Children and Families?

***Ms Brayshaw*:** Well, the training of the Safeguarding Board, reviewing and revising that has made it more pertinent to the key areas for the Island, so I think for all professionals what they are all getting is a more structured and relevant training brochure that they can choose from. For this service in particular, we look at what is in that brochure and we identify each year what we consider to be a priority for all staff to attend. Obviously there are basics that staff must attend in

relation to a general safeguarding overview; everybody must have that no matter what their background.

Mr Perkins: Thank you

Q54. The Chairman: So, from a continued professional development point of view, specifically for social workers, is there a set criterion of a number of hours per year that they have to attend?

***Ms Brayshaw*:** Yes, there is. So we enable people to do up to three days over the course of a year. They are also now required under registration with Social Work England to account for their professional development over the course of a year as well, to maintain their registration.

Q55. The Chairman: So that is just 24 hours of CPD?

***Ms Brayshaw*:** Fifteen hours of CPD.

The Chairman: Five per day.

***Ms Brayshaw*:** We enable them to do up to three days, but the requirement is 15 hours.

Q56. The Chairman: Okay. So what would you like to see introduced from a training programme? Is there anything that you would like to see introduced, either on safeguarding or anything that you are not doing at present?

***Ms Brayshaw*:** I think everything that is a priority is being considered by the Safeguarding Board at the moment. Again, the challenge at the moment is what we can deliver virtually whilst we have the restrictions that we have, and when can we move back.

Within our service, one of the things that we have been doing over the last few years, and this has been across the whole of the service, is that we have been implementing training and development for us to become a trauma-informed service, so that we approach our work having an understanding of how children, young people and families are traumatised by the experiences that they have and the difficulties that they have been in as well.

Q57. Mr Greenhill: Perhaps you can widen the questioning; when you are considering plans to establish and implement a new children's strategy, what do you think, yourself, is needed here?

***Ms Brayshaw*:** I personally find that a difficult to answer because I think there is some foundation training that is always required – that relates to the basic procedural provision with regards to safeguarding, it relates to understanding the legal position with regard to everything that we do across the service and where our powers are established. The trauma-informed work is now going to be rolled out through the Safeguarding Board, so that would go right across the professional network as well. I think it has to be an iterative process though. The training has to be responsive to the needs that have been identified and the gaps that have been identified as well. We need to look to start to move more as well; we can always build on working in partnership with families and how we move to that position. Some families, particularly where it is disability, we might want to look at co-production of services and those sorts of issues. I do not believe there are any significant gaps at the moment, and I do believe the Safeguarding Board is responsive to the needs that have been identified.

Q58. The Chairman: What progress has been made with data-sharing agreements for use between the Safeguarding Board or other entities?

***Ms Brayshaw*:** So that is a piece of work that the Safeguarding Board are looking at at the moment. We do have a sharing information agreement and that is currently being reviewed, and that is being led by the Chair of the Safeguarding Board.

I do not believe, in practical terms, that it has got in the way of where we need to share information and I think where that has needed to happen, it has happened, and that it has happened fairly and lawfully as well.

Q59. The Chairman: So which other entities do you have data-sharing agreements with?

***Ms Brayshaw*:** The data-sharing agreement from the Safeguarding Board covers all agencies and entities, so that is an umbrella process that covers everything in that. In our services particularly, if we are working in the area of child protection, then there is a requirement for information to be shared because we have a duty to make inquiries, and information should be shared with the Department on the premise of that duty. In all other matters, if the family are consenting to their information being shared, then that consent is the basis for the information to be shared with the Department.

Q60. Mr Perkins: Is the family kept abreast of all the information that you have on them? One of the things I remember reading somewhere is that some of the parents were actually denied that information and consequently they maintained that they were denied their rights because they did not know what information you had on them?

***Ms Brayshaw*:** Yes, they are entitled to all of the information on them, and I think we are in a better position with regard to subject access requests. There has been a big push practice-wide to ensure that key things are shared automatically with families, so testament reports, care plan information is shared with them. The same for children and young people, they are entitled to that information, and obviously from the age of 16 onwards a young person can determine for themselves who has their information and who it is shared with as well.

Q61. Mr Perkins: And what would happen if they dispute the information you have on them; if they did not agree with it?

***Ms Brayshaw*:** Yes, then there should be an investigation where they dispute that. Factual inaccuracies should be corrected; when it is a question of opinion, or difference of opinion, then we would resolve that by ensuring that every opinion is recorded on the file. Where that dispute is not concluded to the satisfaction of an individual, then obviously they have recourse through the Information Commissioner's Office.

Q62. Mr Perkins: Does this sort of thing arise because evidence is based on professional opinion, rather than on facts?

***Ms Brayshaw*:** I think evidence is a combination of facts and professional judgement as opposed to professional opinion. For the purposes of evidence, it has to be a professional judgement that can be properly evidenced, and of course it should be open to challenge as well.

Q63. Mr Perkins: Thank you.

So just going back on that once more, all the records would be made available to them?

Ms Brayshaw: Records are available to anybody who makes a subject access request. There is information that we would share automatically with families. There will be information that is redacted if it is not about that person specifically, or if somebody has not given consent for some

information to be shared. Again, it is a complex process of determining what is and is not shared, but anybody can make a request to have access to the information that we hold upon them, yes.

Mr Perkins: Okay, thank you.

Q64. The Chairman: We are going to move on to transition to Adult Services. Can you explain the process for young people transitioning out of care due to their age?

***Ms Brayshaw*:** Okay, are we talking about young people generally becoming care-leavers?

The Chairman: Yes.

***Ms Brayshaw*:** Okay. So, care-leavers, in the first instance, the support that they would continue to get would come through the after-care service that we commission from St Christopher's. Any young person who becomes an adult and transitions to Adult Services would need to meet the criteria of being vulnerable in some way, or requiring a specific service within Adult Services to be transitioned into Adult Services. Not all young people leaving care automatically require support from Adult Services. They are also in a position when they are 18 where they can self-determine what support they get as well.

For children with disabilities as they become 18, there is a formal process of transition into Adult Services that starts at age 14 and that process concludes by the time the child is 18.

Q65. The Chairman: So for Adult Services the child can be involved from age 14, is that what you have just stated?

***Ms Brayshaw*:** Adult Services are alerted to those young people from the age of 14 and they are kept abreast of the services that are being provided. Then, in the 12 months prior to them becoming 18, agreements over the transition of care and arrangements for that young person are made, where there is a role for Adult Services in that.

Q66. The Chairman: Okay, so the young person at the age of 14, so between 14 and 16, when they can make decisions for themselves at 16, are they aware of what is being shared with Adult Services at that point?

***Ms Brayshaw*:** They would be aware, yes.

Q67. Mr Perkins: Do you think this could be improved, the transition for the youngsters?

Ms Brayshaw: Yes, I think it can be improved and I think we have the perfect opportunity to improve it as we move into the new arrangements post-April next year and Social Care of Children and Families and Adult Social Care will become one care group, so I think the opportunities to improve that transition are there, certainly.

Q68. Mr Greenhill: And how would you see those improvements?

***Ms Brayshaw*:** I think we have to make the system more seamless. We have to start to look and reduce – there is a very clear difference in the level of service somebody might get in Children's Services to the level of service and what services are available to them as an adult. I think bringing families along to understand the nuances of a young person at 18 being an adult in their own right, and first of all being able to determine if they have capacity to make decisions for themselves, even though their family may be carers for them. We need to do more to understand the complexity of those situations that are going to transition, but I think that is the area where

we can look more at things like co-production where we can look more at where we give autonomy to individuals and families to determine what services they want after a person becomes 18.

Q69. Mr Perkins: And how does that link in with the Department of Education, or perhaps an apprenticeship? How do we help these young people progress in that respect? Are you getting co-operation from the various bodies?

Ms Brayshaw: Absolutely. If we are looking at care-leavers specifically, then obviously we have got the Corporate Parenting Group that meets on a very regular basis where all the agencies are represented and all of those areas are considered through the Corporate Parenting Group. The Department of Education has recently made a specific appointment that is looking at Children and Young People with additional needs, and also incorporate some key responsibilities to children and young people that have been in care, and I think that role is going to be really helpful in moving that forward.

Mr Perkins: Thank you.

Q70. The Chairman: Obviously you are talking about care-leavers – with regards to any of the families that have involvement with you, is there broader support to help families that have been involved with you to get the same level of support to look for apprenticeships, and working with Education, whether they are a care-leaver or not? What process is in place for families that are just under the services?

Ms Brayshaw: Right, I need to qualify what I have said because I am not saying that there are apprenticeships available in Education and that we are working with them on that, not at all; I think that is something that needs to be considered as an initiative and should also include the Department of Enterprise, as well as Education. But I think a scheme to look at any child or young person and how they are supported into their employment should be more readily available, which would suggest that it may not necessarily fit within the remit of the Department of Health and Social Care. Looking at that from a vulnerable young person's point of view, then the corporate parenting group is where that is being considered in the first instance.

Q71. The Chairman: I think you said there has been a new appointment, or a new role, and that is very specific, is it?

***Ms Brayshaw*:** It is.

Q72. The Chairman: And you will be working with that person within that group?

Ms Brayshaw: Sorry, yes, that is the Advisor for Additional Needs and for looked-after children and care-leavers as well. It is not a role specific to employment and apprenticeship; it is a role that is looking for advocating for the needs of those individuals and ensuring that with agencies within the Education setting, everybody is doing their piece to support them.

Q73. Mr Perkins: Thank you.
Just coming on to the parents' rights, etc. again, do you have specialist workers to explain things and offer independent support to parents on their own?

Ms Brayshaw: No, we do not. The only work we have at the moment is a contracted service through Adult Social Care which would provide support to any parent that was deemed not to have capacity in any procedures that we are operating. It is a gap that has been identified, and

moving forward it will be for Manx Care to commission a full-scale advocacy service that will provide that support both to children, young people and parents as well.

Q74. Mr Greenhill: Could you give us some insight into what rights parents actually have when dealing with Children and Families?

***Ms Brayshaw*:** In what respect? Obviously any parent has parental responsibility for their children, so they are entitled to be involved in the arrangements. It depends where we start on the process, so it goes back to the issue of consent and when consent does not apply in the work that we are doing. The principle that we should be working by is that we can work in partnership with parents where that is necessary and we can do that. Where that is not possible and there are significant differences in the family's position and the Department's position, then equally they have the right to challenge that, and most of those challenges would happen through a legal process and the use of an advocate.

Where it is a service that we are offering that depends on, if required, consent, then the family can withdraw their consent to work with the Department. We cannot enforce a service on somebody if we do not have a duty or a power to be involved with them, and the duties and the powers relate to the protection and support of children and young people.

Q75. Mr Perkins: Is that the same with foster parents as well?

***Ms Brayshaw*:** Well, the role with foster parents is very different because foster parents are approved and registered by the Department, by the agency, and there are certain fostering standards that, by law, they must comply with. So a foster parent does not have the same rights as a birth parent, not at all.

Mr Perkins: Okay, thank you.

Q76. The Chairman: So how would you describe the current working relationship with Children and Families and foster parents?

***Ms Brayshaw*:** I think we have gone through a very difficult time with foster carers and we have put constructive processes in place to start to rebuild those relationships with the carers that we have got. You will be aware that we have got a plan in place now with moving to a new way of working, the Mockingbird programme, and the reason that we chose the Mockingbird programme was because it fulfilled two of our requirements at the moment.

The first requirement was that we needed to achieve placement stability in fostering for children and that was not being achieved so children were moving very, very regularly between carers; and the second one was that we absolutely had to improve the level of foster carer satisfaction with the role that they were undertaking.

The evaluations from the projects of the Mockingbird within the UK and where it emanates from in the US demonstrate quite clearly that the Mockingbird programme improves both of those areas significantly. So that is the model that we will be using moving forward, and we hope to build on the constructive work that we have done with Minister Baker when he was the Children's Champion, and his independent report that identified all the issues for foster carers, and that has informed some of the planning moving forward. So I think things are improving.

Q77. Mr Greenhill: Do we have sufficient foster parents on the Island at the moment, and are they split between short-term and long-term?

***Ms Brayshaw*:** We do not have sufficient foster carers on the Island at the moment. From September we have launched a recruitment campaign which goes hand-in-hand with the move

towards the Mockingbird programme, so we do need to increase our sufficiency. There is a mix of carers and they can be approved for any number of children, obviously depending on their personal circumstances, the preferred ages that they feel they have the skills and abilities to work with, and in some instances whether it is long term or short term. In some instances, if they have children short term, they can become long-term placements if that is the right decision for the child as well. But we are in the process of recruiting more at the moment.

Q78. Mr Greenhill: And what is the shortfall at the moment in terms of foster parents?

***Ms Brayshaw*:** We anticipate that 75% of our looked-after children should be in a family environment, and at the moment that is sitting at 68%. In actual number terms, it is difficult to say because it depends on the ages of children as well, but I would roughly indicate that the shortfall is between 10 and 20 sets of carers.

Mr Greenhill: Thank you.

Q79. The Chairman: With regard to adoption services, can you provide an update as to where you are with that at the present time?

***Ms Brayshaw*:** Okay, so the key piece of work that has been ongoing in adoption at the moment is the new adoption legislation and the consultation on that with draft legislation has just finished. We are in the process of analysing the consultation responses, of which we had approximately 100, I think it was, responses to that consultation.

Adoption Services operate as part of the Family Placement Service and it is twofold. We offer a service to people who potentially want to become adopters, and we offer a service to children that require to be adopted. The numbers of children that require to be adopted are very small, they are anything between four and six per year on average that we are looking at adoption for as a position, and then we have to temper that and balance it with the number of people that are coming forward to be assessed, and how many it is realistic to assess, otherwise we have a backlog of people that can be waiting for a significant period of time.

Once an adopter is assessed, the process, when a child is ready to be adopted, there is a matching process. It is not automatic that whoever is assessed first gets the next child because there is a matching process between the needs of the child and the requirements of the adoptive carers as well. Potential adopters also have the opportunity of going over to the UK and being assessed by UK local authorities should they wish to do so, and some do prefer that as a mechanism because they would rather do it with no involvement from the Department or the Government on the Island.

Q80. The Chairman: How adequate has the legislation been for dealing with …? That is just one example that people would opt to go up to the UK, and obviously with regard to ongoing processes within your Department during COVID and virtual hearings and things like that, are you happy that you have had adequate input to the legislation to ensure that your services can continue, should there ever be a cause for it to be a lockdown or to have evidence from the UK? Are you content that you can receive the information you need and the legislation has come past you to make sure it is adequate?

***Ms Brayshaw*:** Yes. The Department has led the draft legislation and so has led that for everybody; it is not a piece of work that has been led by the judiciary. Should we go back into lockdown, the impact of that on adoption is obviously the movement of children and people between here and across would be restricted and there may be some delay in processes as a consequence of that. I think that is a practical reality that we are living with. That is considered on a case-by-case situation as to what should happen in those circumstances.

Q81. The Chairman: Just generally with regard to parental rights and access to children where there is, say, a court order in place and perhaps a family member lives off-Island, have you seen any impact on children with regard to that, or have they been given access to a parent that perhaps lives off Island?

***Ms Brayshaw*:** I am not aware of any specific circumstances where we have not been able to make alternative arrangements for any individual child or young person to have contact with people that they are connected with and are relevant to them. Obviously the virtual arrangements that we have available to us, that is possible where that needs to happen. I would not be advocating that as a method for introduction between a child and an adoptive family because that obviously needs to be done on a face-to-face basis, but where we are looking at indirect contact with a child and a member of their family that is connected and significant to them, then virtual mechanisms should be able to suffice until we can move back to face-to-face arrangements of people moving to and from the UK.

Obviously, it is a preferred position where face-to-face contact is needed, but obviously we need to stay within the restrictions to keep everybody safe.

The Chairman: Okay, thank you. The Committee will now sit in private and will resume again in public at 2 p.m. this afternoon.

The Committee sat in private at 12.16 p.m.
and resumed its hearing in public at 2.05 p.m.

Department of Health and Social Care

Procedural

The Chairman (Ms Edge): Welcome to this public meeting of the Social Affairs Policy Review Committee, a Standing Committee of Tynwald. I am Julie Edge MHK, and I chair this Committee. With me today are Martyn Perkins MHK, and Peter Greenhill MLC.

Please can we all ensure our mobile phones are off or on silent so that we have no interruptions. For the purposes of *Hansard*, I will be ensuring that we do not have two people speaking at once.

Today we welcome the Minister for the Department of Health and Social Care, Mr David Ashford MHK, and the Interim Director for Health and Social Care, Kathryn Magson.

EVIDENCE OF
Hon. David Ashford MHK; and
Ms Kathryn Magson, Interim Chief Executive Officer *(appearing virtually)*,
Department of Health and Social Care

Q82. The Chairman: For the record, I would like to begin by asking each of you to please state your name and job title and how long you have been in that role.

Minister, would you like to comment on the evidence provided by Debbie Brayshaw this morning as well?

The Minister for Health and Social Care (Mr Ashford): I cannot comment on the evidence provided by Debbie Brayshaw this morning because I have been in meetings all day, so I have not actually heard the hearing, Madam Chairman!

The Chairman: That is fine.

The Minister: I am David Ashford, Minister for Health and Social Care. I took up post, it seems like a lifetime ago now, in January 2018, and of course prior to that I was a member of the Social Affairs Policy Review Committee.

***Ms Magson*:** Kathryn Magson, Interim Chief Executive Officer of DHSC and I took up post on 8th January 2020.

Q83. The Chairman: Thank you. We are going to start with Social Services. How would you describe the DHSC's relationship with Social Services provision?

***The Minister*:** So, if I can come in first before Kathryn does, I think the actual relationship is very good. We engage very heavily in that area, there has been a lot of change in that area over the years as well. It is not an easy area of the Department because every single case is pretty much unique when it comes to Social Services; there are no two cases that are alike. So I know there have been frustrations in the past, but we have been working hard over the last few years to try and change things. There has been a lot of work going on in that area.

The Chairman: Kathryn?

***Ms Magson*:** Yes, I agree with the Minister, but in addition this work never stops; it is going to evolve. As part of the new governance structures that we have implemented within the Department, we actually have established a new Patient, Public and Service User Engagement Committee. Within that, we intend to also appoint patient, public and service user representatives. It is part of the work that is ongoing at the moment.

We intend to do that before the end of this financial year and that will move also into Manx Care as we go through the transition, so it will continue to evolve. It is something that is particularly dear to my heart, and I know we want to continue to progress it as we go through the coming six months and then into the future of Manx Care. So absolutely, progress made but more to be done.

Q84. The Chairman: Okay, how would you rate the success – how successful is the inter-agency working between the services?

***The Minister*:** That that is something that has been building, to be perfectly honest, it has been a building block; I am not going to try to turn round and say, 'It's all done, job done.' Far from it. There is a lot of work to go on in terms of inter-agency engagement. I think one of the things I commented on when I was a back bencher a lot and a member of this Committee, and also since I became Minister, is I always felt DHSC used to be very siloed. I think particularly in the social services side, it was *very* siloed. I think we have been breaking that down over the last few years. We have been engaging more on an inter-agency basis, but there is still work – it is still work in progress and there is still a long way to go.

Q85. Mr Greenhill: Is there a specific area or areas that you think that could really be improved?

***The Minister*:** I think in relation, particularly when it comes to Children and Families, in the connect between the social services side and sometimes the medical side – I think getting those two to connect together could actually be absolutely key. I think it is happening, but again it is something that is slowly building over time

Q86. Mr Perkins: And what about adults and children with disabilities?

***The Minister*:** Yes, obviously adults and children with disabilities are quite a passion of mine, and I know we have had several conversations around this area, Mr Perkins. I think, though, again there is work still to be done there. Again, it has been a section in past years where it has been out on a limb, out on its own, and they have just got on with their bits that they can do in-house; but I think one of the things I have seen certainly from my time in the Department is there is much more inter-agency working in that area now.

There is much more knowledge in that area as well, and certainly speaking to the staff on the ground, because that is always the measure for me. I can hear many great things as Minister coming back up to me, but for me it is the measure of the staff on the ground, who I think in the past themselves have been very frustrated about the lack of sometimes getting inter-agency working. The feedback I am getting is that there is a lot more than there was previously.

Mr Perkins: Thank you.

Q87. The Chairman: So I ask the Minister for the Department, can you get involved in individual cases? Do you have any role within that?

***The Minister*:** In terms of individual cases, obviously from time to time, should we say, I have the odd few people contact me about individual cases. I will always raise the query and I will come back to them. I never try and interfere in relation to that. We have to remember with Children and Families, particularly, they are a statutory service so you cannot have political interference in the delivery and the final outcome, but obviously if someone contacts me, I will raise the query through the appropriate channels to be able to get them an answer.

But it is very important that there is that delineation between myself as Minister and what are statutory functions within the Department of Health, and I cannot be interfering in the operation of someone exercising those statutory functions.

Q88. The Clerk: Can I ask a couple of follow-ups on that, Ms Edge? It is something that comes up quite a lot, as the Minister is aware. You say that as a Minister, you cannot impose a decision in an individual case because it is a statutory service. Is there any difference between that principle and the way it works on the health side of the Department?

***The Minister*:** Again, I would not impose my opinion on an individual case. One of the things I have always been very clear on as Minister is that I am not a clinician. I should not be involved in people's medical decisions on the health side: that would be completely and utterly inappropriate. Where I intervene, potentially is policy side, so you will see that while I make ministerial decisions around policy side, I will never attempt to override a clinical decision on the health side. I think that would be downright dangerous if you started getting politicians involved in that.

Q89. The Clerk: And where does the boundary lie? Because I think we can all understand a clinical decision in an individual case.

***The Minister*:** So I can tell you exactly, I can tell Mr King exactly where the boundary lies for me. The boundary, for me, between policy and an individual case is it is wider than that one case? Is it something like, for instance … I will give an example; one of the things I did by ministerial

decision was the access to the cystic fibrosis drugs. Now that is something that had been trial-tested, it is available in the UK and actually benefits a wide cohort of people. That is something I would get involved in. If it was someone who was having a specific procedure, while I may raise the case, find out where on the list they are, what any complications are, we have formal complaint processes in place, and if it looks like it is going to be a complaint it will go through that formal process.

Q90. The Clerk: And if it flips back – just one last, and then I will let the Members do their job – just if we were to flip back to the social services side of the Department, is there a similar boundary? In other words, there is something called policy and there is something called casework, but in between that I think there is something called operational policy. How you align the services, for example – is that exclusively an area for professionals or is it something where politicians can get involved?

***The Minister*:** Ultimately, if it is to redesign a service, it would come to the Department board, so that would include myself chairing the board and obviously the political Members if we were redesigning a service, but obviously we would receive recommendations from the professionals.

Ultimately, the way the services are run – outside of what is laid down in primary legislation obviously, because that that is there, that is fixed – would be a Department decision which would involve myself as Minister approving any changes.

The Clerk: Thank you.

Q91. The Chairman: Okay. Carrying on talking about a statutory service, an independent inspection of that and governance, so you would have input into the governance of that statutory function and also with regard to an independent inspection.

We heard this morning from Deborah Brayshaw that there has not been an inspection since 2017, and obviously we have had COVID, and she said that they were liaising with the Scottish Board. So when do you hope as Minister to have that independent review of that statutory function which you obviously do not have any direct input to?

***The Minister*:** From my point of view, I do need to clarify, Madam Chairman, that although I do not have direct input, so to speak, I do have an oversight role as Minister, so if the service is not complying with its statutory functions, then as Minister there is a role there for me to step in because they are not compliant with what they should be doing under statute.

In relation to the reviews, I am very keen on reviews, and particularly independent inspection. One of the whole points of what we are doing around Manx Care is to have that constant ability of independent inspection.

Now, Children and Families is an interesting one because, again, CQC does not do those functions, so that is why we have always said it will have to be a mix of regulators, but that is why we are so keen to press ahead and get that in place. COVID has thrown that, because a lot of the organisations, CQC included, quite understandably will not allow their inspectors to travel at this time, so that has thrown us back on that but we would hope to have it in place as quickly as possible; and that is across the whole range of DHSC services, not just the statutory services but absolutely everything.

The Chairman: So we have seen an independent review take place with the Department for Education, Sport and Culture during COVID, and obviously quite an extensive report. Is there any opportunity that you could do something to ensure that there is some continuity? Obviously Manx Care is not going to be in place until April.

***The Minister*:** In terms of that, I am not personally convinced that would actually offer much reassurance. I want to see more ongoing inspection. I think what you are talking about there, which is the Beamans Report for Education, that was on one specific issue that was occurring within the Department. We had similar in the Department of Health: we had Sir Jonathan Michael review that came out of that, so that was what I would see that sort of independent reporting doing.

When it comes to the services, be it Children and Families, Health, Mental Health, it needs to be continuous inspection regimes we put in place, rather than going out and commissioning someone to just come in and do a one-off independent review, because I am going to be quite frank now, as I always tend to be, we have seen loads of independent one-off reviews in Health over the years. When I was a backbencher, I was very critical of a lot of them, because what they did is they came in at a point of time, they looked at something, made loads recommendations, went again, but there was no continual oversight and that is what we need to get to.

So I would be very reluctant to go out and do one independent review that just gives us yet more recommendations. I would rather focus on getting in place the continual cycle of review, because that will tell us a lot more and give us a lot more useful information.

Q92. The Chairman: And when do you hope for that? Obviously we know that Manx Care is coming, but –

***The Minister*:** As soon as possible, to perfectly honest. I have got to be honest that COVID has thrown things, because we are reliant on the external organisations being able to put the stuff in place. It has knocked us back, but we are absolutely committed in DHSC to have that oversight in place, which hopefully was shown by the Manx Care Bill itself which, for the first time, actually puts independent reviews within DHSC on a statutory footing.

Q93. The Chairman: Okay, thank you. We will move on to mental health now: how has COVID affected Mental Health Services and waiting times on the Island?

The Minister: So in relation to the waiting times, we have seen some increases in waiting times. We have seen some more referrals as well. I will bring Kathryn in in a minute to talk maybe a bit more around this, but obviously it has been a difficult year for a lot of people. We went through lockdown. We have been lucky as an Island that we are not still there, we are not in the same position as the UK, but it did profoundly affect some people.

Many of the people it affected were people who were already known to the Mental Health Service, so it has been about giving that additional support and trying to find ways of working with people who may have already been known to the service, but it has been a frightening time and so we have seen some additional demand.

Q94. The Chairman: Okay, does Kathryn have some statistics on that as to increases for – ? I know when we previously talked about mental health in front of this Committee, we had the triage and you had your various stages, so can you do it by that or …?

***Ms Magson*:** So we are obviously looking at quarter 2 data at the moment, so really I am talking about quarter 1 in particular, but we have seen a significant increase. We have talked about it in this Committee as well. We still have the similar issues, particularly in Child and Adolescent Mental Health Services (CAMHS), and that is probably our biggest question that we are most concerned about. We have actually recently brought in some additional resources to support that as well, and including the service redesign pathway that is under way around autism.

It is a constant balance, it is a constant demand. We have definitely had a spike. We are aware of pressures more broadly across the multi-agency work around suicide prevention, so we are reviewing that and part of that new suicide prevention group, but then at the other end we have

also, in the process as part of our integration pilot, working on a suite of services that we hope to be able to wrap around Primary Care which will support early intervention. So it is a continuous challenge here, but, yes, undoubtedly we have seen a growth in demand around mental health.

Q95. The Chairman: And since the last time you were in front of the Committee where you were talking about additional resources, when you say yes, you have taken some on for CAMHS, have you taken any on in other areas? There was talk of third-party organisations being brought in to support; I think it was Ross Bailey, is he head of the Mental Health Services at the moment? (**The Minister:** Acting, yes.) Yes, so you were looking at some form of counselling services; have you bought any services like that online since the last time you were in front of the Committee?

***The Minister*:** I know we have been looking to bring in additional resource, but to be perfectly frank at this moment in time, it is a bit hard to recruit in relation to a lot of these services with everything that is going on in different areas. I do not know if there has been any success in recruitment, I will hand over to talk to Kathryn for that –

Q96. The Chairman: You talked when you were in front of the Committee last time that you would be using third parties rather than employing individuals yourself to try and deal with the demand?

***The Minister*:** But again, the issue has been access to those third parties, but … Kathryn?

***Ms Magson*:** Yes, the Minister is quite right. Clearly, there is only one finite hole here now. We do have a number of vacancies and we have progressed one particular area around psychological support, also taking on a locum in the last few weeks to look at waiting lists and to do some catch-up waiting lists around CAMHS, as I have just talked about. So, the recurrent funding position and our approach around well-being and early intervention and the counselling support that Ross talked about is part of our integrated pilot which we are expanding and has successively been approved, so we are rolling that out at the moment.

So, yes it is definitely still in train, still very much on our minds, and also we have been doing quite a lot of promotion around evidence-based suicide awareness training, 'Are You Okay?' campaigns, so Members will be familiar with that and the videos that are being promoted. So, quite a breadth and depth of things that will continue to work collectively either with other agencies or as ourselves as DHSC.

Q97. The Chairman: Okay, so have you seen any changes with the Drug and Alcohol Team services since COVID? Has there been an increase within the requests for services from the Drug and Alcohol Team?

***The Minister*:** I am not aware of any, but Kathryn might be.

***Ms Magson*:** I do not have those exact – again, the quarter 2 data. Quarter 1 was quite a difficult quarter for us, for obvious reasons, so really what we would want to see is what the quarter 2 position looks like, but we are seeing pressure on all our services, Ms Edge. So we should not underestimate that, not least because of a general growth in demand, awareness, but also clearly the backlog that has been created through COVID.

***The Minister*:** I know the caseload for the Drug and Alcohol Team, certainly as of March anyway, March this year was 334, if that helps the Committee at all.

Q98. Mr Greenhill: Has there been a similar growth in gambling addiction cases coming forward at all?

***The Minister*:** Again, gambling addiction cases, I am talking off the top of my head now, Mr Greenhill, but it seems to come in different spikes. If you go back through the data, that was something I was very interested in when I was a member of this Committee, and I seem to remember it spikes up at different periods; it does not necessarily have a smooth increase or decline. Gambling seems to be, because the numbers are fairly – one or a couple of people change the numbers quite dramatically, it goes up and down.

Mr Greenhill: It is just that during COVID people are going to be at home and often playing more that way and that was what I was –

***The Minister*:** I am not aware of any major increase in that area.

Mr Greenhill: Thank you.

Q99. Mr Perkins: Are you still sending people away for drug and alcohol rehabilitation?

***The Minister*:** I will bring Kathryn in, but I believe people are still travelling relating to that, as far as I am aware, Kathryn?

***Ms Magson*:** Yes, we do need to do it. We are trying to keep care as close to home as we can, and obviously step down individuals as needed, but yes, we do continue to do that either with block arrangements or on a case-by-case as needed.

Q100. Mr Perkins: And how many – do you know the figures off the top of your head or not? If not, do not worry. If you could let us know, that would be good.

Ms Magson: Perhaps maybe if the Committee would like to delve further into each of these specific areas that is completely fine outside the meeting, but yes we can certainly do. But again, it is going to be the trend in information; we are going to have to be really careful about looking at quarter 1 versus quarter 3, and actually making sure that we are taking certain things into account in how they explain the data. So yes, certainly we can provide some details around gambling and Drug and Alcohol services outside the Committee if that is needed.

***The Minister*:** If I could just add, Madam Chairman, I think as well we need to be very careful, as Kathryn has just said, with the quarter 2 data, because obviously that is feeding into when the pandemic started and lockdown. We really need to get the quarter 3 data and even what we are moving into now, and also even the full quarter 4 data when it is eventually available, which will show us if there is more of a trend or if it is a spike that went up and then went down. We will not really know that until probably around about April or May next year really, because in quarter 2 obviously you are going to see an increase in cases, particularly around mental health and so on, because that is when the pandemic hit and when people were the most restricted.

Q101. The Chairman: So do you think the current waiting times for Mental Health Services is safe for individuals?

***The Minister*:** I think there has been a lot of work in this area. We do work hard to ensure that people are prioritised. We mentioned when we last came before this Committee about the triage system. I have spoken, as you would expect, to quite a few families; some do not like the triage system, to be perfectly honest, they do not feel that works for them or their loved ones; but there are other people who feel that it has worked for them and that they feel it did speed things up and that when there was a decline in someone's mental health, they moved up the tiers and they were seen accordingly.

One of the big things that I think will be making a difference, and, in fact, the Chief Constable has said it himself is our joint working continuously with the Isle of Man Constabulary. That was something that I was very keen on when I became Minister. It was something we pushed very hard to keep it in place, so it was not just a trial. It was there permanently, and again, you can go … the best evidence is the people on the ground and the police officers have said to me, the police officers I have spoken to, that it has worked exceptionally well from their point of view because they now feel they actually have support there to help.

It has also, in some cases I am aware of, meant that the person has not had to be detained. They have not had to be shoved in the back of a police van, taken up to police headquarters, or even intervention in A&E for instance. The mental health professional has been able to deal with that on the ground, calm the situation down and the person has remained within their residence, and that has got to be a win for both sides; both the Police, who were not having to deal with something that, to be perfectly frank and I have been honest about this before, they should not be having to do as part of their day-to-day anyway, and also from the health service and the fact you have not got people going round the circle, as I call it.

Q102. The Chairman: So do you think that the current waiting lists are safe for individuals?

***The Minister*:** I think with the triage system, yes, personally, I do. I think the issue, though, is – because there is a difference between safe and acceptable – Do I believe that waiting lists are acceptable? No is the answer, and we need to do work on that; across a lot of our waiting lists, even on the general health side of it; that is work that is ongoing. So I just want to make the distinction there: there is a very big difference between me saying that I think the current waiting lists are safe because the triage system does ensure that if things change, then the intervention can be changed. But in terms of 'Do I believe the waiting lists are acceptable?' that is a very different question, and the answer is no.

Q103. The Chairman: Okay, so are we still sending people off-Island for mental health treatment? Are there people currently off-Island and –?

***The Minister*:** Yes.

Q104. The Chairman: Okay. And what is the pathway for individuals to that? How quickly can they get through the triage system to receive that really specialist help?

The Minister: Do you want to come in, Kathryn?

***Ms Magson*:** Yes, so it is a multi-discipline panel process and we have a number of … *[Inaudible]* some contracts, as well as a block contract, with providers over in the UK. What we try to aspire is that people get access to the care they need as quickly as possible, so a blend of different approaches, clearly the Crisis Response on Island, and Primary Care Needs as well, but also in-patient facilities on Island.

It is a panel process. Clearly we can commission spot placements as needed, and that is what we do. In answer to your earlier question around the waiting lists, our biggest area of focus, since we last spoke really, was around CAMHS. We talked significantly last Committee about the waiting list base, which are very heavily driven by autism, and I referred to that earlier on pathway development. But our aim, and I think going back to one of the very early questions, was about how they worked together as. Agencies. So this is not just about cross-Government agencies and voluntary sector agencies and other providers, but also within DHSC itself. So within Health and Social Care we have been working on a joint service model, where ultimately the aim is to address waiting lists as well as future needs. We have come up and designed, over the summer, a joint service model for mental health with Mental Health Services, and also women and children. It is

the tiered approach, and exactly as we have been talking about, we have discussed with around access to targeted communications at tier 1, to what you're talking about with intensive care in controlled hospital environments generally as we go across the water.

So those tiers and who deliver those is what we are trying to achieve here. For example, the role of the health visitor; how they have a role in promoting community working with children and their families, the role of school nursing in tier 2, the role of CAMHS in tier 3, and obviously in-patient beds in tier 4. So, we have a new model in place; that has been developed across both Social Care and Health throughout the summer. We are working at all tiers of provision in relation to its delivery, and, most importantly, integration of that, so it is seamless from a patient and a service user perspective.

We have a developmental journey between now and in line with transformation pathway around autism, so April 2022, which includes the specification and a procurement of a new delivery pathway in that particular case, but we intend to then implement all stages of this tiered model as part of our integration agenda. Ultimately, that is one example of what we are trying to address and the new way of working across integrated service provision, but it relates specifically to your question around how we are going to improve our times, as the Minister said, and the acceptability of those waiting times.

Q105. Mr Perkins: Is there a waiting list to get on the waiting list? *(Laughter)*

***The Minister*:** We have a waiting list. (**Mr Perkins:** Right, okay.) Sorry, Kathryn. Things have not gone as bad quite yet that we need a waiting list for the waiting list, I am happy to say, Mr Perkins.

Mr Perkins: Yes, I ask the question because the public perception is that you have a waiting list before you actually get on the actual waiting list.

***The Minister*:** No, I can confirm you are on the actual waiting list.

Mr Perkins: Okay, thank you.

Q106. The Chairman: Okay. Just to follow up on the Dickinson report, obviously in the last Committee we did talk about that and Manannan Court. Have you continued to see improvements?

***The Minister*:** Yes, the recommendations from the Dickinson report are being implemented as we mentioned at the last hearing, particularly around the step model that was mentioned in the report. I think one of the important things to focus on as well is, of course, in the Dickinson report he found evidence of good practice that he mentioned. It was not a completely damning report, he actually praised several aspects of the service, and I think it is important to put that on record as well. The recommendations that he made were sensible recommendations, and we have been acting on them.

Q107. The Chairman: And your capacity at Manannan Court at the present time, is it – ?

***The Minister*:** I do not have the current capacity figures in front of me. As with a lot of these services, you would expect it comes in peaks and troughs.

The Chairman: Okay, because again –

***Ms Magson*:** They will be around 96% to 97%, Ms Edge.

Q108. The Chairman: Okay, thank you. We will move on to off-Island care now. So how has our off-Island care been impacted by COVID-19?

***The Minister*:** Well, we have had waves of impact, should we say, because obviously when it first started, COVID, the UK's reaction was to basically shut down most services unless they were emergency services. That meant that we were restricted, so we tried to do more on Island, particularly around cancer, to try and help patients over here to get treatments that perhaps they would normally travel for. The oncology team stepped up exceptionally well over the period, as did all the teams across DHSC to try and help patients that could not necessarily travel.

The UK then restored their services as far as they could, but then with the second – I mean people talk about it being a second wave; it is not really a second wave, it is just an upward spike on the first wave because it never come down far enough to be a second wave, but that then impacted again because we have seen hospitals in the North-West starting to shut down services again, particularly because of the bed space where, and particularly elective surgery, where there their capacity now is about 96% to 97% full.

So there has been an impact in terms of that, but in terms of emergency treatment, we do need to be absolutely clear that we are not just reliant, although we use Liverpool and we use the North-West, we are not just reliant on them; we could send patients elsewhere, we could send them to Birmingham, we have access to other areas should that be required.

Q109. The Chairman: Okay, so do you think any patients have suffered significant deterioration in their health or prognosis as a result of being unable to access off-Island care?

***The Minister*:** Most definitely, I am not going to try and shy away from that question. I am sure there will be, but it is not just off-Island care. The fact is obvious – again, we have got to be honest, we had to restrict services over here, particularly around elective surgery, so there are people who may have required hip replacements, other things, that they could not have done, so their situation and their quality of life has declined over the period. We are trying to get back on to our elective lists over here and we are seeing an increased capacity pushed through in that area.

For those that were referred into the UK, like I say, I think in relation to cancer treatment, the oncology team over here really stepped up to the mark to go out of their comfort zone in trying to keep things going, but I think anyone who says COVID has not had an impact on patient care is burying their head in the sand. So I am going to be perfectly honest on that: when you are in the middle of a worldwide pandemic, unfortunately, there will be other areas of patient care where people have suffered

Q110. The Chairman: One of the concerns that have been raised, certainly within the public domain, is with regard to the way patients are receiving bad news when they have had tests done. It seems to be phone calls, perhaps from an oncologist or from whoever is the representative of the service. Do you think that is an appropriate service at the present time, bearing in mind that our hospital is open?

***The Minister*:** It is judged by the clinicians how they deliver, should we say, bad news, good news, as to what is the best receptor for them. I have not heard the reports of that, I will be perfectly honest, so if you have any information on that, Madam Chairman, I would happily take it away and take a look at it. But how news is delivered is the same at GP level as well, which is at that clinician's discretion. They tend to know their patients better than most.

We are all different, aren't we? Some people would take a phone call fine, other people will be absolutely floored by it and would want to be told, bad news, face to face so that they can ask questions and be directed to different areas. But I think how that is communicated should be a clinical judgement on the point of view of how the patient will take it.

Q111. Mr Greenhill: There are a number of people who, via patient transfer, go across to specific hospitals for annual scans. Is that continuing now or is that effectively on hold until such time as that can be replaced?

***The Minister*:** Some have been undertaken, but again we are beholden to the UK system. In some areas, obviously they have shut down their services, so we have not got access to that. But for those that can, they are still travelling as normal.

Mr Greenhill: So whenever that particular hospital is prepared to, and can, accept people, that –

***The Minister*:** Then it will extrapolate back.

Mr Greenhill: Okay. If not, they will just have to wait until –

***The Minister*:** Yes, and again it is one of the unfortunate things about being in a worldwide pandemic. There is always going to be those delay.

Q112. The Chairman: With regard to waiting times for the individuals that are on, perhaps, UK lists, how does the Department monitor for those individuals? So you are already referred into the UK system, you have got your NHS number for the UK; over here an example is that of most appointment letters, people are receiving one saying it is cancelled and it is moving on about three months. How are you keeping track of the UK referrals and the individual?

The Minister: I would bring Kathryn in on this one, if I may?

***Ms Magson*:** So at the moment, we receive information from the UK that is relatively limited, it is fair to say. It is generally activity-based; we take our assurance in the way that we look at our contracts over there in relation to the totality of the position, and therefore most of the UK have a slightly different approach around waiting times. As we know, they have the 18-week pathway, and clearly that is monitored significantly over across the water. It is fair to say that the waiting times are better than they are in the Isle of Man in a number of specialties, although in a number of areas we have made significant progress ourselves with particular specialties that have taken some innovative solutions in how they might approach different waiting times – for example, dermatology.

So it is the totality of the assurance of the provider as a whole that we would take, and that is how we monitor, but we should not forget, as the Sir Jonathan Michael report talks about, we have an enormous amount to do around data, recording information, and that includes not only our own provision, but includes how we monitor other providers, how we receive information, how we build the commissioning and contracting space in that space, and then ultimately how do we monitor all parts of the pathway, specifically as we are moving towards more integrated pathways on a network basis between on-Island provision and off-Island position, so it is very much part of the Transformation agenda as well as the here and now.

Q113. The Chairman: Okay, and obviously there are patients in the middle of this, and I think key is communication. How do you feel the communication is currently with the individuals? If you are feeling the data is not that great with responses for people getting treatment off-Island, how do you think the communication down to the individual is? Could that be made better in any way?

***The Minister*:** I think we can always improve communication, if I can come in first? I think it is better than it has been in the past. A few years ago communication across the Department out to

patients was absolutely appalling. There are still breakdowns on occasions, I am not going to try and claim the world has now revolutionised and everything was wonderful, but we do need to work harder at communicating with patients, and we are working on that.

The Chairman: With regard to –

***Ms Magson*:** I have had a couple of instances but to be honest, I have been quite impressed with the relationship – we obviously use a key number of providers across the water so it tends to be where it is providers that we have not necessarily used in the North-West, and that may well be for different reasons. We have a lot of relationships with North-West providers and they are part of our discharge processes. The relay of communication with those patients that need to be discharged into Noble's because they cannot go into the community is strong. We have a complex patient transfer co-ordinator, that works extremely well.

So actually, there are always, as the Minister says, ways that we can improve, but in the main, those discharge protocols – my perspective is from what I have seen, and I am not aware of any particular trend that does not suggest that that is not working as it should need to be.

Q114. The Chairman: With regard to joined-up systems – I am not saying it is happening at the present time, but certainly historically, people would arrive over for hospital appointments in the UK and their information records/scans could not be viewed. Is that more of a joined-up approach now?

Ms Magson*:** Yes. (The Minister:*** Yes) There is more work to be done, and actually it works *vice-versa*, so the consultants that come over to the Island to deliver a part of a network solution with the North-West providers in particular have access to records when they are on-Island. So we are particularly focused around the cancer records in that respect.

More to be done, but again, we have got an interface, we encourage individuals to communicate accordingly with their consultants and the patient interfaces within those hospitals directly, but we are always happy to help with any issues that people have.

Q115. The Chairman: With regard to on-Island, so a GP accessing your hospital records, that still seems to be a bit of a barrier. Is that progressing in any way that they would be able to access both systems?

***The Minister*:** My understanding, although Kathryn might correct me on this, is it requires a legal change for them to access between both because I remember when I raised it when I first became Minister, it is the fact that the hospital record is under GDPR theirs, and the actual surgery record rests with the surgery is my understanding.

Q116. The Chairman: Has that legal change been …? Have you managed to look at doing that? Is it secondary –?

***The Minister*:** I know that we were looking at ways we can combine up into a single patient record, but I do not know where that was, but that was certainly the impression I was given when I was Minister. There was a requirement for legal change, I do not know if Kathryn knows any more on that? She is going to tell me that I am completely wrong now!

***Ms Magson*:** So it does, Minister, so particularly around some of the prescribing. This is a very complicated ask, and it is … actually is an Island, we would hope to be forthright in our thinking around how we might come up with innovative solution. We do need an integrated care record, absolutely and undoubtedly. It is part of the Transformation Programme. There is now one being produced and we are working on … at the moment at DHSC, but also collectively with the

Transformation Programme. There are a set of deliverables that move towards that. There is a business case that has been prepared, it was actually prepared a little while ago. It is currently being refreshed at the moment as part of that strategy and its delivery. *[Inaudible]*

The Chairman: You have just frozen. Could you just go back a little bit?

Mr Greenhill: We lost you a minute, that is all!

***Ms Magson*:** Tell me I have gone back far enough; so it is quite a complicated process of which we will need to procure a solution, but the work has begun, the strategy is in place. The initial business case has been developed and needs to be future-proofed as part of an integrated provision, as part of our Sir Jonathan Michael delivery of transformation. But it is not a quick fix, this is going to be a multi-year programme, but we do have an enormous opportunity not only for health, but I would also want to add around social care as well.

Clearly, there are mechanisms in place that exist already, for example, in the way people view diagnostics, for instance. But actually we want … this needs to be, if we are going to go for an integrated health and care delivery model, then we need an integrated IT solution, and it is very much at the forefront of our thinking.

Q117. The Clerk: Sorry, I think we might have lost a bit at the very beginning of that answer. The question was: the Minister says you need a legal change; is that the case and has it been done?

***Ms Magson*:** Yes, in some parts of this we will, yes.

Q118. The Chairman: So has the drafting of that happened, or is it something that you could have (***The Minister*:** Not to date.) done in the Manx Care?

***The Minister*:** I think the plan is for it to come forward in the NHS Bill that we have got later, which is the follow-up to Manx Care.

Q119. Mr Perkins: While you are at it, can you include transfer of information for family services from across the agencies? Or is that one step too far?

***The Minister*:** Well, actually, I am very glad you have raised that, Mr Perkins, because this is one of the wonderful myths that seems to go round about GDPR. It was myself and Mr Thomas that took the GDPR legislation through the House of Keys, and there always seems to be this myth that it prevents people sharing information.

There is no bar on agencies sharing information if they are acting in good faith for the best interests of the patient. There is absolutely no bar in that regard under GDPR for agencies sharing data. In fact, actually, they have more of an issue if they do not share and something happens. There is nothing to prevent agencies from sharing information between themselves and DHSC and beyond, as long as they do it in good faith, believing that it is in the best interests of that patient or service user.

Mr Perkins: Thank you.

Q120. The Chairman: Just to be clear, you have done a business case to try to get an integrated database for an individual's medical care, but we have not done anything about moving forward with the legislation, so you could get the business case approved, but you have not actually got the legislation in place to be able to operate it once it you have got it.

***The Minister*:** We have to be very clear about what we are talking about when we say a business case. In terms of an IT system this would be huge. This would mean removing a lot of systems that are currently in DHSC because we have a lot of legacy systems and combining up, so it is not something that is going to be switched on overnight. We need to be absolutely clear that even if this business case is approved and the system develops, we are talking years down the line before everything is going to be in.

If I come from my IT background for a minute, you have got to be able to keep the existing systems running alongside, you cannot just shut them down overnight and data-dump because you are potentially missing something that is happening in certain people's records. So there is an awful lot from an IT side to do that to pull it together, so it is not going to be an overnight system. We are doing things in line, in terms of legislation, with the Sir Jonathan Michael review, we have got the follow-up Bill which will be in the life of the next House that is coming forward, and we will not have an IT system before that legislative change is done. I can guarantee that.

Q121. The Chairman: But it is quite critical to the individual, so is it not something that can be achieved so that GPs can see hospital records? I am sure there would be an awful lot of time saving, and –

***The Minister*:** My understanding is it is not a simple change, it feeds into other things, and that is why it needs to be done as part of the NHS Bill. (**The Chairman:** So what have –) So it is not a one-line Bill or something like that, it is wider than that. But at the moment there is nothing, as I mentioned to Mr Perkins, to stop GPs sharing information with the hospital and *vice versa*. It is just the fact that records are not combined up at the moment.

I will give a prime example. I think I have probably got the most widely publicised leg cyst on the Island, at the back of my kneecap. I went to the GP to begin with. The GP then referred me to the hospital, and they shared the data, obviously, backwards and forwards, so the hospital has done their bit. They shared it back with the GP, the GP shared when they referred me in, and that works, but what we want is to get to that single record point, so we are not talking about the fact that there is this great big brick wall between the hospital and the GPs, they are able to communicate and share data; what they do not have at the moment is a push-button system where they can just access it. We need to be clear on that.

Q122. The Chairman: Could they not have access to both systems?

The Minister: Not legally at the moment, is my understanding.

Q123. The Chairman: Even if the patient gives permission?

The Minister: My understanding at the moment is we need legislative change in order to facilitate that.

The Chairman: Okay, thank you.

The Minister: The patient could obviously – well, they do not need the patient's permission to contact the hospital to get information, but to have live continuous access to the system would require a legislative change, is my understanding.

Q124. The Chairman: Just seems if there is too – many of us have worked in IT where you can sit with two systems operating; you have said yourself that you have to have them running in conjunction. Surely a GP could have a hospital system and their own –

***The Minister*:** Well, we also have to remember the status of GPs in this, because GPs are effectively a private organisation contracted by the Department of Health and Social Care.

Q125. The Chairman: Okay, thank you.

We are going to move on to staffing now. How would you describe the current culture and morale of the DHSC?

***The Minister*:** I will be honest: I think it is mixed. In some areas we have seen an improvement. I have spoken to quite a lot of frontline staff; there are quite a few who are very happy about the development of Manx Care. I do not know if it was this Committee or another Committee I spoke to when I mentioned that, when we first had the Sir Jonathan Michael review, there was a bit of cynicism out there because there were people who had seen report after report after report for many years, and who were quite honest with me and said, 'Oh come on, David, it is just going to be another one shoved into the cupboard to collect dust.' Now they have actually seen some movement on it, they really believe that the change is coming.

There are other areas in the Department where we still need to do more work, but it is an ongoing process. With culture, as in any organisation or any business, it is a continual job. It is not something you ever get to the point where you go, 'Oh that is the job done, we can all sit back now and relax, isn't everything wonderful?' It is a continual process; it involves communicating with staff, it includes listening to staff, and it also includes making them feel included within decisions that are made and that they understand why decisions are made.

For instance, I think an example I have used in the past is if someone comes forward with an idea, it is not just important to recognise that idea and say, 'We will have a look at that.' If, for whatever reason, there is a perfectly good reason you cannot do that, it is just as important to go back to the person and explain why you cannot do it, not just that it disappears into the ether somewhere.

Culture for me is an ongoing one, we will never hit that sort of heavenly peak where the job is done. Culture is something 24/7, 365 days a year that you have got to be working on.

Q126. Mr Perkins: You have quite a few key workers coming in from off-Island. How have border restrictions affected that?

***The Minister*:** In terms of DHSC, obviously, we have had the key worker pathways to allow workers in. There has been an impact in the fact that some obviously will not travel because of the issue in the UK, but generally most of the people we have … and obviously when we had the first lockdown, there was a restriction around certain services in the UK, so we were not getting the people over as much as would maybe like in some areas, but generally we have managed to get, in DHSC, the people that we require.

Q127. Mr Perkins: Have you had any complaints about people coming in for a couple of days and then going back to the UK without quarantining, for example consultants?

***The Minister*:** No, I have not. I am not aware of any of that, no case of that has been brought to my attention. You have to remember these people are medical professionals, so they know more than ever about the impact of this virus, so in fact, they are probably the more responsible ones because they have seen it first-hand what this virus does. They do clean their hands, they do keep their distance. Even when they are working in the UK they are very much aware of what is going on around them.

Mr Perkins: Thank you.

Q128. The Chairman: What proportion of your staff currently are agency workers?

***The Minister*:** I will hand it to Kathryn for that, I am not certain.

***Ms Magson*:** Ms Edge, it varies per service, and clearly we have bank and agency. We have seen a reduction in our agency spend, and an increase in our bank spend. So overall, the position is improving and clearly some individuals make a decision that they would prefer to be on the bank rather than being in full employment. It varies per team. We have seen an improvement, but it is one of the biggest areas that causes the largest overspend, particularly in Noble's or secondary care itself.

Q129. Mr Greenhill: Can you quantify in any way that sort of improvement that has gone on, in numbers or …?

***Ms Magson*:** I could probably give – I would have to give it to you outside the meeting. (**Mr Greenhill:** That is fine) I was thinking about it more in finances rather than the people themselves.

The other thing I want to say is that we are doing quite a lot of work at the moment to understand what should be to treat baseline position, so that includes the way we describe 'safer staffing', particularly around the nursing complement, for instance. When we have used a number of tools we would be ready to tell what the true position would look like, and that applies to whether it is waiting list initiatives or whether it is just management of wards, or in different parts.

At the moment we are monitoring it financially and then, when we have completed all of this work that we need in relation to our base case, then we are determining what that might look like and come to what we call a 'safer staffing' model across a variety of our services. But it does vary; Children and Families have made significant progress, they are well below 50%. But in some services, say there are only two people, it is 50% because one of them is an agency worker, so it is a continuous thing here. We have significant work to do, but we are going to be constantly challenged around smaller services and also ensuring what we can deliver on and off the Island …

Mr Greenhill: Sorry, you have gone into freeze mode again.

Ms Magson: Can you hear me?

Mr Greenhill: We can now.

***Ms Magson*:** Yes, so we are very much monitoring it financially at the moment because the size is so big for us to address, and then, as we get closer and closer to these models, what it will look like, then we will start to manage it according to the numbers. That is where we are in the timing, but the position is definitely improving.

Mr Greenhill: If you could give us something outside the meeting that gives us some idea of both the money side and the people side, that would be very useful. Thank you.

Q130. The Chairman: With regards to nurses' training on Island, and obviously finishing their qualifications, I know during COVID you brought some of them forward: did every single one that received the nursing qualification subsequently get a job within the services?

***Ms Magson*:** We are continuing to improve that further. We would like to encourage as many people as we can to remain on Island, that is part of the work that we do. I know Kath Quilliam from a director of nursing perspective is very proud of the work that she undertakes here and how we can expand that further. So yes, that is my understanding.

Q131. Mr Perkins: How much reliance do you put on the third sector agencies?

***Ms Magson*:** Again, it varies service by service. We have had to have more reliance because of COVID. So again, probably goes back to your previous question, but it is difficult to point at one point in time. It is a constant moving feast, and we very much look at the trend in the position rather than necessarily where we were today, for instance, so that is how we do it.

Q132. Mr Perkins: A lot of these third sectors operate on charitable giving, and we know that through COVID that has dropped away. If they disappeared off the scene, would you be able to cope?

***The Minister*:** It would cause difficulties, I will be perfectly blunt, depending upon the organisation. There are some organisations that do more than others, but one of the key things we are going to be moving to with third sector organisations is more of a contractual basis, and I think that is quite important, because previously it has all been around grants. We are in a lot of cases, but we are moving with Manx Care to contracting services. That will be an absolutely key step change, so the organisation knows what they have got to deliver and we know what we are commissioning, so there is no confusion then.

But certainly, yes, we do have third sector organisations providing services on our behalf and that is quite the right thing to do. I think you have probably heard me several times, Mr Perkins, say we should not be thinking that the DHSC is the right place to deliver everything. There are organisations out there that are closer to the people on the ground that know the needs of the people out in our community, and if they have the ability to offer the service then we should be commissioning them to do so, and in many cases they will do a better service and cheaper.

Mr Perkins: Thank you.

Q133. The Chairman: Okay. I want to touch on GP services. Obviously, one practice closed down and you were moving the patients. Have we still got an issue with recruitment to GPs on the Island, or are we at capacity, are we under-capacity? How are we dealing with it?

The Minister: I will bring Kathryn in first, if I may, Madam Chairman? And then I will come in afterwards.

***Ms Magson*:** Yes, we did close, obviously, the prom, and we have had since then, although we successfully transferred those patients over to another practice, we have had a number of pressures most recently in a couple of … *[Inaudible]*

The Chairman: Sorry, you are breaking up again

***Ms Magson*:** Can you still hear me okay? Can you hear me now?

The Chairman: Yes.

Mr Perkins: Would you like to turn off the video and just go on sound? It may be better.

***Ms Magson*:** Is it any better?

Mr Perkins: To start with, yes. *(Laughter)*

***Ms Magson*:** Okay, I will start again. We did move several thousand patients from one practice successfully to an extent without any cause of concern around transition. I would like to thank the practices that were involved in that. Then also, we have had a couple of other instances over summer which gave us cause for concern, which were relatively personal decisions for individuals,

which we have managed, as I sit here at the moment, to work with the practices to fill. We have a number of new recruits starting and also a different blended workforce model.

But this is an enormous issue, and this is probably the tip of an iceberg that we need to try to resolve more consistently as we move forward going into the end of this year and into next year. There is a finite pot of GPs, we are not alone in these issues Some of them are funding issues that we are working with GPs on, but also there are some changes that we need to take a closer … way that services are delivered and commissioned.

Some of those relate to what we call 'enhanced services'; services that sit more in the community which will not only improve patient care in relation to how they access services, but also will strengthen the appetite for other GPs to want to come and move to the Island. But we are also looking at, as part of the changes and the pathways, other different types of workforce models, so advanced nurse practitioners, clinical pharmacists, first-contact physios. All of these have evidence-based improvements in the way that care can be delivered and also resilience of the practice workforce, and it does not just also apply to GPs; across the whole of primary care, optometry, pharmacy and dentistry, we are having all the same conversations.

We are working across Government to try to encourage people to come to the Isle of Man and we are going to need to have an attractive solution in order to future-proof this very critical and important service delivery model. So as it sits at the moment, we are very focused on ensuring that we have a recruitment and also retention plan. GPs can retire much earlier here on the Isle of Man than they can across the water, and we need to encourage people – we would like to encourage people to stay as long as they can in practice.

But this is all part of a whole journey. It is all part of a whole new story for the future here now, in the way that there is an enormous opportunity to deliver integrated care. We clearly want Primary Care to be at the heart of that model for patients, but also how opportunity exists for GPs and other practitioners in Primary Care to get involved in different stages of an integrated care pathway, and they might develop specialisms that, ultimately, on a small Island we are able to offer that others may not be able to do.

So we are going to have to think of lots of different approaches here in order to be able to respond to the challenge, because there is no magic bullet and we are going to need to develop all of those to maximise the opportunities and the advantages of working on the Isle of Man.

Q134. Mr Perkins: I hear that one of the problems is with GPs that the Crown indemnity does not extend to the Isle of Man. Have you done any work on that at all?

***The Minister*:** We are doing work around that. We have been negotiating with the GPs for quite a while in relation to the indemnity policy. I do not have anything I can announce here today, but I think progress has been made and I hope that we will have a proposal we can put forward that I hope will be acceptable to both sides.

Mr Perkins: Thank you.

Q135. The Chairman: Has there been an increase with the Manx Emergency Doctor Care (MEDS) services, and certainly the A&E services? I can speak from experience myself, having sat in A&E on a couple of Saturday nights. It does appear to be getting utilised as a GPs' practice at certain times of the evening. What work and what progress are you doing there with regards to: has there been an increase in the referrals, the out-of-hours to GPs, and then the same is happening within A&E?

***The Minister*:** I will bring Kathryn in in a minute, but yes, we have seen an increase in A&E attendance. In some cases, it has been stuff that would generally have been dealt with by GP practice. I think at the moment it is going to take a while for people to settle into the new regime

with GPs. People have been presenting to A&E, but we are doing pieces of work around that, and I will bring Kathryn in.

***Ms Magson*:** MEDS itself has been … there are peak pressures, absolutely, but it is pretty static in what we have seen as the activity –I am talking post-COVID now because there is significant … *[Inaudible] …* so it took the slack and also of the development of 111. Ultimately, it is all part of an integrated solution around how urgent care is accessed.

The Minister is quite right: we have seen the biggest spike in ED referrals, so people turning up rather than phoning MEDS themselves. That is where we are feeling the most pressure. Now, some of that is a blend of late presentations as a result of COVID, some of it may well be down to access issues, or perceptions around access issues, or clearly then a greater demand itself, and clearly we are in a particular period now where we go very firmly into the winter, so we would expect to see that is the case. But we are under significant pressure there; we are pretty full on a day-to-day basis, I would say, and our admissions are significant. There are … presentations that are in the right place, so we do monitor this carefully, clearly.

What our Transformation and our pathway solution, which we are also focusing on, is an integrated, on-the-day, urgent access pathway, which includes not just the emergency department, but all the different elements of it and making sure that we have, effectively, one access point. Individuals then can go up and down the pathway as they need, and at the same time that makes sure that we utilise our resources as best as we can, not only the pressures that sit in Primary Care, but the pressures that sit in ED, and how we make sure that the right people get to see the right individuals for that on-the-day access.

Clearly 111 is also serving its purpose in that, clearly was established for COVID, it is still working in that way, but it is also part of that solution. Urgent and Emergency Care is a definite Transformation pathway; we have a worksheet located to it, an SRO within DHSC is working with the transformation team, and a clinical lead in the Emergency Department is also going to be taking the mantle in leading those changes through. So, definitely something for the future and definitely some progress we can make in how we integrate all of those services.

Q136. The Chairman: Do you think there has been a significant increase due to the changes with moving the MEDS away from the same building? I will give you from my experience: people were arriving and it was quite clear that they thought they were going to the GP rather than to the Emergency Department, because previously they were housed in close proximity. Do you think that is where you have seen a peak, and is that purely – it was because of COVID that you did that restriction I believe, but – ?

***The Minister*:** No, I do not personally think that one of the reasons. I do not think the human behaviour has quite worked in that way, but I do not know if Kathryn has anything to add on that?

***Ms Magson*:** We are not seeing that. We are seeing, for the reasons I listed, admissions, so a rise in admissions as well, so that would evidence that individuals are going to the right places. Ultimately, we do need an integrated solution; we have moved MEDS back on to a hospital site as well, but, as we talked about earlier with some of the patterns and trends, quarter 1 is an incredibly different quarter for us, and then quarter 2 stabilises so we see what the pattern looks like. What we do know is we definitely need an integrated, urgent, on-the-day solution for the Island, and that is absolutely part of the work stream that we need to deliver, and then ultimately how that message is communicated and how people access that, and there is always room for improvement there.

Q137. The Chairman: Just to add, I am not sure you will have the statistics, but whether you can provide them? You said you are seeing an increase in admissions. Do you have statistics as to whether people have been discharged and re-admitted within a 48-to-72-hour period?

***The Minister*:** I am not sure if we have it, but I am certainly willing to take it away and see if we do, and if we do, we share with the Committee.

***Ms Magson*:** We do not have readmissions with us, no.

Q138. The Chairman: Okay, thank you. So, COVID-19. We know the Minister does, virtually, a weekly briefing on this, so we are going to be quite brief ourselves! What would you do differently if the pandemic occurred in the future?

***The Minister*:** This is always the interesting question, isn't it? With the benefit of hindsight, if it was COVID- 19 again, I think one of the things we have that is very different is that we have increased testing capacity now in-Island. We have to remember that the decisions taken at the time were taken with the background that we had very limited testing capacity on-Island, we did not know at this point the true extent of what we were going to face. We had seen what had happened in Italy, we had seen what had happened in Singapore, we saw it coming as a wave.

Our knowledge of COVID-19 and how it works and interacts is massively different, so I am not sure it is something I could really do with hindsight now, because one of the things I would change is the way Government communicated at the very beginning, but I think I have stated that publicly. The first few press conferences I thought we were quite clunky, and I think we got it right after that, but in terms of the medical response to a pandemic I think you have to look at what was available to us at the time.

I think the clinical teams, the public health teams and, like I say, the DHSC staff on the ground and all those community workers out there as well, the response was absolutely phenomenal. They did what they needed to do, and we have to remember it was a very scary time for them as well. They did not have any secret knowledge that we did not have, and they continued to work and they continued to deliver. So, I am not sure in that sense there is anything I would change because the actions we took were in relation to what was happening at that particular time.

Q139. Mr Perkins: Do you have idea how this is going to affect your budget? Obviously you have had to put a lot of resource into it.

***The Minister*:** It gives me a chance to praise our Treasury colleagues because they have had the COVID Contingency Fund, which we will be applying to, obviously for the stuff such as Personal Protective Equipment (PPE) that we have been sourced from around the world that again the team is very good at. It will be completely impossible to strip out every COVID-related cost within the Department's budget, but at the moment the Department's budget picture, I do not want to curse it now, but it has become pretty stable.

Certainly Treasury has been very supportive of the Department. They have not really, COVID-related, turned around and said no to us on anything as such. They have been exceptionally supported. They have made funding available, and that has made things an awful lot easier in our response.

Mr Perkins: Excellent, that sounds good.

Q140. Mr Greenhill: If we believe some of the press that is coming out today regarding vaccinations, I wonder if you have opinions between the two of you about what effect that might have and when it might have, and is there anything you can help us to understand?

***The Minister*:** As a politician, I am never short of an opinion, so I will now come in first, if I may, Madam Chairman, for Mr Greenhill's question? Then I will bring Kathryn in.

I have always been quite clear in public that people should not see vaccination as a silver bullet because there are limitations in vaccination. You do not go from a situation of one day you have

not got a vaccine, the next day you have got one and everything is fine; you have to roll it out. Across DHSC we have been developing a logistical plan, and by goodness, it is a very big logistical plan because you have to have the roll-out.

The vaccinations have to be kept at low temperatures and it will come in batches, so I think I have said publicly before that if we are going to do a rollout, we will focus on front-line workers, medical workers, and then move to the vulnerable categories. It is not going to be an overnight process; that if there is – and you know how cautious I am – I still need to emphasise an 'If one does get authorised' rollout. It is looking optimistic, but until we physically have it in our hands, I am always a bit dubious there. It is not a silver bullet to anything, but certainly, in the longer term it is a game changer if it is there and available. Kathryn?

***Ms Magson*:** Yes, if it is okay, may I answer a couple questions there? If you take vaccinations first, then, as the Minister says, there is an SRA for that programme work. We are well linked in to the UK, and we have a workshop across Government, actually, tomorrow afternoon to work through some of the more logistics. We get new information on a weekly basis. We understand the characteristics of the front-runners, and ultimately we will do as much as we can to plan as and when, as long as the go-ahead is given.

There are enormous implications here, not only about exit strategies and how we measure this, but also in actually how we administer and receive and logistically manage the vaccination and ultimately a potential legislation change. All parties are involved, all parties are briefed and we will clearly be communicating with the public as we know more, but it is not a magic bullet. This is going to be in answer to one of your questions: we still feel like we are managing COVID. I say it must have been great news with the success of the management and the containment and elimination strategy on the Island. Despite the issues that everybody has faced getting to this point, even from an operational perspective maintaining this is a constant daily challenge for us and I really do not want to underestimate the work that the team do. What we have done and reflecting back and you asked the question 'What would we do differently?' – operationally, we have already done a questionnaire with our staff to ask them how might we approach this differently, and as a management team in particular how might we go about that. So there are different ways that we can improve communication; things were moving very fast, clearly at the time back in March, April, May and June.

We have already started to think about how we might make some changes further around on the shop floor, particularly around visibility with some of the middle management, senior management and the executives around to ensure that people are aware of those decisions and how they are consistently messaged. So that is one particular learning that came out. There are a variety of different things, but we are going to do what we can to try and improve that as we go through winter, and ultimately as we are seeing a few more cases at the moment. So we are going to constantly learn.

Operationally, the other issue for us are the practicalities; we are going to do as much as we can to try to keep elective capacity open. We have referred earlier in the session about harm and individuals waiting lists and we are absolutely cognisant of this, we have talked a lot about mental health this afternoon, but we should not forget client care waiting lists within Secondary Care whether it is on or off-Island. We have a plan in place to try to keep elective capacity going for as long as we can, but we have to manage the third dynamic here now; previously it was elective and winter, now it is elective, winter and COVID. Our plan does do that with the capacity that we have built, the infrastructure we have built and all the investment that was made, but it is going to be a difficult challenge and I do not underestimate it, but we are going to do what we can to make sure that we keep people safe and we manage all of those three different domains as we go through now, certainly through to the spring period.

The last thing was a question particularly about COVID expenditure. The Minister referred to, yes, we are within our … *[Inaudible]* position which was agreed by Tynwald in July. We have had considerable support in relation to COVID Contingency Fund, that support is about £7 million. The

majority of that is in relation to PPE, and Members will know that we spent a considerable amount of time and investment right at the front-end, building our own supply chains around PPE and, actually, consequently we had a good supply, which meant that we were able to support all delivery partners across the Island, and we still have that supply now and will continue to keep those supply chains open. So that was where the majority of our expenditure has been, but actually, the way that we have worked has changed considerably.

We talked earlier about tests that come on and people that are coming into the hospital and how they are managed. Well, actually, ultimately we have invested in all of that. We have now invested and are testing a pre-operative testing strategy and there is a self-isolation element of that. All of that did not exist. The Covid Assessment Unit (CATU) is another example, that did not exist. So it is very difficult to lift out what is the recurrent position and what was the pre-COVID position, but we know definitely there will be an impact and we are clearly, as we go through the next six to 12 months we will be monitoring that underlying expenditure carefully and working with Treasury.

Q141. The Chairman: A question that has come up quite often with residents is, why was Ramsey Cottage Hospital not considered as a COVID …? Previously with TB and things like that, there were infirmaries set-up. Was there an actual strategic reason why you would not have thought to use Ramsey Cottage Hospital for that rather than using it for the emergency …?

***The Minister*:** Yes, I would say yes. The reason being that COVID patients, depending on what happens to them, require access to a wide range of medical services. You can have COVID patients who are absolutely fine and then deteriorate very quickly. You do not want to be transferring them from Ramsey down to Douglas to ICU in the event of that happening, whereas within Noble's if you had someone, say, on the COVID wards that we had earlier and they deteriorated, where they went from, say, needing oxygen therapy to needing full-on intervention, they could be very quickly transferred from the ward into ICU.

We also know that with COVID-19 that it can exasperate underlying health conditions. So again, it might not be the COVID that causes problems, but they may have issues with underlying health conditions so they may need to be seen by other sections, such as oncology, etc., very quickly. So, the ideal place is to have them at the main hospital site, not in an offshoot area, because you do not have the same access to medical services, and in some cases you could be talking very quick intervention. I do not know if Kathryn wants to add anything.

***Ms Magson*:** The Minister is quite right, what we did is try to put more services into Ramsey to maximise the opportunities to provide other services. So we are currently running fracture services and also trauma and orthopaedic (T&O) services, and obviously we had the Minor Injury and Illness Unit (MIU) and expansion of … part of that on-the-day access rather than individuals coming to ED. We are currently also using Ramsey for stepdown in relation for winter to avoid pressures on our capacity at Noble's. So, it is absolutely at the forefront of our mind to make sure that we maximise that opportunity, but in a slightly different way.

Q142. Mr Perkins: I think I asked the Minister a question in the Keys the other week, or it may have been at Tynwald, I can't remember, about cataracts? (***The Minister:*** Yes). Is that one of the … you were mulling over where you were going to join them, eat away at the waiting list for that, was that one of the things you are thinking of putting up to Ramsey?

***The Minister*:** With the cataracts, it is more around resource. It is more around having the resource to do it, rather than where you do, so with the cataracts it is more about getting that resource in so that we can bring the list down.

Mr Perkins: We have had quite a bit of public backlash on the list on that. It seems to be growing, and obviously it is a thing that we need to really focus on, if we can.

***The Minister*:** It most definitely is. I think in answer to your question, Mr Perkins, I made it clear that the two areas that I felt were the big pinch points is cataracts and also orthopaedics. They are the two that we need to concentrate on to ensure that things can be dealt with, because in both cases it is only going to go one way. Someone is not going to wake up one morning and suddenly go, 'My eyesight has improved, hallelujah!' Same with hips and joints, you are not suddenly – says me as I am hobbling around! – you are not suddenly going to wake up one morning and say, 'Everything is fine, I am fully improved, I am coming off the list now.' It is important we actually get the resource in place to be able to address both of those.

Q143. Mr Perkins: One of things I would like to mention is the fact that you have come up trumps with the diabetic monitors: you know how concerned I have been about that over the years, I have been mithering you about it and I really thank you for the latest news release on that. Have you any thoughts on extending it to type 2 diabetics?

***The Minister*:** Not at this stage. The diabetic monitors have a very defined role. We must be very careful, because there are even some types of type 1 where the monitors may not be suitable for them. I think the evaluations, when they were done in the UK, were that they are not really that suitable for type 2. Type 2 is more management and managing each issue, whereas obviously for type, there is no way of managing it; you have it and you have it for life.

They are not really designed to be used in that sort of area of type 2, and you have to be careful that you do not do something that is actually quite dangerous for people. We know that there are no plans at this current time to roll out to type 2 because that is not really the sort of area they are designed for. They are designed for the type 1 who have it for life and their situation is going to change.

Mr Perkins: Thank you.

Q144. The Chairman: The Minister will remember my motion on type 2 diabetes and lifestyle choices, and the commitments from the Department to make sure that there was more highlighted to the public with regards to the health benefits and changes to diet and things like that, that could help with type 2 diabetes. I know we have had a pandemic this year, but certainly last year we did not and I did not see a lot of information about that. Is that something that you are still going to continue with?

***The Minister*:** Well from memory, Public Health did quite a bit last year around the healthy living aspect. It is something that would fall under the Public Health remit from my point of view, and I know that the Director of Public Health is very much engaged in that area. I do not know what is going to be in her report this year, but I know certainly it is something that is very high on her agenda around the healthy living. It has featured in several of her last reports in one way or another, and I am sure that will go forward. I do see that more, and that is one of the good things with what we have done with Sir Jonathan Michael: we have separated out the Public Health element, it has gone into Cabinet Office, and it gives them more of a wide-ranging remit. But that is something I would see more as a promotion of Public Health than I would necessarily of DHSC that is supposed to be the day-to-day delivery of the services.

The Chairman: But obviously you will work together.

***The Minister*:** Well, cross-Government working, you know my views on silos, Madam Chairman.

Q145. Mr Perkins: One of the things that is going to happen, I think, after the COVID situation, is we will get a lot of post-viral problems, and I assume it is similar to ME post-viral type illness. Have you focused in on that, this long COVID thing? How we are going to tackle that?

***The Minister*:** The long COVID is quite interesting, because the big problem is, again with COVID, that it interacts with the individual differently, depending upon the person. We are seeing – when I say we are seeing, I am talking worldwide now – we are seeing very different types of things, so it is not just people feeling fatigued, that is one element of it. I have a friend in the UK who had it back in March, and if they go even a few steps they are feeling absolutely exhausted. They have lung damage, which is something that is emerging.

There is also a thing which, some people may have heard me refer to, the rather delightfully entitled sticky-blood syndrome. We are seeing thickening of blood to everything like, and he would probably kick me for this for mentioning it again, the sort of milder thing like the Chief Minister's had where his taste and smell has not returned after it. The studies on long-COVID are still, should we say the jury is still out, I think, is the way to put it. There is guidance by NHS England and Public Health England being drawn up. We are paying close attention to that, and we will obviously monitor it.

The other thing we need to be very careful of with this is that we do not just put it down to someone having COVID because there are many symptoms that could be largely seen as long-COVID that actually might relate to other illnesses. Certainly, I have been contacted by people who were determined that because they have got a certain thing wrong with them they have had COVID, when there is no evidence they have, and it is very important that we do not fall into that box of just saying, 'Oh well you may have had COVID at some point' and that we do not investigate other alternatives as well as to why people are having that particular thing, that there might be a problem with their lungs, there might be an issue with blood clots that are nothing to do with long COVID.

So it is getting that fine balance, but we are looking at the guidance that is emerging around the world. There are some very good stuff starting to emerge from NHS England in that area, but it is still very early days so we need to be very careful that we do not do something that is actually a detriment to people.

Mr Perkins: Thank you.

Q146. The Chairman: Just on waiting lists again; you have talked about orthopaedics and cataracts but with regards to the other areas, particularly cancer, has been in the press over the past couple of weeks. The performance is out there and you reported that in the answer to the question. What can you do to rectify some of that situation?

***The Minister*:** One of the things we have to do is engage with our partners in the UK and try to get back on track. We have been hit by COVID, which has thrown out the waiting times. We need to try where we can to see what we can do additional resource-wise to support the services, but I would love to be able to sit here and say there is going to be a quick fix to it, but there is not.

Q147. The Chairman: With regard to an individual on-Island getting that two-week referral, it is not necessarily a referral to the UK, that seems to have slipped significantly as well. So is that something that is in your control?

***The Minister*:** We have had, certainly in one area of cancer, we have had staffing issues which I think you are aware of, Madam Chairman, so there have been various things like that, but we are working hard, again, to try to get back up to where we were pre-COVID.

I do not know if Kathryn wants to add anything in there?

***Ms Magson*:** Yes, there are a few things here, I suppose, for the planned care perspective, before I go to cancer. Clearly, the issues that we are facing are not just a COVID issue; it is a pre-COVID issue. Many of the pathway transformations that we have spoken about and are part of the programme are meant to sustainably help resolve that as well, so it is in that context, plus then you add COVID, which has then amplified that. So our starting position really needed to improve, but what we are trying to do is, pathway by pathway, look at what we can do. We have already made some changes around endoscopy, for instance, with a third room opening, and some extra waiting lists that we actually started this month.

We are doing a deep-dive around trauma and orthopaedics. The Minister has talked about ophthalmology and then also EMT, and in that I am also considering options around outsourcing. Clearly, that is going to be restricted in the UK, but there are other options. So those conversations are happening, we are doing what we can to try and improve that, but ultimately we are talking about, for the future sustainability here of our planned care pathways and waiting times, very much new pathways and how we manage care in a different way in the community before secondary care is needed and ultimately to reduce the level of secondary care referrals that do not even need to go there in the first place.

If you take ophthalmology, we have agreed with the ophthalmologists to go live on our new minor eye service in the community. A number of those ophthalmologists are training. We are going to train the rest of the profession between now and the end of the financial year and then go live with that service, which will stop people going to ED.

The Chairman: Okay.

***Ms Magson*:** If you take then the cancer … *[Inaudible]* you would be aware in relation to the Minister's answer to Tynwald that actually, yes, we have seen a deterioration certainly since COVID. We did start to see some improvements in 2019-20, and we are regularly reporting our brief position that is available – these stats are available on the internet. But we have had a clear backlog of … *[Inaudible]* endoscopy suspension during COVID. We have seen a significant increase in the two-week waiting referrals. Previous to COVID, we would have about 50 a week; we are now at two a week, and then … *[Inaudible]* for which are planned but in reality do also create pressures, particularly when there are resilient services that are reliant upon, say, a commission coming over from the UK, and the obvious then around the delivery of that at the moment – Breast Cancer Awareness Month, for instance.

So for the right reason, we are seeing a record number of new suspected cancer referrals, but at the same time, with existing capacity that is coming over, we have then have to try to manage that within the two-week wait programme. Patients will continue, and it is our absolute priority within the cancer pathway for patients to be seen as soon as possible, but at the moment in some areas that may not be within the 14-day target and consequently we do have a knock-on with the 31 and the 62. It is a very close area that we work with, and where possible we are using whatever options that we have with Clatterbridge, which includes telemedicine, particularly as we go throughout the winter and clearly the constraints around capacity in the UK is also and will continue to bite for us.

So definitely one of huge focus within the Department and will continue to be so.

Q148. The Chairman: You have talked quite a lot about the Transformation Programme. Obviously we will finish this session, just asking you a few questions on that. Can you provide an update and what progress you feel – are you comfortable with the progress that has been made, or would you like to have seen it a bit quicker? What is your main aim within the Transformation Programme at this present time?

***The Minister*:** I will come in first. I am exceptionally impatient, I would like to see it all done right now, but I have to be a realist. I think the Transformation team are making good progress.

One of the important things we stated at the very outset of this – this has been something that has slowed down some of the things, but it is very important. As we said, this has to be something that involves the people on the ground, not something done *to* them. That is, I think, a very critical distinction compared to some things that have happened in the past. That means that the people on the ground who know the services have to be involved in this redesign as well; it is not just something for the Transformation team to do. The Transformation team can guide, assist, but they cannot physically do it all.

Now, obviously people have been busy with other things over the last few months. That has slowed down some of the pathways, but there is pathway development going on. The first seven, I think, of the pathways have been designed up now within the Transformation team. We have the Manx Care Bill progressing. We will have Manx Care in place on time – unless something goes horribly wrong in the Legislative Council and then with Royal Assent. No pressure, Mr Greenhill! Then we will have Manx Care in on time for the new financial year.

Then from there, we will develop. We have always said with Transformation, it is not something that is going to be done quickly. It is going to take several years for everything to be put in place, but the team has been working hard. They have been engaging well with the various service areas and things are moving on at a pace.

I do not know if Kathryn has anything else to add.

***Ms Magson*:** No, I agree. I think there is an enormous amount. It might not always necessarily be visible, but actually we need to recognise that even just getting to the Manx Care and the delivery of that change, there is still an enormous amount to do. It is not just about Manx Care; it is about reframing of DHSC in that. So that is just one of the work streams.

There is then all the legislative work, the regulation work, the pathway work, the air bridge, IT – all of the different things we have talked about. But we are one team, we are working closely with the Transformation team. In fact earlier on today, there was a joint discussion around a stock take which we regularly have of all the pathways, as an executive management team, and within DHSC we have an executive lead alongside the transformation lead. So it is very much a joint approach.

As the Minister says, it is really important, and certainly I do in my weekly communications to all the stuff is trying to translate one of the programmes into what that means down on the ground in reality to individuals. Yes, we would like to have gone quicker. COVID clearly, from an internal perspective, put us behind in that. But I do think we have caught up and I do think we have made significant progress. I think the art of the ask is still considerable and one of the things that we need to make sure that we do is that there is not … This is a longer-term programme here now, the Minister has talked about the cultural changes, taking people with us, and therefore this is a multi-year programme, not just something that is about 31st March and 1st April and the establishment of Manx Care.

Ultimately, as we develop an integrated system, collectively with the DHSC, then that is really what this is all about. It is about a sustainable platform, and it is financial and it is clinical, and it is a work force, and a number of things that we have debated here this afternoon, which all of those work streams go to support. We need to continue to maintain that rigour around the pace and I do think that rigour exists, but there is a finite number of people doing this as well, so it is going to need to be balanced in recognising how much we can actually do, particularly when we have certain things on our plate that we were not expecting to do in the first place.

So yes, I am comfortable with the progress we have made, still lots to do, and it is very much a long-term journey, would be my message.

Q149. The Chairman: It is clear that, and obviously you keep stating that it is a move towards – clearly there are people on patient pathways currently, on old pathways, not moving to new. Are there not going to be any delays for those individuals whilst you are waiting for your new pathway, depending on what the services that is required?

***The Minister*:** In a word, no.

Q150. Mr Perkins: Okay. You have changed things in the Western Wellbeing set-up. How is that going?

***The Minister*:** It has been going very well. I answered a Question, I think it was in Tynwald on it recently, where I laid out some of the statistics. I will emphasise again what I emphasised in Tynwald: although the number of referrals might seem low, you have to remember that normally they would have been four or five referrals. The number would have been higher because they would have been referred into multiple different services. It is the fact that it is a single point of contact that means it is one referral.

The feedback I have seen from people using the service has been excellent, from the practitioners themselves, and from the third-sector organisations as well that have fed in, that have felt it really is multi-agency working, and across the board. So we are now looking to roll it out into the south of the Island, which is the next area, and then, after that, we will be looking at the east and the north.

In terms of the integrated care, I think one of the key things, and we have said this all along, is that it will be tweaked slightly depending on the area we are in. Although we are a small Island, we have very different communities and different parts of the Island, so something that necessarily works in the west might need changing for the south, or adapting for the north, but the people on the ground who know what they need are the practitioners that are there and the organisations out in the community and the patients themselves. That is what integrated care allows us to do; it allows us to deliver community services closer to the community.

Mr Perkins: Thank you.

Q151. The Chairman: A general question really about GPs' services: there is significant concern in the community that there is a lot of people moving to the Island and then they are trying to get onto waiting lists at GPs for services. What cross-checking does the Department do to make sure that an individual has got a genuine contract and has actually moved physically to the Island, and they are not just on a contract within an internal family situation?

***The Minister*:** My understanding is the way the system is set up, you cannot actually physically be on both a UK GP list and an Island GP list. I will bring Kathryn in about what we do as the checks, but also I am not aware personally of any evidence of large numbers of people moving into the Island. I know there were rumours that went round, particularly around property sales, but I can say that after, as a Government, we checked with the estate agents that around 95% of property sales are local.

Q152. The Chairman: What about rentals?

***The Minister*:** Again, we have no evidence that we have seen, or certainly I have not seen as a member of the Council of Ministers, evidence of an increase in people coming into the Island to rent.

Q153. The Chairman: Have you had an increase in people trying to register with a GP since COVID?

***The Minister*:** Not as far as I am aware, unless Kathryn has some information that I have not?

***Ms Magson*:** No, I am sorry. Maybe … *[Inaudible]* … but I am not particularly aware of that either. There are always temporary registration policy processes, but they are consistent with the

UK as you have described, and we use the NHS spine accordingly to match that and we would have a reconciliation programme on a regular basis to check registrations, so it has not particularly come to our attention, I have to say.

Q154. The Chairman: Just one last question for Kathryn with regard to your plans for returning to the Island; are you actually classed as a key worker?

***Ms Magson*:** Technically, I am not a front-line worker; ultimately I could be, but I would be subject to the 14 days' continuous self-isolation. Clearly the importance of what we have done is try to manage risk in relation to individuals that come over in the way that they deliver services and obviously depart. So my job is predominantly, as you can see, is management of the Department which is not on a front-line basis, but ultimately I am still able to do many parts of my job in relation to the way that we can interface with the community, interface with patient groups, interface with staff, and mechanisms to do that.

Directly, in delivery of front-line services I am not a resident, clearly, on the Island and was on a rotational basis. So, in relation to my presence, I would like to be there as soon as I possibly can, but ultimately conscious that we are leading by example and making sure that we are managing risk.

***The Minister*:** Can I just come in as well? Sorry, Madam Chairman. Can I say, I think Kathryn has been an absolutely excellent CEO of the Department. She has been engaged across the board. No way when she accepted the job could she have ever expected a worldwide pandemic to fall in the middle of it either, and I must actually say, I know at the time there were some Members concerned about the idea of the CEO who was partially on Island, partially off. I actually think if we had to hold up a blueprint for how remote working works, Kathryn is it from my point of view.

Q155. The Chairman: Okay. So with regard to your interim appointment, I cannot quite remember when that started. Have you still got a significant time for that?

***The Minister*:** Kathryn will answer better for me, but I think – is it January 2022?

***Ms Magson*:** That is quite correct, Minister, and I am looking forward to coming back as soon as I possibly, practically can. Absolutely a key priority for me.

The Chairman: Thank you very much. The Committee will now sit in private.

The Committee sat in private at 3.45 p.m.

7th December 2020

Evidence of

Mr Graham Clucas, Director of Quing

STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

MENTAL HEALTH

Douglas, Monday, 7th December 2020

PP2020/0246 **SAPRC-MH, No. 1/20-21**

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Members Present:

Chairman: Ms J M Edge MHK
Mr P Greenhill MLC
Mr M J Perkins MHK

Clerk:
Mr J D C King

Assistant Clerk:
Ms G Phillips

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Standing Committee of Tynwald on Social Affairs Policy Review

Mental Health

The Committee sat in public at 2.08 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MS EDGE *in the Chair*]

Procedural

The Chairman (Ms Edge): Welcome to this public meeting of the Social Affairs Policy Review Committee. I am Julie Edge MHK and I chair the Committee. With me today are Mr Peter Greenhill MLC and Mr Martyn Perkins MHK.

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

EVIDENCE OF
Mr Graham Clucas, Director of Quing

Q1. The Chairman: I would like to welcome you and thank you for coming to talk to the Committee. We have invited you here today because we would like to talk to you about mental health on the Isle of Man. To begin with could you please state your name and tell us a little bit more about the background as it relates to this subject?

Mr Clucas: My full name is Mr Alan Graham Clucas and I am the founder and director of the local mental health charity called Quing.

I have what is called the 'lived experience'. I have been through mental health, I have been through drugs and alcohol, I have been through the prison system and I have also been through probation, and I have been in prison on-Island and off-Island. So in many ways I have the T-shirt.

Q2. The Chairman: I do just need to declare to the Committee and to the public that I do attend some of the Quing meetings and keep up to date with the work of the charity.

Please could you tell the Committee a bit more about Quing, including how and why it was formed and the services that you offer?

Mr Clucas: Quing is a very modern expression of mental healthcare. We do not actually describe ourselves as a mental health charity because instead of siloing problems we look for people's strengths, and if you look for people's strengths … you do not see the problems and the problems fall away.

At the moment we do four distinct different projects within Quing: one is, we are in the process of becoming an accredited therapeutic community with the Royal College of Psychiatry. We are

an accredited education centre, offering bespoke qualifications in peer mentoring and trauma-informed care. We hold a social space where people who have nowhere else just turn up and can have conversations with people who are training to be peer mentors; or just anybody else. The last thing we do is we are a peer-led community, which basically means people learn they have a safe space to experiment and get it wrong, in their aim of getting it right in the future.

We are part of the international ABCD movement, which is Asset-Based Community Development. We are part of the Lived Experience Recovery Organisation movement, which is an international group of like-minded organisations, based around the work of Dr Ed Day who is the recovery champion to Westminster, and he is one of the founding fathers of that. We are part of the Community of Communities, which is a membership organisation of the Royal College of Psychiatrists and we are in the middle of a three-year process of being accredited with them.

Q3. Mr Perkins: How would you describe your relationship with Government?

Mr Clucas: What relationship?

Q4. Mr Perkins: Okay, thank you.
Do you feel there should be much more assistance in some ways?

Mr Clucas: From my perspective, I have felt bullied and I have felt ignored. I have been stood upon and so have the community members. We invited Mental Health down a few months ago and I was utterly shocked at how they treated us. The maturity of the members of Quing surprised me; but there was a professional and another politician present when Mental Health came down and they were horrified at how they treated us.

Q5. Mr Perkins: Right.
I understand that you offer health training for professionals?

Mr Clucas: We have tried more than once to offer to healthcare professionals, but we have always been ignored.

Q6. Mr Perkins: Nobody from Government attended at all?

Mr Clucas: No. Really interestingly we have had more world experts over – that is in community building and modern mental health practices. They have been award winning. One of the organisations we had over in March was given an award by the Houses of Parliament for their work on reducing suicide nationally, and nobody from Mental Health or the Prison service came down.

Q7. Mr Greenhill: Could you expand a bit on the bullying and ignoring you, without too many specific examples, where I am thinking about the sorts of things that were happening that have left you in a very difficult position?

Mr Clucas: The Sir Jonathan Michael Report, I had quite a lot to do with the team who were organising it. The person who was meant to be the third-sector liaison completely ignored me and in the end they had to send me the invitation – so I had to go around.

Another really interesting, non-specific … this is actually more about the membership rather than me and we only found this out last week. One of our members had been working towards a work placement with Mental Health, a permitted earnings scheme, it was a step back into employment. They had been working towards this for three months, and they went down on Monday last week to find out where it was up to, and without any conversation, 'We have taken you off this scheme and we have given it to someone else.'

When we talked about it, it was like she was being punished because she was coming to Quing. Where is the safeguarding in that? This person has a history of mental health problems, a history of suicide and they can just get rid of her like that.

Q8. Mr Greenhill: On the aspect of bullying, can you give some background to that at all?

Mr Clucas: With the bullying, it feels from my experience that if I just nodded and said the right thing there would be funding available. If I shut up and did not talk about trauma-informed care and practice, if I did not talk about proper community building I would be accepted within the cohort of things that happen. If I say something, I have been threatened to be sued.

Quing is part of the BioMed group, and I was asked to give a presentation around what Quing was about and the latest thinking in mental health. Motiv8 emailed me the next day and said if I said anything … They surmised, from the slides that I released, what I had talked about. I had an email a couple of days later threatening if I said anything ever again that they would sue me.

Q9. The Chairman: That was Motiv8?

Mr Clucas: That was Motiv8. And from the same set of slides my ex-key worker, which was highly inappropriate, contacted one of our off-Island suppliers basically telling him he should not work with us, because he surmised from the slides that I had said this.

I am a trained professional. I am a member of the British Association for Counselling and Psychotherapy (BACP). If I knew that one of my ex-clients had said something that I disagreed with, if I wrote to one of their off-Island suppliers, I would get kicked out. There is a complete lack of accountability within the staff of Motiv8 and Mental Health.

Q10. The Chairman: You have said a couple of times, from what you have talked about, that you do not feel they recognise you because you are from Quing. (***Mr Clucas:*** Yes.) You have given examples of what you have perceived as bullying.

Is there any other reason that you can see from that? Is it because you are trying to do training?

Mr Clucas: I will give you an example from my own life. It makes me smile, this example.

I went through the mill: I have been sectioned, I have been to prison and I have had more diagnoses than I care to remember. Because of my own journey I have moved around quite a lot over the last 15 years, and every time I go to see a GP there is a set process you go through: you pee in a bottle and you go to see the practice nurse. Every time I go to see the practice nurse it is the same conversation. They test to make sure I have diabetes and then they go through my files, and they start looking at what is in my files and then comes the question: 'I see you have been diagnosed with schizoaffective disorder' – bipolar and all the other things – 'but I see you are on no medication', and they start to move away from me. 'So, have you learnt to manage your symptoms?' 'No, I am healed.' 'People like you do not heal!'

In the model that the medical profession use, people like me do not heal, it is a chronic disease that I will suffer from all my life. I am the lived example that their model is wrong. Their view of me is: 'He's just Graham. He's the guy with all those problems.'

Q11. The Chairman: So from your Quing experience, and you talked about recovery, what have you experienced when you have sold it as a recovery package to try and gain support?

Mr Clucas: From my perspective, because we are not a medical model we do not get any support. We are not run by doctors, we are not medical. They have tried to copy what we do.

At the moment they are talking about setting up a recovery college on the Isle of Man. They came down to talk to us about our experience and then told us, 'We're not going to fund you; we're going to set our own up.'

Q12. The Chairman: Can I just ask, when you say you are setting up a recovery college, who is …?

Mr Clucas: Tania Linden, who is a senior member of the Mental Health team, and there was another woman whose name I cannot remember. They came down about three months ago and we talked, we explained what we do and then they said, 'Okay, that's all right. We're going to set up something very similar to what you're doing already.'

Q13. The Chairman: So were they looking at you as help and support for that? Or do you think they were just establishing …?

Mr Clucas: I am born cynical, unfortunately, and my experiences have proved my cynicism is more than often right. So they came down, they were quite condescending to what we did; then we went up and we talked to them. Then about a week later I got a message from one of the Quing members saying: 'I have just got this Facebook message from an organisation I am with, which was basically Mental Health offering a group of people with lived experience exactly what we offer groups with lived experience.'

So they came down, they looked at what we were doing and then a group who we had had a few conversations with said, 'Mental Health have offered to raise this money and to pay for counselling and to train us to be peer mentors.'

Q14. The Chairman: So do you think there is going to be duplication?

Mr Clucas: Oh, the duplication within Social Care, within the medical model and with the third sector on the Isle of Man is utterly ridiculous. We have been doing asset-based community development for the last three and a half to four years on the Isle of Man. We have spent £100,000 of charitable money building a community at a community level – not at a third-sector level, actually on the street. That is where community happens. Community does not happen in charities, they become *proxies* for community. We have been working on a street level. We worked all the way through COVID. We have been training people around the Isle of Man for four years, nearly.

There was a tender that went out about six weeks ago, the Department of Health and Social Care were wanting a 'community co-ordination …' which is basically a different term for a community building. We did not even get a sniff at it. We will continue running our community building, but why set something up to compete with something that is already existing? Why not just help fund what is already going on?

Q15. The Chairman: Have you queried that? Did you meet all the criteria? Did you get feedback?

Mr Clucas: There is no feedback unless you challenge the decision, and my experience is there is no point. We applied for it. We are the only organisation in the space for peer mentoring and have been for three and a half years.

Q16. The Chairman: So from your experience of peer mentoring over that three and a half years, can you explain to the Committee what it means and what success can be achieved?

Mr Clucas: Can I just draw you a quick little diagram?

So, you want to change mental health, offending and addiction? Natural healing. You do not have to medicalise it, you can have *natural* healing.

You build five things into people's lives: one is social capital, which is healthy relationships. The next one is cultural capital, which is an understanding of the culture we live in; that is the dominant

culture. The next one is personal capital which is emotional intelligence, education levels and those personal attributes. The next one is material capital, which is the physical resources you have, which is housing, which is the food that you can afford and which is access to transport. The last one is what we call political capital, which is how much you feel you are in control of your environment, and what choices do you have. If you build that into someone's life they will change and they will heal naturally. That is what we specialise in.

I have some testimonials of these with me. I think I most probably have 20, which have been put together over the last couple of weeks. That is what we do. We go into people's lives, so they no longer have to be on benefits and they no longer need to be in Mental Health. In fact it is all about key performance indicators these days. Our key performance indicator is not lessening of symptoms, it is about active citizenship and people getting back into work.

Q17. The Chairman: Do you have or can you share any – not individuals, but the success? So, say you had 20 people, what is your …?

Mr Clucas: I actually have written permission to read out all of these, so what I am going to do is when we do this – and we have been collecting these for quite a long time. So we ask five questions on each testimony and the first one is a short paragraph to explain: your background; how you are trying to cope or get support in the past; your experience with Quing; why Quing worked for you; and where you are today. The last one, where you are today, we also ask: if you had not found Quing, where would you be?

Q18. The Chairman: If you could just select some of the themes –

Mr Perkins: Without the names. Thank you.

Mr Clucas: Yes, there are no names involved, they been anonymised, so that is why I am okay to read them out. Here is one for you:

> 'I have been in the Mental Health system since 1987. In all that time, it feels like all they did was heavily medicate me most of the time. I have lost count of the times I have been hospitalised. I have found engaging with Mental Health over the years really hard at times. Many years ago, there was an amazing doctor who really helped me and was really easy to engage. My mental health rapidly improved when I was under him, but since he left I have been passed from doctor to doctor and all they do is medicate me and my mental health has slowly got worse and worse. This is like I have a trap I have been in for years and I need to get out of.'
>
> 'I have been diagnosed over the years with loads of different things: autism, bipolar, schizoaffective disorder, panic attacks, severe anxiety to name just a few …

So after coming to Quing for three months, that is all this guy has been coming to Quing for, is three months:

> … and since I started at Quing, my life has radically changed for the better. My confidence has increased, my self-esteem, self-worth and self-belief have all begun to increase. I am putting structure into my life so that I can cope, and I have friends in my life who support me to the best I can be rather than professionals telling me what is wrong. My mental health has also radically improved. Instead of having two or three panic attacks a week, I might have one a month. My head is clearer and the doctor has begun reducing my medication. I am beginning to heal and I have hope for the future. I am being more proactive, engaging with other organisations and courses, and I am definitely beginning to take control of my life. It feels that I have finally realised I have been stuck going round for 30 years on meds and my life has been lived in ever-decreasing circles. It is time to grow up, mature and make progress in every area of life. I am hopefully about to start a part-time paid job for the first time in decades.'
>
> 'My background is massively chaotic, mental health problems, addiction, homelessness, isolation. I am sure all of this is due to me being sexually, physically and emotionally abused as a child. I drifted from place to place and have sought help time and time again. Quing has radically improved my quality of life, as I have

somewhere I can belong; give rather than take; meet new friends who I can talk to, or just be around. This year has been really tough and COVID brought home how isolated you can become. Since lockdown has lifted, finding work has been really hard. Everything going online has been really stressful and the pressure to get a job, even when it has been really hard to get one, has had a profound effect on my mental health. If it wasn't for Quing, I am utterly convinced my mental health would have utterly collapsed and I am aware there would have been a high likelihood that I would have relapsed back into the chaos of my old life, losing everything.'

'I don't think my life could have been any more chaotic. I'm a care leaver, I was always stressed, emotionally and physically abused by both parents. I really didn't have a chance going into adulthood. Over the last few years, I have known that I needed to untangle and understand certain behaviours and attitudes I have, so I can flourish. I tried myself, but soon realised I needed help. The GP just wanted to medicate me. There was a two-year waiting list with Mental Health and I started to go downhill. My health visitor gave me a load of pamphlets, but they were next to useless as I was so full of fear and anxiety. I was like a rabbit in the headlights. Then lockdown happened and all the symptoms of anxiety, fear, depression, anger just magnified. I really just couldn't cope anymore.
Quing came up on Facebook and I thought I should give it a try. I emailed and arranged to come down just after lockdown and met the community. I felt welcome and supported from the first time I walked through the door. The change in my life has been truly amazing in such a short time. I am far less angry. In fact, I am calm and more confident and can meet the challenges of life. I am a better parent and partner. I can step back and support my children and partner rather than get sucked into the drama. Work-wise, I have had the confidence to change my job, which has radically improved the quality of my life. Quing works for me for loads of reasons. It is not clinical. It does not remind me of the system I was in for so long. It is laid back. It is calm. When I arrive, and in whatever state, I feel welcome and part of the family. If I had not found Quing, I would have just got worse and worse – fear, anxiety, pushing people away, silently struggling in an ever-decreasing vicious circle.'

Q19. Mr Perkins: Okay, how does somebody refer themselves to you?

Mr Clucas: Usually they just turn up, or they give us a ring, or an email. We do not have any criteria. If you are lonely, if you have had life challenges, you are more than welcome.

Q20. Mr Perkins: And do you start the counselling straight away? Or how does it work?

Mr Clucas: Because of our limited funding and how we operate, counselling is not the first thing we do with people. We have a social space where people could come down and just connect with people, and within that space there are usually two or three peer mentors, or people training to be peer mentors who have the lived experience of where that person is at.

Q21. The Chairman: What capacity do you have? Is there no restriction? Will you try and see anybody that contacts you?

Mr Clucas: Usually at any one time there are between 20 and 30 people within the group, sometimes there is a few more, sometimes a few less, but there are usually about 20 or 30 people regularly coming.

Q22. Mr Greenhill: You mentioned the financial position there. Has COVID affected the income that you are receiving and what you can do to help people?

Mr Clucas: At the moment we are open between 1 p.m. and 4 p.m. because I actually have to work full time to pay my bills. So at the moment we are just about covering our rent, our electricity and our gas bill, and other bills.

Q23. Mr Greenhill: So people donating to charity, has that dropped off? Is that what is happening that is causing a problem?

Mr Clucas: If we were in the UK we would be fully funded by government. So if I look at all the organisations we are linked to in the UK, they came out with a decision 15 to 20 years ago that people with lived experience should be in control of the commissioning of services, or have a huge say in what is commissioned. That never happened on the Isle of Man. In fact, the Service Users' Network was closed down, which would be something quite similar.

Q24. The Chairman: Do you know why it was closed down?

Mr Clucas: I would have my suspicions, but I will keep them to myself.

Q25. The Chairman: What do you believe is the current biggest risk to the safety of individuals experiencing mental health issues on the Island?

Mr Clucas: The waiting lists.

If you manage harm, which is what the medicalisation of mental health services does, and addiction, and you do not look at the trauma … So if you look at symptoms and say, 'This is what we manage', it just gets bigger and bigger and bigger. You will never stop the underlying reasons why people have mental health, which is our greatest learning as a society: mental health is not something wrong with your brain, mental health is how our society works. COVID taught us that.

If you have a mental health service that is at capacity, and more and more stress is happening to the community, eventually mental health will collapse. This is not just my opinion. The UN special report on physical and mental health has basically said once their needs are radically changed, mental health is not a medical problem, it is a societal problem. In fact I have this report with me, if you would like me to give it to you.

The Chairman: A copy, yes.

Mr Clucas: If you look at the systems that damage people and give them mental health problems … because the most damaged people in our society are damaged by the systems that are meant to help them. You need to deal with that. The medical model is not helping people, it is just managing symptoms. If you are going to do something *really* beneficial for mental health, it is actually looking at the reasons why we have it. I have stories of why people end up at Quing and something in our evaluation over those two weeks that I had never even noticed came out.

One of the things we teach people is: if one person says something, take it with a pinch of salt. If two people say something, okay, there might be some truth. If three people say something there is definitely a truth there that you need to look at. So when we did the evaluation over the last two weeks, three stories came up: the Family Court system and men, and the treatment that the Family Court system gives men. I was horrified. Three middle-class, successful businessmen all talking about killing themselves because of how they have been treated in the court system – bullying, evidence not being taken seriously.

From a mental health perspective, why are men being put in that position? They just feel bullied. There are three testimonies which basically say the same thing, that the system is against the man; and if you try to fight the system you will end up suicidal. Is that right?

Q26. The Chairman: So the biggest risk at the present time is the system as a whole?

Mr Clucas: Yes.

Q27. The Chairman: You talked about a recovery college and the DHSC, and possibly it is a new policy which is emerging. How long would it take to set up a recovery college?

Mr Clucas: We are already doing it.

Q28. The Chairman: So how long did it take you to get that mechanism and your accreditations?

Mr Clucas: We worked at it over about a year and a half.

I have something else that I feel may be relevant at this point in time. I have been studying the Knottfield report that this Committee did.

Q29. The Clerk: The Committee is not able to hear about that at the moment.

Mr Clucas: Okay. So, from my understanding nothing has really come of it. I have dealt with people who have been through the Knottfield system.

Henrietta Ewart, Director of Public Health, has been trying to get a thing called adverse childhood experiences, which is the core part of mental health … and to get all the other parts of Government to recognise this is one of the causes for mental health. If you look at the stats: if you have more than four adverse childhood experiences you are four times more likely to be a high-risk drinker; six times more likely to have had or caused unintended teenage pregnancy; six times more likely to smoke; six times more likely to have sex under the age of 16; 11 times more likely to smoke cannabis; 14 times more likely to have been a victim of violence over the last 12 months; 15 times more likely to have committed violence against another in the past 12 months; 16 times more likely to have used crack cocaine or heroin; 20 times more likely to have been incarcerated at any point in their life.

Trauma-informed care and practice is pretty simple stuff. It is one of the key things that we do at Quing and I think the easiest and simplest way of understanding it is as follows. In the simplest terms, the concept of trauma-informed care is straightforward. If professionals were to pause and consider the role trauma and lingering traumatic stress plays in the lives of specific client populations served by an individual, professional, organisation or an entire system, how would they behave differently? What steps would they take to avoid or at least minimise, adding new stress or inadvertently reminding the clients of their past traumas? How can they better help their traumatised clients heal? In effect by looking at how the entire system is organised and services are delivered through a trauma lens. What should be done differently?

At this moment in time, Minister Cregeen is down at Tromode opening the new bail hostel and probation centre, which used to be a children's home. The vast majority of people of a certain age within the prison system will have been in that children's home. Motiv8 have moved into the old Knottfield complex. Where is the common sense? Where is the compassion? Where is the humanity to basically bring people who are really struggling back to the place where they were raped?

This makes me angry. It upsets me that our society has no respect whatsoever for people who were deeply damaged by a system. It just continues, and continues, and continues.

Q30. The Chairman: At any point, from a Quing point of view, did you make any representation with regard to the new centre?

Mr Clucas: Going back a few years ago in the presence of a witness, who is in this room, I questioned the Head of Probation about turning the old children's home into this new bail hostel. 'It's what we were given', she said.

Q31. The Chairman: Did she understand the historic …?

Mr Clucas: Oh, absolutely.

Q32. The Chairman: So you talked about a trauma lens and quite clearly we can see the impact that that has. What policy do you feel is failing in the area?

Obviously we have all talked about joined-up silos, but what from your experiences from Quing from the outset to now would have benefited everybody rather than chosen …?

Mr Clucas: If you take a step back from the pain and you think about this rationally. At the moment you have silos within Government; each one wants to build their empire and say that is the only way.

If you start recognising that every MHK, every MLC and every Minister is actually responsible for the wellbeing and mental health of every person who lives on the Isle of Man, you start giving the power of commissioning services and everything that is tendered to public health, who understand trauma-informed care and practice and the recovery model. And through everything that is commissioned, what is it investing in? Is it investing in the capitals being increased in the people at the very bottom's life? Or is it about investing in the middle-life lifestyles of the managers and the directors of charities?

Q33. The Chairman: So what do statutory services do well? Can you give any examples?

Mr Clucas: Unfortunately the people who turn up at Quing and who I deal with, very rarely have anything positive to say about statutory services. We have people who have been treated so badly by statutory services that their hair has fallen out. We have stories of people who have been treated by Family Social Services, family and children … you just could not believe it.

I do accept for some people that Mental Health does work. I do accept it, but I do not meet many of them, because that is not the world I live in. It never helped me.

Q34. The Clerk: When you say that mental health works, do you mean that the Mental Health system within the Department of Health and Social Care works? (***Mr Clucas:*** Yes.)

So when they talk about the tiered system of different levels of need, do you think that at the highest level of need, a community-based peer-mentoring group is able to cope with that?

Mr Clucas: If you were to look at what we do at Quing … I will give you some stats. A very similar organisation to Quing in Slough, Berkshire, working with the 100 most expensive clients in Slough – which is quite a deprived area, if any of you have ever been there? (**Mr Greenhill:** I have.) The year before these guys started working with the Assist and Embrace programme, they had four and a half thousand nights of secure mental health beds, which cost £1.5 million.

The year they were with Assist and Embrace, they went from four and a half thousand unplanned bed nights down to zero unplanned bed nights and 425 planned bed nights, saving £1.5 million.

Again, if you look at the bigger picture, which is A&E, which is a GP, which is the police, which is all those other things, in the first year alone it has saved between £2.5 million and £3 million.

Q35. The Clerk: So can you deliver that with the current regime, where you are only open three hours a day?

Mr Clucas: If we were funded we could deliver that from tomorrow. If I did not have to work a full-time job to be able to have the afternoons off and come down, I could deliver that tomorrow.

Q36. The Clerk: So just to be clear, you have a full-time job which has nothing to do with this, in some other sector of the economy?

Mr Clucas: Actually I am a private therapist.

Q37. The Clerk: Okay, that is your business. And because you are doing that to make ends meet, as it were, you are able to run Quing, I think you said from 1 p.m. to 4 p.m.

Mr Clucas: Yes, from 1 p.m. to 4 p.m.

Q38. The Clerk: Is that Monday to Friday?

Mr Clucas: Monday to Friday.

Q39. The Clerk: And is it just you?

Mr Clucas: Yes, and we have about six or seven other people who are trained to be peer mentors as well. So I manage the peer mentors and I do the more intense work.

Q40. The Chairman: From that point of view, how many cases could you manage as an individual before you got peer mentors or other therapists involved?

Mr Clucas: As a member of the BACP, I live by an ethical framework. I would see up to 20 clients a week and that would be my limit. I know how many people I could hold.
With the peer mentoring system we can most probably have 30, which is quite an easy number to manage. So instead of me taking responsibility for people, peer mentoring is about people taking responsibility for themselves.

Q41. Mr Greenhill: How many cases do you think there are on the Island at the moment? How many people could be helped by …?

Mr Clucas: Again looking at the models in the UK six people, who are paid, run something like Quing for a city of – I think there are about half a million people there; and they do the courses we do, they run peer mentoring, they do assertive outreach.

Q42. Mr Perkins: Have you lost any of your clients to suicide recently?

Mr Clucas: When we first began, quite a long time ago, we lost one of our members to suicide. Unfortunately, Children and Families came to the person's house and told them that they would never see their children again, and three days later the person killed themselves.

Q43. The Chairman: When you talked before of examples of what your clients have to endure, is that a theme?

Mr Clucas: Yes. It is the abandonment, it is the not being able to fit the boxes, or to be able to fit the criteria to get the help they need. So one of the testimonies – I will just find it …

Q44. The Chairman: One of my next questions, so just keep this in mind, is: what do statutory services need to improve on? Keep that in mind, but read that testimony first!

Mr Clucas: This is a testimony from one of the guys who has been around. He is actually training to be a peer mentor at the moment.

> 'My childhood was pretty tough, I have a high adverse childhood experience score. I am ex-military, I have pretty severe mental health problems that are caused by complex post-traumatic stress and have been referred to Combat Stress.'

Does everybody know what Combat Stress is?

The Clerk: No, assume not.

Mr Clucas: It is an organisation that helps ex-military with post-traumatic stress.

> 'When I got out of the military, I was in a mess: head spinning, explosive emotions and self-isolating, not looking after myself. But over time I sort of got used to civvy life. I had episodes on and off of acute phases of post-traumatic stress. I tried engaging with Mental Health but found them next to impossible to engage with. In 2006, I was in a right state and went for help and was told they could not give me any because I was not suicidal. All they did was up my medication time and time again. I struggled by and kept employment, but in the end I was so heavily medicated that I had to give up work. I crashed the van twice in a few weeks and realised it was the meds.'

Q45. The Chairman: From a crisis point of view, what experience have you had? Obviously taking into account that statutory services need to improve. Have most of the people that come to Quing been at that crisis point prior to …?

Mr Clucas: Oh yes, and one of the interesting things with a crisis is that they quite often ring up the Crisis Mental Health team: 'Have a cup of tea or go for a walk' or 'We'll ring you back …' Two months later they get rung back while they are busy, and then they are just abandoned because they cannot talk. I have testimonies saying this.

Q46. The Chairman: One of the questions we were going to ask as a Committee was: do you think the access to the statutory services is fair? Do you understand the process of the access to the services?

Mr Clucas: Yes.

Q47. The Chairman: And do you think it is fair?

Mr Clucas: From my perspective, pain is pain. If you are in physical pain you can go to A&E. If you have psychological pain, and it does not matter whether it is huge or big, it is unbearable.

If they start saying, 'You have to be here, here, here, here …' what is that person meant to do with that pain that they are suffering from?

I was fortunate enough to work in some really good projects in the UK before I came back – in fact I was invited to come back by the *last* Government, and that is why I ended up back in the Isle of Man, because I was invited back. I walked away from a career in the south-east.

When I got back to the Isle of Man it was like walking back to the Stone Age. Criteria were used to stop people getting services, from my experience and the experience of the members of Quing. If you do not fit, you do not get anything. There is an expectation that you will meet services where they are at, rather than services meeting you where you are at.

I am aware that this Committee invited me and members of Quing to come here, but if we think about the trauma-informed care and practice, which I talked about before, why would I want to bring any of the members of Quing to be sat here in a situation that would remind them of being in court? Whether that is having their kids taken off them; whether they have been charged; whether they were getting taken off their parents; or maybe it was at an inquest. It is a different building, but actually this is very similar.

So I would like to invite the Committee to come down to Quing at some point.

Q48. The Chairman: Thank you for that. I am sure as Chair, and with the other Committee Members, I hope in that invitation we did not cause any … But I think as a Committee we would welcome that.

Mr Clucas: No. As a community we talked about it, and I came up and offered that.

The Chairman: We will organise that in the future.

Q49. Mr Greenhill: Perhaps I could ask: if the DHSC were sitting here in the room now, what do you think they would be saying? What would be their opinion of this?

Mr Clucas: So what would I be accused of? I would be accused of being disruptive, anti-psychiatry. I have no evidence base … It is like the lunatics are taking over the asylum, that is the one I hear the most.

In the special report of the UN on mental health, they actually wrote a very interesting paper a couple of months ago, saying these are the things that are thrown at organisations like Quing. I am not anti-psychiatry. There is a place for it. But if everything is about treating acute problems and being reactive, you will never cope. If you start actually looking at the reasons why people have mental health problems in the first place – which are societal, which are not medical – we can get their mental health down.

Q50. Mr Greenhill: But what would they be saying that they are doing right?

Mr Clucas: I do not know, I am so far divorced from them that I do not know.

The UN special report talks about over-medication. There was a freedom of information request in last week about how much medication for anxiety has been delivered so far this year.

Q51. The Chairman: Is this on the Isle of Man?

Mr Clucas: This is just on the Isle of Man.

In 2018 there was about £600,000 worth of drugs bought off-Island to treat anxiety symptoms. Last year, there were £515,000; and for the first eight months of this year there was £485,000. That is just on anxiety drugs – that is not on anti-depressants, that is just on anti-anxiety drugs. Maybe they are good at medicating people.

Q52. Mr Perkins: Do you think the relationship has irretrievably broken down between yourselves and the DHSC?

Mr Clucas: One of the reasons people come to Quing is because we are not DHSC. If you look at the role of organisations like Quing in the UK, and in the States, and around the world, the organisations –or LEROs, as we are called – are the ones that have begun to hold traditional services to account.

Q53. The Clerk: Sorry, did you say LEVOs?

Mr Clucas: LEROs – Lived Experience Recovery Organisations.

The UN special report says governments and states should support organisations that have lived experience to hold traditional services to account. I will submit the report as evidence, if you would like?

What Quing and myself are trying to do is not just an Isle of Man-based thing, it is an international problem. They all take it personally, because that is human nature. It is not personal, but actually we can do better.

Q54. The Clerk: So what do you want from the DHSC? Is it mainly about funding, or is it more about their response and the way they talk about you and what they say about you?

Mr Clucas: My take would be, we have offered to work with Mental Health and we have offered to work together, and after the event with someone within Mental Health offering … I talked before about Mental Health. I actually emailed Tania Linden, who is the Head of this part of Mental Health. As always, if you challenge them: 'Choice is good' is their reply.

For me co-operation is better, if we are going to work, if we are going to lower the problems of mental health addiction and offending on the Isle of Man. It is not about choice is better, it is: 'What are you good at and how can we co-operate?' That is what I would like. It is not going to happen. It would shock me if it did.

Q55. The Chairman: When they say choice is good, what is the choice available to people?

Mr Clucas: Mental Health provision; us; there is Isle Listen; and you have got Hospice, maybe they have some mental health workers.

Q56. The Chairman: Do any of these receive funding direct that you are aware of?

Mr Clucas: I am not sure.

It feels for me, if you silo stuff … Good people go into silos to do daft things. Maybe that is the best way of looking at it.

If you start siloing provision for mental health and addiction and offending, what happens is you get a little bit of support from here or you will get no support from there. I do not know if this is still correct but at one point, a couple of years ago, if you were under the Drug and Alcohol Team (DAT) you could not go to see a psychologist or a therapist at Mental Health.

If you look at the evidence in the UK you can get someone clean, but unless you deal with the underlying trauma they will keep using again.

Q57. Mr Greenhill: Does the UK work on a choice is good basis?

Mr Clucas: I can only talk about my experience and I have been back on the Isle of Man for five years now. It is about collaboration. I would work for one organisation which would collaborate with three or four others. One of the organisations I used to collaborate with was called Blue Sky Development, which has now been bought out by a major corporate third-sector organisation and the model has now transferred around the country.

The best example that is presently running is called Jobs, Friends & Houses in Blackpool. People coming out of prison, and they do this: they collaborate with local mental health; they collaborate with probation; they collaborate with the local DAT team; they collaborate with the local public health; and the police. They have a collaborative approach.

Q58. The Chairman: We do not have anybody doing that at present on the Island?

Mr Clucas: I have tried.

So, 50 offenders coming out of prison back into Blackpool, most probably the 50 worst ex-offenders or community returners coming out that year, back into Blackpool. Pretty simple opportunity for people coming out: eight-week course, help with finding a house, a secure job when they got out. What was the percentage in crime decrease committed? It was 94%, and that was from the police records, not self-reported.

We have the Chief Constable at the moment talking about crime going up, drug offences going up and lots of the more serious crime going up. Do you think a new bail hostel will fix that? I do not. We need to be investing in this and in collaborative work, like Jobs, Friends & Houses in Blackpool.

Q59. The Clerk: Can I ask: we are talking about a range of services and processes which is all about risk. It is a very risky world out there for anyone who is putting out their hand and trying to help to run a recovery organisation. So from the point of view of the DHSC is there any risk involved in, for example, signposting people to you?

Mr Clucas: No. We minimise risk as much as we can. We train people professionally, we are fully insured. All our therapists – and I am not the only therapist at Quing – have a minimum qualification of membership to the BACP.

Q60. The Clerk: So in all of the international comparisons which you have been talking about in the UK and the US, etc. are there any instances where a statutory service has been challenged, sued, criticised or accused of negligence, or anything like that, in circumstances where they had referred somebody to an organisation like yours?

Mr Clucas: Not to the best of my knowledge.

Q61. The Chairman: One question that was not asked there was with regard to safeguarding, which is across the whole of Government. I assume you have a safeguarding policy and you have all the …?

Mr Clucas: Absolutely. We probably have the most forward-thinking policies and procedures of any third-sector organisation. The reason why is because as a LERO we have been working with Dr Ed Day, Prof. David Best and some of the top LEROs in the country to get all our policies and procedures right. We collaborate.

Q62. The Chairman: Have you reduced your hours to just afternoons? It was previously …

Mr Clucas: Yes. We had some funding from before COVID, we kept going from 10 a.m. to 5 p.m. and then doing other things as best we can. But unfortunately I had to start to earn a living again. So we have dropped down to between 1 p.m. and 4 p.m. about three or four weeks ago.

Q63. The Chairman: In line with most services within the DHSC and shortages of a particular type of staff, social workers, etc. is there a shortage of psychotherapists or therapists?

Mr Clucas: I am going to be slightly controversial here! I am deeply aware that there is a difference between someone who has counselling skills and someone who is a counsellor or psychotherapist.

Q64. The Chairman: Could you quickly say what the difference is?

Mr Clucas: Someone who has counselling skills has been on courses but does not know their own process, they have not worked on themselves. They have not developed their ability to not be acting out of their own pain. So if you want to train as a counsellor or a psychotherapist there is a minimum amount of hours of counselling or personal development work you have to do before you can become a therapist or a counsellor.

In my case, I think I did about three years' full-time work and over 150 hours of training therapy, as they call it. My experience of people who take counselling roles on the Isle of Man – and this is quite a general comment – is actually they have done no bloody work at all on themselves. They claim to be counsellors when in fact they do not have any professional qualifications of any standard, BACP or UKCP.

Q65. The Chairman: From a lot of what you have said today, do you see Quing as bridging a gap for services, or do you see them as complementing and reducing and helping people get access to a form of help quicker?

Mr Clucas: From my perspective, Quing is there both to support people while they wait for services, and help them after they have had their acute phase; and to stop them getting stuck in the revolving door of services, whether that is with medication or not.

Q66. Mr Perkins: Are you working with the Police at all?

Mr Clucas: We have had conversations with the Police, yes.

Q67. Mr Perkins: So you are not actually getting clients directly from the Police when they are at a crisis point?

Mr Clucas: No. As in many things on the Isle of Man, a lot of these relationships are pre-existing and there are contracts and there are grants, because they do this or they do that, and because as a general rule we do not tender for very much because we are very … We are not about building an empire, we are about supporting people. We do not tender for stuff that we are not qualified to do.

Q68. The Chairman: The qualifications you talk about and helping people back to employment. Are they transferable qualifications?

Mr Clucas: Oh, absolutely.

The three qualifications we have at the moment – which are Level 1, Level 2 and Level 3 – have loads and loads of transferable skills. In the UK other organisations deliver them, exactly the same qualification, and people end up managing drug and alcohol units; people end up running charities with them; people end up working in NHS and other third-sector organisations.

Q69. The Clerk: Is that the sort of stuff you could deliver inside the prison as well?

Mr Clucas: In the UK, these qualifications are delivered inside the prisons.

Q70. The Clerk: And in the Isle of Man?

Mr Clucas: We tried to form a relationship with the Prison, but it just did not go anywhere. All the doors closed.

Q71. The Chairman: Was that a voluntary offer?

Mr Clucas: We went up to talk to them and they said, 'Yes, yes, yes'. When I started to try to move it forward all the doors came down and we have never heard anything back.

Q72. The Chairman: Just to go back to your Jobs, Friends & Houses, and the success of that: what is available to people on the Island if they are coming out of the prison system?

Mr Clucas: A homeless hostel. I am aware that I think the Social Security are now working with people about a week before or maybe two weeks before they come out. There is no joined-up thinking.

Q73. The Chairman: What about support? You have been institutionalised in a way for a period of time, what is the support from Mental Health, etc.? Are you aware of anybody that is …?

Mr Clucas: No. I can use my experience in the UK here. So in the UK there is joined-up thinking. My experience of what happens on the Isle of Man is you go to prison and you are medicated so you cannot stand up.

Q74. The Chairman: From the minute you have …?

Mr Clucas: As you walk in the door, they start upping your medication – that is anti-psychotics, anti-anxieties, that is all the hard core medications. If you end up in prison you are zombified; and as you come out you have to then wait to go to see DAT, or you have to wait …

There is no joined-up thinking. I go up to the Prison and I go and see people – not as the CEO of Quing, I go up as a private individual. I am utterly shocked by the state of some of the people. I have been medicated, heavily; and some of the people I have gone to see up there could not even hardly talk. Why? I will be cynical again: because they are easier to look after.

Q75. The Clerk: There must be co-ordination between the Prison and Probation in this jurisdiction because they are organised by the same small management team.

Mr Clucas: Yes, but as I said, we tried forming relationships with Probation; we tried forming relationships with the Prison; we tried to form relationships with Mental Health; we tried forming with DAT. No door was open to us. It feels as if: 'This is our empire and unless you do what I say we don't want anything to do with you.'

Q76. The Chairman: Do you think the barrier is because it is something different? Something new?

Mr Clucas: Yes, and it is a different model to what they use.

Q77. The Chairman: So do you feel you have maximised what you can do at the present time?

Mr Clucas: From my perspective, I will keep Quing going as long as I can. I do not mind working two jobs, I quite like a challenge. We will raise bits and pieces to keep the heating bills going and keep the electricity bills going, and we will keep paying the rent; and whether we can raise a couple of thousand pounds here, and a couple of thousand pounds there, we will get to still bring the world experts over and we will still deliver the courses. Life would be easier if we got some funding from somewhere, but if it is not …

Q78. The Chairman: From an impact point of view, because you have reduced down, because you are having to go out … What is the impact on your users?

Mr Clucas: It has been noticeable that our numbers have dropped since we have gone down to 1 p.m. to 4 p.m.

Q79. The Chairman: Do you have any contact with the individuals that are not …?

Mr Clucas: Oh yes. We have been running Quing for three to four years now, four years nearly, and the people who have come through the system or through the community are still in contact. It might be a telephone call. It might be a cup of coffee. Or they might just nip in to see us.

There is that sense of belonging, there is a sense of welcome with us, and people know that they can come down whenever they want.

Q80. The Chairman: From a recovery point of view, you are already set up and you are running, but you have had to reduce the opportunity. The risk that that has put on any of your current individuals …? Or is just going forward for the future that is a risk?

Mr Clucas: The final question of the testimonies: If I had not found Quing, where would I be?

> 'Imprisoned, in my flat, alone, isolated back in the hell of severe mental health problems, and there is a good chance that I would have killed myself, as I really don't want to go back to that hell.'
>
> 'If I had not found Quing, I am not sure where I would be. It would be somewhere slipping back into the old habits, totally isolated or institutionalised again. There is a good chance I would be dead by my own hand.'
>
> 'I am pretty sure if I had not found Quing I would be dead. Why shine individually when you can all shine together? Even stars share the space.'
>
> 'If I had not found Quing, I would have just got worse and worse, fear, anxiety, pushing people away, silently struggling in an ever-decreasing vicious circle.'
>
> 'If it wasn't for Quing, I am utterly convinced my mental health would have utterly collapsed and I am aware that there would have been a high likelihood that I would have been replaced back into the chaos of my old life, losing everything.'
>
> 'If I had not found Quing I would be either in jail or dead. I would have gone back to my old ways of drug violence and gang membership.'

Those are not my words. Those are the people who come to Quing.

Q81. The Chairman: One of the things which we pick up on, and we have used it a lot this afternoon, and apologies, is 'service user'. You use 'member'. There is quite a distinct difference there …

Mr Clucas: What we do is called 'co-creation'. I am not the expert. Everybody who comes to Quing, we do not tell them what to do. We support them or they work it out for themselves.

Quing is about the members co-creating what is going on. So they say, 'Graham, can you do this?' 'No. But what can you do, and I will help you do the rest.'

It is about empowering people to go on their own journey. It is not about me being in charge.

Q82. The Chairman: Is it centred on the individual from the outset?

Mr Clucas: Yes.

Q83. Mr Perkins: Have you got a connection with the Food Bank? Because obviously these people are needy when they …

Mr Clucas: I would struggle with the model used at the Food Bank.

I will draw you a nice little diagram on the board.

There are four ways of working with people and there is a place for each. You can do two people, so there is a place for that. I am a great kayaker and if I throw my shoulder again, I really hope when I get to Accident & Emergency they will put my shoulder in without me having to help too much.

You can do four people, which is the traditional charitable model. You have some really forward-thinking charities who will deal with people. And the last is, it is done *by* the person. Recovery is there. We start here and we go to there.

With this the danger is if you do two people or you do four people they become co-dependent on the service that you deliver. And if you do not have the service, the middle-class people who

run the service do not get their wages to pay for their lifestyle. So if you think of the Food Bank, it is very much there. It is dealing with four people.

We have been working in the background on a completely different model, which is what we are calling 'Community Coffee' which is about, 'Actually we realise that you do not have a lot of money, and you cannot really afford food. But what you are willing to donate? Can you donate a couple of hours' time? What skills do you have that you can give to the community?' That is what we have been doing for four years. We do not talk about it because we do not need to.

What can you give back, rather than take, take, take, take?

Q84. The Chairman: Access to housing for individuals, and I think you did an article when the 'Mr H' report came out and you had concerns. Do you see any difference going forward?

Mr Clucas: Not really.

Way back then, I was one of the guys who set up Graih back in 2006; I was actually part of Graih before it was Graih. The housing or the homelessness changed in 2009 to 2010 on the Isle of Man, we went from having quite a high proportion of people living in squats to very few. It has been quite similar and the numbers at Graih have gone up of late.

From our perspective we see sofa-surfers, we do see people who are street homeless now and again and we help them find the right housing. But often because their lives are so chaotic they cannot hang on to them. They are so heavily medicated all day; and they are self-medicating as well as being heavily medicated. So we are around and we are in the space, but not everybody wants to move forward, so we cannot help everybody.

Q85. The Chairman: How do individuals find out about you?

Mr Clucas: Everything is done by word of mouth. Because of the mistrust of many of the people who have been promised the earth by other services, actually the best recommendation for what we do are the people who have been through our services and they will tell them.

If you do not see someone for six months and then you meet them and they are completely different you say what happened to them? So you ask … 'Oh, I have been going to Quing for six months.'

You can change or I can change; we will give it a go. And that is how we have worked from day one.

The Chairman: I have not got anything else. Is there anything else you would like to say to the Committee?

Mr Clucas: Just thank you for inviting me and allowing me to be a voice of the people who often do not have a voice.

The Chairman: As a Committee, we have agreed that we will come down. It may be after the holiday season, but we will endeavour to get down.

So thank you for coming today, and the Committee will now sit in private.

Mr Clucas: Okay. Thank you.

The Committee sat in private at 3.29 p.m.

WRITTEN EVIDENCE

Appendix 1: - 22nd December 2020 -

Letter from Thea Ozenturk, Chief Executive Officer of Motiv8

SUPPORT FOR ANYONE IMPACTED BY ALCOHOL, DRUGS OR GAMBLING
Motiv8
Addiction Services

90 to 92a Woodbourne Road
Douglas
Isle of Man
IM2 3AS

Email: contact@motiv8.im
www.motiv8.im

Alcohol Advisory Service **627656** DrugAware **627650** Family Alcohol Service **627656** IOM Gambling Service **622011** YP@Motiv8 **627656**

Mr Jonathan King
Social Affairs Policy Review Committee
Clerk to the Committee
Legislative Buildings
Finch Road
Douglas
Isle of Man
IM1 3PW

22nd December 2020

Dear Mr King,

I write in regard to the statements made by Mr Graham Clucas about Motiv8 Addiction Services. The remarks were made during his presentation about his views on the state of mental health services in the Isle of Man, to the Social Policy Review Committee.

Mr Clucas suggested that Motiv8 had threatened to 'sue him' following his presentation to the Bio Medical group at the Villa Marina.

My understanding of this event is as follows. Mr Clucas gave a presentation at the Manx Biomed Conference in 2018 in which he used examples, giving Christian names and personal client information of Motiv8 clients who he alleged had received unsatisfactory support from this service.

We did write to Mr Clucas as an ex-member of staff at Motiv8 to remind him of his legal responsibilities on confidentiality and the detrimental remarks which were in my opinion fabricated and off putting to prospective and current clients of the service. I believe I had just cause to do this as the manager and safeguarding lead of this charity.

We believe Mr Clucas has also taken issue to Motiv8's premises. We are now situated in part of the old Children's Centre. We would like to assure the Committee that a great deal of thought went into moving to these premises. However, as the building was largely used for the Nursery in the latter part of the Children's Centre tenure on Woodbourne Road, we felt it posed no major issues.

To date no one has complained about being seen on these premises.

This move was essential given the large building we are now accommodated in for a lesser rent than our old premises. Motiv8 is suffering a financial crisis at a time when its service is facing an unprecedented demand for its services.

The intimation that there are few qualified counsellors working in this field is also contentious. Motiv8 is a Charity of 42 years standing and employs a consummate team of highly qualified, approved professional counsellors who are accredited, supervised and legally compliant with every aspect of safeguarding vulnerable service users. They offer interventions in line with best practice and our outcomes are published annually.

On a personal note, I feel giving service users and those who work in the field an opportunity to give supported anonymous feedback would be a far more useful approach to understanding the reality of mental health services on the Island. This critical one-sided narrative style interview, affording him the opportunity to decry several key support services, could deter those struggling with mental health issues from accessing support and damage frontline morale at a time when many are struggling with the mental health impacts of Covid.

The routes to recovery are diverse and extensive, and I will not diminish the work of Quing as I'm sure it has its place in the Island's recovery landscape. But it is extremely unhelpful to diminish the hard work of other services at this critical moment in our community.

Kind regards,

Signature: Thea Ozenturk]

Thea Ozenturk CEO@Motiv8 Addiction Services.

Appendix 2: - 11th February 2021 -

Email from Mr Stuart Quayle,

Chief Registrar

From: Quayle, Stuart (General Registry)
Sent: 11 February 2021 10:59
To: Grace Phillips
Subject: FW: Suicides in 2019 and 2020

Dear Grace

Further to our conversation, please find below the figures which we recently supplied to Tim Glover from Manx Radio (following his request).

2019 – 6 Suicide verdicts
2020 – 22 Suicide verdicts

For comparison

2018 – 10
2017 – 5

Please note that these numbers are from the year that the inquest was concluded and **not** the year that the person died.

I mentioned a recent FOI request. Please search 'suicide' from the link below you'll find that one and a small number of others which may be of interest.

https://services.gov.im/freedom-of-information/search

Best wishes
Stuart

Stuart Quayle
Chief Registrar

Appendix 3:

Relevant entries in the Council of Ministers' Tynwald Policy Decisions Report (laid October 2020)

Post Office	45/18	11/12/2018	**Isle of Man Post Office – That Tynwald receives the Isle of Man Post Office Strategic Business Case 2017– 2022 [GD No 2018/0087] and the Report of the Isle of Man Post Office Board Strategic Recommendations Requiring Tynwald Approval Report [GD No 2018/0085] and:** **4. approves the reduction of letters delivery from six days a week to five days a week removing the Saturday;**	The change was implemented to plan on 21 October 2019	Implemented
Post Office	46/18	11/12/2018	5. approves that following the public consultation the IOMPO will undertake further work on the format of the delivery of retail services and will report back to Tynwald with its results and recommendations no later than October 2019.	The "STRATEGIC RECOMMENDATION ON MODERNISING THE ISLE OF MAN POST OFFICE RETAIL NETWORK" report with recommendations was received by Tynwald and debated at the October 2019 Tynwald sitting. All the recommendations were approved without amendment.	Implemented
Department of Health and Social Care	03/19	15/01/2019	**Recommendation 3** That further provision be put in place by the Department to support carers and that this provision should be available throughout the Island.	Some initial work commenced pre-COVID regarding the commissioning of the statutory carer assessments that are currently undertaken by Adult Social Care. There remains scope for delivering this under the strategic partnership. Delivering consistent and regular reviews alongside the development of a carer register would promote a far greater understanding of unmet need and allow the Department to produce trend/demographic information regarding carers and the changing need and demand for support. The Department is scoping the requirements for externally commissioned support for carers and it is a piece of work that will be completed and delivered through Manx Care from September 2021, following a likely procurement exercise.	Ongoing
Department of Health and Social Care	06/19	15/01/2019	**Recommendation 6** That mental capacity legislation containing Deprivation of Liberty Safeguards be drafted and introduced into the Branches of Tynwald.	The department is experiencing resource issues within legislative team and so no progress has been made regarding this. Capacity legislation is now the main legislative priority for the Department, discussions are ongoing with AGCs/external party with regard to finalising the drafting instructions. August 2020 – In August 2020 the Department will commence public consultation on the policy and resultant legal framework for the making of decisions on behalf of those who do not have the capacity to make decisions. This will cover the person's welfare, property, financial affairs and medical treatment. It will also cover a person making their own arrangements about how their affairs should be managed in the future if they lose the capacity to make decisions. The purpose of the public consultation is to obtain views and where relevant evidence to support those views on policies that will shape the Island's Capacity laws. The Department intends to introduce the first phase of this legislation into the Branches in early 2021. Concurrently a review of the mental health legislation framework will be undertaken in 2020-21 which will include phase two of the capacity legislation covering deprivation of liberty. Further policy development and consultation on this second stage will be undertaken in 2021.	Ongoing
Department of Health and Social Care	07/19	15/01/2019	**Recommendation 7 That the Department of Health and Social Care submit a yearly report to Tynwald on the progress towards the goals of the Mental Health and Wellbeing Strategy. In particular this report should focus on waiting times for patients in all service areas, support for carers and signposting and communication between service areas.**	The report is due for submission to Tynwald in November 2020	Ongoing
Cabinet Office	08/19	19/02/2019	Constitutional and Legal Affairs and Justice Committee: That the Constitutional and Legal Affairs and Justice Committee First Report for the Session 2018–19: Ministerial Responsibility for Justice be received and the following recommendation be approved: That the Council of Ministers should include within the portfolio of a Minister lead responsibility for protecting and advancing the principles of justice. This responsibility should include Government policy in relation to the justice system, whilst respecting and upholding the constitutional principle of an independent judiciary.	Currently under consideration by the Council of Ministers.	Under consideration

Department of Health and Social Care	48/19	15/10/2019	**That the Report of the Select Committee on Accommodation for Vulnerable Young People 2018-19 [PP No 2019/0088] be received and the following recommendations be approved:** **Recommendation 1** **That statutory services place vulnerable people at the centre of all aspects of planning and delivering services for them.**	The DHSC Children and Families service is required under the Children and Young Persons Act 2001 to "advise, assist and befriend[a young person looked after or previously looked after] with a view to promoting his welfare after (s)he ceases to be looked after by the Department" The Department does this through formal contract of support services for this, and every young person has a Pathway Plan to independence developed with them to identify support required and services to meet that need. It is the Department's intention to amend the Children and Young Persons Act 2001 to strengthen the statutory duties to care leavers to reflect best practice that occurs through contract. This is planned on the Legislative programme for 2021.	Ongoing
Department of Health and Social Care	49/19	15/10/2019	**Recommendation 2** **That the Department of Health and Social Care and Department of Infrastructure, in conjunction with third sector stakeholders and the Voices in Participation Council, develop a cross-government accommodation for vulnerable young people strategy;** **a) that this be a framework that focuses on need, rather than narrowly defined categories, and accommodates bespoke strategies for specific groups; and** **b) that a cross-government steering committee, including representatives of third sector stakeholders and the Voices in Participation Council, be established to oversee the implementation and continued operation and evolution of the strategy.**	This recommendation of the Select Committee has not been concluded. Progress was put on hold during the Covid response. During the Covid response there was a collaborative approach to providing accommodation to homeless people. This enabled a greater understanding of need to be achieved. Building on that collaborative approach the Social Affairs Policy Committee has agreed that an overarching accommodation strategy will be completed and as it engages a number of departments will be lead by the Cabinet Office. Work on this has re-started and a business case to support it is underway.	Ongoing
Department of Health and Social Care	50/19	15/10/2019	**Recommendation 3** That legislation be introduced into the Branches containing a statutory definition of homelessness and a duty to support and accommodate people who become homeless unintentionally	This recommendation of the Select Committee has not been concluded. Progress was put on hold during COVID response. All of the recommendation of the Select Committee will now be amalgamated into the development of a Housing Strategy lead by Cabinet Office.	Ongoing
Department of Health and Social Care	51/19	15/10/2019	**Recommendation 4** That a youth homelessness strategy with a focus on the prevention of housing crises be developed; and that this sit within the overarching accommodation for vulnerable young people strategy.	This recommendation of the Select Committee has not been concluded. Progress was put on hold during the Covid response. During the Covid response there was a collaborative approach to providing accommodation to homeless people. This enabled a greater understanding of need to be achieved. Building on that collaborative approach the Social Affairs Policy Committee has agreed that an overarching housing strategy will be completed and as it engages a number of departments will be lead by the Cabinet Office. In the interim period a joint commissioning proposal for emergency housing has been developed and the initial procurement process has begun.	Ongoing
Department of Health and Social Care	52/19	15/10/2019	**Recommendation 5** That the Department of Health and Social Care will commission a feasibility study to establish the need and development of a 'night stop' or similar support scheme within the Isle of Man context.	All accommodation provided by the Department directly is subject to registration and regulation in accordance with the Regulation of Care- care home standards 2013. The accommodation is regularly inspected and remedial action taken if quality standards are not maintained.	Ongoing
Department of Health and Social Care	53/19	15/10/2019	**Recommendation 6** That service outcomes for vulnerable young people be measured against agreed "corporate parent" standards, and that those standards should take into consideration what would be considered good enough for one's own child	This recommendation of the Select Committee has not been concluded. Progress was put on hold during COVID response. All of the recommendation of the Select Committee will now be amalgamated into the development of a Homeless Strategy lead by Cabinet Office.	Ongoing
Cabinet Office	54/19	15/10/2019	**Recommendation 7** That Public Health undertake a joint strategic needs assessment of loneliness to include a consistent measure of loneliness and a summary of the existing evidence of its causes and impacts.	The capacity, resources and supporting structures to enable the delivery of a prioritised and ultimately comprehensive Joint Strategic Needs Assessment Programme (led by Public Health) are being taken forward through the Transformation Programme following the Sir Jonathan Michael Report. Until this work has completed, Public Health is unable to set out a schedule for future JSNAs or to undertake the scoping work to determine content of future JSNAs	Ongoing

Cabinet Office	85/19	10/12/2019	**Recommendation 2** Design and deliver an Isle of Man core dataset to measure inequalities in health and socio-economic status.	Work has been unable to progress due to the pressures of COVID-19 and also because we are waiting for additional resource/capacity in the Public Health Intelligence Team to support core dataset and JSNA work.	Ongoing
Cabinet Office	86/19	10/12/2019	**Recommendation 3** Test the feasibility and usefulness of designing a geographically based Isle of Man Index of Multiple Deprivation, bearing in mind the limitations of this approach for rural populations.	Work has been unable to progress due to the pressures of COVID-19 and also because we are waiting for additional resource/capacity in the Public Health Intelligence Team to support core dataset and JSNA work.	Ongoing
Cabinet Office	87/19	10/12/2019	**Recommendation 4** **Explore the potential of working with others to maximise learning relevant to our population. This could include: • working with Public Health England and the Local Government Association to keep up to date with the progress of work to develop a better understanding of deprivation in rural areas;** **• Working with organisations such as the Health Equity Institute (to participate in networks of nations and cities which are applying the Marmot principles as a framework for policy and action), or the Commission for Social Metrics to develop measures of poverty that are most meaningful for our context;** **• Working with the Crown Dependencies of Jersey and Guernsey to share capacity and improve understanding of the specific context of small nation islands.**	Prior to March 2020 (and the onset of the COVID-19 pandemic), links had been established with PHE, LGA and the Association of Directors of Public Health in relation to developing metrics for social and economic inequalities in remote, rural and island communities. Unfortunately, COVID-19 has meant that this work is currently suspended due to lack of capacity both in PHD here and in partner organisations across.	Ongoing
Post Office	88/19	10/12/2019	**Report of the Isle of Man Post Office Strategic Recommendations relating to pensions V2 [GD No 2019/0094]** **1. The intention of the Isle of Man Post Office to submit for approval the Isle of Man Post Office Superannuation (Amendment) (No. 2) Scheme 2019 [SD No 2019/0488] which includes, in addition to changes of an administrative nature, material amendments:** **To close access to current benefits for new entrants on 31st December 2019;Impacting current members in order to meet funding requirements; To establish a class of benefits to facilitate the DB Lump Sum Scheme for new staff joining Isle of Man Post Office on or after 1st January 2020.**	The recommendation was approved without amendment at the December 2019 sitting of Tynwald. The agreed changes were implemented with effect from 1st January 2020.	Implemented
Post Office	89/19	10/12/2019	**2. The proposal detailed within the strategic recommendations report for the Board of Isle of Man Post Office to establish a competitive, benchmarked and socially responsible contract based defined contribution pension scheme for new staff joining Isle of Man Post Office on or after 1st January 2020.**	The recommendation was approved without amendment at the December 2019 sitting of Tynwald. The agreed changes were implemented with effect from 1st January 2020.	Implemented
Cabinet Office	1/20	21/01/2020	**Government Climate Change Action Plan** **1. Receives the independent report Isle of Man Programme for Achievement of Climate Targets by Professor Curran [GD No 2019/0102] and agrees the Council of Ministers' commitments and actions, as laid out in the Isle of Man Government Action Plan for Achieving Net Zero Carbon Emissions by 2050 Phase One [GD No 2019/0101]; and notes the commitment to further research work to develop a Phase Two Action Plan; with a progress report to be laid before Tynwald in July 2020.**	Consultation completed and legislation going to Tynwald in October 2020.	Ongoing
Department of Health and Social Care	10/20	18/02/2020	**Recommendation 5** **5)** That the Mental Health Service review its training procedures relating to the 1998 Act and disseminate guidance to all staff, who require this understanding as part of their role, on its relevant requirements and provisions.	The recently appointed Mental Health Act administrator has developed a training package for all registered professionals within the Mental Health Service. Mental Health Act awareness also now features within the Mental Health Service induction. A schedule of delegation has been recently approved by the Executive Team and Department subsequently which includes a detailed training needs analysis and implementation plan specific to the Mental Health Act.	Ongoing

Department of Health and Social Care	11/20	18/02/2020	**Recommendation 5** **6)** That mental capacity legislation containing Deprivation of Liberty Safeguards be drafted and introduced into the Branches of Tynwald.	In August 2020 the Department will commence public consultation on the policy and resultant legal framework for the making of decisions on behalf of those who do not have the capacity to make decisions. This will cover the person's welfare, property, financial affairs and medical treatment. It will also cover a person making their own arrangements about how their affairs should be managed in the future if they lose the capacity to make decisions. The purpose of the public consultation is to obtain views and where relevant evidence to support those views on policies that will shape the Island's Capacity laws. The Department intends to introduce the first phase of this legislation into the Branches in early 2021. Concurrently a review of the mental health legislation framework will be undertaken in 2020-21 which will include phase two of the capacity legislation covering deprivation of liberty. Further policy development and consultation on this second stage will be undertaken in 2021.	Ongoing
Department of Health and Social Care	12/20	18/02/2020	**Recommendation 5** **7) That the Department of Health and Social Care submit a yearly report to Tynwald on the progress towards the goals of the Mental Health and Wellbeing Strategy. In particular this report should focus on waiting times for patients in all service areas, support for carers and signposting and communication between service areas.**	The report is due for submission to Tynwald in November 2020	Ongoing
Department of Health and Social Care	13/20	18/02/2020	**Recommendation 6** **That the Department of Health and Social Care should include the assessment of additional provision of psychological support (including access and cost) within the ongoing Mental Health Strategy, with a clear link through to the Joint Strategic Needs Assessment.**	A business case has been developed and included within the wider primary care at scale transformation business case to secure funding to recruit additional psychotherapists. In addition the Mental Health Service is working in partnership with DESC to facilitate on island training enabling existing staff to gain accredited status in Cognitive Behavioural Therapy.	Ongoing
Department of Home Affairs	14/20	18/02/2020	**Recommendation 7** That the Department of Home Affairs and Department of Health and Social Care review methods of restricting mentally disordered persons from holding firearm licences where it would be a safety risk for such a person to do so.	The Department has taken initial steps to reconvene the Firearms Licensing Consultative Committee with a view to considering this matter, along with the progression of a new Firearms Bill. As part of the reconvention of this Committee the DHSC Mental Health Service will be represented within the Committee membership for the first time.	Ongoing
Department of Home Affairs	15/20	18/02/2020	**Recommendation 9** That the Department of Home Affairs and the Communications Commission should monitor developments in the UK relating to online harms and should ensure that the Island keeps pace with any relevant international standards.	The Department will enter into discussions with the Communications Commission in order to progress this recommendation.	Ongoing
Cabinet Office	16/20	18/02/2020	**Recommendation 10** **That Tynwald notes that the Public Health Directorate routinely collates, analyses and reports information; and that this must feed directly into the Joint Strategic Needs Assessment which should examine, among other things:** **i) the involvement of suicide victims with statutory services;** **ii) the incidence of mental disorders among suicide victims;** **iii) the care received by mentally disordered suicide victims;** **iv) the drugs commonly used in self-poisonings by overdose to enable the development of policies to restrict the access to such drugs for people at risk of suicide; and** **v) the existence of suicide hotspots.**	As noted above (87/19), Public Health is unable to give any time commitment for completion of any JSNA. In respect of recommendation 10 (v), data on completed suicides over the past 10 years does not indicate any high frequency locations for suicide and therefore there are no actions to take forward in this respect.	Ongoing
Department of Home Affairs	17/20	18/02/2020	**Recommendation 11** That the police and the courts should continue to improve the support they give to people affected by suicide.	This will be considered as part of the Criminal Justice Strategy.	Ongoing
Cabinet Office	18/20	18/02/2020	**Recommendation 12** **That Tynwald is of the opinion that there is a need for additional support for those bereaved by suicide, including additional training for relevant front-line staff, a focal point for the co-ordination of the response to a suicide, and a survivors group.**	Significant progress has been made on rolling out ASIST training and in rapid response to suspected suicide driven by the need to respond to the impact of COVID-19 on mental health and wellbeing on Island. Public Health is working closely with the constabulary and other government departments and agencies to undertake 'real time suicide surveillance' and co-ordinate response including post-vention as appropriate.	Ongoing

General Registry	19/20	18/02/2020	**Recommendation 13** That Prevention of Future Death Reports should be published as a matter of routine.	The General Registry will publish redacted details of any prevention of future death reports (to respect the privacy of those involved where necessary) to identify key findings and recommendations. Details will be made available alongside currently published coroner of inquests verdicts via the judgments online website - https://www.judgments.im/content/home.mth	Implemented
Cabinet Office	2/20	18/02/2020	**Social Affairs Policy Review Committee's Second Report for the Session 2019-20: Suicide [PP No 2019/0142(1)] [PP No 2019/0142(2)]** **Recommendation 1** **That a Joint Strategic Needs Assessment on suicide prevention, leading to an evidence based achievable strategy and a timed, costed and accountable delivery plan, will be delivered by the Director of Public Health no later than March 2021, and that information and data on suicide should be included in future Public Health annual reports to Tynwald as soon as practical.**	A JSNA will not be completed by March 2021 for the reasons stated above. (54/19)	Ongoing
Department of Health and Social Care	3/20	18/02/2020	**Recommendation 2** That all gatekeepers, particularly health and social care providers, be encouraged to routinely enquire into vulnerable service users' suicidal ideation; and that risk assessment tools be created to assist them in doing so.	The DICES risk assessment and management system has been in use by the Mental Health Service since July 2019 and is used by registered professionals – those who complete formal risk assessments and management plans. Accreditation requires 2 days training and a 3 yearly refresher. Much of the training focuses on suicide risk and the system includes a suicide risk assessment checklist. As of today, the MHS has trained 136 registered professionals in the DICES system.	Ongoing
Cabinet Office	4/20	18/02/2020	**Recommendation 3** That guidance from relevant bodies should be utilised for relevant professionals and service users to assist in the completion of risk assessments.	Evidence based guidance will be reviewed and included within the JSNA when this is able to progress.	Ongoing
Cabinet Office	5/20	18/02/2020	**Recommendation 4** That Applied Suicide Intervention Skills Training be encouraged for gatekeepers and other interested individuals, and that systems be put in place to support the active use of the skills gained from this training.	ASIST training has been made widely available across government as part of response to protecting mental health and wellbeing from the impacts of COVID-19 (through the Silver Health and Wellbeing Group).	Ongoing
Department of Health and Social Care	6/20	18/02/2020	**Recommendation 5** **That Tynwald reaffirm its commitment to the resolution of 15th January 2019 – That the Social Affairs Policy Review Committee Second Report for the Session 2018- 19: Mental Health [PP No 2018/0151] be received and the following recommendations be approved:** **1) That the Department of Health and Social Care should review the operational and legal basis for the confidentiality protocols in place in the Mental Health Service and disseminate clear guidance to all staff.**	The Mental Health Service induction process has been subject to review and now includes an explicit focus on the application of both the existing GDPR legislation and Caldicott principles, in particular principle 7. It is a mandatory requirement for all staff to undertake GDPR training via the E-learn Vannin platform with this now subject to regular compliance audit by patient safety and quality. A suite of department policies concerning information governance were uploaded to SharePoint in December 2019. Furthermore the incident reporting system Datix, has significantly enhanced both the process of reporting data breaches and the opportunities to investigate and share learning	Ongoing
Department of Health and Social Care	7/20	18/02/2020	**Recommendation 5** **2) That Tynwald is of the opinion that every effort should be made to ensure that patients' records are retained and referred appropriately, and that patients and, where appropriate, next of kin should be kept informed insofar as practical and in conformity with relevant confidentiality law.**	Following the introduction of GDPR it is stressed that the emphasis under the GDPR is data minimisation, both in terms of the volume of data stored on individuals and how long it's retained. Article 5 (e) of the GDPR states personal data shall be kept for no longer than is necessary for the purposes for which it is being processed. There are some circumstances where personal data may be stored for longer periods (e.g. archiving purposes in the public interest, scientific or historical research purposes). GDPR also states that the period for which the personal data is stored should be limited to a strict minimum and that time limits should be established by the data controller for deletion of the records (referred to as erasure in the GDPR) or for a periodic review. The Department has in place Retention of Record Policies which sets out how long it retains patient/service user's personal data. The DPO is available to the public (patients and service users) and staff to answer any questions in relation to confidentiality law. The Department's Data Protection Policy, Confidentiality Policy and Employee's Guide are in place to ensure all staff are familiar with the new data protection legislation. The Mental Health Service CPA policy (updated in 2019) includes explicit guidance regarding the involvement of family members and carers.	Implemented

Department of Health and Social Care	8/20	18/02/2020	**Recommendation 5** **3)** That further provision be put in place by the Department to support carers and that this provision should be available throughout the Island.	Version 5 of the Care Programme Approach Policy ratified on the 15/05/2019 includes additional explicit guidance pertaining to effective collaboration with carers. Particular reference is made to both the inherent value of proactive carer involvement in treatment and guidance relating to how professionals navigate challenges associated with information sharing in the absence of explicit consent. The department recognises that the absence of consistent, defined advocacy provision is an existing service shortfall. The department is committed to exploring a range of commissioning strategies in order to address the existing lack of provision. The recently launched 'are you ok' campaign aims to encourage people to talk about what's worrying them and look out for one another, with signposts to self-help resilience advice and organisations available to those who need help. As a key partner the Mental Health Service will be utilising a variety of platforms to publicise a range of accessible, evidenced based resources aimed at developing awareness and understanding of treatment pathways in respect of common mental health conditions. This will include explicit advice, support and guidance aimed at carers.	Ongoing
Department of Health and Social Care	9/20	18/02/2020	**Recommendation 5** **4)** That the Department for Health and Social Care make available clear guidance for service users and families on how they can access the available complaints systems.	The department is currently redrafting an interim complaints policy in advance of the Manx Care Bill. Once this is complete (Autumn 2020), a new complaints leaflet will be produced and this will be uploaded to the gov't website along with a central inbox for complaints. The current process is available on the website, although this needs updating. https://www.gov.im/about-the-government/departments/health-and-social-care/complaints-and-compliments/	Ongoing
Cabinet Office	20/20	16/06/2020	**Poverty Reports -** That Tynwald is of the opinion that the Economic Affairs Section of the Cabinet Office should publish by the end of July 2020 its a) Fuel Poverty in the Isle of Man 2020 Report, including Low Income High Cost (LIHC) model measurement.	Completed – published 20 July 2020	Implemented
Cabinet Office	21/20	16/06/2020	b) Living Wage Report 2020, including the calculation of the living wage in February 2020.	Completed – published 20 July 2020.	Implemented
Cabinet Office	22/20	16/06/2020	**Housing** - That Tynwald is of the opinion that the Isle of Man Government should a) integrate all housing policy, law and provision, building on the positive inter-Departmental initiatives arising from the Programme for Government	A report is being drafted for the October 2020 sitting of Tynwald.	Ongoing
Cabinet Office	23/20	16/06/2020	b) promote and assist the formation and extension of one or more approved housing associations or similar.	A report is being drafted for the October 2020 sitting of Tynwald.	Ongoing
Cabinet Office	24/20	16/06/2020	c) review the Section 13 regulations under the Town and Planning Act 1999, which provide for agreements for affordable housing, with consideration to be given to introducing a site specific Community Infrastructure Levy.	A report is being drafted for the October 2020 sitting of Tynwald.	Ongoing
Cabinet Office	25/20	16/06/2020	d) report back to Tynwald in respect of these matters by October 2020.	A report is being drafted for the October 2020 sitting of Tynwald.	Ongoing
Cabinet Office	26/20	21/07/2020	**Gas Regulation** 2. that the Heads of Terms will be brought for Tynwald approval in October 2020;	Work is ongoing on the Heads of Terms.	Ongoing
Cabinet Office	27/20	21/07/2020	3. the bringing forward of enabling legislation in relation to gas regulation concurrently with continued negotiation on the Heads of Terms	Work is ongoing on the enabling legislation.	Ongoing
Cabinet Office	80/19	10/12/2020	**Recommendation 5** That Tynwald is of the opinion that the Isle of Man Household Income and Expenditure Survey should be conducted every five years and Minimum Income Standards should be estimated and published annually.	Next Household Income and Expenditure Survey planned for 2023/24. 2020 Minimum Income Standards published as part of Living Wage Report on 20 July 2020.	Implemented

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