STANDING COMMITTEE
OF
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OFFICIAL REPORT

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SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Department of Health and Social Care

HANSARD

Douglas, Monday 21st June 2021

PP2021/0169 **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

Department of Health and Social Care

The Committee sat in public at 12.12 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MS EDGE *in the Chair*]

Procedural

The Chairman (Ms Edge): We now welcome representatives of the Department of Health and Social Care. They were last before the Committee on the 19th April as part of the panel talking about the pandemic. Welcome back.

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

Q1. The Chairman: For the benefit of *Hansard* and anybody listening, please could you both introduce yourselves, including your title and how long you have been in post.

The Minister for Health and Social Care (Mr Ashford): David Ashford, Minister for Health and Social Care, and I have been in post since January 2018.

Ms Magson: Kathryn Magson, Interim Chief Executive of the Department of Health and Social Care, been in post since 8th January 2020.

Q2. The Chairman: With regard to the pandemic, do you know exactly up until 31st March this year what the actual cost to the Department was?

The Minister: So in terms of the contingency, I believe the contingency in the end was £3.9 million, unless Kathryn is going to correct me. I think it was £3.9 million for the COVID contingency up to the end of this financial year. So that was £8 million on PPE; swabbing and testing was about £685,000; home care of £240,000; and vaccination programme of about £385,000.

Q3. The Chairman: Okay. So you managed to achieve some of that within your current budget, the extra that you asked for was only £3.9 million? (***The Minister*****:** Yes.) Because the PPE was £8 million, so you managed quite well.

Ms Magson: So one of the things we did with PPE, being one of the key risks that the Committee will be aware of, is throughout … well, I suppose that effectively in March and April we did quite an extensive programme, making sure we had a minimum of three months' worth of stock at any one point in time.

So effectively, once we had built those supply chains, we then just stocked it up and so whenever we had gone through the rest of the last 12 months, we have made sure at all times we have three months' available, and that still is the case now. So that was the majority of spend as the Minister says.

Obviously, there is also in our year-end position an accrual for annual leave, because of course individuals were not able to take their leave last year. We did not Manx Care to be set up without knowing the position there, so that has been accrued for, and we will obviously work with Manx Care in relation to how that is spent. So there is a lot of that built up in the last financial year, as you would expect.

So in total, as the Minister says, I blame the PPE, swabbing and testing, home care vaccination – and some of that continues obviously into this year. So we obviously do have 20221-22 costs as you would expect. So … some of that is the vaccination programme, and then testing. But in relation to PPE it is more just the top-up rather than the full cost of what we had to do to make sure we had sufficient stock, and ultimately as you know, that PPE supplied more than just the DHSC as it was; it also provided support for other providers on the Island.

Q4. The Chairman: Okay.

So what has been the reduction in the overall budget for the DHSC? What is the DHSC budget now going forward? And also, obviously there has been significant reduction in the staffing budget and management roles.

The Minister: So in terms of DHSC, this is the important thing because there is the split now between Manx Care and DHSC. So with DHSC, people will have seen quite a few of the posts, such as in relation to Director of Mental Health, etc. have all transferred over to Manx Care. So in relation to DHSC, it has come down quite significantly. We are a very small Department now because we are focused on the Corporate Services, which remains within DHSC and also the policy and strategy side of it. The vast majority of anything – well, everything really – that is operational has transferred over to Manx Care.

Q5. The Chairman: So what is the current FTE of the DHSC now?

The Minister: Kathryn, do you have that figure?

Ms Magson: Sorry, Ms Edge, you said FTE?

Q6. The Chairman: Yes, sorry, the full-time equivalent posts.

Ms Magson: Yes, sorry I just could not quite hear it. Yes, so by the end of it we expect to have around 40 posts. In our delivery plan for DHSC for the first quarter of this year, we pretty much started with what we had, which was 19 individuals, and then we have been recruiting to the remainder of those posts that were built into those infrastructures that were agreed last year. So we have had good progress. We still have some gaps, particularly in this Strategy and Commissioning Team but other than that we have pretty much completed now the care quality and safety, and reassurances in the inspection area. Policy and legislation is under way also. But that is the area, really, that we have had less success, I would say, on Island with our recruitment. It is not to say that there are no people out there; we are just having a slightly different approach around how we get back around that again.

So our original aim was the end of quarter one to have that complete. I think it will be more like the end of July when we will have completed that recruitment for the Department.

And then the final stage is the completion of a move to part-time sessional advisory roles from our clinical and professional support. That was always part of our plan. That is planned to do in quarter four and we will go out to advert for those in quarter three. So there will be sessional, part-time, one or two sessions a week, and they will also, depending on … we will need some core medical input also, social worker input, nursing input and so forth. Medicines management is the other core one.

Then depending on what our legislative policy programme is, we will then use certain advisors to help us out as experts in their fields. So it was a bit that will be fluid and a bit more fixed, but that will be the final position, and it is mapped out in our delivery programme plan that we have on the website.

Q7. The Chairman: So could I just clarify, I think you said that you were left with 19 individuals when everybody transferred over to Manx Care, but you are going to have 40 posts? If all the workload is transferred over to Manx Care, what is the difference between the 19 and 40?

Ms Magson: The big number that was in that 19 is the Regulation and Inspection team, so I think I beg to differ on all the workload has transferred over, which I am sure we will all smile at! But in reality, there is a significant amount of workload that clearly needs to be undertaken, as well as what is undertaken that has not transferred over. So clearly it is the assurance regulations and inspection element. So that is one …

We are calling ourselves three legs of the stool: one is that care quality and safety, which includes that regulation and inspection, and also the patient engagement element. So the assessor will probably … around that.

The second leg of the stool is around legislation and policy, and I think we would all recognise that in the past the Department has not had the resources and people to be able to get that extensive legislation programme under way. We have built a programme, we started to deliver some of those already, which is the Adoption Bill and the Capacity Bill. We have pretty much a full programme mapped out beyond, which clearly will be part of the next administration discussions, and there is a huge amount to do in that space in relation to catching up on what is effectively some very old … I would not say NHS but also social care, there will be some significant change, so mental health, medicines management, the list is endless. So that is where we want to point … a significant point of our focus in relation to that staff.

And then the third element, then, is obviously that the responsibility of the Department is to a strategic agenda. So it is building on the frame that Sir Jonathan Michael set. We will do that collectively and collaboratively as a partnership board with a proper system, and probably that includes political Members as well as other parts of the community, whether that is individuals in their own right or other parts of the sector beyond Manx Care, but it is our responsibility to make sure that that strategy and that strategic commission on the agenda is met.

So those are the three legs of our stool and clearly a lot of those responsibilities have sat with the Department but we are now set up and are setting ourselves up in order to be able to respond to that agenda. So that is really what the resource is about.

Q8. The Chairman: So, as a priority, would you put the Capacity Bill at the top of your agenda going forward? Obviously you have recently consulted on that. Are those outcomes published yet?

The Minister: Well I can only speak for myself, Madam Chairman. Obviously I cannot bind a new administration. I may well not be Minister for Health and Social Care in a few months' time, so what I can say is certainly, from my point of view, it is a priority. I think changes in capacity are long overdue. We need to have the legislation in place. I have made it quite clear in Tynwald several times that I believe it is a legislative priority of the Department and there will be a briefing

to Members on where we are up to in coming weeks, I do not know if it is this week or next week in fact.

There is movement already, but what happens come the end of September, that would be for a new administration and potentially a new Minister for Health and Social Care to decide. But certainly, from my point of view, it is a legislative priority.

Q9. Mr Greenhill: But are there any other areas that, at the moment, you would look to the future and say these are areas you think need – ?

The Minister: As Minister for Health and Social Care, one thing I have found in this role is you can build up a lot of priorities, to be perfectly frank. I think there are. I think there are around medicines prescribing; I have already said in the past about medicinal cannabis as well, personally for me I think is a priority.

But what we have to do is we have to appreciate there is limited resource and I think where things go wrong is when Government Departments try doing too many things at the same time and you end up actually slowing the whole thing down. So I would say if we had to focus on one legislative priority. That one priority from my point of view is capacity and ensuring that that is in the right place, because certainly as far as I can recollect, I think it has been talked about for about 11 years now.

Q10. The Chairman: And with regard to medicines and prescription charges, the previous Minister was coming forward with a paper for the increase in prescription charges. That has never come forward since you have been Minister. Obviously, it was felt by the Department it was the right policy to bring forward at that point in time, I think it was quite a significant increase, but you have not brought that forward.

The Minister: Well, it also did not find favour, if you remember, on the floor of Tynwald. The document was published by the Department at the time. It included not just an increase in prescription charges, but it also changed the criteria as well. There were several people who spoke out against it. In fact, I was one of them and I think you were as well, Madam Chairman, if I remember rightly at the time, because we did not feel the balance was right.

The Department has been looking at this, and hopefully in time for the start of the next administration there will be something that the Department can consider to be brought forward that hopefully might find more favour politically.

Q11. The Chairman: And with regard to … I know the CEO … I will bring you in just now, but in response, could you advise with regard to the NICE recommendations and how that would be tied in in the future?

Ms Magson: Do you want me take that, Minister?

The Minister: Yes, you can come in Kathryn.

Ms Magson: Can I just take a step back and do all of that at the same time, Ms Edge, if that is alright? So yes, from a legislative programme, we do have an extensive programme. Capacity is absolutely a priority, you have referred to the work we have under way. I think the private discussions with Tynwald Members as part of our consultation on the Bill is actually on Friday this week. That will be the second one we have done already, and that is the first stage of the capacity legislation.

The second stage we plan to do in autumn, under the next administration. So deprivation of liberty would be an area that we need to focus on with the next Minister.

There has been some really great feedback. After that we have the outcome of the consultation, and we are really ready to start the next phase. So it is on track, and members of the Committee will also be aware of the complaints legislation work that we are doing around regulations which, again, is a priority. The Minister has referred to everything being a priority and we are making sure we do all of these things well.

We are really keen as a Department to get that all right. We have this opportunity before November to get as far as we can, but ultimately that feeds into the third element, which is about the NHS Reform Bill. So there is a huge agenda there, and actually if fair to the NHS Reform Bill, that actually really is the reform Bill around health and care. We must remember that it must include both to make this work.

There is an extensive programme with the transformation team. They have with this significant policy work and legislative work, which we will not be able to do alone; we will need to do it with the professionals in Manx Care and also experts that we would might like to bring in, and I have referred to earlier, in those advisory roles. So that in itself, there are three big areas there.

In addition to that, we also have all of the work around the Mental Health Act. So, there is all the code of practice, the regulations around it, and also what is effectively, I would expect, a complete rewrite of the Mental Health Act as well. So that in itself, similarly, is another huge programme.

Then, as the Minister referred to, there are a number of Medicines Acts, and the issue with the medicines is that we are building and building, and effectively we need a wholescale review, and that is probably also long overdue. So, significant amount of areas there to address. (**The Chairman:** Okay.)

In relation to pharmacy, we are doing some work over the summer, again in the policy and legislation strategy teams that I referred about, in a couple of areas actually. One is the procedures of limited clinical effectiveness, so they are commissioning policies. So we do have some already but we are doing a benchmarking and gap analysis and then looking at where we should be in relation our sustainable future; a financial model but also a future clinical model that works with the right pathways that are working closely with Manx Care on it as part of its Transformation Programme. So we are doing a piece of work there to understand what changes need to take place and then it will be our intention to consult with the public on those.

Then the second one is also then the pharmacy charges that you have referred to. We do not think in reality there is a link between NICE technological appraisals (TAs) and pharmacies. Some people have created that link. Actually, they are two separate programmes of work in their own right, so we do need to look at a wholescale review of the position around prescription charges, so that work is also under way. As the Minister referred to, obviously there have been numerous conversations over this administration in doing so. But we do need to get that right and this is the intention of the officer teams to bring that to the next administration, for them to take forward with some suggestions. Again, that would also demand some consultation.

Then the last point you referred to about NICE TAs, again another one that has been closely around for a number of years: as you will be aware, the Department took a bid in last year in 2020-21 business cases; we have also been discussing that position again with Treasury and we will continue to do so. We do believe that that is important support that is needed, but clearly it needs to be in balance around what is funded by the public purse and how that links into other areas that we are trying to work. So for example, pathway transformations: how does the funding of NICE TAs support different ways in which we are delivering care and community, and similarly on and off island.

So, it is all interlinked and interdependent, but in their own right also separate, individual work streams and key pieces of work that the Department has to undertake in its role.

Q12. The Chairman: Just following on from that, one of the concerns which is always raised, and I am sure the Minister has this query raised, certain individuals for conditions that are classed as long term get their prescriptions for free, but certainly long-term cancer drugs are not included

within that. How would you be addressing that within any of this? Would it then change it to being just NICE recommendations? I do not know, how do you envisage addressing –?

***The Minister*:** That is a slightly different issue because that is around the model of prescriptions. So that does not necessarily tie in with NICE TAs as such because the NICE TAs would be basically following NICE to ensure that for anyone where it holds an approved TA, we would actually give it.

In terms of prescriptions, this again goes back to what happened the last time the Department came forward where the entire criteria were relooked at and changed. Now, maybe it was a bit too radical of a change, if I am being diplomatic – because of course as I said, both of us were quite vocal at the time about some of the changes – but I think the criteria do need to be looked at because they have not been updated for goodness knows how many years. In fact, I am happy to be corrected, but I think it might even be about 20 years since it was last *properly* looked at from top to bottom.

So, I think personally it does, but it is getting that fine balance of making it more modern, but at the same time not potentially penalising elements of society that potentially cannot afford for their prescriptions. So it is a fine political balance, and time will tell if the Department gets that right. That is one of the reasons why it has not come forward in quick time, because we want to make sure we take the time to think about it and that we assess it properly and then bring it forward when the time is right.

Q13. The Chairman: Obviously from our Committee's point of view, when we look at the social issues for people who perhaps cannot afford some of the prescriptions that are not within the criteria, you have continued help and support within those areas, have you? Or is it now getting people referred to charities?

The Minister: In what sense?

The Chairman: So, for instance, say somebody who could not afford to go away for treatment, and then they come back and the continuation of prescription is perhaps one they have to pay for. So obviously, there should be a link that if they could not afford … if there were difficulties for them when they were away having their treatment and being able to afford it, because they are, we used to call them, 'just about managing' in many areas. We do have people who sit just either side of the income support routes … How do you support people in those scenarios if a GP says this individual … how do they get their prescriptions if they cannot afford it?

The Minister: Well, the legislation is you pay or you do not based on the criteria in place and it is actually a legislative measure. It is not something within the gift of DHSC. The exemption criteria, I think I remember us being told, it is a huge majority of prescriptions that are free that are issued. There are very few people actually who do not fall into one of the criteria and do actually have to pay for their prescriptions.

Q14. The Chairman: So is that exemption criteria something that could be looked at and revisited?

I have seen it change actually myself when I have been either in the doctors' surgery or at the dental services, it does change on an annual basis when you put the orders through to increase the charges, but some of the categories have changed as well, so is that something that can be done through policy and legislation?

The Minister: I think maybe we are mixing two different points here. The prescription charge is a set charge and that has not actually gone up, I think, in about 10 years. Dental charges are slightly different. In terms of dental, that is completely separate.

Q15. The Chairman: But the criteria of list on all of these seems to be different, depending on which service you are doing. Is there one place that individuals could go to and look to see if they should be in an exemption category? Because perhaps they do not know.

The Minister: Well, for prescriptions it on the website. It is on the Government website, if people put in 'prescription exemption criteria'.

Q16. The Chairman: And the same for service provision?

The Minister: Well, for service provision it would depend – (**The Chairman:** Free dental.) Well dental, it would obviously depend if they were registered with an NHS dentist as a patient. If it is an emergency treatment, obviously they can access the emergency dentist, but it would depend upon them being registered as an NHS patient because dentistry is actually private.

I do not know if Kathryn has anything to add to that.

Ms Magson: No, I think you are absolutely right. There is a big difference between the elements of primary care around your GP versus your dentist, for the reasons that you have listed, but we do follow the guidance from across the UK. In all honesty when we have had this conversation, the key thing is clearly around the ongoing funding and the policy position around NICE TAs, so in reality that is the … we have learnt lots of different things, but that is really the nut to crack, I would suggest, in the first instance. As I have mentioned earlier, that is key around transformation in lots of different ways, whether that is through design as well as obviously the funding of that opportunity.

Ultimately, things like cancer drugs funds, which is a way that the UK is also structured for costly cancers, then that is something then that you can potentially look at as a further step-on, but for me the NICE TAs is the key. We can certainly, if anybody has got any specifics, point people to where they can find information around exemption criteria for prescriptions, but as I have referred to earlier we are going to do a piece of work on that anyway, as we look at prescription charges.

Q17. The Chairman: I think you said you have put another submission into Treasury. It sounded like you have put two in, one last year, one this year, for the NICE TAs. Both refused?

The Minister: We are in discussions with Treasury at the moment in relation to NICE TAs. There was a budget bid last year that actually was not approved; but I do need to point out the DHSC actually did get a lot of their bids approved last year by Treasury. There was a lot of support given to Health and Social Care, but one of the unsuccessful cases was the NICE TA drugs, and we have been having conversations with Treasury since, to see if there are any ways to get around that because it is important, and I have said this again publicly before, that people are able to access the drugs that will help them with their treatment.

Q18. The Chairman: So when do you hope to have an outcome to those discussions?

The Minister: I do not want to become a hostage to fortune on that! The conversations are ongoing, is what I would say.

Q19. The Chairman: Okay. And with regard to … I know a lot of the services have been transferred over to Manx Care now, but obviously as the Department, DHSC, you must have concerns about waiting lists and then the impact on other services. What support and help are you providing, and what business case would you be putting forward to make sure external and the tertiary care model …?

The Minister: I will bring Kathryn in in a moment, but the Department has been engaging very closely with Manx Care around this. I have expressed again publicly many times as Minister, my great concern is waiting lists, and particularly with the impact that COVID has had on that. If people were to ask me what keeps me awake at night as Minister, a lot would probably expect me to say COVID. It is not. It is actually the waiting lists and the potential impact on other treatments that we have seen, particularly in orthopaedics, to name just one of the areas.

So we have been engaging with the executive of Manx Care around a business case to try and actually bring waiting lists down. We have also … we have also been speaking with Manx Care, and I know Manx Care is keen to see what initiatives they can do in-house as well to try and speed things up. Certainly, for instance, during the last lockdown while we were not able to do potentially some overnight stay procedures, some of the day procedures went ahead to bring the day procedure lists down, so there are different ways of working that have been involved as well.

One of the issues, of course, though that we have is where, if you are going to do a waiting-list initiative and put resource at it, that resource has to come from somewhere. Now, the default position would normally be that resource would come from the UK. But in fact, the UK is in a very similar position. In fact, my UK counterpart this morning, Matt Hancock, was quite clear that it could take up to five years for the UK themselves to deal with the backlog that they have experienced.

So we have to be realistic in the fact that there is not a huge pool of resource out there that we can just drive, so we have been working with Manx Care on trying to come up with some innovative ways that we can try and work to bring the waiting lists down, because from my point of view, it is crucial that we do that, because in the COVID world we certainly have been living in for the last 15 months, it is important we do not forget everything else as well. It is very easy to become completely COVID-focused and we have to remember there are other people still suffering from other illnesses too, that need to be treated and need to be seen.

I will bring Kathryn in.

Ms Magson: Yes, just to add. So we have split up, in essence, with Manx Care the COVID backlog created by COVID *vis-à-vis* what was effectively the inherent waiting list, which had issues as we know. So if you are talking about the former, first of all, as the Minister has referred to, that business case has been developed. It is in the process of going through governance and discussions, and trying to map out, as the Minister says, a way to deliver that, because there is only finite resource and being able to use the resource in slightly different ways.

So an opportunity around using virtual clinics, for example, with out-patients, there are options around that. So there are lots of different ways that we are trying to crack this nut, but we are definitely in discussions then with Treasury then about how we might look at that in relation to the last 12 months.

Clearly, over the last 12 months we have taken a slightly different approach as we have got further along with COVID, and we have learnt, and increasingly obviously, we are clearly going to have to learn how do we manage services as well as living with COVID? As every lockdown has gone through, we have got better and better at keeping those services going. So clearly we would want to continue to ensure that footfall is as great as we can. So that piece of work is on train.

Then there is the inherent backlog of the waiting lists, of which there are a number of specialties with significant backlogs, as we know, that have only been compounded over the last 12 months.

So there are a lot of interdependencies here. Some are linked to pathway and design and some of the changes that are going on, particularly around primary care and grappling services around the registered list in the community. Some of those will take a number of years to come through to fruition, but … the ongoing form that is going in and particularly how care is delivered for patients, that ensure that waiting lists do not get longer and longer and we are just so reliant on secondary care. So that is one route.

There is clearly then a role for the community, self-management, self-care, and how we encourage people to think about where to access services and when services are relevant and when they are not. So there is a whole strategic agenda around that space, and the role of public health and people's health and well-being. So that clearly has a space in the longer-term.

Then more tactically, just to give you some ideas of what we have been doing, we have been doing catch-up clinics, so some of the cancer pathways that we probably talked about in this Committee before have been rolling since before Christmas. We have also been doing some extra waiting-list initiatives, we call them, in endoscopy, and the diagnostics. The Minister has referred to the work that we did in January around DNO, trauma orthopaedics and going to the day cases rather than focusing on in-patient beds, so that waiting list was cleared. That was in spite of the COVID lockdown position, that was something we felt could do and deliver on, which was important.

So there are lots of things like that been under way, but we have also then, in conjunction with Manx Care, started the theatres review, which was some years ago but that work is under way. In fact it is coming to completion now in the next few weeks. A key part of that work was looking at theatre sufficiency. Manx Care have started to see – because clearly operationally they are leading on this now – they are starting to believe that there is significant input that we can see, there are some changes that we could make in relating to the way theatres work from an efficiency perspective, which will help with that in-patient backlog which, as we know in some of those specialties, is significant in its own right.

So, a complex web of different issues, but there is the inherent risk and then there is the COVID risk. So managing this slightly differently, but ultimately our aim obviously is to be able to see the right person at the right place at the right time, as quickly as we can.

Q20. The Chairman: So, with regard to reducing waiting lists, it is not actually necessarily fixed resources as in the equipment; it is more human resource that is causing the issue? Obviously you can hire mobile units, and you see them in many places. So it is more the fixed resources? And have we done anything to focus, post-COVID, on how the successful the Isle of Man has been in not having overwhelming situations in the hospital at any point in time, to try and attract people to the island?

The Minister: Well, I would actually say that is already happening. There have been social media campaigns; we have been tying in with the Department for Enterprise as well. I know the Isle of Man is being talked about. I have friends who I went to university with who strangely were on very different courses to medicines, but ended up somehow in the medicine world, and I have one friend who is in Newcastle who said the Isle of Man is the talk of their WhatsApp group about the fact of 'Where would you rather be, in Newcastle A&E on a Saturday night or would you rather be on the Isle of Man?' And the international publicity the Isle of Man as a whole has had around COVID, as far afield as *The Sydney Herald* and also papers in Canada, I think has had impact.

Also, I think the other thing is that the changes that have been happening within Manx Care, the split off and the fact we have now got a very different health service being designed – many people are seeing that as an opportunity, so we have been recruiting in some areas that have been hard to recruit to in the past within the health service over the last … Nothing to do with COVID; even pre-COVID we were starting to recruit to some hard-to-recruit-to posts, and certainly of people who have started who I have been speaking to over that period, they have actually said that they believe that it is an opportunity for them to be part of something new, and to mould something.

But I think one of the issues you have is there is also this tendency that when you are in the middle of something, people stick with what they know, and at the moment – and it is not just in the medical profession, it is all the professions as well – the reluctance of people to chop and change because they still feel there is a level of uncertainty, and I think you see that in the UK NHS as well where people are sticking with what they know, rather than going off and taking up

another opportunity. But I think as things start to come down, I think certainly from a recruitment point of view, we have a great piece to market, not just around what happened with COVID, but also the fact that we are in a changing health and care system. It is changing in ways that you cannot really do in the UK with the multiple number of trusts, the legislation backing that up, the division by regions, the division by nations, Scotland, Wales, England. You have a real opportunity to be part of something here, where you can be part of the change and actually see that change delivered, and I think that is just as powerful a message as well. So I think there is a two-pronged message there for our health services to be sold wider afield.

I do not know if Kathryn has anything to add on that?

Ms Magson: Yes, I agree with you, Minister. This challenge is never going to go away where of course, particularly … it will never stop being high risk in a sense, especially for a small island. The key is making sure we have … We struggle with single points of failure, as we know. That is a constant balance.

But we have had some success, and I can name two examples. Even through the establishment of the changes that we have made, the structural changes which are only structural changes – we have to remember this is a long-term transformation programme – there are some really great people that have joined the health and care system over the last couple of years, which we are really proud of that, we have been able to achieve and it is on that momentum and that wheel that the Minister is talking about of attracting the right people to the Island because of what they believe the future holds as well.

Then to give another example, GP recruitment in particular has been one of the things that has taxed the Department for a number of years and will continue to tax, but we have to constantly look at the way and refresh the way, the things that we can do. So we did a specific dedicated programme with Locate.im. We supported around relocation costs. We did a programme where we worked on bringing people in as a salaried GP first, and then encouraging them to become partners. That has had some success. It is not the ultimate magic bullet, but it has had some success and I know that a number of individuals have been recruited to those roles on Island and have joined on Island in the last six months.

So, that is one example but there are many others, and it will be about some of the parts of making this work. So yes, there are lots of opportunities as well as lots of issues to manage and we will continue to do so.

Q21. Mr Greenhill: Are there any specific areas where we are hitting some problems? I know, for example in neurology, finding consultants has been a problem for some time. Is that still the case and are there some other areas that specifically are a problem?

The Minister: Yes, within that consultant level, that does tend to sometimes cause issues in trying to recruit to those. In some specialities as well, they are in high demand around the world, so it is not just here in the Isle of Man. In fact, the UK has very similar problems, as does Europe as well. So in terms of the specific specialities, I am not aware of any particular one that stands out. There are some that … It seems to come in peaks and troughs, I believe, in certain specialities, but certainly at consultant level that has been a problem in the past. The UK experience, as I say, absolutely similar problems and so does most of western Europe in trying to get the right staff in place.

I am not sure if Kathryn is aware of any specific blockage points?

Ms Magson: No, I think I would like to talk about two really big care groups in particular, we are all familiar with consultants and there are a number of single points of failure, one of which you referred to – the breast multi-disciplinary team we also struggle with. So we could go through a list of individuals as you know, but actually mental health is a big area with recruitment. We are not alone, but in reality we have the same issues and same concerns as the UK do, but that is one

that has struggled and continues to struggle, and we need to think of, and are thinking of, different innovative ways of trying to have a blended workforce that supports individuals holistically in an intermediate care approach.

The other one is social workers. We should not just talk about health; the care element is significant here and keeping that going is a really hard task, in fairness. Children's and adults', we should not underestimate that. So just to give you some examples, it is because of the depth and breadth of the services, the team are constantly focusing on it. As I said there is no one magic bullet that solves it, but it is going to be independency in lots of different things in taking this forward. Ultimately, looking at lots of different ways we can deliver services.

So, one of the things that clearly we have significantly seen is the change to a virtual model for the delivery of services. There is a role undoubtedly in that respect, in all elements of health and care, but there are also a model where that clearly is not appropriate.

But one of the ways that if you take a particular consultant, for instance, is that you use a solution that perhaps provides more resilience, where you have a networked and alliance-based approach. We definitely need to expand that further. I know Manx Care are having some strong conversations with the north-west network on how they do that. How they have individuals on a rotational basis – it is a really good development for them as well as obviously a benefit for the rest of the Island. But also how individuals are able to access clinicians virtually on Island and travel when they need to. It does not necessarily always mean that it has to be a face-to-face with a consultant on Island.

So we are going to have to look at lots of different ways that we can provide a solution here, particularly with the small services where more specialist care is needed, so lots of different interdependencies in order to be able to keep this going.

Q22. Mr Greenhill: There are some specific areas that have been really improved dramatically with the new MRI scanner, for example, that came in, in terms of being able to have the scan done here and have an online conversation with a consultant somewhere else has been a massive improvement.

The Minister: And that is the future. From my point of view that is the future. As the technology moves on, things can become a lot more digital. It can be transferred over, and I think that allows us, again, if we keep up with this, a unique opportunity where you can engage with specialist centres without actually physically having to send the patient. I know I have come before this Committee for, what, three years now as Minister? And one of the things Members will know is that my continuous thing is we need to digitise, we need to minimise the fact of patient travel. Where patients do not physically have to travel, then we should not be having to make them do so and if they can have those conversations over video link, then that is what we should be trying to utilise, but there has been some great innovations with huge charity support. It always amazes me the amount of money that the general public out there will raise to put into the health service and how passionate they are about it. We are very lucky with the third sector that we have on Island and their engagement, and that example is another one whereby working with charities we have been able to come up with a world-class facility; and it is a world-class scanner that we have managed to get in.

Q23. Mr Perkins: I would just like to come in there, if I may. The general public, you hear on the news about the share of data and stuff like that, does that impact on this sort of telemedicine?

The Minister: No. Obviously if the patient is receiving treatment, then the patient effectively has consented to the sharing of their data. If a patient wanted to turn around and say, 'Well, we do not want a specialist to look at our scan' or something like that, then the patient has the right to do that, but it is part of the treatment pathway. So again, it is one of these things with GDPR. GDPR is about ensuring that there is informed consent; if a patient is undergoing a treatment

pathway they are not going to want their data not shared with the relevant consultant. GDPR should not be seen as a barrier to sharing where it is necessary, and that is another prime example. So no, if it is in the patient's interests, it is part of the patient's treatment pathway, the data can be shared – in exactly the same way as when we used to send over physical files to the hospital where the patient was going, physical paper files. It is exactly the same process.

Q24. Mr Perkins: Caldicott principles and all that sort of stuff, yes?

The Minister: Yes.

Q25. Mr Perkins: Your local GP still has to agree to send patient data to the hospital. Am I correct in saying that?

The Minister: At the moment there is still the division. The GPs are data holders in their own right under law, so they have responsibilities as data holders and data co-ordinators in that regard. So yes, currently, there is still that division between the two.

Q26. Mr Perkins: Does that hold things up? Patients getting a hospital appointment or treatment?

The Minister: No, because generally it works the other way. So normally, what will happen is when someone tries to seek treatment, their first point of call is not always the hospital; it is actually the GP. So the GP is the one normally actually referring the person into services and, of course, in order to do the referral, the GP has to share the information to be able to do so.

Q27. Mr Perkins: And a patients has to sign something to say that is okay, or …?

The Minister: No, it is a referral, so the fact the patient has presented and is seeking help is effectively the consent.

Q28. Mr Perkins: Okay. One of the things this Committee is always interested in is early intervention and carrying on from the share of data, how much do you share data with the Department of Education, the Department of Home Affairs about possible problem families, if you like? Are you working closely with them in that regard?

The Minister: We work closely with all the Departments, not just Education and Home Affairs, but also, of course, Cabinet Office now because Public Health, after the Sir Jonathan Michael Review, has shifted into Cabinet Office. So, obviously specific personal information we have to be very careful again around this. That would get shared if there was seen to be a severe detriment, but in terms of the actual anonymised data we do work closely with Education and Home Affairs and in fact, that relationship has only got stronger during the COVID pandemic period when we have had to work together on many things to pull things together. That is an ongoing relationship, both not just at my level of ministerial but also at CEO level and at the officers below that as well.

Q29. The Chairman: Just touching back onto the topic of mental health, which is quite a serious one on the Island and has been exacerbated by the pandemic; however prior to that we did have large waiting lists. Previously, we had Mrs Murray in front of the Committee with, I think, either interim or then Head of Mental Health, Ross Bailey, and we were advised that they put a triage system in place and they would be appointing therapists.

I appreciate we have had a pandemic. I am not sure if that work did continue, that the people can access therapists and go through the triage? I think the triage was online, but obviously people

with mental health issues do not have access to online always. I am just wondering, has that continued? Will it continue? Was it done as a handover to Manx Care?

The Minister: I will bring Kathryn in first and then I will comment afterwards, if I may.

Ms Magson: Yes, so we did clearly come back to the latest provision of where they are. Nothing is stopped, in fact in the end it has been a seamless transition. The actual piece of work that was fundamental to the Mental Health team is trying to get the triumvirate structure in place. All the care groups have gone through a similar position where you have a medic, a nurse and a manager all working together to deliver for that care group. So they were successful in recruiting towards those posts a number of months ago now, actually. I was going to say the last quarter of this year, I just cannot quite remember off the top of my head, but it was around that time. That seemed fundamental to some of the work that they have been doing around their pathway work.

So everything that was linked to the Mental Health and Wellbeing Strategy is all continuing, so none of that has stopped and in essence, it is handed over, elements of: if it is about the operational delivery to Manx Care; if it more the strategic planning then it will be for DHSC to continue.

So we can certainly ask that care group to provide an update report for the Committee if that would be helpful, but nothing has stopped. Certainly, we had a mental health deep-dive with members of DHSC only a few weeks ago, looking particularly around the work they are doing, the work they are doing across the tiered structure and the approach that they are trying to enact which is all part of that plan that we have seen in the past. So we can certainly share that with the Committee, no problem.

Q30. The Chairman: I think it would be helpful for whoever comes in to take the Committee forward in the future.

The Minister: And of course mental health operates to a tiered structure, there is a tiered structure in place for assessment. There are the online facilities both for adults and children as well, which is what Ross was referring to when he appeared before the Committee with Angela, but one of the key things – and it ties in with early intervention that we keep talking about and I know we all in this room are passionate about – is in relation to children's mental health. That has been one of the pinch points in terms of waiting lists for quite a substantial time. But one of the issues is we have always combined up the autism within the CAMHS, and that is now being looked to separate out, and so a key piece of work that will actually help with the waiting list around children's mental health is the autism pathway and that is now starting to become quite an advanced piece of work, but that will be the one that will have the biggest impact on waiting times for children's mental health.

Q31. The Chairman: Okay. With regard to new appointees to our services on the Island that come over from the UK system, I have had a couple of constituents concerned about the way that they have been advised to go off and pay for this service there and do that, which seems to be a lack of understanding of the Manx way and how we do things differently here and how we support people. How does that transition work with an employer that comes from the UK that was perhaps familiar with … you have to go out and pay for a service?

I will give you an example of a discharge from hospital, for instance, they are advised, 'Well, you will have to get support in at home', whereas that has never been the way we have done it in the Isle of Man. We have always made sure that everything is put in place for people coming out of hospital. So how does that transition take place with employees coming out of a different jurisdiction to make sure they know the laws and the rules of the Island and how we deal with our patients?

The Minister: When someone joins the organisation, there are induction programmes, they are given information on how systems differ. You would also expect at that sort of level, they are professional people, you would expect them to ask if they are not certain and actually find out the information rather than just presuming. I know it is very easy to presume things sometimes, but you would expect at that level they would be going out and actually seeking the information or seeking guidance if they were not 100% certain on it.

Q32. The Chairman: I think it is the delivery to the patient that is the area of concern, so you could have a highly skilled consultant that does not necessarily know the process for discharge.

But another example is the 'Isle Listen' service that has been recommended to some people who are possibly not quite at crisis point, but go to Isle Listen, they get a phone number and they do not get an answer for over a week sometimes. How is that service being recommended by the Department? Is it supposed to be a response within … Is it a service level agreement? Is it a service that you are in contract with?

The Minister: No, it is not a service where we contract with, as far as I am aware. I know that they are there, Isle Listen. They are a very good charity. I have had involvement with them. They go out of their way to try and help clients, it would be at the low level. So maybe it is someone who …

I mean without knowing the details of the individual case, it is very hard. I have to assume here, I have to make some assumptions. But in relation to that, I would imagine that is someone who perhaps does not quite meet the threshold for being in the statutory services, but there is some underlying problems there. It is an accredited local organisation that is there to be referred to, so they have suggested that they contact Isle Listen.

Certainly the feedback I have had from people who have engaged with Isle Listen at all ages has been that it has been exceptionally helpful to them.

Q33. The Chairman: Okay. I think that is just again, signposting is always the difficulty for everybody –

The Minister: It is, and I think one of the key things again, it ties into the fact that we have a wonderful community here on Island with various different organisations out there, that in a larger jurisdiction such as the UK you just would not have. Your only alternative would be to end up in a statutory service, and if you did not meet the threshold you wait until you do; whereas here we have community-based organisations that we should, from my point of view, be utilising more and more to try to prevent it getting to the stage where we need to actually refer everyone into statutory services.

Q34. The Chairman: Okay. Just moving on to Manx Care quickly. Obviously we had the debate on Manx Care. How do you think … what has come out of that debate going forward and how do you feed as DHSC into Manx Care?

The Minister: Well, that is probably one more for me than the Kathryn as an officer. I thought the debate was exceptionally good. I thought it was a wonderful debate and it gave Members a chance to air their views. As I said when I opened the debate, and it was probably the shortest speech I have ever … anyone has had to be subjected to from me, where I simply said, 'I want to hear your views' basically, because that is what it was. It was a chance for Members to give their views and feedback.

The mandate, which is what the debate obviously was about, it is the first time we have ever done this and, as I said, it is not written in tablets of stone. It is an evolving document and it is going to evolve and change over the years. There will be things in there that will work. There will

be things in there that will not work, and what is important is we keep that evolution going by working with Manx Care.

So it was highlighted in the debate, there were some sections Members were not happy with. There were other sections that Members thought were absolutely amazing within the mandate, and the feedback from that debate will then inform the discussions as DHSC and Manx Care start moving forward to develop the next mandate, which will be for the financial year 2022-23.

So I think it was very worthwhile having, and I would like to thank all Members who input into that debate because it really gave a broad range of views to be considered.

Q35. The Chairman: Would you consider that prior to actually bringing the mandate forward, that should take place beforehand? You are saying the budget for 2022-23 –

The Minister: Well, the way the mandate works is before each financial year a mandate has to be agreed between DHSC and Manx Care based off the back of what the budget is likely to be. The mandate then has to be laid before Tynwald, so it is a laid before, although personally, as I said in the debate – although everything can change very shortly so I cannot tie anyone else – I personally would not have a problem with that actually being picked up for debate. Because it is laid before item, if the Minister does not move it in Tynwald, someone else could pick it up and do it anyway, so –

Q36. The Chairman: But sometimes it is too late when it is laid before. What I am talking about is perhaps discussions or some form of workshop with Members prior to the DHSC and Manx Care going forward with the mandate.

The Minister: I was just about to move on to that. I think particularly with it being a general election year, I would expect that after the election there would need to be engagement with Members so Members can understand the process, more than anything, and also have input into it, because it could be all change. The views expressed in the debate represent Tynwald as it is now. The views in just over three months' time might be very different. So we will need to have that engagement piece in DHSC afterwards with the new Tynwald around what they want to see

But the other thing with the mandate is the mandate will evolve continuously, but if you start getting the mandate right – it is dreadful to say this – it should actually be a rather boring document because it should not have to change too radically year on year. It should be tweaks and movement.

So although for the initial couple of years, I would fully agree that maybe there needs to be Members' engagement around it, after that if you are having to radically change it year on year, from my point of view there is something wrong. It should be tweaks here and there to keep it up to date and keep it in line with the latest medical thinking and the way the services are going, but it should not be a top-to-bottom rewrite every single year. After the first couple of years, it should evolve into a document that effectively just needs updating once a year with additional things.

Q37. Mr Perkins: Do you think we should have the Head of Manx Care appearing before this Committee in future?

The Minister: There is nothing to prevent you from doing so! In fact, you could do it as part of the evidence session, this annual evidence session. The world has changed now, so perhaps the annual evidence session should be the CEO of Manx Care, CEO of DHSC and myself, whoever is Minister. But since it is an independent organisation, I am not going to tie them to it as Minister.

Mr Greenhill: You have stolen my question!

Mr Perkins: Oh, sorry! (*Laughter*)

Q38. The Chairman: Okay. I think the good thing that everybody is really happy with is that Manx Care are doing public meetings that the public can go along, and I think there is opportunity to ask questions. I do not think they have to be answered, but I think there is opportunity. But with regard to that, from a Member's point of view and a parliamentary committee point of view, there was certainly a document or an e-mail put out with regard to how they will communicate with elected Members and deal with issues.

Obviously, as elected Members, we deal with our constituents in the best way possible. When that came out, I must admit, I was a little bit surprised to see it because we have always had good relationships with officers in the DHSC and we have always been able to get answers quite quickly to help support our constituents. Do you have a view on that, Minister?

The Minister: Yes, I think it was important to have a formalised document. Obviously, I had many discussions with both the Chairman and CEO of Manx Care ahead of that document, mainly the Chairman before it came out. I think it was important to formalise it and structure it because Manx Care is independent as a body. So there needed to be that separation between where queries went because Members have a multitude of queries. I do myself. I put a lot of queries in via my office from people who contact me. So where it is care and delivery related, it would go through the CEO's office of Manx Care. Where it is policy or strategy, it will come through DHSC, and in fact there may well be queries that cover both where there needs to be an answer, the joined-up answer, between the two. So it was important that Members were aware of how that system was going to work.

Now, I know there was a bit of concern around this 20 days thing that came out, about 20 days to respond to queries, but that is in relation to complicated queries. Most queries, certainly the ones I have raised, have been back and forth within a couple of days. I know a couple you have raised with me, Madam Chairman, have come back within a couple of days, and it works that way.

But I think it was important to have some form of structure around how Manx Care is going to engage with Members, just so there is no confusion on both sides, really. There is something clear that is there, because while it was all one Department, what tended to happen was political Members would get in touch with me as Minister, and then it would go through my office and then it would normally come back through me to the political Member, unless the political Member had approached an officer.

But also, under the old system, while there was no formal structure as such, you could have people who may know someone at certain points in the chain contacting that person. Now, that might not be the appropriate person to contact, and what that actually did was it slowed down the query, and you had Members perhaps even on some occasions contacting officers that, at their level, they are not really the appropriate level to be contacting. So that actually convoluted the process.

So that is what this was all about. It is about trying to show to Members there is a formal structure in place, and also to hold Manx Care to account by elected Members, that if that structure is not followed and Members are not getting answers, they have something they can physically wave and say, 'Where is my answer? You are not following your own policy in dealing with elected Members.'

Q39. The Chairman: Right. As Minister, and this is definitely one for the Minister with regard to the political make-up of the Department, do you see that changing going forward?

The Minister: I think it will change. One of the things I have changed within it already is obviously, the Members used to have individual delegations. They still do, but they are delegations that are now policy in that area.

So for instance, Mrs Sharpe has held the Children and Families delegation since she joined the Department. That was an operational delegation so she would be talking to children and families about how services run on the ground. That has now switched to how she is a point for children

and families in Manx Care to be able to politically contact in the Department if they have issues with policy and strategy.

I think the structure after the election probably will change dramatically, but that will again be up to whoever is sat in my seat in three and a bit months' time.

Q40. The Chairman: Just touching there, you mentioned Children and Families. How do you feel that service is providing support and help to families at the present time? Is there a new CEO?

The Minister: Children and Families, I think, has struggled mainly because of the pandemic period because a lot of what Children and Families do has to be face to face. They have tried to maintain that, and I think they have done a very good job of trying to maintain that over the period, but it has been a struggle for them, and it has been a struggle for families as well because they have been used to that support and engagement at a face-to-face level. That has not been able to be delivered in the same way.

I think the Department has managed to come through. I think there is a very different culture in Children and Families that has developed over several years now. There are still issues and pinch points, but I think the service is moving forward. Also, there has been a bit more stability around the staffing as well, from my understanding.

Q41. The Chairman: And that is obviously the succession planning and training our own, if you like. That has helped.

The Minister: I think all of the initiatives that have been put in place – even before my time, I am not going to try and claim credit for as Minister – predate me, that have taken several years. The problem is when you change something in a Department like Children and Families, it is like the trickle-down effect. It can take five, six years before things embed in place. So what we are seeing now is the realisation of things that were starting a long time ago.

Q42. The Chairman: Okay. Anything else? The last one that we have asked everybody in front of us today: what would you say the priorities for the Department are in the new parliamentary term?

The Minister: Well, we have touched on it already so it is a nice, easy one for me – the Capacity Act.

Q43. The Chairman: Only one? You haven't got a top three? (*Laughter*)

The Minister: I have got a top 20, Madam Chairman, (*Laughter*) but I will not bore you with the full list!

The Chairman: Okay. Thank you both for coming in this morning. It has been a bit of a whistle stop, but thank you for attending.

The Minister: I will just add, because this might be my last appearance before the Committee as Minister. Can I thank the Committee for the courtesies they have shown the Department over my time as Minister. And prior to my time as Minister, of course, I was a member of the Committee, so I have seen it both sides and I would like to thank the Committee and their Members for the scrutiny work they have done for the Department.

The Chairman: Thank you. Okay, we will now sit in private.

The Committee sat in private at 1.15 p.m.