BOARD OF DIRECTORS – MEETING TO BE HELD IN PUBLIC
1 September 2022 9.30 – 12.30 PM

Ramsey Town Commissioners, Town Hall, Ramsey, IM8 1RT

manx care
Kiarail Vannin

NB. There is a presumption that papers will have been read in advance, so presenters should be prepared to take questions as directed by the Chair. They will not be asked to present their reports verbally. Questions should be advised to the Chair in advance of the meeting where possible.

A G E N D A

Minute number	GOVERNANCE	Lead	Page	Time
125.22	**A Public Apology to the Isle of Man Information Commissioner** **Welcome & apologies** **A welcome to Tim Bishop and Aneurin Pritchard**	Chair	3 Verbal	9:30
126.22	**Declarations of Interest**	Chair	5	9.35
127.22	**Minutes of the meeting held in public** *- 24 May 2022*	Chair	9	9.40
128.22	**Matters arising/Review of Action Log**	Chair	18	9.45
129.22	**Notification of any other items of business**	Chair	Verbal	9.50
130.22	**Board assurance framework for 2022-2023**	Bd Sec	19	9.50
	UPDATES			
131.22	**Chair's report**	Chair	27	10.00
132.22	**Chief Executive's report and horizon scan** - DHSC Department Plan - Manx Care 2021-22 Annual Report	CEO	28	10.10
133.22	**Committee Chairs' Exception Reports** - Audit - Digital & Informatics - QSE - FP&C - People – BMA Racism in Medicine Survey	Comm Chairs	133	10.30
	REFRESHMENT BREAK 11am			
	PRIORITY ONE – PATIENT SAFETY			
134.22	**Integrated Performance Report**	Dir of Operations	192	11.10
135.22	**Quality Dashboard**	Dir of Nursing	244	11.15

136.22	**Nursing Workforce Update**	Dir of Nursing	251	11.20
137.22	**Safeguarding Structure Update**	Dir of Social Care	267	11.30
138.22	**Restoration and Recovery Update** - Update on waiting times - Theatres & Anaesthetics	Dir of Operations	272	11.40
139.22	**CQC Inspection**	Dir of Nursing	275	11.50
PRIORITY TWO - CREATING A POSITIVE WORKING CULTURE				
140.22	**Social Care Investigation, Workforce and Culture Review and Action Plan**	Dir of Social Care	281	12.00
141.22	**BMA Survey and Action Plan**	CEO	316	12.10
PRIORITY THREE – SUSTAINABLE FINANCE				
142.22	**Finance Report:** - **July 2022 Management Accounts** - **2023/24 Budget Submission** - **Back to Balance**	Director of Finance	323	12.20
ANY OTHER BUSINESS				
143.22	**With prior agreement of the Chair** - **A thank you to Barbara Scott**	Chair		12.30
FORMAL MEETING CLOSES AT 12.30 - QUESTIONS FROM THE PUBLIC				
The Board will respond to questions from the public		All		
MEETING EVALUATION				
Board review – feedback on the meeting: effectiveness and any new risks and assurances		Chair	Verbal	
DATE OF NEXT MEETING TO BE HELD IN PUBLIC: 1 November 2022				

PUBLIC APOLOGY

This is a public apology to be made on behalf of the Board of Manx Care to The Information Commissioner.

At the board meeting of Manx Care held in public on 24 May 2022 the minutes of the board meeting held on 5 April 2022 were approved. It was subsequently brought to my attention by the Information Commissioner that the minutes of 5 April 2022 contained wording which was factually inaccurate.

During an update given by Mr Andrew Guy at agenda item 48.22 the minutes state that 'The integration of primary care was being hampered by the inability to satisfy the ICO of the robustness of data sharing agreements that had been drafted by subject matter experts. The ICO was also making clinical judgements regarding the level of information that clinicians could access. Such delays could pose a threat to the Transformation programme'.

The statement that 'The ICO was also making clinical judgements regarding the level of information that clinicians could access' was not made by Mr Guy or any other participant at the meeting. This statement is simply inaccurate. I wish to make clear that the Information Commissioner has not made any clinical judgements whatsoever.

The reference to 'data sharing agreements' is also inaccurate. The reference was to data sharing in general.

The full transcript of the discussion is detailed in full below:

48.22 Committee Chair Reports

Audit Committee (recording time 1.05.14 – 1.07.40)

Andy Guy

"There is only one thing to basically raise which is, what you have already heard from two separate pieces is about data sharing and at Audit Committee we effectively heard that trying to satisfy the Data Commissioner about the robustness of our arrangements is actually hampering and is likely to hamper progress particularly in the Integrated Care space which is absolutely dead in our sights for our requirements for this year. We have to make progress and therefore that's the only thing we can see particularly would be a very, very large obstacle to get over and we need to get over it quickly. I'm not quite sure what approach we should take but I guess it's reasonable to have a few other ideas."

Teresa Cope

"I think we've got a meeting scheduled with the ICO in the next two or three weeks and they are sat on our Advisory Board so we do have their expertise and advice into the Advisory Board. What we need to try and convey is a level of co-operation so they understand the context in which we are working but then we work with them. They would rather know things in advance and work with us

through that journey. I think we do start on the back foot a little bit but I am hoping that the meeting we have in the next couple of weeks where we share a wider set of plans and a route to compliance, which we will discuss at the Advisory Board tomorrow will start to reshape that relationship with the ICO. I do acknowledge it's incredibly challenging and has all the potential of stopping us really proceeding with the level of integration that we all hope and aspire to, and the reason Manx Care was fundamentally established, but I am confident we can work through that."

Andy Guy

"Would you be happy if we just brought that back to the Audit Committee in a couple of months just to check to make sure we are making adequate progress?"

Teresa Cope

"Yes, absolutely, I think that whole journey to information governance, compliance and data sharing is one of our key risks and our key priorities to resolve in the next few weeks."

Andy Guy

"Thank you"

The minutes of the 5 April 2022 will be amended to reflect that it is not a true and accurate record. The minutes of this meeting will accurately record what was said.

I, on behalf of the Board of Manx Care, offer my sincere and unreserved apologies to the Information Commissioner for this error. I would like thank the Information Commission for bringing this to my attention and for providing the opportunity for the minute to be corrected.

Register of Directors' Interest
1 August 2022

manx care

Kiarail Vannin

Name	Position within, or relationship with Manx Care	Type of Interest	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates		Is the interest direct or indirect?	
				From	To	Direct	Indirect
Andrew Foster	Chair	Other interest	Remunerated Non-Executive Director of Health Education England which has an indirect bearing on clinical education and training on the Isle of Man	Nov-19	Nov-23	X	
Andrew Foster	Chair	Other interest	Unremunerated Trustee of ENT UK	Jul-20	-	X	
Andrew Foster	Chair	Other interest	Unremunerated President of the Global Training and Education Centre at WWL NHS FT. May be used by Manx Care for international recruitment	Oct-19	-	X	
Sarah Pinch	Non-Executive Director	Direct Financial Interests	Managing Director, Sarah Pinch Limited T/A Pinch Point Communications, consultancy provider for many NHS organisations in England	Jan-13	-	X	
Sarah Pinch	Non-Executive Director	Direct Non Financial Professional Interest	Chair of The Taylor Bennett Foundation, a charity supporting BAME young people into careers in PR and Communications	Oct-17	-	X	
Sarah Pinch	Non-Executive Director	Direct Non-Financial Personal	Independent Advisor to the Senedd, chair of REMCOM	Nov-18	-	X	
Sarah Pinch	Non-Executive Director	Direct Non-Financial Personal	Trustee of Bristol Students Union, member of REMCOM	Nov-20	July-22	X	
Katie Kapernaros	Non-Executive Director	Direct Non-Financial Professional Interests	Non – Executive Director, The Property Ombudsman. Remuneration and Nominations Committe	Jan-19	-	X	
Katie Kapernaros	Non-Executive Director	Direct Non-Financial Professional Interests	Non – Executive Director, The Pensions Regulator. Remuneration and People Committee.	Apr-20	-	X	
Katie Kapernaros	Non-Executive Director	Direct Non-Financial Professional Interests	Non – Executive Director, Oxford University Hospitals NHS Foundation Trust. Remuneration, Appointments and Audit Committees, Equality and Diversity board champion.	Oct-19	-	X	
Katie Kapernaros	Non-Executive Director	Direct Non-Financial Professional Interests	Non – Executive Director, BPDTS (Digital supplier to Dept. of Work and Pensions) Remuneration and Nominations Committees.	Feb-19	Jun-21	X	
Andy Guy	Non-Executive Director	Indirect Interest	Son is employed by St Christopher's Fellowship who are a supplier of services to Manx Care	current		n/a	
Nigel Wood	Non-Executive Director	Indirect Interest	Wife is employed by Manx care as a part-time radiographer in the X ray department of Nobles Hospital		July 22		X
Nigel Wood	Non-Executive Director	Other Interest	Nigel's business offers a registered office facility to a Radiology online training service owned by an un connected individual. Previously had provided guidance on establishing a business. No remuneration received.	current		X	
Dr Richard Hillier	Independent Committee Member of the Mental Act Legislation Committee	Nothing to declare	Nothing to declare	n/a		n/a	

Name:	Position within, or relationship with Manx Care:	Type of Interest	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates		Is the interest direct or indirect?	
				From	To	Direct	Indirect
Dr Sree Andole	Medical Director	Professional	Specialist Advisor, Care Quality Commission UK	2012	-	X	
Dr Sree Andole	Medical Director	Financial	Governing Body member, Southend on Sea CCG, UK	2019	-	X	
Dr Sree Andole	Medical Director	Non-Financial/Professional	Expert Advisor, National Institute of Clinical Excellence (NICE) UK	2019	-	X	
Dr Sree Andole	Medical Director	Non-Financial/Professional	Physician assessor for MBRRACE-UK Confidential Enquiry into Maternal Deaths, Royal college of Physicians, UK	2019	-	X	
Dr Sree Andole	Medical Director	Non-Financial/Professional	Clinical Reference Group for Neurosciences – NHSE, UK	2019	-	X	
Dr Sree Andole	Medical Director	Non-Financial/Professional	Honorary Consultant in Stroke, Liverpool University Hospital's NHS Foundation Trust	2022		X	
Sally Shaw	Director of Social Care	Direct Non Financial Professional Interest	A member of Unison the Trade Union	2019	-	X	
Sally Shaw	Director of Social Care	Direct Non Financial Professional Interest	Board member of a third sector organisation in Aberdeen - Inspire	2018	2021	X	
Paul Moore	Director of Nursing & Clinical Governance	Financial	Director & Shareholder of PM Governance Limited providing Risk Management and Governance Consultancy in UK & Europe	2013	-	X	
Paul Moore	Director of Nursing & Clinical Governance	Financial	Wife is a Director & Shareholder of PM Governance Limited providing Risk Management and Governance Consultancy in UK & Europe	2013	-		X
Paul Moore	Director of Nursing & Clinical Governance	Direct Non Financial Professional Interest	Justice of the Peace, Greater Manchester Bench, UK	2008	2018	X	
Paul Moore	Director of Nursing & Clinical Governance	Non-Financial/Professional	Specialist Advisor, Care Quality Commission UK	2015	-	n/a	
Barbara Scott	Director of Infrastructure	Direct Professional	Accepted the role as CEO, Elder Care effective on retirement from Manx Care	June-22		n/a	
Oliver Radford	Director of Operations	Nothing to declare	Nothing to declare	n/a		n/a	
Teresa Cope	Chief Executive	Indirect interest	Husband was employed by Manx Care as a bank porter	2021	2021		
Teresa Cope	Chief Executive	Direct Non Financial Professional Interest	Trustee of Cornerhouse Yorkshire	TBC		x	
Jackie Lawless	Finance Director	Non-Financial/Professional	Employed by Treasury Department's Financial Advisory Service - Assigned to Manx Care	n/a		n/a	
Anne Corkill	Director of HR Business	Non-Financial/Professional	Member of Prospect Trade Union	1989	-	X	
Anne Corkill	Director of HR Business	Non-Financial/Professional	HR Director of Business for Office of Human Resources	May-21	-	X	
Richard Wild	Chief Information Officer	Direct Non Financial Professional Interest	Shareholder in Ethos Ltd, a company providing expertise in the regulatory and compliance field for software for healthcare in the UK	2014	-	X	
Richard Wild	Chief Information Officer	Non-Financial/Professional	Chair of the Treasury ICT Governance Board	Apr-21	-	X	
Dr Oliver Ellis	Executive Director, Primary Care	Financial	Partner, Peel Group Practice	Jan 21		X	

Dr Oliver Ellis	Executive Director, Primary Care	Financial	Partner, Laxey Village Practice	Sept 18	Dec 20	X	
Dr Oliver Ellis	Executive Director, Primary Care	Financial	Zero Hours Contractor, MEDS	Aug 18		X	
Dr Oliver Ellis	Executive Director, Primary Care	Non-Financial	Chair, Isle of Man Primary Care Network ('PCN'). The PCN received funding from Manx Care for its ongoing operation.	Nov 20		X	
Dr Oliver Ellis	Executive Director, Primary Care	Non-Financial	Wife is a physiotherapist employed by Manx Care and a CSP trade union representative				
Elaine Quine	Board Secretary	Nothing to declare	Nothing to declare				

BOARD OF DIRECTORS
Tuesday 24 May 2022
The Lodge, Nobles Campus, Braddan
1.30pm-3.00pm

Present:

Non-Executive Directors

Andrew Foster (AF)	Chair
Sarah Pinch (SP)	Vice Chair
Andrew Guy (AG)	Non-executive Director
Nigel Wood (NW)	Non-executive Director
Katie Kapernaros (KK)	Non-executive Director

Executive Directors Voting

Teresa Cope (TC)	Chief Executive Officer
Paul Moore (PM)	Director of Nursing and Governance
Sally Shaw (SS)	Director of Social Care
Dr Sree Andole (SA)	Medical Director

Executive Directors Non-Voting

Dr Oliver Ellis (OE)	Medical Director, Primary Care
Andy Chittenden (ACH)	Director of Corporate Affairs
Anne Corkill (AC)	Director of HR Business
Oliver Radford (OR)	Director of Operations
Richard Wild (RW)	Chief Information Officer

In Attendance:

Sam Allibone (SAL)	Finance Business Partner (Deputising for Director of Finance)
Elaine Quine (EQ)	Deputy Board Secretary and Minute Secretary

Apologies

Barbara Scott (BS)	Director of Infrastructure
Jackie Lawless (JL)	Finance Director

GOVERNANCE

Item **Action**

111.22 Welcome and apologies

AF welcomed everyone to the meeting. Apologies had been received from Jackie Lawless and Barbara Scott.

112.22 Declarations of Interest

There were no declarations of interest relevant to the meeting**.**

113.22 Minutes of the Board meetings held on 5 April 2022 (public)

The minutes of the meetings held on 5 April 2022 (public) were accepted as an accurate record.

114.22 Matters Arising and Review of Action Log

There was one matter on the action log which had been completed and another matter that was on the agenda for discussion.

115.22 Notification of any other items of business
There were no additional items to be added to the agenda.

116.22 Governance Developments
Board Assurance Framework ('BAF')
The Board assurance framework ('BAF') for 2022-23 was previously discussed by the Board on 5 April 2022. At that time the BAF captured seven risks of failure to achieve the objectives for the current year. The objectives and the risks of failure to achieve them related to the three priorities set out in the required outcome framework. That framework sets out how Manx Care plans to respond to the Mandate issued by the Department of Health & Social Care ('DHSC').
Those three priorities for 2021-22, which are retained for 2022-23 are:

1. Improving patient safety.
2. Creating a positive working culture.
3. Improving financial health.

Each of the '22-23 BAF risks had an allocated Executive lead and specific Board Committees that have a role in seeking and scrutinising assurances as to the effective operation of control systems take a lead in evaluating the prudent control of strategic risk. These Committees review progress made in developing controls and providing assurance against delegated risks monthly or bimonthly. The Audit Committee has an interest in the whole process and collectively these Committees provide assurance to the Board through escalation reports. It was requested that the background colour be changed from green. It was noted that some scores were 25 but had been rated as amber. ACH would review with each owner. **ACH**

UPDATES

117.22 Chair's Report
AF explained the rationale for holding the current meeting and an annual public meeting later in the afternoon. The former meeting would deal with the usual Board business and the latter would be the opportunity for Manx Care to look back on its performance over the past twelve months and to provide a look forward to the next twelve months. There would be representatives from care groups and service partners and members of the public would have an opportunity to meet with colleague ask questions about the services provided.

The recruitment for the new non-executive director was ongoing and interviews would take place in June.

118.22 Chief Executive's Report and Horizon Scan
Covid -19
The Isle of Man moved to an endemic approach to Covid-19 from 1st April. The number of Covid positive patients in hospital had continued to reduce and the dedicated Covid ward had closed in mid-May.

Vaccination Programme
The vaccine programme was continuing to deliver the spring booster programme in parallel with the 5-11 vaccine programme as well as offering the jab to anyone who required a booster dose.

ME/CFS/Long Covid Service Development Project
Following the securing of £450k of recurrent funding as part of the 22/23 budget settlement, a Service Development Lead had been secured who was dedicated to the development of the

ME/CFS/Long Covid service. In addition a dedicated therapist had also been resourced to take a lead on the clinical aspects of service development for a limited period until the service is launched. This would allow the development of the service to be achieved at pace. A project governance structure had been developed and the first cycle of project board/project delivery group and the sub groups had taken place and a first draft of the project plan had been formulated with a proposed launch date of the adult service of the third week in September.

Required Outcomes Framework 22/23

Following approval of the Required Outcomes Framework for 22/23 at the Manx Care Board on 3rd May, the documents had been shared with the staff, partners and placed on the Manx Care website. The document has also been shared with DHSC and will be laid before Tynwald in June 2022.

Annual Performance Review

The Annual Performance Update provided a summary of Manx Care performance against the commitments outlined within the 2021/22 Required Outcomes Framework (ROF). Ambitious targets had been set with the aim being to make substantial progress during the first year operating as an independent organisation at arm's length from the DHSC, whilst also recognising and accepting that it will take a longer period of time to fully deliver and embed all of the recommendations from Sir Jonathan Michael's independent review.

During 2021/22 activity was aligned against three strategic priorities

- Improving Patient Safety
- Creating a positive Working Culture
- Improving Financial Health

The service improvements that had been made had been delivered during what had proved to be an extremely difficult and challenging period due to the pandemic. The performance update was not designed to be exhaustive, but to provide a summary of the progress made. Full details would be provided in the Annual Report which would be published later in the year.

TT Preparation

System wide preparations for the TT had been ongoing for several months. Staffing gaps, due to either increased vacancies or increase in demand (or both) had been identified and requests for additional staff have been made. All of these gaps have now been filled either through agency requests or, in the case of the Ambulance Service, through a request for mutual aid which has been filled by the Welsh Ambulance Service and the Guernsey Ambulance Service. As such staffing resilience across all services is now showing 'green' on the RAG status. All impacted services had undertaken at least one emergency planning exercise to stress test the system should a mass casualty incident occur. As a result of these exercises, operational arrangements have been amended and additional equipment ordered. A new command structure would apply to this year's event which has been possible thanks to the introduction of an exec level on call rota within Manx Care.

Emergency Department ('ED') Staffing

The ED Safe Staffing business case had been submitted and approved by Business Case Review Group and Executive Management Committee for budgetary approval for 50% of funding in-year.

Cancer Services

Macmillan Matron funding and administration support had been approved from Macmillan Cancer Support. A Cancer Performance Day had been held in April whereby all cancer tumour site teams and support services presented their activity, challenges, successes and vision as part of the Cancer Clinical Lead's Bi-Annual Programme.

Performance and Accountability Reviews ('PAR's)
PAR's had been held with each care group. The purpose of the reviews was to obtain assurance of the sound governance and control systems in each group.

BMA Survey
An action plan to address the findings of the BMA survey was being devised.

119.22 Committee Chair Reports
The Chair invited the respective Chairs of Board assurance Committees to escalate to the Board matters of note relating to the Committees' scrutiny of controls and assurances that strategic risks were being mitigated effectively.

Audit Committee (re meeting on 20.05.22)

AG made the following observations:

- The 2022/23 audit plan would be reviewed in light of the BAF. There was a concern regarding the limited resource available from Internal Audit

Quality Safety and Engagement Committee Update (re meeting on 17.05.22)

SP made the following observations:

- A review of the ENT service had been undertaken and an action plan was being devised and would be brought back to the QSE which would maintain a watching brief on the service.

Finance, Planning and Commissioning Committee Update (re meeting on 20.05.22)

NW made the following observations:

- The Referral to Treatment plan would require discussion at the board as it could have significant financial implications for Manx Care

People Committee Update (re meeting on 09.05.22)

SP made the following observations:

- A very positive staff story had been received
- Pay negotiations remained ongoing

Data and Informatics Committee Update (re meeting on 12.05.22)

KK made the following observations:

- The representation of Manx Care colleagues at the Manx Care Record Advisory Board

would be strengthened

Mental Health Act Legislation Committee (re meeting on 19.05.22)

AG made the following observations:

- The delegations in place for independent bodies were outdated and had been raised at the Board to Board meeting with the DHSC
- The Association of Hospital Managers was understaffed and there were too few hearings taking place
- The MHAL would change designation from a Board committee to a management committee and any concerns would be escalated via the QSE committee

120.22 Integrated Performance Report (IPR)

The report was noted.

Director of Operations Update
A concern had been raised by the Primary Care Network in regard to data sharing. A meeting would be held with the Information Commissioner and the Chief Pharmacist to find a solution. It was queried why if the number of theatre sessions were increasing theatre utilisations figures were decreasing. OR explained that utilisation had declined largely due to cancellations due to bed pressures which were due to Covid. All wards were now operational and it was hoped that the figures would improve from April onward.

Director of Social Care Update
The number of individuals (or their carers) who had received a copy of their Adult Community Care Assessment had reduced from 88% to 30% which was a concern. Children's data remained static however there were no referrals so SS would look into this. The numbers of young people requiring CAMHS support was continuing to increase. SS stated that Covid had a large impact on young people's mental health. Some young people had been transferred to Isle Listen to relieve the pressure on CAMHS but additional funding was required to continue the service. The 'I Thrive' model was very important to the development of the children and adolescent strategy for the forthcoming year.

Director of Nursing Update
The statistics on falls management were good especially regarding falls with harm. Serious incident exposure was below the threshold and there were no outstanding investigations. Good progress was being made on the safer surgery project and there had been full compliance with the duty of candour during the reporting period. Items requiring improvement were VT assessment needs, antimicrobial stewardship, the timeliness of complaints processing, CAS alerts and mandatory training.

121.22 Restoration and Recovery ('R&R') Update
Endoscopy
The in-house endoscopy R& Restoration elective work stream was progressing well.

Cataracts
From mid-March to date 265 cataract operations have been successfully completed. This included each patient having their 6 week post op appointment. It was anticipated that a third block of cataract operations would be delivered in June.

Outpatients
The intention of the business case was to deliver this cohort of consultations via a virtual hospital model. Medefer Ltd had been identified as being able to deliver the required service. A cautious approach was being taken to ensure that Manx Care could acclimatise to the impact of the contracted increase in activity.

Mental Health Patient Backlog
Minds Matter the proposed partner for the procurement that will address the Mental Health patient backlog. Minds Matter would facilitate a treatment programme of 12 month duration for 157 patients.

Hip and Knee Activity
Manx Care would complete 49 hips or knee replacement operations between 20th April 2022 and 13th of June 2022. All surgery will be led by Nobles Orthopaedics Consultants supported by Synaptic theatre and nursing staff. Over 70% of patients had a one day length of stay.

Wait Times
There had been doubt expressed by GP's regarding the wait times. OR stated that there were significant data quality issues and there was an ongoing data validation exercise which should be completed within three months.

122.22 Workforce and Culture Update
Vacancy figures were now in a steady state. A mandatory training policy was being drafted as was a dashboard of courses available on E-Learn Vannin. The workforce and culture 22/23 plan would need to be re-prioritised and aligned to the OHR plan. This would be monitored at the People committee.

PRIORITY THREE – IMPROVING FINANCIAL HEALTH

123.22 Finance Update

The March management accounts were noted.

The April figures were on budget but it was expected that costs would increase due to higher tertiary and employee costs. A forecast had been prepared to highlight the current financial risks and had been shared with the DHSC to agree how the funding gap could be bridged.

124.22 Any Other Business with Prior Agreement of the Chair

There being no further business the meeting closed.

The Chair invited questions from the public observers.

(Q) The GP surgery in Ramsey requires urgent attention. A triage system should be introduced and the current appointment system should be abandoned.

(A) The comments were noted. GP's would always be interested in innovative solutions to improve accessibility for patients.

Questions that had been received in writing prior to the meeting had received written answers which are reproduced in full below.

(Q) Given that the Chief Minister, Health Minister and Treasury Minister are now all located in the north of the Island can Manx Care please identify what the difficulty is in providing a new modern medical centre for the north of the Island. In particular, can Manx Care please detail what steps have been taken so far to evaluate the project, to meet with stakeholders and interested parties and to otherwise open a detailed consultative process. Could Manx Care please identify any party or individual that has opposed the proposal and the reasons given.

(A) *Whilst it is appreciated that the Chief Minister, Health Minister and Treasury Minister are all located in the North this has no bearing on any plans for the service provision in the North which of course is based on patient need. The North is currently served by two GP Practice Premises, one in Jurby and one in Ramsey. The surgery in Jurby was purpose built by IOM Government in 2010-11 and the Practice Premises in Ramsey which are owned by the Ramsey GP Practice Partnership were recently updated. In addition to the two GP Practice premises the North is currently also served by the Cottage Hospital, which provides a minor injuries unit, phlebotomy service and an in-patient service. Manx Care are currently reviewing the requirements for some additional clinical facilities in the North, South, East and West in order to fulfil the intentions of providing 'Primary Care at Scale'. Any plan for these facilities will be developed in 2022-23 and 23-24.*

(Q) Given my previous question at the last meeting on the matter of the pain relief clinic, could Manx Care please clarify what this service is actually doing. It appears to have lengthy waiting lists of individuals who are clearly in pain whilst an alternative private service is apparently available. Will Manx Care please update on why a further consultant has not been engaged or why the private service has not been utilised (at public expense) to clear the backlog.

(A) The Chronic Pain Service continues to deliver outpatient services and has seen 172 patients in April in clinic, which is split by 64 new patients and 108 follow up patients. There are currently 169 patients waiting to be given a date for their first appointment with the Pain Management team, with a waiting time of 4 months from date of referral to being seen. Additional capacity has also been commissioned within Pain Management via our virtual outpatient provider, Medefer, and this is expected to commence in Phase II of the roll out which is in July 2022.

(Q) Likewise, as follow up to my question at the last meeting could Manx Care please update on how many times the Great North West Air Ambulance service has been used for patients in the Isle of Man and what the current cost to date has been for the service.

(A)The Great Northern Air Ambulance has not yet been used for patient treatment or transfer on the Isle of Man. We cannot disclose the costs incurred as this is commercial in confidence.

(Q) It has proved impossible, yet again, to obtain more than a months supply of prescription medication despite a letter to my GP. There also appear to be shortages or supply line delays resulting in regular owing notes at pharmacies. Would it be possible please for Manx Care to circulate all GPs notifying them that 3 monthly supplies should become the norm. Such action will reduce administration time for repeat prescriptions in both GP surgeries and pharmacies.

(A) It is the GP surgeries decision as to length of supply they provide to their patients, and this decision is taken based on risk and reducing waste. Manx Care advises no more than 3 month supply at any one time, as it is considered that the prescriber needs to be involved in the monitoring of each patient, and most long-term medication requires ongoing checks that the medicine is:

a) *Still required*
b) *The patient may need physical monitoring e.g. Blood pressure checks or blood tests*
c) *Interventions to assess mental health.*

It is not common practice across the UK to provide three month supplies, most areas issue one month supply only and occasionally two months supply; this decision is based on reducing waste associated with stopping or changing medications.

There are national and international shortages of many medicines, and the reasons are complex but are affected by:

- *Shortages in raw materials from supplying countries e.g. India*
- *Supplying countries reducing their manufacturing, due to Covid pressures.*
- *Delays in the transporting of medicines across the world.*

The Isle of Man is supplied its medicines via wholesale dealers in England, therefore the pressures on the supplies in England do directly affect the Isle of Man. The Department of Health and Social Care is investigating the possibility of a wholesale dealer to be situated on the island, in order to control supplies where possible.

(Q) Could Manx Care please identify the source of expert medical and scientific advice that has resulted in the provision of free covid lateral flow tests being stopped at a critical point at which thousands of visitors from all over the world are due for the TT.

(A) Lateral Flow Tests will be available free of charge throughout the TT festival. Policy around provision of Lateral Flow Tests is decided by the Council of Ministers however Manx Care has not yet been informed of any impending changes around provision.

(Q) I have noted the provision of a mobile medical unit at the TT Grandstand to augment the service for visitors. Will Manx Care please apply the same criteria to the shortfall in appointments at GP surgeries across the Island and utilise similar mobile units throughout the year ie to give the same service to our local population that we are suddenly able to fund and now intending to give to visitors.

(A) The Mobile Unit at the TT Grandstand has been established by Manx Roadracing Medical Services, which is a private company contracted by the Department for Enterprise to provide medical services to the TT event. Manx Care has had no involvement in the provision of this facility.

(Q) It has been noted that the Island has been able to obtain the services of additional consultants and support staff at Nobles Hospital for the TT period. Can Manx Care please explain why this has not been done much sooner to clear the waiting lists and why visitors are being provided with a much better service at Nobles Hospital than those currently on the various waiting lists and those referred to the hospital throughout the year.

(A) Manx Care has been successful in securing over £2.5m of funding to start to clear waiting lists across a number of specialties including orthopaedics, ophthalmology and endoscopy plus outpatient appointments within seven specialties including cardiology and pain management. The securing of additional staff during TT is to help cope with the increased unplanned demand on health services for the TT fortnight and are placed in areas that do not waiting lists such as the Ambulance Service and Emergency Dept

(Q) Could Manx Care please detail the total cost to date of holding the public board meetings in various locations during the past year and why an alternative less costly boardroom at Nobles has not been continuously used and less costly fixed audio utilised as operated by most local authorities at their public meetings.

(A) We can provide the information on costs as a range within which costs have fallen. This is to ensure we do not prejudice the commercial interests of the suppliers by revealing their prices for contracts. This is in accordance with Section 30 of the Isle of Man Freedom of Information Act 2015.

The range of costs for rental of space, hospitality / catering services and technical services for 3 occasions on which Board meetings have been held in public settings since inception on 1 April 2021 is: £6000 and £8,500.

The boardroom at Nobles Hospital has insufficient capacity to accommodate a board meeting which is open to the public. Manx Care has chosen to visit locations outside of the hospital to make the meetings more accessible to the public.

The DHSC mandate to Manx Care for 22/23 provides as an objective (no2) requiring Manx Care to proactively 'engage service users and vulnerable groups' and holding accessible Board meetings is one way we aim to do so.

We remain open to suggestions for future venues.

(Q) Taking into account new patients coming onto each waiting list to date, could Manx Care please detail which areas of expertise at Nobles the waiting lists have increased and which areas of expertise the waiting lists have decreased by comparison with the figures when Manx Care first came into being.

(A) It is not possible to extract the data specialty by specialty due to time constraints however since Manx Care's launch to the present day, the overall daycase waiting list has reduced by 779 patients. The inpatient waiting list (where an overnight stay is required after surgery) has increased by 130 patients.

The Board is asked to consider the following action log which is brought forward from the previous meeting

Manx Care Board - Action Log

completed	update required	not yet due	overdue/ delayed

Board Minute Ref No./Month	Action	Lead	Target Closure Date	Due date or revised date	Update	Date Closed
116.22/May	Review the risks that had been scored as 25 but rated amber.	Bd Sec	01.09.22		Complete. The rating was changed to Red to accurately reflect the score of 25.	

manx care Kiarail Vannin	SUMMARY REPORT	Meeting Date: 1 September2022	

Meeting:	**Manx Care Board**		
Report Title:	**Board Assurance Framework ('BAF')**		
Authors:	Elaine Quine, Board Secretary		
Accountable Director:	Teresa Cope, CEO		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/ Recommendation from that Committee**
	Exec Team		

Summary of key points in report							
The Board approved the recognition of six strategic risks to populate the BAF for 2022-23 at its meeting on 5 April 2022. Those risks are as follows: 1. A failure to provide safe health and social care (split here into 1a healthcare and 1b social care) 2. Overwhelming demand. 3. Competition for staff leading to critical shortages. 4. Major incident. 5. Loss of stakeholder support and confidence. 6. Failure to achieve financial sustainability. The Board approved the BAF on 24 May 2022. Since then, each risk has been monitored by the Executive owner and reviewed by each Committee to which the risk has been assigned. There have been no adjustments to any of the risks or to the corresponding risk ratings during the reporting period.							
Consider for Action		**Approval**		**Assurance**	x	**Information**	x

Is this report relevant to compliance with any key standards? ~~YES OR~~ NO		**State specific standard**
IG Governance Toolkit	No	
Others (pls specify)	No	

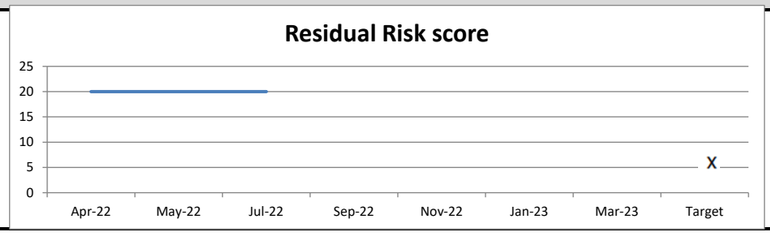
Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient Safety and Experience	No	
Financial (revenue & capital)	No	
OD/Workforce including H&S	No	
Equality, Diversity & Inclusion	No	
Legal	No	

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

1a	Failure to provide safe health care.	Overall risk owner: Paul Moore

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.	x	8	Continuous improvement.	x
3	Transforming health & social care delivery.	x	9	Workforce engagement and development.	
4	Corporate, clinical and social care governance.	x	10	Primary Care at scale.	x
5	Transform urgent and emergency care.	x	11	Early interventions.	x
6	Financial balance.		12	Environmental sustainability contribution.	



Amendment date:	May-22
Committee scrutiny:	QSE Committee
TARGET: L x I	3 x 2 = 6
May '22: L x I	5 x 4 = 20
June '22: L x I	5 x 4 = 20
Jul '22: L x I	5 x 4 = 20
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

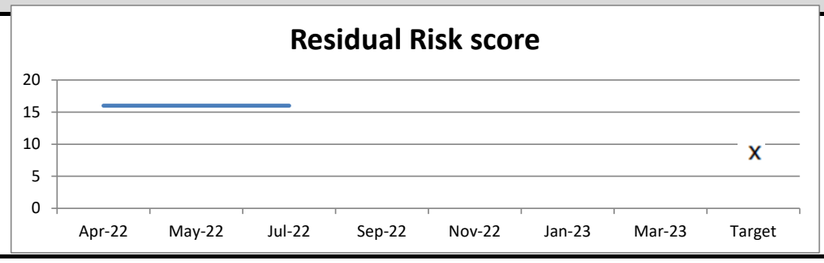
Related operational risks:	Main Controls 1-3	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction.	1. Clinical safety controls Clinical service structures, accountability & quality governance arrangements at MC, CG & service levels including: - Monthly meeting of Operational Clinical Governance Group (OCGG) with work programme aligned to CQC registration regulations Monthly meeting of Quality & Safety Committee (QSC) with escalation from (OCGG) - Implementation of the 'Road map - 10 point Improvement Programme'. 10 high-impact work streams aligned to CQC regulatory compliance. - Nursing and Midwifery and AHP Business meeting - Implementation of Clinical guidelines, pathways, supporting documentation & IT systems - Clinical audit programme & monitoring arrangements - Developing Clinical staff recruitment, induction, mandatory training, registration & re-validation - Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) - Ward assurance/ metrics & accreditation programme - Nursing & Midwifery Strategy - AHP Strategy - Scoping and sign-off process for incidents and SIs PLANS TO IMPROVE CONTROLS: - Standardising Manx Care policies and development a single repository for Policies/SOPs/Guidelines - Staffing - Workforce profiling, establishment reviews twice yearaly initially but look towards more frequent, Health Roster implementation, Leave Management, International recruitment pland and trajectory via GTEC, - Implementation of the 'Road map - 10 point Improvement Programme' WS1 - Establish Manx Care Integrated Clinical Governance & Patient Safety Support Unit WS2 - Develop Effective Manx Care wide Risk Management Framework WS3 - Work-Stream 3 - Develop Manx Care Quality & Safety Dashboard WS4 - Develop and Implement Operational Clinical Governance Group WS5 - Develop & Implement Improved Complaints Management systems WS6 - Patient/Service User Experience WS7(a) - Workforce Safeguards (Staff Training & Competencies) WS7(b) - (WF Planning & Nursing Rota Management) WS8 - Review Clinical Policies WS9 - Mortality Reviews WS10 - CQC Readiness	Paul Moore	Management: - OCGG monthly assurance report to QSC monthly - Learning from deaths Report to OCGG, QSC and Board - Quarterly Strategic Priority Report and to Board - Senior leadership walk around – 15 steps assurance report to QSC Jul - Senior Leadership Walkarounds weekly; - CG Risk Reports to RC 6-monthly; - EoLC Annual Report to OCGG, QSC and Board - Safeguarding Annual Report to OCGG, QSC and Board Compliance: Quality Dashboard to OCGG & QSC Monthly (Board Quarterly); SI & Duty of Candour report to OCGG Significant Risk Report to RC monthly Independent assurance: Internal Audit Medicines Optimisation Report to OCGG	- Multiple repositories for Policies and Guideline - Policies and Guidelines out of date - Staff recruitment is not meeting needs (more leavers than joiners and vacancy factor high) - Regular short-falls in available staff to meet optimum/safe staffing standards in response to acuity and demand. - Lagging and inaccurate performance data - Incomplete and low quality patient records due to mixed electronic and paper based record competing. - Electronic patient record is cumbersome and difficult for staff to use - No clinical coding used in patient care & treatment making it impossible to effectively monitor quality of patient care; patient outcomes; and identify where there may be concerns relating to standards of care and patient safety - No effective mandatory training systems and assurances - Absence of clear boundaries and scope of practice for advance nurse practitioners and advanced clinical practitioners - Inadequate response to safety-ctitical CAS Alerts	- Manx Care response to single oversight framework. - Performance Data for patient/service user experience is limited in scope - Ineffective systems supporting mandatory & role-specific training are not integrated and do not reflect operational reality. - lack of systems providing independent assurances	R
If MC does not work effectively with patients and local communities in the planning and delivery of care, services may not meet the needs of local communities.	2. Clinical effectiveness Each of the organisation's Care Groups have been asked by the Medical Director to identify three clinical effectiveness quality markets against which to measure performance and improvement. These need not be identical across the Care Groups. When selected, performance against the markers will be measured and audited to confirm data quality; identify learning and embed improvement. Care Group Quality meetings will then provide the forum for monitoring the effectiveness of the controls. Examples from amongst which to choose quality markers in a clinical seeting include incidence of venous thromboembolism ('VTE'); incidence of medication errors; incidence of delayed ransfer of care ('DToC'). PLANS TO IMPROVE CONTROLS Currently advertising for three new Associate Medical Directors to build capacity for governance of patient safety and clinical effectiveness; with respective responsibilities for quality & safety; mortality review (Medical Examiner) and appraisal systems. Further work underway to identify and mitigate risk and to deliver a system of clinical effectiveness.	Sree Andole	Integrated data sets.	The Care Groups have yet to coalesce around this governance development and have been asked to prioritise. Short staffing and poor data quality undermine mamagement efforts to futher develop governance - however a new Performance Manager together with appointments of some new Clinical Drectors will further strengthen management resources to make progress.	Within the Island health and care system, no specific audits are mandated and as a result, few were undertaken in 21-22. There is no current Clinical Effectiveness Strategy; the Clinical Strategy is limited to the ambitions described within the Required Outcomes Framework ('ROF'). There is no Clinical Audit Policy.	R.
	3 Patient/Service User experience controls, including learning from complaints - patient/service user experience data collated at organisational level through Manx Care Advice & Liaison Service (MCALS) - Patient safety walks coordinated by the patient/service user experience Officer include 'patient/service user experience questions' - CG level patient/service user experience surveys undertaken on ad-hoc basis - Complaints team support CG in responding to complaints PLANS TO IMPROVE CONTROLS - Implementation of standard methodology for surveying patient/service user experience - Implementation of instant reply sums messaging based on UK FFT fro patient/service users (include outpatients and community based clients and services users) - Implementation of the 'Road map - 10 point Improvement Programme' Work streams: WS5 - Develop & Implement Improved Complaints Management systems WS6 - Patient/Service User Experience	Paul Moore	- MCALs report OCGG and distributed to CGs - quality Dashboard contains metrics on MCALs contacts - complaints report to OCGG/QSC/Board - quality Dashboard contains metrics of complaints performance - performance reporting of patient/service user experience data and feedback is limited to ward/service level - there is No evidence to demonstrate that patient/service user experience feedback results in operational changes in service delivery - there is No evidence to demonstrate that patient/service user experience feedback is considered within service developments	- There is No standard methodology for surveying patient/service user experience across MC making it difficult to identify thematic learning - Patients attending outpatient clinics are not routinely surveyed - No facility in place for gaining instant patient/service user feedback i.e. sums satisfaction instant reply messaging - Responsiveness to complaints not yet at levels that satisfy the Board	- There is No evidence to demonstrate that patient/service user experience feedback results in operational changes in service delivery - There is No evidence to demonstrate that patient/service user experience feedback is considered within service development	R.

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

1b	Failure to provide safe social care.	Overall risk owner: Sally Shaw

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.	x	8	Continuous improvement.	x
3	Transforming health & social care delivery.	x	9	Workforce engagement and development.	
4	Corporate, clinical and social care governance.	x	10	Primary Care at scale.	
5	Transform urgent and emergency care.	x	11	Early interventions.	x
6	Financial balance.	x	12	Environmental sustainability contribution.	x



Amendment date:	May-22
Committee scrutiny:	QSE Committee
TARGET: L X I	3 x 3 = 9
May '22: L x I	4 x 4 = 16
June '22: L x I	4 x 4 = 16
Aug '22: L x I	4 x 4 = 16
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

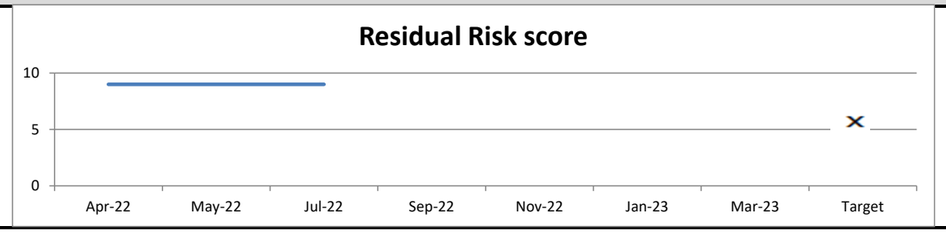
Related operational risks:	Main Controls 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
CF1 Fostering Service placement sufficiency. CF2 Residential placements sufficiency. CF3 Family placement service. CS1 Information governance - children and families data breaches. Information governance - lack of expertise and resource to improve compliance. Gaps between legislative requirements and developments in professional practice. Inadequate sufficiency of placement opportunities. Criminal exploitation of young people. Compliance with the Regulation of Care Act 2013 re provider of last resort.	1. Policy governance	Sally Shaw	The review and completion of the suite of policies governing social care is a current project in 2022-23. There are clear plans on the work to be done and the process to be used. Policies are ratified by the Operational Care Quality Group ('OCQG') and its deliberations are reported by exception to the Executive Management Committee ('EMC') monthly. The end of a care episode all service users are invited to provide feedback on their experience. Together with complaints and compliments intelligence, these are used as prompts for further improvement in the design of controls.	Whilst the policy suite remains incomplete, it does not cover the wide range of areas required nor can it be consistently applied. A mechanism remains in development with DHSC to reliably identify the numbers of individuals requiring support - which impacts upon the design of policy.	Manx Care has contracted with external partners (Tri-X) to assist in the design of the policy suite but completion remains to be achieved. Carer's Strategy under development. The safeguarding Board has contracted external support to review and develop safeguarding policy and practice.	A.
	2. Mandatory training	Sally Shaw	Assurance is currently weak and dependent upon manual systems.	The curriculum for mandatory training is under review by Social Care with input from OHR (via records held) but not yet agreed. The application of mandatory training frameworks is not consistently applied.	We are not yet able to demonstrate a quarterly improvement in mandatory training performance.	A.
	3. Design and launch the multi-agency safeguarding hub (MASH)	Sally Shaw	The introduction of the MASH will be the focussed approach to safeguarding children and vulnerable adults. Police, Health and Social Work colleagues are to be co-located to enhance communication, including daily meetings and connecting routinely with colleagues in other departments where involved. The DPOs of each participating organisation has been consulted re data sharing conventions.	The MASH is planned to be fully operational by June 2023.	Progress in developing and implementing an agreed plan will be reported to the QSE. Manx Care and the Constabulary will review the arrangements as they progress and report during 2022.	A.
	4. Functional design, consistent application and effective operation of the Scheme of Delegation	Sally Shaw	Review of existing Schemes of Delegation will commence during 2022, alongside introduction of Schemes where there are currently gaps.	Some high cost packages of care for individuals have been approved via unclear and inconsistent authorisation processes.	We lack assurance that the scheme of delegation is appropriately designed - though the scheme currently is consistently applied.	A.
	5. Complete, communicate and consistently apply a suite of standard operating procedures across adult social care.	Sally Shaw	Effective controls by the deployment of a suite of procedures are being developed through partnership with Tri.X (external contactors).	Until all procedures have been ratified by a group of appropriate subject matter experts, there remain gaps in control effectiveness.		A.
	6 Adding resilience and capacity to the *provider of last resort* facilities and capabilities within Manx Care.	Sally Shaw	Social Care team meet regularly with management in externally commissioned partners; care homes are subject to inspection; CQC will include an advisory inspection in its scope of work in 2022 (except day care). The Regulation & Quality Improvement Authority ('RQIA') will visit, review and report on Children's Services during 2022.	Currently very challenging to place a sibling group in care. Manx Care has little / no current resource to bridge any capacity gap created by the withdrawal of any private sector or charitable provider.		A.

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

2	**Overwhelming demand.**	Overall risk owner: Oliver Radford

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.	x	8	Continuous improvement.	x
3	Transforming health & social care delivery.	x	9	Workforce engagement and development.	x
4	Corporate, clinical and social care governance.		10	Primary Care at scale.	x
5	Transform urgent and emergency care.	x	11	Early interventions.	
6	Financial balance.		12	Environmental sustainability contribution.	



Amendment date:	May-22
Committee scrutiny:	FPC Committee
TARGET: L X I	6
May '22: L x I	9
June '22: L x I	9
Aug '22: L x I	9
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

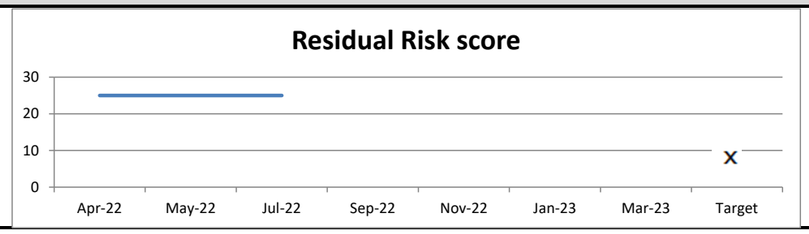
Related operational risks:	Main Controls 1-4	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
#281 CCU demand may exceed capacity. #242 Covid 19 impact upon cohort of renal patients. #289 Insufficient staff to deliver renal replacement therapy to ventilated renal patients. Nursing vacancy rate is 20%. Anaesthetist vacancy rate close to 40%.	1 Covid 19 adaptation, vigilance and vaccination campaigns	Oliver Radford	Island vaccination programme reduced mortality and morbidity, allowing a much reduced demand on hospital services from people who are Covid positive. Island vaccination rates in the target groups are 87% for one dose; 82% for two doses. From April 2022, Manx Care CEO will chair the Monthly Vaccine Board, which includes representation from Manx Care, DHSC and Public Health. The Manx Care internal escalation plan has been shown to be effective with clear allocation of well understood resources when response to infection has to be ramped up. This is overseen by the Performance & Delivery Group which reports by exception to the EMC.	The resources for Covid vigilance and vaccination are currently funded only for the 22-23 year.	The systematic capture of timely, high quality date on health and social care remains to be achieved.	G.
	2 General escalation planning	Oliver Radford	The Operational Pressure Escalation Levels ('OPEL') framework is in place and embedded. It is in a constant state of review by the Access and Capacity Team and has been shown to be an effective tool in managing and escalating operational pressure. OPEL reporting is a constant item of review for the Performance and Delivery Group which reports by exception to the EMC.		The systematic capture of timely, high quality date on health and social care remains to be achieved.	G.
	3 Service transformation of urgent and emergency care	Transformation team	Clear project aims established to divert appropriate patients into community pathways (i.e. Intermediate Care) allowing for a reconfiguration of ED services and non-elective pathways. Led by the Transformation resources within Cabinet Office and reported into the Transformation Oversight Group. Internally, Manx Care project leaders (M Cox , S Taylor) report progress to Executives. Manx Care CEO is a member of the Transformation Programme Officer Board and the Manx Care Chair is a member of the Transformation Political Board.		Sir Jonathan Michael review of progress made to date in transforming urgent care (Nov 21) identified a lack of progress due to a lack of clinical and managerial staff to resource the project. The systematic capture of timely, high quality date on health and social care remains to be achieved.	A.
	4 Capacity and demand planning	Oliver Radford	Continuously improving methodology for 'make or buy' decision making for clinical services which have low throughput or very high costs to deliver, and where off island provision is safer or even more cost effective. Improved Air Bridge arrangements. Manx Care has successfully engaged with Cheshire and Mersey Cancer Network and the other tertiary providers in Liverpool to ensure acess to off-Island services. Further strenthening of strategic relationships with Cheshire & Mersey providers ongoing. Synaptic contract delivering additional orthopedic and cataract capacity. Additional Restoration & Recovery business case under consideration to extend Synaptik programme to cover remainder of the orthopaedic and cataract waiting list and also to encompass general surgery. Capacity & demand Planning team report to the Performance and delivery Group routinely and P & G reports by exception to EMC.	The Capacity & Demand Team is a new one, with it's purview limited in scope to date to services falling within the Restoration & Recovery Business case at the moment, however this will expand to encompass all specialties, including mental health. The was not a substantive Performance manager post within Manx care on establishment, but a new post has been created and recruitment has been successful (appointee due to start June 22).	The systematic capture of timely, high quality date on health and social care remains to be achieved.	A.

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

3	**Competition for staff leading to critical shortages.**	Overall risk owner: Anne Corkill

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.	x	8	Continuous improvement.	x
3	Transforming health & social care delivery.	x	9	Workforce engagement and development.	x
4	Corporate, clinical and social care governance.		10	Primary Care at scale.	
5	Transform urgent and emergency care.	x	11	Early interventions.	
6	Financial balance.		12	Environmental sustainability contribution.	



Amendment date:	May-22
Committee scrutiny:	People Comm.
TARGET: L X I	9
May '22: L x I	25
June '22: L x I	25
Aug '22: L x I	
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

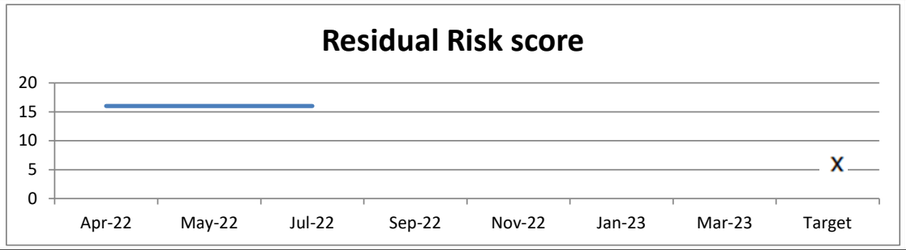
Related operational risks:	Main Controls 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
#417 ED establishment is under-resourced. #306 Recruitment and retention of ICU staff. Shortage of theatre & anaesthetics staff. Diagnostic breast service - lack of clinical capacity.Endoscopy capacity. Ramsay Theatres admin support. Insufficient access to attractive accommodation for lower paid staff.	Development of a Recruitment and Retention Strategy	Anne Corkill	Manx Care values have been included in evaluation criteria for recruitment. Manx Care provides mandatory and other training for colleagues to ensure that they have the required skills and knowledge to perform effectively. Manx Care has a policy project plan governing the review of all policies and procedures relating to recruitment, incuding that governing the acquisition and scrutiny of DBS checks. A 'People Dashboard' with relevant key performance indicators relating to staff churn is being developed and reported to the People Committee. Pulse surveys of staff attitudes are being deployed to take the 'cultural temperature' amongst the staff. new Induction Programme is in place for Manx Care. A CARE Award scheme has been introduced., based on CARE values. The approach to and methodology for workforce planning has been agreed by the Transformation Team. The approach will be tailored by Care Group.	Vacancy rate of circa 20% across the organisation. Exit interviews rarely undertaken, thereby losing the opportunity to learn or in some cases, dissuade. The Mandatory Taining portal E-Learn Vannin has a reporting modele for mandatory training which is not currently enabled. Demand and capacity planning are at low levels of maturity which hamper the collation of input data into workforce planning. 'Make or buy' decision making for on/off island services remain a current project following a review of surgical services and the outcomes will impact upon workforce planning.	Recruitment & Retention Strategy is planned to be shared with the People Committee. Time window between advert and start date is not decreasing. Staff leavers not historically participating in *Exit Interviews,* thereby losing Manx Care the opportunity to learn causes of resignation. The quality of the data in the 'People Dashboard' is not assured with high dependence upon manual systems of collation. Managers depend on local spreadsheets to track mandatory training compliance. Transformation Team plans to develop a Workforce Model in line with Sir Jonathan Michael's recommendation No 25 are at an early stage.	R.
	Development of the Equality, Diversity and Inclusion programme	Workforce & Culture team	work has indicated that a supportive workplace in relation to EDI aids retention and will also improve recruitment of those in minority groups. Phase one research has commenced in preparation for creating an EDI forum for Manx Care, reviewing the availability of data, mapping the Diversity profile and seeking to improve the quality of the data captured. The project team have linked in to wider	EDI forum yet to be established. An assessment to be made of EDI data and performance indicators required. EDI consultancy in process of procurement - quotes received, funding agreed and provider in process of drafting terms.	Early indication is that the quality of EDI data which is available is poor, however focus groups have been beneficial to understand the scale of the work and has helped to inform the initial approach.	R.
	Development of a systemic change management programme	Workforce & Culture team	The CARE values have been reviewed with engagement from Manx Care staff and as a result the values have been redesigned. The Transformation project team will relaunch the values in July 2022. Leadership Academy Programme launched. Manx Care is developing its approach to Communications & Engagement (Board review May 22). 'Have your Say' survey results have been analysed by the project team with recommendations for	Change Management Course modules provided by LEaD will be reviewed with a view to informing the gap between those available and required. Approach to change management needs to be determined in order to feed into continuous improvement. Development of methods for systems thinking in Manx Care.	Chief Minister to launch a review of HR following *Ronson V DHSC* judgement.	R.
	Development of a programme to support psychological safety in the workplace.	Workforce & Culture team	Significant research has been undertaken in order to design a bespoke workshop for Manx Care to develop a psychologically safe workplace. First workshops to be piloted in June 2022 with the Executive Team and Change Coaches.	Cascade approach to training across the organisation will take some time to reach all employees. Expectation is that the workshops will be facilitated by Managers and Change Coaches, supported by online training - intended to be rolled out during 22-23.		R.
	Targeted sickness absence management programme	Anne Corkill	Analysis has been undertaken on data available on absences. This will inform absence management iniatives, including taking into account continuing impact of Covid on absence patterns.	Options are being explored to introduce control designs that have been shown to have a beneficial impact elsewhere and decisions are pending.		R.
	Roll out of the new appraisal system	Workforce & Culture team	A review of the current appraisal system for clinical and non clinical colleagues has been undertaken and the findings used to inform a proposal on a new appraisal system to be rolled out by Manx Care in 22-23.	There is a need to review the MPTC pilot appraisal documentation in the Autumn.	Roll out has a dependency on the launch of the CARE values and the success of the initiatives to embed the values.	R.

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

4	**Major incident**	Overall risk owner: Oliver Radford

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.	x	8	Continuous improvement.	
3	Transforming health & social care delivery.		9	Workforce engagement and development.	x
4	Corporate, clinical and social care governance.		10	Primary Care at scale.	x
5	Transform urgent and emergency care.	x	11	Early interventions.	
6	Financial balance.		12	Environmental sustainability contribution.	



Amendment date:	May-22
Committee scrutiny:	FPC Comm
TARGET: L X I	6
May '22: L x I	16
June '22: L x I	16
Aug '22: L x I	
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

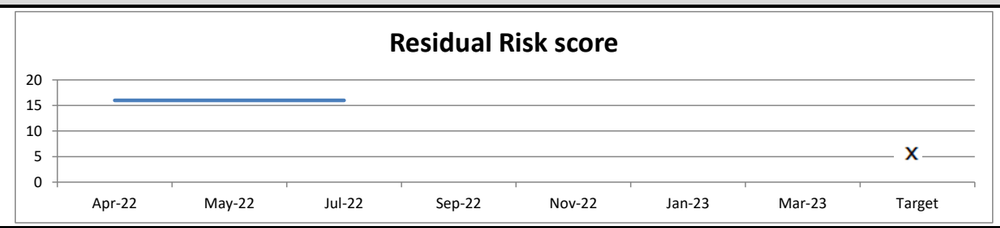
Related operational risks:	Main Controls 1-3	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
#172 Ambulance staffing. #174 Lack of specialist ambulance personnel. Business continuity plans across all Manx Care locations are not accessible electronically from a central intranet resource.	1 Incident planning and control governance structure	Oliver Radford	Manx Care has a Major Incident Plan. Governance and response arrangements are designed, reviewed and tested under the auspices of the Emergency Planning Committee. This committee is chaired by GD who is a direct report of the Manx Care Medical Director. Issues are escalated to the EMC. Manx Care has just appointed an Emergency Planning Manager who will commence in May 2022 and will take an operational and tactical lead on MI planning IoM also has a government wide approach to emergency planning, chaired by DHA's Dan Davies. The Manx Care Director of Operations is a member.		Some of these governance arrangements have been developed in recently (21/22) and have not been demonstrated to be fit for purpose through contemporaneous incidents.	A.
	2 Safety management arrangements in collaboration with Manx TT	Oliver Radford	IoM has a National Motorsport Committee on which Manx Care CEO and Director of Operations sit. Learning has been demonstrated from experience of incidents. Race management has accessed advice from the Auto Cycle Union in UK and sought independent views of the efficacy of incident planning arrangements, to which racing authorities and the promoter (Dept for Enterprise) have ressponded. The TT promotor has sponsored development of the safety management system which will be used during TT2022 for the first time. Manx Care will have a written plan for TT2022, approved by Exec Team and the Board, which will outline proactive actions implemented during the event to help cope with increased demand as well as actions required by clinical and managerial teams in the case of a significant increase in demand			A.
	3. Business continuity planning	Oliver Radford	Governance and response arrangements are designed, reviewed and tested under the auspices of the Emergency Planning Committee. Manx Care has employed an Emergency Planning Manager effective May 2022. This is a first time appointment. The job holder will review current governance arrangements, contrast with best practice guidance from the Emergency Planning College and recommend further improvements. The arrangements were tested deeply during Covid and the secondary care systems and processes withstood the demand for care for Covid patients.	Current scope of the business continuity arrangements are limited to the Nobles campus. A central repository of all business continuity plans for services and locations acorss Manx care is yet to be established.	The governance arrangements need to be developed to include care homes and community services. There has been no independent review of the effectiveness of the arrangements. During Covid, many patients on non-Covid pathways failed to present, presented late or were deferred for treatment, thereby delaying treatment and care - the full impact of which is not yet known.	A.

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

5	**Loss of stakeholder support & confidence**	Overall risk owner: Teresa Cope

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.	x	8	Continuous improvement.	x
3	Transforming health & social care delivery.	x	9	Workforce engagement and development.	
4	Corporate, clinical and social care governance.	x	10	Primary Care at scale.	x
5	Transform urgent and emergency care.	x	11	Early interventions.	
6	Financial balance.		12	Environmental sustainability contribution.	x



Amendment date:	May-22
Committee scrutiny:	Board
TARGET: L X I	3 x 2 = 6
May '22: L x I	4 x 4 = 16
June '22: L x I	4 x 4 = 16
Sep '22: L x I	
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

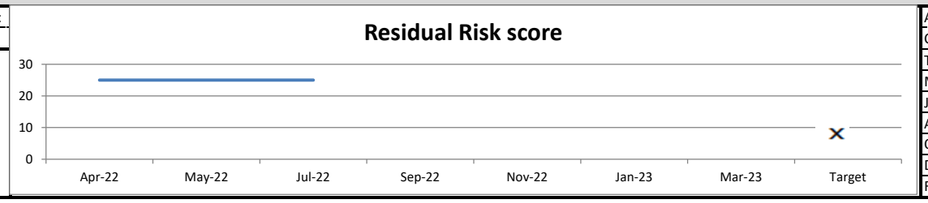
Related operational risks:	Main Controls 1-7	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
Public perceptions of Manx Care affected by four charges of manslaughter being laid against four anaesthetists. Inability to effectively deliver mental health services across the Island due to recruitment challenges. DHSC electronic systems lack communication inter-operability to the depth sought and required for effective care. Staff vacancy rates impact on operational throughput which impacts waiting times for consultation, diagnosis and intervention. Recruitment and retention of GPs and other clinicians and care workers. Prison healthcare staffing challenges. Clinically sound 'make or buy' decisions may not be understood by service users and carers and other stakeholders, leading to perceptions of an intention to run down Manx Care services on island in favour of normalising off island treatment. Non-compliance with CQC regulatory framework which Manx care seeks	1. Proactive engagement with the Minister and DHSC leadership.	Andrew Foster & Teresa Cope	Required Outcomes Framework (22/23) approved by Board 03/05/22. Chair meets regularly with the Minister. CEO meets regularly with DHSC CEO. The four Principals meet together monthly. Joint Oversight Group includes leadership from DHSC and Manx Care at which greatest mutual risks discussed, including safety; reputational; financial (monthly) Mandate assurance meetings (quarterly). Health & Care Partnership Board (quarterly). Board to Board meetings. Positive poliitcal engagement in NED recruitment process. Performance & Accountability Framework agreed and aligned to Single Oversight Framework.		DHSC Oversight group: Terms of reference and approved minutes to be shared with the FPC Committee. Health & Care Partnership Board terms of reference and approved minutes to routinely be shared with QSE Committee. A paper on compliance with the guidance 'Working with Elected Members' to be provided to the People Committee.	G.
	2 Proactive engagement with other government officials and departments with a regulatory oversight role including Attorney General; Coroner; Health & Safety at Work Inspectorate; Information Commissioner ('ICO').	Teresa Cope	CEO engaging positively with the H & S at Work Inspectorate re. ionising radiation compliance. CEO engaging construcively with the Island Constabulary; DHA and DHSC. Information governance arrangements are beginning to be strengthened via the Non Clinical Quality group with oversight of the Digital & Informatics Committee of the Board.	Medical Director formalising engagement with the Coroner calendar (Q2 calendar '22). CEO and Chief Constable formalising an MoU on parallel investigations (Q2 calendar '22). Manx Care has not yet demonstrated compliance with the DSTP Toolkit, which would contribute to assuring the ICO, but has am aim for compliance by May '23 (as stated IGAB on 04/05/55).	Manx Care CEO is not a formal member of the Island's Chief Officers Group, involvement limited to attendance for specific items by invitation. Manx Care continues to be subject to significant enforcement action by the ICO. Approved minutes of the Multi-Agency safeguarding Hub to be shared with the QSE Committee routinely. The QSE Committee to be provided with a paper setting out the proposed engagement activity with the IoM Coroner. When finalised, the MoU on parallel investigations with IoM Constabulary to be provided to QSE Committee. Pay awards with all staff for '21/'22 yet to be concluded - arbitration initiated.	A.
	3 Proactive engagement with Manx government shared support and technology services including GTS; HR; Transformation; Infrastructure, Treasury; Dept for Education; Internal Audit.	Teresa Cope	Chair & CEO meet Principals in Transformation to discuss governance and progress. Developing constructive working relationships with education providers including University College IoM and training establishments to increase placement opportunities and numbers. Executive Team members have additional portfolio based links ensuring Manx Care oversight of respective formal contracts with shared service agreements in place, coordinated by the Contracting Team; with alignment to Board Committees for review.	Insufficient numbers of rotational training opportunities results in students in training not being exposed to manx opportunities for subsequent employment. Transformation programme management approach still underplays the potential benefits of Manx Care views of the most effective ways to transform. Transformation leadership not yet routinely reporting in person to the Manx Care Board.	Manx Care CEO is not a formal member of the Island's *Chief Officers Group,* involvement limited to attendance for specific items by invitation. Board Committees yet to normalise reviews of shared service governance effectiveness (D&I being the exception).	A.
	4 Proactive engagement with all staff; including clinical staff and social care staff.	Teresa Cope	Induction includes an introduction by an Exec Team member. Bi-monthly open sessions for the CEO & Medical Director to listen to consultant body. Monthly *Let's Connect* . Weekly *all staff* bulletins. Regular reports on workforce and culture provided to the People Committee with a developing dashboard of metrics.	Action plans being developed but not yet finalised, at Care group level to address cultural gaps identified in BMA survey. A Communications & Engagement Plan is due to be reviewed and approved by the Board May 2022.	BMA survey of Manx Care consultants (Feb '22: respondents = 49) indicated a low baseline for cultural engagement. Monthly '*Let's connect* ' online presentations / pod casts yet to reach desired depth of audience. People Committee to be provided with assurance of improvement in cultural 'temperature' amongst consultant body (autumn '22). Data quality of human resource dashboard metrics requires further refinement.	A.
	5 Proactive engagement with providers of tertiary and specialist care in England.	Teresa Cope	Proactive engagement with the Chief Finance Officer and Director of Strategy at Liverpool University Hospitals NHS FT. CEO is an engaged member of the Cheshire & Mersey Cancer Alliance. Working towards a strengthened strategic partnership approach. IoM representation into specialty networks such as Major Trauma Network; Critical Care Network; Paediatric Network being formalised.	Notes of tertiary provider and network meetings yet to feed into Manx Care governance processes.		G.
	6 Proactive engagement with Island media including radio, newsprint; social media.	Teresa Cope	Manx Care Head of Comms maintains close contact with opinion formers and journalists at principal Island outlets. Manx Care has a planned calendar of engagement activity.	Media channels cannot be controlled - Manx Care aims only to ensure our voice is represented accurately and heard.	Communications and Engagement Strategy is under development - draft to be shared with Board in calendar Q2 '22.	G.
	7 Proactive engagement with the Island's voluntary and charity sector.	Teresa Cope	CEO has a seat on the Council of Voluntary Organisations ('CVO') Board and meets frequently with the CVO Chair. Manx Care works in a structured way with *Hospice IoM.* CEO engages with *Crossroads* charity, *putting carers first.*		A paper on Manx Care engagement with coluntary and charity sector to be provided to QSE Committee Q2 calendar '22.	G.

MANX CARE: 2022-23 BOARD ASSURANCE FRAMEWORK

6	**Failure to achieve financial sustainability.**	Overall risk owner: Jackie Lawless

Which of the 2022-23 objectives may be impacted:

1	Covid-19 response.	x	7	Reducing waiting times.	x
2	Service user feedback drives improvement.		8	Continuous improvement.	x
3	Transforming health & social care delivery.	x	9	Workforce engagement and development.	x
4	Corporate, clinical and social care governance.	x	10	Primary Care at scale.	
5	Transform urgent and emergency care.	x	11	Early interventions.	
6	Financial balance.	x	12	Environmental sustainability contribution.	x



Amendment date:	May-22
Committee scrutiny:	FPC Comm
TARGET: L X I	9
May '22: L x I	25
June '22: L x I	25
Aug '22: L x I	25
Oct '22: L x I	
Dec '22: L x I	
Feb '23: L x I	

Related operational risks:	Main Controls 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Assurance RAG
#1 Significant cost and operational pressures risk overspend against budget - particularly Agency spend to cover high vacancy rate and Tertiary spend #2 Pay awards remain under negotiation / arbitration. #3 Significant investment required to reduce waiting list backlogs #4 Transformation projects generating significant future funding pressures #5 Future funding not yet agreed - growth has been agreed but no funding for investment / service development #6 Inherited widespread non-compliance with Financial Regulations with regard to contracting and procurement	1. Tools to establish financially sustainable staffing are poorly designed and available data is of low quality or is not available to managers, planners and leaders to support effective decision making.	Anne Corkill & Jackie Lawless	Work is scoped and planned for 22-23 to improve the provision of management information to budget holders and recruiting managers which adequately connects budgets to HR system PIP numbers; to identified workers, including those who are on limited term appointments; permanent contracts, flexible working contracts and agency staff. Resources are being committed from the CIP programme to progress control design improvements. One additional FTE has been recruited in the Finance reporting / analysis function to focus. Financial scrutiny occurs at quarterly Performance and Accountability Reviews of the Care Groups. Improvements to activity are included within the scope of the CIP Programme Board. Plans to acquire internal audit review of improved systems and processes in 23-24.	High vacancy rates do not always produce underspends - they produce overspends as temporary / flexible workers are retained at premium rates (20%-70% premiums) which reflect the fluid markets in which the workers are contracted. These circumstances support a forecast overspend on staffing of circa £3.5M in 22-23 compared to the budgeted establishment for these overspent departments / services. There are likley to be instances where managers have recruited above their budgeted establishment which is not always clearly visible There are opportunities to improve forecasting techniques and reporting	Connecting budget holders with budgets, aligned to accurate HR system PIP numbers; to those who are on limited term appointments; permanent contracts, flexible working contracts and agency staff is at an immature level of sophistication. Internal Audit plan for 22-23 does not include financial governance.	**R.**
	2. Improvements in the control systems which link health and care activity delivery with cost of doing so are being made.	Jackie Lawless	The Restoration & Recovery workstream at Manx Care has shown that effective tools can be developed to provide insight into performance and planning.	In most service areas, there is little or no data linking activity delivered with the cost of doing so - making it impossible to assess value for money or inform 'make or buy' decision making.	The Transformation team have undertaken a review of surgical services to more accurately assess activity and cost, but the detail of the review remains reserved.	**R.**
	3. Improvements to control design re contracting and procurement	Jackie Lawless	Manx Care has invested in some additional resource in house in the Contracting & Commissioing teams to provide additional expertise and resource to address the inherited non-compliance position. This work is reviewed by the FP&C Committee This often requires Financial Waivers in the first instance to bring existing arrangements into compliance while the need and scope is fully reviewed and examined. A robust system for requesting Financial Waivers exists but further improvements to the process are being deveoped and will be proposed to Treasury in order to speed it up Manx Care has joined a number of NHS Frameworks to allow access directly to 'pre-approved' providers which avoids the need for full procurement exercises each time a service is required.	Contracting and procurement decision making can be inflexible and lacking in agility - this can result in lost opportunities to take advantage of advantageous pricing; shortened delivery times; or unexpetedly availability of preferred supplier resource.	The Attorney General's (AG) office leads on tendering but has predicted that should a high volume of tender activity be likely in 22-23 as is anticipated), the AG's office may not be resourced sufficiently to meet the demand. Operational areas may also not be sufficiently resourced to carry out the full service / contract reviews necessary	**R.**
	4. Improvements to the design of the scheme of delegation	Jackie Lawless	A process of review of financial delegation is planned in 22-23 Dir of Finance sits on a Government wide management group scoping the provision of an electronic 'purchase to pay' system for all of Government Regular and granular scrutiny of spend by each budget holder to ensure appropriate purcashing decisions and authorisations are being made	Across Manx Care, some purchasing is currently undertaken with the use of paper pads in quadruplicate - building in a lack of financial grip without the use of an electronic system. This system potentially provides any colleague with the ostensible authority to make purchaes from a supplier whilst in possession of a purchase requisition pad without the necessary authority	The scheme of financial delegation has design weaknesses which do not accurately align delegated powers with appropriate officers. It is not possible for the Finance Shared Service team to ensure full compliance with Delegations before making payments due to the process being paper based.	**R.**
	5. Closing the gap between Transformation and Manx Care	Jackie Lawless	Transformation Oversight Group with representatives from Manx Care and the Transformation team has been formed to monitor and drive progress of the Transformation programme.	There are delays in completing and implementing transformation projects - with delayed benefits realisation and can result in cost pressures as near obsolete or obsolete systems maintained at high cost.	Understanding Manx Care's baseline cost for delivering planned service levels remains uncertain - undermining any discussion about establishment funding. Without longer term financial planning, Manx Care	**R.**
	6. Adressing future funding requirements	Jackie Lawless	The principle of growth funding has been agreed with Treasury and is included in the projected increase in budget over the next 3 years. Transformation New Funding Arrangements project investigating options for government to fund health and social care in future e.g. taxation changes. Transformation have also produced a paper detailing potential mechanisms for agreeing the funding allocation to Manx Care proposing a blended approach to cover 'baseline' and additional 'activity components'. This will require a zero based budgeting exercise to establish the corect funding baseline for Manx Care's core activities	Whilst future funding has been indicated in the Pink Book it is not guaranteed and does not allow for significant service investment, rather underlying growth. The view of Treasury has been that this funding should cover all future requriements of the system and this position needs to be tested The budget setting and mandate setting cycles are misaligned with budgets for future years being set before mandate has been agreed	Understanding Manx Care's baseline cost for delivering planned service levels remains uncertain - undermining any discussion about establishment funding. Without longer term financial planning, Manx Care cannot adequately plan to grow services or plan other investment decisions. The implementation of the recommendations of Transformation are likley to take some time - a number of years	**R.**
	7. Improving internal financial governance mechanisms	Jackie Lawless	Regular meetings between Finance Business Partners and Budget Holders to review financials and address any anomalies / overspends and to improve financial forecasting Training provided to budget holders regarding their responsibilities and access to reporting has been trialled and will be rolled out across Manx Care Investment has been made in additional resource in Finance Team to aid with financial reporting and analysis Weekly Financial Assurance Group meetings between Manx Care & DHSC to address finances / financial planning. Monthly Management Accounts produced that show current and predicted performance and highlighting areas of risk / pressure Monthly FP&C Committee meeting to review and address financial, performance and commissioning issues. Monthly CIP Programme Board meeting to oversee delivery against target of the CIP programme and address any blockages / significant risks Business Case Review Group established to provide effective review and challenge of business cases before approving for funding Monthly Performance and Accountability Reviews with Care Groups that include scrutiny of financial performance / pressures Quarterly reporting to COMIN to discuss forecast position, financial pressures, risks and mitigations	CIP programme requires additional operational resource to drive performance - this is currently provided by external resource but work is underway to recruit a CIP Programme Manager Further improvements to financial reporting can be made to provide more meaningful and timely information to a range of stakeholders Improved formal review and scrutiny planned of spend in operational areas that sit outside of Care Groups e.g. Tertiary, Corporate, Operations	Service level reviews continue to highlight deficiencies in service provision which often require additional investment, which is unforseen. The outcome of CQC inspections is likely to generate signficant funding pressures not already identified Further education and deepening relationships with finance are required to ensure adequate visibility of risks	**R.**

Chair's Report Manx Care Board Meeting in Public

1 September 2022

Public Meetings

This is our third Public meeting in this financial year and after the summer break, follows our well attended first Annual Public Meeting on 24 May. It also continues the policy of holding meetings around the island and it is good to be in Ramsay today.

New NED

We are delighted to welcome Tim Bishop as our new Non Executive Director. Tim has many years experience in health and care including a number of senior appointments in English local government, inspection bodies, and NHS as well as non-executive roles in safeguarding, assurance and a Housing Association. Above all he brings great expertise and experience in Social Care to our Board.

Island visits

This is my 21st Island visit and last time, along with most of the Non-Executive Directors, we toured some excellent community facilities and we were very impressed by their services. Tall Trees is a purpose-built, modern facility that supports adults with the most complex and challenging physical and learning disabilities, whilst Greenfield Park is made up of an Industrial Unit, a Garden Centre and a café. It was great to see the Industrial Unit, which supports adults with a learning disability in a range of activities such as woodworking, metalwork and weaving. The Garden Centre is fully functioning, open to the public and operated by adults with a learning disability. I was delighted to see that both this and the Industrial Unit are supported by Greenfield Park Shop, which sells products manufactured on site! I am so glad we're able to deliver high quality Social Care services in buildings which reflect the needs of service users. We then attended the Greenacres Community Home - opened in 2016, which is a purpose-built modern home for five adults with complex physical and learning disabilities. The facility is built over two levels, and upstairs is Spring Meadows (also home to five adults with a learning disability). We were so impressed with the space, and with the great team.

We also spent some time with the teams at Crookall House, the Information Governance team and much of the Integrated Primary and Community Care team. It's always a privilege to meet staff and see the excellent work they do.

Andrew Foster 25 August 2022

CEO Report September 2022.

Section 1: Purpose and Introduction

Background

1.1 This report updates the Manx Care Board on activities undertaken by the Chief Executive Officer and draws the Board's attention to any issues of significance or interest.

The report is accompanied by the **CEO Horizon Scan** which provide a summary of key activities in each of the Manx Care Operational Care Groups and Corporate Departments. The Horizon Scan is prepared monthly led by the CEO and forms part of the communication cascade across the organisation.

Section 2: Covid -19 and Vaccination Program Update

2.1 **Covid -19**
Executive Lead: Director of Operations

The Isle of Man moved to an Endemic Approach to Covid-19 from 1st April in accordance with its '**Moving to an Endemic Approach**' Plan. As at 22nd August 2022, there were no patients in hospital with covid 19 and the command structures that were put in place during June and July, following an increase in cases on the Island have now been stepped down. Staff absence as a result of covid continues to be monitored via business as usual arrangements.

Government decision on Lateral Flow Testing (LFTs)
Executive Lead: Director of Operations

From 15th August 2022, free Lateral flow tests (LFT) will only be available to health and social care staff, patients having a hospital procedure or those who are considered very high risk of serious illness from Covid-19 infection. Visitors to health and social care settings as well as the Isle of Man Prison will no longer be required to take an LFT before attending. This includes visitors to Nobles Hospital, residential and care homes.
Those who are eligible for free LFTs will be able to access their free tests from;

- Health and Social Care staff – LFTs will continue to be provided by their place of work
- Patients with a planned hospital admission – LFTs will be provided by the Preoperative Assessment Clinic
- 'High risk' individuals who are eligible for anti-viral treatments (GPs will provide an eligibility letter)

Those who are eligible for antiviral treatment can contact their GP to receive a letter which can be used to access free LFTs via their local Pharmacy. People will be required to undergo a telephone assessment with their GP to ascertain eligibility.

This change to LFT access and requirements is part of our endemic approach to living with COVID-19, as we move towards managing the virus like any other respiratory infection. The population

now has much stronger protection against COVID-19 than at any other point in the pandemic due to the vaccination programme, natural immunity, access to antivirals, and increased scientific and public understanding about how to manage risk. Immunity will further be boosted with the commencement of the Autumn Booster programme, starting in September.

2.2 **Vaccine Programme – Autumn Booster Campaign.**
Executive Lead: Director of Operations.

The Vaccine Delivery Team is currently in the final stages of planning to commence delivery of the Autumn Booster Programme on the 5th September, based on the JCVI categories which includes health and care staff, anyone over 50 years of age, care home residents and those with clinical vulnerabilities. The new Moderna bivalent vaccine, which contains specific protection against the Omicron variant, will be offered to everyone who attends for a vaccination.

The Autumn Booster Programme will also see the launch of a new Vaccine Management System which is an end to end system to allow people to book appointments online and record their consent details online. The system also allows vaccine clinical staff to review the consent details logged by the patient and input the specific vaccine administration details, i.e. batch number, date/time of administration and name of vaccinator. Not only do we hope this system will make booking easier for people, it will significantly reduce the admin burden of double entry of details into the current vaccine management system and Medway. 111 will remain available for people who cannot access the online system themselves.

The Autumn Booster Programme intends to vaccinate around 500 people per day with a completion target of Christmas 2022. Most vaccinations will be administered in the Chester Street Vaccine Hub however pop up clinics and the vaccination bus will also be deployed to provide a local delivery alternative. Vaccine staff will also visit care homes and the housebound to ensure the most vulnerable in our society get boosted. We will also be offering a co-administered seasonal flu vaccination for those who would like both jabs at the same time, although this will not be available until late September due to manufacturing delays affecting the UK. Flu vaccines will also be offered by all GP practices and most community pharmacies, as per previous years. The School Nursing Service will be providing flu vaccines to eligible primary and secondary school children.

The Vaccine Team are also working alongside the Sexual Health Service to offer pre-exposure Monkeypox vaccines to eligible individuals during w/c 29th September. We anticipate to deliver 15-20 vaccines to those who elect to receive one.

Section 3: Key Risks and Escalations

3.1 **Information Governance**

Executive Lead: Chief Information Officer

In response to the findings in the KPMG report, Manx Care, with support from the Health and Care Transformation Programme (H&CTP), has a clear action plan and road to compliance.

The Manx Care Corporate Information Governance team has had a number of vacancies approved. These are all now in the recruitment process. The previous backlog of Freedom of Information (FOI) requests and Data Subject Access Request (DSAR) and delays in breach reporting are now addressed and progress has been good.

Additional resources for the regulatory compliance work in the Care Groups has been approved and the jobs are out for advert. The two subject matter experts are now in post and working closely with the team.

Manx Care has begun the completion of the NHS Data Security and Protection Toolkit (DSPT). The toolkit submission has now re-set and will run from 1st July 2022 to 30th June 2023. We are actively collecting the mandatory evidence that underpins our DSPT submission and it is anticipated that the full set will be complete in 2023. As part of the external independent accreditation to support our continuous improvement programme, an external auditor will need to be appointed to assure our DSPT self assessment.

We are soon to announce the move to NHS Digital's DSPT "IG Mandatory Training" module. This is a nationally approved set of modules that will support our DSPT submission. Communications will go out on this change once the system has been set up for Manx Care users announcing the move away from E-Learn Vannin.

A significant piece of work is now underway across all care groups and ancillary units, supported by the subject matter experts. Resources, to complete registers of information assets and map the data and process flows of these to ultimately complete the records of processing activity (ROPA). This work will be supported by the surge resources the posts which are currently being advertised.

The Data Protection Impact Assessments (DPIA) required under GDPR for the two Primary Care Network projects: Muscular Skeletal and Pharmacy have been approved via DHSC and DHSC have submitted them to the Information Commissioner for his input.

The Information Commissioner has imposed a penalty of £170,500. In October 2021, an email was sent with an insecure attachment containing one patient's confidential health data to more than 1870 recipients. Manx Care was subject to an Enforcement Notice at that time (issued in 2020 to the DHSC which Manx Care inherited when it came into effect on 1st April 2021) and a further Enforcement Notice was issued in February 2022. In the view of the Information Commissioner, Manx Care failed to comply with those Enforcement Notices which led to the penalty notice. The Information Commissioner has decided to stay payment of the penalty until 31 December 2022. That stay is dependent on Manx Care demonstrating that it has implemented appropriate technical and organisational measures by 31 December 2022. Failure to do so will mean that the penalty will become payable. In order to ensure the required measures are in place by this date, a project is now underway in collaboration with Business Change Services and Government Technology Services. Regular updates to this project will be communicated to both the Information Commissioner, the Digital and Informatics Committee and the Executive Leadership Team.

3.2 Community Pharmacy Services

Executive Lead: Director of Operations / Chief Executive Officer

Over the last couple of months, Manx Care has been responding to some acute community pharmacy issues in the north of the Island as a result of Lloyds Pharmacy taking the decision to temporarily close the St Pauls Pharmacy in Ramsey due to staffing pressures with very little notice from 1st June 2022. This exacerbated further with Lloyd Pharmacy ceasing their service to the Isle of Man prison from 4th July with one weeks notice. The closure had a significant impact on the service provided to our patients in the north of the Island and to the Ramsey Group Practice.

In response Manx Care teams lead a number of Strategic and tactical meetings and actions across all stakeholders during July, ensuring contingency arrangements were put in place to maintain

services as far as possible and to work with Lloyds Pharmacy to agree a workforce plan and schedule for reopening the pharmacy. The contingency arrangements involved a number of corporate members of the Manx Care pharmacy team supporting operational deliver and I would like to formally express my thanks to Maria Bell, Pharmaceutical Advisor for Manx Care and her team for all the work they undertook to support operational delivery of pharmacy services during this time.

The background to this matter is that community pharmacy (both pharmacists and pharmacy technicians) have been on the hard to recruit list for many years; community pharmacy staffing has for many years been supported by locums from UK and Ireland. There is now a critical shortage of staff across the UK and despite very high locum rates on island, staff are unwilling to travel. Additionally Community Pharmacies do not have 'contracts' with Manx Care. Under National Health Service (Pharmaceutical Services) Regulations 2005, an application is made to Manx Care for a pharmacy to be placed on the 'Pharmaceutical List', and this is awarded in perpetuity. The Regulations on the Island and very dated and weak, and provide Manx Care with no ability to apply financial penalties or revoke any Contractor's place on the Pharmaceutical list unless in very limited circumstances. It is essential that the current legislation arrangements for Pharmaceutical Services are reviewed and updated urgently and as a result of these challenges our current Minister for Health and Social Care has agreed to make this a priority.

The St Pauls Square pharmacy reopened from 1st August and work on a strengthened contract with Lloyds Pharmacy continues. Regular operational meetings continue to monitor staffing levels, any incidents and other operational issues which will be overseen by the Executive Leadership Team.

Section 4: Manx Grand Prix Delivery

4.1 Manx Grand Prix
Executive Lead: Director of Operations

Manx Care completed all of the required planning for the Manx Grand Prix (MGP) motorsport event which took place from the 21st to 29th September. Additional staff was secured for the Ambulance Service, ED nursing and ED medical staff and an operational plan has been drawn up encompassing the organisation's response to the event. A number of operational meetings have taken place to ensure readiness across all impacted services, which has included positive engagement with Aintree Major Trauma Centre. The governance structure that was implemented during the TT will be replicated for MGP, with a gold, silver and bronze command system in place with an exec director taking gold, hospital senior manager taking silver and a senior nurse taking bronze. Daily Safety Huddles will take place to assess organisational readiness (including readiness of the Major Trauma Centre) prior to commencement of racing, with confirmation provided to Race Control that Manx Care is ready. An operational debrief will take place in the weeks following the event, and a combined TT/MGP clinical debrief, alongside clinical colleagues from Aintree Major Trauma Centre is scheduled for October to review all major cases to identify learning points for both parties.

Section 5: Communications and Engagement

5.1 **Royal College of Midwives Visit 6th and 7th September**
Executive Lead: Director of Nursing, Allied Health Professionals and Clinical Governance

The regional officers from the Royal College of Midwives are going to be on island on the 6th and 7th September. Member of the Executive Team will be involved in the visit. The visit will focus on the requirement for a Maternity Strategy for the Island which Manx Care is committed to progress.

5.3 **Manx Care Shortlisted for Preceptorship Programme of the Year Award**
Executive Lead: Director of Nursing, Allied Health Professionals and Clinical Governance

Manx Care has been shortlisted in the Preceptorship Programme of the Year category for the Nursing Times Workforce Summit & Awards. All finalists will find out if they have won at the Nursing Times Workforce Awards on 22 November in London.

5.4 **Government Conference – 20th and 21st September 2022**
Executive Lead: Chief Executive Officer

Manx Care will be contributing to the Government Conference on the Economic Strategy for the Island which will be taking place on the 20th and 21st September at the Villa Marina. Manx Care will be undertaking some stand-alone and joint session with DHSC Healthcare and the future of the Economy.

Teresa Cope,
Chief Executive
22nd August 2022

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Horizon Scan JULY/AUGUST 2022

Medicine, Urgent Care and Ambulance Service

- Recruitment of Consultants, Doctors, Nurses, HCAs and Paramedics continues; recruitment remains the Care Group's number one priority. These initiatives are beginning to be realised with new staff arriving and taking up their posts. This activity is key to the reduction of staff costs and meeting CIP targets.
- The CQC have conducted their pilot visit to the ED; we have now received their formal report and are working through an Action Plan to address the issues highlighted prior to their next visit in October. Medicine is preparing for their initial visit to them.
- The Care Group's operational model and plan for the MGP has been submitted. A review of our recent TT activity has informed the revisions we have made.

Cont'd/2…

Medicine, Urgent Care and Ambulance Service Cont'd/2…

- CIP activities continue; Frailty is making good progress and we are quantifying the savings made with the assistance of MIAA. The provision of SDEC is continuing within the constraints of current resources which is hampering the savings we can make as the service is under resourced and lacks resilience. It also is constrained by the space available to the service – these issues we hope will be addressed in due course.
- Transformation activity continues, despite the pause on funding. Any improvements that can be made with no or low cost are being progressed. Those initiatives that require funding to progress will continue to be developed and planned to ensure that they are ready for implementation when resource and funding becomes available.
- Resources allocated exclusively to transformation are being redeployed where capacity exists to support CIP activities.
- Work is on going with the Service Development team to address Waiting Lists in medical specialities with the assistance of Manx Care staff, Medefer and other groups.
- Work is ongoing with the Service Development Manager to identify and articulate Tertiary Provider contracts and services and ensure appropriate agreements are in place.
- Work is ongoing to reconfigure staffing to appropriate cost centre codes to ensure costs are reflected accurately for each service area.
- Recognising the significant staffing challenges in recent months, changes to the UEC Leadership Team will come into effect from 5 September to enhance the level of resilience in the nursing structure. This will enable us to safely deliver patient care and transform the service at the same time.

Integrated Women & Children and Family Services

- 4 new Student Practitioners re Specialist Community Practitioner Qualification (2 x Health Visitor positions and 2 x School Nurses positions)
- RCM conference promoting Midwifery on island.
- RCM visit 5-7 Sept to meeting MxCare, DHSC/Minister re Maternity Strategy for the IOM.
- CQC reports filtering through to support the CQC Inspection Framework. Positive meetings with CQC Representatives.
- New Obs & Gynae Consultant - start in New Year
- Service Lead for 0-19 Public Health Lead and Senior Nurse for W&C are adopting an integrated role to ensure all areas are covered due to the diversity of the Care Group. This has proved to be successful and has supported the integration of teams.
- Assoc Dir Nursing (Primary Care) and Assoc Dir Nursing (Surgery) have joined the Care Group's Triumvirate, working/supporting the Care Group.
- Ward 4 has moved to a surgical based ward. Gynae patients will be seen in this area by a Gynae Nurse.
- Pilot project trialling CNS post and Community Support Worker to invest/streamline Oncology services.
- Oncology application to Macmillan Cancer Services for a Gynae Oncology CNS & Support Service.
- Women's Health Strategy/Vision was presented at Lets Connect in August.
- Introduced a new Leadership Governance meeting to the Care Groups Governance Structure.
- Positive working relationship with MIAA Colleagues. Ongoing work with IWC&F CIP Projects
- Neonatal unit has reduced the number of available cots on the Unit to 4 (staff pressures)
- New Neonatal Transport Incubator has arrived.
- The Sexual Health team along with other Manx Care colleagues held a stall at the 50th Anniversary of PRIDE.
- Working in partnership with tertiary services to improve patient experience and outcomes, delivering care on island through visiting practitioners.

Integrated Cancer and Diagnostics Services

- Cancer Services – Macmillan Associate Director of Nursing is out to advert, closing date 19 September.
- Cancer Services – Gynaecology Cancer Transformation Programme work underway, to implement a redesign supportive model to those affected by Gynaecology cancers
- Cancer Services - redesign of the Cancer PTL (Patient Tracking) meeting is continuing to develop better communication with the clinical teams
- Cancer Services – Development of relationship with new Lead SACT nurse at Clatterbridge Cancer Centre to support Oncology Day Unit services moving forward
- Cancer Services – Cancer Intelligence report published by Public Health Isle of Man. This is a joint project between Public Health, Manx Care, and NHS digital; the data is aligned with the UK reporting of incidence rates and will be published annually.
- Radiology – Options paper regarding the future of Nuclear Medicines Service is going through governance meetings prior to presentation to the Board in September.
- Pharmacy – The role of Chief Pharmacist (Acute Services) advert extended until 28 August with interest from worthy candidates
- Pharmacy - The role of Specialist Pharmacist (Oncology) recruitment process ongoing.
- Pathology – Consultant Histopathology advert unfortunately attracted no candidates. The job has now been split and two posts will go onto Jobtrain this week.
- Pathology – LIMS high level design underway, though there are staff resource implications
- Pathology – Business Case for digital pathology is in progress
- Pathology – RCPath review took place in May – draft report back.
- Pathology – BC for CL3 build approved and has gone to Treasury to seek capital funding

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Surgery, Theatres, Critical Care and Anaesthetics

- 23 Aug – interviews for Medical Retina Ophthalmology Consultant
- 16 Sept – Interviews for Consultant in Oncoplastic Breast and Plastic Surgery
- Pending consideration by Transformation Board – work now commencing on implementation of Eye Care Transformation project business as usual elements
- Developing bespoke 2WW referral form for Ophthalmology which can then be used by GPs' and Community Optometrists
- Nobles Hospital Equipment Fund have given funding for purchase of 2 additional flexiscopes for use in ENT
- Jackie Nickson has progressed work to purchase 7 replacement and 3 additional bladder scanners
- Post & Franking – cost saving being explored to reduce printing and toner costs with potential savings of £60k+ per annum if implemented
- Partial booking is currently in test with live systems team and a demonstration has been arranged for week commencing 22 August. Launch will drastically reduce cancellation/ rebooking and printing and franking costs
- Sarah Corkill is doing The Great North Run in Newcastle on Sunday 11 September to raise money for Bowel Cancer UK

Integrated Mental Health Services

- Business case for DAT prescribing has been agreed/ratified by EMC
- CQC visit completed and feedback received
- Positive feedback on DAT processes and positive team support across other clinical teams from CQC
- Recruitment of Older Persons Mental health Consultant Psychiatrist
- Recruitment of Associate Specialist Doctor for Manannan Court
- Preceptorship programme for newly registered nurses has been nominated for Nursing times award for second year running

Integrated Primary Care & Community Services

- 3 nurses due to start Tissue Viability course in September through Huddersfield University.
- Orthotics and prosthetics workshop improvement with manufacturing capabilities on island
- Dashboard now created for Community Nursing Service demonstrating service output and delivery.
- Pharmacy is recruiting a Band 3 support worker to assist with the CIP.
- The 2 new PCN pharmacists are beginning work within the Frailty Service
- The Controlled Drugs policy for non-acute settings has been launched
- The joint prescribing committee now has open pages which both staff and the public can access (Manx Care communications due)
- Continued involvement in transformation pathways. Eyecare BC has been approved by BCRG and moving into implementation phase with formatting a new optical contract and enhanced services specifications.
- CQC meetings taking place in GP practices – Dental have completed with 12 out of 13 practices having been inspected.
- IG project commenced with phase one - IARs being created for each of the 21 areas within the care group.
- Directed and focussed headhunting recruitment process via UK agencies commencing to address current GP shortfall.
- Scoping document for Paediatric Long Covid Services Completed

Integrated Social Care Services

- Inspection by Ofsted for C&F – in initial scoping stages
- Partnership meetings with commissioned services in C&F recently reconvened – a positive experience, with insightful reports provided by our partners and good communication ongoing between C&F, C&C and commissioned services
- Review of current budget situation undertaken – Social Care remain on target for a 1% positive variance at year end
- Social Care Resource Allocation Panel – process mapped – TOR – for large packages of care – first Panel held in August.
- Meeting between Social Care/Mental Health to continue to develop the 'Grow Our Own' social work degree programme, due to take place mid Sept

RECRUITMENT:

- C&F Group Manager for Initial Response – successful recruitment with internal appointment made.
- C&F – x2 Team Managers
- Interviews for Senior Social Workers in Care Management Teams, C&F taking place on 19/09/22
- Number of live Social Work vacancies in C&F, OHR and Locate team have been a great support in helping to advertise a range of roles
- Adult Social Work Learning Disabilities – currently recruiting a Team Manager on a 12 month limited term basis, with an acting up opportunity for a Senior Practitioner in the same team also being advertised through expressions of interest
- Adult Social Work Generic Team backfill post– currently advertising for a Senior Practitioner as an acting up opportunity.
- Assistant Director, Adult Social Work – successful recruitment with person in post from 16 August.

CEO Horizon Scan – JULY/AUGUST 2022

Care Group PAR: 19 July (Medicine/IC&D); 09 Aug (Surgery)
Manx CARE AWARD: Hospital Volunteers (July)
Schwarz Round – Working the night shift: 12 July
Manx Radio, Mannin Line: 15 July
RCN Branch Event: 18 July
Diabetes Team Meet: 20 July
Mandate Assurance: 22 July
CARE Values re-launch: w/c 25 July
Manx Care Inductions: 27 July / 31 Aug
Haematology Team Meeting: 01 Aug
Henry Bloom Noble Trust Presentation: 02 Aug
Isle Learn student presentation: 22 Aug
MGP Practice: starts 21 Aug

Department of Health and Social Care: Department Plan 2022-23

Isle of Man Government
Reiltys Ellan Vannin

Our Island Plan:
An Island Of
Health & Wellbeing

Contents

Minister and Members' foreword

Hon Lawrie Hooper, MHK, Minister for Health and Social Care

Joney Faragher, MHK
Michelle Haywood, MHK
Tanya August-Hanson, MLC

Since we joined the Department in October 2021 there has been a whirlwind of activity focused around the development of the Department's key aims. This work is related to the Island Plan strategic pathways, and ongoing development of the Manx Care Mandate and associated assurance processes.

It is fair to say that the Department and Manx Care have a long road to travel before we truly deliver the transformational change we all accept is needed across our health and social care system.

The plan sets out the first steps we will take to address the demands of this change programme, both within the formalised Health and Care Transformation Programme driven by the Cabinet Office, and also the broader change and evolution needed.

Underpinning this journey is a significant amount of legislative change, as well as a lot of work to develop and enhance policy across the spectrum of health and social care services.

Not all of this change will be easy, but it will be essential to ensuring that we have a sustainable system on the Island. It will mean reform of how services are delivered and what services are delivered – but always with a focus on providing the right care, at the right time and in the right place.

It is also critical that, as we progress down this road, we remain true to the core principle that access to NHS services is based on need, not financial means.

As we embark on this journey, there is every reason to be optimistic, even in light of the challenges that we know lie ahead.

Executive team introduction



Interim Chief Executive Officer, Stuart Quayle

Executive Director - Phil Evans
Executive Director - Julie King

As we enter year two of operating as the redesigned Department of Health and Social Care, we welcome the Government's vision to provide our community with access to a comprehensive, high quality and fully integrated health and social care system.

In our redesigned form, the Department is a strategic commissioner. We are responsible for planning health and social care services which will meet our population's needs now and in the future.

Our new mandate assurance process allows us to focus on monitoring the performance, quality and safety of our Island's health and care services. Through our work with the Care Quality Commission (CQC), other external regulators and the Health and Care Transformation Programme, we are conducting an external baseline inspection of the majority of Manx Care services.

These activities are fundamental to ensuring that our health and social care services keep people safe and well.

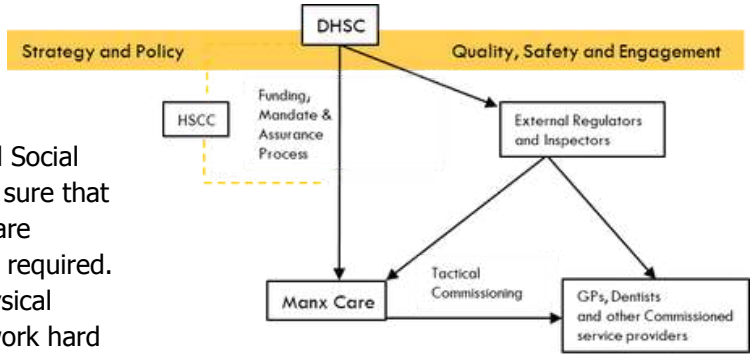
Our executive team is leading the formulation of policy and development of legislation to ensure Departmental priorities are delivered over the next year. These priorities include capacity legislation, modernisation of the complaints process, and a review of our regulation of care legislation.

Financial governance and risk mitigation planning remain critical priorities. Achieving service improvement in an affordable and sustainable way will present significant challenges, particularly with increases in both the demand for services and the costs of treatment and care. The Department is committed to working in partnership with Manx Care and Treasury to remain in budget whilst we recover, restore and develop services, and adjust to the endemic approach of living with COVID-19.

The resilience of all colleagues within our Island's health and social care services is demonstrated through their commitment to patients and service users. Individually and collectively we must continue striving to make our health and social care services safe, well-led, accountable and compassionate.

What we do

What we are responsible for



The core purpose of the Department of Health and Social Care is to develop long-term strategies for making sure that health and social care services on the Isle of Man are available for residents whenever care or support is required. We are committed to making improvements in physical health, mental health and wellbeing, and we will work hard to reduce health inequalities so that everyone has the opportunity to live long, happy and healthy lives.

The Department is responsible for setting health and social care priorities and developing strategies, policies and legislation that enable Manx Care to deliver a comprehensive range of health and social care services. This is a new model for Government that separates policy from delivery.

Manx Care is the Isle of Man's provider of health and social care services, and they are responsible for the delivery of services in accordance with the Manx Care Mandate. The Mandate is issued by the Department and details the services required to meet our population needs and the funding available for Manx Care to deliver them. Manx Care independently decides how services will be delivered. They tactically commission private providers and third sector organisations where necessary in order to provide the right care, at the right time and in the right place.

The Department remains accountable to Tynwald for health and social care services, so we are responsible for monitoring Manx Care's performance against the general objectives and deliverables of the Mandate. A performance framework, referred to as the System Oversight Framework (SOF), has been established to provide assurance that consistent, high quality care is being delivered in accordance with the expectations set out in the Manx Care Act 2021. In 2022, we will publish this information on our website.

Improvements in quality and safety across health and social care services will continue to be a long-term focus for the Department and Manx Care. The Department has commissioned the independent inspection services of the CQC, who are working alongside our Registration and Inspection Unit to establish a baseline for improvements in health and social care services. The inspection programme commenced in May 2022 and we expect to publish these initial inspection reports by late 2022.

The Department, alongside the Cabinet Office, Treasury and Manx Care continues to work towards the 26 recommendations of Sir Jonathan Michael's independent review of the Island's health and social care system.

Our vision and values

Our Vision

'Right care, right time, right place'

We are passionate about creating a health and social care system which is efficient, effective, fair and sustainable. We want to deliver the right care, at the right time and in the right place.

We want to see fully integrated services which are accessible and responsive. This means more community led care, better use of digital resources, and helping people to manage their ailments and long-term conditions at home and in local communities.

In order to achieve our vision, we will need to work collaboratively with key partners. We must provide stability and continuity whilst being flexible and adaptive to the future needs of our population. We will do this whilst remaining true to the core principle that access to NHS services is based on clinical need, not an individual's ability to pay and that NHS services are free of charge, expect in limited circumstances sanctioned by Tynwald.

Our Values

We are committed to improving our culture and supporting our colleagues to thrive within their roles. We do not want to define ourselves by past challenges, or have these represent what we are known for - we are determined to change, learn and improve, and we will achieve this by living our values in everything we do.

Our priorities

The Department will develop an Integrated Health and Social Care Framework to describe our journey for delivering better health and wellbeing outcomes for our population over the next 10 years. The framework will focus on three priorities for building a health and social care system which emphasises prevention and early intervention.

These three priorities support Government's Island Plan and its overarching vision to build a secure, vibrant and sustainable future for our Island.

Priority 1 - focuses on empowering people to manage their own health and care needs, and emphasises prevention and earlier interventions.

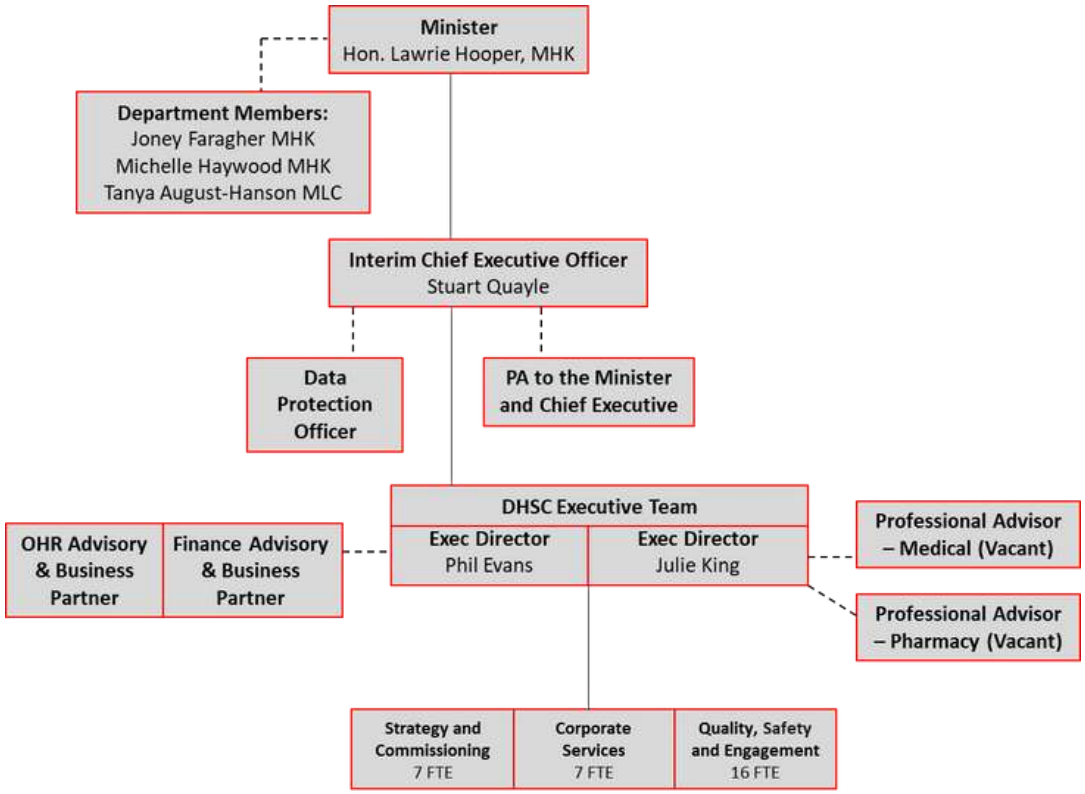
Priority 2 - focuses on care in the community and ensuring communities have services and support networks that are accessible. This will enable people to remain at home for longer, avoiding reliance on hospital based services.

Priority 3 - focuses on integrated care that best meets the needs of patients, service users and families. Coordinated and joined-up care across the system, with all providers supporting Manx Care's mission to become the best small Island health and social care system in the world.

Focusing on these three priorities will help us build a care system which:

- Empowers people to look after their complete physical, mental and social wellbeing;
- Places greater emphasis on care in the community;
- Offers services which are better coordinated and more accessible;
- Makes it easy for an individual to navigate their health or social care journey;
- Delivers more effective preventative and community-based interventions.

Our team and what we provide



The Department of Health and Social Care has three core operational teams. They are responsible for:

Corporate Services

- Supporting operational activities of the Department;
- Supporting the Minister and Chief Executive;
- Corporate governance and the management of strategic and operational risk.

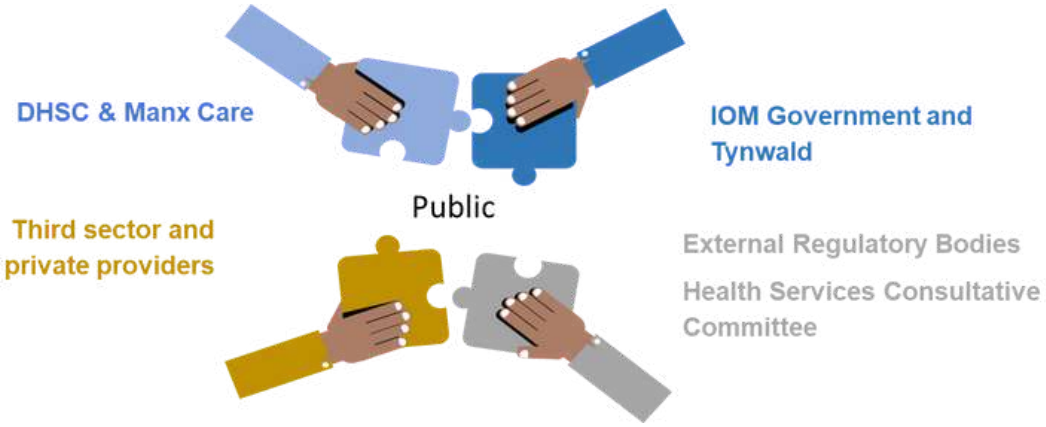
Quality, Safety and Engagement

- Registration, inspection and audit of health and social care providers;
- Safeguarding;
- Development of legislation;
- Public engagement;
- Embedding the patient and service user experience within the agreed frameworks for evaluating service quality.

Strategy and Commissioning (incorporating Mandate performance and assurance)

- Developing health and social care strategy and the formulation of policy;
- The creation of the Manx Care Mandate;
- Oversight and assurance of Manx Care's performance;
- Championing the development of a cross-government commissioning initiative for social policy and matters of national strategic importance.

Our health and social care system



The Department is responsible for delivering the objectives set out in Our Island Plan, but we will only achieve the outputs described in this document if we work closely with other partners across the health and care system.

Manx Care has the autonomy to decide how to deliver health and social care services – some services are provided by Manx Care directly, others are provided by third sector and private organisations commissioned by Manx Care.

Partnership working is essential. The Department will engage with Manx Care, the third sector and private providers when developing strategies so that we can make sure our work aligns with the common goal of delivering improved outcomes for the people of the Isle of Man.

Our colleagues in Public Health are responsible for undertaking strategic needs assessments relating to the population's health and wellbeing. These will help inform and shape new policies and strategies. Together, the Department and Public Health will forge a joint strategic commissioner role for population screening programmes to be delivered by Manx Care.

Tynwald remains a key enabler in our development journey, and through Our Island Plan we have an opportunity to progress cross-Government working initiatives that improve social outcomes for our population.

Our dedicated Registration and Inspection team will continue to work closely with the CQC and other external regulators, and we will continue to value close working with Health Services Consultative Committee (HSCC), who provide independent scrutiny and advice on the effectiveness of health and social care services.

A health and social care system is all about the people we serve; listening to and engaging with the public is fundamental when shaping person centred services. In March 2022 we launched our first DHSC Engagement Strategy, 'Let's start a conversation', which describes the approach we will take in encouraging the public to interact with the Department and to participate in consultation and engagement activities.

Our Department objectives

The Department is committed to the delivering the following objectives:

On track/complete Risk to deliver Not on track

What	Output	By When	Status
Ensure adequate Department resources are dedicated to fulfilling statutory and regulatory obligations	1 Annual assessment and completion of NHS Digital Data Security and Protection Toolkit. 2. Continued support of the NHS Covid Pass, aligned to UK policy where practicable. 3. Membership of Devolved Administrations COVID group. 4. Provision of evidence to Tynwald questions and inquiries (including COVID inquiry).	Ongoing / enduring	
Improve governance systems.	Develop frameworks that promote quality improvement and performance assurance: 1. Implement a System Oversight Framework (SOF). 2. Implement a revised Manx Care Mandate Assurance Process. 3. Create a three year Manx Care Mandate (2023/26). 4. Introduce a common strategic framework for strategy design. 5. Create policies associated with Information Governance compliance. 6. Implement a robust financial assurance and governance framework. 7. Publish a three year Quality Strategy in partnership with Manx Care.	April 2023 July 2022 October 2022 January 2023 January 2023 January 2023 February 2023 September 2023	
Internal culture and values.	Review our department structure to ensure capability to successfully deliver our objectives. Embed a culture of performance management and coaching, to boost colleague engagement and productivity. Champion cross-Government working by building and sustaining relationships.	September 2022 November 2022 April 2023	
Develop a Sustainable Funding Model.	In recognition of the significant financial pressures facing the health and social care system, the Department will work with Manx Care and Treasury to develop a three year financial plan.	March 2023	
Publish Engagement Strategy Implementation Plan	Deliver the implementation plan associated with the DHSC Engagement Strategy, as part of our broader commitment to improving communication and engagement with the public and care providers.	December 2022	

What	Output	By When	Status
Address the outstanding Tynwald Decisions/ recommendations assigned to the DHSC.	Establish a programme of actions to address the outstanding recommendations made by Parliamentary Committees of Tynwald.	August 2022	
Identify clear and acceptable ways of transitioning to carbon neutrality and meet our Climate Change plan objectives.	Contribute to the Isle of Man Government's statutory obligation to reach carbon neutrality (Net Zero) by 2050. Produce a combined Department and Manx Care action plan that will achieve net zero in line with Isle of Man Government targets and commitments.	April 2023	
Review and update arrangements for emergency incidents.	Emergency response protocols that include effective arrangements across the health and social care sector, ensuring services can respond to a wide range of incidents and national emergencies that could impact our health and social care system. We will update the Island's Emergency Prevention, Preparedness and Response (EPPR) plan.	January 2023	
Successful delivery of the Health and Care Transformation Programme in order to create a high quality, clinically and financially sustainable health and care system.	Continue to collaborate with the Health and Care Transformation Programme, and other key stakeholders to enable Government to deliver the recommendations of Sir Jonathan Michael's review. **Action:** Collaborate with key stakeholders on the following Transformation Programme projects: • Improve Legislative framework • New funding arrangements • Care Pathways and Service Delivery Transformation • Primary Care at Scale • Governance and Accountability • Information Governance • Manx Care Record • External Quality Regulation • Air Bridge • Undertake Needs Assessments • Workforce and Culture • Data / Business Intelligence	Key milestones for each of the projects can be found here: https://www.gov.im/about-the-government/departments/cabinet-office/health-and-care-transformation/ See 'plan on a page' in the 'Downloadable document' section.	

Island Plan objectives the Department is responsible for delivering

The Department is delivering the following Island Plan objectives. The outputs represent a hybrid of deliverables associated with the Island Plan, DHSC Objectives and Manx Care's Mandated Objectives for 2022/23. An asterisk (*) in the 'by when' column, highlights where Manx Care are responsible for delivering the output. The Department will make quarterly reports available online to monitor progress.

IP Ref	What	How	We will	Outputs	By When	Status
COMO3D	Ensure our towns and villages are clean, well-maintained and provide the basis for our people to build great communities.	Ensure that we meet the needs of our older population and those with disabilities living in all our communities, from design and adaptation, care and extra care provisioning through to the provision of residential, nursing and respite care.	1. Develop a strategy for the long-term provision of residential and nursing care that aligns with the outcomes of the Health and Care Transformation Programme's Future Funding Arrangement Project.	1. A strategic plan for designing service delivery models that offer improved coverage of care.	Ongoing	
			2. Support the completion of the Joint Strategic Needs Assessment (JSNA) for 'Ageing Well'.	2. Identify key health and wellbeing indicators and develop a strategic plan to address JSNA findings.	Aug 2023	
			3. Create an Estates Strategy that incorporates the needs identified in the residential, nursing and respite care project.	3. Establish key strategic principles for developing an Estates Strategy.	Jan 2023	
			4. Review respite care.	4. Commence a gap analysis of existing respite care.	Feb 2023	
HEA01A	Successful delivery of the Health and Care Transformation Programme in order to create a high quality, clinically and financially sustainable health and social care system.	Continue to deliver the projects within the overall Health and Care Transformation Programme in accordance with the published plans ensuring the delivery of the recommendations of Sir Jonathan Michael's review.	Progress a programme of legislative reform, including:			
			1. Capacity Bill, which introduces a framework for practitioners to determine capacity.	1. Capacity Bill 1 entered branches of Tynwald.	May 2022	
			2. Health and Social Care Regulation Bill, new primary legislation to establish the Department as the Island's regulator of all health and social care services.	2. Consultation on Health and Social Care Regulation Bill.	Mar 2023	
			3. Health and Social Care Services Bill, to further integrate health and social care legislation.	3. Principles of Health and Social Care Services Bill agreed with Transformation Programme.	Jan 2023	

IP Ref	What	How	We will	Outputs	By When	Status
			4. Implementation of the 2021 Adoption Act.	4. Implementation plan for Adoption Act published.	Dec 2022	
			5. Modernisation of complaints regulations.	5. Implementation of modernised complaints regulations.	Nov 2022	
HEA01A	Successful delivery of the Health and Care Transformation Programme in order to create a high quality, clinically and financially sustainable health and social care system.	Continue to deliver the projects within the overall Health and Care Transformation Programme in accordance with the published plans ensuring the delivery of the recommendations of Sir Jonathan Michael's review.	Progress the external inspection programme relating to services directly delivered or commissioned by Manx Care.	1. Implementation of inspection programme agreed between the Department, Transformation Programme and CQC.	Apr 2023	
				2. Baseline of quality and compliance established to support ongoing improvement.	Apr 2023	
				3. External regulators identified for inspection of services outside scope for CQC, and Service Level Agreements in place.	Feb 2023	
			Develop a framework for the inspection of care services not provided or commissioned by Manx Care.	1. Inspection methodology written to align with CQC 5 domains.	Jul 2023	
				2. Consultation with affected providers.	Jul 2023	
				3. Inspection programme implemented.	Jul 2023	
HEA01A	Successful delivery of the Health and Care Transformation Programme in order to create a high quality, clinically and financially sustainable health and social care system.	Continue to deliver the projects within the overall Health and Care Transformation Programme in accordance with the published plans ensuring the delivery of the recommendations of Sir Jonathan Michael's review.	1. Expand Health and Wellbeing Hubs across the Island, providing more care closer to home and ensuring hospital care is not always the first point of call.	1. Wellbeing Hubs operational in four locations on the Island. (North, South, East and West).	Dec 2022 *	
			2. Develop an Integrated Health and Social Care Strategy that promotes integration of systems and services.	2. Establish key strategic principles for developing the Integrated Health and Social Care Strategy.	Jul 2023	
			3. Develop a Children's Mental Health Strategy to improve early intervention and access to services in times of crisis.	3. Establish key strategic principles for developing the Children's Mental Health Strategy.	Apr 2023	

IP Ref	What	How	We will	Outputs	By When	Status
			4. Review the urgent and emergency mental health pathways for adults and children, and identify recommendations for service improvement.	4. Complete the review and make recommendations (including business cases where appropriate) to secure improvements.	Apr 2023 *	
			5. Complete a National Autism Strategy for children, young people and adults that promotes awareness and acceptance, and sets out a journey to improve access, care and support over the next five years.	5. Publish National Autism Strategy and multi-year plan for implementing the strategic vision.	Jan 2023	
			6. Redesign the Appropriate Adults scheme with key partners, to provide young people and vulnerable adults in police custody with support during police interviews.	6. Implement the Appropriate Adult Scheme.	Oct 2022	
HEA02A	An accessible, accountable, and compassionate 'Right Care, Right Time, Right Place' health and care system which is there for people throughout their lives.	Through the DHSC Mandate to Manx Care, address waiting times for all mandated services to be reduced to levels comparable with other health and care systems. This will include continued delivery of the approved COVID restoration and recovery and additional elective recovery plans to reduce all backlogs, in order to improve waiting times across services. Target of 18 week referral to treatment consistently met.	1. Establish a broader elective recovery plan to improve access, waiting and treatment times to pre-COVID levels.	1. Approval of the elective recovery plan business case.	Apr 2023 *	
			2. Implement a reporting mechanism for 'referral to treatment' performance statistics related to planned care.	2. Publish performance dashboard.	Apr 2023 *	
			3. Report on appointment waiting times in Primary & Secondary Care.	3. Publish reports that are comparable with other health and social care systems.	Apr 2023 *	
			4. Develop and implement clear tumour site pathways, reflecting best practice standards.	4. Implementation of pathway and associated reporting mechanisms.	Apr 2023 *	
			5. Introduce phase 1 of NICE Technology Appraisals (NICE TA's) as part of a three year phased approach.	5. a) Publish phase 1 of the NICE treatments available in 22/23.	Apr 2023 *	
				5. b) Determine legislation that gives statutory powers to make NICE TA's available within recommended timeframes.	Apr 2023	
			6. Oversee the reinstatement of elective private patient treatment.	6. Access to private services resumed. (Dependant on elective recovery programme).	July 2023 *	

IP Ref	What	How	We will	Outputs	By When	Status
HEA02C	An accessible, accountable, and compassionate 'Right Care, Right Time, Right Place' health and care system which is there for people throughout their lives.	Provide appropriate support for those who choose to care for others at home by evaluating and reviewing the value of carers in the community and deliver improvements as part of the Health and Care Transformation Programme.	1. Implement a mechanism for capturing the needs of carers, to address gaps in support, safeguarding and broader carer risk. Utilise mechanism to inform a longer term strategic plan. 2. With key partners, develop a Carer and Young Carer Strategy.	1. Complete engagement exercise to evaluate effectiveness of existing support in order to develop a long term strategic plan for carers. 2. Establish key strategic principles for supporting carers and young carers.	Dec 2022 Apr 2023	
HEA02D	An accessible, accountable, and compassionate 'Right Care, Right Time, Right Place' health and care system which is there for people throughout their lives.	Value partnership with third sector and community groups by commissioning specific services where possible.	1. Lead a joint commissioning approach across Manx Care, Government departments, third sector and community groups. 2. Embed the key principle that all joint commissioning priorities are supported by a JSNA, joint strategies and joint action plans. 3. Develop policy to cover partnership agreements / alternative commissioning models for the delivery of health and social care services.	1. Devise and lead a cross government framework to enable joint commissioning of services. 2a. Influence a programme of JSNAs aligned to the shared priorities of the joint commissioning approach. 2b. Create a network of cross-Government and third sector partnerships to create strategies and action plans aligned to the shared priorities of the joint commissioning approach. 3. Write a discussion paper for consideration with Treasury.	Dec 2022 Mar 2023 Mar 2023 Mar 2023	
HEA05B	Promote healthy lifestyles and acknowledge the role of quality of life in a healthy and well society.	Provide increased health & social care services in communities through primary care at scale and care pathway reviews to ensure care is delivered in the most appropriate setting and in a clinically and financially sustainable way.	1. Establish options for designing a 'hospital to home' pathway that promotes the principles of integrated transitionary care. 2. Expand coverage of Local Area Coordination that enables non-clinical community triage and signposting to community based support rather than statutory services.	1. Completed options appraisal. 2. All-Island coverage implemented.	Apr 2023 * Apr 2023 *	

IP Ref	What	How	We will	Outputs	By When	Status
			3. Implement the NHS Summary Care Record to provide authorised healthcare staff with faster, secure access to essential health record information.	3. Develop and submit a business case for the NHS Summary Care Record.	Apr 2023	
			4. Assist in developing a Primary Care Operating Model for population health improvement.	4. Long term Delivery Plan for Primary Care at Scale published.	Jan 2023	
			5. Undertake Strategic Need Assessments for dentistry care and pharmacy.	5. Complete Strategic Need Assessments and establish key strategic priorities.	Apr 2023	
			6. Formulate Policy set for a number of health and social care related matters:	6. Part a) Establish policy principles to create a modern and consistent policy set.	Sep 2022	
			• Over the Counter Medicines	6. Part b) Formulate and issue policy set.	Apr 2023	
			• On-Island Non-Emergency Patient Transport Services		Apr 2023	
			• Procedures of Limited Clinical Effectiveness		Apr 2023	
			• Prescription Charges		Apr 2023	
			• Concessionary Fares		Apr 2023	
			• Off-Island Patient Transfer Services		Aug 2023	
			7. Undertake a service review and gap analysis of the Island's Gender Incongruence pathway.	7. Implement changes that will enhance existing pathway.	Aug 2023	
			8. Commission a pilot on-Island dispensing service for individuals to access Cannabis Based Medicinal Products (CBMP) via private prescription.	8. Fully operational pilot dispensing service.	Sept 2022	
			9. Implement a re-designed Palliative and End of Life (PEOL) pathway with Hospice IOM.	9. Implemented Palliative and End of Life pathway.	Apr 2023 *	

Island Plan objectives the Department is supporting

IP Ref	What	Accountable Department
COM01A	Establish a Housing and Communities Board to bring together and focus policy and actions across Government on housing for all. Seek to address issues of affordability, homelessness, security of tenancy and vacant or derelict properties.	Cabinet Office
COM01B	Commissioned provision of emergency night shelter and 'Housing First' supported living arrangements including facilitation of stepped approach to social housing.	Cabinet Office
COM05A	Consider policies and impact relating to demographics and population. Take account of and address demographic challenges.	Treasury
ECOO3A	Present the National Insurance Review to Tynwald by the Budget in 2023. Contribute to secure and sustainable funding model for health services.	Treasury
HEA02B	Implement recommendations of the Tynwald Mental Health and Suicide Reports.	Cabinet Office
HEA03A	Establish a Community Safety Board in partnership with the third sector to address early interventions. Multi-agency approach to support and protect children and all victims of abuse.	Home Affairs
HEA03B	Establish a Community Safety Board (to create a subcommittee of the Criminal Justice Board) in partnership with the third sector to address early interventions.	Home Affairs
HEA03C	Implement the Domestic Abuse Act 2020.	Home Affairs
HEA04A	Identify, review and implement other aspects of health and social care provision to address any inequalities.	Cabinet Office
HEA04B	Establish role of Public Health as joint commissioner with DHSC for public health programmes delivered by Manx Care.	Cabinet Office
HEA05A	Ensure the root causes of health and wellbeing inequalities are addressed in all policies so that people can make healthy choices, in communities that are safe, and with infrastructure and design in towns and villages which promotes and supports health and wellbeing.	Cabinet Office
HEA05C	Take a whole system approach and advocate for collaborative working to ensure our communities can easily make healthy lifestyle choices.	Cabinet Office
HEA05D	Commencement of the national Joint Strategic Needs Assessment Programme to continue to work to ensure that root causes of population health and wellbeing issues are addressed in all policies.	Cabinet Office
HEA06A	Policies and services which mean that people can make healthy choices, in communities that are safe, and with infrastructure and design in towns and villages which promotes and supports health and wellbeing.	Cabinet Office
LEA02A	Child Care Strategy with recommendations and delivery plan helping to ensure that children have the best possible start in life, including equal access to early years education.	Education, Sport and Culture
LEA02B	Consider the potential role, benefit and remit of a Children's Commissioner and Child First policy approach across Government.	Cabinet Office

Metrics and measures to monitor delivery and performance

The Department is revising its performance assurance process. The System Oversight Framework (SOF) will become the reporting template, and Manx Care will complete this on a monthly basis so that the Department can evaluate Manx Care's performance against its objectives.

The images below provide an example of the metrics Manx Care will be required to report on. These initial metrics will evolve over time to ensure we capture relevant and appropriate information, with data separated by speciality.

In the Programme for Government 2016-2020, the Isle of Man Government set out an open data commitment, to make Government information available for anyone to access and use. We are committed to regularly publishing data from the SOF, and intend to develop an online dashboard for ease of use by the public.

Quality of Care, Access, and Outcomes		
Metric Name		Monthly Target
Care Quality	Serious Incidents	3 (40 PA)
	Never Events	0
	Medication errors with harm	1 (10 PA)
Elective Care	Number of patients with a length of stay - 0 days	Monitor
	Number of patients with a length of stay - > 7 days	
	Number of patients with a lenth of stay - > 21 days	
	Number of patients waiting for first hospital appointment	Monitor
	Patients waiting more than 52 weeks to start consultant-led treatment	0
	% of urgent GP referrals seen for first appointment within 6 weeks	85%
	Number of patients in planned care exceeding 18 week RTT	0
	Number of discharges - pre 1000	Monitor
	Number of discharges - pre 1600	Monitor
	Number of discharges - weekend	Monitor
	Delayed transfers of care	Monitor
Urgent & Emergency Care	Time to attend to life-threatening 999 calls by an Emergency Responder	75% within 8 minutes
	Time to attend life-threatening 999 calls by a crewed ambulance	95% within 19 minutes
	Time to admin, discharge of transfer patients after arrival at ED (Nobles and Ramsey)	95% within 4 hours
	Total time spent in ED	< 4 hours
	Time to Initial Assessment within ED	15 minutes
	Wait time to see first Doctor in ED	< 3 hours
	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	Monitor
	Emergency re-admissions within 30 days of discharge from hospital	Monitor
Cancer Services	Maximum two week wait from referral to first outpatient appointment	93%
	Maximum two week wait from referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment.	93%
	Maximum 28 days from referral for suspected cancer (via 2WW or Cancer Screening) to date of diagnosis	75%
	Maximum 31 days from decision to treat or other appropriate date to start of second or subsequent treatment - Surgery	94%
	Maximum 31 days from decision to treat or other appropriate date to start of second or subsequent treatment - Drug treatment	98%
	Maximum 31 days from decision to treat or other appropriate date to start of second or subsequent treatment - Radiotherapy	94%
	Maximum 62 days from referral for suspected cancer to first treatment	85%
	Maximum 62 days from urgent referral from a Cancer Screening Programme to first treatment	90%

Quality of Care, Access, and Outcomes		
Metric Name		Monthly Target
Social Care	Supervisions completed on time - Adult Social Care	90-100%
	Supervisions completed on time - Children & Families	
	Average caseload per Social Worker - Adult Social Care	16 to 18
	Average caseload per Social Worker - Children & Families	
	% of re-referrals in total referrals - Adult Social Care	<15%
	Number of referrals - Children & Families	74-78
	% of re-referrals in total referrals - Children & Families	<20%
	Number of Safeguarding inquiries	17-21
	Fair Access to Care Services (FACS) completed in agreed timescales.	80%
	Copy of FACS Assessment received by Patient or Carer	100%
	All Residential beds occupied	85-100%
	All Respite beds occupied	90-100%
	Service Users with a Person-Centred Plan in place (PCP)	95-100%
	Complex Needs Reviews held on time	85%
	Total Child Protection Conferences held on time	90%
	Total Initial Child Protection Conferences held on time	90%
	Child Protection Reviews held on time	90%
	Looked After Children reviews held on time	90%
	Pathway Plan in place	100%
	Children (of age) participating in, or contributing to, their Child Protection review	90%
	Children (of age) participating in, or contributing to, their Looked After Child review	90%
	Children (of age) participating in, or contributing to, their Complex Review	79%
	Occupancy at Ramsey – overnight stays	up to 80%
	Number of reported Safeguarding alerts in care homes	Monitor
	Number of Adult Social Care Services serious incidents	0
	Number of Adult Social Care Services incidents	<110
Integrated Community Care	Community Nursing Service response target met - Urgent	4 hours
	Community Nursing Service response target met - Non urgent	24 hours
	Community Nursing Service response target met - Routine	7 days
	West Wellbeing Contribution to reduction in ED attendance	5% per 6 months
	West Wellbeing Reduction in admission to hospital from locality	10% per 6 months
	Clinical Assessment and Treatment Service waiting time from urgent referral	80%
	Clinical Assessment and Treatment Service waiting time from routine referral	80% in 12 weeks
Primary Care	Average wait time for a GP Appointment - by Practise	Monitor
	Average wait time for a Dental Appointment- by Practise	Monitor
Mental Health Services	Patients requiring Mental Health liaison services within the ED, seen within one hour.	75%
	Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours.	75%
	Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral	75%
	Patients with Severe Mental Illness (SMI) who received a full physical health check in Primary Care every 12 months	100%
	People under adult mental illness specialities on a Care Programme Approach, followed up in seven days of being discharged from psychiatric inpatient care.	100%

Our strategic risks

Risk	Mitigation measure
Ineffective legal framework – impacts the delivery of services; risks increasing health inequalities and substandard service provision.	Prioritisation and incremental delivery of legislation programme (in consultation with Attorney General's Chambers, Health and Care Transformation Programme and Council of Ministers). Bringing legislation to the branches as part of a five-year programme by 2026. Putting secondary legislation to Tynwald and implementing on approval as part of a five-year legislative action plan.
Insufficient information and unavailability of good quality data limit the ability of the Department to assess the performance of Manx Care and to provide assurance in respect of quality, safety and care.	Implementation of a System Oversight Framework (SOF). Implementation of revised Manx Care Mandate Assurance process.
Quality, safety and care - improvements required in clinical and social delivery, risk and governance.	Revision of Quality Assurance Framework to align with CQC's regulatory model. Implementation of a jointly developed (DHSC & Manx Care) three year Quality Strategy. New primary and secondary legislation to drive improvements in care.
Technology and digitisation: an accessible digital platform is required to deliver care in the community (visual wards, virtual outpatients, tele-health and tele-care, single shared records).	Health and Social Care Digital priorities work programme. Wellbeing Hubs providing access to some forms of digitised service provision in local communities.
Workforce challenges: acknowledging high vacancy rates; difficulties recruiting to niche, specialist and hard-to-fill posts; an ageing workforce and training and development needs.	The Health and Care Transformation Programme Workforce and Culture Programme. Work collaboratively with Departments to develop a Government Key Worker Strategy.
COVID: continued impacts of the pandemic on the delivery of acute and social care services, resulting in the diversion of workforce and restrictions in service provision.	Working to Government's 'moving to an Endemic Approach' strategy; monitoring and reviewing resource allocation to COVID related service provision. Financial forecasting and reporting to Treasury on a quarterly basis.
Finances: expenditure levels cannot be brought under control under existing policies and operations, necessitating reviews of business, operational services and structure.	Monthly scrutiny of Manx Care's management accounts and Cost Improvement Programme. Develop a DHSC Cost Improvement Programme. Manage in-year financial pressures to remain within the budget allocation, whilst remaining cognisant of planned investments in service improvement or new services.
Regulation (Internal and External) – the scale of the external review and subsequent follow-up reporting requirements exceed the existing resource capacity.	Service Level Agreements to include maximising external regulatory resource. Monthly Departmental review of project deliverables and effectiveness. Manx Care colleagues to deliver front line pre/post external inspection work.

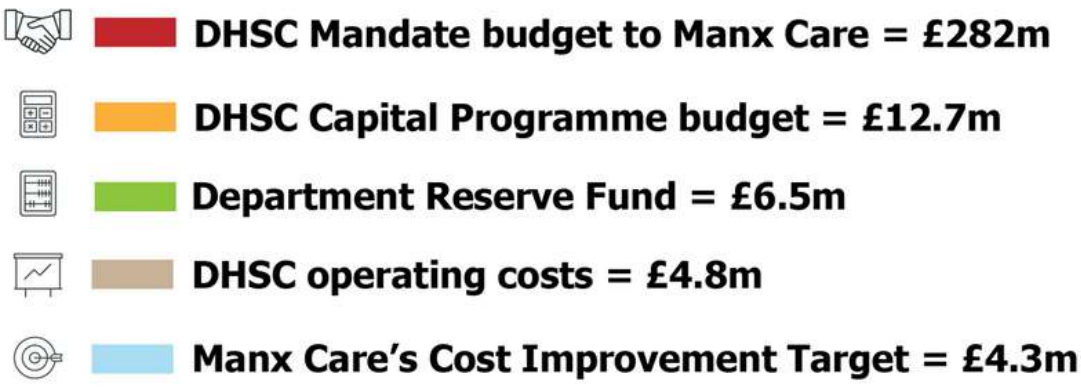
Financial summary

The funding that the Department has allocated to Manx Care for 2022/23 is c. £282m. This figure is net of the mandated Cost Improvement Programme (CIP) target of £4.3m that Manx Care is expected to deliver as part of continued efforts to balance finances.

The funding position for 2022/23 will continue to present a number of challenges for the Department and Manx Care, despite additional funding being made available by the Treasury.

Significant work is required to strengthen financial governance and the DHSC are working with Manx Care and Treasury to develop a long term funding plan as part of the current budget process.

The DHSC welcomed the support of Tynwald in respect of the supplementary vote, and from Treasury for the allocation of a £6.5m reserve budget which will be utilised to deliver outputs associated with the Mandate.



DHSC Capital programme

The Department has a budget for the development of capital schemes that will improve on-Island facilities for a wide range of patients and service users. The capital programme is managed by Manx Care.

Scheme	Description
Asset Replacement Scheme	Scheme to replace DHSC assets in use by Manx Care as and when required through a replacement programme.
Strategic Development Fund	Scheme in place to support the ability for strategic and management decisions to be progressed in relation to covering the cost of possible unexpected restructuring works and any professional fees prior to a full capital scheme being in place, as well as facilitating any upgrade work needed to buildings prior to new equipment being introduced.
Older Persons Residential & Resource Unit East	Construction of a 60 bed residential facility, day care unit and dementia unit for the East region to replace Reayrt ny Baie
Older Persons Residential & Resource Unit North	Construction of a 45 bed residential facility for the North region to replace current Cummal Mooar building
Radiology Equipment Replacement Scheme	Planned five year replacement of significant items of equipment within Radiology at Noble's Hospital
Reconfiguration of Learning Disabilities (Radcliffe Villas)	Construction of a new purpose built Respite Facility building to replace Radcliffe Villas
Redevelopment of Emergency Dept, Noble's Hospital	Redevelopment of ED at Noble's to include isolation facilities and six bed ancillary ward
Redevelopment of Grianagh Court	Refurbishment and conversion of Grianagh Court to accommodate Child and Adolescent MHS and Older Persons MHS on hospital estate
Replacement LIM system, Pathology, Noble's Hospital	Replacement Laboratory Information Management System (LIMS) computer system for Pathology at Noble's Hospital

Appendix 1 - Legislation Programme

Title of Bill	Description	Status	Target
Capacity Bill (part 1)	The creation of a framework under which a practitioners will be able to operate when determining capacity. Introduction into Branches possibly April or May 2022, depending on progress settling remaining policy issues.	Enter branches May 2022	2021/22
Health and Social Care Regulation Bill	A level playing field for all health and social care providers with clear requirements or standards of care and treatment.	Policy Development	2022/23
Capacity Bill (part 2)	Introduce statutory safeguards for adults lacking mental capacity with respect to their care and treatment, specifically where an action (or combination of actions) may amount to that person being deprived of their liberty.	Policy Development	2023/24
Health and Social Care Services Bill	To replace the National Health Service Act 2001, National Health and Care Service Act 2016 and the Social Services Act 2001 with one modern, integrated Health and Social Care Service Bill. To clarify responsibilities of the Department and Manx Care within those Acts post the introduction of the Manx Care Act 2021, and to address weaknesses or gaps in the current system as well as enabling the implementation of the recommendations in Sir Jonathan Michael's report.	Policy Development	2024/25
Human Embryology and fertilisation	To update and replace Part 9 Children and Young Persons Act 2001 bringing it in line with the Human Fertilisation and Embryology Act 2008. Specifically to change the definitions of 'mother' and 'father' to recognise same sex parents who have had children using fertilisation and embryology methods. To amend Civil Registration Act 1984 to allow same sex couples to register births.	Not Commenced	2024/25*
Safeguarding Vulnerable Adults Bill	Isle of Man equivalent of the Care Act 2014 (England & Wales) or Adult Support and Protection (Scotland) Act.	Not Commenced	2024/25
Children and Young Persons Bill	Up-to-date legislation in line with other jurisdictions. Increased safeguards and protection for vulnerable children and support for looked after children, care leavers and young people estranged from families. The creation of additional rights for grandparents.	Not Commenced	2025/26
Medicines Bill	A comprehensive, fit for purpose and up to date framework for medicines legislation.	Not Commenced	2025/26

* The Department recognises that leave to introduce has been granted to Miss Tanya August-Hanson MLC for the purposes of completing this legislation.

Appendix 2 - Glossary of terms

Appropriate Adults	These are people who can be called upon to assist in safeguarding the rights and welfare of young people and vulnerable adults in police custody.
Assurance	This is the process by which the DHSC checks how Manx Care is performing, against its responsibilities as laid out in the Mandate to Manx Care.
Carer and Young Carers	A carer is defined as someone who supports a relative, friend or a neighbour (who, for any reason, needs help with daily living) and receives no payment for doing so. A young carer is someone who is under 18 and cares for a relative they live with.
Corporate Governance	This is the system of rules, practices and processes which dictate how an organisation works. It identifies who has power and accountability and who makes decisions.
Digital Care	This is the use of digital technology in delivering services in the health and social care system.
Elective Recovery Plan	This is a plan to show how Manx Care will reinstate and improve elective services over the coming years, including how they will reduce long waits for elective care.
Engagement Strategy	This is a plan showing how the department will involve patients and service users in improving health and social care.
Gap analysis	This is the process used to compare current performance with desired or expected performance. This analysis is used to assess whether we are meeting expectations and using resources effectively.
Health and Wellbeing Hub	These are centralised locations for delivering care and support services for all residents in a community. They provide health and social care services closer to home, and allow Government and Third Sector organisations to work together to produce better outcomes for our communities.
Health inequalities	Health inequalities are avoidable differences in people's health across the population and between specific population groups.
Inspection regime	This is how we check to make sure that services are meeting an agreed set of standards and qualities.
Integrated Care	Making sure people can easily access continuous care in one location, instead of receiving fragmented care across several locations.
Joint Strategic Needs Assessment (JSNA)	A joint strategic needs assessment is where more than one department/organisation is involved in deciding how to tackle a problem.
Local Area Co-ordination	Local Area Coordination is having one person or team which coordinates services and support in a local area.

Long-term conditions	Long-term conditions, or chronic diseases, are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.
NICE T/As	NICE is the National Institute for Health and Care Excellence. NICE T/A's are technology appraisals (recommendations) that NICE make about the use of new and existing medicines and treatments within the NHS, including drugs, devices, diagnostics, surgical procedures and health promotion activities.
Pathway	In health and social care, a pathway describes what someone's treatment or care journey will look like
PEOL	Palliative and End of Life Care pathway – this is a specific pathway for someone who is either seriously ill and/or is in the last stages of their life. It is focused on making the patient as comfortable and pain free as possible.
Primary Care Operating Model	This covers the policies, standards and operating procedures that GPs have to use.
Respite Care	Allows carers to take a break from caring while the person they care for is looked after by someone else.
Safeguarding	Actions that are taken to promote the welfare of children and vulnerable adults, and protect them from harm.
Self-care and self-management	Enabling self-care means giving people the right information and skills to look after themselves well. Self-management is managing the symptoms of disease, either alone, in partnership with healthcare professionals, or alongside other people with the same health conditions.
Strategy	This is a plan of action designed to achieve a long-term or overall aim.
Third sector	Voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), and social enterprises.
Virtual outpatient appointments	Using telephone and video calls so that health professionals can have consultations with patients without having to be in the same room.
Vulnerable Adults	Those with a learning disability, mental health difficulty or those who for other reasons have difficulty communicating or understanding what is happening to them.

Isle of Man Government

Reiltys Ellan Vannin

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manx care
Kiarail Vannin

ANNUAL REPORT
2021-2022

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SERVICE YEAR:
2021/2022

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contents

1. foreword

We are pleased to share our first Annual Report, which provides a summary of our performance during the 2021/22 financial year.

In accordance with the Manx Care Act (2021), this Annual Report describes how Manx Care exercised its functions during 2021/22, including an assessment of the extent to which it met the objectives and requirements specified within the Department of Health and Social Care's (DHSC) Mandate.

The Mandate details the requirements of Manx Care as the Department of Health and Social Care's (the 'Department' or 'DHSC') provider of health and care services, setting out the services required, the funding available and the obligations and limitations of the delivery of the services. It forms the basis on which services required to be delivered are described and mandated by the Department to Manx Care. The Required Outcomes Framework (ROF) is Manx Care's response to that, and outlines a set of indicators and standards to monitor performance, drive transparency and accountability, and improve quality outcomes. It also details some important key commitments for Manx Care in developing credible plans for improvement over the course of 2021/22.

We set ourselves some ambitious targets, and aimed to make substantial progress during the first year operating as an independent organisation at arm's length from the DHSC, whilst also recognising and accepting that it will take a longer period of time to fully deliver and embed all of the recommendations from Sir Jonathan Michael's independent review into the provision of health and social care on the Isle of Man. During 2021/22, the Manx Care Board identified three priorities on which it would focus during its first year:

1. Improving the quality and safety of service
2. Improving the culture of the organisation
3. Improving the financial health of the organisation

The service improvements that have been made have been delivered during what proved to be an extremely difficult and challenging period, as we continued to respond to the demands of the global Covid-19 pandemic, working alongside the Island's community and the wider Government to ensure the safety of our residents. Despite the challenges, we can evidence progress against our ambitions to enhance patient, service user and carer experience, create a continuous learning culture, improve safeguarding of our adults, children and younger people, and improve access to our services.

We recognise that improving the culture of the organisation will take time, but we believe we have made a positive start on our commitment during year one. We have listened to – and we will continue to listen to – our colleagues and ensure that, as far as is possible, we act on what we hear. We have reviewed our organisational Care Values to ensure they resonate with and are reflective of the views of our colleagues, and reflect what is important to the future of Manx Care. We are committed to open and transparent communication with our colleagues, our patients, services users and their carers, and are committed to co-production and taking a partnership approach to all that we do.

Managing our finances has proven to be extremely challenging during our first year. We ended the year having sought additional funding from Treasury in order to support our expenditure on some items which we are not able to predict or influence the cost of, for example rising drugs costs, high-cost patients, difficulties recruiting substantive staff and thus a costly reliance on Agency/Bank staff, and the cost of managing Covid. A huge amount of work has been done to understand our expenditure and manage our costs, and we remain fully committed to operating within our allocated budget. We expect to make significant progress in this regard, with further focus around our Cost Improvement Programme during 2022/23.

As with the Required Outcomes Framework, the intended audience for this document is broad, and includes our people, our patients and service users, their families and carers, service partners, and the Manx community, all of whom have an important role to play in making Manx Care a success.

Andrew Foster CBE
Chair, Manx Care

Teresa Cope
CEO, Manx Care

chairman's report

Reflecting on the first year of Manx Care, I think back to my first update to the newly established Manx Care Board in April 2021. This reported on the newly established Governance arrangements of the Manx Care Board and outlined a baseline position for the organisation across the domains of Quality and Safety, People and Culture, Finance and Performance, and Data and Digital. It laid the foundations for the Board to move towards its core purposes of strategy, scrutiny and assurance. We chose three main priorities – improving patient safety, improving culture and improving financial health – and these remained the cornerstone of our focus throughout the year.

The Required Outcomes Framework also highlighted that there was much work to do on improving safety across our services, and accordingly the majority of Year One commitments related to this.

In our first months, travel restrictions remained in place and our early Board meetings were held virtually, but we were able to hold our first meeting in public on 27 July 2021. The impact and the effect of the pandemic has been well documented and I don't intend to dwell upon it here, save to say that its impact was unprecedented. We managed the situation to the best of our abilities and it has provided valuable learning for Manx Care. I pay enormous tribute to so many colleagues who more than rose to the challenge in terms of our response to the pandemic.

It is abundantly clear to me that everyone who works for Manx Care deserves full recognition for the hard work and commitment displayed, and all that they did to continue to provide services to residents of the Isle of Man throughout the year. The first phase of the restoration and recovery activity, which required us to address the inevitable increase in waiting lists, continues to make good progress, and we hope that the second phase will be rolled out later in 2022.

During the year we said 'goodbye' to our colleague, Vanessa Walker, who passed away in January 2022 following a period of illness. As a Non-Executive Director, Vanessa was a remarkable find, bringing so many different skills and perspectives to the Board. First and foremost she was a Nurse, with that caring profession at the centre of everything she did. Vanessa worked tirelessly to ensure those groups that were under-represented in society were given a voice. The Board lost a great member, the Island lost a great friend and we all lost a great person.

On behalf of the Board, I would like to take this opportunity to pay tribute to the dear colleagues we also sadly lost during the year, many of whom have devoted their lives to delivering exceptional care to the people of the Isle of Man. In order to maintain their privacy, and that of their families, we have chosen not to name them publicly. However, I would like to recognise their contributions and the role that they played in our first year.

I would also like to offer my personal thanks to our Director of Infrastructure, Barbara Scott, who retired in July 2022. Barbara moved to the Island 26 years ago, following many years of service as a Nurse in the UK. She played a leading role in the supply of PPE during the Covid-19 pandemic, as well as establishing the swabbing and testing facility at the Grandstand in Douglas in April 2020, and the launch of the two vaccination hubs in January 2021. Barbara made a significant contribution to the lives of many of our colleagues, as well as many Manx residents, during the course of her career. She will be greatly missed by everyone in Manx Care, and we wish her the very best for her well-deserved retirement.

Next year will be different, but also challenging as we continue to strive to innovate and to provide a more joined-up, integrated health and social care system for the Isle of Man. I would like to take this opportunity to thank all of our colleagues for their tireless work and unyielding dedication to all of our patients and service users during our first year, and look forward to embracing the opportunities the coming year will undoubtedly bring.

Andrew Foster CBE
Chair, Manx Care

ceo report

I am pleased to share Manx Care's first Annual Report. It is a comprehensive read, and will help members of the public to understand the journey that the organisation is going on in order to transform the way that health and statutory social care is delivered on the Island, and support us in achieving our goal to be the best small Island health and care system in the world. We set ourselves some ambitious targets, and aimed to make substantial progress during our first year of operating as an independent organisation at arm's length from the Department of Health and Social Care (DHSC), whilst also recognising and accepting that it will take a longer period of time to fully deliver and embed all of the recommendations and improvements from Sir Jonathan Michael's independent review into the future provision of health and care on the Island.

In Year One we can evidence strong progress against our priorities of improving the quality and safety of the services that we deliver. These improvements have been delivered against the challenging backdrop of continuing to respond to the demands of the global Covid-19 pandemic. Our remarkable and dedicated colleagues are our greatest asset and have demonstrated significant resilience and compassion in their commitment to their roles, working alongside the Island's community, our delivery partners and the wider Government to ensure the safety of our residents.

I am encouraged by the progress and the feedback on our commitment to improve the culture of the organisation, including listening and acting on feedback from our colleagues and partner organisations, promoting leadership visibility and engagement, implementing wellbeing opportunities and rolling out the Manx Care Leadership in Practice Academy as a key development programme. We recognise that establishing a positive and inclusive working culture takes time and we will continue to work hard and focus on this across all levels and parts of the organisation.

Manx Care ended the year under review, having sought additional funding from Treasury in order to support our expenditure on some items which we are not able to predict or influence the cost of, for example rising drug costs, high-cost patients and the cost of managing Covid. A huge amount of work has been done to understand expenditure and manage costs across the organisation, and I would like to thank every colleague who has been involved in what has been an extensive exercise.

The year under review was very much a year of discovery, establishing a baseline from which to develop across all services, and making a number of changes that should help the organisation to achieve success in Year Two and beyond. Members of the public will see a significant amount of progress being made across the 2022/23 financial year, and I hope that you will continue to provide your input and feedback to help us shape the range of services we provide.

Teresa Cope
CEO, Manx Care

2. our corporate structure

the manx care board

About Manx Care

Manx Care was established with effect of the Manx Care Act 2021, with the organisation being authorised on 01 April 2021.

The Board is of a unitary nature with 11 statutory, voting Directors recognised as filling the roles described in Schedule 1 of the Act.

Non-Executive Directors
Andrew Foster CBE, Chair
Sarah Pinch, Vice Chair
Andy Guy
Katie Kapernaros
Nigel Wood
Vacancy[1]

Executive Directors
Teresa Cope, Chief Executive Officer
Dr. Sree Andole, Medical Director
Jackie Lawless, Director of Finance
Paul Moore, Director of Nursing and Governance
Sally Shaw, Director of Social Care

Tenure

Non-Executive Directors were appointed by a process of open competition for the role, starting in late 2020, with recruitment activity and initial meetings of the Shadow Board all being conducted virtually due to the pandemic and the lockdown restrictions that were in place in the Isle of Man at that time.

During the year under review, the Board was very sorry to lose a valued colleague, Vanessa Walker, who passed away following a period of illness. A recruitment process has recently concluded to appoint a new Non-Executive Director, with the appointment having been approved by Tynwald in July 2022.

In addition to these Directors, the senior management team reporting to the CEO includes four non-voting Directors and the Board Secretary, with the portfolios set out below:

- Anne Corkill, Director of HR Business (OHR Shared Service)
- Oliver Radford, Director of Operations
- Barbara Scott, Director of Infrastructure[2]
- Richard Wild, Director of Digital & Informatics
- John Middleton, Board Secretary[3]

Note 1: The vacant Non-Executive Director position was held by Vanessa Walker until her resignation in December 2021 on the grounds of ill health

Note 2: Barbara Scott subsequently retired from Manx Care, on 29 July 2022. A replacement has been recruited for her position

Note 3: John Middleton resigned from Manx Care on 22 November 2021. On 24 January 2022 he was replaced by Andy Chittenden who assumed the role of Executive Director of Corporate Affairs on an interim basis, which included responsibility for the Board Secretariat portfolio.

board structure

voting board

Manx Care Chair
Andrew Foster CBE

Non-Executive Director
Nigel Wood

Non-Executive Director
Andy Guy

Non-Executive Director
Katie Kapernaros

Non-Executive Director, Vice Chair
Sarah Pinch

Non-Executive Director
Vacant

Executive Director of Corporate Affairs and Board Secretary (Interim)
Andy Chittenden

Chief Executive Officer
Teresa Cope

executive leadership team

Executive Director of Nursing
Paul Moore

Finance Director
Jackie Lawless

Executive Medical Director
Dr. Sree Andole

Executive Director of Social Care
Sally Shaw

non-voting

Director of Infrastructure
Barbara Scott

Director of Operations
Oliver Radford

Director of HR Business
Anne Corkill

Chief Information Officer
Richard Wild

Medical Director, Primary Care
Oliver Ellis

board biographies

Andrew Foster CBE
Chair

Andrew was appointed in September 2020 having just concluded a number of executive roles for NHS England, including Executive Lead for Leadership, Interim Managing Director of the Leadership Academy, chairing the work on Leadership Culture as part of the NHS People Plan and managing the programme to bring back retired staff to help in the fight against Covid-19. He is a Non-Executive Director at Health Education England and Trustee of ENT UK.

Previously he was Chief Executive at Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) from January 2007 to October 2019. His main interests have been quality and staff engagement, with a particular desire to learn from the best health systems in the world. WWL developed a significant reputation for all-round performance, whilst also achieving almost all major targets and enjoying financial stability. It won many national and regional awards including HSJ Provider Trust of the Year in 2014. It is rated 'Good' by the CQC in all domains, for all sites and for Use of Resources.

Before WWL, he spent five years as the NHS Director of Human Resources (Workforce Director General) at the Department of Health with principal responsibility for implementing the workforce expansion and HR systems modernisation set out in the NHS Plan of 2000. Previously he spent two years as part time Policy Director (HR) at the NHS Confederation. Andrew was also the Chairman of WWL NHS Trust from 1996 to 2001 and, before that, Chairman of West Lancashire NHS Trust and Non-Executive Director at Wrightington Hospital NHS Trust.

Teresa Cope
CEO

Teresa Cope worked in the NHS in England before moving to the Island in December 2020 to take up the role as Chief Executive of Manx Care. Teresa began her NHS career as a Diagnostic Radiographer. During her clinical career, she was a Clinical Lecturer for the Royal Military College of Science (Cranfield University) based in Oxfordshire training undergraduate Radiographers in their clinical placements across the local area, and later lecturing on CT Scanning at Sheffield Hallam University. Her last clinical Radiography role was Superintendent Radiographer for United Lincolnshire Hospitals.

She subsequently moved into general management, fulfilling roles across a broad number of specialities including Surgery, Critical Care, Theatres and Cancer and Diagnostics Services. She undertook a number of external reviews on behalf of the East Midlands Strategic Health Authority on waiting list irregularities, and was part of an advisory panel on the procurement of Independent Sector Diagnostics for the region.

In 2008, she moved into High Secure Forensic Mental Health Services upon her appointment as General Manager for Rampton High Secure Hospital. She was also part of the core team leading Nottinghamshire Healthcare NHS to achieving Foundation Trust status and expanding its services into Offender Healthcare Provision.

From there, she moved to Nottingham City Clinical Commissioning Group (CCG) as the Director for Quality, Contracting and Delivery, joining when the CCG was in shadow form and progressing through the authorisation process and becoming one of only a handful of Allied Health Professionals nationally who held the quality portfolio lead for the CCG. She also oversaw establishment of the System Resilience Group and Urgent and Emergency Care Transformation Programme for the Nottinghamshire and Derbyshire system.

In 2015, Teresa assumed the Chief Operating Officer (COO) role at Humber NHS Foundation, an integrated Mental Health, Community Services and Primary Care provider covering a large geography, and led a number of transformation programmes before becoming COO of Hull University Teaching Hospital. The Trust provided a range of tertiary services and was a Major Trauma Centre, Cancer Centre, Cardiac Centre and regional Infectious Diseases (ID) Centre. In January 2020, she also assumed its Covid-19 Gold Commander role following Hull diagnosing the first two UK cases of Covid-19 in its ID unit. As well as leading the operational delivery of the Trust, she chaired the A&E Delivery Board, and was Vice Chair of the Regional Radiotherapy Network and Integrated Care System (ICS) Lead for Endoscopy and Diagnostics Transformation.

Teresa supported production of Channel 5's 'A&E After Dark' documentary following night shift teams at Hull Royal Infirmary. Its aim was to show the outstanding, compassionate and dedicated work of its Emergency Department (ED) during some exceptionally challenging situations and generate a greater level of understanding from the public, and other parts of the health and care system, on the demands placed on the ED. A second series was commissioned following the success of the first.

Sarah Pinch
Non-Executive Director, Board Vice Chair

Sarah Pinch is Vice Chair and a Non-Executive Director of Manx Care, and chairs the People Committee.

Sarah is MD of Pinch Point Communications (PPC), an Independent Advisor to The Senedd, Trustee of Bristol Students' Union and Chair of the Taylor Bennett Foundation.

Starting as a BBC journalist, she has worked in corporate communications since 2000, in-house for Christian Aid, Children's Hospice South West, First Group plc and the NHS. She founded PPC in 2013 and the agency works across all sectors, specialising in all areas of change management, staff engagement, strategic communication and issues and crisis management.

She launched Spring Forward in 2018, an annual conference aimed at women who want to run the show, was President of the Chartered Institute of Public Relations in 2015 and served five years as a Non-Executive Director of the Health and Safety Executive. In March 2022 she was nominated for Women in PR's inaugural '45 Over 45' list of outstanding women in communications.

Sarah lives in Bristol with her young family, and is married to a Manxman. She enjoys visiting the Isle of Man through her family connections. She started running six years ago and is evangelical about its benefits.

Katie Kapernaros
Non-Executive Director

Katie Kapernaros is a Non-Executive Director for Manx Care and chairs the Digital and Informatics Committee.

She is an experienced executive in the IT industry, spending most of her career at IBM managing large operational teams and budgets. She has lived and worked in Australia, Singapore and the UK, and has managed teams across the world. One of her notable projects was working on the Sydney Olympics.

Katie now has a portfolio of Non-Executive roles in the public sector covering digital, property and health organisations. She has done a lot of voluntary work in the charity and sports arenas, and is a Fellow of the British Computer Society, where she also volunteers on some of their committees.

Andy Guy
Non-Executive Director

Andy Guy is a Non-Executive Director for Manx Care and chairs the Audit Committee and the Mental Health Act Legislation Committee.

He moved to the Isle of Man over 20 years ago with his family. He initially trained as a Pharmacologist and retains a deep interest in health and medicine. He has ten years of medicine research experience with one of the world's largest pharmaceutical companies, working on anxiety and depression initially, and then exclusively on learning and memory dysfunction as it relates to dementia. He has a PhD in Neurophysiology where his thesis explored the brain pathways and mechanisms of spatial memory.

Upon moving to the insurance industry, Andy re-trained as a Life Assurance Underwriter for a global life insurance company, spending a considerable period as Research Underwriter managing life, serious illness and long-term sickness risk, helping to translate medical advances into better underwriting practice and lower premium rates. He has held two 'Chief Underwriter' positions and continues to offer an underwriting consultancy service.

Andy has sat on two Isle of Man Government independent boards, with over ten years' experience in those roles. He was a Member of the Independent Review Body (IRB) dealing with complaints against the NHS, chairing the IRB for half of his ten-year tenure which came to an end in late 2019. He was also a member of the Health Service Consultative Committee, with oversight areas including integrated care and Programme for Government as it applied to the National Health Service.

He holds a firm belief that Manx Care is the beating, caring heart of society and represents just what can be achieved by a civilisation when people work together to create something they all want.

Nigel Wood
Non-Executive Director

Nigel Wood is a Non-Executive Director for Manx Care and chairs the Finance, Performance and Commissioning Committee.

A proud Manxman and Manx resident, Nigel is a British Chartered Accountant and is Principal Director of Harley Partners, his own boutique consulting practice founded in 2013. He is a retired Trust and Estates practitioner (TEP) and international tax practitioner (ITPA). He continues to enjoy a broad and varied career in the Isle of Man's Financial Services sector.

In 1981 he moved from a Chartered Accountancy practice to join the IOMA Group, a privately owned Risk and Financial Services Group, and has experience in International Life Insurance, Reinsurance, Captive Insurance, Trust and Corporate Services, Closed Ended Funds and high-level governance. He was formerly a shareholder and Group Managing Director for 13 years, having been Finance Director for 14 years prior to that.

He has served as a Non-Executive Director of two substantive Alternative Investment Market (AIM) listed companies on the London Stock Exchange, chairing the Audit Committee of one of those. He is an Executive Director (and Shareholder) of an International Life Insurance Company based in The Bahamas, and Chairman and shareholder of Ascentiom, an Island-based recruitment company run by his son Guy. Until July 2020 he was the Chairman of the Board of Governors of King William's College and the Buchan School, and remains a Governance Council member.

Nigel has been privileged to speak at a number of global conferences, and has supported Isle of Man Government roadshows. He is married to Lorraine; together they have three adult children and four granddaughters. His interests include travel, cycling, walking, sailing, down-hill skiing, music, nature and the outdoors.

Dr. Sreeman Andole
Executive Medical Director

Dr. Sreeman Andole, fondly known by his friends as 'Sree', is a Stroke Consultant and carried out his specialist training in London. He joins Manx Care from Kings College Hospital in South London. Sree is also Assistant Medical Director for NHSE/I, and is an interim Medical Director for the East of England Ambulance Service NHS Trust, as a part of the National Improvement Team for challenged systems.

Sree has worked in several regional and national roles including the Clinical Standards Committee for the British Stroke Association, a Committee member for the Clinical Reference Group, within Neurosciences UK, as Specialist Advisor for the Care Quality Commission (CQC), a Governance Body member for Southend CCG, and is a member of the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) collaboration. He is currently a NICE expert advisor for stroke treatment update guidelines, as well as for the LINQ cryptogenic stroke monitor. In addition to this, he is an Associate Professor of Stroke Medicine.

Sree has worked across Primary, Secondary and Tertiary care settings with GPs, hospital doctors and other service providers, and has previously played a key role in acute service reconfigurations in London and South East Essex in the UK. He has won several awards including the Stroke Association Professional Excellence award in 2018, was HSJ Clinical Leader of the Year finalist in 2013 and HSJ BME Pioneer of the Year in 2013.

Outside of work, Sree loves dogs and has a passion for curries!

Paul Moore
Executive Director of Nursing and Governance

Paul Moore joined Manx Care from Stockport NHS Foundation Trust where he led on quality governance, risk and safety management and assurance. With over 32 years' experience in the NHS, this is Paul's sixth Executive Director post having also previously worked at Wirral University Teaching Hospitals NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, St George's University Hospitals NHS Foundation Trust and the University Hospitals of South Manchester (UHSM). He brings to the team leadership expertise, experience in overcoming quality and safety concerns, and also building a culture of high ambition, high-quality care and organisational resilience.

Paul is focused on engaging and empowering front-line teams to deliver better health, better care and value. He has an interest in improvement science and believes success is achieved through a proactive, anticipatory and highly adaptive approach to care. His unique and innovative model for quality governance won the HFMA's Governance Award in 2011, and his approach to safety management led to UHSM (in 2013) and Wirral (in 2020) achieving Gold Awards from the Royal Society for the Prevention of Accidents. He graduated in Nursing from the Victoria University of Manchester in 1997 and specialised in emergency and trauma nursing. He completed the Institute for Healthcare Improvement's Patient Safety Officer's Executive Development Program in 2008 (Boston, Massachusetts), acquired a Master of Science degree in Healthcare Management from Manchester Business School in 2012, and completed the Risk and Corporate Leadership Executive Development Programme at Harvard Business School in 2014.

He has sat on the National Institute for Health and Clinical Excellence and National Patient Safety Agency's Patient Safety Advisory Committee, and the National Health Service Litigation Authority's Risk Management Forum. He has published a number of papers and presented at many international conferences and symposia, including at the 2005 United Kingdom Presidency of the European Union Patient Safety Summit.

Paul is retained as a Special Advisor to the Care Quality Commission in England and Wales. He is also currently developing the Quality and Safety Module for the upcoming Executive Director Pathway commissioned by the NHS Leadership Academy.

Sally Shaw
Executive Director of Social Care

Sally Shaw began her career in North West England in 1986 as a Nursing Assistant in a long-stay hospital that supported children and adults with a learning disability, going on to qualify as a Registered Nurse in 1991. She worked both as a Community Nurse for children with disabilities and then as a Resettlement Nurse, supporting the closure of the hospital and supporting the development of community-based models of care and support.

Having moved to work for a Local Authority in Warrington, she began to study at Salford University and graduated as a Qualified Social Worker in 1997. After this, she was instrumental in bringing together a large multidisciplinary community-based team to support adults with learning disabilities, managing the social work provision of this team. Whilst in this post, the Authority became a Unitary Authority and so Sally led on the development of emergency out-of-hours social work provision alongside her substantive post. She continued to both provide management support and cover frontline shifts to support the development of the service and to maintain her registration for several years.

In 2005, she took on a significant piece of transformation activity for the Authority in respect of the then contract and commissioning arrangements and practices for all learning disabilities services, before moving into the Third Sector working across England and Wales.

Following her relocation to Scotland, in 2011 she began a senior post in Shetland and soon had the opportunity to take on a joint role between the Health Board and Local Authority as Interim Director of Community Care before taking a senior role in 2013 within the Care Inspectorate in Scotland, the scrutiny and improvement body within the Scottish care sector. During this time, she led on the joint inspections of health and social work services across adult service provision with colleagues in Health Care Improvement Scotland, before moving back into operations in 2017, with significant experience in developing integrated health and social care services.

She has worked closely with the European Social Network, predominantly collaborating on aging and disability-related issues.

Jackie Lawless
Finance Director

Jackie Lawless moved to the Isle of Man in 2020 and has extensive experience in various sectors, sizes and types of organisations including Government, construction, housing and medical device manufacture. Her career has taken her across the world, with periods spent living and working in Ireland, Belgium, Japan, Israel and the UK.

Jackie sees the role of Finance Director as being to provide financial information and insight that supports organisations in making good, solid decisions. She has significant experience in driving and implementing change, and encouraging a culture of continuous improvement by getting the best from systems, processes and people.

Jackie is a keen motor-racing and classic car enthusiast, and enjoys both practising and teaching creative crafting.

Oliver Radford
Director of Operations

Oliver Radford grew up in Lancashire and has a BSc degree in Physiology from the University of Leeds and an MSc in Health Informatics from the University of Manchester. He started working for the NHS in 2004 as a Clinical Governance Manager at Central Manchester University Hospitals NHS Trust, as one of the first people dedicated to embedding the principles of clinical effectiveness within clinical services.

He moved to his first service management position in 2007, taking over the management of the Anaesthetic Directorate which, at the time, employed 60 Consultant Anaesthetists. By the time he left the role in 2014, that number had increased to more than 90 consultants. During his time in Anaesthetics, Oliver also oversaw the construction of a new Critical Care complex which had 52 beds across three separate units. Following his period within Anaesthesia and Critical Care, he accepted a 12-month secondment with the Central Manchester Trust's Transformation Team, overseeing transformation activity across all elective services, concentrating on improving theatre efficiency. He concluded his UK NHS career with a 12-month position leading the Manchester Head and Neck Centre, which provides specialist Head and Neck Cancer and Audiology services for Greater Manchester.

In 2016, Oliver moved to the Isle of Man to take up the role of Surgical Divisional Manager at Noble's Hospital, before moving to become General Manager for Unscheduled Care at Noble's and, most recently, Integrated Community Care Group Lead.

Barbara Scott
Director of Infrastructure

Beginning her career in nursing in the UK, Barbara Scott worked in Intensive Care for many years before moving to general surgery where day case, Endoscopy and five-day ward services were developed to maximise patient experience, and improve quality and throughput.

This success led to her project managing and commissioning a new combined Day Case and Endoscopy Unit with its own theatre complex with funding from the Mersey region. She was subsequently appointed to the Surgical Divisional services as Contracts Manager following Halton's move to Trust status. This was an exciting time to develop the Trust into a successful business model with low waiting lists, and the ability to be creative in managing the hospital and providing services.

Barbara moved to the Isle of Man following the birth of her second daughter and stayed at home for 12 months before accepting a part-time nursing post offering insight into the Island's Health and Care system, and fuelling her desire to play a role in its future change. She was appointed Deputy Hospital Manager in 1998 and led the move to the new Noble's Hospital site in 2003, becoming Hospital Manager in 2006. In 2016, she moved to undertake the commissioning of the Salisbury Street Care Home in Douglas, alongside a number of other projects.

Appointed as Director of Infrastructure for the Department of Health and Social Care (DHSC) in 2017, Barbara played a leading role in developing a shared service model with the Department of Infrastructure (DOI), which she found as rewarding as it was challenging. She prides herself on bringing a different perspective to her role, developing her department from a functional buildings service to one focused on meeting client needs. The Director of Infrastructure remit allows her to play a critical role in shaping the development of Manx Care's transformation agenda.

Dr. Oliver Ellis
Medical Director, Primary Care

Oliver is Chair of the Isle of Man Primary Care Network, and is a non-voting member of the Manx Care Board. Oliver's appointment will support one of Manx Care's strategic focuses which is to strengthen the relationship with our Primary Care practitioners on the Island and drive forward the transformation of our services.

Oliver qualified from Leeds Medical School in 2012 with an MbChB and an MA in Biomedical Ethics. He was Student Editor at the British Medical Journal (BMJ) in 2010-2011. He moved to the Isle of Man to work as an F1 doctor in 2012. He worked as a Clinical Fellow for the Mental Health Service in 2014 and is approved under Section 12 of the Mental Health Act.

Oliver trained as a GP on-Island, qualifying in 2018. He worked as a GP partner at the Laxey and Village Walk practices before moving to Peel Group Practice as a GP partner in January 2021.

He has experience of many of the clinical areas within our Island's health and social care service including Medicine, Orthopaedics, General Surgery, Psychiatry, Drug and Alcohol services, Emergency Department, Paediatrics, Obstetrics and Gynaecology, Hospice, MEDS (Manx Emergency Doctor Service) and General Practice.

His wife is a physiotherapist, and together they have two children and two cats. He has a passion for cookery and science fiction novels.

Richard Wild
Chief Information Officer

Born and raised on the Isle of Man, Richard Wild graduated from the University of London with an MSc in Advanced Computer Science and began his career at Demon Internet in 1994 as a computer programmer. With expertise in internet development, he subsequently moved to California and worked with one of the world's largest e-retailers as Chief Technical Architect.

Returning to the UK in 2002, Richard became the Lead Security Architect at the Cabinet Office and moved to the Department of Health in 2004. In this role, he became a respected expert in confidentiality, privacy and information risk management. He was a trusted advisor to Dame Fiona Caldicott, the National Data Guardian, and was the Director of her two Caldicott reports on confidentiality and data security.

Returning to the Island in 2015, Richard joined the Department of Health and Social Care and was lead author of its 'Health and Social Care in the next five years' strategy published that year. He moved to the Cabinet Office in 2017 as Executive Director of Government Technology Services, before joining Manx Care in January 2021 as Chief Information Officer.

Outside of work, Richard is a skipper for Sailing for the Disabled charity and a regular competitor in the Island's Parish Walk, having completed the challenge a number of times, and with a fastest finish of 16 hours and three minutes!

Anne Corkill
Executive Director of HR Business

Anne Corkill is Director of HR Business for Manx Care. She has a long-standing career working for Isle of Man Government across a number of sectors and departments.

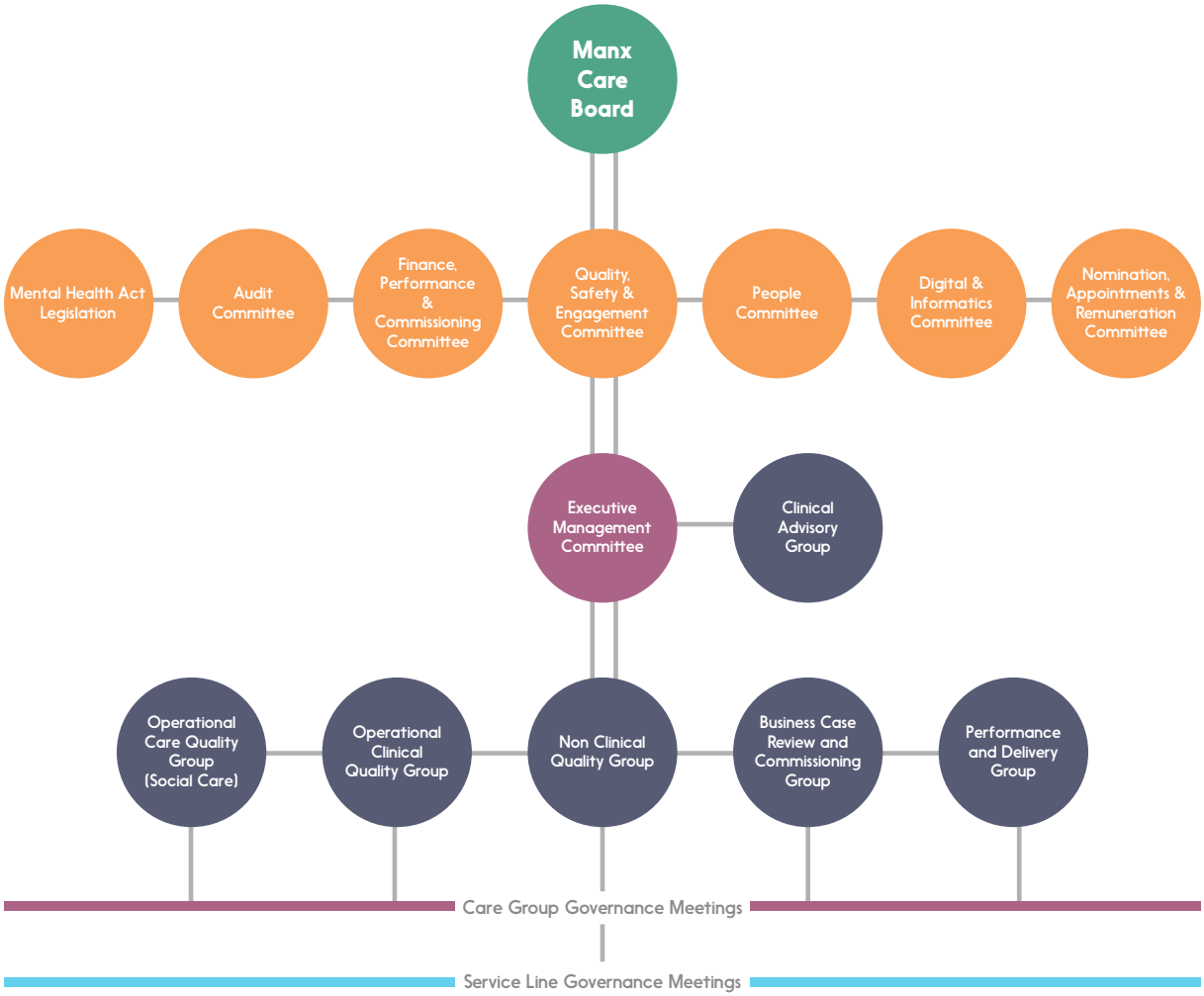
Andy Chittenden
Executive Director of Corporate Affairs and Board Secretary (interim)

A biochemist (BSc) and Parasitologist (MSc) by original qualification, Andy worked and lived abroad in Kenya and Papua New Guinea in the 1980s, and more latterly in Qatar (Head of Governance in Qatar NHS, 2013/14) as well as travelling extensively in Eastern Europe marketing laboratory instrumentation in the 1990s.

Andy took his MBA through the Open University between 1994 and 1997 and qualified as a Chartered Company Secretary with ICSA, being elected to Fellow in 2012. He has been involved in charity governance for more than 20 years, and joined the NHS in 2007, firstly as Company Secretary at Wirral University Hospitals NHS Foundation Trust, and then at the University Hospitals of South Manchester NHS Foundation Trust. He established his own consultancy in 2014 and has undertaken many consultancy and interim appointment contracts since.

Andy doesn't focus his work in the Governance sector 100% of the time. For example, he ran an industrial design, innovation and rapid prototyping bureau at Liverpool University between 1998 and 2002 and ran the Liverpool Anglican Cathedral between 2003 and 2007.

board to service governance structure



how the board works

The Board works in accordance with the principles of a unitary Board in which, whilst in the Boardroom, each Director carries the same and equal legal responsibilities as the others for the decisions taken.

Outside of the Boardroom, the Non-Executive and Executive roles differ widely, not only in time commitment and remuneration, but also in the degree of delegated responsibility for operational matters. These differences are highlighted in the table below.

The roles of Directors within a unitary Board:

Inside the Boardroom: All directors acting collectively as 'The Board'

1. Establish and communicate the values and behaviours underpinning organisational culture.
2. Determine the organisational strategy from amongst options provided / recommended by the Executive.
3. Allocate resources using budgets.
4. Monitor performance using an integrated performance report / *balanced scorecard*.
5. Hold the Executive to account, exercising constructive challenge.

Outside the Boardroom: Non-Executive directors meeting periodically to exercise independent oversight:

Using a risk-based approach, acquire and scrutinise assurances* that the system of internal controls is well designed, consistently applied and operating effectively, thereby gaining confidence that objectives will be met.

** 'assurance' is taken to mean the elimination of doubt through the provision of multiple documented sources of data and information, some of which may be independent of management e.g. Peers, stakeholders, regulators.*

Outside the Boardroom:

CEO and Exec Team use detailed knowledge to:

1. Cultivate the culture.
2. Establish the operational controls by which organisational objectives are met.
3. Hold management to account.

the board's work

During the year under review, the Board met monthly. Although Covid restrictions prevented it from meeting in a public setting initially, the Board made efforts to ensure that where possible, Board meetings were not only held in a public setting, but also live streamed, with the live stream being recorded and made available to view via YouTube. During the year under review, four Board meetings were held in a public setting and these remain available to view on YouTube.

The Board has established six Committees, each of which undertakes a process of scrutiny into the system of internal control. These are:

- Quality, Safety and Engagement
- Finance, Performance and Commissioning
- Digital & Informatics
- Audit
- People
- Mental Health Act Legislation

The work of the Committees is to seek and scrutinise assurances that the systems by which Manx Care is controlled on a day to day basis are appropriately designed, consistently applied and operating effectively. Where such assurances are available, the Board takes confidence that the objectives are likely to be met.

Audit

The Committee's overarching duty is to provide assurance to the Board that there are effective systems of governance across the health and statutory social care services delivered by Manx Care which lead to better outcomes for patients and service users. The Committee will review the effectiveness of the other Board committees within Manx Care, whose work can provide relevant assurance on the effectiveness of that governance system.

Finance, Performance and Commissioning

The Finance, Performance and Commissioning Committee assists in ensuring that Board members have a sufficiently robust understanding of key performance and financial issues to enable sound decision-making. The committee monitors financial and operational performance, CIP (Cost Improvement Programme) delivery and Restoration and Recovery activity. It also oversees the performance of the commissioning and contracting functions, as well as financial planning and budget setting. It highlights risks and areas for consideration and provides reports to the Board on key issues.

Quality, Safety and Engagement

The Quality, Safety and Engagement Committee provides scrutiny and challenge with regard to all aspects of the quality of care, and clinical and professional safety. This includes care strategy and delivery, clinical and professional governance, patient, public and service user engagement, clinical and professional audit, and research in order to obtain assurance and make appropriate reports or recommendations to the Board.

People

The People Committee provides scrutiny and challenge with regard to all aspects of people, engagement, workforce and organisational development (OD) planning. This includes workforce strategy and delivery, clinical and professional training, and colleague engagement in order to obtain assurance and make appropriate reports or recommendations to the Board.

Digital and Informatics

This Committee provides advice and assurance to the Board in relation to the direction and delivery of digital and informatics strategy development and information governance, to drive continuous improvement and support IT-enabled health and social care to achieve the strategic objectives of the Manx Care Board. The Committee seeks assurance on behalf of the Board in relation to Manx Care's arrangements for the development and effective management of data and information to support a fit and proper system of performance management and business intelligence, in line with the Board's strategic objectives. The Committee will seek assurance on behalf of the Board in relation to Manx Care's arrangements for appropriate and effective management and protection of information (including patient and personal information), in line with legislative and regulatory responsibilities.

Mental Health Act Legislation

The Mental Health Act Legislation Committee is responsible for ensuring Manx Care is working within the legal requirements of the Isle of Man Mental Health Act (1998), and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act. It has an oversight of related risks, providing additional scrutiny of any such risks and giving assurance to the Board around the management of such risks.

statement of internal control

As Accountable Officer for Manx Care, the Chief Executive Officer (CEO) has overall responsibility for the management of the risks to the achievement of the strategic aims, whilst safeguarding public funds and departmental assets. Consequently the CEO is responsible for ensuring that a sufficient and appropriate system of internal control is maintained across the area, by which these risks are managed. The CEO has ensured that each Head of Division responsible for strategic delivery within the area has completed the required Self Review Questionnaire in order to gain appropriate information and assurances that the system of internal control that is relied upon to manage risks is adequate, enabling the CEO to give reasonable assurance that risks are being appropriately managed and to identify any improvements that may be required.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Manx Care to evaluate the likelihood of those risks being realised, and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Risk and Control Framework

Risk is the effect of uncertainty on the delivery of objectives. When identifying risk we anticipate what could stop us from achieving our goals. To help identify risk we look at our historic performance and trends, previous events, current challenges, and needs of the people who use our services, both now and in the future. Risk analysis involves estimating the severity (the impact the risk has on Manx Care, and the people in our care) and likelihood (the probability of that impact happening). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and monitor acceptable amounts of risk. Risk management is an integral component of Manx Care's Quality Governance Framework.

Manx Care's governance framework is supported by a risk management system that aims to deliver continuous improvements in safety and quality, and maximise opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

The Board Assurance Framework

The key risks to the delivery of Manx Care's strategic objectives are identified in the Board Assurance Framework, with the key risks impacting on the operational performance being identified in the Corporate Risk Register. The Board Assurance Framework provides the mechanism for the Board to monitor risks and controls, and the assurances that controls are effective. The Board recognises the importance of the Board Assurance Framework in mitigating Manx Care's strategic risks. During 2020/21, the Board Assurance Framework was reviewed by the Board, and sections reviewed by the relevant Board committees.

Information Governance

Manx Care identified that Information Governance is an area of significant risk and, in order to understand the levels of risk, a review of the Information Governance function within Manx Care was undertaken by KPMG in its position as the Cabinet Office's appointed health and care transformation partner. The executive summary of the report contained a number of findings and recommendations, which have been reflected in the programme of work that Manx Care has developed.

An Information Governance Advisory Board (IGAB) was established and is chaired by the CEO. The Digital and Informatics Group, along with the Non-Clinical Quality and Safety Group, meet bi-monthly and reports on performance are provided to IGAB, along with other established groups, within and external to Manx Care.

The IGAB approved the development of Manx Care's compliance-based programme based on the standards of the Data Security and Protection Toolkit which can be benchmarked against a National NHS compliance standard.

Information Governance Training is a mandatory training module for all employees within Manx Care.

From the period April 2021 to December 2021, there were seven significant information governance and data security breaches where patient identifiable information was shared with a number of groups and sub-groups, many of whom were not involved with that patient and their care. These were reported to the Information Commissioner's Office which resulted in enforcement action being taken against Manx Care. Policies and procedures have been introduced to remediate and mitigate the risk of such breaches occurring in the future.

Board-level and programme-level risk registers have been recorded and reported through Manx Care's reporting groups and reported to the Senior Information Risk Owner (SIRO)/ Chief Information Officer who represents the Information Governance function at Board level.

Data Quality and Governance

Having the right information about the right patients, available to the right people in real time in order to make informed decisions is essential in providing high quality, integrated health and care services that reflect the needs of the population both now, and for future generations. Currently Manx Care has a large number of systems which are resource intensive. Waiting list data is acknowledged as being an area requiring improvement. Manx Care needs to engage and develop patient confidence and trust in its services, ensuring data is safe and secure whilst encouraging research and innovation through partnerships which improve patient outcomes through appropriate information sharing.

manx care board meeting attendance, 2021/2022

	27 April 2021	25 May 2021	24 June 2021	27 July 2021	24 August 2021	02 September 2021	14 September 2021	28 September 2021	26 October 2021	23 November 2021	21 December 2021	25 January 2022	22 February 2022
Andrew Foster													
Andrew Guy													
Katie Kapernaros													
Sarah Pinch													
Vanessa Walker													
Nigel Wood													
Teresa Cope													
Cath Quilliam													
Paul Moore													
Jackie Lawless													
Sree Andole													
Sally Shaw													
Richard Wild													
Oliver Radford													
Barbara Scott													
Clare Conie													
Anne Corkill													
John Middleton													
Oliver Ellis													
Andy Chittenden													

Present

Not Present

3. how our services are led

Our services are delivered through a Care Group structure, supported by a broader corporate team. There are seven Care Groups in total.

With the exception of Social Care, all follow the same management structure with a lead doctor (Clinical Director), a lead Nurse or Allied Health Professional (Matron) and a General Manager. Social Care is led by a lead Manager across its different divisions.

The Care Groups are outlined below, with a summary of the work that each delivers overleaf:

care groups

- MEDICINE, URGENT CARE AND AMBULANCE SERVICE
- SURGERY, THEATRES, CRITICAL CARE AND ANAESTHETICS
- INTEGRATED DIAGNOSTICS AND CANCER SERVICES
- INTEGRATED MENTAL HEALTH SERVICES
- INTEGRATED WOMEN'S, CHILDREN'S AND FAMILIES SERVICES
- INTEGRATED PRIMARY AND COMMUNITY CARE SERVICES
- SOCIAL CARE SERVICES

medicine, urgent care and ambulance

What do we deliver in our Care Group?

MEDICINE:

- // Cardiology
- // Gastroenterology and Hepatitis C
- // Neurology
- // Rheumatology and Osteoporosis
- // Day Assessment and Treatment Unit (DATU)
- // Anti-Coagulation
- // Respiratory
- // Ward 1 – Acute Medical Unit
- // Ambulatory Emergency Care (incorporating Acute Oncology services)
- // Ward 6 – Geriatrics
- // Ward 7 – Stroke
- // Ward 9 – Respiratory
- // Coronary Care Unit (CCU)
- // Ward 21 – Renal and Nephrology
- // Martin Ward – Ramsey and District Cottage Hospital

URGENT AND EMERGENCY CARE:

- // Emergency Department
- // Minor Ambulatory Care Unit
- // Manx Emergency Doctor Service
- // Minor Injuries Unit– Ramsey and District Cottage Hospital

AMBULANCE SERVICE:

- // Emergency response
- // Patient conveyance
- // Helicopter Air Ambulance Service

Care Group Management Structure	
General Manager:	Mark Cox
Head of Ambulance Service:	Will Bellamy
Matrons:	Dr. Lyz Howard, Martin Hamm
Clinical Directors:	Dr. Gareth Davies, Dr. Ishaku Pam

surgery, theatres, critical care and anaesthetics

What do we deliver in our Care Group?

THEATRES:
// Elective and 24-hour emergency care

GENERAL SURGERY – SURGICAL SPECIALTIES
// Ear, Nose & Throat

// Oral Surgery

// Plastics & Dermatology

// Breast Service

ORTHOPAEDICS

DAY PROCEDURE SUITE
// 18-bed ward, open five days per week

// All surgical specialities: Cardiology, General Surgery, Endoscopy, ENT, Ophthalmology, Oral Surgery and Urology

// Elective medical procedures: Diagnostic Radiology, ECT and Infusion/ Transfusions

ENDOSCOPY SUITE
// Open five days per week

PRE-ASSESSMENT CLINIC (PAC)
// Covering procedures on the Isle of Man and at tertiary centres in the UK

STERILE SERVICES DEPARTMENT
// Sterilisation and decontamination of a range of equipment Island-wide (including for other Government departments as appropriate)

OUTPATIENTS DEPARTMENT
// Blood Clinic

PAIN MANAGEMENT SERVICE
// A multi-disciplinary team including a part-time Consultant, part-time SAS, Clinical Nurse Specialist Non-Medical Prescribers, part-time Physiotherapist, part-time Consultant Health Liaison Clinical Psychologist, part-time Secretarial support and Bank staff

// Nurse Led inpatient Pain Service

// Outpatient Pain Management Service

CRITICAL CARE
// Critical Care

// Critical Care Outreach Team

// Resuscitation & Informatics

// Organ Donation liaison

FIXED-WING AIR AMBULANCE SERVICE

CLINICAL ADMINISTRATION
// Medical Secretaries

// Patient Information Centre

INPATIENT WARDS
Ward 11 – Trauma

Ward 12 – Orthopaedic Elective

Ward 8 – Surgery

Ward 2 – Surgery

Care Group Management Structure

General Manager:	James Watson
Matrons:	Stuart Hemingway
Clinical Directors:	Dr. Sivakumar Balasubramanian, Mr. Andre Risha

integrated diagnostics and cancer services

What do we deliver in our Care Group?

- Full range of Cancer Services support, from initial diagnostic assessment through to treatment and support for patients in remission
  - Alignment with the care delivered at tertiary centres in the UK (Clatterbridge @ Noble's model of care)
  - Macmillan support
  - Close working with charities and third sector organisations locally to ensure joined-up support and service development
- Significant on-Island diagnostic capability, including X-Ray, CT and MRI scanning
- On-Island Pathology Lab, based at Noble's Hospital
  - This performs and reports results on more than 500 different types of tests every year
- Acute Pharmacy department supporting hospital-based services (based at Noble's)
  - Clinical (ward-based) service
  - Aseptic and oral dispensing services
  - Procurement and Supply
  - Oncology Service support
  - Antimicrobial support

Care Group Management Structure	
General Manager:	Lisa Airey
Head of Cancer Services:	Theresa Faragher
Chief Pharmacist:	Craig Rore
Radiology Manager:	Kathleen McDowall
Head of Pathology:	Steve Doyle
Clinical Director:	Partha Vaiude

integrated mental health services

What do we deliver in our Care Group?

MANANNAN COURT:

- // Crisis and Home Treatment Team
- // Harbour Suite (18-65 years of age)
- // Glen Suite (over 65 years of age)
- // Pit Stop café

COMMUNITY-BASED SERVICES:

- // Older Persons Mental Health Service (over 65 years of age)
- // Community Mental Health Service for Adults (18-65 years of age)
- // Child and Adolescent Mental Health Services
- // Drug and Alcohol Team
- // Community Wellbeing Services & Psychological Therapies Service
- // Recovery College

Care Group Management Structure

General Manager:	Ross Bailey
Matron:	Dr. Mick Fleming
Clinical Director:	Dr. Marina Hudson

integrated women's, children's and families services

What do we deliver in our Care Group?

- // In-patient paediatric care
- // Outpatient paediatric clinics
- // Children's Community Nursing Team
- // Infant Feeding Team
- // Maternity services (in-patient and community)
- // Neonatal care (in-patient and outreach services)
- // In-patient gynaecology services
- // Outpatient gynaecology clinics
- // Sexual health services including GUM clinic, Family Planning services, Termination services
- // Health Visiting and School Nursing Service
- // Safeguarding Children and Adults service

Care Group Management Structure

General Manager:	Linda Thompson
Matron:	Liz Cullinane
Head of Midwifery:	Barbara Roberts
Clinical Director:	Dr. Pradumal Thakker

integrated primary and community care

What do we deliver in our Care Group?

PRIMARY CARE SERVICES

- // GP Contracting
- // Dental Contracting
- // Optical Contracting
- // Pharmaceutical Contracting
- // Orthodontic Services (Primary and Consultant Lead Service)
- // Community Pharmacy
- // Community Dental Service
- // Primary Care (NHS) Back Office
- // Medicines Optimisation Team

COMMUNITY SERVICES

- // Community Nursing Service – District Nursing
- // Long Term Conditions Co-ordinators, Parkinson's Nurse, Learning Disabilities Nurse and Health Visitor for Vulnerable Adults
- // Prison Healthcare Service
- // Tissue Viability and Wound Management Service
- // Continence Advice Service
- // Manx Centre for Diabetes and Endocrinology
- // Therapies and Podiatry

Care Group Management Structure	
General Manager:	Annmarie Cubbon
Matron:	Emma Cleator
Pharmaceutical Advisor:	Maria Bell
Associate Director of Primary Care:	Dr. John Snelling

social care services[1]

Care Group Management Structure	
Assistant Director, Adult Social Work:	Stephen Lonsdale
Assistant Director, Children's and Families:	Julie Gibney
Head of Operations, Adult Social Care:	Jonathan Carey
Head of Corporate Business:	Louise Hand

What do we deliver in our Care Group?

CHILDREN'S AND FAMILIES SERVICES

- // Fostering and Adoption support
- // Birth records counselling and tracing
- // Family finding for adoption and fostering
- // Fostering and adoption recruitment
- // Family days, support groups and forums
- // Training
- // Fostering and Adoption Panel
- // Out of Hours support, 365 days per year
- // Care management
- // Supporting children with disabilities
- // Initial response
- // Early help
- // Family placement
- // Resource Centres
- // Safeguarding and Quality Assurance
- // Supporting families
- // Youth Justice
- // Oversight of contracted services

[1] All roles outlined on this page report to the Executive Director of Social Care.

social care services

What do we deliver in our Care Group?

ADULT – OPERATIONAL SERVICES

- Residential care for Older Adults and Adults with a Learning Disability
- Residential Care for Older Adults with Dementia
- Community Support Service (domiciliary care)
- Reablement Service
- Day Services for Older Adults and Adults with a Learning Disability
- Respite Care for Older Adults and Adults with a Learning Disability
- Learning Disability Supported Living
- Learning Disability Supported Employment

ADULT – SOCIAL WORK SERVICES

- Adult Generic Team
- Adult Services Access Team
- Community Older Peoples Team
- Learning Disabilities
- Hospital Discharge Team
- Safeguarding
- Wellbeing Partnerships

OPERATIONAL SERVICES: NUMBERS

- Residential Care – 240 Beds
- Dementia Care – 70 Beds
- LD Respite – 12 Beds
- CSS – 120 service users
- Reablement – 500 referrals per year
- OPS Day Services - approx. 375 services users per week
- LD Day Services – approx. 85 service users per day

support functions

- **Contracts and Commissioning (including Tertiary Care and Patient Transfers)**
- **Infrastructure**
- **Information and Digital**
- **Information Governance, including Data Protection**
- **Company Secretariat (Manx Care Whistleblowing Lead)**
- **Communications and Brand**
- **Programme Management**
- **Finance***
- **OHR (Office of Human Resources)***
- **GTS (Government Technology Services)***

** Finance, OHR and GTS are shared services.*

4. improving quality and safety

The provision of high quality, safe care is Manx Care's primary objective. The improvements achieved during the last year are best summarised under the following set of headings, which were identified within the Required Outcomes Framework:

- **Preventing Harm**

  The Operational Clinical Quality Group (OCQG), with its associated reporting schedule, has been established in accordance with Manx Care's quality assurance framework, and has representation from six Care Groups. For clarity, Manx Care is internally organised into six Care Group structures, sitting alongside Social Care. Social Care has established an Operational Quality Group (OQG). The OCQG and OQG meetings take place monthly, with the OCQG co-chaired by the Executive Director for Nursing and Governance and the Executive Medical Director, and with the OQG chaired by the Executive Director for Social Care. Both committees report to the Quality, Safety & Engagement Committee of the Manx Care Board.

  A Quality Dashboard, based on the CQC Key Lines of Enquiry (KLOE), has been developed and is updated monthly for the attention of the OCQG. To date the dashboard has relied on manual updates; however work is ongoing to automate metrics for the majority of indicators. Each Care Group has specific metrics and indicators to report against which feed into the overarching Manx Care position. A programme of Care Group reporting has been established whereby analysis of indicators is submitted, highlighting both positive assurance and gaps in assurance, and identifying actions to address areas that require improvement.

  Since November 2018, the NHS Safety Thermometers have been recorded across all Adult Inpatient Wards. This looks at avoidable harm in hospitals around the key areas of pressure ulcers, falls, Urinary Tract Infections (UTI) with associated catheter and acquired Venous Thromboembolism (VTE). This has been adapted to include other relevant measures and Maternity, and Children and Young People Thermometers, have also been added. All are scoring consistently above the 95% threshold.

  By 'shining a light' on specific areas of care through the Quality Dashboard, improvements and positive assurances have been realised, and consequently a number of areas have seen improvements during the year.

- **Enhancing patient, service user and carer experience**

  Manx Care recognises that in order to provide a high quality patient and service user experience, it needs to actively seek, respond to and learn from feedback. Throughout the year Manx Care has been developing its range of interventions to enhance patient, service user and carer experience and to listen to and act upon patient and service user feedback to improve services.

  Inpatient Surveys: More than 470 have been returned since April 2021. The aim is to obtain ten surveys each month from each inpatient area. Ninety-three percent of respondents were satisfied with their hospital experience.

Patient Safety Walks are undertaken across health facilities and services. 'Walks' are undertaken by senior personnel involving on-site structured conversations with patients, visitors and staff. Feedback is anonymised and submitted to the relevant Care Group or service, along with any recommendations to drive enhancements in quality and experience. Action plans are developed, implemented and monitored in line with recommendations to shape services that better meet patient needs. Between April 2021 and February 2022, 25 walks were undertaken.

Complaint Management: Since April 2021, response times have been monitored via the Quality Dashboard. The two-day target for complaint acknowledgment is set at 98%, with a year-to-date average achieving a positive result of 99%.

Manx Care is working hard to achieve the 20-day response target, as identified in the NHS Complaints Regulations, setting a target of 95%. The year to date average stands at 60%, although the second half of the year's average (75%) shows improvement on the first half (58%).

Since February 2022, Manx Care's Chief Executive has been reviewing and signing off complaint response letters to ensure Executive-level oversight, improve compliance with regulation and ensure the approach to responses is consistent and service-user focused.

Duty of Candour: In accordance with Duty of Candour (DoC) regulations and to ensure compliance with these, Manx Care implemented its associated DoC policy and procedure in April 2021.

DoC functionality has been activated in Datix, the Safety and Quality Risk Management System, to facilitate the recording of the assessment for each individual incident. However, some challenges have been experienced in Adult Social Care (ASC) with regard to the availability of a Registered Professional who can undertake the assessment (this reflects the fact that many staff working in ASC are not registered with a professional regulatory body).

In addition to standards identified in the DoC policy, Manx Care has introduced a ten-day target for writing to patients or service users impacted by a DoC incident to inform them of this, the plans for investigation, and to offer an apology. Compliance in respect of serious incidents is monitored via the SI Tracker overseen by the Serious Incident Review Group.

From January 2022 compliance with the ten-day target for all incidents is being reported via the Quality Dashboard, with 71% achieved in January 2022 and 100% in February 2022.

District Nursing Survey: Since October 2021, the service has issued questionnaires to all patients during home visits. All feedback is anonymous and includes questions on access and responsiveness of the service. The District Nursing Service received 123 patient survey responses between October and December 2021.

Manx Care Advice and Liaison Service (MCALS): In August 2021, the Manx Care Advice and Liaison Service launched as a six-month pilot, and has recently become a substantive service. For the first time this gives members of the public a direct helpline spanning both health and social care services. If someone has a query about Manx Care or its services, they can speak with the MCALS team in confidence who will point them in the right direction, put them in touch with the service they need to speak to, or give them other essential information they require. Data is captured and shared via weekly summaries and a monthly dashboard in order to drive service improvements, and help to shape the care quality agenda.

- **Creating a continuous learning culture**

  Manx Care recognises that employees have a background in a wide range of disciplines and aims to agree a standardised improvement approach which will build capacity and capability to support continuous improvement.

  A Safety and Quality Risk Management System Officer (Datix Administrator) has been appointed, enabling internal capability for system maintenance and development, reporting and training. The structure and security profiles within Datix have been subject to a review to ensure they are reflective of the organisational structure and compliant with GDPR.

  In October 2021 the Manx Care Board signed off Manx Care's policy and procedure for Incident Reporting, Investigation and Learning developed by the Care Quality and Safety Team. The policy has resulted in the implementation of a robust procedure for the reporting and management of Serious Incidents in accordance with NHS England's Serious Incident Framework.

  The Serious Incident Review Group (SIRG) meets weekly and is chaired by the Executive Director for Nursing and Governance and the Executive Medical Director, and has been established with senior leadership representation from across the organisation.

  A positive reporting culture, evidenced through the use of Datix, has been developed across the organisation with Executive oversight for incidents involving severe harm or death enabled via automated email functionality. Action plans arising from SI investigations are overseen by the Care Quality and Safety Team in conjunction with the relevant Care Group triumvirate leadership team and associated governance committee.

  Serious Incident training has been rolled out across Care Group leads to enhance investigation capability whilst ensuring consistent application of, and compliance with, the policy and procedures.

  A Standard Operating Procedure (SOP) has been developed and implemented for Inquest Management, which followed consultation with the Coroner of Inquests, Coroner's Officer and the Attorney General's Office. This describes the process for the request and supply of evidence and enables Manx Care, via the Care Quality & Safety Team, to quality check that evidence provided is compliant with professional and legal standards.

  A bi-monthly Manx Care Patient Safety Summit, chaired by the Executive Medical Director, has been introduced with invitations extended to all employees. The Summit invites guest speakers to present and share the outcomes and learning from incident investigations, audits, inquests, peer reviews and any other type of feedback. In order to establish links across the whole organisation, including contracted providers, discussions have commenced with the Primary Care Network so opportunities for wider learning can be maximised.

  A Safety and Learning bulletin was introduced in February 2022 and is circulated across Manx Care on a monthly basis via the Communications Team. The bulletin, edited by the Care Quality and Safety Team, features a range of topics aimed at driving improvements in the safety culture across the organisation and the experiences of those who access services.

- **Safeguarding adults, children and young people**

  A new arrangement has been developed creating a structure for Adult and Children's Social Care, led by an Executive Director who is a voting member of the Manx Care Board. This will strengthen the governance arrangement for social care and increase safeguarding capacity.

  A Head of Safeguarding has been appointed to lead the Safeguarding Team, committed to enabling the safety of young people and adults who access Manx Care's services, and for staff within the services to be able to recognise signs of abuse and how to report it.

- **Improving access to services**

  An Access Policy was developed during the second half of the year, which outlines the rules and regulations as to how Manx Care manages its access to services and monitors its waiting time. This policy begins to facilitate movement to 18-week Referral to Treatment Time monitoring and compliance, whilst also including some robust practical tools. Underlying processes are now in the process of being implemented, whilst funding has been secured for key roles to support the process and to ensure there is senior managerial oversight of the elective programme. Manx Care will continue to work to reduce waiting times across all services and ensure equitable, transparent and fair access.

  In order to improve openness and transparency, and promote better engagement with the public, bi-monthly Board meetings are opened up to the public to attend, in addition to being streamed live via social media. This provides the opportunity for advanced submission of questions and topics for discussion.

- **Improving the effectiveness of services**

  Manx Care is committed to improving outcomes for patients and service users. As part of that commitment, Manx Care will continue to develop closer links with regional academic partners to improve training and education and ensure effective and efficient links with providers of tertiary care.

  In addition, Manx Care will participate in relevant national clinical audits and implement recommendations where possible. Manx Care continues to develop its digital strategy including opportunities for patients and service users to have digital (telemedicine) rather than face to face appointments where clinically appropriate.

  As detailed within the Required Outcomes Framework, full and accurate coding of activity in health and care services is a critical enabler to safe and effective service delivery, achievement of targets, effective resource and performance management, and effective clinical governance. To support our aspirations in this regard, we have developed a clinical coding policy and supporting procedures, and the clinical coding function has subsequently been outsourced to a company that specialises in this field, which is able to provide the requisite resilience in order to safeguard future sustainable delivery of a clinical coding function for Manx Care.

5. service and performance developments

Response to the Covid-19 pandemic

Manx Care played a central role in the provision of Covid-19 related services and supporting the Isle of Man population through the pandemic, and successfully led the vaccination programme delivering initiatives as advised by the Joint Committee on Vaccination and Immunisation (JCVI). We delivered swabbing and testing capacity of up to 1,000 swabs and tests per day and provided a secure supply chain of personal protective equipment (PPE) and Lateral Flow Devices to the Island.

Integration

The development of the Wellbeing Partnerships has taken a positive step forward following the establishment of Manx Care, accompanied by the commencement in post of the three Wellbeing Partnership Leads. Highlights during the year include:

- Transfer of the responsibility for the Wellbeing Partnerships into Social Care from Community Health
- Beginning the development of the Southern and Northern Wellbeing Partnerships, with formal launch of the Southern Wellbeing Partnership in December and public consultation sessions for the development of the Northern Partnership
- The Western Wellbeing Partnership continuing to support the local population through coordination of referrals, ensuring an integrated approach to the provision of care either at home or as close to home as possible, as well as providing a local venue for the delivery of services such as Community Midwifery, Podiatry and the Memory Clinic, and services from Government departments including a benefits drop-in session
- Initial planning getting underway for the development of the Eastern Wellbeing Partnership

In a separate programme, Local Area Co-Ordination – which is a multi-agency programme chaired by Manx Care's Executive Director of Social Care – saw two Local Area Coordinators appointed to cover the southern region. They will lead on the development of the foundation level of integrated care, namely building an engaged and connected community that supports its local population.

The Community Frailty project began in early 2021/22; however, progress has been limited due to lack of community Geriatrician availability. This will improve from April 2022 when two new substantive Consultant Geriatricians join the workforce. The development of care pathways and a Comprehensive Assessment document have been finalised which will be used to assess frailty both in the community and in hospital.

Care pathways and job descriptions have been progressed in order to support a new model for Intermediate Care, which includes both community and bed-based care, but progress has been limited due to the availability of funding. This will now be sought as part of the wider Urgent and Emergency Integrated Care Transformation business case, with a current expectation that this will progress early in the 2022/23 financial year.

Performance

There has been a new focus and fresh impetus on performance across all services, such as cancer, and both elective and non-elective activity. The development of the Integrated Performance Report has tracked performance since April 2021, which is overseen by the Finance, Performance & Commissioning Sub-Committee of the Manx Care Board, and the Performance Delivery Group, a subgroup of the Executive Management Committee.

Urgent and Emergency (Non Elective) Care

Performance across all non-elective standards has been challenging in-year due to a significant increase in demand on the non-elective pathway, in particular calls to the Ambulance Service and to MEDS. Although attendances at the Emergency Department (ED) were stable during 2021/22, conversion rate from attendance to admission has increased by 7%, meaning more demand on inpatient capacity and increased instances of exit block in ED which has impacted on four-hour performance.

Work to develop an Ambulatory Emergency Clinic (AEC) has helped to deflect admissions, whilst further work on the Urgent and Emergency Integrated Care Transformation Project will develop diversionary pathways to reduce pressure on ED due to the presence of practitioners with advanced clinical skills in the community.

Important developments in-year include:

Cancer Care: Stabilisation of the two-week wait cancer standard following some significant performance variance within several tumour groups in early 2021/22. Significant resilience issues have been identified across several tumour sites, and funding for additional capacity has been allocated in order to improve performance and outcomes. This includes funding of a second Consultant Breast Radiologist, allocation of recovery funding to Endoscopy to reduce historic waiting lists and improve the suspected cancer 'direct to test' pathway, and increasing the number of Colposcopy clinics in Gynaecology. Investment in the Cancer Tracking Team has resulted in increased oversight and the proactive co-ordination of all cancer patients going through diagnosis and treatment. Manx Care has also invested in additional nursing posts in its Oncology Service so is able to provide timely Chemotherapy to patients working within the 'Clatterbridge @ Noble's' service.

Planned (Elective) Care: In July 2021, Manx Care was awarded £1.86m of Treasury funding to deliver its 'Restoration and Recovery of Elective Activity' programme to begin to address the lengthy waiting lists it inherited across several clinical specialisms, which were further exacerbated by Covid-19. By February 2022, the Endoscopy waiting list of around 450 people had been cleared thanks to a solution delivered internally within Manx Care; since then, 350 patients have had their cataract pre-assessments and 150 have had their surgery thanks to a partnership with Synaptik. Patients across seven clinical specialisms have been offered the choice of having a telemedicine assessment through a partnership with Medefer, and a number of young people on the Child and Adolescent Mental Health Service (CAMHS) waiting list have been offered the option of having their psychological therapy treatment with a professional from the Isle of Man-based charity, Minds Matter. In addition, Manx Care worked with Synaptik to develop plans to deliver hip and knee surgery to some of those patients on the Orthopaedic waiting list who had been waiting for their surgery the longest, based on clinical prioritisation. This would involve a team made up of both Manx Care and Synaptik colleagues, with activity beginning in the new financial year. A larger restoration and recovery business case is under development in order to complete the recovery programmes within Orthopaedics and Ophthalmology, and will also address other specialties with lengthy waiting lists such as ENT.

Theatre Improvement: Phase One of the Theatre Improvement Programme was completed, with the delivery of seven rapid improvement projects aimed at improving productivity and ensuring safety of the Operating Theatre department. This activity included an initial audit by the Association for Perioperative Practice (APP) utilising the 'Five Steps for Safer Surgery' framework, and resulted in the delivery of targeted action plans. Further project planning is now being progressed in order to build on the initial activity in anticipation of seeking formal accreditation during 2022, whilst future focus will be on further improving productivity through the development of a continuous improvement culture.

Women's, Children's and Families Services: Maternity Services across the UK are undergoing a transformation in line with the recommendations outlined in the Ockenden report – an independent review into the provision of midwifery services – and Manx Care is investing a significant amount of resource and focus on this too, alongside work to integrate all of the sexual health services provided on the Island under one management team. Ultimately this will allow the delivery of more joined-up, integrated care to people who require support. Manx Care's Maternity, Neonatal Unit and Health Visiting Service teams also received accreditation from Unicef (BFI Level One) for their hard work to promote infant feeding across the Island.

Mental Health Recovery College: In late 2021/22, plans were being made for the launch of the Isle of Man's first 'Recovery College', a concept being developed by Manx Care as an integral part of recovery-focused, integrated mental health service provision. Recovery College Isle of Man (RCM) will offer a range of courses and learning experiences focused on helping individuals to develop new skills that will support their recovery from mental health and wellbeing challenges they may face, co-produced with people who have lived experience of having overcome mental health challenges and professional experts. RCM will help its students learn self-management strategies that they can confidently apply to their everyday lives, allowing them to build a life that they find satisfying, meaningful and valuable. It will launch in early 2022/23 as an initial pilot, with a full launch planned in Autumn 2022.

In addition to the developments listed above, a number of commitments were made within the Required Outcomes Framework, for which a significant amount of activity was undertaken during the year led by the Transformation Programme that has laid the foundations for further service developments across 2022/23. A summary is outlined as follows:

- The Primary Care at Scale (PCAS) project has made significant progress during 2021/22, but progress slowed towards the end of the financial year due to complications in relation to data sharing agreements. We remain committed to the development of this work, and progress to date has included the recruitment of various roles to work within GP practices, including First Contact Practitioners, Primary Care Pharmacists and Counsellors. The Target Operating Model across all Primary Care modalities (i.e. Optometrists, Dentists and GPs) has been drafted, followed by proposals around Leadership Development and Population Health Management.
- Much work has also been undertaken on assessing the opportunities that exist for improving same-day emergency care through the continued development of our Ambulatory Emergency Care model. This aims to create additional capacity so that when deemed clinically appropriate patients can be diagnosed and/or treated within a designated area, avoiding the need for a hospital admission. Existing pathways of care are often reported as being fragmented, and having an appropriately resourced facility to streamline patient care will provide an alternative to inpatient care, resulting in the release of capacity for other patients as well as delivering improved convenience and quality of care. A comprehensive assessment of options has been completed and a business case produced, approval of which is due to be sought.

- Significant progress has been made with the Cancer Tumour Site pathway reviews, which have seen a revised deployment approach agreed to reflect the scale of the task in hand. Workshops and 121s with key stakeholders have been held across all 12 tumour sites, and the first group of business cases (covering Dermatology, Upper GI and Lower GI) have been developed. These are currently progressing through the review and approval process ahead of implementation. The remaining three groups will be progressed during the first half of 2022.

6. twelve months in review

Manx Care began life in an unprecedented situation – in another lockdown period due to Covid-19, with a large number of Covid-positive patients in Noble's who required round-the-clock care, and with a significant amount of our workforce off sick themselves or having to look after their families at home. Given that the Island's health and social care sector has continued to be impacted by the virus since then, Manx Care's achievements against our three strategic priorities during our first year of operation is truly remarkable, and testament to the resilience and determination of our people.

To recap, our three strategic priorities as outlined in Manx Care's Required Outcomes Framework are:

1. To improve patient quality and safety
2. To improve our financial health
3. To create a positive working culture

Although by no means an exhaustive list, this section outlines some highlights from our first 12 months, alongside a summary of three of Manx Care's strategic programmes.

Developing the Manx Care Advice and Liaison Service (MCALS)

At Manx Care's Board meeting on 25 May 2021, its CEO committed to the launch of the Manx Care Advice and Liaison Service (MCALS) for a six-month trial period, with a view to this becoming a substantive service if demand for this could be proved. The trial commenced on 02 August 2021, with MCALS going on to become a substantive service.

MCALS is based on the functions of the well-established notion of a 'Patient and Liaison Service' (PALS) which is commonplace in NHS Trusts across the UK. It is committed to listening to, learning from, and responding to people who use Manx Care's services, as well as partners and stakeholders – all of whom have a vested interest in improving the delivery and performance of health and statutory social care services across the Isle of Man. It strives to be accessible to all minority groups, community groups, hard-to-reach groups and voluntary sector organisations, and works to support people in a number of ways, including but not limited to:

- Signposting to the wide range of services/functions which are the responsibility of Manx Care, including liaison across our tertiary care settings
- Listening to and acting on queries and concerns
- Provision of information and advice about Manx Care's services
- Searching efficiently for solutions to problems and difficulties encountered
- Providing support and advice on how to make a formal complaint, if all other avenues to resolve an issue have been exhausted
- Ensuring feedback, comments, concerns and compliments are listened to and used to improve Manx Care's existing and future services

A key objective for Manx Care is to improve safety and experience of those utilising its services, and to respond effectively to members of the public and those who represent the public. MCALS has supported this objective, with 87% of queries received during its first calendar year being resolved on the same day.

87% of queries received by MCALS during its first calendar year were resolved on the same day

The role that MCALS plays with members of the public

Analysis of the enquiries dealt with by MCALS during its trial period highlight that the type of interactions it manages on a daily basis are highly varied in terms of subject matter and level of complexity. Resolution of service user concerns often requires MCALS officers to take on a number of different, problem-solving roles, including:

- Messenger
- Go-between
- Supporter
- Mediator
- Resource Mobiliser

Three further roles have been identified as being intrinsic to problem-solving:

- Information provider
- Listener
- Facilitator

How MCALS is supporting Manx Care in the delivery of its corporate objectives

MCALS wholeheartedly supports the achievement of Manx Care's strategic objectives, particularly the improvement of patient safety through the provision of high quality care. Through weekly trend analysis and reporting, it aims to drive positive change and innovation in Manx Care's services, quickly identifying any areas of concern and taking steps to support any small changes or enhancements that are needed. In addition, it captures positive feedback and shares this with colleagues and teams who've made a difference to a patient, service user or member of the community. It will enable Manx Care to capture, consolidate and utilise patient and service user feedback to shape the design and delivery of future integrated service provision, leading to better outcomes for patients, safer services and improved patient experience.

Meet the MCALS Team

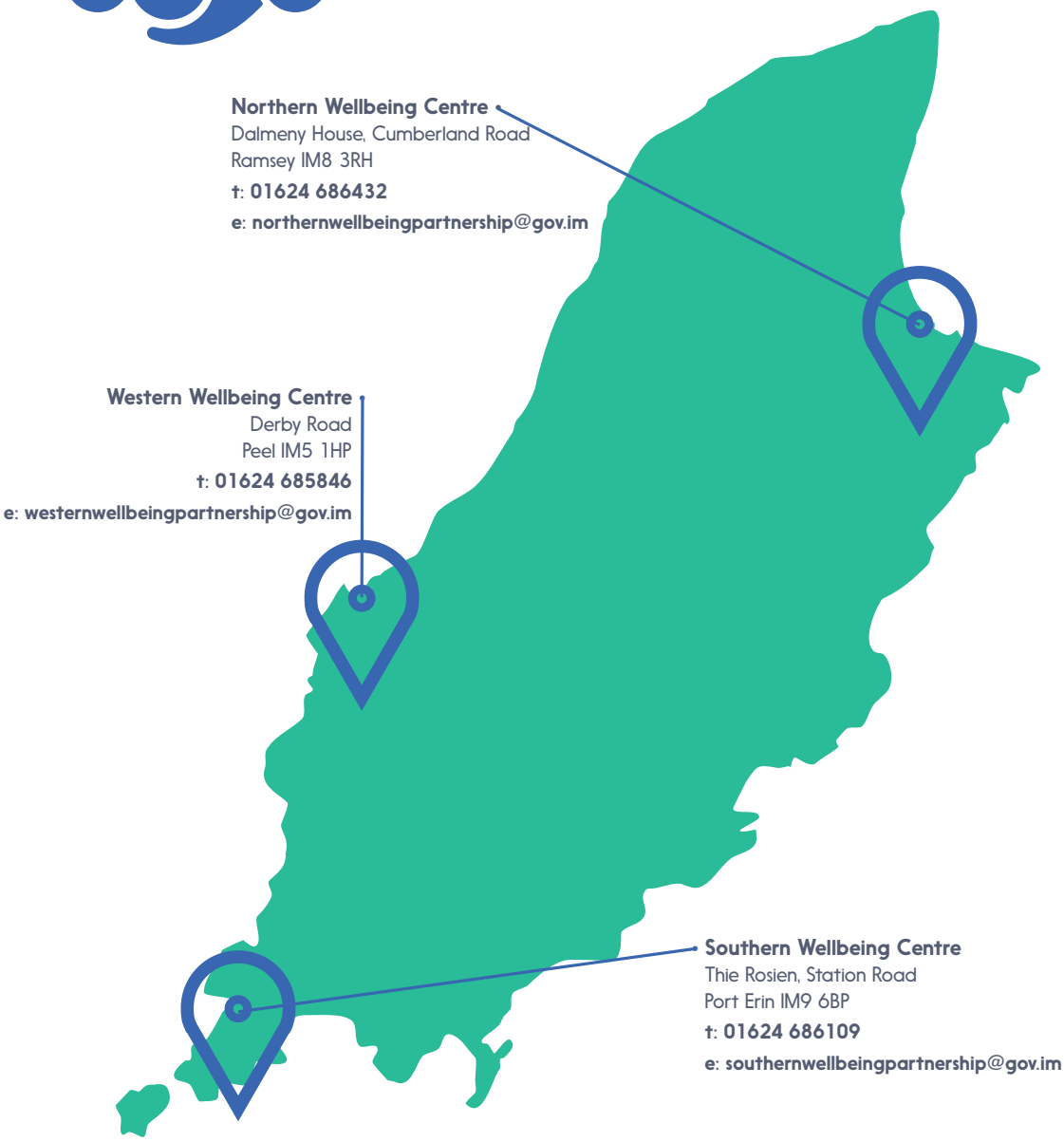
Karen Maddox
MCALS Service Lead

Cat Simpson
Patient Experience Officer

Sandra Keene
MCALS Officer

Rachael Douglas
MCALS Officer

The Wellbeing Partnerships



Statutory and community-based organisations working together to deliver the right care, in the right place, at the right time.

The Wellbeing Partnerships are becoming more talked about across the Island, and rightly so. Essentially these are locations that will become a hub for the provision of integrated community care in the four corners of the Island – care that's delivered as close to an individual's home as possible. They are a partnership between Manx Care, organisations in the third sector and Government departments. The Western Wellbeing Centre celebrated its first year of operation in September 2021, public consultations to shape the development of the Northern Wellbeing Partnership began in November 2021 across the Northern communities, and the Southern Wellbeing Partnership was officially opened by the Island's Minister for Health and Social Care, Lawrie Hooper MHK in December 2021. Plans are being developed for the launch of an Eastern Wellbeing Partnership, and Manx Care would encourage members of the public to input into consultation events when these are advertised given that public feedback is incredibly important in shaping services that work for local residents.

The Western Wellbeing Partnership is the most developed service, and is an exemplar of how integrated community care can be delivered as close to a person's home as possible. In Peel, alongside the day centre for the people of the West of the Island, multiple clinics are delivered there – both by Manx Care practitioners and from other agencies. This prevents people from having to travel to Noble's for routine appointments that they can attend in a more convenient location for them.

The Hubs operate on a single point of referral principle. People living in any of the Island communities can make a referral on behalf of themselves or someone they may be worried about by speaking to one of the Referral Co-Ordinators in confidence. The Partnership Teams meet weekly to discuss the referrals they have and make sure that people are getting appropriate, integrated care that's as close to their homes as possible.

The Western Wellbeing Partnership

The Western Wellbeing Hub is co-located with the Western Laa Menagh Day Centre opposite the large Shoprite store in Peel, providing a social space for the community to use. This site has been very well received by residents in the West, and is very well utilised by a broad range of Manx Care's practitioners, as well as groups from the third sector and Isle of Man Government.

Consultation and treatment rooms are used for services and clinics including:

- Podiatry
- Diabetes
- District Nursing
- Community Mental Health Service, individual counselling sessions, Older People's Mental Health Service
- Social Work team
- Early Health Service (children and families) and Midwifery
- Hear2Hear drop-in clinic
- Quit4You
- QEII School (out of school support sessions during term time)
- Benefits drop-in clinic
- Debt advice drop-in clinic
- Probation Service
- Housing Matters
- Hospice
- Stroke Society

Hot-desking and refreshment facilities are available for practitioners, and those hosting clinics and drop-in sessions from the third sector and Government, with weekly practitioner meetings and quarterly development meetings diarised to ensure the service continues to meet the demand of residents living in the West of the Island.

The Southern Wellbeing Partnership

Based in Thie Rosien in Port Erin, the Southern service supports people living in the catchment areas of the Ballasalla, Castletown and Southern GP surgeries, and is becoming a well-used facility with practitioners working across Manx Care's services, as well as those from the third sector. Its bookable meeting and event space is popular in the community, with weekly practitioner meetings and monthly development meetings taking place to ensure services are developed in line with the needs of the Southern population.

The Northern Wellbeing Partnership

A counter service is operating from Dalmeny House on Cumberland Road in Ramsey whilst the physical office space is in the process of being developed. However, weekly practitioner meetings are taking place and drop-in sessions can be arranged if required. Virtual clinics are established, and home visits are being undertaken by the team. A monthly development meeting is also taking place, as well as the Northern Community meeting which is held at Ramsey Town Hall. The team continue to host public engagement sessions across the Island's northern communities in order to support the development of this facility.

Meet the Wellbeing Partnership Team

Adrian Tomkinson
Wellbeing Partnerships Group Manager

Claire Bader
Western Wellbeing Partnership Lead

Gary Lord
Northern Wellbeing Partnership Lead

Joanne Kneen
Southern Wellbeing Partnership Lead

Julie Lister
Wellbeing Partnerships Group Support Officer

Hilary Yates
Referral Coordinator, Western Wellbeing Partnership

Caroline Jagger
Referral Coordinator, Northern Wellbeing Partnership

Wiki Bartlett
Referral Coordinator, Southern Wellbeing Partnership

Developing the Island's Covid-19 vaccination programme

By the time Manx Care launched on 01 April 2021, the Covid-19 vaccination programme had been operating for three months, from a bespoke hub created in Chester Street in Douglas town centre and from a pop-up clinic established at Isle of Man Airport in Ronaldsway. This was deemed to be the best use of space for the Airport at the time, given that the Island remained in lockdown.

Delivery of the Island's Covid vaccination programme has fallen in line with the advice being delivered from the Joint Committee on Vaccination and Immunisation (JCVI), with different cohorts prioritised in terms of age and clinical vulnerability initially, before different cohorts were prioritised for the delivery of third doses and booster doses. Colleagues from across Manx Care supported the vaccination effort through the year, many being redeployed from their substantive roles to deliver as many 'jabs in arms' as possible.

During Manx Care's first year of operation, it:

- Delivered over 138,000 Covid vaccinations in total
- Celebrated the 100,000th Covid jab delivered on the Island with local resident, James Redmond – his jab was delivered by former Paramedic, Peter Smith
- Managed delivery of the Booster programme alongside the Annual Flu programme, meaning uptake of the flu vaccination was higher than in previous years
- Established new vaccination venues in the North (Ramsey Cottage Hospital), South (Castletown Civic Centre) and West (Western Wellbeing Hub)
- Worked with GPs in order for Covid vaccinations to be delivered at surgeries in the South, East and West, giving residents more choice on where to have their jab
- Delivered over 2,400 vaccine in one day in response to the increased risk of the Omicron variant (December 2021)

A personal highlight for the team during the first year of Manx Care happened in the two weeks before Christmas 2021, when colleagues from across Manx Care joined them to deliver 14,772 vaccinations in response to the emerging treat of the Omicron variant. This was a huge undertaking, and many people gave up their spare time – including planned family occasions – to ensure so many members of the population were able to receive their booster jab in a timely manner.

The Vaccination Team pictured at the Chester Street Hub, December 2021

(picture credit courtesy of Dave Kneale, Isle of Man Newspapers)

a month-by-month review of key successes

April 2021

The impact of Covid-19 tore through our services across the early part of 2021 – so much so that at one point, Manx Care had to reach out to the Cheshire and Merseyside Critical Care Network to provide support for the Critical Care Unit at Noble's Hospital. Critical Care staff from the North West flew to the Island to support their counterparts here when Manx Care was struggling with the availability of colleagues to meet the rapidly growing demand for our services. One thing that's really become apparent over the course of the 2021/22 financial year is the strength of our relationships with various networks in the UK, and how these continue to drive some of the positive changes taking place as Manx Care continues to improve services for our patients.

May

Manx Care is undergoing a significant period of transformation to change the way that health and statutory social care services are delivered on the Island, which will ultimately achieve the true integration of health and social care. Primary Care is one area which will experience the greatest change. In time, Manx residents will see more of the services they need being delivered through their GP Surgery or in a Community Care setting rather than in a hospital setting.

One such service is Dermatology. In May 2021, five GPs began a bespoke training programme in this clinical specialism, resulting in them being able to treat patients for a wide range of skin conditions they would have previously been referred to hospital for. This will result in faster access to treatment and a reduction in waiting lists, as well as care delivered closer to home. In May, Manx Care also integrated its Primary Care and Community Care services together under one singular leadership structure.

June

June was the month in which the 100,000th Covid vaccination was delivered on the Isle of Man. This was a momentous day, and testament to the incredible effort from colleagues working across Manx Care's services to get as many members of the population vaccinated as possible. The Covid-19 vaccination programme has been a standout success across the year under review, with many individuals deserving credit for stepping out of their day jobs to support this.

The team who delivered 180 second doses to adults with learning disabilities at the bespoke Vaccination Hub created at the Tall Trees Resource Centre

James Redmond received the 100,000th vaccination delivered on the Island from Paramedic, Peter Smith

(picture credit courtesy of Cabinet Office Communications Team, Isle of Man Government)

In June, Manx Care also went to town embracing Pride, showing our support for the event and our wider commitment to equality and inclusion.

manx care

Kiarail Vannin

July

In July, Diagnostic services were struggling to meet the two-week wait standard for urgent referrals for people with suspected breast cancer. Given the importance of being able to offer people the opportunity to be seen by Specialist within two weeks, Manx Care established a partnership with Spire Hospital on the Wirral in order to increase capacity whilst it looked to address long-standing recruitment challenges and the impact of Covid on on-Island diagnostic capacity. This partnership and other interventions quickly brought Manx Care back within the two-week standard.

This partnership heralded the start of a broader programme to transform the delivery of cancer services on the Island, address recruitment gaps, invest in services, and work to develop partnerships with tertiary care providers so that Manx residents receive the same level of treatment on-Island as they would receive in the North West. Manx Care has established the 'Clatterbridge @ Noble's' model of care so that it is aligned with the pioneering treatment that is delivered at the world-renowned cancer centre, and CEO, Teresa Cope, was invited to join the Cheshire and Merseyside Cancer Alliance partnership board.

Furthermore, we have established bi-annual Cancer Performance Days for all of the individuals involved in the treatment of people diagnosed with cancer on the Island to help shape the future of our care pathways, and we're working hard to strengthen our partnerships with the third sector on-Island and those charities who support people with a cancer diagnosis.

We have also increased our resilience in the provision of both diagnostic and cancer services on-Island through a significant recruitment programme, and are proud of the level of care and diagnostic capability that can be provided on-Island.

It was a momentous day for Maternity Services on the Island on 12 July 2021 as the team welcomed Bonnie Papper – the first baby to be born in the new Noble's Hospital – back to celebrate her 18th birthday with them. It was fantastic for the team to be able to take time out of their day to do this and reflect on how maternity services have changed so much in that time.

Maternity Services across the UK are currently undergoing a transformation in line with the recommendations outlined in the Ockenden report, an independent review into the provision of midwifery services. Accordingly, Manx Care is investing a significant amount of focus and resource here too, alongside work to integrate all of the Island's sexual health services under one management team. Ultimately this will allow them to deliver more integrated care to people who require this support.

Locally, the Maternity Services team have invested a lot of time and effort into the level of personal support they are able to provide to parents and their families. In July, they launched the Rainbow Care service for pregnant ladies who have previously lost their baby, whereby they receive extra support throughout subsequent pregnancies. This team continues to support a number of Island-wide activities to help people remember babies who were born sleeping.

Recruitment across health and care services is a global issue, and in the UK, it is estimated that there is a shortage of around 50,000 Nurses and 10,000 Doctors. Manx Care continues to be impacted by historic and long-standing recruitment issues, but is equally focused on addressing this in part by increasing on-Island training opportunities and developing home-grown talent. In the year we welcome our first Student Midwife, Jess Roberts (left), on placement with us. Manx-born Jess is a student at Salford University but is able to study part of her course at home, with the intention that she will return to a job here when she graduates.

In July, we also celebrated the first 100 days of Manx Care.

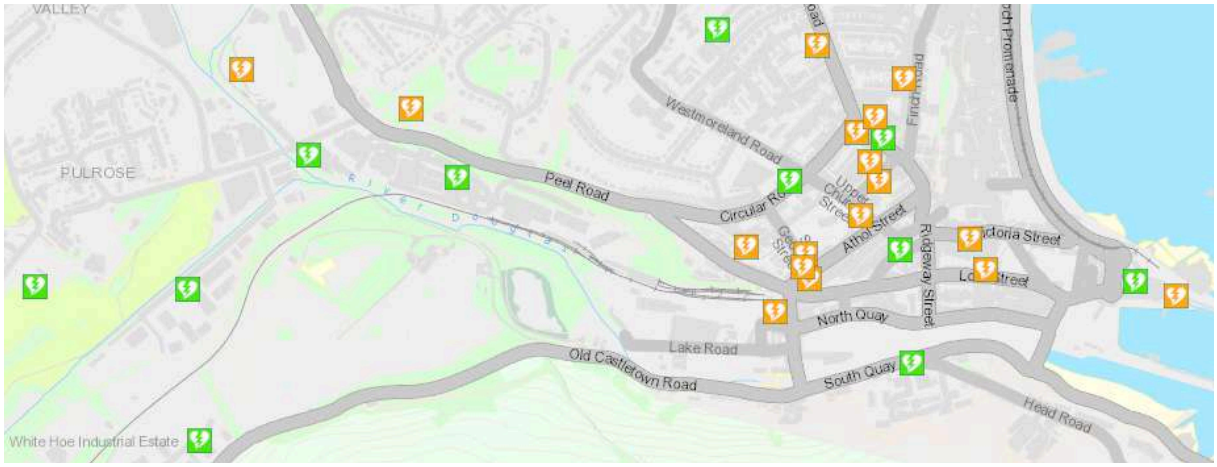
August

August saw the launch of MCALS – the Manx Care Advice and Liaison Service – giving members of the public a direct helpline spanning both health and social care services for the first time. This is comprehensively referenced elsewhere within this Annual Report.

September

September was the month where Manx Care really began to lay the foundations for its programme to reduce waiting lists, which have only been exacerbated by Covid-19. This piece of work is called the 'Restoration and Recovery of Elective Activity' programme, and is being delivered in NHS Trusts across the UK as well as here on the Isle of Man. Essentially, Trusts are looking to private healthcare providers to work alongside them to help reduce their waiting lists, and supplement the capacity they have to offer appointments and operations themselves. Manx Care secured £1.86m of Treasury funding to support the initial phases of this work, which began to deliver significant progress in February 2022.

In September, Isle of Man Ambulance Service launched a website called Defibs.im – this allows anyone who has a defibrillator on the Island to register its location on the site so that these can be used in the event of an emergency – and potentially save someone's life. This project was led by Dave Scambler, a Senior Paramedic, in collaboration with colleagues in Government Technology Services, and has to date proven incredibly popular.



Finally, we saw a first in the Isle of Man, with two Advanced Nurse Practitioners (ANPs) becoming Partners in a GP surgery for the first time, with Mary-Rose Pritchard and Janette Qualtrough joining Dr. Steffen Osbelt at Snaefell Surgery in Douglas. Although this is a recognised GP partnership model in the UK given the evolution of the Primary Care model there, until now the Isle of Man has followed a traditional GP Partner model.

October

In October, Manx Care celebrated the landmark 40th anniversary of the Cummal Moar residential home in Ramsey. Cummal Mooar really is an institution in the town, having supported so many members of the community and their families over the last four decades. The residents planned and got together for a Ruby-themed lunch which they were delighted with, especially after the Covid lockdowns and the impact this has had on their social events.

Early in 2022, plans were submitted to redevelop a piece of land on Waterloo Road in Ramsey into a new site for Cummal Mooar, working with the local housing authority and the local Commissioners. If approved, this will allow Manx Care to provide purpose-built en-suite residential accommodation for elderly people for years to come, helping them to retain their independence and creating a wonderful home in the North.

Manx Care also began advertising for applicants to join the two Nurse training programmes it delivers here on the Island at Keyll Darree, our purpose-built training facility based on the Noble's Hospital site. As already highlighted, Nurse recruitment is incredibly challenging, and Manx Care continues to carry a large number of historic Nursing vacancies, heavily impacting service delivery. Increasing the number of training places for people on-Island is something Manx Care is looking at, and would like to achieve. However, this isn't solely a decision that can be made by us, and requires input and support from multiple other agencies. The quality of on-Island Nurse training is demonstrated by the fact that a recent Mental Health Nurse graduate and current colleague, Isobel Jagus, was named 'Student of the Year' at the annual University College Isle of Man graduation ceremony in October 2021.

Manx Care has formed a strategic partnership with a specialist recruitment agency, GTEC, to address and reduce Nursing staff shortages. In the year under review, we welcomed six new colleagues from countries including India, Nigeria, Ghana, Malawi and Lesotho to the Island, with more due to join in the second financial year. We will continue to welcome new colleagues through this partnership, as well as continue to invest in our people and develop future training opportunities for all colleagues.

November

Our people were recognised for their continual efforts in going above and beyond for their profession both on the Isle of Man, and professionally by their industry colleagues. Our Professional Development Team, at the time led by David Neilan, Nicola Howard and Kelly Gold, were shortlisted at The Nursing Times Awards for 'Preceptorship Programme of the Year', a programme they have developed on-Island to support newly qualified Nurses and Midwives during their first year 'on the job', ensuring they have access to development and mentoring opportunities that will help them to flourish in their careers with Manx Care.

In addition, Manx Care colleagues won the 'Public Sector Achievement of the Year' Award at the Isle of Man Awards for Excellence for the role they played in the Island's response to the Covid-19 pandemic in 2020.

In November, we launched the first of the public consultations for the development of the Northern Wellbeing Partnership.

December

In December, Noble's became one of the first hospitals in the world to become pager-free thanks to the implementation of Smartpage Clinical. This is a first-of-type smartphone-based emergency alert system that eliminates the need for pagers and improves response times to urgent calls. It gives colleagues the ability to use two-way instant messaging and better communication to enable rapid clinical decision-making and faster patient care. Manx Care's Chief Technical Information Officer, Dr. Gregor Peden, worked with Alcidion – an external technology solutions provider – on the development of this. It is just one way in which Manx Care has invested in the development of its digital capability across the last year, which it will continue to do.

During the 12 days before Christmas, Manx Care developed a social media campaign called 'The Twelve Days of Manx Care Christmas', essentially shining a spotlight on the large and diverse number of teams and colleagues working across the organisation, and to recognise their hard work. Colleagues and teams put themselves forward for this – and they were overwhelmed with the level of public affection shown towards them.

Blood Clinic Team, Noble's

Western and Southern Wellbeing Partnership Teams

Pathology Team

Northern District Nurse Team, Dalmeny House, Ramsey

Endoscopy Unit, Noble's Team

Southern Group Practice Clinical Team

Pathology Team, Noble's

Outpatient Nursing Team in Surgical Clinics

Ward 2 Team, Noble's

Skin Service Team at Ramsey Cottage Hospital

Children's Community Nursing Team

Audiology Service Team

MIU Nurse Practitioners Malcolm Dyche and Vince Roberts, Ramsey Cottage Hospital

ICU Team, Noble's

Grandstand Swabbing Team

Air Ambulance Team

Noble's Pharmacy Team

Keyll Darree Library Team

Harbour Suite Team, Manannan Court

Hailwood Medical Practice Team

January 2022

January 2022 saw Manx Care celebrate a phenomenal achievement with Noble's Hospital finishing first – ahead of 170 NHS trusts across the UK – in a survey by the General Medical Council designed to report on the quality of medical education amongst IMT1 (Internal Medical Trainees working their first year as a junior Doctor). Junior Doctors come to the Isle of Man for the first year of their three-year training programme – and it was their feedback that led to this. Manx Care invests a significant amount of time in them as individuals, and we were delighted that they recognised and appreciated this.

In January, Manx Care also began to experience the impact of a significant increase in community transmission of Covid-19, which subsequently impacted services and led to a large rise in colleague sickness and absence. We launched our 'Mask Up' campaign as Manx Care began to re-introduce measures across every service to protect the most vulnerable people in our care.

February

In February, Manx Care began to see substantial progress in the 'Restoration and Recovery of elective activity' programme. By the end of the month, the Endoscopy waiting list backlog had been cleared thanks to a substantial amount of work invested by the in-house team, using surplus theatre capacity across weekend periods. Around 450 people had their procedures in that time. Over the following weeks, around 150 cataract operations and 350 pre-assessment appointments were delivered through Manx Care's partnership with Synaptik, we began to offer some patients the choice of having their assessment virtually using a specialist working for a company called Medefer, and we began planning for the delivery of some orthopaedic activity too. Delivery of this began early in the second financial year.

The Integrated Mental Health Services Care Group announced a working partnership with Island-based mental health charity Minds Matter to deliver psychological therapies for children, young people and adults awaiting treatment. This is a fantastic way of not only working with a local charity and the Island's third sector – something Sir. Jonathan Michael identified as key in his independent review into the future provision of health and social care on the Isle of Man – but in supporting a number of young people who had been waiting for specialist support to help them deal with some challenges to their mental health and wellbeing.

General Manager of Integrated Mental Health Services, Ross Bailey, with Andrea Chambers, CEO of Minds Matter

March

Another of the key recommendations of Sir Jonathan Michael's independent review was to establish a 24/7 emergency air bridge in order that people who are critically ill or injured can be transported to a specialist Trauma Centre in the UK as quickly as possible. In March, Manx Care launched a six-month trial with GNAAS – the Great North Air Ambulance Service – to operate a helicopter emergency service and create an emergency air bridge to support our local community.

We also delivered the last of our public engagement sessions on Long Covid, ME and Chronic Fatigue Syndrome in order for this feedback to be used to shape the development of on-Island support services, and began to make real progress in the development of an Island-wide Palliative and End of Life care pathway in collaboration with Hospice. Both of these will be key deliveries during Manx Care's second year of operation.

At the end of the year under review, Manx Care analysed the performance of its Pathology Team, which found itself frequently in the spotlight due to the role it played in Covid-19 testing on the Island, and the incredible number of Covid test results it reported in that time. On-Island testing capability is significant, with the team delivering a staggering number of other test results which have been a crucial part of our patients' diagnostic journeys. The team performs more than 500 different types of tests in the Lab at Noble's, reporting more than two million individual test results in the year under review. It is important to highlight the extent of the services that the team provides, and how much the work from teams like Pathology underpins the care being delivered across the organisation.

Engaging with colleagues, patients and service users

Giving colleagues and patients a voice

In order to better understand the reality faced by our patients and our colleagues, Manx Care's Board invites both groups to share their experiences of our organisation, whether that be receiving treatment or working across our services. Feedback is then used to shape the organisation and drive positive change across the services it provides, for the ultimate benefit of other patients and service users, and current and future employees.

Staff stories are shared at the bi-monthly People Committee, which is a Board committee led by a Non-Executive Director; patient stories are shared monthly in private at Manx Care's Board meetings. This is complementary to feedback which is captured from both groups using multiple other mechanisms.

Patient Stories

Patients are invited to attend a monthly Board meeting in order to tell their story, or alternatively, they may share this anonymously either through a written account they have produced, through a piece they have pre-recorded, or through an account which is presented by a member of the team who's been involved in their care. The Board isn't interested in hearing just about the positive experiences, instead wanting to hear about when there's room for improvement in the services and experiences we provide across both health and social care.

Across the 2021/22 financial year, the Board has heard about a range of patient experiences including from someone actively receiving treatment at Clatterbridge Cancer Centre in Liverpool, someone who was flown to Liverpool for heart surgery before beginning a lengthy recuperation on the Island – a journey touching many of our services, the diagnosis and subsequent treatment journey between Alder Hey Hospital in Liverpool and Noble's Hospital of a child with a tumour, and the provision of respite care on the Island.

Patient stories are heard by the Board in private in order to protect the confidentiality of individuals and their families.

Staff Stories

In the same way that patients are invited to share their experiences in person or anonymously, our colleagues are invited to do the same at the bi-monthly People Committee, with their feedback used to shape the culture of Manx Care. We have invited a number of our colleagues working across our services to share their stories with you as part of our Annual Report:

Nicola Burgess
Nurse Endoscopist, Noble's Hospital

In November 2021, Nicola Burgess became Manx Care's first locally-trained Nurse Endoscopist.

Nicola has achieved her qualification after years of study and more than ten years of work-based experience at Noble's Hospital, following many years of experience gained in the NHS in the UK. She attended the National Nurse Endoscopy Course at St Thomas's Hospital, London, and had to gain the Independent Prescriber qualification and Advanced Life Support qualification to fulfil the requirements necessary to qualify as Nurse Endoscopist.

Nicola became an Endoscopy Nurse 'by accident' in her own words, having accepted an opportunity to work in this specialism following time spent as a Surgical Urology Nurse. The passion for Endoscopy as a speciality developed rapidly and next year is her twentieth anniversary of starting work in Endoscopy in the UK. She is committed to delivering exceptional patient-focused, evidence-based care and continuing to support the development of the Endoscopy services on the Island, and has become a member of the British Society of Gastroenterology.

Nicola commented: "I'm delighted to become the Island's first Nurse Endoscopist after years of studying, and actually turning my passion into a reality! It means that we have increased specialist capacity here on the Island, and can continue to develop our Endoscopy provision for people living on the Isle of Man. It's been very challenging managing my day-job alongside family commitments and studying, but my passion for Endoscopy has really helped me to focus on this."

Nurse Endoscopist trainees are expected to attend the same JAG (Joint Accreditation Group) courses as their medical colleagues working in this field. Following a period of supervised practice it is then necessary to be assessed by two independent examiners observing real-time procedures in order to gain certification in delivering these. Now qualified, Nicola is currently working through five waiting lists and two admission lists per week, including patients on urgent and two-week pathways.

Nicola is incredibly grateful for the opportunity and support that she has had from Manx Care with regard to the training, funding, travel support and other resources that she has been provided with, and the mentorship she has received from her senior Consultant and Endoscopy colleagues, especially her training supervisors, Mr. Glen Husada and Mr. Abdul Khan, alongside the Endoscopy Manager, Mary Walmsley. Indeed, she claims it 'would not have been possible' without their support! She hopes to be able to pay this back in some small way by supporting the development of future Nurse Endoscopists, as well as the wider service.

Sydney Clark
Community Health Nurse – 0-19
Public Health Nursing Service

I moved to the Island in August 2020 (from South Wales) as a newly qualified Adult Nurse. I started working as a Community Nurse with the Peel District Nursing Team in the September.

As a newly qualified Nurse, I was enrolled onto the preceptorship programme run at Keyll Daree. All newly qualified Nurses and Midwives were offered this and it was a great course to be a part of. We met once a month for a year, and the sessions involved talks from specialist nurses, clinical training/ competencies and group supervision.

My favourite part was group supervision as we could all talk about work and our experiences in a safe space. Even though the others had different backgrounds, we all shared similar experiences and challenges that we could learn from.

I enjoyed my time as a Community Nurse in Peel. There was a great sense of community there and I loved visiting the patients in their own homes. I am very enthusiastic about Primary Care and the thought that I was contributing in helping to keep people out of acute, hospital settings was very rewarding. The team of Nurses I worked with were very welcoming and supportive. I was assigned a preceptor, as part of the preceptorship programme, whom I met with frequently and worked through my Band 5 competencies with.

After a year as a Community Nurse, I started working as a Community Health Nurse in the 0-19 Public Health Nursing Service (Health Visitors and School Nurses). I was unaware that I could work in the service as an Adult Nurse but found out that you can as any form of registered Nurse/Midwife. I work closely with Health Visitors, School Nurses and Community Nursery Nurses to provide a universal and targeted service for children and young people on the Island.

In the last couple of weeks, I've been accepted onto the Specialist Community Public Health Nursing (SCPHN) Masters course with the University of Chester, run through Keyll Daree. This is an amazing opportunity to progress and is fully funded by Manx Care. It gives you the opportunity to branch off as a qualified District Nurse, Health Visitor or School Nurse. I have chosen to take the School Nursing path as I am very passionate about providing public health and safeguarding care to school aged children. I start in September and will finish in August 2023.

I would say to anyone thinking of working for Manx Care that it is a supportive environment that gives you lots of training opportunities to develop your career. Manx Care offer a generous relocation package and preceptorship bundle for new colleagues.

Will Bellamy
Head of Isle of Man Ambulance Service

I started in post in January 2022, following my move to the Island from Kent, England. I started my career within the Ambulance Service straight from leaving school, joining Surrey Ambulance Service in 2004 to work in the Patient Transport Service (PTS) prior to going onto St George's Medical School to complete my degree in Paramedic Science. Whilst undertaking my studies, I worked in the Control Room taking 999, urgent and routine calls in our Banstead Control Centre. In 2008, I moved to Kent working as a dual role Control Room Duty Manager and Paramedic, working six weeks in each of the different settings.

In 2012, I was privileged to be seconded to the London Olympics and Paralympics as a Paramedic. Most recently I have worked in leadership positions in a variety of backgrounds from front-line Operations, within the project team setting up the NHS 111 Service, leading the merger of our Control Rooms and implementing a new computer aided dispatch system, to most recently leading the team across North Kent during the Covid-19 pandemic.

It is an absolute privilege to lead the team here in Isle of Man Ambulance Service. I have a committed and enthusiastic team who are passionate about the role they play within our Island community. Since starting here, I have been on a journey of discovery and learning about the service. My initial reflections are of the challenges we face, about how we manage the continuous activity growth, how we deal with our staffing concerns, how we can create training opportunities for Paramedics on-Island and how we can manage our demand in a more efficient way then our current process.

I have had a steep learning curve with regard to getting to know and prepare the team for the Isle of Man TT and Manx Grand Prix. It was my first one this year. I really enjoyed it and found it an amazing experience to be a part of.

Moving to the Island has inevitably presented some challenges for me. However, I have colleagues with similar stories to tell and experiences to share who have always been helpful in providing advice and guidance. One thing about people here on the Island is that they are more than willing to help – or they know someone who can!

For me, coming from the NHS to the Isle of Man has given me the ability to have a better work-life balance. Being on the beach on my paddleboard within 15 minutes of finishing work is priceless.

Dr. Ian Duffus
GP Partner, Southern Group Practice and former Emergency Department doctor

I moved to the Island in 2017 from London with my wife after completing my foundation training. My wife grew up on the Isle of Man, so we already had close ties here and felt that moving here would present us with a unique opportunity to develop our professional lives and have a better quality of life outside of work. We live close to the beach and make the most of living on this glorious Island with our two young children; we feel so safe here. We initially only came to the Isle of Man for a year, but enjoyed Island life so much, that year turned into four and now we have decided to stay.

When we first moved to the Isle of Man I was working in the Emergency Department (ED) at Noble's as a hospital doctor. However, I heard about the on-Island GP trainee programme and decide this was something I really wanted to pursue.

I found my time working in Noble's ED thoroughly engaging. In the UK, most hospitals have a 'specialism' and patients can be sent to hospitals outside of their local area for specialist treatment. The Island does do this to some extent, but because Noble's is the only ED for the whole population, it has to cover all manner of services – you literally have to deal with everything that walks through the door, so the spectrum of injuries that colleagues see and treat in the hospital is unlike anything else I have experienced. The TT, for example, has given me exposure to a variety of trauma injuries that I don't think I would have seen in my career if I hadn't have been here. In the UK, serious injuries would be taken to their closest trauma centre, but we manage everything here.

When the opportunity to train as GP came up, I applied and this was supported by Manx Care. I was very grateful for the development opportunity, and the fact that there are many professional development opportunities available to you. The level of support and mentorship from my senior colleagues was incredible; the amount of time they afforded me and the continued opportunities to develop my skillset have been invaluable. The training on the Island is flexible and has more of a 'community' feel, which is what you want from your GP. Throughout my training I continued to work some shifts in Noble's ED, which again really helped me to develop my clinical skills all-round.

My wife, who is also a GP, has taken professional development opportunities too since we moved here. She is currently training to be a Dermatology specialist for her GP practice. This is done through the Skin Clinic at Ramsey Cottage Hospital, and supported by Manx Care's Consultant Plastic Surgeon who's also the Clinical Director for Cancer Services.

I have recently completed my GP training and have just started working as a GP Partner at the Southern Group Practice in Port Erin. It is down to the support and training opportunities offered by Manx Care that I now have a fantastic balance between my work life and personal life. I have built up really good working relationships with my Manx Care colleagues in the hospital, and the wider organisation, which is really beneficial when you're working in Primary Care because you already have that network of people you know in Secondary Care, and can reach out to for advice.

I would say to anyone thinking of joining Manx Care – do it! There is so much scope for development and the training routes, in my experience, have been flexible and so worthwhile.

7. creating a positive working culture

Year One deliverables

Manx Care has been supported in the delivery of this objective by the Workforce and Culture team, a team which is aligned to the Health and Care Transformation programme in Cabinet Office. By year-end, a number of tangible changes has been delivered following an essential fact-finding stage, which set out to understand and document a baseline assessment for Manx Care in terms of its structure, processes, people and culture. This activity informed and shaped the approach to the priorities and engagement with Manx Care staff, and through this activity the project team has developed some excellent relationships with colleagues in Manx Care.

It's important to highlight that Manx Care recognises that establishing a positive and inclusive working culture cannot, and will not, be achieved in 12 months. Instead, this is something which requires continued hard work and focus across all levels of the organisation.

Deliverables from Year One include:

- Designing and implementing a bespoke Manx Care **Induction Programme**, with each session delivered personally by Manx Care's CEO
- Improving **Leadership Visibility,** through the design and facilitation of a number of colleague engagement activities with members of the Executive Team and Board. Plans are currently being developed to support additional initiatives that will further enhance the visibility of all leaders across the organisation
- **Cultural reviews and assessments** being undertaken across a number of teams, with detailed themed actions plans created, the delivery of which will continue to be supported by the project team. Further cultural assessments are scheduled and planned for delivery during Year Two
- Analysing data from Isle of Man Government's **'Have Your Say' surveys** and consolidating this into a report, together with recommendations for consideration. This survey data provides an important baseline, together with the local surveys which were undertaken as part of the cultural assessment work
- Completing analysis on available **sickness absence** data. This will be used to inform strategies for reducing sickness absence rates in the future. It must be acknowledged that the three waves of Covid-19 during 2020/21 and into 2022 are having an impact on this activity
- Reviewing the current provision of **wellbeing opportunities** by Isle of Man Government – a cohort of Manx Care colleagues are actively involved in wellbeing focus groups to progress suggestions that will improve the availability of opportunities and help to promote what is already available
- Designing and implementing a **Team of the Month Award** – a recognition scheme aligned to Manx Care's CARE Values
- Facilitating a number of **Values workshops** and away days for teams across a number of Care Groups, and supporting the rollout of the **Manx Care Leadership in Practice** (MCLIP) Academy.

As Manx Care moves towards its second year of operation, preparatory work has been undertaken with regard to establishing two key components that will support the ongoing programme of cultural transformation, including:

- Change Coaches: A number of individuals who have supported colleague engagement initiatives across the year will become 'Change Coaches' for the organisation in order to influence change and sustain the transformational activity over a longer term.
- Workforce Planning: A revised methodology and approach have been agreed, but a number of factors have stalled the progress of this. However, this remains one of the key deliverables within the Year Two plan.

CARE Values

A review of Manx Care's CARE Values was undertaken during the course of the year, with engagement from colleagues across the organisation, in order to ensure that these remained fit for purpose and reflective of the cultural transformation activity taking place. The Values have subsequently been refreshed to ensure alignment with Manx Care's strategic objectives, and are due to be re-launched in summer 2022. This will include a new framework with tools to help embed the Values in the everyday lived experience of the workforce, and will be supported by dedicated resource.

The CARE Values are:

Committed & Passionate

Accountable & Reflective

Respectful & Inclusive

Excellent & Innovative

Based on Isle of Man Government's People Qualities, these have been developed to help ensure that Manx Care is a place that colleagues enjoy working in, and that patients and service users are receiving the best possible support.

The framework is there to support positive personal development for every individual within the Organisation, and is based on four CARE Values which are of equal importance.

The CARE Values framework helps to set expectations, standards and types of behaviour for all colleagues, and supports positive personal development, effective leadership and positive interactions.

CARE Award Winners, November 2021 – Acute Medical Unit, Noble's

CARE Award Winners, December 2021 – Endocrinology, Diabetes and Metabolism Team

CARE Award Winners, January 2022 – Endoscopy Team

CARE Award Winners, February 2022 – The Reablement Team

CARE Award Winners, March 2022 – The Housekeeping Team

8. improving financial health

The final year-end position for 2021/22 is a £9.9m deficit, summarised below:

FINANCIAL SUMMARY - 31 MARCH 2022				
	YTD £'000			
	Actual	Budget	Var (£)	Var (%)
TOTAL - OPERATIONAL	**276,870**	**271,764**	**(5,106)**	**(2%)**
Income	(14,581)	(14,464)	118	1%
Employee Costs	169,804	169,700	(104)	(0%)
Other Costs	121,647	116,528	(5,120)	(4%)
CIP	**(1,700)**	**(2,700)**	**(1,000)**	**(37%)**
SV REQUEST	**3,893**	**0**	**(3,893)**	**-**
Pay Award (above 1%)	3,670	0	(3,670)	-
High Cost Patient (IFR)	223	0	(223)	-
GRAND TOTAL	**279,062**	**269,064**	**(9,997)**	**(4%)**

Supplementary vote funding of £10m to cover this deficit was approved by Tynwald.

Manx Care faced significant cost pressures during the year, many of which were largely outside of its control. The organisation began the year with its £4.5m contingency fund entirely allocated against inherited funding pressures which left little scope to deal with business as usual pressures, including the rising cost of drugs, high agency spend driven by high vacancy rates, and pay awards above the 1% that was initially budgeted for (3% for HMD (Health, Medical and Dental) and 4% for MPTC (Manx Pay Terms and Conditions)).

During the year, improved financial governance and control mechanisms were put in place across the organisation to allow for improved accountability, better forecasting and earlier visibility of potential issues which will allow time for appropriate mitigation.

Cost improvement delivery fell short of the target of £2.7m, delivering £1.7m. Whilst this is disappointing, it reflects the fact that the programme was not fully agreed until June 2021 and so only represents a partial year of activity. However, significant progress has been made in-year to establish the strong governance and oversight mechanisms referred to above, and lay the foundation for strong performance in 2022/23. Many of the issues faced in 2021/22 around data and staff absence have delayed delivery rather than creating a shortfall in the overall delivery, and approximately £1m in savings has already been secured for 2022/23.

The development of the modelling behind the Growth Business Case submitted to Treasury for the 2022/23 financial year has provided a clear formula (3% + CPI less CIP) to apply when planning future funding requirements for Health and Social Care. This is the first step towards developing a sustainable financial plan. The next is to accurately establish what the current service provision ‘should’ cost. Work is underway with the Cabinet Office Health and Care Transformation Programme Team to develop this further. Manx Care continues to work towards a multi-year funding model that will allow even greater security and flexibility regarding spending and finances.

The outlook for 2022/23 remains challenging as Manx Care continues to invest in core functions and faces inflationary and other cost pressures. However, the organisation remains committed to achieving financial balance during the next financial year and beyond.

9. mandate objectives – performance summary

Within the Mandate for 2021/22, the DHSC outlined its strategic objectives for Manx Care and associated, specific deliverables (where relevant) for the first year of operation. Progress against the delivery of these is summarised as follows:

Objective	RAG Rating
Contribution towards the Island's response to the COVID-19 pandemic as directed by DHSC. This includes but is not limited to the ongoing delivery of the COVID-19 testing and vaccination programme in accordance with the strategy set by the Department and Government	
Demonstrate that the experience of service users, patients and carers is effectively captured, matches the agreed standards and that feedback is used to drive continuous improvement and better outcomes for people accessing and using all services.	
Demonstrate changes in transforming an integrated health and care service delivery following international standards for quality and outcomes.	
Ensure that all aspects of health and care have balanced equity of decision making, accountability and provision.	
Demonstrate, embed and lead an effective and robust corporate, clinical & care governance structure across all services for the effective management of risk, the ability to provide real time intelligence about performance, and promotion of a safe, learning and improvement focused culture.	
Demonstrate continued financial balance through delivery of agreed cost and service improvement plans (CIP) and the delivery of the agreed sustainable financial plans.	
Waiting times for Mandated Services to be reduced to levels comparable with other developed health and care systems.	
Adopt and embed a principle of continuous improvement in design, development and delivery of social care and health care services to ensure high quality measured outcomes are achieved, including, where appropriate, new opportunities to innovate including through the use of new technology.	

Objective	RAG Rating
Effective and collaborative partnership working within the integrated care system	
Developing and integrating Primary Care at Scale as an essential part of service delivery within Manx Care.	
Demonstrate a continuous improvement in workforce engagement, personal and professional development.	
The Isle of Man Government now has a commitment to reach net zero greenhouse gas emissions by 2050, and the Climate Change Bill due to come into operation in 2021 gives every public body a statutory duty to play an active role in achieving that goal.	

DHSC RAG Rating Definition

Rating	Criteria
Green	Objective was met
Green / Amber	Evidence that the objective was mostly achieved, and that appropriate plans and actions were put in place where it was not possible to meet the objective.
Amber / Red	Appropriate actions and plans were put in place but the objective remains at risk.
Red	The objective was not met and actions and adequate plans or mitigations were or will not be sufficient to meet the objective.


manx care
Kiarail Vannin

AUDIT COMMITTEE CHAIR'S REPORT TO BOARD
26 July 2022
MS Teams
2.00PM – 4.00PM

manx care
Kiarail Vannin

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**AUDIT COMMITTEE**
Meeting Date:	**26 JULY 2022**
Chair/Report Author:	**ANDREW GUY**

KEY ITEMS DISCUSSED AT THE MEETING

Your Committee discussed the response from Internal Audit to the NHS England Audit Committee Handbook, the process for commissioning internal and external clinical and social care audits, the 2022/23 internal audit plan and the statement of internal control. Minutes and outstanding actions from all board committees were reviewed.

TO ALERT (Alert the Board to areas of non-compliance or urgent matters or new risks or issues that need to be escalated to DHSC or other IoM departments)

Issue	Committee concern	Action required	Timescale
NHS England Audit Committee Handbook	A gap analysis had been undertaken by internal audit to identify where more audit coverage may be required. In order to comply with the standards in the handbook additional Internal Audit resource would be required.	To be escalated to the Board.	01.09.22

ASSURE (Detail here any areas of assurance that the Committee has received)

Issue	Assurance Received	Action	Timescale
Clinical and Social Care Audits	The committee was assured that audits in these areas were undertaken however there was no policy or framework to govern the process.	The Director of Nursing and Governance would work with the Medical Director and the Director of Social Care to ensure the correct governance was in place and the QSE Committee would add audit as a standing agenda item.	

2022/23 Audit Plan	The internal audit plan for 2022/23 was reviewed and approved by the committee.	For noting.	
Statement of Internal Control	The 2021/22 statement of internal control was reviewed and approved by the committee.	For noting.	

The following existing risks were identified during the meeting: (if none please state "none") None	**Risk:**	**CRR/BAF Nº:**	**Risk Score:** L x C =
	Risk:	**CRR/BAF Nº:**	**Risk Score:** L x C =
	Risk:	**CRR/BAF Nº:**	**Risk Score:** L x C =

DIGITAL AND INFORMATICS COMMITTEE CHAIR'S REPORT TO BOARD
12 July 2022
MS Teams
10.00AM – 12.00PM

manx care
Kiarail Vannin

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**DIGITAL AND INFORMATICS COMMITTEE**
Meeting Date:	**12 JULY 2022**
Chair/Report Author:	**KATIE KAPERNAROS**

KEY ITEMS DISCUSSED AT THE MEETING

Your Committee received comprehensive papers covering:

1. Secure e-mail
2. Manx Care Record Advisory Board
3. Manx Care Record
4. Clinical Coding
5. Information Governance

TO ALERT (Alert the Board to areas of non-compliance or urgent matters or new risks or issues that need to be escalated to DHSC or other IoM departments)

Issue	Committee concern	Action required	Timescale

ASSURE (Detail here any areas of assurance that the Committee has received)

Issue	Assurance Received	Action	Timescale
Secure e-mail	A secure email system (based on NHS standard) would be implemented by GTS by 1 September 2022 so that emails would be encrypted. A policy covering emailing of	For noting.	

	patient identifiable details was also being drafted.		
Clinical Coding	Regular clinical coding audit reports were now being received and more detailed reports are being sought, to include a breakdown of specific areas audited.	Future reports would demonstrate how Manx Care was meeting the recognised clinical coding standard. Once sufficient data was available benchmarking would be introduced.	
Manx Care Record Advisory Board	Due to the Strategic Partnership work with Liverpool here may be an opportunity to join Liverpool's procurement process for an electronic patient record.	For noting.	
Information Governance	Funding for additional business as usual and surge resource had been secured in line with the KPMG recommendations.	For noting.	

The following existing risks were identified during the meeting: (if none please state "none") None	**Risk:**	**CRR/BAF N°:**	**Risk Score:** L x C =
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	Risk:	**CRR/BAF N°:**	**Risk Score:** L x C =

COMMITTEE CHAIRS'S REPORT TO BOARD

manx care
Kiarail Vannin

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**Quality, Safety & Engagement Committee**
Meeting Date:	**22 July 2022**
Chair/Report Author:	**Sarah Pinch**

KEY ITEMS DISCUSSED AT THE MEETING

Your Committee received updates on the following matters:

- Quality Dashboard
- Theatre Improvement Plan
- ENT Review
- Operational Clinical Quality Group – Summary Reports
- Infection, Prevention and Control
- Mortality

A separate meeting was held on 23 August to discuss the response to the Ockenden report.

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently or new risks)

Issue	Committee concern	Action required	Timescale
Staffing to meet future demand	Risks to the supply of workforce are intensifying as people retire and vacancies remain high. There is a growing demand for care meaning	To be escalated to the Board.	01.09.22

	that the risk of unmet clinical need is increasing (i.e. expanding waiting lists); and our focus on reducing expenditure to achieve a break-even position for Manx Care should prompt discussion of value for money to balance financial constraints effectively alongside clinical need, quality and safety.		
ENT Review	There had been no progress made to develop and deliver a plan to respond to the clinical risks and concerns identified in the review. This is of concern to the committee, and the board is asked to support the work currently underway to ensure greater engagement and ownership amongst the service	To be escalated to the Board.	01.09.22
Ockenden Report	A detailed gap analysis has been undertaken and received by QSE. Such is the extensive gap analysis undertaken and volume of gaps requiring QSE's consideration, it was agreed to hold an extra-ordinary meeting of QSE in August to examine the assurances provided and prepare advice for the Board of Directors. These assurances were reviewed in detail by QSE at this extra-ordinary meeting held on 23/08/22. Manx Care is not compliant with all recommendations of the Ockenden II report applicable for UK Maternity services. Members of QSE considered that the learning from Ockenden II is relevant for Manx Care's Maternity service and is aligned to Manx Care's vision and core purpose. Consideration by QSE established that Manx Care's ability to implement all the recommendations in full is likely to be constrained by available resources namely funding for medical and midwifery staffing. It was agreed to prepare for the	To be escalated to the Board.	01.09.22

	Board's consideration and approval a Maternity Services Strategy, informed by Ockenden II, which can be used to reach a decision on the future provision of Maternity services on the Isle of Man and how best to resource this clinical need. The immediate focus of the service remains on delivering safe care within the current funding envelope and in the context of current staffing constraints. It is also recommended that the board dedicates time in its October meeting to discuss maternity services on island.		
Operational Care Quality Group	Reported via the Operational Clinical Quality Group Report. Recognising and responding to the signs of clinical deterioration remained a concern for the Director of Nursing. Whilst there is good evidence of intervention and improvement in both the timeliness of vital sign measurement and also response to clinical deterioration, the Director of Nursing indicated his intention to achieve higher reliability against this important aspect of our work. QSE supported the Director of Nursing to intensify his focus on vital sign measurement and NEWS II escalation in the acute sector.	For escalation.	
ASSURE (Detail here any areas of assurance that the Committee has received)			
Issue	**Assurance Received**	**Action**	**Timescale**
Patient Story	The lead of the Northern Wellbeing Hub and a district nurse had shared an anonymised patient story with the Board. The patient had terminal cancer and by the district nurse accessing the hub it had enabled the patient to receive more efficient and bespoke care as only one referral was required.	For noting.	

Quality Dashboard	The quality dashboard continued to develop. Areas of specific improvement had been seen in antimicrobial stewardship, falls without harm, VTE assessments and CAS alerts. The Quality Dashboard is to be made available in full to the Board of Directors at their meeting to be held on 01/09/2022. The Director of Nursing will summarise quality improvements made and indicators subject to intervention.	For noting.	
Theatre Improvement Plan	QSE took the report as read but were not able discuss the report in detail, due to annual leave of the accountable officer. Taken as read, the report received indicated that there are delays in implementing the recommendations as per the agreed schedule. The Committee concurred that it was imperative that the recommendations be fully implemented in accordance with the timetable indicated and will seek further assurances at its next meeting.	For noting.	
Infection, Prevention and Control	The position with infection, prevention and control continued to be stable.	For noting	
MCALS Report	MCALS was reported via the Operational Clinical Quality Group Report. The QSE received assurance that the service is becoming established and that 87% of concerns raised by service users were responded to on the day there and then by MCALS. This is an excellent achievement and demonstrates our commitment to improving the patient experience and learning from feedback.	For noting	

The following existing risks were identified during the meeting: (if none please state "none")	**Risk:**	**CRR/BAF Nº:**	**Risk Score:** L x C =
	None		

FINANCE, PERFORMANCE & COMMISSIONING COMMITTEE CHAIR'S REPORT TO BOARD
24th August 2022
MS Teams
9.30AM – 1PM

manx care
Kiarail Vannin

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**FINANCE, PERFORMANCE & COMMISSIONING COMMITTEE**
Meeting Date:	**24th August 2022**
Chair/Report Author:	**NIGEL WOOD**

KEY ITEMS DISCUSSED AT THE MEETING

Your Committee received comprehensive papers covering:

Risks number 2,4 and 6 of the Board Assurance Framework, July management accounts, the 2023/24 budget submission to Treasury, strategy to achieve a balanced budget, restoration and recovery update, the Intergrated Performance Report.

Much of the meeting was spent discussing how to overcome the financial challenges within Manx Care and ensure it ends the year in a balanced positon.

TO ALERT (Alert the Board to areas of non-compliance or urgent matters or new risks or issues that need to be escalated to DHSC or other IoM departments)

Issue	Committee concern	Action required	Timescale
July Management Accounts	The July management accounts continued to forecast an over spend of approximately £8.7m at year end. The biggest contributing factors were agency staffing costs and pay award above the budgeted 2% An overarching strategy regarding recruitment and retention was required to address this is the longer term. The CIP will support development. Tertiary costs were also returning to pre-Covid levels and global inflationary pressures were	Escalation to the Board.	01.09.22

	all contributing to increased costs. Without policy changes these costs are not controllable.		
Back to Balance	Manx Care has been provided with a clear Directive that ending the year within its agreed funding was its number 1 priority and has produced a plan to achieve financial balance in year. This would be done through a combination of having some access to utilising the DHSC Reserve, expanding the CIP Programme and introducing additional operational mitigations to curb spending. Additional financial controls and governance will also be introduced. This will have implications for service levels and the FP &C see alignment of stakeholder interests as being a key imperative. The core cost improvement plan was on track to deliver the target savings of £4.3m in year. However, it would now be expanded to accelerate saving from existing opportunities and expand its scope to incorporate new savings opportunities identified. MIAA continued to assist with the programme to help address the issue of staff capacity. Another issue impacting CIP delivery is the speed of policy decision making from DHSC as every week that goes by will impact on the results for the year under review		
2023/24 Budget Submission	The DHSC had submitted the budget submission to Treasury. Two options had been modelled and the DHSC had chosen option 2 which would mean a shortfall of £16.7m against the total funding requirement put	Escalation to the Board.	01.09.22

	forward. This will create immediate financial tension in our modelling. The process provides that our initial funding allocation would be confirmed by Treasury in October 2022 at which point prioritisation of delivery and spending objectives will be required to be reviewed, if appropriate		
Unfunded Mandate Objectives	Following the production of the Mandate Assurance Report for the Quarter 1 Mandate Assurance Meeting, which took place on 22 July 2022, a key theme emerged across the objectives listed in the 2022/23 Mandate. A key tenet of the Manx Care Act requires reporting to the DHSC for assurance of delivery purposes. However in the event that key imperatives (either now defined or historically promised) are actually unfunded then the ability to deliver those objectives will be compromised. The perceived reality of the present situation is that Manx Care will unlikely be unable to deliver on many of the objectives within the 2022/23 Mandate if investment for those specific developments is not forth coming. For example: the strict adherence to RTT rather than the principles espoused.	Escalation to the Board.	01.09.22

ASSURE (Detail here any areas of assurance that the Committee has received)			
Issue	**Assurance Received**	**Action**	**Timescale**
Integrated Performance Report	The IPR prototype continued to improve and would be presented to the next meeting.	For noting.	
Q1 Council of Ministers Update	The Q1 update had been submitted to the Council of Ministers via the DHSC.	For noting.	

The following existing risks were identified during the meeting: (if none please state “none”)	**Risk:**	**CRR/BAF N°:**	**Risk Score:** L x C =
	Risk:	**CRR/BAF N°:**	**Risk Score:** L x C =
	Risk:	**CRR/BAF N°:**	**Risk Score:** L x C =

PEOPLE COMMITTEE CHAIR'S REPORT TO BOARD
12 July 2022
MS Teams
2.00PM – 4.00PM

manx care
Kiarail Vannin

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**PEOPLE COMMITTEE**
Meeting Date:	**12 July 2022**
Chair/Report Author:	**Sarah Pinch**

KEY ITEMS DISCUSSED AT THE MEETING

The Committee received a very positive staff story from a colleague within the housekeeping team, reviewed the KPI dashboard and received an update on the pay award. There were discussions regarding the results of BMA Racism in Medicine survey, the BMA survey action plan, staff suggestion scheme, change champions and consideration was given to Government consultations on Family Leave Rights, Zero Hours Contracts and Whistleblowing.

TO ALERT (Alert the Board to areas of non-compliance or urgent matters or new risks or issues that need to be escalated to DHSC or other IoM departments)

Issue	Committee concern	Action required	Timescale
BMA Racism in Medicine Survey	A recent report published by the BMA had found that Racism was widespread within the medical workforce in the UK. Over three quarters of respondents had experienced racism in their workplace on at least one occasion in the last two years.	To be raised at the next board meeting and NHS Workforce Race Equality Standards to be introduced as a matter of course.	01.09.22
BMA Survey Results	An action plan in response to the BMA survey had been devised and signed off by all stakeholder groups.	To be presented to the Board.	01.09.22

ASSURE (Detail here any areas of assurance that the Committee has received)

Issue	Assurance Received	Action	Timescale

Staff Suggestion Scheme	The scheme rules had been approved and the scheme would be rolled out.	For noting.	
Change Champions	37 colleagues had volunteered to become change champions. The commitments was for 3 hours and would help hugely to assist to spread the work force and culture message.	For noting.	
Consultations	The committee was supportive of the changes proposed in the consultations. The Director of OHR would provide a response on behalf of Manx Care.	For noting.	

The following existing risks were identified during the meeting: (if none please state "none")	**Risk: None**	**CRR/BAF Nº:**	**Risk Score:** L x C =
	Risk:	**CRR/BAF Nº:**	**Risk Score:** L x C =
	Risk:	**CRR/BAF Nº:**	**Risk Score:** L x C =

BMA

Racism in medicine

British Medical Association
bma.org.uk

Contents

Introduction

This report presents the findings of the BMA racism in medicine survey, which ran from October to December 2021. The survey sought to gather evidence of the racism experienced by doctors and medical students working in the NHS, and the impact of these experiences on their working lives and their career opportunities. All doctors and medical students in the UK, from all ethnic backgrounds, were invited to participate.

The survey received 2030 responses in total, making it one of the largest of its kind. We found a concerning level of racism in the medical profession, stemming from fellow doctors, other NHS staff, and patients. These experiences of racism present in a variety of forms in the institutions and structures of the medical profession.

This report is accompanied by two further BMA reports detailing the impact of racism on the medical workforce. The first report, *Why are we still here? The factors still affecting the progression of ethnic minority doctors in the UK*, is a commissioned piece of research examining the barriers to career progression for ethnic minority doctors, with proposed solutions. The second, *Delivering Racial Equality in Medicine*, is an overarching report which presents a high-level overview of the barriers that are preventing racial equality in the medical profession and recommendations to address these barriers.

Key findings

Racism is widespread within the medical workforce. Over three quarters (76%) of respondents experienced racism in their workplace on at least one occasion in the last two years. Of these, 17% experienced racist incidents on a regular basis. Experiences of racism included discriminatory comments, being given fewer opportunities, more scrutiny of work, bullying by patients and colleagues, continued mispronunciation of names, and social exclusion.

Overseas qualified doctors experience racism more often than doctors trained in the UK. 84% of respondents who qualified overseas said they had experienced racist incidents in their workplace in the last two years, compared to 69% of respondents who trained in the UK. Respondents who had qualified overseas were twice as likely to think that racism was a barrier to their career progression than those who had qualified in the UK (60% compared to 27%).

Experiences of racism are significantly under-reported. 71% of respondents who personally experienced racism chose not to report this to anyone. The most common reasons given by respondents for not reporting experienced incidents were not having confidence that the incident would be addressed (56%) and being worried about being perceived as a troublemaker (33%). For those who did report, the most common outcome reported was that no action was taken (41%).

Reporting experiences of racism results in backlash. Of those who had reported experiences of racism, nearly 6 in 10 total respondents (58%) said that doing so had a negative impact on them. Negative impacts described included being viewed as a troublemaker, being made to feel like the report was an overreaction, being overlooked for progression opportunities, and being made to feel like the incident was their fault.

Racism has an impact on career progression for many doctors. Six in ten (60%) of respondents from Asian backgrounds, 57% from Black backgrounds, 45% from Mixed backgrounds, 36% from White non-British backgrounds, and 58% from all other backgrounds said they felt racism had been a barrier to their career progression, compared to 4% of White British respondents.

Experiences of racism are affecting doctors' confidence and mental and physical wellbeing. Six in ten respondents (60%) said that the racism they had experienced had negatively impacted their wellbeing. Respondents detailed a range of negative impacts including depression and anxiety, increased stress levels, lowered confidence and self-esteem, sleep issues, worsened physical health, and feelings of demotivation, frustration, and anger.

Many doctors are considering leaving or have left their jobs because of racial discrimination. Almost a quarter of respondents (23%) said they had considered leaving a job because of racial discrimination and a further 9% said they had actually left a job.

About the survey

This survey received 2030 responses from doctors and medical students across the UK. A full demographic breakdown of respondents is available in Appendix 1.

The survey excluded educational settings such as medical schools and other non-medical places of work. However, medical students who undertake placements within medical workplaces were also invited to participate.

This report includes direct quotes from respondents which contain racist language and may be uncomfortable or hurtful to read. The BMA's free and confidential wellbeing support services are available to all medical students and doctors in the UK, regardless of BMA membership.

Methodology

In this survey, respondents were given a choice of 24 categorisations, including 'other' categories and free text options. These categories were then combined into aggregate ethnic groups. These aggregations are:

- Black backgrounds: includes Black British, Black African, Black Caribbean, other Black background
- Asian backgrounds: includes Asian British, Bangladeshi, Chinese, Indian, Pakistani, other Asian background
- White British backgrounds: includes English, Northern Irish, Scottish, Welsh
- White non-British backgrounds: includes White other and White Irish
- Mixed backgrounds: includes White and Asian, White and Black African, White and Caribbean, other mixed background
- Other backgrounds: includes Arab and all other ethnic groups not covered above.

Groups were aggregated in this way for two reasons. Firstly, our preliminary analysis identified no notable differences within aggregate groups except for between respondents from White British and White non-British backgrounds. For this reason, these respondents are grouped separately. Secondly, small sample sizes in many categories required that categories be combined to ensure confidence in our findings and to be able to draw reliable comparisons between groups.

We recognise that this methodology is imperfect and may mask some further differential experiences between individuals within these aggregated groups. We have included qualitative responses from respondents throughout this report to highlight the individual experiences of respondents.

The survey focused on racism and race-based discrimination. However, it is important to recognise that experiences of racism will not be the same for each person and may also be experienced differently for those who share other protected characteristics, such as disability and gender. There is still work to be done to better understand the experiences of people who are subjected to multiple forms of discrimination or the way that different protected characteristics intersect.

What do we mean by racism in this context?

For the purposes of this survey and report, 'race' has the same meaning as set out in section 9 of the Equality Act 2010.[1] Race includes colour, nationality, and ethnic and national origins.

The Equality Act 2010 defines four types of racial discrimination:

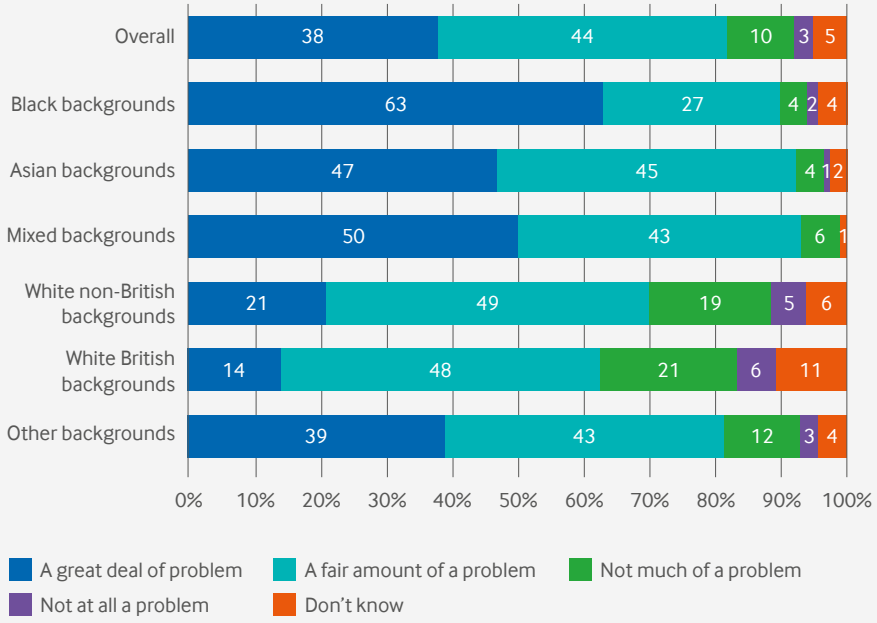
1. Being treated worse than another person in a similar situation because of one's race (direct discrimination).
2. When an organisation has a particular policy or practice that puts people from a certain racial group at a disadvantage (indirect discrimination).
3. When someone is made to feel humiliated, offended or degraded in relation to their race (harassment).
4. Someone being treated badly because they have made a complaint of racism (victimisation).

In addition, in criminal law, race hate is a range of criminal behaviour where the perpetrator is motivated by hostility or demonstrates hostility towards a person's race.

1 The Equality Act 2010 applies only to England, Scotland, and Wales. For definitions of racial discrimination in Northern Irish law, see The Race Relations (Northern Ireland) Order 1997.

General views on the scale of racism as an issue in medicine

To what extent do you think racism is a problem in the medical profession? (n=1845)



Over 8 in 10 respondents (82%) considered that racism is a problem in the medical profession, with 17% believing it to be a great deal of a problem.

Responses varied by ethnic group: 90% of respondents from Black backgrounds, 93% from Asian backgrounds, 73% from Mixed backgrounds, 70% from White non-British backgrounds, 62% from White British backgrounds, and 82% from other backgrounds considered racism to be a problem in the medical profession.

Respondents who gained their primary medical qualification overseas had differing views from respondents who trained in the UK. Of respondents who gained their primary medical qualification outside the UK, 89% thought racism was a problem, compared 74% of those who trained in the UK.

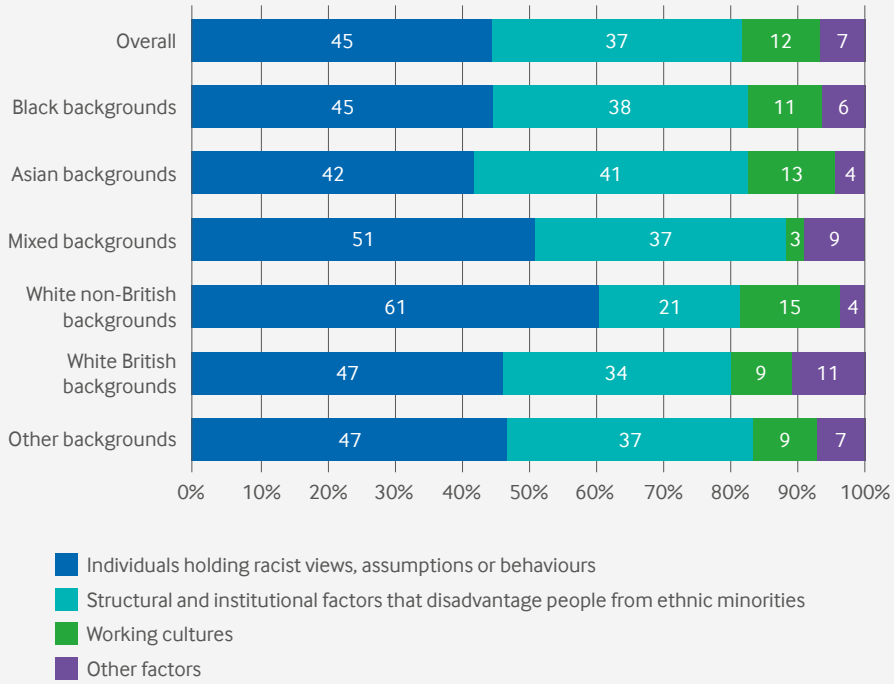
More than half of respondents (58%) also considered that racism was a problem in their workplace, with 17% considering it to be a great deal of a problem.

There was considerable difference in the responses from different groups: 77% of respondents from Black backgrounds, 69% from Asian backgrounds, 64% from Mixed backgrounds, 53% from White non-British backgrounds, 26% from White British backgrounds, and 68% from other backgrounds thought racism was a problem in their workplace.

Respondents who gained their primary medical qualification overseas had differing views from respondents who qualified in the UK, with 75% of respondents who qualified overseas believing that racism was a problem in their workplace, compared to 43% of UK qualified respondents.

Perceptions of the key drivers of racism in medicine

What do you think are the main drivers of racism in your workplace? (n=1534)



Understanding the factors that drive racism in medicine is critical to establishing how to prevent it occurring. We asked respondents whether they felt that racism was predominantly driven by the attitudes and behaviours of individuals, wider working cultures, or systemic and structural factors. Systemic and structural factors include the ways in which policies and practices are designed and implemented that may (consciously or unconsciously) disadvantage particular groups. However, it should be noted that all three proposed drivers are interlinked, with both structural factors and individual behaviours impacting on working cultures, and vice versa.

Within their own workplaces, respondents predominantly considered individuals holding racist views, behaviours, and assumptions to be the main driver of racism (45%) rather than structural and institutional factors (37%) or working culture (12%).

However, respondents had different views on the main driver of racism within the wider profession. More respondents felt that structural or institutional factors (55%) were the main driver rather than individual behaviours (30%) or working cultures (10%), with the remaining 5% attributing this to other factors. This view was held across the Black, Asian and White British aggregate groups.

> "There was an incident where a baby with dark skin's jaundice was missed. There was a lot of resistance to tackle the institutional factors that contributed to this."
> **(Consultant, Black Caribbean, England)**

"Consistently small, dingy and unclean Muslim prayer rooms are provided across all NHS hospitals I have worked at, while the Christian Chapel is often large, airy and unused. This is a clear form of institutional racism. There are times where I have not been able to say my daily prayers (which are a religion obligation for Muslims) due to lack of space/social distancing during the pandemic in these small prayer rooms."

(Junior doctor, Pakistani, England)

"I feel racism has taken a different form in the recent years, it is not so much about the personal remarks against someone, but it is more of an institutionally managed atmosphere that makes sure that the working rights of the minority are curtailed or not heard, which in a way makes working in NHS a misery rather than pleasure."

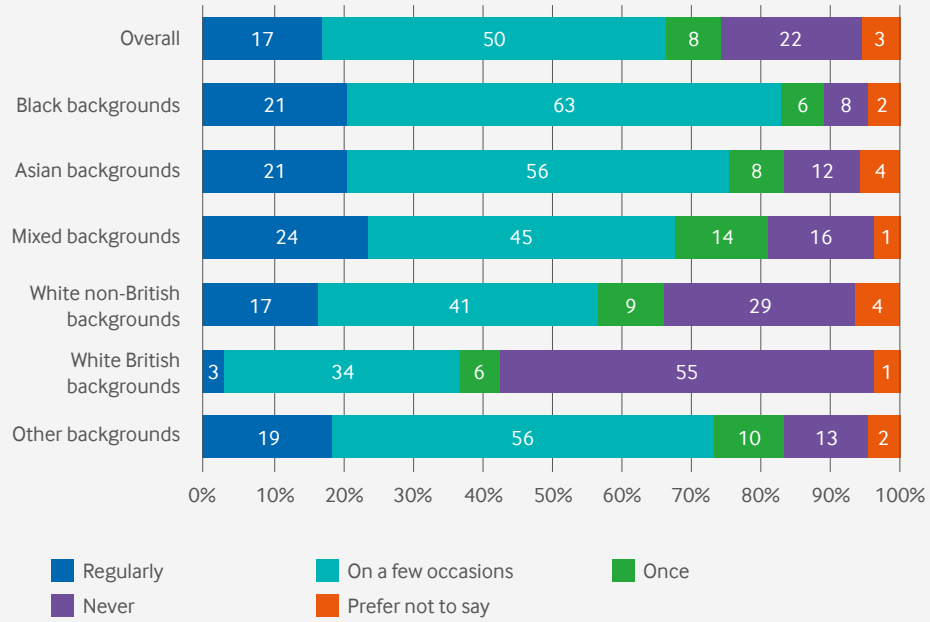
(Consultant, Indian, England)

Experiences of Racism

Over two thirds (76%) of respondents reported that they experienced racism in their workplace on at least one occasion in the last two years. Of these, 17% experienced racist incidents on a regular basis. Respondents from Black backgrounds were most likely to have experienced racism (91%), followed by those from Asian backgrounds (85%), other backgrounds (85%), Mixed backgrounds (82%), White non-British backgrounds (67%), and White British backgrounds (43%).

Respondents were asked about their experiences of different forms of discrimination, including bullying, having their clinical ability doubted, and being ignored and socially excluded. Responses these questions are presented in full in Appendix 2 and are explored in detail throughout this report.

Within the past two years, how frequently have you experienced racist incidents at work? (n=1464)



Experiences of racism – UK graduates vs overseas graduates

Respondents who gained their primary medical qualification overseas had differing experiences from respondents who qualified in the UK. 84% of respondents who qualified overseas said they had experienced racist incidents in their workplace on at least one occasion in the last two years. Of these, 25% said they experienced racist incidents on a regular basis. For UK trained respondents, 67% of respondents said they had experienced racist incidents in their workplace on at least one occasion, with 12% saying they experienced racist incidents on a regular basis.

> "I constantly feel treated as if the UK is doing me a favour giving me a job, instead of recognising the value I bring to the country and the NHS, sometimes by colleagues, but definitely by senior management. I feel I am not part of their club, and I will never be."
> **(Consultant, White, England)**

> "IMGs with strong accents are thought of as not as good as their British accented colleagues and are often discriminated against by both patients and staff alike."
> **(Junior doctor, Black African, England)**

> "I have the fortune of passing as English due to my accent but since I studied abroad – the second people find out where I studied their approach/demeanour changes regarding my competence ... constantly justifying your presence – your right to belong – as a professional is mentally taxing and to extent tiring to the point where over time I have begun to let things pass as highlighting this will label me as 'difficult' Black man. There are number of colleagues that struggle more than me but the experience is deterring me from pursuing a long term career in UK."
> **(Locum junior doctor, Black African, Northern Ireland)**

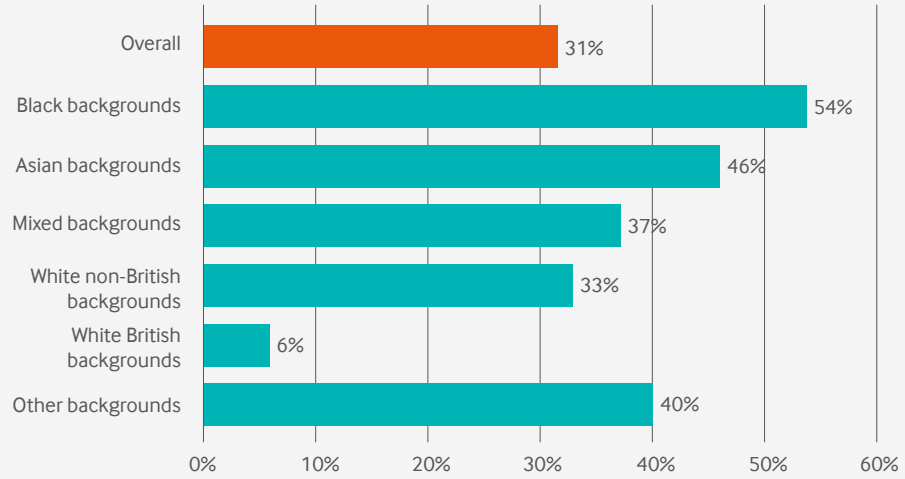
Only 12% of overseas qualified respondents said they had never experienced racism, compared with 31% of UK qualified respondents. Across all types of incidents, respondents who had qualified overseas were more likely to experience these incidents than respondents who had qualified in the UK. For example, 52% of overseas qualified respondents reported having their clinical ability doubted, compared to 27% of UK qualified respondents. 43% of overseas qualified respondents reported being subject to bullying, compared to 20% of UK qualified respondents. A full breakdown of these responses is presented in Appendix 2.

Key Themes

1. Discrimination regarding clinical practice and judgement

1.1 Assumptions about clinical ability or professionalism

Having your clinical ability or professionalism doubted (n=857)



Respondents reported having their clinical ability doubted due to their ethnicity. 54% of respondents from Black backgrounds, 46% from Asian backgrounds, 40% from other backgrounds, 37% from Mixed backgrounds, 33% from White non-British backgrounds, and 6% from White British backgrounds reported this.

Respondents described instances in which their clinical practice was considered unprofessional, but the same behaviour from a colleague of a different ethnicity was applauded.

> "I stayed over my scheduled time to help with a patient and this was commented on as not having boundaries whilst the same act by a Caucasian colleague a few weeks later was lauded by the same person as 'conscientious'."
> **(Consultant, Pakistani, Scotland)**

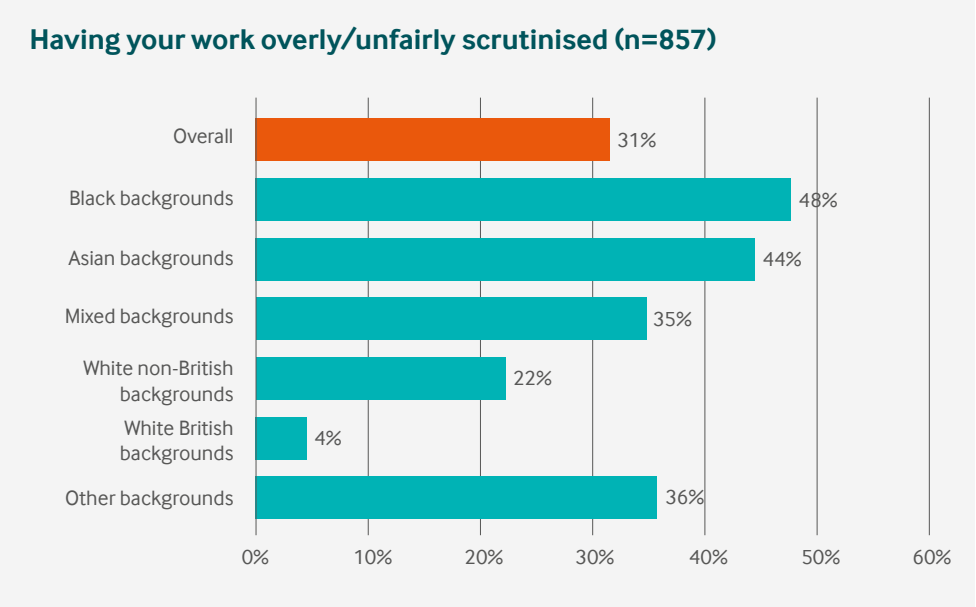
Several respondents noted that colleagues made assumptions about their medical training and about the practice of medicine outside the UK.

> "Within the last month, I had one individual make prejudiced statements about my culture, stating that we practise unethical practices. The comment made was very ignorant and insulting."
> **(Junior doctor, Asian British, England)**

> "I started my journey here and did not find any difficulty or bad experience till I came across a consultant who said 'the English way is the best way of practice and not the Indian way'."
> **(Locally employed doctor, Indian, England)**

> "A consultant implying that my med school education is faulty because it was not in the UK by repeating in a loud voice for others to hear that 'this is NOT how we learned it here' and that I should get back to UK medical student books to learn it."
> **(Junior doctor, Other Black background, England)**

1.2 Unfair scrutiny and criticism



Respondents described being overly or unfairly scrutinised compared to colleagues from other ethnic backgrounds. 48% of respondents from Black backgrounds, 44% from Asian backgrounds, 35% from Mixed backgrounds, 36% from other backgrounds, 22% from White non-British backgrounds, and 4% from White British backgrounds reported this.

> "It is always subtle, like you have to explain the reasons of your decision, whereas your colleagues just say and it is done. You have to give explanation all the time."
> **(Junior doctor, Pakistani, England)**

> "Made to justify my clinical reasoning on a regular basis, which for me is not a problem but I don't think most white men are subject to this degree of scrutiny."
> **(Consultant, Pakistani, England)**

Respondents felt that there was an expectation that they would make mistakes, whereas colleagues from other ethnicities were given more trust.

> "We are treated more harshly and there's definitely a double standard. My behaviour is scrutinised twice as much – it's as if people are waiting for me to make a mistake to leap upon it. Also I feel there is an automatic lack of trust and an expectation of incompetence. My plans will be questioned, whereas a white male, doing the exact same actions, will sail through with no resistance."
> **(GP Trainee, Black Caribbean, England)**

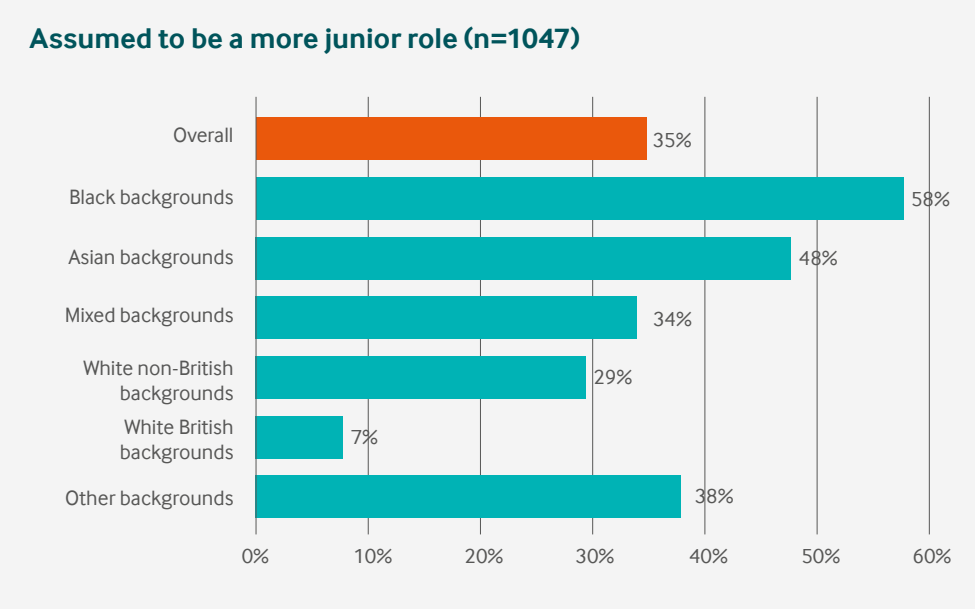
Respondents also felt that they were more likely to face sanctions and receive complaints compared to colleagues from other ethnic backgrounds. A number of respondents described instances in which they had been reported or investigated without reason.

"Rapid and unjust escalation of trainees from ethnic minorities with no effort to communicate – often complaints from white members of staff or staff from different ethnic background."
(Junior doctor, Black African, England)

"British work colleague raised false allegations leading to me being arrested and handcuffed and also her best friend raised concerns to the GMC without any evidence."
(SAS doctor, White non-British, England)

"False allegation by White staff which is promptly believed despite no evidence. Observed racist bullying to Brown clinician by White staff. Conveniently ignored leading to resignation of Brown staff."
(Trust grade doctor, Asian British, England)

1.3. Assumptions about clinical role or position



Respondents reported that they had been assumed to be in a more junior role. 58% of respondents from Black backgrounds, 48% from Asian backgrounds, 34% from Mixed backgrounds, 38% from other backgrounds, 29% from White non-British backgrounds, and 7% from White British backgrounds reported this.

In addition to being assumed to being in a more junior position, several respondents described instances in which they had been assumed not to be clinicians.

"When I go to a ward, it is assumed that I am the porter, was sent to take out the trash – any low skilled job that they are expecting someone to turn up for."
(Consultant, Black Caribbean, England)

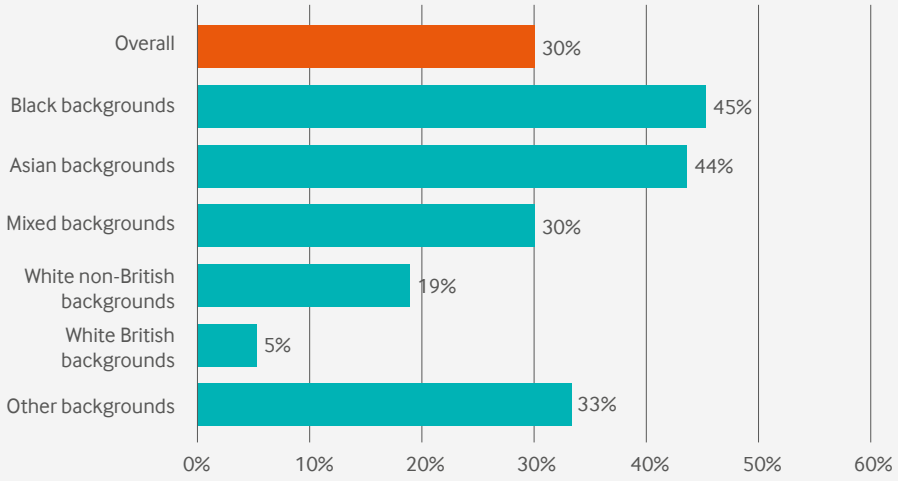
"Turning up to a clinic and being referred to as a support worker even though I was a physician. I also attended a board meeting … and was asked by an attendee if I had entered by mistake – I was an Assistant Director!"
(Consultant, Black African, England)

"I have been mistaken for a taxi driver. I have been mistaken for a junior doctor and the junior doctor (White) was assumed to be the consultant. It seems to be pervasive that White doctors are assumed to be better."
(Consultant, Pakistani, England)

"A patient was calling me when I was taking bloods from a patient in an adjacent bay where I had closed the curtains for privacy. I did not know that the patient was addressing me, as he was shouting 'nurse, nurse' repeatedly. When I had finished with my patient and opened the curtains the patient shouted 'you ignorant p*ki b*tch' and muttered further comments under his breath about how foreigners are rude."
(Medical student, Pakistani, England)

1.4 Differences in workplace responsibilities

Being disproportionately asked to do specific tasks (n=857)



Respondents reported being asked to do specific tasks that were not expected of colleagues from other ethnicities. 45% of respondents from Black backgrounds, 44% from Asian backgrounds, 33% from other backgrounds, 30% from Mixed backgrounds, 19% from White non-British backgrounds, and 5% from White British reported this.

Respondents described being disproportionately given specific tasks, with some reporting that they had been unfairly sent to work in COVID-19 wards during the pandemic:

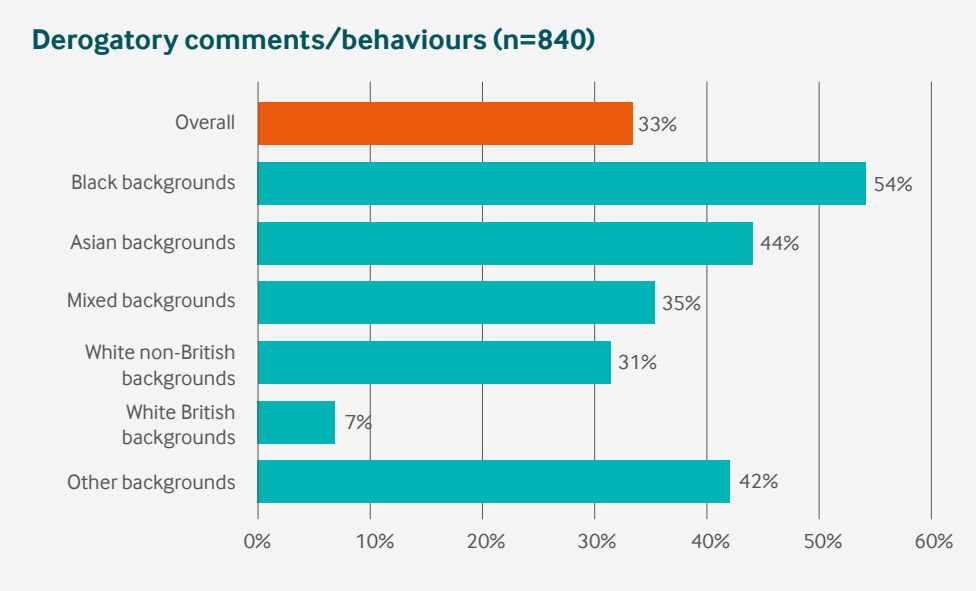
"Individuals who are ethnic minority and at high risk are all allocated to frontline care of COVID-19 patients, while the others took managerial and non-frontline roles."
(Consultant, Indian, England)

"NHS frontline staff placed in COVID-19 rotations were unrepresentatively comprised of ethnic minority staff, putting them at high risk."
(Medical student, Indian, Wales)

"I have been given tasks (as someone from a White British background) rather than colleagues whose ethnicity is different."
(Junior doctor, White British, England)

2. Racist language, comments, and behaviour

2.1 Derogatory comments and behaviours



Respondents reported being subjected to derogatory comments and behaviours due to their ethnicity. 54% of respondents from Black backgrounds, 44% from Asian backgrounds, 42% from other backgrounds, 35% from Mixed backgrounds, 31% from White non-British backgrounds, and 7% from White British backgrounds reported this.

Almost half of respondents (49%) described being subject to discriminatory comments from more senior doctors. Respondents also experienced this behaviour from doctors at the same or more junior level (36%), from another medical staff member (32%), or from a non-medical staff member (31%).

> "I was once told by a consultant that the 'whites' are a superior race and that the rest of us were all just rubbish!"
> **(Locally employed doctor, Asian, England)**

> " [A senior doctor] said 'we don't negotiate with terrorists' as a joke but I didn't find it funny. You are constantly made to feel different and you are reminded every day that you are not the same as everyone even though you are just there trying to do your job. All the jokes were very subtle in a way you cannot say its racist. Because they are smart they choose the right words to hurt you but still comes across as a joke … I was called 'Osama' by the same reg, but he did it in a way everyone found it funny and I had to laugh too, I don't know why, I just felt the best course of action was to laugh it off. Even though I was actually hurting at the time. I couldn't say anything."
> **(Medical student, Arab, England)**

Respondents also described senior colleagues making derogatory comments towards patients based on ethnicity, which made them feel uncomfortable. Respondents often felt unable to advocate for patients in the face of this racism, particularly if they were the only team member who shared the same ethnicity as the patient.

> "[A consultant made] racist remarks about how the patient's parents kept wanting him to eat more and it was making him fat and how that must be an Indian thing (the patient was Pakistani) … I was the only person of colour on the medical team"
> **(Medical student, Indian, England)**

> "Families of deceased patients have been treated very poorly if they've been from BAME backgrounds. There has been disdain, sneering, mocking of patients and their families from BAME backgrounds. This is a regular occurrence. There is a culture of actively stripping BAME patients and relatives of their dignity."
> **(GP Trainee, Asian British, England)**

Two in five respondents (41%) described derogatory comments from patients regarding their ethnicity, country of origin, heritage, name, and accent.

> "When I was speaking to a patient on my GP placement, he asked me repeatedly where I was from to which I initially replied 'St George's', then where I lived in the UK, then finally told him my parents were Indian, to which he replied 'No work in India, is there?'."
> **(Medical student, Indian, England)**

> "A patient said to me ... 'your people have a lot to answer for with this COVID.'"
> **(Consultant, Chinese, England)**

> "An example of subtle, slightly ambiguous prejudice: I introduced myself to an elderly patient and asked to sit in on the consultation. The patient said 'I'm so glad to see you making something of your life'"
> **(Medical student, Black African, England)**

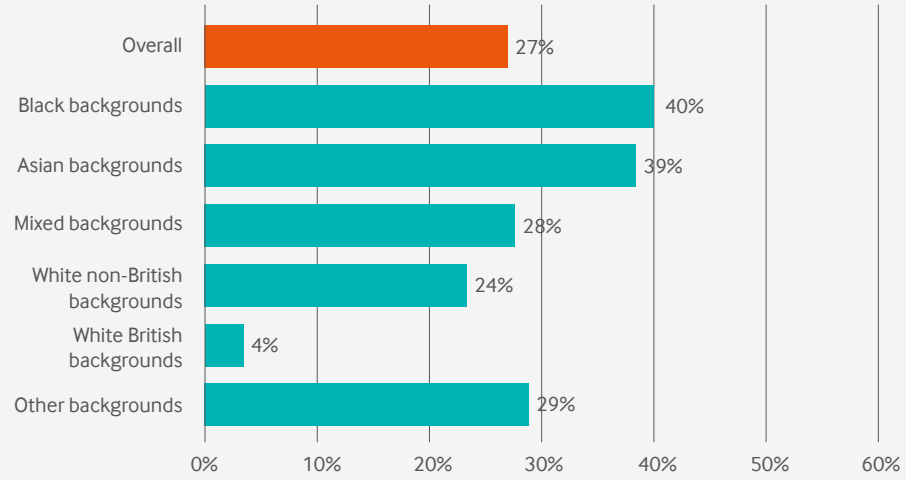
Some respondents also described that their colleagues belittled and laughed at instances of racism from patients:

> "I experienced racism one day at work. I was new there and therefore was still getting familiar with the way things work. I was looking after a Caucasian male patient who noticed I was taking more time than normal to do a particular task. He commented saying 'come on, you monkey man'. Other members of staff around me heard it but said nothing. In fact, one of my colleagues, a female Caucasian middle-aged lady, laughed with him. I felt horrible and wanted to curl into a ball. No one stood up for me and I did not have the courage to speak up. I was expected to continue caring for this patient as normal. Racism is still present in our society and is still, for some bizarre reason, being tolerated in the healthcare environment. Something MUST be done about this."
> **(Medical Student, Asian British, England)**

> "A patient made a very racist remark towards Pakistanis and a senior found it hilarious (patient knew) and tried to brush it off."
> **(Junior doctor, Asian British, England)**

> "Told to take a history from patient known to be racist, doctor I was shadowing was aware but did not warn me but seemed to find it amusing."
> **(Medical Student, Black Caribbean, Wales)**

Continued mispronunciation of your name (n=1047)



Several respondents reported that they have experienced derogatory comments made about their accent and / or name. 40% of respondents from Black backgrounds, 39% from Asian backgrounds, 28% of respondents from Mixed backgrounds, 29% of respondents from other backgrounds, 24% of respondents from White non-British backgrounds, and 4% of respondents from White British backgrounds reported experiencing mispronunciation of their name.

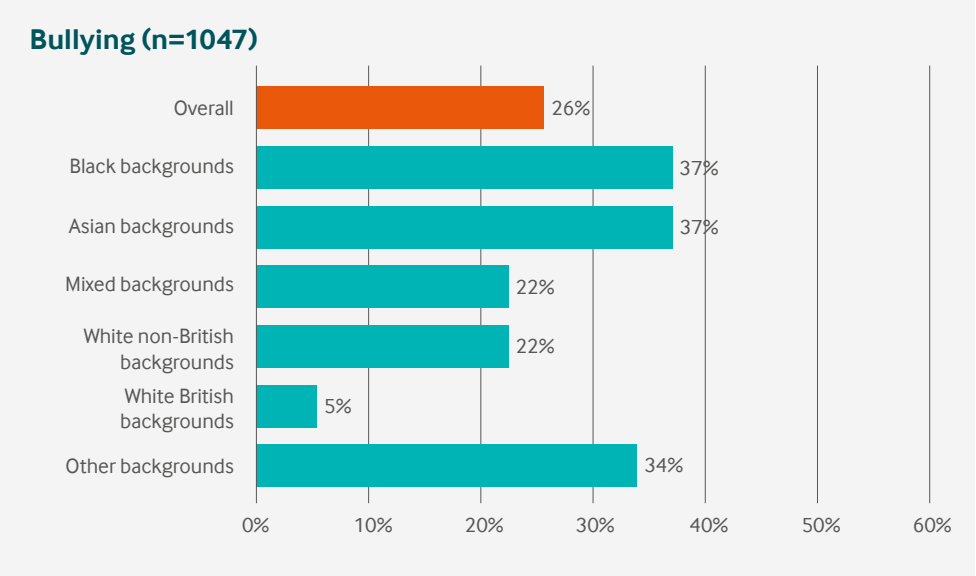
Respondents described having their name purposefully mispronounced by colleagues and patients, as well as comments made on accents, accents being mocked, patients pretending not to understand accents, and being subject to stereotypical assumptions made based on accents:

> "My supervisor wrote in my CSR that I have an accent and he never discussed this with me."
> **(GP trainee, Black African, England)**

> "I overheard someone who I just asked to help with an equipment mimicking my accent when she went next door"
> **(Locum junior doctor, Black African, England)**

> "I have an uncommon name, but it isn't impossible to say. Many people (management included) fail to pronounce it properly despite me telling them how it is pronounced. This microaggression pales in comparison to what I have observed with other individuals ... who I have observed being asked if staff can use a short form to address them rather than learn how to say their name."
> **(Consultant, Other ethnic group, Scotland)**

2.2 Bullying



Many respondents experienced bullying in their workplace due to their ethnicity. 37% of respondents from Black backgrounds, 37% from Asian backgrounds, 34% from other backgrounds, 22% from Mixed backgrounds, 22% from White non-British backgrounds, and 5% from White British backgrounds reported this.

Bullying was most often perpetrated by senior doctors, with 68% of those who had been bullied reporting that they had been bullied by senior doctor. Respondents also reported being bullied by doctors at the same or more junior grade (41%), by another medical staff member (35%) and by non-medical staff members (36%).

> "Medical director shouting at me in the corridor referring to me as having mental health problems. Refusing leave that I was entitled to, I had to resign from my job as a result after working more than 14 years as consultant – it was becoming increasingly stressful for me, could not cope anymore."
> **(Consultant, Asian British, Wales)**

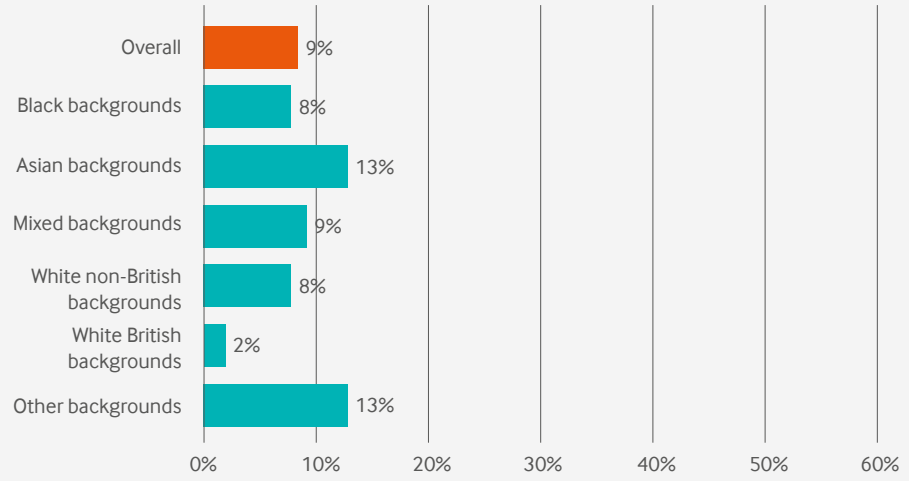
> "At times the tone of senior colleagues would be so rude that I would cry in the washroom. Fellow junior colleagues who were locally from the UK would notice this and also be rude (they would mirror each other's rude behaviour). This would make me feel isolated and hesitate to ask for help."
> **(Junior doctor, Pakistani, England)**

> "Line manager bullying and using derogatory language. Treating the White doctors much more favourably than the Black and Asian doctors"
> **(Junior doctor, Arab, Northern Ireland)**

One fifth (20%) of respondents who experienced bullying reported being bullied by patients or their relatives.

> "I was constantly harassed and bullied by a patient in the hospital for my appearance, I was called a sheikh, I would be asked about my place of birth, and my name was ridiculed"
> **(Junior Doctor, Arab, England).**

Physical attack or threat of violence (n=840)

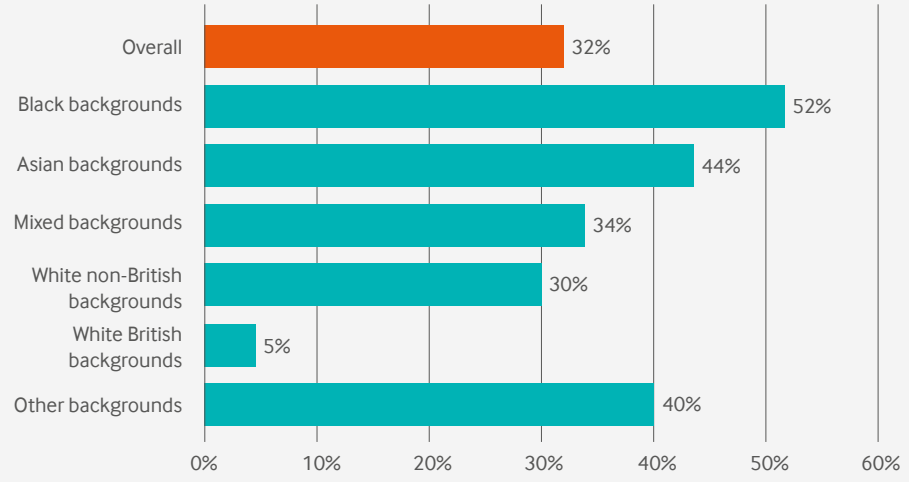


A small number of respondents reported that they had experienced physical attack or threat of violence due to their ethnicity. 13% of respondents from Asian backgrounds, 13% from other backgrounds, 9% from Black backgrounds, 9% from Mixed backgrounds, 8% from White non-British backgrounds, and 2% from White British backgrounds reported this.

> "[The patient] started raising his voice at me and saying I was asking him stupid questions and didn't understand why he had been made to see me. I tried continuing the consultation in a professional manner but patient was becoming visibly more aggressive towards me and raising his voice. I wasn't feeling safe and comfortable anymore left alone with him in the consulting room and proceeded to end [the appointment]. I was quite shaken by the experience."
>
> **(Junior doctor, Black African, England)**

2.3 Exclusion and othering

Being ignored or socially excluded from conversations, communications or group activities (n=840)



Respondents reported being excluded, ostracised, and othered due to their ethnicity. 52% of respondents from Black backgrounds, 44% from Asian backgrounds, 40% from other backgrounds, 34% from Mixed backgrounds, 30% from White non-British backgrounds, and 5% of respondents from White British backgrounds reported this.

> "Being clannish with English colleagues and excluding me. No social interaction. Not being invited to homes when others have been."
> **(Consultant, Pakistani, England)**

> "On placement surgeon not speaking to me, only to my white counterpart. Wouldn't even make eye contact with me. Went to the extent that I was getting curtains closed on me"
> **(Medical student, Pakistani, England)**

> "People around me often make no effort to have a conversation with me and feel left out and quite isolated most of the time. I have been unable to form any bonds at work and it feels quite frustrating. Members of staff have been disrespectful and condescending on numerous occasions and I know for sure they wouldn't have done or said the same things to a White colleague. What I find the surprising is most of my international colleagues still feel the same way in spite of spending decades in UK and I wonder if I would always be treated as an outsider!"
> **(SAS doctor, Indian, England)**

2.4 Patients refusing treatment

Several respondents described instances in which patients refused to be treated due to the respondent's ethnicity.

> "Unnecessary hostility from patients and refusal to see/speak to people of colour, yet having polite conversations with White members of staff. This was then followed by gaslighting behaviours and blaming the ethnic minority doctor of being 'aggressive' and making the patient anxious, which was not the case at all."
> **(Medical student, Asian British, England)**

> "During the pandemic I have had a number of patients on the telephone who have assumed I am White, once we arrange a face to face they are surprised I am the GP they have spoken to on the phone and then chose to no longer see me instead preferring to see my White colleagues. This has been quite a common occurrence."
> **(GP, Black British, England)**

Some respondents noted that they received no support from colleagues upon reporting that patients refused to be seen by them.

> "I was called 'headscarf b*tch' by a patient. A patient refused to be seen by me as my name did not sound British. A supervisor did not wish to discuss the experience of the patient not wishing to be seen by me and I was met with mostly silence."
> **(Junior doctor, Mixed other background, England)**

> "A patient with a hearing disability wrote on a piece of paper that he did not want to be treated by me because he had a problem with my religion and my headscarf. I reported this to my consultant, who just shrugged it off."
> **(Junior Doctor, Pakistani, England)**

A number of respondents from White backgrounds described incidents where they were asked to see a patient instead of an ethnic minority doctor.

> "Patients would ask refuse to see my consultant, asking instead for me, 'a real doctor', for no other reason than I was a White man."
> **(Junior doctor, White English, England)**

> "During my foundation years when on call a colleague who wears a hijab was asked to review an acutely unwell patient. The patient refused to be reviewed or examined by my colleague in any way. My colleague felt that the patient needed to be seen and so asked me to review instead, despite the fact that we were at the same stage of training, because of my ethnicity the patient allowed me to review them."
> **(Junior doctor, White British, England)**

3. Scepticism of actions to reduce racism

Respondents noted a lack of institutional action to address racism. Though some provided examples of good practice (see p.34), others felt that their workplace was not making enough change at a structural level to adequately address racism. Respondents from ethnic minorities felt that they were often burdened with the responsibility of educating their colleagues, with little engagement from management or staff.

> "I made a medical meeting presentation about racism in healthcare to medical colleagues. The conversation was mostly hijacked by White people in the room, and no action was taken after it."
> **(Junior doctor, Arab, England)**

> "Action plans don't reduce racism, they just create work for people, which they associate with race, and are probably pushed to adopt a more negative attitude to race as a result."
> **(Other speciality, Indian, England)**

> "I have seen no interest in improving racism equality in my career in Scotland and the North of England. In general, White colleagues are reluctant to even acknowledge that racism exists and will often undermine and explain away concerns of they are raised."
> **(SAS doctor, Mixed ethnic background, Scotland)**

Respondents felt that those tasked with developing actions to reduce racism did not have the knowledge to develop effective solutions, and that actions were treated as a tick box exercise rather than a legitimate effort to eliminate racism in their workplace.

> "There is nothing positive to say as HR and management have no real intention of tackling this issue. All the support offered us to tick the boxes for their own survival, the ground reality is different."
> **(Consultant, Indian, England)**

> "Greater awareness means that my workplace knows that racial inequality is a problem but because the people trying to come up with solutions do not really understand the problem, their efforts appear patronising. For example, mentor programme for BAME staff with predominantly White mentors, to 'improve confidence and leadership skill'. It would be better for programmes to help White people understand what it is like on the other foot before trying to fix the problem."
> **(GP locum, Mixed ethnic background, England)**

A small number of respondents felt that actions to reduce racism favoured those from ethnic minorities, and that they were disadvantaged as a result. One respondent noted that support groups and listening events for ethnic minority staff members were not available to white staff.

Intersectionality

Respondents were asked whether they thought incidents of racism they had experienced were linked to other characteristics, for example their religion, gender, or disability status. The results showed that a significant proportion of people felt the racism they experienced was amplified by other factors.

Three in ten respondents (30%) thought that the racism they experienced to was linked to religion and belief, with many respondents mentioning Islamophobic, Antisemitic, or other faith-based slurs and discrimination:

> "Not allowing Muslims a prayer space – it literally takes 5-10 minutes to pray, this does not affect my job as a doctor ... is a key factor putting me off certain careers in medicine."
> **(Medical student, Bangladeshi, England)**

> "People seem to exhibit cognitive dissonance ... they accept overt racism towards people of colour is wrong, but somehow do not apply the same standard to anti-Jewish racism."
> **(Consultant, White British, England)**

> "Recently it was Diwali and I fasted in the day to eat in the evening after prayer. Work colleague said 'you're fasting again!', I asked 'what do you mean?', 'Don't you eat at night and fast in the day for 40 days?', I replied 'that's in Islam, I'm Hindu, Diwali is our Festival of Lights, I'm not Muslim.' 'Oh, I thought you were all the same.' I smiled and did not answer."
> **(Salaried GP, Indian, England)**

Over a quarter respondents (28%) reported that experiences of racism were exacerbated by sex, with many women describing instances in which they had been degraded and belittled.

> "I think in general sometimes it seems easier to criticise someone who is small and brown and female – because they are an easy target ... sometimes it feels like you don't get taken very seriously just because of who you are. You could say the same thing as your tall White male colleague and that would be taken a lot more seriously."
> **Locum Junior Doctor, Asian British, England)**

> "Racist remarks from delirious elderly patients. Racism associated with sexism – the assumption of not being a real doctor due to being an Asian female."
> **(Junior doctor, Asian British, England)**

> "Called a White wh*re by a male colleague because I declined his sexual advances. Told I was dirty and dressed like all White sl*ts who are asking for it."
> **(Consultant, White British, Female, England)**

The intersection of ethnicity, religion, and gender was evident in comments from respondents who wore headscarves. They described discriminatory policies and behaviours that made it more difficult for them to practice medicine while wearing a headscarf.

> "Being removed from emergency operating theatre by a senior ODP/ theatre manager who took offence to my headscarf, could not provide a head covering that would fit over it."
> **(Locally employed doctor, Asian, England)**

> "Not being able to wear a theatre hijab in theatre without a disposable cap on top which truly makes no sense."
> **(Medical student, Pakistani, England)**

One respondent noted that he did not receive support as a carer.

> "I have carer responsibility as well with a child who is seven with severe special needs and my wife at the time was unwell. A similar degree of help was not offered to me as was my colleague who rightfully was awarded time and space to handle it and then return later."
> **(Salaried GP, Asian British, England)**

Reporting experiences of racism

Reporting personally experienced racism

The majority of survey respondents (71%) who had personally experienced racism chose not to report this to anyone.

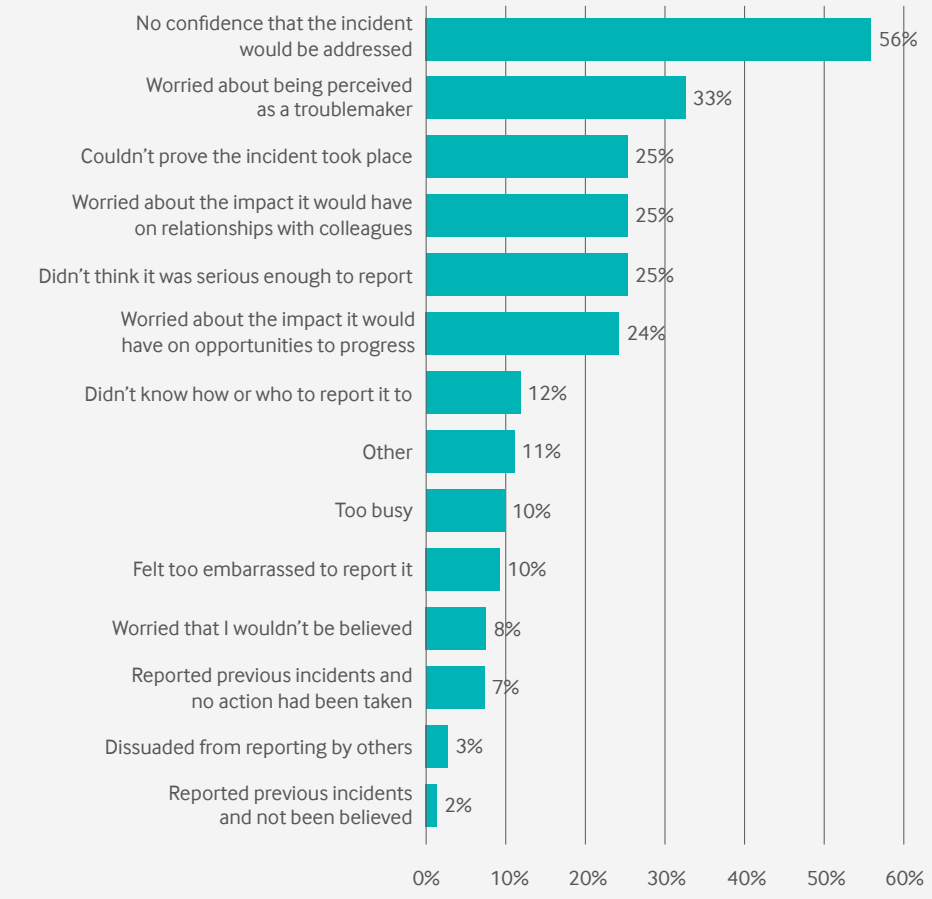
69% of respondents from Black backgrounds, 70% from Asian backgrounds, 76% from Mixed backgrounds, 60% of those from other backgrounds, 84% from White British backgrounds, and 70% from White non-British backgrounds did not report. 66% of overseas qualified respondents chose not to report to anyone, compared to 75% of UK qualified respondents.

Of those who did report, most reported to their employer directly (21%) and smaller proportions reported to the BMA (8%), Freedom to Speak Up Guardians (5%), or regulators (3%). 7% of respondents reported to a range of other bodies. Examples of other ways people reported included to other colleagues, medical schools, occupational health, the Equality and Human Rights Commission, and via anonymous feedback or appraisal systems.

Reasons for not reporting

The most common reasons given by respondents for not reporting experienced incidents were not having confidence that the incident would be addressed (56%) and being worried about being perceived as a troublemaker (33%).

Reasons given for not reporting personal experiences of racism (n=640)



Respondents from Black backgrounds most commonly gave their main reasons for not reporting incidents as having no confidence the issue would be addressed (65%) and being worried about being perceived as a troublemaker (38%). Respondents from Asian backgrounds also gave these as their main reasons, with 58% saying they had no confidence the issue would be addressed and 36% being worried about being perceived as a troublemaker.

For White British respondents, the reasons most commonly given were that they didn't think the incident was serious enough (33%) and lack of confidence that it would be addressed (25%); for respondents from White non-British backgrounds the top reasons were lack of confidence that it would be addressed (59%) and being worried about the impact it would have on relationships with colleagues (35%).

The top reasons given by overseas qualified respondents were having no confidence the issue would be addressed (61%) and fear of being perceived as a troublemaker (37%). These were the same reasons given by UK qualified respondents; 51% of UK qualified respondents said having no confidence was the top reason, with 27% fearing they would be perceived as a troublemaker.

A number of respondents described instances in which they were advised by senior colleagues not to report experiences of racism, either because nothing would be done or because reporting would have a negative impact on them.

> "Patients making monkey chants, and using the 'N' and 'P' words. I've had a very senior White male staff member tell me that I when I raised the subject of racist abuse at work, it was 'toe curling' and he clearly implied that I should not have done this. Another senior White woman said we shouldn't bother reporting racist hate crime because in her view, the police did nothing anyway."
> **(Consultant, Asian British, England)**

> "I was shouted at by a consultant and told that I should be 'hung upside down by my beard' (I am Muslim, and a beard is a religious symbol for me). I was then told by the Training Programme Director that I should avoid making a formal complaint as it 'would probably not get very far and result in me being impacted negatively'. I still have PTSD from this event and have never felt that I got justice."
> **(Junior doctor, Pakistani, England)**

Outcomes of reporting

For those who did report, the most common outcome reported was that no action was taken (41%). Respondents from Asian backgrounds were more likely to say no action had been taken (47%) than respondents from Black backgrounds (30%) and White Backgrounds (28% White British backgrounds, 37% White non-British backgrounds). The next most frequent outcome was the incident being investigated but no action being taken (11%). In only 6% of cases was the incident investigated and action taken against the perpetrator. In 7% of cases, respondents did not know what had happened as a result of them reporting the incident.

In some cases, respondents said that they had themselves been blamed for the incident and/or for raising it. Several respondents noted that when they reported racist incidents, their concerns were ignored, and they were made to feel like they were at fault.

> "I have been bullied and made to work where none of my colleagues wanted to work. I complained and I was asked by the AMD to shut up"
> **(Consultant, Indian, Wales)**

> "Patients have threatened me and called me awful names but when I complained to the management it was trivialised and I was told I could have managed the situation better and was told to do a reflection on the encounter for my appraisal."
> **(Salaried GP, Black African, England)**

> "I have been personally victimised for trying to raise issues and 'complaint' raised against me. I have been asked to go for counselling session but no acknowledgement of the 'actual problem'."
> **(Consultant, Indian, England)**

Reporting witnessed incidents of racism

As with personal experiences, the majority of people who witnessed racist incidents directed at others chose not to report them (77%). This proportion was similar across ethnic groups.

For those who did report incidents they witnessed, most reported directly to their employer (17%) with smaller percentages reporting to the BMA (4%), Freedom to Speak Up Guardians (4%), and regulators (2%).

The most common reasons given for not reporting witnessed incidents were similar to the reasons given for not reporting personally experienced incidents. These were having no confidence that the issue would be addressed (49%), being worried about being perceived as a troublemaker (27%), feeling that the incident was not about them (26%), being worried about the impact it would have on relationships with colleagues (23%), and being unable prove the incident took place (18%).

Of those who reported, no action was taken in over three quarters of cases (78%). Only 9% said the report had been investigated and action taken against the perpetrator, a further 13% said there was an investigation, but no action taken against the perpetrator.

Overall, respondents were more likely to report events that they had directly experienced rather than incidents they had witnessed, although reporting rates were low for both categories of incident.

Impact of reporting experiences of racism

Of those who had reported personally experienced incidents of racism, nearly 6 in 10 respondents (58%) said that doing so had had a negative impact on them.

Respondents from Mixed backgrounds were more likely to say this (73%) than respondents from Asian backgrounds (61%), other backgrounds (58%), Black backgrounds (50%), White British backgrounds (47%), and White non-British backgrounds (50%). There was little difference between those who qualified overseas (60%) and those who were UK qualified (62%).

Many respondents described experiencing adverse consequences at their workplaces after reporting an experience of racism. Respondents described a range of hostile behaviours from their colleagues. These included being bullied, socially isolated, and feeling that they been labelled as a troublemaker.

> "Less confident to report such incidents again because no action was taken against the perpetrator. I feel uncomfortable and anxious of reprisals"
> **(Consultant, Black African, England)**

Some respondents said that the adverse consequences experienced were related to career progression. Some specific examples included difficulties getting job plans signed off, impact on salary negotiations, not having a contract extended, and not being given training or leadership opportunities.

> "Judged by the colleagues and staff. Personal trauma of going through mediation. No other support for myself. My career progression has been affected"
> **(SAS doctor, Asian, Wales)**

Many respondents said that no action was taken on their complaint and some others said that they felt disbelieved or were made to feel that they had overreacted. Some respondents also described the reporting process as being stressful and having an impact on their mental health.

> "It has caused a tremendous strain, knowing that nothing has been done against the perpetrators of systemic bullying steeped in racism. I am now viewed as being 'difficult' for frankly describing my experiences."
> **(GP Trainee, Asian, England)**

> "[Patient] asked in quite a rude way 'so which sh*thole did you come from?' I was stunned. I said Northern Ireland. He laughed harshly and replied 'Yeah, right. You're from Northern Ireland? What a joke.' ... Although it is irrational, racism makes you doubt yourself and question your own place in the country. I found it distressing when my portfolio tutor saw my portfolio entry about it and decided to challenge me about whether this incident was racism or not. I don't think it's appropriate to do that to the person who has had the experience ... Being dismissed in this way can be worse than the incident itself sometimes, because it tells you that the person you're speaking to doesn't care about your wellbeing in the slightest."
> **(Medical student, Asian British, Northern Ireland)**

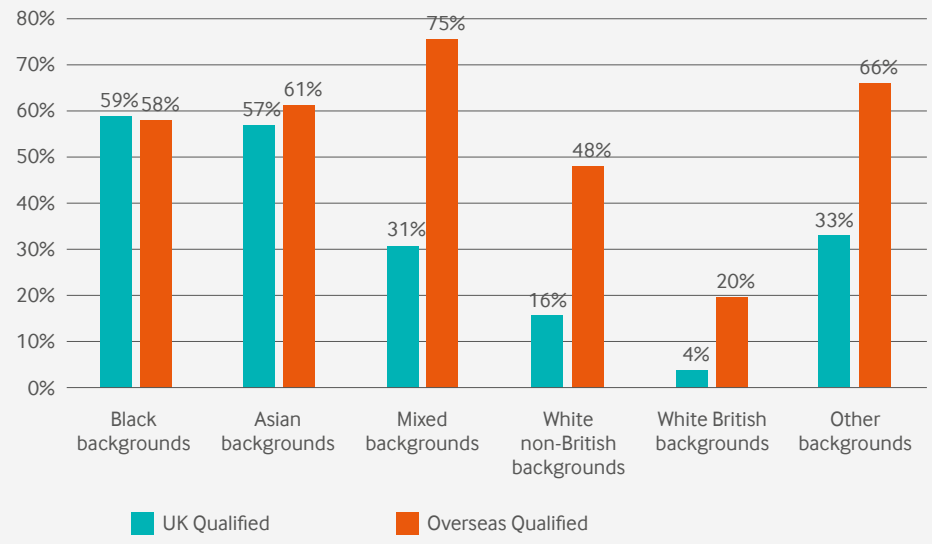
Around half (47%) of respondents who reported a witnessed incident of racism said this had led to a negative impact on them. This is lower than the 58% of people who experienced negative impacts of reporting a directly experienced event, but still a significant proportion. Respondents from White non-British backgrounds were more likely to say this (85%) than respondents from Asian backgrounds (51%), Black backgrounds (50%), other backgrounds (47%), Mixed backgrounds (38%), and White British backgrounds (18%).

Racism and career progression

Many respondents felt that racism was a barrier to their career progression. 60% of respondents from Asian backgrounds, 57% from Black backgrounds, 45% from Mixed backgrounds, 36% from White non-British backgrounds, and 58% from all other backgrounds said they felt racism had been a barrier to their career progression, compared to 4% of White British respondents.

Respondents who had qualified overseas were much more likely to think that racism was a barrier to their career progression than those who had qualified in the UK. 60% of overseas qualified respondents thought that racism had been a barrier to their career progression, compared to 27% of UK-qualified respondents. This finding was consistent across all ethnic groups.

Do you think racism has been a barrier to your career progression? (n=1246)



A number of respondents described they had been actively prevented from applying for roles due to their ethnicity.

> "It feels like there is no point trying even to be considered for a management post"
> **(SAS doctor, Asian, Wales)**

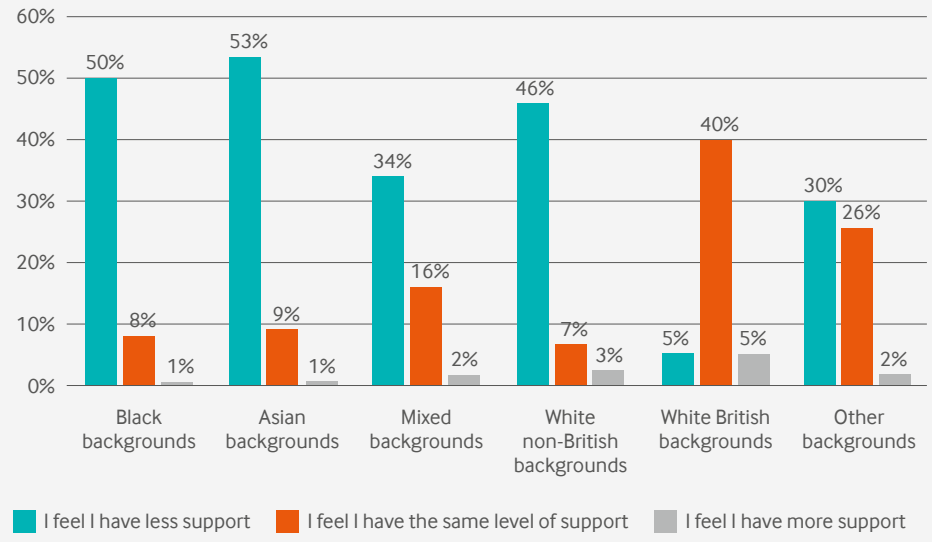
> "Working in A&E was a nightmare. Continued racist behaviour from patients and their relatives. Due to this, I have decided not to pursue a career in emergency medicine."
> **(Junior doctor specialty, Indian, England)**

> "When I had to fight to be paid equally to that of a White colleague for the same post – the White colleague was offered better terms in spite of being less experienced and being in the trust for considerably shorter time."
> **(SAS doctor, Asian, England)**

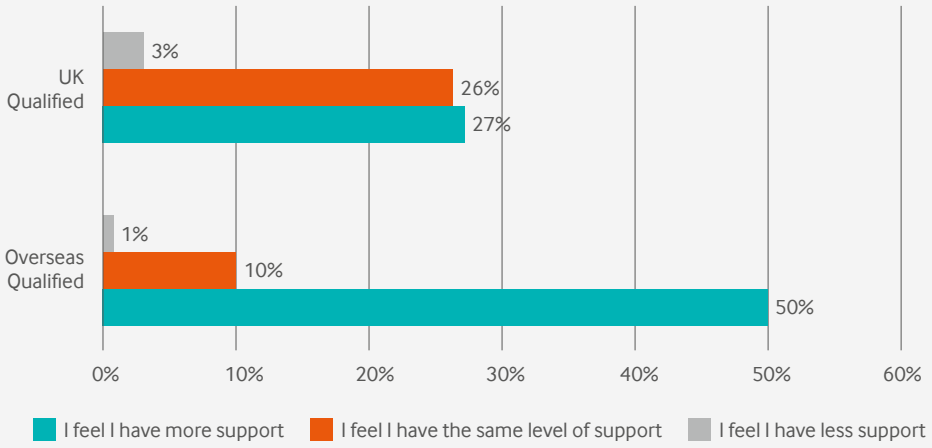
> "Overlooked for promotion, paid less than White man who was recruited into the department and took over some of my responsibilities – we have equivalent experience."
> **(Consultant, Asian British, England)**

Access to opportunities and support

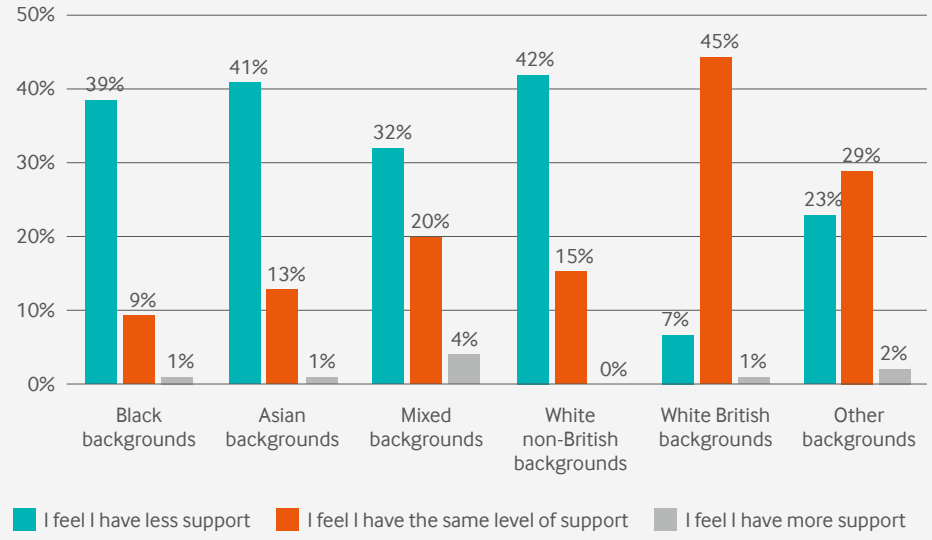
Do you feel you receive the same support to apply for senior roles as your colleagues of a different race/ethnicity? (n=1230)



Do you feel you receive the same support to apply for senior roles as your colleagues of a different race/ethnicity? (n=1230)



Do you feel you receive the same support to apply CEAs, distinction awards, and commitment awards as your colleagues of a different race/ethnicity? (n=1230)



There were significant differences between ethnic groups regarding support to access opportunities and Clinical Excellence Awards. Those from Black, Asian, Mixed, and other ethnic backgrounds felt they had less support than their colleagues as a result of their ethnicity. Those from White British backgrounds felt they had the same level of support. Those from White non-British backgrounds felt they had less support to access opportunities, but the same level of support to access Clinical Excellence Awards.

Overseas qualified respondents were almost twice as likely as UK qualified respondents to feel that they had less support to access opportunities as a result of their ethnicity.

> "When interacting with senior colleagues, I would notice that they were nicer and more helpful towards other junior doctors who were born in UK and were White. I would be clearly treated and spoken to differently."
> **(Junior doctor, Pakistani, England)**

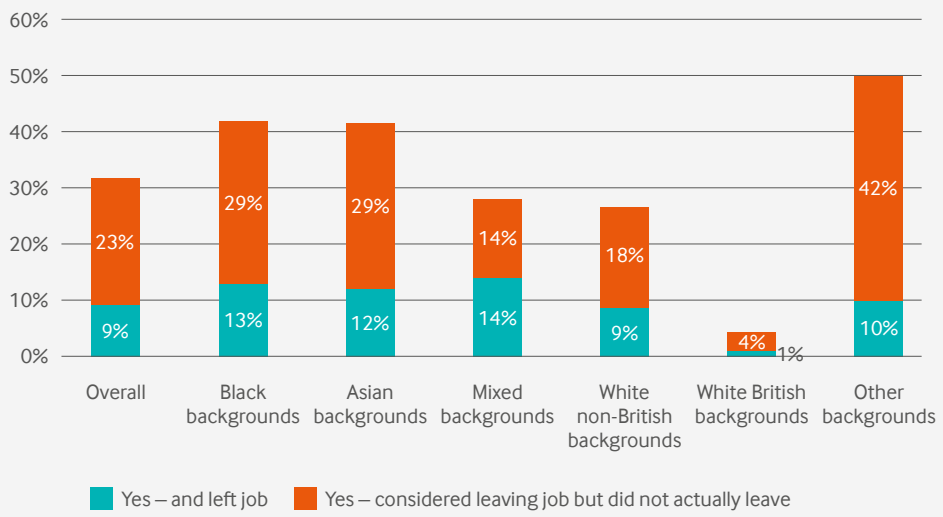
> "Managers of different ethnicities from me not providing support I needed to carry out my job then criticising my work performance."
> **(Consultant, Asian, England)**

> "An English trainee was moved from a practice when the trainee had a problem with a trainer, whereas I had to keep going and raising the issues I had and nothing was done despite repetitive requests for a different practice."
> **(GP Trainee, Indian, England)**

> "I had tried to participate in one of the surgeon's surgery and wasn't spoken to the entirety of two operations. However, on other occasions, to a White male, the same surgeon was very willing to teach and explain the operation throughout. From my knowledge, they did not know each other beforehand and had no personal history. I could only put it down to my race, as he treated other White students significantly better, and simply ignored my existence."
> **(Medical student, Asian, Scotland)**

Impact of racism on staff retention

In the past two years, have you considered leaving a job or left a job due to racial discrimination? (n=1239)



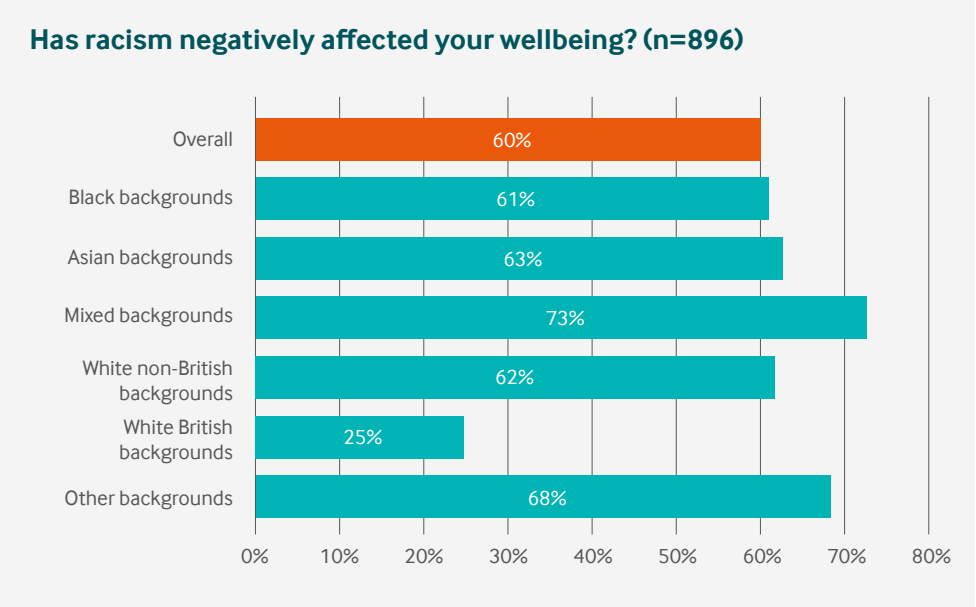
More than one in five respondents (23%) said they had considered leaving a job because of racial discrimination. There was variation between respondents, with 29% of respondents from Black backgrounds, 29% from Asian backgrounds, 18% from White non-British backgrounds, 14% from Mixed backgrounds, and 42% from other backgrounds feeling this way, compared with 4% of White British respondents. A third (32%) of overseas qualified respondents said they had considered leaving a job due to racial discrimination, compared with 13% of UK qualified respondents.

A further 9% of respondents left their job due to racial discrimination. There was again variation between respondents, with 14% of respondents from Mixed backgrounds, 13% from Black backgrounds, 12% from Asian backgrounds, 9% from White non-British backgrounds, and 10% from other backgrounds reporting that they had left their job, compared with 1% of White British respondents. 14% of overseas qualified respondents said they had left their job due to racial discrimination, compared with 4% of UK qualified respondents.

> "I was a happy person, I am not anymore. I terribly miss my home country, here I don't recognize myself. I can't leave just yet, due to financial reasons. But one day I will leave, because at home we never treat another human being badly just for their skin colour."
> **(Junior doctor, Bangladeshi, England)**

> "In recent years I have purposely moved away from people (and teams) with racist behaviour. I consider myself lucky to have been able to do that. But that is after 17-18 years of near-daily attempts at demoralisation and discrimination. Those people now sit in some of the most coveted decision making positions in the country!"
> **(Consultant, Pakistani, England)**

Impact of racism on wellbeing



Six in ten respondents (60%) reported that racist incidents they had experienced had negatively impacted their wellbeing. 73% of respondents from Mixed backgrounds, 68% from other backgrounds, 63% from Asian backgrounds, 62% from White non-British backgrounds, 61% of from Black backgrounds, and 25% from White British backgrounds reported this.

Respondents frequently mentioned mental health impacts, ranging from low mood and stress to severe depression and anxiety. Some respondents described experiences that made them feel unsafe at work and unable to trust their colleagues. Many noted that they had lost confidence in themselves and their skills, and that their self-esteem was affected.

> "I am not the same person anymore. I feel less confident with bruised self-esteem."
> **(GP trainee, Asian, England)**

> "[As a] visibly Muslim woman wearing a headscarf ... [I was] targeted by having a complaint made about me for politely raising concerns regarding patient confidentiality during Prevent training. Several White doctors made similar comments and no action was taken against them .... I was too frightened and concerned about my career progression to take things further, particularly in the current virulently Islamophobic climate. I never imagined something like this could happen to me. I no longer feel safe at work, cannot trust my colleagues, and would leave medicine/the NHS completely if I had alternative employment."
> **(Consultant, Indian, England)**

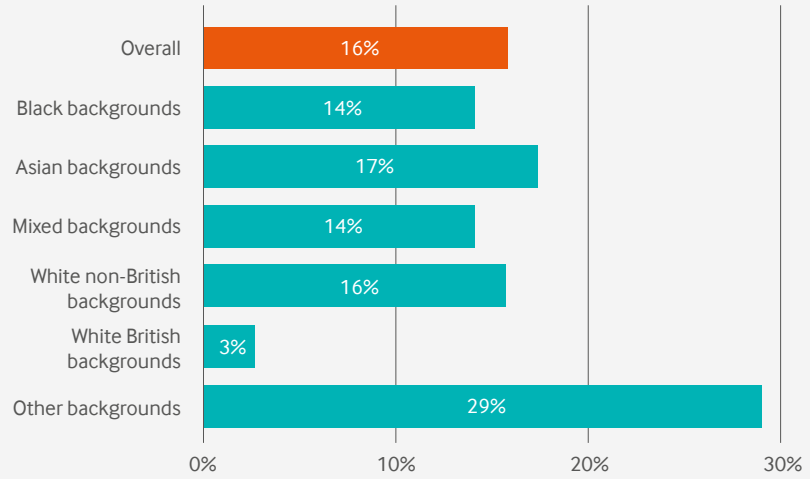
A number of respondents mentioned adverse impacts on their physical health. Symptoms mentioned by respondents included aggravated blood pressure and diabetes, weight gain, weight loss, heartburn, mouth ulcers, headaches, migraines, hypertension, and back pain. Many respondents mentioned insomnia and other sleep issues.

> "I have noticed I'm suffering from more physical ailments in the past two years when I was a perfectly healthy person all my life."
> **(Consultant, Asian, England)**

Some respondents described how their experiences of racism at work had affected their personal lives, sharing examples of feeling unable to stop thinking about work at home and having relationships with family and friends affected. A small number of respondents mentioned suicidal thoughts. Some respondents noted that they were receiving counselling and/or psychological support to deal with their experiences.

Impact of racism on sick leave and taking time off work

In the past two years, have you taken sick lave or time off work due to racism in your workplace? (n=849)



16% of all respondents said they had taken sick leave or time off work due to racial discrimination. 29% of respondents from other backgrounds, 17% from Asian backgrounds, 16% from White non-British backgrounds, 14% from Black backgrounds, 14% from Mixed backgrounds, and 3% from White British backgrounds said they had done so.

Respondents who gained their primary medical qualification overseas were twice as likely to say they had taken time sick leave or time off work due to racism, with 20% saying this compared to 11% of UK qualified respondents.

Examples of good practice

Respondents offered a range of examples of actions that their workplaces have taken to promote race equality and positive working environments.

Opportunities for safe and open discussions

Respondents felt that creating space for open and honest discussion was important to build understanding. Many stated that it was important for everyone to feel comfortable asking questions and learning about one another's cultures and religions. Some respondents found Schwartz rounds particularly useful to share their experiences with colleagues.

> "Open conversations. Particularly when seniors will ask openly about how they can help or better understanding of racial/cultural differences, e.g. consultant having no understanding of Ramadan, but asking for more information, so that he could better understand and accommodate the needs of those fasting."
> **(Locum junior doctor, Mixed, England)**

> "Regular informal coffee mornings with the team; so that we can talk about our cultures and personal experiences in a safe space."
> **(Consultant, Black, England)**

> "When staff and patients openly discuss their presumptions, e.g asking me whether Diwali is the same as Eid, conversations as simple as this allow incorrect assumptions to be openly corrected and for the individuals to build a better understanding and cooperation."
> **(Medical student, Indian, Wales)**

> "Having members of staff who may not be part of an ethnic minority but are willing to have conversations about this and treat your experiences as valid."
> **(Medical student, Asian British, Northern Ireland)**

Respondents felt that social events and opportunities to socialise outside of the workplace were an important way to break down cultural barriers and to learn more about one another. However, they emphasised that these events needed to be inclusive. For example, social events should not be organised solely in pubs or venues that are centred around alcohol consumption.

> "In our hospital dept, we work as a team and are always inclusive, ensuring colleagues regardless of race or background are invited to social work events."
> **(Consultant, White non-British, England)**

Supportive managers and senior colleagues

Some respondents mentioned having senior colleagues who listened to their experiences and others positively described examples where senior colleagues had not dismissed their concerns.

> "My foundation programme director made sure I was treated equally in the workplace. She spoke to me along with my clinical supervisor on multiple occasions to make sure I felt comfortable and for that I am grateful. It made a big difference."
> **(Locum junior doctor, Black, Northern Ireland)**

> "When consultants stand up for you and don't take the side of racist patients just to please them."
> **(Junior doctor, Indian, England)**

Respondents also spoke about the importance of a diverse leadership team, with many feeling that workplaces with a diverse leadership had lowered incidents of racism.

> "In hospital where you have mixed representation of different ethnicities at the top I will argue that racism often is less there."
> **(Junior doctor, Black African, England)**

> "Our clinical lead makes positive and encouraging comments to celebrate important dates for different religions and it is obvious that our recruitment has been inclusive with more than half of the group having grown up overseas."
> **(Consultant, Mixed ethnic background, England)**

> "The trust I am currently with has more BAME consultants and hence I feel more comfortable. My supervisor has a pro immigrant poster in his office, in full view of webcam meetings."
> **(Junior doctor, Asian, England)**

> "The Medical Director has made a big issue of racism which has decreased the amount of in your face type of racism, not necessarily because the attitude of the people involved has changed but due to fear that if it raised up, there might be repercussions from the director."
> **(SAS doctor, Indian, England)**

Recognising and celebrating cultural events

Some respondents described examples of their workplaces recognising and celebrating cultural and religious festivities at key dates. This included offering flexible working around fasting times and widening the selection of food in the canteen.

> "My current hospital celebrated Diwali recently with a themed menu in the canteen which I felt was a good attempt at inclusivity. It highlighted that this celebration was happening for some ethnic groups and it allowed those of us who do not share the same beliefs to be aware and understanding towards colleagues."
> **(Junior doctor, White non-British, England)**

> "One of my colleagues is a practicing Muslim and has had her hours adjusted during Ramadan to allow her to sleep around her fasting times."
> **(Medical academic, White English, Scotland)**

Learning events and training

Respondents had mixed views about the value of equality and diversity training. Specialised training courses, such as the STEPs course for GPS in Scotland, were regarded highly. Some respondents felt that events and training were a positive way to share information between colleagues, encourage anti-racist behaviour, and to raise awareness of ethnic inequalities in health outcomes.

> "My specialty in my deanery has organised excellent teaching/ learning events about race inequalities for us which have been really useful. My colleagues have taken up national leadership roles in this field and help share information with their colleagues (e.g. me). Inequalities in health outcomes (in O&G) is also something we are talking more."
> **(Junior doctor, White Scottish, England)**

However, others felt that lectures and events had little benefit because those who attended generally already had an interest and understanding of racism and discrimination, while perpetrators of racism did not engage with these events. A small number of respondents believed that they did not need to have training because there were no ethnic minority doctors in their team.

> "My team is all white so there have been no training events on this issue."
> **(Consultant, White British, Scotland)**

Some respondents had mixed feelings, noting that that these events were used as a way for organisations to look as if they were dealing with racism without tackling the root of the issue, but that they also provided an opportunity for ethnic minority healthcare workers to share their experiences.

> "Whilst I think a lot of anti-discrimination talks are just talk and often an institution's way to feel better about themselves, it is nice to have them as reminders and to encourage POC [People of Colour] to talk up about their experience, as well as showing the frustration and issue of micro aggressions."
> **(Medical Student, Mixed, Scotland)**

Social movements and collective action

Some respondents noted that social movements, particularly the Black Lives Matter movement, gave them the courage to speak out about racism.

> "The culture shift due to the BLM movement has cracked down on racism incidents and this needs to be encouraged whilst also encouraging people to safely discuss prejudiced views without repercussion so they can be corrected"
> **(Medical student, Indian, Wales)**

> "I have started openly discussing race, the issues I face day to day and its impacts with my White colleagues. I used to believe I had to keep these issues quiet, but the BLM protests gave me to confidence to be open about it. I had made sure my White colleagues have an awareness, if not full understanding, of these complex issues and how it impacts us and patients."
> **(Junior doctor, Black British, England)**

A number of respondents responded that their workplace had established staff networks for ethnic minority staff. They described that participating in these networks allowed them to share their experiences, support and mentor more junior colleagues, and push for positive change in their workplaces.

> "I have become a co-chair of my local BMA BAME network and have liaised with my Medical Director around how best to support ethnic minority doctors in the workplace."
> **(Junior doctor, Black African, England)**

> "I am an active senior doctor promoting cultural diversity in NHS with my academic work and educational modules. I see casual racism every day at work. I have not been able to stand up against it due to fears of career progression. But I am not afraid anymore. I have overcome my fear and will be very open and vocal."
> **(SAS doctor, Asian, England)**

Institutional policies and processes

Respondents described several policies and practices that they felt helped to tackle racism in their workplaces. These included campaigns against racist abuse within their trust, race action charters, equality and diversity strategies, and zero tolerance policies on racism. However, they noted the importance of support from senior leaders in implementing these policies and campaigns.

Respondents also noted the importance of inclusive recruitment and hiring processes. Examples included widening participation for student entry to medicine, recruitment initiatives, equal opportunity hiring for management roles, and open and transparent selection processes.

Some respondents noted that practical changes such as name badges, providing disposable hijabs, and local language signs could be used to create a more inclusive working environment.

> "Name badges. Sounds silly but these were not given out as standard to doctors in my trust. Once people could see what name I preferred to be called, there was no mispronunciation or forgetful issues. This broke that awkward first barrier and allowed normal conversation to resume."
> **(Junior doctor, Asian British, England)**

> "Implementing disposable hijabs for hijab wearing Muslim women creates an easier environment for Muslim women to navigate. In Wales, phrases of commonly used terms in Welsh being put up around the hospital for staff to learn and make Welsh speaking patients more comfortable are a great initiative."
> **(Medical student, Pakistani, Wales)**

Bystander intervention

Some respondents described situations where a racist behaviour from colleagues or patients had been effectively challenged by a colleague, or where they had challenged behaviour on behalf of a colleague. Some respondents developed practical anti-racism and bystander training in their workplaces to teach colleagues how to address incidents of racism, which received positive feedback. Respondents generally favoured bystander training over unconscious bias training, as they felt it had greater practical use in their workplace.

> "On appointment committees, there was one secretary who was designated to introduce the candidates as they walked in the door. If a candidate has a foreign name she would always mispronounce it and then laugh. When this was pointed out her she stopped doing it."
> **(Consultant, male, White non-British, England)**

> "The patients appeared more understanding and trusting of their doctor (who was foreign) once I told them they were good at their job and that their race/nationality has no bearing on their ability."
> **(Junior doctor, White Irish, Northern Ireland)**

Effective responses to racist patient behaviour

Some respondents described how their workplaces had effectively responded to racist patient behaviour. Examples given included sending warning letters to racist patients and removing patients from the premises when appropriate to do so.

> "A strict intolerance towards patients who demonstrate racist behaviour. Senior staff members who have treated racism as equivalent to physical abuse are making positive changes in the working environment."
> **(Junior doctor, Asian, England)**

Occupational and mental health support

A small number of respondents attended occupational health support, therapy sessions, or training to help them to deal with the impacts of racism.

> "Occupational health support and regular Cognitive Behavioural Therapy sessions."
> **(Consultant, Indian, England)**

> "I am scared that managers and a colleague will try and make fake complaints against me. I took meditation classes and attended resilience courses to withstand the attack."
> **(Consultant, Indian, Wales)**

Appendix 1 – Demographic breakdown of respondents

There were 2030 survey respondents in total.

Gender

50% of respondents were women, 47% were men, 0.5% were non-binary and 2.5% preferred to self-describe or not say.

Ethnicity

Respondents were given a choice of 24 categorisations, including 'other' categories and free text options. 34 respondents in total chose to leave the question blank. Following preliminary analysis to confirm that there were no significant differences between categories, these categories were combined into aggregate groups. Aggregated findings have been presented in this report to allow for comparative analysis.

Asian	45%
White British	26%
Black	10%
Other	6%
White non-British	6%
Mixed	5%
Prefer not to say	2%

Disability

20% of respondents had a physical or mental health condition or illness that has lasted or is expected to last 12 months or more. 15% of that group identified as disabled. 60% of respondents said that their condition or illness had a negative effect on their ability to carry out normal day-to day activities.

Religion

Christian (including Catholic, Protestant and all other Christian denominations)	27.5%
No religion	24.4%
Muslim	19.5%
Hindu	17.6%
Prefer not to say	5.1%
Jewish	2.8%
Buddhist	1.8%
Sikh	1.3%

Place of Primary Medical Qualification (PMQ)

49% percent of respondents gained their PMQ in the UK, while 51% gained their PMQ overseas.

Sexual orientation

87.5% of respondents identified as Straight or Heterosexual, 2.9% as Gay or Lesbian, 3.5% as Bisexual, 0.9% had another sexual orientation and 5.2% preferred not to say.

Main country of work

74.7% of respondents said England was their main country of work, 13.6% said Scotland, 6.8% said Wales and 2.4% said Northern Ireland. 2.6% of respondents said Other.

Age

25 and under	16.4%
26 to 35	22.4%
36 to 45	21.0%
46 to 55	22.7%
56 to 65	13.1%
66 to 75	2.3%
76 and over	0.9%
Prefer not to say	1.2%

Branch of Practice

Consultant	33.1%
Medical student	17.1%
Junior doctor – Specialty Registrar (Core/Higher Specialty trainee)	12.0%
Staff, Associate Specialist and Specialty doctor (SAS)	10.6%
GP contractor/principal	5.5%
Trust employed/trust grade doctor	4.0%
Junior doctor – Foundation years trainee	3.9%
Salaried GP	3.6%
GP trainee	3.0%
Other	2.4%

	Overall	Black backgrounds	Asian backgrounds	Mixed backgrounds	White British backgrounds	White non-British backgrounds	All other backgrounds
Assumed to be in a more junior role	**35%**	58%	48%	34%	7%	30%	38%
Derogatory comments/behaviours	**33%**	54%	44%	35%	7%	31%	42%
Being ignored or socially excluded from conversations, communication, or group activities	**32%**	52%	44%	34%	5%	30%	40%
People have made assumptions about your character based on stereotypes	**32%**	50%	42%	36%	7%	31%	41%
Having your clinical ability or professionalism doubted	**31%**	54%	46%	37%	6%	33%	40%
Having your work overly/unfairly scrutinised	**31%**	48%	44%	35%	4%	22%	36%
Being disproportionately asked to do specific tasks	**30%**	45%	44%	30%	5%	19%	33%
Humiliated, degraded, or offended	**29%**	44%	38%	33%	6%	27%	40%
Receiving poor/little feedback	**28%**	41%	40%	40%	5%	21%	32%
Continued mispronunciation of your name	**27%**	40%	39%	28%	4%	24%	29%
Bullying	**26%**	37%	37%	22%	5%	22%	34%
Being asked invasive questions about your personal life	**27%**	40%	30%	34%	4%	26%	29%
Physical attack or threat of violence	**9%**	8%	13%	9%	2%	8%	13%
Unwanted physical conduct	**8%**	12%	10%	9%	1%	8%	14%

Appendix 2 – Responses by ethnic group and country of qualification

	Overall	UK Qualified	Overseas Qualified
Assumed to be in a more junior role	**35%**	28%	54%
Derogatory comments/behaviours	**33%**	29%	48%
Being ignored or socially excluded from conversations, communication, or group activities	**32%**	22%	51%
People have make assumptions about your character based on stereotypes	**32%**	27%	46%
Having your clinical ability or professionalism doubted	**31%**	27%	52%
Having your work overly/unfairly scrutinised	**31%**	21%	52%
Being disproportionately asked to do specific tasks	**30%**	23%	48%
Humiliated, degraded, or offended	**29%**	22%	46%
Receiving poor/little feedback	**28%**	19%	46%
Continued mispronunciation of your name	**27%**	23%	38%
Bullying	**26%**	20%	43%
Being asked invasive questions about your personal life	**24%**	22%	32%
Physical attack or threat of violence	**9%**	8%	13%
Unwanted physical conduct	**8%**	7%	10%

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