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

Ballafletcher Pavilion, Hospital Approach Rd, Strang, IM4 4RS

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
144.22	**Welcome & apologies**	Chair	Verbal	9:30
145.22	**Declarations of Interest**	Chair	3	9.35
146.22	**Minutes of the meeting held in public** *- 1 September 2022*	Chair	7	9.35
147.22	**Matters arising/Review of Action Log**	Chair	24	9.40
148.22	**Notification of any other items of business**	Chair	Verbal	9.40
149.22	**Restoration and Recovery Update** - **Mr Hutchinson and Mr Baird to Present**	Dir of Operations	Verbal	9.45
150.22	**Board assurance framework for 2022-2023** - **Risk 6 Failure to Achieve Financial Stability**	TC/NW	To follow	10.05
	UPDATES			
151.22	**Chair's report**	Chair	25	10.30
152.22	**Chief Executive's report and horizon scan** - Feedback from Association of Peri-operative Practitioner Inspection - ENT Action Plan – Update - Update on Information Governance – progress against October Milestone plan - Update on Winter Planning - Integrated Care Partnership Committee update - Feedback on Inaugural Risk Management Committee	CEO Dir of Ops Dir of Ops CIO Dir of Ops CEO CEO	26	10.45
153.22	**Committee Chairs' Exception Reports** - QSE – 18 October 2022 - FP&C – 13 October 2022	Comm Chairs	72	11.00

PRIORITY ONE – PATIENT SAFETY				
154.22	**Integrated Performance Report** - Exception report and progress update on the plans to publish waiting time information	Dir of Operations	To follow	11.15
155.22	**Quality Dashboard**	Dir of Nursing	78	11.25
156.22	**Independent Review of Self Neglect**	Dir of Social Care	84	11.40
157.22	**Review of Respite Provision**	Dir of Social Care	135	11.50
REFRESHMENT BREAK 11.10AM				
158.22	**CQC Inspection**	Dir of Nursing	Verbal	12.00
159.22	**Workforce and Culture Update** • Progress against Culture of Care Barometer Action Plan • Update on Pay	Dir of OHR	Verbal	12.15
160.22	**Finance Report:** - **September 2022 Management Accounts**	CEO	143	12.25
ANY OTHER BUSINESS				
161.22	**With prior agreement of the Chair**	Chair		
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	12.30
DATE OF NEXT MEETING TO BE HELD IN PUBLIC: 10 January 2023				

Register of Directors' Interest
26 October 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 was 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	
Tim Bishop	Non-Executive Director	Direct Financial interest	Director / Shareholder Wellingham Partners Ltd consultancy	Apr-16		x	
Tim Bishop	Non-Executive Director	Direct Non-Financial interest	Unremunerated Chair and Trustee of St Martin of Tours Housing Association	Jan-22		X	
Tim Bishop	Non-Executive Director	Professional	Remunerated member of Assurance Committee Professional Record Standards Body	Nov-20		X	
Tim Bishop	Non-Executive Director	Direct Non-Financial	Unremunerated Vice Chair and Trustee Camphill Village Trust	Jan-18		X	
Tim Bishop	Non-Executive Director	Professional	Registered member: Social Work England	Aug-12		X	

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	
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 – Assigned to Manx Care	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	Financial	Partner, Laxey Village Practice	Sept 18	Dec 20	X	

	Care						
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				
Aneurin Pritchard	Director of Infrastructure	Nothing to declare	Nothing to declare				
Elaine Quine	Board Secretary	Nothing to declare	Nothing to declare				

BOARD OF DIRECTORS
Thursday 1 September 2022
Ramsey Town Commissioners, Town Hall, Ramsey
9.30am-12.30pm

Present:

Non-Executive Directors

Andrew Foster (AF)	Chair
Sarah Pinch (SP)	Vice Chair
Tim Bishop (TB)	Non-executive Director
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
Anne Corkill (AC)	Director of HR Business
Elaine Quine (EQ)	Board Secretary
Oliver Radford (OR)	Director of Operations
Richard Wild (RW)	Chief Information Officer

In Attendance:

Jane Wolstencroft (JW) Deputy Board Secretary and Minute Secretary

Apologies

Aneurin Pritchard (AP) Director of Infrastructure

GOVERNANCE

Item **Action**

125.22 A Public Apology to the Isle of Man 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 the attention of AF 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 stated 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 was simply inaccurate. The Chairman wished to make clear

that the Information Commissioner has not made any clinical judgements whatsoever.

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

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

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"

AF, on behalf of the Board of Manx Care, offered his sincere and unreserved apologies to the Information Commissioner for this error. He expressed thanks to the Information Commission for bringing the error to his attention and for providing the opportunity for the minute to be corrected.

Welcome and apologies
AF welcomed everyone to the meeting. Apologies had been received from Aneurin Pritchard.

AF introduced TB to the meeting.

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

127.22 Minutes of the Board meetings held on 24 May 2022 (public)

The minutes of the meetings held on 24 May 2022 (public) were accepted as an accurate record subject to a minor correction at minute ref 119.22 regarding the Association of Hospital Managers.

128.22 Matters Arising and Review of Action Log
There was one matter on the action log which had been completed.

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

130.22 Board Assurance Framework
There had been no change in the risks or associated ratings since the previous meeting. It was agreed that a deep dive on an individual risk be presented to each meeting going forward. **Bd Sec**

UPDATES
131.22 Chair's Report
AF expanded upon the wealth of experience TB would add to the Board, most notably his experience in social care. He reflected upon the non-executive Director's visit to the Tall Trees facility and to Greenfield Park where they had the opportunity to meet with colleagues and service users.

132.22 Chief Executive's Report and Horizon Scan
<u>Covid -19</u>
The autism booster campaign would commence on 5 September.

<u>Information Governance</u>
A non-compliant information governance position had been inherited from the DHSC which included outstanding enforcement notices. In conjunction with Transformation a considerable amount of work had been undertaken to understand the size and scale of the issues that existed and KPMG review had undertaken a full review and produced a report with several recommendations. The requirement for additional resources had been identified along with several development work streams. It was likely that the work streams would take approximately 18 months to deliver. An Information Governance Advisory Board has been established as well as the roll out of the NHS Data Security and Protection Toolkit

(DSPT) and it was hoped that compliance with the toolkit would be achieved by June 2023. Additional posts were also being recruited for. A penalty of £170,500 in respect of a data breach that occurred during 2021 had been received. A full public apology for the breach had been made at the time the breach occured and TC reiterated her regret for the breach and to the people that had been affected. The Information Commissioner has decided to stay payment of the penalty until 31 December 2022. That stay was dependent on Manx Care demonstrating that it has implemented appropriate technical and organisational measures by 31 December 2022. Failure to do so would mean that the penalty would become payable. A detailed plan had been submitted to the Information Commissioner as to how Manx Care would achieve compliance regarding secure e-mail and associated actions and the ICO had given early indication that the plan was acceptable.

Provision of Community Pharmacy Services

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. This was done with very little notice on 1st June 2022. This was exacerbated further when Lloyd Pharmacy ceased their service to the Isle of Man prison from 4th July with one week's notice. The closure had a significant impact on the service provided to patients in the north of the Island and to the Ramsey Group Practice. There was insufficient legislation to prevent pharmacies closing at short notice and Manx Care were working with DHSC to make the relevant changes to the legislation. TC paid tribute to Maria Bell and the Manx Care pharmacy team who were able to divert resource to ensure the continuation of the provision of pharmacy services. St Paul's pharmacy re-opened on 1 August and Manx Care were working with Lloyds to strengthen the contract until the changes in legislation could come into effect. It was intended that Lloyds contract would be updated so that there was assurance of delivery and oversight of a business continuity plan. TC pointed out that Manx Care were not obliged to step in to provide pharmacy services but in order to protect provision in the North of the Island the correct decision was taken. Manx Care would work more closely with pharmacy providers going forward to provide more resilience should a similar situation occur. There was commitment by the DHSC to do all it could to bring the legislation changes forward and it was hoped that an emergency slot could be identified.

DHSC Department Plan

The DHSC Department Plan was noted. TC stated that Manx Care had contributed to the report and would continue to have dialogue with the department regarding how the priorities in the plan translated to the mandate and in particular the objectives that currently did not have associated funding streams.

Manx Care 2021/22 Annual Report

The report was a performance review of the first year of Manx Care and would be submitted to the DHSC for a formal response and the report and the response would be laid before Tynwald. TC commented that the first year of Manx Care was one of discovery and many deficits had been unearthed which would need to be corrected to provide the health service that adequately serves the needs of the Island. The baseline that had been presented at the commencement of Manx Care was not entirely accurate which corroborated with Sir Jonathan Michaels interim review where he highlighted that the challenges that Manx Care faced were much greater than he had anticipated in his original report. The focus for the past 12 months had been to improve quality and safety and the progress made was evidenced by the papers being presented to the Board. Manx Care acknowledged the difficult financial position it was in but remained committed to continue to improve financial balance.

Accordingly the 2021/22 Manx Care Annual Report was approved.

Cost of Living Crisis

It was noted that staff shortages were affecting all aspects of Manx Care and it was difficult to attract workers to relocate to the Island. It was queried in the context of the current cost of living crisis what was in place to assist staff. TC stated that there was nothing currently in place however she had attended a Chief Officer Group meeting and this was high on the agenda and Manx Care was in discussions with wider Government to see what could be put in place. The Chief Minister had talked about emergency packages and this would be kept under review as it was acknowledged that staff may need assistance with basics such as heating and food. TC would provide an update to the next Board. SS added that a group had recently been established to look at rising energy costs in particular as service users have been returning equipment required for their health as they are unable to afford to us them at home.

133.22 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 26.07.22)

The report was noted. There were no additional comments.

Digital and Informatics Committee Update (re meeting on 12.07.22)

KK made the following observations:

- Audit reports were now being received on clinical coding which was good progress
- There was good cross-functional input at the Manx Care Record Advisory Board
- Additional funding had been secured for IG resource in accordance with the KPMG recommendations
- Secure e-mail would be rolled out effective from 1 September
- There remained concern regarding the level of shared service performance as no reports had been made available although the Committee had been assured that a web based portal was being developed. The Committee was keen to receive assurance that the IT services provided were supporting patient care quality and safety.

People Committee Update (re meeting on 12.07.22)

SP made the following observations:

- Staffing shortages remained the largest concern
- The BMA Racism in Medicine had been considered and the Committee recommended that implementation of the Workforce Race Equality Standards be introduced
- The BMA Barometer of Culture results and action plan were reviewed
- 37 colleagues had volunteered to become change champions

The remaining Committee Chair's reports would be considered under the corresponding agenda item.

PRIORITY ONE – IMPROVING PATIENT SAFETY

134.22 Integrated Performance Report (IPR)

The IPR continued to improve and a focus would be on producing a dashboard summarising the key performance indicators with the underlying data sitting behind.

OR made the following specific observations:

- Bespoke reports for care groups would be produced going forward
- Limited success had been seen in offering outpatient appointments within 6 weeks. There had been an increase in cancer referrals that had to be seen within 2 weeks and these took priority
- Clinical capacity had been reduced as locums were not being used to cover doctors holiday and sickness leave and this was necessary to reduce costs
- The access policy was being rolled out so patients could ring in and arrange appointment times convenient to them under the partial booking system. Patient led follow up where the patient could decide whether a follow up appointment was necessary was being trialled. A pilot would be rolled out in orthopaedics
- Several specialities were receiving additional funding under the restoration and recovery programme and as a result waiting lists were beginning to reduce
- Dental waiting lists continued to decrease and a plan to have the waiting list cleared by year end was on track

OR reflected that many patients may not have seen tangible improvements in the service provided by Manx Care but he was confident that with ongoing improvements in clinical and operational governance, improvements would become visible.

The Chairman queried when the IPR data for the previous month would be available. OR confirmed that automated reports were being progressed and could be run on the 1st of each month. The two most complex care groups already had this reporting framework and whilst there was still work to roll out to the remaining care groups, he was confident that prior month reporting would be available for the next public Board meeting in November. TB added that it was important that data on outcomes was also made available to the Board.

KK queried why there was disparity within theatre utilisation. OR stated that this was due to theatre use by Synaptik under the restoration and recovery programme. Synaptik organised their work in blocks so the theatres could be at full capacity for several days whilst they were on Island. He continued that staff shortages in anaesthetics remained and that also affected theatre utilisation. The anaesthetists that had been subject to criminal charges earlier in the year, which had since been dismissed, remained at work however they required additional support to return to full capacity. It was noted that none of those involved were subject to any professional or regulatory sanction. Manx Care would continue to support them to return to full time practice.

AG queried whether there was a common factor in the 'did not attend' rates. OR replied that people continued to be asked not to attend any hospital building if they were suffering with covid and this was the predominant factor. The TT festival road closures had also impacted. As discussed earlier in the meeting it was hoped that patients being able to make their own appointments using the partial booking system would significantly reduce the 'did not attend' rates. There was also a validation programme to validate the current waiting lists. It was hoped that booking appointments closer to the appointment dates would also improve did

not attends. This was being monitored by the FP&C Committee under the roll out of the access policy.

AG queried why there had been four black breaches in ambulance data during the reporting period. OR replied that in June there had been an increase in both ambulance and ED demand. The ED capacity was based on approximately 18,000 attendances per annum however the current figures were between 38-40,000 per annum so often each room in ED was full and there was no free space to hand over an ambulance patient. ED was being redesigned to develop an ambulance handover bay which would hopefully alleviate the situation. TC added that patient safety when ED was full was a priority and a full capacity protocol was in place and was implemented as soon as ED was reached capacity.

AG sought assurance that the required 10 point reporting framework required by the DHSC would not be in addition to the reporting produced for the IPR. OR stated that initial discussions on the required reporting under the single oversight framework had been collaborative and a sub-set of the IPR data could be used to satisfy the reporting requirements. It had been disappointing that the collaborative approach appeared to have slipped however OR believed Manx Care would continue to gain traction so that reporting from the IPR could be used to satisfy the Single Oversight Framework and the Mandate Objectives to the DHSC. It was in neither party's interest to have unnecessary duplication. AG observed that whilst reporting in prescribed formats was a necessity, it was essential that it did not become burdensome.

Director of Social Care Update

SS stated that there had been an issue with the coding in Adult social care and children and families which had resulted in the absence of data for the past four months. She had been assured by the BI team that this was being resolved and the automated dashboard would be available by the end of October. During June no child protection conferences had been held within the agreed time and this was largely due to road closures and availability of police due to the TT festival which was a concern. There would be improved planning for 2023. Adult Social care KPI's were being developed and would continue to be improved upon. SS extended her thanks to colleagues working in care and nursing homes for their resilience since the pandemic. There had been some initial inspections of facilities by the CQC and whilst there had been some concerns raised regarding the environmental issues there had been no concerns raised regarding the quality of care.

135.22 Quality Dashboard

QSE Chair's Committee Report

SP made the following observations:

- She had spent the previous morning with the obstetrics and midwifery team and the reality of staff shortages were abundantly clear
- There had been a little engagement from the ENT consultants following the ENT review which had been disappointing. This would be followed up at the next Committee meeting
- The Ockenden recommendations could not be fully implemented but a maternity strategy was being developed in conjunction with the Royal College of Midwifery
- During the course of the first year of Manx Care the staffing and safety issues had been much greater than initially believed
- The quality dash Board continued to improve
- The theatre improvement plan continued to progress
- A meeting had been held with representative of MCAL's and the non-executive Directors the previous day and 87% of people who ring have their issues dealt with to

their satisfaction within 24 hours which was excellent

Quality Dashboard Review

PM had developed the dash Board which was a series of key performance indicators based upon the CQC's key lines of enquiries. The dashboard required further development however during the course of the year PM had built up sufficient data sets so provide the Board and colleagues with a picture of the safety and quality of care that was being delivered. The indicators that demonstrated Manx Care was good and improving outperformed those that had not improved by a ratio of 2:1. Whilst this was broadly positive, it also demonstrated that Manx Care was not perfect. Staffing constraints would always impact on quality and safety but progress was being made. AF congratulated PM on the development of the dashboard. He queried how the most serious issues were identified and escalated and whether there was a system in place to address both. PM confirmed that a mechanism to escalate was in place. He added that it had been a difficult process to compile the data as often the data did not exist and, where it did, it could not be relied upon for accuracy. Many data repositories were unreliable. Benchmarking was in place for metrics where possible and where it was not possible, a tolerance would be applied. Any issues would be escalated via the Operational Care Quality Group and the QSE. The quality challenges remained huge and it was essential that prioritisation continued as it was not possible to fix everything at once. The intelligence form the dashboard and the outcome of the CQC inspection would influence the Board's decision when considering quality priorities. Further work was required on complaints as it was essential that the nature and outcome of complaints was known in order to feed into the Board strategy. It was essential that the data included in the dashboard was meaningful and PM would continue to improve. PM reflected that whilst the complaints data was not a surprise to him, it required improvement. It was noted that it had been necessary for several colleagues and himself to return to front line nursing duties due to staff shortages as patient safety was always the priority.

TB queried what action was being taken to address the lack of training in safeguarding which was currently rated red. SS confirmed that training had been arranged and would take place in October to ensure that all colleagues were trained to the appropriate level. This had been documented in the required Outcomes Framework.

136.22 Nursing Workforce Update

PM described the very difficult process he had undertaken to obtain a true picture of the nursing establishment. Basic information regarding headcount, vacancy rate, acuity and dependency had been unknown when he came into post. He reiterated that staffing remained the biggest threat to the success of Manx Care achieving its goals but it could also provide an opportunity if overcome to improve the standard of care. Many of the financial challenges were caused by extremely expensive bank and agency staff. If the planned international recruitment delivered by year end the situation would be vastly improved however that did not help with the current situation. It was PM's recommendation that international recruitment be continued as a strategy as it was the only way the work force could be increased quickly. PM outlined the subtle but important impacts of staff shortage such a deteriorating patients being ineffectively monitored. The lack of demand and capacity modelling was also hampering the ability to devise a strategy and have meaningful workforce planning. During July staffing levels were much lower than was would be expected for the activity that had taken place. Counter measure such as agency staff, redeployment had been put in place to mitigate but some departments such as ED and maternity remained particularly vulnerable. PM could not provide assurance that staffing levels were safe, he could however assure the Board that when staffing levels became unsafe every possible step was taken to ensure that patient were safe. This often resulted in appointment cancellations which whilst disappointing was unavoidable. It was essential the production of local

registered nurses was prioritised as continued international recruitment was not a sustainable model. 50% of the Pilipino workforce recruited had left during the year and PM would confirm the reasons for this. PM would bring a report back detailing options to increase domestic production of nurses in due course. AF observed that workforce England had estimated that in 15 years time, whilst the general population would not have increased significantly, the amount of population over the age of 80 would have and this will further impact service demand and corresponding workforce. It was essential that other solutions such as community care, promotion of self-care and technology solutions were also considered in order to close the gap. SS concurred and added that the situation was similar in social care and an integrated skills academy model should be considered. It was acknowledged that the work undertaken by PM regarding nurses would need to be replicated across social care and allied health professionals so a complete picture of future workforce was known. There was a discussion regarding service sustainability on Island as the current model, if it were to be fully staffed, would likely be unaffordable. It would be necessary to redesign the current clinical delivery models operating within Manx Care and not transforming services was not an option. JL added that as part of the work of the CIP programme there was a focus on what services could be delivered with the current level of resource. This would be developed further to include workforce planning as part of the CIP programme.

It was noted that the recommendations within the report were accepted and AF reiterated his request for a report on wider workforce planning to be submitted in three months time. **PM**

137.22 Safeguarding Structure Update

The report advocated an integrated Manx Care approach to make the best use of current and developing resources. The initiative would be the first step to develop further into a Multi-Agency Safeguarding Hub (MASH) on the Island which would see greater alignment with the constabulary and other stakeholders. The MASH has a multi-agency commitment and it was planned that the co-location would be established by June 2023. Colleagues from Manx Care and the IOM Constabulary would visit Liverpool in early September to review the safeguarding approaches and develop an understanding of operation Medusa which was an operation set up between Merseyside and Dorset police Officers as a joint operation, led by Merseyside Police to tackle county lines drug dealing and child criminal exploitation. SS would become the system lead for safeguarding across Manx Care and she would be responsible for designing and implementing the appropriate quality assurance framework to support colleagues in this work and to provide the necessary assurance to the Board via the QSE Committee. A business case had been developed for additional safeguarding resource and work was ongoing with the POCN to identify a lead GP for safeguarding.

Accordingly the following requests were approved:

- The creation of the Manx Care Integrated Safeguarding Team.
- The Executive Director of Social Care develops the appropriate quality assurance framework to support colleagues in this work and to provide the necessary assurance to the Board via the Quality, Safety & Engagement Committee.
- Approves the further development of the MASH
- That full plans of the MASH development are brought to the next Board meeting, setting out timescales and project milestones

138.22 Restoration and Recovery Update

OR stated most of the phase one activities were winding down and he outlined the numbers of operations that had been carried out in conjunction with Synaptik. Minds Matters had also been engaged to provide therapeutic pathways. The engagement with Medefer had not

been as productive as had hoped but all issues had been raised with Medefer and agreed way to move forward had been reached. The phase two Restoration Business Case detailing Manx Care's proposed plan to reduce the three largest inpatient waiting list namely Orthopaedics, General Surgery and Ophthalmology has been discussed by Manx Care, Treasury and DHSC colleagues at a meeting chaired by the Treasury Minister, on Wednesday 3rd Aug 2022. An interim funding envelope to allow the R&R programme to continue at the current pace has been requested and it was hoped that a decision would be reached today. The full business case requiring Tynwald sign off would be heard after the summer recess. The phase three business case focussing on outpatients was also being developed which would also address funding to bridge historic funding gaps and referral to treatment which was a mandate objective. JL queried what additional work was ongoing to ensure the waiting list position did not decline once the third party providers fell away. OR explained that demand and capacity work was ongoing to discover what areas were oversubscribed and what areas were in deficit. Robust performance trackers were also being developed which would assist consultants to optimise their time management to provide the best value.

139.22 CQC Inspection

The inspection programme was well underway and was moving at pace. It was hoped it would be completed at the end of October with reports issued soon after. This would provide a complete baseline to see where improvements were required and these would be prioritised accordingly. The CQC had made some initial observations and whilst some improvements were required, it was noted that some positive feedback had been received. The areas requiring improvements were no surprise and the Board and the exec team were well versed on what the CQC would likely report on. Many of the areas the CQC had commented on related to the shared service model upon which Manx Care relies so it would be essential to work with all stakeholders once the final report was known as it was likely that changes to the shared service model would be required. The main themes were health and safety, environmental factors such a water quality management, the conditions of premises and the control of substances hazardous to health. OE stated that whilst at the beginning of the process there had been some nervousness amongst primary care colleagues they now welcomed the opportunity to receive the guidance the CQC could provide in order to make improvements to patient care. TC expressed her concern regarding the level of data quality in particular in relation to the well led domain. She queried whether there was anything that could be put in place to improve the situation ahead of the inspection and whether clarity could be provided on what data limitations existed. It was essential that the Board be made aware of data gaps and the quality dashboard rated the quality of most of the data as either low or medium. Risk and performance management would also be inspected and it was acknowledged that there would also be challenges in these areas. It was essential the data that existed was used to make the best decisions possible with robust challenge from colleagues when making those decisions.

PRIORITY TWO – CREATING A POSITIVE WORKING CULTURE

140.22 Social Care investigation, Workforce and Culture Review and Action Plan

SS stated that a major focus of her time had been spent addressing the cultural issues raised anonymously by colleagues in the social care team. An e-mail had been sent in April 2021 which vividly described the poor culture that existed within social care. A number of sessions had been arranged by workforce and culture to give all social care colleagues the opportunity to raise any concerns or observations. A separate independent investigation was commissioned to review the 17 alleged poor behaviours and the investigation concluded that 11 of these could be evidenced. It became apparent that staff were being managed by fear of disciplinary action being taken against them, bullying and micro-management. SS and TC had presented the summary to social care staff via a special 'Lets Connect' session and colleagues were given the opportunity to meet with both TC and SS again to raise any issues or to

provide feedback. Whilst there had been little uptake, several e-mails had been received to thank SS and TC for the work that had been undertaken and to their commitment to ensure that culture reflected the CARE values that Manx Care espouses. There was a minority view that the actions arising from the investigation had not gone far enough however in balancing all factors SS was confident that the correct actions had been taken and she and TC would meet with colleagues to explain the approach. The summary had subsequently been shared with all Manx Care staff and the associated action plan had been circulated. Whilst there was still work to do SS was pleased with progress made and this had been assisted by making further appointments to strengthen the senior social work leadership team by promotion of colleagues within the current team or former colleagues seeking to return. Sylvia Manson who had conducted an independent review in 2020 had returned recently to review progress from her recommendations. Following interviews with staff across social care she had reported good improvements within the culture. SS extended her thanks to colleagues that had been brave enough to raise their concerns to allow the review to take place and to allow the required improvements in social care to be undertaken. A further update would be provided to the People Committee in six months.

141.22 BMA Survey and Action Plan

The survey was conducted in March and the findings were accepted at the meeting in May. The findings were not comfortable but it was essential that it was used as a base line from which to improve. The action plan had been devised in conjunction with the BMA and the clinical Directors and the medical staffing group. The action plan was an iterative document and would be monitored by the People Committee on a monthly basis and quarterly updates would be presented to the Board. Colleagues want to see improvements and it was essential the decisive progress was made at pace. Accordingly the action plan was approved.

PRIORITY THREE – IMPROVING FINANCIAL HEALTH

142.22 Committee Chair's Report – Finance, Performance and Commissioning

NW echoed comments made earlier in the meeting regarding the current heightened global financial pressures. There had been some suggestion that the financial governance within Manx Care was perhaps not as robust as it could be however NW assured the Board in his capacity as the chair of the FP&C Committee that Manx Care's financial position was thoroughly scrutinised on a monthly basis and he was satisfied that the current financial governance was comprehensive and fit for purpose. There had been a clear directive that Manx Care must meet its 2022/23 financial envelope and to do so it was essential that Manx Care became more agile to respond to a rapidly evolving financial landscape. This would involve stakeholders making strategic decisions in a timely manner. There was a plan to bring Manx Care back to balance however its success would depend upon strategic decision making as some services could not be delivered within the current budget. The current forecast predicted a deficit of £9m which whilst unacceptable was not a surprise and NW suggested that the current budgeting process may require a review so that more accurate budget planning could be undertaken. As discussed earlier in the meeting, it was essential that a fit for purpose recruitment and retention strategy was developed so that staff costs could be managed as this was the largest risk to the financial stability of Manx Care. Tertiary costs were also increasing post covid and without strategic change, these costs were essentially uncontrollable to Manx Care. Successful delivery of the back to balance plan would require policy changes that were not within the remit of Manx Care. MIAA were assisting with the Cost Improvement Plan ('CIP') as colleagues were already stretched providing front line services. The 23/24 budget submission had been prepared with input from DHSC however the submission that had been made to Treasury would result in a shortfall of £17m. It was noted that if the funding model recommended by Sir Jonathan Michael had been followed Manx Care would be in considerable surplus in 23/24. A final decision on the budget would

be made in October however the process to date had highlighted a misalignment between Manx Care, DHSC and Treasury and it was essential that this strategic alignment was restored. Furthermore, the Manx Care Act 2021 required all mandate objectives to have an associated funding stream and currently many of the objectives were unfunded. An example of this was the referral to Treatment ('RTT') objective which if it were to be implemented would costs several million pounds and whilst all would welcome the introduction of RTT the money may well be better spent elsewhere.

July Management Accounts

The July Management Accounts were noted. JL explained how by using the DHSC contingency fund and progressing and extending the CIP programme the deficit could be bridged to bring Manx Care back to balance. There were also a range of costs saving measures which would be temporary but could be introduced if it was looking likely that balance would not be achieved. AF concurred and stated that it was the intention of Manx Care to achieve financial balance by year end with the assistance of DHSC and Transformation. It could be achieved easily by closing services and reducing the corresponding staffing costs however this was not possible as 24/7 services had to be maintained.

AG highlighted that achieving a balanced budget and delivering the mandated objectives were two entirely separate matters. JL concurred and stated that prioritisation of services was key and the focus would remain on compliance and safety and that any other items after that, such as the mandated objectives, would likely fall away as there was insufficient funding. PM added that it was essential that the Board fully understood the impact of the decisions taken to ensure that balance was achieved and this should be seen in the post-pandemic era where patients were presenting after having managed their illness during the covid period so were often more acutely unwell and the Board and the wider public must understand the impact these decisions would have. The budget setting process, if unchanged, would result in a similar situation in the coming years and it was essential that future demand and capacity was understood to match to budget. The delivery of the back to balance plan would be scrutinised on a monthly basis by the FP&C Committee with any issues being escalated to the Board as appropriate.

143.22 Any Other Business with Prior Agreement of the Chair

A thank you to Barbara Scott

AF, on behalf of all colleagues at Manx Care, extended his thanks to Barbara Scott who had a long career serving the needs of the Islands patients and service users and extended his best wishes for a very long and happy retirement.

There being no further business the meeting closed.

The Chair invited questions from the public observers.

(Q) Could Manx Care please detail specifically what improvements it has made in the provision GP services in the north of the Island since 1st April 2021.

(A) Ramsey Group Practice continue to provide GP services in Ramsey for the north of the Island, including at their branch surgery in Jurby. Ramsey Group Practice have increased their Jurby provision

from 50% of the working week to 100% of the working week which has been supported financially by Manx Care. The practice have also implemented a new phone system 'Arc' which allows for the queuing of calls and for patients to have access to relevant areas quicker i.e. if calling for test results they would not hold in the queue of people waiting for appointment bookings.

(Q) Could Manx Care please detail specifically what improvements it has made in the provision of hospital services at Ramsey Cottage Hospital since 1st April 2021 and also what services have been transferred elsewhere or terminated during the same period.

(A)There have been no services transferred away from or curtailed at RDCH since 1st April 2021. With regards to improvements, we are constantly seeking to improve the delivery of existing services at RDCH, this includes making improvements in the delivery of the Minor Injuries Unit service, which following a prolonged period of public communication via social media and other channels has seen a significant increase in usage in since April this year. Martin Ward continues to provide rehabilitation and respite services and the ward is consistently covered by a Consultant Geriatrician and specialist doctors. Dialysis continues to be delivered at RDCH making travel for treatment easier for renal patients based in the North of the Island. There are several improvements that are due to be implemented at RDCH in the near future; the Bone Densitometry Service is due to relocate to RDCH from CCHC later this year, the Radiology Department is being upgraded to a digital unit in line with those at Noble's allowing additional specialist x-ray examinations to be undertaken that are currently not offered at Noble's (e.g. whole spine x-rays for managing scoliosis patients and leg length x-rays to assist the Orthopaedic Teams to manage complex lower limb conditions). We are also imminently due to commence building work on the new Phototherapy Suite in the Skin Service (Dermatology and Plastics) which will offer many patients with chronic skin conditions effective treatment. We are also due to have a new Ultrasound Outpatient service in the OPD at RDCH and we are waiting a commencement date from the Lead Sonographer.

(Q) Could Manx Care please detail specifically what steps it has taken since the last meeting in public to alleviate the difficulties in GP provision across the Island.

(A) There have been ongoing recruitment attempts, both through conventional advertising, by GP practices and by Primary Care Services. Additionally we have been investigating specific headhunting routes using UK recruitment agencies. We have implemented and funded a GP retention scheme designed to encourage GPs to stay in practice longer (through financial incentives).

(Q) Could Manx Care please explain how the ambulance service is currently being operated in the north of the Island, how the ambulance station behind Ramsey Cottage Hospital is being manned and used and during any 24 hour period how many ambulances are stationed geographically in the north of the Island to serve the population on an emergency basis particularly in the period between 8pm and 8a.m.

(A) The Ambulance Service provides a 24/7 Emergency Ambulance Fleet of 4 x Double Crewed Ambulance during and 3 x Ambulances at Night.

Ramsey Ambulance Station has currently 1 x Ambulance based there from 07.00 – 19.00 & 19.00 til 07.00 shifts. The vehicle is moved dynamic around the island to provide cover for the rest of the island when vehicles are allocated incidents to attend. The same with Castletowns vehicle heads north when Ramsey goes out.

(Q) Could Manx Care please explain why the blood clinic waiting area at Ramsey Cottage Hospital cannot open half an hour before the clinic ie at 7.30a.m. to spare patients waiting in the wind and rain outside particularly as the winter months are approaching.

(A) Opening the blood clinic waiting area would require the waiting area to be staffed earlier and would impact on the ability to deliver the service and other functions within RDCH over the required hours of operation; if we start 30 minutes earlier to facilitate a waiting area opening (which would have to be staffed, but deliver no specific clinical benefit), we would have to finish 30 minutes earlier, or ask staff to work beyond their contracted hours and pay them additionally to do so. If you arrive on time for your appointment then clinic and its waiting area will be open. This question has been raised multiple times over the last 10 years, and unfortunately having staff start earlier to ensure safety of the patients in the waiting room is not a viable option as indicated above. The canopy that was built around the Main Entrance in 2015 was designed to allow shelter for those queuing outside prior to our opening time of 8am.

(Q) Could Manx Care please provide a start date for improvements to A & E at Nobles and details of why the minor injuries unit at Ramsey has had to close on occasions to provide staff in Douglas.

(A)The MIU at Ramsey forms part of the wider Urgent and Emergency service on the Island, and as such is only separate and distinct from the Emergency Department in terms of geography, it operates its service at RDCH as part of a complimentary service to all Island residents serving their urgent and emergency needs. It focuses on the delivery of a service that means that the Emergency Department is better able to deliver care to medical emergencies and those potentially requiring hospitalisation and specialist intervention, rather than those requiring treatment for minor injuries, dressing changes or repeat prescriptions for example. When the Emergency Department is particularly busy or when staffing levels are not sufficient to support demand there are occasions when the MIU staff will support their colleagues in the Emergency Department to ensure that those in greatest and most pressing needed receive the treatment they require. On very rare occasions this might require the closure of the MIU to facilitate this support, when it does, this decision is always taken on the balance of risk to patients.

(Q) Could Manx Care please explain why the improvements in A & E and recruitment of additional essential staff has not occurred much sooner.

(A) Many of the planned improvements to the Urgent and Emergency Care service are predicated on the requirement for additional funding to support these improvements, both in relation to infrastructure and services. When funding is secured via the DHSC, the Health and Care Transformation Programme or the Treasury, along with the commitment to provide the necessary recurring funding to ensure resilience of the services where appropriate, these improvements will be made; to make changes without the appropriate funding in place to support them on an enduring basis would be inappropriate. Recruitment to vacant posts is the number one priority of the Care Group. All healthcare settings are short staffed and this is replicated across the UK and more widely across the other jurisdictions, as such, it is a competitive market and any healthcare professional has the opportunity to work within a few miles of their home without the need to relocate. This is why we have put significant effort in to the recruitment of staff from the UK and further afield, as the vast majority of those capable of working in healthcare and willing to do so who are on the Island are already doing so. We offer a number of incentives to off-Island recruits including (receipted) relocation expenses and assistance with housing, but the cost of living and of housing on Island has an impact on affordability. We have been successful in recruiting a number of newly qualified nurses recently and they are starting work this month and next as soon as they are appropriately registered – whilst waiting for their registration, we have been able to utilise them as Health Care Assistants in order to assists with their induction.

(Q) Could Manx Care please indicate how many former permanent members of nursing staff have transferred to become "bank" staff instead?

(A)In the period 1 August 21 to 31 July 2022 a total of 2 Nurses left a permanent post and took up a bank post immediately after. It should be noted that many Manx Care staff hold bank positions in addition to their substantive posts and retain the bank post on leaving their substantive post, rather than changing from one type of appointment to another.

(Q) Could Manx Care please indicate how many newly recruited staff paid relocation grants then subsequently leave Manx Care employment within 12 months.

Between 1 August 2021 and 31 July 2022 two members of staff left who had been in post for 12 months or less and had been paid relocation grants.

(Q) Since 1st April 2021 what is the total sum of relocation money paid to all new Manx Care staff and is the money paid from funds normally spent on healthcare provision. also, are the relocation grants restricted to lower grades of salary or are they also paid to highly paid GPs Consultants and Admin staff?

(A)Between 1 April 2021 and 29 August 2022 a total of £86,713.96 was paid for relocation expenses. This figure is net of amounts repaid. Employees are required to repay a proportion of relocation payments if the leave within two years of starting, based on the amount of the two-year period that remains.
The relocation payments are paid form the debit code for the salary of the position that has been recruited to.

A recruiting manager will indicate that a post is eligible for a relocation grant when the recruitment pool for the post is likely to be off-island, ie the skills are unlikely to be available locally. This would not normally apply to non-professional roles such as administrative roles. The recruitment pool for Consultants is normally off-island and these posts are generally offered relocation payments.

(Q) Could Manx Care please detail the structure and responsibilities of the four top managers of Primary Care Services inclusive of the role that Dr Ellis carries out together with the overall annual total of the wage bill involved.

(A)Primary Care Services within the Integrated Primary and Community Care Group (IPCCG) is led by a leadership team with the same 'Triumvirate' structure as all of Manx Care's Care Groups. The structure comprises of a General Manager, a Clinical Director, an Associate Director of Nursing, and in the case of the IPCCG, also the Pharmaceutical Advisor and Joint Therapy Services Leads. The total annual remuneration for the IPCCG leadership team of 6, who together manage 20 different clinical teams/services is £663,258.

In terms of the role that Dr Ellis carries out, Dr Ellis is the lead for the Primary Care Network and recently appointed as Executive Medical Director, Primary Care working alongside Manx Care's Medical Director. Dr Ellis is not within the IPCCG structure.

(Q) Given the recent risk to nuclear facilities in Europe with capacity to cause fall out similar or worse than Chernobyl, is Manx Care holding sufficient medical supplies to treat radiation sickness in the community should that become an emergency situation, if not, what stocks does Manx Care envisage obtaining in the near future.

(A)*We have sought advice from the UK Health Security Agency on necessary precautions to protect the population of the Isle of Man should a nuclear accident occur in Ukraine – they have advised that it is not foreseeable, even in a relatively extreme event associated with the nuclear power plants in the Ukraine (including the residual hazards at Chernobyl), that stable iodine prophylaxis would be required to manage any public health risks. Such countermeasures are unlikely to be required at distances more than 100km from the accident site due to the dispersion and half-life decay of radio-iodine.*

(Q) Could Manx Care detail the range of surgical areas of expertise that were being provided at Nobles Hospital as at 1st April 2021 by comparison with the range of surgical areas of expertise now being delivered at Nobles Hospital (excluding in both cases where the actual operation is being carried out in the UK)

(A)There have been so significant changes in the surgical specialties offered at Nobles hospitals between

April 2021	August 2022
Breast	Breast

Cardiology	Cardiology (Suspended, awaiting recruitment)
Endoscopy	Endoscopy
Ear Nose & Throat	Ear Nose & Throat
General Surgery	General Surgery
Gynaecology	Gynaecology
Obstetrics	Obstetrics
Opthalmology	Opthalmology
Oral Surgery	Oral Surgery
Orthopaedics	Orthopaedics
Psychiatry	Psychiatry
Vascular surgery	Vascular surgery
Plastic Surgery	Plastic Surgery

(Q) Could Manx Care please detail the total number of IOM patient operations carried out in the UK since 1st April 2021

- *Day case activity total 2,626*
- *Elective activity total 3,635*
- *Non-Elective activity total 1,692*
- *Outpatient Procedure activity total 243*

(Q) Could Manx Care please detail the average daily number of significant surgical operations carried out in the operating theatres at Nobles Hospital and Ramsey Cottage Hospital and the comparative average cost per operation (inclusive of travel) with the UK**.**

(A) Main theatres at nobles are currently running a hybrid model delivering restoration and recovery work streams alongside BAU and supporting staffing shortages within the Jane.

From date :01/04/2022 To date :14/07/2022

Volume of Activity in main theatres From date :01/04/2022 To date :14/07/2022	
Mean	11
Min	1 *
Max	26

*Typically a patient safety day where elective activity is reduced to allow time to collaborate and focus on the patient safety agenda.

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
122.22/Sep	Provide an update on workforce planning	PM	10.01.23			

Chair's Report Manx Care Board Meeting in Public

1 November 2022

Island visits

This is my twenty second Island visit and on the previous occasion I had the privilege of meeting the new Minister for Health and Social Care, Rob Callister. With Sarah Pinch, I also attended an event at the Lieutenant Governor's residence to celebrate long service awards for ambulance staff. The Chief Executive and I did a joint question and answer session on the Mannin Line.

On this occasion I will be meeting the Minister, the Cabinet Secretary and representatives of the HSCC. I will also be visiting a number of GP practices with the Chief Executive and Medical Director.

Public Meetings

This is our fourth Public meeting in this financial year and we continue to welcome questions, comments and suggestions from the public. The Chief Executive and I will be answering questions on the Mannin Line again from around 12.00 tomorrow.

CQC

The CQC has completed its programme of inspections and is now conducting a round of interviews with staff and stakeholders. The final report will go to DHSC who are expected to make it public in due course.

Waiting List Reduction

It was very pleasing to see Treasury approval for our Waiting List Business Case. Once completed this will mean that most waiting lists on the Isle of Man will be much shorter than those in the UK.

Andrew Foster 26 September 2022

CEO

manx care Kiarail Vannin	**SUMMARY REPORT**	**Meeting Date:** 1ST November 2022	
		Enclosure Number:	

Meeting:	**Manx Care Board**		
Report Title:	**Chief Executive Report and Horizon Scan.**		
Authors:	Teresa Cope, Chief Executive Officer		
Accountable Director:	Teresa Cope, Chief Executive Officer		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/ Recommendation from that Committee**

Summary of key points in report

- The Autumn Booster programme continues. To date, overall uptake is 37.8% of the total eligible cohort, which is compared to 32% in England, however it is hoped the introduction of drop in sessions plus reinforced communications across the general public and specifically to health and care staff will drive uptake.

- The inaugural risk management committee took place on the 14th October 2022, chaired by the Chief Executive Officer. The Risk Committee will meet monthly and will provide a report to the Manx Care Board as part of the Chief Executive's Report.

- The Associate for Perioperative Practice (AfPP) conducted an accreditation re-visit of Nobles main theatre complex on the 28th and 29th of September 2022. Informal verbal feedback was received on the 29th September. The department was observed to have made good progress towards accreditation with a number of areas which were previously identified as 'amber' following the previous visit 16 months ago, now achieving a 'green' rating for compliance.

- The Chief Executive has schedule a number of 'Ask me Anything' sessions and 'Back to the floor' sessions to meet with staff groups and also shadow staff in their roles. Sessions have been scheduled with the following department which will take place over the next 3-4 months.

- The inaugural meeting of the Equality Diversity and Inclusion forum was held on the 17th October, chaired by the Chief Executive. Priorities for the group have been identified and the group is seeking a Non Executive Director Champion and a further Executive Director Champion.

- Progress is being made on the ENT Action Plan taking account of the recommendations from the external review by ENT UK and considering 'Getting it Right First Time (GIRFT) indicators.

Recommendation for the Committee to consider:

Consider for Action	**X**	**Approval**		**Assurance**	**X**	**Information**	**X**

- It is recommended that the Manx Care Board note the content of this report
- The Board is asked to consider a Non Executive Director champion to contribute to the EDI forum and a further Executive champion
- The Board is asked to consider if the ENT Action Plan should be moved to be overseen by the Quality Safety and Engagement Committee of the Board

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

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	

CEO Report OCTOBER 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. The Horizon Scan for September / October is attached at Appendix 1.

Section 2: Vaccination Program Update

2.1 **Vaccination Programme Update**
Executive Lead: Director of Operations

The Autumn Booster programme commenced on the 5th September, in line with the commencement of the programmes across England and the devolved nations, with over 80s and health and care staff initially invited to receive their vaccine, by appointment letter or online booking. The new Spikevax bivalent booster vaccine has been offered to all people electing to receive the vaccine, which contains specific protection against the Omicron variant as well as the original Wuhan strain of Covid-19. Since the launch of the programme, additional cohorts have been invited to come forward for their vaccine, with all eligible cohorts being invited to receive their jab from Monday 17th October, in line with the UK's opening up to all cohorts on Thursday 13th October. Appointments can be booked online, via 111 or by attending a drop in session which commence from Tuesday 1st November.

To date, overall uptake is 37.8% of the total eligible cohort, which is compared to 32% in England, however it is hoped the introduction of drop in sessions plus reinforced communications across the general public and specifically to health and care staff will drive uptake.

Plans for the Spring booster programme are awaited from the Joint Committee on Vaccination and Immunisation (JCVI), however preparations are underway to transfer the ongoing responsibility of delivery of the Covid-19 vaccination programme to the Primary Care Network from 1st April 2023, which aligns the delivery of the Covid-19 vaccination against all other adult vaccination programmes.

2.2 **Update on Winter Planning 22/23.**
Executive Lead: Director of Operations

Predictions for the winter period 22/23 is that it will be one of the most challenging periods ever for health and care services – this include a possible resurgence of Covid-19 (including the potential

of a new variant), alongside a possible difficult influenza season (as experienced by Australia during their winter period earlier this year), along with the impact of the rising cost of living.

As a result of these threats to the stability of the health and care service over the winter period, a winter plan has been developed by a working group, led by the Director of Operations which has been considered by the Executive Leadership Team (ELT). The plan is reflective of the fact that there is no dedicated separate funding for initiatives for Winter and schemes have been identified which are considered to have the greatest impact with affordability for the organisation.

The plan includes schemes that will provide

- alternative pathways to the deployment of a 999 ambulance for lower acuity calls,
- development of alternative pathways other than admission to an inpatient bed,
- increase in senior decision making capacity in the hospital,
- bringing forward the development of an Acute Frailty Ward, meaning a reduced length of stay for those patients who are admitted due to syndromes of frailty.

In addition, work is underway alongside our insourcing partners, Synaptik, which will see elective activity ring-fenced throughout the winter months which will ensure that procedures requiring an overnight stay or more in hospital go ahead, as these procedures have traditionally being subject to high rates of cancellation due to a lack of beds.

Section 3: Updates from Executive Team

3.1 Risk Management Committee
Executive Lead – Chief Executive Officer

The inaugural risk management committee took place on the 14th October 2022, chaired by the Chief Executive Officer. The Risk Committee will meet monthly and will provide a report to the Manx Care Board as part of the Chief Executive's Report. Terms of Reference for the Committee have been agreed and the Risk Management Policy endorsed.

The committee has agreed that the Board Assurance Framework (BAF) will be subject to a comprehensive review and updated ahead of the November Risk Management Committee meeting and subsequently reported to the Manx Care Board in December.

A number of Risk Management Training sessions have also been delivered across the organisation with further planned over forthcoming weeks, led by the Interim Risk Manager and a comprehensive review of all 'live' risks on the risk register is ongoing. A comprehensive report on the Risk Management training programme and the review of all risk is due to come to the next committee and a position statement on this will be provided to the Manx Care Board in December

3.2 Information Governance Update
Executive Lead: Chief Information Officer

Having commenced our Transformation Programme, Manx Care, with support from the Health and Care, has made good progress with implementing our remediation action plan. Manx Care Corporate Information Governance team have welcomed our interim Head of Information Governance. The vacancies within the team are being progressed.

Additional resources for the regulatory compliance work in the Care Groups have begun and allocated surge resources have started in post. There are still some remaining surge vacancies to be filled. The subject matter experts have made considerable progress with approximately 60% of Care Groups completing their first iteration of their Information Asset Registers and working closely with each care group. Workshops are scheduled for November co-ordinated by care group business managers. This will improve competence and aid with Care Group engagement and completion of Information Asset Registers.

Manx Care is progressing well with the completion of the NHS Data Security and Protection Toolkit (DSPT). The toolkit submission has now re-set and will run to 30th June 2023. Evidence is being actively collected. This is the evidence that underpins the DSPT submission and it is anticipated that the full set will be complete in 2023. As part of the external independent accreditation to support Manx Care's continuous improvement programme, an external auditor will need to be appointed to assure the DSPT submissions.

Manx Care is soon to announce the move to NHS Digital's DSPT "IG Mandatory Training" module. This is an approved set of modules that will support the DSPT submission. Communications will go out on this change as soon as the system configuration has been finalised and will announce the move away from E-Learn Vannin and the adoption of e-LFH. The IG team has commenced the operational and communications plan for implementation and organisational rollout.

3.3 **Association of Perioperative Practitioners (AFPP) Assessment of Theatres, Nobles Hospital**
Lead Executive: Executive Director of Operations

The Associate for Perioperative Practice (AfPP) conducted an accreditation re-visit of Nobles main theatre complex on the 28th and 29th of September 2022. Informal verbal feedback was received on the 29th September.

The department was observed to have made good progress towards accreditation with a number of areas which were previously identified as 'amber' following the previous visit 16 months ago, now achieving a 'green' rating for compliance. It was evident that significant progress had been made to provide assurance that risks have been identified, managed and evaluated to ensure the provision of safe patient care. Evidence of exemplary practice was observed within the Breast Theatre Team, with inspectors observing a complex and challenging cases being undertaken on the 1st day of inspection and providing positive feedback on the management of the theatre team, focus on patient safety and staff welfare. A response to a challenging airway was also observed with the actions taken by the team being described as exemplary.

The culture of the department was noted to have visibly improved, with staff being described as engaged, and welcoming. A formal report will be provided in due course at which time the hospital will be informed whether it has achieved the standard required to receive accreditation.

The Improvement Plan contains action owners and ambitious timescales with many areas of improvement, such as the establishment of additional weekend clinics to reduce the backlog, demand and capacity planning and validation of both inpatient and outpatient waiting lists showing good progress so far.

3.4 **ENT Action Plan Update**
Executive Lead: Chief Executive / Director of Operations

Following positive feedback from the CEO at the last board meeting regarding progress made by the ENT team in relation to assurances around sustainability, appraisal, management of DNAs and

management of emergencies (as highlighted by the ENT UK report), a more expansive improvement plan has been developed. The plan has taken recommendations from the ENT UK report of Manx Care's ENT service and the from the NHS Getting It Right First Time (GIRFT) report for ENT, as well as feedback from complaints, incidents, as well as staff and patient feedback to influence the recommendations contained within the document. This improvement plan comprises 31 recommendations split over the following areas:

- **Access to Services – Outpatients** – includes actions around short and long term management of the ENT outpatient waiting list and review of ENT medical establishment

- **Access to Services – Inpatients** – includes actions around short and long term management of the ENT inpatient waiting list and implementation of Procedures of Limited Clinical Value policies

- **On Call Arrangements** – explores options around sustainability of the current 1 in 2 ENT consultant on call rota, and lack of junior doctor support for ENT

- **Working Relationship**– resolution of long term issues between the ENT team and Care Group Management Team including formalising of regular ENT Team Meetings and holding a 'team building day' to improve working relationships

- **Collection and Use of Data** – recommends development of a specific ENT clinical and operational dashboard to enable the team to recognise and respond to areas that require attention. In addition, the development of Patient Reported Outcome Measures (PROMs) is recommended

- **Clinical Governance, Assurance & Training** – includes recommendations around review of the current clinical governance processes and completion of outstanding SOPs (many already completed).

- **Premises & Equipment** – Refurbishment of ENT and Audiology Departments, development of ENT asset register and capital replacement programme .

- **Staffing** – Review current staffing levels within Audiology, ENT specialist nursing, Speech Therapy and secretarial team based on current demand and capacity, and resolve staffing shortages where possible

The Improvement Plan contains action owners and ambitious timescales with many areas of improvement, such as the establishment of additional weekend clinics to reduce the backlog, demand and capacity planning and validation of both inpatient and outpatient waiting lists showing good progress so far. It is recommended that ongoing monitoring of the Improvement Plan is undertaken by the Quality Safety and Engagement Sub-committee.

The Board is asked to support the ENT Improvement Plan being monitored by the Quality Safety and Engagement sub-committee going forward.

Section 4: Communications and Engagement

4.1 **Chief Executive 'Back to the Floor' and 'Ask me Anything' Sessions**
Executive Lead: Chief Executive

The Chief Executive has schedule a number of 'Ask me Anything' sessions and 'Back to the floor' sessions to meet with staff groups and also shadow staff in their roles. Sessions have been scheduled with the following department which will take place over the next 3-4 months.

- Imaging (Radiography Nobles)
- Theatres
- Critical Care
- Neurology
- Anaesthetics
- Care for the Elderly
- Emergency Department
- Maternity, Obs & Gynae
- Paediatrics
- Mental Health
- Gastroenterology
- Diabetes & Endocrinology
- Drug & Alcohol team
- Ophthalmology
- Oncology
- Rheumatology
- Orthopaedics
- ENT & Audiology
- Oral Surgery
- Urology
- Pathology
- General Surgery
- Dermatology / Plastic Surgery
- Renal
- Martin Ward (Ramsey)
- MIU (Ramsey)
- Physiotherapy (Westmoreland Rd)
- Podiatry (Westmoreland Rd)
- Community Dental (Westmoreland Rd)

4.2 **Equality Diversity and Inclusion (EDI) Group**
Executive Lead – Chief Executive Officer

The inaugural meeting of the Equality Diversity and Inclusion forum was held on the 17th October, chaired by the Chief Executive. The Workforce and Culture team have previously held a number of focus groups to help identify some of the key priorities for the group to take forward. Those priorities include development and implementation of a zero tolerance policy; setting up employee resource network groups and reviewing signage across the organisation.

A revised EDI training programme has been developed across government which is due to be implemented from December. Manx Care has committed to identify EDI Champions to support LEaD with the roll out of the training. The group has committed to develop an EDI strategy for Manx Care from April 2023. The group will meet monthly and provide quarterly update to the People Committee. The CEO will chair the EDI Forum and is seeking a Non Executive Director Champion and a further Executive Director Champion.

The Board is asked to consider a Non Executive Director Champion and a further Executive Director Champion for the Manx Care Board.

Section 5: Manx Care Mandate

5.1 **Assessment of Manx Care by DHSC 21/22**
Executive Lead: Chief Executive Officer

The Department of Health and Social have published its formal assessment of Manx Care for 21-22. This was published on Friday 21st October ahead of being laid before Tynwald. The assessment recognises the significant contribution of the health and care system in responding to the Covid-19 pandemic and delivering the vaccine programme and our progress on patient and service user engagement and partnership working with the wider system. The assessment highlights that progress on having timely and accurate data has been slower than desired and this an area where improvement is expected.

The Board is asked to consider the Assessment and consider whether any additional actions are required in response to the assessment.

The Assessment is shown at Appendix 2.

Teresa Cope,
Chief Executive
20th October 2022

Isle of Man Government
Reiltys Ellan Vannin

Department of Health and Social Care

Rheynn Slaynt as Kiarail y Theay

Department of Health and Social Care
Belgravia House, Circular Road
Douglas, Isle of Man IM1 1AE

Mr Andrew Foster, Chair

Ms Teresa Cope, Chief Executive Officer

(By e-mail)

Dated: 11th October 2022

Dear Andrew and Teresa

Re: Assessment of Manx Care for 2021-22

Foreword

Pursuant to Part 6 ('Plans and Reports') of the Manx Care Act 2021 ("the Act"), this letter sets out my summary assessment of the extent to which Manx Care was able to demonstrate having met its obligations under the Mandate to Manx Care from the period 1st April 2021 to 31st March 2022.

Through the Act, I am obliged to report on:-

(a) the extent to which Manx Care met any objectives or requirements specified in the mandate for that year; and

(b) the extent to which it gave effect to the proposals in its operating plan for that year.

In doing this, I have considered information shared between the Department of Health and Social Care ("the Department") and Manx Care during the service year, together with Manx Care's Annual Report and required Outcomes Framework for 2021-22.

In future years, we will see an Operating Plan which is closely aligned to the Mandate, in order that we can be sure of the activities supporting the direction of travel set by Our Island Plan.

Annex 1 to this letter sets out in greater detail my assessment of the specific strategic objectives set within the Mandate to Manx Care, and Annex 2 evaluates Manx Care's performance against the specifically mandated targets for 2021-22.

Manx Care Annual Report 2021-22

I must begin by thanking every member of staff across our health and social care services for their contribution during this period, acknowledging the rapidly changing situation with COVID-19 and the challenges of the first year of operation in a completely new infrastructure for Health and Social Care delivery here on the Isle of Man.

I do not underestimate the complexities of meeting the needs of our population and this can only be done with the dedication shown by staff at all levels.

As we move through the 2022-23 service year, I am confident that the vision provided by Our Island Plan will serve as a foundation for building a sustainable health and care system which delivers greater access to a comprehensive, high quality, and fully integrated health and social care system, not just in the hospital setting but across Primary Care, Community Care and Social Care.

Further to a general debate in Tynwald in June 2022 brought by Minister Hooper, the Department intends to use the Mandate to Manx Care from April 2023 to set out its strategic vision for the next three years.

The Department were required to approach Tynwald with a supplementary vote for £10m, although I fully acknowledge that many factors contributed to this being necessary.

I am clear that, for the future, excellent governance and planning is required to keep spending within budget. We have worked together to begin forecasting what resources are required for 2022-23 and I expect that we will continue refining this process for future years and explore options for multi-year funding.

I have been particularly pleased to see the work undertaken by Manx Care to listen to advice, feedback and opinions from their established network locally and further afield, and most importantly from the Manx public.

Engagement with our patients and service users will be integral to shaping the delivery of services going forward and truly understanding our needs.

Manx Care particularly excelled in delivering the Island's response to the pandemic, demonstrating agility and flexibility where it was needed.

Since April 2021, Manx Care have worked tirelessly to deliver testing and vaccination at pace and in line with JVCI recommendations.

Swabbing peaked at over 1000 per day in support of border changes and symptomatic patients, with test results being provided in a timely manner. This was all delivered in parallel with providing an inpatient service for those most affected by COVID-19 related symptoms.

To date, a clear accounting of waiting lists is still being worked through by Manx Care and we welcome the progress on the restoration and recovery programme.

Whilst I am confident that progress has been made to improve waiting times across services, it has sometimes been difficult to understand the aggregated position and I would like to see Manx Care improve their reporting of this to the Department and to the public.

I am determined that the Manx Public know what to expect from us when accessing services, particularly how long they should expect to wait, and this will continue to be a key theme in future service years through the Mandate to Manx Care.

I am also somewhat discouraged by the slow progress made jointly between Manx Care and our Transformation colleagues in the real use of performance data, through a core dataset, to understand and manage risk.

I appreciate the work that has been undertaken to improve clinical coding, which is a foundation of accurate information, however I cannot stress enough the importance of

validating, automating and sense-checking the data we gather, to make sure we are accurately reflecting the experiences of our service users.

I cannot confidently say that the standards set by the Mandate were met and, as Annex 2 makes clear, in many cases no data were available. I would draw your attention to Section 33 of the Manx Care Act and I hope that going forward, we can openly share information in a timely manner.

By the time this letter is laid before Tynwald, the Department will be using its Oversight Framework to take a holistic view of the health and care system. In reviewing progress towards outcomes for 2022-23 this time next year, I hope to be in a position to provide even greater detail.

Conclusion

Overall, Manx Care have made progress against the objectives in the Mandate for 2021-22, and have made positive steps towards achieving delivery.

The end of the service year does not mean that the objectives will be forgotten about and, through the joint creation of the Mandate for 2022-23, we will ask Manx Care to continue building on the successes already achieved.

I believe that positive foundations have been laid this year and relationships have been established to allow us to significantly improve, but this must now happen at pace and with an eye on making the most of what is within our gift.

Yours Sincerely

Mr Rob Callister

Minister for Health and Social Care

Dr Michelle Haywood

Member of the House of Keys

Ms Joney Faragher

Member of the House of Keys

Annex 1

At a Glance: Mandate Objective Progress Summary

Objective Number	Heading	RAG Rating
1	Pandemic Response	Achieved
2	Service User Engagement	Mostly Achieved
3	Integration of Services	Mostly Achieved
9	Partnership Working	Mostly Achieved
4	Equity of Governance	Partly Achieved
5	Risk and Clinical Governance	Partly Achieved
7	Waiting Times	Partly Achieved
8	Continuous Improvement	Partly Achieved
10	Primary Care at Scale	Partly Achieved
11	Workforce Engagement	Partly Achieved
6	Financial Balance	Not Achieved
12	Climate and Net Zero	Not Achieved

Progress per Mandated Objective

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	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.	1. Vaccination programme; 2. Testing programme; and 3. Operational response to the pandemic;	1. All eligible groups vaccinated where desired 2. Statistics for delivery of tests within timeframes 3. None relevant	Achieved

Summary of Deliverables and Outcomes

Manx Care has successfully provided COVID-related services and support to the Island through the swabbing and testing services, vaccination programme and secure supply of PPE and LFDs, which has meant that everyone who wishes to have a vaccination has been able to do so in a timely way and we were able to protect those most vulnerable.

We have seen dedicated support provided to those in a residential setting, as well as safe and effective inpatient treatment and isolation for those with acute symptoms. Manx Care managed the hospital facilities efficiently whilst space was required for patients in isolation.

From 1st January 2022, Manx Care facilitated transfer of the 111 telephone service from the Cabinet Office.

In relation to COVID-19, Manx Care demonstrated an ability to be flexible and provide information at short notice to facilitate decision-making.

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
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; Measure the experience of service users, patients and carers, and define plans to improve that experience by 30th July 2021 and commence implementation of that plan to enable demonstrable improvement within the Service Year	1. Actively seeking, responding to and learning from patient feedback. 2. Set out a range of interventions to enhance patient and carer experience 3. Listen to and act upon patient feedback to improve our services 4. Identity the measure that will be used to monitor the effectiveness of patient, service user and carer feedback. 5. Create a framework for capturing and acting on feedback during the first quarter	1. Example MCALS Dashboard; 2. No supporting evidence provided 3. Action Plan associated with Patient Safety and Satisfaction walks (awaiting receipt by Department) 4. No supporting evidence provided 5. Patient, Service User and Carer Engagement Framework (awaiting receipt by Department)	Mostly Achieved
	Summary Systems had not matured at a rate which enabled the ambitious 30th July deadline to be met, despite Manx Care's required Outcomes Framework pointing to comprehensive baselining in all areas. However, the Department welcomes plans established since then, including the introduction of MCALS which has since provided an important additional contact point for patients and service users and is increasing its ability to report on interactions with the public. In coming years, it will be important to understand how this service is utilised and how themes and trends can inform future service provision. There is evidence of a number of ways in which patient feedback has been actively sought, such as patient safety and satisfaction walks, feedback forms being used at discharge within Social Care and Manx Care Board meetings being made public bi-monthly. It is also important to note high rates of engagement in some statutory service provision, such as children being given the opportunity to input during 'Looked After' reviews. However, evidence of feedback being directly used to drive improvement is unclear at this time.		

	This position is also applicable in the area of complaint handling – the work undertaken by Manx Care is important but the Department would like to see examples of where feedback has directly affected an approach, through a culture of sharing and learning. I look forward to the planned use of 'Friends and Family' testing during the next service year as a further way of understanding how we're doing and making sure that the people who use our services feel heard.	

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Demonstrate changes in transforming integrated health and care service delivery following international standards for quality and outcomes	1. Develop plans to maintain patients and service users in their own homes and their own communities and avoid admission to hospital where possible, through the development of a comprehensive tiered model of community care 2. Wellbeing Partnerships established across all localities of the Isle of Man by the end of calendar year 2022, 3. A multi-disciplinary team (MDT) approach taken to the management of all referrals where more than one community service is requested, facilitated through a shared care record and care planning document. 4. Reduce delayed transfer of care from inpatient setting by having timely and responsive community assessment and provision 5. The Community Nursing Services (CNS) will respond to all urgent requests within 4 hours, non-urgent requests within 24 hours and routine referrals within 7 days.	1. Data supplied at Annex 2 indicates a contribution by Western Wellbeing to reduction in ED attendance, this will take time to stabilise and validate; 2. Some wellbeing partnerships established and operational 3. Local Area Co-Ordinators in post; 4. There is no data that would support and reduction in delayed transfers of care. 5. No data has been provided for these indicators this year (See Annex 2).	Mostly Achieved
	Summary There has been positive work in this area around the Wellbeing Hubs as part of Social Care and the appointment of three Wellbeing Partnership Leads, with the Western Wellbeing Partnership being a good example of how services can be co-ordinated and delivered in a locality venue. The foundations for building more engaged care in the community have been set through the appointment of Local Area Co-Ordinators and this will continue to feature in Mandates for 2023 onward.		

	There has not been as much progress in the area of intermediate care and the Department is keen to support this wherever possible. We would also like to see continued progress in the development of a frailty pathway, both in the acute setting and the community. The Department and Manx Care will require continued support of colleagues in the Transformation Programme to facilitate timely delivery of these work-streams and ensure that proposed Primary Care Homes support the work that has already been undertaken, and that the Operating Model supports a truly person-centred and multidisciplinary way of working in our communities.	

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Ensure that all aspects of health and care have balanced equity of decision making, accountability and provision	1. Ensure that there is an integrated approach to managing quality, performance, workforce and finance. 2. Implement a new delivery framework for Children's and Adult's Social Care under a (single) Executive Director of Social Care to strengthen governance arrangements 3. Adult Social Care will ensure that the staff teams across directly provided services are qualified and have the skills and abilities to deliver services in a safe and person-centred manner. 4. Adult Social Care will ensure access to service provision is fair, equitable and based on assessed needs. 5. Adult Social Care will ensure compliance across directly provided services with the minimum standards as set out in the Regulation of Care Act 2013 responding to any recommendations or requirements set out in the post inspection report. 6. Adult Social Care will ensure premises are appropriate and fit for purpose to ensure effective service delivery and an environment that is regarded as safe and welcoming. 7. Adult Social Care will work collaboratively with specialist services to establish clear pathways in, through and moving on from services. 8. Adult Social Care will work collaboratively with colleagues, other care and support services and third sector organisations to safeguard vulnerable adults by promoting	1. No supporting evidence provided 2. Framework is established and operational 3. No supporting evidence provided 4. Anecdotal evidence to support progress towards holistic assessment but no documentary evidence provided 5. Action Plans have been received by individual services in respect of requirements made and escalated where appropriate but there is no evidence to demonstrate addressing these in a system-wide manner 6. There is evidence of replacement or refurbishment of some facilities but there is no assurance that all facilities are fit for purpose 7. No evidence provided to support progress 8. There is anecdotal evidence of some good relationships in the third sector but no evidence to provide assurance.	Partly Achieved

	the stated policy that Safeguarding is Everybody's Business.		
	Summary The creation of one combined care group for Children's & Families services and Adult Social Work and Adult Social Care sets a fundamental infrastructure for balanced decision-making and collaborative working. The Department intends to keep focus in future years on a multi-disciplinary approach to providing care in the community, supported by the proposed Partnership Assessment. The Department would like to see further development of evidence that Social Care, Mental Health and Primary Care are given equal representation within all governance structures. Appointment of Non-Executives with interest in these areas would be a positive step.		

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
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, in 2021/22	1. Each of the established Care Groups will have regular Performance and Accountability Review with the Executive Team. 2. A Manx Care Risk Management Strategy and Policy will be developed by Manx Care and agreed by the Manx Care Board during Service Year 2021-22. 3. An Integrated Performance Management Framework will be established alongside a revised governance structure for Manx Care which will ensure the balance in achieving or exceeding the agreed performance standards. 4. Manx Care will promote a multi-disciplinary approach to improvement. To support this, Manx Care will agree a standardised improvement approach to be adopted across the organisation which will further build capacity and capability to support continuous improvement. 5. Manx Care will play an active role in the Workforce and Culture Project of the Transformation Programme	1. No supporting evidence provided but framework is in place which would support this in principle. 2. Policy for Formation, Ratification and Management of Manx care Policies and processes. 3. Performance and Accountability Framework; 4. Document Control Policy 5. No evidence provided to support	Partly Achieved

Summary

The Department is encouraged to see progress against the automation and validation of data being produced, though work in this area has been slow due to resource constraints. There is still a way to go before real-time intelligence about performance can be provided and the delay in receiving data or, in the case of some metrics, no data at all, means that the Department does not feel assured that risk is being effectively managed. The Department would like to understand more about how Manx Care are prioritising areas of data automation or validation and associated timeline. Without this, there is a concern that there may be unknown areas of risk.

There is evidence that governance structures to support harm prevention have matured through Manx Care's Quality, Safety and Engagement Committee and I would expect to see the ways in which that Committee interacts with the Department to develop in the coming year.

The development of a Quality Dashboard is a positive step and the Department appreciates the increase in communication over the service year to jointly discuss key risks and celebrations in the area of Quality and Safety relating to Nobles Hospital. In 2022-23, the Department's Oversight Framework will set down clear, joint reporting requirements and this will be made available to the public.

It would be good to see this work replicated, particularly in Social Care and the Department understands that this is in planning.

Receipt of an Enforcement Notice from the Information Commissioner during the year was disappointing and strong governance is required to ensure that action plans following events like these are followed up in a timely way.

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Demonstrate continued financial balance through delivery of agreed cost and service improvement plans (CIP) and the delivery of the agreed sustainable financial plans	1. A 1% efficiency target has been applied to year 1 of Manx Care as part of an 8 year efficiency profile. This equates to £2.7M in the Service Year 2021-22. 2. Manx Care will initiate the development of a framework in Service Year 2021-22 that will describe how it will identify, impact assess, monitor and evaluate cost improvement and efficiencies. Successful implementation of that framework is expected to take several years.	1. Regular Management Accounts 2. CIP Plan	Not Achieved
	Summary A supplementary vote was required to be submitted to Tynwald. CIP savings of £1m were achieved but this was below the target of £2.7m. The Department notes that in many cases, achievement of the saving is delayed due to other constraints, rather than indicating an overall shortfall. Going forward, sound financial governance and control mechanisms have been put in place for improved accountability, better forecasting and earlier visibility of potential issues to enable time for mitigation. However, finance will continue to be a key risk for the organisation. The Department is committed to consideration of a multi-year funding model in future years.		

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Waiting times for Mandated Services to be reduced to levels comparable with other developed health and care systems. Confirm the current baseline wait times for all Mandated Services by 30th July 2021. Develop a plan by 31st October 2021 to reduce clinically/need-based prioritised wait times	1. During Service Year 2021-22 Manx Care will develop and implement an Access Policy which will govern its approach to the management of waiting times. 2. Manx Care will monitor and report against eight key waiting time standards for integrated cancer care. Manx Care will put credible plan in place to improve on the baseline position and will commit and improving against the baseline position. 3. Manx Care is committed to Improving Screening Services for the Island population. Specifications for the Breast Screening Services, Cervical Screening Services and Bowel Screening Services have been developed and a gap analysis has been undertaken against the revised specifications. The gap analysis identifies significant gaps and therefore Manx Care will develop a costed Improvement Plan for consideration by Department and Public Health. 4. During Service Year 2021-22 Manx Care will continue to monitor against the 4hour standard in urgent and emergency care and commits to make improvement against this target from the baseline position. 5. Manx Care will establish mechanisms to monitor against a broader set of urgent and emergency care indicators 6. Manx Care will ensure that no patients waits more than 12 hours for a hospital bed following a Decision to Admit.	1. Access Policy 2. Data has been provided for two of the eight key waiting times, however, the remaining six have had little to no data provided (See Annex 2). The baseline position has improved throughout the year. 3. No evidence to support progress in this area 4. The yearly data shows performance has remained stable though has decreased slightly in the final quarter. 5. The Department has been sighted on a broader set of indicators and notes ongoing validation work in underway. 6. The Department has not seen any information on this indicator.	Partly Achieved

	7. Manx Care is committed to ensuring that no patients wait over 52 weeks for their treatment, 8. During Service Year 2021-22 Manx Care will achieve a reduction in the number of patients waiting over 52 weeks (against the 31st March 2022 baseline) and will develop costed plans during Service Year 2021-22 to eradicate 52 week waits within the next 3 years. 9. A standardised approach to clinical and administrative validation of Waiting Lists will be established 10. Manx Care will report and monitor its Waiting List Volume (WLV) overall and at speciality and sub-specialty levels. Manx Care will develop plans to reduce WLV during Service Year 2021-22.	7. Though no data has been provided, the Department is aware this indicator is undergoing validation. 8. No evidence provided. 9. The Department is aware data validation is ongoing. 10. No evidence provided.	
	Summary Systems were not in place to be able to aggregate a full picture of waiting times in time for the 30th July deadline, with Manx Care focussing on core services and procedures with the longest lists. A full programme of restoration and recovery has been ongoing with significant effort to address waiting lists in some core areas. However, the Department remains unsighted on full current waiting times for all mandated services (particularly Primary Care), or an aggregated plan for when and with what prioritisation this is currently being undertaken and the plans to maintain accurate lists in the future to prevent further deterioration of waiting times. Ambulance response times remain of concern and the Department notes the intention for review of the metrics used in urgent and emergency care, which is welcomed as the planned improvement in performance against the 4 hour standard has not yet been achieved.		

	There have been some significant fluctuations during the year, particularly in performance relating to waiting times for patients referred with suspected cancer symptoms and the Department notes that these are likely become more stable as methods for gathering and validating data are developed further. Little progress was made in the area of screening for three primary cancers in order to align them with recognised standards, which is disappointing given that the gap analysis already conducted would provide a baseline from which to plan. This objective has been carried forward to the Mandate for 2022-23 in order to better support our Public Health colleagues in delivering these important preventative services.	

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
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.	1. Manx Care will agree a standardised improvement approach to be adopted across the organisation which will further build capacity and capability to support continuous improvement.	1. Serious incident investigation Policy (awaiting receipt by Department) Action Plan associated with AFPP Report (awaiting receipt by Department) Standards for Inquest Management (awaiting receipt by Department) Process for Mortality Reviews (awaiting receipt by Department)	Partly Achieved
	2. An Integrated Performance Management Framework will be established together with the enhanced governance structure for Manx Care	2. Performance and Accountability Framework	
	3. During Service Year 2021-22 Manx Care will further develop strategic partnerships with both providers of tertiary care and with voluntary and community services providers	3. No evidence provided to support	
	4. During Service Year 2021-22 Manx Care will prepare its Strategy for 2022-2027 utilising a service based, bottom up approach.	4. No evidence provided to support	
	Summary Validating performance data will be key in understanding the baseline and planning for improvements, and the Department would like to understand more about how Manx Care is prioritising this work through its Finance, Performance and Commissioning Committee. There has been evidence of improvement in service model design in areas such as the introduction of a 'Smart Page' emergency alert system.		

	The Department understands that many planned improvements in the area of technology will be dependent on delivery of the Manx Care Record by the Transformation Programme and this should be treated as a priority. We will also continue to ask Manx Care to explore how outward-facing technology can assist patients in managing their care at home.	

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Effective and collaborative partnership working within the integrated care system.	1. Manx Care will develop its plans to maintain patients and service users in their own homes and their own communities and avoid admission to hospital where possible 2. Our Wellbeing Partnerships, which will be established across all localities of the Isle of Man by the end of calendar year 2022, will receive and coordinate all referrals into community based statutory services and some third sector providers who are members of the partnership 3. Standards linked to admission avoidance and reducing delayed transfer of care will be developed in support of this during Service Year 2021-22 to supplement the existing standards.	1. No documented evidence provided to support – Western Wellbeing contribution to prevention of unheralded A&E attendance is noted below. 2. Target date is within subsequent service year - to review in 2023 Letter of Assessment 3. No evidence provided to support	Mostly Achieved
	<u>Summary</u> Manx Care is able to evidence progress against this objective through the Integrated Partnership Board and representation through the Council of Voluntary Organisations. There is evidence of good work both locally and further afield to establish networks and alliances which support best practice and information sharing, particularly in Mental Health Services. The Department would like to work closely with its Transformation colleagues in subsequent years to ensure that an approach is taken which considers the whole system and is able to prioritise areas of most need.		

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Developing and integrating Primary Care at Scale as an essential part of service delivery within Manx Care.	1. Manx Care will work with the Transformation Programme's Primary Care at Scale Project to develop services to be provided by the Primary Care Network for GPs and to promote collaborative working within the other primary care professions. 2. Manx Care will develop a Primary Care at Scale Strategy and Implementation Plan by the end of quarter one which will redefine the Model of Care and the Operating Model to build a new approach to collaboration across Primary Care,	1. Evidence of participation/attendance but not how this is linked to outcomes. 2. Primary Care at Scale Baseline Strategy (Transformation Paper)	Partly Achieved

Summary

The outcomes associated with this objective sit primarily with colleagues in the Transformation Programme of the Cabinet Office and whilst Manx Care have played an active role, progress was not always solely in their gift. A project pause due to change in contracted partner did affect this workstream during The nominated Manx Care representative was actively involved in work to develop the strategy and target operating model, with a focus on governance and integration with the wider system.

The Department notes progress with recruitment of additional staff through prototype interventions but is concerned by the slow nature of progress in data sharing agreements between GP practices and Manx Care, which have ultimately affected the scope of the project.

During 2022-23, concerted efforts between the Transformation programme, DHSC and Manx Care will be required to achieve the vision set out by this project.

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
Demonstrate a continuous improvement in workforce engagement, personal and professional development.	1. Manx Care will play an active role in the Workforce and Culture Project of the Transformation Programme; 2. Manx Care will participate in the regular government wide staff engagement surveys and supplement these with additional Manx Care focussed engagement surveys, using the results to establish a clear baseline and to plan improvements during the course of 21/22. 3. Manx Care has established formal listening events across staff groups since February 2021 and these will continue throughout the year with updates on actions taken in response to staff feedback forming part of regular updates to the People Committee and the Manx Care Board.	1. No evidence provided to support. 2. Manx Care did utilise the surveys, though response rate was low and is now subject to Government-wide review. No evidence of what has been used to replace or supplement. 3. No evidence to show whether these continued or how the information was used.	Partly Achieved
	Summary Manx Care have been able to demonstrate positive initiatives such as the implementation of a bespoke staff Induction Programme, staff and team recognition schemes and a Leadership Academy Programme. However, it is unclear whether these initiatives have contributed to any improvement in workforce engagement, for which it was difficult to establish any meaningful baseline and reported response to staff surveys has remained low. Manx Care undertook a 'refresh' of the set of values during the year and I would like to see during the next year how these are embedded and used to drive a culture of consistency. Whilst it is acknowledged that electronic systems which support completion of mandatory training require some improvement, it is disappointing that there is still no clear position on numbers of staff who are compliant with the Mandatory Training Policy.		

	Manx Care have suffered from high rates of staff sickness absence during the period, much like many other organisations, and a plan will be required to support staff to improve this and ensure that the workforce is sustainable for the future.	

Mandate Objective	Manx Care Planned Response	Supporting Evidence Provided (where applicable)	Rating
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. Over the next five years, Manx Care will continue to pursue work to with the Department, Treasury, Department of Infrastructure and the climate change transformation team of the Cabinet Office to assess the emissions from the current estate and reduce them wherever possible, including opportunities for natural carbon sequestration in our grounds; Manx Care will pursue the reduction of the use of polluting anaesthetic gases and the improved use of asthma inhalers (in line with work going on in the UK); and support our staff and patients to choose low carbon options in all aspects of our operation	1. All new capital schemes will reflect developing technologies and where possible our existing structures will be enabled to utilise low to zero carbon technology. 2. Combined heating and power systems will be the norm in our design specification, providing carbon savings with an estimated payback timeframe for financial consideration and decision making. 3. All changes to current structures will consider thermal transmittance, the use of natural daylight, solar gain without overheating, alternative heating and power sources, thermal stores and the minimisation of water consumption. 4. To demonstrate Manx Care's commitment to protecting our natural resources we will be submitting our application to become a partner to UNESCO Biosphere, Isle of Man.	1. No evidence provided. 2. No evidence provided. 3. No evidence provided. 4. No evidence provided.	Not Achieved
	The Department notes the delay in the Guidance for Public Bodies only being published in March 2022. However, there is work that could have been ongoing in the meantime, specifically in relation to anaesthetic gases and asthma inhalers as well as smaller enhancements to the estate, for which no information has been forthcoming.		

Annex 2

Manx Care Mandated Metrics Performance – 2021/22

It should be noted that Manx Care have undertaken significant work to establish a programme to enhance the collation, integrity and validation of performance data. This work-stream is ongoing and the data provided below is that which was contemporaneously available. Since the time of publication, the metrics and methods for measuring Manx Care's organisational performance have matured such that some of the performance information detailed below may not accurately reflect the actual performance levels achieved. At the time the Mandate for 2021-22 was written, the scoping exercise regarding the reporting mechanisms and methodologies had not been completed, and therefore the Department accepts this position.

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Medicine, Urgent Care and Ambulance Service	Time to attend to life-threatening 999 calls by an Emergency Responder (Category 1) (min:sec)	75% within 8 min	10:09	08:42	10:42	10:28	08:34	09:09	09:51	12:00	11:10	10:09	10:17	16:42
	Time to attend life-threatening 999 calls by a crewed ambulance	95% within 19 min	#	#	#	#	#	#	#	#	#	#	#	#
	Time to admin, discharge of transfer patients after arrival at ED (Nobles and Ramsey)	95% within 4 hours	75%	78%	77%	79%	80%	77%	75%	72%	71%	70%	69%	#
Surgery, Theatres, Critical Care and Anaesthetics	% of Urgent GP referrals seen for first appointment within 6 weeks	85%	57%	56%	61%	54%	56%	52%	50%	49%	47%	47%	53%	61%
Integrated Diagnostics and Cancer Services	Number of patients waiting for urgent diagnostics tests	Within 2 weeks	#	#	#	#	#	#	#	#	#	#	#	#
	Number of patients waiting for routine diagnostics tests	Within 20 weeks	#	#	#	#	#	#	#	#	#	#	#	#
	Time from receipt of urgent referral for suspected cancer to first outpatient appointment	93% within 2 weeks	71%	76%	73%	61%	73%	77%	83%	80%	77%	78%	82%	83%

	Time from receipt of referral for breast symptoms (other than suspicion of cancer) to first hospital appointment	93% within 2 weeks	35%	33%	42%	29%	38%	60%	84%	84%	92%	55%	67%	55%
	Time from receipt of referral for suspected cancer, urgent referral from screening programme or any breast symptoms to date of patient confirmed diagnosis or ruling-out of cancer	75% within 28 days	#	#	#	#	#	#	81%	#	#	85%	#	72%
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is surgery	94% within 31 days	#	#	#	#	#	#	100%	#	#	100%	#	#
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is drug treatment	98% within 31 days	#	#	#	#	#	#	100%	#	#	100%	#	#
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is radiotherapy	94% within 31 days	#	#	#	#	#	#	#	#	#	#	#	#
	Time from urgent referral for cancer to first treatment	85% within 62 days	#	#	#	#	#	#	28%	#	#	40%	#	50%
	Time from urgent referral from a screening programme for suspected cancer to first treatment	90% within 62 days	#	#	#	#	#	#	67%	#	#	79%	#	75%
Integrated Mental Health Services	Time to response from ED urgent referral for mental health assessment	75% within 1 hour	#	#	#	#	#	#	#	#	#	#	#	#
	Time to response from ward referral for mental health assessment	75% within 24 hours	#	#	#	#	#	#	#	#	#	#	#	#

Integrated Primary and Community Care Services	Time to follow-up following inpatient stay for patients on Care Programme Approach (CPA)	100% within 7 days	100%	92%	100%	92%	91%	100%	100%	75%	100%	90%	100%	80%
	Time to NICE-approved treatment in patients with first episode clinical psychosis	75% within 2 weeks	#	#	#	#	#	#	#	#	#	#	#	#
	Annual physical health check in patients with serious mental illness	100% annual	#	#	#	#	#	#	#	#	#	#	#	#
	West Wellbeing contribution to reduction in ED attendance	5% per 6 months	#	#	#	#	#	#	-9%	-19%	-19%	-3%	-19%	-3%
	West Wellbeing reduction in admission to hospital from locality	10% per 6 months	#	#	#	#	#	#	10%	20%	18%	15%	4%	-9%
	Clinical Assessment and Treatment Service waiting time from urgent referral	80%	70%	58%	71%	67%	75%	67%	65%	58%	75%	#	#	#
	Clinical Assessment and Treatment Service waiting time from routine referral (within 12 weeks)	80%	75%	92%	70%	30%	18%	28%	40%	58%	24%	50%	47%	73%
	Community Nursing waiting time following urgent referral	4 hours	#	#	#	#	#	#	#	#	#	#	#	#
	Community Nursing waiting time following non-urgent referral	24-48 hours	#	#	#	#	#	#	#	#	#	#	#	#
	Community Nursing waiting time following routine care	One week	#	#	#	#	#	#	#	#	#	#	#	#
Social Care Services	Adult Social Care supervisions completed on time	90-100%	33%	56%	31%	75%	80%	74%	71%	42%	88%	64%	38%	66%
	Adult Social Care average caseload per Social Worker	16 to 18	11	12	12	10	10	10	10	10	10	10	10	11

	Fair Access to Care Services (FACS) completed in agreed timescales	80%	88%	75%	83%	71%	74%	79%	79%	87%	80%	50%	67%	33%	
	% of individuals (or their carers) who have received a copy of their FACS assessment	100%	16%	24%	25%	31%	28%	38%	39%	26%	28%	0%	80%	33%	
	% of total residential beds occupied	85-100%	85%	83%	85%	84%	79%	80%	81%	83%	80%	79%	83%	83%	
	% of total respite beds occupied	90-100%	50%	60%	81%	74%	58%	54%	58%	50%	75%	69%	73%	68%	
	Service Users with a Person-Centred Plan in place (PCP)	95-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Complex Reviews held on time	85%	39%	52%	45%	100%	100%	60%	46%	67%	100%	91%	67%	#	
	Total Child Protection Conferences held on time	90%	59%	90%	100%	100%	100%	75%	78%	65%	86%	36%	68%	#	
	Total Initial Child Protection Conferences held on time	90%	33%	100%	100%	100%	100%	22%	45%	35%	86%	7%	68%	#	
	Child Protection Reviews held on time	90%	67%	90%	100%	100%	100%	87%	100%	79%	79%	55%	71%	#	
	Looked After Children reviews held on time	90%	95%	67%	85%	100%	100%	88%	100%	71%	88%	83%	69%	#	
	Children and Family supervisions completed on time	90%	97%	96%	84%	97%	86%	94%	93%	91%	82%	75%	94%	#	
	Pathway Plan in place	100%	83%	83%	95%	86%	82%	81%	68%	76%	71%	75%	71%	#	
	Children participating in, or contributing to, their Child Protection review	90%	85%	94%	100%	100%	63%	53%	87%	66%	48%	86%	55%	#	
	Children participating in, or contributing to, their Looked After Child review	90%	100%	100%	100%	100%	89%	100%	100%	86%	100%	95%	100%	#	
	Children participating in, or contributing to, their Complex Review	79%	100%	100%	50%	100%	56%	23%	78%	88%	43%	63%	100%	#	
	Occupancy at Ramsey – overnight stays	80% maximum	93%	73%	81%	65%	26%	79%	68%	68%	87%	84%	89%	#	

KEY # No data available. Target guidelines: Green: within 5% of target. Amber: within 6-15% of target. Red: >15% of target.

Annex 2

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	Time to attend life-threatening 999 calls by a crewed ambulance	95% within 19 min	#	#	#	#	#	#	#	#	#	#	#	#
	Time to admin, discharge of transfer patients after arrival at ED (Nobles and Ramsey)	95% within 4 hours	75%	78%	77%	79%	80%	77%	75%	72%	71%	70%	69%	#
Surgery, Theatres, Critical Care and Anaesthetics	% of Urgent GP referrals seen for first appointment within 6 weeks	85%	57%	56%	61%	54%	56%	52%	50%	49%	47%	47%	53%	61%
Integrated Diagnostics and Cancer Services	Number of patients waiting for urgent diagnostics tests	Within 2 weeks	#	#	#	#	#	#	#	#	#	#	#	#
	Number of patients waiting for routine diagnostics tests	Within 20 weeks	#	#	#	#	#	#	#	#	#	#	#	#
	Time from receipt of urgent referral for suspected cancer to first outpatient appointment	93% within 2 weeks	71%	76%	73%	61%	73%	77%	83%	80%	77%	78%	82%	83%

	Time from receipt of referral for breast symptoms (other than suspicion of cancer) to first hospital appointment	93% within 2 weeks	35%	33%	42%	29%	38%	60%	84%	84%	92%	55%	67%	55%
	Time from receipt of referral for suspected cancer, urgent referral from screening programme or any breast symptoms to date of patient confirmed diagnosis or ruling-out of cancer	75% within 28 days	#	#	#	#	#	#	81%	#	#	85%	#	72%
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is surgery	94% within 31 days	#	#	#	#	#	#	100%	#	#	100%	#	#
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is drug treatment	98% within 31 days	#	#	#	#	#	#	100%	#	#	100%	#	#
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is radiotherapy	94% within 31 days	#	#	#	#	#	#	#	#	#	#	#	#
	Time from urgent referral for cancer to first treatment	85% within 62 days	#	#	#	#	#	#	28%	#	#	40%	#	50%
	Time from urgent referral from a screening programme for suspected cancer to first treatment	90% within 62 days	#	#	#	#	#	#	67%	#	#	79%	#	75%
Integrated Mental Health Services	Time to response from ED urgent referral for mental health assessment	75% within 1 hour	#	#	#	#	#	#	#	#	#	#	#	#
	Time to response from ward referral for mental health assessment	75% within 24 hours	#	#	#	#	#	#	#	#	#	#	#	#

	Time to follow-up following inpatient stay for patients on Care Programme Approach (CPA)	100% within 7 days	100%	92%	100%	92%	91%	100%	100%	75%	100%	90%	100%	80%
	Time to NICE-approved treatment in patients with first episode clinical psychosis	75% within 2 weeks	#	#	#	#	#	#	#	#	#	#	#	#
	Annual physical health check in patients with serious mental illness	100% annual	#	#	#	#	#	#	#	#	#	#	#	#
Integrated Primary and Community Care Services	West Wellbeing contribution to reduction in ED attendance	5% per 6 months	#	#	#	#	#	#	-9%	-19%	-19%	-3%	-19%	-3%
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	Community Nursing waiting time following urgent referral	4 hours	#	#	#	#	#	#	#	#	#	#	#	#
	Community Nursing waiting time following non-urgent referral	24-48 hours	#	#	#	#	#	#	#	#	#	#	#	#
	Community Nursing waiting time following routine care	One week	#	#	#	#	#	#	#	#	#	#	#	#
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	Pathway Plan in place	100%	83%	83%	95%	86%	82%	81%	68%	76%	71%	75%	71%	#
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	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is surgery	94% within 31 days	#	#	#	#	#	#	100%	#	#	100%	#	#
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is drug treatment	98% within 31 days	#	#	#	#	#	#	100%	#	#	100%	#	#
	Time from decision to treat (diagnosis) to start of second or subsequent treatments for all cancer patients where mechanism is radiotherapy	94% within 31 days	#	#	#	#	#	#	#	#	#	#	#	#
	Time from urgent referral for cancer to first treatment	85% within 62 days	#	#	#	#	#	#	28%	#	#	40%	#	50%
	Time from urgent referral from a screening programme for suspected cancer to first treatment	90% within 62 days	#	#	#	#	#	#	67%	#	#	79%	#	75%
Integrated Mental Health Services	Time to response from ED urgent referral for mental health assessment	75% within 1 hour	#	#	#	#	#	#	#	#	#	#	#	#
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	West Wellbeing contribution to reduction in ED attendance	5% per 6 months	#	#	#	#	#	#	-9%	-19%	-19%	-3%	-19%	-3%
	West Wellbeing reduction in admission to hospital from locality	10% per 6 months	#	#	#	#	#	#	10%	20%	18%	15%	4%	-9%
	Clinical Assessment and Treatment Service waiting time from urgent referral	80%	70%	58%	71%	67%	75%	67%	65%	58%	75%	#	#	#
	Clinical Assessment and Treatment Service waiting time from routine referral (within 12 weeks)	80%	75%	92%	70%	30%	18%	28%	40%	58%	24%	50%	47%	73%
	Community Nursing waiting time following urgent referral	4 hours	#	#	#	#	#	#	#	#	#	#	#	#
	Community Nursing waiting time following non-urgent referral	24-48 hours	#	#	#	#	#	#	#	#	#	#	#	#
	Community Nursing waiting time following routine care	One week	#	#	#	#	#	#	#	#	#	#	#	#
Social Care Services	Adult Social Care supervisions completed on time	90-100%	33%	56%	31%	75%	80%	74%	71%	42%	88%	64%	38%	66%
	Adult Social Care average caseload per Social Worker	16 to 18	11	12	12	10	10	10	10	10	10	10	10	11

	Fair Access to Care Services (FACS) completed in agreed timescales	80%	88%	75%	83%	71%	74%	79%	79%	87%	80%	50%	67%	33%	
	% of individuals (or their carers) who have received a copy of their FACS assessment	100%	16%	24%	25%	31%	28%	38%	39%	26%	28%	0%	80%	33%	
	% of total residential beds occupied	85-100%	85%	83%	85%	84%	79%	80%	81%	83%	80%	79%	83%	83%	
	% of total respite beds occupied	90-100%	50%	60%	81%	74%	58%	54%	58%	50%	75%	69%	73%	68%	
	Service Users with a Person-Centred Plan in place (PCP)	95-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Complex Reviews held on time	85%	39%	52%	45%	100%	100%	60%	46%	67%	100%	91%	67%		#
	Total Child Protection Conferences held on time	90%	59%	90%	100%	100%	100%	75%	78%	65%	86%	36%	68%		#
	Total Initial Child Protection Conferences held on time	90%	33%	100%	100%	100%	100%	22%	45%	35%	86%	7%	68%		#
	Child Protection Reviews held on time	90%	67%	90%	100%	100%	100%	87%	100%	79%	79%	55%	71%		#
	Looked After Children reviews held on time	90%	95%	67%	85%	100%	100%	88%	100%	71%	88%	83%	69%		#
	Children and Family supervisions completed on time	90%	97%	96%	84%	97%	86%	94%	93%	91%	82%	75%	94%		#
	Pathway Plan in place	100%	83%	83%	95%	86%	82%	81%	68%	76%	71%	75%	71%		#
	Children participating in, or contributing to, their Child Protection review	90%	85%	94%	100%	100%	63%	53%	87%	66%	48%	86%	55%		#
	Children participating in, or contributing to, their Looked After Child review	90%	100%	100%	100%	100%	89%	100%	100%	86%	100%	95%	100%		#
	Children participating in, or contributing to, their Complex Review	79%	100%	100%	50%	100%	56%	23%	78%	88%	43%	63%	100%		#
	Occupancy at Ramsey – overnight stays	80% maximum	93%	73%	81%	65%	26%	79%	68%	68%	87%	84%	89%		#

KEY # No data available. Target guidelines: Green: within 5% of target. Amber: within 6-15% of target. Red: >15% of target.

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Horizon Scan OCTOBER 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 across the Care Group. This activity is key to the reduction of staff costs and meeting CIP targets.
- We continue to work through an Action Plan to address the issues highlighted by the CQC during their pilot visit
- Positive verbal feedback has been received from the CQC during their visit at the beginning of the month; service improvement plans will be developed where necessary in line with the reports once they have been received.
- Winter planning proposals across the care group have been developed and put forward to ELT for consideration.

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. 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.
- We are waiting for resources allocated exclusively to transformation to be redeployed 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.
- Recognising the significant staffing challenges in recent months, changes to the UEC Leadership Team have been made 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.
- The advert for the recruitment of a new Senior Nurse (8a) post in ED is now live with interviews scheduled for early November.
- The Workforce & Culture Team have begun their drop-in sessions as part of cultural development work programme in ED.
- The CQC will visit the Manx Emergency Doctors Service in November now a framework for the inspection has been agreed.
- Planning has commenced to accelerate the completion information asset registers across the Care Group.

Integrated Women & Children and Family Services

- HPV Programme has been delivered to year 8 students. A total of 624 vaccines were given.
- Flu Programme is underway. This covers all children in Primary and Secondary Schools.
- Working Group meeting in coming weeks to look at the 'Loss of Baby and Miscarriage' pathway. Care Group implemented revised pathway for pregnant women to be referred to ward 4 if concerns around miscarriages/potential miscarriages.
- Ongoing work around Women's Health Strategy/Vision. Raising awareness around Menopause and promoted 'Menopause Day (18 Oct) with members of the public and staff.
- On-going staffing challenges within Neonatal Services. Working closely with the Neonatal Network who are supporting the team. Expressions of interest for Interim Senior Nurse within Neonatal Services has been circulated. Interviews to take place on 25 October
- On-going staffing challenges within Children's Ward. Support is being provided by the Community team where possible.
- We had representation from our Midwifery colleagues at the Royal College of Midwifery Conference promoting our midwifery services and promote working on the island.
- Oncology application to Macmillan Cancer Services for a Gynaecological Oncology CNS and Support Worker has been approved. Job Descriptions are being finalised and will go for Job Evaluation prior to advertisement.
- Oncology soft pilot due to go live 01 Nov 2022.
- Interviews for Speciality Dr in Obs & Gynae taking place on 21 October
- Integrated Sexual Health Services project has moved from the initiation phase into the planning phase with various working groups commencing significant pieces of work. The project is due to move into execution phase on January 2023.

Integrated Cancer and Diagnostics Services

Pathology

- Consultant Histopathology advert has now been split into 2 posts, Breast and Colorectal.
- LIMS high level design underway.
- Digital pathology project is progressing – talks with NHS supply chain recently
- BMS staffing issues in Histology. Two vacancies with limited interest.
- Promising talks in October around membership of Merseyside and Cheshire Pathology Network
- BC for CL3 build approved and has gone to Treasury to seek capital funding

Radiology

- Consultant radiologist appointed following Sept interviews.
- RIS/PACS procurement progressing.
- Five year capital equipment replacement programme business case submitted to the DHSC last month, awaiting outcome.
- Sonographer, radiographer and nurse post being advertised
- Discussion underway with R&R regarding funding for waiting lists

Pharmacy

- After interviews on 13th October, the role of Chief Pharmacist has now been offered, and accepted. Start date still to be confirmed.
- Ward based Pharmacy Services continue to struggle due to 3.0 WTE Rotational Pharmacist vacancies - these roles currently have a live advert (closing 30th October) with extensive advertising in specialist publications – Our Bank Pharmacists (Band 7) rolling advert went live 19th October to support on-going recruitment
- OHR Talent Acquisition Service (TAS) are engaging with Business Manager at end of October regarding all Pharmacy vacancies

Cancer Services

- Macmillan Associate Director of Nursing post has been offered
- Cancer Performance Day planned for 11th November and will feature guest speakers from the Cancer Alliance and NHS Digital to look at developments around MDT optimisation
- Recruitment of specialist staff continues to be a challenge within the Oncology Day Unit
- Positive feedback from the CQC visit around Cancer Services, especially noting the Oncology Day Unit
- Continued high number of suspected cancer referrals is impacting across the Care Group and wider Manx Care

Surgery, Theatres, Critical Care and Anaesthetics

Theatres:

- AfPP accreditation report expected in November
- Theatre scheduling now reliably working between 6 and 8 week forecast with introduction of Golden patient due for December.
- Restoration and Recovery activity for General Surgery confirmed for first 2 weeks of December. This will mark the third pathway established with support of Synaptik.
- Theatre Simulation training including human factors confirmed for November patient safety day.
- Trauma-focused peer support system (TRiM) designed to help people who have experienced a traumatic, or potentially traumatic event, booked for December 19 and 20
- Management and insight training being supported by the Workforce and Culture team.
- Hip and knee theatre packs have been refined to release 50% saving per procedure for theatre consumables.
- Trainee Nurse Endoscopist has been appointed and will commence training under the guidance of Glen Husada.
- Sterile Service Department Team leader post has been advertised.

Integrated Mental Health Services

- Triumvirate and operational managers reviewing themes within existing international Mental Health and Wellbeing strategies to support realisation of a local pan government strategic approach.
- Multi agency steering group TOR's developed for THRIVE project.
- X 2 Speciality Doctors are being interviewed in Oct for substantive positions within CAMHS.
- X3 existing locum Speciality Doctor colleagues transferring from agency contract to bank contracts.
- IMHS now have access to a dedicated team within MIAA to support CIP.
- IMHS allocated 0.6 FTE LTA to support data protection and security toolkit.
- Restoration and Recovery programme in alliance with Mind Matters continues at pace with over 130 children and young people now in receipt or due to commence psychological therapies.
- Work progressing towards realisation of a live dashboard enabling effective assurance reporting in line with ROF's, RTT and demand analysis.
- SOP developed to support consistent e-harvest and analysis of REQUAL (Patient Reported Outcome measure).
- Acute inpatient Physical health audit demonstrates theme of significant improvement.
- Ministerial visits across the IMHS planned for Nov.

Integrated Primary Care & Community Services

- 3 members of staff from Therapies and Podiatry are on the non-medical prescribing course
- Wound Management & Chronic Oedema (CBD Accreditation) training on 16.11.22, organised by Tissue Viability Team.
- 4 Members of staff will attend The National District Nursing Conference organised by NHS National Performance Advisory Group in Coventry on 22 November 2022
- 2 members of staff will attend Wounds UK Conference in Harrogate on 7/9 November 2022
- Diabetes Nurse Specialist will attend (virtually) the Diabetes UK - Diabetes in Pregnancy Conference on 15 November 2022
- New Prison Healthcare Manager has been appointed and will commence in her role on 7 November 2022
- Commenced frailty work on Martin Ward, 2 days per week with medicines optimisation team, supporting consultant ward rounds and facilitating safe transfers in patient care back to their community settings. In first 6 sessions, reviewed 17 patients and saved approximately £3k in annualised savings.
- Supporting wider frailty community monthly MDTs at Salisbury Street nursing home providing patient-centred care and optimisation patient therapies – reducing polypharmacy related issues and improving patient care at their home. In the 2 MDTs so far, reviewed 9 patients and saved approximately £2k in annualised savings.

Integrated Social Care Services

- All CQC reports are now received and action plans either completed or ongoing across all ASC services. Adult Social Care staff teams found the experience positive and supportive
- External factors (shared services) demonstrate a pattern across all reports identifying lack of compliance;
- RQF progress, a new cohort of learners has been registered through UCM with in house delivery from ASC staff this is incorporating candidates from C&F for the first time, within ASC's new City & Guilds Centre based at Keyll Darree;
- Three Social Care finalists for most recent Care Award;
- 19 ASC staff team members finally celebrated their RQF Level 2 award at a ceremony on 11 October 2022. They all completed their qualification during the Pandemic, including three lockdowns.

RECRUITMENT:

- Recruitment; (vacant positions) whilst slowly improving, recruitment is still challenging across ASC and the social care sector;
- Adult Social Work – 5 permanent vacancies are due to go live on JobTrain in the next 2 weeks;
- C&F Social Work recruitment continues, with little or no interest at this stage.

CEO Horizon Scan – OCTOBER 2022

03/10/2022 – IOM Constabulary Chief Constable's Awards
04/10/2022 – Manx Care Board meeting (Private)
07/10/2022 – Keyll Darree/UCM Graduation Ceremony
11/10/2022 - Chief Officers Group (COG)
11/10/2022 – Level 2 Adult Care awards ceremony
12/10/2022 – Hospice Big Splash event
14/10/2022 – Inaugural Risk Management Committee meeting
18/10/2022 – Tynwald briefing (Safeguarding Board)
19/10/2022 – Safeguarding Board
19/10/2022 – Let's Connect
21/10/2022 – Level 3 Adult Safeguarding training
24/10/2022 – CQC / Well Led Interview
24/10/2022 – Health & Care Trans Extra Ord meeting
28/10/2022 – DHSC & Trustees of LoF
31/10/2022 – Manx Care Board Strategy Day
01/11/2022 – Manx Care Board Meeting (Public)
02/11/2022 – Mannin Line, Manx Radio

COMMITTEE CHAIRS'S REPORT TO BOARD

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COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**Quality, Safety & Engagement Committee**
Meeting Date:	**18 October 2022**
Chair/Report Author:	**Tim Bishop**

KEY ITEMS DISCUSSED AT THE MEETING

Your Committee received updates on the following matters:

- The Board Assurance Framework, risks 1a and 1b
- The ongoing CQC inspection
- Quality Dashboard
- Theatre Improvement Plan
- Complaints Policy
- ENT Review
- ERCP Update
- Report from the Operational Clinical Quality Group

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

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

Issue	Assurance Received	Action	Timescale

Board Assurance Framework – Risk 1a	The risk could not be downgraded at the present time as gaps in controls remained. As the plans to address the gaps mature and further mitigations are put in place it was hoped that the risk could be downgraded during Q4. A more visual representation of unmitigated risk and mitigate risk will be explored.	For noting.	
CQC Inspection	There had been some positive emerging themes from the CQC inspection in several areas including supportive working culture, high quality person centred care and an exemplary district nursing service. Areas for improvement included availability of staffing, immature risk management and systems of governance and oversight of quality. The final report was expected in November. There was a discussion about proactive comms via various media.	For noting.	
Quality Dashboard	Performance levels in all areas had dropped during September and the reasons were not yet know but were being investigated.	For noting.	
Theatre Improvement Plan	The AFPP had conducted its final inspection in September and the final report was awaited. Initial feedback had been very positive in particular the improvement in culture. An AFPP audit would be conducted every two years and a peer review conducted annually.	For noting.	
Complaints Policy	The complaints policy had been updated in line with the recent changes to the Isle of Man Complaints Regulations. The changes would improve responses to complaints. The need to focus on the outcome desired by the patient/complainant was identified.	For noting.	
ERCP Update	The service remained suspended pending review by Liverpool. There was no patient	For noting.	

	harm caused by the continued suspension as the existing pathway to Liverpool was being followed.		
ENT Update	The action plan had been assigned owners and timelines to progress.		
Report from the Operational Clinical Quality Group	The report provided level 1 assurance to the Committee with the exception of the ICNARC audit report of Nobles Intensive Care unit which provided the highest level of assurance being level 3.		

FINANCE, PERFORMANCE & COMMISSIONING COMMITTEE CHAIR'S REPORT TO BOARD
13th October 2022
MS Teams
9.30am – 1pm

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COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	**FINANCE, PERFORMANCE & COMMISSIONING COMMITTEE**
Meeting Date:	**13 October 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**
- **A review of the Terms of Reference for the Committee**
- **Private and public sector nursing homes and GP and Consultant salary levels**

A verbal update on the 23/24 budget and financial exemptions was given.

A presentation was received on waiting list validation and demand and capacity modelling.

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
23/24 Budget	An indication of the 23/24 funding envelope had been received by the Director of Finance which was significantly less than the Manx Care preferred budget and was also less than the figure DHSC had requested from Treasury. If the indicative figure were to be the final	Escalation to the Board	1 November 2022

	award, it would enable Manx Care to meet its statutory obligations only.		
Private and public sector nursing homes.	The initial review of nursing homes managed by Manx Care indicated that there was sufficient evidence to conclude that a deep dive into the matter and that it should be carried out with additional resource to support.	Escalation to the Board	1 November 2022
ASSURE (Detail here any areas of assurance that the Committee has received)			
Consultant salary levels	The initial review of consultant salary levels indicated that there was sufficient evidence to conclude that a deep dive into the matter should be carried out in conjunction with the Medical Director.	**Action**	**Timescale**
GP salary levels	The initial review indicated that GP's funding is made up of a very complex funding formula via a contract with Manx Care. The committee concurred that there was sufficient evidence to conclude that a deep dive into the matter should be carried out by Internal Audit. The matter would be referred to the Audit Committee.	Referral to Internal Audit via the Audit Committee	22 November 2022
Tertiary Spend	A review of tertiary spend indicated that funding for specialised and highly specialised treatments were largely the reason for the continued overspend. MIAA would be asked to review.	For noting.	
Waiting list validation and demand and capacity modelling	Phase three of the Restoration and Recovery plan was being scoped. Good progress was being made on the validation of wait list times.	For noting	
Financial Exemptions	Proposed changes to the Financial Regulations would be submitted to Treasury for consideration. The proposed changes would	For noting	

	streamline the approvals process for Manx Care to enable quicker decision making.		
Term of Reference	The Terms of Reference for the Committee were reviewed and some minor changes were agreed.	For noting	

Manx Care Quality Dashboard

Safe

Indicator	Scope/Status	Responsible	Target	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD/Mean	13 month Trend	DQ*
All inpatient falls per 1000 bed days	Acute Hospitals and Mental Health inpatients from Datix	CQS	<6.63	NHS Benchmark	8.8	7	7.5	5	12.5	11.3	9.1	8.7	8.8	6.1	5.9	6.21	6.32	8.50	7.0		Medium
Inpatient Health Service Falls (with harm) per 1000 occupied bed days reported on Datix	Datix	CQS Team	<2	NHS Benchmark	Data not previously collated to	0.39	0.32	0.19	0.63	0.86	0.21	0.30	0.15	0.4	0	0.36	0	0.33	0.2		Medium
All falls - Adult Social care	All ASC	CQS Team	50 per month	Local	46	37	44	55	41	60	57	57	66	56	56	64	56	49	57.8		Medium
Falls with harm - Adult Social Care	Moderate, Severe, Death	CQS Team	<6 per month	Local	2	3	4	10	1	0	3	2	4	3	2	7	2	4	3.7		Medium
Eligible patients having VTE risk assessment within 12 hours of decision to admit.	Mannually collected	CQS Team	95.00%	NHS Standard	98%	63%	99%	98.75%	97.30%	91.79%	96.67%	78.70%	70.03%	81.80%	91.50%	91.70%	96.07%	79.09%	85%		Low
Percentage of adult patients (within general Hospital) who had VTE prophylaxis prescribed if appropriate	Mannually collected	CQS Team	95.00%	Local	99%	63%	99%	100%	99.30%	99.38%	100.00%	99.50%	96.00%	95.43%	100.00%	98.77%	98.94%	90.48%	97%		Low
Harm Free Care Score Adult (Safety Thermometer)	Mannually collected	CQS Team	95.00%	NHS Standard	100%	90.30%	89.65%	97.5%	98.10%	97.00%	99.00%	98.90%	99.40%	98.50%	98.90%	98.45%	94.06%	97.49%	98%		Low
Harm Free Care Score Maternity (Safety Thermometer)	Mannually collected	CQS Team	95.00%	NHS Standard	94%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%		Low
Harm Free Care Score Children (Safety Thermometer)	Mannually collected	CQS Hospitals	95.00%	NHS Standard	100%	100%	96%	95%	100.00%	100.00%	100.00%	100.00%	100.00%	97.00%	95.00%	96.00%	96.00%	99.00%	97%		Low
Pressure Ulcer incidence total	Datix	CQS Team	≤ 204PA	Local Standard	0	3	3	6	8	7	13	17	19	16	19	21	20	17	112		Medium
Pressure Ulcers Grade2 and above	Datix	CQS Team	≤ 204PA	Local Standard	Data not previously seperated							16	18	13	17	16	13	11	88		Medium
Serious Incidents declared	Datix/ SI Meeting	CQS Team	<40PA	Local	5	3	5	3	3	1	1	3	4	4	1	2	1	3	15		High
Never Events	Datix	CQS Team	Zero	NHS Standard	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Medium
CAS Alerts not completed by deadline	Across all care groups	CQS Team	Zero	Local	Indicator under development						8	3	4	2	0	0	1	0	7		Medium
Clostridium Difficile	ICNet	IPCT	<30 per year	Local	4	0	0	2	1	0	2	1	1	0	0	2	0	0	3		Medium
MRSA bacteraemia	ICNet	IPCT	Zero	Local	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Medium
Total number of confirmed cases of E.coli bacteraemia	ICNet	IPCT	72 or less in 2022/2023	Local	4	4	10	3	7	4	5	7	5	5	10	10	3	7	40		Medium
Total number of confirmed cases of Klebsiella spp	ICNet	IPCT	No national threshold	Local	3	1	2	0	0	1	2	2	0	1	0	2	3	1	7		Medium
Total number of confirmed cases of Pseudomonas aeruginosa	ICNet	IPCT	No national threshold	Local	0	0	0	0	1	0	1	1	1	1	1	0	0	1	4		Medium
The overall positive blood culture contamination rate for the total number of blood cultures received	ICNet	IPCT	<3%	Local	4.8%	12.4%	5.4%	3.8%	3.2%	5.40%	4.50%	3.70%	3.60%	3.20%	2.6%	1.8%	4.6%	5.4%	4%		Medium
Hand Hygiene Compliance	Manx Care Wide	IPCT	96.00%	Local	96%	92%	92%	96%	96%	98.00%	97.00%	98.00%	98.00%	96.50%	98.00%	95.00%	95.00%	97.00%	97%		Medium
Total antibiotic consumption (ddd/1000 admissions)		IPCT			6085	4812	5138	4423	7972	5487	7534	6053	7160	6883	5799	7334	9171	4659	6834		
Indication recorded		IPCT	≥ 98%				50%	54%	61%	72%	67%	65%	54%	61%	51%	58%	61%	69%	59.00%		
48-72 hr review complete		IPCT	≥ 98%				7%	17%	37%	53%	47%	46%	28%	58%	70%	72%	77%	67%	62.00%		
Stop date documented		IPCT	≥ 98%				67%	58%	65%	67%	75%	74%	62%	72%	70%	67%	62%	63%	66.00%		
Appropriate choice		IPCT	≥ 98%				76%	90%	93%	87%	93%	91%	83%	80%	82%	79%	73%	84%	80.17%		
WHOSurgical Safety Compliance	Ad hoc paper/ computer system	Lynn Reid, James Watson, Siva	≥98%	Local	91%	88%	88%	89%	93%	87%	92%	95%	91%	97%	97%	99%	98%	99%	96.88%		Low
Medicines Storage audits - % of areas fully compliant. CD's only	Manually Collated	Craig Rore, Interim Chief Pharmacist, Maria Bell, Community	>98%	CQC	Indicator under development				71%			Not received			83%				77%		
Medication errors with harm	Datix	CQS Team	≤25 PA	Local	0	0	0	0	2	0	0	0	1	1	0	0	0	1	3		Medium
Medication errors involving high risk medication (Including insulin, sedatives, anticoagulants & opiates)	Datix	CQS Team	≤70 PA	Local	0	3	2	6	5	4	10	9	12	11	4	8	6	8	49		Medium
Incidence of Violence against patients/ service users	Datix	Datix	<10 PA	Local	1	2	0	0	0	2	0	0	0	0	0	0	0	0	0		Medium
Incidence of violence against staff	Datix	Datix	<10 PA	Local	2	1	1	1	1	5	0	1	1	0	1	3	10	0	15		Medium
Incidence of self-harm while an inpatient while under observation- moderate harm, severe harm or death	Mental Health Only	CQS Team	<10 PA	Local	1	2	0	0	0	1	0	0	0	0	0	0	0	0	0		Medium
Fire signals at Manx Care facilities	Datix	Datix	<5 PA	Local	0	1	0	0	1	0	0	0	0	1	0	1	3	0	5		Medium
Ligature safe environment	Manannan Court - 6 monthly audit	CQS Team	100%	Local					100%						100%				100.0%		Low
Sickness absence % (12-month rolling average)	OHR	OHR	<5%	Local	7.81%	7.50%	8.41%	8.59%	8.40%	11.18%	8.38%	10.23%	9.70%	7.98%	9.91%	7.89%	6.92%	Not available	8.48%		Medium

Manx Care Quality Dashboard

	Indicator	Scope/Status	Responsible		Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD/Mean	Trend	DQ*
Effective	Mortality - Hospitals LFD (Learning from Death reviews)	Mortality Hospitals LFD	Medical Director	80%	Local	Data not previously available						100%	76%	56%	19%	12%	24%	25%	24%	27%		Low
	Nutrition and Hydration - MUST completed at 7 days within inpatient areas - Acute Hospitals and Mental Health	Acute Hospital & Mental Health Services	Matrons or equivalent	95.00%	NHS/Local					86.95%	83.30%	83.96%	80.70%	88.57%	81.70%	87.10%	74.79%	84.73%	77.16%	82.34%		Low
	ALOS (Average Length of Stay) - Nobles	Recorded/ Business Intelligence	Associate Director of Nursing for Flow		NHS Arverage	5.43	4.93	4.25	4.40	5.09	5.05	4.87	4.3	5.5	5.4	4.79	4.89	4.8		5.15		Low
	ALOS (Average Length of Stay) - Ramsey	Recorded/ Business Intelligence	Associate Director of Nursing for Flow		NHS Arverage	32.58	50.78	42.75	35.42	40.75	35.6	42	33.7	50.2	39.4	38.97	42.16	36.24		42.0		Low
	Post discharge follow-up appointment within 72 hours (MHS)	Discharge follow up from Manannan Court	General Manager	95%	Local	91%	100%	100%	75%	100%	90.00%	100%	80.00%	75.00%	100.00%	91.00%	Not received	Not received		88.67%		Medium
	Delayed Transfers of Care. Number of people with LOS 21 days or more	Recorded/ Business Intelligence	Care Groups	TBC	Local	74.00	69.00	67.00	51.00	82.00	68	83	72	123	107	95	87.00	88.00		See previous month		Low
	% Theatre Utilisation	Theatre Man	Surg, theatre & Critical care		Local	69%	67%	62%	85%	75.0%	82.0%	71.0%	69.0%	73.0%	86.0%	75.0%	No data received	No data received	81.0%	78.00%		Medium
	Use of Rapid tranquilisation	Pharmacy	Matron	≤ 36 PA	Local	3	6	0	2	5	2	2	3	4	3	4	1	2	2	16		Medium
	Use of prone restraint	Report from Datix	Matron	Baseline	Local	3	3	0	0	0	0	0	0	2	1	0	1	0	0	4		Medium
	Use of supine restraint	Report from Datix	Matron	Baseline	Local	0	2	0	0	0	3	0	0	0	0	1	0	0	0	1		Medium
	Use of seclusion	Mental Health Service	Matron MHS	Alert at 4 per month	Local	1	0	0	2	1	1	4	0	3	3	1	2	0	1	10		Medium
	Crisis Team one hour response to referral from ED	Manual reporting via Matron / CRHT	Matron MHS	90%	Local	72%	77%	68%	97%	96%	96%	82%	83%	88%	94%	100%	100%	85%	97%	94%		Medium

Manx Care Quality Dashboard

	Indicator	Scope/Status	Responsible		Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD/Mean	Trend	DQ*
Caring	**Same sex accommodation breaches**	Datix	Matrons	Zero	Local	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Medium
	Child admitted onto Adult Ward	Mental Health	Care Groups	Zero		0	0	0	0	0	0	0	0	0	0	0	1	0	0	1		Medium
	FFT Overall Response Rate	Do not use FFT. Currently use a range of different satisfaction surveys and feedback methodologies	Care Groups		Indicator under development													600				Low

Manx Care Quality Dashboard

Indicator	Scope/Status	Responsible		Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD/Mean	Trend	DQ*
Average Number of Minutes between Arrival and Triage at Nobles ED	Recorded	Care Group Managers - urgent care	15 mins	DHSC					20	21	24	24	23	25	22	23	20	24	23		
Average Number of Minutes between Arrival to Clinical Assessment at Nobles ED	Recorded	Care Group Managers - urgent care	60 mins	DHSC					57	63	73	70	59	65	67	80	71	77	70		
Average Number of Minutes between Arrival to Clinical Assessment at Ramsey MIU	Recorded	Care Group Managers - urgent care	60 mins	DHSC					7	8	11	11	15	12	14	19	17	18	16		
Average Number of Minutes between Arrival to Clinical Assessment for MTS Category 1&2 Patients	Recorded	Care Group Managers - urgent care	10 mins	DHSC					43	44	54	52	47	48	44	53	49	54	49		
Average Number of Minutes between Arrival to Clinical Assessment for MTS Category 3 Patients	Recorded	Care Group Managers - urgent care	60 mins	DHSC					63	68	84	75	69	77	74	84	76	84	77		
Average Number of Minutes between Arrival to Clinical Assessment for MTS Category 4 Patients	Recorded	Care Group Managers - urgent care	120 mins	DHSC					72	80	91	83	68	75	87	98	83	94	84		
Average Number of Minutes between Arrival to Clinical Assessment for MTS Category 5 Patients	Recorded	Care Group Managers - urgent care	240 mins	DHSC	New measures from December 2021 as per National Guidelines				46	85	79	40	52	62	64	120	73	85	76		
Total Time in Nobles ED (Average)	Recorded	Care Group Managers - urgent care	360 mins	DHSC					243	246	226	278	304	257	261	245	242	258	261		
Emergency Care Time (Average Number of minutes between arrival and referral to speciality OR discharge)	Recorded	Care Group Managers - urgent care	180 mins	DHSC					176	182	170	193	229	197	189	187	175	190	195		
Specialty Time (Average Number of Minutes between first speciality request and DTA)	Recorded	Care Group Managers - urgent care	120 mins	DHSC					111	107	88	115	110	98	102	109	120	129	111		
Transit Time (Average Number of Minutes Between Decision to Admit and Admission)	Recorded	Care Group Managers - urgent care	60 mins	DHSC					117	125	112	198	162	111	132	107	123	124	127		
Number of patients exceeding 12 hours in Nobles Emergency Department	Recorded	Care Group Managers - urgent care	0.00	DHSC					42	50	42	98	135	88	70	27	33	38	65		
Total Time in Ramsey MIU	Recorded	Care Group Managers - urgent care	360 mins	DHSC					37	38	41	42	44	47	66	56	57	54	54		
% of Urgent GP referrals that are seen for their first appointment within 6 weeks	Recorded/ Business Intelligence	Care Group Managers - urgent care	85%	DHSC	56%	52%	50%	49%	47%	46%	53%	61%	57%	61%	50%	58%	65%		58%		Medium
Cancer Waiting Times - 2 week referrals FROM DECEMBER 2021 - Maximum two weeks from Receipt of urgent referral for suspected cancer to first outpatient attendance	Recorded/ Business Intelligence	Care Group Managers	93%	DHSC	73%	77%	83%	79%	0%	0%	0%	71%	69%	78%	72%	50%	44.86%	48.20%	60%		Medium
Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment - Maximum of 2 weeks. FROM DECEMBER 2021 - Maximum two weeks from Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	Recorded/ Business Intelligence	Care Group Managers	93%		38%	60%	84%	84%	92%	45%	54%	61%	69%	89%	63%	5%	26%	31%	47%		Medium
Maximum one month (31 days) from Decision to treat to first definitive treatment	Recorded/ Business Intelligence	Care Group Managers	96%						83%	71%	84%	90%	83%	84%	86%	90%	91%	72%	84%		
Maximum 31 days from Decision To Treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where subsequent treatment is Surgery	Recorded/ Business Intelligence	Care Group Managers	94%						N/A	N/A	N/A	N/A	n/a	NA	N/A	N/A	N/A	N/A	NA		
Maximum 31 days from Decision To Treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where subsequent treatment is Drug treatment	Recorded/ Business Intelligence	Care Group Managers	98%						100%	N/a	100%	100%	N/A	100%	75%	71%	86%	75%	81%		
Maximum 31 days from Decision To Treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where subsequent treatment is Radiotherapy	Recorded/ Business Intelligence	Care Group Managers	94%		Guidelines updated as per National Guidance December 2021				100%	100%	100%	100%	100%	60%	89%	100%	N/A	N/A	87%		

Manx Care Quality Dashboard

Maximum two months (62 days) from urgent referral for suspected cancer to first treatment (62 day classic)	Recorded/ Business Intelligence	Care Group Managers	85%						63%	35%	42%	51%	41%	28%	34%	37%	40%	22%	34%		
Maximum two months (62 days) from urgent referral from cancer screening programme to first treatment	Recorded/ Business Intelligence	Care Group Managers	90%						100%	100%	78%	71%	86%	92%	100%	100%	100%	78%	93%		
Maximum 28 days from Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	Recorded/ Business Intelligence	Care Group Managers	75%						74%	74%	84%	71%	76%	76%	64%	52%	63%	61%	65%		
Cancelled outpatient appointments	Recorded/ Business Intelligence	Care Group Managers	TBC	DHSC	BI Team developing																Medium
Cancelled elective admissions - TCIs	Recorded/ Business Intelligence	Care Group Managers	TBC	DHSC	BI Team developing								229	197	189	No data received	No data received				Medium
Cancelled Operations (on the day of planned surgery)	Recorded/ Business Intelligence	Care Group Managers	TBC	DHSC	43	34	20	6	16	41	53	58	44	30	27	No data received	No data received	9	28		Medium
DNA rate Consultant led New and Follow up outpatient appointments	Recorded/ Business Intelligence	Care Group Managers	TBC	DHSC	8.90%	11.30%	10.20%	9.50%	9.60%	11%	10%	9%	10.50%	9.9%	13.8%	9.90%	10.90%		11.00%		Medium
DNA rate Nurse led New and Follow up outpatient appointments	Recorded/ Business Intelligence	Care Group Managers	TBC	DHSC	5.80%	5.30%	5.50%	6.50%	7.00%	5%	5%	6%	5.70%	6.2%	6.0%	6.00%	5.20%		5.82%		Medium
DNA rate Allied Health Professional New and Follow up appointments	Recorded/ Business Intelligence	Care Group Managers	TBC	DHSC	10.40%	9.20%	9.90%	9.90%	9.80%	9%	8%	11%	12.50%	11.3%	12.7%	11.10%	10.40%		11.60%		Medium
Number of complaints received in month	Recorded/ Business Intelligence	CQS Team	≤ 450 PA	Local	31	52	34	46	32	36	34	41	27	38	31	36	21	26	30		Medium
Complaint acknowledged within 2 working days	Recorded/ Business Intelligence	CQS Team	98%	Local	99%	98%	100%	93%	99%	96%	96%	86%	86%	96%	100%	100%	100%	87%	95%		Medium
First written response within agreed response time	Recorded/ Business Intelligence	CQS Team	95%	Local	63%	50%	70%	64%	83%	78%	80%	69%	61%	43%	77%	50%	22%	33%	48%		Medium
Number of re-opened complaints - second response	Recorded/ Business Intelligence	CQS Team	<60 per annum	Local	0	4	1	3	2	2	1	1	2	2	3	4	3	2	16		Medium
Complaints escalated for external review (IRB)	Recorded/ Business Intelligence	CQS Team			2	1	1	2	0	0	2	0	1	2	2	1	2	0	8		
Manx Care Advice and Liaison Service contacts	Recorded/ Business Intelligence	CQS Team	Baseline	Local	260	226	202	519	434	516	421	714	680	329	383	474	526	526	2918		Medium
Manx Care Advice and Liaison Service same day response	Recorded	CQS Team	80%	Local												90%	90%	90%	90%		

Manx Care Quality Dashboard

	Indicator	Scope/Status	Responsible		Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD/Mean	Trend	DQ*
Well Led	Duty of Candour application within 10 days	Moderate or above	CQS	>98%	Manx Care	Data not available					71%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Medium
	% Mandatory Training compliance core subjects	First line assurance/ manual	Care Groups	85%	Local			77%			70%			71%			69.50%			71.8%		Low
	% Appraisal compliance	Unable to pull easily from central source. Have to manually collate from care groups	Care Groups	>90%	Local	Indicator under development																Low
	Child Safeguarding - % compliant (Level 1) Training	First line assurance/ manual	Care Groups	95%	Local																	Low
	Child Safeguarding - % compliant (Level 2) Training	First line assurance/ manual	Care Groups	95%	Local			59%			58%			64%			63.50%			61.1%		Low
	Child Safeguarding - % compliant (Level 3) Training	First line assurance/ manual	Care Groups	95%	Local																	Low
	Adult Safeguarding - % compliant (Level 1) Training	First line assurance/ manual	Care Groups	95%	Local																	Low
	Adult Safeguarding - % compliant (Level 2) Training	First line assurance/ manual	Care Groups	95%	Local			76%			70%			71%			74.60%			73.1%		Low
	Adult Safeguarding - % compliant (Level 3) Training	First line assurance/ manual	Care Groups	95%	Local																	Low

*Low = First line assurance/ manual collection/ Care Groups directly
Medium = Validated by PS&Q or BI Team
High = Externally Validated Data

manx care Kiarail Vannin	**SUMMARY REPORT**	**Meeting Date:**	**01.11.2022**
		Enclosure Number:	

Meeting:	**Board Meeting**		
Report Title:	**Thematic Review of Self Neglect**		
Authors:	Sally Shaw – Executive Director for Mental Health, Social Care & Safeguarding.		
Accountable Director:	Executive Director for Mental Health, Social Care & Safeguarding		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/ Recommendation from that Committee**

Summary of key points in report

The IOM Safeguarding Board commissioned a Serious Case Management Review of self-neglect after a series of deaths. The attached at Appendix 1 is the report that covers the findings of the independent reviewer, Sylvia Manson.

This thematic review explores the individual circumstances surrounding the deaths of 7 individuals, whose deaths are attributed to self-neglect. The names used in the report are not the true names of the individuals but pseudonyms that were agreed by family members.

Only the case of 'Robin' actually met the criteria for commissioning a Serious Case Management Review, but it was considered of benefit to look at this cluster of cases to enhance learning around this very complex and growing issue.

Adult safeguarding is complex, but self-neglect is significantly more complex and especially whilst there has been a void of any supportive legislative framework(s).

The report has two recommendations, these are shown on page 44 of the report. The first recommendation is focussing on activity that the Safeguarding Board need to do and includes 5 areas;

- Pathway – a pathway for 'team around the adult' approach to self-neglect.
- Policy & Procedures – detailing application of the pathway.
- Training and supervision
- Resources
- Involvement of families and communities

The second recommendation is focused on Mental Health services. The Mental Health Service is currently reviewing the entire Care Planning Approach which will be concluded this month and will be reported to Quality Safety and Engagement Committee in 19 December 2022. From this work, practice and policy will be developed in respect of none attendance at appointments, which will include guidance on risk assessment, proportionate and reasonable measures, including communication with other agencies and family as appropriate.

The Board has had sight on various initiatives that will support Manx Cares ability to identify and respond appropriately to adult safeguarding concerns, two of those initiatives being the creation of a Manx Care Integrated Safeguarding Team (operational from 1 November 2022) and the development of the Multi Agency Safeguarding Team (M.A.S.H) – which the Executive Director for Mental Health, Social Care & Safeguarding has previously been instructed by the Board to provided regular updates.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	X	**Information**	X

It is recommended that the Board/Committee :

- Accept the report and instruct the Executive Director for Mental Health, Social Care & Safeguarding to provide progress reports at agreed intervals to Quality Safety & Engagement Committee, of those recommendations directed to the Safeguarding Board.

  And

- Reports to Quality, Safety & Engagement Committee the detail of the review of Care Planning Approach in Mental Health, explicitly changes made to process and policy around how the services deal with those individuals who do not attend appointments.

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

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient Safety and Experience	Yes	To develop safeguarding practice to support individuals to reduce levels of self-neglect and hoarding in order to maintain their health and wellbeing.
Financial (revenue & capital)		
OD/Workforce including H&S	Yes	Competency frameworks and training for all relevant staff in relation to self-neglect. Supervision standards to be agreed.
Equality, Diversity & Inclusion		
Legal	Yes	The proper and timely implementation of the Mental Capacity legislation.

SAFEGUARDING BOARD
ISLE OF MAN

Serious Case Management Review

A Thematic Review of Self-Neglect

Independent Author: Sylvia Manson

Date: August 2022

Contents

1. Introduction

1.1. This Thematic Serious Case Management Review (SCMR) concerns the lives of seven people who all died in circumstances of self-neglect.

1.2. Each person's death was in sad circumstances. Not all those people were well known to IOM services. The Isle of Man Safeguarding Board (IOMSB) wanted to understand how effectively services and communities in the IOM work together to support people who may be self-neglecting and use that learning to make improvements.

2. Context of Serious Case Management Reviews

2.1 The IOMSB will convene a SCMR in circumstances where:

(a) there is cause for concern about how the Safeguarding Board, it's partner agencies or any other relevant body have worked together to safeguard the vulnerable adult, and
(b) a vulnerable adult has died or suffered serious harm and
(c) where abuse or neglect is known or suspected.

2.2. The IOMSB judged that these criteria were met for a man 'Robin'. Robin was in his eighties when he died. Robin was known to several different agencies.

2.3. The IOMSB wished to maximise learning by also exploring the circumstances of six other people who died in IOM within the last two years, also in conditions of self-neglect. Each death is a tragedy for the family, friends and agencies who knew the person. Although the circumstances of those people's deaths had not met criteria for a SCMR, the IOMSB felt it appropriate to make proportionate enquiries to understand common themes that could extend learning.

2.4. The purpose of SCMRs is to promote learning and improvement with the aim of reducing risk of deaths or serious harm to others. A SCMR is not about apportioning blame. The review seeks to understand the systems in which agencies operate and explore factors that aid and present barriers to delivering best practice.

2.5. The IOMSB commissioned an independent author, Sylvia Manson, to lead the review. The reviewer is wholly independent of IOMSB and its partner agencies. She is an experienced chair and author of Safeguarding reviews and has led other reviews in IOM including a quality improvement review of Safeguarding Adults.[1] She has a professional social work background, managing Health and Social Care, specialising in mental health and safeguarding.

[1] Isle of Man Safeguarding Board Review of Multi-agency Safeguarding Adults Arrangements, Interim Report 2020; Available through IOMSB [Accessed May 2022]

3 Terms of Reference and Methodology

3.1. Terms of Reference

3.1.1. The aim of this thematic SCMR is to understand the experience of those seven adults whose lives ended in circumstances of self-neglect. The learning will be used to develop the responses to self-neglect by IOMSB partner agencies.

3.1.2. Objective is to:

- Identify commonalities in precipitating factors that led to a person self-neglecting
- Hear from family/carers/friends about their experience, what interventions by agencies helped and what could be improved
- Understand the challenges, enablers, and barriers that different agencies and their frontline practitioners experience in responding to self-neglect.
- Identify and extend good practice
- Make recommendations to the IOMSB for further development of strategic and practice resources for self-neglect

3.1.3. The thematic SCMR explored whether there were opportunities for services to work together to reduce risks from self-neglect.

3.1.4. 1. The review explored how well best practice factors in working with self-neglect were evidenced[2]

Practice Factors Most Successful in Self Neglect	
Engaging	**1.** Time to build rapport and a relationship of trust, through persistence, patience, and continuity of involvement
	2. Trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history
	3. Working at the individual's pace, but spotting moments of motivation that could facilitate change, even if the steps towards it were small
Working with Risk	**4.** Understanding the nature of the individual's mental capacity in respect of self-care decisions
	5. Having an in-depth understanding of legal mandates providing options for intervention
	6. Being honest, open and transparent about risks and options
Working Across Agencies and Communities	**7.** Creative and flexible interventions, including family members and community resources where appropriate
	8. Effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals.

[2] Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-neglect Policy and Practice: Research Messages for Managers*, Available from: https://www.scie.org.uk [Accessed January 2022]

3.1.5. 2. The review also examined how practitioners were supported by systems and resources to work with people who are self-neglecting[3]

Organisational Factors to Support Practice in Self Neglect	
Systems and Structures	**1.** A clear location for strategic responsibility for self-neglect
	2. Data collection on self-referrals, interventions and outcomes
	3. Clear referral routes to respond to self-neglect
	4. Systems in place to ensure coordination and shared risk management between agencies
Supporting Workforce	**5.** Time allocations within workflow patterns that allow for longer-term supportive relationship-based involvement
	6. Training and practice development around the ethical challenges, legal options and skills involved in working with adults who self-neglect
	7. Supervision systems that both challenge and support practitioners

3.1.6. 3.The SCMR also analysed practice against the Safeguarding Adult Principles[4]:

Empowerment:	Understanding how agencies maximised decision making, involvement and respected individuals' views – Making Safeguarding Personnel. How effective was assessments of decision making i.e. considering capacity or undue influence impacting on decision making?
Prevention:	Examining earlier opportunities to engage and reduce risk of future harm
Protection:	Considering how well risks were understood and the effectiveness of risk reduction measures.
Proportionality:	Weighing whether responses were reasonable and proportionate to the risks of harm and within legal parameters – least restrictive of rights and freedoms
Partnership:	Reflecting on the quality of inter-agency interactions toward coordinated care planning and safeguarding responses.
Accountability:	Understanding accountable practice in line with statute and Safeguarding Adult procedures Exploring whether the appropriate level of professional expertise was applied, along with use of supervision and management consultation

[3] Ibid
[4] The Safeguarding Adult Principles are contained in the Care Act 2014 Statutory Guidance as underpinning all safeguarding work. The principles have been incorporated into IOM safeguarding adult policy and procedures.

3.2. Methodology

3.2.1 The review sought to maximise learning in a way that was proportionate and made most effective use of agency resources and public funds. This combined:

3.2.2. 1. Reports from agencies relating to their involvement with the seven people:
- Narrative report/analysis and chronology of agencies involvement with Robin
- Summary overview reports of agencies involvement with the six other people included within this thematic review

3.2.3. 2. Learning events:
- Learning event to hear the views and perspectives of practitioners/agency representatives involved with Robin.
- Learning event with IOMSB/relevant agencies practitioners/managers involved in working with self-neglect.

3.2.4. Understanding the experiences and perspectives of those most closely involved is fundamental to learning. The review sought to involve family and friends of those seven people who are the subjects of this thematic SCMR. The author is grateful to the people who felt able to contribute, including neighbours and friends and family members. Their perspectives are included within the report.

3.2.5. Pseudonyms have been used to protect the identities of those involved. Robin's niece chose his pseudonym. Dates have been generalised and the names of smaller agencies have also been anonymised.

Participating Agencies	
Manx Care: Health Services	IOM Constabulary
Manx Care: Adult Social Care/Adult Safeguarding Team	IOM Fire and Rescue
GP Practices for the seven people	IOM Environmental Health
Independent Sector care agency	Housing Providers
Volunteers Befriending Scheme	

3.2.6. The thematic review covers a period from April 2018 to February 2022. This spanned the last 2 years of each person's life. However, agencies were asked to provide any historical information from the person's background that was relevant to the terms of reference. The thematic review also benefitted from the Coroner's reports and findings relating to the individuals' deaths.

3.3. Structure of Report

The report is structured as follows:

- Section 4 gives the context of self-neglect and what is known to be best practice in working with self-neglect.
- Section 5 provides background, key events for the seven people, and draws out learning themes relating to practice factors
- Section 6 considers the wider systems factors that aid or present barriers to practice, and some recent changes and opportunities
- Section 7 provides a conclusion.
- Section 8 makes recommendations for the IOMSB and its partner agencies.

4. Context of Self-Neglect

4.1. 'Self-neglect' refers to a range of behaviours. It may include lack of self-care in areas such as personal hygiene, dietary needs and health needs. Self-neglect may also relate to lack of care to one's environment –for example unsafe or unhygienic home conditions; clutter arising from hoarding resulting in risks to health and safety and fire risks. Self-neglect may be shown in refusal of assessments and interventions by services that may alleviate the issues.

4.2. Defining self-neglect can be open to interpretation, with subjective judgements about what are 'acceptable' standards. Practitioners need to make professional judgements about levels of risk but weigh this as part of wider considerations about the adult's wellbeing.

4.3. A state of wellbeing is dependent on many factors - physical and mental health, occupation and economic security. Wellbeing is also dependent upon social and psychological factors including dignity, protection from abuse and neglect, and control by the individual over their day-to day life.[5]

4.4. Wellbeing is an individualised concept. Individuals' may put different weight on the factors that combine to give them wellbeing, for example some may put greater emphasis on safety and security, where others may put more weight on retaining independence even though it may compromise safety and security.

4.5. Safeguarding Adults should be founded on Making Safeguarding Personal[6] (MSP). This recognises individuals' rights to self-determine how they live their lives. Safeguarding interventions need to be person centred and guided by the adult toward the outcomes they want i.e. promoting their wellbeing. MSP can be challenging to achieve where a capacitous adult's resistance to care, leaves them at high risk

[5] The description is drawn from definition in the Care Act 2014 Department of Health Care and Support Statutory Guidance Issued Under the Care Act 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

[6] The Care Act 2014 Statutory Guidance endorses Making Safeguarding Personal. Whilst the Care Act is not statute in the IOM, the Board has agreed to adopt the key principles as good practice following national guidance. Local Government Association: Making Safeguarding Personal https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal [Accessed Feb 2022]

from self-neglect. Respect for self-determination needs to be balanced with duty of care. [7] This requires taking reasonable (and lawful) steps that are proportionate to risk, working with the person to reduce risks of harm.

4.6. All of this makes for a complex context for practitioners to work within. A recent review of Safeguarding Adult Reviews[8] in England[9] highlighted that self-neglect was the most common concern that had led to the review being held, accounting for 45% of all reviews.

4.7. Mental Capacity is a key factor when working with self-neglect – determining whether a person has the mental capacity to make decisions (and then to execute those decisions) about their self-care. This is central to the rights of the adult to make decisions, even where others may view those decisions as unwise. Where the adult lacks the relevant capacity, it confers duties on others to make decisions for the adult in their Best Interest. However, this still requires taking account of the adults past and present views and wishes - understanding what 'wellbeing' means to them; and working in the least restrictive way of the adult's rights and freedoms.

4.8. The IOM does not yet have capacity legislation in place. At the time of the review, the IOM Capacity Bill was in its second reading within the Parliamentary process. The IOM did have a capacity policy in place[10] but without the weight of statute.

4.9. The IOM also had policy and procedures on managing self-neglect. [11] This set out steps for engaging, risk assessment and coordinated multi-agency working. It also referenced a self-neglect panel, an escalation pathway in respect of safeguarding thresholds and risk appraisal. As is described in sections below, the policy was not routinely being used and the self-neglect panel was no longer operating.

4.10. IOM was also working to the Department of Health and Social Care Interagency Safeguarding Adults Policy and Adult Protection Procedures 2018 – 2020. At the time of the review, this procedure was under review. Section 6 discusses further the systems that support practice.

4.11. Research has highlighted factors that are most successful in working with self-neglect, and the systems that need to support practice.[12] These have formed the basis of the terms of reference for this review, as set out in 3.1 above. The following sections will use these factors to analyse the responses to the seven people subject of this review.

[7] LGA and ADASS Myths and realities about Making Safeguarding Personal 2019 https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf [Accessed January 2022]
[8] Safeguarding Adult Reviews are equivalent to a SCMR
[9] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; October 2020
[10] Isle of Man Government Department of Health and Social Care Capacity Guidance v2018
[11] Isle of Man Department of Health and Social Care Self-Neglect Policy and Procedures 2017 https://www.gov.im/media/1358673/self-neglect-updated-policy-and-procedures-sept-2017.pdf

[12] Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-neglect Policy and Practice: Research Messages for Managers*, Available from: https://www.scie.org.uk [Accessed April 2022]

5 The People this Review is About

5.1 Robin: Background and Key Events

5.1.1. Robin was a man in his eighties who died of hypothermia. At the time of his death, the conditions in which Robin was living were unsanitary, the building was unsafe with very basic provision of essential utilities such as heating and hot water. Robin's house was often cold as he declined to put heating on despite advice. Robin's self-care was very poor. Robin had lived in this way for many years but lately his health had declined.

5.1.2. Robin had been born in that house and lived there with his parents. Robin's father had died when he was a young man and his mother died around 20 years ago. Robin's (second) cousin described Robin's mother as a strong-willed person who exerted control over many aspects of Robin's life. She reported that he was largely confined to home and did not have the opportunity to develop skills for daily living or the freedom to go out for work or social relationships.

5.1.3. Robin struggled to come to terms with his mother's death. The family home had been kept in pristine condition, but it gradually fell into disrepair and Robin's self-care deteriorated.

5.1.4. Robin had no other family members on the IOM but had very regular phone contact from his cousin. She lived in the UK and would visit him annually. However, Robin took efforts to avoid her visiting his house.

5.1.5. Over the years, the house conditions deteriorated. When Adult Social Care (ASC) became involved in 2011, the house was in a near derelict condition. When Robin's cousin eventually saw the inside of his home in 2015, she described dire conditions. The floorboards, walls and chimney were crumbling, there was no heat or hot water, and the only source of electricity was a single socket.

5.1.6. Robin appeared to have financial means but preferred to keep his money in cash in the house. Robin's cousin described him as kind and generous, but he worried about not having money, so spent very little on himself. He hated any waste and salvaged out-of-date food from supermarket bins. His cousin described him reusing dirty plates for months on end because he didn't want to (or was unable to) wash up.

5.1.7. Robin's cousin was clear that Robin was content in the way that he lived although she acknowledged this may be difficult for others to contemplate. Robin's cousin would periodically buy him new clothes, but he preferred to wear his old clothes that were very dirty.

5.1.8. Robin's lack of self-care could lead to physical health problems, such as skin integrity/wound management and stomach upsets. Robin had several health needs. As a young man, he had had a motorbike accident and required a metal plate to be fitted in his head. It is not known whether there were any residual problems from this accident. In his later years, Robin had developed hypertension and chronic kidney disease. Robin also had osteoarthritis in the knee and was unable to walk without aids. Robin engaged well in treatment from his outpatient clinics, Community Health Services and GP.

5.1.9. Robin was also well known to other agencies. Historically Robin had had some contact with the Fire Service for fire safety tests, and with Environmental Health due to rat and mice infestation. Robin was

also known to ASC and had weekly contact with a care agency. He also had informal support from his neighbour and a Community Police Officer along with a volunteer befriender although their contact had reduced during the Covid pandemic restrictions.

5.1.10. Robin seemed to enjoy the company of professionals and volunteers and they described his warm, dry sense of humour. However, Robin was very clear about what care and support he was prepared to accept. He remained adamant he wanted to remain in his own home and did not require any additional support.

5.1.11. In the time leading up to Robin's death, ASC had recently become reinvolved, following a referral by his GP. Contact had been made but sadly, Robin died before a formal assessment could be carried out.

- ## Key events

5.1.12 Robin was first known to Adult Social Care in **2001,** referred by his GP. The referral noted that he was living in squalor, had poor mobility, was isolated relying on informal networks and was resistance to help and support. ASC passed the referral to their Homecare service (now Community Support Services CSS).[13] There are no records of any follow up.

5.1.13. In **2008**, ASC had contact from a cousin expressing concern regarding Robin's living conditions. Information was posted out to the relative for discussion with Robin. No further action

5.1.14. A year later, a neighbour contacted ASC reporting concerns about Robin's living conditions. A Senior Social Worker carried out two home visits (unannounced) without gaining access and sent a letter but got no response. There was no further action.

5.1.15. The following year (**2011**), Robin sought help from ASC to sort out affairs. He described being "*in a mess but not knowing where to start*". He was allocated a Social Worker (SW) from the Older Persons Community Social Work Team (OPCSWT). They found very poor conditions in the structure of the property, lack of utilities and unsanitary conditions. Robin's house had a rat infestation. He had sores on his legs as rats had eaten away the padding in his mattress

5.1.16. This SW remained involved for the next 10 years trying, with limited success, to improve Robin's living conditions. They negotiated with Robin to have some periods of short-term respite care during **2012 – 2014**. The SW also arranged for Robin to occasionally attend residential units to have a bath. However, Robin voiced how much he hated this experience and stopped going.

5.1.17. **In 2013** an Environmental Health pest control officer treated a rat and mice infestation. (It is not clear where the referral had originated)

5.1.18. In **2015**, Robin's SW contacted his cousin to discuss the state of his property. The cousin's recall of this, was that Robin was at risk of being moved from his home as it was in such poor condition. Robin reluctantly accepted the need for work to be done and moved to respite care for 2-3 weeks while his cousin carried out some major renovation work. There was an infestation of mites and Robin's cousin

[13] CSS is part of Adult Social Care. CSS is a service provide packages of support to enable people to live at home and to retain their independence – this can include practical tasks such as shopping, personal care, food preparation and medication prompting

acted on advice to burn the contents, replacing everything with new. When Robin returned home, he was highly distressed about what had happened to his belongings. He stopped all contact with his cousin for the next 6 months.

5.1.19. In **2016**, Robin's SW arranged for a volunteer befriender. The befriender visited regularly, helping him with tasks such as bill paying. They maintained their relationship right up to Robin's death.

5.1.20. In **2016** a member of public contacted the police, concerned about Robin's living conditions. The Police Officer who attended was concerned by what he found, but Robin was adamant about remaining in his home. The officer contacted ASC and liaised with his SW. This Police Officer remained involved on an informal basis – visiting regularly and providing practical help over the next 3 years. The officer worked with Robin's SW to try and encourage change but with limited affect.

5.1.21. In **2019**, the ASC Community Support Service (CSS) commissioned a Health and Safety report of Robin's property. The report highlighted Health and Safety risks in the property and recommended CSS staff not to enter. Robin dismissed the findings as '*over the top.'* The CSS support plan was revised so that staff would not go into his house but met Robin at his front door. Robin's SW tried to negotiate with him to get some repair work done but without success.

5.1.22. Later that year, a SW assistant carried out a review. Robin had been receiving help from CSS with shopping, cleaning and collecting his pension from CSS. He had been paying for this support and the intention was to transfer this service to a private company.

5.1.23. Robin had been attending outpatient clinic for his kidney condition and District Nurses (DN) were asked to visit Robin for blood tests. The DN's records from their visit in **January 2020** reference dirty conditions in the house, evidence of mice and Robin being unkempt.

5.1.24. In **January 2020**, the SW from OPCSWT ended their involvement as it was felt that there were no identified tasks for the SW. Robin's situation was stable and he was being supported by his befriender and had weekly visits by CSS.

5.1.25. Robin attended his Renal Clinic appointment in **March 2020**. He also was seen by Podiatry who recorded Robin's personal hygiene as poor.

5.1.26. At the end of **March 2020,** the restrictions related to Covid Pandemic began. There were periods when professionals were unable to make home visits to any service user unless in emergency. Robin's befriender and the community police officer were not able to see Robin but maintained contact by phone. Robin maintained his stance that he wanted to remain in his home.

5.1.27. In **April 2020**, an ASC SW assistant contacted Robin. During the pandemic, SW assistants were supporting CSS by providing additional capacity. The SW Assistant arranged shopping for Robin and visited to check his home conditions. Robin also contacted ASC, phoning OPCSWT in **May 2020**, to report he was '*fit and well …just catching up'*. OPCSWT arranged for the local meal service to provide a weekly service as his befriender was unable to visit.

5.1.28. By **June 2020**, CSS recommenced shopping. CSS reviewed Robin's care plan and risk assessment with him. CSS recorded concerns regarding the property and falls risk. Robin was explicit that he understood

the risk of falls and did not want any other help. In **July 2020** CSS transferred their service to a private care provider along with a care plan and risk assessment.

5.1.29. Over the next few months, Robin attended medical appointments for medication review; chronic kidney disease and to receive his flu vaccine

5.1.30. In **Dec 2020**, The fire service contacted ASC. They had attended Robin's house to fix a smoke alarm and were concerned about him. When ASC followed up, Robin minimised the concerns and declined any support, so the referral was closed with no further action. Robin continued to attend to his health care, being proactive in asking for help to attend clinic.

5.1.31. In **May 2021**, Robin was allocated a Named GP. His Consultant Nephrologist was concerned about him and asked the GP to refer him to ASC. The GP spoke with Robin and referred him to OPCSWT. The OPCSWT were also contacted by Police in **June 2021**. Police had made a welfare call to Robin due to concerns by a neighbour. Robin was safe and well, but Police were concerned about his living conditions. When the OPCSWT followed up, Robin confirmed he was receiving weekly support from the private agency and was having contact with his befriender and a neighbour. OPCSWT did not view Robin's needs as a priority, so he was on a waiting list for allocation.

5.1.32. The podiatry service had attended Robin at home in **June** and again in **Sept 2021**. Their records noted his poor conditions at home. Robin also attended the GP Practice, supported by his informal carer and had follow up home visits by DN's.

5.1.33. In **October 2021**, Robin's cousin, wrote a detailed letter to his GP, wanting the GP to understand Robin and his living circumstances. She described his poor living conditions and that he had refused attempts by family to help and his past response to respite care.

5.1.34. The letter detailed the care Robin was receiving from paid agency and volunteers. His cousin believed NHS staff were refusing to enter his property and that Social Services were no longer involved because he had money to pay for services. The letter emphasised the distress it would cause Robin to leave his cottage and his view that he had been born there and that he wanted to die there. The cousin felt that any move '*would kill him*' and urged the GP to avoid hospital admission unless absolutely necessary. Robin's cousin asked to be contacted for any interventions or if his health declined so that she could travel over to support him.

5.1.35. A GP contacted Robin and spoke with his care agency, arranging for them to bring Robin in for an appointment with his Named GP. When Robin attended, he was provided with treatment and given advice about fire safety. The GP Practice put an alert in Robin's records.

5.1.36. In **November 2021**, DN's attended Robin's home for blood tests. A few days later, a GP spoke with Robin's cousin, (with Robin's consent). The cousin reiterated Robin's circumstances and his wish to remain in the property. The GP also spoke with Robin's care agency who agreed that Robin '*would not last long'* if he was forced to move and live elsewhere. Robin was viewed as having mental capacity.

5.1.37. OPCSWT had allocated Robin a SW Assistant (SWA). When they visited Robin at home, the case record referenced living conditions as '*…filthy, cluttered, cold with a strong odour of rodents, urine and faeces and [Robin] noticeably thinner*.' Robin refuted the concerns. The SWA liaised with Community Health

services to try to arrange a joint visit '*to get fresh eyes*' They felt that raising a safeguarding alert would not be in Robin's best interest because it would likely sabotage any chance of engaging with him. (There is no recorded of a joint visit being carried out)

5.1.38. The SWA made enquiries with CSS about accessing a bath or shower at a day centre but were advised this was not possible due to risks to other patients and reduced staffing. The SWA also spoke with Robin's neighbour and befriender. The befriender felt that Robin was emotionally tied to his property and a move would "*finish him off*"

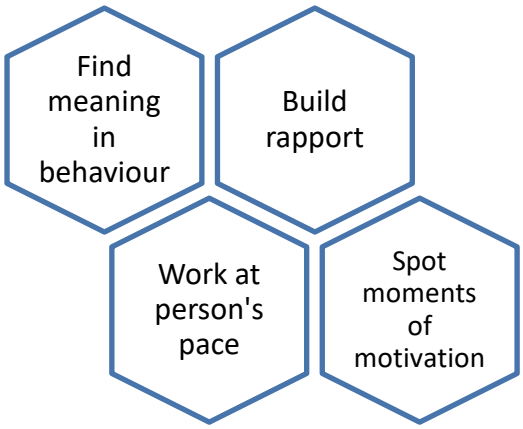
5.1.39. The SWA discussed their concerns with their senior practitioner, and they agreed a visit by a qualified SW. When the SW and SWA visited Robin a few days later, he was not well due to eating contaminated food. Robin remained clear he wanted to live, and die, in his home. The SW arranged a follow up visit for the following week.

5.1.40. The next day, Robin was seen by his Consultant Nephrologist. The Consultant was concerned about his wellbeing and lack of support and wrote to Robin's GP.

5.1.41. The following week, **Dec 2021**, Robin's befriender contacted the SWA as they had not been able to contact him. The SWA spoke with Robin's neighbour and then alerted the Police. Robin's neighbour called round before police attended. Sadly, Robin had died of hypothermia.

Robin: Learning Themes

- Engaging With Adults



5.1.42. Research has emphasised the importance of using a relationship to negotiate small steps toward change. [14] The chronology identifies good practice with key people who had sustained relationships with Robin over many years. Robin had the support of caring and compassionate people – both those engaging with Robin in a professional capacity, and those working informally, such as his befriender and the Community Police Officer who demonstrated great commitment to him.

5.1.43 The ASC author felt that the SW had demonstrated good practice in building a relationship with Robin, demonstrating empathy and a non-judgemental approach, and respecting his autonomy.

14

5.1.44. Robin enjoyed the company of people. Establishing a relationship with him was not the challenging issue. The challenge was in using those relationships purposefully to understand the under lying reasons for his behaviours; demonstrating professional curiousity and using this understanding to negotiate change.

5.1.45. There was some good evidence in the earlier years of using moments of motivation. Examples of times when Robin had been unwell or during cold periods, when his SW persuaded him to accept respite care or to go to a residential centre for a bath. However, Robin described how miserable he felt during those times. He described being stripped off as soon as he got through the door, having his hair cut off, shaved and clothes removed. He soon opted out.

5.1.46. Robin's SW described the difficult balance of being tenacious and persuasive with Robin about the need to change his sef-neglecting behaviours, whilst seeking to maintain their relationship. The ASC author was clear that all ASC staff had been extremely caring. They were motivated to help and wanted to do more but were limited by the boundaries put in place by Robin and the fear he might withdraw from services all together. It seems that Robin was very able to voice his wishes and views. However, advocacy can be a helpful resource where a person may feel an imbalance in power. There is no advocacy provision in IOM so this option was not available to practitioners.

Recommendation Arising

5.1.47. The length of engagement demonstrates the ability of the SW to maintain the relationship – the section below 'Working with Risk,' examines how effective this was in addressing risks.

5.1.48. Despite the involvement of so many professionals over the years, it seems that there was limited understanding of the reasons behind Robin's behaviours. There are multiple reasons why people may self-neglect. Robin talked about how important his home and his belongings were but this seemed at odds with lack of care to those belongings as well as to himself.

5.1.49. Robin had had a head injury many years earlier. There were no records that this had affected his functioning. His cousin believed that Robin's way of living was due to lacking the skills for daily living (a consequence of his very controlled upbringing by his mother), rather than any mental health needs. However, there are no records of whether there had ever been a neurological assessment following Robin's head injury as a young man.

5.1.50. Robin had difficulty coming to terms with his mother's death and continued to be tearful when talking of this. Professionals were not aware of the nature of Robin's upbringing. There was no knowledge of whether there may have been a psychological basis for his behaviour, such as trauma. There was also no obvious symptoms of a depression or other mental illness.

5.1.51. Research highlights that depression in older adults is common but recognition rates are lower than for younger people.[15] The effectiveness of psychological treatments for older adults is well established but

[15] Joint Commissioning Panel for Mental Health Guidance for Commissioners of Services for Older People 2017 https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/old-age-jcp-for-mental-health.pdf?sfvrsn=8242f3c2_4 [Accessed May 2022]

are often not fully provided. Where psychological services are provided, older adults are more likely to attend, but GPs are less likely to refer.[16]

5.1.52. ASC records from 2014 note that a referral to mental health services had been considered at that time but when Robin accepted some repair works to his property, the referral was not progressed.

5.1.53. It is not known whether Robin's circumstances would have met the existing critieria for referral to talking therapies or for other mental health assessments. It is quite possible that Robin would have declined a referral had one been offered, given his general dismissive response to people's concerns. However, there was no liaison between the ASC and the GP to explore potential reasons for his behaviour.

5.1.54. Access to psychological and mental health assessment is an important component in working with self-neglect. Assessments can be useful if only to rule out functional or organic mental disorders that may be affecting the adult's ability to self-care. However, agencies discussed the limited provision of talking therapies and more specialist resources such as neuro psychologists in the IOM.

Recommendation Arising

5.1.55. Robin was allocated a Named GP in 2021. This is standard practice for older adults and patients with long term conditions, to provide overall responsibility for the patient's care and support. Robin's cousin felt his GP did not really know him well. The GP had no knowledge of Robin's living conditions until they received the letter from Robin's cousin in October 2021. Robin was appropriatly accessing health care so to their knowledge, there were no concerns. Historically, DN's had built productive and consistent relationships with him. The Health author reflected that in the last 2 years, it was difficult to see how DN's used relationships with Robin to address self-neglect concerns.

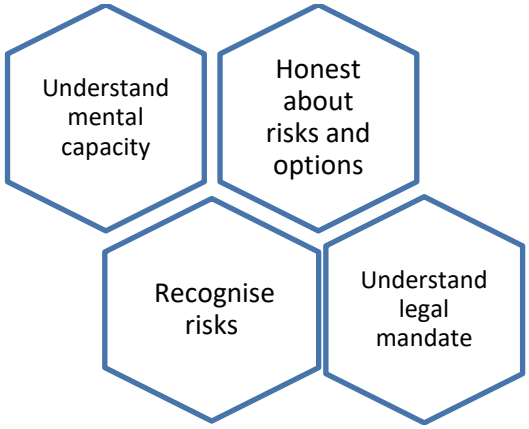
5.1.56. Contributors observed that those strong relationships that Health and Social Care had had in the past, appeared to falter in later years. Some of this was undoubtably related to the Covid pandemic - the restrictions put in place on home visits and the additional pressures on staff. However, the change in contact had pre-dated Covid.

5.1.57. Contributors questioned whether practitioners had simply become demotivated in the face of Robin's ongoing resistance to any changes. ASC's view was that the decision to end the SW's involvement in 2020, was less to do with a change in attitude, as a change in ASC policy. ASC had restructured services and staff felt there was an organisational shift way from long-term casework. ASC commented that closure to the OPCSWT appeared to have been based on Robin being a capacitous adult, a private payer for services and that he was declining any further support. The rationale was that Robin's situation was longstanding, and the care agency; befriender or neighbour could flag concerns if Robin's circumstances deteriorated.

5.1.58. The ASC author reflected that there seemed to be no value placed on the value of low key monitoring as a form of critical assistance. The following section considers the decision to end ASC involvement as part of wider analysis of working with risk and the quality of multi-agency working.

[16] Royal College Psychiatry Suffering in Silence: Age Inequality on Older Peoples Mental Health Care 2018 https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/cr221 [Accessed May 2022]

- Working with Risk



5.1.59. Section 4 gave an over view of the challenges in working with self-neglect. Partners and public may understandably question why an adult, who appears very vulnerable is 'allowed' to live in unsafe and unsanitary conditions.

5.1.60. The IOMSB endorses and promotes Making Safeguarding Personal. All agencies also need to operate within the law. Safeguarding Adults legislation provides duties on agencies, but as Lord Justice Munby clearly set out, it does not of itself, provide any powers over an adult.[17]

> *'…whatever the extent of a local authority's positive obligations under Article 5, its duties, and more important its powers, are limited. In essence, its duties are threefold: a duty in appropriate circumstances to investigate; a duty in appropriate circumstances to provide supporting services; and a duty in appropriate circumstances to refer the matter to the court. But this is a key message, whatever the positive obligations of a local authority under Article 5 may be, they do not clothe it with any power to regulate, control, compel, restrain, confine or coerce. A local authority which seeks to do so must either point to specific statutory authority for what it is doing….or obtain the appropriate sanction of the court…'*
>
> Para 96, Re A (Adult) and Re C (child): A Local Authority v A (2010) EWHC 978 (Fam), Lord Justice Munby

5.1.61. Working with risk requires

1. A clear analysis of the nature and likelihood of harm(s) to the adult or others
2. Understanding the views of the adult in relation to risk i.e. what is important for their wellbeing and the outcomes they wish
3. Understanding the whole circumstances of the adult's situation including views of other professionals; relevant family /representatives

Exploring viable options for harm reduction i.e.:

4. Risk mitigation

[17] Though this case referenced English law, it applies equally to application of legislation in the IOM

- Strengths, assets and solutions offered by the adult; their family/representatives and community
- Potential mitigating actions/resources from partner agencies

5. Exploring levers for change – the adult's motivations and clarity about the legal mandate

5.1.62. Research highlights the risks of practitioners developing complacency and desensitisation to risks, when working with people in circumstances of self-neglect, particularly over the long term.[18] There is a risk of minimising concerns, simply not acknowledging the high levels of risk that are in plain sight. Formal risk assessment provides the evidence base for accountable practice. It provides the objective counterbalance to practitioners' subjective reactions.

5.1.63. Robin's self-neglect had been long-standing. There was some evidence that practitioners became desensitised and blunted to his day-to-day experience. The long-standing nature of his self-neglect seemed to become a justification for minimising concerns without asking basic questions or taking the necessary follow up actions. The responses to concerns raised by fire service in 2020 and in 2021 when allocation to ASC was not seen as a priority, was an example of this.

5.1.64. There were significant gaps in the quality of risk assessments and the risk management plans throughout the period of involvement of all services so there was no objective baseline to challenge the apparent blunted responses from practitioners.

5.1.65. The ASC report author highlighted that there was a lack of formal assessment undertaken by OPCSWT during their period of involvement. The last update to a risk assessment had been in 2014. In the weeks preceeding Robin's death when OPCSWT had re-engaged, the plan had been to carry out a full social work assessment and risk assessment. However it was still not clear when this would occur and a qualified SW had not been allocated. ASC highighted that there had been over-reliance on able, but unqualified SWAs from 2018.

5.1.66. ASC also recognised the OPCSWT had tried to work with risk over the years of their involvement. There are records of long discussions with Robin about the nature of risks. OPCSWT were working on the basis that Robin had mental capacity to make informed choices and gentle encouragement was the only means to mitigate risks. Their records referred to Robin as having full capacity. While there was no indication that Robin had any impairment to the functioning of the mind or brain, there was no formal capacity assessment.

5.1.67. Although the IOM mental capacity policy[19] directs a presumption of capacity, a formal assessment of capacity (decisional and executive functioning[20]) should be carried out where an adult is acting in a way that may question their ability to make decisions, even if only to eliminate lack of relevant capacity as a possible explanation for behaviours. Having capacity, and the right to make 'unwise decisions' does not mean agencies can just walk away where the capacitous adult's decisions leave them at high level of risk. Duty of care requires sustaining engagement – using assertive outreach techniques for purposeful

[18] Day, McCarthy et al 2017 Self-Neglect in Older Adults: A Global, Evidence-Based Resource for Nurses and Other Healthcare Providers https://www.researchgate.net/publication/320191009_Self-Neglect_in_Older_Adults_a_Global_Evidence-based_Resource_for_Nurses_and_Other_Healthcare_Providers [Accessed August 2022]
[19] IOM Mental Capacity Policy
[20] Executive functioning refers to the ability to think abstractly, integrate inputs such as situation and memory, to put a decision into action

engagement and working across agencies to try and reduce risks. There is a need to extend training in mental capacity.

Recommendation Arising

5.1.68. It is worth noting that even had a capacity assessment found that Robin lacked capacity for the relevant decision(s), any interventions would need to be based in his Best Interests – this includes considering the adult's past and present views and wishes, the views of carers and others involved. It is questionable whether a Best Interest based decision would have endorsed Robin forceably being moved out of his home, given the strength of his views and the requirement for actions to be the least restrictive of his rights and freedom.

> *'…Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness.*
>
> *What good is it making someone safer if it merely makes them miserable?'*
>
> Re MM (An Adult); Local Authority X v MM [2007] EWHC 2689 (Fam)
> Lord Justice Munby

5.1.69. Best Interest decisions could feasibly have enabled less restrictive intervention such as an increased care package and arranging repairs to Robin's property. However, in the absence of a Mental Capacity Act, this would still need legal sanction.

5.1.70. There was some indication that ASC considered other legal levers, for example, liaison with Environmental Health to explore their legal sanctions. There was also discussions with some other agencies such as Community Health (who had been providing District Nursing) to try and address risks associated with Robin's health.

5.1.71. There was no referral through Safeguarding Adult procedures. The reasons are unclear. It may be that self-neglect was not seen as a safeguarding matter, but there was also reference made to not viewing Safeguarding as the appropriate route - it is not clear whether this decision was endorsed through line management.

5.1.72. There was an apparent absence of managerial over-sight to assure practice standards, including Safeguarding Adult considerations were met. ASC management should have provided scrutiny to assessments and endorsed/questioned risk management plans including assuring self-neglect guidance and Safeguarding Adult policy was followed and providing supervision to counter risks of desensitisation. Management did endorse (and encouraged) the decision to end SW involvement in 2020. It is not clear what scrutiny was given to the planned closure. It appears that other agencies such as GP and Community Services, were not consulted or informed about the closure and nor was there a clear contingency plan to manage residual risks. Robin's befriender service was a main player in his continuing support. They did not feel in a position to challenge the way in which Robin continued to live, having been told early on that Robin had capacity so was able to choose to continue to live that way.

5.1.73. One function of managers is to seek solutions where there are barriers to care. An example where managers could have helped related to funding requirements. Robin had been paying for his care. He did not believe he needed additional support so was not prepared to pay more. It is not clear whether Robin would have accepted additional services, if he were not required to pay. It seems this was never considered as an option. ASC does need to be equitable in applying criteria for charging for care services. Nonetheless, there needs to be some discretionary criteria for exemptions. There was no protocol for this in DHSC/Manx Care. The new Manx Care Executive Director has identified this as an area the service needs to address.

Recommendation Arising

5.1.74. CSS had involved Health and Safety in 2019 to assess risks from the home environment. This led to a directive for staff not to enter his property. This action met the duty of care to CSS staff but the ASC author observed there was no clarity about who else within DHSC/Manx Care the directive applied to or who the information should be shared with – notably Health professionals, his befriender and the Community Safety Officer were all visiting Robin at home. It is also not clear how managers ratified their duty of care toward Robin i.e. how the ability to continue to manage risks was affected by the changed care plan and what mitigation was put in place. The ASC author highlighted a lack of operational policy and guidance to support this situation.

Recommendation Arising

5.1.75. The decision by CSS to transfer Robin's care to a private agency, appeared to be purely a practical measure to transfer his paid support to another service provider. This decision did not sufficiently consider the value of CSS's role as a service within ASC and their continued duty of care i.e. redressing risks, monitoring and escalating signs of deterioration. This was an important aspect of ASC's accountability in safeguarding an adult with significant self-neglect risks. The private provider had no involvement or requirement to be involved with other agencies and no regulatory requirements relating to safeguarding responsibilities.

5.1.76. Manx Care has reflected on the value of in-house provision, in working with people with more complex care needs, including self-neglect. The Manx Care Executive Director has identified this as an area to develop.

Recommendation Arising

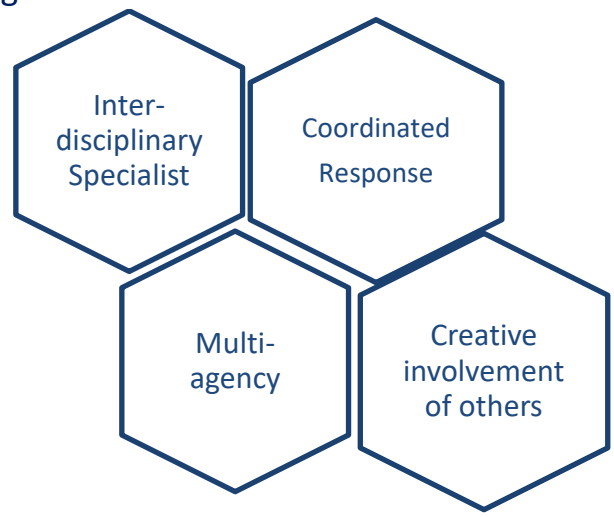
5.1.77. CSS did complete a needs and risk assessment in July 2020. The risk assessment listed hazards and confirmed with Robin that he understood the consequence of his decisions, for example, increased risk of falls. It was shared with the private care agency. CSS's practice also fell short of assessing capacity; formulating a risk management plan and triggering multi-agency responses in line with the Self Neglect and Safeguarding Adults policy.

5.1.78. The author of the Health report to this review also highlighted learning. Contrary to Robin's cousin's understanding, DN's and Podiatrist had been visiting Robin at home. Both services recorded concerns about Robin's lack of self care and the poor conditions of the home but took no further action. There was no risk assessment or management plan. Despite the abject conditions in which Robin was living, none of the health professionals appeared to consider his self-neglect as a safeguarding issue. There was no onward referral through the Self -Neglect policy or Safeguarding Adult procedures. Health professionals became task orientated and desensitised to the high levels of risks that were in plain sight.

5.1.79. The author of the Health report questioned whether Robin's acceptance of health care, was viewed as evidence he could make his own decisions. As noted, upholding a person's rights to self-determine their affairs does not eliminate the duty of care to take reasonable steps to reduce risks from self-neglect.

5.1.80 Alongside the risks of practitioners becoming desensitised to self-neglect, over time, practitioners may develop a sense of hopelessness and develop compassion fatigue[21] where their continued efforts seem to have little impact. Individual practitioners who had known Robin over the years, may have felt at a loss to know how to affect any change. The following section discusses the added value that multi-agency working could have offered.

- Working Across Agencies and Communities



5.1.81 Robin had an extensive network of professionals and informal support through the community and his cousin. Collectively this offered great potential for a multi-agency response. This network could have brought together this expertise and individuals'knowledge of Robin. It was an opportunity to explore the perceptions of his circumstances, his strengths, assets and risks. It was an opportunity to search for creative solutions and develop a coordinated plan with Robin, to reduce risks. It was also a mechanism to share responsibility for risks that remained. Unfortunately, this potential was not used. At no time, was this network brought together.

5.1.82. There were some pockets of joint working, for example, OPCSWT working with Community Services; Police and Environmental Health but this was primarily in the earlier years. There were also some examples of good practice in later years, for example, the SWA speaking with Robin's befriender and carer. The SWA had also tried to arrange a joint assessment with Community Services in the weeks before Robin died – it is unfortunate that this was not facilitated.

5.1.83. There was a lack of a cohesive response from Health services. The Health author commented on silo working and a lack of partnership engagement. Robin's GP had been alerted to general concerns about his wellbeing by a Consultant Nephrologist and information sharing between them was good. It was positive that the Consultant was taking a broader holistic approach to Robin's wellbeing. The Consultant could have referred directly to ASC for support, notifying the GP. The Consutant was not aware of

[21] Ibid

Robin's home circumstances and the extent of self-neglect. Community Health services had attended Robin at home but had not shared their concerns about Robin with his GP, nor made a Safeguarding Adult notification.

5.1.84. There was no communication from ASC to the GP about his self-neglect or the concerns raised by others agencies such a Police and Fire Service. The GP remained unaware of any concerns until Robin's cousin wrote to them in 2021. It was good practice for the GP to gain Robin's consent to speak with his cousin on receiving the letter; arranging to see Robin and speaking to his care agency. However, this did not lead to convening a multi-agency meeting, using the Self-Neglect policy or Safeguarding Adults policy.

5.1.85. Robin's cousin played a key role in his life. She had had past contact with ASC but would have valued greater contact with services. There were missed opportunities by all agencies to involve Robin's cousin more in care planning. Research has highlighted the value that Family Group Conferences can bring in Safeguarding Adult work.[22] This is under used in IOM.

Recommendation Arising

5.1.86. Information sharing is often posed as a barrier to multi-agency working, despite the permissive provisions within General Data Protection Regulations. (section 6 references guidance that the IOMSPB has recently developed relating to this.) It is cited as a main area of learning in a thematic review of Safeguarding Adult Reviews (the term for SCMR's within the UK).[23] Robin readily consented to information being shared between professionals and for professionals to talk with his informal carers and cousin. Despite this opportunity, there was a lack of multi-agency working.

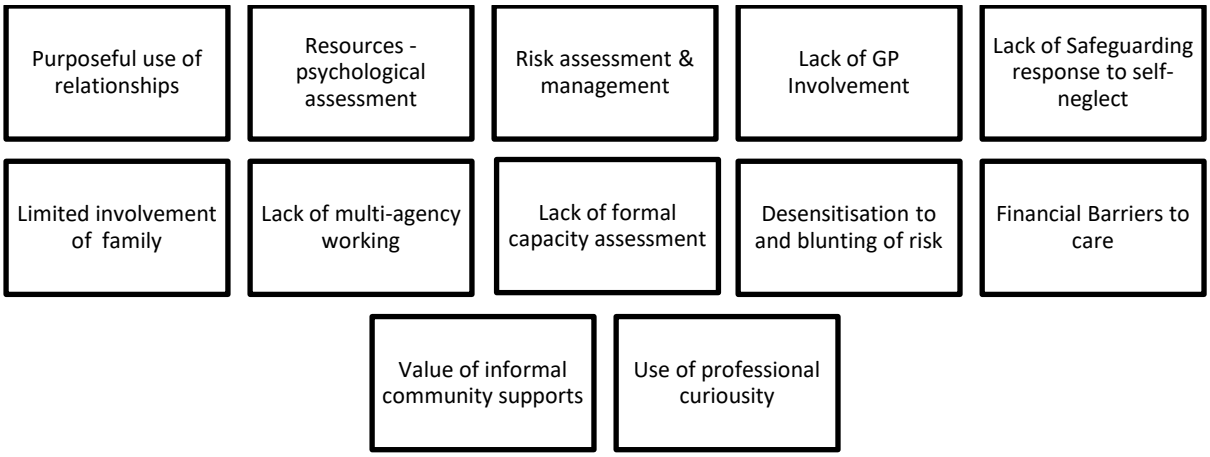
5.1.87. It is not possible to say whether robust risk assessments and multi-agency safeguarding response, could have averted the sad circumstances of Robin's death. Robin may well have continued in his warm but assertive way, to dismiss everyone's concerns and decline any futher help.

5.1.88. What we do know is that robust risk assessment and coordinated multi-agency working would have increased the likelihood of success.

5.1.89. Contributors to the review, reflected that the responses to Robin's self-neglect, were not unique. This suggests gaps in the wider strategic factors that should support practice. The following sections, explore those best practice factors in relation to the other six people and then considers some of the systemic barriers that need to be addressed.

[22] Social Care Institute for Excellence Safeguarding Adults: Mediation and Family Group Conferences 2012 https://www.scie.org.uk/publications/mediation/ [Accessed May 2022]
[23] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; Executive Summary October 2020 https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed May 2022]

Robin: Summary of Learning Themes



5.2. Andrea: Background and Key Events

5.2.1. Andrea was a woman of Manx heritage who was in her 40's when she died. Andrea died of broncho-pneumonia, but the Coroner found that self-neglect was a significant factor in her death. Her accommodation was described as in an uninhabitable state at the time of her death.

5.2.2. Andrea had had mental illness since her twenties and was well known to mental health services. She was diagnosed with a schizoaffective disorder though her mental health had been stable for the last few years. Professionals involved had had some concerns that Andrea may have been using alcohol excessively, but this had not been confirmed.

5.2.3. Andrea lived alone in her Local Government Housing flat. In the period leading up to Andrea's death, she had been unable to leave her house and had missed appointments with mental health services.

5.2.4. Andrea was supported by her family. In the months leading up to Andrea's death, her sister had been concerned about her and alerted mental health services. When her Psychiatrist spoke to Andrea, she dismissed the concerns. Sadly, Andrea died three weeks later.

Andrea: Key Events

5.2.5. Andrea had been involved with mental health services since **2000.** Andrea had some periods in inpatient care and then was supported through Community Mental Health Services (CMHS).

5.2.6. Andrea's Community Psychiatrist began working with her in **2003** and remained involved until she died. The Psychiatrist provided regular reviews, at one monthly, three monthly or six-monthly intervals dependent upon Andrea's mental health need.

5.2.7. In **2005**, Andrea was referred to the CMHS for additional support. From that point until 2016, she was offered support by a Community Mental Health Professional (CMHP) – a Nurse and then a Social Worker. Andrea was also provided additional support by Occupational Therapists (OT), helping build confidence

and skills in daily living. A Community Support Worker also visited twice weekly to provide home support.

5.2.8. The level of support varied according to Andrea's mental health and her wishes. In **2011**, Andrea ended her home support as she felt she no longer needed it. By **2015**, the frequency of visits by her CMHP had reduced to three monthly, by mutual agreement.

5.2.9. In **2016**, Andrea's CMHP left the service. Andrea did not wish a new CMHP. Her mental health had remained stable, and Andrea stated her life was as she wanted it. Her Psychiatrist continued to see Andrea for outpatient appointments.

5.2.10. In **Nov 2017**, Andrea's family contacted her Psychiatrist, expressing concerns about Andrea's self-neglect – the state of her property and hoarding. Andrea's sister requested a meeting with the Psychiatrist, but this was declined giving confidentiality as the reason.

5.2.11. In **June 2018** an OT visited Andrea at home to carry out an assessment of Andrea's hoarding. The OT's assessment was that there was evidence of mild hoarding, but no significant concerns. Andrea's mental health needs did not meet criteria for CMHS and she was not eligible for home care services. The OT discussed some aids that may help her bathing and offered a physiotherapy referral, but Andrea declined.

5.2.12. Andrea was seen by her Psychiatrist at outpatient clinic in **Sept 2018.** Her mental health was stable. Andrea then cancelled the next four appointments. Andrea did attend her appointment with her Psychiatrist in **April 2019**. Her mental health remained stable. Andrea told the Psychiatrist that her conditions at home, self-care and hygiene were adequate, but the Psychiatrist noted that objectively, this was '*somewhat lacking*.' The Psychiatrist noted that Andrea had contact with her extended family.

5.2.13. Andrea was being seen at six monthly intervals at this stage. She cancelled her next appointment and the following six rearranged appointments with her Psychiatrist.

5.2.14. In **March 2020:** Andrea's sister contacted her Psychiatrist again, leaving a message '*really worried about [Andrea]…. living in one room and flat is filthy…. [Andrea] has no strength, her hair is matted, and she has not washed for some time.'* Her sister was informed that the information could be noted but no information about Andrea could be shared as Andrea had not completed a consent to share form. Andrea's sister said that Andrea did not want her mother or sister to know what was wrong.

5.2.15. One month later in **April 2020**, the Psychiatrist phoned Andrea and discussed the concerns (without disclosing her sister as the source). Andrea denied any self-neglect. The Psychiatrist arranged a follow up appointment for six months' time. Sadly, Andrea was found dead 3 weeks later.

Andrea: Learning Themes

- ### Engagement

5.2.16. Research from service users' experience, highlights the importance of continuity of care.[24] It was good practice that Andrea had some long-term relationships with mental health services; two key CMHPs over a seven-year period and the same Consultant Psychiatrist for seventeen years.

5.2.17. The records indicate that mental health services worked to try and support Andrea's activities of daily living and social inclusion although with limited impact. Her last CMHP observed that Andrea had made little use of her CMHP. Andrea did not want what she saw as interference and intrusion in her life.

5.2.18. The CMHP records reference Andrea's seclusion as part of her personality. Her Psychiatrist's assessment was that Andrea's social seclusion was a result of the natural progression of her illness (negative symptoms) and age, as well as under reported but longstanding harmful use of alcohol.

5.2.19. Practitioners were able to maintain a relationship with Andrea. However, it is not clear how practitioners were able to use that relationship purposefully to understand the meaning behind Andrea's behaviours and to use this to lever change.

5.2.20. The author of the Manx Care report to this review observed that there appeared to be no formulation about Andrea's history and a possible psychological basis for her misuse of alcohol and self-neglect, for example experience of trauma. From the records it was not clear to what degree practitioners tried to draw this out and to understand what Andrea wanted to stay safe and well.

- ### Working With Risk

5.2.21. The chronology captures periods when Andrea was withdrawing from services. There were seven occasions when Andrea cancelled or did not attend appointments. It does not appear that mental health services have any 'Did Not Attend' policy to guide decision making when service users miss appointments. This is an omission. Policy needs to set out reasonable steps that respect a person's rights to decline services, with proportionate follow up and risk management relevant to individual circumstances. This was not clear in Andrea's case.

Recommendation Arising

5.2.22. Andrea had the right to decline care. Her Psychiatrist was clear that she had capacity to decide about care and treatment and there were no grounds for compulsion under the Mental Health Act. Mental health services continue to have a duty of care that balances respecting the person's wishes, with taking reasonable steps to maintain engagement in treatment. The level of assertive outreach will be proportionate to the risk presented. Applying assertive outreach techniques, requires skill to avoid the person opting out of services completely if they feel contact is too intrusive. Andrea's mental health had been stable. Mental health services recognised that there had been recurring concerns about Andrea's self-care over the years. They reported that these concerns were mostly not corroborated by home visits by the OT although Andrea did often present as unkempt.

[24] Biringer, E., Hartveit, M., Sundfør, B. *et al.* Continuity of care as experienced by mental health service users - a qualitative study. *BMC Health Serv Res* **17,** 763 (2017). https://doi.org/10.1186/s12913-017-2719-9

5.2.23. A lower level of contact was reasonable but with a contingency plan in the event of any deterioration. It is not clear how effectively Andrea's risk assessment and management plan incorporated involvement of family as a contingency plan. Andrea's extended family were the only point of contact other than Andrea's low-level involvement with outpatient Psychiatry. Her family were therefore in a key position to alert services to a relapse in Andrea's mental health and/or a deterioration in her self-care.

5.2.24. The mental health records do reference Andrea's extended family involvement. Professional guidance[25] references good practice in involving families and carers. It can be challenging where the person does not wish their family to be involved. However, information can be received from family, without disclosing information about the person without their consent and as noted in 5.1., Family Group Conferences[26] can be highly effective in Safeguarding Adults. The response to Andrea's family fell short of expected practice.

5.2.25. The Coroner raised concerns about the Psychiatrist declining to meet with Andrea's family to hear their concerns in November 2017 and recommended the service review guidance on information sharing. It was not until seven months later that an OT carried out a home visit. There is no information of any other follow up actions in the interim.

5.2.26. The assessment carried out by the OT in June 2018, did endeavour to assess the scale of concerns. The OT used a clutter rating scale. This does help to define the nature and degree of hoarding but needs to be used with sensitivity. The Manx Care author noted that the OT had introduced the reason for their visit as being to assess the scale of Andrea's hoarding and to plan interventions. This could be very anxiety provoking for Andrea. Engaging in work on hoarding needs to begin by understanding the reasons for those behaviours and the function it has for the person's wellbeing. For Andrea, it is not clear if she was distressed by the clutter and/or whether she viewed it as serving a positive function in her life, e.g. attachment to belongings rather than people as a psychological defence strategy.[27]

5.2.27. On the second occasion Andrea's family raised concerns, (March 2020), this coincided with a long period when Andrea had missed appointments. This lack of engagement coupled with the family's concerns, and Andrea's history of poor self-care, should have triggered professional curiosity and prompted more assertive follow up. There was a one-month gap between the family raising concerns and any contact being made with Andrea. The response that was made was by phone and was overly reliant on Andrea's self-reporting. Given the very explicit concerns about Andrea's deterioration, a more proactive, home-based assessment was indicated rather than a further outpatient appointment arranged for six-months' time. This response may well have been affected by the Covid pandemic - the uncertainty in those early

[25] NICE Guidance (2011) Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#care-and-support-across-all-points-on-the-care-pathway [Accessed May 2022]

[26] Social Care Institute for Excellence Safeguarding Adults: Mediation and Family Group Conferences 2012 https://www.scie.org.uk/publications/mediation/ [Accessed May 2022]

[27] British Psychological Society, Understanding Hoarding When our relationship with possessions goes wrong 2016 https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Understanding%20Hoarding%20When%20our%20relationship%20with%20possessions%20goes%20wrong.pdf [Accessed May 2022]

days of restrictions and the additional pressures on all services. However, Mental Health services acknowledged that an earlier contact should have been made. The fact that there had been long term concerns about Andrea's self-care raises questions about the risk of desensitisation and complacency to self-neglecting behaviours.

- Working Across Agencies and Communities

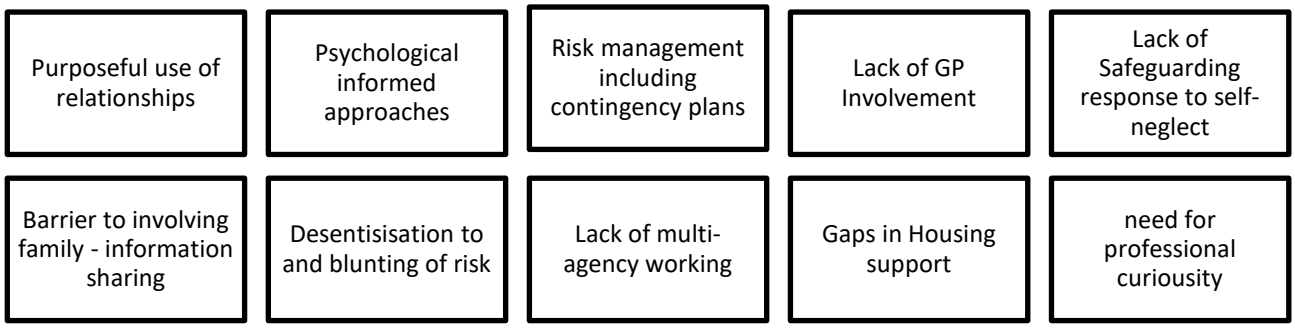
5.2.28. Andrea's care over the years demonstrated multi-disciplinary working but there was limited evidence of working across agencies or applying the IOMSB Self-neglect policy or Safeguarding Adults policy.

5.2.29. There are no records of liaison between Mental Health Services and Andrea's GP. The GP should have been a key player in Andrea's care plan, particularly when she was discharged from CMHS. There is no reference to the GP Practice being informed of concerns about her self-care.

5.2.30. Andrea also lived in Local Government Housing property. Having secure housing is fundamental to wellbeing and sustaining mental health. The Housing sector can provide an essential role in providing Supported Housing for people like Andrea, with additional needs that impact on their ability to sustain a tenancy.[28]

5.2.31. This provision is not applied consistently in the IOM so a resource such as a Housing Support Officer was not available to provide low level ongoing support and monitoring to Andrea. Andrea's social landlord was clear in their response to this review, that their role was limited to annual occupancy reviews and maintenance matters. No concerns were raised about Andrea's ability to manage her tenancy. This response highlights the inconsistencies in approach, particularity for smaller public sector landlords. Section 6 considers the role that Housing could play as part of a wider systems approach to self-neglect.

Andrea: Summary of Learning Themes



5.3. Emma: Background and Key Events

5.3.1. Emma was in her fifties when she died in **2020**. Emma died of sepsis consequent to bronchopneumonia and an overdose of her prescribed pain relief medication. At the time of her death, police noted the poor state of her home with a substantial amount of clutter making most areas inaccessible. This had been a long-standing problem.

[28] One example https://www.lookahead.org.uk/our-services/services-we-provide/mental-health/

5.3.2. Emma lived alone in a Local Government Housing property. She had an adult daughter who was studying away from home but who she had regular phone contact with.

5.3.3. Emma had physical health problems and was prescribed opiate-based analgesics. Emma had experienced multiple losses/bereavements in her life, and she struggled with her mental health. Emma had had a long history of deliberate self-harm and thoughts of suicide when in crisis. Her crisis was often precipitated by psycho-social stress factors. Past assessments had not indicated any formal mental illness. Following a crisis in **2016**, she was assessed as having had an Acute Stress Reaction.[29]

5.3.4. During **2018-2020** Emma contacted police on multiple occasions highly distressed believing people were harming her and stealing from her. Police found no basis for her allegations but were very concerned about her mental health. Neighbours also contacted police on multiple occasions concerned for Emma and/or complaining about her shouting and screaming and bizarre behaviour.

5.3.5. When police attended, they completed Multi-Agency Referral Forms (MARF) due to concerns about her living conditions and her mental health. When mental health services followed up, Emma had a pattern of declining follow up.

5.3.6. In **January 2020** Emma had an acute mental health episode. Her daughter felt Emma's mental health had deteriorated over the last year. Emma was detained for assessment under the Mental Health Act. She was assessed as having an Acute Stress Reaction.

5.3.7. During this admission, Housing officers expressed concern about the state of Emma's property. Emma had been writing all over her walls – this was a vivid expression of her distress. Housing expressed concern about Emma's ability to live independently.

5.3.8. Emma was discharged after four days admission. A CMHP visited her at home and noted the poor state and level of clutter. The Mental Health Crisis team questioned whether Emma had been discharged too early. They made a Safeguarding Adult referral (although there is no record of outcomes from this). A multi-disciplinary meeting was also arranged. The plan was to arrange for Emma to be readmitted on an informal (voluntary) basis. There is no record of this being followed up. A planned follow up professional meeting in May 2020 did not occur.

5.3.9. In **February 2020**, an independent psychiatrist assessed Emma as having a Personality Disorder and episodes of brief reactive psychosis.

5.3.10. Emma continued to be supported initially by the mental health crisis team and was then referred to the CMHS. Emma was viewed as living in a chaotic environment and tended to minimise her difficulties.

5.3.11. From **March 2020**, the Covid Pandemic restrictions meant that CMHP's were unable to visit but they arranged twice weekly phone contact and deliveries from the food bank. Neighbours continued to report concerns about Emma's behaviours. Throughout **March – April 2020** mental health services made further attempts to assess Emma's mental health. However, Emma denied professionals entry as she

[29] A transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. ICD-10 https://icd.who.int/browse10/2019/en#/F43.0

was concerned about the risk of Covid. The episodes of paranoia and apparent thought disorder continued.

5.3.12. In **June 2020**, police and CMHP visited Emma at home following complaints by neighbours that Emma was throwing glass. There was no response. Sadly, three days later police attended Emma's home again, having been alerted by Housing that her shopping had not been collected from her doorway. Police found Emma's body with medication and what appeared to be a suicide note.

Emma: Learning Themes

5.3.13. Agencies involvement with Emma was extensive. It is beyond the terms of reference to make any detailed analysis of Emma's mental health care and treatment. General observations are made relating to best practice factors in working with self-neglect, whilst acknowledging that Emma's self-neglecting behaviours were inextricably linked to her mental health distress.

- ### Engagement

5.3.14. Mental health services had some challenges in establishing effective relationships with Emma. The records reference Emma had a lifelong tendency to disengage or decline psychiatric services. Emma's last diagnosis was of a personality disorder. Difficulties in forming or sustaining relationships are common traits in many forms of personality disorders.

5.3.15. The records indicate mental health services were often responding to Emma during times of crisis. The model of Crisis Intervention Teams is often one of short-term involvement, with support being offered by various team members. This model is not always the most helpful for people with a personality disorder. Emma had been presenting in crisis repeatedly, but it was not until February 2020, after she was diagnosed with a personality disorder, that Emma had the consistency of an allocated CMHP.

5.3.16. Records reference Emma's involvement with friends and a partner though it is not clear whether they were a protective factor for her. Mental health professionals working with Emma, had information about her history – earlier traumas, bereavements, and losses. They also recognised how current stress factors impacted upon her mental health. Emma's chaotic home environment mirrored her periods of crisis.

5.3.17. It is not clear how Emma's known history was used to inform her care and treatment plan. Psychological therapies are the primary intervention for people with a Personality Disorder, as well as for people who have had an Acute/Post Traumatic Stress Reaction. It is not clear what psychological therapies Emma was offered or accepted, or what work was done with her to help her develop coping strategies and safety plans. Engaging an adult in specialist therapy can take time and be dependent on forming a trusting therapeutic relationship. The review also noted comments from agencies regarding the limited provision of psychological services in the IOM.

Recommendation Arising

5.3.18. There was no information within the records to indicate a change of treatment plan following the independent psychiatrist's diagnosis of a Personality Disorder.

- Working with Risk

5.3.19. The author of the Manx Care report highlighted the view of the Independent Psychiatrist that there had been multiple occasions when Emma did appear to be suffering from:

- mental illness with a defined risk to her health,
- a less-well-defined risk to herself and others,
- aggression towards others
- a lifelong tendency to disengage or decline psychiatric services,
- vulnerability in the community
- long-standing concerns about her ability to engage in community care plans
- Suicidal ideation

5.3.20. The Manx Care author concluded there were missed opportunities to detain Emma under the Mental Health Act to clarify diagnosis and treatments. This view is noted. However, it can be difficult to retrospectively judge the decision making, without understanding all circumstances of the case at the time of those Mental Health Act assessments. Decisions about the necessity and therapeutic value of an admission for a person with a personality disorder may be finely weighed. Dependent upon the type of personality disorder guidance recognises that the person may be best helped by maintaining autonomy and being supported in the community to develop skills to manage crises. However, guidance recognises the fine balance needed as refusal to admit the person may endanger them.[30]

5.3.21. When Emma was detained for inpatient care in January 2020, she was discharged after four days. It was concerning that despite Housing raising concerns about her home environment, there was no evidence of using professional curiosity to explore this further - Emma was discharged before her home conditions could be assessed.

5.3.22. There did not appear to be any comprehensive assessment or risk management plan in relation to self-neglecting behaviours. It is also not clear what work had been done with Emma on developing a safety plan or whether she was able to use any strategies to reduce risks of relapsing back into crisis and the lack of self-care that was part of this. The Crisis Team expressed a view that Emma had been discharged too early – the plans to readmit Emma as an informal patient perhaps supports this view.

5.3.23. There is little information regarding the role of Emma's GP in responding to risks, including risks arising from self-neglect. Emma was prescribed pain killers for her physical health conditions. Guidance highlights the risks of addiction to pain killers, particularly where the patient has a history of trauma and where there is risk of deliberate self-harm.[31] All GPs and Pharmacists in IOM should be reminded of these guidelines relating to the role of drug treatment and drug treatment in crisis for people with personality disorder.

[30] NICE https://www.nice.org.uk/guidance/cg78/evidence/cg78-borderline-personality-disorder-bpd-full-guideline3 [accessed May 2022]
[31] National Institute for Clinical Excellence Borderline personality disorder: recognition and management Clinical guideline [CG78]Published date: 28 January 2009 https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#general-principles-for-working-with-people-with-borderline-personality-disorder [Accessed May 2022]

5.3.24. Police had taken a major role in responding to welfare concerns about Emma. Records indicate that Police Officers were responsive and made appropriate follow up through MARFs and direct referrals to mental health services – nine referrals during the last two years of Emma's life.

5.3.25. Emma had a history of a contentious/abusive relationship with ex-partner(s). She had talked about an ex-partner moving in and taking her medication, and also feeling persecuted by the partner. In May 2020 she told her Psychiatrist that she had been sexually interfered with two years earlier by her ex-partner. Research highlights the impact that domestic abuse has on mental health including risk of suicide.[32] The psychological damage of domestic abuse also impacts on a person's motivations/ability to care for themselves and their environment.

5.3.26. It is not clear from the records, how well services recognised and responded to Emma's vulnerabilities to Domestic Abuse. A recent IOM SCMR[33] has highlighted the lack of basic infrastructure in IOM to identify and respond to domestic abuse.

5.3.27. Emma had also made many allegations about her property being stolen. Police investigations found no evidence. Emma felt fearful and had periods where she kept a knife under her pillow. It was believed that her beliefs and fears were part of her psychiatric presentation. This may well have been the case but there is a risk of diagnostic over shadowing i.e. where a person's mental illness causes biased judgements about the validity of statements/accusations made or the reasons for behaviours. There is a need to ensure rigour in assessing concerns through the lens of safeguarding making referrals were Safeguarding Adult criteria apply.

- ## Working Across Agencies and Communities

5.3.28. As noted, police did complete MARFS following contacts with Emma. The crisis team had also made a referral to Safeguarding Adults – it is not clear whether this was due to concerns about self-neglect or of other concerns. It is concerning that ASC have no record of this referral and that the lack of response was not escalated by mental health services. An IOMSB independent review in 2020 of Safeguarding Adults made several recommendations to strengthen Safeguarding Adults[34] but there has been limited progress. The systems to support practice is discussed in section 6.

5.3.29. There is substantial research into the challenges of working with people who have personality disorders.[35] Interventions can lead to divisions and conflict between professionals where there is not a shared understanding of the person's needs and care plans.

5.3.30. There was a record of a multi-disciplinary meeting within mental health services but plans for further meetings were not followed through. There were some good examples of collaboration between police

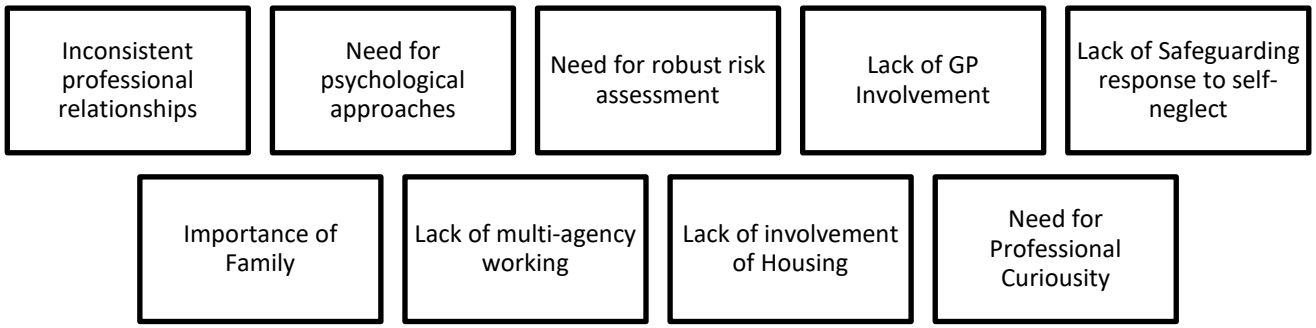
[32] Professor Sylvia Walby 'The Cost of Domestic Violence', London: Women and Equality Unit, 2004 https://www.lancaster.ac.uk/fass/resources/sociology-online-papers/papers/walby-costdomesticviolence.pdf [Accessed June 2022]
[33] IOMSB SCMR 'Family K' 2022
[34] Isle of Man Safeguarding Board Review of Multi-agency Safeguarding Adults Arrangements, Interim Report 2020; Available through IOMSB [Accessed May 2022]
[35] British Journal Medical practitioners Current healthcare challenges in treating the borderline personality disorder "epidemic 2018;11(2):a1112 https://www.bjmp.org/files/2018-11-2/bjmp-2018-11-2-a1112.pdf [Accessed December 2020]

and mental health services, for example joint visits in response to crisis. Whilst this was good practice, this could have been built on by developing a shared crisis response plan with Emma and seeking her consent to share with police and other key agencies involved at point of crisis.

5.3.31. As noted, there was very limited evidence of any joint work with Emma's GP – one contact in the month she died. Housing had had some involvement due to the concerns about damage to Emma's tenancy and responses to complaints and concerns from neighbours. However, there is no sense of any partnership working with Housing in Emma's ongoing care planning. This may reflect a wider lack of involvement of Housing providers in care and support, including working with self-neglect. An earlier SCMR[36], highlighted gaps in Social Housing policy for tenants with vulnerabilities and recommended Housing related support.

Recommendation Arising

Emma: Summary of Learning Themes



5.4. Thomas: Background and Key Events

5.4.1. Thomas was in his thirties when he died in **June 2020**. The cause of his death was an overdose of Venlafaxine whilst under the influence of alcohol. It is not clear whether he intended to die. At the time of his death, Thomas was neglecting his self-care, with very poor and unhygienic conditions in his home.

5.4.2. Thomas lived alone having separated from his wife although his wife remained a key support for him. He had a long history of anxiety and depression. Thomas also had problematic substance and alcohol use. He was well known to mental health services, the Drug and Alcohol Team (DAT) and his GP. Thomas had periods of successfully controlling his alcohol use but also recurrent relapses. At times of relapse, Thomas could behave impulsively, with acts of deliberate self-harm and suicidal thoughts and attempts.

5.4.3. At times, Thomas self-referred to police when in mental health crisis. Police were also contacted at times by Thomas's ex-wife, requesting welfare checks. In **early 2020,** Thomas was working with DAT with his keyworker and psychiatrist. He appeared to be stable and doing well.

5.4.4. In **May 2020**, Thomas had a phone consultation with his psychiatrist. He remained stable and the psychiatrist had plans to discharge him if he continued to be settled. Very sadly, six weeks later, Thomas took an over-dose while intoxicated and died.

[36] The Isle of Man Safeguarding Board The Learning from a Serious Case Management Review in respect of Mr H Independent Author: Domini Gunn-Peim Published May 2020

Thomas: Learning Themes

5.4.5. Thomas' impulsive self-harm and periods of self-neglect appeared to be a directly attributable to his relapse in alcohol use. Alcohol Change UK[37] highlighted the need for early intervention before chronic dependency on alcohol is established with alcohol screening, advice and referral onto specialist services. People who may be resistant to change can be helped through assertive outreach approaches and a structured/coordinated multi-agency approach. Alcohol UK highlighted the high rates of co-existent depression (60- 70%), poor sleep and poor nutrition. The guidance also referenced the psychological barriers that people may face. Building motivation and self-belief can be challenging. There is a double bind of using alcohol to blot out past emotional traumas but drinking causing further suffering.

5.4.6. Thomas was engaged with specialist services and received multi-disciplinary input. Thomas responded well to mental health services but could not always sustain engagement. The cycle of behavioural change is well established in alcohol and substance misuse services. This plots the different stages of motivation in addressing problematic substance use[38]and recognises that progress is unlikely to be straight trajectory.

5.4.7. There is evidence of mental health services and DAT being responsive to Thomas – using opportunities when he was more motivated to address his alcohol use. Services attempted to understand the triggers and stressors for his relapse and his self-harm, although the records did not give any background history or identify potential reasons for drinking or self-harm.

5.4.8. There is good evidence of police responsiveness and sensitivity toward Thomas. Police also engaged with Thomas' ex-wife when she raised welfare concerns, enlisting her to support Thomas at Emergency Department when police had conveyed him there during a crisis. Police followed these episodes up by submitting an adult MARF.

5.4.9. Prior to his death, there were no concerns that indicated a need for a safeguarding response. Thomas' alcohol use was the primary focus and this was being appropriately addressed through the DAT, working with mental health services and Thomas' GP, supported by police at points of crisis.

5.4.10. Thomas lived in private accommodation. It is not known whether he was a homeowner or was in private rental. It is also not known whether he had any difficulty sustaining his accommodation. People with alcohol dependency can often have problems sustaining a tenancy, and be at higher risk of eviction. Overcoming addiction becomes all the more difficult for people who are homeless.[39] The Housing sector across the UK are commissioned to provide specialist housing support for people with a range of vulnerabilities including mental health problems and drug or alcohol problems. There is national

[37] Alcohol Change Uk Blue Light Project https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project [Accessed June 2022]
[38] World Health Organisation (2003) Intervention for Substance Use: Brief Intervention for Substance Use: a Manual for Use in Primary Care -Draft https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf [Accessed May 2022]
[39] The Housing Needs and Experiences of Homeless Drug and Alcohol Users in Stoke-on-Trent Sheffield Hallam University 2009 file:///C:/Users/sylma/Downloads/housing-needs-exp-drug-alcohol-stoke.pdf [Accessed June 2022]

guidance to support this work.[40] This provides an essential network of support but is under-developed in the IOM.

Recommendation Arising

Thomas: Summary of Learning Themes

Correlation alcohol and self-neglect	Need for Housing support [TBC]	Importance of Family

5.5. James: Background and Key Events

5.5.1. James was a man of White British heritage who was in his sixties when he died. The primary cause of death was Myocardial Ischemia, secondary diagnosis liver cancer. At the time of James' death, he was very poorly nourished. His house was in very poor state of repair and he had been sleeping with no sheets on a blackened bed.

5.5.2. James had a daughter who remained in the UK. She had monthly phone contact with him. James' daughter and one of his friends provided some background information about him.

5.5.3. In the past, James had owned a hotel in the UK which he ran with his wife before they separated. James had struggled with mental illness since his teenage years. Records indicate he was diagnosed with bi-polar affective disorder in 2000, although his family note he was diagnosed in the UK in 1987.

5.5.4. James' daughter recalled that James would have long periods where he would shut himself away. James moved to the IOM nearly twenty years ago and used all his money to buy a house that was near derelict. He had little spare money. Over the years, he became more financially stable but chose not to spend his money.

5.5.5 James' friend recalls that in the past, James had been smart in his appearance and managed everything well. She recalled that he loved his dogs and was devasted when they died. He stopped going out. His friend recognised that James could struggle if there were '*any bumps in the road*' and had period when he would just stop answering the phone. James' daughter also experienced these periods when she would lose any contact with her father but understood he would come out of his seclusion in time.

5.5.6. James had very limited contact with his GP. He had been prescribed sleeping medication (Zopiclone) for 20 years. Up until the year before he died, James had not had any involvement from mental health services.

5.5.7. In **October 2020**, James attended his GP. He appeared dishevelled, flustered and distressed. He declined any support other than sleeping medication. The GP noted James had capacity to decline any other

[40] Local Government Association Specialised supported housing: guidance for local government and NHS commissioners 2020 https://www.local.gov.uk/publications/specialised-supported-housing-guidance-local-government-and-nhs-commissioners [Accessed June 2022]

support. The GP stopped his medication and referred him to the mental health Crisis Team. The Crisis Team made a home visit. James had some symptoms of illness but did not want any further support. Three days later, Police found James in a confused state. He was admitted to general hospital for checks. James' daughter contacted the hospital and provided background about his mental health. James was admitted for mental health inpatient care.

5.5.8. James was very thought disordered and had poor self-care. He was fixated on spending large sums of money. His daughter had been concerned about risk of over-spending and of financial exploitation. The bank had contacted her concerned about James' presentation and in discussion with her, had frozen his financial assets.

5.5.9. James was discharged from hospital in **November 2020** with follow up support from the Older Adults Mental Health Service (OAMHS). He was discharged from that service in **March 2021** at his request.

5.5.10. Sadly, James was found to have died at home in **September 2021**. His neighbour had contacted the police after not seeing him for a few days.

James: Learning Themes

- ### Engagement

5.5.11. James had had life-long struggles with his mental health and yet until the last year of his life, had very limited support from agencies. People with stable mental illness can be well supported within Primary Care, without needing involvement from secondary mental health services. However, it seemed that James was lost from sight. He had very little contact with his GP though had been prescribed sleeping medication for nearly twenty years. Treatment guidance for bi-polar disorder recommends a review of treatment and care, including medication, at least annually and more often if the person, carer or healthcare professional has any concerns. Guidance is also to offer evidence based psychological interventions.[41]

5.5.12. There is no evidence these guidelines were followed. Although James had very little contact, it appears there was no system to flag his vulnerabilities associated with his bipolar illness; no professional curiosity about his lack of contact and the need to make more assertive outreach to review his care. It was not until he was reviewed by a Locum GP in 2020, that there was a proactive response to pause his medication and seek review by mental health services.

5.5.13. James' daughter confirmed that James felt he did not need any services. He had always backed away from any discussion about his mental illness – it had been a taboo subject within their family. James' daughter's view was that her father was good at avoiding services and that mental health services had done as much as they could to keep involved. She described his mental health hospital care as good as was the follow up from OAMHS – both services kept her involved and informed. James' friend confirmed that he liked members of the OAMHS but didn't want them to keep calling.

[41] National Institute for Health and Care and Excellence Bipolar disorder: assessment and management Clinical guideline [CG185]Published: 24 September 2014 Last updated: 11 February 2020 https://www.nice.org.uk/Guidance/cg185 [Accessed June 2022]

5.5.14. The OAMHS tried different ways to sustain engagement but ultimately, James' decided to end involvement. His daughter recalls the OAMHS contacting her to let her know they were ending involvement and passing on contact details if concerned.

- Working with Risk

5.5.15. James had the right to end involvement. There were no concerns about his capacity, his mental health was stable and there were no grounds for compulsory treatment. Mental Health services did develop a relapse prevention plan with him. James' daughter had also asked services to provide them with information about his illness and signs of relapse. She found this very helpful in being able to open up conversations with her father for the first time – the materials had helped her to get over the taboo of talking to him about his mental health.

5.5.16. There was good practice in managing risks around James' over spending and risk of financial exploitation. The IOM Bank identified concerns about James' mental health and alerted his daughter. The bank also kept her in touch during James' admission when inpatient staff were trying to help him access accounts.

5.5.17. It is not clear from records how well risks associated with self-neglect had been specifically assessed. There are no records to indicate home based assessments, prior to James' discharge and no assessments by Occupational Therapy post discharge. It may be that his CMHP had been able to carry out home based assessments. Given the concerns about James' self-care at point of admission, this should have been clearly referenced within a risk assessment and management plan. James died six months after OAMHS ended their involvement and at that point he was in poor physical condition and his home was in very bad repair. There is no benchmark to judge whether his self-care and home environment had deteriorated quickly over this period, or whether these concerns had been apparent at point of closure.

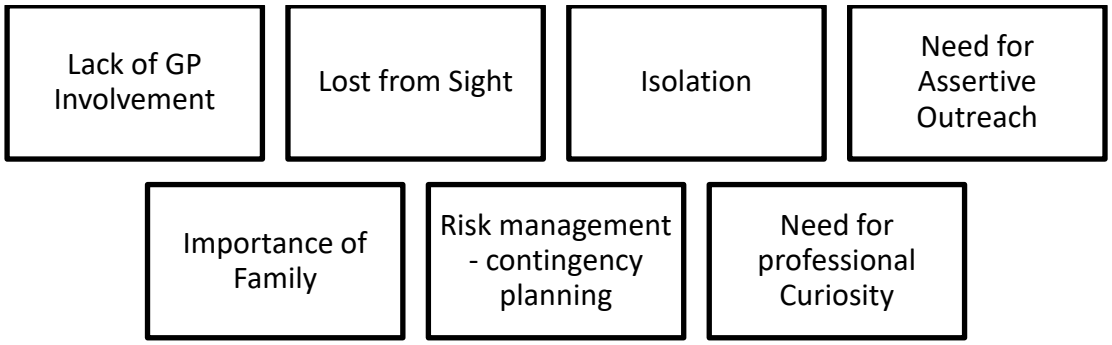
- Working Across Agencies and Communities

5.5.19. James' had lived a relatively isolated life. When he ended involvement with OAMHS, there was a limited safety net of supports that could escalate concerns about a relapse. As noted, there was good communication between mental health services and James' daughter, but she did not live in the IOM.

5.5.20. There was limited communication between mental health services and James' GP practice. There are no records of liaison between those services prior to James' discharge from hospital. OAMHS did write to inform James' GP that they were ending involvement. However, it is not clear how that discharge planning was coordinated within the GP Practice i.e. additional steps to keep him engaged; understanding of relapse indicators and a contingency plan. There is a need for agencies to consider how they can come together to provide a 'Team Around the Adult' network of support. Primary Care can play in central role in this.

Recommendation Arising

James: Summary of Learning Themes



5.6. Margaret: Background and Key Events

5.6.1. Margaret was a woman in her eighties when she died in **March 2021.** She died of hypothermia following a fall in her unheated house. Margaret was not registered with a GP and was not known to any other services.

5.6.2. Margaret originated from a European Country and had come to live in the IOM many years ago. Margaret's neighbour (and friend) described her as a very private and independent person. She lived alone having separated from her husband. Margaret was believed to be financially secure. She enjoyed fine furniture, paintings, and fashion. Margaret had been an accomplished artist and enjoyed the company of other artists.

5.6.3. Margaret's life changed approximately four years before she died. Margaret sustained a hip injury following a fall outside her house. Margaret stopped being able to drive and the standards in her home began to deteriorate. Her neighbour believes that Margaret became embarrassed about this and so stopped contact with her friends. She gradually became more isolated.

5.6.4. Her neighbour had known Margaret for many years, and had phone contact most days. He seemed to be one of the few people Margaret would allow into her home. He recalled she never put the heating on. Over time, her neighbour noted deterioration in the hygiene standards of the house. At one point, Margaret asked her neighbour to help find a cleaner. However, she then declined to let the cleaner into the house, saying she would rather clean up a bit first.

5.6.5. Margaret's ex-husband had engaged his IOM financial investment manager to visit Margaret to try and help. She declined to let them in. Her neighbour believes this investment manager arranged for a care agency and tried to get an alarm pendant in place, but Margaret declined. The investment manager asked the neighbour to '*keep an eye'* on Margaret.

5.6.6. Latterly, her neighbour noted Margaret had become very thin – her diet being very limited. She used to tell her neighbour that she wanted nothing to do with social services. He believed that she was well able to make decisions for herself, her only impairment being her physical mobility.

5.6.7. Margaret's death was discovered by the police who had been alerted by her neighbour, having not seen her for a few days. The Coroner '*did not find that failings on the part of any person or body contributed to their deaths but do consider that …..fell through the net of support that might have been available.*'

Margaret: Learning Themes

5.6.8. Margaret's world seemed to close in following her fall. There are no records of Margaret attending for any treatment following her fall. Had services known of Margaret's injury, potentially the combination of acute care and rehabilitative physio and occupational therapies could have limited the impact and maintained her independence and wellbeing.

5.6.9 It is not clear why Margaret was so resistant to having any external involvement from agencies. Sadly, no professional got close enough to understand her motivation. It is difficult to see how the network of support that the coroner referred to, could have been mobilised for Margaret as she was out of sight of any agency.

5.6.10 Her neighbour was one of the few people in Margaret's life that had any contact. She appeared to value his support. The neighbour appeared to be compassionate and respectful, recognising her loss of dignity. His view was that even had agencies known about her circumstances, Margaret would have resisted any offers of help and that there was little that services could have done.

5.6.11. Margaret's circumstances demonstrate the key role that neighbours, and local communities can play in supporting people who may be isolated, not known to agencies and resistant to involvement from others. There is potential for friends and neighbours to provide a catalyst to linking into agency support. However, the public are often not aware of what role service can offer in relation to self-neglect.

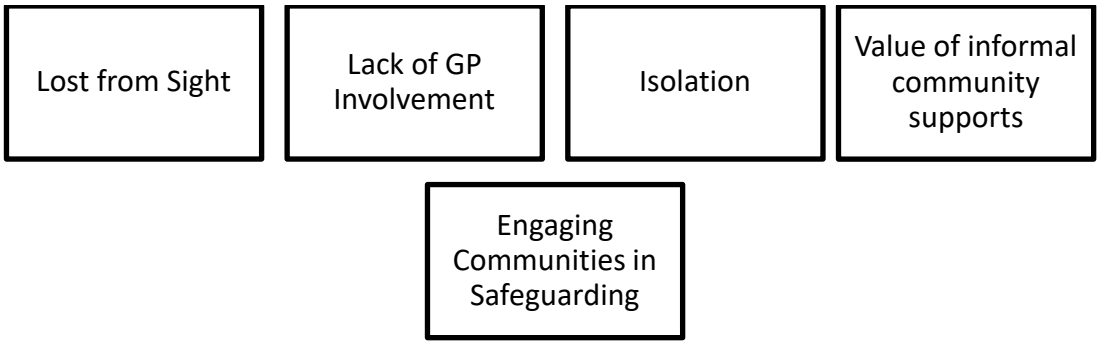
5.6.12. A review of Safeguarding Adult in 2020,[42] highlighted that there is a low level of public awareness and community engagement in Safeguarding Adults work. Margaret's neighbour had no knowledge of what 'Safeguarding Adults' was or who he would contact if he was concerned about someone was being abused or neglected. He felt that he would not have been able to go against Margaret's wishes.

5.6.13. Margaret's ex-husbands financial advisor was also clearly trying to find ways to help her. The lack of any contact with ASC does seem to reinforce a lack of public awareness within the IOM about supports available for people who may be self-neglecting.

5.6.14. Margaret was lost from sight of agencies. Sadly, this precluded any opportunities for agencies to try and engage her, assess risks or coordinate multi-agency support for her.

[42] Isle of Man Safeguarding Board Review of Multi-agency Safeguarding Adults Arrangements, Interim Report 2020; Available through IOMSB [Accessed May 2022]

Margaret: Summary of Learning Themes



5.7. Harriet: Background and Key Events

5.7.1. Harriet was a Manx woman who was in her seventies when she died of hypothermia. Her house was in very poor condition. A window had fallen out and there was hole in the roof. There was no heating or food in the house. There was clutter and rubbish everywhere. The house was full of thick, matted cobweb and there was no working toilet, shower or bath within the property. Harriet had been sleeping on a very small corner of a dirty bed that was predominantly covered with rubbish and household items.

5.7.2. At the time of her death, no agencies were involved with Harriet. Harriet had received repeat prescriptions but had had no direct contact with her GP. Agencies knew very little about her but a friend who had known her from childhood was able to provide some information about her.

5.7.3. Harriet lived in her own house. She had a reclusive lifestyle with no known contact with her family or others apart from her friend. Harriet's friend described her as a very kind, tender and intelligent person. Harriet had attended university. She was an artist and played piano very well. She was a 'great collective of things' particularly piano keyboards, and her house was crowded with belongings.

5.7.4. A friend of Harriet's had contacted Police in **November 2017,** concerned about Harriet's welfare. Police visited and were concerned about her home conditions so made a MARF referencing '*very dusty, damp and messy…clear evidence of hoarding, making it very difficult to move around the property and, in the Officer's opinion, not fit to be lived in*.' There is no record of what followed this referral.

5.7.5. The last time Harriet's friend visited her was on her birthday, but Harriet didn't want to let her in. Her friend thought this was because she would be too embarrassed about not coping and not wanting to trouble anyone.

5.7.6. Harriet's death was discovered in **December 2020** when police responded to a call from a member of the public. The person narrowly missed being hit on the head by a skylight that had fallen off her property. The Coroner did not find any failing on any person or agency but did highlight that Harriet '*…fell through the net of support that might have been available*.'

Harriet: Learning Themes

5.7.7. Harriet's friend said she was very closed toward people she didn't know. Harriet wanted to keep her problems to herself and fought very hard to be independent. It is not clear the reasons why Harriet

became reclusive. Her friend referenced her mother dying when she was young, and a difficult relationship with her stepmother.

5.7.8. Harriet had been on repeat prescriptions but had not been seen. It is not clear whether the extent of her health needs would have merited the GP Practice nominating a Named GP and/or having a system for reviews such as annual health checks. Potentially, a holistic review could have identified concerns about her self-neglect and hoarding behaviours although Harriet was adept at keeping her difficulties hidden.

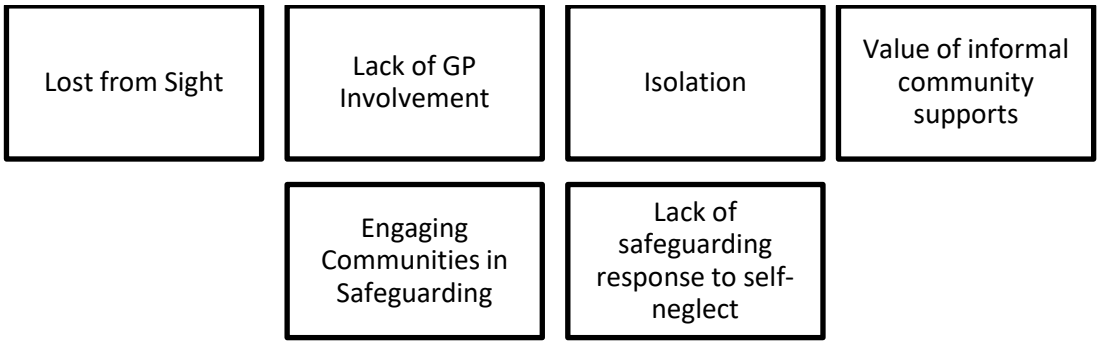
5.7.9. There was a brief record from 2017 of ASC offering support to Harriet. It is not clear whether this involvement was triggered by her GP - the record does reference the GP had concerns about her bone density and potential arthritis. The record provides no detail to indicate eligibility or reason for the need for support. There is no reference to concerns of self-neglect and no record of what Harriet's response to the contact was.

5.7.10. Harriet's friend had not known the extent of Harriet's problems. Her friend was not aware of what Safeguarding Adults was or how to raise concerns.

5.7.11. The occasion, in November 2017, when a friend did raise concerns through the police, was a significant missed opportunity. Police appropriately raised a MARF. It is very concerning that there is no record of that MARF – it is not clear if it was received, and if it was, what the rationale was for any decisions made regarding assessment and responses to self-neglect. There is no evidence of any follow up response. This reinforces findings from an Independent Review of IOM Safeguarding Adults, that highlighted a concerning lack of any robust Safeguarding Adult pathway for self-neglect.[43]

Recommendation Arising

Harriet: Summary of Learning Themes



[43] Ibid

6. Strategic Responses to Self-Neglect

6.1. The stories of the seven people who are subject to the review identified a number of themes:

Engagement	➢ Risks where people are isolated and out of sight. ➢ The need to raise public awareness of safeguarding responses to self-neglect ➢ Time and support needed to develop consistent and purposeful relationships ➢ The need for professional curiosity ➢ The value of assertive outreach approaches ➢ A need to improve access for psychological/mental health assessment ➢ A need to develop psychological approaches and resources, to understand behaviours and provide therapeautic responses
Working with risk	➢ Risks of desensitisation by practitioners working with self-neglect ➢ The need to strengthen risk assessment and risk management, incorporating principles of wellbeing and Making Safeguarding Personal ➢ The importance of legal literacy - understanding what legislation may apply including formal assessment of mental capacity where indicated.
Working Across Agencies and Communities	➢ The key role of family and friends and the need to involve them in partnership responses ➢ The value of wider communities in building informal network of support – 'Team Around the Adult' ➢ Appreciating the value of Primary Care as a safety net and the need to ensure GP's are engaged in responses to self-neglect ➢ The need to develop Housing support and involve in partnership working ➢ Lack of multi-agency responses ➢ Lack of Safeguarding Adult responses to self-neglect

6.2. Research identified key strategic factors required to support practice.[44]

[44] Social Care Institute for Excellence, Braye., S, Orr, D., and Preston-Shoot, M., (2015), *Self-neglect Policy and Practice: Research Messages for Managers*, Available from: https://www.scie.org.uk [Accessed January 2022]

6.3. The learning from the review of the seven people indicate systemic barriers to effective practice.

6.4. It is striking that there was no use of Self Neglect guidance in any of the seven cases and none resulted in a Safeguarding Adult Enquiry. This is not just about individual practitioners failing to follow procedures. There is a need to understand why this was so wide spread.

6.5. In some cases, there was a lack of identfying the person's behaviours as self-neglecting. In other cases, self-neglect was identified but then not connected to being a safeguarding matter. There had been no training on self-neglect. Contributors also talked about a generally accepted view that the self-neglect policy was not fit for purpose. The policy when launched, had been supported by the IOMSB and by managers. However, over time, and with changes in management this drifted. The policy now appeared to be operating in a vaccum without the training, resources or commitment from leaders to support it. One example was the self-neglect panel. This was set up to guide practitioners but faltered without any ownership or leadership.

6.6. There appeared to be lack of policy direction or clear pathway about when self-neglect should be responded to as a Safeguarding Adult Enquiry or when responses can be made through other multi-agency mechanism. Multi-agency working should be core to each worker's practice and each worker is accountable for ensuring effective information sharing. There were no alternative multi-agency structures designed to respond to self-neglect. Although any practitioner could have called a meeting, none did.

6.7. The Independent Review of Safeguarding Adults highlighted a concerning lack of leadership and accountability for Safeguarding within ASC and for self-neglect.[45] This meant there was a lack of rigour and accountability in managing risks, and a lack of supervision to support practitioners, including prompting the need for professional curiousity and providing critical reflection on areas such as compassion fatigue and desensitisation.

6.8. Lack of leadership also meant that gaps in resourcing were not addressed.The review learning event heard that practitioners were constrained by time. This limited the ability to apply assertive outreach techniques that go beyond the transactional task focused approach, that standard practice may allow.

6.9. The restrictions resulting from the Covid Pandemic was noted in some, but not all the cases. For people such as Robin, the restrictions limited contact by key people in his life such as his befriender. However, the Covid Pandemic did not appear to be a significant factor in the learning themes about responses from agencies. There was no substantive changes to the way that practitioners had been responding to self-neglect.

6.10 The review of the seven people, did highlight those who were isolated and lost from sight, including from their GP. This raises bigger questions about how well GP Practices identify patients in vulnerable circumstances and what network of support can be offered at Primary Care level. Contributors commented on a culture of not involving GP's in safeguarding and of recurring blocks to sharing

[45] Ibid

information. A recommendation relating to this has been made in another SCMR.[46] The IOMSB has also recently developed information sharing guidance to assist in this.[47]

6.11. Practitioners talked about the lack of resources to support their work with people who self-neglect. One example was access to psychological resources for assessment and therapies. Practitioners also need to be able to apply for a financial waver for exceptional circumstances where risks from self-neglect are due to resistance to paying for services.

6.12. Improving responses to self-neglect is not just a matter for IOM's Health and Social Care Directorate. Currently there is a notable lack of any coordinated strategic approach to self-neglect across IOM Directorates. There is a need to understand what resources there are in local communities and how those resources can be mobilised to respond to self neglect. Gaps in Housing support also featured in the learning and reinforced learning from an earlier SCMR.[48] There is a need to develop Housing Support provision within the Housing sector and/or through developing third sector provision.

6.13. There is a need for a IOM self-neglect strategy that sets out how the IOM Departments will work together to develop responses to self-neglect - building a network of support across services and communities.

Recommendation Arising

6.14. This is a substantial agenda but there are also opportunities. The IOMSB has recognised the risks and is prioritising improvements in self-neglect. There is a working group to update the Safeguarding Adult procedures and the self neglect procedures. While it is positive that some progress has been made, there does need to be caution that these changes are not made in a vaccum. Procedures need to be written to reflect agreed pathways and reference resources that are available.

6.15. Manx Care has new leadership and is focusing on strengthening Safeguarding Adults across Health and Social Care – management accountability for standards of practice, developing operational guidance and risk assessment tools, and embedding Safeguarding in day-to-day practice. There have been new Designated Safeguarding Adult posts within Health, providing leadership and developing systems to improve responses by health services.

6.16. Manx Care is planning to establish a multi-agency safeguarding hub (MASH) that will improve the response to Safeguarding Adult referrals – collating information across partners and improving the multi-agency decision making. At time of the review, there was a business case to approve funding for additional specialist posts to support the MASH. There were also plans to establish a Vulnerable Adults Risk Management Panel.

6.17. Manx Care had also broadened the remit of their Adult Generic Social Work team. Pracititoners are given the time to engage, and the flexibility to work creatively with adults who are self-neglecting.

[46] IOMSB SCMR 'Family K' 2022
[47] Isle of Man Safeguarding Board Information sharing guidance for professionals working with children and adults at risk of abuse or neglect. https://www.safeguardingboard.im/media/kxujdg0h/20220201-final-information-sharing-guidance.pdf [Accessed May 2022]
[48] The Isle of Man Safeguarding Board The Learning from a Serious Case Management Review in respect of Mr H Independent Author: Domini Gunn-Peim Published May 2020

6.18. Manx Care is also developing Wellbeing Partnership Hubs across the IOM. These Wellbeing Partnerships, cluster agencies together to coordinate care. There are new roles of Local Area Coordinators that help to reach out to people and connect them to services and communities.

6.19. The Wellbeing Hubs provide great potential to offer a 'Team Around the Adult' approach to supporting people with more complex care needs including self-neglect. Any practitioner can refer into the Wellbeing Partnership Hub. Their meetings provide the mechanism to bring all the potential players together in a coordinated, solution focused way. The Wellbeing Partnership Hubs could be a core part of the pathway in responses to self-neglect but this will need to be formalised and supported through the leadership of strategic partners.

6.20. The Department of Infrastructure (DOI) Housing, contributed to the review and confirmed their intent to develop their Housing Support offering as a potential intervention across the sector. Doing so will require political support, funding and ultimately appropraitely trained resource, however would provide a natural link to the LAC work as part of their longer term Housing Strategy. The imminent implementation of the Mental Capacity Act also offers the DOI Local Government Team and Legislation an opportunity to collaborate with the IOMSB to ensure agencies provide training and guidance and that the Act is embedded in practice. This is also an opportunity to engage the public and communities in understanding Safeguarding Adults and the relevance of the Mental Capacity Act to this.

6.21. These initiatives are welcomed. There is the opportunity to bring these strands together through a IOM self-neglect strategy, to address many of the learning points raised within this review.

Recommendation Arising

7. Conclusions

7.1. This review has considered the very sad circumstances surrounding the deaths of seven people. The review has highlighted the care and compassion shown by members of the community and has also given many examples of good practice by committed practitioners.

7.2. The review has highlighted the risks where people are lost from sight. It has demonstrated the challenges in supporting people who are resistant to receiving any help. It has also highlighted some recurring concerns regarding practitioners becoming desensitised and working in the absence of robust risk assessments. Recurring themes included the lack of professional curiosity about people's lack of engagement and home circumstances. There was a lack of appropriate assertive outreach and the failure to follow multi-agency procedures.

7.3. The learning themes reveal significant gaps in the strategic systems that should support frontline practice. Addressing those gaps must be coordinated through a comprehensive cross-departmental strategy if the IOM is going to reduce the risks of people dying in such sad circumstances of self-neglect.

8. Recommendations

The following recommendation take account of individual agencies own recommendations and improvements recently made.

Recommendation 1

The IOMSB, on behalf of the IOM Government, should lead a strategy and implementation plan for self-neglect, with sign up by the relevant IOM Government Departments. The strategy and implementation plan should deliver:

1.1. Pathway	A pathway for a 'Team Around the Adult' approach to self-neglect
	• Building support around Primary Care:
	  ○ Policies/quality assurance on use of repeat prescriptions
	  ○ Regular review of vulnerable patients
	  ○ Systems to flag patients with vulnerabilities who are 'lost from sight'
	• Role of communities and families
	• Role of Wellbeing Partnership Hubs
	• Role of Safeguarding Adult Enquiries
	• Robust Information sharing across the pathway

1.2. Policy and Procedures	Policy, procedure and guidance detailing application of the pathway • Working with self-neglect and Making Safeguarding Personal • Guidance on risk assessment and risk management • Guidance on legal framework • Cross referenced to related policy e.g. information sharing guidance; financial waver protocol • Quality standards and managerial accountability
1.3. Training and Supervision	• Competence framework and training plan for self-neglect • Training in mental capacity • Agency standards for supervision
1.4. Resources	• Housing strategy to support tennants with additional needs including adults who may self-neglect • Access to mental health/psychology assessments and treatments (including assertive outreach approaches) • Case load weighting to enable additional time/assertive outreach for self-neglect • Provision of advocacy • Mapping and gaps analysis of third sector provision • Development of a multi-agency, solution focused panel to support practitioners
1.5. Involvement of Families and Communities	• Development of Family Group Conference within the self-neglect pathway • Campaign to raise public awareness to self-neglect and Safeguarding Adults and mobilise support within communities

Recommendation 2

Manx Care mental health services should develop a policy to guide practice where service users do not attend appointments. The policy should include guidance on risk assessment, proportionate and reasonable measures for follow up, including communications with other agencies and family as appropriate.

Sylvia Manson,

Date: August 2022

Glossary

ASC Adult Social Care

CSS Community Support Service

CMHP Community Mental Health Professional

CMHS Community Mental Health Services

DN District Nurse

IOMSB Isle of Man Safeguarding Board

MASH Multi-Agency Safeguarding Hub

OPCSWT Older peoples Community Social Work Team

OT Occupational Therapist

SCMR Serious Case Management Review

SW Social Worker

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manx care Kiarail Vannin	**SUMMARY REPORT**	**Meeting Date:**	**01.10.2022**
		Enclosure Number:	

Meeting:	**Manx Care Board**		
Report Title:	**Review of Respite**		
Authors:	Sally Shaw		
Accountable Director:	Executive Director for Mental Health, Social Care & Safeguarding		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/ Recommendation from that Committee**

Summary of key points in report

The review of respite provision is a work stream held by the DHSC, but Manx Care is working in partnership alongside Crossroads.

It is the Departmental Plan 22/23 that sets the requirement for the DHSC to undertake a gap analysis of respite provision. It is recognised in order for the DHSC to undertake this work then they will need to gain input from Manx Care and the Transformation Programme. This work has come about due to the Departments Engagement Forum which back in October 2021 documented a potential risk of insufficient respite facilities available to support those with a caring role, including young carers.

In section 3 of the attached Department Report, due to go before the DHSC in the coming weeks, it is recognised that the gap analysis has yet to be completed. This work has not been completed as the DHSC is waiting for the feedback from the Carers & Young Carers Survey, which has been facilitated by Crossroads. This survey is due to run until the 25 November 2022. This will provide essential data to be considered when looking a further review and gap analysis in respect of respite provision across all client groups.

Section 3 of the attached Departmental report does advise that the list of current provision is non exhaustive, it does not mention respite provision within residential care homes, provided to older adults and their carers.

The DHSC need to drive this piece of work with full support and contribution from Manx Care as it is likely to require a strategy to develop further respite/ short break options which should then be clear within future Mandates with additional resource to fulfil future required outcomes.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**		**Information**	**X**

It is recommended that the Board/Committee :

Notes the work to date and the intention in respect of further review and gap analysis and request the Executive Director of Mental Health, Social Care & Safeguarding to provide regular updates at agreed intervals.

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

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient Safety and Experience	Yes	It is the interest of both the individual with care and support needs and their carer to have good quality respite care provision to allow the individual to remain living within the community and to ensure that the carer is able to continue in their role as carer. 2.3 of the report sets out some potential consequences for carers who are not adequately supported. Poor outcomes for carers translates into poor outcomes for the individual.
Financial (revenue & capital)	Yes	Additional services, in addition to bed based type provision may need to be developed. This will require both revenue and capital investment by the DHSC as it will potentially require new Mandate requirements.
OD/Workforce including H&S	Yes	Current and new models of service provision will need to be fully considered in respect of recruitment. As identified in the paper then some areas of service provision have a lack of adequately trained workforce, e.g. Huntington's
Equality, Diversity & Inclusion	Yes	That all individuals with care needs and their carers have equality of provision to support them in their caring role and takes their other cultural needs into account.
Legal	No	None identified at present.

Department of Health and Social Care

Meeting: Department		
Title	**Carers / Carer Respite**	**Paper Nº TB**
DHSC Official Sensitive: Commercial	☐ *Check the box if paper contains commercial information which may be damaging to the DHSC, IOMG or a third sector organisation if improperly accessed.*	
DHSC Official Sensitive Personal Data	☐ *Check the box if paper contains personal information relating to an identifiable individual where inappropriate access could have damaging consequences.*	
Purpose* (click appropriate box)	Decision ☐ Approval ☐ Discussion ☐ Assurance ☐ Information only ☒	

Author and Job Title	**Responsible Director**	**Date Approved by ELT**
Will McCann, Interim Deputy Director S&C.	Julie King, Executive Director	n/a

Short summary of paper	In October 2021, the Department's Engagement Forum documented a potential risk suggesting there was insufficient respite facilities available on-Island to support those in a Carer role. The Department accepted this risk and pledged to undertake a gap analysis of existing respite provision as part of its Department Plan 22/23 objectives. The target date to complete this work is April 2023. This paper highlights some of the respite provision we know exists on the Island; the cross government work projects currently reviewing respite care and the immediate actions being taken to identify gaps in respite care for carers.
Financial Impact:	n/a
Resource Impact:	n/a
Impact Assessments:	n/a
Risk Management/BAF:	n/a
Recommendation(s):	Paper is an update paper. No action required.

Document Control for attached paper

Version Reference		Document Status	
Document Owner		Approved By; When	
Stakeholders		Stakeholders cont…	
Date of Last Review		Date of Next Review	
Supersedes		Related Documents	

Version Control

Date of Review	Version Subject to Change	Changes	Approved Version

Carer / Carer Respite

1. Context

1.1 The Isle of Man like our counterparts in the UK are under significant pressure to deliver good quality, efficient and effective services that are sustainable and offer value for money to the taxpayer. The Department's vision to deliver 'right care, right time right place' highlights the importance of community based care that's built on early interventation and prevention and reduces the need for more expensive based support in either an accute or residential/nursing care settings.

1.2 Carers are integral to a community based support model and often represent the first line of prevention. A Carer is any person who provides unpaid support and care to a relative, parent, child, partner, other family member, neighbour or friend, who, due to disability, physical or mental illness, addiction or frailty is unable to manage without help. They often provide personal care, practical help and emotional support.

1.3 In the UK 2011 Census, 6.5 million people were classified as an unpaid carer with that figure estimated to rise to 9 million carers by 2037. A report publicised by Carers UK and the University of Sheffield (2015) stated that the economic value of the contribution made by unpaid carers in the UK is £132 billion which is roughly the same amount as the overall NHS budget for 2018/19.

1.4 In the Isle of Man 2011 Census, 3485 people identified themselves as a Carer. In the local carer strategy 2007 -2010, the Minister for the then Department of Health and Social Security (DHSS) stated that the role of the carer on the Island saved the Government between £40m - £90m per annum.

2. Carer Impact

2.1 Caring can have a significant impact on a Carer's physical and mental wellbeing with burnout, stress, anxiety, depression and ill health all prevalent in Carers. A 'State of Caring Report' published by Carers UK in 2018 highlighted that **72% of carers having suffered mental ill health** as a result of caring and **61% suffering physical ill health**.

2.2 Local research, *Who Carers for the Carer?,* commissioned independently by Crossroads Care assessed the psychological, emotional, physical and social costs of caring on the Isle of Man.

2.3 The research determined that;

- 48% of carers level of burden signified they were "burning out"
- 26% of carers needed to seek immediate respite
- Only 13% of carers scored "well" on the measure of health, wellbeing and quality of life - *compared to 69% of the general population*
- 26% of carers were classed clinically depressed
- 15% of carers felt they received low levels of social support with 9% stating they received none.

3. Existing respite services

3.1 The Department **has not** conducted any formal gap analysis at the time of submitting this paper.

The following non-exhaustive list simply outlines the existing facilities across Manx Care and in the Community.

3.2 **Manx Care**

- Braddan Hub provides day care and respite services for children with disabilities and additional needs.

- Ramsey Respite Centre provides the only overnight respite service for children with disabilities and additional needs.

- Thie Quinney – offers 2 respite beds for individuals with acquired brain injury and or physical disability. The service is commissioned by Manx Care – provided by Leonard Cheshire.

- Hollydene residential respite***** – offers regular respite to families of adults with a learning disability and emergency accommodation for service users experiencing a significant breakdown in their usual carer support. The Unit comprises 11 bedrooms however capacity is limited due to needs, abilities and compatibility of users.

3.3 **Third sector provision**

- **Crossroads Care** is the only dedicated Carer organisation on the Isle of Man delivering regular and consistent respite to Carers. In 2017/18 Crossroads delivered approximately 64,000 hours of direct respite to carers and just over 68,000 hours of services to 'the cared for'. Crossroads deliver a 'Care at Home' respite package that gives Carers a short break (typically three hours per week). Manx Care commission c.50% of the service.

- **Hospice -** Rebecca House Children's Hospice, offers day and overnight respite for children with life-limiting or life-threatening conditions. The ony service that can provide respite within the family home.

Note * *In May 2018 Adult Social Care commissioned an external agency (Care and Health Solutions) to review Adult Learning Disability respite care. The report recommended that no significant change to the required number of LD respite beds.*

Furthermore there is a capital programme recently approved to construct and develop a new 12 bed LD respite facility at Radcliffe Villas in Douglas.

4. Work programmes / forums with a specific interest in Respite for Carers

4.1 Parliamentary Scrutiny Committees

In recent years, a number of Parliamentary Scrutiny Committees (i.e. Social Affairs Policy Review Committee - Mental Health Second Report 2018-19 and the Social Affairs Policy Review Committee's Second Report for the Session 2019-20: Suicide) have highlighted the need to secure a broader range of support services for Carers.

4.2 Health and Care Transformation Programme

The Nursing and Residential funding model project, led by Transformation, has explored the feasibility of providing more 'Care at Home' services at the impact on Carers. Some initial challenge statements have been identified:

- Limited availability of respite care is leading to the decline in physical and mental health and wellbeing in Carers.

- Some respite facilities are trying to cater for people with conditions that they are not competently trained to deliver (i.e. acquired brain injuries; Huntington's, Corsicos Dementia (alcohol related) or multiple dementia's.

- Admission criteria's need to be reviewed as concerns there are reports of rigidity, especially across EMI units.

- There is limited emergency overnight provision. (For example - if a Carer is admitted to hospital and there is no respite availability then the 'Cared for' will have to go to hospital).

4.3 Strategic Business Case for Children and Young Person's with continuing care needs

The strategic business case has highlighted a deficiency in respite provision for children with continuing / complex care needs. The review identified gaps in nursing provision that is required to adequately support children; and this shortage led to regular cancellation of planned respite.

4.4 DHSC – Department Plan 22/23

The Department has made commitment in the Department Plan 22/23 to undertake a gap analysis of respite. This will require input and collaboration with Manx Care and the Transformation Programme.

Simultaneously, the Department has commenced work on an interrelated task in the Department Plan which will see the development of Carer and Young Carer Strategies. In September 2022 the Department collaborated with Crossroads Care to run a consultation / survey with the public to understand more about the needs of carers on the Isle of Man.

5. Closing statement

5.1 There is an apparent shortage of respite provision for Carers. The outcome of the Carer and Young Carer survey will identify public views regarding the forms of respite provision

required on the Island and will help drive the formation of strategic direction to address Carer needs.

5.2 We envisage a number of key priorities will be identified in the carer survey:

- Provision of short breaks (few hours per week) / long breaks (overnight or weekend)
- Clear pathway for emergency respite beds
- Compassionate communities to enable and empower people to help and support one another at times of crisis
- Tracking transitional cases to assist in demand capacity.
- Greater accessibility to respite once individual transitions from child to adult services
- Access to carer assessments
- Accelerated access to support services whenever the physical or mental wellbeing of a carer is at risk.

5.3 In addition to the outcome of the survey, the Department will work with relevant parties to ascertain key data. This includes:

- Occupancy rates across existing respite provision
- Waiting times to access respite
- Respite cancellation rates
- Assessment of any recent / past respite reviews
- Barriers preventing access (including urgent operational demands)

Manx Care Management Accounts

September 2022

Financial Advisory Service

FINANCIAL SUMMARY

MANX CARE FINANCIAL SUMMARY - 30 SEPTEMBER 2022

	MONTH £'000				YTD £'000				FY £'000				Mov't to Prior Month	Mov't to Prior Forecast
	Actual	Budget	Var (£)	Var (%)	Actual	Budget	Var (£)	Var (%)	Forecast	Budget	Var (£)	Var (%)		
OPERATIONAL COSTS	**24,869**	**23,571**	**(1,298)**	**(6%)**	**147,654**	**141,429**	**(6,225)**	**(4%)**	**289,217**	**282,858**	**(6,360)**	**(2%)**	**798**	**3,143**
Income	(1,130)	(1,274)	(144)	(11%)	(6,810)	(7,646)	(836)	(11%)	(13,613)	(15,292)	(1,679)	(11%)	32	40
Employee Costs	15,343	14,819	(524)	(4%)	92,927	88,917	(4,010)	(5%)	182,464	177,834	(4,630)	(3%)	667	3,364
Other Costs	10,656	10,026	(630)	(6%)	61,538	60,158	(1,379)	(2%)	120,367	120,316	(50)	(0%)	99	(260)
FUND CLAIMS	**880**	**0**	**(880)**	**-**	**6,684**	**0**	**(6,684)**	**-**	**20,234**	**0**	**(20,234)**	**-**	**224**	**(11,429)**
Pay Award (Above 2%)	0	0	0	-	0	0	0	-	6,779	0	(6,779)		0	(6,779)
Medical Indemnity	78	0	(78)	-	615	0	(615)	-	1,950	0	(1,950)	-	24	3
Covid Costs	98	0	(98)	-	2,950	0	(2,950)	-	2,950	0	(2,950)	-	78	347
Covid Vaccination	69	0	(69)	-	427	0	(427)	-	641	0	(641)	-	(22)	0
Restoration & Recovery	622	0	(622)	-	2,615	0	(2,615)	-	7,130	0	(7,130)	-	135	(5,000)
Transformation Fund	12	0	(12)	-	77	0	(77)	-	783	0	(783)	-	10	(0)
ADD'N FUNDING - DHSC	**30**	**0**	**(30)**	**-**	**252**	**0**	**(252)**	**-**	**445**	**0**	**(445)**	**-**	**(3)**	**8**
111 Service	30	0	(30)	-	252	0	(252)	-	445	0	(445)	-	(3)	8
MANDATE INCOME	**(25,780)**	**(23,571)**	**2,208**	**9%**	**(154,590)**	**(141,429)**	**13,161**	**9%**	**(309,896)**	**(282,858)**	**27,039**	**10%**	**(1,020)**	**15,057**
GRAND TOTAL	**0**	**0**	**0**	**-**	**0**	**0**	**0**	**-**	**0**	**0**	**0**	**-**	**0**	**0**

Overview

- The result for September is an operational overspend of (£1.3m) with the YTD position now being an overspend of (£6.2m). Costs reduced from last month by £0.8m with further detail on the movement provided in Table 1.

- The operational forecast overspend has reduced by £3.1m due to additional funding being received from the DHSC / Treasury towards the cost of pay awards. For previous reporting the overall pay assumption used for the forecast was 4%, this has reduced to 2% which is line with the funding received in the original budget. The additional cost for the pay award above 2% is now included as a fund claim.

- Further detail on the full year variance to forecast is provided in Table 2.

- DHSC hold a Reserve Fund of £6.5m that is not shown as part of Manx Care's financials. Applications to this fund are currently being finalised and until approved, all cost pressures (actual and forecast) will be held in Manx Care's figures. These pressures are currently forecast at £3.4m and cover the loss of PPU income (due to the ward being used for restoration work), high cost & nursing placements, additional requirements for TT/Grand Prix including off-island activity and the Information Commissioners fine.

- Should the £3.4m be approved from the Reserve Fund, the overspend position will reduce to £3.0m. Additional CIP opportunities and mitigations have been identified to address this position, additional resource has been allocated to support delivery of these savings and achieve a balanced position by year end.

- The target CIP for this financial year is £4.3m with £1.3m relating to drugs savings being allocated to the relevant Care Groups. The remaining £3.0m is currently netting from the contingency budget, but as CIP Projects are agreed and finalised they will be allocated against the relevant operational area. Further detail on the CIP is provided below.

- The operational variances are summarised in Table 3 and variances by Care Group are in Appendix 1. Further details on the fund claims are included in Appendix 2.

Table 1 – Forecast Movement to Prior Month

Forecast Movement to Prior Month	£'000	
Income	40	No changes in assumptions to the previous forecast.
Employee costs	3,364	Relates to additional funding being received to cover the pay award above 2% (which was the original amount included in the budget).
Other Costs	(260)	Mainly relates to an increase in costs for s115 nursing care placements, these additional packages are expected to be recovered from the DHSC reserve fund.

Table 2 – Operational Forecast FY Variance to Budget

Forecast Variance to Budget	£'000	
Other Income	(1,679)	(£1.4m) of this variance relates to PPU where the gross income target is (£1.8m) but (£0.4m) has been set as an internal target for diagnostic services only as the PPU will be used for the restoration work. The forecast for other areas where income is below target (mainly in Adult Services residential services) have been forecast more prudently but is being revised in line with the latest occupancy data.
Employee Costs	(4,630)	The forecast variances vary between Care Groups with Medicine being the main driver of the employee overspend with significant agency spend being utilised to cover vacancies. The forecast will be updated depending on successful recruitment to vacancies. Any additional costs incurred due to the TT/Grand Prix are currently being identified and are approx. £0.2m, a request for additional funding from the DHSC will be made.
Other Costs - Tertiary	(3,399)	The Tertiary forecast is based on the latest activity data from our UK providers. It also includes £0.6m for high cost patients (which will potentially be funded from the DHSC reserve fund).
Other Costs - Contingency	3,348	Although there are a number of variances across the Care Groups, the forecast reflects the contingency budget of £3.3m which is netting against known cost pressures.
Total	**(6,360)**	

Table 3 - Operational YTD Variance to Budget

YTD Variance to Budget	£'000	
Other Income	(836)	The main area where there is a variation to budget is in PPU where the gross full year income target is £150k pm with only £164k being received YTD. The internal income target for the service has been reduced to £33k pm with the remainder being netted from the contingency budget. Additional funding to cover the overall net loss of income from the PPU will be a request to the DHSC reserve fund. The other area where income is below target is residential services in Adult Services where occupancy rates are below levels set in the budget with the forecast being revised on the latest levels.
Employee Costs	(4,010)	Variances differ across services as some areas are unable to fill vacancies and/or cover with agency. Other areas, in particular in acute are experiencing additional costs due to the need to cover a significant number of vacancies with agency. There are also some favourable variances in services where additional funding was given as part of the budget process but delays in recruitment will result in part year costs being incurred.
Other Costs - Tertiary	(2,841)	The baseline budget does not cover current activity with the forecast assuming similar levels to 21/22. Activity is being reviewed to understand if any of the current costs relate to high cost patients which will form part of the claim to the DHSC.
Other Costs - Contingency	1,462	The impact of the contingency budget YTD is £1.6m (which has been fully allocated to cover some of the cost pressures).
Total	**(6,225)**	

Employee Costs

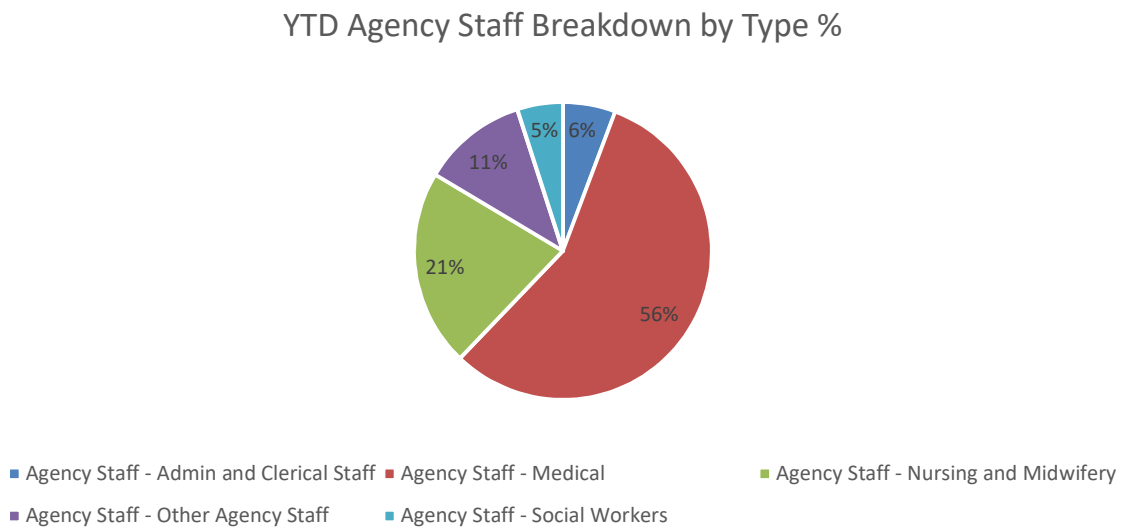
YTD Employee Costs are currently (£4.0m) over budget and are expected to be (£4.6m) over budget by year end. This assumes that savings on the CIP reduce the current run rate.

Agency spend is a significant factor driving this overspend, with a total spend YTD of £7.3m. This spend is broken down across Care Groups below.

The Care Groups with the largest spend are Medicine (£2.1m), Surgery (£1.7m) and Mental Health (£1.3m). This cost is primarily incurred to cover existing vacancies in those areas.

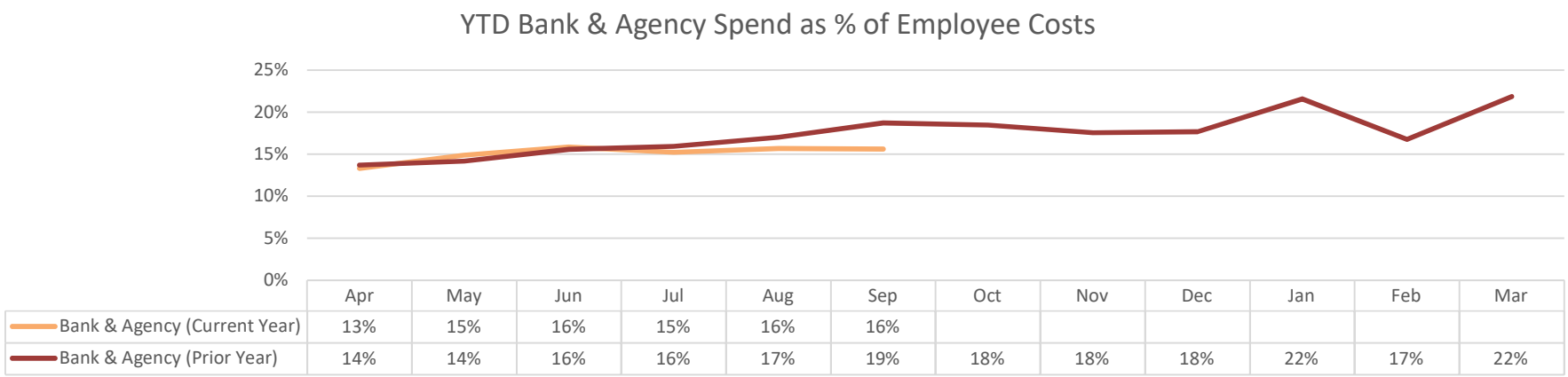
	Apr	May	Jun	Jul	Aug	Sep	Total	Month Mov't
Total Agency £'000	**932.0**	**1,254.2**	**1,192.8**	**1,226.0**	**1,331.0**	**1,364.3**	**7,300.2**	**(33.2)**
Corporate Services	45.4	49.1	29.2	(3.1)	35.8	47.1	203.6	(11.3)
Infrastructure & Hospital Operations	18.5	23.5	20.4	17.0	21.5	26.8	127.6	(5.2)
Integrated Cancer & Diagnostics Services	41.2	57.5	69.6	196.9	98.7	87.0	551.0	11.7
Integrated Mental Health Services	112.6	306.9	216.9	105.8	206.0	339.9	1,288.1	(133.9)
Integrated Primary Care & Community Services	8.3	40.0	35.7	18.3	6.1	19.0	127.4	(12.9)
Integrated Social Care Services	57.1	75.4	93.7	52.7	49.5	55.8	384.1	(6.3)
Integrated Women, Children & Family Services	54.6	59.1	72.5	86.5	94.1	101.3	468.1	(7.2)
Medicine, Urgent Care & Ambulance Service	314.1	326.8	272.8	434.2	430.5	315.6	2,094.0	114.9
Nursing, Patient Safety & Governance Services	1.8	1.8	0.6	1.3	1.8	3.6	11.0	(1.8)
Operations Services	20.6	57.7	84.1	10.7	57.0	80.0	310.1	(22.9)
Surgery, Theatres, Critical Care & Anaesthetics	255.1	254.8	294.8	303.8	321.2	279.4	1,709.0	41.8
Tertiary Care Services	2.7	1.7	2.4	1.9	8.8	8.8	26.3	0.0

Greater than 75% of our Agency spend is associated with Medical, Nursing & Midwifery staff, highlighting the significant workforce gaps in these areas.



A key focus this year is on recruitment activity to address the 20% vacancy rate across the organisation. Care Groups have been asked to produce recruitment plans to address key vacancies and there is a project underway to drive international nurse recruitment. The CIP programme will provide oversight and co-ordination to support delivery of those plans. As these start to take effect, we will expect to see spend on temporary resource such as Bank & Agency as a proportion of total spend to reduce. The below table shows this data against last year when the proportion of spend ranged from 14% to 22% with an average of 17%.

So far, spend is tracking closely against last year, and showing a small improvement from last year in the last quarter.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bank & Agency (Current Year)	13%	15%	16%	15%	16%	16%						
Bank & Agency (Prior Year)	14%	14%	16%	16%	17%	19%	18%	18%	18%	22%	17%	22%

Tertiary

The Tertiary budget has been amended to reflect the activity that was transferred to the Cancer & Diagnostics Care group but the underlying baseline budget is not expected to cover the predicted activity which assumes similar levels to 21/22. The forecast has not changed from prior month reporting and includes high cost & TT patient costs of £0.6m (where funding will be requested from the DHSC reserve fund).

The agreement of indicative annual activity plans with linked NHS trusts in the North West of England for the 2022/23 service year are currently in progress. Indicative activity plans have been agreed to date with the Walton Centre and Wrightington, Wigan and Leigh Teaching Hospitals. Further activity data is expected to enable performance reporting against activity plans.

Table 4 – Movement in Operational Cost from Prior Month

Movement to Prior Month	**£'000**	
Income	32	Income levels in line with last month.
Employee Costs	667	The positive movement is due to August costs being higher than normal with prior month costs including a one off payment and additional bank / relief costs to cover leave. September's costs have returned to the expected run rate.
Other Costs	99	Movements within care groups but overall costs are in line with last month.
Total	**798**	

CIP

The CIP target for 22/23 has been set at £4.3m, which is reflected in the forecast. This is made up of the 1% efficiency target of £2.7m plus an additional £1.5m as part of the agreed growth funding. The original CIP plan identified £7.3m of potential cash out savings. However, there are a number of risks associated with these projects that may impact delivery, so the totals have been adjusted based on those risks. The risk adjusted total is £4.7m. To date, £2.6m of cash-out savings have been delivered, representing 60% of the total target of £4.3m. Efficiency savings of £700k have also been delivered so far this year.

Given the projected overspend position, additional measures totalling £5m have been identified and will now form part of an expanded CIP programme totalling £10m. A further 32 individual CIP opportunities have been identified bringing the total number of CIP projects to 109. The majority of these are cash releasing or spend avoidance with 11 projects seeking to deliver efficiency savings of £2.6m. There are 26 CIP projects where the savings calculations are still being worked through and these will add further value to the 22-23 CIP plan.

The 22-23 CIP Plan is much broader in its scope than the 21-22 Plan and now includes all areas across Manx Care. However, there are some workstreams that cut across various operational areas to address some of the key cost pressures facing Manx Care:

- Workforce
- Drugs Spend
- Clinical Consumables Spend
- Contracting & Tertiary Spend
- Demand and Capacity Reviews
- Service Delivery Models

Whilst these workstreams will deliver savings in 22-23, they will also contribute significantly to CIP savings in 23/24

The single biggest risk to CIP delivery is capacity within Manx Care so additional support from DHSC and Transformation was agreed and allocated during October to deliver these savings. This resource should allow more of the £7.3m originally identified to be delivered in-year and allow additional measures identified totaling £5m to be put into effect as soon as possible. The first priorities of this work is to validate the current actual and projected savings, assign savings values to those CIP Projects where the savings values have not been calculated and to establish improved reporting and governance around the CIP.

However, staffing gaps (particularly in Secondary Care Pharmacy) and competing priorities around supporting CQC inspections and Transformation activity continues to hamper the capacity that Manx Care staff have to deliver against the CIP.

A number of CIP initiatives that rely on policy agreement from the DHSC are at risk whilst we await DHSC's input. These are primarily around Procedures of Limited Clinical Value, Low Clinical Value Prescribing, Prescription Charges, and Patient Transport and represent delivery risk of approx. £600k.

Financial Risks & Opportunities

The following risks and opportunities have been identified but have not yet been incorporated into the forecast position:

Risk / (Opportunity)	£'000	
Pay Award	846	Pay negotiations for 21/22 are still ongoing for MPTC/NJC and no pay awards for all pay groups for 22/23 have been agreed. The risk included is an additional 0.5% to that included in the forecast.
Tertiary Costs	2,000	Activity levels are being reviewed which has showed an increase in cost. The exact reasons for this increased activity have not yet been determined and are being investigated. If this continues there is a risk that the outturn will be higher than currently forecast.
UK Placements	887	The current forecast is based on committed and known costs but additional activity may be incurred or existing placements extended and no contingency is included for this.
Contract Inflation	250	Where contracts are going out to Tender this year, the uplift may be higher than the assumptions used in the budget planning as inflation has increased significantly since the beginning of the year
On Island Care Packages	720	High level costings for individual care packages in Social Care, these are being reviewed to understand the requirements for this year and into 2023/24.
Children's Home	300	There may be a requirement for the recommissioning of a home in Children & Family Services and is not currently included in the forecast.
Transformation Funding	240	Funding for the Primary Care Network has been paid by Manx Care which is part of the PCAS Transformation project. Funding is still to be agreed by the Transformation Project but is currently excluded from the actuals & forecast.
Review of internal business cases	3,395	On-going internal business cases that are being reviewed as part of the BCRG governance process with timelines and funding still to be identified. These are not included in the current forecast. There are also a number of Transformation business cases including UEIC and Cancer Pathways where the proposal is that implementation begins in 22/23 but funding is still to be agreed.
Total	**8,638**	

Appendix 1 - Summary by Care Group as at 30th September 2022

OPERATIONAL COSTS BY CARE GROUP - 30 SEPTEMBER 2022

	YTD £'000				FY £'000			
	Actual	Budget	Var (£)	Var (%)	Forecast	Budget	Var (£)	Var (%)
TOTAL BY CARE GROUP	**147,653**	**141,429**	**(6,223)**	**(4%)**	**289,219**	**282,858**	**(6,359)**	**(2%)**
CLINICAL CARE GROUPS	**136,277**	**129,971**	**(6,307)**	**(5%)**	**270,265**	**259,942**	**(10,323)**	**(4%)**
Medicine, Urgent Care & Ambulance Service	20,673	16,695	(3,978)	(24%)	40,404	33,392	(7,012)	(21%)
Surgery, Theatres, Critical Care & Anaesthetics	19,869	17,939	(1,931)	(11%)	37,651	35,877	(1,774)	(5%)
Integrated Cancer & Diagnostics Services	10,805	11,335	530	5%	21,787	22,670	883	4%
Integrated Women, Children & Family Services	8,485	8,240	(245)	(3%)	16,445	16,479	35	0%
Integrated Mental Health Services	12,517	11,911	(606)	(5%)	24,684	23,821	(863)	(4%)
Integrated Primary Care & Community Services	27,418	29,554	2,136	7%	57,909	59,108	1,199	2%
Integrated Social Care Services	24,437	25,065	628	3%	49,520	50,129	609	1%
Tertiary Care Services	12,074	9,233	(2,841)	(31%)	21,865	18,466	(3,399)	(18%)
SUPPORT & CORPORATE SERVICES	**11,374**	**11,458**	**84**	**1%**	**18,952**	**22,916**	**3,964**	**17%**
Infrastructure & Hospital Operations	4,394	4,407	13	0%	8,574	8,814	240	3%
Operations Services	1,816	1,598	(218)	(14%)	3,539	3,196	(343)	(11%)
Nursing, Patient Safety & Governance Services	1,700	2,154	454	21%	3,738	4,308	569	13%
Medical Director Services & Education	1,542	1,099	(443)	(40%)	3,119	2,197	(922)	(42%)
Corporate Services	1,921	2,200	279	13%	(19)	4,401	4,420	100%

Appendix 2 – Fund Claims

Fund Claim	
Medical Indemnity	Covers compensation claims and associated legal fees. Central fund held by Treasury and adjusted based on on-going claims, a paper will be prepared for the DHSC/Treasury to formally approve the funding required for 22/23.
Covid Costs	Business cases are provided to the DHSC/Treasury quarterly in advance and costs of £2.5m for Q1 were approved. A further business case for Q2 costs of £0.9m has also been approved by Treasury.
Covid Vaccination	Funding of £0.6m has been agreed so far for 22/23. A further business case will be submitted to Treasury to secure any additional funding required.
Restoration & Recovery	Funding of £2.1m is available in 22/23 to clear waiting list backlogs. This relates to two business cases approved in 21/22 and activity carried over into 22/23. Further funding of £5m has also been agreed in year.
111 Service	Funding of £1.4m for the 111 service has remained with the DHSC and Manx Care will currently reclaim any costs incurred.