Integrated Performance Report

Jun-23

Version: Final v.1.6

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Integrated Performance Report (IPR) development
The programme of work to develop and improve the content and format of the IPR continues. The aim of this work is to ensure that the IPR continues to improve in its provision of a meaningful context for the levels of performance being achieved across the organisation. A more structured and concise format gives a clearer and greater sense of assurance that areas of challenge are being identified and addressed efficiently and effectively, and that areas of good practice are being highlighted and learned from.

The development of the IPR is an iterative process which will continue over the course of 2023/24.The Performance Improvement & Management Service (PIMS) remain responsive to feedback received from colleagues, the Board and the public with regard to the evolution of the content and format of this report. Recent developments/amendments to the report include:

- **Key Performance Indicators (KPIs)**
  PIMS continue to work with the Care Group leads within Manx Care, and the DHSC to review the KPIs and operational metrics and standards that are currently being used to monitor and manage the organisation's performance. This is to ensure that they are aligned with the requirements of Manx Care's Required Operating Plan, the DHSC's Mandate to Manx Care and Single Oversight Framework (SOF) and the government's 'Our Island Plan'. Nominated leads within the Care Groups are being identified to be responsible for the delivery of each KPI. Where existing reporting does not cover all of the requirements, PIMS are working with the Business Intelligence (BI) team and service area leads to develop the required measurement and reporting mechanisms and processes. A number of additional metrics are now included in the report, including: Pressure Ulcer incidence (Grade 2+), Mental Health average length of stay (ALOS) by service user category , Children participating in their Social Care reviews, and Ambulance Turnaround Times.

- **Integrated Care Women Children & Families Performance metrics**
  A number of the key performance indicators (KPIs) and supporting metrics regarding the services delivered by the Integrated Care Women Children & Families team are being integrated into the IPR. As such, the Effective and Responsive sections of the report now contain performance reporting against such areas as Maternity, Paediatrics and the Neonatal Unit (NNU). This development work is ongoing, and work is underway to expand the scope of reporting to include safeguarding and the community paediatric and sexual health teams. A programme of work to review the care group's Demand & Capacity and theatre planning requirements is also underway.

Notes regarding the format of the IPR

- **Red/Amber/Green (RAG) ratings for Reporting Month performance**
  The achieved performance against each KPI is colour coded to make it clearer whether or not the required standard has been achieved in the reporting month:

Achieved performance is equal to, or exceeds the required standard.

Achieved performance is 15% or less below the required standard.

Achieved performance is more than 15% below the required standard.

It should be noted that the RAG rating is only representative of the performance achieved in the current reporting month, and does not necessarily give the full picture in terms of an improving or worsening position. It should therefore be considered in conjunction with the Variation and Assurance indicators as described on the following page.

Only KPIs and metrics with an associated standard/threshold have been RAG rated.

- **Alignment to CQC recognised domains**
  The key performance metrics are categorised and aligned to the following CQC recognised domains:

Safe - are our service users protected from abuse and avoidable harm.
Effective – does our care, treatment and support achieve good outcomes, help service users to maintain quality of life and is based on the best available evidence.
Caring – do staff involve and treat service users with compassion, kindness, dignity and respect.
Responsive - services are organised so that they meet service user needs.
Well Led - the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around service users' individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

To ensure that the holistic view of a Service Area's performance is not lost, future iterations of the report will also include a Performance Summary for each Service Area.

- **Structured narrative**
  Supporting narratives for the performance indicators are structured in a consistent format. This sets out the detail of the issues and factors impacting on the performance, the planned remedial and mitigating actions that Manx Care is taking to address the issues, and the expected recovery timescales in which performance is expected to become compliant with the required standards (through the implementation of the remedial actions).

Issue -> Remedial Action -> Recovery Trajectory

Introduction - 2

Data Validation and Automation
It has been acknowledged that, in its current form, the compilation of the IPR (and the reporting of performance in general) is an extremely manual process, pulling together data from a variety of un-validated reports and data sources without clear definitions of the purpose and value of each Key Performance Indicator (KPI).

The BI team have been working to re-develop, automate and validate the KPI reporting through the construct of datasets. This is a large task and involves spending time in and working with every service area within the department. The plan of works to develop an automated dataset for each area has continued into 2023/24.

As each new dataset is developed, new reporting will replace the current reporting and eventually Manx Care will have a fully automated report.
PIMS is working with the BI team to support the development of performance reporting in a format that aligns with the perform ance monitoring processes and requirements under the Performance & Accountability Framework. This currently involves an interim reporting process requiring some manual input until the BI team have automated all of the required datasets.

Each domain summary sheet includes a 'B.I. Status' indicator which indicates which KPIs / datasets are still collated manuall y (or the automated data is still being validated with the service area), those indicators that have been validated and automated and those indicators where the automation work or other issue means that the data is temporarily unavailable:

- Data automated and validated.
- Data collated manually or automated data still being validated by service area.
- Data currently unavailable or validation in initial stages only

In this context 'Validation' means that the input, methodology/calculation and outputs for a given metric have been checked by both the Business Intelligence Team and Care Group leads and confirmed tobe in accordance with the corresponding technical specification for that KPI. This is to ensure that the performance for that item is being measured and reported accurately.
However, it is possible that unforeseen data quality issues may exist within the validated data. Manx Care has therefore impl emented a Data Quality Working Group that will pro-actively look to identify and address any matters of quality or integrity within the data used for operational and reporting purposes.

Statistical Process Control (SPC) Charts
The report uses Statistical Process Control (SPC) charts to enable greater analysis of trends and variation in performance. S PC charts are used to measure changes in data over time, and help to overcome the limitations of Red-Amber-Green (RAG ratings) through the use of statistics to identify patterns and anomalies to distinguish changes worth investigating (Extreme values) from normal and expected variatio ns in monthly performance.

This ensures a consistent approach to assessing both Variation and Assurance for achieved performance:

VARIATION		
If 6 points or more in a row of continuous improvement or If 6 dots or more in a row are better than the base line mean	Special Cause of Improving variation (High/Low)	
If 6 points or more in a row of continuous worsening or If 6 dots or more in a row are worse than the base line mean	Special Cause of Concerning variation (High/Low)	
If none of the above criteria is met	Common cause	

ASSURANCE		
If last 6 points are equal to or better than the target	Consistently hit target	
If last 6 points are worse than the target	Consistently fail target	
If last 6 points are a mix of better and worse	Inconsistently passing and falling short of target	

The process for assigning the categories to each KPI is currently a manual one, but PIMS are currently working with the BI te am to automate the process of generating the SPC charts and allocating the appropriate categories for Variation and Assurance.

Benchmarking
In order to measure Manx Care's performance against recognised best practice and the performance of other peer organisations within Health and Social Care, some initial benchmarks have been added to a number of the KPIs and metrics within the report. Th is benchmarking will enable Manx Care to identify internal opportunities for improvement.

When making such comparisons, it is vital to ensure that the methodology used to calculate Manx Care's performance exactly ma tches that of the benchmarked performance to ensure that a like-for-like comparison is being made.

Therefore, the benchmarks included in this month's report should be treated as indicative only until such time as the alignme nt of the methodologies used has been reconciled and confirmed.
Work to identify appropriate peer organisations and metrics to benchmark Manx Care's performance against is ongoing, and curr ently many of the benchmark figures within this report use Manx Care's 2022/23 performance as a baseline. Details of the benchma rk methodologies applied for each KPI and metric can be found within the 'Assurance / Recovery Trajectory' section of the supporting performance narra tives.

Executive Summary

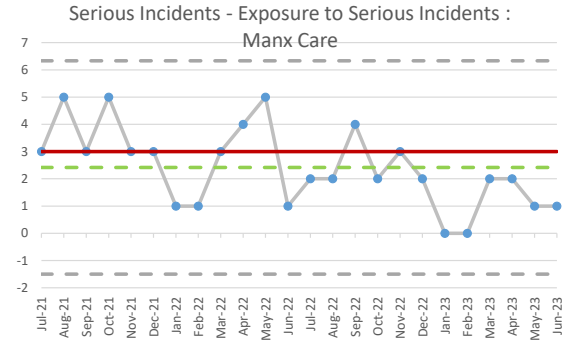
	Going Well	Cause for Concern
Safe	• Exposure to serious incidents remains lower than threshold with one incident reported in June. • 23-consecutive months without a Never Event. • Zero Medication Error with harm across Manx Care in June. • Numbers of Falls that resulted in Harm remain low and within the expected threshold. • Positive achievement against Safety Thermometer for Adults, Maternity and Children . • Compliance of hand hygiene was met this month. • VTE risk assessment within 12 hours slightly increased to 89.6% and performance of VTE prophylaxis has gone up to 97.4% and that's above the target of 95% .	• There have been 6 cases of E.coli. Five cases are community associated and one case is hospital associated. The potential source of infection in four of the community cases was urine (two had a urinary catheter present) and one potential source was a leg ulcer. The potential source of infection in the hospital case was cellulitis. • CDI cases are higher than the target of two cases per month for the third month in a row. There have been four CDI cases. Two cases were community associated and two cases were hospital associated. All cases relate to high risk antibiotic usage. Other patient specific risk factors include comorbidities, age, protein pump inhibitors. • 48-72 hr senior medical review of antibiotic prescription has increased slightly but remains below threshold. • There was one hospital associated case in June. This is the first case since Feb 2021. Potential source of infection was identified as a wound caused by intravenous drug use which originated while in the community.
Effective	• 98% of Learning from Death reviews were completed within timescale which exceeds the target for the fifth month in a row. • The Crisis Team continues to meet the 1 hour response time threshold for Emergency Department referrals. • Nutrition & Hydration: 98.8% across all inpatient areas was completed at 7 days, and that's above target of 95% for the third month in a row in the reporting year. • 100% of Looked After Children reviews were completed within timescales, and 100% of child protection review conferences were held on time. • The number of MH re-referrals increased in June but still within the threshold, with 124 service users re-referred, against an average of 100 in 2022/23. • The completion of Wellbeing Partnership assessments in June achieved the required threshold. • Adult Social Care re-referral rates remain within expected levels.	• Access to surgical bed base continues to challenge theatre efficiency and utilisation. • Consultant anaesthetic staffing and theatre staffing position remains a challenge and will do for some time. • The number of Complex Needs Reviews are being completed within timescale in Children's Social Care remains below the required threshold. • 23.3% of Initial Child Protection Conferences were held within the timescales in June.
Caring	• Manx Care has consistently met gender appropriate accommodation standards in the year to date. • MCALS is responding to a high proportion of queries within the same day (91%). • Service user satisfaction remained high for the fifth consecutive month: 85% of service users rated their experience as 'Very Good' or 'Good' using the Friends & Family Test in month. • 27 complaints logged, which is up slightly from May but remains below target. • Overall Manx Care compliance of complaints acknowledged within 5 days in June is 100%.	
Responsive	• Outpatients waiting list has slightly decreased in June. • Inpatient and Daycase waiting list numbers and waiting times remain at lower levels as a result of the Restoration & Recovery activity for Orthopaedics, Ophthalmology and general surgical specialties. • The 6 hour Average Total Time in Emergency Department standard continues to be achieved. • A good performance was maintained in Ambulance service for Category 2 - 5 response times. • Mental Health caseloads remain within expected levels. •Although remaining below the required threshold of 95%, the ED achieved it's highest level of performance against the 4 Hour standard in over 20 months at 76%. • The ED did not reach the level 4 of the highest Operational Pressures Escalation Level (OPEL) in June, fourth month in a row.	• Manx Care has seen a significant impact of Covid-19 on elective capacity, which has led to significant increases in waiting list sizes and wait times. • Emergency care demand remains high and the Emergency Department (ED) footprint does not meet the needs of the service (e.g. no CDU). Staffing has also impacted on KPI delivery but recruitment to all grades of doctor within ED and nurses is ongoing. • There were 12 12-Hour Trolley Waits, comparing to 5 in the previous month. • Demand for the Ambulance service increased in June, and Category 1 Ambulance response times (mean, at 90th percentile) still above threshold. • Access to routine diagnostics within 6 weeks and 26 weeks remains challenging due to increasing demand exceeding current capacity. • There were 17 breaches of the 60 minute handover time in June. This represents a 70% increase in breaches against the previous month (10 in May). • Cancer Two Week Wait performance remains outside of the expected threshold.
Well Led (People)	• Manx Care continue to see positive engagement from staff across all areas in relation to GDPR responsibilities. The willingness of Manx Care staff to engage demonstrates their commitment to handling data safely and correctly. • Manx Care has made its first Data Security and Protection Toolkit Assessment (DSPT). This toolkit is used by organisations who have access to NHS patient data and systems and provides assurance that good data security is being practiced and that personal data is being handled correctly.	• There were 16 Data Breaches in June. • As reported previously the number of Subject Access Requests and Freedom of Information Requests continues to show an upward trend and meeting the legal timeframes for responses continues to be challenging. At the end of May there were 51 Subject Access Requests overdue for response, at the end of June this had reduced to 20 and whilst it is disappointing does demonstrate the efforts being made to improve. We will continue to make all efforts to continue this improvement.
Well Led (Finance)		• The full year forecast is now an overspend of (£27.2m) although £4.9m of this is expected to be approved from the DHSC reserve fund reducing this to (£22.2m). • YTD Total staff costs are 0.3m over budget.

Safe Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
SA001		Exposure to Serious Incidents	Jun-23		1	1	4	< 36 PA		
SA002		Duty of Candour Letter sent within 10 days of the application	Jun-23		50%	68%	-	80%		
SA018		Compliance with the Duty of Candour Regulations	Jun-23		50%	83%	-	100%		
SA003		% Eligible patients having VTE risk assessment within 12 hours of decision to admit	Jun-23		90%	88%	-	95%		
SA004		% Adult Patients (within general hospital) with VTE prophylaxis prescribed	Jun-23		97%	95%	-	95%		
SA005		Never Events	Jun-23		0	0	0	0		
SA006		Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	Jun-23		0.2	0.3	-	< 2		
SA007		Clostridium Difficile - Total number of acquired infections	Jun-23		4	4	12	< 30 PA		
SA008		MRSA - Total number of acquired infections	Jun-23		1	0	1	0		
SA009		E-Coli - Total number of acquired infections	Jun-23		6	6	19	< 72 PA		
SA010		No. confirmed cases of Klebsiella spp	Jun-23		1	1	4	-		
SA011		No. confirmed cases of Pseudomonas aeruginosa	Jun-23		0	0	0	-		
SA012		Exposure to medication incidents resulting in harm	Jun-23		0	1	2	< 25 PA		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
SA013		Harm Free Care Score (Safety Thermometer) - Adult	Jun-23		98%	97%	-	95%		
SA014		Harm Free Care Score (Safety Thermometer) - Maternity	Jun-23		100%	100%	-	95%		
SA015		Harm Free Care Score (Safety Thermometer) - Children	Jun-23		95%	92%	-	95%		
SA016		Hand Hygiene Compliance	Jun-23		99%	98%	-	96%		
SA017		48-72 hr review of antibiotic prescription complete	Jun-23		79%	76%	-	>= 98%		
SA019		Pressure Ulcers - Total incidence - Grade 2 and above	Jun-23		19	16	47	<= 17 (204 PA)		

Safe	Serious Incidents	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis



Reporting Date	Performance	Op. plan #
Jun-23	1	QC1

Threshold	YTD Mean	Benchmark
< 36 PA	1	2

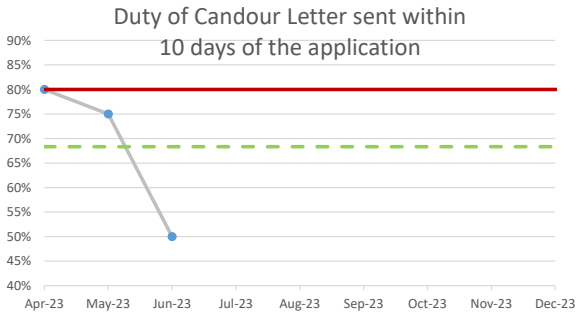
(Lower value represents better performance)

+ Variation Description

Special Cause of Improving variation (Low)

+ Assurance Description

Consistently hit target



Reporting Date	Performance	Op. plan #
Jun-23	50.0% (1 of 2)	QC112

Threshold	YTD Mean	Benchmark
80%	68.3%	68.33%

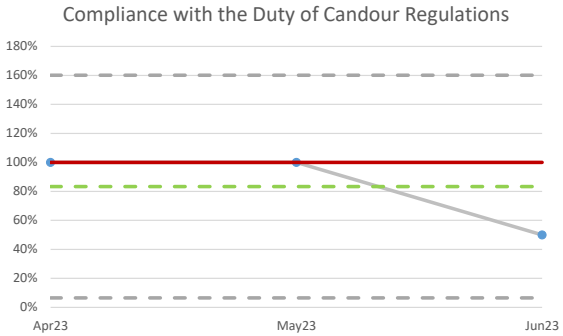
(Higher value represents better performance)

- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target



Reporting Date	Performance	Op. plan #
Jun-23	50.0% (1 of 2)	QC112

Threshold	YTD Mean	Benchmark
100.0%	83.3%	83.3%

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary

Serious Incidents:

• IC&PCS - one incident was declared as meeting the criteria for a SI at SIRG during June. The incident concerned a young person in the community who had experienced a delay when an urgent referral to ENT was not processed for a swollen lymph node.

Letter has been sent in accordance with Duty of Candour Regulations :

• 50%. There was one incident that was declared an SI and letter was sent, one patient developed a pressure ulcer in hospital and there is no evidence of a letter being sent

Planned / Mitigation Actions

Serious Incidents:

• The Duty of Candour has been applied. Full investigation underway, led by the Clinical Director for the ICPCS.

Letter has been sent in accordance with Duty of Candour Regulations :

• In order to capture incidents which fit the criteria for D0C on time, a weekly review of all incidents is being put in place via the CQS Leads. This is then raised in the Care Group Governance meetings to aid care groups in completing this in accordance with the regulations.

Assurance / Recovery Trajectory

Serious Incidents:

• 4 SIs have been declared YTD against an annual threshold of 36. At the same point in time in 2022/2023 10 SIs had been declared. Incident reporting remains consistent, with a high degree of confidence in our surveillance capability.

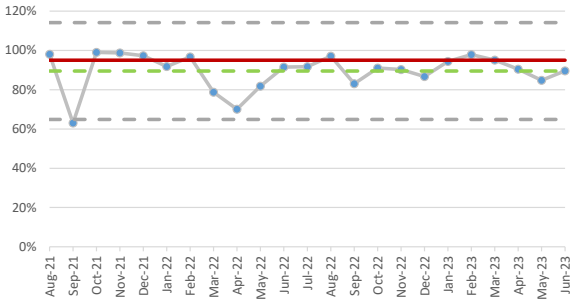
Letter has been sent in accordance with Duty of Candour Regulations :

• This is a new indicator, and so a baseline is still being established.

Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Safe	Venous thromboembolism (VTE)	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Patients having VTE risk assessment within 12 hours of decision to admit: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	89.6%	QC113

Threshold	YTD Mean	Benchmark
95.0%	88.2%	89.2%

(Higher value represents better performance)

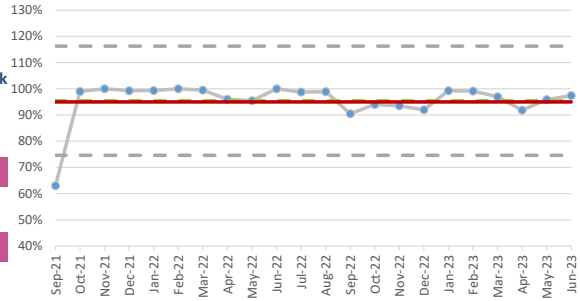
+	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

% Adult Patients (general hospital) VTE prophylaxis prescribed: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	97.4%	QC114

Threshold	YTD Mean	Benchmark
95.0%	95.0%	96.2%

(Higher value represents better performance)

+	Variation Description

Common cause

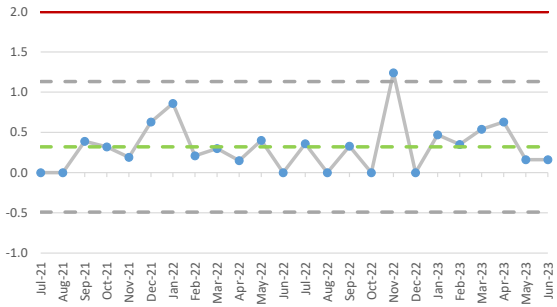
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
VTE risk assessment within 12 hours: • 89.6% for June **VTE Prophylaxis:** • 97.4% across adult inpatient areas.	**VTE risk assessment within 12 hours:** • There was a dip on Wards 4, (50%) 7, 8, 9 and Martin Ward this month. This was raised with the ward teams at the point of audit. There was one VTE assessment missed in Mental Health Services for a patient who had been readmitted shortly after discharge; this is being followed up by the ADoN **VTE Prophylaxis:** • With the exception of Wards 2 and 4 all areas had 100% of patients who were prescribed prophylaxis where required	**VTE risk assessment within 12 hours:** • This target required ongoing focus and showed some improvement in February and March. However, since April a decline in performance has been demonstrated which is being raised with the care groups at their governance meetings and subject to further scrutiny at OCQG. **VTE Prophylaxis:** • This target requires ongoing focus but is on an upward trajectory overall since the beginning of monitoring and reporting. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Safe	Falls; Medication Errors	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Falls Inpatient (Harm only) per 1,000 bed days : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	0.2	QC4

Threshold	YTD Mean	Benchmark
< 2	0.3	0.3

(Lower value represents better performance)

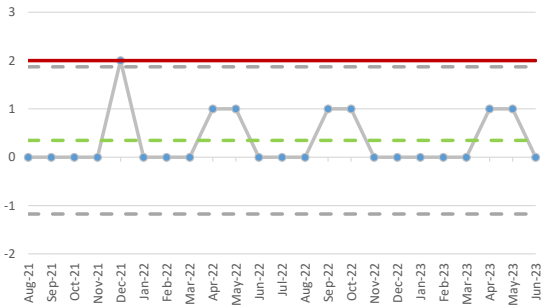
+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

Exposure to medication incidents resulting in harm: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	0	

Threshold	YTD Mean	Benchmark
< 25 PA	1	0

(Lower value represents better performance)

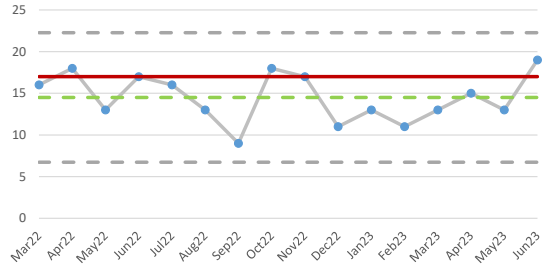
+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

Pressure Ulcers - Total incidence - Grade 2 and above



Reporting Date	Performance	Op. plan #
Jun-23	19.0	QC4

Threshold	YTD Mean	Benchmark
<= 17 (204 PA)	15.7	14.1

(Lower value represents better performance)

-	Variation Description

Common cause

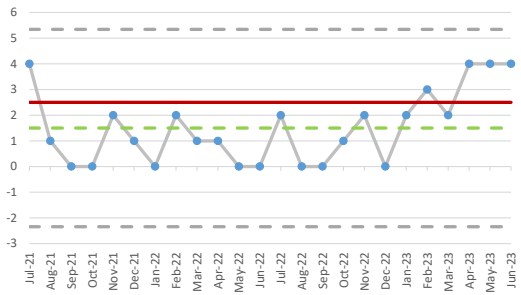
-	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Falls (with Harm): • The threshold for falls with harm is <2 per 1000 bed days and the performance has consistently exceeded this target throughout the previous year and into this year, recording 1.16 for June which was a total of 3 patients. One was a patient attending for a procedure who fell in the main entrance, one a patient on a medical ward who was incontinent and slipped in the urine and one a patient who slipped getting out of bed. **Medication Errors (with Harm):** • Zero errors with harm across Manx Care in June.	**Falls (with Harm):** • Close review of falls with harm is being undertaken to ensure that high quality risk assessment and robust mitigations are being put in place **Medication Errors (with Harm):** • Exposure to harm from medication errors remains low. Continue high vigilance and monitoring to ensure continued low exposure.	**Falls (with Harm):** • Due to the ongoing high numbers of falls, there is a real concern that harm from falls will continue to rise **Medication Errors (with Harm):** • Reasonable assurance that errors leading to harm will remain low. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Safe	Infection Control	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

C.Diff - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	4	QC115

Threshold	YTD Mean	Benchmark
< 30 PA	4	1

(Lower value represents better performance)

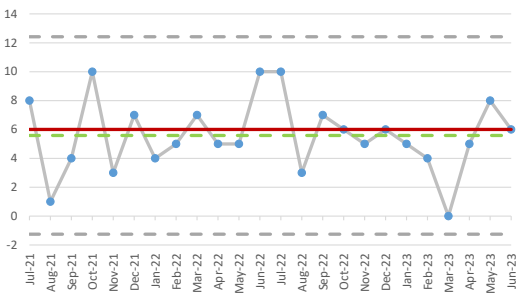
-	Variation Description

Special Cause of Concerning variation (High)

-	Assurance Description

Inconsistently passing and falling short of target

E.Coli - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	6	QC116

Threshold	YTD Mean	Benchmark
< 72 PA	6	6

(Lower value represents better performance)

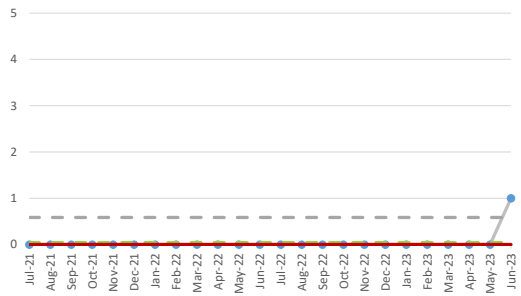
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

MRSA - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	1	QC8

Threshold	YTD Mean	Benchmark
0	0	0

(Lower value represents better performance)

-	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory

C.Diff:
• CDI cases are higher than the target of two cases per month for the third month in a row. There have been four CDI cases. Two cases were community associated and two cases were hospital associated. All cases relate to high risk antibiotic usage. Other patient specific risk factors include comorbidities, age, protein pump inhibitors.

E.Coli:
• There have been six cases in June. Five cases are community associated and one case is hospital associated. The potential source of infection in four of the community cases was urine (two had a urinary catheter present) and one potential source was a leg ulcer. The potential source of infection in the hospital case was cellulitis.

MRSA:
• There was one hospital associated case in June. This is the first case since Feb 2021. Potential source of infection was identified as a wound caused by intravenous drug use which originated while in the community.

Pseudomonas aeruginosa:
• There were no cases this month.

C.Diff:
• RCAs are undertaken in all CDI cases.

E.Coli:
• To continue to undertake surveillance and undertake RCAs where the cases are hospital associated.

MRSA:
• To continue to monitor and undertake surveillance.

Pseudomonas aeruginosa:
• To continue to monitor and undertake surveillance.

C.Diff:
• There is no evidence that the hospital or community associated cases are connected
To continue to identify any new cases via the ICNet surveillance system and escalate to DIPC, Lead IPC Nurse and Consultant Microbiologist. The DIPC has called an urgent CDI review to look at cases from January – July. Antimicrobial stewardship (hospital and community), cleaning, decontamination of patient equipment , hand hygiene, thorough check of mattresses will be undertaken as part of the review.

E.Coli:
• There is no national target set. Surveillance continues to monitor if there is any commonality between cases.

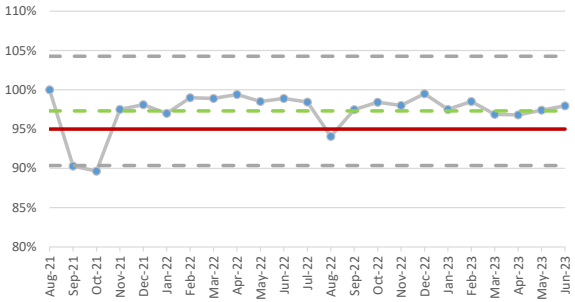
MRSA:
• Patient was discharged from hospital. RCA has been undertaken.

Pseudomonas aeruginosa:
• There is no national threshold set.

Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Safe	Safety Thermometer	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Harm Free Care Score (Safety Thermometer) - Adult: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	98.0%	QC119

Threshold	YTD Mean	Benchmark
95.0%	97.4%	98.0%

(Higher value represents better performance)

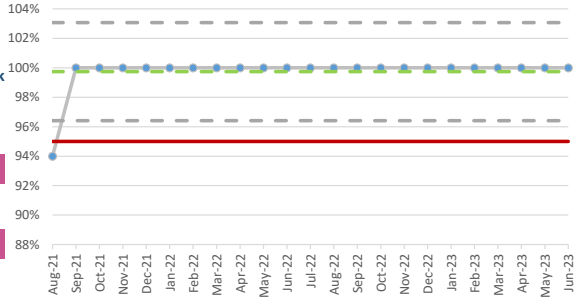
+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

Harm Free Care Score (Safety Thermometer) - Maternity: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	100.0%	QC120

Threshold	YTD Mean	Benchmark
95.0%	100.0%	100.0%

(Higher value represents better performance)

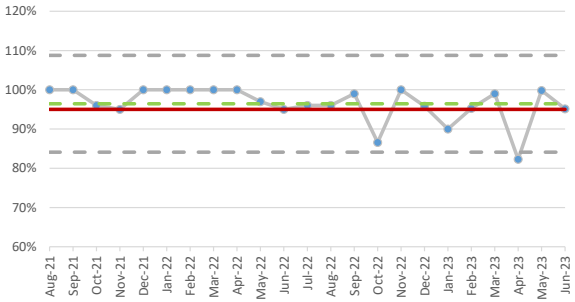
+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

Harm Free Care Score (Safety Thermometer) - Children: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	95.2%	QC121

Threshold	YTD Mean	Benchmark
95.0%	92.4%	95.8%

(Higher value represents better performance)

-	Variation Description

Common cause

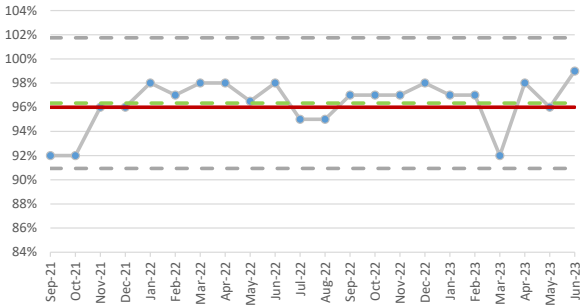
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Adult: • Harm Free scores for Adult in patient measures were complaint at 97.95% **Maternity:** • Harm free scores for Maternity in patients were compliant at 100% **Children:** • Harm free scores for Children in patients were compliant at 95.2%.	**Adult:** • Continued and sustained high level of performance throughout the year for adult in patient general areas. **Maternity:** • Continue with activities to maintain compliance. **Children:** • Continue with activities to maintain compliance.	**Adult:** • High level of confidence that high levels of compliance will continue. **Maternity:** • High level of confidence that performance will continue to exceed the target. **Children:** • High level of confidence that performance will continue to exceed the target. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Safe	Hand Hygiene; Antibiotic Review	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Hand Hygiene Compliance: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	99.0%	QC112

Threshold	YTD Mean	Benchmark
96.0%	97.7%	96.5%

(Higher value represents better performance)

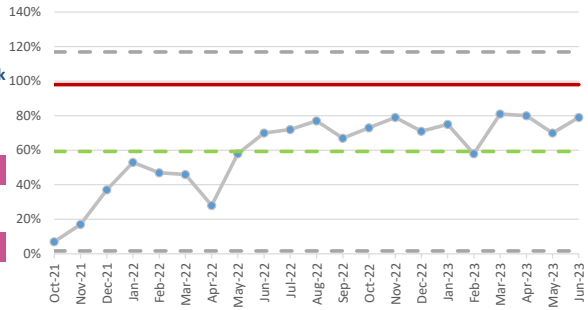
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

48-72 hr review of antibiotic prescription complete: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	79.0%	QC123

Threshold	YTD Mean	Benchmark
>= 98%	76.3%	67.4%

(Higher value represents better performance)

+	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hand Hygiene: • Compliance was met this month. Hand hygiene for Bare Below the Elbow was 99 % and the Five Moments of Hand Hygiene was 98 %. There is evidence of sustained compliance since April 2023. **Review of Antibiotic Prescribing:** • 79% for June, an increase from May.	**Hand Hygiene:** • To continue to monitor hygiene compliance in the monthly audits and undertake training in areas where compliance is not met. **Review of Antibiotic Prescribing:** To continue to monitor.	**Hand Hygiene:** • There is reasonable confidence that hand hygiene audits will remain compliant. **Review of Antibiotic Prescribing:** Limited confidence that this will improve as performance is being propped up through antimicrobial ward rounds rather than step change in prescribing practice. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective Performance Summary (page 1 of 2)

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF001		Planned Care - DNA Rate (Consultant Led outpatient appointments)	Jun-23		10%	11%	-	5% by Apr '24		
EF002		Planned Care - Total Number of Cancelled Operations	Jun-23		284	288	864	-		
EF005		Length of Stay (LOS) - No. patients with LOS greater than 21 days	Jun-23		114	116	-	-		
EF050		Total Number of Inpatient discharges-Nobles	Jun-23		866	891	2672	-		
EF051		Total Number of inpatient discharges-RDCH	Jun-23		40	73	101	-		
EF003		Theatres - Number of Cancelled Operations on Day	Jun-23		28	35	104	-		
EF004		Theatres - Theatre Utilisation	Jun-23		68%	72%	-	85%		
EF006		Crude Mortality Rate	Jun-23		13	23	271	-		
EF007		Total Hospital Deaths	Jun-23		13	23	279	-		
EF024		Mortality - Hospitals LFD (Learning from Death reviews)	Jun-23		98%	95%	-	80%		
EF025		Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	Jun-23		99%	97%	-	95%		
EF008		ASC -West Wellbeing Contribution to reduction in ED attendance	Jun-23		-6%	2%	-	-5%		
EF009		ASC - West Wellbeing Reduction in admission to hospital from locality	Jun-23		-25%	-13%	-	-10%		
EF010		IPCC - % Dental contractors on target to meet UDA's	Jun-23		17%	-	-	96%		
EF011		MH - Average Length of Stay (LOS) in MH Acute Inpatient Service	Jun-23		83.0	48.7	-	-		
EF064		MH - Number of patients with a length of stay - 0 days	Jun-23		1	1	4	-		

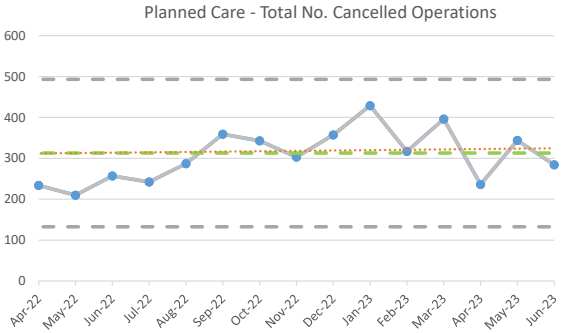
KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF065		MH - Number of patients aged 18-64 with a length of stay - > 60 days	Jun-23	-	3	49	10	-		-
EF066		MH - Number of patients aged 65+ with a length of stay - > 90 days	Jun-23	-	1	9	3	-		-
EF013		MH - % service users discharged from MH inpatient to have follow up appointment	Jun-23		90.5%	97%	-	90%		
EF047		% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	Jun-23		100%	100%	-	75%		
EF048		% Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral	Jun-23		100%	83%	-	75%		
EF026		MH - Crisis Team one hour response to referral from ED	Jun-23		100%	96%	-	75%		
EF063		ASC - No. of referrals	Jun-23		59	71	213			-
EF015		ASC - % of Re-referrals	Jun-23		2%	3%	-	<15%		
EF016		ASC - % of all Adult Community Care Assessments completed in Agreed Timescales	Jun-23		29%	36%	-	80%		
EF017		ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment	Jun-23		100%	57%	-	100%		
EF052		Referrals to Adult Safeguarding Team	Jun-23		95	90	270	-		-
EF053		Adult Safeguarding Alert	Jun-23		48	51	154	-		-
EF054		Discharges from Adult Safeguarding Team	Jun-23		96	90	271	-		-
EF055		Re-referrals to Adult Safeguarding Team	Jun-23		20	20	59	-		-
EF056		% MARFs Completed by Adult Safeguarding Team	Jun-23		50%	73%	-	-		-

Effective Performance Summary (page 2 of 2)

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF049		C&F -Number of referrals - Children & Families	Jun-23		144	144	432	-		
EF019		CFSC - % Complex Needs Reviews held on time	Jun-23		66%	80%	-	85%		
EF021		CFSC - % Total Initial Child Protection Conferences held on time	Jun-23		23%	74%	-	90%		
EF022		CFSC - % Child Protection Reviews held on time	Jun-23		100%	74%	-	90%		
EF023		CFSC - % Looked After Children reviews held on time	Jun-23		100%	100%	-	90%		
EF044		C&F -Children (of age) participating in, or contributing to, their Child Protection review	Jun-23		93%	64%	-	90%		
EF045		C&F -Children (of age) participating in, or contributing to, their Looked After Child review	Jun-23		100%	100%	-	90%		
EF046		C&F -Children (of age) participating in, or contributing to, their Complex Review	Jun-23		42%	37%	-	79%		
EF030		Maternity - Caesarean Deliveries (not Robson Classified)	Jun-23		32%	37.83%	-			
EF031		Maternity - Induction of Labour	Jun-23		11%	25.53%	-	< 30%		
EF032		Maternity - 3rd/4th Degree Tear Overall Rate	Jun-23		1%	0.33%	-	< 3.5%		
EF033		Maternity - Obstetric Haemorrhage >1.5L	Jun-23		0%	0.00%	-	< 2.6%		
EF034		Maternity - Unplanned Term Admissions To NNU	Mar-23		4%	-	-	-		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF035		Maternity - Stillbirth Number / Rate	Jun-23		0	0	0.0	<4.4/1000		
EF036		Maternity - Unplanned Admission To ITU – Level 3 Care	May-23		2	-	-	-		
EF037		Maternity - % Smoking At Booking	Jun-23		8%	11.3%	-	-		
EF038		Maternity - % Of Women Smoking At Time Of Delivery	Jun-23		5%	7.9%	-	< 18%		
EF039		Maternity - First Feed Breast Milk (Initiation Rate)	Jun-23		73%	70.4%	-	> 80%		
EF040		Maternity - Breast Feeding Rate At Transfer Home	Dec-22		84%	-	-			
EF041		Maternity - Neonatal Mortality rate/1000	Jun-23		0	0	-			
EF059		W&C - Paediatrics- Total Admissions	Jun-23		119	119	119	-		-
EF060		W&C - NNU - Total number of Admissions	Jun-23		8	7	21	-		-
EF061		W&C - NNU - Avg. Length of Stay	Jun-23		9	9	9	-		-
EF062		W&C - NNU -Community follow up	Jun-23		6	6	18	-		-

Effective	Planned Care (1 of 2)	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson

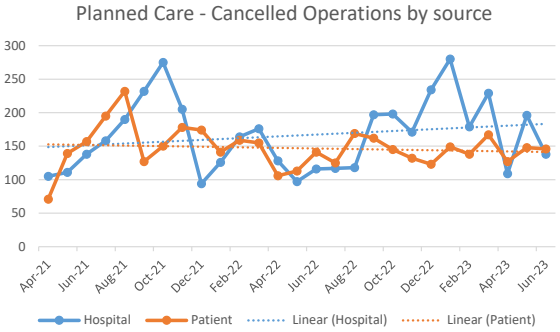


Reporting Date	Performance	Op. Plan #
Jun-23	284	QC157
Threshold	**YTD Mean**	**Benchmark**
-	288	311

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Threshold	**YTD Mean**	**Benchmark**

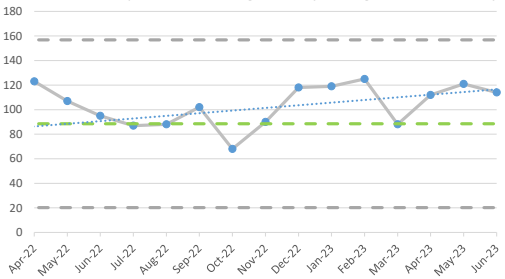
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Cancelled Operations: The number of cancelled operations in Quarter 1 (864) represents a 24.3% decrease on the number of cancellations against the previous quarter (1,142). The largest reduction has been in hospital driven cancellations which were 36% in Quarter 1 than in the previous quarter. However, the figures do show an increase of 23% against the same period in 2022/23 (701). Over Quarter 1 there has been a fairly even split between hospital driven cancellations (443, 51.3%) and those initiated by patients (421, 48.7%)	**Cancelled Operations:** The new Planned Care Dataset that is currently being developed by the Business Intelligence Team will enable more robust and detailed analysis of the factors contributing to cancellations. This will enable appropriate remedial actions to be identified and enacted.	Note - Benchmarks are the Manx Care monthly average for 2022/23.

Effective	Planned Care (2 of 2)	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson	

No. patients with Length of Stay (LOS) greater than 21 days



Reporting Date	Performance	Op. Plan #
Jun-23	**114**	QC10c
Threshold	**YTD Mean**	**Benchmark**
-	116	101

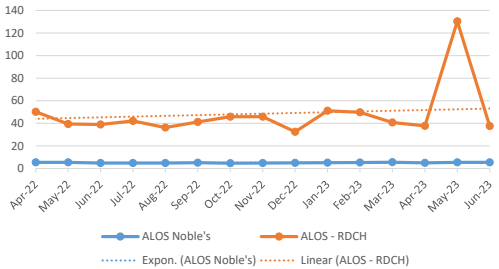
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Average Length of Stay (ALOS) by site

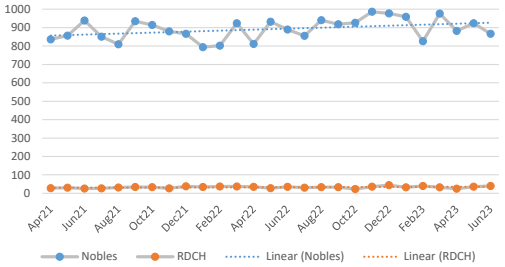


Reporting Date	Performance	Op. Plan #
		QC156
Threshold	**YTD Mean**	**Benchmark**

-	Variation Description

Assurance Description

Inpatient Discharges



Reporting Date	Performance	Op. Plan #
	Nobles **866**	
	RDCH **40**	

Threshold	YTD Mean	Benchmark
	Nobles 891	916
	RDCH 34	33

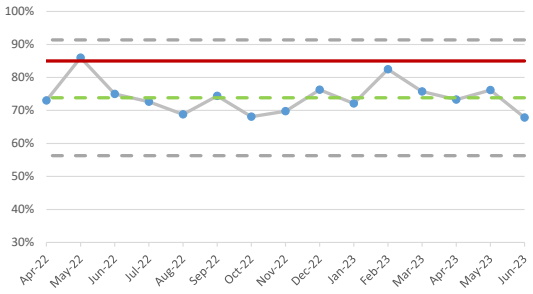
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Length of Stay: • The spike in average LOS for RDCH in May was due to a single patient with a very high length of stay being discharged . • Staffing pressures, closures of ward 12, re-enablement delays and lack of availability of residential and nursing care beds have all contributed to longer lengths of stay. • The acuity of patients being admitted has increased for surgical patients driving longer lengths of stay in hospital. • Access to surgical bed base continues to be a challenge - continuing high levels of medical patients being admitted means that medical patients are having to be accommodated on surgical wards with a direct impact on number of elective surgical procedures that can be undertaken. • Regularly have 30–50 medical outliers in surgical beds – which creates pressures on medical staffing establishments to review and care for the additional patients as not staffed with medics for these additional patients; staffed according to the number of medical wards. • Ongoing problems successfully recruiting locum doctor cover for vacant posts and planned leave means that there has been a reduction in endoscopy and outpatient clinic capacity. **Inpatient Discharges:** Overall, discharge numbers continue on a slight upward trend, with discharges in Quarter 1 (2,773) at a similar level to the same period in the previous year (2,730). This demonstrates the consistent discharging of patients despite the challenges around patient flow.	**Length of Stay:** • Daily activity to ensure surgical patients discharged as soon as clinically appropriate to do so. • Spot purchasing of community beds • Implementation of enhanced recovery pathways under the Restoration & Recovery (R&R) programme. • Increasing throughput through Day Procedures Suite by using it to start the perioperative surgical journey for the first patient on each operating list to facilitate starting the operating list on time plus reducing number of inpatient procedure where appropriate. • Ward 12 is being used as an escalation ward when required – however there are challenges ensuring safe nursing staffing levels to allow the ward to open. Ward 12 is being staffed by Synaptik nursing teams as part of R & R for specific weeks – in these instances Synaptik nursing staff are able to accommodate a limited number of suitable surgical patients as part of escalation plan.	**Length of Stay:** • Significant improvements in the reduction of length of stays for both R&R and BAU activity (e.g. orthopaedic hip & knee ALOS from 4.5 days down to 1.3 days) will deliver overall decreases in length of stay at both Noble's Hospital and Ramsey & District Cottage Hospital. • Reduced LOS on the R&R pathway have allowed all patients to be accommodated on the 15 bed private patient ward (PPU). • Active programme of advertising and recruiting to vacant doctors posts is underway to minimise and reduce locum doctor requirement. Note - Benchmarks are the Manx Care monthly average for 2022/23.

Effective	Theatres	Executive Lead	Oliver Radford	Lead	James Watson	

Theatres - % Theatre Utilisation



Reporting Date	Performance	Op. Plan #
Jun-23	67.8%	QC16

Threshold	YTD Mean	Benchmark
85.0%	72.4%	74.5%

(Higher value represents better performance)

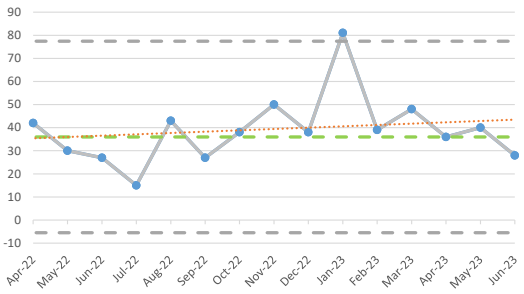
Variation Description

Common cause

- **Assurance Description**

Consistently fail target

Theatres - No. of Cancelled Operations on Day



Reporting Date	Performance	Op. Plan #
Jun-23	28	QC15

Threshold	YTD Mean	Benchmark
-	35	40

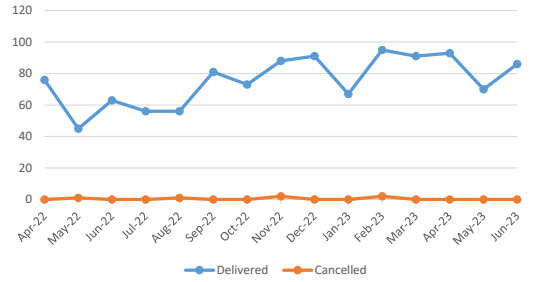
(Lower value represents better performance)

+ **Variation Description**

Common cause

Assurance Description

Theatres - Delivered (vs Cancelled Sessions)



Reporting Date	Performance	Op. Plan #
Jun-23	71	

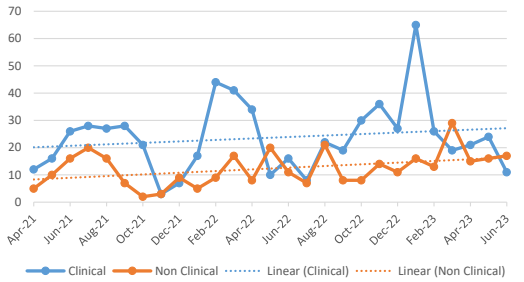
Threshold	YTD Mean	Benchmark
-	76	75

(Higher value represents better performance)

Variation Description

Assurance Description

Theatres - Cancelled Operations on Day by source



Reporting Date	Performance	Op. Plan #
Jun-23	-	QC15

Threshold	YTD Mean	Benchmark
-	-	-

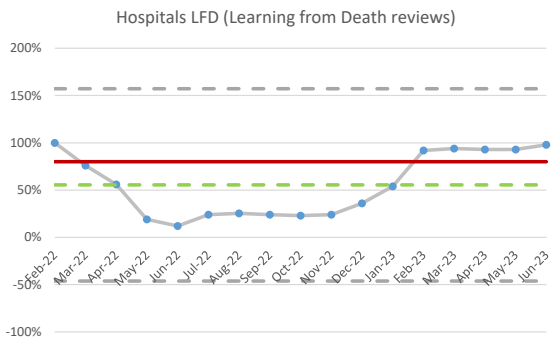
(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Theatre Utilisation: • The number of theatre sessions delivered in Quarter 1 (227) represented a 23% increase compared to the same period in the previous year (185). • No planned theatre sessions have been cancelled so far in 2023/24. • Theatre sessions continued to be run during the TT period this year, which contributed to a lower level of theatre utilisation being achieved and a higher proportion of patient led cancellations on the day. •June saw the lowest number of cancelled operations on the day for 9 months (28 cancellations). • Access to surgical bed base continues to challenge theatre efficiency and utilisation which is resultant in late start to operating lists whilst beds are sourced for elective inpatients, on the day cancellation of patients or entire elective list cancellations. Ultimately these issues are increasing the surgical speciality waiting lists. • Consultant anaesthetic staffing and theatre staffing position remains a challenge and will do so for some time. This will represent a significant cost pressure for the care group for the remainder of this financial year. • Maternity Theatre staffing - maternity is severely short staffed resulting in theatre teams supporting C Section lists 24/7 to mitigate the risk to mother and baby. In order to facilitate this additional activity theatre BAU activity has been reduced.	• Increasing throughput through Day Procedures Suite by using it to start the perioperative surgical journey for the first patient on each operating list to facilitate starting the operating list on time – surgical teams informed to Allocate first patient on the To Come In (TCI) list. BAU is being supported with Synaptik nursing teams on ward 12 where beds are ring fenced to designated specialties. •Planning is progressing with regard to an admissions lounge where all surgical patients will be admitted, prepared for theatre and returned to a surgical ward post operatively. This will provide time for Bed Flow & Capacity team to source a bed without delaying the start to operating sessions, reduce the need to cancel and increase theatre efficiency & utilisation. • Synaptik continues to support the Restoration & Recovery (R&R) waiting list initiatives for ophthalmic, orthopaedic and general surgical specialties through the provision of theatre teams, surgeons & anaesthetists to undertake the surgical activity. Recruitment remains in progress for substantive and Agency staff to sustain the BAU activity in 4 theatres. The vacancy position has improved slightly with successful appointments being made. • Theatre staff continue to support Maternity to mitigate the risk to mother and baby until the situation improves. • Enhanced recovery pathway for orthopaedic patients delivering significantly reduced Length of Stay (LOS) – from approx. 4.5 days to 1.3 days. • Synaptik supported Ophthalmology cataracts all run through ambulatory care pathway facilitated by use of topical anaesthesia no use of the Noble's bed base.	• Manx Care commenced a Theatre Improvement Programme in April 2021 with an initial visit in September 2021, where it was noted that there was evidence of good practice and adherence to the AfPP standards, but also areas where improvements could be made. The Association returned in September 2022, when it was found that all recommendations were met and they were pleased to recommend accreditation of Manx Care's theatres for two years. • The implementation of a surgical admissions lounge which is in the project stages. • Synaptic support is anticipated to continue until March 2024 under Phase 2 of the R&R programme. • Business case development is in progress to increase the funded establishment to staff 7 theatres which is inclusive of maternity theatre. • Proposal to staff the maternity theatre entirely from the main theatre staffing establishment to mitigate risk as above. • Reinforced 48 Hour call out pathway with the rebooking of short notice cancellations into slots where patient has cancelled. • Exploration of Red to Green Criteria led discharge and assertive in-reach. • Care Group operational leads undertaking deep dive analysis of reasons/causes of hospital led cancellations on the day. Note - Benchmarks are the Manx Care monthly average for 2022/23.

Effective	Mortality	Executive Lead	Marina Hudson	Lead	David Hedley; Alison Hool	



Reporting Date	Performance	Op. Plan #
Jun-23	98.0%	QC126

Threshold	YTD Mean	Benchmark
80.0%	94.7%	40.3%

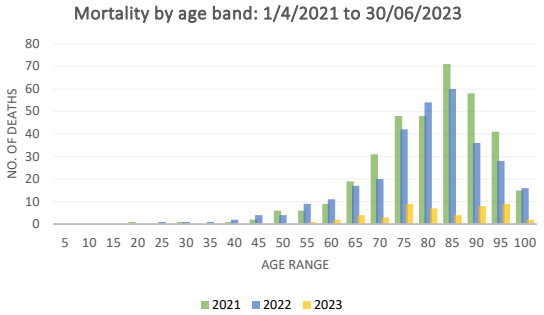
(Higher value represents better performance)

+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target



Reporting Date	Performance	Op. Plan #
-	657 in Total	

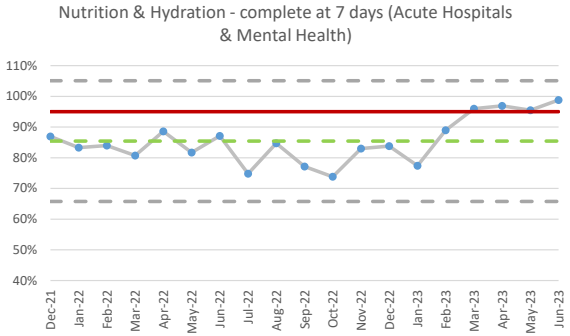
Threshold	YTD Mean	Benchmark
-	-	-

+	Variation Description

-	Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hospitals LFD (Learning from Death) Reviews: • 98% completed level 1 learning from death reviews completed in June which exceeds the target.	**Hospitals LFD (Learning from Death) Reviews:** • Continued focus on completion and work underway to review establish a robust process around Level 2 reviews via the Medical Examiner roles in Manx Care.	**Hospitals LFD (Learning from Death) Reviews:** • Reasonable assurance that high levels of compliance with level 1 reviews will continue. Note - Benchmarks are the Manx Care monthly average for 2022/23.

Effective	Nutrition & Hydration	Executive Lead	Paul Moore	Lead	Paul Hurst, Sue Davis	



Reporting Date	Performance	Op. Plan #
Jun-23	98.8%	QC124

Threshold	YTD Mean	Benchmark
95.0%	97.1%	83.1%

(Higher value represents better performance)

+ Variation Description

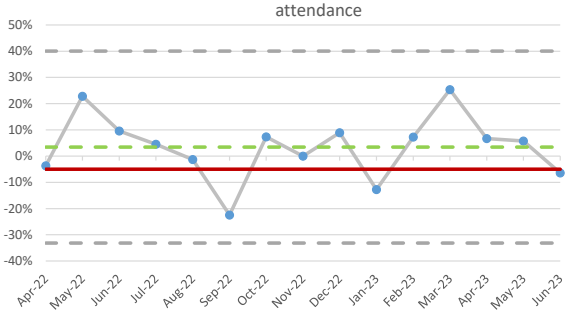
Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Nutrition & Hydration: • 98.8% for June, with sustained compliance above 95% since March 2023.	**Nutrition & Hydration:** • Ward 2 had one patient who had not had his assessment completed. However, this patient did not speak English and communication had been limited. Efforts were being made to ensure this was done.	**Nutrition & Hydration:** • Requires continued high levels of attention on a daily basis from ADONS and senior nurses; however target has been achieved for third consecutive month. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Wellbeing Services	Executive Lead	Oliver Radford	Lead	Adrian Tomkinson	



Reporting Date	Performance	Op. Plan #
Jun-23	-6.4%	QC63

Threshold	YTD Mean	Benchmark
-5.0%	2.0%	3.8%

(Lower value represents better performance)

+ Variation Description
Common cause

+ Assurance Description
Inconsistently passing and falling short of target

Reporting Date	Performance	Op. Plan #
Jun-23	-25.3%	QC64

Threshold	YTD Mean	Benchmark
-10.0%	-12.7%	14.6%

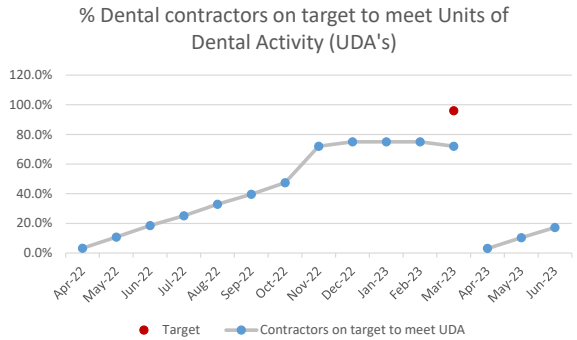
(Lower value represents better performance)

+ Variation Description
Common cause

+ Assurance Description
Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Wellbeing Services: • The goal of integrated care is to reduce reliance on ED in the long term. Attendance will naturally fluctuate throughout the year due to seasonal variation. • Significant Covid impact where ED attendances artificially lower for that period, as people were discouraged from attending ED. Also an increase in admissions across the Isle of Man, as patients' conditions during that period were not being addressed in as timely a manner and have become more acute. • Patients may be attending A&E due to capacity in community services, e.g. dementia patient unable to access Community Occupational Therapy services, falling and attending A&E. • Concern re: metric with data collected on short term basis (6 months), and difficulty in evidencing the direct contribution of the service on ED and Hospital attendance as there are many factors contributing to the demand for those services that are outside the scope and control of the Wellbeing service.	**Wellbeing Services:** • The service is raising awareness regarding the impact the lack of capacity in community services has on ED. • New frailty service identifying patients at an earlier stage. • Targeting of nursing homes specifically for falls.	**Wellbeing Services:** • The service will look to refer more patients to third sector services, e.g. respite services as appropriate. • Technical specification of this metric has been reviewed. Will move to a 12 month timescale to ensure a more appropriate indication of the service's performance, and to better evidence the direct impact of the Wellbeing service on ED and hospital demand. • Impact of frailty service is being reviewed. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Integrated Primary & Community Care (1 of 2)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon	



Reporting Date	Performance	Op. Plan #
Jun-23	17.2%	QC161

Threshold	YTD Mean	Benchmark
96.0%	-	-

(Higher value represents better performance)

+ Variation Description

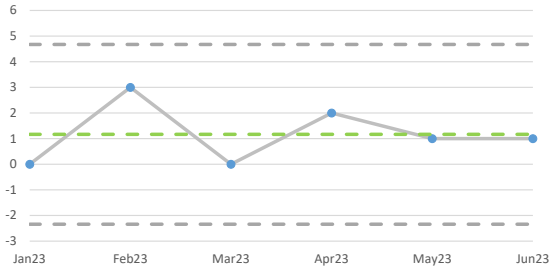
- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Dental Contractors: • 1 contractor is considering options available to them for 2023 -2024 in relation to their dental contract.	**Dental Contractors:** • Quarterly reviews will be held to review contract delivery and discussions will be had with contractors in relation to contract reduction in year if they are not on track to fulfil their contract in full.	**Dental Contractors:** • Contractors who are not on target to deliver their contract may have their contract reduced in year; any under-achievements above 96% will be paid back in full to Manx Care at year and a discussion will then be had with contractors in relation to reviewing their UDA target for the following financial year. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Mental Health (1 of 3)	Executive Lead	David Hamilton	Lead	Ross Bailey	

Mental Health - Number of patients with a length of stay - 0 days



Reporting Date	Performance	Op. Plan #
Jun-23	1	QC87

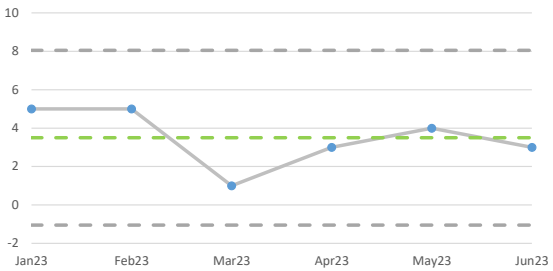
Threshold	YTD Mean	Benchmark
-	1	1

- Variation Description

Common cause

Assurance Description

Mental Health - Number of patients aged 18-64 with a length of stay - > 60 days



Reporting Date	Performance	Op. Plan #
Jun-23	3	QC88

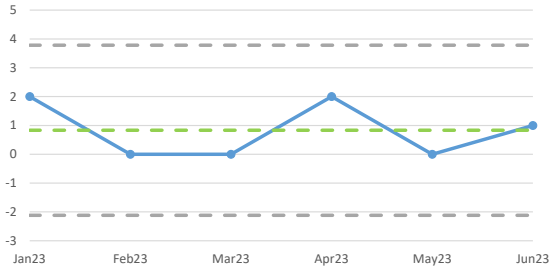
Threshold	YTD Mean	Benchmark
-	49	4

+ Variation Description

Common cause

Assurance Description

Mental Health - Number of patients aged 65+ with a length of stay - > 90 days



Reporting Date	Performance	Op. Plan #
Jun-23	1	QC89

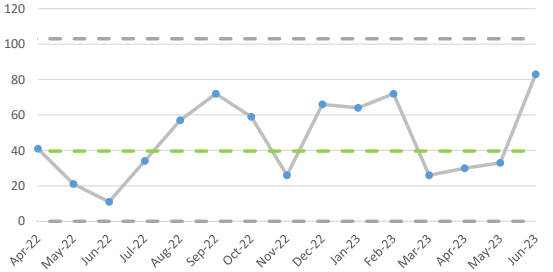
Threshold	YTD Mean	Benchmark
-	9.0	0.7

- Variation Description

Common cause

Assurance Description

MH - Average Length of Stay (ALOS) in MH Acute Inpatient Service (Based on Discharges)



Reporting Date	Performance	Op. Plan #
Jun-23	83	QC158

Threshold	YTD Mean	Benchmark
-	49	46

- Variation Description

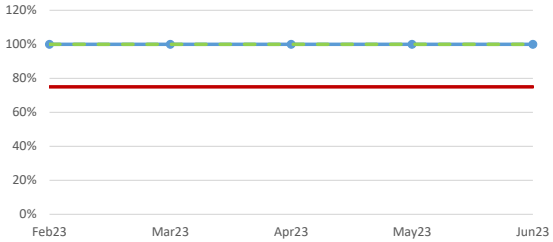
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Average Length of Stay (ALOS): • ALOS has increased in June. The average length of stay on Glen Suite is 549 days, and Harbour Suite 37. •The ALOS on the Glen suite is consistently higher, given the challenges in securing dementia beds. For current inpatients, the ALOS per ward are: Glen - ALOS 125 days Harbour - ALOS 36 days		**Average Length of Stay (ALOS):** • The service regularly monitor patients who are admitted and actively look to progress the most appropriate treatment/care plan on an individual basis. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Mental Health (2 of 3)	Executive Lead	David Hamilton	Lead	Ross Bailey	

% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours



Reporting Date	Performance	Op. Plan #
Jun-23	100%	QC69

Threshold	YTD Mean	Benchmark
75%	100%	100%

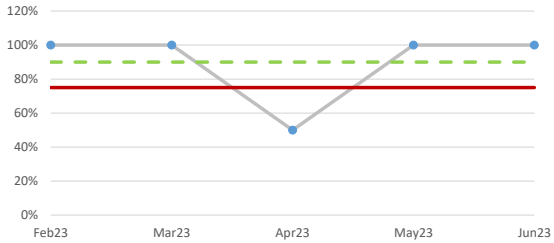
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

% Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral



Reporting Date	Performance	Op. Plan #
Jun-23	100%	QC70

Threshold	YTD Mean	Benchmark
75%	83%	100%

+ Variation Description

Common cause

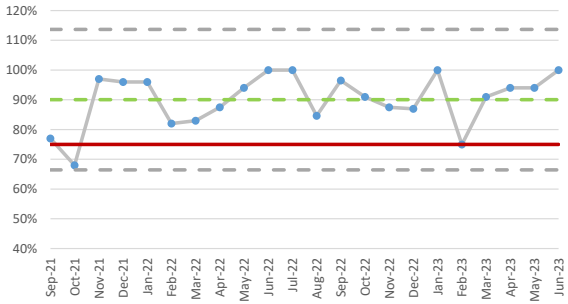
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Patients Admitted to Physical Health Wards: All patients requiring a Mental Health Assessment have continued to receive them within 24 hours. **First Episode of Psychosis Treated with NICE care package:** All respective patients were treated with a NICE recommended care package within the required timescales.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Mental Health (3 of 3)	Executive Lead	David Hamilton	Lead	Ross Bailey	

Crisis Team one hour response to referral from ED



Reporting Date	Performance	Op. Plan #
Jun-23	100.0%	QC68

Threshold	YTD Mean	Benchmark
75.0%	96.0%	91.2%

(Higher value represents better performance)

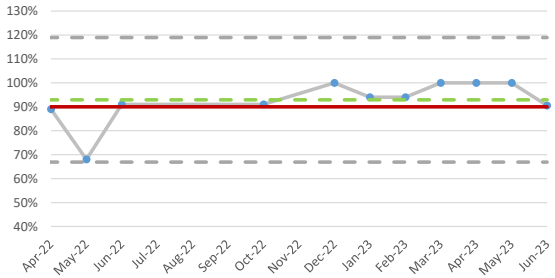
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

MH - % service users discharged from MH inpatient that have follow up appointment within 3 days



Reporting Date	Performance	Op. Plan #
Jun-23	90.5%	QC72

Threshold	YTD Mean	Benchmark
90.0%	96.8%	90.9%

(Lower value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary

Crisis Team:

• 100% - The target for response from the wider hospital was also met.

3 Day follow up:

• In June the performance threshold of 90% was achieved.

Planned / Mitigation Actions

3 Day follow up:

• IMHS are working with Live Systems team and the BI team to gather this information electronically. RiO has a "bug" which makes mandatory fields, non-mandatory, making data quality checks difficult. Awaiting confirmation from the Live Systems team, via the supplier to confirm a "fix" date we can make a decision to progress with or with the data quality checks.

Assurance / Recovery Trajectory

Crisis Team:

• This was the second time a perfect score has been posted in the past 12 months, and the first time since January 2023. More generally the target of 75% is being exceeded consistently.

3 Day follow up:

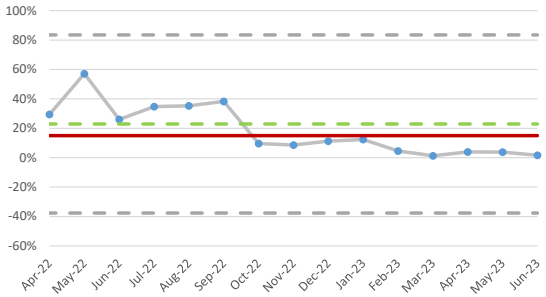
Local performance consistently outperforms NHS England which reported 73% for Q3

Note -

Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Adult Social Work	Executive Lead	David Hamilton	Lead	Michele Mountjoy

ASC - % of Re-referrals



Reporting Date	Performance	Op. Plan #
Jun-23	1.7%	QC41

Threshold	YTD Mean	Benchmark
<15%	3.2%	22.4%

(Lower value represents better performance)

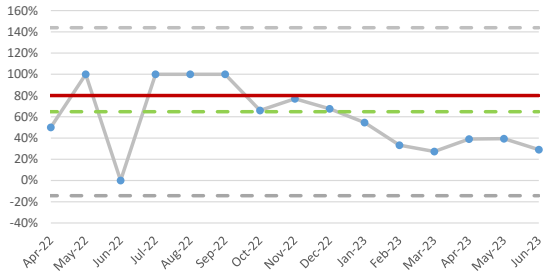
+ Variation Description

Special Cause of Improving variation (Low)

+ Assurance Description

Consistently hit target

ASC - % of all Adult Community Care Assessments completed in Agreed Timescales



Reporting Date	Performance	Op. Plan #
Jun-23	29.2%	QC44

Threshold	YTD Mean	Benchmark
80.0%	35.9%	64.6%

(Higher value represents better performance)

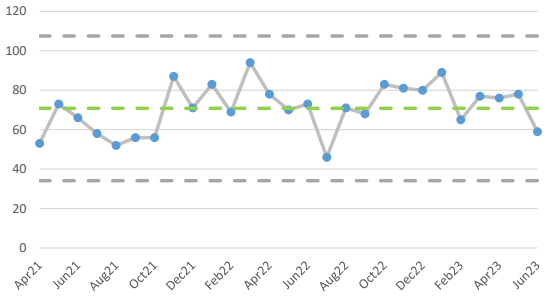
- Variation Description

Common cause

- Assurance Description

Consistently fail target

ASC - No. of referrals



Reporting Date	Performance	Op. Plan #
Jun-23	59	QC40

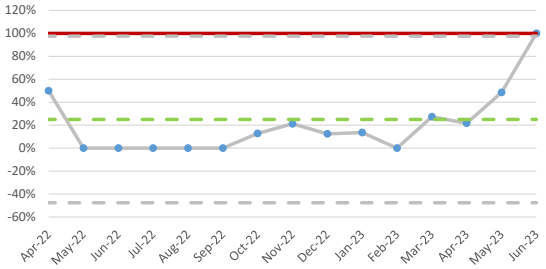
Threshold	YTD Mean	Benchmark
-	71	73

+ Variation Description

Common cause

Assurance Description

ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment



Reporting Date	Performance	Op. Plan #
Jun-23	100.0%	QC45

Threshold	YTD Mean	Benchmark
100.0%	56.7%	11.4%

(Higher value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary

Referrals:
The number of new referrals received in June was 59.

Re-Referrals:
• We have significantly reduced our re-referral rate to 1.7% in the first quarter, which is slightly higher than the last quarter (1.3%), but it is decreasing.

Assessments completed within Timescales:
• The completion of Wellbeing Partnership assessments in June remained below the required threshold. A number of these assessments are complex, particularly in respect of Learning Disabilities.

Individuals receiving copy of Assessment:
• The reported number of individuals receiving copies of their Wellbeing Partnership assessments in June achieved the required threshold of 100%.

Planned / Mitigation Actions

• Processes are being continually reviewed to make them more streamlined.

Assessments completed within Timescales:
• The Adult Social Work teams have had some relief to staffing pressures, with the Learning Disabilities Team particularly having made some recent improvements. With the improved staffing position, this is expected to further improve in July. Complexity of some assessments is still a factor, with specialist assessment required before an assessment can be completed, e.g. Parkinson's, SALT assessments.

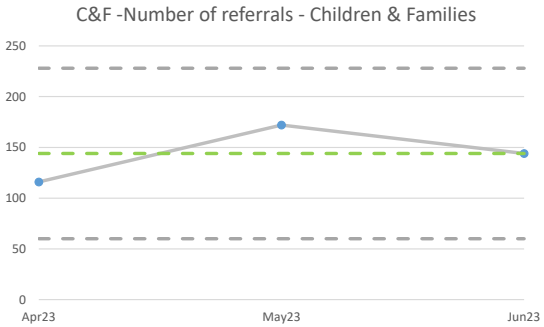
Individuals receiving copy of Assessment:
• The Interim Principal Social Worker organised a learning session with the team who achieved 'zero' in the sharing of assessments in April to support and help the team's understanding of the importance of this KPI. The team were completing and sharing assessments, however they were not completing this information in RiO for accurate data capture.
• Following the learning session, it is encouraging to note that this figure is now 100%.

Assurance / Recovery Trajectory

Assessments completed within Timescales:
• Overall completion of assessments in Adult Social Work, using the Wellbeing Partnership Assessment model, is expected to continually improve following progress in recruiting both agency and substantive social workers to the teams.
• The previously reported data capture issue has now been resolved.

Note -
Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Social Work (Children & Families) 1 of 3	Executive Lead	David Hamilton	Lead	Julie Gibney	



Reporting Date	Performance	Op. Plan #
Jun-23	**144**	

Threshold	YTD Mean	Benchmark
-	144	144

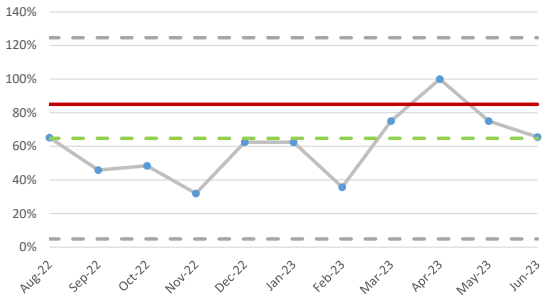
+	Variation Description
	Common cause

-	Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals: Referral levels have remained fairly static over Quarter 1.		**Referrals:** Work is ongoing with the Business Intelligence Team to develop the underpinning data to enable the reporting of Re-Referral rates for the C&F Service in future months. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Social Work (Children & Families) 2 of 3	Executive Lead	David Hamilton	Lead	Julie Gibney

% Complex Needs Reviews held on time



Reporting Date	Performance	Op. Plan #
Jun-23	65.5%	QC49

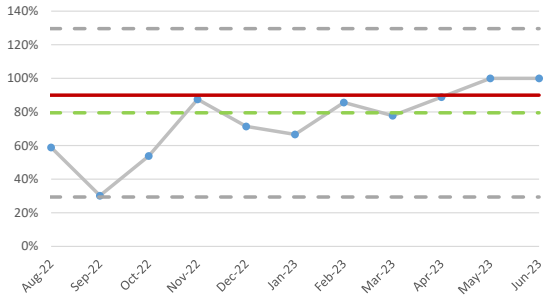
Threshold	YTD Mean	Benchmark
85.0%	80.2%	53.4%

(Higher value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

% Total Child Protection Review Conferences held on time



Reporting Date	Performance	Op. Plan #
Jun-23	100.0%	QC52

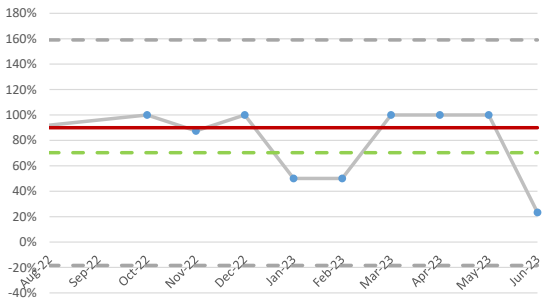
Threshold	YTD Mean	Benchmark
90.0%	90.0%	66.5%

(Higher value represents better performance)

+	Variation Description
	Common cause

+	Assurance Description
	Inconsistently passing and falling short of target

% Total Initial Child Protection Conferences held on time



Reporting Date	Performance	Op. Plan #
Jun-23	23.3%	QC51

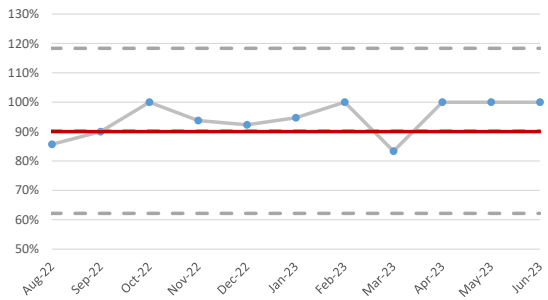
Threshold	YTD Mean	Benchmark
90.0%	74.4%	81.3%

(Higher value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

% Looked After Children reviews held on time



Reporting Date	Performance	Op. Plan #
Jun-23	100.0%	QC53

Threshold	YTD Mean	Benchmark
90.0%	100.0%	92.5%

(Higher value represents better performance)

+	Variation Description
	Common cause

+	Assurance Description
	Inconsistently passing and falling short of target

Issues / Performance Summary

Complex Needs Reviews held on time:
• These cases are predominantly held in the CWD (Children With Disabilities) Team where there are continuing staffing pressures. The manager of this team has oversight of this process and will be striving to improve performance in this area.

Initial Child Protection Conferences held on time:
• 23.3% of initial child protection conferences were held within timescale in June.

Child Protection Review Conferences held on time:
• 100% of conferences were completed within the timescales in June.

Looked After Children reviews held on time:
• 100% of reviews were held within the timescales in June.

Planned / Mitigation Actions

Complex Needs Process:
• The team that holds the majority of these cases is the Children With Disabilities team which has had significant staffing issues, with only 1 staff member for several months. This is now resolved and the manager has oversight of these meetings and will be striving to improve performance in this area. Performance has significantly improved in the CWD team overall, however it is recognised that the resource this team requires review.
• The holding of these reviews on time is a prioirity for the team manager in CWD, with additional capacity being put into the administrative role to better support this process.

Initial Child Protection Conferences held on time:
• 10 out of 14 Initial Child Protection Conferences had to be held out of timescale as they fell during TT fortnight. It was not possible to hold conferences during this period due to road closures and availability of other agencies, e.g. Police.

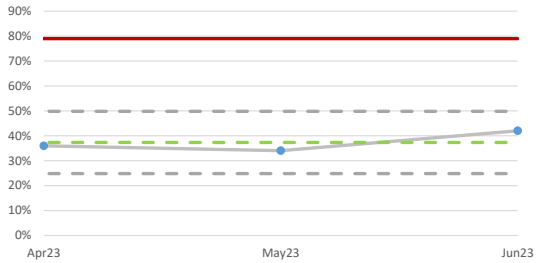
Assurance / Recovery Trajectory

Complex Needs Process:
• A potential data quality/timing issue has been identified with the historically reported performance for this metric and the service area and BI Team are actively working to resolve these issues.

Note -
Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Social Work (Children & Families) 3 of 3	Executive Lead	David Hamilton	Lead	Julie Gibney

Children (of age) participating in, or contributing to, their Complex Review%



Reporting Date	Performance	Op. Plan #
Jun-23	42%	

Threshold	YTD Mean	Benchmark
79%	37%	37%

(Higher value represents better performance)

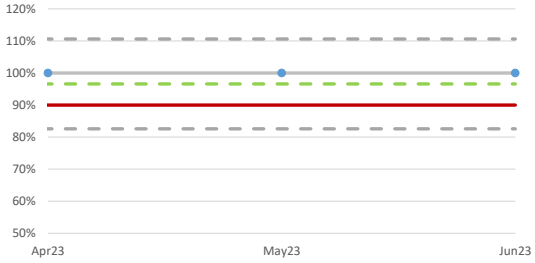
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

Children (of age) participating in, or contributing to, their Looked After Child review%



Reporting Date	Performance	Op. Plan #
Jun-23	100%	

Threshold	YTD Mean	Benchmark
90%	100%	100%

(Higher value represents better performance)

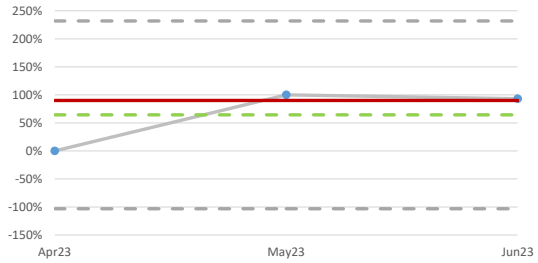
+ Variation Description

Special Cause of Improving variation (High)

+ Assurance Description

Consistently hit target

Children (of age) participating in, or contributing to, their Child Protection review%



Reporting Date	Performance	Op. Plan #
Jun-23	93%	

Threshold	YTD Mean	Benchmark
90%	64%	64%

(Higher value represents better performance)

+ Variation Description

Common cause

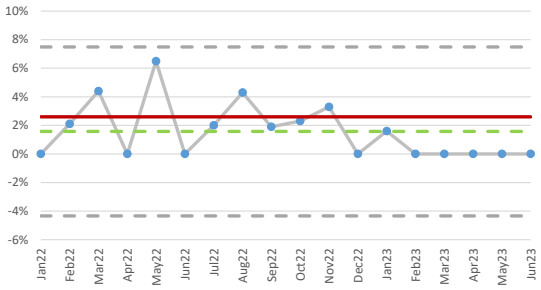
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Participation in conferences for Looked After Children has a designated worker to encourage and develop participation, and therefore this metric is usually high. There is no specific role to provide this in CWCN and work continues to develop participation in this area, especially in the CWD team.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Women & Children (1 of 4)	Executive Lead	Oliver Radford	Lead	Linda Thompson	

Obstetric Haemorrhage >1.5L



Reporting Date	Performance	Op. Plan #
Jun-23	0%	

Threshold	YTD Mean	Benchmark
< 2.6%	0.00%	1.8%

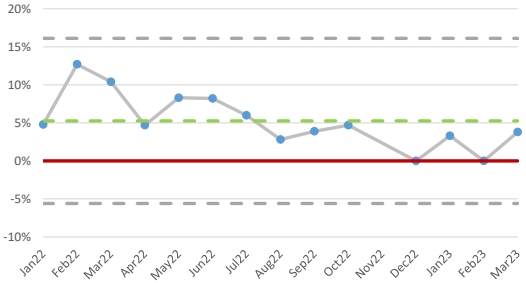
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Unplanned Term Admissions To NNU



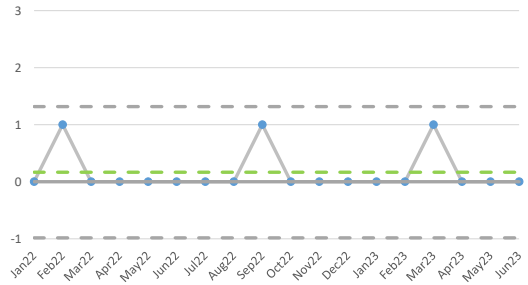
Reporting Date	Performance	Op. Plan #
Mar-23	-	

Threshold	YTD Mean	Benchmark
-	-	4.2%

Variation Description

Assurance Description

Stillbirth Number / Rate



Reporting Date	Performance	Op. Plan #
Jun-23	0	

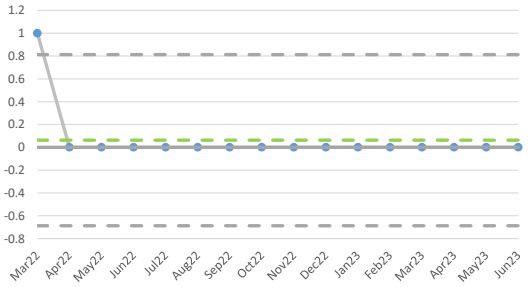
Threshold	YTD Mean	Benchmark
<4.4/1000	0	16.7%

+ Variation Description

Common cause

+ Assurance Description

Neonatal Mortality rate/1000



Reporting Date	Performance	Op. Plan #
Jun-23	0	

Threshold	YTD Mean	Benchmark
-	0	0.0%

+ Variation Description

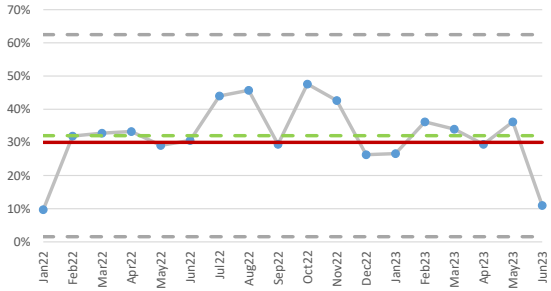
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Obstetric haemorrhage >1.5 litre: this is monitored via the maternity dashboard in order to identify cases of major haemorrhage and prompt a review of care and to identify and learning. **Smoking at booking and delivery:** all women are asked regarding their smoking status and receive carbon monoxide testing at the booking appointment. Women who smoke are offered smoking cessation support.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Women & Children (2 of 4)	Executive Lead	Oliver Radford	Lead	Linda Thompson

Induction of Labour



Reporting Date	Performance	Op. Plan #
Jun-23	11.0%	

Threshold	YTD Mean	Benchmark
< 30%	25.5%	27.7%

(Lower value represents better performance)

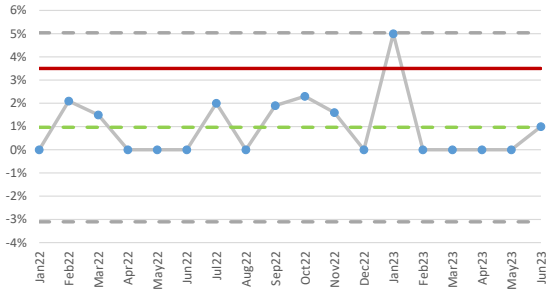
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

3rd/4th Degree Tear Overall Rate



Reporting Date	Performance	Op. Plan #
Jun-23	1.0%	

Threshold	YTD Mean	Benchmark
< 3.5%	0.3%	1.1%

(Lower value represents better performance)

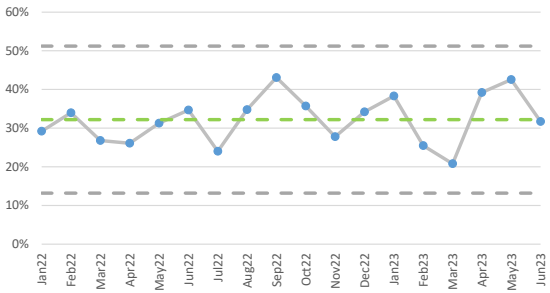
+ Variation Description

Common cause

Assurance Description

Consistently hit target

Caesarean Deliveries (not Robson Classified)



Reporting Date	Performance	Op. Plan #
Jun-23	31.7%	

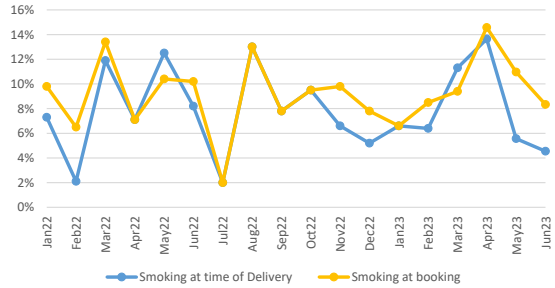
Threshold	YTD Mean	Benchmark
-	37.8%	31.4%

- Variation Description

Common cause

Assurance Description

% Smoking



Reporting Date	Performance		Op. Plan #
Jun-23	Booking	8.3%	
	Delivery	4.6%	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

Total caesarean deliveries:
YTD Average 37.8%. Caesarean section rates across UK have been steadily increasing in recent years and maternity services.

Induction of labour: Manx Care rates for induction of labour are often greater than the national standard of 30%. This maybe because we have a higher proportion of pregnant women who are >40 years of age and for this group it is recommended that induction of labour is performed at term.

Third and fourth degree tear rates: these remain low and below the national standard of >3.5%.

Smoking at booking and delivery: all women are asked regarding their smoking status and receive carbon monoxide testing at the booking appointment. Women who smoke are offered smoking cessation support.

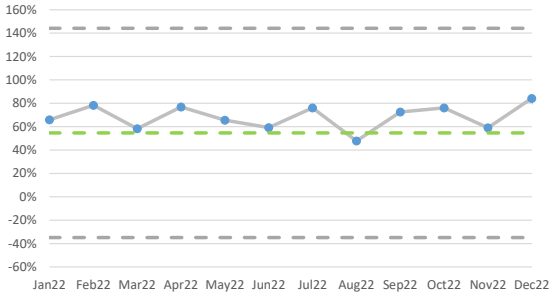
Planned / Mitigation Actions

Assurance / Recovery Trajectory

Note -
Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Women & Children (3 of 4)	Executive Lead	Oliver Radford	Lead	Linda Thompson

Breast Feeding Rate At Transfer Home



Reporting Date	Performance	Op. Plan #
Dec-22	84.2%	

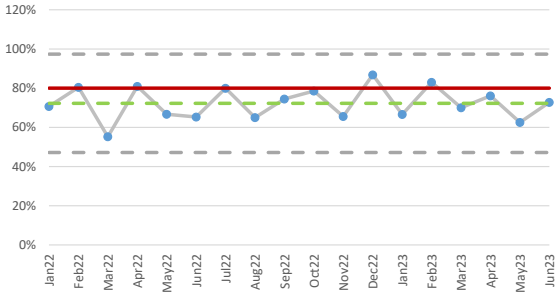
Threshold	YTD Mean	Benchmark
-	-	51.4%

(Higher value represents better performance)

Variation Description

Assurance Description

First Feed Breast Milk (Initiation Rate)



Reporting Date	Performance	Op. Plan #
Jun-23	72.7%	

Threshold	YTD Mean	Benchmark
> 80%	70.4%	73.6%

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
First Feed Breast Milk (Initiation Rate): Initiation rates remain just below the required standard.		**Breast Feeding Rate at Transfer Home:** Work is ongoing with the Care Group and Business Intelligence Team regarding the provision of validated data to enable the reporting of achieved performance in 2023/24. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Women & Children (4 of 4)	Executive Lead	Oliver Radford	Lead	Linda Thompson

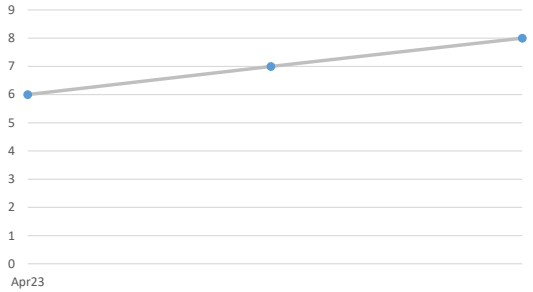
Paediatrics- Total Admissions

Reporting Date	Performance	Op. Plan #
Jun-23	119	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Assurance Description

NNU - Total number of Admissions



Reporting Date	Performance	Op. Plan #
Jun-23	8	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Assurance Description

NNU - Avg. Length of Stay

Reporting Date	Performance	Op. Plan #
Jun-23	9	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Assurance Description

NNU - Community follow up

Reporting Date	Performance	Op. Plan #
Jun-23	6	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Assurance Description

Issues / Performance Summary

NNU Admissions:
7 admissions unplanned, emergencies.
1 repatriation for ongoing care using own staff nurse/medic.

Planned / Mitigation Actions

NNU Admissions:
Only able to accept repatriation when sufficient cot space allowed due to reduced cot numbers.

Assurance / Recovery Trajectory

NNU Admissions:
All babies will be cared for in the appropriate centre as soon as systems allow, until staffing, education & training enables otherwise.

Note -
Benchmarks are the Manx Care monthly averages for 2022/23.

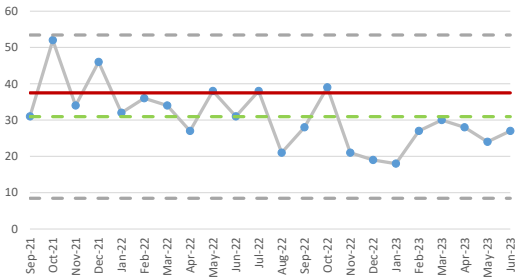
Caring Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
CA001		Mixed Sex Accommodation - No. of Breaches	Jun-23		0	0	0	0		
CA002		Complaints - Total number of complaints received	Jun-23		27	26	79	<= 450 PA		
CA007		Complaint acknowledged within 5 working days	Jun-23		100%	95%	-	98%		
CA008		Written response to complaint within 20 days	Jun-23		98%	99%	-	98%		
CA010		No. complaints exceeding 6 months	Jun-23		0	0	0	0		
CA011		No. complaints referred to HSCOB	Jun-23	-	0	0	0	-		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
CA012		FFT - How was your experience? No. of responses	Jun-23	-	2,096	1,128	3,385	-		
CA013		FFT - Experience was Very Good or Good	Jun-23		85%	88%	-	80%		
CA014		FFT - Experience was neither Good or Poor	Jun-23		6%	4%	-	10%		
CA015		FFT - Experience was Poor or Very Poor	Jun-23		9%	8%	-	<10%		
CA016		Manx Care Advice and Liaison Service contacts	Jun-23	-	517	581	1,742	-		
CA017		Manx Care Advice and Liaison Service same day response	Jun-23		91.0%	89.0%	-	80%		

Caring	Complaints	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Complaints - Number of complaints: Manx care



Reporting Date	Performance	Op. plan #
Jun-23	27	L7

Threshold	YTD Mean	Benchmark
<= 450 PA	26	28

(Lower value represents better performance)

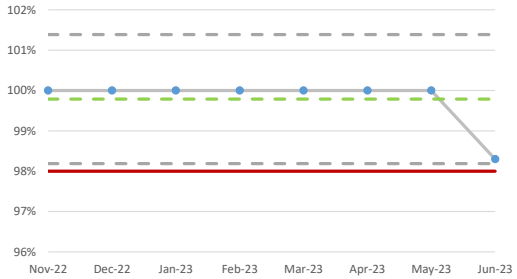
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Complaint - Written response within 20 days: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	98.3%	L8

Threshold	YTD Mean	Benchmark
98.0%	99.4%	-

(Higher value represents better performance)

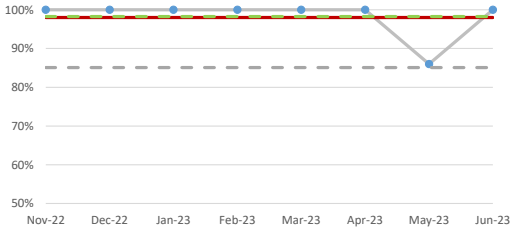
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Complaint acknowledged within 5 working days: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	100.0%	L8

Threshold	YTD Mean	Benchmark
98%	95.3%	-

(Higher value represents better performance)

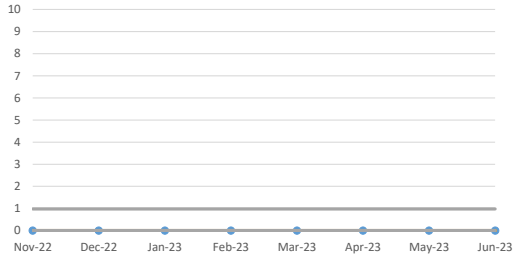
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Complaint - No. complaints exceeding 6 months: Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	0	L8

Threshold	YTD Mean	Benchmark
0	0	-

(Lower value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary

Number of Complaints:
- A total of 27 complaints were received in June which is up slightly from May but remains below target.

Acknowledged within 5 Days:
- Compliance in June is 100%.

Written Response within 20 days:
- Compliance in June is 98% with one letter that was sent out at day 23.

No. Complaints Exceeding 6 Months:
- None.

No. complaints referred to HSCOB:
- None.

Planned / Mitigation Actions

Number of Complaints:
- Continue with processes.

Acknowledged within 5 Days:
- None required.

Written Response within 20 days:
- Continue to monitor closely.

No. Complaints Exceeding 6 Months:
- N/A.

No. complaints referred to HSCOB:
- An introductory meeting was held with CQS team leads and HSCOB. The disbanded IRB have passed 45 legacy complaints to the HSCOB. It is therefore likely that some of these will be taken on by HSCOB.

Assurance / Recovery Trajectory

Number of Complaints:
- Monthly average last year 28; no great variation YTD.

Acknowledged within 5 Days:
- Reasonable degree of confidence in target being met going forward.

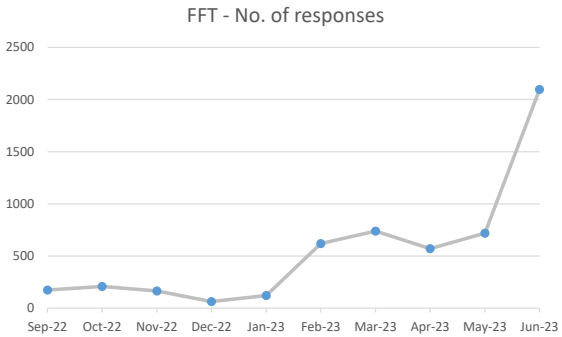
Written Response within 20 days:
- Reasonable degree of confidence in target being met.

No. Complaints Exceeding 6 Months:
- Reasonable degree of confidence.

No. complaints referred to HSCOB:
Given the historic backlog from the IRB, it is likely that some will be taken to the second stage of the complaint process.

Note -
Benchmarks are the Manx Care monthly averages for 2022/23.

Caring	Friends & Family Test	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

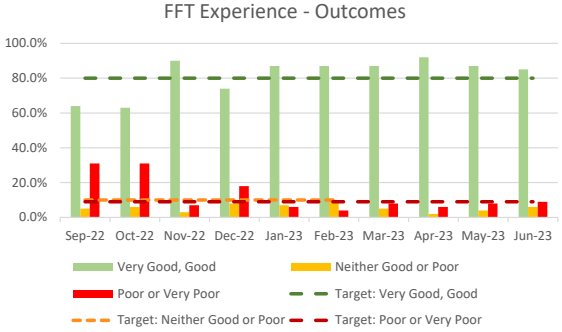


Reporting Date	Performance	Op. plan #
Jun-23	2,096	QC127

Threshold	YTD Mean	Benchmark
-	1,128	-

Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Jun-23	85.0%	QC128-129-130

Threshold	YTD Mean	Benchmark
80.0%	88.0%	-

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary

FFT Total number of responses:

• A total of 2096 Surveys have been completed for June 2023. Increase of 66% since May 2023.

• **FFT – Experience was very good or good:** 1792 completed surveys rated experience as Very Good or Good equating to 85%.

• **FFT – Experience was neither good or poor:** 118 completed surveys rated experience as Neither Good nor Poor equating to 6%.

• **FFT – Experience was poor or very poor:** 186 completed surveys rated experience as Poor or Very Poor, equating to 9%.

Planned / Mitigation Actions

FFT Total number of responses:

• Continue to promote/encourage feedback.

• **FFT – Experience was very good or good:** Target is 80% - consistently scoring above target month on month

• **FFT – Experience was neither good or poor:** Continue to promote/encourage feedback.

• **FFT – Experience was poor or very poor:** Consistently achieving under the 10% target which is a positive indicator.

Assurance / Recovery Trajectory

FFT Total number of responses:

• Confident that submissions will continue to be of a level where valid analysis can be undertaken.

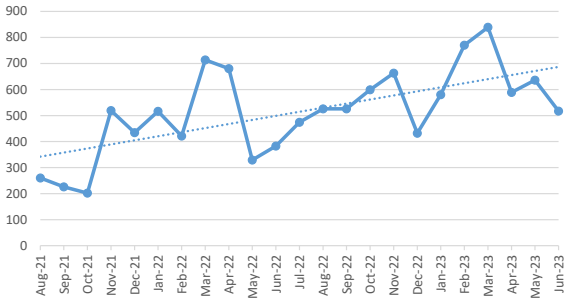
• **FFT – Experience was very good or good:** Continue to promote/encourage feedback. Experience and Engagement award due to be shared across teams for Q1 for demonstration of consistent Good and very good ratings along with high level of quality feedback

• **FFT – Experience was neither good or poor:** Consistently achieving under the 10% target which is a positive indicator.

• **FFT – Experience was poor or very poor:** Monthly dashboards and quarterly review meetings with all care group triumvirates are held to report feedback. Next quarterly reviews to be held in mid July. Poor feedback is reported in the themes and trends as well as the anonymous commentary and care groups develop action plans within their governance groups to target poor feedback. Trends are monitored monthly via dashboards for care groups and drilled down further to team level to highlight positive and negative themes.

Note -
Benchmarks are the Manx Care monthly averages for 2022/23.

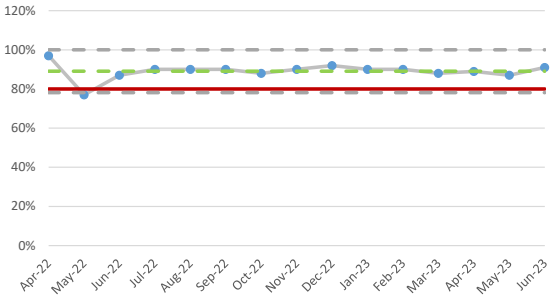
Caring	MCALS	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis



Reporting Date	Performance	Op. plan #
Jun-23	517	QC131
Threshold	**YTD Mean**	**Benchmark**
-	581	567

Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Jun-23	91.0%	QC132
Threshold	**YTD Mean**	**Benchmark**
80.0%	89.0%	-

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Number of Contacts: • 517 contacts received in June 2023. **Same Day Response:** • In June, MCALS has resolved ALL contacts within 24 hours 91% of the time. Key Line of Enquiry Target is 80% of contacts receive a response within 24 hours.	**Number of Contacts:** • MCALS continues to provide excellent support in ensuring that where possible service user issues are addressed. **Same Day Response:** • MCALS continues to provide excellent support in ensuring that where possible service user issues are addressed.	**Number of Contacts:** Continued good performance in dealing with service user contacts. **Same Day Response:** • Continued good performance in dealing with service user contacts. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Responsive Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE058		Cons Led- OP Referrals	Jun-23	-	3075					
RE056		Hospital Bed Occupancy	Jun-23	-	60.1%			92%		
RE001		RTT - No. patients waiting for first Consultant Led Outpatient appointment	Jun-23		15,703	15,640	-	< 15413		
RE002		RTT - No. patients waiting for Daycase procedure	Jun-23		2,334	2,323	-	< 2286		
RE003		RTT - No. patients waiting for Inpatient procedure	Jun-23		534	546	-	< 535		
RE004		RTT - % Urgent GP referrals seen for first appointment within 6 weeks	Jun-23		57%	58%	-	85%		
RE061		Diagnostics-% patients waiting 26 weeks or less	Jun-23		61%	60%		99%		
RE005		Diagnostics - % requests completed within 6 weeks	Jun-23	-	87%	84%	84%	-		
RE006		Diagnostics - % Patients waiting over 6 weeks	Jun-23	-	70%	71%	-	1%		
RE007		ED - % 4 Hour Performance	Jun-23		76%	73%	74%	95%		
RE008		ED - % 4 Hour Performance (Non Admitted)	Jun-23	-	84%	82%	82%	-		
RE009		ED - % 4 Hour Performance (Admitted)	Jun-23	-	29%	28%	28%	-		
RE010		ED - Average Total Time in Emergency Department	Jun-23		220	231	-	360 mins		
RE011		ED - Average number of minutes between Arrival and Triage (Noble's)	Jun-23		21	23	-	15 mins		
RE012		ED - Average number of minutes between arrival to clinical assessment - Nobles	Jun-23		56	63	-	60 mins		
RE033		ED - Average number of minutes between arrival to clinical assessment - RDCH	Jun-23		19	15		60 mins		
RE013		ED - 12 Hour Trolley Waits	Jun-23		12	8	23	0		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE014		Ambulance - Category 1 Response Time at 90th Percentile	Jun-23		19	19	-	15 mins		
RE015		Ambulance - Category 1 Mean Response Time	Jun-23		9	10	-	7 mins		
RE016		Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	Jun-23		64%	54%	-	100%		
RE034		Category 2 Response Time at 90th Percentile	Jun-23		29	33		40 mins		
RE035		Ambulance - Category 3 Response Time at 90th Percentile	Jun-23		39	44		120 mins		
RE036		Ambulance - Category 4 Response Time at 90th Percentile	Jun-23		63	74		180 mins		
RE037		Ambulance - Category 5 Response Time at 90th Percentile	Jun-23		72	84		180 mins		
RE038		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	Jun-23		181	165	-	0		
RE039		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	Jun-23		17	13	-	0		
RE026		IPCC - % patients seen by Community Adult Therapy Services within timescales	Jun-23		56%	53%	-	80%		
RE031		IPCC - % of patients registered with a GP	Jun-23		5.5%	5.5%	-	5.0%		
RE054		Did Not Attend Rate (GP Appointment)	Jun-23	-	0	3%		-		
RE027		IPCC - No. patients waiting for a dentist	Jun-23	-	3,872	3,682	-	-		
RE074		Response by Community Nursing to Urgent / Non routine within 24 hours	Jun-23	-	100%	100%	-	-		
RE075		Community Nursing Service response target met (7 days)- Routine	Jun-23	-	100%	100%	-	-		

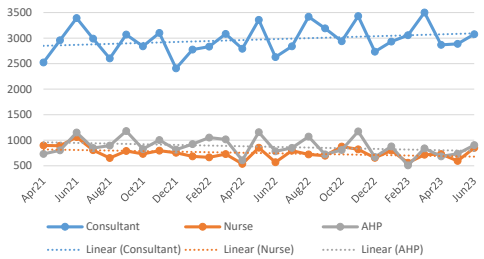
Responsive Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assuranc
RE025		CWT - % 28 Days to diagnosis or ruling out of cancer	Jun-23		58%	63%	-	75%		
RE017		CWT - % patients referral for suspected cancer to first outpatient attendance within 2 weeks	Jun-23		33%	44%	-	93%		
RE020		CWT - % Two Week Wait (Breast Symptomatic)	Jun-23		0%	11%	-	93%		
RE018		CWT - % patients decision to treat to first definitive treatment within 31 days	Jun-23		78%	79%	-	96%		
RE019		CWT - % patients urgent referral for suspected cancer to first treatment within	Jun-23		36%	35%	-	85%		
RE021		CWT - % 31 Day Subsequent Treatment (Surgical)	Jun-23		-	-	-	94%		
RE022		CWT - % 31 Day Subsequent Treatment (Drugs)	Jun-23		100%	100%	-	98%		
RE023		CWT - % 31 Day Subsequent Treatment (Radiotherapy)	Jun-23		-	83%	-	94%		
RE064		No. on Cancer Pathway (All)	Jun-23	-	766	755	-	-		
RE065		No. on Cancer Pathway (2WW)	Jun-23	-	645	641	-	-		
RE066		Cancer - Total number of patients Waiting for 1st OP	Jun-23	-	197	152	-	-		
RE067		Cancer - Median Wait Time for the 2WW referrals (Days)	May-23	-	17	17	-	-		
RE044		MH- Waiting list	Jun-23	-	1572	1572	1572	-		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assuranc
RE045		MH- Appointments	Jun-23	-	6528	6630	19891	-		
RE046		MH- Admissions	Jun-23	-	21	20	59	-		
RE028		MH - No. service users on Current Caseload	Jun-23		5,129	5,104	-	4500 - 5500		
RE051		Maternity Bookings	Jun-23		48	549	169			
RE052		Ward Attenders	Mar-23	-	196	-	-			
RE053		Gestation At Booking <10 Weeks	Jun-23	-	21%	27%	-			
RE030		W&C - % New Birth Visits within timescale	Jun-23	-	86%	89%	-	-		
RE032		Births per annum	Jun-23	-	144	100	-	-		

Responsive	Demand	Executive Lead		Lead	

Referrals for First Outpatient Appointment

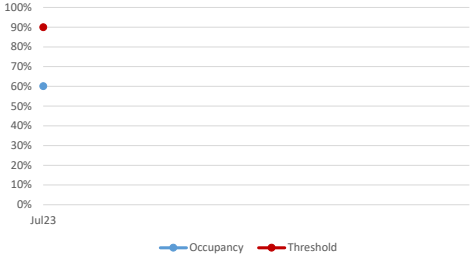


Reporting Date	Performance		Op. Plan #
Jun-23	Consultant	3075	
Threshold	**YTD Mean**		**Benchmark**
-	2943		3068

Variation Description

Assurance Description

Hospital Bed Occupancy



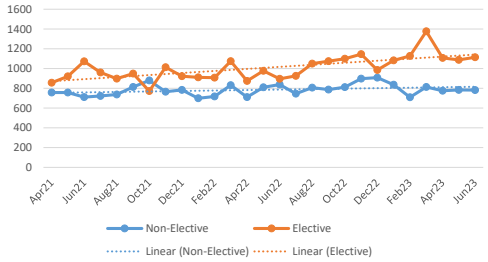
Reporting Date	Performance	Op. Plan #
Jun-23	60.1%	QC79
Threshold	**YTD Mean**	**Benchmark**
92.0%	-	-

(Lower value represents better performance)

Variation Description

+ Assurance Description

Elective and Non Elective Admissions



Reporting Date	Performance		Op. Plan #
Jun-23	Elective	1114	
	Non Elective	782	
Threshold	**YTD Mean**		**Benchmark**
-	-		-

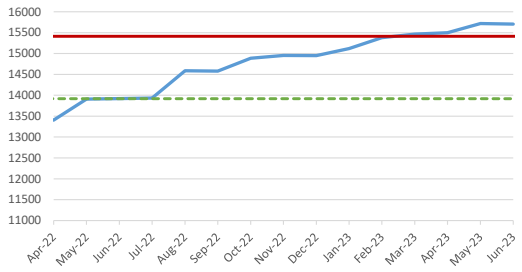
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals for First Outpatient Appointment: Referral levels for Consultant led services have remained at a high level into 2023/24. The number of referrals received in Quarter 1 (8,829) was about 1% higher than the number received over the same period in the previous year (8,777). **Elective and Non Elective Admissions:** Elective Admissions have increased by approximately 20% in Quarter 1 (3,309) against the same period last year (2,748). Non Elective admission numbers have remained fairly static over the opening quarter, with 2,341 in Q1 of 23/24 compared to 2,359 in 22/23.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Responsive	Referral to Treatment (RTT)	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson

RTT - No. patients waiting for 1st Consultant Led Outpatient Appointment



Reporting Date	Performance	Op. Plan #
Jun-23	15,703	QC11

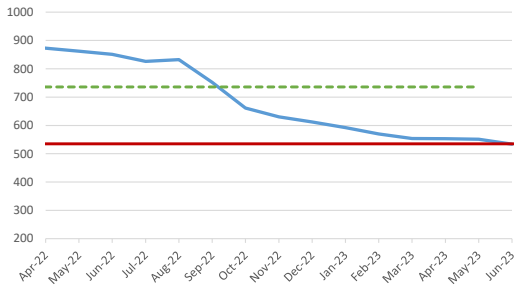
Threshold	YTD Mean	Benchmark
< 15,413	15,640	15,500

(Lower value represents better performance)

Avg Wait Time (Referral to 1st Cons Led OP Appt.)
48 weeks

No. patients waiting 52 weeks or more for 1st OP
5,247

RTT - No. patients waiting for Inpatient procedures



Reporting Date	Performance	Op. Plan #
Jun-23	534	QC11

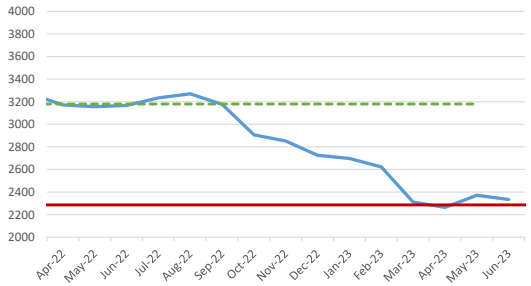
Threshold	YTD Mean	Benchmark
< 535	546	553

(Lower value represents better performance)

Avg Wait Time (Decision to Treat to Treatment - IP)
41 weeks

No. patients waiting 52+ weeks from Decision to Treat
134

RTT - No. patients waiting for Daycase procedures



Reporting Date	Performance	Op. Plan #
Jun-23	2,334	QC11

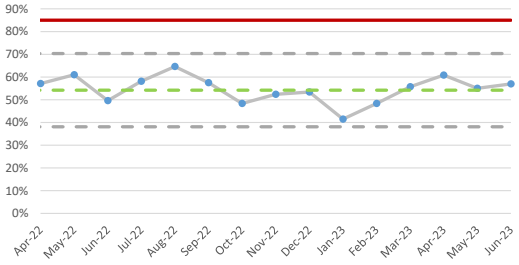
Threshold	YTD Mean	Benchmark
< 2,286	2,323	2,264

(Lower value represents better performance)

Avg Wait Time (Decision to Treat to Treatment - DC)
42 weeks

No. patients waiting 52+ weeks from Decision to Treat
617

% Urgent GP referrals seen for 1st appointment within 6 weeks



Reporting Date	Performance	Op. Plan #
Jun-23	57.0%	QC13

Threshold	YTD Mean	Benchmark
85.0%	57.6%	54.0%

(Higher value represents better performance)

- Variation Description
Common cause

- Assurance Description
Consistently fail target

Issues / Performance Summary

- Reduction in outpatient clinic capacity due to:
  - Impact of TT period (e.g. R&R Programme paused).
  - Staff vacancies, annual leave and other absences.
  - Difficulties in recruiting locum cover
  - Ensuring prioritisation of doctor resource for 24/7 on call cover, inpatient, theatre and endoscopy activity.
- Following the ease on Covid restrictions, GP practices have been seeing more patients face to face which has led to an overall increase in referrals.
- Many outpatient pathways require considerable diagnostic intervention to enable their progression.

Planned / Mitigation Actions

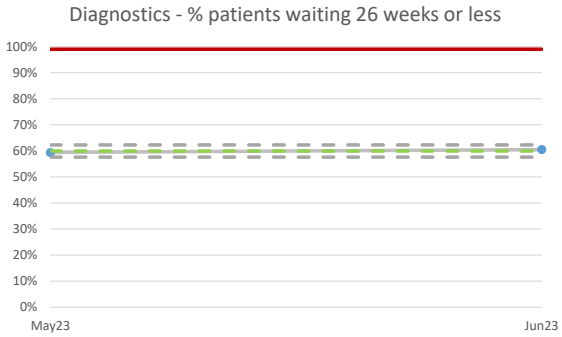
- R&R delivery (Nov'21 to June'23) of 993 outpatient appointments; 458 Endoscopic, 1,982 Ophthalmic, 680 Orthopaedic procedures, 177 procedures for other surgical specialties, 183 mental health referrals and 467 radiological scans.
- Dedicated waiting list validation team established and programme of waiting list validation commenced in October '22. To date over 15,000 referrals have been through technical validation and over 6,400 letters have been sent to patients checking if they still require to be on the waiting list. Based on the outcomes of the validation to date, there will have been a 7% reduction in the outpatient waiting list. No patient is removed from the waiting list without a clinical decision being made.
- ENT recovery plan commenced in November, including weekend outpatient clinics.
- Addition diagnostic capacity has been commissioned for approximately 1,300 scans (Echocardiograms, Cardiac Computed Tomography and Ultrasound) to improve outpatient pathway progression.
- Ward 12 has provided additional bed capacity to Urology, Gynaecology and ENT elective inpatients as required.
- Restoration &Recovery (R&R) Phase 3 Business Case has been developed which includes modelling of demand, capacity and sustainability of outpatient services and waiting lists across 10 specialties. This is being expanded to cover all specialties.

Assurance / Recovery Trajectory

- General Surgery R&R activity commenced in November '22.
- Recovery of ENT waiting times from November with the start of weekend clinics.
- Enhanced Waiting List Management programme established to implement procedural and operational improvements to embed Access policy and improve waiting list management. This includes:
  - Waiting List Validation; started in October '22.
  - Patient Tracking List (PTL) meetings (non Cancer);
  - Referral & Booking (initial focus on partial booking and patient initiated follow ups)
  - Referral To Treatment (RTT) Rules and System implementation;
  - Reducing patient Did Not Attend (DNA) rates;
  - Harm Review

Note -
Benchmark for '% Urgent GP referrals seen for 1st Outpatient' is the Manx Care monthly average for 2022/23.
The benchmarks for the OP, IP and DC waiting lists are currently the waiting list sizes in Apr '23. In future reporting the benchmark will be a comparison to UK waiting list sizes using the numbers waiting per 1,000 population.

Responsive	Diagnostics Wait Times (1 of 2)	Executive Lead	Oliver Radford	Lead	Lisa Airey



Reporting Date	Performance	Op. Plan #
Jun-23	60.5%	QC37b

Threshold*	YTD Mean	Benchmark
99.0%	60.0%	-

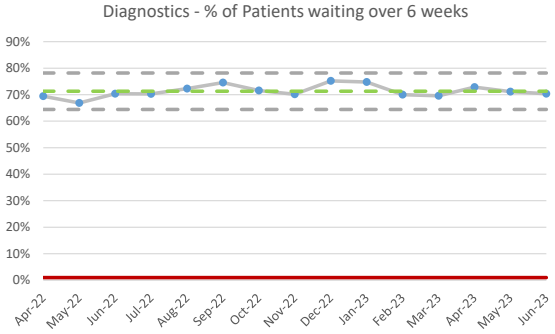
(higher value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Consistently fail target



Reporting Date	Performance	Op. Plan #
Jun-23	70.4%	QC37

Threshold	YTD Mean	Benchmark
1%	71.5%	25.9%

(lower value represents better performance)

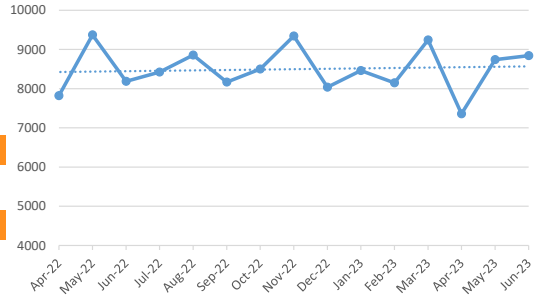
+ Variation Description

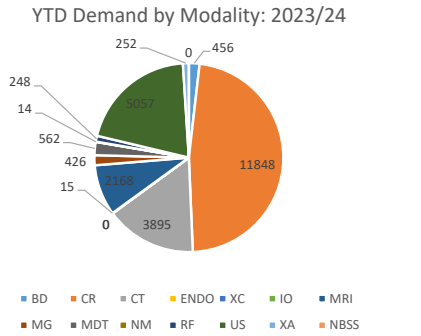
Common cause

- Assurance Description

Consistently fail target

Modality	Jun-23		
	WL	>6 wks	% >6 wks
Bone Densitometry	183	59	32%
Computed Radiography	700	296	42%
Computed Tomography	996	599	60%
Endoscopy	0	0	-
Intra-oral Radiography	2	1	50%
Magnetic Resonance Imaging	713	352	49%
Mammography	1,114	1,082	97%
Miscellaneous	40	17	43%
Nuclear Medicine	36	31	86%
Radiofluoroscopy	63	53	84%
Ultrasound Breast	18	3	17%
Ultrasound Non Obs	2,970	2,219	75%
Ultrasound Obs	407	330	81%
X-ray Angiography	303	266	88%
Total	**7,545**	**5,308**	**70%**





Reporting Date	Performance	Op. Plan #
Jun-23	24,941	

Threshold	YTD Mean	Benchmark
-	8,314	8,546

Variation Description

Assurance Description

Issues / Performance Summary

- Overall demand continues to exceed capacity, with demand for services continuing to increase. Demand was 25.5% higher than capacity in June.
- Emergency Department (ED) 27%, Outpatient Department (OPD) 34% and General Practitioner (GP) 22% are the primary source of referrals. and there has been no significant change on the distribution compared to last month.
- Inpatient referrals(837) remain high. This equates to 12% of all requests.
- 39% of exams were reported within 2 hours, 25% have taken 96 hours or longer which is a decrease on last month likely due to increased urgent TT workload.
- Of the 7046 exams, just under 48% were turned around on the same day (3% increase compared to last month) and, a further 32% in 1- 28 days (same as last month).

Planned / Mitigation Actions

- Projects ongoing to increase capacity to reduce waiting times further.
- Engagement continues with third parties under the Restoration & Recovery (R&R) programme Phase 1 with regard to delivery of an insourced option to address high Cardiac CT, MRI and Ultrasound waiting times.
- Waiting list validation process implemented in October, validating all aspects of the diagnostic waiting list - technical, administrative and clinical validation.
- Further technical validation of the waiting list numbers is being undertaken by the care group in July and August.

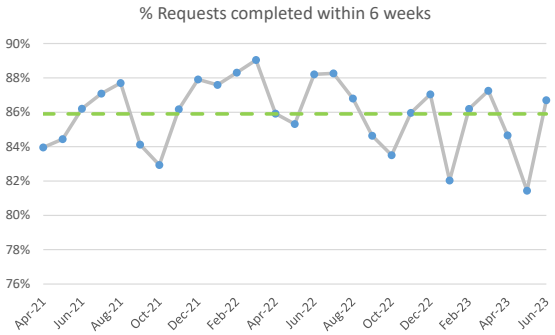
Assurance / Recovery Trajectory

- Requirements for sustainable increased Radiology capacity being scoped as part of the demand & capacity element of the Phase 3 Restoration & Recovery (R&R) business case.

* Manx Care aspires to deliver a maximum six-week wait for all routine diagnostic tests; however, the baseline position identified that waiting times for routine diagnostics were significantly longer than six weeks. Therefore, Manx Care has committed to initially reduce the overall waiting list to a maximum of 26 weeks for the key modalities, with the development of credible, costed plans for reduction to a maximum of six weeks by the end of 2023/24.
Reporting of achievement against the 26 week threshold will be included in future reports.

Note -
Benchmark for '% Patients Waiting over 6 Weeks' is the UK NHSE performance figures for Apr 23.
Benchmarks for '% Requests < 6 Weeks' and 'No. of requests received' are the Manx Care monthly average for 2022/23.

Responsive	Diagnostics Wait Times (2 of 2)	Executive Lead	Oliver Radford	Lead	Lisa Airey	



Reporting Date	Performance	Op. Plan #
Jun-23	86.7%	
Threshold	**YTD Mean**	**Benchmark**
-	84.3%	85.9%

+ Variation Description

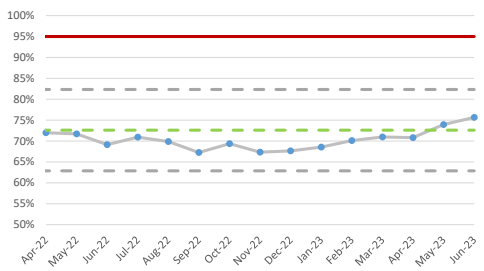
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% Requests completed within 6 weeks: Approximately 87% of requests completed in June were undertaken within 6 weeks. This was slightly higher than the average of 84% for the year so far.		

Responsive	Emergency Department (1 of 2)	Executive Lead	Oliver Radford	Lead	Mark Cox

ED - % 4 Hour performance : Manx Care



Reporting Date	Performance	Op. Plan #
Jun-23	75.7%	QC23
	Admitted 29.4%	
	Non-Admitted 84.0%	

Threshold	YTD Mean	Benchmark
95.0%	73.5%	73.3%

(Higher value represents better performance)

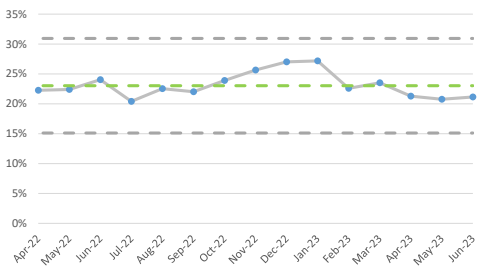
+	Variation Description

Common cause

-	Assurance Description

Consistently fail target

A&E - Admission Rate : Noble's Hospital



Reporting Date	Performance	Op. Plan #
Jun-23	21.2%	QC24

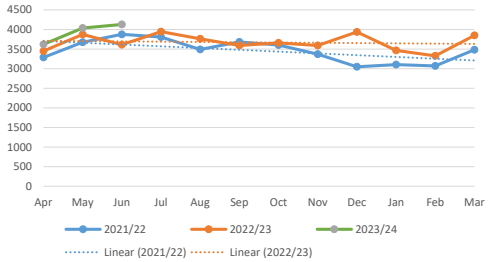
Threshold	YTD Mean	Benchmark
-	21.1%	27.5%

Variation Description

Common cause

Assurance Description

ED - Total Attendances : Manx Care



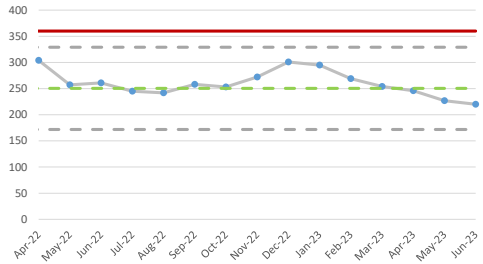
Reporting Date	Performance	Op. Plan #
Jun-23	4,128	

Threshold	YTD Mean	Benchmark
-	3,928	3,671

Variation Description

Assurance Description

ED - Average Total Time in ED : Noble's Hospital



Reporting Date	Performance	Op. Plan #
Jun-23	220	QC150

Threshold	YTD Mean	Benchmark
360 mins	231	268

(Lower value represents better performance)

+	Variation Description

Common cause

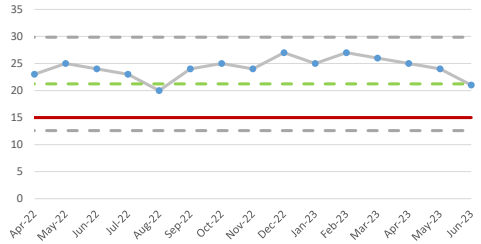
+	Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• June's performance of 75.7% remained below the 95% threshold but slightly higher than the UK's performance of 73.3% and is the highest achieved in over 20 months. • Admitted Performance: 29.4%; • Non Admitted Performance: 84%; • Certain patient groups are managed actively in the department beyond 4 hours if it is in their clinical interest. This includes elderly patients at night, intoxicated patients, back pain requiring mobilisation etc. In June, the average admission rate from Noble's ED of 21.2% was lower than that of the UK (27.5%). Performance due to: • Lack of ED observation space (Clinical Decision Unit space) • Lack of physical space to see patients • Lack of Ambulatory Emergency Care capability and capacity. • Limited Same Day Emergency Care (SDEC) capability. • Delays in transfer of patients to in-patient wards due to a lack of available beds. • Staffing availability (particularly nursing) and sickness. • Elderly case mix. • Lack of organisational Pathways for example back pain , optician, DVT, dental.	• New staff are being recruited to positions in ED, both doctors and nurses. • A business case for safer medical staffing is being completed. • Further embedding of Ambulatory Emergency Care and MACU to divert patients away from the main ED department for practitioner led and ambulatory treatment that would normally require inpatient admission such as IV therapy or deep vein thrombosis treatment. • Work on accuracy of time stamps for triage and treatment at briefings. Development of Rapid Assessment by senior clinical staff • Review of GIRFT Programme National Specialty Report (Emergency Medicine) and potential for alignment with current processes and metrics. • Two current non-emergency workstreams should also contribute to the improvement of performance within ED: - Work streams around time of discharge - Other work streams around exit block	• Average total time in department remains within the required 360 minute standard. • Expectation that performance will remain in line with the UK, but it should be noted that as expected the position has remained challenging over the period due to the additional seasonal pressures. • Application for Healthcare Transformation Funding to pump prime Intermediate Care for year 1 of operation (£1.2m) which develops diversionary pathways away from ED and invest in community services. • Result of increase to Nursing Staffing availability and reducing sickness levels. • ED recruitment still underway for 6 Band 6 nurses , 2 band 7 nurses , 2x Band 5 nurses, 2 Speciality Doctors ,2 consultants and 3 F3 positions In addition to this 10 TSRs for agency nurses have been approved to bridge the gap for new recruits beginning in the dept. • Secured funding to make improvements to the infrastructure. In the planning stages at present. Note - Benchmarks for '4 Hour' and 'Admission Rate' are UK NHSE performance figures for May' 23. Benchmarks for 'Total Attendances' and 'Average time in ED' are the Manx Care monthly averages for 2022/23.

Responsive	Emergency Department (2 of 2)	Executive Lead	Oliver Radford	Lead	Mark Cox

Average number of minutes between Arrival and Triage (Noble's)



Reporting Date	Performance	Op. Plan #
Jun-23	21	QC26

Threshold	YTD Mean	Benchmark
15 mins	23	24

(Lower value represents better performance)

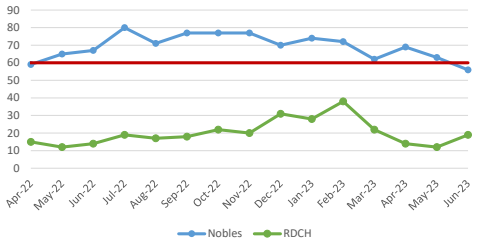
+	Variation Description

Special Cause of Concerning variation (High)

-	Assurance Description

Consistently fail target

ED-Average number of minutes between arrival to clinical assessment



Reporting Date	Performance		Op. Plan #
Jun-23	Nobles	56	
	RDCH	19	

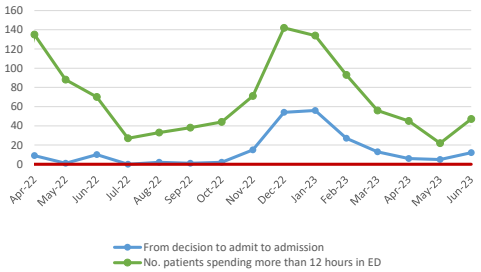
Threshold	YTD Mean	Benchmark
60 mins		-

(Lower value represents better performance)

Variation Description

Assurance Description

A&E - 12 Hours waits



Reporting Date	Performance		Op. Plan #
	%Trolley 12h Wait	0.3%	QC78
	% ED 12h Wait	1.1%	

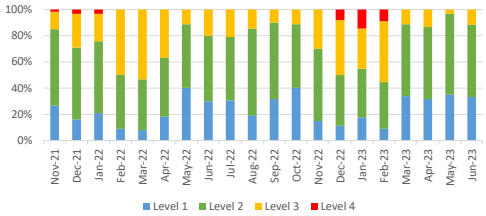
Threshold	YTD Mean	Benchmark
0		-

(Lower value represents better performance)

-	Variation Description

-	Assurance Description

Operational Pressures Escalation Level (OPEL)



Reporting Date	Performance	Op. Plan #

Threshold	YTD Mean	Benchmark

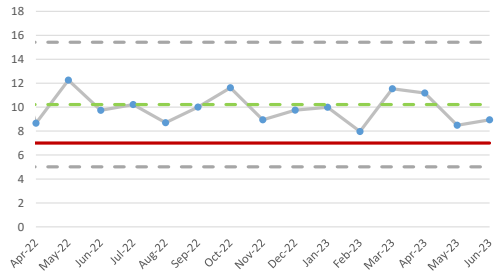
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The ED did not reach level 4 (the highest Operational Pressures Escalation Level (OPEL)) in June, for the fourth month in a row. • The number of 12 Hour Trolley Waits was 12 (0.3% of attendances; UK 1.2%) • 47 patients had a stay of more than 12 hours in ED in June. That equated to 1.1% of attendances.		Note - Benchmark for 'Average number of minutes between Arrival and Triage' is the Manx Care monthly average for 2022/23.

Responsive	Ambulance (1 of 3)	Executive Lead	Oliver Radford	Lead	Will Bellamy

Ambulance - Category 1 Average (Mean) Response Time



Reporting Date	Performance	Op. Plan #
Jun-23	00:08:56	QC20

Threshold	YTD Mean	Benchmark
7 mins	00:09:32	00:08:41

(Lower value represents better performance)

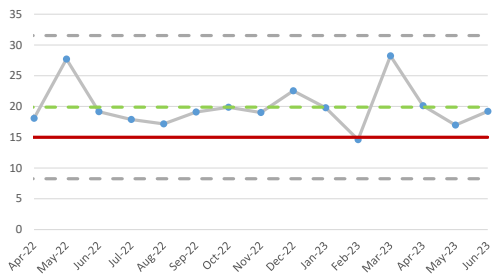
- Variation Description

Common cause

- Assurance Description

Consistently fail target

Ambulance - Category 1 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Jun-23	00:19:12	QC21

Threshold	YTD Mean	Benchmark
15 mins	00:18:46	00:15:27

(Lower value represents better performance)

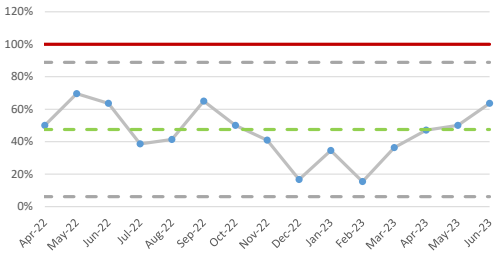
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call



Reporting Date	Performance	Op. Plan #
Jun-23	63.6%	

Threshold	YTD Mean	Benchmark
100.0%	53.6%	43.5%

(Higher value represents better performance)

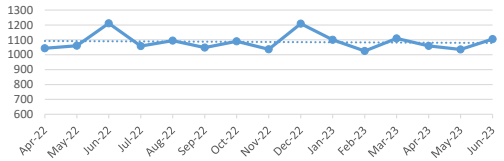
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

Ambulance - Service Demand : All call types



Reporting Date	Performance	Op. Plan #
Jun-23	1,105	

Threshold	YTD Mean	Benchmark
-	1,066	1,090

Variation Description

Assurance Description

Jun-23	East	North	South	West	Total
Category 1 Calls	23	11	7	2	**43**
No. reached within 15 mins	22	8	5	1	**36**
% response within 15 mins	95.7%	72.7%	71.4%	50.0%	**83.7%**

Issues / Performance Summary

- Demand for Ambulance services has slightly decreased in June '23 = 1105, comparing to [June '22 = 1211];
The number of calls is approximately 7.8% lower than in the previous year.
- Category 1 Performance remains stable but still below national standards. Activity during TT 2023 overall was down compared to 2022 (although traumatic injury/ road traffic incident numbers increased vs TT 2022). Same for the 15 minute standard for the 90th percentile of patients. We are hampered in this area by geography, resource availability and access to care (only one hospital on Island).
- The service is facing staffing pressures both in terms of recruitment and long term sickness / modified duties. Steps are being taken to resolve with recent paramedic recruitment advert receiving a number of applicants. Interviews and assessments are scheduled for August 2023.
- CQC have advised that 'See and Treat' proportion (26.61%) is lower than the UK (approx. 4.4%).
- Stroke data is currently based on information given to a non-clinical call handler who selects "Stroke or TIA" as the primary issue for prioritisation. The actual patient condition found once on scene, and whether it was a confirmed as Stroke needing rapid transportation may or not may differ. The data is therefore as yet unrefined and needs further work (see mitigations).

Planned / Mitigation Actions

- Clinical Navigator Soft Launch phase has commenced with volunteer existing ambulance staff involved. They have received IMAS training package and have commenced ad-hoc, mentored navigation shifts within ESJCR.
- A full time (LTA) and Bank Clinical Navigator has been appointed and is being trained. The service is moving to 7 days per week , day time only provision once all staff are in place.
- Initial root cause analysis of handover breaches has been undertaken.
- KPIs and associated reporting mechanisms regarding Handover times to be developed as per Operating Plan 2023/26.
- Clearly defined pathways exist for the rapid assessment, pre alert to the stroke team and transfer under blue light conditions of patients with new onset unresolved stroke symptoms so they can be assessed and scanned as rapidly as possible. Reporting to be developed in 2023/24 for patients that may have had a stroke but initially presented with something else (such as a fall where stroke was later found to be the cause).
- Clinical Navigation / Hear and Treat continues to build with recruitment for full time posts now finished. A bank provision has also been created. New team member training is currently underway and we envisage Hear and Treat to be in robust operation 365 daytime only at the end of September 2023.

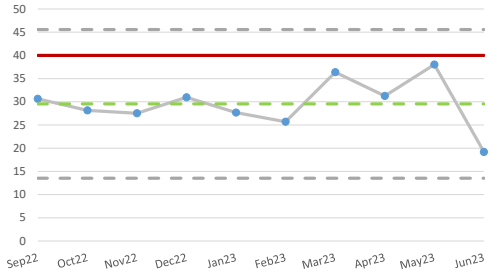
Assurance / Recovery Trajectory

- Development of supporting processes for robust management and reporting of Handover times will be undertake as per the timescales set out in the Operating Plan for 2023/26.
- Reviewing the current limitations with Stroke performance data capture and reporting to improve accuracy and will align reporting metrics with recognised best practice KPIs as appropriate.

Note -
Benchmarks for Category 1 'Average Response Time' and 'Response time at 90th Percentile' are UK NHSE performance figures for June' 23.
Benchmarks for 'CVA/Stroke' and 'Service Demand' are the Manx Care monthly averages for 2022/23.

Responsive	Ambulance (2 of 3)	Executive Lead	Oliver Radford	Lead	Will Bellamy

Ambulance - Category 2 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Jun-23	00:29:24	QC136

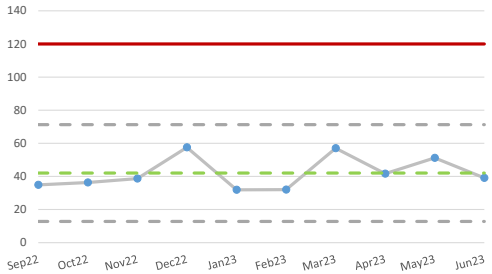
Threshold	YTD Mean	Benchmark
40 mins	00:32:54	01:18:53

(Lower value represents better performance)

-	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

Ambulance - Category 3 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Jun-23	00:39:05	QC138

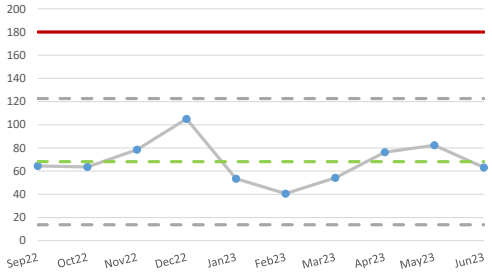
Threshold	YTD Mean	Benchmark
120 mins	00:43:59	05:03:18

(Lower value represents better performance)

-	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

Ambulance - Category 4 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Jun-23	01:03:11	QC140

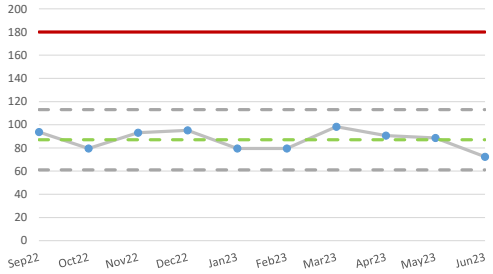
Threshold	YTD Mean	Benchmark
180 mins	01:13:56	06:39:53%

(Lower value represents better performance)

-	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

Ambulance - Category 5 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Jun-23	01:12:23	QC142

Threshold	YTD Mean	Benchmark
180 mins	01:23:54	-

(Lower value represents better performance)

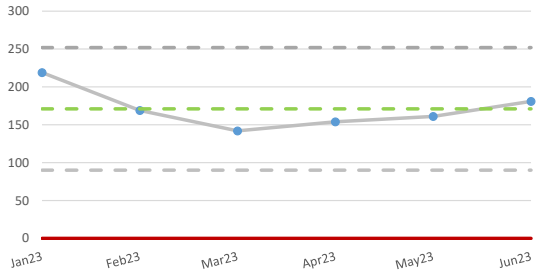
+	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• We remain bench marking well against the categories (2,3,4 and 5) standards: - Category 2; Standard < 40 mins; 90th percentile = 00:29:24 - Category 3; Standard < 120 mins; 90th percentile = 00:39:05 - Category 4; Standard < 180 mins; 90th percentile = 01:03:11 - Category 5; Standard < 180 mins; 90th percentile = 01:12:23		Note - Benchmarks for Category 2,3,4 'Response time at 90th Percentile' are UK NHSE performance figures for June' 23.

Responsive	Ambulance (3 of 3)	Executive Lead	Oliver Radford	Lead	Will Bellamy

Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.



Reporting Date	Performance	Op. Plan #
Jun-23	181	QC85

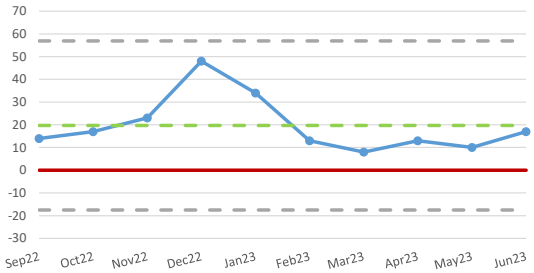
Threshold	YTD Mean	Benchmark
0	165	177

(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.



Reporting Date	Performance	Op. Plan #
Jun-23	17	QC86

Threshold	YTD Mean	Benchmark
0	13	22

(Lower value represents better performance)

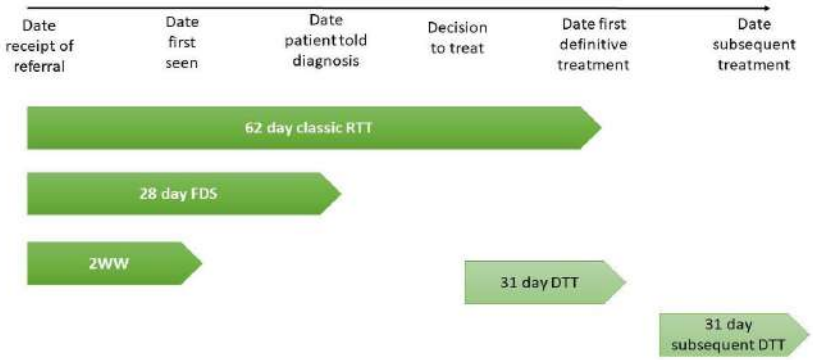
-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• There were 17 instances where handover Turnaround Times were greater than 60 mins, and 181 where greater than 30 mins.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Cancer Waiting Times Reporting – Refocussing onto the Diagnostic Target

Over recent years, there had a strong focus on the 2 week wait (2WW) Cancer Waiting Times (CWT) target. This is the time from the receipt of referral of a suspected cancer to the first appointment (outpatient or diagnostic). Unfortunately the 2WW target on its own is often used as a barometer of CWT performance; however this does not reflect the performance of the whole cancer pathway.



The CWT reporting needs to reflect the whole of the cancer pathway in order to understand the overall performance and the patient experience.

Work is underway within Manx Care to align our CWT reporting to the UK NHS National Cancer Waiting Times Monitoring Dataset Guidance. Currently the UK NHS have published version 11.1^ in April 2023 and with the support of Manx Care's BI team, our reporting is in line with this guidance. We are also working with the Cheshire & Merseyside Cancer Alliance to understand future developments of the guidance and planning towards future expectations.

Faster Diagnosis Standard

The CWT guidance has more recently included the new 28 day Faster Diagnosis Standard (FDS). This aim of this target is to:

* reduce the time between referral and diagnosis of cancer
* reduce anxiety for patients, who will receive a diagnosis or an 'all clear' but do not currently receive this message in a timely manner
* work alongside the delivery of the 62-day referral to treatment cancer waiting times standard, including the standard to reduce waiting times, through improved analysis and pathway improvements of faster diagnosis.

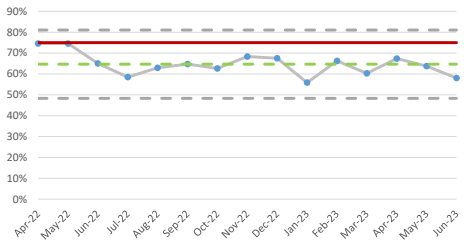
The 28 day FDS gives a fuller indication of the first part of the suspected cancer pathway rather than using the 2WW performance alone. It reflects not only the first appointment, but also that the diagnostic work has been completed and most importantly that the patient has been informed of a cancer or non-cancer diagnosis.

Best Practice Timed Pathways

Cheshire & Merseyside Cancer Alliance are working on a future development expected as part of the National CWT Monitoring Guidance. This is the Best Practice Timed Pathways (BPTP) – and these are being introduced for specific tumour groups. Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, improve people's experience of care, and meet the Faster Diagnosis Standard (FDS). It will also ensure consistency between Manx Care's pathways and that of the Cancer Alliance pathways.

Responsive	Cancer Wait Times (1 of 3)	Executive Lead	Oliver Radford	Lead	Lisa Airey

CWT - 28 Days to diagnosis or ruling out of cancer



Reporting Date	Performance	Op. Plan #
Jun-23	58.0% (243 of 419)	QC31

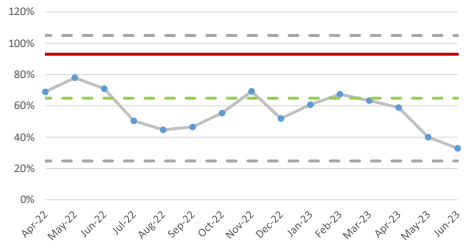
Threshold	YTD Mean	Benchmark
75.0%	63.0%	72.00%

(Higher value represents better performance)

- Variation Description: Common cause

- Assurance Description: Consistently fail target

CWT - Two Week Wait (2WW) performance



Reporting Date	Performance	Op. Plan #
Jun-23	32.9% (144 of 360)	QC29

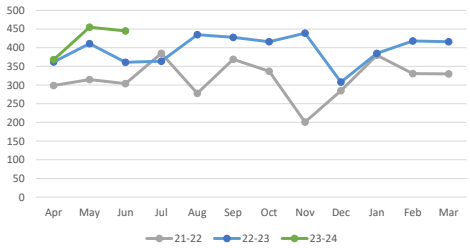
Threshold	YTD Mean	Benchmark
93.0%	43.9%	83.90%

(Higher value represents better performance)

- Variation Description: Common cause

- Assurance Description: Consistently fail target

2WW referrals received for all suspected cancers



Reporting Date	Performance	Op. Plan #
Jun-23		

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Tumour Group	2WW Referrals								
	Jun-23	Apr - June 2023	Apr - June 2022	Year on Year Increase	Monthly Avg. 2023/24	Monthly Avg. 2022/23	*Trajectory 2023/24	Total 2022/23 (Apr 22-March 23)	Forecast Demand Growth
Breast	66	205	168	22.0%	70	53	831	635	30.8%
Colorectal	84	234	212	10.4%	117	76	1,287	913	41.0%
Dermatology	115	302	245	23.3%	151	40	1,661	995	66.9%
Gynaecology	50	130	109	19.3%	65	38	715	476	50.2%
Haematology	8	12	15	-20.0%	6	6	66	72	-8.3%
Head & Neck	46	119	98	21.4%	59	35	650	422	54.0%
Lung	8	31	35	-11.4%	15	10	166	120	38.3%
Other	1	8	10	-	4	2	44	29	51.7%
Upper GI	27	82	88	-6.8%	41	34	451	406	11.1%
Urology	37	95	93	2.2%	47	36	518	432	19.9%
Sub-Total	**442**	**1,218**	**1,073**	**13.5%**	**152**	**35**	**6,389**	**4,500**	**42.0%**

**Tumour Group	Monthly number of	
	Jun-23	12 month Avg.
Breast symptomatic (non-suspected cancer)	3	13

*Forecast is straight line 12ths only - based on actuals plus avg. referrals per month received Apr 23 - Mar 24.

**Monthly referral figures for Breast Symptomatic are shown separately as the methodology for recording and reporting them changed in Oct 21, meaning that a YTD year on year comparison would not be appropriate.

Previously breast symptomatic were 'upgraded' but these are now reported on the Somerset Cancer Registry in line with the 'exhibited breast symptoms – cancer not suspected' category in line with UK reporting.

Issues / Performance Summary

- Increased number of referrals for suspected cancer continue to impact on performance due to capacity
- All suspected cancers continue to be monitored against Cancer Waiting Times (CWT) targets by operational PTL and tumour specific PTLs
- Administration delays noted as impacting on patient pathway – currently being investigated
- Some delays to communication of diagnosis of non-cancer are being picked up via tumour specific PTLs (28 day FDS)
- Capacity for Endoscopy and Outpatient appointments due to lack of staff to cover clinics noted at PTL
- Impact of previous month's Bank Holidays and increased referrals have also impacted on outpatient capacity. Additional clinics have been accommodated where possible – these can be limited by availability of specialist staff or outpatient area
- Volatility of percentages due to small numbers, especially for some targets

Planned / Mitigation Actions

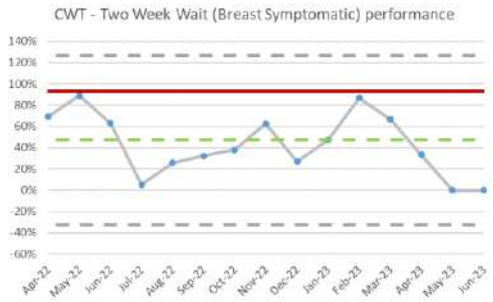
- Review of Suspected cancer GP proforma against new Cancer Alliance templates underway with specialist teams – this should give better guidance to GPs
- Continued roll out of tumour specific PTLs to ensure better communication between clinical/MDT staff over potential to breach CWT targets
- Review of administration of referrals with PIC underway to streamline process and ensure days not lost in pathway ahead of first appointment being booked.
- Draft Cancer Access Policy, Cancer Escalation Policy and Inter-hospital transfer and breach allocation SOP are with IDCS Triumvirate for consideration ahead of wider circulation. A number of the 62 day Referral to Treatment (RTT) breaches are due to the wait times at the UK specialist centres providing treatment, and as such are outside of Manx Care's control. These documents will support this process. They will also support better communication/escalation of possible breaches and identify root cause of any unavoidable breaches
- Further work needed on subsequent treatment tracking and data reporting
- Review of Cancer Services and resources underway – further work needed to understand pathways against Cancer Alliance clinical pathways in addition

Assurance / Recovery Trajectory

- Reporting data now taken directly from the Somerset Cancer Registry and automated.
- KPIs and performance management governance brought in line with the National Cancer Waiting Times Monitoring Dataset Guidance.
- Review of Cancer Services underway

Note -
Benchmarks for '2WW Performance' and '28 days to diagnosis' are UK NHSE performance figures for Q4 22-23.
Benchmark for '2WW referrals received' is the Manx Care monthly average for 2022/23.

Responsive	Cancer Wait Times (2 of 3)	Executive Lead	Oliver Radford	Lead	Lisa Airey



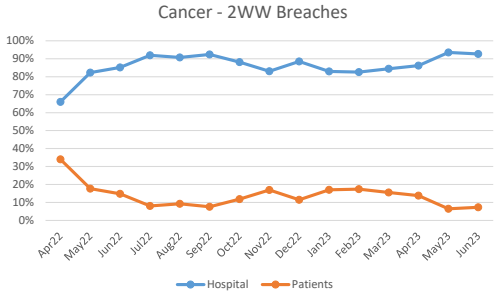
Reporting Date	Performance	Op. Plan #
Jun-23	0.0% (0 of 20)	QC30

Threshold	YTD Mean	Benchmark
93.0%	11.1%	72.20%

(Higher value represents better performance)

- Variation Description: Common cause

- Assurance Description: Consistently fail target

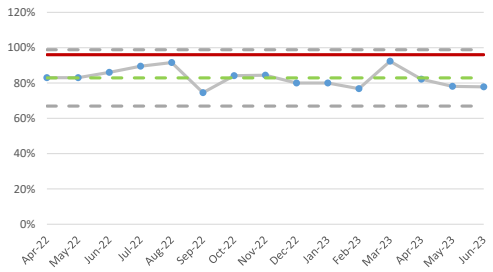


Reporting Date	Performance	Op. Plan #

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description



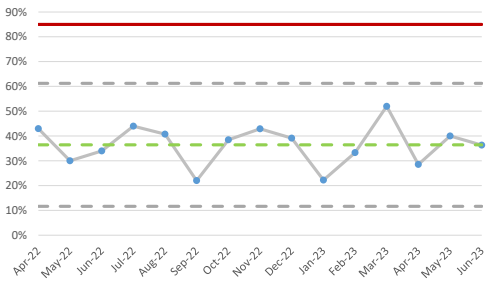
Reporting Date	Performance	Op. Plan #
Jun-23	77.8% (28 of 36)	QC35

Threshold	YTD Mean	Benchmark
96.0%	79.3%	90.80%

(Higher value represents better performance)

- Variation Description: Common cause

- Assurance Description: Consistently fail target



Reporting Date	Performance	Op. Plan #
Jun-23	36.4% (8 of 22)	QC34

Threshold	YTD Mean	Benchmark
85.0%	35.0%	59.10%

(Higher value represents better performance)

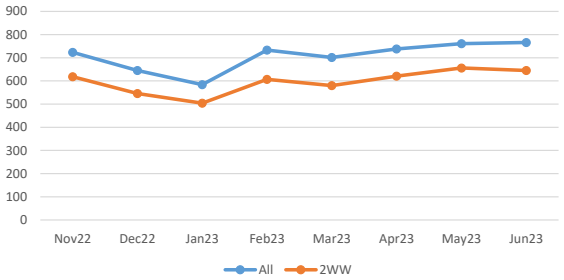
- Variation Description: Common cause

- Assurance Description: Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The 93% 2WW standard allows 7% for patient choice – in previous months there has been a slightly higher percentage of patient choice breaches. For June'23: Reason for Breach - Hospital: 92.6% Reason for Breach - Patient Choice: 7.4%		Note - Benchmarks for 'Breast Symptomatic', '31 days diagnosis to treatment' and '62 days referral to treatment' are UK NHSE performance figures for Q4 22-23

Responsive	Cancer Wait Times (3 of 3)	Executive Lead	Oliver Radford	Lead	Lisa Airey

Number of patients on Cancer Pathway



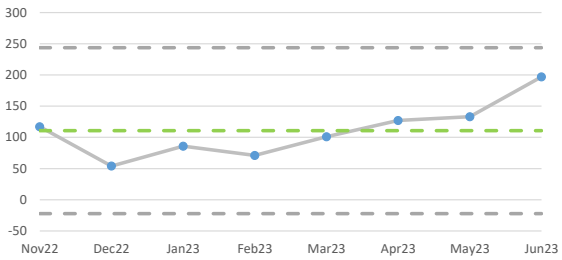
Reporting Date	Performance	Op. Plan #
Jun-23	766	

Threshold	YTD Mean	Benchmark
-	755	677

Variation Description

Assurance Description

Cancer - Total number of patients Waiting for 1st OP



Reporting Date	Performance	Op. Plan #
Jun-23	197	

Threshold	YTD Mean	Benchmark
	152	86

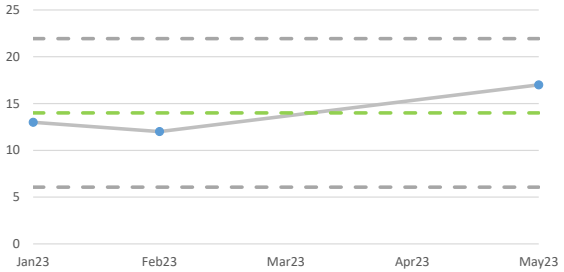
(Lower value represents better performance)

Variation Description

Common cause

Assurance Description

Cancer - Median Wait Time for the 2WW referrals (Days)



Reporting Date	Performance	Op. Plan #
May-23	17	

Threshold	YTD Mean	Benchmark

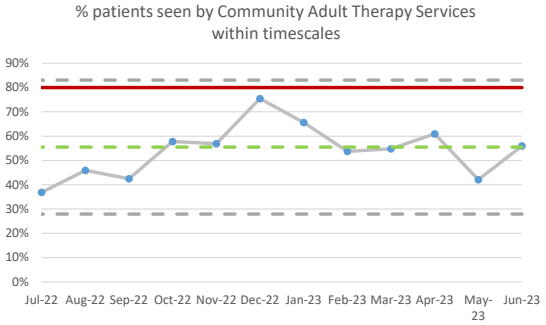
Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Please see page 50 for supporting narrative.		

Responsive	Integrated Primary & Community Care (1 of 4)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon



Reporting Date	Performance	Op. Plan #
Jun-23	56.0%	QC62

Threshold	YTD Mean	Benchmark
80.0%	53.0%	54.4%

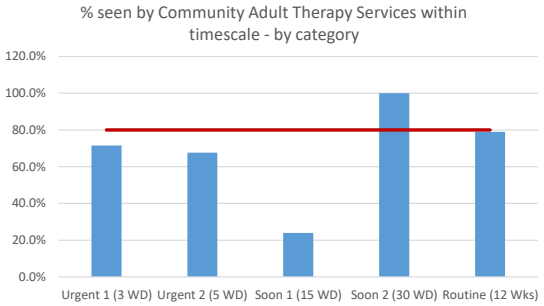
(Higher value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Consistently fail target



Reporting Date	Performance	Op. Plan #
Jun-23	-	

Threshold	YTD Mean	Benchmark
80%	-	-

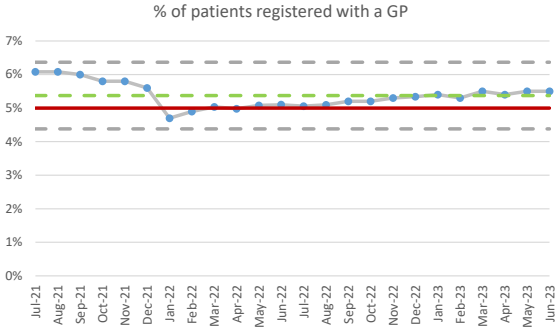
(Higher value represents better performance)

+ Variation Description

- Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Community Adult Therapy: • 71.5% of Urgent 1 (3 working day) and ;67.7% of Urgent 2 (5 working day) patients were seen within the required timescales in June. • The complexity of patients being seen remains high, with therapists needing to spend longer with each patient and consequently being able to see fewer patients each week. • Reduction of inpatient beds in Hospice from (10 to 3) has impacted the team as they are now getting referrals for palliative and end of life patients, which of course may be intensely time-consuming.	**Community Adult Therapy:** • Recording and reporting of Urgent referrals split into 2 categories from July '22; 'Urgent 1 - Seen within 3 working days' and 'Urgent 2 - Seen within 5 working days'. • Following successful focus on response times for the Urgent categories, scope has been widened to the other urgencies.	- Note: Benchmark for '% patients seen by CAT' is the Manx Care monthly averages for 2022/23.

Responsive	Integrated Primary & Community Care (2 of 4)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon



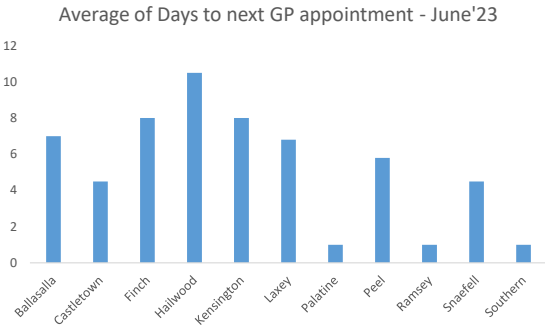
Reporting Date	Performance	Op. Plan #
Jun-23	5.5%	QC99

Threshold	YTD Mean	Benchmark
5.0%	5.5%	5.2%

(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target



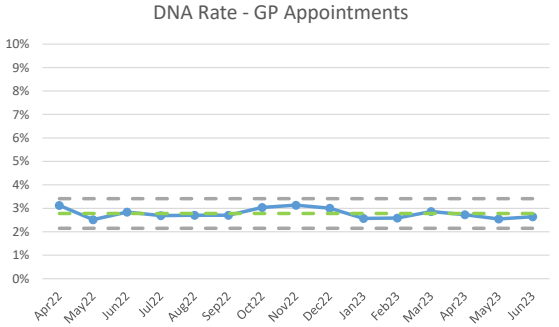
Reporting Date	Performance	Op. Plan #
Jun-23	-	

Threshold	YTD Mean	Benchmark
-	5.709090909	-

(Lower value represents better performance)

Variation Description
Common cause

Assurance Description



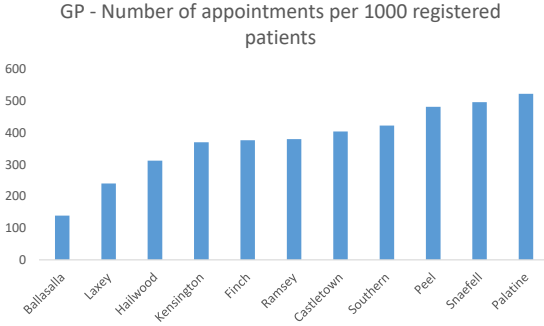
Reporting Date	Performance	Op. Plan #
Jun-23	2.6%	QC151

Threshold	YTD Mean	Benchmark
-	2.6%	2.8%

(Lower value represents better performance)

-	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Jun-23	-	

Threshold	YTD Mean	Benchmark
-	-	

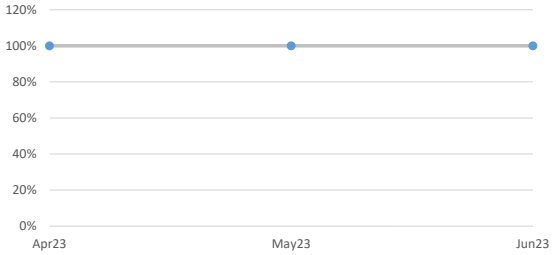
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% of patients registered with a GP: • Remains above the 5% tolerance.	**% of patients registered with a GP:** • List cleansing is fully operational, with monthly / quarterly and annual checking. An additional validation is conducted with practices by the Primary Care GP registrations team to ensure that practices patient lists match the GP registration system. • The GP Contracts manager has also discussed with practices in making contact with any patients on their list who haven't been into the practice in the last 3-5 years to establish if they are still on the Island, in order to reduce the lists further.	**% of patients registered with a GP:** • The 2021 Census identified that there was a resident population of 84,069, and there has been movement on and off the Island since that date. Whilst we can continue to list cleanse and work with the practices to remove 'Ghost patients' to bring it back under 5% we are working to a 2021 Census figure and have also received a number of Ukrainian guests who have registered since the Census. • We will continue to review the % on a monthly basis, working to the list cleansing timetable and with practices accordingly. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Responsive	Integrated Primary & Community Care (3 of 4)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon

Response by Community Nursing to Urgent / Non routine within 24h



Reporting Date	Performance	Op. Plan #
Jun-23	**100%**	QC61

Threshold	YTD Mean	Benchmark
-	100.0%	-

(Higher value represents better performance)

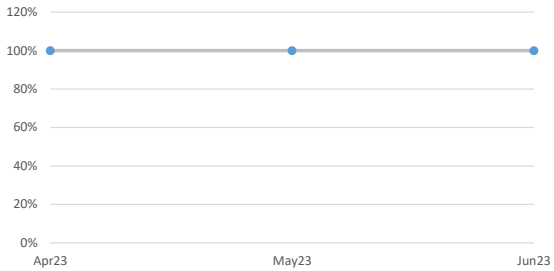
Variation Description

-

Assurance Description

-

Community Nursing Service response target met (7 days) - Routine



Reporting Date	Performance	Op. Plan #
Jun-23	**100.0%**	QC62

Threshold	YTD Mean	Benchmark
-	100%	-

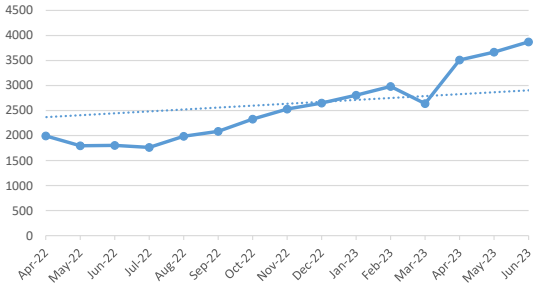
(Higher value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Both Community Nursing response standards continue to be fully met.		

Responsive	Integrated Primary & Community Care (4 of 4)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon



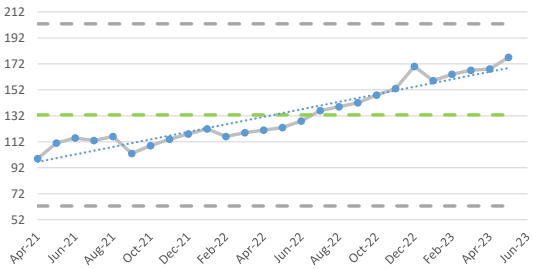
Reporting Date	Performance	Op. Plan #
Jun-23	3872	

Threshold	YTD Mean	Benchmark
-	3682	1019

(Lower value represents better performance)

- Variation Description

Assurance Description



Reporting Date	Performance	Op. Plan #
	181	

Threshold	YTD Mean	Benchmark
		168

Variation Description

Assurance Description

Issues / Performance Summary

Dental:

• In June 2023 145 patients were added to the dental allocation list. At the end of June 2023 the total number of patients awaiting allocation to a NHS dentist was 3,872.

Planned / Mitigation Actions

Dental:

• To explore options by end of September 2023 with dental contracting regarding unifying the UDA value across the new dental contracts and increasing capacity by introducing a new KPI to cleanse patient lists on a quarterly basis for providers to take new patients from the list regularly.

• To look at options of increasing the capacity if the UDA value increases on the new dental contract and encourage recall periods to be expanded to allow for more patients to be seen and patients to be taken from the waiting list.

• Work underway to cleanse the dental waiting list. A letter will go to every patient who has been on the waiting list for more than 6 months (all patients added on or before 31st January 2023) requesting a response to notify Manx Care if they still wish to remain on the list.

Assurance / Recovery Trajectory

Dental:

• To update and review figures once dental allocation list cleansed .

• The dashboard for the dental allocation list has been completed.

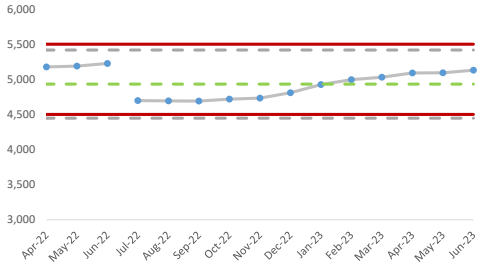
Note -

Benchmarks for '% patients seen by CAT' and 'Longest time waiting for GDP' are the Manx Care monthly averages for 2022/23.

Benchmark for 'No. patients waiting for dentist' is the number waiting in Apr '23.

Responsive	Mental Health (1 of 2)	Executive Lead	David Hamilton	Lead	Ross Bailey	

MH - No. service users on Current Caseload



Reporting Date	Performance	Op. Plan #
Jun-23	5129	QC73

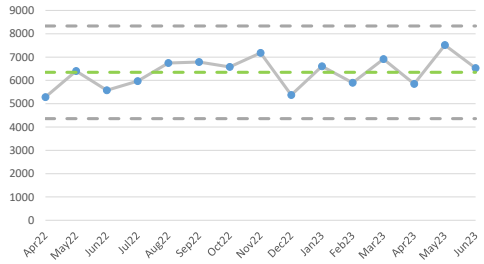
Threshold	YTD Mean	Benchmark
4500 - 5500	5104	4907

(Value within range represents better performance)

+	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

MH- Appointments



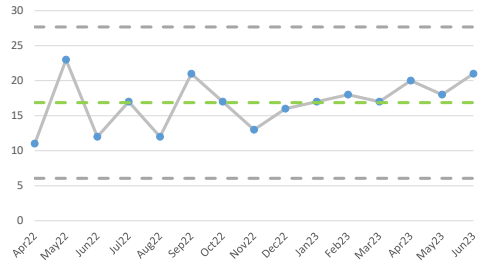
Reporting Date	Performance	Op. Plan #
Jun-23	6528	

Threshold	YTD Mean	Benchmark
-	6630	6276

+	Variation Description
	Common cause

Assurance Description

MH- Admissions



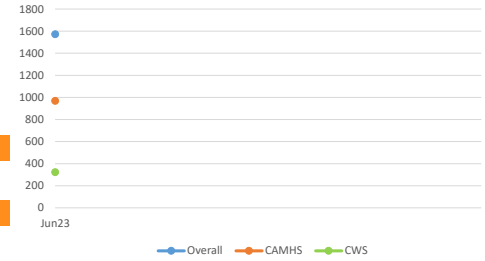
Reporting Date	Performance	Op. Plan #
Jun-23	21	

Threshold	YTD Mean	Benchmark
-	20	16

-	Variation Description
	Common cause

Assurance Description

Mental Health Waiting Lists



Reporting Date	Performance	Op. Plan #
Jun-23	**1572**	

Threshold	YTD Mean	Benchmark
-	1572	

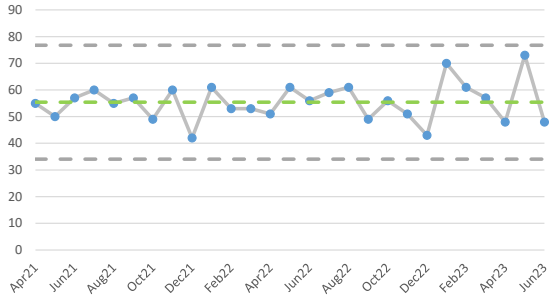
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Current Caseload: • Caseload remains within the expected range. This range is benchmarked upon historic demand.		**Current Caseload:** • Current caseload is significantly higher locally than you would expect within the English NHS, this is particularly evident within CAMHS whose caseload is some 4 times higher than you would expect per 100 thousand per population equivalent in England.

Responsive	Women & Children (1 of 2)	Executive Lead	Oliver Radford	Lead	Linda Thompson

Maternity Bookings



Reporting Date	Performance	Op. Plan #
Jun-23	**48**	

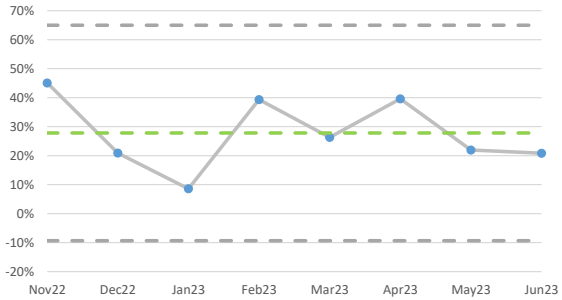
Threshold	YTD Mean	Benchmark
-	549	56

Variation Description

Common cause

Assurance Description

Gestation At Booking <10 Weeks



Reporting Date	Performance	Op. Plan #
Jun-23	**21%**	

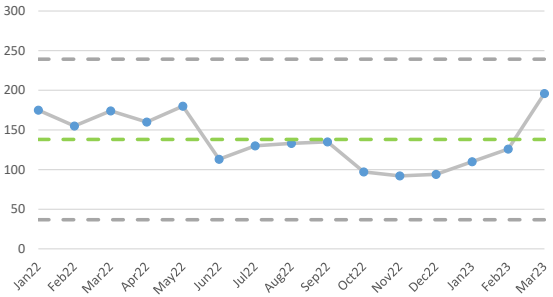
Threshold	YTD Mean	Benchmark
-	27%	28.0%

Variation Description

Common cause

Assurance Description

Ward Attenders



Reporting Date	Performance	Op. Plan #
Mar-23	**196**	

Threshold	YTD Mean	Benchmark
-	-	131

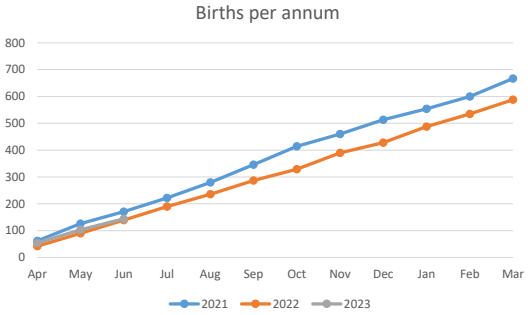
Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Gestation<10 weeks at booking: it is recommended that women book for care in pregnancy before 10 weeks gestation in order to access screening tests. Our data shows that this is not currently being achieved for all women. We have identified that there is often a delay in receiving the referral letters from GP practices, to address this we are looking to introduce a 'self-referral pathway'.		

Responsive	Women & Children (2 of 2)	Executive Lead	Oliver Radford	Lead	Linda Thompson	

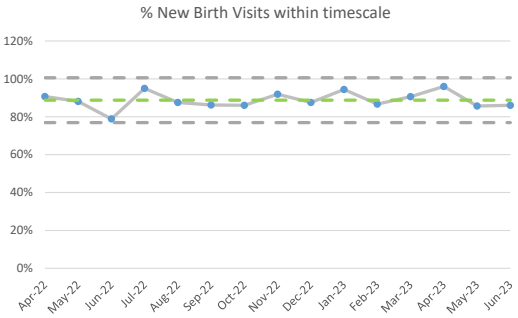


Reporting Date	Performance	Op. plan #
Jun-23	**144**	
Threshold	**YTD Mean**	**Benchmark**
-	100	-

(Higher value represents better performance)

+	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Jun-23	**86%**	QC133
Threshold	**YTD Mean**	**Benchmark**
-	89%	89%

Variation Description

Assurance Description

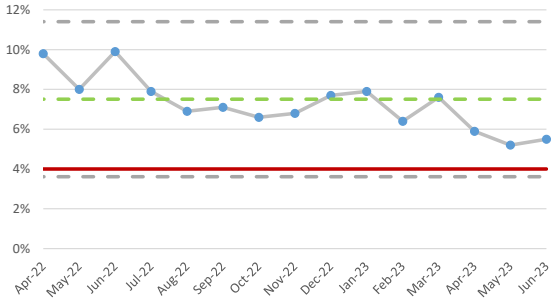
Issues / Performance Summary	Planned / Mitigation Actions	
In June 2023 there were 50 New Birth Visits conducted. 43 of which were within timeframe of within 14 days. 7 were out of timescale; 4 infants were in NNU's (UK and IOM) and three had been offered appointments at 15 days by the HV, this was to ensure continuity of care.	There are currently no concerns around NBV.	All new birth visits will be conducted within timeframe where within our control.

Well Led (People) Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
WP001		Workforce - % Hours lost to staff sickness absence	Jun-23		5.5%	5.5%	-	4.0%		F
WP002		Workforce - Number of staff on long term sickness	Jun-23	-	69	72	-	-		
WP003		Workforce - % Staff not on permanent contract	-	-	-	-	-	-		
WP004		Workforce - Number of staff leavers	Jun-23	-	24	23	68	-		
WP005		Workforce - Number of staff on disciplinary measures	Jun-23	-	8	7	20	-		
WP006		Workforce - Number of suspended staff	Jun-23	-	1	1	3	-		
WP007		Governance - Number of Data Breaches	Jun-23		13	11	34	0		F
WP008		Governance - Number of Data Subject Access Requests (DSAR)	Jun-23	-	52	52	156	-		
WP009		Governance - Number of Access to Health Record Requests (AHR)	Jun-23	-	2	1	4	-		
WP010		Governance - Number of Freedom of Information (FOI) Requests	Jun-23	-	6	10	31	-		
WP011		Governance - Number of Enforcement Notices from the ICO	Jun-23	-	0	0	0	-		
WP012		Governance - Number of SAR, AHR and FOI's not completed within their target	Jun-23		109	82	245	0		F
WP013		Staff 12 months turnover rate	Jun-23		10.4%	10.8%	32.3%	10%		F
WP014		Training Attendance rate	Jun-23		65.0%	62.3%	187.0%	90%		F

Well Led	OHR (1 of 2)	Executive Lead	Anne Corkill	Lead	Hannah Leighton	

% Hours lost to staff sickness absence



Reporting Date	Performance	Op. plan #
Jun-23	5.5%	P1

Threshold	YTD Mean	Benchmark
4.0%	5.5%	7.7%

(Lower value represents better performance)

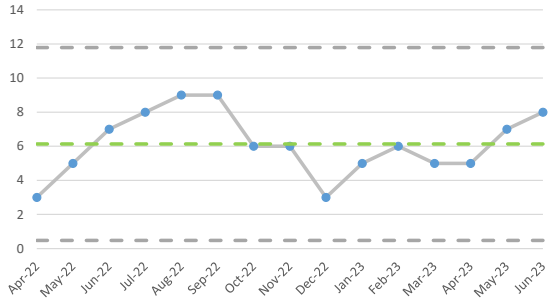
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Number of staff on disciplinary measures : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	8	P5

Threshold	YTD Mean	Benchmark
-	7	-

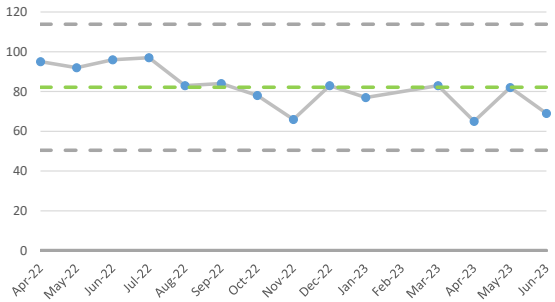
(Lower value represents better performance)

-	Variation Description

Common cause

Assurance Description

Number of staff on long term sickness : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	69	P4

Threshold	YTD Mean	Benchmark
-	72	-

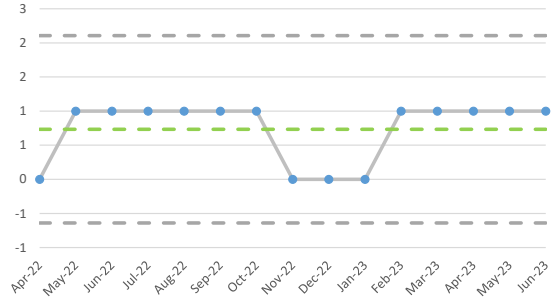
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Number of suspended staff : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	1	P6

Threshold	YTD Mean	Benchmark
-	1	-

(Lower value represents better performance)

-	Variation Description

Common cause

Assurance Description

Issues / Performance Summary

• Worktime lost in June '23 by sickness category:

Stress, Anxiety & Depression	- 1.4%
Cough, Cold & Flu	- 0.3%
Musculoskeletal	- 1.1%
Covid-19	- 0.3%
Other sickness	- 2.4%

• Worktime lost in June'23 by Area:

Integrated Social Care Services	- 6.4%
Medicine, Urgent Care & Ambulance Services	- 5.7%
Integrated Mental Health Services	-
Infrastructure	- 7.1%
Integrated Primary & Community Care Services	- 5.2%
Integrated Cancer & Diagnostic Services	- 2.2%
Women, Children & Families	- 4.1%
Surgery, Theatres, Critical Care & Anaesthetics	- 6.3%

Planned / Mitigation Actions

• Ongoing support for proactive management of absence provide by OHR to managers. This helps ensure appropriate staff support is given and staff are directed to welfare and occupational health support if appropriate.

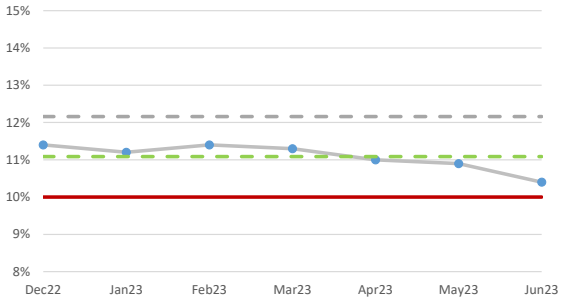
• The decision to suspend staff which may occasionally be necessary is normally taken in consultation with HR to ensure the measures are appropriate and proportionate.

Assurance / Recovery Trajectory

• Absence rates, including bradford factor reports and trends data are monitored at a care group level. Effective absence management relies on a proactive approach by managers as well as they use of appropriate information and support provided by OHR. Absence is also impacted by staff engagement and wider initiatives relating to wellbeing and culture which should have a positive impact.

Well Led	OHR (2 of 2)	Executive Lead	Anne Corkill	Lead	Hannah Leighton	

Staff 12 months turnover rate



Reporting Date	Performance	Op. plan #
Jun-23	10.4%	P2

Threshold	YTD Mean	Benchmark
10.0%	10.8%	11.3%

(Lower value represents better performance)

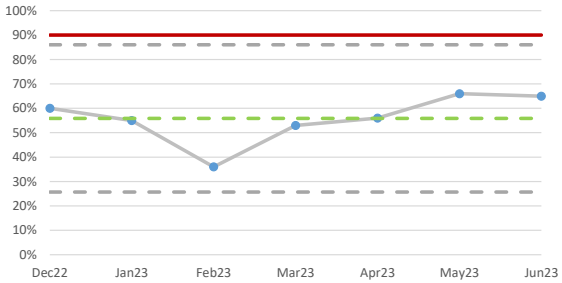
+	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Training Attendance Rate



Reporting Date	Performance	Op. plan #
Jun-23	65%	P7

Threshold	YTD Mean	Benchmark
90%	62%	51%

(Higher value represents better performance)

-	Variation Description

Common cause

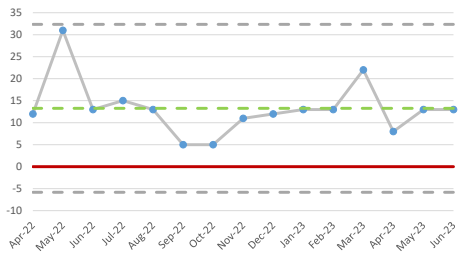
-	Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory

Well Led	Governance	Executive Lead	Simon Collins	Lead	Jennifer Maynard	

Governance - Number of Data Breaches : Manx Care



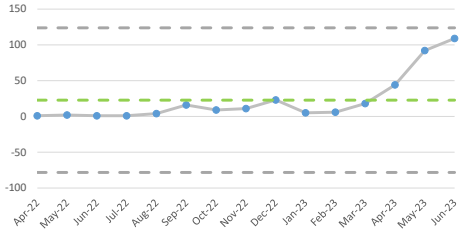
Reporting Date	Performance	Op. plan #
Jun-23	13	L1

Threshold	YTD Mean	Benchmark
0	11	-

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Governance - DSAR, AHR and FOI's not completed within timescale : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	109	L6

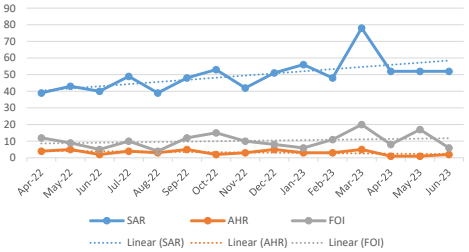
Threshold	YTD Mean	Benchmark
0	82	-

(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Governance - Information requests by type : Manx Care



Reporting Date	Performance	Op. plan #
Jun-23	-	L2-3-4

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Issues / Performance Summary

Total: 16

6 x data subjects been informed.
Not informed 10. [1 x Clinician advice not to inform; 9 x low risk to the data subject]

16 Breaches relate to:

7 x Email;
9 x written communication

Dates:

Date DPO notified	Date of breach
01/06/2023	01/06/2023
06/06/2023	05/06/2023
05/06/2023	02/06/2023
07/06/2023	14/05/2023
08/06/2023	06/06/2023
15/06/2023	14/06/2023
15/06/2023	Unknown
20/06/2023	19/06/2023
21/06/2023	20/06/2023
22/06/2023	19/06/2023
21/06/2023	20/06/2023
26/06/2023	22/06/2023
29/06/2023	14/02/2023
04/07/2023	29/06/2023
04/07/2023	02/06/2023
04/07/2023	30/06/2023

Planned / Mitigation Actions

• Manx Care continues to report all incidents reported to the Manx Care DPO as breaches to the ICO

• Where a data breach occurs Manx Care will inform the data subject(s) unless there is a clinical reason not to do so or if there is a very low risk to the data subject, for example patient data being shared with the incorrect GP

• Any incident reported to the Manx Care DPO as a breach is fully investigated and the Information Governance team work closely with the relevant service area and the Risk and Quality Assurance Manager to ensure any improvements and remedial actions are incorporated into Standard Operating Procedures and adherence to procedures is monitored.

Assurance / Recovery Trajectory

• Manx Care staff are actively encouraged to report any data breach, or suspected breach, to the Manx Care DPO. Staff reporting breaches to the Manx Care DPO is a positive reflection of the awareness amongst staff of the responsibility for good information governance. Willingness by staff to report ensures that Manx Care is continuously reviewing and strengthening the way the organisation manages and secures data subjects' information.

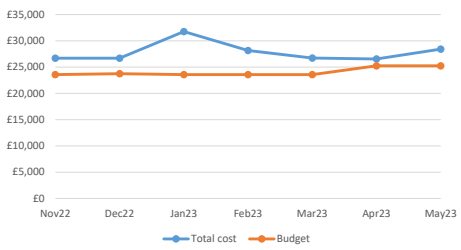
• Manx Care has now completed its first Data Security Protection Toolkit (DSPT) submission, which represents a significant step for Manx Care. This will be the first of what will be an annual assessment which will allow Manx Care to measure its performance and provide assurance that we are practicing good data security and that personal information is handled correctly.

• The increasing number of DSAR and FOI requests being received by Manx Care is presenting the Information Governance team with a significant challenge in responding to these requests within the legal timeframes. Longer term this pressure is likely to remain high and the IG team are actively exploring ways to increase efficiency and resourcing. These actions will result in a significant improvement in the position going forward but will take time to become embedded into all Information Governance processes.

Well Led (Finance) Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
WF001		% Progress towards Cost Improvement Target (CIP)	Mar-23		170%	-	0%	100% (equiv. 1%)		
WF002		Total income (£)	May-23	-	-£1,205,890	-£1,238,717	-£2,495,256	-		
WF003		Total staff costs (£)	May-23	-	£17,794,224	£16,177,273	£34,667,073	-		
WF004		Total other costs (£)	May-23	-	£13,965,736	£11,886,589	£26,299,357	-		
WF005		Agency staff costs (proportion %)	May-23	-	7%	9.1%	15%	-		
WF009		Actual performance against Budget	May-23		-3,187	-£4,401	-£4,488	-		

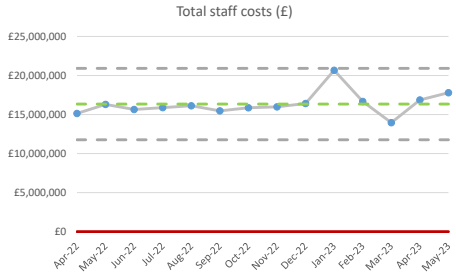
Well Led	Finance (1 of 2)	Executive Lead	Jackie Lawless	Lead	Samantha Allibone	



Reporting Date	Performance	Op. plan #
Threshold	**YTD Mean**	**Benchmark**

Variation Description

Assurance Description



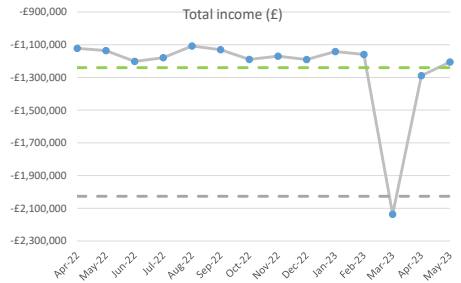
Reporting Date	Performance	Op. plan #
May-23	£17,794,223.57	F4
Threshold	**YTD Mean**	**Benchmark**
-	£16,177,272.85	-

(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description



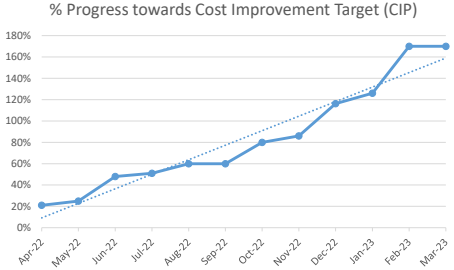
Reporting Date	Performance	Op. plan #
May-23	-£1,205,889.53	F3
Threshold	**YTD Mean**	**Benchmark**
-	-£1,238,717.02	-

(Higher value represents better performance)

+ **Variation Description**

Common cause

Assurance Description



Reporting Date	Performance	Op. plan #
Mar-23	170.0%	F1
Threshold	**YTD Mean**	**Benchmark**
100% (equiv. 1%)	-	-

(Higher value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

% Progress towards Cost Improvement Target (CIP):
• The CIP target allocated to Manx Care as part of the budget process is 1.5% (£4.5m).
• Spend is expected to increase by £24.4m compared to the prior year, whilst funding has increased by £20m.

Total income (£):
• The operational result for May is an overspend of (£2,170k) but it was expected that costs would increase this month as April has a lower than normal run rate. Further detail is provided in Table 1 in (Manx Care Management Accounts) to show the movement in costs but part of this increase, particularly in staff costs, is being investigated further to understand the change from April. The majority of the movement in non pay was expected & also relates to a catch up in costs from the prior month.

Total staff costs (£):
• YTD year employee costs are (£0.3m) over budget.
• Agency spend is contributing to this overspend and reducing this is a key factor in improving the financial position by the year end. The total spend YTD of £2.3m is broken down across Care Groups below. The Care Groups with the largest spend are Medicine (£0.6m), Women & Children (£0.4m) and Social Care (£0.3m), where spend is primarily incurred to cover existing vacancies in those areas.
• The prior year overspend (including DHSC Reserve Claims and Pay Award Claims) was £22.8m. Additional funding of £20m has been awarded for 23/24. If costs remained static, that would mean an overspend position of £2.8m this year, however, based on current projections, costs are expected to increase by £24.4m (7%).
• Increases in Operations Services (46%) and Nursing (29%) are due mainly to service developments and additional funding for nursing staff.

Planned / Mitigation Actions

% Progress towards Cost Improvement Target (CIP):
• As part of the calculations for the current forecast it is assumed that the CIP set out in the mandate is fully achieved this year (£4.5m) but no further savings are included. As CIP plans develop and crystallise, the forecast will be adjusted to reflect actual spend reductions achieved.

Total income (£):
• The full year forecast is now an overspend of (£27.2m) although £4.9m of this is expected to be approved from the DHSC reserve fund reducing this to (£22.2m).

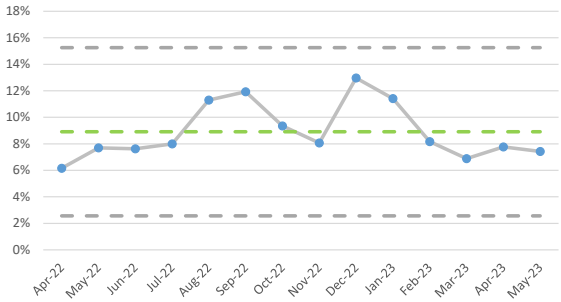
Total staff costs (proportion %):
• Costs in some Care Groups are rising more slowly which reflect the impact of recruitment and other cost saving initiatives. Most notable are Medicine (4%) , Surgery (4%) and Tertiary Care (2%).

Assurance / Recovery Trajectory

% Progress towards Cost Improvement Target (CIP):
• Due to the expected outturn additional mitigations are being explored as part of a financial planning exercise which will see the Care Groups prepare plans on ways to address the financial gap. All Care Groups have been given an efficiency target within their budgets and initial reports have been collated which will include any financial implications as well as the impact on performance & quality. These are being reviewed and If applicable will form part of an expanded CIP or will be additional mitigations that can be implemented in year. Further detail will be available in the June report.

Total income (£):
• Of this overspend £7.2m relates to a cost pressure for the 23/24 pay award above 2%. The budget allocated to Manx Care includes funding for 2% but the financial assumption for the forecast (and in line with the planning guidance received from Treasury) is that the pay award should be included at 6%. For reporting purposes a provision of 2% is included in the Care Groups actuals & forecast with the remaining 4% accounted for centrally.

Well Led	Finance (2 of 2)	Executive Lead	Jackie Lawless	Lead	Samantha Allibone	



Reporting Date	Performance	Op. plan #
Threshold	YTD Mean	Benchmark

(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Please see 'Total staff costs (£):' section on the previous page.		