Integrated Performance Report

Nov-23

Version: Final v.3

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Introduction - 1

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 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 havebeen 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.

- **Dental Dashboard**
  With the development of the Dental Dashboard, the IPR now includes additional metrics regarding allocations to dental practices.

- **Eyecare Transformation**
  With the ongoing development and implementation of the eyecare transformation workstream, additional metrics detailing the associated performance have been added to the report, with further additions planned over the coming months.

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.

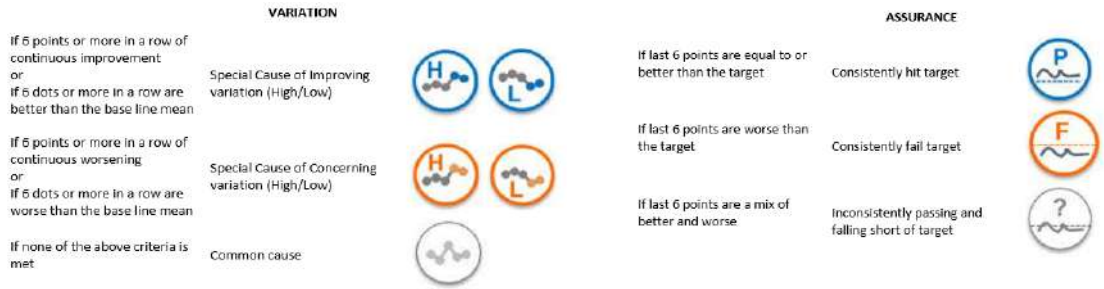
As each new dataset is developed, new reporting will replace the current reporting and eventually ManxCare will have a fully automated report.
PIMS is working with the BI team to support the development of performance reporting in a format that aligns with the performance monitoring processes and requirements 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 manually (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:

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 to be 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 implemented 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. SPC 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 variations in monthly performance.

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



The process for assigning the categories to each KPI is currently a manual one, but PIMS are currently working with the BI team 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. This 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 matches 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 alignment 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 currently many of the benchmark figures within this report use Manx Care's 2022/23 performance as a baseline. Details of the benchmark methodologies applied for each KPI and metric can be found within the 'Assurance / Recovery Trajectory' section of the supporting performance narratives.

Executive Summary

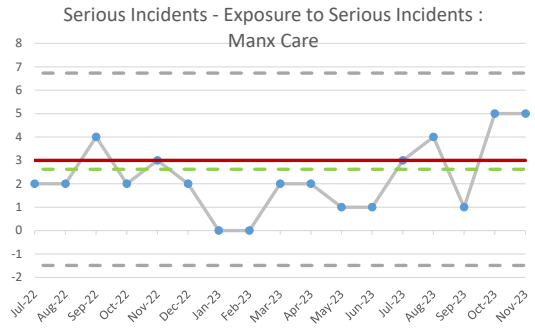
	Going Well	Cause for Concern
Safe	• 28 consecutive months without a Never Event. • Zero Medication Error with Harm across Manx Care in November. • Numbers of Falls that resulted in Harm remain low and within the expected threshold. • Positive achievement against Safety Thermometer for Adults, Maternity and Children. • Performance of VTE prophylaxis exceeded the threshold with 99%. VTE risk assessment within 12 hours was 92.5% which is just belowthe 95% standard. • There were no cases of MRSA in November. • 100% of letters were sent in accordance with Duty of Candour Regulations. • 48-72 hr senior medical review of antibiotic prescription remains below the 98% threshold but increased to 88% in November and has remained above 80% for the last 3 months.	• 5 SIs were declared during November'23 but remains within annual threshold. • 3 cases of C.Diff. 2 are community and 1 is hospital associated. • There have been 11 cases of E.coli bacteraemia. 10 community associated, 1 hospital associated.
Effective	• 99% of Learning from Death reviews were completed within timescale which exceeds the target for the tenth month in a row. • The Crisis Team performance increased in November, and they continue to meet the 1 hour response time threshold for Emergency Department referrals. • Adult Social Care re-referral rates remain within expected levels. • The reported number of individuals receiving copies of their Wellbeing Partnership assessments remained high in November, with the average monthly achievement now at 83%. • Nutrition and Hydration 7 days compliance remained high in November, with continued achievement of the 95% threshold. • 95.8% of MARFs were completed on time during November (23 out of 24). • 100% of Child Protection Conferences, Looked After Children Reviews and Initial Child Protection Conferences were held on time in November.	• Access to surgical bed base continues to challenge theatre efficiency and utilisation. • Consultant anaesthetic staffing and theatre staffing position remains a challenge.
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 (90%). • Service user satisfaction remains high with 91% of service users rating their experience as 'Very Good' or 'Good' using the Friends & Family Test in month. • Overall Manx Care compliance with the standard of complaints to be acknowledged within 5 days in November was 100%.	• 27 complaints were logged in November, but this remains below the expected threshold.
Responsive	• Inpatient and Daycase waiting list numbers and waiting times remain below the baseline levels, primarily 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. • November has seen an improvement in Category 1 Ambulance response times despite an increase in 999 demand in the month. • Good performance was maintained in the Ambulance service for Category 2 - 5 response times. • Mental Health caseloads remain within expected levels.	• Outpatient waiting list has slightly decreased in December but remains above the baseline. • The ED Performance against the 4 hour standard has slightly decreased in November but remains below the required target at 69.5%. • 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 30 12-Hour Trolley Waits, comparing to 48 in the previous month. • Access to routine diagnostics within 6 weeks and 26 weeks remains challenging due to increasing demand exceeding current capacity. However, additional diagnostic activity is being undertaken under the auspices of the restoration & recovery programme. • There were 22 breaches of the 60 minute ambulance turnaround time in November (24 in October). • The ED reached the highest Operational Pressures Escalation Level (OPEL), Level 4, in November for 1.5 days. • Cancer 28 Day performance in November was below the 75% threshold at 65%. This was due to unavoidable staffing pressures within the Breast service and Urology administration capacity.
Well Led (People)	•Although there were 8 Data Breaches in November, Manx Care staff across all specialisations continue to demonstrate their commitment to their GDPR responsibilities and engage well with the Information Governance team and their responsibilities to handling data safely and correctly. Manx Care staff engage in training, and often when courses are arranged they are oversubscribed. In those instances additional dates are arranged to ensure all staff are accommodated. • The trend of reduced rates of sickness absence, compared to previous years, evidenced in the first quarter 23/24 has continued, with November's rate remaining below the previous year's mothly average of 7.7%. An executive level review of sickness absence cases commenced in November '23 to ensure proactive management of absences by Care groups.	• The number of Subject Access Requests and Freedom of Information Requests, whilst varying from month to month, still maintains an upward trend and meeting the deadlines to issue responses continues to be challenging. The number of overdue Subject Access Requests at month end has remained fairly static, but unfortunately the number of overdue FOIs has increased. Additional staff resources are being allocated to address this.
Well Led (Finance)		• The operational result for October is an overspend of (£1.4m) with costs reducing by £0.3m compared to the previous month. • The forecast includes £4.9m of cost which is expected to be approved from the DHSC reserve fund which would reduce this to (£25.3m). • YTD employee costs are (£3.4m) 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	Nov-23		5	3	22	< 36 PA		
SA002		Duty of Candour Letter sent within 10 days of the application	Nov-23		100%	85%	-	80%		
SA018		Compliance with the Duty of Candour Regulations	Nov-23		100%	91%	-	100%		
SA003		% Eligible patients having VTE risk assessment within 12 hours of decision to admit	Nov-23		92.5%	90%	-	95%		
SA004		% Adult Patients (within general hospital) with VTE prophylaxis prescribed	Nov-23		99%	97%	-	95%		
SA005		Never Events	Nov-23		0	0	0	0		
SA006		Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	Nov-23		0.5	0.4	-	< 2		
SA007		Clostridium Difficile - Total number of acquired infections	Nov-23		3	3	23	< 30 PA		
SA008		MRSA - Total number of acquired infections	Nov-23		0	0	1	0		
SA009		E-Coli - Total number of acquired infections	Nov-23		11	8	61	< 72 PA		
SA010		No. confirmed cases of Klebsiella spp	Nov-23	-	2	2	12	-		
SA011		No. confirmed cases of Pseudomonas aeruginosa	Nov-23	-	0	0	3	-		
SA012		Exposure to medication incidents resulting in harm	Nov-23		0	0	3	< 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	Nov-23		97%	97%	-	95%		
SA014		Harm Free Care Score (Safety Thermometer) - Maternity	Nov-23		100%	99%	-	95%		
SA015		Harm Free Care Score (Safety Thermometer) - Children	Nov-23		100%	97%	-	95%		
SA016		Hand Hygiene Compliance	Nov-23		97%	98%	-	96%		
SA017		48-72 hr review of antibiotic prescription complete	Nov-23		88%	79%	-	>= 98%		
SA019		Pressure Ulcers - Total incidence - Grade 2 and above	Nov-23		17	18	144	<= 17 (204 PA)		

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



Reporting Date	Performance	Op. plan #
Nov-23	5	QC1

Threshold	YTD Mean	Benchmark
< 36 PA	3	2

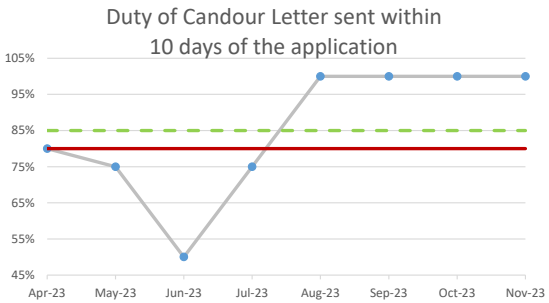
(Lower value represents better performance)

-	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target



Reporting Date	Performance	Op. plan #
Nov-23	100.0%	QC112

Threshold	YTD Mean	Benchmark
80%	85.0%	85.00%

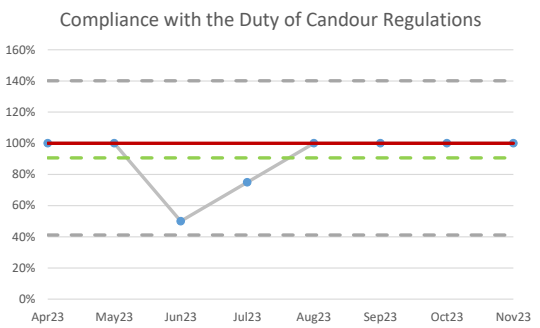
(Higher value represents better performance)

+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target



Reporting Date	Performance	Op. plan #
Nov-23	100.0%	QC112

Threshold	YTD Mean	Benchmark
100.0%	90.6%	90.6%

(Higher value represents better performance)

+	Variation Description

Common cause

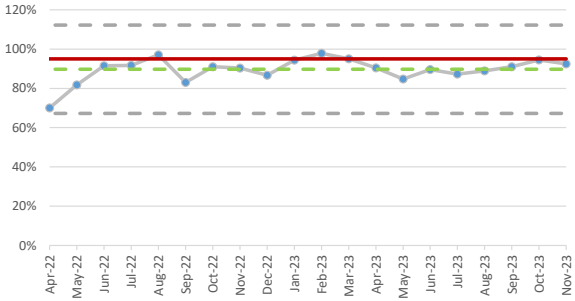
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Serious Incidents: In summary, 5 SIs were declared during the month: • ID&CS – declared 2 Serious Incidents in November. One relating to the delay in diagnosis of pituitary cancer and one relating to a processing error in the pathology lab. **Letter has been sent in accordance with Duty of Candour Regulations:** • 100% compliance for November.	**Serious Incidents:** • Continued reporting of all untoward incidents and review at SIRG meetings in accordance with embedded Incident Policy. **Letter has been sent in accordance with Duty of Candour Regulations:** • Continue to monitor closely.	**Serious Incidents:** • The organisation has a positive reporting culture and confidence can be taken from compliance with robust internal processes. **Letter has been sent in accordance with Duty of Candour Regulations:** • Expect performance to continue.

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 #
Nov-23	92.5%	QC113

Threshold	YTD Mean	Benchmark
95.0%	89.9%	89.2%

(Higher value represents better performance)

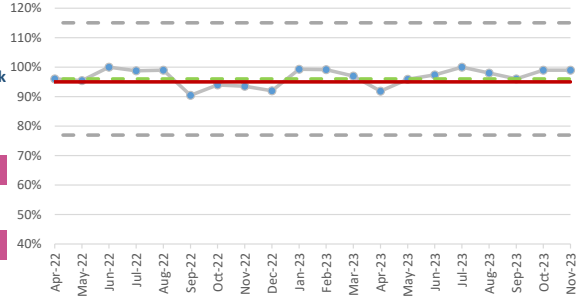
-	Variation Description

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 #
Nov-23	99.0%	QC114

Threshold	YTD Mean	Benchmark
95.0%	97.1%	96.2%

(Higher value represents better performance)

+	Variation Description

Common cause

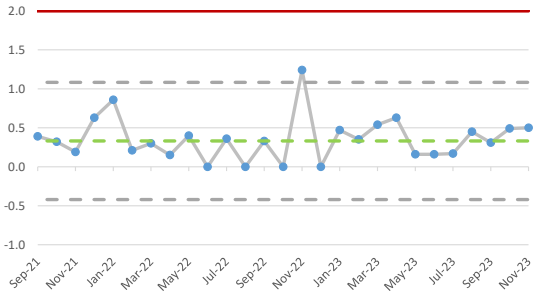
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
VTE risk assessment within 12 hours: • 92.5%, a drop from last month. YTD average is 89%, again below target. **VTE Prophylaxis:** • Excellent performance identified - 99% reported for November, in excess of the target 95% and for the seventh consecutive month. YTD monthly average stands at 97%.	**VTE risk assessment within 12 hours:** • Staff made aware to complete the assessment form on all in-patients. **VTE Prophylaxis:** • Focus to remain on risk assessments.	**VTE risk assessment within 12 hours:** • This target requires ongoing focus. **VTE Prophylaxis:** • Confident performance in this area will be maintained. 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 #
Nov-23	0.5	QC4

Threshold	YTD Mean	Benchmark
< 2	0.4	0.3

(Lower value represents better performance)

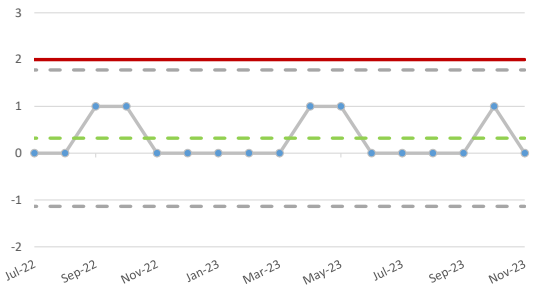
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Exposure to medication incidents resulting in harm: Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	0	

Threshold	YTD Mean	Benchmark
< 25 PA	0	0

(Lower value represents better performance)

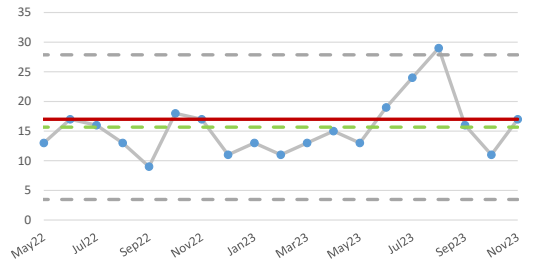
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Pressure Ulcers - Total incidence - Grade 2 and above



Reporting Date	Performance	Op. plan #
Nov-23	17.0	QC4

Threshold	YTD Mean	Benchmark
<= 17 (204 PA)	18.0	14.1

(Lower value represents better performance)

- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary

Inpatient Health Service Falls (with harm) per 1000 occupied bed days:
• 7.9 per 1000 bed days. This remains above the target of 6.63 but is consistent with previous months and a slight drop from October.

Medication Errors (with Harm):
• Zero errors with harm

Pressure Ulcer incidence:
new or having deteriorated under Manx Care services. Of the new or deteriorating ulcers, 17 were category 2 or above.
Of the 17, 6 were category 3, 4 or unstageable – all of these occurred in the patient's own home. A recurrent theme of non-concordance is evident in these community incidents, in particular prolonged sitting periods against documented nursing advice. Two of these patients were also receiving EOL care.

Planned / Mitigation Actions

Inpatient Health Service Falls (with harm) per 1000 occupied bed days:
• Continue with risk reduction activity to minimise harm.

Medication Errors (with Harm):
• Exposure to harm from medication errors remains low. Continue high vigilance and monitoring to ensure continued low exposure.

Pressure Ulcer incidence:
Continued implementation of preventative measures and monitoring.

Assurance / Recovery Trajectory

Inpatient Health Service Falls (with harm) per 1000 occupied bed days:
• The staffing situation, which is understood to be a factor in preventing falls, remains a challenge. Until this is resolved it is likely that the target will not be met.

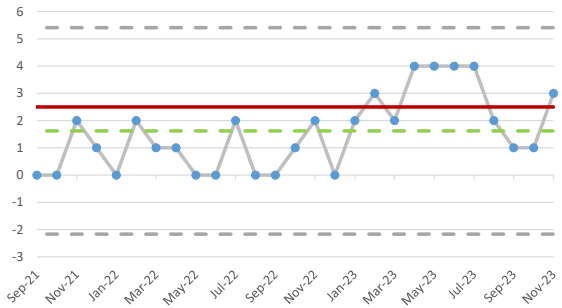
Medication Errors (with Harm):
• Reasonable assurance that errors leading to harm will remain low, with 3 incidents reported YTD.

Pressure Ulcer incidence:
The overall number of PUs this month is higher both for present on admission and new or deteriorating incidents. Whilst there was a high number of category 3 and above incidents in community these represent complex clinical/ environmental circumstances. There was documented evidence of preventative interventions and multi-agency working where applicable. There were no identified incidents of category 3 or above in the acute or social care settings.

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 #
Nov-23	3	QC115

Threshold	YTD Mean	Benchmark
< 30 PA	3	1

(Lower value represents better performance)

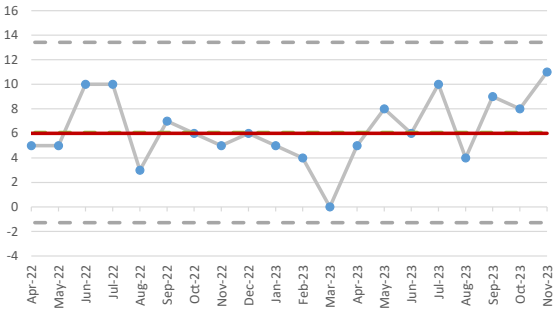
-	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

E.Coli - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	11	QC116

Threshold	YTD Mean	Benchmark
< 72 PA	8	6

(Lower value represents better performance)

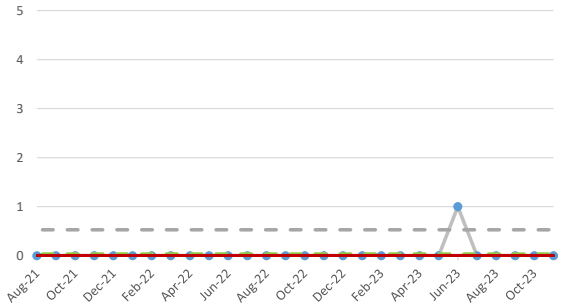
-	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

MRSA - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	0	QC8

Threshold	YTD Mean	Benchmark
0	0	0

(Lower value represents better performance)

+	Variation Description

Common cause

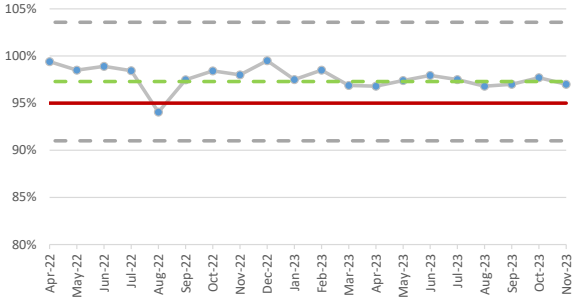
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
C.Diff: • 3 cases. 2 are community and 1 is hospital associated.	**C.Diff:** • Antimicrobial prescribing was deemed appropriate. RCA has been completed for the hospital associated case with appropriate treatment and no other learning outcomes.	**C.Diff:** • The CDI Safety Management plan actions are progressing with no escalation. Surveillance maintained with RCA to support learning.
E.Coli: • 10 community associated, 1 hospital associated. Sources Biliary, co-morbidities (including Oncology and chest infections) and urine. 2 patients had a catheter in situ and a UTI.	**E.Coli:** • Drive the urinary catheter project forward. Continue surveillance and RCA process for hospital associated cases.	**E.Coli:** • Further work undertaken to implement Catheter Care Pathways using the HOUDINI principle of 'make that urinary catheter disappear' if it's not required.
MRSA: • Zero cases reported	**MRSA:** • Not action required	**MRSA:** • Maintain surveillance.
Pseudomonas aeruginosa: • Zero reported	**Pseudomonas aeruginosa:** • No action required.	**Pseudomonas aeruginosa:** • Maintain surveillance.
		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 #
Nov-23	97.0%	QC119

Threshold	YTD Mean	Benchmark
95.0%	97.3%	98.0%

(Higher value represents better performance)

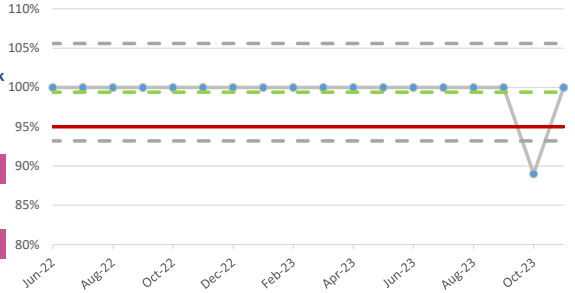
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

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



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

Threshold	YTD Mean	Benchmark
95.0%	98.6%	100.0%

(Higher value represents better performance)

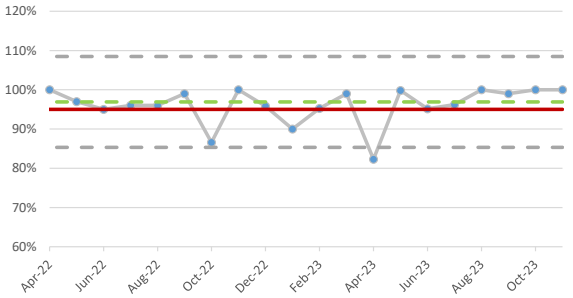
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

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



Reporting Date	Performance	Op. plan #
Nov-23	100.0%	QC121

Threshold	YTD Mean	Benchmark
95.0%	96.6%	95.8%

(Higher value represents better performance)

+ Variation Description

Common cause

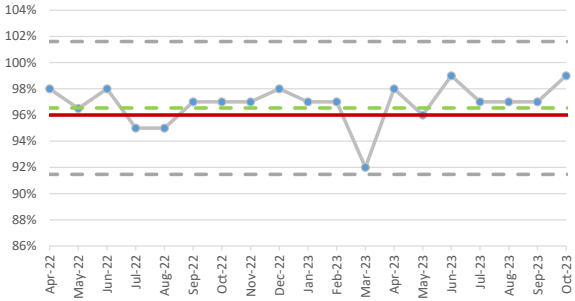
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Adult: • 97% for month and 97% for YTD monthly average. This remains above the target for the whole of the reporting year. **Maternity:** • Excellent performance of 99.8% **Children:** • Excellent performance of 98.8%	**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:** • Performance exceeds target. **Children:** • Performance exceeds 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 #
Nov-23	97.0%	QC112

Threshold	YTD Mean	Benchmark
96.0%	97.5%	96.5%

(Higher value represents better performance)

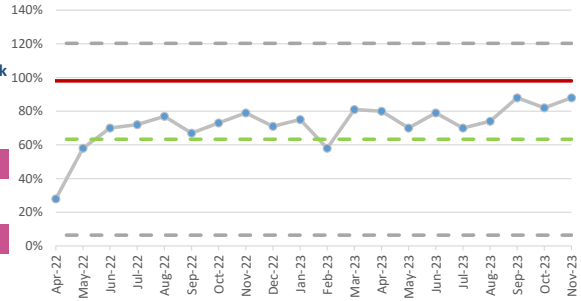
+ Variation Description

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 #
Nov-23	88.0%	QC123

Threshold	YTD Mean	Benchmark
>= 98%	78.9%	67.4%

(Higher value represents better performance)

+ Variation Description

Special Cause of Improving variation (High)

- Assurance Description

Consistently fail target

Issues / Performance Summary

Hand Hygiene:
- 97% which is compliant with target of above 95%.

Review of Antibiotic Prescribing:
- 88% up from 82%

Planned / Mitigation Actions

Hand Hygiene:
No action required.

Review of Antibiotic Prescribing:
- Continue to monitor.

Assurance / Recovery Trajectory

Hand Hygiene:
Continue to monitor.

Review of Antibiotic Prescribing:
- AMS ward rounds – consultant microbiologist reviewing all prescriptions

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)	Nov-23		13%	12%	-	5% by Apr '24		
EF067		Planned Care - DNA Rate - Hospital	Nov-23		11.0%	-	-	5%		
EF002		Planned Care - Total Number of Cancelled Operations	Nov-23		348	319	2555	-		
EF005		Length of Stay (LOS) - No. patients with LOS greater than 21 days	Nov-23	-	81	109	-	-		
EF050		Total Number of Inpatient discharges-Nobles	Nov-23	-	995	927	7413	-		
EF051		Total Number of inpatient discharges-RDCH	Nov-23	-	38	76	296	-		
EF003		Theatres - Number of Cancelled Operations on Day	Nov-23		31	37	292	-		
EF004		Theatres - Theatre Utilisation	Nov-23		76%	77%	-	85%		
EF006		Crude Mortality Rate	Nov-23	-	0	23	271	-		
EF007		Total Hospital Deaths	Nov-23	-	27	23	279	-		
EF024		Mortality - Hospitals LFD (Learning from Death reviews)	Nov-23		99%	97%	-	80%		
EF025		Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	Nov-23		95%	96%	-	95%		
EF008		ASC -West Wellbeing Contribution to reduction in ED attendance	Nov-23		6%	8%	-	-5%		
EF009		ASC - West Wellbeing Reduction in admission to hospital from locality	Nov-23		67%	-1%	-	-10%		
EF010		IPCC - % Dental contractors on target to meet UDA's	Nov-23		53%	-	-	96%		
EF011		MH - Average Length of Stay (LOS) in MH Acute Inpatient Service	Nov-23	-	39.0	35.6	-	-		
EF064		MH - Number of patients with a length of stay - 0 days	Nov-23	-	1	1	7	-		

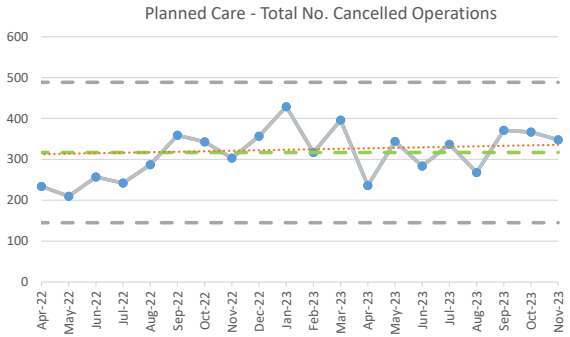
KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF065		MH - Number of patients aged 18-64 with a length of stay - > 60 days	Nov-23	-	1	2	14	-		-
EF066		MH - Number of patients aged 65+ with a length of stay - > 90 days	Nov-23	-	1	1	8	-		-
EF013		MH - % service users discharged from MH inpatient to have follow up appointment	Nov-23		100.0%	99%	-	90%		
EF047		% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	Oct-23		100%	100%	-	75%		
EF048		% Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral	Oct-23		-	80%	-	75%		
EF026		MH - Crisis Team one hour response to referral from ED	Nov-23		90%	91%	-	75%		
EF063		ASC - No. of referrals	Nov-23	-	74	75	598	-		-
EF015		ASC - % of Re-referrals	Nov-23		4%	3%	-	<15%		
EF016		ASC - % of all Adult Community Care Assessments completed in Agreed Timescales	Nov-23		30%	34%	-	80%		
EF017		ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment	Nov-23		96%	83%	-	100%		
EF052		Referrals to Adult Safeguarding Team	Nov-23	-	117	99	793	-		-
EF053		Adult Safeguarding Alert	Nov-23	-	72	60	477	-		-
EF054		Discharges from Adult Safeguarding Team	Nov-23	-	89	95	762	-		-
EF055		Re-referrals to Adult Safeguarding Team	Nov-23	-	19	20	156	-		-
EF056		% MARFs Completed by Adult Safeguarding Team	Nov-23	-	96%	83%	-	-		-

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	Nov-23		199	149	1194	-		
EF019		CFSC - % Complex Needs Reviews held on time	Nov-23		44%	62%	-	85%		
EF021		CFSC - % Total Initial Child Protection Conferences held on time	Nov-23		100%	80%	-	90%		
EF022		CFSC - % Child Protection Reviews held on time	Nov-23		100%	80%	-	90%		
EF023		CFSC - % Looked After Children reviews held on time	Nov-23		100%	96%	-	90%		
EF044		C&F -Children (of age) participating in, or contributing to, their Child Protection review	Nov-23		100%	87%	-	90%		
EF045		C&F -Children (of age) participating in, or contributing to, their Looked After Child review	Nov-23		100%	99%	-	90%		
EF046		C&F -Children (of age) participating in, or contributing to, their Complex Review	Nov-23		71%	49%	-	79%		
EF030		Maternity - Caesarean Deliveries (not Robson Classified)	Nov-23	-	43%	42.27%	-	-		
EF031		Maternity - Induction of Labour	Nov-23		40%	31.01%	-	< 30%		
EF032		Maternity - 3rd/4th Degree Tear Overall Rate	Nov-23		0%	0.50%	-	< 3.5%		
EF033		Maternity - Obstetric Haemorrhage >1.5L	Nov-23		0%	0.50%	-	< 2.6%		
EF034		Maternity - Unplanned Term Admissions To NNU	Nov-23	-	40%	-	-	-		
EF035		Maternity - Stillbirth Number / Rate	Nov-23		0	0.125	1.0	<4.4/1000		
EF036		Maternity - Unplanned Admission To ITU – Level 3 Care	Nov-23	-	0	-	-	-		
EF037		Maternity - % Smoking At Booking	Nov-23	-	12%	8.4%	-	-		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF038		Maternity - % Of Women Smoking At Time Of Delivery	Nov-23		12%	7.8%	-	< 18%		
EF039		Maternity - First Feed Breast Milk (Initiation Rate)	Nov-23		71%	69.4%	-	> 80%		
EF040		Maternity - Breast Feeding Rate At Transfer Home	Nov-23		76%	-	-			
EF041		Maternity - Neonatal Mortality rate/1000	Nov-23		0	0	-			-
EF059		W&C - Paediatrics- Total Admissions	Nov-23		197	143	859	-		-
EF060		W&C - NNU - Total number of Admissions	Nov-23		5	7	55	-		-
EF061		W&C - NNU - Avg. Length of Stay	Nov-23		21	8	48	-		-
EF062		W&C - NNU -Community follow up	Nov-23		9	4	33	-		-
EF068		Pharmacy - Total Prescriptions (No. of fees)	Oct-23		£137,848	£140,198	£981,383	-		-
EF069		Pharmacy - Chargable Prescriptions	Sep-23		£22,055	£18,525	£129,673	-		-
EF070		Pharmacy - Total Exempt Item	Sep-23		£155,968	£138,107	£966,748	-		-
EF071		Pharmacy - Chargeable Items	Sep-23		£21,924	£18,397	£128,781	-		-
EF072		Pharmacy - Net cost	Sep-23		£1,643,309	£1,449,070	£10,143,492	-		-
EF073		Pharmacy - Charges Collected	Sep-23		£84,646	£71,019	£497,134	-		-
EF081		IPCC - Dental - Additions	Nov-23		206	180	1,439	-		
EF082		IPCC - Dental - Allocations	Nov-23		105	62	369	-		
EF086		IPCC - Number of Sight Test	Jul-23		2237	2,335	9,339	-		
EF074		Total Number of OP & Dementia Beds Available	Nov-23		195	195	-	-		
EF075		Total Number of OP & Dementia Beds Occupied	Nov-23		65	108	-	-		
EF076		Total Number of LD Beds Available	Nov-23		85	83	-	-		
EF077		Total Number of LD Beds Occupied	Nov-23		69	70	-	-		

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



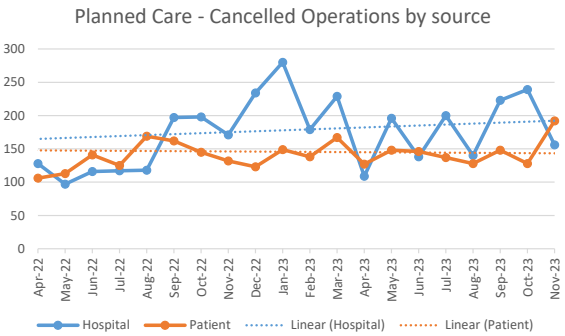
Reporting Date	Performance	Op. Plan #
Nov-23	348	QC157

Threshold	YTD Mean	Benchmark
-	319	311

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Nov-23		

Threshold	YTD Mean	Benchmark

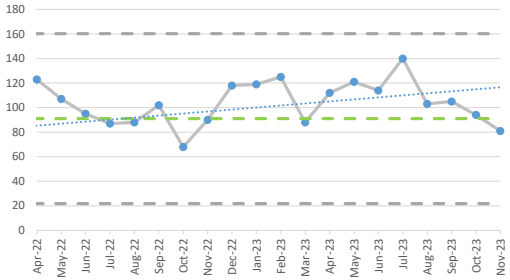
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Cancelled Operations: The number of cancelled operations in November was (348), it's 5.2% lower than last month, and 14.9% higher than November'22. In November the split of cancellations sources was (158, 44.8%) for hospital, and (191, 55.2%) for patient.	**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 #
Nov-23	81	QC10c
Threshold	**YTD Mean**	**Benchmark**
-	109	101

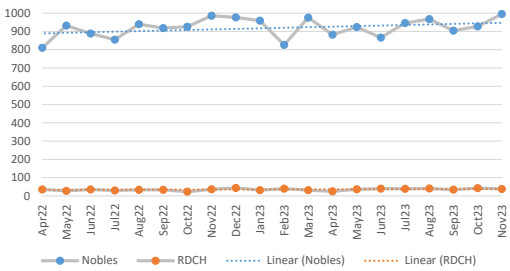
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Inpatient Discharges

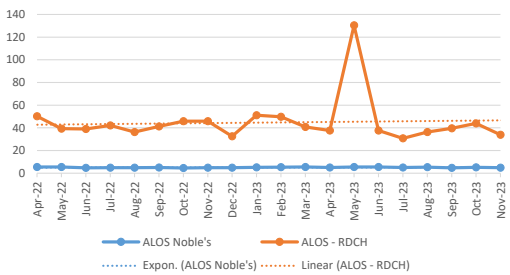


Reporting Date	Performance		Op. Plan #
Nov-23	**Nobles**	995	
	RDCH	38	
Threshold	**YTD Mean**		**Benchmark**
	Nobles	927	916
	RDCH	37	33

Variation Description

Assurance Description

Average Length of Stay (ALOS) by site



Reporting Date	Performance	Op. Plan #
Nov-23		QC156
Threshold	**YTD Mean**	**Benchmark**

-	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 some 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 (and their higher acuity) 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 November (1033) slightly higher than November'22 (1022). 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.

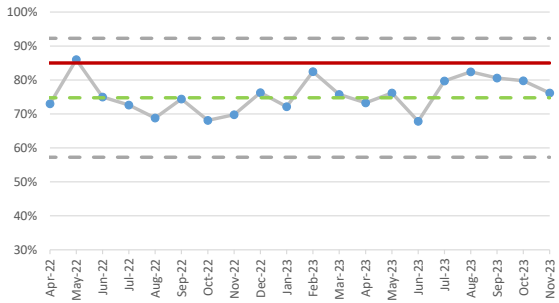
Length of Stay:

- 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 1.1 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 #
Nov-23	76.2%	QC16

Threshold	YTD Mean	Benchmark
85.0%	77.0%	74.5%

(Higher value represents better performance)

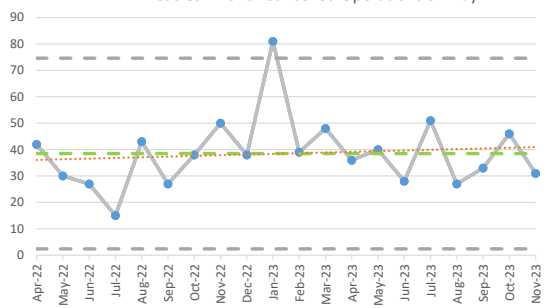
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Theatres - No. of Cancelled Operations on Day



Reporting Date	Performance	Op. Plan #
Nov-23	31	QC15

Threshold	YTD Mean	Benchmark
-	37	40

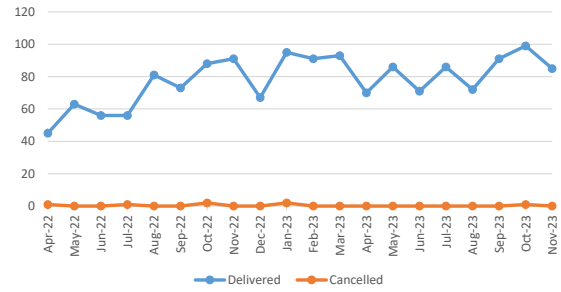
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Theatres - Delivered (vs Cancelled Sessions)



Reporting Date	Performance	Op. Plan #
Nov-23	85	

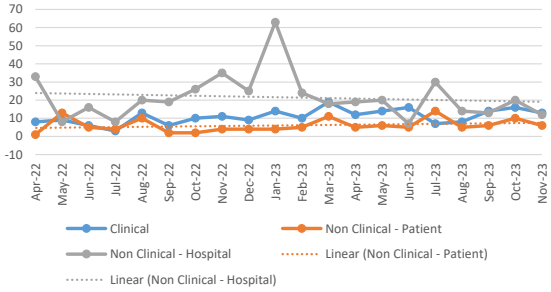
Threshold	YTD Mean	Benchmark
-	83	75

(Higher value represents better performance)

+	Variation Description

Assurance Description

Theatres - Cancelled Operations on Day by source



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

Threshold	YTD Mean	Benchmark
-	-	-

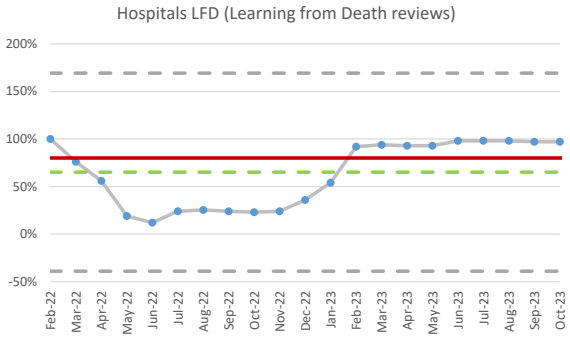
(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Theatre Utilisation: • The number of theatre sessions delivered in November was (85). •The number of cancelled operations on the day decreased to 31 in November. Most common reason was "Unfit for Surgery-Acute illness" and "Ward Beds Unavailable". • 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.	• 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 orthopaedic and general surgical specialties through the provision of theatre teams, surgeons & anaesthetists to undertake the surgical activity. Recruitment remains in progress for substantive staff to sustain the BAU activity in theatres.	• 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. A peer review was undertaken in September and provided assurance that standards were continuing to be met. AfPP were also engaged to perform a Staffing Establishment Review to confirm accurate staffing & skill mix to safely deliver 4 - 7 theatres (inclusive of maternity theatre) which was conducted in October, resuts to be published December. • 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. • 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. • The Theatre team are undertaking monthly deep dive analysis of reasons/causes of hospital led cancellations on the day which is reported monthly through the CG1 Governance Structure. 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 #
Nov-23	99.0%	QC126

Threshold	YTD Mean	Benchmark
80.0%	96.6%	40.3%

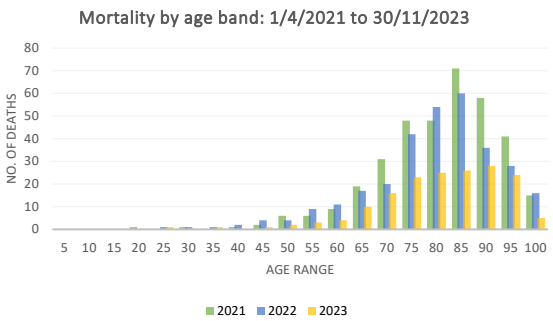
(Higher value represents better performance)

+ Variation Description

Special Cause of Improving variation (High)

+ Assurance Description

Consistently hit target



Reporting Date	Performance	Op. Plan #
-	777 in Total	

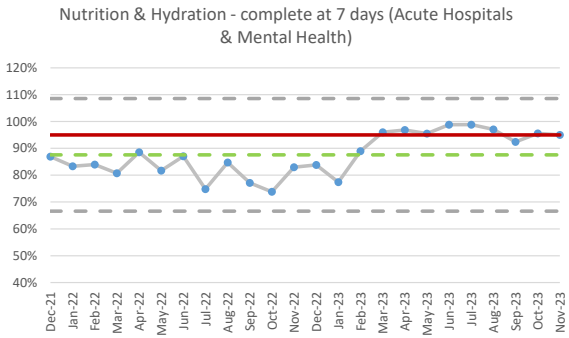
Threshold	YTD Mean	Benchmark
-	-	-

+ Variation Description

- Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hospitals LFD (Learning from Death) Reviews: • 99% reported. The target continues to be exceeded, as it has every month since February 2023.	**Hospitals LFD (Learning from Death) Reviews:** • The current approach appears successful.	**Hospitals LFD (Learning from Death) Reviews:** • There is reasonable confidence that the challenges experienced last reporting year have been overcome and significant progress has been made. 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 #
Nov-23	95.0%	QC124

Threshold	YTD Mean	Benchmark
95.0%	96.3%	83.1%

(Higher value represents better performance)

- Variation Description

Special Cause of Improving variation (High)

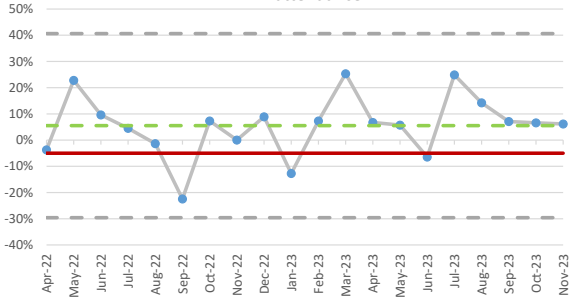
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Nutrition & Hydration: • 95% compliance reported for November. The continued focus on this target has meant only one month has fallen below target since February 2023.	**Nutrition & Hydration:** • Missing assessments were brought to the attention of ward staff at the time of audit with several resolved at the time.	**Nutrition & Hydration:** • This will continue to be monitored and reported upon. Confident in positive performance. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Wellbeing Services	Executive Lead	Oliver Radford	Lead	Adrian Tomkinson

West Wellbeing service contribution to reduction in ED attendance



Reporting Date	Performance	Op. Plan #
Nov-23	6.2%	QC63

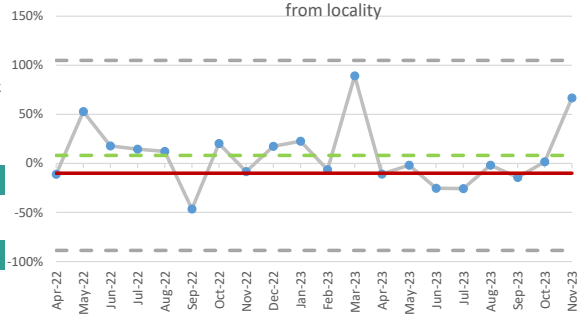
Threshold	YTD Mean	Benchmark
-5.0%	8.1%	3.8%

(Lower value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

West Wellbeing service reduction in admission to hospital from locality



Reporting Date	Performance	Op. Plan #
Nov-23	66.7%	QC64

Threshold	YTD Mean	Benchmark
-10.0%	-1.4%	14.6%

(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

Issues / Performance Summary

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.

Planned / Mitigation Actions

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.

Assurance / Recovery Trajectory

Wellbeing Services:

• The service will look to refer more patients to third sector services, e.g. respite services as appropriate.

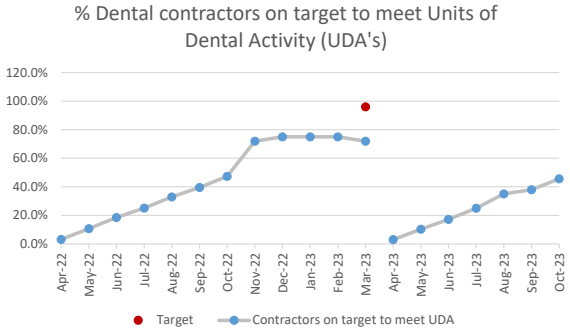
• Technical specification of these metrics have been reviewed. Will move to a 12 month timescale to ensure a more appropriate indication of the service's performance, and to better evidence the direct impact of the Wellbeing service on ED and hospital demand.

• The PIMS team are working with the Wellbeing leads to produce a schedule of alternative KPIs that better reflect and evaluate the performance and impact of the Wellbeing Partnerships.

• 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 #
Nov-23	53.0%	QC161

Threshold	YTD Mean	Benchmark
96.0%	-	-

(Higher value represents better performance)

+ Variation Description

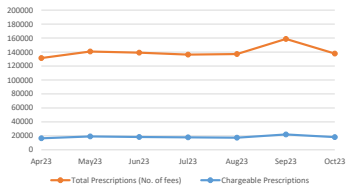
- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Dental Contractors: • 1 contractor returned their contract to Manx Care in November. This became a salaried practice as of 1st December and work continues to ensure the smooth transition of patient care.	**Dental Contractors:** • The majority of contractors are on target of 30% deliver for mid-year. Mid-year reviews are currently being undertaken and up date will be provided in due course.	**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	Integrated Primary & Community Care	Executive Lead	Oliver Radford	Lead	Maria Bell	

Pharmacy - Prescriptions



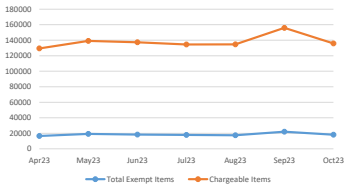
Reporting Date	Performance	Op. Plan #
Oct-23		-

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Pharmacy - Items



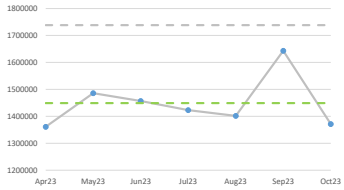
Reporting Date	Performance	Op. Plan #
Oct-23		

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Pharmacy - Net cost



Reporting Date	Performance	Op. Plan #
Oct-23	**£1,643,309**	

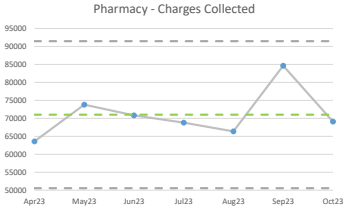
Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Common cause

Assurance Description

Pharmacy - Charges Collected



Reporting Date	Performance	Op. Plan #
Oct-23	**£84,646**	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

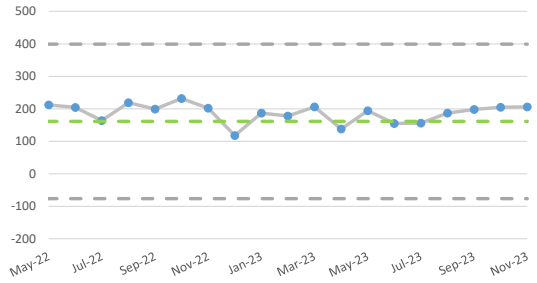
Common cause

Assurance Description

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

Effective	Integrated Primary & Community Care	Executive Lead	Oliver Radford	Lead	Rebecca Dawson	

Additions to the Dental Waiting list

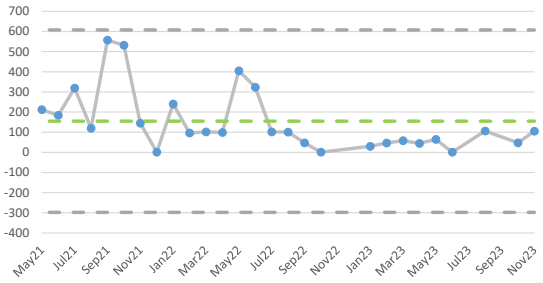


Reporting Date	Performance	Op. Plan #
Nov-23	**206**	-
Threshold	**YTD Mean**	**Benchmark**

Variation Description

Assurance Description

Patients Allocations to Dental Practices

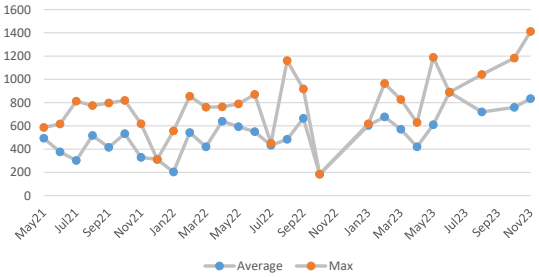


Reporting Date	Performance	Op. Plan #
Nov-23	**105**	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Assurance Description

Waiting time for dental allocations



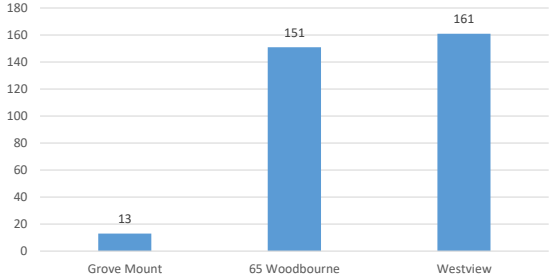
Reporting Date	Performance	Op. Plan #
Nov-23		
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Common cause

Assurance Description

Allocations by Practice - YTD



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

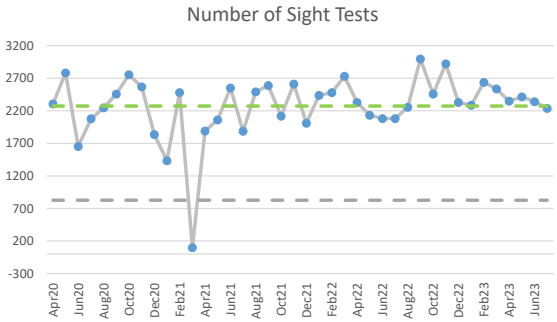
Variation Description

Common cause

Assurance Description

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

Effective	Integrated Primary & Community Care	Executive Lead	Oliver Radford	Lead	



Reporting Date	Performance	Op. Plan #
Jul-23	**2237**	-
Threshold	**YTD Mean**	**Benchmark**

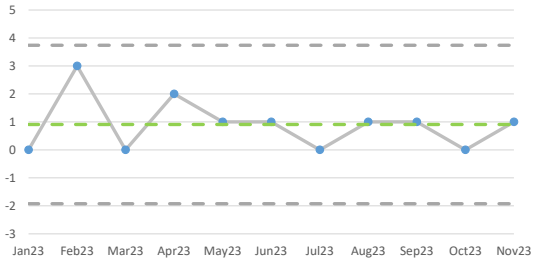
Variation Description

Assurance Description

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

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 #
Nov-23	1	QC87

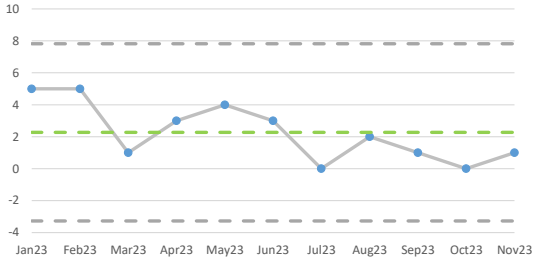
Threshold	YTD Mean	Benchmark
-	1	1

+ 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 #
Nov-23	1	QC88

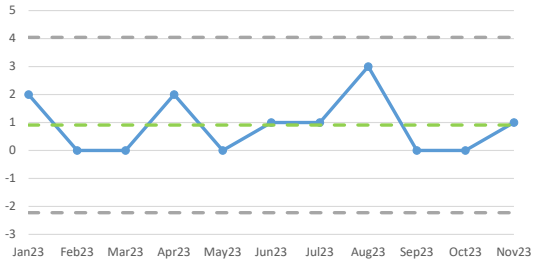
Threshold	YTD Mean	Benchmark
-	2	4

+ 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 #
Nov-23	1	QC89

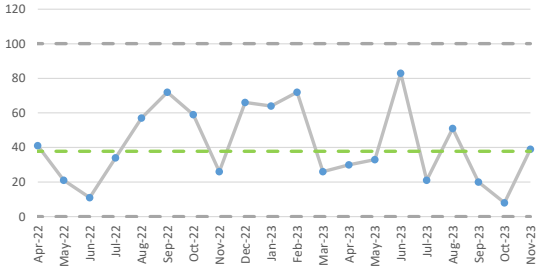
Threshold	YTD Mean	Benchmark
-	1.0	0.7

+ 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 #
Nov-23	39	QC158

Threshold	YTD Mean	Benchmark
-	36	46

- Variation Description

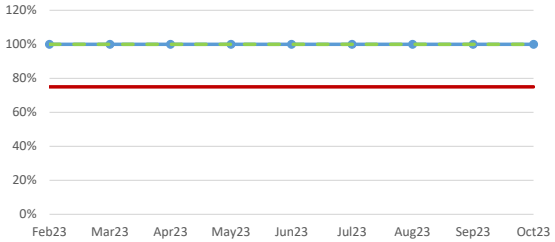
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Average Length of Stay (ALOS): • ALOS for those discharged in November has increased. The average length of stay for those dicsharged from Harbour Suite is 14 days. • For current inpatients, the ALOS has increased to a high for this reporting year and we will monitor to be assured individual patients are receiving appropriate treatment/care plans and for any barriers that might prevent this. **NHSE recognised standard measures are as follows:_** Number of patients aged 18-64 with a length of stay - > 60 days; Nov = 1 Number of patients aged 65+ with a length of stay - > 90 days; Nov = 1	Continue to monitor and report against recognised NHSE standards.	**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 #
Oct-23	100%	QC69

Threshold	YTD Mean	Benchmark
75%	100%	100%

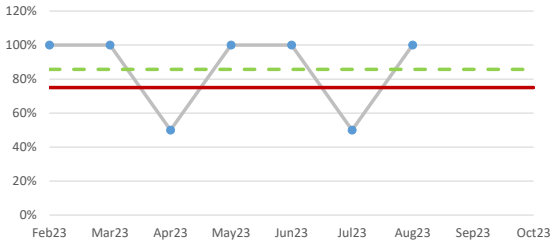
+ Variation Description

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 #
Oct-23	-	QC70

Threshold	YTD Mean	Benchmark
75%	80%	100%

+ Variation Description

Common cause

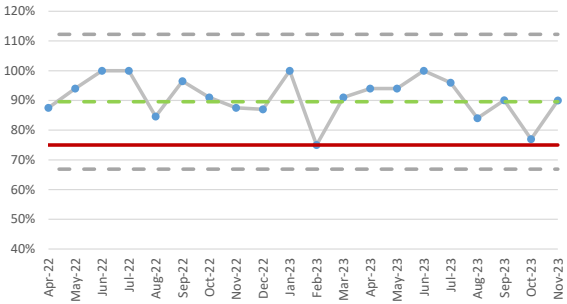
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
		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 #
Nov-23	90.0%	QC68

Threshold	YTD Mean	Benchmark
75.0%	90.6%	91.2%

(Higher value represents better performance)

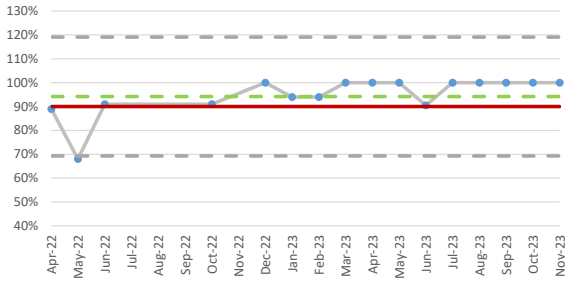
+ Variation Description

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 #
Nov-23	100.0%	QC72

Threshold	YTD Mean	Benchmark
90.0%	98.8%	90.9%

(Higher value represents better performance)

+ Variation Description

Common cause

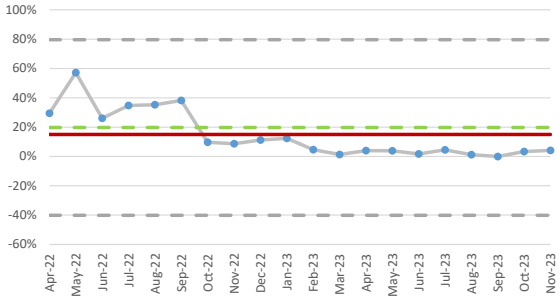
+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Crisis Team: • Performance was 90%, which exceeds the target of 75%. This target has been met for consistently for more than a year. 2 ED reviews did not meet the targeted one hour time frame due to referral being received during staff handover. **3 Day follow up:** • Excellent results - 100% compliant; all 72 hour follows were completed within the time frame and documented within the patient record in RIO.	**Crisis Team:** To continue to monitor response times monthly. **3 Day follow up:** Reminders have been sent to operational managers as RiO documentation is note to not always be completed at the time of the event, meaning our dashboard may not reflect actual compliance.	**Crisis Team:** • Target continues to be achieved monthly and service area is motivated to achieve 100% compliance. **3 Day follow up:** There is confidence that this target will be effectively maintained. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Adult Social Work (1 of 3)	Executive Lead	David Hamilton	Lead	Michele Mountjoy

ASC - % of Re-referrals



Reporting Date	Performance	Op. Plan #
Nov-23	4.1%	QC41

Threshold	YTD Mean	Benchmark
<15%	2.8%	22.4%

(Lower value represents better performance)

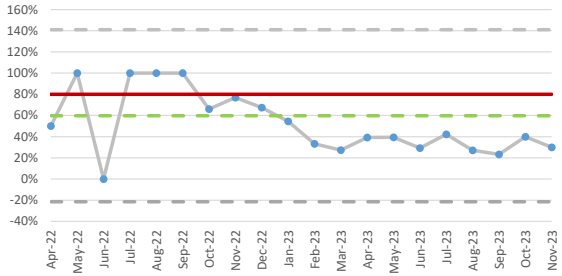
- Variation Description

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 #
Nov-23	30.0%	QC44

Threshold	YTD Mean	Benchmark
80.0%	33.8%	64.6%

(Higher value represents better performance)

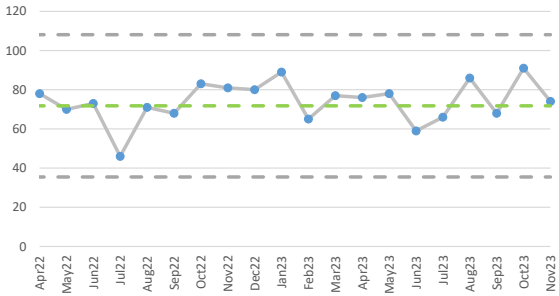
+ Variation Description

Special Cause of Concerning variation (Low)

- Assurance Description

Consistently fail target

ASC - No. of referrals



Reporting Date	Performance	Op. Plan #
Nov-23	74	QC40

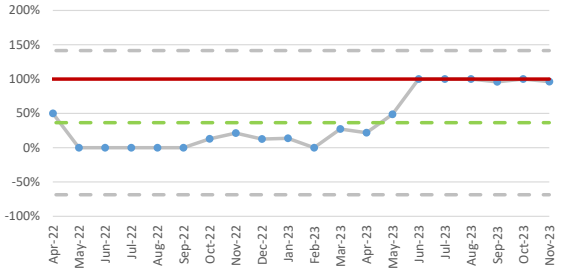
Threshold	YTD Mean	Benchmark
-	75	73

- 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 #
Nov-23	96.3%	QC45

Threshold	YTD Mean	Benchmark
100.0%	82.8%	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 November decreased to 74

Re-Referrals:
• We have significantly reduced our re-referral rate to 4.1% in November.

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

Individuals receiving copy of Assessment:
• The assessment sharing level was 96.3% during November, slightly below the threshold.

Planned / Mitigation Actions

Assessments completed within timescales:-
An issue with the dashboard pull-through has been identified, where the first referral date keeps being referred to as the starting point for any reassessments. This means that the dashboard is incorrectly showing some assessments taking months or even years, where a service user has been assessed and re-assessed over a long period of time. This issue is due to be resolved in Dec '23 and figures corrected for the next IPR.

The focus of Adult Social Work in recent months has been to improve the rate of assessment sharing, which continues to be a positive area. Waiting list volumes have been reduced in recent months, particularly within the Older Peoples Community Team (a reduction of 90 down to approx. 25).

There has been some sickness absence within Adult Social Work which has affected completion of assessments, a number of staff have recently been supported back to work.

The completion of assessments in Learning Disabilities within 4 weeks isn't realistic due to the complexities and input of other professionals being required. Conversations have started with the DHSC around changing this metric to 6 weeks in the next financial year.

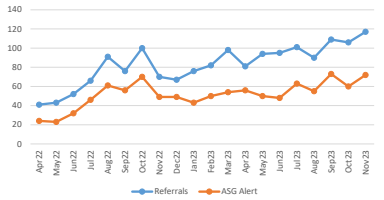
Assurance / Recovery Trajectory

Assessments completed within Timescales:
• The data capture issue around assessments is still being worked through in conjunction with the BI Team. We are hoping to see a fix implemented and subsequent improvement in numbers by the December IPR (produced in January '24). This will be influenced by the Learning Disabilities Team, who are seeing an increased caseload both in terms of numbers and complexity of client needs.

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

Effective	Adult Social Work (2 of 3)	Executive Lead	David Hamilton	Lead	Michele Mountjoy

Adult Safeguarding Referrals



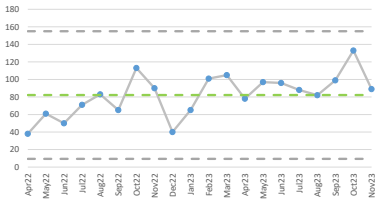
Reporting Date	Performance		Op. Plan #
Nov-23	Referrals	117	QC59
	Alert	72	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Discharges from Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Nov-23	89	

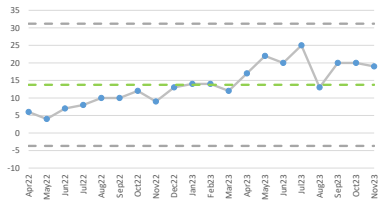
Threshold	YTD Mean	Benchmark
-	95	74

Variation Description

Common cause

Assurance Description

Re-referrals to Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Nov-23	19	

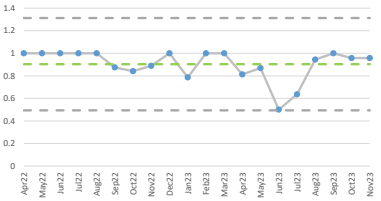
Threshold	YTD Mean	Benchmark
-	20	10

Variation Description

Common cause

Assurance Description

% MARFs Completed by Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Nov-23	95.8%	

Threshold	YTD Mean	Benchmark
-	83.5%	94.9%

(Higher value represents better performance)

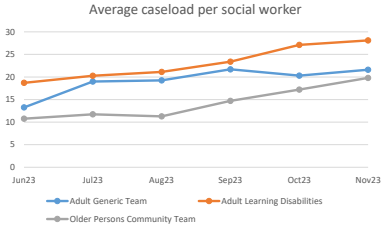
Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The number of alerts received continues to be high and increasing. The team can demonstrate a 30% increase in alerts when comparing 2022 to 2023 (to date). • Currently the Adult Safeguarding Team is depleted. The Team Manager is new to post and is in a 4-month secondment. A Senior Practitioner (also a 4-month secondment) will be in post early in 2024. There is an existing vacancy for a safeguarding officer (social worker) and a further vacancy is about to exist owing to the resignation of a further safeguarding officer. The recruitment of permanent staff is underway but may not prove fruitful. • Discharges are likely to vary significantly month to month as each safeguarding alert must be processed individually, with some being discharged rapidly and others taking longer period of time (sometimes several months), owing to complexity and levels of risk. • Re-referral rates fluctuate somewhat but are broadly consistent across an annual period. The reasons for re-referrals are generally appropriate and as would be anticipated e.g., resident on resident physical abuse recurring, and necessitating multiple referrals. • MARFs are a means by which the police share concerns. These are appropriate but do not always meet thresholds for action to be taken by the adult safeguarding team. • Making Safeguarding Personal (MSP) assessments are not captured in the dashboard. This is unfortunate as the percentage of these completed in timescale is usually 100%.	• Referrals and ASG alerts methodology will be discussed with the B.I team. • A Business Case for additional staffing resources is in the process of being devised.	The safeguarding team is typically meeting its timescales for taking appropriate action e.g., convening planning meetings. Where there are delays these are occasional and usually at the request of the person at risk of harm. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Adult Social Work (3 of 3)	Executive Lead	David Hamilton	Lead	Michele Mountjoy	



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

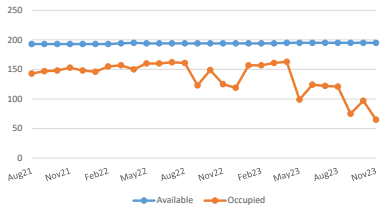
Variation Description

Assurance Description

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

Effective	Adult Social Care	Executive Lead	David Hamilton	Lead	Jonathan Carey

Total Number of OP & Dementia Beds



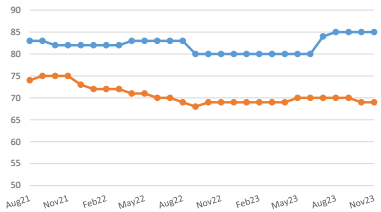
Reporting Date	Performance		Op. Plan #
Nov-23	Available	195	
	Occupied	65	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Total Number of LD Beds



Reporting Date	Performance		Op. Plan #
Nov-23	Available	85	
	Occupied	69	

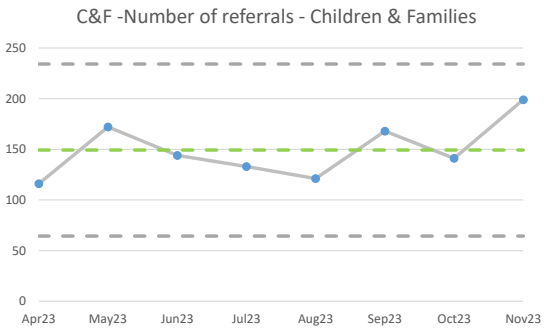
Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
The vacancy factor across Older Peoples Services is largely attributable to recent announcements at Cummal Mooar where they currently have 7 vacant beds + 3 respite beds. Southlands are carrying 4 vacancies but have 4 people on the waiting list. Dementia Care & Support Services have 4 vacancies and 5 people on the waiting list. Therefore in reality where there are vacancies people are transitioning into those beds. Across LD services 81 beds are available, of which: • 67 are occupied (82.7%) • 1 is due to be decommissioned once current service user transfers • 14 are vacant (17.3%), of which 6 are currently unavailable due to challenges by existing service users (not 5 as stated) – meaning; • 7 beds (8.6%) are available Of the 7 available beds, 4 are under active consideration: • 1 provisionally allocated • 1 current assessment is in progress • 2 cases are being actively explored Therefore, actual net available LD residential capacity for new cases arising is 3 beds (3.7% of overall capacity).	Decisions in regard to the future use of Cummal Mooar will help provide additional certainty. Decisions in regard to Summerhill View and the part or full commissioning of that service will support a more stable position. Business cases are pending in regard to LD services which if approved, will support increased capacity.	

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



Reporting Date	Performance	Op. Plan #
Nov-23	**199**	
Threshold	**YTD Mean**	**Benchmark**
-	149	149

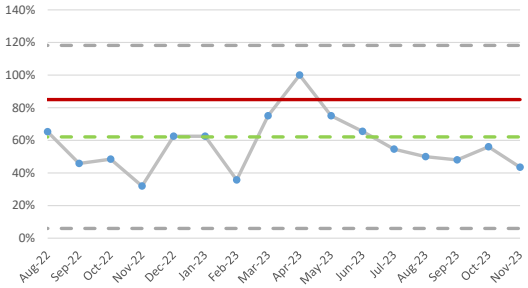
-	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals: Referral levels have remained fairly static over this reporting year.		**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 #
Nov-23	43.5%	QC49

Threshold	YTD Mean	Benchmark
85.0%	61.6%	53.4%

(Higher value represents better performance)

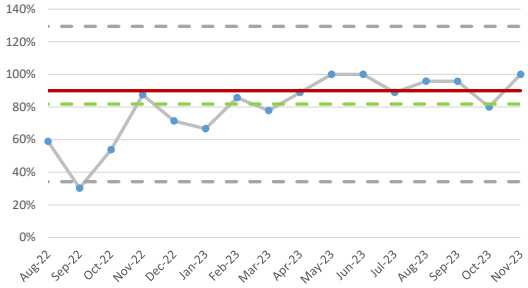
-	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

% Total Child Protection Review Conferences held on time



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

Threshold	YTD Mean	Benchmark
90.0%	90.0%	66.5%

(Higher value represents better performance)

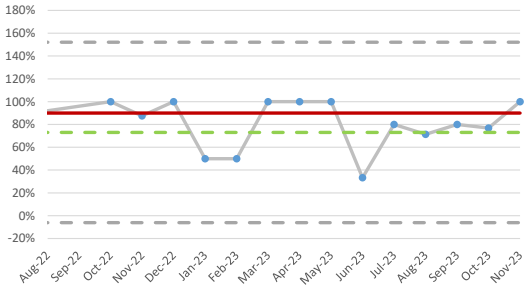
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

% Total Initial Child Protection Conferences held on time



Reporting Date	Performance	Op. Plan #
Nov-23	100.0%	QC51

Threshold	YTD Mean	Benchmark
90.0%	80.2%	81.3%

(Higher value represents better performance)

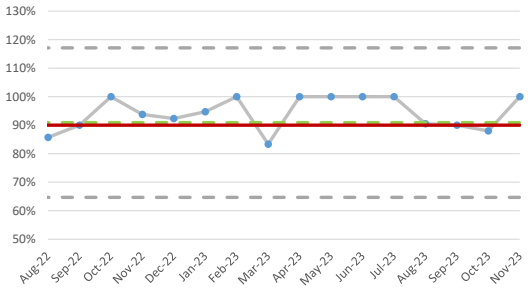
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

% Looked After Children reviews held on time



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

Threshold	YTD Mean	Benchmark
90.0%	96.1%	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:

• 23 Reviews held and 10 were in timescale and 13 were out of timescale

Reasons for delayed meetings:

Family Unavailable – 5
Relevant Professional/Agency Unavailable - 5
Chairperson Unavailable – 2
Non-quorate - 1

Initial Child Protection Conferences held on time:

• 4 meetings were due and 4 were held in time

Child Protection Review Conferences held on time:

• 27 RCPC's were held and 27 were on time

Looked After Children reviews held on time:

• 100% of reviews were held within the timescales in November.

Planned / Mitigation Actions

The Complex Needs Reviews are undertaken by the Children with Disabilities Team, the CWD has 107 children shared between 4 Social Workers. A watching brief is being kept on capacity generally within this team. These numbers mean that there are 98 children reviewed twice per year, creating 196 Reviews which need to be held within timescale and with the coordination of the Team Manager, the Social Worker, schools and the families themselves. This is often challenging as dates have to be manually altered, as CWCN meetings have to take place during term time. The CWD team are holding at least 200 reviews per annum between the 4 Social Workers, not including the network meetings are held between each review.

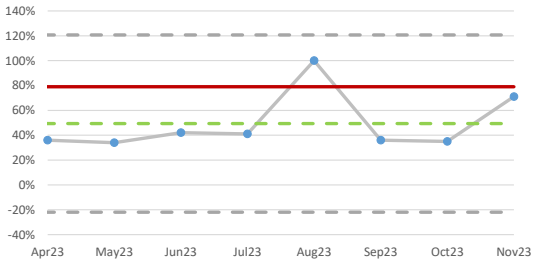
Assurance / Recovery Trajectory

Additional agency staff have recently been engaged in the CWD team as a mitigation to the whole workload of this team, additional administrative resourcing is also now in place.

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 #
Nov-23	71%	

Threshold	YTD Mean	Benchmark
79%	49%	49%

(Higher value represents better performance)

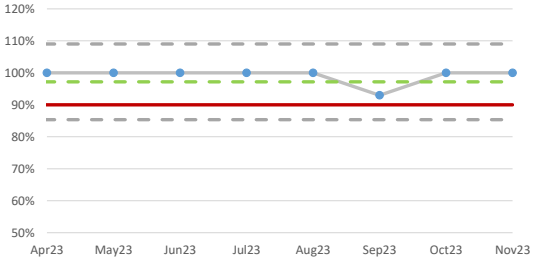
+ Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

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



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

Threshold	YTD Mean	Benchmark
90%	99%	99%

(Higher value represents better performance)

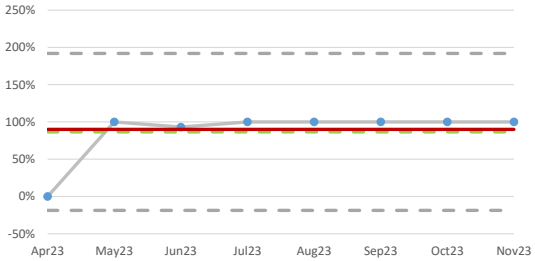
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

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



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

Threshold	YTD Mean	Benchmark
90%	87%	87%

(Higher value represents better performance)

+ Variation Description

Common cause

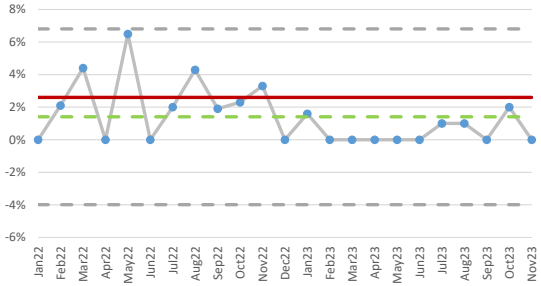
+ Assurance Description

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.	Engagement by children is encouraged, however this does not guarantee engagement as there is choice by the children involved. 13 meetings were held out of timescale, which is contributing to this low number.	Please see page 33 for supporting narrative. 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 #
Nov-23	0%	

Threshold	YTD Mean	Benchmark
< 2.6%	0.50%	1.8%

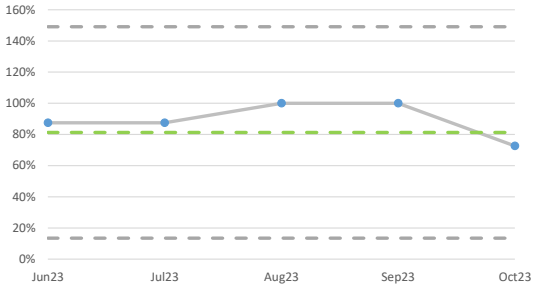
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Unplanned Term Admissions To NNU



Reporting Date	Performance	Op. Plan #
Nov-23	40.0%	

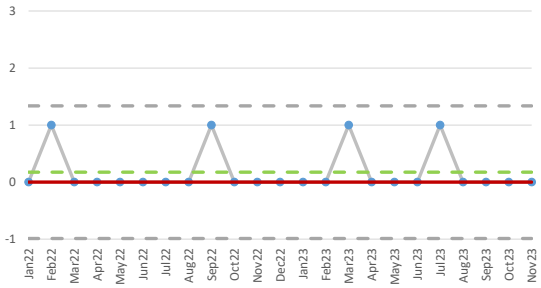
Threshold	YTD Mean	Benchmark
-	-	#DIV/0!

Variation Description

Common cause

Assurance Description

Stillbirth Number / Rate



Reporting Date	Performance	Op. Plan #
Nov-23	0	

Threshold	YTD Mean	Benchmark
<4.4/1000	0	16.7%

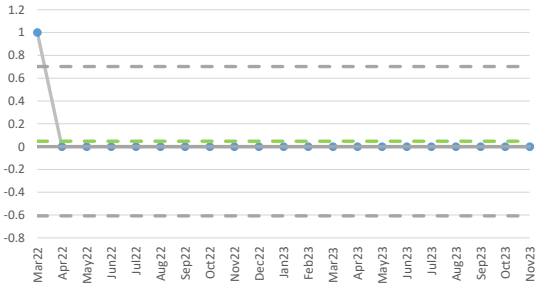
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Neonatal Mortality rate/1000



Reporting Date	Performance	Op. Plan #
Nov-23	0	

Threshold	YTD Mean	Benchmark
-	0	0.0%

+ Variation Description

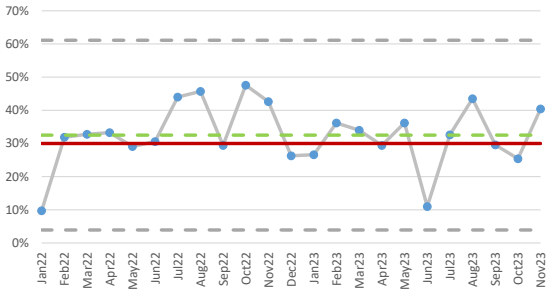
Special Cause of Improving variation (Low)

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Obstetric haemorrhage >1.5 litre: Zero PPH's in November. **Unplanned Term Admissions To NNU** 2 babies were above 37 weeks gestation (term), unplanned admissions.		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 #
Nov-23	40.4%	

Threshold	YTD Mean	Benchmark
< 30%	31.0%	31.3%

(Lower value represents better performance)

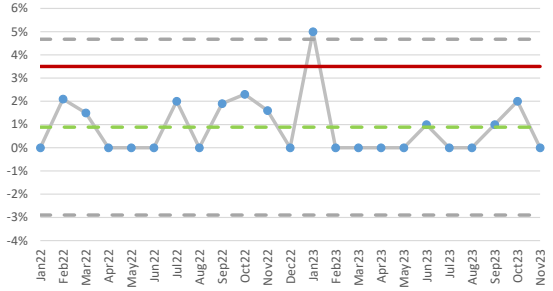
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

3rd/4th Degree Tear Overall Rate



Reporting Date	Performance	Op. Plan #
Nov-23	0.0%	

Threshold	YTD Mean	Benchmark
< 3.5%	0.5%	1.1%

(Lower value represents better performance)

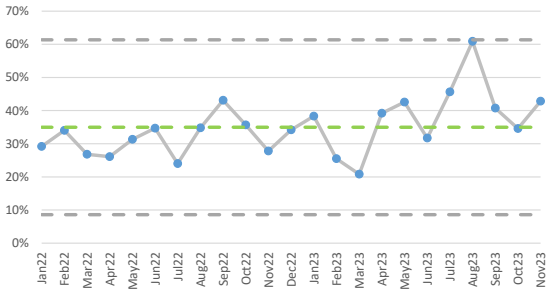
+ Variation Description

Common cause

Assurance Description

Consistently hit target

Caesarean Deliveries (not Robson Classified)



Reporting Date	Performance	Op. Plan #
Nov-23	42.9%	

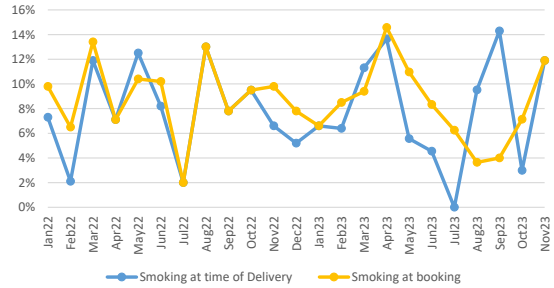
Threshold	YTD Mean	Benchmark
-	42.3%	31.4%

+ Variation Description

Common cause

Assurance Description

% Smoking



Reporting Date	Performance	
Nov-23	Booking	11.9%
	Delivery	11.9%

Op. Plan #

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

Total caesarean deliveries:
for the month of November was 18 (42.86%). Caesarean section rates are no longer considered a KPI in England.

Induction of labour: There was a significant increase to IOL in November from 25.4% in October to 40.4% in November. We need to review November's inductions to assure ourselves that these inductions were clinically appropriate and the outcomes for the women were safe.

Third and fourth degree tear rates: Zero 3rd degree tear occurred in Nov'23.

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. Up from 3.0% last month to 11.9%. The midwives continue to offer Quit4You Support to all women who are identified as smokers and their partners at any point during pregnancy or postnatal.

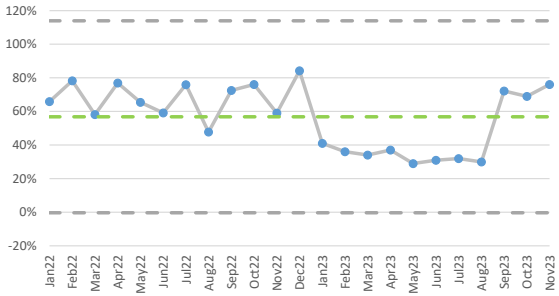
Planned / Mitigation Actions

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 #
Nov-23	76.1%	

Threshold	YTD Mean	Benchmark
-	-	60.7%

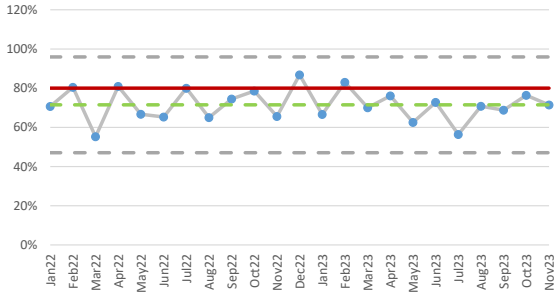
(Higher value represents better performance)

+	Variation Description

Common cause

Assurance Description

First Feed Breast Milk (Initiation Rate)



Reporting Date	Performance	Op. Plan #
Nov-23	71.4%	

Threshold	YTD Mean	Benchmark
> 80%	69.4%	73.6%

(Higher value represents better performance)

-	Variation Description

Common cause

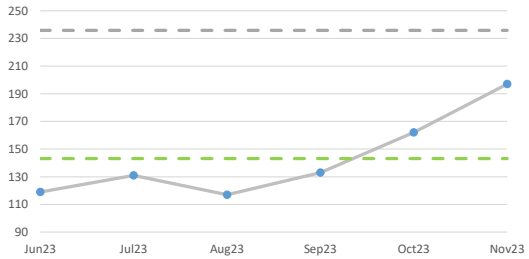
-	Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
First Feed Breast Milk (Initiation Rate): 76.1% of babies received breastmilk as their first feed, this was higher than last November which recorded 57% of babies received breastmilk as their first feed. We will continue to support women to feed their babies in the best way for both the baby and the family. The Midwives remain committed to establishing breast feeding for those women who wish to and the infant feeding team have a daily presence on the Maternity unit.		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 #
Nov-23	197	

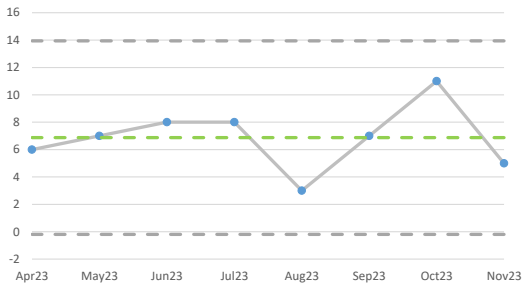
Threshold	YTD Mean	Benchmark
-	143	-

- Variation Description

Common cause

Assurance Description

NNU - Total number of Admissions



Reporting Date	Performance	Op. Plan #
Nov-23	5	

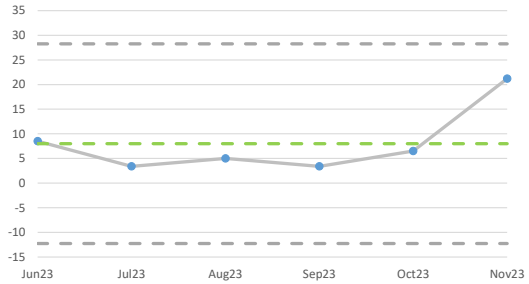
Threshold	YTD Mean	Benchmark
-	7	-

+ Variation Description

Common cause

Assurance Description

NNU - Avg. Length of Stay



Reporting Date	Performance	Op. Plan #
Nov-23	21	-

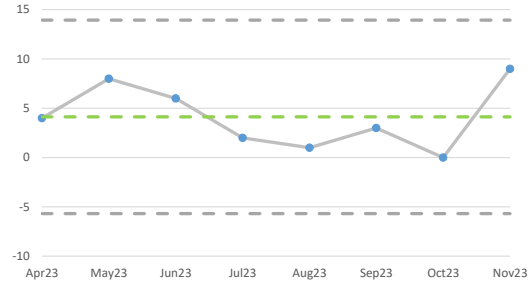
Threshold	YTD Mean	Benchmark
-	8.0	-

- Variation Description

Common cause

Assurance Description

NNU - Community follow up



Reporting Date	Performance	Op. Plan #
Nov-23	9	

Threshold	YTD Mean	Benchmark
-	4	-

Variation Description

Common cause

Assurance Description

Issues / Performance Summary

- 2 babies were above 37 weeks gestation (term), unplanned admissions.
- 1 baby was admitted following preterm delivery at 35+6/40 requiring small for gestational age.
- 1 x set of twins @ 35+3/40 born in poor condition and required respiratory support (high dependency)
- All babies were admitted from the labour ward/theatre were between 19 mins and 34 mins of age.
- 1 x baby were admitted with respiratory symptoms & preterm requiring NCPAP/surfactant/monitoring, antibiotic therapy/iv fluids/ supplemental oxygen.
- 1 x baby treated with iv antibiotics for 14 days for a meningitis diagnosis.
- Staffing -1WTE sickness. Nursery nurse long term sickness, no support staff. Staff working extra hours to fill gaps.
- Band 6 neonatal nurse to commence next month.
- 2 x ANNP's commenced employment.

Planned / Mitigation Actions

- The Neonatal Unit is ready to admit any sick/preterm neonate, when capacity allows.
- Regular communication between maternity and Neonatal Unit when capacity is a concern, with daily or more frequent huddles to plan/mitigate.
- Lead nurse/ANNP attending obstetric hand over most days.
- Improving communication between maternity unit and neonatal unit with ANNP performing NIPE's and liaising with NNU staff any cause for concern.
- Early communication with obstetric team regarding high risk ladies and early transfer to a tertiary unit, where possible.
- Northwest neonatal Network aware of capacity issues, offering support & advice.
- Embrace available to support transfer process when necessary.
- Neonatal nurse transfer team now increased to two trained staff. An on call rota is managed to enable that a nurse is available as often as possible during the hours of 07.45- 20.15hrs. All transfers outside these hours are managed on a case by case basis.
- The Neonatal Unit nursing team take part in the on call rota to provide support at high acuity times, although this isn't consistently filled due to reduced staffing levels (staff already doing extras as well as on calls).

Assurance / Recovery Trajectory

All neonates will be cared for with the appropriate level of care as soon as practicable, and transferred to a Level 3 center as soon as possible if required for ongoing care.

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

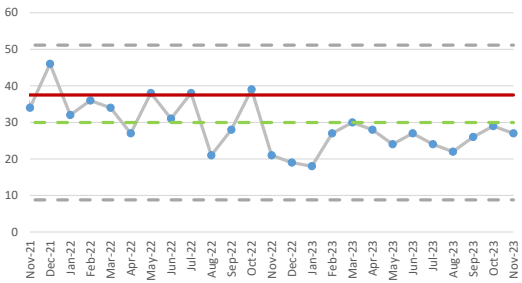
Caring Performance Summary

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	Nov-23		0	0	0	0		
CA002		Complaints - Total number of complaints received	Nov-23		27	26	207	<= 450 PA		
CA007		Complaint acknowledged within 5 working days	Nov-23		100%	98%	-	98%		
CA008		Written response to complaint within 20 days	Nov-23		100%	98%	-	98%		
CA010		No. complaints exceeding 6 months	Nov-23		0	0	0	0		
CA011		No. complaints referred to HSCOB	Nov-23	-	2	2	18	-		

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	Nov-23	-	1,650	1,297	10,376	-		
CA013		FFT - Experience was Very Good or Good	Nov-23		91%	89%	-	80%		
CA014		FFT - Experience was neither Good or Poor	Nov-23		4%	4%	-	10%		
CA015		FFT - Experience was Poor or Very Poor	Nov-23		5%	7%	-	<10%		
CA016		Manx Care Advice and Liaison Service contacts	Nov-23	-	958	666	5,329	-		
CA017		Manx Care Advice and Liaison Service same day response	Nov-23		90.0%	89.6%	-	80%		

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

Complaints - Number of complaints: Manx care



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

Threshold	YTD Mean	Benchmark
<= 450 PA	26	28

(Lower value represents better performance)

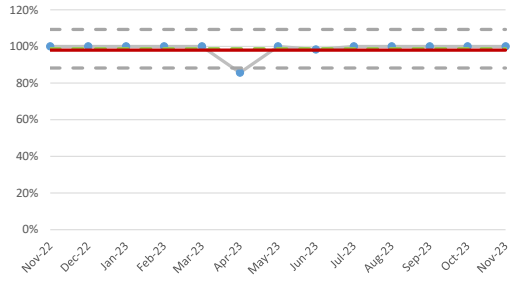
+ Variation Description

Special Cause of Improving variation (Low)

+ Assurance Description

Consistently hit target

Complaint - Written response within 20 days: Manx Care



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

Threshold	YTD Mean	Benchmark
98.0%	98.0%	-

(Higher value represents better performance)

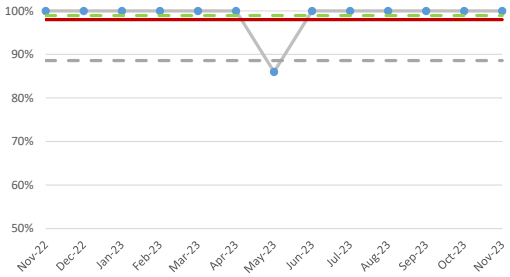
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Complaint acknowledged within 5 working days: Manx Care



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

Threshold	YTD Mean	Benchmark
98%	98.3%	-

(Higher value represents better performance)

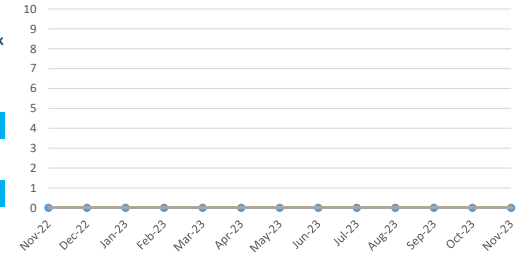
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Complaint - No. complaints exceeding 6 months: Manx Care



Reporting Date	Performance	Op. plan #
Nov-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:
- 27 received in November which is similar to previous months

Acknowledged within 5 Days:
- 100% compliance.

Written Response within 20 days:
- 100% compliance demonstrated in November and for 5 consecutive months.

No. Complaints Exceeding 6 Months:
- Zero recorded.

No. complaints referred to HSCOB:
- 2 complaints were referred to HSCOB for independent review.

Planned / Mitigation Actions

Number of Complaints:
- MCALS continues to help keep the numbers to a manageable level.

Acknowledged within 5 Days:
- Continue to monitor closely.

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

No. Complaints Exceeding 6 Months:
- Continue to monitor closely.

No. complaints referred to HSCOB:
- In accordance with Complaint Regulations we have published on our webiste a written statement (action plan) in respect of HSCOB report 2023/103 and our actions have been shared with the complainant, the DHSC and QSE Committee for assurance purposes.

Assurance / Recovery Trajectory

Number of Complaints:
- No target, but trends will be monitored.

Acknowledged within 5 Days:
- High degree of confidence in target being met as there has been no negative deviation since introduction of the Regulations in October 2022.

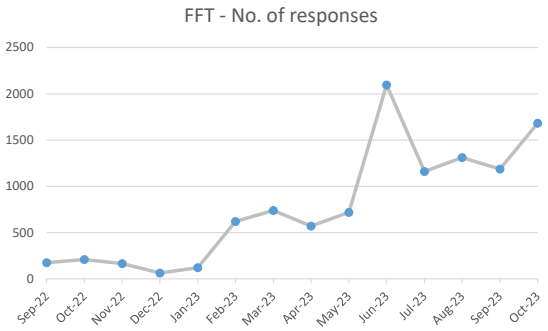
Written Response within 20 days:
- Reasonable degree of confidence in target being met.

No. Complaints Exceeding 6 Months:
- Reasonable degree of confidence in target being met.

No. complaints referred to HSCOB:
Monitor for trends in areas to identify need for improved complaint response.

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

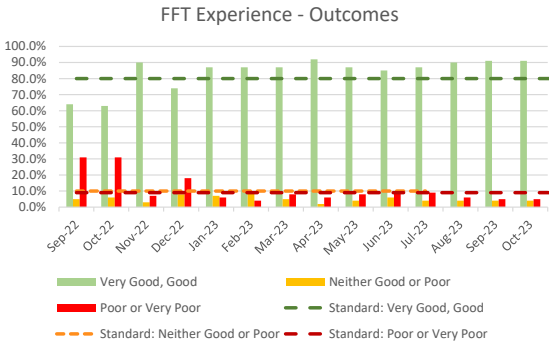
Caring	Friends & Family Test	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis



Reporting Date	Performance	Op. plan #
Nov-23	1,650	QC127
Threshold	**YTD Mean**	**Benchmark**
-	1,297	-

+ Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Nov-23	91.0%	QC128-129-130
Threshold	**YTD Mean**	**Benchmark**
80.0%	89.3%	-

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary

FFT Total number of responses:

• A total of 1,650 surveys completed for November 2023. 10,412 surveys completed YTD.

• **FFT – Experience was very good or good:** 1,494 completed surveys rated experience as Very Good or Good equating to 91% against a target of 80%. Target exceeded for every month YTD.

• **FFT – Experience was neither good or poor:** 60 completed surveys rated experience as Neither Good nor Poor equating to 4% against a target of 10% or less. Again, performance fort the year remains strong.

• **FFT – Experience was poor or very poor:** 96 completed surveys rated experience as Poor or Very Poor, equating to 5% against a target of 10% or less. Again, performance for the year remains strong.

Planned / Mitigation Actions

FFT Total number of responses:

• Continue to promote / encourage feedback – outpatient departments and GP Practices continue to deliver consistent feedback via the survey – uptake from inpatient settings is still relatively low by comparison and work continues to promote engagement with teams and senior nursing leads to encourage feedback via the survey (Walk the Wards programme continued on the 24 November 2023. Active recruitment of public reps to support inpatients to take surveys at the bedside with first reps due to commence end of December 2023.

• **FFT – Experience was very good or good:** Experience and Engagement Team, MCALS and service leads to continue to encourage and promote engagement with the survey.

• **FFT – Experience was neither good or poor:** Experience and Engagement Team, MCALS and service leads to continue to encourage and promote engagement with the survey. Monthly dashboards are reported to the Care Group Triumvirates with both Positive and Negative trends reported for the last month.

• **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:

• Experience and Engagement Team continue to conduct monthly walk rounds of the wards to collect surveys and speak to staff to encourage completion of surveys at discharge. Pre-paid envelopes are available to provide to service users who are inpatients and post boxes are accessible on all wards and outpatient departments including Primary Care based practices. Easy read version of survey launched in November and text message reminder service due for launch in the early part of 2024. There is a reasonable degree of confidence in increasing survey returns.

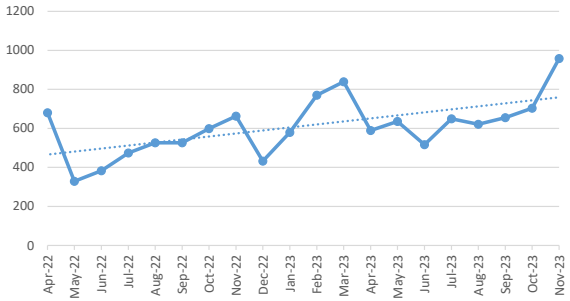
• **FFT – Experience was very good or good:** Reasonable degree of confidence that reporting targets will continue to be met.

• **FFT – Experience was neither good or poor:** Reasonable degree of confidence that reporting targets will continue to be met.

• **FFT – Experience was poor or very poor:** Monthly dashboards and quarterly review meetings with all care group triumvirates are held to report feedback. 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.

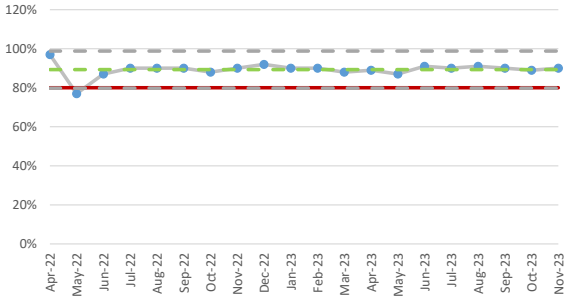
Caring	MCALS	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis	



Reporting Date	Performance	Op. plan #
Nov-23	958	QC131
Threshold	**YTD Mean**	**Benchmark**
-	666	567

+ Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Nov-23	90.0%	QC132
Threshold	**YTD Mean**	**Benchmark**
80.0%	89.6%	-

(Higher value represents better performance)

- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary

Number of Contacts:

• 958 contacts received in November 2023, demonstrating an increase of 256 contacts (27%) compared to October 2023. In person contacts have increased to 452 contacts in November due to proactively seeking feedback in the community during drop in sessions across the island. Extra winter warm space hubs have been added as drop in sessions in November to reach seldom heard voices.

Same Day Response:

• In November, MCALS had resolved all contacts within 24 hours 90% of the time against a Key Line of Enquiry Target of 80%.

Planned / Mitigation Actions

Number of Contacts:

• MCALS will continue to provide excellent support in ensuring that where possible service user issues are addressed.

Same Day Response:

• MCALS will continue to provide excellent support in ensuring that where possible service user issues are addressed as promptly as possible.

Assurance / Recovery Trajectory

Number of Contacts:

• Continued good performance in dealing with service user contacts and confident this will continue.

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	Nov-23	-	2857	2967	23371	-		
RE056		Hospital Bed Occupancy	Nov-23	-	60.1%			92%		
RE001		RTT - No. patients waiting for first Consultant Led Outpatient appointment	Dec-23		16,861	16,152	-	< 15431		
RE002		RTT - No. patients waiting for Daycase procedure	Dec-23		2,126	2,276	-	< 2286		
RE003		RTT - No. patients waiting for Inpatient procedure	Dec-23		432	513	-	< 535		
RE004		RTT - % Urgent GP referrals seen for first appointment within 6 weeks	Nov-23		49%	55%	-	85%		
RE061		Diagnostics-% patients waiting 26 weeks or less	Nov-23		67%	61%		99%		
RE005		Diagnostics - % requests completed within 6 weeks	Nov-23	-	85%	85%	85%	-		
RE006		Diagnostics - % Patients waiting over 6 weeks	Nov-23		61%	70%	-	1%		
RE007		ED - % 4 Hour Performance	Nov-23		69%	72%	72%	76% (95%)		
RE008		ED - % 4 Hour Performance (Non Admitted)	Nov-23	-	79%	81%	81%	-		
RE009		ED - % 4 Hour Performance (Admitted)	Nov-23	-	23%	23%	23%	-		
RE010		ED - Average Total Time in Emergency Department	Nov-23		275	257	-	360 mins		
RE011		ED - Average number of minutes between Arrival and Triage (Noble's)	Nov-23		35	26	-	15 mins		
RE012		ED - Average number of minutes between arrival to clinical assessment - Nobles	Nov-23		80	68	-	60 mins		
RE033		ED - Average number of minutes between arrival to clinical assessment - RDCH	Nov-23		16	14		60 mins		
RE013		ED - 12 Hour Trolley Waits	Nov-23		30	32	252	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	Nov-23		18	19	-	15 mins		
RE015		Ambulance - Category 1 Mean Response Time	Nov-23		8	10	-	7 mins		
RE016		Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	Nov-23		40%	49%	-	100%		
RE034		Category 2 Response Time at 90th Percentile	Nov-23		26	29		40 mins		
RE035		Ambulance - Category 3 Response Time at 90th Percentile	Nov-23		61	47		120 mins		
RE036		Ambulance - Category 4 Response Time at 90th Percentile	Nov-23		78	79		180 mins		
RE037		Ambulance - Category 5 Response Time at 90th Percentile	Nov-23		71	79		180 mins		
RE038		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	Nov-23		198	185	-	0		
RE039		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	Nov-23		22	20	-	0		
RE026		IPCC - % patients seen by Community Adult Therapy Services within timescales	Nov-23		68%	52%	-	80%		
RE031		IPCC - % of patients registered with a GP	Nov-23		4.0%	4.1%	-	5.0%		
RE081		IPCC - N. of GP appointments	Nov-23	-	20263	37927.5	303420	-		
RE054		Did Not Attend Rate (GP Appointment)	Nov-23	-	2.8%	3%		-		
RE027		IPCC - No. patients waiting for a dentist	Nov-23	-	4,528	4,037	-	-		
RE074		Response by Community Nursing to Urgent / Non routine within 24 hours	Nov-23	-	95%	99%	-	-		
RE075		Community Nursing Service response target met (7 days)- Routine	Nov-23	-	100%	100%	-	-		

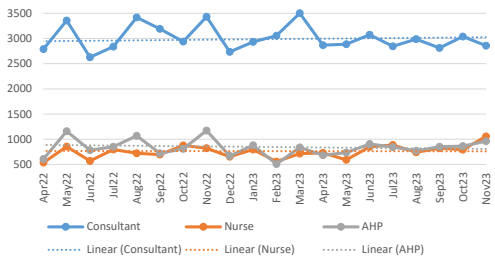
Responsive Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE025		CWT - % 28 Days to diagnosis or ruling out of cancer	Nov-23		65%	65%	-	75%		
RE018		CWT - % patients decision to treat to first definitive treatment within 31 days	Nov-23		86%	78%	-	96%		
RE019		CWT - % patients urgent referral for suspected cancer to first treatment within 62 days (RTT)	Nov-23		50%	47%	-	85%		
RE064		No. on Cancer Pathway (All)	Nov-23	-	611	692	-	-		
RE065		No. on Cancer Pathway (2WW)	Nov-23	-	507	588	-	-		
RE066		Cancer - Total number of patients Waiting for 1st OP	Nov-23	-	68	95	-	-		
RE067		Cancer - Median Wait Time from the Referral Date to the Diagosis Date	Nov-23	-	21	15	-	-		
RE044		MH- Waiting list	Nov-23	-	1750	1652	9912	-		
RE045		MH- Appointments	Nov-23	-	7169	6493	51942	-		
RE046		MH- Admissions	Nov-23	-	15	18	140	-		
RE028		MH - No. service users on Current Caseload	Nov-23		5,359	5,215	-	4500 - 5500		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE051		Maternity Bookings	Nov-23	-	60	991	439			
RE052		Ward Attenders	Nov-23	-	230	-	-			
RE053		Gestation At Booking <10 Weeks	Nov-23	-	45%	33%	-			
RE030		W&C - % New Birth Visits within timescale	Nov-23	-	96%	89%	-	-		
RE032		Births per annum	Nov-23	-	391	220	-	-		
RE082		Meds Demand - N.patient interactions	Nov-23	-	2574	2541.75	20334	-		
RE083		Meds Overnight Demand	Nov-23	-	552	293	2344	-		
RE084		Meds - Face to face appointments	Nov-23	-	571	484.5	3876	-		
RE086		Meds - TUNA%	Nov-23	-	1.1%	1.3%	-	-		
RE088		Meds- DNA%	Nov-23	-	1.4%	1.7%	-	-		
RE089		Total Number of OP & Dementia Beds Available	Nov-23	-	0	195	-			
RE090		Total Number of OP & Dementia Beds Occupied	Nov-23	-	0	114	-			
RE092		Total Number of LD Beds Available	Nov-23	-	0	83	-			
RE093		Total Number of LD Beds Occupied	Nov-23	-	0	70	-			

Responsive	Demand	Executive Lead		Lead	

Referrals for First Outpatient Appointment



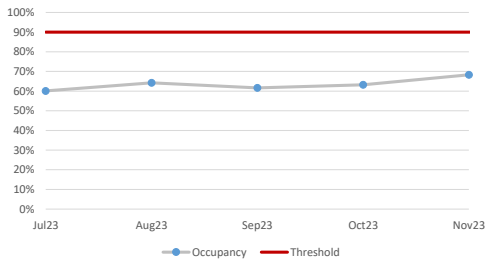
Reporting Date	Performance		Op. Plan #
Nov-23	Consultant	2857	

Threshold	YTD Mean	Benchmark
-	2921	3068

Variation Description

Assurance Description

Hospital Bed Occupancy



Reporting Date	Performance	Op. Plan #
Nov-23	60.1%	QC79

Threshold	YTD Mean	Benchmark
92.0%	-	-

(Lower value represents better performance)

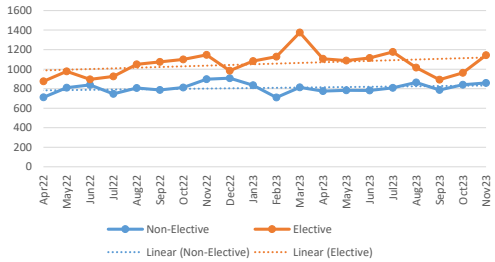
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Elective and Non Elective Admissions



Reporting Date	Performance		Op. Plan #
Nov-23	Elective	1144	
	Non Elective	859	

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 November (2857) was about 16.8% lower than the number received in November'22.

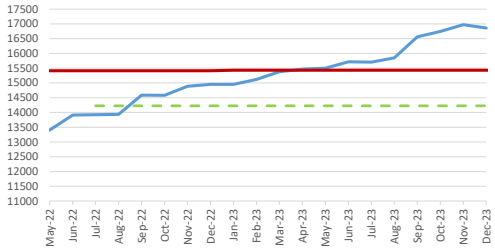
Elective and Non Elective Admissions:
Elective Admissions have slightly increased by approximately 18.9% in November (1144) against October (962)

Non Elective admission numbers have also slightly increased to 859 in November compared to 840 last month.

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; A.Cubbon

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



Reporting Date	Performance	Op. Plan #
Dec-23	16,861	QC11

Threshold	YTD Mean	Benchmark
< 15,431	16,152	15,465

(Lower value represents better performance)

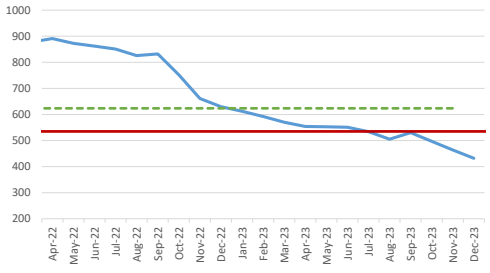
Avg Wait Time (Referral to 1st Cons Led OP Appt.)

47 weeks

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

5,487

RTT - No. patients waiting for Inpatient procedures



Reporting Date	Performance	Op. Plan #
Dec-23	432	QC11

Threshold	YTD Mean	Benchmark
< 535	513	554

(Lower value represents better performance)

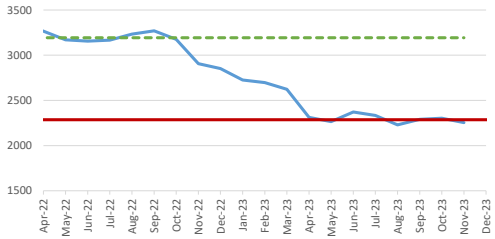
Avg Wait Time (Decision to Treat to Treatment - IP)

33 weeks

No. patients waiting 52+ weeks from Decision to Treat

78

RTT - No. patients waiting for Daycase procedures



Reporting Date	Performance	Op. Plan #
Dec-23	2,126	QC11

Threshold	YTD Mean	Benchmark
< 2,286	2,276	2,311

(Lower value represents better performance)

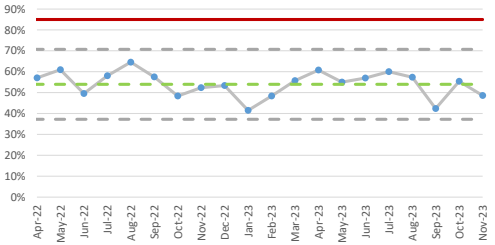
Avg Wait Time (Decision to Treat to Treatment - DC)

45 weeks

No. patients waiting 52+ weeks from Decision to Treat

580

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



Reporting Date	Performance	Op. Plan #
Nov-23	48.6%	QC13

Threshold	YTD Mean	Benchmark
85.0%	54.6%	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:
  - 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

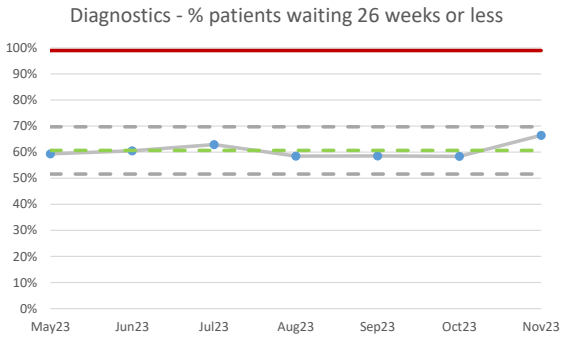
- R&R delivery (Nov'21 to Nov '23); 2,150 Ophthalmology procs in total; 53 Orthopaedic procs in Nov (913 in total); 52 GSU procs in Oct (417 in total); Other surgical specialties – 54 in total; 510 ENT OP attendances in total; Radiology – 106 scans in Nov; 23 Cardiac CT, 83 Ultrasound (1,104 in total); Mental Health – 313 referrals in total.
  - o Overall R&R delivered about a 77% reduction in the Ophth DC waiting list.
  - o Overall there's been about a 43% reduction in orthopaedic DC/IP waiting lists.
  - o Overall there's been about a 42% reduction in the General Surgery DC/IP waiting lists.
- Dedicated waiting list validation team established and programme of waiting list validation commenced in October '22. To date over 20,500 referrals have been through technical validation and over 10,300 letters have been sent to patients checking if they still require to be on the waiting list. Based on the outcomes of the technical and administrative validation to date, there will have been a 16% reduction in the outpatient waiting list. No patient is removed from the waiting list without clinical oversight.
- A dedicated programme of clinical validation has commenced, starting with Ophthalmology, with nearly 3,500 referrals reviewed to date, and almost 750 (21%) have been identified as can be either discharged or removed from the lists following this detailed clinical review.
- The additional diagnostic capacity commissioned for Cardiac CT scans is on course to achieve the target waiting list by the end of December 2023.
- 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 waiting list volumes across all specialties for consultant, nurse and Allied Health Practitioner (AHP) led elective services.

Assurance / Recovery Trajectory

- General Surgery R&R activity commenced in November '22.
- 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 #
Nov-23	66.5%	QC37b

Threshold	YTD Mean	Benchmark
99.0%	60.7%	-

(higher value represents better performance)

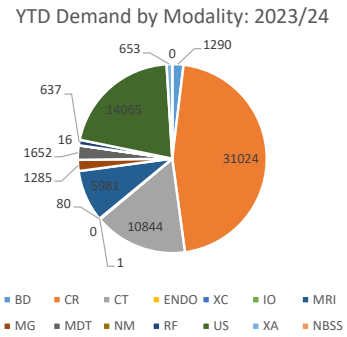
+ Variation Description

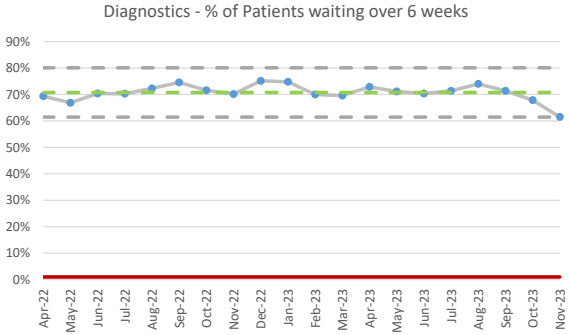
Common cause

- Assurance Description

Consistently fail target

Modality	Nov-23		
	WL	>6 wks	% >6 wks
Bone Densitometry	245	117	48%
Computed Tomography	568	189	33%
Magnetic Resonance Imaging	357	83	23%
Ultrasound Non Obs	2,452	1,838	75%
Total	**3,622**	**2,227**	**61%**





Reporting Date	Performance	Op. Plan #
Nov-23	61.5%	QC37

Threshold	YTD Mean	Benchmark
1%	70.1%	26.3%

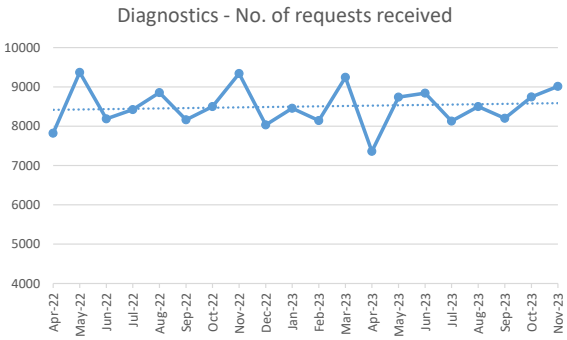
(lower value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Consistently fail target



Reporting Date	Performance	Op. Plan #
Nov-23	67,528	

Threshold	YTD Mean	Benchmark
-	8,441	8,546

Variation Description

Assurance Description

7053

Issues / Performance Summary

- Overall demand continues to exceed capacity, with demand for services continuing to increase. Demand was 27.8% higher than capacity in November.
- Emergency Department (ED) 23.3%, Outpatient Department (OPD) 36% and General Practitioner (GP) 23.2% are the primary source of referrals. and there has been no significant change on the distribution compared to last month.
- Inpatient referrals(949) remain high and slightly more than November. This equates to 13.5% of all requests.
- 62.7% of exams were reported within 2 hours, 6% have taken 97 hours or longer which is a decrease on last month.
- Of the 7053 exams, 45.4% were turned around on the same day (1% decrease compared to last month) and, a further 37.3% in 1- 28 days (slightly higher than 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 and Ultrasound waiting times. The additional diagnostic capacity commissioned for Cardiac CT scans is on course to achieve the target waiting list by the end of December 2023.
- Waiting list validation process implemented, validating all aspects of the diagnostic waiting list - technical, administrative and clinical validation.

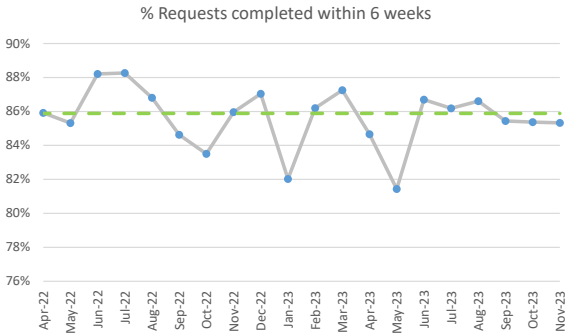
Assurance / Recovery Trajectory

- 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.

Note -
Benchmark for '% Patients Waiting over 6 Weeks' is the UK NHSE performance figures for September 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 #
Nov-23	85.3%	
Threshold	**YTD Mean**	**Benchmark**
-	85.2%	85.9%

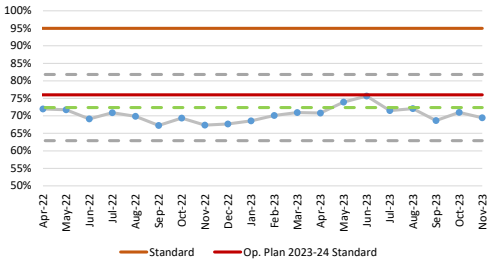
-	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% Requests completed within 6 weeks: Approximately 85.3% of requests completed in November were undertaken within 6 weeks. This was slightly higher than the average of 85.2% for the year so far.		

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

A&E - % 4 Hour performance



Reporting Date	Performance	Op. Plan #
Nov-23	69.5%	QC23
	Admitted 22.6%	
	Non-Admitted 79.3%	

Threshold	YTD Mean	Benchmark
76% (95%)	71.6%	69.7%

(Higher value represents better performance)

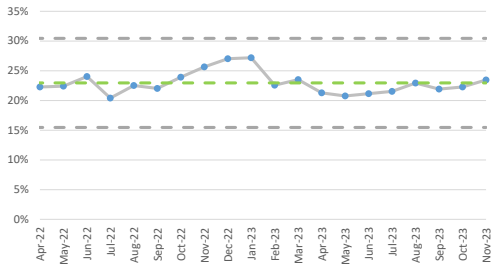
- Variation Description

Common cause

- Assurance Description

Consistently fail target

A&E - Admission Rate : Noble's Hospital



Reporting Date	Performance	Op. Plan #
Nov-23	23.5%	QC24

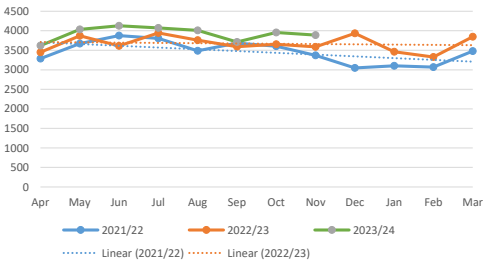
Threshold	YTD Mean	Benchmark
-	21.9%	28.6%

Variation Description

Common cause

Assurance Description

ED - Total Attendances : Manx Care



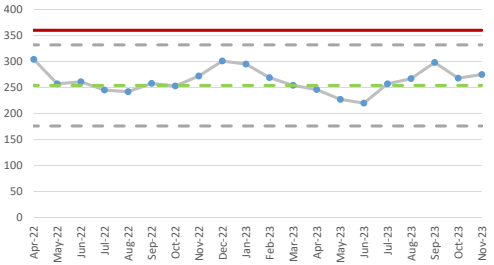
Reporting Date	Performance	Op. Plan #
Nov-23	3,890	

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 #
Nov-23	275	QC150

Threshold	YTD Mean	Benchmark
360 mins	257	268

(Lower value represents better performance)

- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary

• November's performance of 69.5% remained below the 95% threshold but slightly lower the UK's performance of 69.7%.
  • Admitted Performance: 22.6%;
  • Non Admitted Performance: 79.3%;
• 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 November, the average admission rate from Noble's ED of 23.5% was lower than that of the UK (28.6%).

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.

Planned / Mitigation Actions

• 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

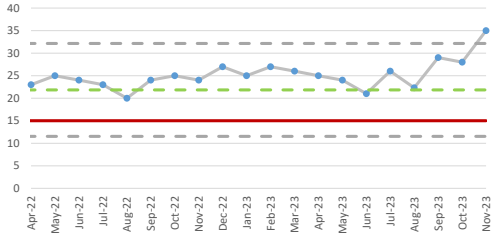
Assurance / Recovery Trajectory

• 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.
• Work is ongoing regarding the Healthcare Transformation Funding and the development of diversionary pathways away from ED and investment in community services.
• Development work continues regarding the establishment of the Ambulatory Assessment and Treatment Unit (AATU) service.
• Result of increase to Nursing Staffing availability and reducing sickness levels.
• Secured funding to make improvements to the infrastructure.

Note -
Benchmarks for '4 Hour' and 'Admission Rate' are UK NHSE performance figures for November' 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 #
Nov-23	35	QC26

Threshold	YTD Mean	Benchmark
15 mins	26	24

(Lower value represents better performance)

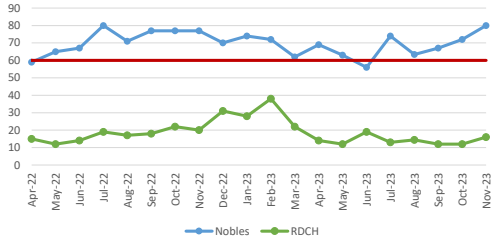
-	Variation Description

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 #
Nov-23	Nobles	80	
	RDCH	16	

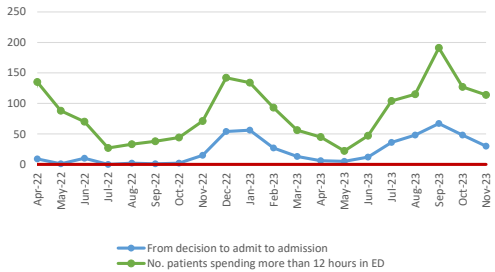
Threshold	YTD Mean	Benchmark
60 mins		-

(Lower value represents better performance)

Variation Description

Assurance Description

A&E - 12 Hours waits



Reporting Date	Performance		Op. Plan #
	%Trolley 12h Wait	0.8%	QC78
	% ED 12h Wait	2.9%	

Threshold	YTD Mean	Benchmark
0		-

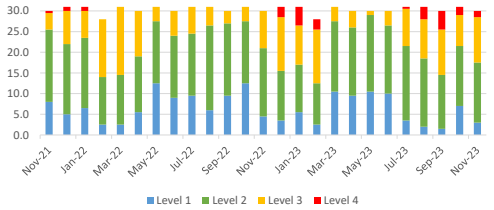
(Lower value represents better performance)

-	Variation Description

-	Assurance Description

Consistently fail target

Operational Pressures Escalation Level (OPEL) (Days)



Reporting Date	Performance	Op. Plan #

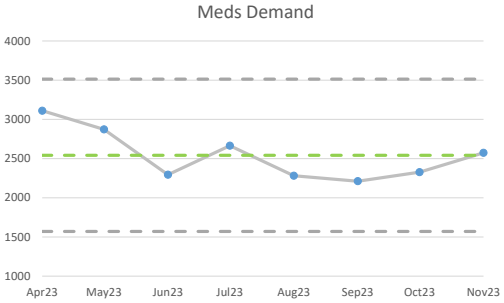
Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The service was on the highest Operational Pressures Escalation Level (OPEL), Level 4, for 1.5 days in November. • The number of 12 Hour Trolley Waits was 30 (0.8% of attendances; UK 2%) • 114 patients had a stay of more than 12 hours in ED in November. That equated to 2.9% of attendances.		Note - Benchmark for 'Average number of minutes between Arrival and Triage' is the Manx Care monthly average for 2022/23.

Responsive	MEDs Demand	Executive Lead	Oliver Radford	Lead	Mark Cox



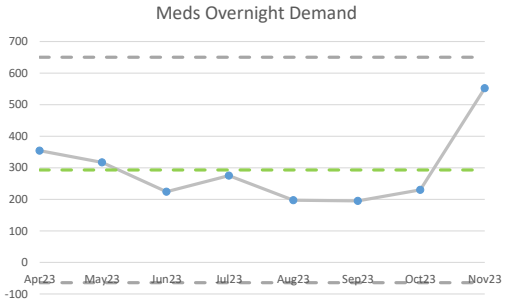
Reporting Date	Performance	Op. Plan #
Nov-23	**2574**	-

Threshold	YTD Mean	Benchmark
-	2542	-

Variation Description

Common cause

Assurance Description



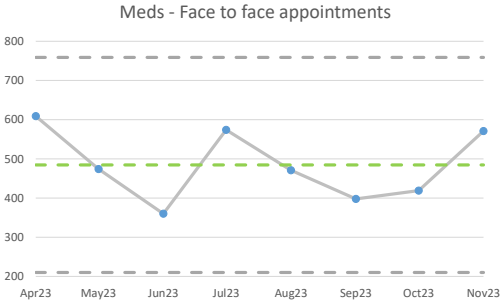
Reporting Date	Performance	Op. Plan #
Nov-23	**552**	-

Threshold	YTD Mean	Benchmark
-	293	-

Variation Description

Common cause

Assurance Description



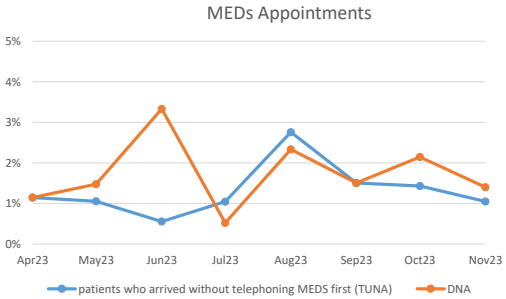
Reporting Date	Performance	Op. Plan #
Nov-23	**571**	-

Threshold	YTD Mean	Benchmark
-	485	-

Variation Description

Common cause

Assurance Description



Reporting Date	Performance		Op. Plan #
Nov-23	**TUNA**	**1.1%**	-
	DNA	**1.4%**	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

•In November 2023 MEDS provided 2574 patient interactions.

• In November 2023 MEDS offered a total of 571 Face to face appointments either at base or in the community. This was 29.48% of the total telephone contacts for this period.

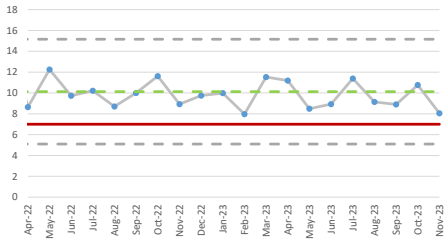
• Of the 571 face to face appointments 6 were patients who arrived without telephoning MEDS first. And 8 of the patients failed to attend given appointment.

Planned / Mitigation Actions

Assurance / Recovery Trajectory

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

Ambulance - Category 1 Average (Mean) Response Time



Reporting Date	Performance	Op. Plan #
Nov-23	00:08:03	QC20

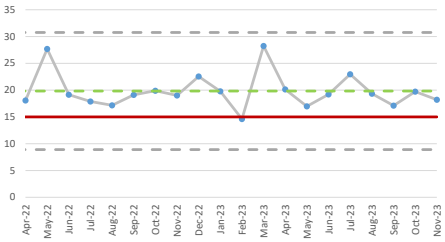
Threshold	YTD Mean	Benchmark
7 mins	00:09:36	00:08:32

(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 #
Nov-23	00:18:13	QC21

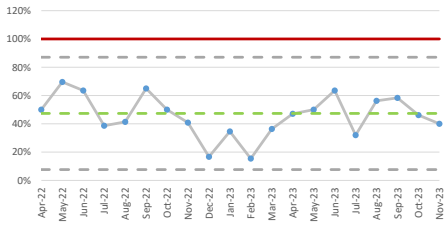
Threshold	YTD Mean	Benchmark
15 mins	00:19:12	00:15:08

(Lower value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

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



Reporting Date	Performance	Op. Plan #
Nov-23	40.0%	

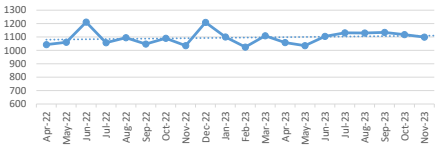
Threshold	YTD Mean	Benchmark
100.0%	49.2%	43.5%

(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 #
Nov-23	1,099	

Threshold	YTD Mean	Benchmark
-	1,101	1,090

Variation Description

Assurance Description

Nov-23	East	North	South	West	Total
Category 1 Calls	18	3	5	2	28
No. reached within 15 mins	17	3	4	1	25
% response within 15 mins	94.4%	100.0%	80.0%	50.0%	89.3%

Issues / Performance Summary

• Demand for Ambulance services has slightly increased in November '23 = 1099, comparing to November '22 = 1036;
The number of calls is approximately 6% higher than November'22.
• November has seen an improvement and restoration in Category 1 performance set against an increase in 999 demand month to month. Staffing levels have been strong throughout November with the service being able to cover additional ambulance shifts ad-hoc within our substantive staffing provision. Reduction in the number of and length of Emergency Department delays has assisted along with a reduction in discharge activity requiring ambulance transport. Category 1 performance remains based on a small data set which will always be prone to performance swings.
• Hear and Treat conducted 179 patient triages. This resulted in in 44 cases being downgraded (improving demand management) and 27 patients being directed to service that didn't require an ambulance response. It is our assessment that we are now starting to see Clinical Navigation positively impacting Category 1 response performance. In addition, 92 Hear and Treat triages where upgraded from their original 999 call handling categorisation with a conveyance rate of 74% which represents significant patient safety improvements. As more alternatives pathways of care become available to Clinical Navigators, we expect to see further reductions in frontline ambulance use with further associated performance improvements for those most unwell
• 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

• 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. This is likely to require additional system/data capture mechanisms to accurately record the exact time of handover betwen the ambulance crew and the ED staff.
• 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 Q4 of 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).

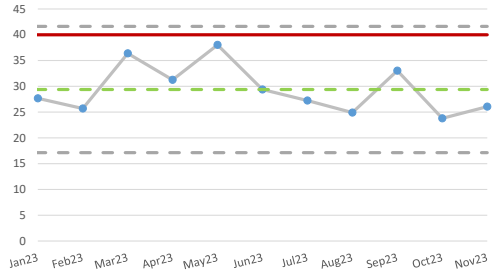
Assurance / Recovery Trajectory

• 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 November' 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 #
Nov-23	00:26:03	QC136

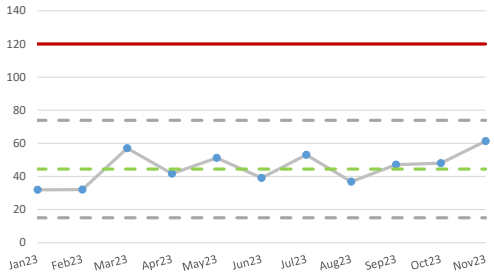
Threshold	YTD Mean	Benchmark
40 mins	00:29:13	01:22:07

(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 #
Nov-23	01:01:19	QC138

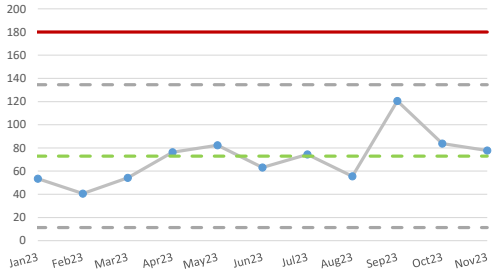
Threshold	YTD Mean	Benchmark
120 mins	00:47:17	05:25:46

(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 #
Nov-23	01:17:48	QC140

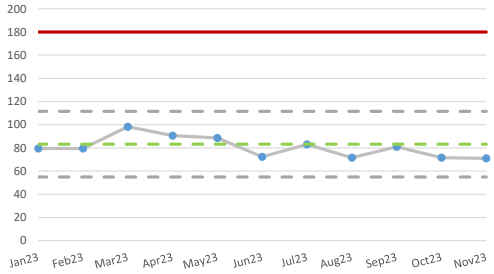
Threshold	YTD Mean	Benchmark
180 mins	01:19:15	06:04:54

(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 #
Nov-23	01:11:00	QC142

Threshold	YTD Mean	Benchmark
180 mins	01:18:43	-

(Lower value represents better performance)

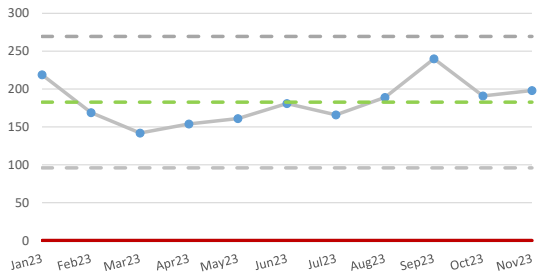
+ Variation Description
Common cause

+ 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 = 00:26:03 - Category 3; Standard < 120 mins; 90th percentile = 01:01:19 - Category 4; Standard < 180 mins; 90th percentile = 01:17:48 - Category 5; Standard < 180 mins; 90th percentile = 01:11:00		Note - Benchmarks for Category 2,3,4 'Response time at 90th Percentile' are UK NHSE performance figures for November' 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 #
Nov-23	198	QC85

Threshold	YTD Mean	Benchmark
0	185	177

(Lower value represents better performance)

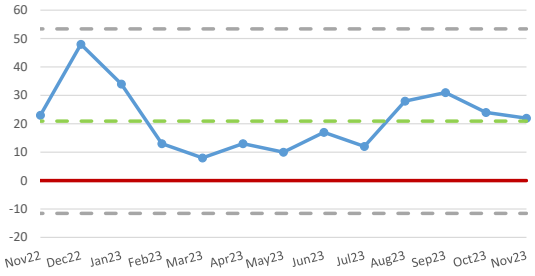
-	Variation Description

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 #
Nov-23	22	QC86

Threshold	YTD Mean	Benchmark
0	20	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 22 instances where handover Turnaround Times were greater than 60 mins, and 198 where greater than 30 mins.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

Manx Care have moved to the new version of the National Cancer Waiting Time Guidance (version 12.0) from October 2023 (https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00654-national-cancer-waiting-times-monitoring-dataset-guidance-v12.pdf).

The IPR data has been aligned to the new reporting guidance from last month, with the reporting of the equivalent October 2023 data. Work is continuing with the Cheshire & Merseyside to understand future developments of the guidance and planning towards future expectations.

The new guidance has simplified the CWT reporting:

- 28 day FDS – target 75% (Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer)
- 62 day RTT – target 85% (From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer)
- 31 day DTT – target 96% (From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer)

Manx Care's reporting will be aligned to this guidance.

The new guidance has removed the reporting of the 2 Week Wait (2WW) however following feedback from Cheshire & Merseyside Cancer Alliance, this will continue to be monitored closely by our clinical and operational teams in order to support the acheivement of the Faster Diagnostic Standard.

Faster Diagnosis Standard

The 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.

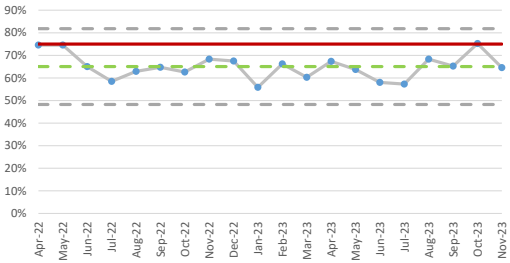
The 28 day FDS gives a fuller indication of the first part of the suspected cancer pathway rather than using the 2WW performance alone. It reflects not only the first appointment, but also that the diagnostic work has been completed and most importantly that the patient has been informed of a cancer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

Best Practice Timed Pathways

The Best Practice Timed Pathways (BPTP) 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. Further work is needed to align with the BPTP pathways from the UK NHS.

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 #
Nov-23	64.6% (268 of 415)	QC31

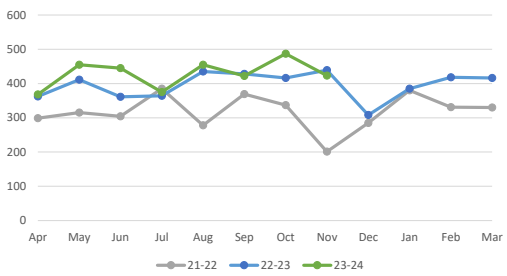
Threshold	YTD Mean	Benchmark
75.0%	65.0%	71.60%

(Higher value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

Suspected Cancer Referrals



Reporting Date	Performance	Op. Plan #
Nov-23	423	

Threshold	YTD Mean	Benchmark

-	Variation Description
	Common cause

Assurance Description

Tumour Group	Suspected Cancer Referrals								
	Nov-23	Apr - Nov 2023	Apr - Nov 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	70	553	427	29.5%	69	53	830	635	30.6%
Colorectal	71	612	619	-1.1%	77	72	918	913	0.5%
Dermatology	80	786	681	15.4%	98	87	1,179	995	18.5%
Gynaecology	48	359	316	13.6%	45	39	539	476	13.1%
Haematology	5	42	44	-4.5%	5	5	63	72	-12.5%
Head & Neck	39	303	301	0.7%	38	36	455	422	7.7%
Lung	13	97	90	7.8%	12	11	146	120	21.3%
Other	0	13	24	-	2	4	20	29	-32.8%
Upper GI	37	279	276	1.1%	35	34	419	406	3.1%
Urology	46	284	269	5.6%	36	36	426	432	-1.4%
Sub-Total	**409**	**3,328**	**3,047**	**9.2%**	**416**	**389**	**4,992**	**4,500**	**10.9%**

**Tumour Group	Monthly number of	
	Nov-23	12 month Avg.
Breast symptomatic (non-suspected cancer)	12	7

*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

- The 28 Day standard was not achieved in November, with performance dropping to 64.6% against the 75% threshold. This was primarily driven by unavoidable staffing pressures within the Breast service and also Urology administration capacity. 5% of breaches were due to patient choice.
- Although the 2 Week Wait standard is no longer reported, this continues to be monitored at the Cancer PTLs to ensure timely access to first appointment and aid achievement of the 28 day target
- Continued high number of suspected cancer referrals across tumour groups is impacting on capacity.
- All suspected cancers continue to be monitored against Cancer Waiting Times (CWT) targets by operational PTL and tumour specific PTLs
- Delays to communication of diagnosis of non-cancer are being picked up via tumour specific PTLs (28 day FDS) and communication with MDT to stop the clock as soon as diagnosis is communicated.
- Volatility of percentages due to small numbers, especially for some targets

Planned / Mitigation Actions

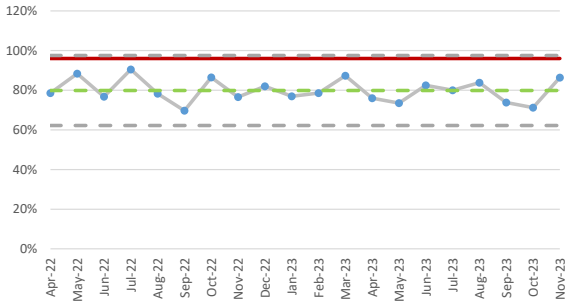
- Review of Suspected cancer GP proforma against new Cancer Alliance templates underway with specialist teams – this should give better guidance to GPs
- Continued roll out of tumour specific PTLs to ensure better communication between clinical/MDT staff over potential to breach CWT targets
- Review of administration of referrals with PIC underway to streamline process and ensure days not lost in pathway ahead of first appointment being booked.
- Cancer Access Policy, Cancer Escalation Policy, Inter-hospital transfer and breach allocation SOP, and SCR Data Quality SOP have been finalised to ensure quality of CWT reporting in the Somerset Cancer Registry. 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.

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

CWT - 31 Day Diagnosis to Treatment



Reporting Date	Performance	Op. Plan #
Nov-23	86.4% (38 of 44)	QC35

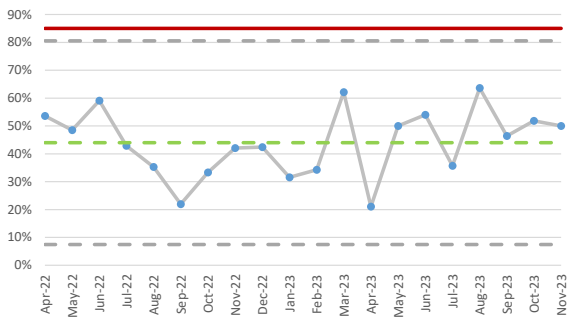
Threshold	YTD Mean	Benchmark
96.0%	78.4%	91.00%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

CWT - 62 Day Referral to Treatment



Reporting Date	Performance	Op. Plan #
Nov-23	50.0% (12 of 24)	QC34

Threshold	YTD Mean	Benchmark
85.0%	46.6%	62.80%

(Higher value represents better performance)

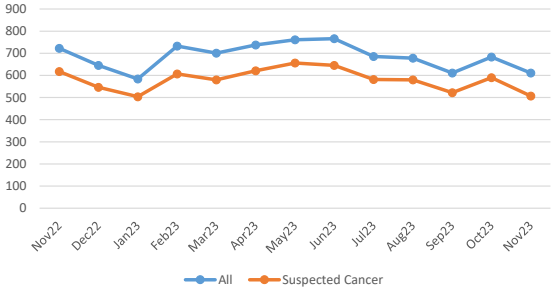
-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
	• 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. • Cancer Access Policy, Cancer Escalation Policy, Inter-hospital transfer and breach allocation SOP, and SCR Data Quality SOP have been finalised to ensure quality of CWT reporting in the Somerset Cancer Registry. 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.	• 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. Note - Benchmarks for 'Breast Symptomatic', '31 days diagnosis to treatment' and '62 days referral to treatment' are UK NHSE performance figures for Aug'23

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

Number of patients on Cancer Pathway



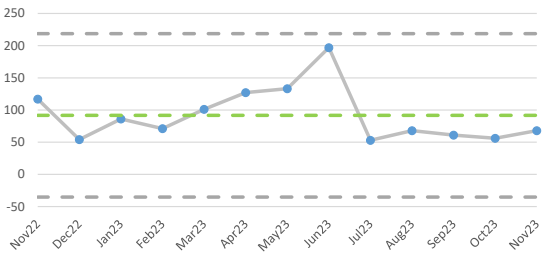
Reporting Date	Performance	Op. Plan #
Nov-23	611	

Threshold	YTD Mean	Benchmark
-	692	677

Variation Description

Assurance Description

Cancer - Total number of patients Waiting for 1st OP



Reporting Date	Performance	Op. Plan #
Nov-23	68	

Threshold	YTD Mean	Benchmark
	95	86

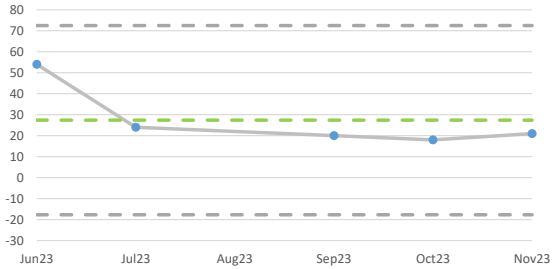
(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description

Cancer - Median Wait Time from the Referral Date to the Diagnosis Date



Reporting Date	Performance	Op. Plan #
Nov-23	21	

Threshold	YTD Mean	Benchmark

- **Variation Description**

Common cause

Assurance Description

Issues / Performance Summary

Please see page 50 for supporting narrative.

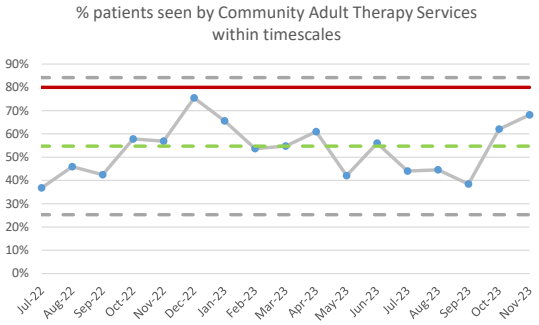
Number of patients on a cancer pathway is based on the figure at the close of the month to give a guide to activity - the amount varies throughout the month.

The number of patients awaiting first appointment is based on the figure reported at the last Operational Cancer PTL of the month to give a guide to activity - the number waiting varies throughout the month.

Planned / Mitigation Actions

Assurance / Recovery Trajectory

Responsive	Integrated Primary & Community Care (1 of 5)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon



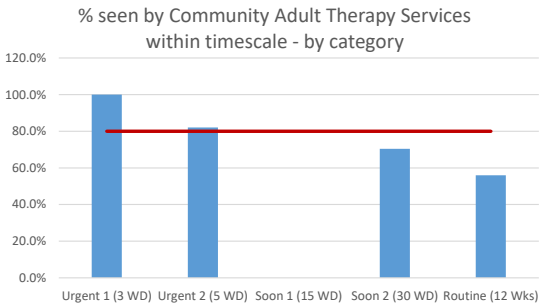
Reporting Date	Performance	Op. Plan #
Nov-23	68.2%	QC62

Threshold	YTD Mean	Benchmark
80.0%	52.0%	54.4%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target



Reporting Date	Performance	Op. Plan #
Nov-23	-	

Threshold	YTD Mean	Benchmark
80%	-	-

(Higher value represents better performance)

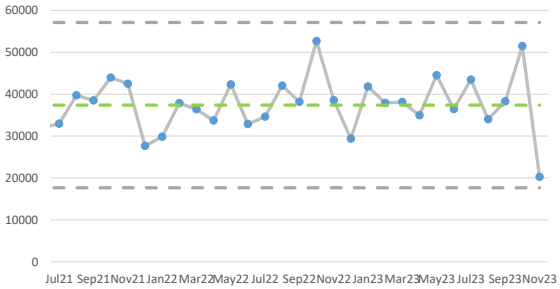
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Community Adult Therapy: • 100% of Urgent 1 (3 working day) and 82.1% of Urgent 2 (5 working day) patients were seen within the required timescales in November. • The team hold heavy caseloads of patients with complex and changing needs requiring regular input and reviews making it more difficult to respond to new referrals.	**Community Adult Therapy:** • Team have reviewed triage priorities and would like to simplify these to Priority 1 (10 day response), Priority 2 (30 day response), Priority 3 (60 day response). This will reflect the service not being an urgent/rapid response service, reduce the pressure on the team to focus on the urgent referrals and improve the response times to the other categories. • Bank OT currently supporting for approx. 26 hours a week. • Part time OT within the team picking up additional hours as able. • TSR requests in place for 2 x B6 OT. • 0.6 OT post currently out to advert. • B5/6 Rotational post out to advert – currently 4/5 posts vacant with this to increase to 5/5 . The post has been on a rolling advert throughout the year, 1 interview to be offered following last closing date. • Team completing waiting list reviews.	- Note: Benchmark for '% patients seen by CAT' is the Manx Care monthly averages for 2022/23.

Responsive	Integrated Primary & Community Care (2 of 5)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon

Number of GP Appointments



Reporting Date	Performance	Op. Plan #
Nov-23	**20263**	-

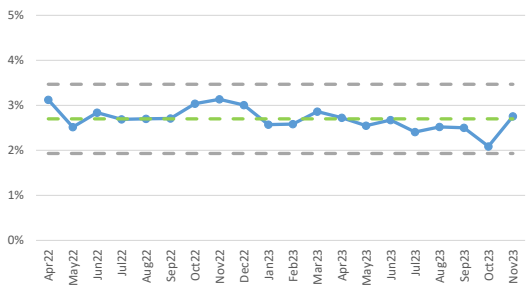
Threshold	YTD Mean	Benchmark
-	37928	38523

Variation Description

Common cause

Assurance Description

DNA Rate - GP Appointments



Reporting Date	Performance	Op. Plan #
Nov-23	**2.8%**	QC151

Threshold	YTD Mean	Benchmark
-	2.5%	2.8%

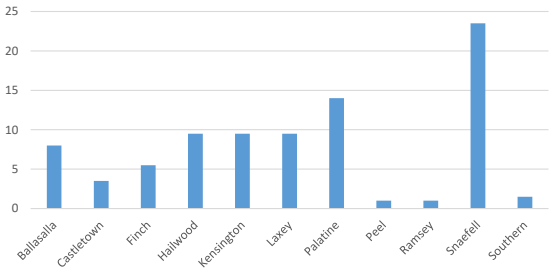
(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description

Average of Days to next GP appointment - Nov'23



Reporting Date	Performance	Op. Plan #
Nov-23	-	-

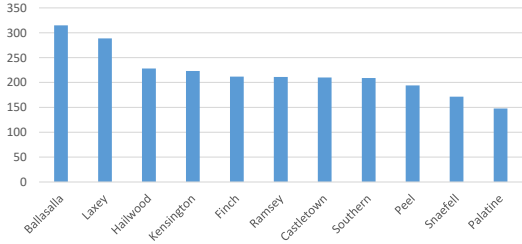
Threshold	YTD Mean	Benchmark
-	7.2	-

(Lower value represents better performance)

Variation Description

Assurance Description

GP - Number of appointments per 1000 registered patients - Nov'23



Reporting Date	Performance	Op. Plan #
Nov-23	-	

Threshold	YTD Mean	Benchmark
-	-	

Variation Description

Assurance Description

Issues / Performance Summary

The number of GP appointments fluctuates each month and is dependent on capacity and demand. Demand is still particularly high at the moment, especially with seasonal illnesses emerging.

DNA rates have been reducing, primarily due to the measures that the practices have put in place, but patients are still booking urgent on the day appointments and then failing to attend.

Planned / Mitigation Actions

Q2 Contract reviews have been completed and a review of all appointment data is being undertaken with a view to understanding any issues and to put plans in place to rectify areas of concern.

Use of EMIS / AccurX / website / email / phone are all ways patients have access for cancelling, appointments. The practices also write to repeat offenders.

Manx Care, Primary Care Services has employed 2 new salaried locum GP's, complementing the single one in employment, with another 2 due to commence next year. These additional staff will assist the practices when they have scheduled leave, as they can be booked in advance.

Practices with vacancies are currently recruiting

We are also in the process of appointing a locum GP from the UK to assist with Winter pressures

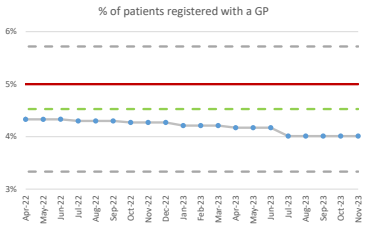
Assurance / Recovery Trajectory

Winter planning additional support / appointment to vacancies and additional salaried GP support will assist in improving capacity.

Practices utilise reminder texts to patients when an appointment is booked, 2 days before the appointment and a day before the appointment. Some patients can receive up to 5 texts in total to remind them of an upcoming appointment.

When all 5 Salaried GP's are in post this will assist practices with resilience and stability, complementing their existing establishment of staff. We also have the Winter planning assistance of 1 GP into Primary Care to assist with capacity issues over the winter period.

Responsive	Integrated Primary & Community Care (3 of 5)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon



Reporting Date	Performance	Op. Plan #
Nov-23	4.0%	QC99

Threshold	YTD Mean	Benchmark
5.0%	4.1%	4.3%

(Lower value represents better performance)

Variation Description

Special Cause of Improving variation (Low)

Assurance Description

Consistently hit target

Issues / Performance Summary

% of patients registered with a GP:

- % tolerance for November is in line with expectations.

Planned / Mitigation Actions

% of patients registered with a GP:

- List cleansing is conducted monthly / quarterly and annually. 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, at the contract review meetings discusses list sizes, ensuring the patients lists are accurate and up to date and also to utilise every opportunity like ensuring that any returned mail is actioned, to reduce the lists further.

Assurance / Recovery Trajectory

% of patients registered with a GP:

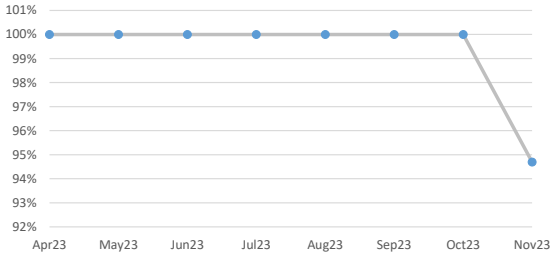
- The 2021 Census identified that there was a resident population of 84,069, and there has been movement on and off the Island since that date. We continue to list cleanse and work with the practices to remove 'Ghost patients' to keep it under the 5% and movement has been made to reduce to 4%.
- We will continue to review the % on a monthly / quarterly basis, working to the list cleansing timetable and with practices accordingly.

We have recently completed a piece of work on multiple occupancy residences and the returns have identified a large number of patients who will in 5 month's time be removed from GP Practice lists should an alternative address not be found.

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

Responsive	Integrated Primary & Community Care (4 of 5)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon

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



Reporting Date	Performance	Op. Plan #
Nov-23	**95%**	QC61

Threshold	YTD Mean	Benchmark
-	99.3%	-

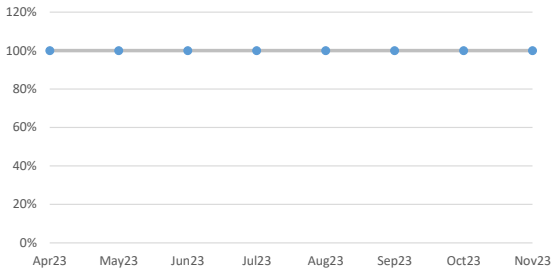
(Higher value represents better performance)

+ Variation Description

Common cause

Assurance Description

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



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

Threshold	YTD Mean	Benchmark
-	100%	-

(Higher value represents better performance)

+ Variation Description

Common cause

Assurance Description

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

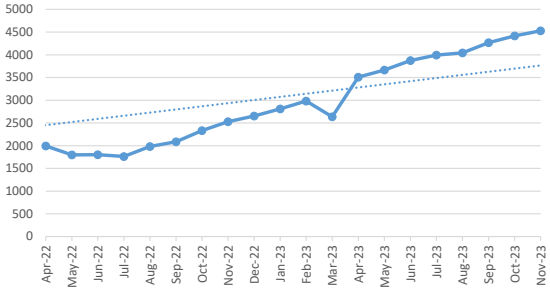
Community Nursing Service response target met (7 days) - Routine

- This response standards continues to be fully met.

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

- Performance in November was below the required 100% threshold at 95%. This was due to 1 patient being seen outside of the required 24 hour timescale at 5 days.

Responsive	Integrated Primary & Community Care (5 of 5)	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon

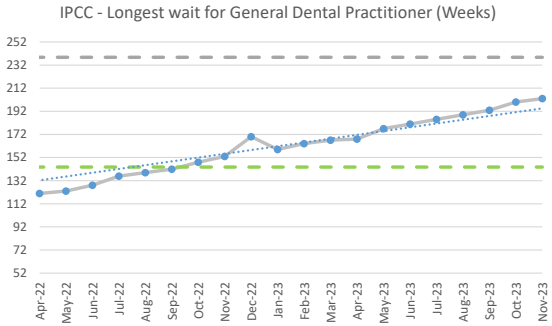


Reporting Date	Performance	Op. Plan #
Nov-23	4528	
Threshold	**YTD Mean**	**Benchmark**
-	4037	944

(Lower value represents better performance)

-	Variation Description

Assurance Description



Reporting Date	Performance	Op. Plan #
	203	
Threshold	**YTD Mean**	**Benchmark**
		168

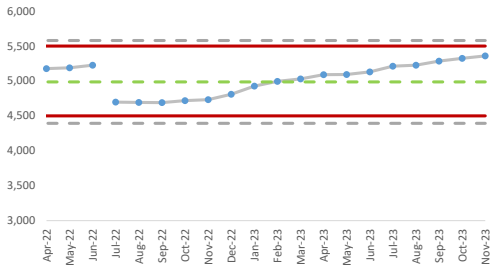
Variation Description
Special Cause of Concerning variation (High)

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Dental: • In November 2023 206 patients were added to the dental allocation list. 64 children were added and 142 adults. 105 patients were allocated to a NHS dental practice. At the end of November 2023 the total number of patient on the allocation list was 4528.	**Dental:** • Currently there are discussions between Manx Care and DHSC in relation to NHS dental services which includes a paper regarding unifying of the UDA value. • Reports in relation to recall periods have been requested from NHSBSA who collate data in relation to NHS dental services and claims. This report identifies that the current recall period is between 7-9 months. Further discussions in relation to reviewing the KPI's on recall periods are being had with contractors by the end of December 2023. • The majority of patients on the waiting list have now been contacted by either telephone or email. the results are now being collated and the waiting list is being updated.	**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 #
Nov-23	5359	QC73

Threshold	YTD Mean	Benchmark
4500 - 5500	5215	4907

(Value within range represents better performance)

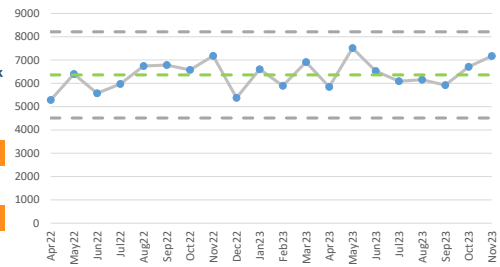
-	Variation Description

Common cause

+	Assurance Description

Consistently hit target

MH- Appointments



Reporting Date	Performance	Op. Plan #
Nov-23	7169	

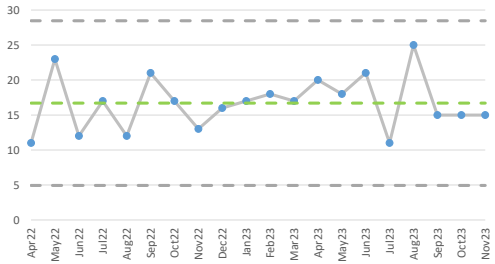
Threshold	YTD Mean	Benchmark
-	6493	6276

-	Variation Description

Common cause

Assurance Description

MH- Admissions



Reporting Date	Performance	Op. Plan #
Nov-23	15	

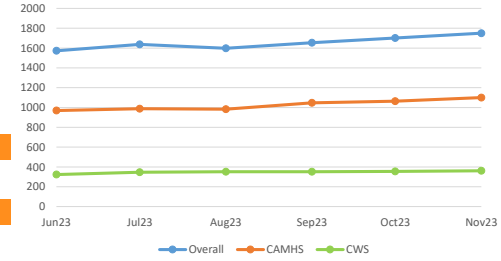
Threshold	YTD Mean	Benchmark
-	18	16

+	Variation Description

Common cause

Assurance Description

Mental Health Waiting Lists



Reporting Date	Performance	Op. Plan #
Nov-23	**1750**	

Threshold	YTD Mean	Benchmark
-	1652	

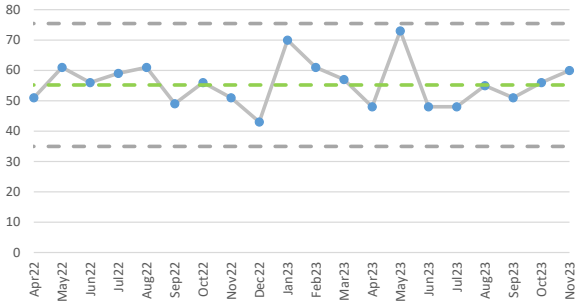
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Current Caseload: Caseload remains within the expected range and continues to steadily increase. It is significantly higher locally than you would expect within the English NHS. Particularly within CAMHS, whose caseload is some 4 times higher than you would expect per 100 thousand population equivalend in England. This range is benchmarked upon historic demand. **MH Admissions to Manannan Court:** Admissions have remained static over the last 3 months.	**Current Caseload:** Business case for additional staff in CAMHS is progressing to treasury. **MH Appointments:** Operational Managers are able to view DNA rates via their reporting dashboard and can take action if negative trends or areas of concerns are identified. **MH Admissions to Manannan Court:** Continue to monitor the impact of succesful recuitment in community services on inpatient admissions. **MH Waiting Lists:** The intention is to report on referral to treatment times, we areworking with the performance team to establish a clear methodology and the scope for RTT reporting. **Reduction in waiting list volume's for CAMHS mental health services** The business case to treasury suggests options to reduce waiting lists, with the assistance of partnership arrangements with third sector providers and shared care agreements with GP's.	**Current Caseload:** IMHS continue to be the main contributing department to the implementation of iThrive on the island. Successful embedding of this initiative should ensure that services other than entry to IMHS are available to children and their families, this should over time reduce demand on the service now and in the future. **MH Waiting Lists** Reduction in waiting list volume's for adults accessing Psychological Services (Low to Moderate) Successful recruitment to difficult to recruit to posts, following a "grow your own" initiative, will ensure that there will be no wait for low to moderate psychological therapies at the start of 2024

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

Maternity Bookings



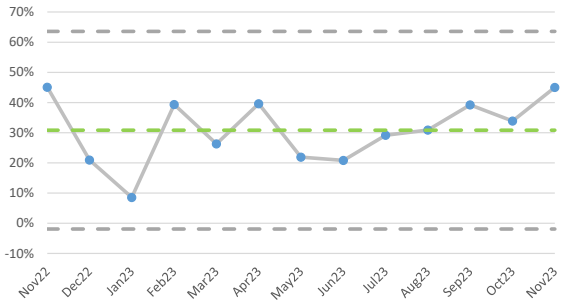
Reporting Date	Performance	Op. Plan #
Nov-23	**60**	
Threshold	**YTD Mean**	**Benchmark**
-	991	56

Variation Description

Common cause

Assurance Description

Gestation At Booking <10 Weeks



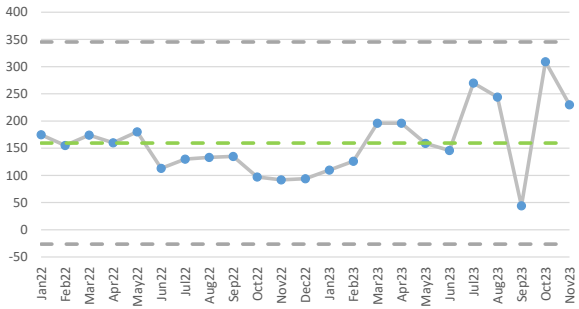
Reporting Date	Performance	Op. Plan #
Nov-23	**45%**	
Threshold	**YTD Mean**	**Benchmark**
-	33%	28.0%

Variation Description

Common cause

Assurance Description

Ward Attenders



Reporting Date	Performance	Op. Plan #
Nov-23	**230**	
Threshold	**YTD Mean**	**Benchmark**
-	-	131

Variation Description

Common cause

Assurance Description

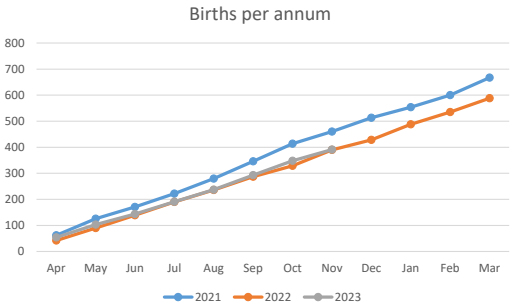
Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory

Maternity bookings

Gestation<10 weeks at booking: Gestation at booking continues to be a concern with only 45.0% of booked women booking before 10 weeks. There has been an issue for the majority of 2023 with receipt of referrals from GP Practices. This means that women are often >10 weeks gestation before we can invite for a booking appointment. The service has plans to change the referral process.

Booking: A total of 60 women have booked for care in November'23 (were 51 in November'22).

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

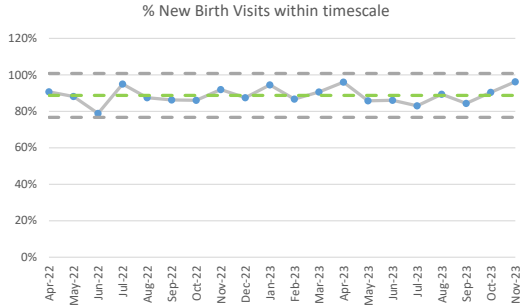


Reporting Date	Performance	Op. plan #
Nov-23	**391**	
Threshold	**YTD Mean**	**Benchmark**
-	220	-

(Higher value represents better performance)

+	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Nov-23	**96%**	QC133
Threshold	**YTD Mean**	**Benchmark**
-	89%	89%

+	Variation Description
	Common cause

Assurance Description

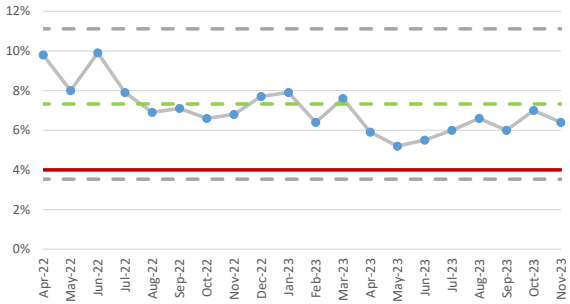
Issues / Performance Summary	Planned / Mitigation Actions	
Over the month of October there was **43 babies born** **New Birth Visits** In November 2023 we received 53 Antenatal referrals into the department. We completed a total of 53 visits. Out of these visits, 51 were completed within the timeframe of 14 days and 2 were not completed within timeframe. Exception Data 2 parents requested to reschedule. Breach Data 0 breaches in November. In November 43 women were assessed as Universal, 7 as Universal Plus and 1 as Universal Partnership Plus at their New Birth Visit		With the establishment increasing as of September we expect all new birth visits to 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	Nov-23		6.4%	6.1%	-	4.0%		
WP002		Workforce - Number of staff on long term sickness	Nov-23	-	116	83	-	-		
WP004		Workforce - Number of staff leavers	Nov-23	-	21	25	197	-		
WP005		Workforce - Number of staff on disciplinary measures	Nov-23	-	11	8	67	-		
WP006		Workforce - Number of suspended staff	Nov-23	-	5	3	21	-		
WP013		Staff 12 months turnover rate	Nov-23		7.0%	9.7%	-	10%		
WP014		Training Attendance rate	Nov-23		69.0%	62.4%	-	90%		
WP007		Governance - Number of Data Breaches	Nov-23		8	11	90	0		
WP008		Governance - Number of Data Subject Access Requests (DSAR)	Nov-23	-	64	57	453	-		
WP009		Governance - Number of Access to Health Record Requests (AHR)	Nov-23	-	5	3	22	-		
WP010		Governance - Number of Freedom of Information (FOI) Requests	Nov-23	-	9	11	84	-		
WP011		Governance - Number of Enforcement Notices from the ICO	Nov-23	-	0	0	0	-		
WP012		Governance - Number of SAR, AHR and FOI's not completed within their target	Nov-23		29	38	304	0		
WP015		Number of DSAR, AHR and FOI's overdue at month end	Nov-23		40	39	309	-		

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

% Hours lost to staff sickness absence



Reporting Date	Performance	Op. plan #
Nov-23	6.4%	P1

Threshold	YTD Mean	Benchmark
4.0%	6.1%	7.7%

(Lower value represents better performance)

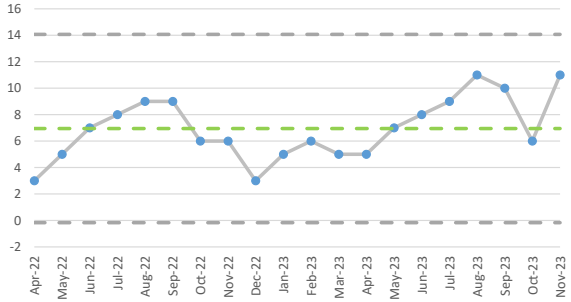
+ Variation Description

Special Cause of Improving variation (Low)

- Assurance Description

Consistently fail target

Number of staff on disciplinary measures : Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	11	P5

Threshold	YTD Mean	Benchmark
-	8	-

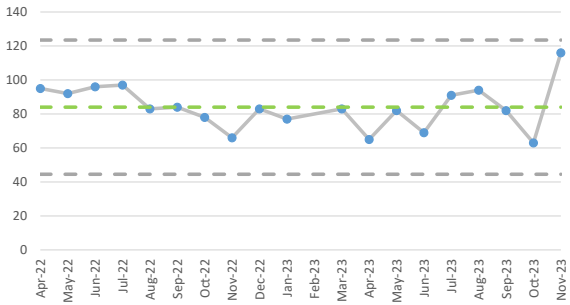
(Lower value represents better performance)

- Variation Description

Common cause

Assurance Description

Number of staff on long term sickness : Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	116	P4

Threshold	YTD Mean	Benchmark
-	83	-

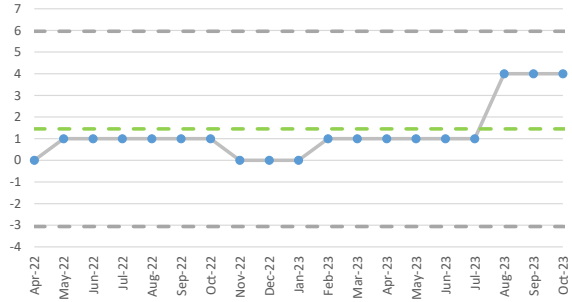
(Lower value represents better performance)

+ Variation Description

Common cause

Assurance Description

Number of suspended staff : Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	5	P6

Threshold	YTD Mean	Benchmark
-	3	-

(Lower value represents better performance)

- Variation Description

Common cause

Assurance Description

Issues / Performance Summary

• Worktime lost in November '23 by sickness category:

Stress, Anxiety & Depression	- 1.8%
Cough, Cold & Flu	- 0.8%
Musculoskeletal	- 1%
Covid-19	- 0.4%
Other sickness	- 2.5%

• Worktime lost in November'23 by Area:

Integrated Social Care Services	- 7.9%
Medicine, Urgent Care & Ambulance Services	- 5.4%
Integrated Mental Health Services	-
Infrastructure	- 6.9%
Integrated Primary & Community Care Services	- 7.2%
Integrated Cancer & Diagnostic Services	- 3.4%
Women, Children & Families	- 4.5%
Surgery, Theatres, Critical Care & Anaesthetics	- 6.5%

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.

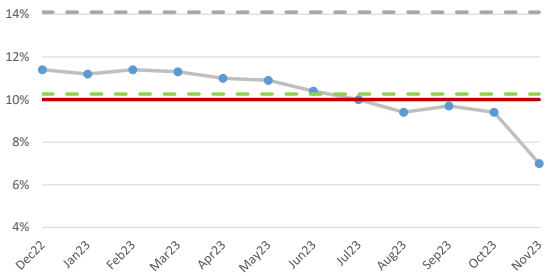
• The decision to suspend staff which may occasionally be necessary is normally taken in consultation with HR to ensure the measures are appropriate and proportionate.

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 #
Nov-23	7.0%	P2

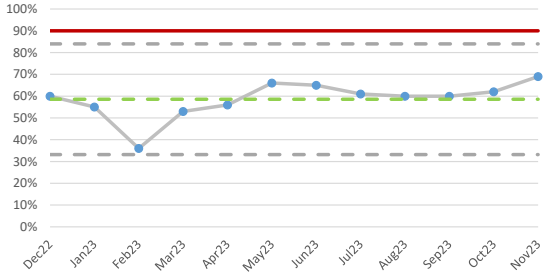
Threshold	YTD Mean	Benchmark
10.0%	9.7%	11.3%

(Lower value represents better performance)

+	Variation Description
	Common cause

+	Assurance Description
	Inconsistently passing and falling short of target

Instructor-led training sessions attendance rate



Reporting Date	Performance	Op. plan #
Nov-23	69%	P7

Threshold	YTD Mean	Benchmark
90%	62%	51%

(Higher value represents better performance)

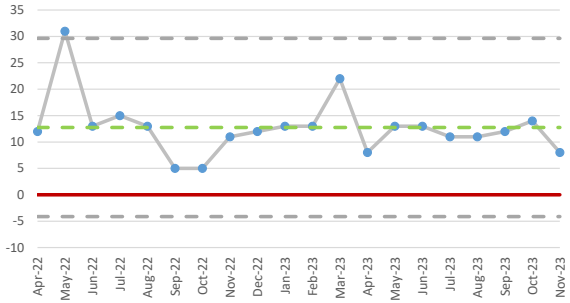
+	Variation Description
	Common cause

-	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 #
Nov-23	8	L1

Threshold	YTD Mean	Benchmark
0	11	-

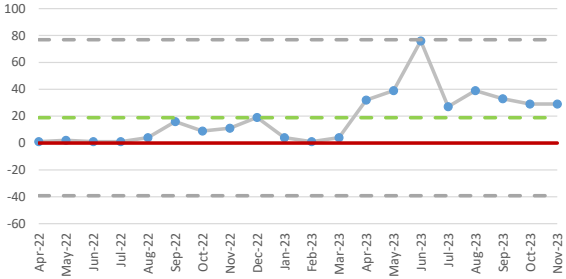
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

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



Reporting Date	Performance	Op. plan #
Nov-23	29	L6

Threshold	YTD Mean	Benchmark
0	38	-

(Lower value represents better performance)

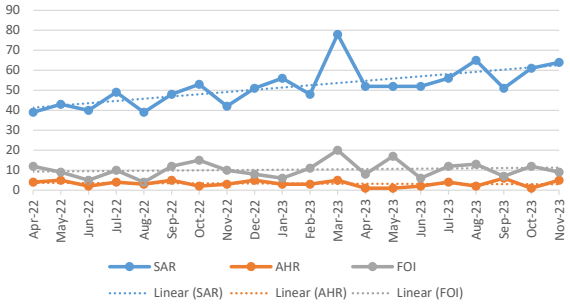
+	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Governance - Information requests by type : Manx Care



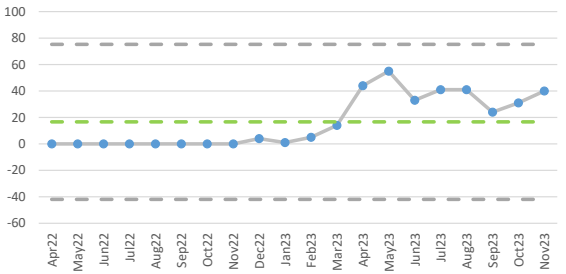
Reporting Date	Performance	Op. plan #
Nov-23	-	L2-3-4

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Governance - DSAR, AHR and FOI's overdue at month end: Manx Care



Reporting Date	Performance	Op. plan #
Nov-23	40	-

Threshold	YTD Mean	Benchmark
-	39	17

(Lower value represents better performance)

-	Variation Description

Common cause

Assurance Description

Issues / Performance Summary

Breaches –

Total: 8
Reported to the Commissioner: 4
Data Subjects informed: 2
Data Subjects Not Informed: 6 (5 x low risk to the patient, 1 x clinical decision not to inform)

Types of breach
Email: 5
Written Communication: 1
Confidentiality: 1
Correspondence: 1

Planned / Mitigation Actions

• Manx Care notifies to the ICO all breaches which they are required to notify, but the Manx Care DPO fully investigates all breaches or suspected breaches which have been reported to them. The DPO will conduct a full internal investigations with the relevant service areas and will continue to work with the IG Risk and Quality Assurance Manager to ensure any improvements and remedial actions identified are progressed. In November Manx Care had 8 breaches, but only 4 met the criteria of being reportable 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

Assurance / Recovery Trajectory

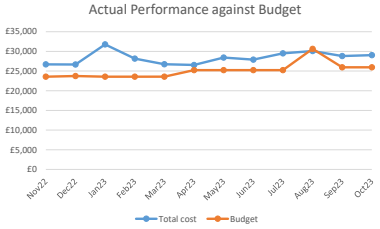
• Manx Care staff are actively encouraged to report any data breach, or suspected breach, to the Manx Care DPO. Staff reporting breaches to the Manx Care DPO is a positive reflection of the awareness amongst staff of the responsibility for good information governance. Willingness by staff to report ensures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

• There is a continued upward trend in the number of DSAR and FOI requests being received by Manx Care. The Information Governance team continues to face a significant challenge in responding to these requests within the legal timeframes. Longer term this pressure is likely to remain high.

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)	Oct-23		87%	-	245%	100% (equiv. 1%)		
WF002		Total income (£)	Oct-23	-	-£1,517,135	-£1,238,717	-£9,161,532	-		
WF003		Total staff costs (£)	Oct-23	-	£17,915,353	£16,177,273	£123,963,922	-		
WF004		Total other costs (£)	Oct-23	-	£12,646,944	£11,886,589	£90,203,302	-		
WF005		Agency staff costs (proportion %)	Oct-23	-	6%	9.1%	-	-		
WF009		Actual performance against Budget	Oct-23		-3,082	-£4,401	-£16,812	-		

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



Reporting Date	Performance	Op. plan #
Oct-23		

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Reporting Date	Performance	Op. plan #
Oct-23	17,915,353	F4

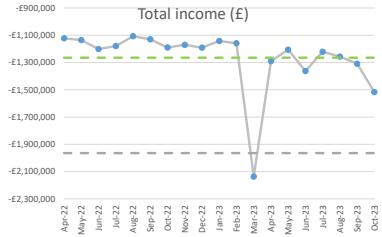
Threshold	YTD Mean	Benchmark
-	16,177,273	-

(Lower value represents better performance)

+ Variation Description

Common cause

Assurance Description



Reporting Date	Performance	Op. plan #
Oct-23	-1,517,135	F3

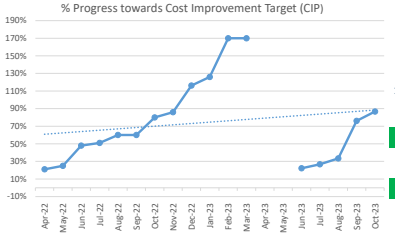
Threshold	YTD Mean	Benchmark
-	-1,238,717	-

(Higher value represents better performance)

- Variation Description

Common cause

Assurance Description



Reporting Date	Performance	Op. plan #
Oct-23	86.7%	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):

• To date, the CIP plan has delivered £4.8m in savings, of which £3.9m are cash out. Overall, delivery at at October stands at 76% of target. These savings have been reflected in the forecast. However, many are serving to hold existing cost pressures in check and avoiding costs. The original target of £9.6m has been reduced to reflect the challenges to delivery on a number of projects. However, it still exceeds the £4.5m target included in the budget.

• Spend is expected to increase by £27.5m compared to the prior year, whilst funding has increased by just £20m creating a gap of £7.5m. The year-end position for 22/23 was an overspend of £8.9m which also contributes to the predicted operational overspend of £17.9m. Appendix 1 compares spend by Care Group in 22/23 against projected spend for 23/24 and includes narrative explaining the spend movement from £305.8m in 22/23 to £333.2m in 23/24.

Total income (£):

• The operational result for October is an overspend of (£1.4m) with costs reducing by £0.3m compared to the previous month. The forecast has remained in line with prior month reporting with an expected overspend of (£30.3m).

•Overall, performance is on target with some potential for over-achievement. 5 workstreams have yet to report savings. However, the total target for these is £120k so the risk to overall delivery is moderate. Some of this is due to late reporting of savings but the Primary Care projects are at risk of not delivering the target savings of £30k. 2 workstreams are rated Amber – Tertiary and Procurement - and include projects that have yet to deliver savings but which are expected to do so towards the end of the year so it's likely they will deliver on target.

Total staff costs (£):

• YTD employee costs are (£3.4m) over budget. Agency spend is contributing to this overspend and reducing this is a factor in improving the financial position by the year end. The total Agency spend YTD of £7.2m is broken down across Care Groups below. The Care Groups with the largest spend are Medicine (£1.5m), Social Care (£1.3m) and Women & Children (£0.9m), where spend is primarily incurred to cover existing vacancies in those areas.

Planned / Mitigation Actions

% Progress towards Cost Improvement Target (CIP):

• There are potential risks of up to £3.8m that could affect the current reported forecast as summarised below & further financial mitigations would be required to manage the financial position if these materialise.

• The Restoration & Recovery programme is showing an overspend on a YTD basis but this is due to activity & invoice timing. Actuals and the forecast for this project are closely monitored to ensure that the programme will be delivered within the funding allocated.

Total income (£):

• The forecast includes £4.9m of cost which is expected to be approved from the DHSC reserve fund which would reduce this to (£25.3m).

• To date, £3.9m in cash out savings have been delivered, which have been reflected in the forecast. £918k in efficiencies have also been delivered but these do not impact the forecast.

Total staff costs (proportion %):

•Although agency costs are continuing to reduce bank costs are increasing which means that overall costs are tracking higher than last year but within expected trends. Agency costs continue to be lower than in 21/22. Bank rates have increased this year due to pay awards which is partly contributing to the rising cost but bank is also being used as a less expensive alternative to agency to cover vacancies and gaps in rotas.

Assurance / Recovery Trajectory

% Progress towards Cost Improvement Target (CIP):

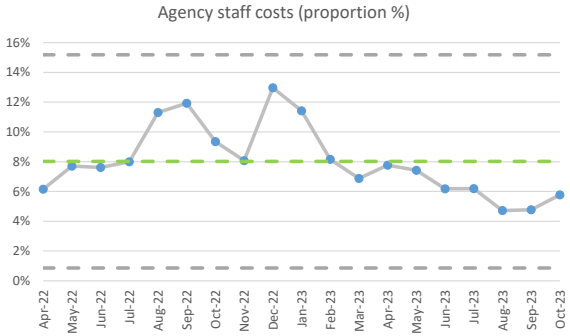
• As CIP plans are implemented the forecast is being adjusted by Care Group to reflect the actual spend reductions achieved, however as not all CIP workstreams impact the run rate there are remaining savings of £1.2m included in the forecast centrally (which is included as a risk). To date, £3.9m in cash out savings have been delivered, which have been reflected in the forecast. £918k in efficiencies have also been delivered but these do not impact the forecast.

Total income (£):

• Of the forecast overspend, £7.4m 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 #
Oct-23	5.8%	

Threshold	YTD Mean	Benchmark
	6.1%	9.1%

(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.		

Performance Scorecard 1

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
SAFE	SA001	Serious Incidents declared	<3 < 36 PA	2	3	2	0	0	2	2	1	1	3	4	1	5	5	22	
	SA002	Duty of Candour letter has been sent within 10 days of incident	80%	N/A	N/A	N/A	N/A	N/A	N/A	80.00%	75.00%	50.00%	75.00%	100.00%	100.00%	100.00%	100.00%		
	SA018	Letter has been sent in accordance with Duty of Candour Regulations	100%	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	100.00%	50.00%	75.00%	100.00%	100.00%	100.00%	100.00%		
	SA003	Eligible patients having VTE risk assessment within 12 hours of decision to admit	95%	91.00%	90.30%	86.68%	94.39%	97.85%	95.06%	90.41%	84.73%	89.60%	87.30%	88.89%	91.00%	94.50%	92.50%		
	SA004	% Adult Patients (within general hospital) who had VTE prophylaxis prescribed if appropriate	95%	94.00%	93.53%	92.00%	99.30%	99.17%	97.00%	91.87%	95.87%	97.40%	100.00%	98.00%	96.00%	99.00%	99.00%		
	SA005	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	SA006	Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	<2	0	1.24	0	0.47	0.35	0.54	0.63	0.16	0.16	0.17	0.45	0.31	0.49	0.5		
	SA019	Pressure Ulcers - Total incidence - Grade 2 and above	<= 17 (204 PA)	18	17	11	13	11	13	15	13	19	24	29	16	11	17	144	
	SA007	Clostridium Difficile - Total number of acquired infections	< 30 PA	1	2	0	2	3	2	4	4	4	4	2	1	1	3	23	
	SA008	MRSA - Total number of acquired infections	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	
	SA009	E-Coli - Total number of acquired infections	< 72 PA	6	5	6	5	4	0	5	8	6	10	4	9	8	11	61	
	SA010	No. confirmed cases of Klebsiella spp	-	2	3	0	0	0	0	0	3	1	2	2	2	0	2	12	
	SA011	No. confirmed cases of Pseudomonas aeruginosa	-	1	0	1	0	0	0	0	0	0	1	1	1	0	0	3	
	SA012	Number of Medication Errors (with Harm)	< 25 PA	1	0	0	0	0	0	1	1	0	0	0	0	1	0	3	
	SA013	Harm Free Care Score (Safety Thermometer) - Adult	95%	98.4%	98.0%	99.5%	97.5%	98.5%	96.9%	96.8%	97.4%	98.0%	97.5%	96.8%	97.0%	97.7%	97.0%		
	SA014	Harm Free Care Score (Safety Thermometer) - Maternity	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.0%	100.0%		
	SA015	Harm Free Care Score (Safety Thermometer) - Children	95%	86.6%	100.0%	95.8%	90.0%	95.2%	99.0%	82.3%	99.8%	95.2%	96.2%	100.0%	99.0%	100.0%	100.0%		
	SA016	Hand Hygiene Compliance	96%	97.0%	97.0%	98.0%	97.0%	97.0%	92.0%	98.0%	96.0%	99.0%	97.0%	97.0%	97.0%	99.0%	97.0%		
	SA017	48-72 hr review of antibiotic prescription complete	98%	73.0%	79.0%	71.0%	75.0%	58.0%	81.0%	80.0%	70.0%	79.0%	70.0%	74.0%	88.0%	82.0%	88.0%		
EFFECTIVE	EF067	Planned Care - DNA - Hospital	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8.7%	12.2%	10.2%	9.4%	11.0%		
	EF001	Planned Care - DNA Rate (Consultant Led outpatient appointments)	5%	11.1%	8.6%	9.4%	9.7%	7.9%	12.0%	11.9%	11.1%	10.4%	11.9%	14.8%	11.5%	11.2%	13.3%		
		Planned Care - DNA Rate (Nurse Led outpatient appointments)		6.2%	5.9%	5.9%	4.2%	4.8%	6.0%	7.4%	7.1%	4.8%	5.1%	8.2%	6.6%	5.4%	6.8%		
		Planned Care - DNA Rate (AHP Led outpatient appointments)		8.9%	10.4%	9.8%	10.0%	9.4%	11.0%	11.3%	9.5%	10.1%	9.0%	11.4%	10.2%	10.0%	9.8%		
	EF002	Planned Care - Total Number of Cancelled Operations		343	303	357	429	317	396	236	344	284	337	268	371	367	348	2555	
		Hospital cancelled		198	171	234	280	179	229	109	196	138	200	140	223	239	156	1401	
		Patient cancelled		145	132	123	149	138	167	127	148	146	137	128	148	128	192	1154	
	EF005	Length of Stay (LOS) - No. patients with LOS greater than 21 days	-	68	90	118	119	125	88	112	121	114	140	103	105	94	81	870	
		Average Length of Stay (ALOS) - Nobles	-	5	5	5	5	5	6	5	5	5	5	5	5	5	5		
		Average Length of Stay (ALOS) - RDCH	-	46	46	33	51	50	41	38	130	38	31	36	40	44	34		
		Total Number of discharges	-	949	1022	1021	991	866	1008	907	960	906	985	1009	938	971	1033	4767	
	EF050	Total Number of inpatient discharges-Nobles	-	926	986	977	959	826	976	882	924	866	946	968	904	928	995	4586	
	EF051	Total Number of inpatient discharges-RDCH	-	23	36	44	32	40	32	25	36	40	39	41	34	43	38	181	

Performance Scorecard 2

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
EFFECTIVE	EF003	Theatres - Number of Cancelled Operations on Day		38	50	38	81	39	48	36	40	28	51	27	33	46	31	292	
		Theatres - Number of Cancelled Operations on Day - Clinical		10	11	9	14	10	19	12	14	16	7	8	14	16	13	100	
		Theatres - Number of Cancelled Operations on Day - Non clinical - Patient		2	4	4	4	5	11	5	6	5	14	5	6	10	6	57	
		Theatres - Number of Cancelled Operations on Day - Non clinical - Hospital		26	35	25	63	24	18	19	20	7	30	14	13	20	12	135	
	EF004	Theatres - Theatre Utilisation %	85%	68.1%	69.8%	76.3%	72.1%	82.5%	75.8%	73.3%	76.2%	67.8%	79.7%	82.4%	80.6%	79.8%	76.2%		
	EF006	Crude Mortality Rate		17.37	32.72	29.28	22.48	20.23	24.24	16.47	15.37	12.75	15.25	19.63	18.81	24.68	0		
	EF007	Total Hospital Deaths		19	38	32	21	23	27	18	18	13	20	21	22	30	27	169	
	EF024	Mortality - Hospitals LFD (Learning from Death reviews)	80.00%	23%	24%	36%	54%	92%	94%	93%	93%	98%	98%	98%	97%	97%	99%		
	EF008	West Wellbeing Contribution to reduction in ED attendance	10% per 12 months	7.3%	0.0%	8.9%	-12.7%	7.3%	25.3%	6.7%	5.8%	-6.4%	24.9%	14.2%	7.1%	6.6%	6.2%		
	EF009	West Wellbeing Reduction in admission to hospital from locality	5% per 12 months	20.4%	-8.3%	17.5%	22.6%	-6.4%	89.2%	-10.9%	-1.8%	-25.3%	-25.6%	-1.8%	-14.3%	1.6%	66.7%	0	
	EF011	MH - Average Length of Stay (LOS) in MH Acute Inpatient Service (Discharged)	-	59	26	66	64	72	26	30	33	83	21	51	20	8	39		
	EF013	MH - % service users discharged from MH inpatient to have follow up appointment	90%	91.0%	0.0%	100.0%	94.0%	94.0%	100.0%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%		
	EF064	Number of patients with a length of stay - 0 days (Mental Health)	-	N/A	N/A	N/A	0	3	0	2	1	1	0	1	1	0	1	7	
	EF065	MH - Number of patients aged 18-64 with a length of stay - > 60 days	-	N/A	N/A	N/A	5	5	1	3	4	3	0	2	1	0	1	14	
	EF066	MH - Number of patients aged 65+ with a length of stay - > 90 days	-	N/A	N/A	N/A	2	0	0	2	0	1	1	3	0	0	1	8	
	EF047	% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	75%	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%		
	EF048	% Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral	75%	N/A	N/A	N/A	N/A	100%	100%	50%	100%	100%	50%	100%	-	-	0%		
	EF026	Crisis Team one hour response to referral from ED	75%	91%	88%	87%	100%	75%	91%	94%	94%	100%	96%	84%	90%	77%	90%		
	EF015	ASC - % of Re-referrals	<15%	9.6%	8.6%	11.3%	12.4%	4.6%	1.3%	3.9%	3.8%	1.7%	4.5%	1.2%	0.0%	3.3%	12%		
	EF063	ASC - No. of referrals		83	81	80	89	65	77	76	78	59	66	86	68	91	74	598	
	EF016	ASC - % of all Adult Community Care Assessments completed in Agreed Timescales	80%	66%	77%	68%	55%	33%	27%	39%	39%	29%	42%	27%	23%	40%	30%		
	EF017	ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment	100%	13%	21%	13%	14%	0%	27%	22%	48%	100%	100%	100%	96%	100%	96%		

Performance Scorecard 3

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
EFFECTIVE	EF019	CFSC - % Complex Needs Reviews held on time	85%	48.4%	32.0%	62.5%	62.5%	35.7%	75.0%	100.0%	75.0%	65.5%	54.6%	50.0%	48.0%	56.0%	43.5%		
	EF021	CFSC - % Total Initial Child Protection Conferences held on time	90%	100.0%	87.5%	100.0%	50.0%	50.0%	100.0%	100.0%	100.0%	33.3%	80.0%	71.4%	80.0%	76.9%	100.0%		
	EF022	CFSC - % Child Protection Reviews held on time	90%	53.9%	87.5%	71.4%	66.7%	85.7%	77.8%	88.9%	100.0%	100.0%	88.9%	95.8%	95.7%	80.0%	100.0%		
	EF023	CFSC - % Looked After Children reviews held on time	90%	100.0%	93.8%	92.3%	94.7%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	90.5%	90.0%	88.0%	100.0%		
	EF049	C&F -Number of referrals - Children & Families		N/A	N/A	N/A	N/A	N/A	N/A	116	172	144	133	121	168	141	199	1194	
	EF044	C&F -Children (of age) participating in, or contributing to, their Child Protection review	90%	N/A	N/A	N/A	N/A	N/A	N/A	0.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
	EF045	C&F -Children (of age) participating in, or contributing to, their Looked After Child review	90%	N/A	N/A	N/A	N/A	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	100.0%	100.0%		
	EF046	C&F -Children (of age) participating in, or contributing to, their Complex Review	79%	N/A	N/A	N/A	N/A	N/A	N/A	36.0%	34.0%	42.0%	41.0%	100.0%	36.0%	35.0%	71.0%		
	EF025	Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	95%	74%	83%	84%	77%	89%	96%	97%	96%	99%	99%	97%	92%	96%	95%		
	EF010	% Dental contractors on target to meet UDA's	96%	47%	72%	75%	75%	75%	72%	3%	10%	17%	25%	35%	38%	46%	53%		
	EF068	Pharmacy - Total Prescriptions (No. of fees)		N/A	N/A	N/A	N/A	N/A	N/A	£131,397	£140,744	£139,132	£136,305	£137,200	£158,757			£843,535	
	EF069	Pharmacy - Chargable Prescriptions		N/A	N/A	N/A	N/A	N/A	N/A	£16,509	£19,236	£18,377	£17,909	£17,376	£22,055			£111,462	
	EF070	Pharmacy - Total Exempt Item		N/A	N/A	N/A	N/A	N/A	N/A	£129,409	£139,125	£137,291	£134,446	£134,685	£155,968			£830,924	
	EF071	Pharmacy - Chargeable Items		N/A	N/A	N/A	N/A	N/A	N/A	£16,410	£19,108	£18,266	£17,909	£17,224	£21,924			£110,841	
	EF072	Pharmacy - Net cost		N/A	N/A	N/A	N/A	N/A	N/A	£1,361,186	£1,486,094	£1,456,788	£1,422,861	£1,401,718	£1,643,309			£8,771,956	
	EF073	Pharmacy - Charges Collected		N/A	N/A	N/A	N/A	N/A	N/A	£63,586	£73,816	£70,832	£68,792	£66,370	£84,646			£428,042	
	EF030	Caesarean Deliveries (not Robson Classified)		36%	28%	34%	38%	26%	21%	39%	43%	32%	46%	61%	41%	35%	43%		
	EF031	Induction of Labour	< 30%	48%	43%	26%	27%	36%	34%	29%	36%	11%	33%	44%	30%	25%	40%		
	EF032	3rd/4th Degree Tear Overall Rate	< 3.5%	2%	2%	0%	5%	0%	0%	0%	0%	1%	0%	0%	1%	2%	0%		
	EF033	Obstetric Haemorrhage >1.5L	< 2.6%	2%	3%	0%	2%	0%	0%	0%	0%	0%	1%	1%	0%	2%	0%		
	EF034	Unplanned Term Admissions To NNU		0%	0%	0%	0%	0%	0%	0%	0%	88%	88%	100%	100%	73%	40%		
	EF035	Stillbirth Number / Rate		0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	
	EF036	Unplanned Admission To ITU – Level 3 Care		0	0	0	0	0	0	0	2	0	1	0	1	0	0	4	
	EF037	% Smoking At Booking		10%	10%	8%	7%	9%	9%	15%	11%	8%	6%	4%	4%	7%	12%		
	EF038	% Of Women Smoking At Time Of Delivery	< 18%	10%	7%	5%	7%	6%	11%	14%	6%	5%	0%	10%	14%	3%	12%		
	EF039	First Feed Breast Milk (Initiation Rate)	> 80%	79%	66%	87%	67%	83%	70%	76%	63%	73%	56%	71%	69%	76%	71%		
	EF040	Breast Feeding Rate At Transfer Home		76%	59%	84%	41%	36%	34%	37%	29%	31%	32%	30%	72%	69%	76%		
	EF041	Neonatal Mortality rate/1000		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	EF059	W&C - Paediatrics- Total Admissions		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	119	131	117	133	162	197	859	
	EF060	W&C - NNU - Total number of Admissions		N/A	N/A	N/A	N/A	N/A	N/A	6	7	8	8	3	7	11	5	55	
	EF061	W&C - NNU - Avg. Length of Stay		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8.5	3.4	5.0	3.4	6.5	21.2		
	EF062	W&C - Community follow up		N/A	N/A	N/A	N/A	N/A	N/A	4	8	6	2	1	3	0	9	33	

Performance Scorecard 4

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
CARE	CA001	Mixed Sex Accomodation - No. of Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CA002	Complaints - Total number of complaints received	-	39	21	19	18	27	30	28	24	27	24	22	26	29	27	207	
	CA012	FFT - How was your experience? No. of responses	-	208	165	63	121	620	739	571	718	2096	1161	1311	1187	1682	1650	10376	
	CA013	FFT - Experience was Very Good or Good	80%	63.0%	90.0%	74.0%	87.0%	87.0%	87.0%	92.0%	87.0%	85.0%	87.0%	90.0%	91.0%	91.0%	91.0%		
	CA014	FFT - Experience was neither Good or Poor	10%	6.0%	3.0%	8.0%	7.0%	10.0%	5.0%	2.0%	4.0%	6.0%	4.0%	4.0%	4.0%	4.0%	4.0%		
	CA015	FFT - Experience was Poor or Very Poor	<10%	31.0%	7.0%	18.0%	6.0%	4.0%	8.0%	6.0%	8.0%	9.0%	9.0%	6.0%	5.0%	5.0%	5.0%		
	CA016	Manx Care Advice and Liaison Service contacts	-	599	663	432	580	770	839	589	636	517	649	621	655	704	958	5329	
	CA017	Manx Care Advice and Liaison Service same day response	80%	88.0%	90.0%	92.0%	90.0%	90.0%	88.0%	89.0%	87.0%	91.0%	90.0%	91.0%	90.0%	89.0%	90.0%		
	CA007	Complaint acknowledged within 5 working days	98%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	86.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
	CA008	Written response within 20 days	98%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%		
	CA010	No. complaints exceeding 6 months	98%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CA011	No. complaints referred to HSCOB	-	0	0	0	0	0	0	0	0	0	7	4	1	4	2	18	
RESPONSIVE	RE058	Cons Led- OP Referrals		2938	3432	2734	2932	3056	3502	2867	2887	3075	2846	2986	2812	3041	2857	23371	
	RE059	Nurse Led- OP Referrals		877	823	656	798	559	717	729	594	850	889	741	824	794	1056	6477	
	RE060	AHP- OP Referrals		809	1174	672	880	508	840	684	736	906	846	770	853	866	962	6623	
		RTT - Number of patients waiting for first hospital appointment		20452	20674	20837	20825	21025	20618	20406	20189	20480	20191	20367	21180	21042	21335		
	RE001	No. patients waiting for first Consultant outpatient	< 15465	14581	14887	14955	14952	15119	15380	15465	15500	15718	15703	15846	16562	16744	16973		
		No. waiting Over 52 weeks - to start consultant-led treatment	0	N/A	4508	4708	4806	5006	4792	4890	4927	5016	5247	5089	5289	5432	5602		
		Average Wait (weeks) - Ref to OP		N/A	49	48	49	51	49	47	47	47	49	48	48	48	49		
		Max wait (weeks) - Ref to OP		N/A	791	794	798	790	794	799	846	836	817	816	840	844	1017		
	RE0011	No. patients waiting for Nurse outpatient		2127	2252	2193	2167	2218	1927	1519	1385	1540	1512	1449	1643	1623	1802		
	RE00111	No. patients waiting for AHP		3744	3535	3559	3684	3688	3311	3422	3304	3222	2976	3072	2975	2675	2560		
	RE002	Number of patients waiting for Daycase procedure	< 2311	3176	2906	2852	2726	2697	2622	2311	2264	2372	2334	2229	2291	2303	2254		
		Average Wait (weeks) - Daycase		0	45	44	43	42	40	41	42	43	43	45	43	44	45		
		Max wait (weeks) - Daycase		0	450	452	291	295	299	304	308	312	316	320	293	297	301		
		No. waiting Over 52 weeks - Inpatient (Daycase only)		0	1022	979	879	787	717	624	609	635	617	602	607	601	604		
	RE003	Number of patients waiting for Inpatient procedure	< 554	752	661	630	612	592	570	554	553	551	534	505	530	497	464		
		Average Wait (weeks) - Inpatient		0	40	39	40	38	40	39	40	41	40	38	38	35	33		
		Max wait (weeks) - Inpatient		0	300	303	308	312	316	321	325	329	333	337	342	235	212		
		No. waiting Over 52 weeks - Inpatient (IP pathway only)		0	198	183	165	155	142	143	144	149	134	124	129	106	95		
	RE004	% Urgent GP referrals seen for first appointment within 6 weeks	85%	48.4%	52.4%	53.4%	41.5%	48.4%	55.7%	60.8%	55.0%	57.0%	60.0%	57.4%	42.4%	55.4%	48.6%		
	RE005	Diagnostics - % requests completed within 6 weeks		83.5%	86.0%	87.0%	82.0%	86.2%	87.3%	84.7%	81.4%	86.7%	86.2%	86.6%	85.4%	85.4%	85.3%		
	RE006	Diagnostics - % Current wait > 6 weeks		72%	70%	75%	75%	70%	70%	73%	71%	70%	71%	74%	71%	68%	61%		
		Diagnostics - Total Waiting List Size (exc. Scheduled & On Hold)		8146	8400	8234	7683	8089	8481	8256	7719	7545	7291	3541	4544	3846	3622		
		Diagnostics - % Current wait <= 6 weeks	99%	28%	30%	25%	25%	30%	30%	27%	29%	30%	29%	26%	29%	32%	39%		
	RE061	Diagnostics-% patients waiting 26 weeks or less	99%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	59%	61%	63%	59%	59%	58%	67%		

Performance Scorecard 5

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
RESPONSIVE	RE007	A&E - % of ED attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at ED (Nobles and RDCH)	76%	69.4%	67.3%	67.7%	68.6%	70.1%	71.0%	70.8%	73.9%	75.7%	71.5%	72.1%	68.7%	71.0%	69.5%		
		A&E - 4 Hour Performance - Nobles		N/A	55.6%	53.1%	55.4%	58.5%	59.6%	61.7%	64.5%	66.5%	61.1%	60.8%	57.9%	60.6%	58.7%		
		A&E - 4 Hour Performance - RDCH		N/A	99.8%	99.2%	98.9%	99.6%	99.8%	99.9%	100.0%	99.6%	100.0%	99.9%	100.0%	99.9%	100.1%		
	RE008	A&E - 4 Hour Performance (Non Admitted)	95%	78.4%	77.2%	78.5%	79.6%	79.6%	80.8%	79.6%	82.1%	84.0%	80.6%	82.9%	78.8%	80.4%	79.3%		
	RE009	A&E - 4 Hour Performance (Admitted)	95%	27.0%	24.9%	20.1%	21.2%	21.4%	22.5%	25.3%	29.0%	29.4%	23.2%	16.8%	16.9%	22.8%	22.6%		
		A&E - Admission Rate		17.6%	18.8%	18.4%	18.9%	16.1%	16.8%	16.1%	15.2%	15.3%	15.7%	16.3%	16.3%	16.4%	17.4%		
	RE0072	A&E - Admission Rate - Nobles		23.9%	25.7%	27.0%	27.2%	22.6%	23.5%	21.3%	20.8%	21.2%	21.5%	22.9%	21.9%	22.3%	23.5%		
		A&E - Admission Rate - RDCH		0.0%	0.2%	0.3%	0.0%	0.3%	0.2%	0.2%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%		
	RE010	A&E - Average Total Time in Emergency Department	360 mins	253	272	301	295	269	254	246	227	220	257	267	298	268	275		
	RE011	A&E - Average number of minutes between Arrival and Triage (Noble's)	15 mins	25	24	27	25	27	26	25	24	21	26	22	29	28	35		
	RE012	Average number of minutes between arrival to clinical assessment-Nobles	60 mins	77	77	70	74	72	62	69	63	56	74	63	67	72	80		
	RE033	ED - Average number of minutes between arrival to clinical assessment-Ramsey	60 mins	22	20	31	28	38	22	14	12	19	13	14	12	12	16		
	RE013	A&E - Patients Waiting Over 12 Hours From Decision to Admit to Admission to a Ward (12 Hour Trolley Waits)	0	2	15	54	56	27	13	6	5	12	36	48	67	48	30	252	
	RE0131	Number of patients exceeding 12 hours in Nobles Emergency Department	0	44	71	142	134	93	56	45	22	47	104	115	191	127	114	765	
	RE080	ED- Emergency Care Time (Average Number of minutes between arrival and referral to speciality OR discharge)	180 min	182	184	181	181	176	177	177	175	161	178	168	182	179	181		
	RE014	Ambulance - Category 1 Response Time at 90th Percentile	15 mins	20	19	23	20	15	28	20	17	19	23	19	17	20	18		
	RE0141	Total Number of Emergency Calls		1090	1036	1209	1100	1025	1109	1059	1035	1105	1131	1130	1134	1118	1099	8811	
	RE0142	Number of Category 1 Calls		35	34	50	37	32	33	25	46	43	41	38	46	24	28	291	
	RE015	Ambulance - Category 1 Mean Response Time	7 mins	12	9	10	10	8	12	11	8	9	11	9	9	11	8		
	RE016	Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	100%	50.0%	40.9%	16.7%	34.6%	15.4%	36.4%	47.1%	50.0%	63.6%	32.0%	56.3%	58.3%	46.2%	40.0%		
		Category 2 Mean Response Time	18 mins	N/A	N/A	N/A	13	12	16	14	16	13	13	11	16	12	13		
	RE034	Category 2 Response Time at 90th Percentile	40 mins	28	28	31	28	26	36	31	38	29	27	25	33	24	26		
		Category 3 Mean Response Time	Monitor	N/A	N/A	N/A	15	16	22	20	20	19	24	17	20	22	24		
	RE035	Category 3 Response Time at 90th Percentile	120 mins	36	39	58	32	32	57	42	51	39	53	37	47	48	61		
		Category 4 Mean Response Time	Monitor	N/A	N/A	N/A	22	19	25	30	35	20	37	26	44	33	36		
	RE036	Category 4 Response Time at 90th Percentile	180 mins	64	79	105	53	41	54	76	82	63	74	56	121	84	78		
		Category 5 Mean Response Time	Monitor	N/A	N/A	N/A	33	31	42	40	36	31	35	32	35	33	30		
		Category 5 Response Time at 90th Percentile	180 mins	80	93	95	80	80	98	91	89	72	83	72	81	72	71		
		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	0	N/A	N/A	N/A	219	169	142	154	161	181	166	189	240	191	198	1480	
		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	0	17	23	48	34	13	8	13	10	17	12	28	31	24	22	157	
	RE043	OPEL level 4 (Days)		0	0	3	5	3	0	0	0	0	1	3	5	2	2	12	
	RE082	Meds Demand - N.patient interactions		N/A	N/A	N/A	N/A	N/A	N/A	3111	2872	2295	2664	2281	2211	2326	2574	20334	
	RE083	Meds Overnight Demand		N/A	N/A	N/A	N/A	N/A	N/A	354	317	224	275	197	195	230	552	2344	
	RE084	Meds - Face to face appointments		N/A	N/A	N/A	N/A	N/A	N/A	609	474	360	574	471	398	419	571	3876	
	RE086	Meds - TUNA%		N/A	N/A	N/A	N/A	N/A	N/A	1.1%	1.1%	0.6%	1.0%	2.8%	1.5%	1.4%	1.1%		
	RE088	Meds- DNA%		N/A	N/A	N/A	N/A	N/A	N/A	1.1%	1.5%	3.3%	0.5%	2.3%	1.5%	2.1%	1.4%		

Performance Scorecard 6

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
RESPONSIVE	RE0171	Referrals received for all suspected cancers		416	439	308	385	418	416	368	455	445	375	455	422	487	423	3430	
	RE018	CWT - % patients decision to treat to first definitive treatment within 31 days	96%	86.4%	76.6%	82.0%	76.9%	78.6%	87.3%	76.0%	73.5%	82.4%	80.0%	83.8%	73.8%	71.2%	86.4%		
	RE019	CWT - Maximum 62 days from referral for suspected cancer to first treatment	85%	33.3%	42.1%	42.4%	31.6%	34.3%	62.2%	21.1%	50.0%	54.0%	35.7%	63.6%	46.4%	51.9%	50.0%		
	RE025	CWT - Maximum 28 days from referral for suspected cancer (via 2WW or Cancer Screening) to date of diagnosis	75%	62.6%	68.3%	67.5%	55.8%	66.2%	60.3%	67.4%	63.7%	58.0%	57.3%	68.4%	65.3%	75.3%	64.6%		
	RE057	All Referrals received for all suspected cancers		515	537	397	483	489	502	434	537	514	460	558	502	599	501	4105	
	RE026	IPCC - % patients seen by Community Adult Therapy Services within timescales	80%	57.8%	56.9%	75.5%	65.6%	53.7%	54.8%	60.9%	42.1%	56.0%	44.0%	44.6%	38.5%	62.1%	68.2%		
		% Urgent 1 - seen within 3 working days	80%	64.0%	55.2%	82.6%	78.6%	86.7%	74.2%	69.8%	50.0%	71.5%	65.6%	54.1%	42.4%	50.0%	100.0%		
		% Urgent 2 - seen within 5 working days	80%	58.3%	61.5%	76.2%	77.2%	68.4%	61.8%	73.7%	54.0%	67.7%	39.3%	50.0%	52.2%	69.8%	82.1%		
		% Soon 1 - seen within 15 working days	80%	48.8%	54.6%	78.4%	47.7%	26.7%	34.9%	38.7%	21.7%	23.9%	32.6%	39.6%	16.4%	0.0%	0.0%		
		% Soon 2 - seen within 30 working days	80%	33.3%	41.2%	44.4%	38.5%	9.1%	38.5%	70.0%	0.0%	100.0%	0.0%	0.0%	51.9%	69.5%	70.5%		
		% Routine - seen within 12 weeks	80%	68.4%	80.0%	69.0%	46.2%	62.5%	40.0%	70.0%	87.5%	79.0%	50.0%	34.8%	42.9%	66.7%	56.0%		

Performance Scorecard 7

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
RESPOSIVE		IPCC - No. patients waiting for a dentist		2330	2528	2651	2808	2983	2638	3509	3666	3872	3993	4042	4268	4415	4528		
	RE0271	IPCC - Longest time waiting for a dentist (weeks)		148	153	170	159	164	167	168	177	181	185	189	193	200	203		
		IPCC - Number patients seen by dentist within the year		55739	55102	54404	54238	54924	53892	53697	53829	53089	53628	53778	54084	54025	53151		
	RE031	The % of patients registered with a GP (PERMANENT REGISTRATION)		4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.0%	4.0%	4.0%	4.0%	4.0%		
		Average of Days to next GP appt - Ballasalla		9.0	9.8	10.0	13.3	9.0	13.0	13.7	5.8	7.0	4.7	6.0	6.3	7.8	8.0		
		Average of Days to next GP appt - Castletown		4.6	5.3	6.0	2.6	4.0	4.3	5.0	7.0	4.5	2.0	3.0	2.3	4.3	3.5		
		Average of Days to next GP appt - Finch		4.6	6.0	8.3	5.0	7.5	7.8	6.7	6.0	8.0	8.3	8.0	5.5	5.3	5.5		
		Average of Days to next GP appt - Hailwood		5.4	6.3	4.0	5.4	8.5	7.0	10.0	9.0	10.5	9.6	13.3	6.0	4.3	9.5		
		Average of Days to next GP appt - Kensington		5.2	4.5	5.5	4.6	4.0	5.8	10.5	4.0	8.0	8.4	12.7	11.0	9.0	9.5		
		Average of Days to next GP appt - Laxey		5.2	3.5	7.8	7.2	5.8	8.5	10.5	8.0	6.8	9.8	10.7	9.0	10.5	9.5		
		Average of Days to next GP appt - Palatine		1.2	1.0	7.5	1.8	4.5	4.3	10.3	1.0	1.0	10.6	15.3	10.0	13.5	14.0		
		Average of Days to next GP appt - Peel		10.0	10.0	9.3	10.2	6.0	9.3	9.3	6.0	5.8	7.6	6.3	1.0	1.0	1.0		
		Average of Days to next GP appt - Ramsey		1.0	1.3	1.0	1.0	1.0	1.0	1.3	1.0	1.0	1.0	1.0	1.0	1.0	1.0		
		Average of Days to next GP appt - Snaefell		18.4	18.0	18.3	19.8	17.3	10.3	16.8	13.0	4.5	15.5	12.0	20.0	17.0	23.5		
		Average of Days to next GP appt - Southern		1.4	1.0	2.0	1.0	1.0	1.3	1.5	2.0	1.0	1.8	2.0	1.3	1.0	1.5		
	RE081	IPCC - N. of GP appointments		52672	38565	29373	41822	37919	38127	34968	44528	36436	43448	33995	38294	51488	20263	303420	
	RE054	Did Not Attend Rate (GP Appointment)	-	3%	3%	3%	3%	3%	3%	3%	3%	3%	2%	3%	3%	2%	3%		
	RE074	Response by Community Nursing to Urgent / Non routine		N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	95%		
	RE075	Community Nursing Service response target met - Routine		N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%		
	RE028	MH - No. service users on Current Caseload	4500 - 5500	4718	4733	4809	4926	4995	5030	5090	5093	5129	5211	5226	5285	5325	5359	41718	
	RE044	MH- Waiting list		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1572	1637	1598	1654	1701	1750		
	RE071	Average caseload per social worker-Adult Generic Team	16 to 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13.3	19.0	19.3	21.7	20.3	0.0		
	RE078	Average caseload per social worker-Adult Learning Disabilities	17 to 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18.7	20.3	21.1	23.4	27.1	0.0		
	RE079	Average caseload per social worker-Older Persons Community Team	18 to 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10.8	11.7	11.3	14.7	17.2	0.0		

Performance Scorecard 8

	KPI ID	Indicator	OP. Plan Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD 2023-24	YTD Performance
RESPONSIVE	RE030	W&C - % New Birth Visits within timescale		86.0%	91.9%	87.5%	94.4%	86.7%	90.6%	96.0%	85.7%	86.0%	83.0%	89.4%	84.3%	90.4%	96.2%		
	RE032	Births per annum		329	390	428	488	535	588	54	103	144	191	237	293	348	391		
	RE051	Maternity Bookings		56	51	43	70	61	57	48	73	48	48	55	51	56	60	439	
	RE052	Ward Attenders		97	92	94	110	126	196	196	159	146	270	244	44	309	230	1598	
	RE053	Gestation At Booking <10 Weeks		0.0%	45.1%	20.9%	8.6%	39.3%	26.3%	39.6%	21.9%	20.8%	29.2%	30.9%	39.2%	33.9%	45.0%		
	RE056	Adult General and Acute (G&A) bed occupancy	<=92%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	60.1%	64.2%	61.6%	63.2%	68.3%		
	RE069	ASC - % of all Residential Beds Occupied	85% - 100%	80%	71%	69%	82%	68%	84%	83%	83%	71%	69%	68%	52%	59%	0%		
	RE070	Respite bed occupancy	>= 90%	71%	50%	79%	96%	81%	79%	92%	80%	69%	70%	81%	65%	58%	0%		
		Total number of Service Users		238	207	207	252	204	262	250	250	212	134	134	162	181	0		
	RE068	ASC-% of Service users with a PCP in Place	95.00%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	0%		
WELL LED (PEOPLE)	WP001	% Hours lost to staff sickness absence	4.0%	6.6%	6.8%	7.7%	7.9%	6.4%	7.6%	5.9%	5.2%	5.5%	6.0%	6.6%	6.0%	7.0%	6.4%		
	WP002	Number of staff on long term sickness		78	66	83	77	0	83	65	82	69	91	94	82	63	116		
	WP004	Number of staff leavers		24	22	16	17	17	19	22	22	24	22	34	34	19	21	197	
	WP005	Number of staff on disciplinary measures		6	6	3	5	6	5	5	7	8	9	11	10	6	11	67	
	WP006	Number of suspended staff		1	0	0	0	1	1	1	1	1	1	4	4	4	5	21	
	WP007	Number of Data Breaches	0	5	11	12	13	13	22	8	13	13	11	11	12	14	8	90	
		Reported to ICO		N/A	11	12	13	13	21	8	13	13	13	11	11	4	4	77	
	WP011	Number of Enforcement Notices from the ICO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	WP012	Number of DSAR, AHR and FOI's not completed within their target	0	9	11	19	4	1	4	32	39	76	27	39	33	29	29	304	
	WP013	Staff 12 months turnover rate	10%	N/A	N/A	11.4%	11.2%	11.4%	11.3%	11.0%	10.9%	10.4%	10.0%	9.4%	9.7%	9.4%	7.0%		
	WP015	Number of DSAR, AHR and FOI's overdue at month end		0	0	4	1	5	14	44	55	33	41	41	24	31	40	309	
		Number of DSAR, AHR and FOI's Breaches		9	11	23	5	6	18	76	94	109	68	80	57	60	69	613	
WELL LED (FINANCE)	WF001	% Progress towards Cost Improvement Target (CIP)	1.5%	80.0%	86.0%	116.3%	126.0%	170.0%	170.0%	N/A	N/A	22.2%	26.7%	33.3%	76.0%	86.7%			
	WF002	Total income (£)		-£1,189,570.33	-£1,169,900.12	-£1,190,786.72	-£1,141,775.07	-£1,159,261.20	-£2,136,829.00	-£1,289,366.95	-£1,205,889.53	-£1,363,058.62	-£1,220,692.80	-£1,256,106.57	-£1,309,283.30	-£1,517,134.68		-£9,161,532	
	WF003	Total staff costs (£)		£15,870,578.46	£15,981,427.72	£16,412,712.32	£20,671,098.02	£16,664,824.49	£13,959,910.00	£16,872,849.17	£17,794,223.57	£17,822,473.03	£17,602,014.00	£17,743,480.14	£18,213,529.79	£17,915,352.77		£123,963,922	
	WF004	Total other costs (£)		£12,588,823.97	£11,884,585.72	£11,462,989.50	£12,235,734.20	£12,660,798.15	£14,906,339.00	£12,333,621.23	£13,965,735.52	£12,377,178.61	£13,156,152.00	£13,621,544.61	£12,102,126.42	£12,646,943.85		£90,203,302	
	WF005	Agency staff costs (proportion %)		9.3%	8.1%	13.0%	11.4%	8.2%	6.9%	7.8%	7.4%	6.2%	6.2%	4.7%	4.8%	5.8%			
	WF007	Actual performance (£ 000)		N/A	£26,696.0	£26,685.0	£31,765.0	£28,166.0	£26,729.0	£26,549.0	£28,435.0	£27,911.0	£29,509.0	£30,100.0	£28,814.0	£29,030.0			
	WF008	budget (£ 000)		N/A	£23,571.0	£23,751.0	£23,571.0	£23,571.0	£23,572.0	£25,248.0	£25,248.0	£25,248.0	£25,248.0	£30,648.0	£25,948.0	£25,948.0			
	WF009	Actual performance against Budget (£ 000)		N/A	-£3,125.0	-£2,934.0	-£8,194.0	-£4,595.0	-£3,157.0	-£1,301.0	-£3,187.0	-£2,663.0	-£4,261.0	£548.0	-£2,866.0	-£3,082.0			