Integrated Performance Report

Jan-24

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manx care
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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 and Business Intelligence Team (PBI) 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)**

  PBI 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 the government's 'Our Island Plan'. Nominated leads within the Care Groups have been identified to be responsible for the delivery of each KPI. Where existing reporting does not cover all of the requirements, PBI are working with the service area leads to develop the required measurement and reporting mechanisms and processes.

- **Planned Care**

  Several new planned care metrics (e.g. Number of discharges by time of day, and Number of delayed transfers of care) will be provided in next month's IPR.

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 PBI 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.
PBI is continuing to progress 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:

🟢 Data automated and validated.

🟠 Data collated manually or automated data still being validated by service area.

⚪ Data currently unavailable or validation in initial stages only

In this context 'Validation' means that the input, methodology/calculation and outputs for a given metric have been checked by both the PBI 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 Oversight 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:
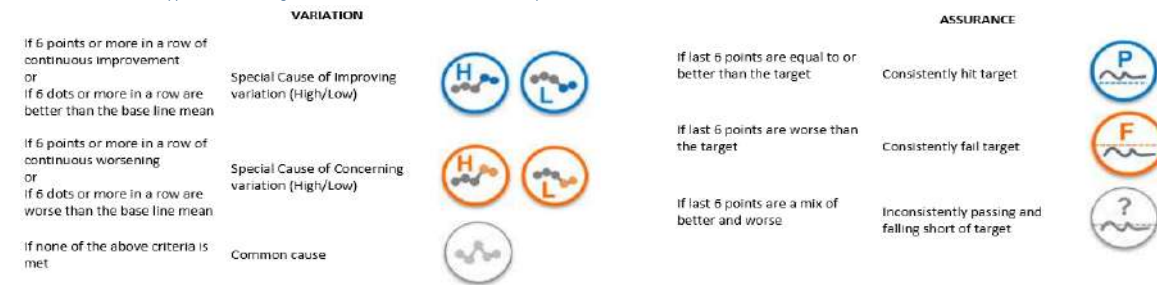
The process for assigning the categories to each KPI is currently a manual one, but PIMS are currently working with the BI team to automate the process of generating the SPC charts and allocating the appropriate categories for Variation and Assurance.

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.
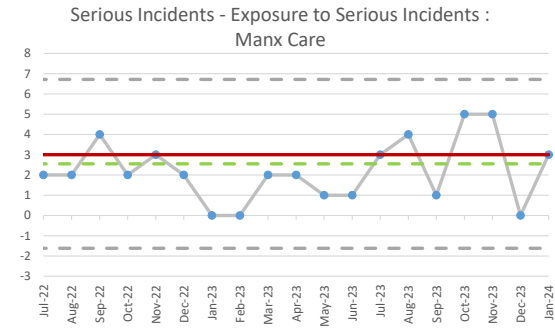Work to identify appropriate peer organisations and metrics to benchmark Manx Care's performance against is ongoing, and currently many of the benchmark figures within this report use Manx Care's 2022/23 performance as a baseline. Details of the benchmark methodologies applied for each KPI and metric can be found within the 'Assurance / Recovery Trajectory' section of the supporting performance narratives.

Executive Summary

	Going Well	Cause for Concern
Safe	• 30 consecutive months without a Never Event. • 3 serious incidents in January, though YTD of 25 remains below threshold of < 36. • Ony one case of C.Diff reported. • Zero Medication Errors with Harm across Manx Care in January. • 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 98% which is above the 95% standard. • There were no cases of MRSA in January. • 100% of letters were sent in accordance with Duty of Candour Regulations.	• 8 cases of E.coli bacteraemia. • 48-72 hr senior medical review of antibiotic prescription remains below the 98% threshold, though increased to 90% in January from 78% in December.
Effective	• 98% of Learning from Death reviews were completed within timescale which exceeds the target for the twelfth month in a row. • The Crisis Team continue to meet the 1 hour response time threshold for Emergency Department referrals with 91% in January. • Adult Social Care re-referral rates remain within expected levels. • The reported number of individuals receiving copies of their Wellbeing Partnership assessments was 96% in January, with the average monthly achievement now at 85%.	• Access to surgical bed base continues to challenge theatre efficiency and utilisation. • Consultant anaesthetic staffing and theatre staffing position remains a challenge. • Induction of labour was above national standard (30%) at 46.9%. YTD Mean 32%. • Complex Needs Reviews held on time was 34% (YTD mean 59%).
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 90% 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 December was 100%.	• 24 complaints were logged in January, but this remains within 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. • Good performance was maintained in the Ambulance service for Category 2 - 5 response times. • Mental Health caseloads remain within expected levels.	• The ED Performance against the 4 hour standard slightly decreased to 66% in January and remains below the required target. • 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 51 12-Hour Trolley Waits. • 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 35 breaches of the 60 minute ambulance turnaround time in January, though this was an improvement compared to 43 in December. • The ED reached the highest Operational Pressures Escalation Level (OPEL), Level 4, in January for 2 days. • Cancer 28 Day performance in January was below the 75% threshold at 69%, though improved from 66% in December.
Well Led (People)	• It is very encouraging to continue to see a high level of engagement from staff across the whole of Manx Care with the Information Governance Team in relation to data protection and data sharing. The team are regularly contacted by staff seeking advice across a range of issues. A Data Protection Impact Assessment (DPIA) course is being run for Manx Care staff on Friday 16th February. The course was oversubscribed and a second course has been scheduled later in February to accommodate staff who requested places.	• The volumes of Freedom of Information Requests, Data Subject Access Requests and Police and Court requests remains high and presents a significant challenge for the Information Governance Team. In January 2024 Manx Care received 77 Data Subject Access Requests. The overall trend continues to increase and it is likely that the average number of requests by the end of 2024 will be almost 80 per month (for comparison the monthly average at December 2022 was 45). • There were 14 Data Breaches in January. All breaches are fully investigated in order that Manx Care can identify 'lessons learned' and improve our processes going forward.
Well Led (Finance)		• The operational result for December is an overspend of (£2.1m). Due to the number of risks identified from November which have now been investigated further the forecast has been moved by (£3.2m) to an overspend of (£34.8m). • YTD employee costs are (£4.9m) over budget. Agency spend is contributing to this overspend and reducing this is a factor in improving the financial position by the year end.

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	Jan-24	🟢	3	3	25	< 36 PA		?
SA002	🟡	Duty of Candour Letter sent within 10 days of the application	Jan-24	🟢	100%	88%	-	80%		?
SA018	🟡	Compliance with the Duty of Candour Regulations	Jan-24	🟢	100%	93%	-	100%		?
SA003	🟡	% Eligible patients having VTE risk assessment within 12 hours of decision to admit	Jan-24	🟢	98%	91%	-	95%		?
SA004	🟡	% Adult Patients (within general hospital) with VTE prophylaxis prescribed	Jan-24	🟢	99%	97%	-	95%		P
SA005	🟡	Never Events	Jan-24	🟢	0	0	0	0		P
SA006	🟡	Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	Jan-24	🟢	0.3	0.3	-	< 2		P
SA007	🟡	Clostridium Difficile - Total number of acquired infections	Jan-24	🟢	1	2	24	< 30 PA		?
SA008	🟡	MRSA - Total number of acquired infections	Jan-24	🟢	0	0	1	0		?
SA009	🟡	E-Coli - Total number of acquired infections	Jan-24	🔴	8	8	76	< 72 PA		?
SA010	🟡	No. confirmed cases of Klebsiella spp	Jan-24	-	2	2	16	-		
SA011	🟡	No. confirmed cases of Pseudomonas aeruginosa	Jan-24	-	0	1	5	-		
SA012	🟡	Exposure to medication incidents resulting in harm	Jan-24	🟢	0	0	3	< 25 PA		P

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	Jan-24	🟢	97%	97%	-	95%		P
SA014	🟡	Harm Free Care Score (Safety Thermometer) - Maternity	Jan-24	🟢	100%	99%	-	95%		?
SA015	🟡	Harm Free Care Score (Safety Thermometer) - Children	Jan-24	🟢	99%	97%	-	95%		P
SA016	🟡	Hand Hygiene Compliance	Jan-24	🟢	96%	97%	-	96%		P
SA017	🟡	48-72 hr review of antibiotic prescription complete	Jan-24	🟡	90%	80%	-	>= 98%	H	F
SA019	🟡	Pressure Ulcers - Total incidence - Grade 2 and above	Jan-24	🟢	14	16	160	<= 17 (204 PA)		?

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

Serious Incidents - Exposure to Serious Incidents : Manx Care

Reporting Date	Performance	Op. plan #
Jan-24	3	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

Compliance with the Duty of Candour Regulations
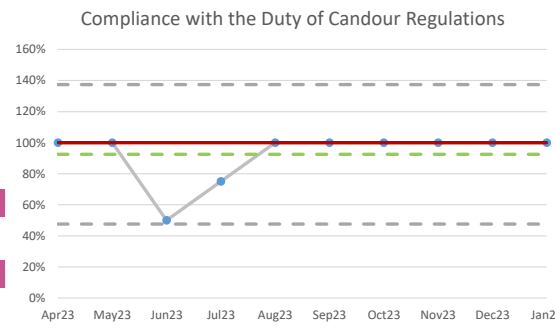
Reporting Date	Performance	Op. plan #
Jan-24	100%	QC112

Threshold	YTD Mean	Benchmark
100.0%	92.5%	92.5%

(Higher value represents better performance)

+	Variation Description
	Common cause

+	Assurance Description
	Inconsistently passing and falling short of target

Duty of Candour Letter sent within 10 days of the application
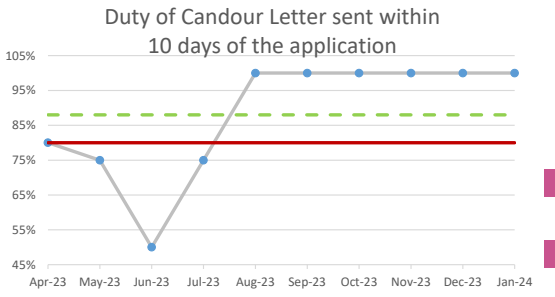
Reporting Date	Performance	Op. plan #
Jan-24	100%	QC112

Threshold	YTD Mean	Benchmark
80%	88.0%	88.00%

(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: 3 serious incidents declared during January, meaning 25 YTD **Letter has been sent in accordance with Duty of Candour Regulations:** • 100% compliance.	**Serious Incidents:** • Continued monitoring via SIRG. **Letter has been sent in accordance with Duty of Candour Regulations:** • Continue to monitor .	**Serious Incidents:** • The percentage of Serious Incidents declared is slightly higher (0.53%) for January than the 2023 average (0.4%); however, due to the relatively low number of SIs declared this figure is subject to variation when viewed over the short term. **Letter has been sent in accordance with Duty of Candour Regulations:** • Performance remains strong.

| 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 #
Jan-24	**98.0%**	QC113

Threshold	YTD Mean	Benchmark
95.0%	91.0%	89.2%

(Higher value represents better performance)

Variation Description
Common cause

Assurance Description
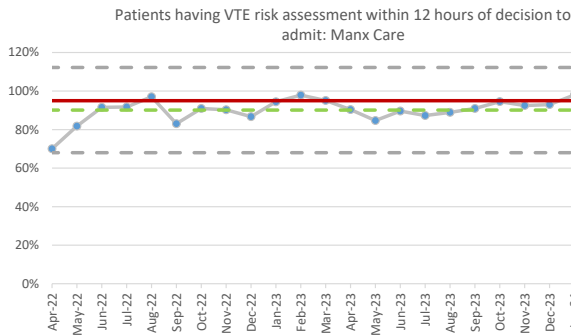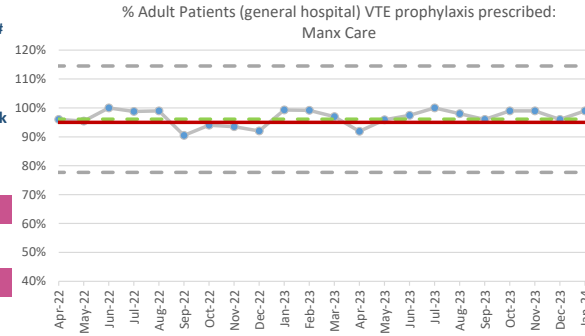Inconsistently passing and falling short of target

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

Reporting Date	Performance	Op. plan #
Jan-24	**99.0%**	QC114

Threshold	YTD Mean	Benchmark
95.0%	97.2%	96.2%

(Higher value represents better performance)

Variation Description
Common cause

Assurance Description
Consistently hit target

Issues / Performance Summary

VTE risk assessment within 12 hours:
• 98% for January which is the highest since March 2023.

VTE Prophylaxis:
• Excellent results for January - 99% VTE prophylaxis treatment was prescribed, exceeding our target of 95% for the ninth consecutive month.

Planned / Mitigation Actions

VTE risk assessment within 12 hours:
• The CQS Team continue to remind clinical staff of the requirement to complete risk assessments.

VTE Prophylaxis:
• The focus continues to remain on completing risk assessments within 12 hours of admission.

Assurance / Recovery Trajectory

VTE risk assessment within 12 hours:
• The Care Groups will continue to monitor performance in this area.

VTE Prophylaxis:
• There is a high level of confidence as performance remains consistently positive.

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

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| | Executive Lead | Paul Moore | Lead | Paul Hurst; Sue Davis |

Falls Inpatient (Harm only) per 1,000 bed days : Manx Care
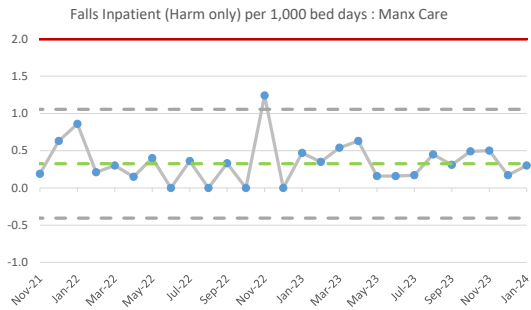
Reporting Date	Performance	Op. plan #
Jan-24	0.3	QC4

Threshold	YTD Mean	Benchmark
< 2	0.3	0.3

(Lower value represents better performance)

- Variation Description
Common cause

+ Assurance Description
Consistently hit target

Exposure to medication incidents resulting in harm: Manx Care
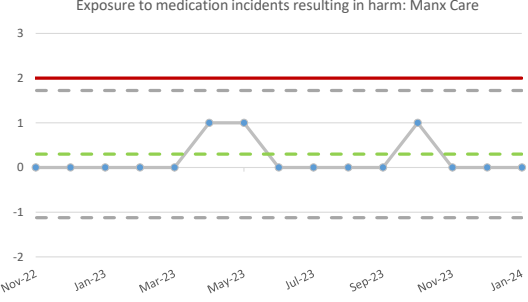
Reporting Date	Performance	Op. plan #
Jan-24	0	

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 #
Jan-24	14	QC4

Threshold	YTD Mean	Benchmark
<= 17 (204 PA)	16.0	14.1

(Lower value represents better performance)

- Variation Description
Common cause

+ Assurance Description
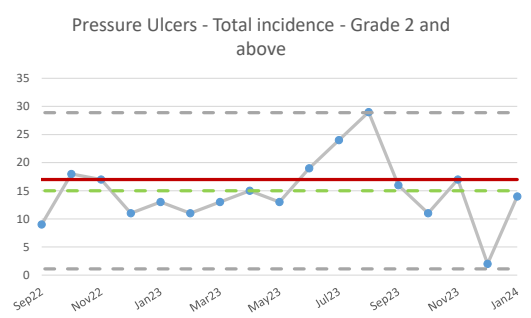Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Inpatient Health Service Falls (with harm) per 1000 occupied bed days: • 0.3 falls with harm, which is below the threshold of <2. YTD mean stands at 0.40; again below the threshold. **Medication Errors (with Harm):** • Zero medication errors with moderate and above harm reported in January, with just 3 cases reported YTD. **Pressure Ulcer incidence:** • There were 14 pressure ulcers reported as occurring or deteriorating in January. This is a notable increase from the 2 reported in December, although that month was a significant outlier. The actual number is consistent with all other previous months (since the indicator was amended). More than half of the pressure ulcers reported over the period occurred outside of Manx Care settings (typically private homes). There were 4 pressure ulcers which were said to have originated in clinical areas; one of these relates to an EoL patient.	**Inpatient Health Service Falls (with harm) per 1000 occupied bed days:** • All inpatient falls are reviewed to ensure that an appropriate risk assessment has taken place and to ensure that mitigation is in place. **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:** • There is evidence of appropriate follow up/management by TVN or district nurses in each case.	**Inpatient Health Service Falls (with harm) per 1000 occupied bed days:** • This has consistently remained below target and monitoring will continue. **Medication Errors (with Harm):** • Reasonable assurance that errors leading to harm will remain low. **Pressure Ulcer incidence:** • The actual baseline is still being established, and this indicator is due to be amended in April 2024 to focus on inpatient settings exclusively. Once community and social care pressure ulcers are excluded, the number will be much lower. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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C.Diff - Actual Cases : Manx Care
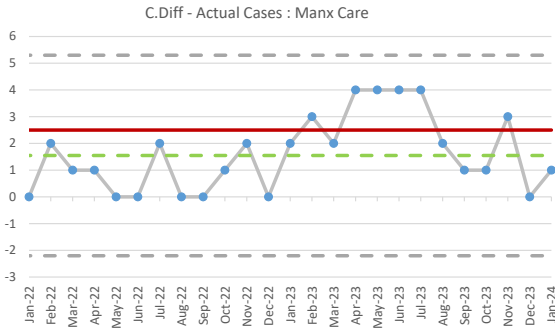
Reporting Date Jan-24 | **Performance** 1 | **Op. plan #** QC115

Threshold	YTD Mean	Benchmark
< 30 PA	2	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
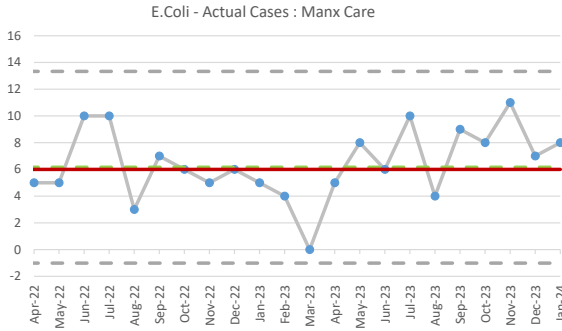
Reporting Date Jan-24 | **Performance** 8 | **Op. plan #** QC116

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
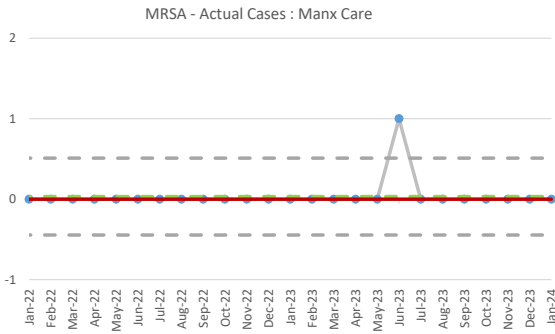
Reporting Date Jan-24 | **Performance** 0 | **Op. plan #** QC8

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: • One case reported in January 2024. **E.Coli:** • 8 cases all community associated. **MRSA:** • Zero cases reported for month. **Pseudomonas aeruginosa:** • 0 cases reported.	**C.Diff:** Continue with CDI patient safety management plan. **MRSA:** • Surveillance and reporting to continue.	**C.Diff:** Continue to monitor **E.Coli:** Continue to monitor. **MRSA:** • Trajectory remains stable/positive. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

	Executive Lead	Paul Moore

Reporting Date Jan-24 | **Performance** 97.0% | **Op. plan #** QC119

Threshold 95.0% | **YTD Mean** 97.1% | **Benchmark** 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

	Lead	Paul Hurst; Sue Davis

Reporting Date Jan-24 | **Performance** 100.00% | **Op. plan #** QC120

Threshold 95.0% | **YTD Mean** 98.9% | **Benchmark** 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 Jan-24 | **Performance** 99.0% | **Op. plan #** QC121

Threshold 95.0% | **YTD Mean** 97.0% | **Benchmark** 95.8%

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Adult: • 97% remains above the target of 95%; YTD average also exceeding target at 97%. **Maternity:** • 100% Maternity patients were kept harm free. Results for the YTD extremely positive with 9 out of 10 months exceeding the target. **Children:** • 99% of children were kept harm free, exceeding the target of 95% for 9 out of 10 months in this reporting year.	**Adult:** • Continue to maintain compliance. **Maternity:** • Continue to maintain compliance. **Children:** • Continue to maintain compliance.	**Adult:** • High level of confidence that this level will be maintained. **Maternity:** • Confident that high level of compliance will be maintained. **Children:** • Confident that compliance will be maintained. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

Hand Hygiene Compliance: Manx Care

Reporting Date	Performance	Op. plan #
Jan-24	**96.0%**	QC112

Threshold	YTD Mean	Benchmark
96.0%	97.4%	96.5%

(Higher value represents better performance)

-	Variation Description

Common cause

+	Assurance Description

Consistently hit target

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

Reporting Date	Performance	Op. plan #
Jan-24	**90.0%**	QC123

Threshold	YTD Mean	Benchmark
>= 98%	79.9%	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:
• 96% reported for the month which is above target and in keeping with YTD average.

Review of Antibiotic Prescribing:
• 90% in January, up from 78% in December.

Planned / Mitigation Actions

Hand Hygiene:
• Continue with existing strategies.

Review of Antibiotic Prescribing:
• Continue to monitor.

Assurance / Recovery Trajectory

Hand Hygiene:
• Confidence in target being maintained

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

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

| 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)	Jan-24	🟡	15%	13%	-	5% by Apr '24		
EF067	🟡	Planned Care - DNA Rate - Hospital	Jan-24	🟡	12.2%	-	-	5%		
EF002	🟡	Planned Care - Total Number of Cancelled Operations	Jan-24	🟡	390	330	3300	-	(variation)	
EF005	🟡	Length of Stay (LOS) - No. patients with LOS greater than 21 days	Jan-24	-	115	108	-	-	(variation)	
EF050	🟡	Total Number of Inpatient discharges-Nobles	Jan-24	-	920	924	9235	-		
EF051	🟡	Total Number of inpatient discharges-RDCH	Jan-24	-	40	38	383	-		
EF003	🟢	Theatres - Number of Cancelled Operations	Jan-24	🟡	44	36	360	-	(variation)	
EF004	🟢	Theatres - Theatre Utilisation	Jan-24	🟡	76%	76%	-	85%	(variation)	F
EF006	🟡	Crude Mortality Rate	Jan-24	-	38	23	271	-		
EF007	🟡	Total Hospital Deaths	Jan-24	-	41	23	279	-		
EF024	🟡	Mortality - Hospitals LFD (Learning from Death reviews)	Jan-24	🟢	98%	97%	-	80%	H	P
EF025	🟡	Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	Jan-24	🟢	95%	96%	-	95%	H	?
EF008	🟢	ASC -West Wellbeing Contribution to reduction in ED attendance	Jan-24	🟡	0.4%	7%	-	-5%	(variation)	F
EF009	🟢	ASC - West Wellbeing Reduction in admission to hospital from locality	Jan-24	🔴	28%	5%	-	-10%	(variation)	?
EF010	🟡	IPCC - % Dental contractors on target to meet UDA's	Dec-23	🟡	55%	-	-	96%		F
EF011	🟡	MH - Average Length of Stay (LOS) in MH Acute Inpatient Service	Jan-24	-	31	34	-	-	(variation)	
EF064	🟡	MH - Number of patients with a length of stay - 0 days	Jan-24	-	0	1	8	-	(variation)	

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	Jan-24	-	1	2	15	-	(variation)	-
EF066	🟡	MH - Number of patients aged 65+ with a length of stay - > 90 days	Jan-24	-	2	1	12	-	(variation)	-
EF013	🟡	MH - % service users discharged from MH inpatient to have follow up appointment	Jan-24	🟡	89%	98%	-	90%	(variation)	P
EF047	🟡	% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	Jan-24	🟢	100%	100%	-	75%	(variation)	P
EF048	🟡	% Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral	Jan-24		-	83%	-	75%	(variation)	?
EF026	🟡	MH - Crisis Team one hour response to referral from ED	Jan-24	🟢	91%	90%	-	75%	(variation)	P
EF063	🟡	ASC - No. of referrals	Jan-24	-	82	74	739	-	(variation)	-
EF015	🟡	ASC - % of Re-referrals	Jan-24	🟢	6%	3%	-	<15%	(variation)	P
EF016	🟡	ASC - % of all Adult Community Care Assessments completed in Agreed Timescales	Jan-24	🔴	28%	32%	-	80%	(variation)	F
EF017	🟡	ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment	Jan-24	🟡	96%	85%	-	100%	(variation)	?
EF052	🟡	Referrals to Adult Safeguarding Team	Jan-24	-	114	100	997	-		-
EF053	🟡	Adult Safeguarding Alert	Jan-24	-	65	59	589	-		-
EF054	🟡	Discharges from Adult Safeguarding Team	Jan-24	-	77	95	949	-	(variation)	-
EF055	🟡	Re-referrals to Adult Safeguarding Team	Jan-24	-	14	19	188	-	(variation)	-
EF056	🟡	% MARFs Completed by Adult Safeguarding Team	Jan-24	-	100%	87%	-	-	(variation)	

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	Jan-24	Red	230	161	1612	-		
EF019		CFSC - % Complex Needs Reviews held on time	Jan-24	Red	34%	59%	-	85%		
EF021		CFSC - % Total Initial Child Protection Conferences held on time	Jan-24	Yellow	80%	72%	-	90%		
EF022		CFSC - % Child Protection Reviews held on time	Jan-24	Yellow	75%	72%	-	90%		
EF023		CFSC - % Looked After Children reviews held on time	Jan-24	Yellow	76%	94%	-	90%		
EF044		C&F -Children (of age) participating in, or contributing to, their Child Protection review	Jan-24	Green	90%	88%	-	90%		
EF045		C&F -Children (of age) participating in, or contributing to, their Looked After Child review	Jan-24	Green	100%	99%	-	90%		
EF046		C&F -Children (of age) participating in, or contributing to, their Complex Review	Jan-24	Red	55%	47%	-	79%		
EF030		Maternity - Caesarean Deliveries (not Robson Classified)	Jan-24	-	39%	42%	-	-		
EF031		Maternity - Induction of Labour	Jan-24	Red	47%	32%	-	< 30%		
EF032		Maternity - 3rd/4th Degree Tear Overall Rate	Jan-24	Green	2%	1%	-	< 3.5%		
EF033		Maternity - Obstetric Haemorrhage >1.5L	Jan-24	Yellow	4%	1%	-	< 2.6%		
EF034		Maternity - Unplanned Term Admissions To NNU	Jan-24	-	10%	-	-	-		
EF035		Maternity - Stillbirth Number / Rate	Jan-24	Green	0	0.1	1.0	<4.4/1000		
EF036		Maternity - Unplanned Admission To ITU – Level 3 Care	Jan-24	-	1	-	-	-		
EF037		Maternity - % Smoking At Booking	Jan-24	-	10%	9.3%	-	-		

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	Jan-24	Green	8%	8%	-	< 18%		
EF039		Maternity - First Feed Breast Milk (Initiation Rate)	Jan-24	Yellow	63%	68%	-	> 80%		
EF040		Maternity - Breast Feeding Rate At Transfer Home	Jan-24		78%	-	-			
EF041		Maternity - Number of Neonatal Mortality	Jan-24		1	0.1	-			-
EF059		W&C - Paediatrics- Total Admissions	Jan-24		169	149	1192	-		-
EF060		W&C - NNU - Total number of Admissions	Jan-24		5	7	65	-		-
EF061		W&C - NNU - Avg. Length of Stay	Jan-24		4	8	65	-		
EF062		W&C - NNU -Community follow up	Jan-24		8	5	49	-		
EF068		Pharmacy - Total Prescriptions (No. of fees)	Nov-23		146,299	140,960	1,127,682	-		
EF069		Pharmacy - Chargable Prescriptions	Nov-23		19,690	18,670	149,363	-		
EF070		Pharmacy - Total Exempt Item	Nov-23		143,793	138,818	1,110,541	-		
EF071		Pharmacy - Chargeable Items	Nov-23		19,273	18,507	148,054	-		
EF072		Pharmacy - Net cost	Nov-23		£1,405,662	£1,443,644	£11,549,154	-		
EF073		Pharmacy - Charges Collected	Nov-23		£74,520	£71,457	£571,654	-		
EF081		IPCC - Dental - Additions	Jan-24		228	179	1,790	-		
EF082		IPCC - Dental - Allocations	Jan-24		3	37	372	-		
EF086		IPCC - Number of Sight Test	Jan-24		1442	2,181	19,631	-		
EF074		Total Number of OP & Dementia Beds Available	Jan-24		195	195	-	-		
EF075		Total Number of OP & Dementia Beds Occupied	Jan-24		95	109	-	-		
EF076		Total Number of LD Beds Available	Jan-24		85	83	-	-		
EF077		Total Number of LD Beds Occupied	Jan-24		69	70	-	-		

Planned Care - Total No. Cancelled Operations
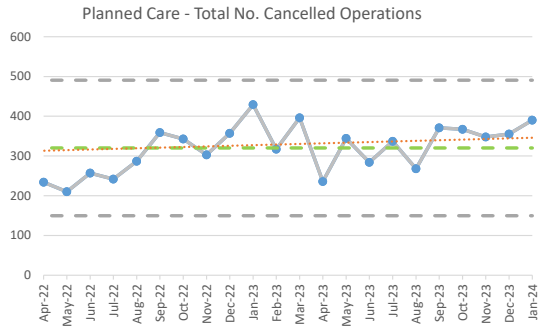
	Reporting Date	Performance	Op. Plan #
	Jan-24	**390**	QC157
	Threshold	YTD Mean	Benchmark
	-	330	311

(Lower value represents better performance)

-	Variation Description
	Common cause

Assurance Description

Planned Care - Cancelled Operations by source

	Reporting Date	Performance	Op. Plan #
	Jan-24		
	Threshold	YTD Mean	Benchmark
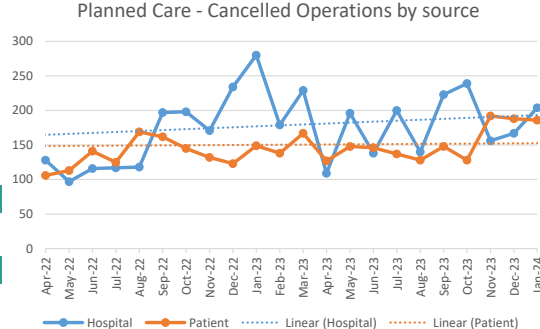
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Cancelled Operations: The number of cancelled operations in January was 390. A deep dive into the reasons behind the categories of Unfit for Surgery - Acute Illness and Appointment Inconvenient are as follows: UNFIT ACUTE ILLNESS x 7; APPOINTMENT INCONVENIENT X 4 MISCALLEANEOUS and OPERATION NOT NECESSARY incidents improved for month of January.	**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. The new planned care metrics will be reported on in next month's report.	Note - Benchmarks are the Manx Care monthly average for 2022/23.

15

No. patients with Length of Stay (LOS) greater than 21 days
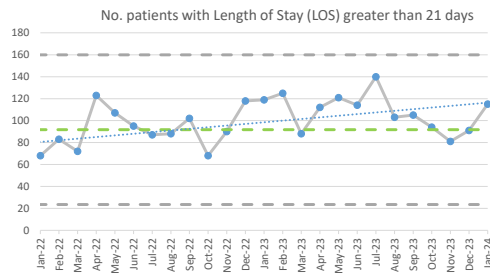
Reporting Date	Performance	Op. Plan #
Jan-24	115	QC10c

Threshold	YTD Mean	Benchmark
-	108	101

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description

Average Length of Stay (ALOS) by site

ALOS Noble's — ALOS - RDCH — Expon. (ALOS Noble's) — Linear (ALOS - RDCH)

Reporting Date	Performance	Op. Plan #
Jan-24		QC156

Threshold	YTD Mean	Benchmark

-	Variation Description

Assurance Description

Inpatient Discharges

Nobles — RDCH — Linear (Nobles) — Linear (RDCH)

Reporting Date	Performance	Op. Plan #
Jan-24	Nobles	920	
	RDCH	40	

Threshold	YTD Mean	Benchmark
	Nobles	924	916
	RDCH	38	33

Variation Description

Assurance Description

Issues / Performance Summary

Length of Stay (LOS):
• The methodology regarding the no. of patients with a length of stay > 21 days is currently subject to review. Going forward, this will be split into 2 separate metrics; no. discharged patients who had a LOS > 21 days; and no. patients still admitted with a LOS > 21 .
• 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.
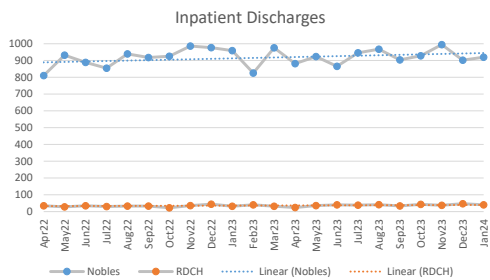• The acuity of patients being admitted has increased for some surgical patients driving longer lengths of stay in hospital.
• Access to surgical bed base continues to be a challenge - continuing high levels of medical patients (and their higher acuity) being admitted means that medical patients are 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:
There were 960 discharges in January, slightly below the year to date average of 962. This demonstrates the consistent discharging of patients despite the challenges around patient flow.

Planned / Mitigation Actions

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.

Assurance / Recovery Trajectory

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.

Theatres - % Theatre Utilisation

Reporting Date	Performance	Op. Plan #
Jan-24	76.1%	QC16

Threshold	YTD Mean	Benchmark
85.0%	76.4%	74.5%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Theatres - No. of Cancelled Operations**

Reporting Date	Performance	Op. Plan #
Jan-24	44	QC15

Threshold	YTD Mean	Benchmark
-	36	40

(Lower value represents better performance)

-	Variation Description
	Common cause

	Assurance Description

Theatres - Delivered (vs Cancelled Sessions)

Delivered   Cancelled

Reporting Date	Performance	Op. Plan #
Jan-24	80	

Threshold	YTD Mean	Benchmark
-	81	75

(Higher value represents better performance)

-	Variation Description

	Assurance Description

Theatres - Cancelled Operations by source**

Clinical   Non Clinical - Patient
Non Clinical - Hospital   Linear (Non Clinical - Patient)
Linear (Non Clinical - Hospital)

Reporting Date	Performance	Op. Plan #
Jan-24	-	QC15

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

	Variation Description

	Assurance Description

Issues / Performance Summary

Theatre Utilisation:
• The number of theatre sessions delivered in January was 80.
• The number of cancelled operations increased to 44 in January (year to date average is 36). Most common reasons were "Unfit for Surgery-Acute illness" (14), "Surgeon unavailable" (6) and "Ward Beds Unavailable" (6).
• 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.

**This metric was previously being reported as 'cancellations on the day'. A review of the methodology for this metric has identified that the figure being reported includes all theatre cancellations, not just those that occur 'on the day'. The reporting methodology is currently being revised to include only those occuring 'on the day', and the figures will be updated accordingly in future reports. It is therefore anticipated that Manx Care's actual number of theatre cancellations on the day will be lower than has been reported.

Planned / Mitigation Actions

• 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 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.

Assurance / Recovery Trajectory

• 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)..
• 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 |

Hospitals LFD (Learning from Death reviews)
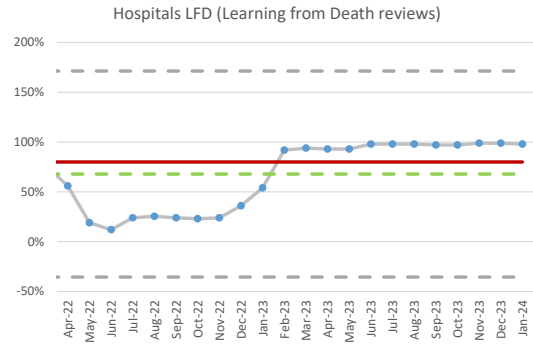
	Reporting Date	Performance	Op. Plan #
	Jan-24	98.0%	QC126

Threshold	YTD Mean	Benchmark
80.0%	97.0%	40.3%

(Higher value represents better performance)

+ Variation Description
Special Cause of Improving variation (High)

+ Assurance Description
Consistently hit target

Mortality by age band: 1/4/2021 to 31/1/2024

■ 2021/22 ■ 2022/23 ■ 2023/24
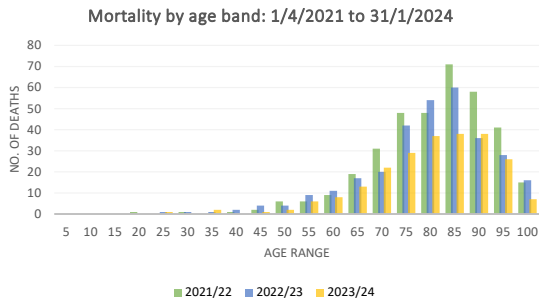
	Reporting Date	Performance	Op. Plan #
	-	2021/22: 329	
		2022/23: 279	
		2023/24: 230	

Threshold	YTD Mean	Benchmark
-	23	-

+ Variation Description

- Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hospitals LFD (Learning from Death) Reviews: • 98% for January. This continues to exceed the target	**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	

Nutrition & Hydration - complete at 7 days (Acute Hospitals & Mental Health)

Reporting Date
Jan-24

Performance
95.0%

Op. Plan #
QC124

Threshold
95.0%

YTD Mean
95.8%

Benchmark
83.1%

(Higher value represents better performance)

+	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary

Nutrition & Hydration:
• 95% for January. The target has been exceeded in 8 out of 9 reporting months YTD.

Planned / Mitigation Actions

Nutrition & Hydration:
• Missing assessments are highlighted to senior staff.

Assurance / Recovery Trajectory

Nutrition & Hydration:
• Progress will continue to be monitored.

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

Effective	Wellbeing Services		Executive Lead	Oliver Radford		Lead	Adrian Tomkinson	

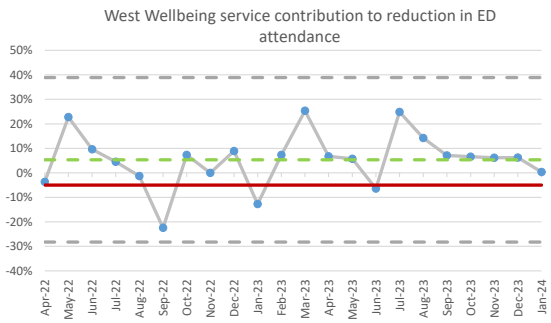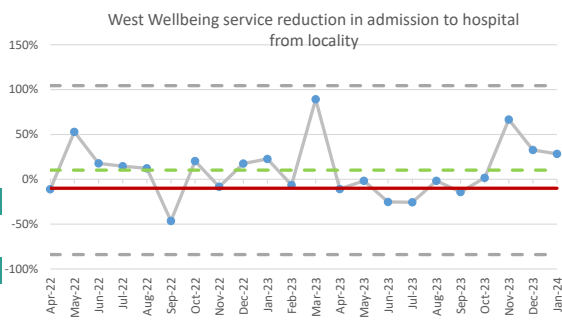**West Wellbeing service contribution to reduction in ED attendance**

Reporting Date	**Performance**	**Op. Plan #**
Jan-24	0.4%	QC63

Threshold	**YTD Mean**	**Benchmark**
-5.0%	7.2%	3.8%

(Lower value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

West Wellbeing service reduction in admission to hospital from locality

Reporting Date	**Performance**	**Op. Plan #**
Jan-24	28.3%	QC64

Threshold	**YTD Mean**	**Benchmark**
-10.0%	5.0%	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 PBI 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.
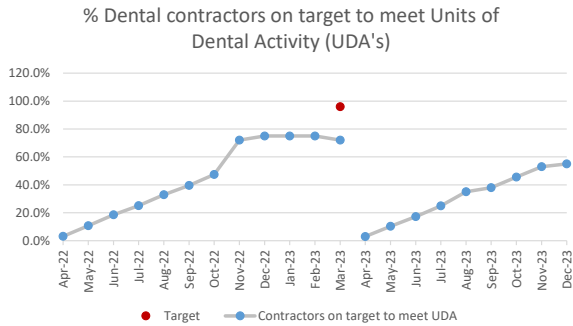
% Dental contractors on target to meet Units of Dental Activity (UDA's)

Reporting Date	Performance	Op. Plan #
Dec-23	55.0%	QC161

Threshold	YTD Mean	Benchmark
96.0%	-	-

(Higher value represents better performance)

+	Variation Description

-	Assurance Description
	N/A

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Dental Contractors: • Hillside Dental practice became a salaried dental service as of 1st December. The new software provider had experienced a serious cyber-attack, which to date has still not been resolved. Alternative solutions are currently being looked into. The practice is providing emergency treatment only at this time.	**Dental Contractors:** • The majority of contractors are on target to achieve their UDA delivery for the year.	**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

Total Prescriptions (No. of fees) — Chargeable Prescriptions

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

Variation Description

Assurance Description

Pharmacy - Items

Total Exempt Items — Chargeable Items

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

Variation Description

Assurance Description

Pharmacy - Net cost

	Reporting Date	Performance	Op. Plan #
	Nov-23	£1,405,662	
	Threshold	**YTD Mean**	**Benchmark**
	-	-	-

Variation Description
Common cause

Assurance Description

Pharmacy - Charges Collected

	Reporting Date	Performance	Op. Plan #
	Nov-23	£74,520	
	Threshold	**YTD Mean**	**Benchmark**
	-	-	-

Variation Description
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Based on latest data available from NHS BSA.		

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

Additions to the Dental Waiting list
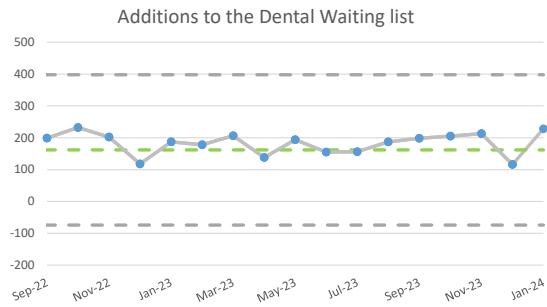
Reporting Date	Performance	Op. Plan #
Jan-24	**228**	-

Threshold	YTD Mean	Benchmark
	179	

Variation Description

Assurance Description

Patients Allocations to Dental Practices

Reporting Date	Performance	Op. Plan #
Jan-24	**3**	-

Threshold	YTD Mean	Benchmark
-	37	-

Variation Description

Assurance Description

Waiting time for dental allocations

— Average — Max

Reporting Date	Performance	Op. Plan #
Jan-24		-

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description
Common cause

Assurance Description

Allocations by Practice - Jan 2024

Reporting Date	Performance	Op. Plan #
Jan-24	**3**	-

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description
Common cause

Assurance Description

Issues / Performance Summary

In January 2024, 228 patients were added to the dental allocation list. 75 children were added and 153 adults.

Planned / Mitigation Actions

Assurance / Recovery Trajectory

| Effective | Integrated Primary & Community Care | | Executive Lead | Oliver Radford | | Lead | Annmarie Cubbon | |

Number of Sight Tests
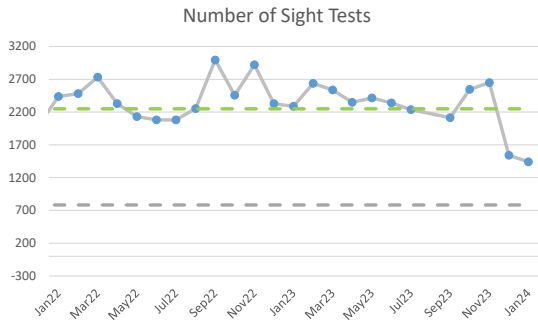
Reporting Date	Performance	Op. Plan #
Jan-24	1442	-

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Issues / Performance Summary

Planned / Mitigation Actions

Assurance / Recovery Trajectory

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

Reporting Date	Performance	Op. Plan #
Jan-24	0	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 #
Jan-24	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 #
Jan-24	2	QC89

Threshold	YTD Mean	Benchmark
-	1.2	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 #
Jan-24	31	QC158

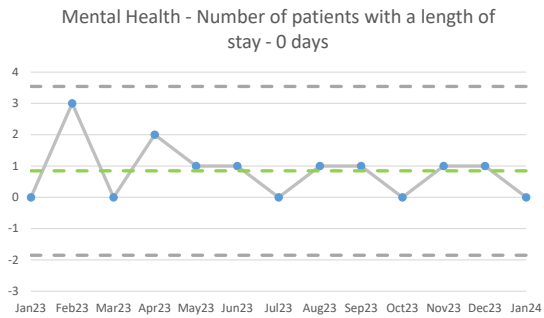| Threshold	YTD Mean	Benchmark
-	34	46

+	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Average Length of Stay (ALOS): * ALOS for those aged 65+ over 90 days is not cause for concern and evidences appropriate discharge of this patient group. For current inpatients, the ALOS is being appropriately monitored and within expected norms.	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.

25

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 #
Jan-24	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 #
Jan-24	-	QC70

Threshold	YTD Mean	Benchmark
75%	83%	100%

+ Variation Description
Common cause

+ Assurance Description
Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
These indicators are both consistently above targets and are of no cause for concern within the care group. They are being regularly monitored. **Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral** No relevant patients in January 2024.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Crisis Team one hour response to referral from ED
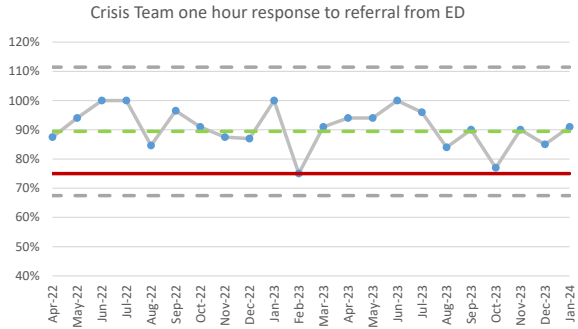
Reporting Date	Performance	Op. Plan #
Jan-24	91.0%	QC68

Threshold	YTD Mean	Benchmark
75.0%	90.1%	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
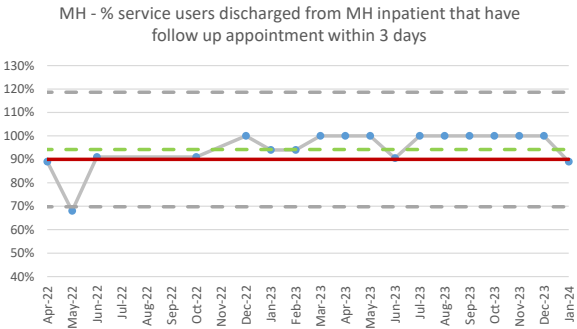
Reporting Date	Performance	Op. Plan #
Jan-24	89%	QC72

Threshold	YTD Mean	Benchmark
90.0%	98.0%	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 91%, 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 workload pressures and demand on CRHTT services. **3 Day follow up:** • Manual calculation of figures shows 89% compliance. Work ongoing to improve dashboard accuracy.	**Crisis Team:** To continue to monitor response times monthly. **3 Day follow up:** Reminders have been sent to operational managers as RiO documentation is not always be completed at the time of the event.	**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.

ASC - % of Re-referrals
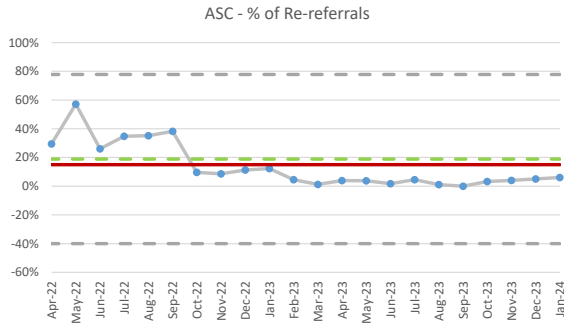
Reporting Date	Performance	Op. Plan #
Jan-24	6.1%	QC41

Threshold	YTD Mean	Benchmark
<15%	3.4%	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 #
Jan-24	27.6%	QC44

Threshold	YTD Mean	Benchmark
80.0%	32.2%	64.6%

(Higher value represents better performance)

+	Variation Description
	Special Cause of Concerning variation (Low)

-	Assurance Description
	Consistently fail target

ASC - No. of referrals
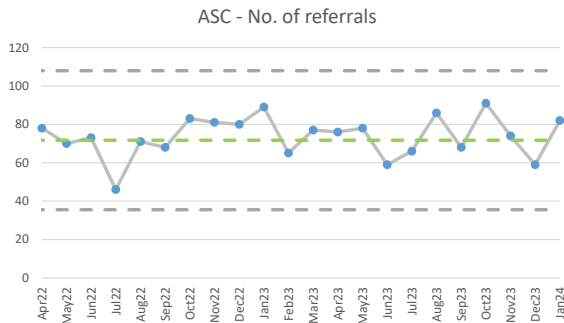
Reporting Date	Performance	Op. Plan #
Jan-24	82	QC40

Threshold	YTD Mean	Benchmark
-	74	73

-	Variation Description
	Common cause

	Assurance Description

ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment
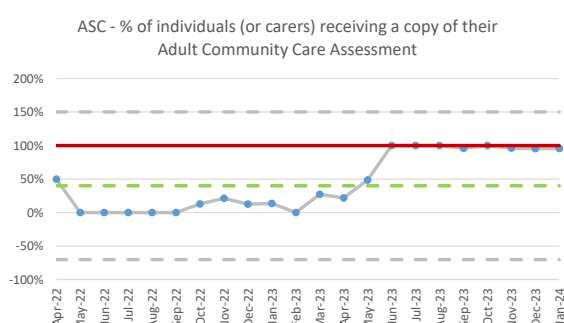
Reporting Date	Performance	Op. Plan #
Jan-24	95.7%	QC45

Threshold	YTD Mean	Benchmark
100.0%	85.4%	11.4%

(Higher value represents better performance)

+	Variation Description
	Common cause

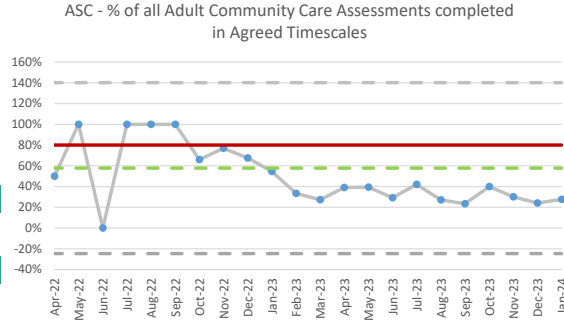| -	Assurance Description
	Inconsistently passing and falling short of target

Issues / Performance Summary

Referrals:
The number of new referrals received in January increased to 82 from 59 in December.

Re-Referrals:
• The re-referral rate continues to be low, indicating good triage and assessment or signposting of incoming referrals.

Assessments completed within Timescales:
• The completion of Wellbeing Partnership assessments in January remained below the required threshold. A number of these assessments are complex, particularly in respect of Learning Disabilities. Areas of Adult Social Work are experiencing staffing pressures, which are planned to be mitigated by both agency and permanent recruitment.

Individuals receiving copy of Assessment:
• The assessment sharing level was 95.7% during January, 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.

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.

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. This is proving to be complex to fix. The numbers are influenced by the Learning Disabilities Team, who are seeing an increased caseload both in terms of numbers and complexity of client needs. A request has been made to amend the timescale from 4 to 6 weeks in this service area.

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

Adult Safeguarding

Legend: Referrals, ASG Alert
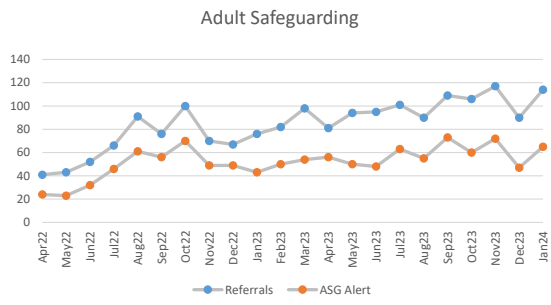
Reporting Date	Performance	Op. Plan #
Jan-24	Referrals 114	QC59
	Alert 65	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Discharges from Adult Safeguarding Team
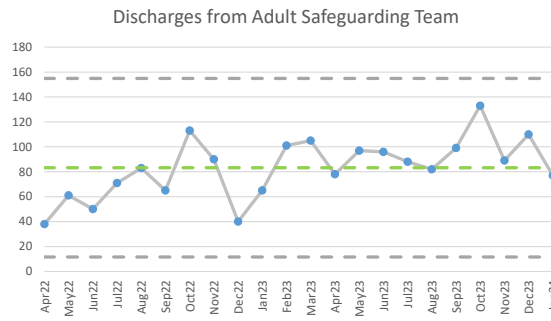
Reporting Date	Performance	Op. Plan #
Jan-24	77	

Threshold	YTD Mean	Benchmark
-	95	74

Variation Description
Common cause

Assurance Description

Re-referrals to Adult Safeguarding Team
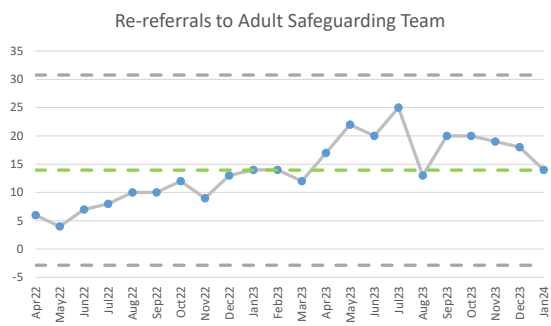
Reporting Date	Performance	Op. Plan #
Jan-24	14	

Threshold	YTD Mean	Benchmark
-	19	10

Variation Description
Common cause

Assurance Description

% MARFs Completed by Adult Safeguarding Team
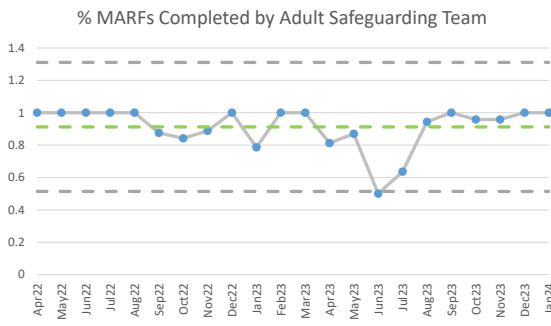
Reporting Date	Performance	Op. Plan #
Jan-24	100.0%	

Threshold	YTD Mean	Benchmark
-	86.8%	94.9%

(Higher value represents better performance)

-	**Variation Description**
	Common cause

Assurance Description

Issues / Performance Summary

• 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 is now in post on a 4-month secondment. 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.
• 22 out of 22 MARFs were completed within timescale during January 2024.

Planned / Mitigation Actions

• Referrals and ASG alerts methodology will be discussed with the B.I team.
• A Business Case for additional staffing resources is under consideration.

Assurance / Recovery Trajectory

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.

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Effective	Adult Social Work (3 of 3)		Executive Lead	David Hamilton		Lead	Bradley Chambers/Samantha Murphy	
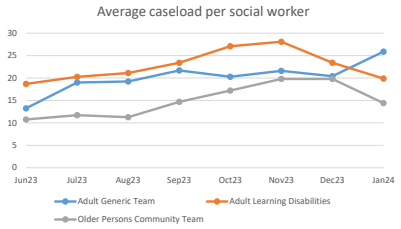
Average caseload per social worker

Reporting Date	Performance	Op. Plan #
Jan-24		

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
A general upward trajectory of caseloads held is contributed to by an increase in complexities we are seeing as well as turnover of staff and vacancy factor.	Social Worker recruitment is planned - permanent where possible and agency to fill in gaps. A business case for additional resource in Adult Safeguarding is under consideration.	

Total Number of OP & Dementia Beds

— Available — Occupied

Reporting Date	Performance		Op. Plan #
Jan-24	Available	195	
	Occupied	95	
Threshold	YTD Mean	Benchmark	
-	-	-	

Variation Description

Assurance Description

Total Number of LD Beds
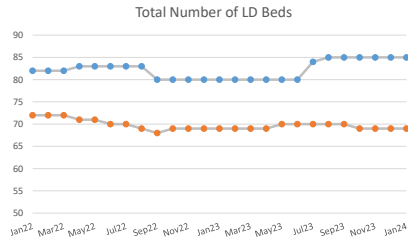
Reporting Date	Performance		Op. Plan #
Jan-24	Available	85	
	Occupied	69	
Threshold	YTD Mean	Benchmark	
-	-	-	

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Across LD services 85 beds are available, of which: • 69 are occupied (81.2%) • 16 are vacant (18.8%)	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.	

C&F -Number of referrals - Children & Families

Executive Lead	David Hamilton

Lead	Julie Gibney
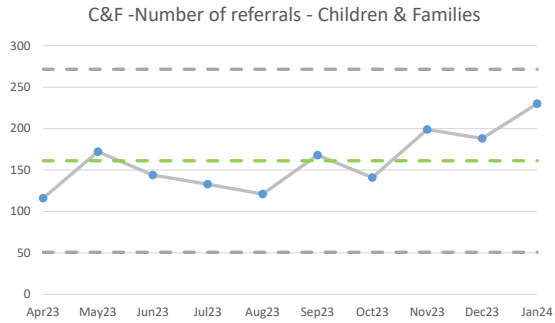
Reporting Date
Jan-24

Performance
230

Op. Plan #

Threshold
-

YTD Mean
161

Benchmark
161

+	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.

Executive Lead — David Hamilton   **Lead** — Julie Gibney

% Complex Needs Reviews held on time
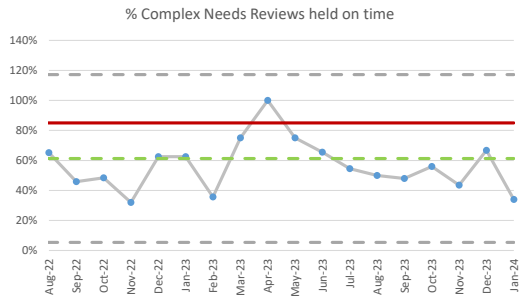
Reporting Date	Performance	Op. Plan #
Jan-24	34.0%	QC49

Threshold	YTD Mean	Benchmark
85.0%	59.3%	53.4%

(Higher value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

% Total Child Protection Review Conferences held on time
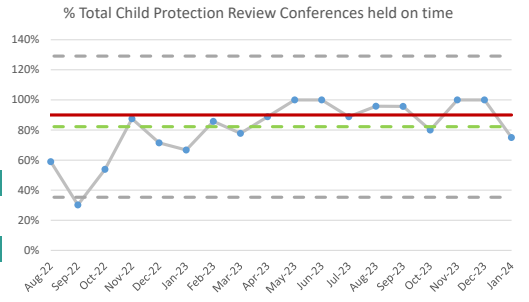
Reporting Date	Performance	Op. Plan #
Jan-24	75%	QC52

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 #
Jan-24	80.0%	QC51

Threshold	YTD Mean	Benchmark
90.0%	72.2%	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 #
Jan-24	76%	QC53

Threshold	YTD Mean	Benchmark
90.0%	94.4%	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:
38 Reviews held and 13 were in timescale and 25 were out of timescale
Reasons for delayed meetings:
Family Unavailable – 6
Relevant Professional/Agency Unavailable - 6
Chairperson Unavailable – 8
Notification by Social Worker Staff: Out of Timescale - 5

Initial Child Protection Conferences held on time:
10 meetings were due and 8 were held in time
Reasons for delayed meetings:
Relevant Professional/Agency unavailable – 1
ICPC delayed until pregnancy had reached 24 weeks - 1

Child Protection Review Conferences held on time:
24 RCPC's were held and 18 were on time with 6 out of timescale
Reasons for delayed meetings:
Chairperson Unavailable – 2
Procedurally Non-Compliant – 1
Safeguarding and quality assurance unit capacity - 3

Looked After Children reviews held on time:
• 76% of reviews were held within the timescales in January.

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.

| Executive Lead | David Hamilton | Lead | Julie Gibney |

Children (of age) participating in, or contributing to, their Complex Review%
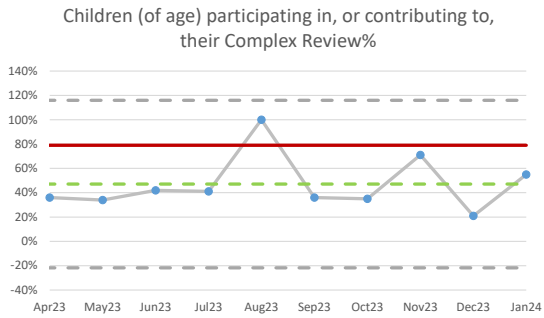
Reporting Date Jan-24
Performance 55%
Op. Plan #

Threshold	YTD Mean	Benchmark
79%	47%	47%

(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%
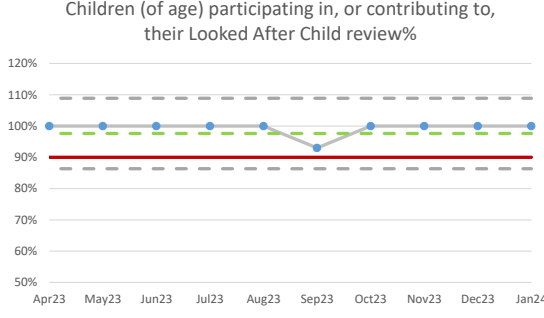
Reporting Date Jan-24
Performance 100%
Op. Plan #

Threshold	YTD Mean	Benchmark
90%	99%	99%

(Higher value represents better performance)

+ Variation Description
Common cause
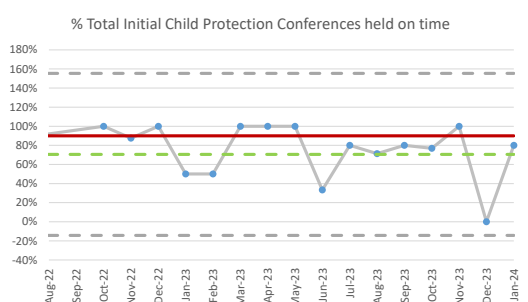
+ Assurance Description
Consistently hit target

Children (of age) participating in, or contributing to, their Child Protection review%
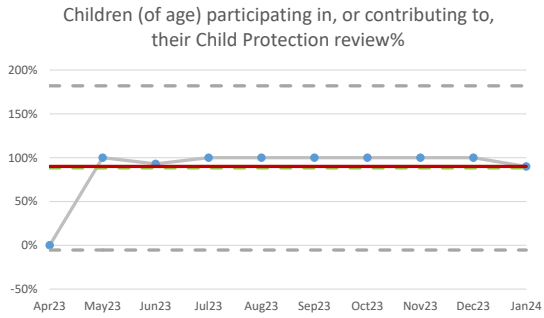
Reporting Date Jan-24
Performance 90%
Op. Plan #

Threshold	YTD Mean	Benchmark
90%	88%	88%

(Higher value represents better performance)

- Variation Description
Common cause

+ Assurance Description
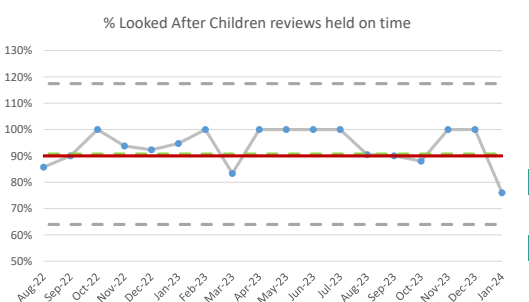Inconsistently passing and falling short of target

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.	Please see previous page for supporting narrative. Note - Benchmarks are the Manx Care monthly averages for 2022/23.	Please see previous page for supporting narrative. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Obstetric Haemorrhage >1.5L
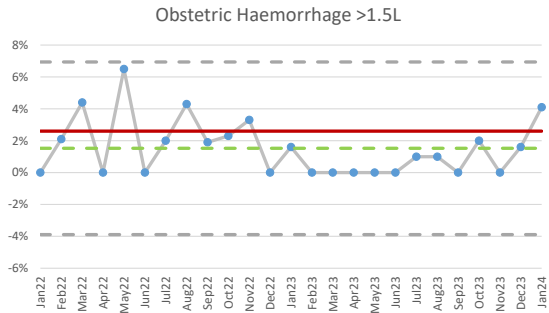
Reporting Date	Performance	Op. Plan #
Jan-24	4.1%	

Threshold	YTD Mean	Benchmark
< 2.6%	0.97%	1.8%

-	Variation Description
	Common cause

-	Assurance Description
	Consistently hit target

Unplanned Term Admissions To NNU
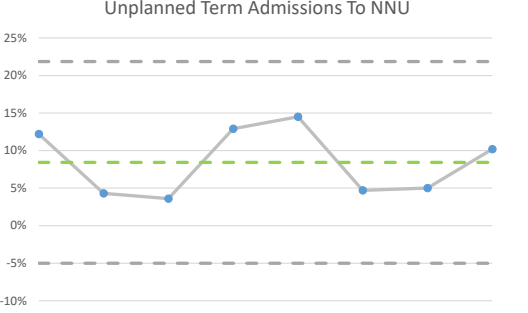
Reporting Date	Performance	Op. Plan #
Jan-24	10.2%	

Threshold	YTD Mean	Benchmark
-	-	

	Variation Description
	Common cause

	Assurance Description

Stillbirth Number / Rate
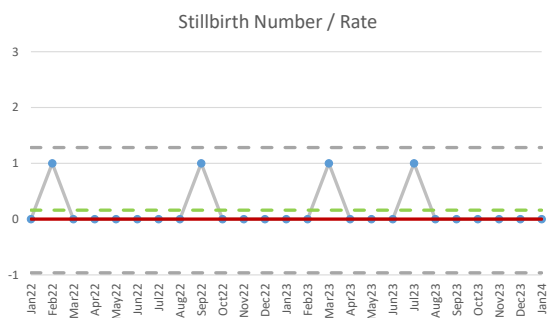
Reporting Date	Performance	Op. Plan #
Jan-24	0	

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
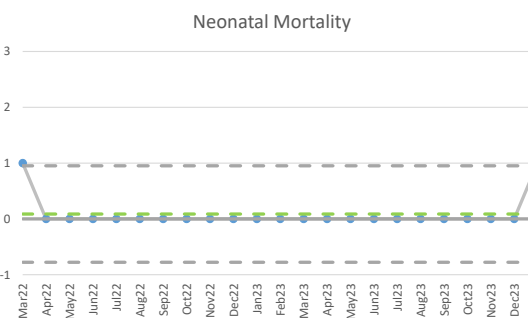
Reporting Date	Performance	Op. Plan #
Jan-24	1	

Threshold	YTD Mean	Benchmark
-	0.1	0

-	Variation Description
	Special Cause of Improving variation (Low)

	Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Obstetric haemorrhage >1.5L – 2 episodes in January, comes in at 4.1% with national standard being <2.6% **Unplanned Term Admissions To NNU** 10.2% in January (national standard <5%). These cases will be reviewed. .		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Induction of Labour
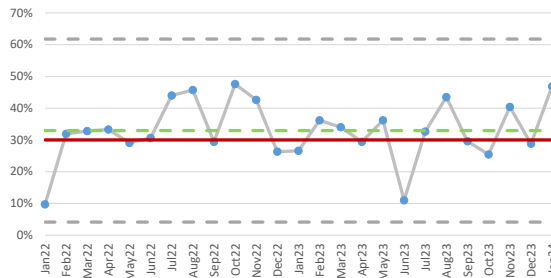
Reporting Date	Performance	Op. Plan #
Jan-24	**46.9%**	

Threshold	YTD Mean	Benchmark
< 30%	32.4%	32.5%

(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

3rd/4th Degree Tear Overall Rate
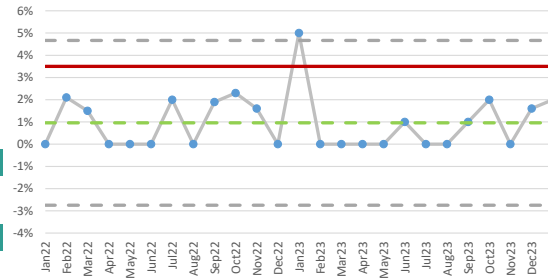
Reporting Date	Performance	Op. Plan #
Jan-24	**2.0%**	

Threshold	YTD Mean	Benchmark
< 3.5%	0.8%	1.1%

(Lower value represents better performance)

-	Variation Description
	Common cause

	Assurance Description
	Consistently hit target

Caesarean Deliveries (not Robson Classified)
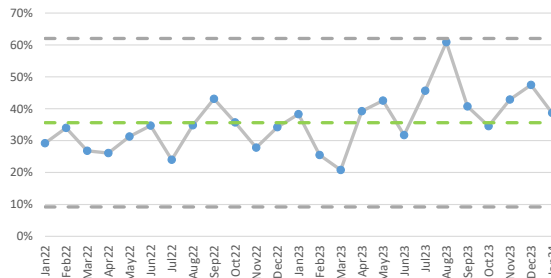
Reporting Date	Performance	Op. Plan #
Jan-24	38.7%	

Threshold	YTD Mean	Benchmark
-	42.4%	31.4%

+	Variation Description
	Common cause

	Assurance Description

% Smoking

- Smoking at time of Delivery
- Smoking at booking
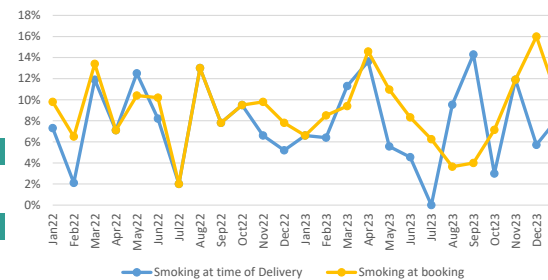
Reporting Date	Performance	Op. Plan #
Jan-24	Booking 10.2%	
	Delivery 8.2%	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

	Variation Description

	Assurance Description

Issues / Performance Summary

Total caesarean deliveries:
For the month of January was 38.7%. Caesarean section rates are no longer considered a KPI in England.

Induction of labour:
Induction of labour above national standard at 46.9%.

Third and fourth degree tear rates:
3rd and 4th degree perineal trauma remains well below national target of >3.5% with 1 tear in January.

Smoking at booking and delivery: slightly up from last month 5.7% to 8.2% in January

Planned / Mitigation Actions

Assurance / Recovery Trajectory

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

Breast Feeding Rate At Transfer Home
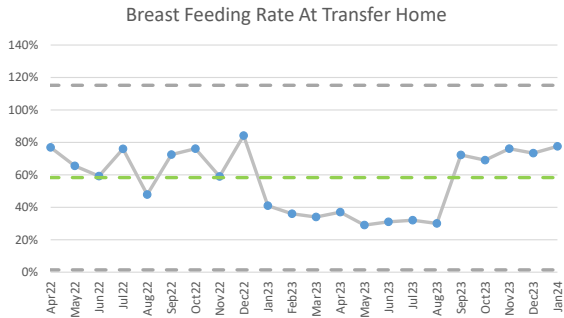
	Reporting Date	Performance	Op. Plan #
	Jan-24	77.5%	

Threshold	YTD Mean	Benchmark
-	-	60.7%

(Higher value represents better performance)

+	Variation Description
	Common cause

Assurance Description

First Feed Breast Milk (Initiation Rate)
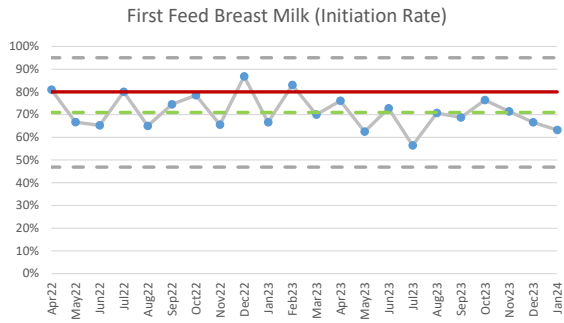
	Reporting Date	Performance	Op. Plan #
	Jan-24	63.2%	

Threshold	YTD Mean	Benchmark
> 80%	68.5%	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): Breast feeding rate - breast milk as first feed 63.2% which is below the national standard of <80%, however 77.5% of babies were breast fed at discharge from the unit. Low staffing levels and acute activity can impact the breast feeding support women receive.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Paediatrics- Total Admissions
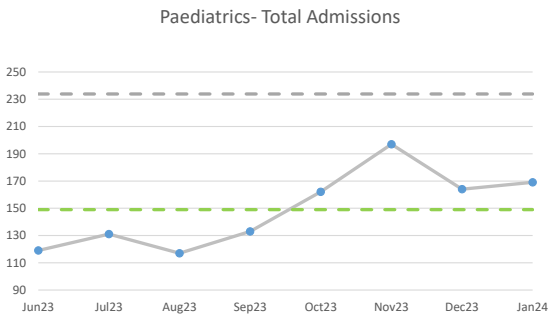
Reporting Date	Performance	Op. Plan #
Jan-24	**169**	

Threshold	YTD Mean	Benchmark
-	149	-

+	Variation Description
	Common cause

Assurance Description

NNU - Total number of Admissions
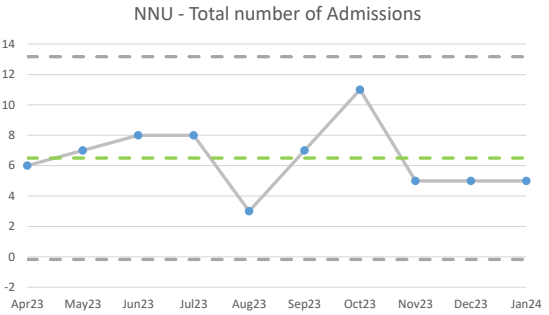
Reporting Date	Performance	Op. Plan #
Jan-24	**5**	

Threshold	YTD Mean	Benchmark
-	7	-

+	Variation Description
	Common cause

Assurance Description

NNU - Avg. Length of Stay
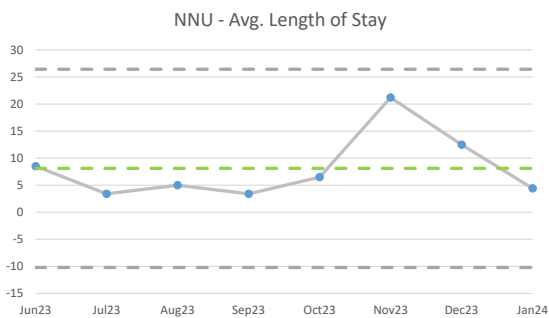
Reporting Date	Performance	Op. Plan #
Jan-24	**4**	-

Threshold	YTD Mean	Benchmark
-	8.1	-

+	Variation Description
	Common cause

Assurance Description

NNU - Community follow up
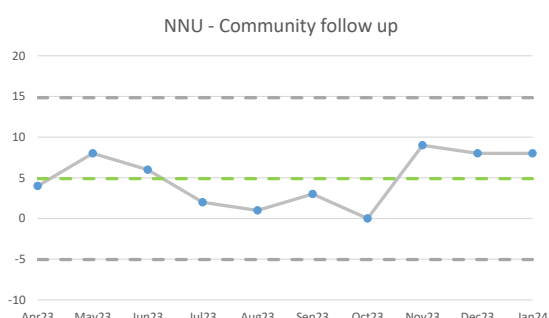
Reporting Date	Performance	Op. Plan #
Jan-24	**8**	

Threshold	YTD Mean	Benchmark
-	5	-

Variation Description
Common cause

Assurance Description

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

Issues / Performance Summary

• 5 babies were above 37 weeks gestation (term), unplanned admissions.
•1 baby was admitted for management of Jaundice on Day 5 of life.
babies were admitted from labour ward/theatre and postnatal ward between 22 mins and 5 days of age.
•1 x baby admitted with history of reduced fetal movements, born in poor condition, requiring intensive care, therapeutic cooling and transfer via air ambulance (using local personnel) to Liverpool Women's Hospital for tertiary care. Baby unfortunately died in LWH.
•4 x babies required intravenous antibiotics.
•1 baby required place of safety due to mother requiring intensive care.
•Staffing -1WTE sickness. 1 x 0.6 WTE on maternity leave. No support staff. Staff working extra hours to fill gaps.
•Band 6 neonatal nurse 1 x WTE agency started this month.
•2 x ANNP's

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	Jan-24		0	0	0	0		
CA002		Complaints - Total number of complaints received	Jan-24		24	26	259	<= 450 PA		
CA007		Complaint acknowledged within 5 working days	Jan-24		100%	99%	-	98%		
CA008		Written response to complaint within 20 days	Jan-24		100%	98%	-	98%		
CA010		No. complaints exceeding 6 months	Jan-24		0	0	0	0		
CA011		No. complaints referred to HSCOB	Jan-24	-	2	2	24	-		

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	Jan-24	-	1,403	1,272	12,722	-		
CA013		FFT - Experience was Very Good or Good	Jan-24		91%	90%	-	80%		
CA014		FFT - Experience was neither Good or Poor	Jan-24		4%	4%	-	10%		
CA015		FFT - Experience was Poor or Very Poor	Jan-24		5%	6%	-	<10%		
CA016		Manx Care Advice and Liaison Service contacts	Jan-24	-	883	683	6,832	-		
CA017		Manx Care Advice and Liaison Service same day response	Jan-24		90%	90%	-	80%		

Complaints - Number of complaints: Manx care

Reporting Date	Performance	Op. plan #
Jan-24	24	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 #
Jan-24	100%	L8

Threshold	YTD Mean	Benchmark
98.0%	98.4%	-

(Higher value represents better performance)

Variation Description
Common cause

Assurance Description
Consistently hit target

Complaint acknowledged within 5 working days: Manx Care

Reporting Date	Performance	Op. plan #
Jan-24	100%	L8

Threshold	YTD Mean	Benchmark
98%	98.6%	-

(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 #
Jan-24	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	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Number of Complaints: • 24 complaints were received across the care groups. 8 originated in Primary Care (all of which involved GPs), 6 were received relating to Medicine and Urgent Care, 7 involved Surgery, Theatres & Critical Care, 3 in Mental Health Services, 2 originated in the Children & Families division, Community Services and Women & Children's and 1 in Adult Learning Disabilities, Logistics and PIC.	**Number of Complaints:** • MCALS continue to be successful in keep the numbers to a manageable level by intervening early.	**Number of Complaints:** • No target, but trends will be monitored. Monthly average of complaints received appears to have stabilised at 26.
Acknowledged within 5 Days: • 100% compliance - All complaints were acknowledged within 5 working days.	**Acknowledged within 5 Days:** • Continue to monitor closely.	**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: • 100% compliance was demonstrated in January.	**Written Response within 20 days:** • Continue to monitor closely.	**Written Response within 20 days:** • Reasonable degree of confidence in target being met.
No. Complaints Exceeding 6 Months: • Zero recorded.	**No. Complaints Exceeding 6 Months:** • Continue to monitor closely.	**No. Complaints Exceeding 6 Months:** • Reasonable degree of confidence in target being met.
No. complaints referred to HSCOB: • 2 complaints were referred to the HSCOB in January.	**No. complaints referred to HSCOB:** • We will await HSCOB reports in due course.	**No. complaints referred to HSCOB:** • : Continue to monitor the trends and continue to learn from feedback to improve complaint responses and service delivery Note - Benchmarks are the Manx Care monthly averages for 2022/23.

FFT - No. of responses
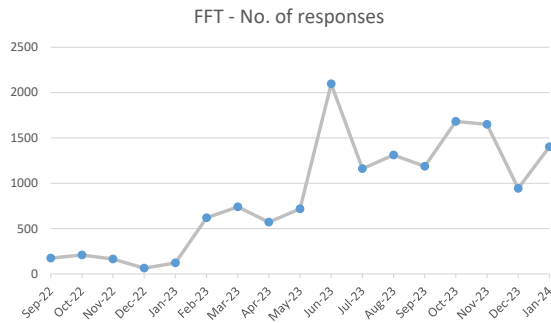
Reporting Date	Performance	Op. plan #
Jan-24	1,403	QC127

Threshold	YTD Mean	Benchmark
-	1,272	-

+	Variation Description

Assurance Description

FFT Experience - Outcomes

Legend:
- Very Good, Good
- Neither Good or Poor
- Poor or Very Poor
- Standard: Very Good, Good
- Standard: Neither Good or Poor
- Standard: Poor or Very Poor
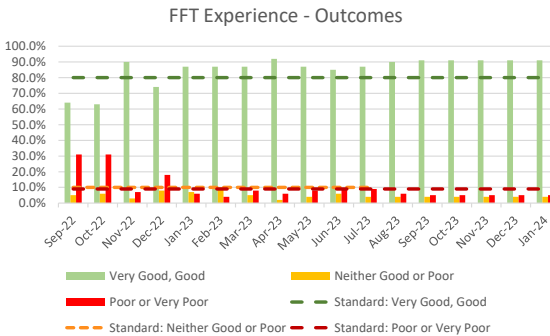
Reporting Date	Performance	Op. plan #
Jan-24	91.0%	QC128-129-130

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

FFT Total number of responses:
• A total of 1403 surveys completed for January 2024. 12,722 surveys completed YTD.

• **FFT – Experience was very good or good: 1271** completed surveys rated experience as Very Good or Good equating to 90% against a target of 80%. Target exceeded for every month YTD (89%).

• **FFT – Experience was neither good or poor:** 54 completed surveys rated experience as Neither Good nor Poor equating to 4% against a target of 10% or less. Again, performance for the year remains strong.

• **FFT – Experience was poor or very poor:** 78 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 19th January 2024.

• **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 and Public Reps Team continue to conduct monthly and extra 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	Caring

MCALS No. of Contacts

Reporting Date	Performance	Op. plan #
Jan-24	883	QC131

Threshold	YTD Mean	Benchmark
-	683	567

+	Variation Description

	Assurance Description

MCALS same day response

Reporting Date	Performance	Op. plan #
Jan-24	90.0%	QC132

Threshold	YTD Mean	Benchmark
80.0%	89.8%	-

(Higher value represents better performance)

+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

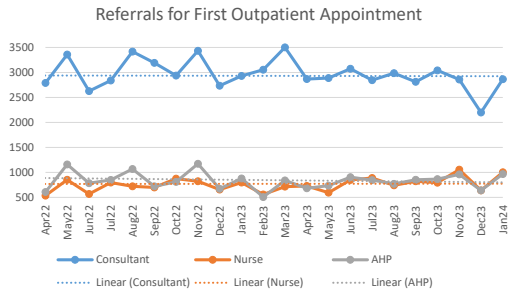| Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Number of Contacts: • 883 contacts received in January 2024, demonstrating an increase of 263 contacts (30%) compared to December 2023. Access to appointments within dental care, ophthalmology orthopaedics, pharmacy medication and general surgery were the dominant themes. In person contacts increased to 273 from 176 contacts due to proactively seeking feedback in the community during drop in sessions across the island. Extra winter warm space hubs had been added as drop in sessions in Q3 to reach seldom heard voices. **Same Day Response:** • In January, MCALS had resolved all contacts within 24 hours 90% of the time against a Key Line of Enquiry Target of 80%.	**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.	**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	Jan-24	-	2864	2844	28435	-		
RE056		Hospital Bed Occupancy	Jan-24	-	65.4%			92%		P
RE001		RTT - No. patients waiting for first Consultant Led Outpatient appointment	Feb-24		16,620	16,237	-	< 15431	H	?
RE002		RTT - No. patients waiting for Daycase procedure	Feb-24		1,854	2,214	-	< 2286	L	?
RE003		RTT - No. patients waiting for Inpatient procedure	Feb-24		445	501	-	< 535	L	?
RE004		RTT - % Urgent GP referrals seen for first appointment within 6 weeks	Jan-24		46%	53.6%	-	85%		F
RE061		Diagnostics-% patients waiting 26 weeks or less	Jan-24		69%	62.3%		99%		F
RE005		Diagnostics - % requests completed within 6 weeks	Jan-24	-	86%	85.6%	86%	-		
RE006		Diagnostics - % Patients waiting over 6 weeks	Jan-24		59%	68.3%	-	1%		F
RE007		ED - % 4 Hour Performance	Jan-24		66%	70.7%	71%	76% (95%)		F
RE008		ED - % 4 Hour Performance (Non Admitted)	Jan-24	-	77%	80.3%	80%	-		
RE009		ED - % 4 Hour Performance (Admitted)	Jan-24	-	18%	22.4%	22%	-		
RE010		ED - Average Total Time in Emergency Department	Jan-24		292	263	-	360 mins		P
RE011		ED - Average number of minutes between Arrival and Triage (Noble's)	Jan-24		30	27	-	15 mins	H	F
RE012		ED - Average number of minutes between arrival to clinical assessment - Nobles	Jan-24		75	69	-	60 mins		? / P
RE033		ED - Average number of minutes between arrival to clinical assessment - RDCH	Jan-24		16	15		60 mins		
RE013		ED - 12 Hour Trolley Waits	Jan-24		51	34	344	0		F

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	Jan-24		15	19	-	15 mins		F
RE015		Ambulance - Category 1 Mean Response Time	Jan-24		8	9	-	7 mins		F
RE016		Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	Jan-24		50%	50%	-	100%		F
RE034		Category 2 Response Time at 90th Percentile	Jan-24		25	29		40 mins		P
RE035		Ambulance - Category 3 Response Time at 90th Percentile	Jan-24		44	48		120 mins		P
RE036		Ambulance - Category 4 Response Time at 90th Percentile	Jan-24		97	80		180 mins		P
RE037		Ambulance - Category 5 Response Time at 90th Percentile	Jan-24		87	81		180 mins		F
RE038		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	Jan-24		238	197	-	0		F
RE039		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	Jan-24		35	24	-	0		F
RE026		IPCC - % patients seen by Community Adult Therapy Services within timescales	Jan-24		77%	56%	-	80%		F
RE031		IPCC - % of patients registered with a GP	Jan-24		-	4.1%	-	5.0%		P
RE081		IPCC - N. of GP appointments	Jan-24	-	-	28,397	255,574	-		
RE027		IPCC - No. patients waiting for a dentist	Jan-24	-	4,878	4,182	-	-		
RE074		Response by Community Nursing to Urgent / Non routine within 24 hours	Jan-24	-	100%	99%	-	-		
RE075		Community Nursing Service response target met (7 days)- Routine	Jan-24	-	100%	100%	-	-		

Responsive Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE025	green	CWT - % 28 Days to diagnosis or ruling out of cancer	Jan-24	amber	69%	66%	-	75%	variation	?
RE018	green	CWT - % patients decision to treat to first definitive treatment within 31 days	Jan-24	amber	83%	79%	-	96%	variation	F
RE019	green	CWT - % patients urgent referral for suspected cancer to first treatment within 62 days (RTT)	Jan-24	red	48%	48%	-	85%	variation	F
RE064	amber	No. on Cancer Pathway (All)	Jan-24	-	558	661	-	-		
RE065	amber	No. on Cancer Pathway (2WW)	Jan-24	-	476	562	-	-		
RE066	amber	Cancer - Total number of patients Waiting for 1st OP	Jan-24	-	61	85	-	-	variation	
RE067	amber	Cancer - Median Wait Time from the Referral Date to the Diagosis Date	Jan-24	-	19	15	-	-	variation	
RE044	amber	MH- Waiting list	Jan-24	-	1702	1671	13366	-		
RE045	amber	MH- Appointments	Jan-24	-	7393	6496	64961	-	variation	
RE046	amber	MH- Admissions	Jan-24	-	22	18	184	-	variation	
RE028	amber	MH - No. service users on Current Caseload	Jan-24	green	5,315	5,234	-	4500 - 5500	variation	P

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE051	amber	Maternity Bookings	Jan-24	-	67	846	556		variation	
RE052	amber	Ward Attenders	Jan-24	-	221	-	-		variation	
RE053	amber	Gestation At Booking <10 Weeks	Jan-24	-	46%	35%	-		variation	
RE030	amber	W&C - % New Birth Visits within timescale	Jan-24	-	88%	89%	-	-	variation	
RE032	amber	Births per annum	Jan-24	-	511	272	-	-	variation	
RE082	amber	Meds Demand - N.patient interactions	Jan-24	-	2464	2613	26133	-	variation	
RE083	amber	Meds Overnight Demand	Jan-24	-	111	279	2792	-	variation	
RE084	amber	Meds - Face to face appointments	Jan-24	-	567	515	5151	-	variation	
RE086	amber	Meds - TUNA%	Jan-24	-	1.4%	1.4%	-	-		
RE088	amber	Meds- DNA%	Jan-24	-	1.2%	1.8%	-	-		

Referrals for First Outpatient Appointment

Legend: Consultant, Nurse, AHP, Linear (Consultant), Linear (Nurse), Linear (AHP)

Reporting Date	Performance		Op. Plan #
Jan-24	Consultant	2864	2864

Threshold	YTD Mean	Benchmark
-	2844	3068

Variation Description

Assurance Description

Hospital Bed Occupancy

Legend: Occupancy, Threshold
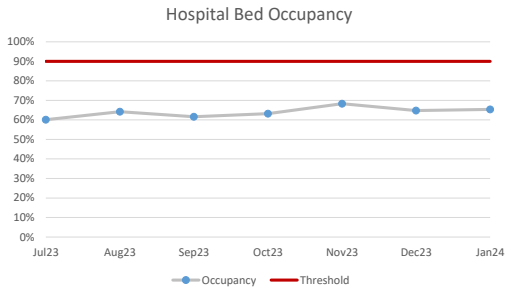
Reporting Date	Performance	Op. Plan #
Jan-24	65.4%	QC79

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

Legend: Non-Elective, Elective, Linear (Non-Elective), Linear (Elective)
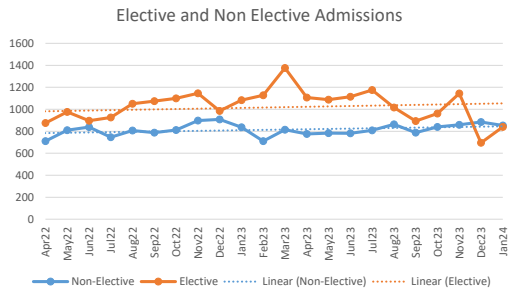
Reporting Date	Performance		Op. Plan #
Jan-24	Elective	840	
	Non Elective	853	

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 increased in January to 2864, compared to 2200 in December. **Elective and Non Elective Admissions:** Elective Admissions have decreased by approximately 17% in January (840) against December (695). Non Elective admission numbers have slightly decreased to 853 compared to 884 last month.		The methodolgy under-pinning the 'Hospital Bed Occupancy' metric is currently being reviewed to ensure that it aligns with the respective guidance, with the occupancy rates for 'acute adult admissions' and 'non acute / child' to be shown separately.

RTT - No. patients waiting for 1st Consultant Led Outpatient Appointment
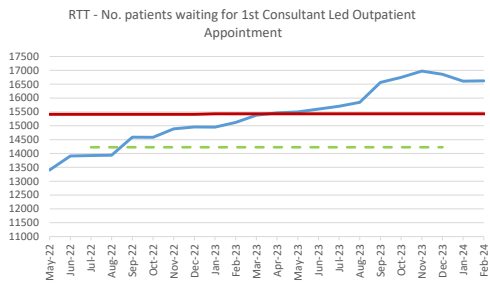
Reporting Date	Performance	Op. Plan #
Feb-24	16,620	QC11

Threshold	YTD Mean	Benchmark
< 15,431	16,237	15,465

(Lower value represents better performance)

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

No. patients waiting 52 weeks or more for 1st OP
5,406

RTT - No. patients waiting for Inpatient procedures

Reporting Date	Performance	Op. Plan #
Feb-24	445	QC11

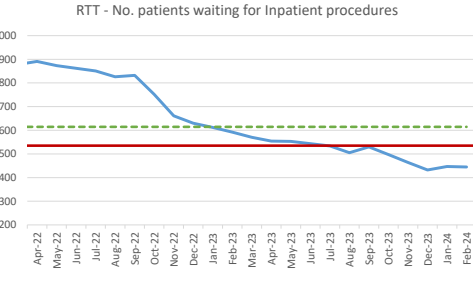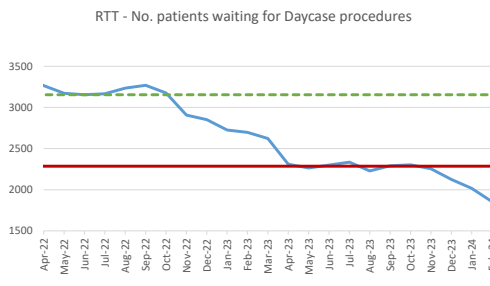| Threshold	YTD Mean	Benchmark
< 535	501	554

(Lower value represents better performance)

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

No. patients waiting 52+ weeks from Decision to Treat
73

RTT - No. patients waiting for Daycase procedures

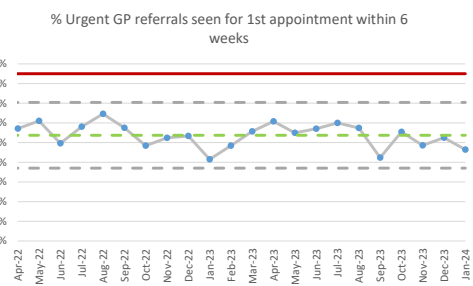| Reporting Date	Performance	Op. Plan #
Feb-24	1,854	QC11

Threshold	YTD Mean	Benchmark
< 2,286	2,214	2,311

(Lower value represents better performance)

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

No. patients waiting 52+ weeks from Decision to Treat
496

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

Reporting Date	Performance	Op. Plan #
Jan-24	46.4%	QC13

Threshold	YTD Mean	Benchmark
85.0%	53.6%	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.
• Many outpatient pathways require considerable diagnostic intervention to enable their progression.

Planned / Mitigation Actions

• R&R delivery (Nov'21 to Jan '24); 2,150 Ophthalmology procs in total; 955 Orthopaedic procs in total; 36 GSU procs in Jan (483 in total); Other surgical specialties – 54 in total; 510 ENT OP attendances in total; Radiology – 80 Ultrasound scans in Jan (1,294 radiology scans in total); Mental Health – 314 referrals in total.
o Overall R&R has delivered about a 77% reduction in the Ophth DC waiting list.
o Overall R&R has delivered about a 49% reduction in orthopaedic DC/IP waiting lists.
o Overall there's been about a 52% 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 23,600 referrals have been through technical validation and over 12,500 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 18% 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 over 4,100 referrals reviewed to date, and over 1,000 (26%) have been identified as can be either discharged or removed from the lists following this detailed clinical review.

• 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 for elective secondary care services covering all specialties for consultant, nurse and Allied Health Practitioner (AHP) led elective services, and Child & Adolescent Mental Health Services (CAMHS) and Community Mental Health Services for Adults(CMHSA).

Assurance / Recovery Trajectory

• General Surgery R&R activity commenced in November '22.
• The additional diagnostic capacity commissioned for Cardiac CT scans achieved the target waiting list by December 2023.
• 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.
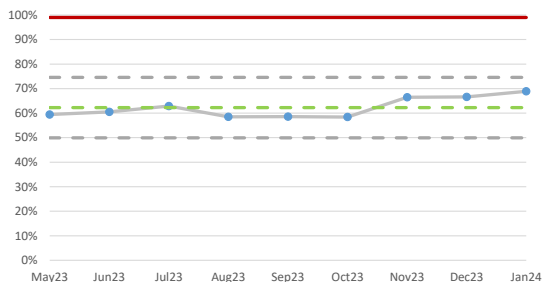
Diagnostics - % patients waiting 26 weeks or less

	Reporting Date	Performance	Op. Plan #
	Jan-24	68.9%	QC37b

Threshold	YTD Mean	Benchmark
99.0%	62.3%	-

(higher value represents better performance)

+ Variation Description
Common cause

- Assurance Description
Consistently fail target

Modality	Jan-24		
	WL	>6 wks	% >6 wks
Bone Densitometry	197	86	44%
Computed Tomography	591	162	27%
Magnetic Resonance Imaging	430	101	23%
Ultrasound Non Obs	2,665	1,948	73%
Total	3,883	2,297	59%

YTD Demand by Modality: 2023/24

Legend: BD, CR, CT, ENDO, XC, IO, MRI, MG, MDT, NM, RF, US, XA, NBSS

Diagnostics - % of Patients waiting over 6 weeks

	Reporting Date	Performance	Op. Plan #
	Jan-24	59.2%	QC37

Threshold	YTD Mean	Benchmark
1%	68.3%	26.8%

(lower value represents better performance)

- Variation Description
Common cause

- Assurance Description
Consistently fail target

Diagnostics - No. of requests received
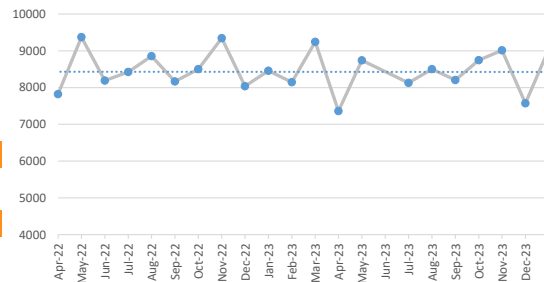
	Reporting Date	Performance	Op. Plan #
	Jan-24	84,152	

Threshold	YTD Mean	Benchmark
-	8,415	8,546

Variation Description

Assurance Description

Issues / Performance Summary

• Overall demand continues to exceed capacity. Demand was 26.3% higher than capacity in January.
• Emergency Department (ED) 23.8%, Outpatient Department (OPD) 37.2% and General Practitioner (GP) 22.9% remain the primary source of referrals, and there has been no significant change on the distribution compared to last month.
• Inpatient Referrals (844) increased in January. This equated to 11.8% of all requests.
• 57.6% of exams were reported within 2 hours, 8.4% have taken 97 hours or longer which is an improvement on last month.
• Of the 7,168 exams, 45.4% were turned around on the same day, and a further 35.9% in 1- 28 days.

Planned / Mitigation Actions

• Over the last 2 years, we have been working to reduce our waiting times in these areas through a combination of waiting list initiatives, synaptik/R&R support, worklist efficiency adjustments and overtime. We are now able to identify potential 'breachers' quicker and where possible appoint routine referrals within 6 weeks.
• 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 Ultrasound waiting t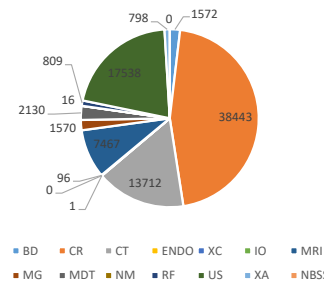imes. The additional diagnostic capacity commissioned for Cardiac CT scans achieved the target waiting list by the end of December 2023.
• Waiting list validation process implemented, validating all aspects of the diagnostic waiting list - technical, administrative and clinical validation.

Assurance / Recovery Trajectory

• Requirements for sustainable increased Radiology capacity has been 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 December '23. Benchmarks for '% Requests < 6 Weeks' and 'No. of requests received' are the Manx Care monthly average for 2022/23.

% Requests completed within 6 weeks
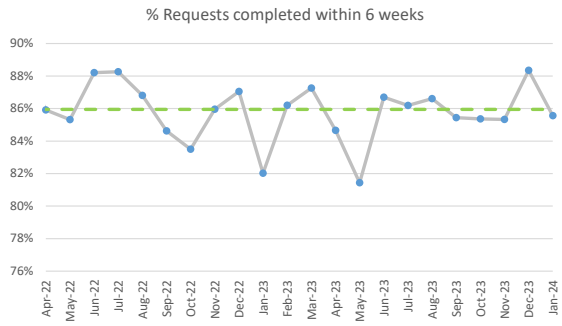
Reporting Date	Performance	Op. Plan #
Jan-24	85.6%	

Threshold	YTD Mean	Benchmark
-	85.6%	85.9%

+	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% Requests completed within 6 weeks: 85.6% of requests completed in January were undertaken within 6 weeks. This aligns with the average of 85.6% for the year so far.		

A&E - % 4 Hour performance

Legend: Standard — Op. Plan 2023-24 Standard
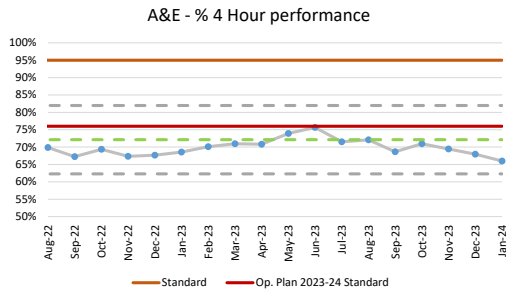
Reporting Date	Performance	Op. Plan #
Jan-24	66.0%	QC23
	Admitted 18.0%	
	Non-Admitted 76.6%	

Threshold	YTD Mean	Benchmark
76% (95%)	70.7%	70.3%

(Higher value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

A&E - Admission Rate : Noble's Hospital

Reporting Date	Performance	Op. Plan #
Jan-24	23.4%	QC24

Threshold	YTD Mean	Benchmark
-	22.4%	25.0%

	Variation Description
	Common cause

	Assurance Description

ED - Total Attendances : Manx Care

Legend: 2021/22 — 2022/23 — 2023/24 — Linear (2021/22) — Linear (2022/23)
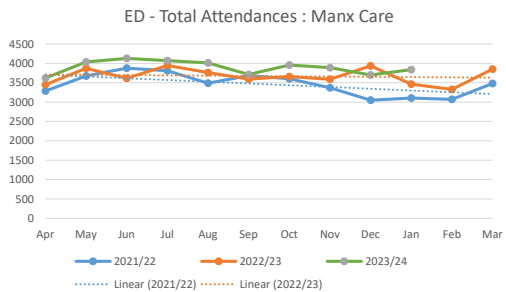
Reporting Date	Performance	Op. Plan #
Jan-24	3,837	QC150

Threshold	YTD Mean	Benchmark
-	3,896	3,671

	Variation Description

	Assurance Description

ED - Average Total Time in ED : Noble's Hospital
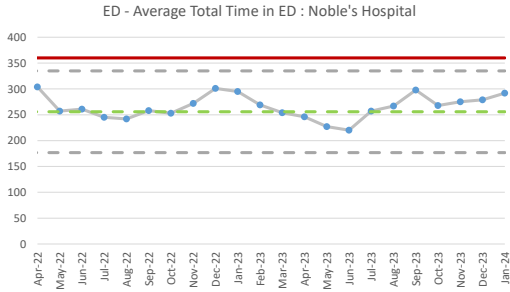
Reporting Date	Performance	Op. Plan #
Jan-24	292	QC150

Threshold	YTD Mean	Benchmark
360 mins	263	268

(Lower value represents better performance)

-	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

Issues / Performance Summary

• January's performance of 66% remained below the 95% threshold but slightly lower the UK's performance of 70.3%.
   • Admitted Performance: 18%;
   • Non Admitted Performance: 76.6%;
• 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 January, the average admission rate from Noble's ED of 23.4%, down fron 25.1% in December, and was lower than that of the UK (25%).

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.
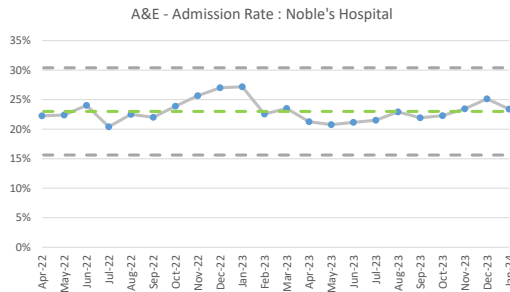   • Delays in transfer of patients to in-patient wards due to a lack of available beds.
   • Staffing availability (particularly nursing) and sickness.
   • Elderly case mix.
   • Lack of organisational Pathways for example back pain , optician, DVT, dental.

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 January' 24.
Benchmarks for 'Total Attendances' and 'Average time in ED' are the Manx Care monthly averages for 2022/23.

Average number of minutes between Arrival and Triage (Noble's)
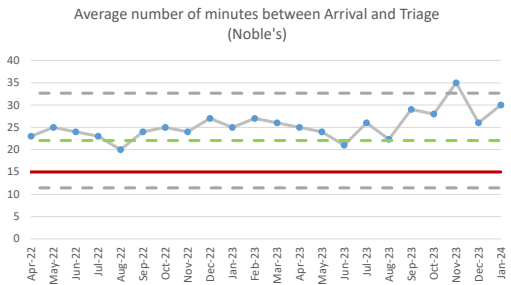
Reporting Date	Performance		Op. Plan #
Jan-24	**30**		QC26

Threshold	YTD Mean	Benchmark
15 mins	27	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

Nobles ● RDCH

Reporting Date	Performance		Op. Plan #
Jan-24	Nobles	**75**	
	RDCH	**16**	

Threshold	YTD Mean	Benchmark
60 mins		-

(Lower value represents better performance)

Variation Description

Assurance Description

A&E - 12 Hours waits

— From decision to admit to admission
● No. patients spending more than 12 hours in ED

Reporting Date	Performance		Op. Plan #
	%Trolley 12h Wait	1.3%	QC78
	% ED 12h Wait	3.9%	

Threshold	YTD Mean	Benchmark
0		-

(Lower value represents better performance)

-	Variation Description

-	Assurance Description
	Consistently fail target

Operational Pressures Escalation Level (OPEL) (Days)

■ Level 1 ■ Level 2 ■ Level 3 ■ Level 4

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 2 days in January. • The number of 12 Hour Trolley Waits was 51 (1.3% of attendances; UK 2%) • 151 patients had a stay of more than 12 hours in ED in January. That equated to 3.9% of attendances.		Note - Benchmark for 'Average number of minutes between Arrival and Triage' is the Manx Care monthly average for 2022/23.

Meds Demand

Reporting Date	Performance	Op. Plan #
Jan-24	2464	-

Threshold	YTD Mean	Benchmark
-	2613	-

Variation Description
Common cause

Assurance Description

Meds Overnight Demand

Reporting Date	Performance	Op. Plan #
Jan-24	111	-

Threshold	YTD Mean	Benchmark
-	279	-

Variation Description
Common cause

Assurance Description

Meds - Face to face appointments

Reporting Date	Performance	Op. Plan #
Jan-24	567	-

Threshold	YTD Mean	Benchmark
-	515	-

Variation Description
Common cause

Assurance Description

MEDs Appointments

● patients who arrived without telephoning MEDS first (TUNA) ● DNA

Reporting Date	Performance	Op. Plan #
Jan-24	TUNA 1.4%	-
	DNA 1.2%	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

• In January 2024 MEDS provided 2464 patient interactions.

• From 8th January 2024 MEDS closed midnight till 8am Monday to Friday. Of the 111 overnight calls 53 were taken before the 8th January, and 58 from the 8th January. There was only 1 appointment and 0 home visits for the month of January 2024.

•In January 2024 MEDS offered a total of 567 Face to face appointments either at base or in the community. This was 31.02% of the total telephone contacts for this period.

• Of the 567 face to face appointments 6 were patients who arrived without telephoning MEDS first. And 5 of the patients failed to attend given appointment.

Planned / Mitigation Actions

Assurance / Recovery Trajectory

Ambulance - Category 1 Average (Mean) Response Time

Reporting Date	Performance	Op. Plan #
Jan-24	00:08:29	QC20

Threshold	YTD Mean	Benchmark
7 mins	00:09:26	00:08:26

(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 #
Jan-24	00:14:55	QC21

Threshold	YTD Mean	Benchmark
15 mins	00:18:46	00:14:59

(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 #
Jan-24	50.0%	

Threshold	YTD Mean	Benchmark
100.0%	49.6%	43.5%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Ambulance - Service Demand : All call types

Reporting Date	Performance	Op. Plan #
Jan-24	1,167	

Threshold	YTD Mean	Benchmark
-	1,118	1,090

	Variation Description

	Assurance Description

Jan-24	East	North	South	West	Total
Category 1 Calls	24	5	4	4	37
No. reached within 15 mins	23	5	4	2	34
% response within 15 mins	95.8%	100.0%	100.0%	50.0%	91.9%

Issues / Performance Summary

• Demand for Ambulance services has slightly decreased in January '24 at 1,167, compared to December'23 (1,201).

• Hear and Treat conducted 195 patient triages. This resulted in in 63 cases being downgraded (improving demand management) and 28 patients being directed to service that didn't require an ambulance response. In addition, 34 Hear and Treat triages were upgraded <1h to face to face assessment and 66 triages were upgraded to a Category 2 response with a conveyance rate of 47.9% 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

• 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 December' 23.
Benchmarks for 'CVA/Stroke' and 'Service Demand' are the Manx Care monthly averages for 2022/23.

Ambulance - Category 2 Response Time at 90th Percentile

Reporting Date	Performance	Op. Plan #
Jan-24	00:25:28	QC136

Threshold	YTD Mean	Benchmark
40 mins	00:29:12	01:27:27

(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 #
Jan-24	00:44:21	QC138

Threshold	YTD Mean	Benchmark
120 mins	00:47:36	05:17:19

(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 #
Jan-24	01:37:20	QC140

Threshold	YTD Mean	Benchmark
180 mins	01:19:34	06:37:26

(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 #
Jan-24	01:27:22	QC142

Threshold	YTD Mean	Benchmark
180 mins	01:21:10	-

(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 = 00:25:28 - Category 3; Standard < 120 mins; 90th percentile = 00:44:21 - Category 4; Standard < 180 mins; 90th percentile = 01:37:20 - Category 5; Standard < 180 mins; 90th percentile = 01:27:22		Note - Benchmarks for Category 2,3,4 'Response time at 90th Percentile' are UK NHSE performance figures for November' 23.

Executive Lead | Oliver Radford | **Lead** | Will Bellamy

Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.
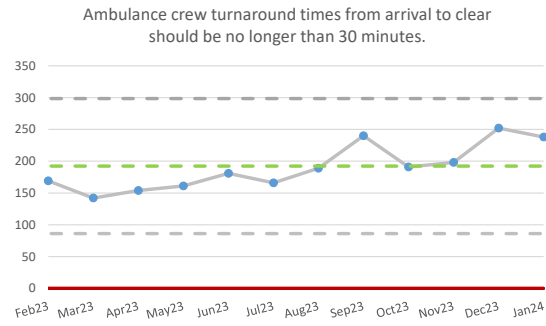
Reporting Date	Performance	Op. Plan #
Jan-24	238	QC85

Threshold	YTD Mean	Benchmark
0	197	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.
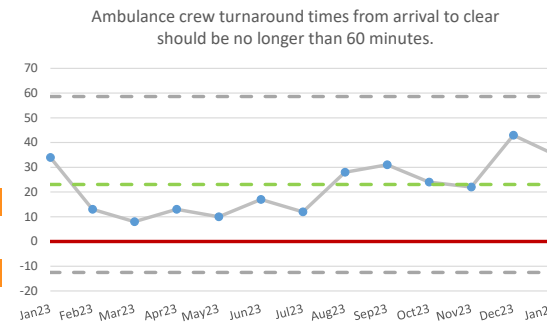
Reporting Date	Performance	Op. Plan #
Jan-24	35	QC86

Threshold	YTD Mean	Benchmark
0	24	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 35 instances where handover Turnaround Times were greater than 60 mins, and 238 where greater than 30 mins.		

CWT - 28 Days to diagnosis or ruling out of cancer
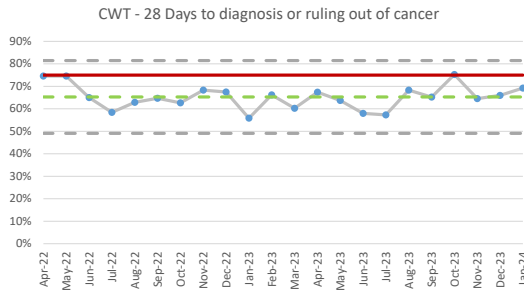
Reporting Date Jan-24
Performance 69.2% (234 of 338)
Op. Plan # QC31

Threshold 75.0%
YTD Mean 65.5%
Benchmark 74.2%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

Suspected Cancer Referrals
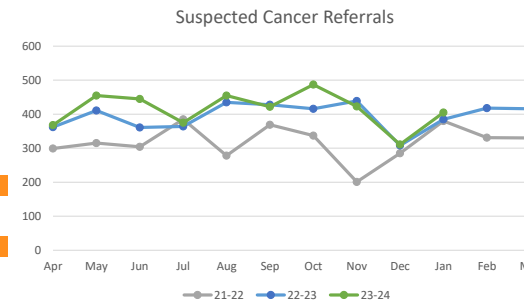
Reporting Date Jan-24
Performance 405
Op. Plan #

Threshold
YTD Mean
Benchmark

-	Variation Description
	Common cause

	Assurance Description

Suspected Cancer Referrals

Tumour Group	Jan-24	Apr 23 - Jan 24	Apr 22 - Jan 23	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	65	671	518	29.5%	67	53	805	635	26.8%
Colorectal	67	742	760	-2.4%	74	72	890	913	-2.5%
Dermatology	68	903	830	8.8%	90	87	1,084	995	8.9%
Gynaecology	51	448	388	15.5%	45	39	538	476	12.9%
Haematology	10	57	60	-5.0%	6	5	68	72	-5.0%
Head & Neck	32	360	362	-0.6%	36	36	432	422	2.4%
Lung	7	114	115	-0.9%	11	11	137	120	14.0%
Other	2	15	43	-	2	4	18	29	-37.9%
Upper GI	39	338	331	2.1%	34	34	406	406	-0.1%
Urology	44	362	361	0.3%	36	36	434	432	0.6%
Sub-Total	385	4,010	3,768	6.4%	446	378	4,812	4,500	6.9%

**Tumour Group	Monthly number of	
	Jan-24	12 month Avg.
Breast symptomatic (non-suspected cancer)	20	8

*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 January, with performance recovering slightly but still remaining below the 75% threshold at 69.2%.
• Although the 2 Week Wait standard is no longer reported, this continues to be monitored as an internal metric 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 weekly tumour specific PTLs and Operational/Escalation PTL
• 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

• The review of our existing suspected cancer (GP referral) proformas with our specialist teams against the current Cheshire and Merseyside Cancer Alliance templates is moving at good pace. We have successfully reviewed and implemented revised forms for Gynaecology, Skin, and Sarcoma. Remaining specialist teams are currently reviewing their forms, and our ambition is to implement all revised forms by close of March 2024. The next GP Education event on the 13th March will be dedicated to Cancer Services, and include presentations by our specialist teams to GPs regarding the updated forms, and how we can develop our relationship further
• Weekly tumour specific PTLs for all tumour groups to ensure robust communication and resolvement/escalation of patient level delays between MDT Team and Business Managers, supporting improvement in CWT Targets
• Review of administration of referrals with PIC to streamline process and ensure days not lost in pathway ahead of first appointment being booked is ongoing
• Cancer Operational and Access Policy, Cancer Escalation Policy, Inter-hospital transfer and breach allocation SOP, Cancer MDT Policy and SCR Data Quality SOP have all been finalised and ratified at the Operational Clinical Quality Group (OCQG) on 12th December 2023. These policies are a comprehensive package of how Manx Care (and it's external relations) operate and deliver a safe and effective cancer service for our patients, and ensure cancer is recognised as an operational priority to support the delivery of all CWTs

Assurance / Recovery Trajectory

• Reporting data now taken directly from the Somerset Cancer Registry (SCR) and is automated
• KPIs and performance management governance brought in line with the National Cancer Waiting Times Monitoring Dataset Guidance
• With effect January 2024 Cancer Services now has weekly tumour specific PTLs in place for all tumour groups
• New post of Cancer Information Reporting and Live Systems Officer is under offer to an existing Cancer MDT Co-ordinator ('home grown') with the post-holder expected to be in place by 1st March 2024 - Post-holder will be dedicated support for cancer data, analysis and reporting (both internal and external) to not only identify areas of operational improvement for patient delays and CWTs but also provide current, meaningful and clear cancer information for the general public of the Isle of Man. This post will link strongly with Manx Care Performance and Improvement, Business Intelligence, and the Public health Directorate for both operational and strategic reporting packages
• Revised suspected cancer proformas now implemented for Gynaecology, Skin and Sarcoma
• Data: Cancer Outcomes and Services Dataset (COSD) has now transitioned to electronic portal submission, and away from e-mail submissions, in-line with UK Trusts

Note -
Benchmark for the 28 Day standard is the UK NHSE performance figures for Dec '23

CWT - 31 Day Diagnosis to Treatment
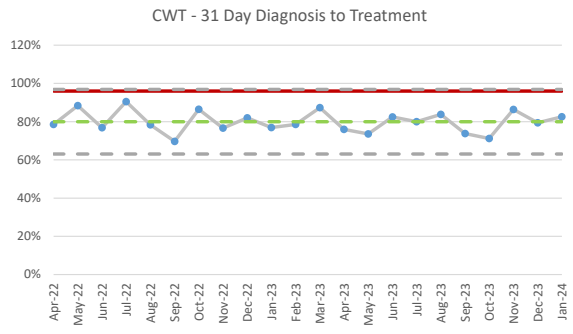
Reporting Date	Performance	Op. Plan #
Jan-24	**82.5%**	QC35
	(33 of 40)	

Threshold	YTD Mean	Benchmark
96.0%	78.9%	91.1%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

CWT - 62 Day Referral to Treatment
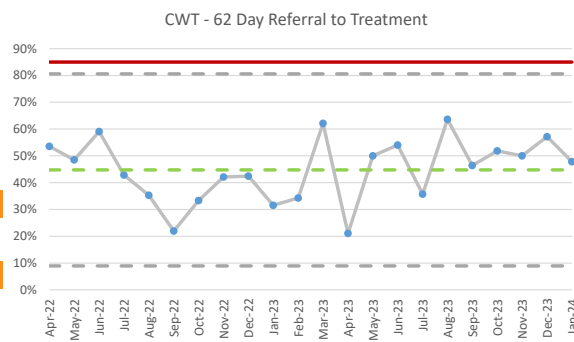
Reporting Date	Performance	Op. Plan #
Jan-24	**47.8%**	QC34
	(11 of 23)	

Threshold	YTD Mean	Benchmark
85.0%	47.8%	65.9%

(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 • Completed 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 to streamline process and ensure days not lost in pathway ahead of first appointment being booked ongoing. • 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 Dec '23

Number of patients on Cancer Pathway

Legend: All, Suspected Cancer
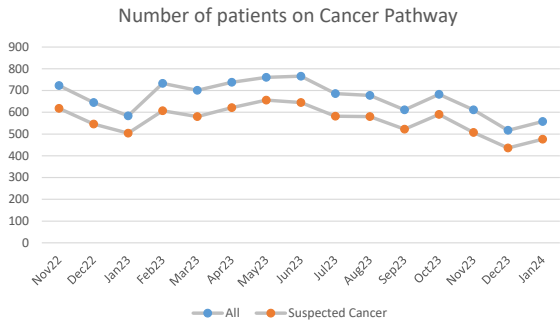
Reporting Date	Performance	Op. Plan #
Jan-24	558	

Threshold	YTD Mean	Benchmark
-	661	677

Variation Description

Assurance Description

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

Reporting Date	Performance	Op. Plan #
Jan-24	19	

Threshold	YTD Mean	Benchmark

- **Variation Description**

Common cause

Assurance Description

Cancer - Total number of patients waiting for first appointment

Reporting Date	Performance	Op. Plan #
Jan-24	61	

Threshold	YTD Mean	Benchmark
	85	86

(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Please see page 55 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.		

Executive Lead	Oliver Radford	Lead	Annmarie Cubbon

% patients seen by Community Adult Therapy Services within timescales
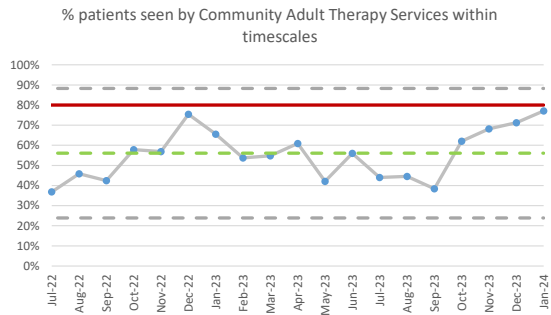
Reporting Date	Performance	Op. Plan #
Jan-24	77.1%	QC62

Threshold	YTD Mean	Benchmark
80.0%	56.5%	54.4%

(Higher value represents better performance)

+ Variation Description
Common cause

- Assurance Description
Consistently fail target

% seen by Community Adult Therapy Services within timescale - by category
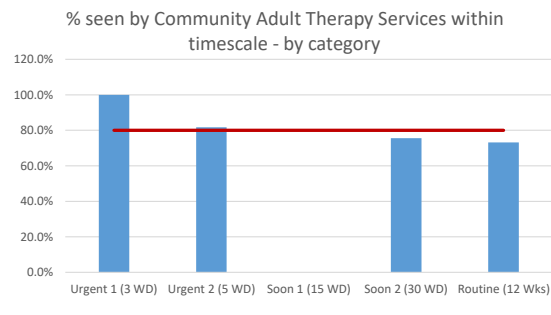
Reporting Date	Performance	Op. Plan #
Jan-24	-	-

Threshold	YTD Mean	Benchmark
80%	-	-

(Higher value represents better performance)

Variation Description

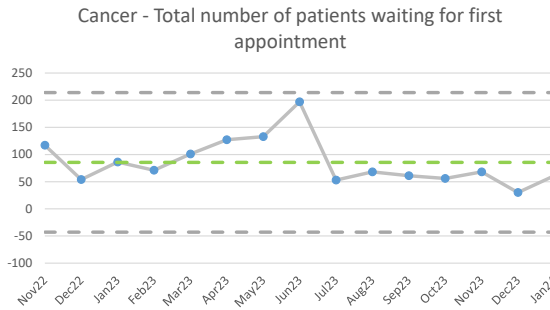**Assurance Description**

Issues / Performance Summary

Community Adult Therapy:
• 100% of Urgent 1 (3 working day) patients were seen within the required timescales in January.
• 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.

Planned / Mitigation Actions

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. These proposed changes will be reflected in reporting for 2024/25.
• 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.

Assurance / Recovery Trajectory

- Note:
Benchmark for '% patients seen by CAT' is the Manx Care monthly averages for 2022/23.

Number of GP Appointments
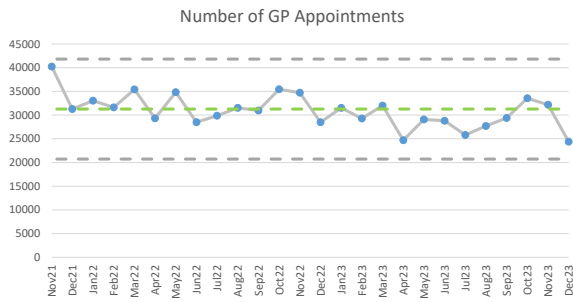
Reporting Date	Performance	Op. Plan #
Dec-23	**24384**	-

Threshold	YTD Mean	Benchmark
-	28397	31375

Variation Description
Common cause

Assurance Description

GP - Number of appointments per 1000 registered patients - Dec 2023

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

Threshold	YTD Mean	Benchmark
-	-	-

-

Variation Description

Assurance Description

Average of Days to next GP appointment - Dec 2023

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

Threshold	YTD Mean	Benchmark
-	7.2	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

January 2024 data unavialble due to re-development of GP Dashboard.

Days to next appointment have formed part of a wider piece of work around appointment data reporting. The new dashboard is almost ready for rollout.

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

DNA rates continue to be an issue, despite the work undertaken by practices to increase patients awareness on how to cancel an appointment.

Planned / Mitigation Actions

Q3 Contract reviews are currently taking place. We discuss the submitted data and review any issues and areas of concern. We review list sizes and GP capacity.

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 in early 2024. These additional staff will assist the practices when they have scheduled leave, as they can be booked in advance.
Practices with vacancies are currently actively recruiting

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 who commenced 15th January 2024 to assist with capacity issues over the winter period to 31/03/2024
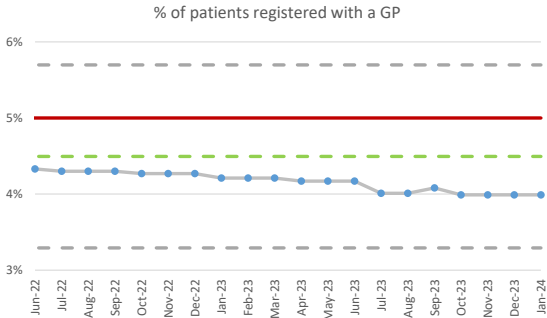
59

| **Executive Lead** | **Oliver Radford** | | **Lead** | **Annmarie Cubbon** |

% of patients registered with a GP

Reporting Date	**Performance**	**Op. Plan #**
Jan-24	3.99%	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	**Planned / Mitigation Actions**	**Assurance / Recovery Trajectory**
% of patients registered with a GP: • % tolerance is currently in line with requirements.	**% 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, suggesting ways that the patients lists can be kept accurate and up to date and also to utilise every opportunity such as ensuring that any returned mail is marked on the patients record, to reduce the lists further.	**% of patients registered with a GP:** • The 2021 Census identified that there was a resident population of 84,069, and there has been movement on and off the Island since that date. 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% and below. • We will continue to review the % on a monthly / quarterly basis, working to the list cleansing timetable and with practices accordingly. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

60

Executive Lead | Oliver Radford | **Lead** | **Annmarie Cubbon**

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

Reporting Date	Performance	Op. Plan #
Jan-24	**100%**	QC61

Threshold	YTD Mean	Benchmark
-	99.0%	-

(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 #
Jan-24	**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

61

No. patients waiting for a Dentist (GDP)

Reporting Date	Performance	Op. Plan #
Jan-24	4878	

Threshold	YTD Mean	Benchmark
-	4182	826

(Lower value represents better performance)

-	Variation Description

Assurance Description

IPCC - Longest wait for General Dental Practitioner (Weeks)

Reporting Date	Performance	Op. Plan #
	211	

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:

•At the end of January 2024 the total number of patients awaiting allocation to a NHS dentist was 4,878, of these 3,341 are adults and 1,537 are children.

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 -

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

MH - No. service users on Current Caseload
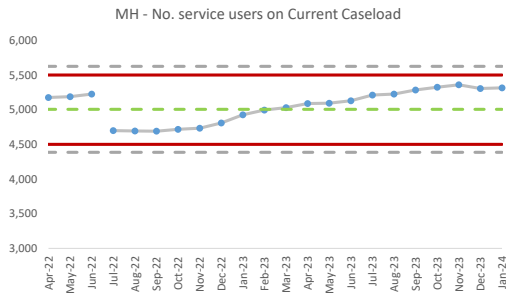
Reporting Date	Performance	Op. Plan #
Jan-24	5315	QC73

Threshold	YTD Mean	Benchmark
4500 - 5500	5234	4907

(Value within range represents better performance)

-	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

MH- Appointments
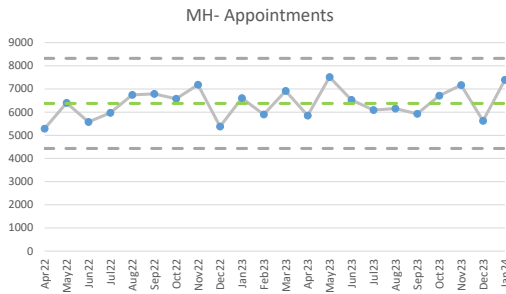
Reporting Date	Performance	Op. Plan #
Jan-24	7393	

Threshold	YTD Mean	Benchmark
-	6496	6276

-	Variation Description
	Common cause

	Assurance Description

MH- Admissions
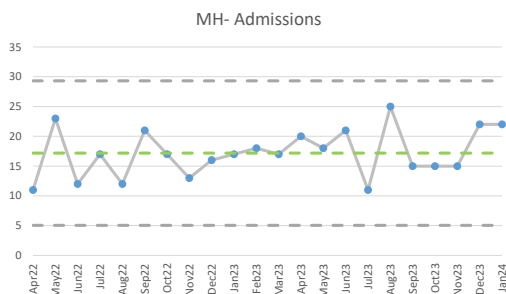
Reporting Date	Performance	Op. Plan #
Jan-24	22	

Threshold	YTD Mean	Benchmark
-	18	16

+	Variation Description
	Common cause

	Assurance Description

Mental Health Waiting Lists

Legend: Overall — CAMHS — CWS
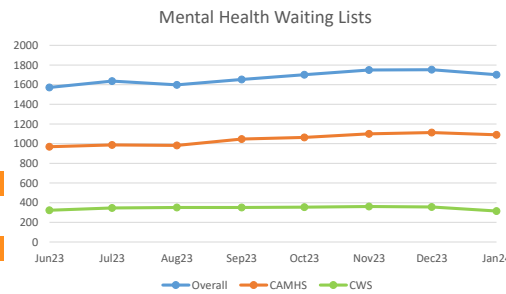
Reporting Date	Performance	Op. Plan #
Jan-24	1702	

Threshold	YTD Mean	Benchmark
-	1671	

	Variation Description

	Assurance Description

Issues / Performance Summary

Current Caseload:
Caseload remains within the expected range with an increase of 10 this month. However, it should be noted that the caseload is significantly higher locally than you would expect within the English NHS. This is particularly evident within CAMHS, whose caseload is some 4 times higher than you would expect per 100 thousand population equivalend in England.
This range is benchmarked upon historic demand.

MH Admissions to Manannan Court:
Admissions in January remained at 22.

Planned / Mitigation Actions

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.

Assurance / Recovery Trajectory

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

Maternity Bookings
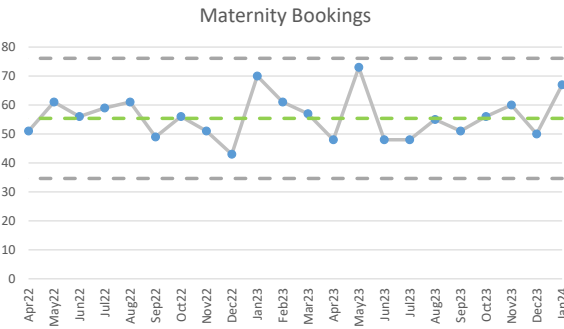
Reporting Date	Performance	Op. Plan #
Jan-24	**67**	

Threshold	YTD Mean	Benchmark
-	846	56

Variation Description
Common cause

Assurance Description

Gestation At Booking <10 Weeks
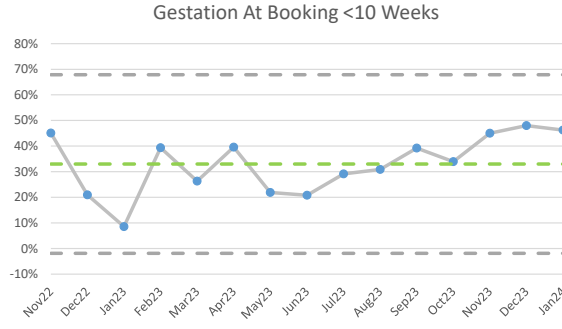
Reporting Date	Performance	Op. Plan #
Jan-24	**46%**	

Threshold	YTD Mean	Benchmark
-	35%	28.0%

Variation Description
Common cause

Assurance Description

Ward Attenders
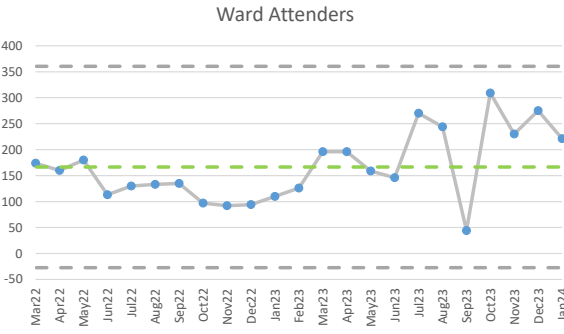
Reporting Date	Performance	Op. Plan #
Jan-24	**221**	

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 46% of booked women booking before 10 weeks. **Booking:** A total of 67 women have booked for care in January (70 in January 23).		

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

Births per annum

Legend: 2021, 2022, 2023

Reporting Date	Performance	Op. plan #
Jan-24	511	

Threshold	YTD Mean	Benchmark
-	272	-

(Higher value represents better performance)

+	Variation Description
	Common cause

Assurance Description

% New Birth Visits within timescale

Reporting Date	Performance	Op. Plan #
Jan-24	88%	QC133

Threshold	YTD Mean	Benchmark
-	89%	89%

-	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary

In January 2024 we received 76 Antenatal referrals into the department.

New Birth Visits

We completed a total of 56 visits. Out of these visits, **44** were completed within the timeframe of 14 days and 7 were not completed within timeframe.

Exception Data
5 1 infant was admitted to Neonatal, 3 were cancelled at parental request and 1 was rescheduled due to staffing

Breach Data
2 breaches in January

In January **40** women were assessed as Universal, 9 as Universal Plus and **1** as Universal Partnership Plus at their New Birth Visit.

Planned / Mitigation Actions

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	Jan-24	🟡	7.0%	6.2%	-	4.0%	(L)	(F)
WP002	🟡	Workforce - Number of staff on long term sickness	Jan-24	-	82	83	-	-		
WP004	🟡	Workforce - Number of staff leavers	Jan-24	-	16	24	236	-		
WP005	🟡	Workforce - Number of staff on disciplinary measures	Jan-24	-	10	9	88	-		
WP006	🟡	Workforce - Number of suspended staff	Jan-24	-	4	3	29	-		
WP013	🟡	Staff 12 months turnover rate	Jan-24	🟢	10.2%	10.1%	-	10%		(?)
WP014	🟡	Training Attendance rate	Jan-24	🔴	57.0%	61.7%	-	90%		(F)
WP007	🟡	Governance - Number of Data Breaches	Jan-24	🟡	14	12	117	0		(F)
WP008	🟡	Governance - Number of Data Subject Access Requests (DSAR)	Jan-24	-	77	56	563	-		
WP009	🟡	Governance - Number of Access to Health Record Requests (AHR)	Jan-24	-	2	3	25	-		
WP010	🟡	Governance - Number of Freedom of Information (FOI) Requests	Jan-24	-	9	10	99	-		
WP011	🟡	Governance - Number of Enforcement Notices from the ICO	Jan-24	-	0	0	0	-		
WP012	🟡	Governance - Number of SAR, AHR and FOI's not completed within their target	Jan-24	🔴	41	38	378	0		(F)
WP015	🟡	Number of DSAR, AHR and FOI's overdue at month end	Jan-24		32	37	371	-		

	Executive Lead	Anne Corkill		Lead	Hannah Leighton

% Hours lost to staff sickness absence
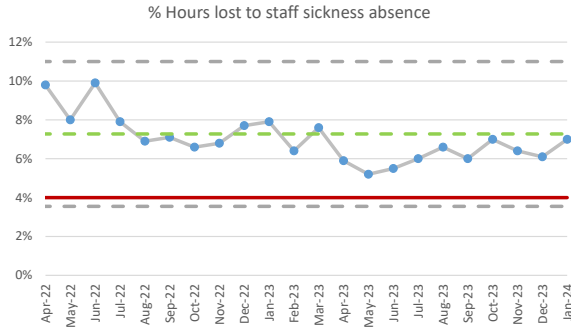
Reporting Date	Performance	Op. plan #
Jan-24	7.0%	P1

Threshold	YTD Mean	Benchmark
4.0%	6.2%	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
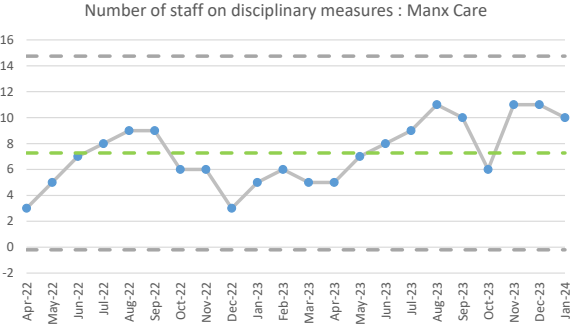
Reporting Date	Performance	Op. plan #
Jan-24	10	P5

Threshold	YTD Mean	Benchmark
-	9	-

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description

Number of staff on long term sickness : Manx Care
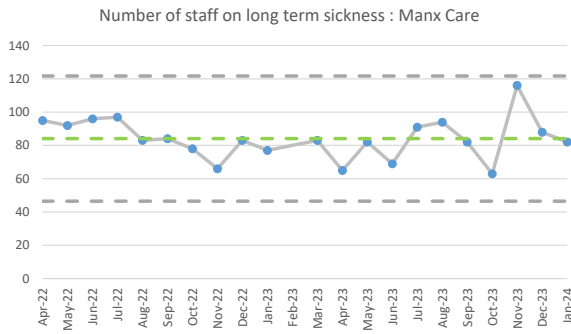
Reporting Date	Performance	Op. plan #
Jan-24	82	P4

Threshold	YTD Mean	Benchmark
-	83	-

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description

Number of suspended staff : Manx Care
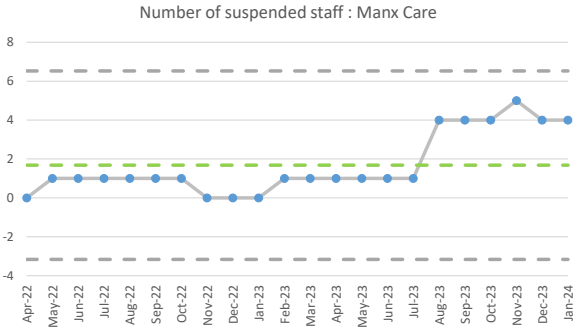
Reporting Date	Performance	Op. plan #
Jan-24	4	P6

Threshold	YTD Mean	Benchmark
-	3	-

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary

• **Worktime lost in January 24 by sickness category:**

Stress, Anxiety & Depression	- 1.3%
Cough, Cold & Flu	- 1.3%
Musculoskeletal	- 1.1%
Covid-19	- 0.9%
Other sickness	- 2.4%

• **Worktime lost in January 24 by Area:**

Integrated Social Care Services	- 8.0%
Medicine, Urgent Care & Ambulance Services	- 7.1%
Integrated Mental Health Services	-
Infrastructure	- 8.7%
Integrated Primary & Community Care Services	- 7.0%
Integrated Cancer & Diagnostic Services	- 6.0%
Women, Children & Families	- 5.3%
Surgery, Theatres, Critical Care & Anaesthetics	- 6.9%

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.

Staff 12 months turnover rate

	Executive Lead	Anne Corkill

Reporting Date Jan-24 **Performance** 10.2% **Op. plan #** P2

Threshold 10.0% **YTD Mean** 10.1% **Benchmark** 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

	Lead	Hannah Leighton

Reporting Date Jan-24 **Performance** 57% **Op. plan #** P7

Threshold 90% **YTD Mean** 62% **Benchmark** 51%

(Higher value represents better performance)

- Variation Description
Common cause

- Assurance Description
Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
NB. Turnover = Leavers/number of staff at start of period. Bank and casual staff excluded. Agency staff also currentlyexcluded. OHR are developing data collection processes.		

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Well Led	Governance		Executive Lead	Simon Collins		Lead	Jennifer Maynard	

Governance - Number of Data Breaches : Manx Care
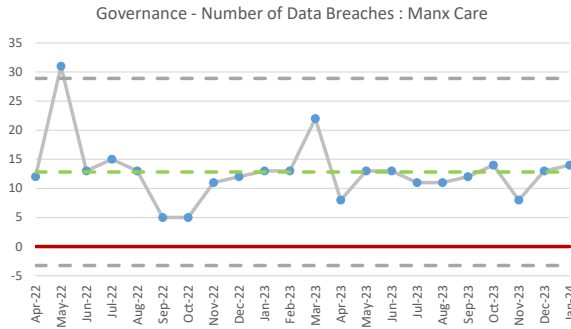
	Reporting Date	Performance	Op. plan #
	Jan-24	14	L1
	Threshold	**YTD Mean**	**Benchmark**
	0	12	-

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Governance - DSAR, AHR and FOI's not completed within their target: Manx Care
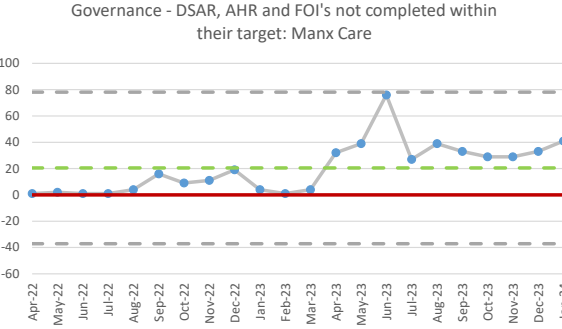
	Reporting Date	Performance	Op. plan #
	Jan-24	41	L6
	Threshold	**YTD Mean**	**Benchmark**
	0	38	-
	(Lower value represents better performance)		

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Governance - Information requests by type : Manx Care

SAR AHR FOI
Linear (SAR) Linear (AHR) Linear (FOI)
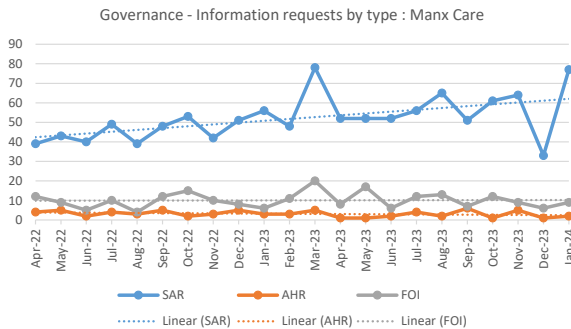
	Reporting Date	Performance	Op. plan #
	Jan-24	-	L2-3-4
	Threshold	**YTD Mean**	**Benchmark**
	-	-	-

Variation Description

Assurance Description

Governance - DSAR, AHR and FOI's overdue at month end: Manx Care
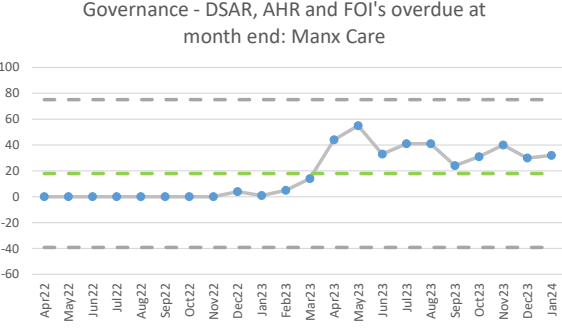
	Reporting Date	Performance	Op. plan #
	Jan-24	32	-
	Threshold	**YTD Mean**	**Benchmark**
	-	37	18
	(Lower value represents better performance)		

+	Variation Description
	Common cause

Assurance Description

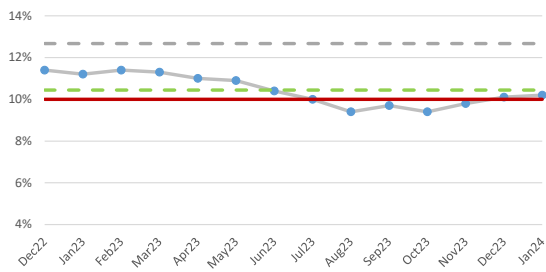| Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Breaches – Total: 14 Reported to the Commissioner: 2 Data Subjects informed: 9 Data Subjects Not Informed: 5 (4 x low risk to data subject, 1 x clinical decision not to inform) Types of breach Email: 3 Written Communication: 4 Confidentiality: 7	• 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 January Manx Care had 14 breaches, but only 2 meeting 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.	• Manx Care staff are actively encouraged to report any data breach, or suspected breach, to the Manx Care DPO and it is encouraging that staff across Manx Care are confident to report data breaches and that such events are used as an opportunity to learn and improve and to 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)	Dec-23		109%	-	445%	100% (equiv. 1%)		
WF002	🟠	Total income (£)	Dec-23	-	-£1,256,596	-£1,238,717	-£11,812,248	-	〰️	
WF003	🟠	Total staff costs (£)	Dec-23	-	£17,624,943	£16,177,273	£159,732,102	-	〰️	
WF004	🟠	Total other costs (£)	Dec-23	-	£13,118,544	£11,886,589	£116,372,746	-		
WF005	🟠	Agency staff costs (proportion %)	Dec-23	-	5.1%	5.8%	-	-	〰️	
WF009	🟠	Actual performance against Budget	Dec-23		-3,491	-£4,401	-£23,706	-		

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

Actual Performance against Budget

Legend: Total cost — Budget

Reporting Date	**Performance**	**Op. plan #**
Dec-23		
Threshold	**YTD Mean**	**Benchmark**

Variation Description

Assurance Description

Total staff costs (£)
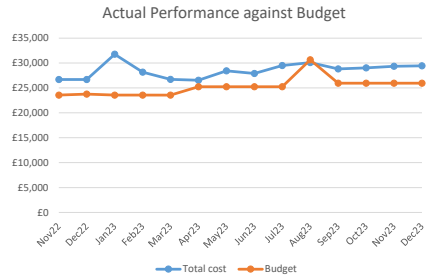
Reporting Date	**Performance**	**Op. plan #**
Dec-23	£17,624,943	F4
Threshold	**YTD Mean**	**Benchmark**
-	£16,177,273	-

(Lower value represents better performance)

+ Variation Description
Common cause

Assurance Description

Total income (£)

Reporting Date	**Performance**	**Op. plan #**
Dec-23	-£1,256,596	F3
Threshold	**YTD Mean**	**Benchmark**
-	-£1,238,717	-

(Higher value represents better performance)

+ Variation Description
Common cause

Assurance Description

% Progress towards Cost Improvement Target (CIP)
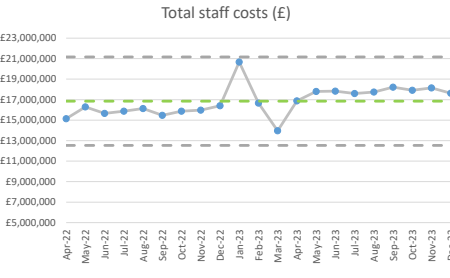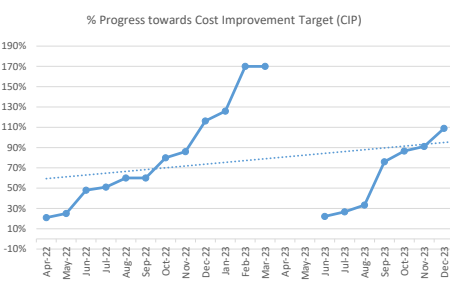
Reporting Date	**Performance**	**Op. plan #**
Dec-23	109.0%	F1
Threshold	**YTD Mean**	**Benchmark**
100% (equiv. 1%)	-	-

(Higher value represents better performance)

+ Variation Description

Assurance Description

Issues / Performance Summary

% Progress towards Cost Improvement Target (CIP):
• To date, the CIP plan has delivered £6m in savings, of which £4.9m are cash out. This is 93% of the adjusted £6.4m target so the target has been further increased to £7.5m. Overall, delivery at December stands at 80% of this revised target. These savings have been reflected in the forecast. However, many are serving to hold existing cost pressures in check and avoiding costs rather than reducing the forecast further.
• Spend is expected to increase by £32.0m compared to the prior year, whilst funding has increased by just £20m creating a gap of £12.0m. The year-end position for 22/23 was an overspend of £8.9m which also contributes to the predicted operational overspend of £21.0m. 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 £337.7m in 23/24.

Total income (£):
• The operational result for December is an overspend of (£2.1m). Due to the number of risks identified from November which have now been investigated further the forecast has been moved by (£3.2m) to an overspend of (£34.8m). These were previously identified as risks in the prior months report.

Total staff costs (£):
•YTD employee costs are (£4.9m) 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 £8.9m is broken down across Care Groups below. The Care Groups with the largest spend are Medicine (£1.8m), Social Care (£1.7m) and Mental Health (£1.2m), where spend is primarily incurred to cover existing vacancies in those areas.

Planned / Mitigation Actions

% Progress towards Cost Improvement Target (CIP):
• There are currently 69 projects expected to deliver savings in this year, many of which will also deliver savings in 24/25. A further 27 projects are under development
for delivery in 24/25 with additional projects expected to be added in the coming months.
• The Restoration & Recovery programme is showing an overspend on an 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.
• he Commercial Opportunities target is unlikely to be met in this year but is expected to deliver in full in 24/25. Infrastructure savings are expected from Q4. Tertiary savings have increased since last month and are expected to recover during Q4. The efficiency target of £825k has now been exceeded with delivery of £1.1m to date.

Total income (£):
• Spend is expected to increase by £32.0m compared to the prior year, whilst funding has increased by just £20m creating a gap of £12.0m. The year-end position for 22/23 was an overspend of £8.9m which also contributes to the predicted operational overspend of £21.0m.
• If all the business cases are approved from the Reserve Fund the operational forecast would reduce to (£28.4m).

Total staff costs (proportion %):
• Although agency costs are continuing to reduce bank costs have been gradually increasing which means that overall costs are tracking higher than last year but within expected trends. Bank costs have reduced by £0.3m since last month, bringing them closer to prior year levels. 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 work streams impact the run rate there are remaining savings of £1.0m included in the forecast centrally (which is included as a risk). To date, £4.3m in cash out savings have been delivered, which have been reflected in the forecast. £976k in efficiencies have also been delivered but these do not impact the forecast.

Total income (£):
• Of the forecast overspend, £7.3m 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 is 6% (in line with pay offers). For reporting purposes a provision of 2% is included in the Care Groups actuals & forecast with the remaining 4% accounted for centrally.
For reporting purposes a provision of 2% is included in the Care Groups actuals & forecast with the remaining 4% accounted for centrally.

Agency staff costs (proportion %)
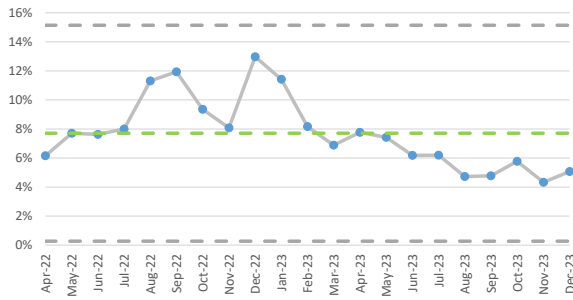
Reporting Date	Performance	Op. plan #
Dec-23	5.1%	

Threshold	YTD Mean	Benchmark
	5.8%	5.8%

(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	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD 2023-24	YTD Performance
SAFE	SA001	Serious Incidents declared	<3 < 36 PA	2	0	0	2	2	1	1	3	4	1	5	5	0	3	25	
	SA002	Duty of Candour letter has been sent within 10 days of incident	80%	N/A	N/A	N/A	N/A	80.00%	75.00%	50.00%	75.00%	100.00%	100.00%	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	100.00%	100.00%	50.00%	25.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
	SA003	Eligible patients having VTE risk assessment within 12 hours of decision to admit	95%	86.68%	94.39%	97.85%	95.06%	90.41%	84.73%	89.60%	87.30%	88.89%	91.00%	94.50%	92.50%	93.00%	98.00%		
	SA004	% Adult Patients (within general hospital) who had VTE prophylaxis prescribed if appropriate	95%	92.00%	99.30%	99.17%	97.00%	91.87%	95.87%	97.40%	100.00%	98.00%	96.00%	99.00%	99.00%	96.00%	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	0.47	0.35	0.54	0.63	0.16	0.16	0.17	0.45	0.31	0.49	0.5	0.17	0.3		
	SA019	Pressure Ulcers - Total incidence - Grade 2 and above	<= 17 (204 PA)	11	13	11	13	15	13	19	24	29	16	11	17	2	14	160	
	SA007	Clostridium Difficile - Total number of acquired infections	< 30 PA	0	2	3	2	4	4	4	4	2	1	1	3	0	1	24	
	SA008	MRSA - Total number of acquired infections	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	
	SA009	E-Coli - Total number of acquired infections	< 72 PA	6	5	4	0	5	8	6	10	4	9	8	11	7	8	76	
	SA010	No. confirmed cases of Klebsiella spp	-	0	0	0	0	0	3	1	2	2	2	0	2	2	2	16	
	SA011	No. confirmed cases of Pseudomonas aeruginosa	-	1	0	0	0	0	0	0	1	1	1	0	0	2	0	5	
	SA012	Number of Medication Errors (with Harm)	< 25 PA	0	0	0	0	1	1	0	0	0	0	1	0	0	0	3	
	SA013	Harm Free Care Score (Safety Thermometer) - Adult	95%	99.5%	97.5%	98.5%	96.9%	96.8%	97.4%	98.0%	97.5%	96.8%	97.0%	97.7%	97.0%	95.5%	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%	89.0%	100.0%	100.0%	100.0%		
	SA015	Harm Free Care Score (Safety Thermometer) - Children	95%	95.8%	90.0%	95.2%	99.0%	82.3%	99.8%	95.2%	96.2%	100.0%	99.0%	100.0%	100.0%	98.5%	99.0%		
	SA016	Hand Hygiene Compliance	96%	98.0%	97.0%	97.0%	92.0%	98.0%	96.0%	99.0%	97.0%	97.0%	97.0%	99.0%	97.0%	98.0%	96.0%		
	SA017	48-72 hr review of antibiotic prescription complete	98%	71.0%	75.0%	58.0%	81.0%	80.0%	70.0%	79.0%	70.0%	74.0%	88.0%	82.0%	88.0%	78.0%	90.0%		
EFFECTIVE	EF067	Planned Care - DNA - Hospital	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8.7%	12.2%	10.2%	9.4%	11.0%	11.9%	12.2%		
	EF001	Planned Care - DNA Rate (Consultant Led outpatient appointments)	5%	9.4%	9.7%	7.9%	12.0%	11.9%	11.1%	10.4%	11.9%	14.8%	11.5%	11.2%	13.3%	16.7%	15.2%		
		Planned Care - DNA Rate (Nurse Led outpatient appointments)		5.9%	4.2%	4.8%	6.0%	7.4%	7.1%	4.8%	5.1%	8.2%	6.6%	5.4%	6.8%	5.8%	8.2%		
		Planned Care - DNA Rate (AHP Led outpatient appointments)		9.8%	10.0%	9.4%	11.0%	11.3%	9.5%	10.1%	9.0%	11.4%	10.2%	10.0%	9.8%	10.4%	9.8%		
	EF002	Planned Care - Total Number of Cancelled Operations		357	429	317	396	236	344	284	337	268	371	367	348	355	390	3300	
		Hospital cancelled		234	280	179	229	109	196	138	200	140	223	239	156	167	204	1772	
		Patient cancelled		123	149	138	167	127	148	146	137	128	148	128	192	188	186	1528	
	EF005	Length of Stay (LOS) - No. patients with LOS greater than 21 days	-	118	119	125	88	112	121	114	140	103	105	94	81	91	115	1076	
		Average Length of Stay (ALOS) - Nobles	-	5	5	5	6	5	5	5	5	5	5	5	5	5	5		
		Average Length of Stay (ALOS) - RDCH	-	33	51	50	41	38	130	38	31	36	40	44	34	35	35		
		Total Number of discharges	-	1021	991	866	1008	907	960	906	985	1009	938	971	1033	949	960	4767	
	EF050	Total Number of Inpatient discharges-Nobles	-	977	959	826	976	882	924	866	946	968	904	928	995	902	920	4586	
	EF051	Total Number of inpatient discharges-RDCH	-	44	32	40	32	25	36	40	39	41	34	43	38	47	40	181	

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	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD 2023-24	YTD Performance
EFFECTIVE	EF003	Theatres - Number of Cancelled Operations on Day		38	81	39	48	36	40	28	51	27	33	46	31	24	44	360	
		Theatres - Number of Cancelled Operations on Day - Clinical		9	14	10	19	12	14	16	7	8	14	16	13	7	16	123	
		Theatres - Number of Cancelled Operations on Day - Non clinical - Patient		4	4	5	11	5	6	5	14	5	6	10	6	7	3	67	
		Theatres - Number of Cancelled Operations on Day - Non clinical - Hospital		25	63	24	18	19	20	7	30	14	13	20	12	10	25	170	
	EF004	Theatres - Theatre Utilisation %	85%	76.3%	72.1%	82.5%	75.8%	73.3%	76.2%	67.8%	79.7%	82.4%	80.6%	79.8%	76.2%	72.3%	76.1%		
	EF006	Crude Mortality Rate		29.28	22.48	20.23	24.24	16.47	15.37	12.75	15.25	19.63	18.81	24.68	19	21.76	38.07		
	EF007	Total Hospital Deaths		32	21	23	27	18	18	13	20	21	22	30	27	20	41	230	
	EF024	Mortality - Hospitals LFD (Learning from Death reviews)	80.00%	36%	54%	92%	94%	93%	93%	98%	98%	98%	97%	97%	99%	99%	98%		
	EF008	West Wellbeing Contribution to reduction in ED attendance	10% per 12 months	8.9%	-12.7%	7.3%	25.3%	6.7%	5.8%	-6.4%	24.9%	14.2%	7.1%	6.6%	6.2%	6.3%	0.4%		
	EF009	West Wellbeing Reduction in admission to hospital from locality	5% per 12 months	17.5%	22.6%	-6.4%	89.2%	-10.9%	-1.8%	-25.3%	-25.6%	-1.8%	-14.3%	1.6%	66.7%	32.7%	28.3%		
	EF011	MH - Average Length of Stay (LOS) in MH Acute Inpatient Service (Discharged)	-	66	64	72	26	30	33	83	21	51	20	8	39	24	31		
	EF013	MH - % service users discharged from MH inpatient to have follow up appointment	90%	100.0%	94.0%	94.0%	100.0%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.0%		
	EF064	Number of patients with a length of stay - 0 days (Mental Health)	-	N/A	0	3	0	2	1	1	0	1	1	0	1	1	0	8	
	EF065	MH - Number of patients aged 18-64 with a length of stay - > 60 days	-	N/A	5	5	1	3	4	3	0	2	1	0	1	0	1	15	
	EF066	MH - Number of patients aged 65+ with a length of stay - > 90 days	-	N/A	2	0	0	2	0	1	1	3	0	0	1	2	2	12	
	EF047	% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	75%	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
	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	100%	100%	50%	100%	100%	50%	100%	-	-	0%	100%			
	EF026	Crisis Team one hour response to referral from ED	75%	87%	100%	75%	91%	94%	94%	100%	96%	84%	90%	77%	90%	85%	91%		
	EF015	ASC - % of Re-referrals	<15%	11.3%	12.4%	4.6%	1.3%	3.9%	3.8%	1.7%	4.5%	1.2%	0.0%	3.3%	4.1%	5.1%	6.1%		
	EF063	ASC - No. of referrals		80	89	65	77	76	78	59	66	86	68	91	74	59	82	739	
	EF016	ASC - % of all Adult Community Care Assessments completed in Agreed Timescales	80%	68%	55%	33%	27%	39%	39%	29%	42%	27%	23%	40%	30%	24%	28%		
	EF017	ASC - % of individuals (or carers) receiving a copy of their Adult Community Care Assessment	100%	13%	14%	0%	27%	22%	48%	100%	100%	100%	96%	100%	96%	95%	96%		

	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD 2023-24	YTD Performance
EFFECTIVE	EF019	CFSC - % Complex Needs Reviews held on time	85%	62.5%	62.5%	35.7%	75.0%	100.0%	75.0%	65.5%	54.6%	50.0%	48.0%	56.0%	43.5%	66.7%	34.0%		
	EF021	CFSC - % Total Initial Child Protection Conferences held on time	90%	100.0%	50.0%	50.0%	100.0%	100.0%	100.0%	33.3%	80.0%	71.4%	80.0%	76.9%	100.0%	0.0%	80.0%		
	EF022	CFSC - % Child Protection Reviews held on time	90%	71.4%	66.7%	85.7%	77.8%	88.9%	100.0%	100.0%	88.9%	95.8%	95.7%	80.0%	100.0%	100.0%	75.0%		
	EF023	CFSC - % Looked After Children reviews held on time	90%	92.3%	94.7%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	90.5%	90.0%	88.0%	100.0%	100.0%	76.0%		
	EF049	C&F -Number of referrals - Children & Families		N/A	N/A	N/A	N/A	116	172	144	133	121	168	141	199	188	230	1612	
	EF044	C&F -Children (of age) participating in, or contributing to, their Child Protection review	90%	N/A	N/A	N/A	N/A	0.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%		
	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	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	100.0%	100.0%	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	36.0%	34.0%	42.0%	41.0%	100.0%	36.0%	35.0%	71.0%	21.0%	55.0%		
	EF025	Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	95%	84%	77%	89%	96%	97%	96%	99%	99%	97%	92%	96%	95%	93%	95%		
	EF010	% Dental contractors on target to meet UDA's	96%	75%	75%	75%	72%	3%	10%	17%	25%	35%	38%	46%	53%	55%			
	EF068	Pharmacy - Total Prescriptions (No. of fees)		N/A	N/A	N/A	N/A	131397	140744	139132	136305	137200	158757	137848	146299			£1,127,682	
	EF069	Pharmacy - Chargable Prescriptions		N/A	N/A	N/A	N/A	16509	19236	18377	17909	17376	22055	18211	19690			£149,363	
	EF070	Pharmacy - Total Exempt Item		N/A	N/A	N/A	N/A	129409	139125	137291	134446	134685	155968	135824	143793			£1,110,541	
	EF071	Pharmacy - Chargeable Items		N/A	N/A	N/A	N/A	16410	19108	18266	17909	17224	21924	17940	19273			£148,054	
	EF072	Pharmacy - Net cost		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	£1,371,536	£1,405,662			£11,549,154	
	EF073	Pharmacy - Charges Collected		N/A	N/A	N/A	N/A	£63,586	£73,816	£70,832	£68,792	£66,370	£84,646	£69,092	£74,520			£571,654	
	EF030	Caesarean Deliveries (not Robson Classified)		34%	38%	26%	21%	39%	43%	32%	46%	61%	41%	35%	43%	47%	39%		
	EF031	Induction of Labour	< 30%	26%	27%	36%	34%	29%	36%	11%	33%	44%	30%	25%	40%	29%	47%		
	EF032	3rd/4th Degree Tear Overall Rate	< 3.5%	0%	5%	0%	0%	0%	0%	1%	0%	0%	1%	2%	0%	2%	2%		
	EF033	Obstetric Haemorrhage >1.5L	< 2.6%	0%	2%	0%	0%	0%	0%	0%	1%	1%	0%	2%	0%	2%	4%		
	EF034	Unplanned Term Admissions To NNU		0%	0%	0%	0%	0%	0%	12%	4%	4%	13%	15%	5%	5%	10%		
	EF035	Stillbirth Number / Rate		0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	
	EF036	Unplanned Admission To ITU – Level 3 Care		0	0	0	0	0	2	0	1	0	1	0	0	0	1	5	
	EF037	% Smoking At Booking		8%	7%	9%	9%	15%	11%	8%	6%	4%	4%	7%	12%	16%	10%		
	EF038	% Of Women Smoking At Time Of Delivery	< 18%	5%	7%	6%	11%	14%	6%	5%	0%	10%	14%	3%	12%	6%	8%		
	EF039	First Feed Breast Milk (Initiation Rate)	> 80%	87%	67%	83%	70%	76%	63%	73%	56%	71%	69%	76%	71%	67%	63%		
	EF040	Breast Feeding Rate At Transfer Home		84%	41%	36%	34%	37%	29%	31%	32%	30%	72%	69%	76%	73%	78%		
	EF041	Neonatal Mortality rate/1000		0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
	EF059	W&C - Paediatrics- Total Admissions		N/A	N/A	N/A	N/A	N/A	N/A	119	131	117	133	162	197	164	169	1192	
	EF060	W&C - NNU - Total number of Admissions		N/A	N/A	N/A	N/A	6	7	8	8	3	7	11	5	5	5	65	
	EF061	W&C - NNU - Avg. Length of Stay		N/A	N/A	N/A	N/A	N/A	N/A	8.5	3.4	5.0	3.4	6.5	21.2	12.5	4.4		
	EF062	W&C - Community follow up		N/A	N/A	N/A	N/A	4	8	6	2	1	3	0	9	8	8	49	

	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	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	-	19	18	27	30	28	24	27	24	22	26	29	27	28	24	259	
	CA012	FFT - How was your experience? No. of responses	-	63	121	620	739	571	718	2096	1161	1311	1187	1682	1650	943	1403	12722	
	CA013	FFT - Experience was Very Good or Good	80%	74.0%	87.0%	87.0%	87.0%	92.0%	87.0%	85.0%	87.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%		
	CA014	FFT - Experience was neither Good or Poor	10%	8.0%	7.0%	10.0%	5.0%	2.0%	4.0%	6.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%		
	CA015	FFT - Experience was Poor or Very Poor	<10%	18.0%	6.0%	4.0%	8.0%	6.0%	8.0%	9.0%	9.0%	6.0%	5.0%	5.0%	5.0%	5.0%	5.0%		
	CA016	Manx Care Advice and Liaison Service contacts	-	432	580	770	839	589	636	517	649	621	655	704	958	620	883	6832	
	CA017	Manx Care Advice and Liaison Service same day response	80%	92.0%	90.0%	90.0%	88.0%	89.0%	87.0%	91.0%	90.0%	91.0%	90.0%	89.0%	90.0%	91.0%	90.0%		
	CA007	Complaint acknowledged within 5 working days	98%	100.0%	100.0%	100.0%	100.0%	100.0%	86.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
	CA008	Written response within 20 days	98%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	98.3%	100.0%	100.0%	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	7	4	1	4	2	4	2	24	
RESPONSIVE	RE058	Cons Led- OP Referrals		2734	2932	3056	3502	2867	2887	3075	2846	2986	2812	3041	2857	2200	2864	28435	
	RE059	Nurse Led- OP Referrals		656	798	559	717	729	594	850	889	741	824	794	1056	640	1002	8119	
	RE060	AHP- OP Referrals		672	880	508	840	684	736	906	846	770	853	866	962	640	966	8229	
		RTT - Number of patients waiting for first hospital appointment		20837	20825	21025	20618	20406	20189	20480	20191	20367	21180	21042	21335	20810	20452		
	RE001	No. patients waiting for first Consultant outpatient	< 15465	14955	14952	15119	15380	15465	15500	15718	15703	15846	16562	16744	16973	16861	16610		
		No. waiting Over 52 weeks - to start consultant-led treatment	0	4708	4806	5006	4792	4890	4927	5016	5247	5089	5289	5432	5602	5487	5361		
		Average Wait (weeks) - Ref to OP		48	49	51	49	47	47	47	49	48	48	48	49	47	48		
		Max wait (weeks) - Ref to OP		794	798	790	794	799	846	836	817	816	840	844	1017	1021	1025		
	RE0011	No. patients waiting for Nurse outpatient		2193	2167	2218	1927	1519	1385	1540	1512	1449	1643	1623	1802	1657	1663		
	RE00111	No. patients waiting for AHP		3559	3684	3688	3311	3422	3304	3222	2976	3072	2975	2675	2560	2292	2179		
	RE002	Number of patients waiting for Daycase procedure	< 2311	2852	2726	2697	2622	2311	2264	2372	2334	2229	2291	2303	2254	2126	2016		
		Average Wait (weeks) - Daycase		44	43	42	40	41	42	43	43	45	43	44	45	45	49		
		Max wait (weeks) - Daycase		452	291	295	299	304	308	312	316	320	293	297	301	301	305		
		No. waiting Over 52 weeks - Inpatient (Daycase only)		979	879	787	717	624	609	635	617	602	607	601	604	580	573		
	RE003	Number of patients waiting for Inpatient procedure	< 554	630	612	592	570	554	553	551	534	505	530	497	464	432	447		
		Average Wait (weeks) - Inpatient		39	40	38	40	39	40	41	40	38	38	35	33	33	34		
		Max wait (weeks) - Inpatient		303	308	312	316	321	325	329	333	337	342	235	212	217	221		
		No. waiting Over 52 weeks - Inpatient (IP pathway only)		183	165	155	142	143	144	149	134	124	129	106	95	78	79		
	RE004	% Urgent GP referrals seen for first appointment within 6 weeks	85%	53.4%	41.5%	48.4%	55.7%	60.8%	55.0%	57.0%	60.0%	57.4%	42.4%	55.4%	48.6%	52.5%	46.4%		
	RE005	Diagnostics - % requests completed within 6 weeks		87.0%	82.0%	86.2%	87.3%	84.7%	81.4%	86.7%	86.2%	86.6%	85.4%	85.4%	85.3%	88.4%	85.6%		
	RE006	Diagnostics - % Current wait > 6 weeks		75%	75%	70%	70%	73%	71%	70%	71%	74%	71%	68%	61%	64%	59%		
		Diagnostics - Total Waiting List Size (exc. Scheduled & On Hold)		8234	7683	8089	8481	8256	7719	7545	7291	3541	4544	3846	3622	3955	3883		
		Diagnostics - % Current wait <= 6 weeks	99%	25%	25%	30%	30%	27%	29%	30%	29%	26%	29%	32%	39%	36%	41%		
	RE061	Diagnostics-% patients waiting 26 weeks or less	99%	N/A	N/A	N/A	N/A	N/A	59%	61%	63%	59%	59%	58%	67%	67%	69%		

	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	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%	67.7%	68.6%	70.1%	71.0%	70.8%	73.9%	75.7%	71.5%	72.1%	68.7%	71.0%	69.5%	68.0%	66.0%		
		A&E - 4 Hour Performance - Nobles		53.1%	55.4%	58.5%	59.6%	61.7%	64.5%	66.5%	61.1%	60.8%	57.9%	60.6%	58.7%	57.2%	55.2%		
		A&E - 4 Hour Performance - RDCH		99.2%	98.9%	99.6%	99.8%	99.9%	100.0%	99.6%	100.0%	99.9%	100.0%	99.9%	100.1%	99.7%	99.7%		
	RE008	A&E - 4 Hour Performance (Non Admitted)	95%	78.5%	79.6%	79.6%	80.8%	79.6%	82.1%	84.0%	80.6%	82.9%	78.8%	80.4%	79.3%	79.1%	76.6%		
	RE009	A&E - 4 Hour Performance (Admitted)	95%	20.1%	21.2%	21.4%	22.5%	25.3%	29.0%	29.4%	23.2%	16.8%	16.9%	22.8%	22.6%	20.0%	18.0%		
		A&E - Admission Rate		18.4%	18.9%	16.1%	16.8%	16.1%	15.2%	15.3%	15.7%	16.3%	16.3%	16.4%	17.4%	18.8%	17.6%		
	RE0072	A&E - Admission Rate - Nobles		27.0%	27.2%	22.6%	23.5%	21.3%	20.8%	21.2%	21.5%	22.9%	21.9%	22.3%	23.5%	25.1%	23.4%		
		A&E - Admission Rate - RDCH		0.3%	0.0%	0.3%	0.2%	0.2%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%		
	RE010	A&E - Average Total Time in Emergency Department	360 mins	301	295	269	254	246	227	220	257	267	298	268	275	279	292		
	RE011	A&E - Average number of minutes between Arrival and Triage (Noble's)	15 mins	27	25	27	26	25	24	21	26	22	29	28	35	26	30		
	RE012	Average number of minutes between arrival to clinical assessment-Nobles	60 mins	70	74	72	62	69	63	56	74	63	67	72	80	71	75		
	RE033	ED - Average number of minutes between arrival to clinical assessment-Ramsey	60 mins	31	28	38	22	14	12	19	13	14	12	12	16	23	16		
	RE013	A&E - Patients Waiting Over 12 Hours From Decision to Admit to Admission to a Ward (12 Hour Trolley Waits)	0	54	56	27	13	6	5	12	36	48	67	48	30	41	51	344	
	RE0131	Number of patients exceeding 12 hours in Nobles Emergency Department	0	142	134	93	56	45	22	47	104	115	191	127	114	132	151	1048	
	RE080	ED- Emergency Care Time (Average Number of minutes between arrival and referral to speciality OR discharge)	180 min	181	181	176	177	177	175	161	178	168	182	179	181	177	183		
	RE014	Ambulance - Category 1 Response Time at 90th Percentile	15 mins	23	20	15	28	20	17	19	23	19	17	20	18	19	15		
	RE0141	Total Number of Emergency Calls		1209	1100	1025	1109	1059	1035	1105	1131	1130	1134	1118	1099	1201	1167	11179	
	RE0142	Number of Category 1 Calls		50	37	32	33	25	46	43	41	38	46	24	28	31	37	359	
	RE015	Ambulance - Category 1 Mean Response Time	7 mins	10	10	8	12	11	8	9	11	9	9	11	8	9	8		
	RE016	Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	100%	16.7%	34.6%	15.4%	36.4%	47.1%	50.0%	63.6%	32.0%	56.3%	58.3%	46.2%	40.0%	52.4%	50.0%		
		Category 2 Mean Response Time	18 mins	N/A	13	12	16	14	16	13	13	11	16	12	13	15	12		
	RE034	Category 2 Response Time at 90th Percentile	40 mins	31	28	26	36	31	38	29	27	25	33	24	26	33	25		
		Category 3 Mean Response Time	Monitor	N/A	15	16	22	20	20	19	24	17	20	22	24	22	19		
	RE035	Category 3 Response Time at 90th Percentile	120 mins	58	32	32	57	42	51	39	53	37	47	48	61	53	44		
		Category 4 Mean Response Time	Monitor	N/A	22	19	25	30	35	20	37	26	44	33	36	32	37		
	RE036	Category 4 Response Time at 90th Percentile	180 mins	105	53	41	54	76	82	63	74	56	121	84	78	64	97		
		Category 5 Mean Response Time	Monitor	N/A	33	31	42	40	36	31	35	32	35	33	30	0	0		
		Category 5 Response Time at 90th Percentile	180 mins	95	80	80	98	91	89	72	83	72	81	72	71	95	87		
		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	0	N/A	219	169	142	154	161	181	166	189	240	191	198	252	238	1970	
		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	0	48	34	13	8	13	10	17	12	28	31	24	22	43	35	235	
	RE043	OPEL level 4 (Days)		3	5	3	0	0	0	0	1	3	5	2	2	2	2	15	
	RE082	Meds Demand - N.patient interactions		N/A	N/A	N/A	N/A	3111	2872	2295	2664	2281	2211	2326	2574	3335	2464	26133	
	RE083	Meds Overnight Demand		N/A	N/A	N/A	N/A	354	317	224	275	197	195	230	552	337	111	2792	
	RE084	Meds - Face to face appointments		N/A	N/A	N/A	N/A	609	474	360	574	471	398	419	571	708	567	5151	
	RE086	Meds - TUNA%		N/A	N/A	N/A	N/A	1.2%	1.1%	0.6%	1.1%	2.8%	1.9%	1.8%	1,27%	0.8%	1.4%		
	RE088	Meds- DNA%		N/A	N/A	N/A	N/A	1.2%	1.5%	3.3%	0.6%	2.3%	1.9%	2.6%	1.7%	1.8%	1.2%		

Performance Scorecard 6

	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD 2023-24	YTD Performance
RESPONSIVE	RE0171	Referrals received for all suspected cancers		308	385	418	416	368	455	445	375	455	422	487	423	311	405	4146	
	RE018	CWT - % patients decision to treat to first definitive treatment within 31 days	96%	82.0%	76.9%	78.6%	87.3%	76.0%	73.5%	82.4%	80.0%	83.8%	73.8%	71.2%	86.4%	79.4%	82.5%		
	RE019	CWT - Maximum 62 days from referral for suspected cancer to first treatment	85%	42.4%	31.6%	34.3%	62.2%	21.1%	50.0%	54.0%	35.7%	63.6%	46.4%	51.9%	50.0%	57.1%	47.8%		
	RE025	CWT - Maximum 28 days from referral for suspected cancer (via 2WW or Cancer Screening) to date of diagnosis	75%	67.5%	55.8%	66.2%	60.3%	67.4%	63.7%	58.0%	57.3%	68.4%	65.3%	75.3%	64.6%	66.0%	69.2%		
	RE057	All Referrals received for all suspected cancers		397	483	489	502	434	537	514	460	558	502	599	501	364	472	4941	
	RE026	IPCC - % patients seen by Community Adult Therapy Services within timescales	80%	75.5%	65.6%	53.7%	54.8%	60.9%	42.1%	56.0%	44.0%	44.6%	38.5%	62.3%	68.2%	71.2%	77.1%		
		% Urgent 1 - seen within 3 working days	80%	82.6%	78.6%	86.7%	74.2%	69.8%	50.0%	71.5%	65.6%	54.1%	42.4%	50.0%	100.0%	NaN	100.0%		
		% Urgent 2 - seen within 5 working days	80%	76.2%	77.2%	68.4%	61.8%	73.7%	54.0%	67.7%	39.3%	50.0%	52.2%	69.8%	82.1%	89.2%	81.7%		
		% Soon 1 - seen within 15 working days	80%	78.4%	47.7%	26.7%	34.9%	38.7%	21.7%	23.9%	32.6%	39.6%	16.4%	0.0%	0.0%	0.0%	0.0%		
		% Soon 2 - seen within 30 working days	80%	44.4%	38.5%	9.1%	38.5%	70.0%	0.0%	100.0%	0.0%	0.0%	51.9%	69.5%	70.5%	70.1%	75.6%		
		% Routine - seen within 12 weeks	80%	69.0%	46.2%	62.5%	40.0%	70.0%	87.5%	79.0%	50.0%	34.8%	42.9%	66.7%	56.0%	42.9%	73.2%		

Performance Scorecard 7

	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD 2023-24	YTD Performance
RESPOSIVE		IPCC - No. patients waiting for a dentist		2651	2808	2983	2638	3509	3666	3872	3993	4042	4268	4415	4528	4648	4878		
	RE0271	IPCC - Longest time waiting for a dentist (weeks)		170	159	164	167	168	177	181	185	189	193	200	203	207	211		
		IPCC - Number patients seen by dentist within the year		54404	54238	54924	53892	53697	53829	53089	53628	53778	54084	54025	53151	41895	57005		
	RE031	The % of patients registered with a GP (PERMANENT REGISTRATION)		4.3%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.0%	4.0%	4.1%	4.0%	4.0%	4.0%			
		Average of Days to next GP appt - Ballasalla		10.0	13.3	9.0	13.0	13.7	5.8	7.0	4.7	6.0	6.3	7.8	8.0	7.7			
		Average of Days to next GP appt - Castletown		6.0	2.6	4.0	4.3	5.0	7.0	4.5	2.0	3.0	2.3	4.3	3.5	5.0			
		Average of Days to next GP appt - Finch		8.3	5.0	7.5	7.8	6.7	6.0	8.0	8.3	8.0	5.5	5.3	5.5	5.0			
		Average of Days to next GP appt - Hailwood		4.0	5.4	8.5	7.0	10.0	9.0	10.5	9.6	13.3	6.0	4.3	9.5	9.3			
		Average of Days to next GP appt - Kensington		5.5	4.6	4.0	5.8	10.5	4.0	8.0	8.4	12.7	11.0	9.0	9.5	6.7			
		Average of Days to next GP appt - Laxey		7.8	7.2	5.8	8.5	10.5	8.0	6.8	9.8	10.7	9.0	10.5	9.5	11.5			
		Average of Days to next GP appt - Palatine		7.5	1.8	4.5	4.3	10.3	1.0	1.0	10.6	15.3	10.0	13.5	14.0	13.0			
		Average of Days to next GP appt - Peel		9.3	10.2	6.0	9.3	9.3	6.0	5.8	7.6	6.3	1.0	1.0	1.0	1.3			
		Average of Days to next GP appt - Ramsey		1.0	1.0	1.0	1.0	1.3	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0			
		Average of Days to next GP appt - Snaefell		18.3	19.8	17.3	10.3	16.8	13.0	4.5	15.5	12.0	20.0	17.0	23.5	12.5			
		Average of Days to next GP appt - Southern		2.0	1.0	1.0	1.3	1.5	2.0	1.0	1.8	2.0	1.3	1.0	1.5	1.3			
	RE081	IPCC - N. of GP appointments		28481	31517	29280	31998	24715	29084	28790	25807	27687	29379	33554	32174	24384		255574	
	RE054	Did Not Attend Rate (GP Appointment)	-	3%	3%	3%	3%	3%	3%	3%	2%	3%	3%	2%	3%	3%			
	RE074	Response by Community Nursing to Urgent / Non routine		N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	94%	96%	100%			
	RE075	Community Nursing Service response target met - Routine		N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%			
	RE028	MH - No. service users on Current Caseload	4500 - 5500	4809	4926	4995	5030	5090	5093	5129	5211	5226	5285	5325	5359	5305	5315	52338	
	RE044	MH- Waiting list		N/A	N/A	N/A	N/A	N/A	N/A	1572	1637	1598	1654	1701	1750	1752	1702		
	RE071	Average caseload per social worker-Adult Generic Team	16 to 18	N/A	N/A	N/A	N/A	N/A	N/A	13.3	19.0	19.3	21.7	20.3	21.6	20.4	25.9		
	RE078	Average caseload per social worker-Adult Learning Disabilities	17 to 18	N/A	N/A	N/A	N/A	N/A	N/A	18.7	20.3	21.1	23.4	27.1	28.1	23.4	20.0		
	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	10.8	11.7	11.3	14.7	17.2	19.8	19.8	14.4		

Performance Scorecard 8

Category	KPI ID	Indicator	OP. Plan Threshold	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD 2023-24	YTD Performance
RESPONSIVE	RE030	W&C - % New Birth Visits within timescale		87.5%	94.4%	86.7%	90.6%	96.0%	85.7%	86.0%	83.0%	89.4%	84.3%	90.4%	96.2%	91.7%	87.5%		
	RE032	Births per annum		428	488	535	588	54	103	144	191	237	293	348	391	451	511		
	RE051	Maternity Bookings		43	70	61	57	48	73	48	48	55	51	56	60	50	67	556	
	RE052	Ward Attenders		94	110	126	196	196	159	146	270	244	44	309	230	275	221	2094	
	RE053	Gestation At Booking <10 Weeks		20.9%	8.6%	39.3%	26.3%	39.6%	21.9%	20.8%	29.2%	30.9%	39.2%	33.9%	45.0%	48.0%	46.3%		
	RE056	Adult General and Acute (G&A) bed occupancy	<=92%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	60.1%	64.2%	61.6%	63.2%	68.3%	64.8%	65.4%		
	RE069	ASC - % of all Residential Beds Occupied	85% - 100%	69%	82%	68%	84%	83%	83%	71%	69%	68%	52%	59%	48%	70%	59%		
	RE070	Respite bed occupancy	>= 90%	79%	96%	81%	79%	92%	80%	69%	70%	81%	65%	59%	73%	88%	43%		
		Total number of Service Users		207	252	204	262	250	250	212	134	134	162	181	153	220	176		
	RE068	ASC-% of Service users with a PCP in Place	95.00%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
WELL LED (PEOPLE)	WP001	% Hours lost to staff sickness absence	4.0%	7.7%	7.9%	6.4%	7.6%	5.9%	5.2%	5.5%	6.0%	6.6%	6.0%	7.0%	6.4%	6.1%	7.0%		
	WP002	Number of staff on long term sickness		83	77	0	83	65	82	69	91	94	82	63	116	88	82		
	WP004	Number of staff leavers		16	17	17	19	22	22	24	22	34	34	19	21	22	16	236	
	WP005	Number of staff on disciplinary measures		3	5	6	5	5	7	8	9	11	10	6	11	11	10	88	
	WP006	Number of suspended staff		0	0	1	1	1	1	1	1	4	4	4	5	4	4	29	
	WP007	Number of Data Breaches	0	12	13	13	21	8	13	13	11	11	12	14	8	13	14	117	
		Reported to ICO		12	13	13	21	8	13	13	13	11	11	4	4	1	2	80	
	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	19	4	1	4	32	39	76	27	39	33	29	29	33	41	378	
	WP013	Staff 12 months turnover rate	10%	11.4%	11.2%	11.4%	11.3%	11.0%	10.9%	10.4%	10.0%	9.4%	9.7%	9.4%	9.8%	10.1%	10.2%		
	WP015	Number of DSAR, AHR and FOI's overdue at month end		4	1	5	14	44	55	33	41	41	24	31	40	30	32	371	
		Number of DSAR, AHR and FOI's Breaches		23	5	6	18	76	94	109	68	80	57	60	69	63	73	749	
WELL LED (FINANCE)	WF001	% Progress towards Cost Improvement Target (CIP)	1.5%	116.3%	126.0%	170.0%	170.0%	N/A	N/A	22.2%	26.7%	33.3%	76.0%	86.7%	91.1%	109.0%			
	WF002	Total income (£)		-£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	-£1,394,119.46	-£1,256,596.46		-£11,812,248	
	WF003	Total staff costs (£)		£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	£18,143,236.48	£17,624,943.48		£159,732,102	
	WF004	Total other costs (£)		£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	£13,050,900.26	£13,118,543.95		£116,372,746	
	WF005	Agency staff costs (proportion %)		13.0%	11.4%	8.2%	6.9%	7.8%	7.4%	6.2%	6.2%	4.7%	4.8%	5.8%	4.3%	5.1%			
	WF007	Actual performance (£ 000)		£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	£29,351.0	£29,439.0			
	WF008	budget (£ 000)		£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	£25,948.0	£25,948.0			
	WF009	Actual performance against Budget (£ 000)		-£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	-£3,403.0	-£3,491.0			