Integrated Performance Report

Feb-24

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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 organisatio n'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.

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.

eved 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 de velop 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:

VARIATION			ASSURANCE		
If 6 points or more in a row of continuous improvement or If 6 dots or more in a row are better than the base line mean	Special Cause of Improving variation (High/Low)		If last 6 points are equal to or better than the target	Consistently hit target	
If 6 points or more in a row of continuous worsening or If 6 dots or more in a row are worse than the base line mean	Special Cause of Concerning variation (High/Low)		If last 6 points are worse than the target	Consistently fail target	
If none of the above criteria is met	Common cause		If last 6 points are a mix of better and worse	Inconsistently passing and falling short of target	

The process for assigning the categories to each KPI is currently a manual one, but PIMS are currently working with the BI 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 organisationswithin 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	• 2 serious incidents in February, though YTD of 27 remains below annual threshold of < 36. • 3 cases of C.Diff reported, though YTD is 27 remains below the annual threshold of <30. • Zero Medication Errors with Harm across Manx Care in February. • Numbers of Falls that resulted in Harm remain low and within the expected threshold. • Positive achievement against Safety Thermometer for Adults, Maternity and Children. • Performance of VTE prophylaxis exceeded the threshold with 99%. • VTE risk assessment within 12 hours was 92%. Areas which were reduced this month are such small numbers this had a significant effect. • There were no cases of MRSA or Pseudomonas aeruginosa in February. • 100% of letters were sent in accordance with Duty of Candour Regulations.	• There was 1 Never Event in Theatre in February. • 9 cases of E.coli bacteraemia. • 48-72 hr senior medical review of antibiotic prescription remains below the 98% threshold at 85% in February from 90% in January.
Effective	• 98% of Learning from Death reviews were completed within timescale which has exceeded the target for over a year now. • The Crisis Team continue to meet the 1 hour response time threshold for Emergency Department referrals with 91% in February. • Adult Social Care re-referral rates remain within expected levels. • The reported number of individuals receiving copies of their Wellbeing Partnership assessments was 100% in February, with the average monthly achievement now at 86.7%.	• 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 37.2%. YTD Mean 32.8%. • Complex Needs Reviews held on time was 29.4% (YTD mean 56.6%).
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 (93%) • Service user satisfaction remains high with 92% 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 February was 100%.	• 30 complaints were logged in February, 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. • Ambulance - Category 1 Response Time at 90th Percentile was within the 15 min standard at 14:21 in February 2024, the second successive month of meeting the standard. • Ambulance service for Category 2 - 5 response times remained within the standards. • Mental Health caseloads remain within expected levels.	• The ED Performance against the 4 hour standard slightly increased to 68% in February and remains below the required target. • Emergency care demand remains high (6% increase year on year) 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 34 12-Hour Trolley Waits, a decrease from 34 last month. • Access to routine diagnostics within 6 weeks and 26 weeks remains challenging due to increasing demand exceeding current capacity. However, additional diagnostic activity is being undertaken under the auspices of the restoration & recovery programme. • There were 33 breaches of the 60 minute ambulance turnaround time, though this was an improvement compared to 35 in January. • The ED reached the highest Operational Pressures Escalation Level (OPEL), Level 4, in February for 2 days, the same as last month. • Cancer 28 Day performance in February was slightly below the 75% threshold at 72%, though improved from 69% in January.
Well Led (People)	• Manx Care staff continue to demonstrate a high level of engagement in Data Protection and Information Governance matters. Training attendance is high and teams across Manx Care are regularly seeking advice from the Information Governance team on a range of matters including Data Processing Impact Assessments (DPIAs), record retention and general advice and guidance. • Manx Care staff continue to engage with our DPO for advice on data breaches. Where breaches occur the engagement with investigation enquiries and compliance with lessons learned is high.	• The volumes of Freedom of Information Requests, Data Subject Access Requests, Police and Court requests remains high and presents a significant challenge for the Information Governance Team. Whilst Subject access, Court and Police requests volumes vary from month to month the overall trend is increasing in both volume and complexity with many requests being for whole of life or for records covering several years. This is not only a challenge for the Information Governance team but also places significant pressure on care groups and specialist services where clinical review and redaction of records is required particularly given the timescales allowed for responses under the relevant legislation. • There were 14 Data Breaches in February. All breaches are fully investigated in order that Manx Care can identify 'lessons learned' and improve our processes going forward.
Well Led (Finance)	• Progress towards Cost Improvement Target (CIP) was 122% in January.	• The operational result for January is an overspend of (£5.2m). The increase in spend in the month is due to payment of the MPTC & NJC 2022/23 pay award arrears (backdated to Apr-22). • YTD employee costs are (£7.6m) over budget.

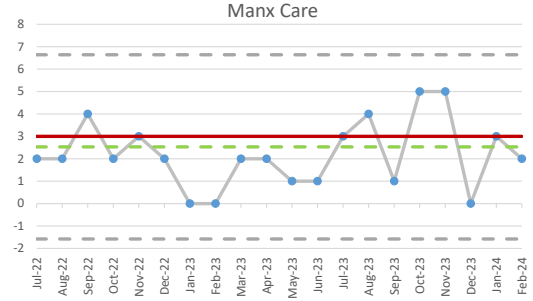
Safe Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
SA001		Exposure to Serious Incidents	Feb-24		2	2	27	< 36 PA		
SA002		Duty of Candour Letter sent within 10 days of the application	Feb-24		100%	89%	-	80%		
SA018		Compliance with the Duty of Candour Regulations	Feb-24		100%	93%	-	100%		
SA003		% Eligible patients having VTE risk assessment within 12 hours of decision to admit	Feb-24		92%	91%	-	95%		
SA004		% Adult Patients (within general hospital) with VTE prophylaxis prescribed	Feb-24		99%	97%	-	95%		
SA005		Never Events	Feb-24		1	0	1	0		
SA006		Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	Feb-24		0.2	0.3	-	< 2		
SA007		Clostridium Difficile - Total number of acquired infections	Feb-24		3	2	27	< 30 PA		
SA008		MRSA - Total number of acquired infections	Feb-24		0	0	1	0		
SA009		E-Coli - Total number of acquired infections	Feb-24		9	8	85	< 72 PA		
SA010		No. confirmed cases of Klebsiella spp	Feb-24	-	1	2	17	-		
SA011		No. confirmed cases of Pseudomonas aeruginosa	Feb-24	-	0	0	5	-		
SA012		Exposure to medication incidents resulting in harm	Feb-24		0	0	3	< 25 PA		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
SA013		Harm Free Care Score (Safety Thermometer) - Adult	Feb-24		98%	97%	-	95%		
SA014		Harm Free Care Score (Safety Thermometer) - Maternity	Feb-24		100%	99%	-	95%		
SA015		Harm Free Care Score (Safety Thermometer) - Children	Feb-24		99%	97%	-	95%		
SA016		Hand Hygiene Compliance	Feb-24		98%	97%	-	96%		
SA017		48-72 hr review of antibiotic prescription complete	Feb-24		85%	80%	-	>= 98%		
SA019		Pressure Ulcers - Total incidence - Grade 2 and above	Feb-24		7	15	167	<= 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 #
Feb-24	2	QC1

Threshold	YTD Mean	Benchmark
< 36 PA	2	2

(Lower value represents better performance)

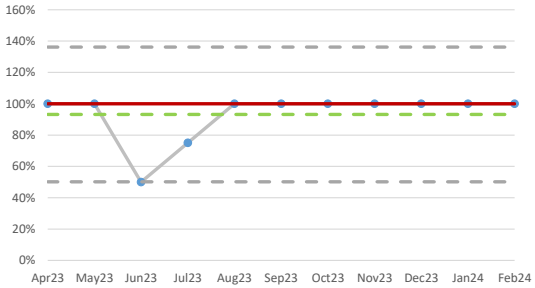
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Compliance with the Duty of Candour Regulations



Reporting Date	Performance	Op. plan #
Feb-24	100%	QC112

Threshold	YTD Mean	Benchmark
100.0%	93.2%	93.2%

(Higher value represents better performance)

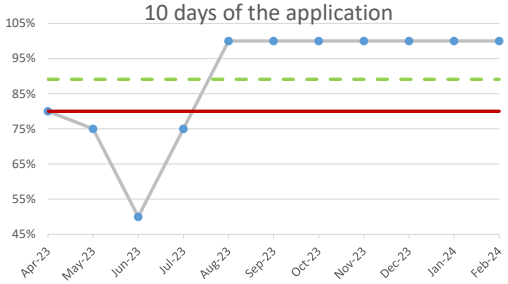
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Duty of Candour Letter sent within 10 days of the application



Reporting Date	Performance	Op. plan #
Feb-24	100%	QC112

Threshold	YTD Mean	Benchmark
80%	89.1%	89.09%

(Higher value represents better performance)

+ Variation Description

Common cause

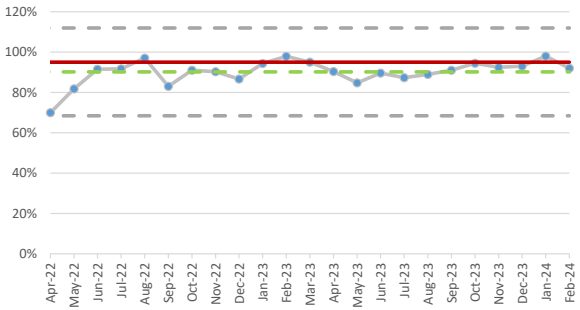
+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Serious Incidents: 2 serious incidents declared in February, one for Radiology and one for Maternity **Letter has been sent in accordance with Duty of Candour Regulations:** • 100% compliance. **Never Events** • **1** Never event in theatre	**Serious Incidents:** • Continued monitoring via SIRG **Letter has been sent in accordance with Duty of Candour Regulations:** • Continue to monitor . **Never Events** As this was classified as no harm, the automatic flagging in Datix did not trigger. This has now been altered so that any never event will be flagged.	**Serious Incidents:** • Reasonably confident that the YTD target will be met. **Letter has been sent in accordance with Duty of Candour Regulations:** • Performance remains strong. **Never Events** Though this involved a wrong sized femoral head being inserted and wound closed, the mistake was noticed and rectified. A 72hr review is being undertaken and will be presented at SIRG on 12 March 2023.

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 #
Feb-24	92.0%	QC113

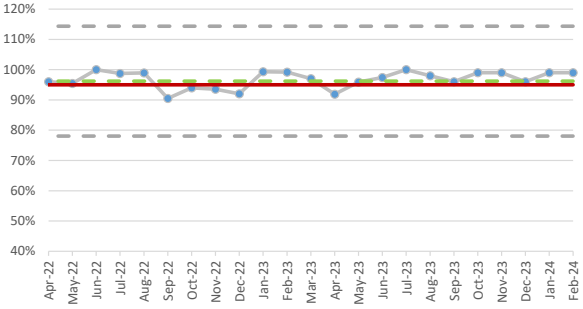
Threshold	YTD Mean	Benchmark
95.0%	91.1%	89.2%

(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 #
Feb-24	99.0%	QC114

Threshold	YTD Mean	Benchmark
95.0%	97.4%	96.2%

(Higher value represents better performance)

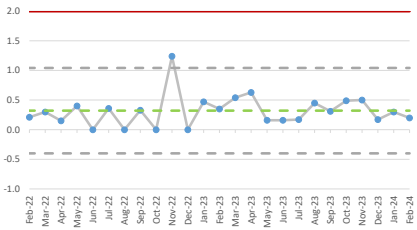
+	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
VTE risk assessment within 12 hours: • 92% which is a reduction of 6% from last month. Areas which were reduced this month were Wards 6, 8, 9 and CCU though, as CCU are such small numbers this had a significant effect. **VTE Prophylaxis:** • 99% of patients had prophylaxis prescribed if appropriate.	**VTE risk assessment within 12 hours:** • Where it was noted that there was no assessment completed, staff were reminded of the requirement to do this. **VTE Prophylaxis:** • Continue to maintain compliance.	**VTE risk assessment within 12 hours:** • As this assessment is being moved from paper to electronic, it is possible that this measure will dip in coming months as it becomes embedded. **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.

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

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



Reporting Date	Performance	Op. plan #
Feb-24	0.2	QC4

Threshold	YTD Mean	Benchmark
< 2	0.3	0.3

(Lower value represents better performance)

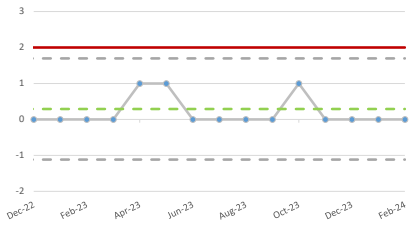
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Exposure to medication incidents resulting in harm: Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	0	

Threshold	YTD Mean	Benchmark
< 25 PA	0	0

(Lower value represents better performance)

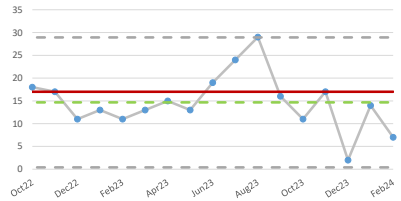
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Pressure Ulcers - Total incidence - Grade 2 and above



Reporting Date	Performance	Op. plan #
Feb-24	7	QC4

Threshold	YTD Mean	Benchmark
<= 17 (204 PA)	15.2	14.1

(Lower value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

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

Inpatient Health Service Falls (with harm) per 1000 occupied bed days:
• 0.2 per 1000 bed days

Medication Errors (with Harm):
• Zero medication errors with moderate and above harm reported in January, with just 3 cases reported YTD and none for four months

Pressure Ulcer incidence:
• 15 PUs were reported across all services, and 7 incidents were recorded under Manx Care services, which is a reduction from 14 last month. 6 of these were new and 1 had deteriorated from category 1 to category 2. Of the new or deteriorating ulcers, all were category 2 or above and, of these, one was a category 3. Four occurred within the patient's own home in the community setting and one in a residential home. In each case appropriate preventative measures, based on the patients' risk level, had been in place prior to the development of the ulcers. In all cases, appropriate advice had been offered and equipment was in place. Of the two incidents occurring in the acute setting, one was device-related, secondary to an oxygen mask, where a preventative dressing was used but slipped resulting in skin damage. The other acute incident was a category 3 occurring on Ward 4. A review of the notes shows an air mattress was in-situ preventatively and personal care and repositioning is demonstrated within the evaluation notes, but a repositioning chart is absent. The electronic SSKIN bundle had been updated but the repositioning element is absent. The SSKIN and repositioning documentation have migrated to electronic version this reporting month and are therefore no longer a single document – this represents a training need with regards the requirement to complete of both aspects. Additionally, the patient was discharged on the day of the reported incident and therefore some elements may have not been actioned due to the timeframe. It is also noted that the patient has a complex anxiety condition and some episodes on non-concordance with personal care and nutrition are recorded. There are no new incidents reported from social care sites.

Inpatient Health Service Falls (with harm) per 1000 occupied bed days:
• All inpatient falls are reviewed to ensure that a suitable 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:
• SSKIN and repositioning documentation has migrated to Patientrack and this is intended to ultimately increase compliance due to improved monitoring. This transition occurred this reporting month along with several other assessments and hence it is as yet too soon to expect this to be fully embedded in practice, but this will be the TVN focus over the next 6 month period, with targeted education based on emerging compliance data.

Inpatient Health Service Falls (with harm) per 1000 occupied bed days:
• This has consistently remained below target and monitoring will continue.

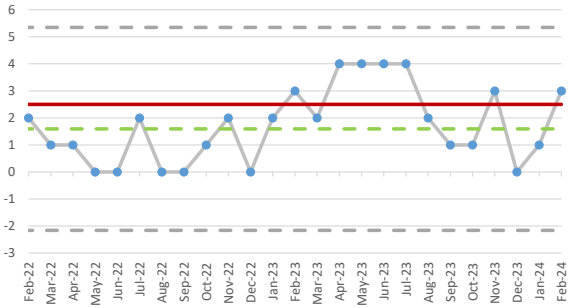
Medication Errors (with Harm):
• Reasonable assurance that errors leading to harm will remain low.

Pressure Ulcer incidence:
• February 2024 demonstrates a reduction in pressure ulcer incidence from the previous month although in reality, as the parameters have been recently re-defined, there is not yet adequate data to establish a baseline. The pressure ulcer indicator used is due to be amended in April 2024 in accordance with DHSC Mandate Metrics, with the focus shifting to inpatient settings exclusively, and specific KPIs established. This will enable a baseline to be established from more reliable conclusions can be drawn with regards performance.

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

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

C.Diff - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	3	QC115

Threshold	YTD Mean	Benchmark
< 30 PA	2	1

(Lower value represents better performance)

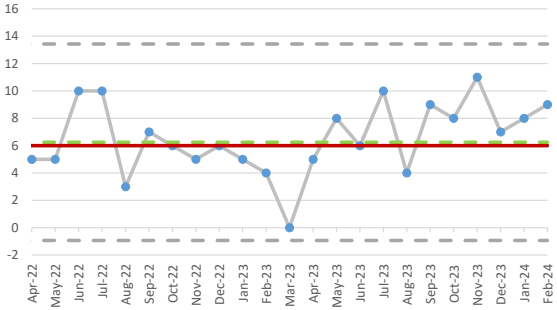
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

E.Coli - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	9	QC116

Threshold	YTD Mean	Benchmark
< 72 PA	8	6

(Lower value represents better performance)

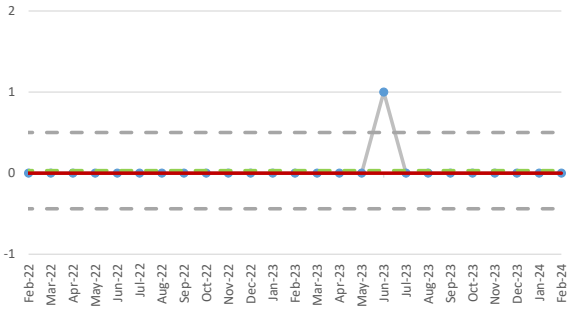
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

MRSA - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	0	QC8

Threshold	YTD Mean	Benchmark
0	0	0

(Lower value represents better performance)

+ Variation Description

Common cause

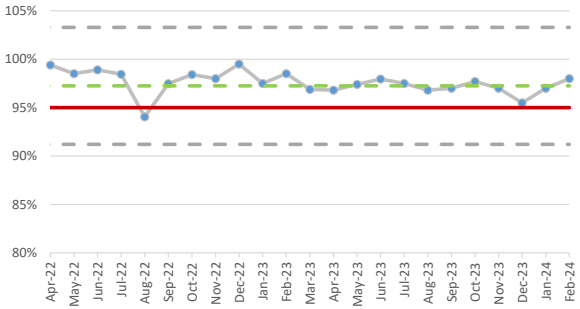
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
C.Diff: • There have been three cases this month, all community associated. This exceeds the target of two per month. Potential sources are antibiotic prescribing and travel.	**C.Diff:** • RCAS are in the process of being completed. CDI action plan is making good progress.	**C.Diff:** • CDI cases remain on target at less than 30 cases in a year.
E.Coli: • There have been nine cases this month. Seven are community associated and 2 Hospital associated. Potential sources of infection are urine and biliary. There was one case with a urinary catheter in situ.	**E.Coli:** • RCAs are in the process of being completed with hospital associated cases.	**E.Coli:** • The number of cases are consistent with trends in the UK.
MRSA: • There have been no cases this month. Planned	**MRSA:** • To continue to undertake surveillance.	**MRSA:** • Reasonable confidence that levels will be maintained.
Pseudomonas aeruginosa: • There have been no cases this month.	**Pseudomonas aeruginosa:** To continue to undertake surveillance.	**Pseudomonas aeruginosa:** Reasonable confidence that levels will remain low. There is no national threshold set. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

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



Reporting Date	Performance	Op. plan #
Feb-24	98.0%	QC119

Threshold	YTD Mean	Benchmark
95.0%	97.2%	98.0%

(Higher value represents better performance)

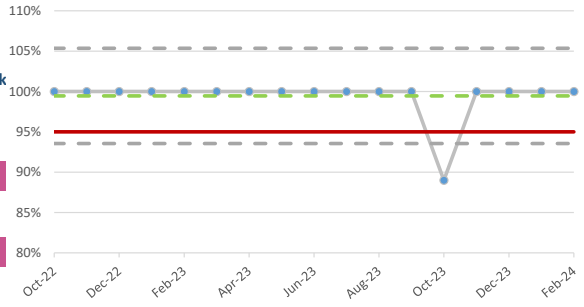
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

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



Reporting Date	Performance	Op. plan #
Feb-24	100.00%	QC120

Threshold	YTD Mean	Benchmark
95.0%	99.0%	100.0%

(Higher value represents better performance)

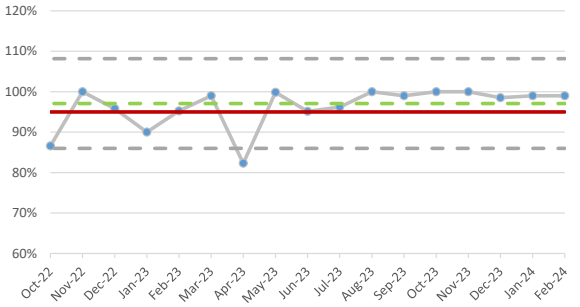
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

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



Reporting Date	Performance	Op. plan #
Feb-24	99.0%	QC121

Threshold	YTD Mean	Benchmark
95.0%	97.2%	95.8%

(Higher value represents better performance)

+ Variation Description

Common cause

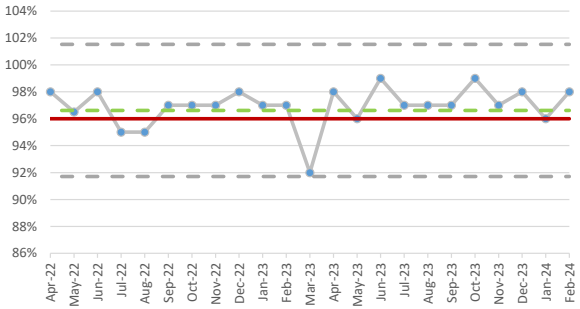
+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Adult: • 98% for February with a YTD average of 97%. **Maternity:** • 99.3% of Maternity patients were kept free from harm. **Children:** • 98.8% of patients were kept free from harm.	**Adult:** • Continue to maintain compliance. **Maternity:** • Continue with activities to maintain compliance. **Children:** • Continue with activities to maintain compliance.	**Adult:** • High level of confidence that this level will be maintained. **Maternity:** • Performance exceeds the target. **Children:** • Performance exceeds the target. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

Hand Hygiene Compliance: Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	98.0%	QC112

Threshold	YTD Mean	Benchmark
96.0%	97.5%	96.5%

(Higher value represents better performance)

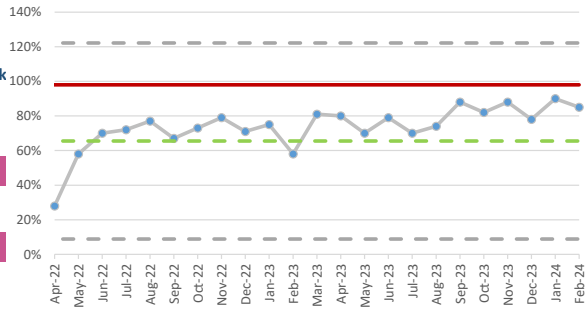
+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

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



Reporting Date	Performance	Op. plan #
Feb-24	85.0%	QC123

Threshold	YTD Mean	Benchmark
>= 98%	80.4%	67.4%

(Higher value represents better performance)

-	Variation Description

Special Cause of Improving variation (High)

-	Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hand Hygiene: • Over all compliance in hand hygiene is 98% (Bare Below the Elbow - 98% and the Five Moments of Hand Hygiene – 97.5%) **Review of Antibiotic Prescribing:** • 85% down from 90%	**Hand Hygiene:** • To continue to monitor audits results and provide additional training when needed. **Review of Antibiotic Prescribing:** • Continue to monitor.	**Hand Hygiene:** • Reasonable confidence that levels will be maintained. **Review of Antibiotic Prescribing:** • AMS ward rounds – consultant microbiologist reviewing all prescriptions Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective Performance Summary (page 1 of 2)

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF001		Planned Care - DNA Rate (Consultant Led outpatient appointments)	Feb-24		14%	13%	-	5% by Apr '24		
EF067		Planned Care - DNA Rate - Hospital	Feb-24		11.1%	-	-	5%		
EF002		Planned Care - Total Number of Cancelled Operations	Feb-24		320	329	3620	-		
EF087		Number of patients (inpatient only) with a length of stay of 0 days	Feb-24		771	915	-	-		
EF088		Number of patients (inpatient only) with a length of stay > 7 days	Feb-24		236	225	-	-		
EF005		Length of Stay (LOS) - No. patients with LOS greater than 21 days	Feb-24	-	103	107	-	-		
EF050		Total Number of Inpatient discharges-Nobles	Feb-24	-	946	926	10181	-		
EF051		Total Number of inpatient discharges-RDCH	Feb-24	-	43	39	426	-		
EF003		Theatres - Number of Cancelled Operations	Feb-24		35	36	395	-		
EF004		Theatres - Theatre Utilisation	Feb-24		82%	77%	-	85%		
EF006		Crude Mortality Rate	Feb-24	-	32	23	271	-		
EF007		Total Hospital Deaths	Feb-24	-	39	23	279	-		
EF024		Mortality - Hospitals LFD (Learning from Death reviews)	Feb-24		98%	97%	-	80%		
EF025		Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	Feb-24		96%	96%	-	95%		
EF008		ASC -West Wellbeing Contribution to reduction in ED attendance	Feb-24		-3.5%	6%	-	-5%		
EF009		ASC - West Wellbeing Reduction in admission to hospital from locality	Feb-24		33%	7%	-	-10%		
EF010		IPCC - % Dental contractors on target to meet UDA's	Dec-23		55%	-	-	96%		
EF011		MH - Average Length of Stay (LOS) in MH Acute Inpatient Service	Feb-24	-	7	32	-	-		
EF064		MH - Number of patients with a length of stay - 0 days	Feb-24	-	1	1	9	-		

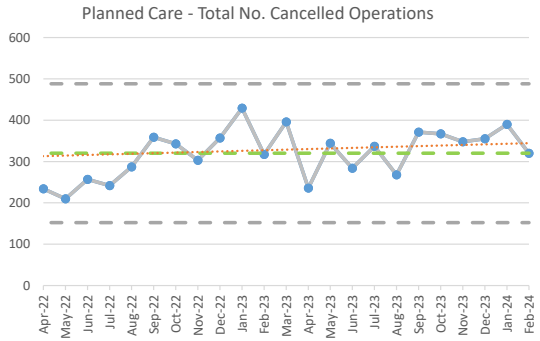
KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF065		MH - Number of patients aged 18-64 with a length of stay - > 60 days	Feb-24	-	0	1	15	-		-
EF066		MH - Number of patients aged 65+ with a length of stay - > 90 days	Feb-24	-	0	1	12	-		-
EF013		MH - % service users discharged from MH inpatient to have follow up appointment	Feb-24		88%	97%	-	90%		
EF047		% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	Feb-24		100%	100%	-	75%		
EF048		% Patients with a first episode of psychosis treated with a NICE recommended care package within two weeks of referral	Feb-24		-	83%	-	75%		
EF026		MH - Crisis Team one hour response to referral from ED	Feb-24		91%	90%	-	75%		
EF063		ASC - No. of referrals	Feb-24	-	74	74	813	-		-
EF015		ASC - % of Re-referrals	Feb-24		7%	4%	-	<15%		
EF016		ASC - % of all Wellbeing Partnership Assessments completed in Agreed Timescales	Feb-24		20%	31%	-	80%		
EF017		ASC - % of individuals (or carers) receiving a copy of their Wellbeing Partnership Assessment	Feb-24		100%	87%	-	100%		
EF052		Referrals to Adult Safeguarding Team	Feb-24	-	93	99	1090	-		-
EF053		Adult Safeguarding Alert	Feb-24	-	56	59	645	-		-
EF054		Discharges from Adult Safeguarding Team	Feb-24	-	129	98	1078	-		-
EF055		Re-referrals to Adult Safeguarding Team	Feb-24	-	18	19	206	-		-
EF056		% MARFs Completed by Adult Safeguarding Team	Feb-24	-	94%	87%	-	-		-
EF090		Number of discharges: Pre-10:00	Feb-24		99	125	500	-		
EF091		Number of discharges: Pre-16:00	Feb-24		859	934	3737	-		
EF092		Number of discharges: Weekend	Feb-24		143	230	918	-		
EF093		Delayed transfers of care	Feb-24		28	19	76	-		

Effective Performance Summary (page 2 of 2)

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
EF049		C&F -Number of referrals - Children & Families	Feb-24		95	155	1707	-		
EF019		CFSC - % Complex Needs Reviews held on time	Feb-24		29%	57%	-	85%		
EF021		CFSC - % Total Initial Child Protection Conferences held on time	Feb-24		73%	72%	-	90%		
EF022		CFSC - % Child Protection Reviews held on time	Feb-24		89%	72%	-	90%		
EF023		CFSC - % Looked After Children reviews held on time	Feb-24		93%	94%	-	90%		
EF044		C&F -Children (of age) participating in, or contributing to, their Child Protection review	Feb-24		67%	86%	-	90%		
EF045		C&F -Children (of age) participating in, or contributing to, their Looked After Child review	Feb-24		95%	99%	-	90%		
EF046		C&F -Children (of age) participating in, or contributing to, their Complex Review	Feb-24		63%	49%	-	79%		
EF030		Maternity - Caesarean Deliveries (not Robson Classified)	Feb-24	-	37%	42%	-	-		
EF031		Maternity - Induction of Labour	Feb-24		37%	33%	-	< 30%		
EF032		Maternity - 3rd/4th Degree Tear Overall Rate	Feb-24		0%	1%	-	< 3.5%		
EF033		Maternity - Obstetric Haemorrhage >1.5L	Feb-24		0%	1%	-	< 2.6%		
EF034		Maternity - Unplanned Term Admissions To NNU	Feb-24	-	9%	-	-	-		
EF035		Maternity - Stillbirth Number / Rate	Feb-24		0	0.1	1.0	<4.4/1000		
EF036		Maternity - Unplanned Admission To ITU – Level 3 Care	Feb-24	-	0	-	-	-		
EF037		Maternity - % Smoking At Booking	Feb-24	-	16%	9.9%	-	-		

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	Feb-24		2%	7%	-	< 18%		
EF039		Maternity - First Feed Breast Milk (Initiation Rate)	Feb-24		58%	68%	-	> 80%		
EF040		Maternity - Breast Feeding Rate At Transfer Home	Feb-24		77%	-	-			
EF041		Maternity - Number of Neonatal Mortality	Feb-24		0	0.09090909	-			-
EF059		W&C - Paediatrics- Total Admissions	Feb-24		179	152	1371	-		-
EF060		W&C - NNU - Total number of Admissions	Feb-24		5	6	70	-		-
EF061		W&C - NNU - Avg. Length of Stay	Feb-24		8	8	73	-		-
EF062		W&C - NNU -Community follow up	Feb-24		3	5	52	-		-
EF068		Pharmacy - Total Prescriptions (No. of fees)	Dec-23		131,619	139,922	1,259,301	-		-
EF069		Pharmacy - Chargable Prescriptions	Dec-23		18,137	18,611	167,500	-		-
EF070		Pharmacy - Total Exempt Item	Dec-23		129,776	137,813	1,240,317	-		-
EF071		Pharmacy - Chargeable Items	Dec-23		17,758	18,424	165,812	-		-
EF072		Pharmacy - Net cost	Dec-23		£1,287,033	£1,426,243	£12,836,187	-		-
EF073		Pharmacy - Charges Collected	Dec-23		£68,322	£71,108	£639,976	-		-
EF081		IPCC - Dental - Additions	Feb-24		197	181	1,987	-		
EF082		IPCC - Dental - Allocations	Feb-24		3	34	375	-		
EF086		IPCC - Number of Sight Test	Feb-24		0	2,181	19,631	-		
EF074		Total Number of OP & Dementia Beds Available	Feb-24		195	195	-	-		
EF075		Total Number of OP & Dementia Beds Occupied	Feb-24		127	111	-	-		
EF076		Total Number of LD Beds Available	Feb-24		85	84	-	-		
EF077		Total Number of LD Beds Occupied	Feb-24		68	69	-	-		

Effective	Planned Care (1 of 3)	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson	



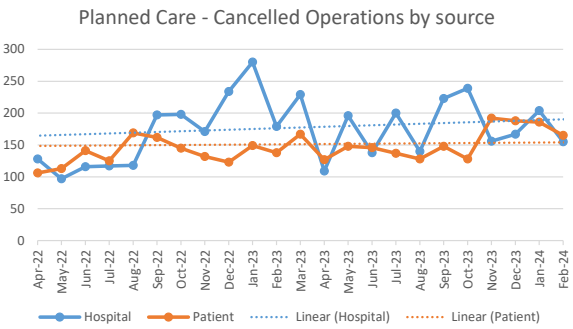
Reporting Date	Performance	Op. Plan #
Feb-24	320	QC157

Threshold	YTD Mean	Benchmark
-	329	311

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Feb-24		

Threshold	YTD Mean	Benchmark

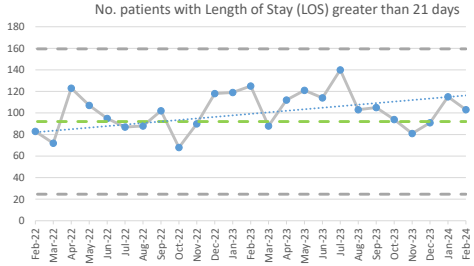
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Cancelled Operations: The number of cancelled operations in February was 320.	**Cancelled Operations:** The new Planned Care Dataset that is currently being developed by the Business Intelligence Team will enable more robust and detailed analysis of the factors contributing to cancellations. This will enable appropriate remedial actions to be identified and enacted.	Note - Benchmarks are the Manx Care monthly average for 2022/23.

Effective	Planned Care (2 of 3)	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson

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



Reporting Date	Performance	Op. Plan #
Feb-24	103	QC10c

Threshold	YTD Mean	Benchmark
-	107	101

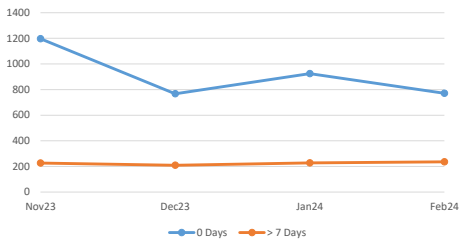
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Planned Care- Lenght of stay



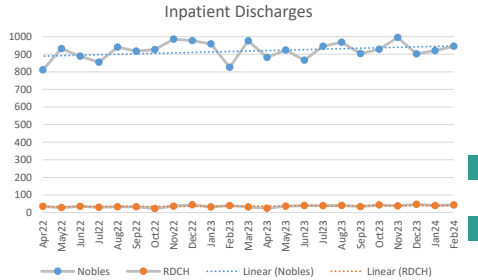
Reporting Date	Performance		Op. Plan #
Feb-24	0 days	771	QC156
	> 7 days	236	

Threshold	YTD Mean	Benchmark

-	Variation Description

Assurance Description

Inpatient Discharges



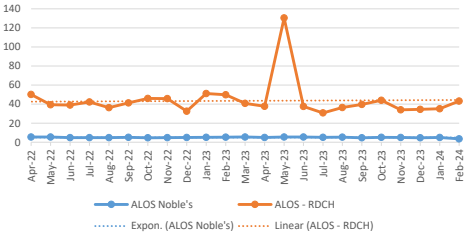
Reporting Date	Performance		Op. Plan #
Feb-24	Nobles	946	
	RDCH	43	

Threshold	YTD Mean		Benchmark
	Nobles	926	916
	RDCH	39	33

Variation Description

Assurance Description

Average Length of Stay (ALOS) by site



Reporting Date	Performance	Op. Plan #
Jan-00		QC156

Threshold	YTD Mean	Benchmark

-	Variation Description

Assurance Description

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

Length of Stay (LOS):

• The methodology regarding the no. of patients with a length of stay > 21 days is currently subject to review. The split for the metric is:

No. discharged patients who had a LOS > 21 days = 68

No. patients still admitted with a LOS > 21 days = 35

• 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 946 discharges in February, slightly above the year to date average of 926. This demonstrates the consistent discharging of patients despite the challenges around patient flow.

Length of Stay:

• Daily activity to ensure surgical patients discharged as soon as clinically appropriate to do so.
• Spot purchasing of community beds
• Implementation of enhanced recovery pathways under the Restoration & Recovery (R&R) programme.
• Increasing throughput through Day Procedures Suite by using it to start the perioperative surgical journey for the first patient on each operating list to facilitate starting the operating list on time plus reducing number of inpatient procedure where appropriate.
• Ward 12 is being used as an escalation ward when required – however there are challenges ensuring safe nursing staffing levels to allow the ward to open. Ward 12 is being staffed by Synaptik nursing teams as part of R & R for specific weeks – in these instances Synaptik nursing staff are able to accommodate a limited number of suitable surgical patients as part of escalation plan.

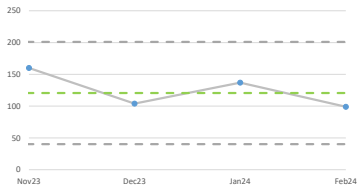
Length of Stay:

• Significant improvements in the reduction of length of stays for both R&R and BAU activity (e.g. orthopaedic hip & knee ALOS from 4.5 days down to 1.1 days) will deliver overall decreases in length of stay at both Noble's Hospital and Ramsey & District Cottage Hospital.
• Reduced LOS on the R&R pathway have allowed all patients to be accommodated on the 15 bed private patient ward (PPU).
• Active programme of advertising and recruiting to vacant doctors posts is underway to minimise and reduce locum doctor requirement.

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

Planned Care	Planned Care (3 of 3)	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson	

Discharges - pre 10:00



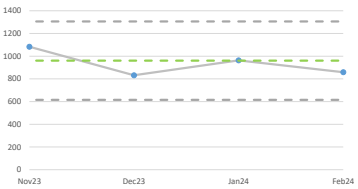
Reporting Date	Performance	Op. Plan #
Feb-24	99	
Threshold	**YTD Mean**	**Benchmark**
-	125	

- Variation Description

Common cause

Assurance Description

Discharges - weekend



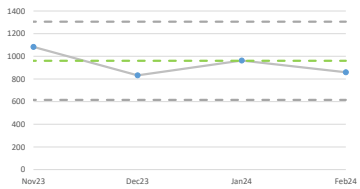
Reporting Date	Performance	Op. Plan #
Feb-24	143	
Threshold	**YTD Mean**	**Benchmark**
-	230	

- Variation Description

Common cause

Assurance Description

Discharges - pre 16:00



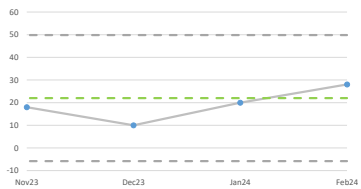
Reporting Date	Performance	Op. Plan #
Feb-24	859	
Threshold	**YTD Mean**	**Benchmark**
-	934	

- Variation Description

Common cause

Assurance Description

Delayed transfers of care (Hospital)



Reporting Date	Performance	Op. Plan #
Feb-24	28	
Threshold	**YTD Mean**	**Benchmark**
-	19	

- Variation Description

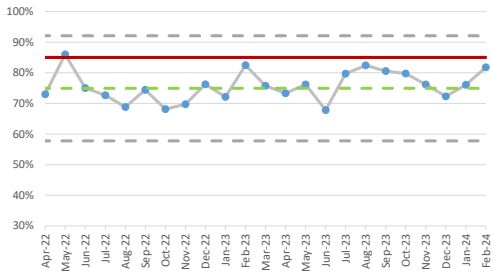
Common cause

Assurance Description

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

Effective	Theatres	Executive Lead	Oliver Radford	Lead	James Watson	

Theatres - % Theatre Utilisation



Reporting Date	Performance	Op. Plan #
Feb-24	81.8%	QC16

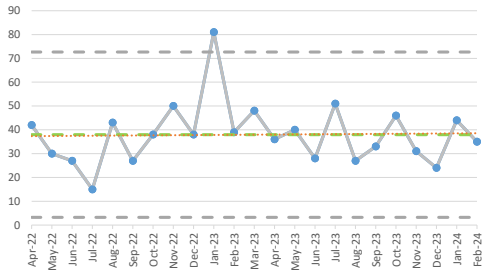
Threshold	YTD Mean	Benchmark
85.0%	76.9%	74.5%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Theatres - No. of Cancelled Operations**



Reporting Date	Performance	Op. Plan #
Feb-24	35	QC15

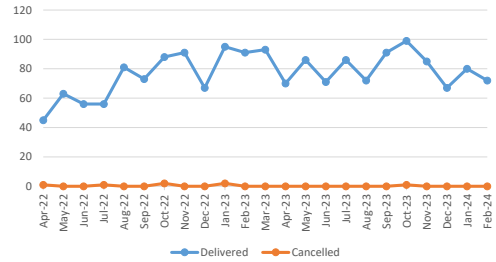
Threshold	YTD Mean	Benchmark
-	36	40

(Lower value represents better performance)

+	Variation Description
	Common cause

	Assurance Description

Theatres - Delivered (vs Cancelled Sessions)



Reporting Date	Performance	Op. Plan #
Feb-24	72	

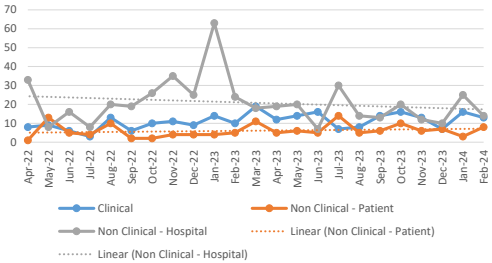
Threshold	YTD Mean	Benchmark
-	80	75

(Higher value represents better performance)

-	Variation Description

	Assurance Description

Theatres - Cancelled Operations by source**



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

Threshold	YTD Mean	Benchmark
-	-	-

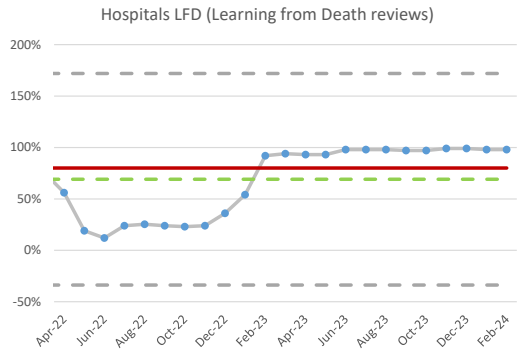
(Lower value represents better performance)

	Variation Description

	Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Theatre Utilisation: • The number of theatre sessions delivered in February was 72. •The number of cancelled operations decreased to 35 in February (year to date average is 36). Most common reasons were "Unfit for Surgery-Acute illness" (8). • 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. • Cancelled sessions figures are currently subject to data quality review to ensure accuracy	• 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.	• 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	



Reporting Date	Performance	Op. Plan #
Feb-24	98.0%	QC126

Threshold	YTD Mean	Benchmark
80.0%	97.1%	40.3%

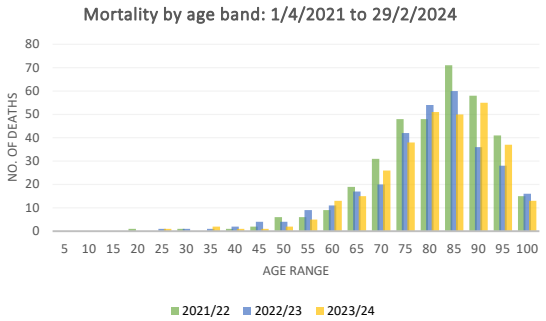
(Higher value represents better performance)

+ Variation Description

Special Cause of Improving variation (High)

+ Assurance Description

Consistently hit target



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

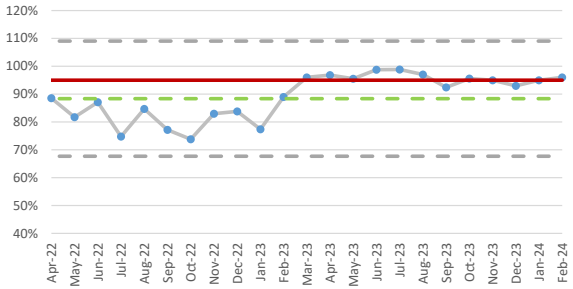
Threshold	YTD Mean	Benchmark
-	23	-

+ Variation Description

- Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hospitals LFD (Learning from Death) Reviews: • 98% of level one reviews have been completed	**Hospitals LFD (Learning from Death) Reviews:** • Work ongoing to increase number of level 2 reviews	**Hospitals LFD (Learning from Death) Reviews:** • Reasonably confident that level 1 reviews will continue to be carried out. Note - Benchmarks are the Manx Care monthly average for 2022/23.

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



Reporting Date	Performance	Op. Plan #
Feb-24	96.0%	QC124

Threshold	YTD Mean	Benchmark
95.0%	95.8%	83.1%

(Higher value represents better performance)

+ Variation Description

Common cause

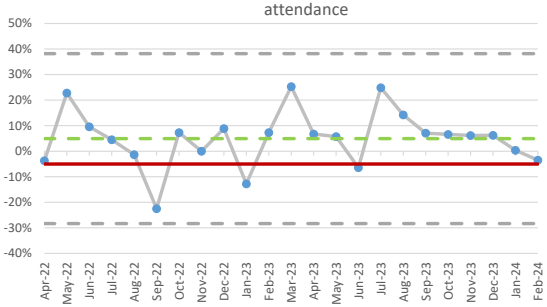
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Nutrition & Hydration: • 96% across adult inpatients. The target has been exceeded in 9 out of 10 reporting months YTD	**Nutrition & Hydration:** • Missing assessments are highlighted to senior staff.	**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 #
Feb-24	-3.5%	QC63

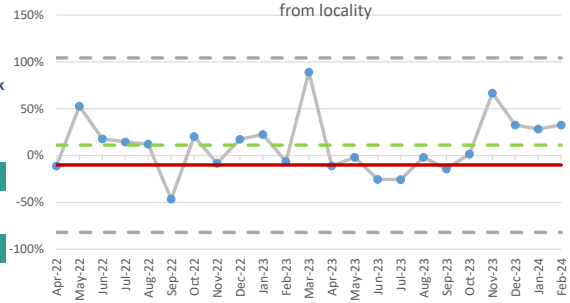
Threshold	YTD Mean	Benchmark
-5.0%	6.2%	3.8%

(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 #
Feb-24	32.7%	QC64

Threshold	YTD Mean	Benchmark
-10.0%	7.5%	14.6%

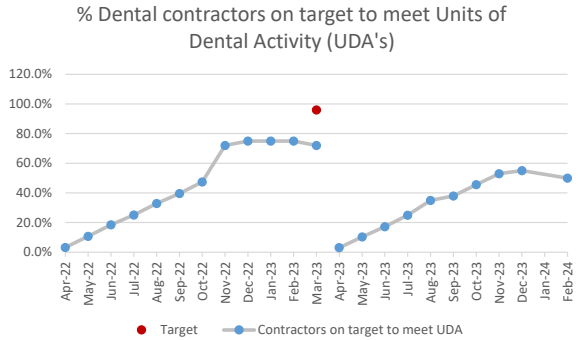
(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

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

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



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

Threshold	YTD Mean	Benchmark
96.0%	-	-

(Higher value represents better performance)

- **Variation Description**

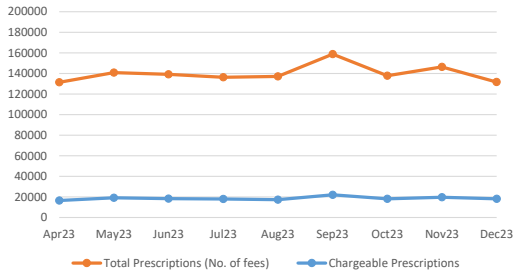
- **Assurance Description**

N/A

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Dental Contractors: • 4 out of 8 dental contractors are now forecasted not to meet minimum target of 96% delivery **Manx Care Dental Practices** • Hillside Dental Practice has been fully operational since 5th February 2024. A new dental software solution for both practices (Hillside and Community Dental Services) is still being sought.	**Dental Contractors:** • Issues raised within Manx Care and DHSC in terms of UDA values, individual contractor difficulties and service delivery.	**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 end and a discussion will then be had with contractors in relation to reviewing their UDA target for the following financial year with breach notices being issued for under-delivery. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Integrated Primary & Community Care	Executive Lead	Oliver Radford	Lead	Maria Bell	

Pharmacy - Prescriptions



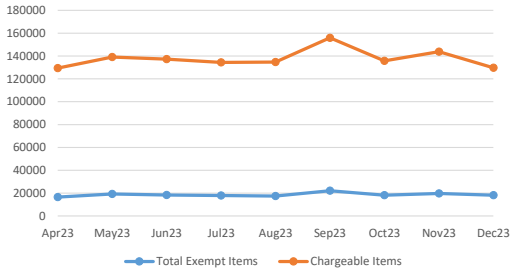
Reporting Date	Performance	Op. Plan #
Dec-23		-

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Pharmacy - Items



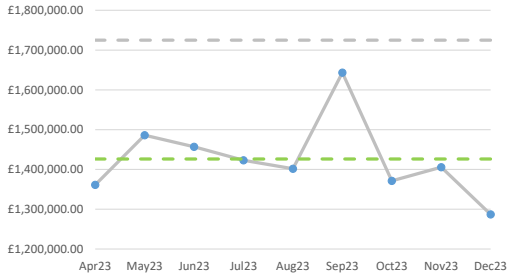
Reporting Date	Performance	Op. Plan #
Dec-23		

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Pharmacy - Net cost



Reporting Date	Performance	Op. Plan #
Dec-23	**£1,287,033**	

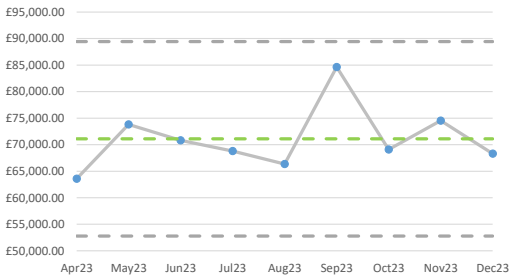
Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Common cause

Assurance Description

Pharmacy - Charges Collected



Reporting Date	Performance	Op. Plan #
Dec-23	**£68,322**	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

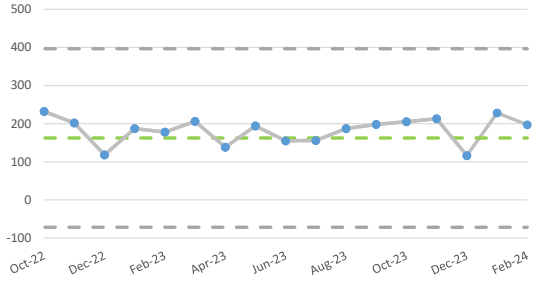
Common cause

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

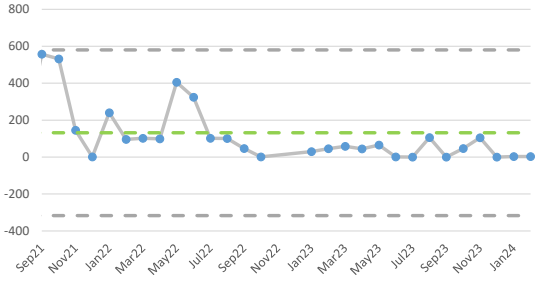


Reporting Date	Performance	Op. Plan #
Feb-24	**197**	-
Threshold	**YTD Mean**	**Benchmark**
	179	

Variation Description

Assurance Description

Patients Allocations to Dental Practices

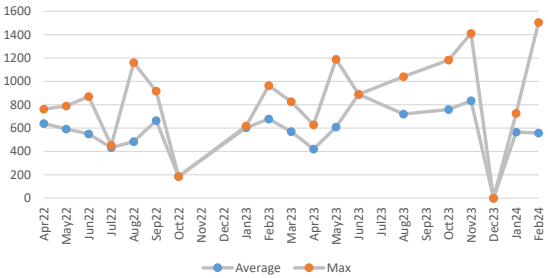


Reporting Date	Performance	Op. Plan #
Feb-24	**3**	
Threshold	**YTD Mean**	**Benchmark**
-	37	-

Variation Description

Assurance Description

Waiting time for dental allocations



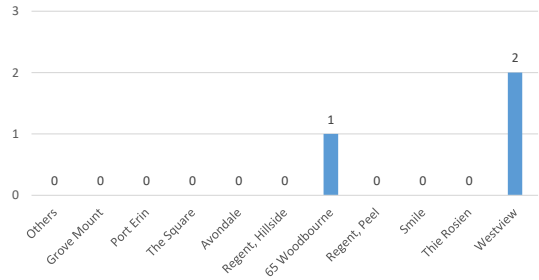
Reporting Date	Performance	Op. Plan #
Feb-24		
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Common cause

Assurance Description

Allocations by Practice - Feb 2024



Reporting Date	Performance	Op. Plan #
Feb-24	**3**	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Common cause

Assurance Description

Issues / Performance Summary

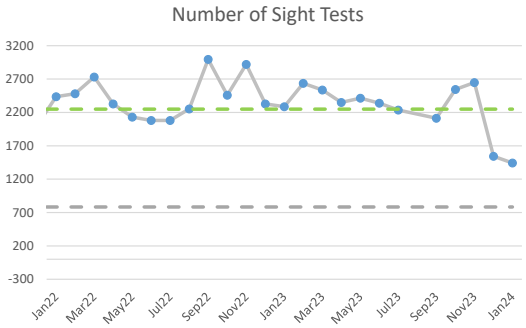
- In February 2024 136 adults were added to the waiting list and 61 children.
- Dental practices are not currently able to take on new patients.

Planned / Mitigation Actions

Dental Team will follow up on unknown age of patients

Assurance / Recovery Trajectory

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



Reporting Date	Performance	Op. Plan #
Jan-24	**1442**	-
Threshold	**YTD Mean**	**Benchmark**

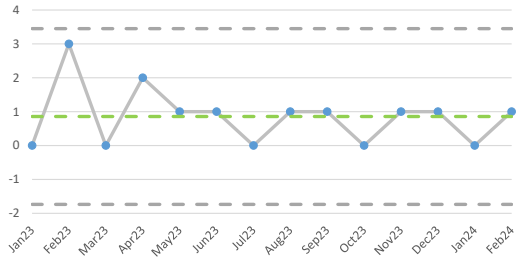
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Latest data for January 2024		

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

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



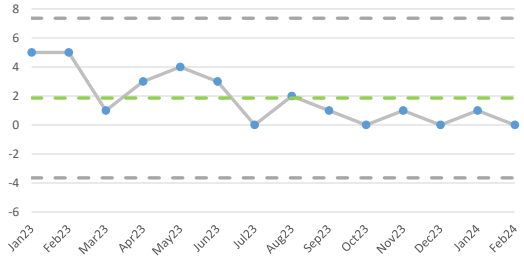
Reporting Date	Performance	Op. Plan #
Feb-24	1	QC87
Threshold	**YTD Mean**	**Benchmark**
-	1	1

- **Variation Description**

Common cause

Assurance Description

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



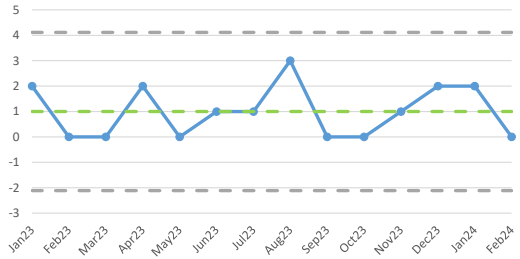
Reporting Date	Performance	Op. Plan #
Feb-24	0	QC88
Threshold	**YTD Mean**	**Benchmark**
-	1	4

+ **Variation Description**

Common cause

Assurance Description

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



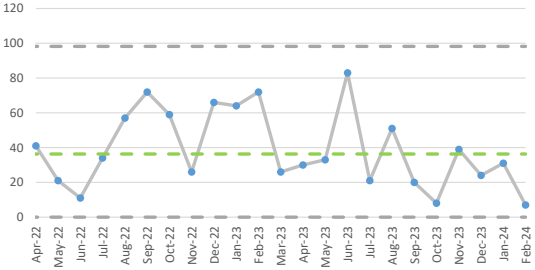
Reporting Date	Performance	Op. Plan #
Feb-24	0	QC89
Threshold	**YTD Mean**	**Benchmark**
-	1.1	0.7

+ **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 #
Feb-24	7	QC158
Threshold	**YTD Mean**	**Benchmark**
-	32	46

+ **Variation Description**

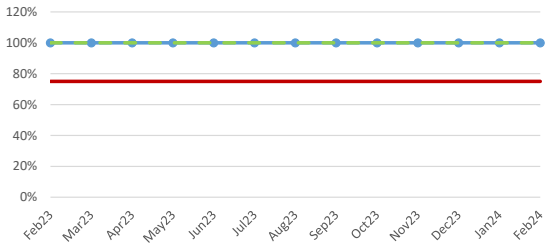
Common cause

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. IMHS Management Team will monitor re-admissions to be further assured that discharges are appropriate. The care group have also made arrangements to report on delayed discharge for greater oversight of patient flow.	**Average Length of Stay (ALOS):** • The service regularly monitor patients who are admitted and actively look to progress the most appropriate treatment/care plan on an individual basis. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

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



Reporting Date	Performance	Op. Plan #
Feb-24	100%	QC69

Threshold	YTD Mean	Benchmark
75%	100%	100%

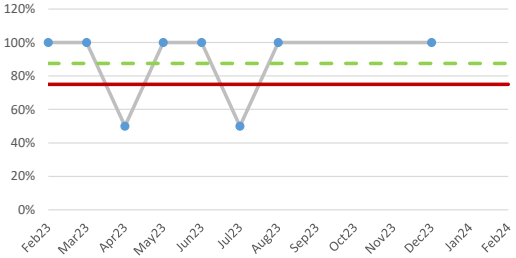
+ Variation Description

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 #
Feb-24	-	QC70

Threshold	YTD Mean	Benchmark
75%	83%	100%

+ Variation Description

Common cause

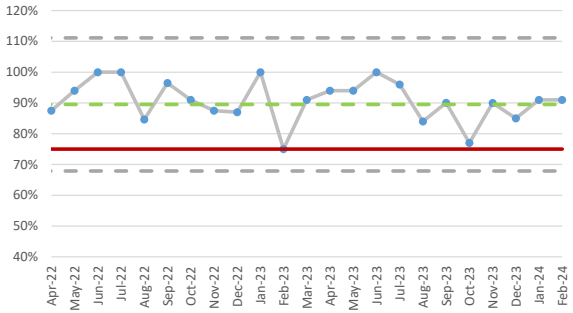
+ Assurance Description

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 February 2024.		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

Crisis Team one hour response to referral from ED



Reporting Date	Performance	Op. Plan #
Feb-24	91.0%	QC68

Threshold	YTD Mean	Benchmark
75.0%	90.2%	91.2%

(Higher value represents better performance)

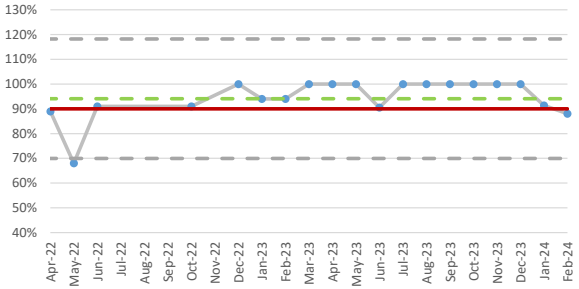
+	Variation Description

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 #
Feb-24	88%	QC72

Threshold	YTD Mean	Benchmark
90.0%	97.3%	90.9%

(Higher value represents better performance)

-	Variation Description

Common cause

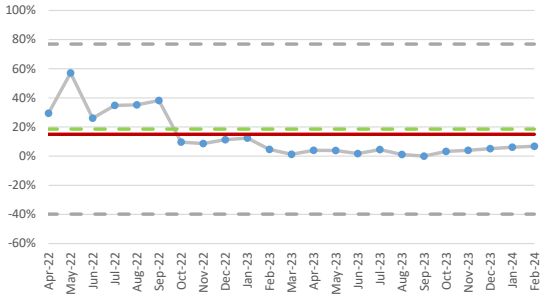
-	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
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 (1 follow up appointment being held on day 4). Work ongoing by BI colleagues to improve dashboard accuracy.	**Crisis Team:** • To continue to monitor performance and compliance. **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. Once reporting is visible and accurate on the dashboard the service will move to electronic reporting.	**Crisis Team:** • Target continues to be achieved monthly; the service area remains motivated to ensure this is achieved. **3 Day follow up:** There is confidence that this target will be effectively maintained. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Effective	Adult Social Work (1 of 3)	Executive Lead	David Hamilton	Lead	Bradley Chambers/Samantha Murphy

ASC - % of Re-referrals



Reporting Date	Performance	Op. Plan #
Feb-24	6.8%	QC41

Threshold	YTD Mean	Benchmark
<15%	3.7%	22.4%

(Lower value represents better performance)

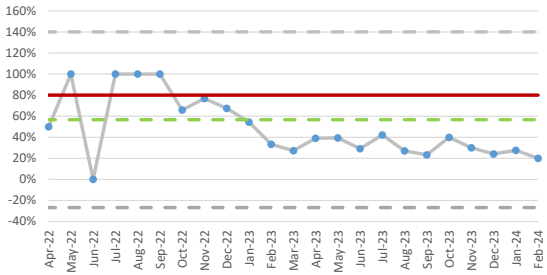
- Variation Description

Special Cause of Improving variation (Low)

+ Assurance Description

Consistently hit target

ASC - % of all Wellbeing Partnership Assessments completed in Agreed Timescales



Reporting Date	Performance	Op. Plan #
Feb-24	20.0%	QC44

Threshold	YTD Mean	Benchmark
80.0%	31.1%	64.6%

(Higher value represents better performance)

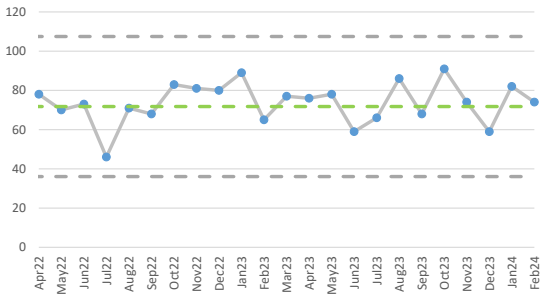
- Variation Description

Special Cause of Concerning variation (Low)

- Assurance Description

Consistently fail target

ASC - No. of referrals



Reporting Date	Performance	Op. Plan #
Feb-24	74	QC40

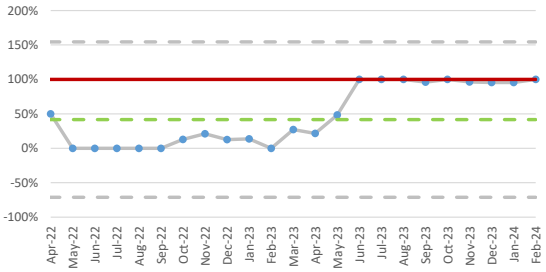
Threshold	YTD Mean	Benchmark
-	74	73

+ Variation Description

Common cause

Assurance Description

ASC - % of individuals (or carers) receiving a copy of their Wellbeing Partnership Assessment



Reporting Date	Performance	Op. Plan #
Feb-24	100.0%	QC45

Threshold	YTD Mean	Benchmark
100.0%	86.7%	11.4%

(Higher value represents better performance)

+ Variation Description

Common cause

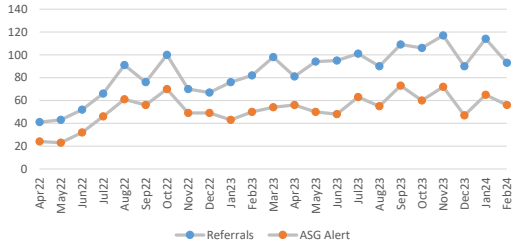
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals: The number of new referrals received in February decreased to 74 from 82 in January. **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 100% during February, achieving the threshold.	**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.	**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.

Effective	Adult Social Work (2 of 3)	Executive Lead	David Hamilton	Lead	Bradley Chambers/Samantha Murphy

Adult Safeguarding



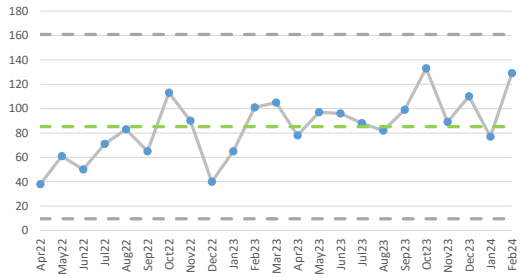
Reporting Date	Performance		Op. Plan #
Feb-24	Referrals	93	QC59
	Alert	56	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Discharges from Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Feb-24	129	

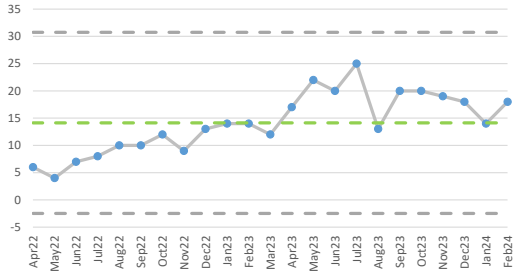
Threshold	YTD Mean	Benchmark
-	98	74

Variation Description

Common cause

Assurance Description

Re-referrals to Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Feb-24	18	

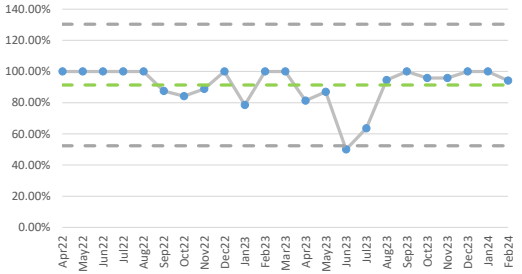
Threshold	YTD Mean	Benchmark
-	19	10

Variation Description

Common cause

Assurance Description

% MARFs Completed by Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Feb-24	94.1%	

Threshold	YTD Mean	Benchmark
-	87.5%	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

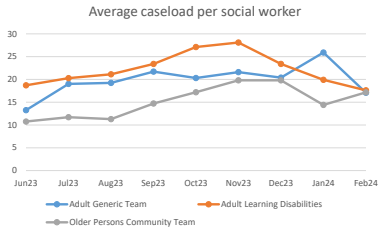
- Referrals and ASG alerts methodology will be discussed with the B.I team.
- A Business Case for additional staffing resources is under consideration.

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.

Effective	Adult Social Work (3 of 3)	Executive Lead	David Hamilton	Lead	Bradley Chambers/Samantha Murphy	



Reporting Date	Performance	Op. Plan #
Feb-24		
Threshold	**YTD Mean**	**Benchmark**
-	-	-

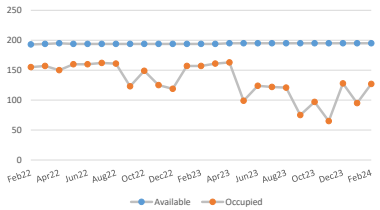
Variation Description

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.	

Effective	Adult Social Care	Executive Lead	David Hamilton	Lead	Jonathan Carey	

Total Number of OP & Dementia Beds



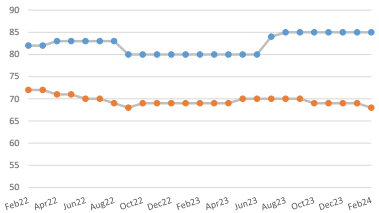
Reporting Date	Performance		Op. Plan #
Feb-24	Available	195	
	Occupied	127	

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Total Number of LD Beds



Reporting Date	Performance		Op. Plan #
Feb-24	Available	85	
	Occupied	68	

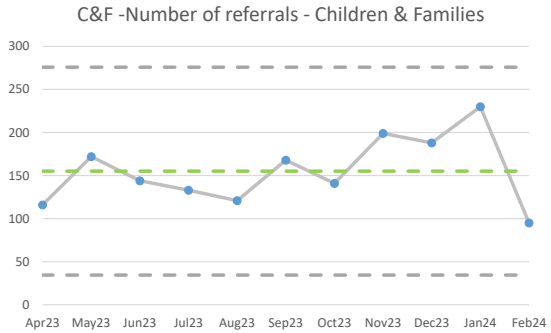
Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Although the position reflects 13 vacancies as beds are empty, the reality is that the service has only got 2 vacancies for potential new referrals at the moment due to various issues, e.g. being earmarked for flexi respite or assessment, compatibility with service user, or decommissioning of beds.		

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



Reporting Date	Performance	Op. Plan #
Feb-24	**95**	
Threshold	**YTD Mean**	**Benchmark**
-	155	155

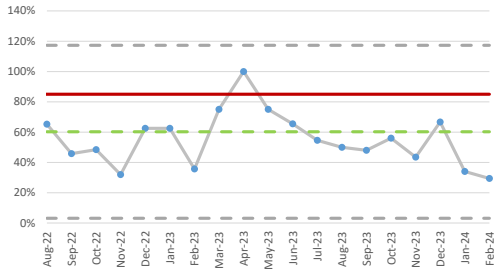
+	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals: Referral levels have decreased to 95 in February.		**Referrals:** Work is ongoing with the Business Intelligence Team to develop the underpinning data to enable the reporting of Re-Referral rates for the C&F Service in future months. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

% Complex Needs Reviews held on time



Reporting Date	Performance	Op. Plan #
Feb-24	29.4%	QC49

Threshold	YTD Mean	Benchmark
85.0%	56.6%	53.4%

(Higher value represents better performance)

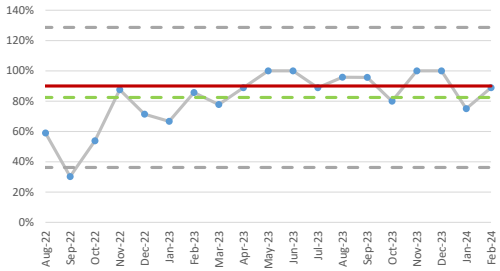
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

% Total Child Protection Review Conferences held on time



Reporting Date	Performance	Op. Plan #
Feb-24	89%	QC52

Threshold	YTD Mean	Benchmark
90.0%	90.0%	66.5%

(Higher value represents better performance)

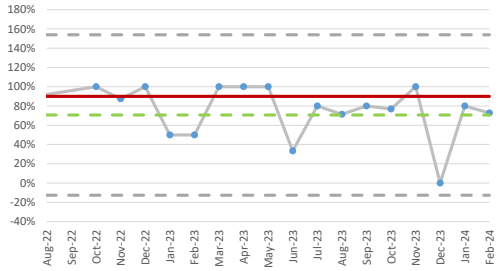
+	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

% Total Initial Child Protection Conferences held on time



Reporting Date	Performance	Op. Plan #
Feb-24	72.7%	QC51

Threshold	YTD Mean	Benchmark
90.0%	72.2%	81.3%

(Higher value represents better performance)

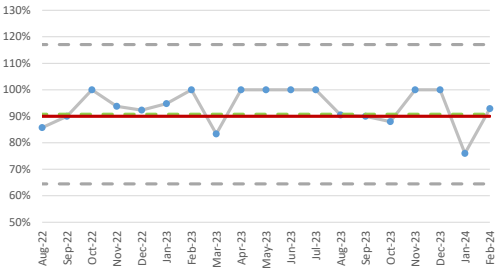
-	Variation Description

Common cause

-	Assurance Description

Inconsistently passing and falling short of target

% Looked After Children reviews held on time



Reporting Date	Performance	Op. Plan #
Feb-24	93%	QC53

Threshold	YTD Mean	Benchmark
90.0%	94.3%	92.5%

(Higher value represents better performance)

+	Variation Description

Common cause

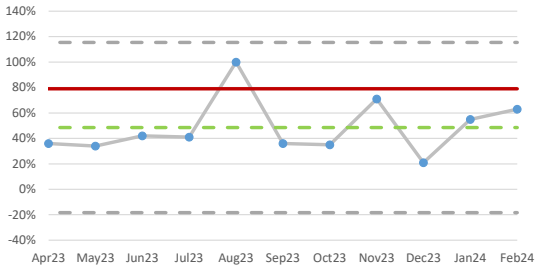
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Complex Needs Reviews held on time: 17 Reviews held and 5 were in timescale and 12 were out of timescale Reasons for delayed meetings: Family Unavailable – 8 Relevant Professional/Agency Unavailable - 3 Notification by Social Worker Staff: Out of Timescale - 1 **Initial Child Protection Conferences held on time:** 11 meetings were due and 8 were held in time and 3 were out of timescale Reasons for delayed meetings: Family Unavailable – 2 Procedurally Non-Compliant- 1 **Child Protection Review Conferences held on time:** 9 RCPC's were held and 8 were on time with 1 out of timescale Reasons for delayed meetings: Relevant Professional/Agency Unavailable - 1 **Looked After Children reviews held on time:** • 93% of reviews were held within the timescales in February.	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.	Additional agency staff have recently been engaged in the CWD team as a mitigation to the whole workload of this team, additional administrative resourcing is also now in place. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

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



Reporting Date	Performance	Op. Plan #
Feb-24	63%	

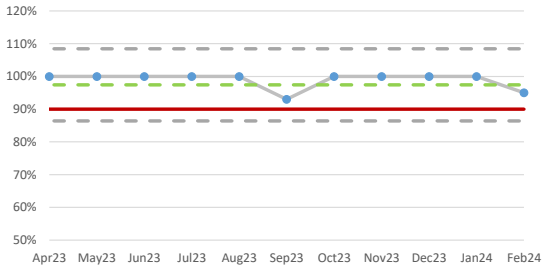
Threshold	YTD Mean	Benchmark
79%	49%	49%

(Higher value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Inconsistently passing and falling short of target

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



Reporting Date	Performance	Op. Plan #
Feb-24	95%	

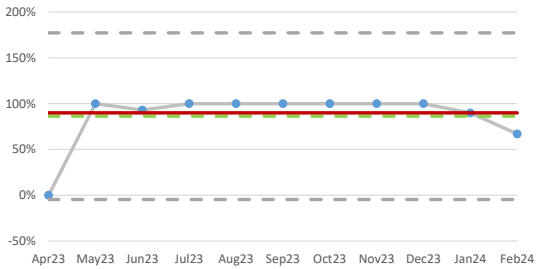
Threshold	YTD Mean	Benchmark
90%	99%	99%

(Higher value represents better performance)

-	Variation Description
	Common cause

+	Assurance Description
	Consistently hit target

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



Reporting Date	Performance	Op. Plan #
Feb-24	67%	

Threshold	YTD Mean	Benchmark
90%	86%	86%

(Higher value represents better performance)

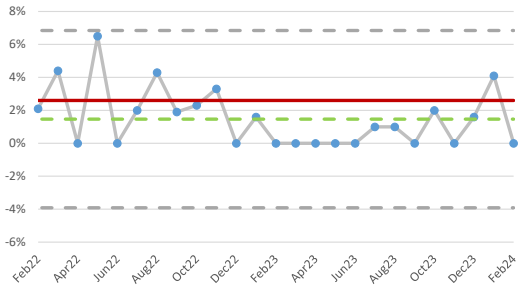
-	Variation Description
	Common cause

-	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.

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

Obstetric Haemorrhage >1.5L



Reporting Date	Performance	Op. Plan #
Feb-24	0.0%	

Threshold	YTD Mean	Benchmark
< 2.6%	0.88%	1.8%

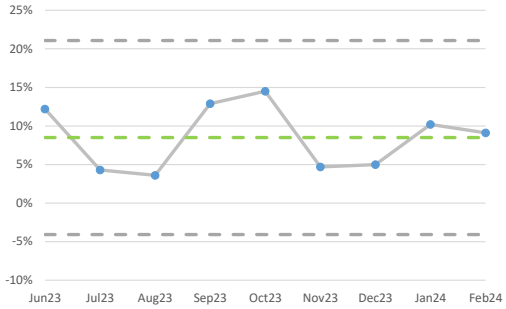
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Unplanned Term Admissions To NNU



Reporting Date	Performance	Op. Plan #
Feb-24	**9.1%**	

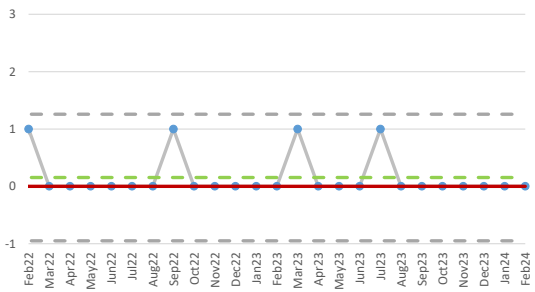
Threshold	YTD Mean	Benchmark
-	-	

Variation Description

Common cause

Assurance Description

Stillbirth Number / Rate



Reporting Date	Performance	Op. Plan #
Feb-24	0	

Threshold	YTD Mean	Benchmark
<4.4/1000	0	16.7%

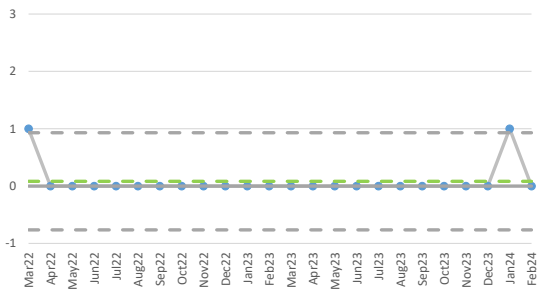
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Neonatal Mortality



Reporting Date	Performance	Op. Plan #
Feb-24	**0**	

Threshold	YTD Mean	Benchmark
-	0.1	0

+ Variation Description

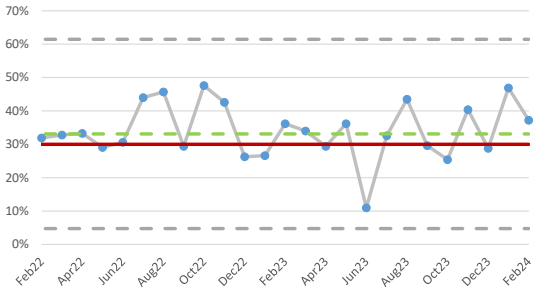
Special Cause of Improving variation (Low)

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Obstetric haemorrhage >1.5L – No PPH's occurred in February, whereas 2 in January. **Unplanned Term Admissions To NNU** No unplanned admissions to ITU, following one admission in January. .		Note - Benchmarks are the Manx Care monthly averages for 2022/23.

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

Induction of Labour



Reporting Date	Performance	Op. Plan #
Feb-24	37.2%	

Threshold	YTD Mean	Benchmark
< 30%	32.8%	32.9%

(Lower value represents better performance)

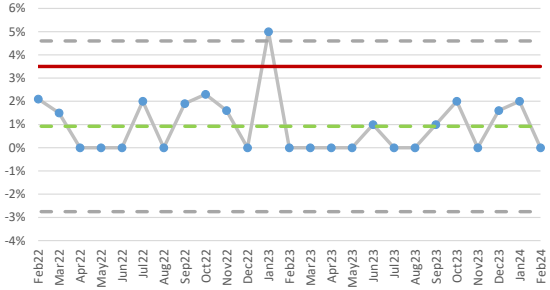
+ Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

3rd/4th Degree Tear Overall Rate



Reporting Date	Performance	Op. Plan #
Feb-24	0.0%	

Threshold	YTD Mean	Benchmark
< 3.5%	0.7%	1.1%

(Lower value represents better performance)

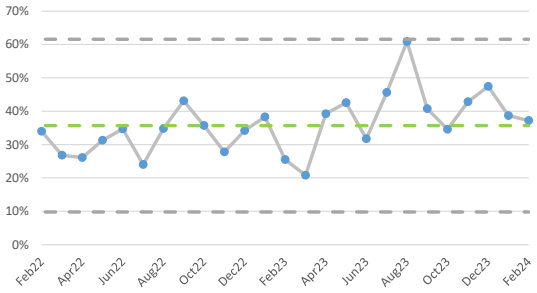
+ Variation Description

Common cause

Assurance Description

Consistently hit target

Caesarean Deliveries (not Robson Classified)



Reporting Date	Performance	Op. Plan #
Feb-24	37.2%	

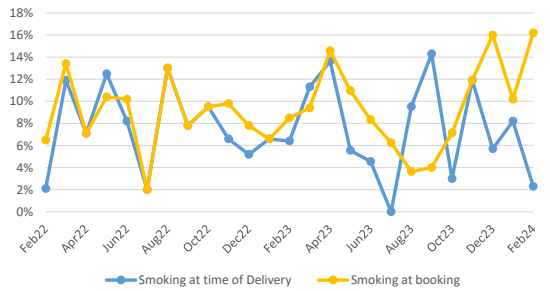
Threshold	YTD Mean	Benchmark
-	42.0%	31.4%

+ Variation Description

Common cause

Assurance Description

% Smoking



Reporting Date	Performance		Op. Plan #
Feb-24	Booking	16.2%	
	Delivery	2.3%	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

Total caesarean deliveries:
For the month of February was 37.2%. Caesarean section rates are no longer considered a KPI in England.

Induction of labour:
Induction of labour above national standard at 37.2%.

Third and fourth degree tear rates:
3rd and 4th degree perineal trauma remains well below national target of >3.5% with 0 tears in February.

Smoking at booking and delivery: Down to 3.0% from 14.2% last month.

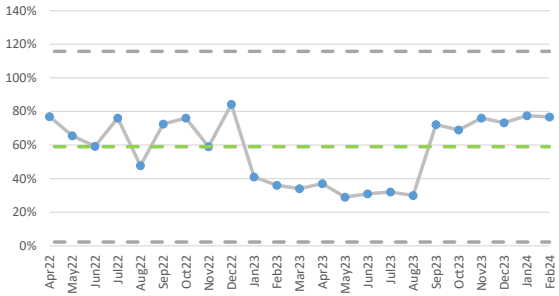
Planned / Mitigation Actions

Assurance / Recovery Trajectory

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

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

Breast Feeding Rate At Transfer Home



Reporting Date	Performance	Op. Plan #
Feb-24	76.7%	

Threshold	YTD Mean	Benchmark
-	-	60.7%

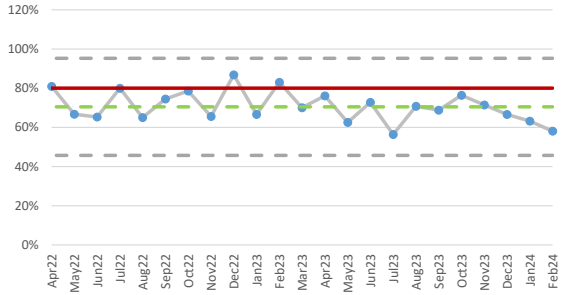
(Higher value represents better performance)

+	Variation Description

Common cause

Assurance Description

First Feed Breast Milk (Initiation Rate)



Reporting Date	Performance	Op. Plan #
Feb-24	58.1%	

Threshold	YTD Mean	Benchmark
> 80%	67.5%	73.6%

(Higher value represents better performance)

-	Variation Description

Common cause

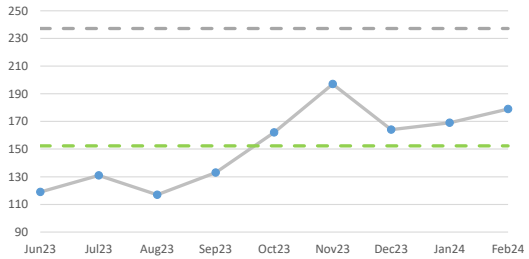
-	Assurance Description

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 58.1% which is below the national standard of >80%, however 76.7% 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.

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

Paediatrics- Total Admissions



Reporting Date	Performance	Op. Plan #
Feb-24	**179**	

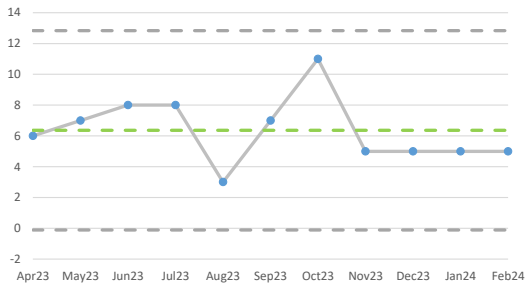
Threshold	YTD Mean	Benchmark
-	152	-

+ Variation Description

Common cause

Assurance Description

NNU - Total number of Admissions



Reporting Date	Performance	Op. Plan #
Feb-24	**5**	

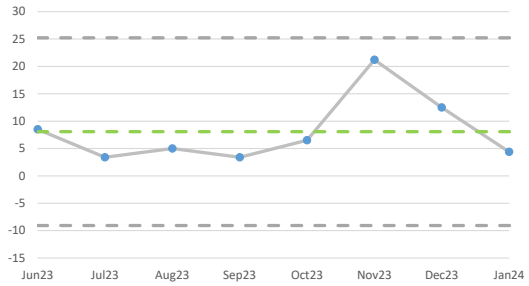
Threshold	YTD Mean	Benchmark
-	6	-

+ Variation Description

Common cause

Assurance Description

NNU - Avg. Length of Stay



Reporting Date	Performance	Op. Plan #
Feb-24	**8**	-

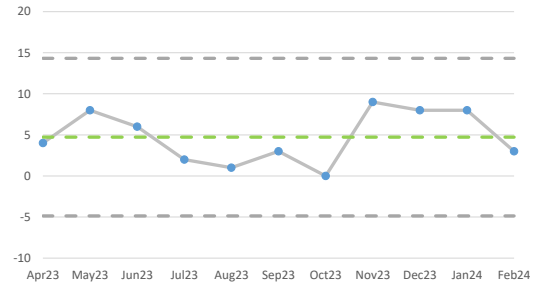
Threshold	YTD Mean	Benchmark
-	8.1	-

+ Variation Description

Common cause

Assurance Description

NNU - Community follow up



Reporting Date	Performance	Op. Plan #
Feb-24	3	

Threshold	YTD Mean	Benchmark
-	5	-

Variation Description

Common cause

Assurance Description

Issues / Performance Summary

- 3 babies were above 37 weeks gestation (term), unplanned admissions.
- 1 baby was admitted at 31+4 weeks, due to baby's generally good condition it was agreed to manage baby locally rather than transfer off island. Baby required short term respiratory support and is progressing well.
- I baby admitted at 34 weeks required short term respiratory support, progressed well and had been discharged hoe with community neonatal nurse follow up.
- Babies were admitted from labour ward/theatre and postnatal ward between 13 minutes and 26hrs of age.
- 4 x babies required intravenous antibiotics.
- Staffing -3 members of staff had sickness absence (1x WTE long term) 1 x 0.6 WTE on maternity leave. No support staff. Staff working extra hours to fill gaps.
- Band 6 neonatal nurse 2.2 x WTE agency required to maintain minimum staffing.
- 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.

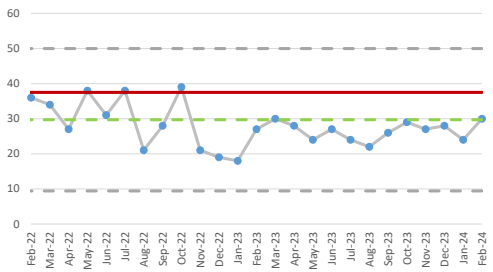
Caring Performance Summary

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	Feb-24		0	0	0	0		
CA002		Complaints - Total number of complaints received	Feb-24		30	26	289	<= 450 PA		
CA007		Complaint acknowledged within 5 working days	Feb-24		100%	99%	-	98%		
CA008		Written response to complaint within 20 days	Feb-24		100%	99%	-	98%		
CA010		No. complaints exceeding 6 months	Feb-24		0	0	0	0		
CA011		No. complaints referred to HSCOB	Feb-24	-	1	2	25	-		

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	Feb-24	-	1,503	1,293	14,225	-		
CA013		FFT - Experience was Very Good or Good	Feb-24		92%	90%	-	80%		
CA014		FFT - Experience was neither Good or Poor	Feb-24		3%	4%	-	10%		
CA015		FFT - Experience was Poor or Very Poor	Feb-24		5%	6%	-	<10%		
CA016		Manx Care Advice and Liaison Service contacts	Feb-24	-	689	683	7,518	-		
CA017		Manx Care Advice and Liaison Service same day response	Feb-24		93%	90%	-	80%		

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

Complaints - Number of complaints: Manx care



Reporting Date	Performance	Op. plan #
Feb-24	30	L7

Threshold	YTD Mean	Benchmark
<= 450 PA	26	28

(Lower value represents better performance)

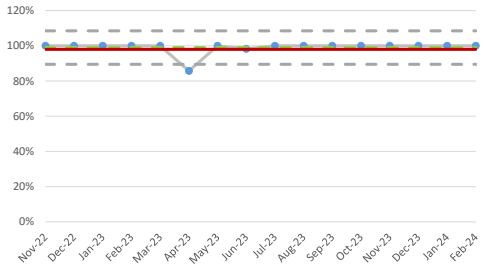
\- Variation Description

Common cause

\+ Assurance Description

Consistently hit target

Complaint - Written response within 20 days: Manx Care



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

Threshold	YTD Mean	Benchmark
98.0%	98.5%	-

(Higher value represents better performance)

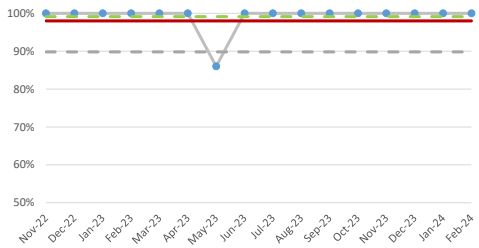
\+ Variation Description

Common cause

\+ Assurance Description

Consistently hit target

Complaint acknowledged within 5 working days: Manx Care



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

Threshold	YTD Mean	Benchmark
98%	98.7%	-

(Higher value represents better performance)

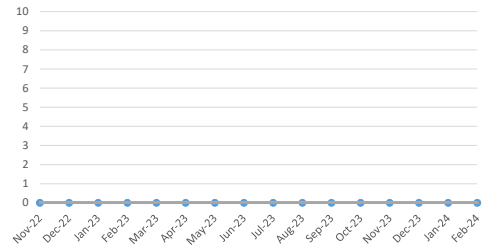
\+ Variation Description

Common cause

\+ Assurance Description

Inconsistently passing and falling short of target

Complaint - No. complaints exceeding 6 months: Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	0	L8

Threshold	YTD Mean	Benchmark
0	0	-

(Lower value represents better performance)

\+ Variation Description

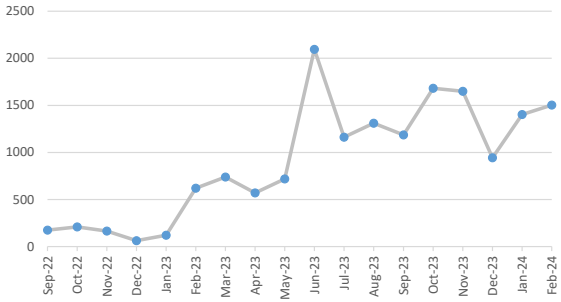
Common cause

\+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Number of Complaints: • 30 in February which is the highest this year. The top areas were 9 for STCC&A, 9 for MUC&AS, 5 for IMHS and 8 for Children & Families. Additionally, there were 16 for PCS relating to contracted services.	**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 had appeared to have stabilised at 26 with YTD average at 28
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 shown in February.	**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: • 1 complaint was referred to the HSCOB in December.	**No. complaints referred to HSCOB:** • Await HSCOB reports and findings.	**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.

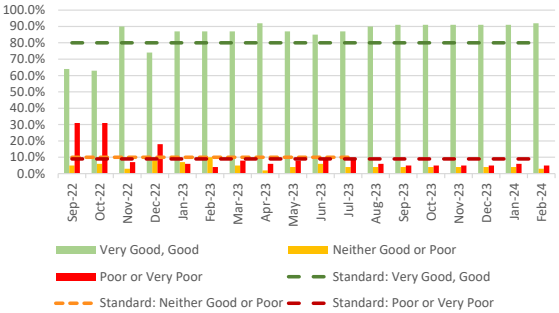
Caring	Friends & Family Test	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis



Reporting Date	Performance	Op. plan #
Feb-24	1,503	QC127
Threshold	**YTD Mean**	**Benchmark**
-	1,293	-

+ Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Feb-24	92.0%	QC128-129-130
Threshold	**YTD Mean**	**Benchmark**
80.0%	89.8%	-

(Higher value represents better performance)

+ Variation Description

Common cause

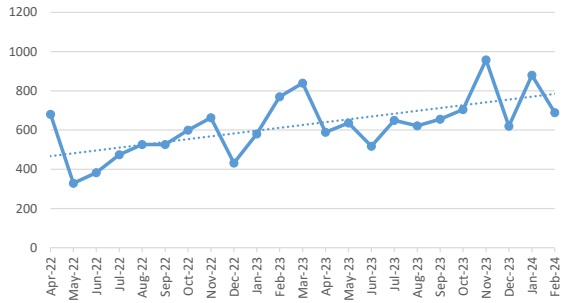
+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
FFT Total number of responses: • A total of 1503 surveys completed in February 2024. 13,171 surveys completed YTD.	**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 in February 2024 with ward uptake on the increase.	**FFT Total number of responses:** • Experience and Engagement continue to conduct monthly walk rounds of the wards to collect surveys and speak to staff to encourage completion of surveys at discharge. Pre-paid envelopes are available to provide to service users who are inpatients and post boxes are accessible on all wards and outpatient departments including Primary Care based practices. Easy read version of survey launched in November and text message reminder service due for launch in 2024. There is a reasonable degree of confidence in increasing survey returns.
• **FFT – Experience was very good or good:** 1378 completed surveys rated experience as Very Good or Good equating to 92% against a target of 80%. Target exceeded for every month YTD (90%).	• **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 very good or good:** Reasonable degree of confidence that reporting targets will continue to be met.
• **FFT – Experience was neither good or poor:** 50 completed surveys rated experience as Neither Good nor Poor equating to 3% against a target of 10% or less. Again, performance for the year is still strong.	• **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 neither good or poor:** Reasonable degree of confidence that reporting targets will continue to be met.
• **FFT – Experience was poor or very poor:** 75 completed surveys rated experience as Poor or Very Poor, equating to 5% against a target of 10% or less. Again, performance for the year is still strong.	• **FFT – Experience was poor or very poor:** Consistently achieving under the 10% target which is a positive indicator	• **FFT – Experience was poor or very poor:** Monthly dashboards and quarterly review meetings with all care group triumvirates are held to report feedback. 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

MCALS No. of Contacts



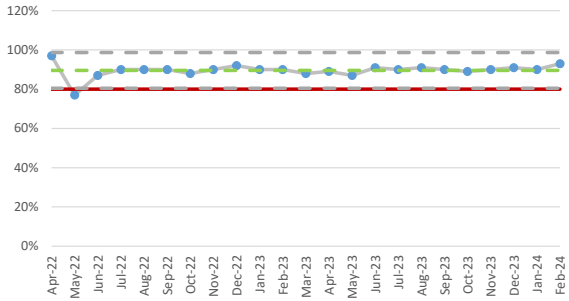
Reporting Date	Performance	Op. plan #
Feb-24	689	QC131

Threshold	YTD Mean	Benchmark
-	683	567

+ Variation Description

Assurance Description

MCALS same day response



Reporting Date	Performance	Op. plan #
Feb-24	93.0%	QC132

Threshold	YTD Mean	Benchmark
80.0%	90.1%	-

(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: • 689 contacts received in February 2024. Access to appointments within ophthalmology orthopaedics and general cardiology were the dominant themes. In person contacts February increased to 232 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 December to reach seldom heard voices. **Same Day Response:** • In February, MCALS had resolved all contacts within 24 hours 93% 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	Feb-24	-	2585	2820	31020	-		
RE056		Hospital Bed Occupancy	Mar-24	-	61.9%			92%		
RE001		RTT - No. patients waiting for first Consultant Led Outpatient appointment	Mar-24		16,619	16,268	-	< 15431		
RE002		RTT - No. patients waiting for Daycase procedure	Mar-24		1,738	2,174	-	< 2286		
RE003		RTT - No. patients waiting for Inpatient procedure	Mar-24		449	497	-	< 535		
RE004		RTT - % Urgent GP referrals seen for first appointment within 6 weeks	Feb-24		53%	53.5%	-	85%		
RE061		Diagnostics-% patients waiting 26 weeks or less	Feb-24		71%	63.2%		99%		
RE005		Diagnostics - % requests completed within 6 weeks	Feb-24	-	88%	85.8%	86%	-		
RE006		Diagnostics - % Patients waiting over 6 weeks	Feb-24		59%	67.5%	-	1%		
RE007		ED - % 4 Hour Performance	Feb-24		67%	70.4%	71%	76% (95%)		
RE008		ED - % 4 Hour Performance (Non Admitted)	Feb-24	-	78%	80.1%	80%	-		
RE009		ED - % 4 Hour Performance (Admitted)	Feb-24	-	20%	22.1%	22%	-		
RE010		ED - Average Total Time in Emergency Department	Feb-24		296	266	-	360 mins		
RE011		ED - Average number of minutes between Arrival and Triage (Noble's)	Feb-24		25	26	-	15 mins		
RE012		ED - Average number of minutes between arrival to clinical assessment - Nobles	Feb-24		83	70	-	60 mins		
RE033		ED - Average number of minutes between arrival to clinical assessment - RDCH	Feb-24		22	16		60 mins		
RE013		ED - 12 Hour Trolley Waits	Feb-24		34	34	378	0		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE014		Ambulance - Category 1 Response Time at 90th Percentile	Feb-24		14	18	-	15 mins		
RE015		Ambulance - Category 1 Mean Response Time	Feb-24		9	9	-	7 mins		
RE016		Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	Feb-24		56%	50%	-	100%		
RE034		Category 2 Response Time at 90th Percentile	Feb-24		23	29		40 mins		
RE035		Ambulance - Category 3 Response Time at 90th Percentile	Feb-24		38	47		120 mins		
RE036		Ambulance - Category 4 Response Time at 90th Percentile	Feb-24		69	79		180 mins		
RE037		Ambulance - Category 5 Response Time at 90th Percentile	Feb-24		61	79		180 mins		
RE038		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	Feb-24		228	200	-	0		
RE039		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	Feb-24		33	24	-	0		
RE026		IPCC - % patients seen by Community Adult Therapy Services within timescales	Feb-24		71%	58%	-	80%		
RE031		IPCC - % of patients registered with a GP	Feb-24		-	4.1%	-	5.0%		
RE081		IPCC - N. of GP appointments	Feb-24	-	-	28,397	255,574	-		
RE027		IPCC - No. patients waiting for a dentist	Feb-24	-	5,092	4,265	-	-		
RE074		Response by Community Nursing to Urgent / Non routine within 24 hours	Feb-24	-	100%	99%	-	-		
RE075		Community Nursing Service response target met (7 days)- Routine	Feb-24	-	100%	100%	-	-		

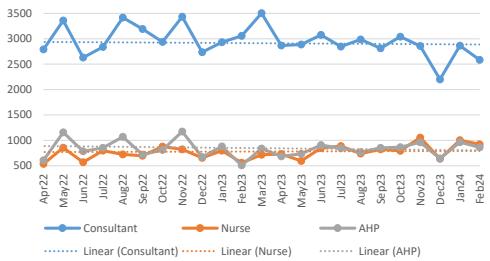
Responsive Performance Summary

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE025		CWT - % 28 Days to diagnosis or ruling out of cancer	Feb-24		72%	66%	-	75%		
RE018		CWT - % patients decision to treat to first definitive treatment within 31 days	Feb-24		73%	78%	-	96%		
RE019		CWT - % patients urgent referral for suspected cancer to first treatment within 62 days (RTT)	Feb-24		38%	47%	-	85%		
RE064		No. on Cancer Pathway (All)	Feb-24	-	514	648	-	-		
RE065		No. on Cancer Pathway (2WW)	Feb-24	-	436	550	-	-		
RE066		Cancer - Total number of patients Waiting for 1st OP	Feb-24	-	59	83	-	-		
RE067		Cancer - Median Wait Time from the Referral Date to the Diagosis Date	Feb-24	-	20	15	-	-		
RE044		MH- Waiting list	Feb-24	-	1723	1677	15089	-		
RE045		MH- Appointments	Feb-24	-	7077	6549	72038	-		
RE046		MH- Admissions	Feb-24	-	29	19	213	-		
RE028		MH - No. service users on Current Caseload	Feb-24		5,302	5,240	-	4500 - 5500		

KPI ID	B.I. Status	KPI Description	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
RE051		Maternity Bookings	Feb-24	-	61	813	617			
RE052		Ward Attenders	Feb-24	-	196	-	-			
RE053		Gestation At Booking <10 Weeks	Feb-24	-	66%	38%	-			
RE030		W&C - % New Birth Visits within timescale	Feb-24	-	94%	90%	-	-		
RE032		Births per annum	Feb-24	-	545	296	-	-		
RE082		Meds Demand - N.patient interactions	Feb-24	-	2539	2607	28672	-		
RE083		Meds Overnight Demand	Feb-24	-	110	264	2902	-		
RE084		Meds - Face to face appointments	Feb-24	-	607	523	5758	-		
RE086		Meds - TUNA%	Feb-24	-	1.9%	1.4%	-	-		
RE088		Meds- DNA%	Feb-24	-	0.9%	1.7%	-	-		

Responsive	Demand	Executive Lead		Lead		

Referrals for First Outpatient Appointment



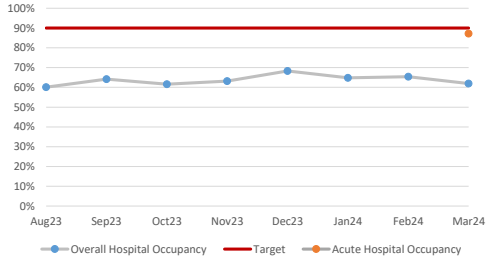
Reporting Date	Performance		Op. Plan #
Feb-24	Consultant	2585	

Threshold	YTD Mean	Benchmark
-	2820	3068

Variation Description

Assurance Description

Adult General and Acute (G&A) bed occupancy



Reporting Date	Performance	Op. Plan #
Mar-24	61.9%	QC79

Threshold	YTD Mean	Benchmark
92.0%	-	-

(Lower value represents better performance)

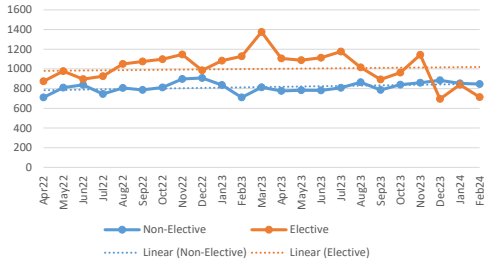
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Elective and Non Elective Admissions



Reporting Date	Performance		Op. Plan #
Feb-24	Elective	713	
	Non Elective	847	

Threshold	YTD Mean	Benchmark
-	-	-

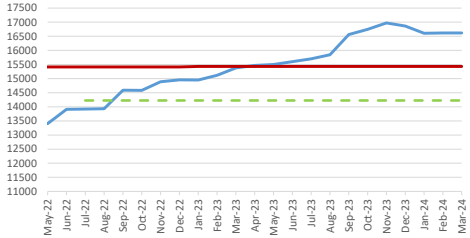
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals for First Outpatient Appointment: Referral levels for Consultant led services decreased in February to 2585, compared to 2864 in January. **Hospital Bed Occupancy** Overall Hospital occupancy is 61.9% Acute Adult Occupancy was 87.2% and Non Acute/ Child Occupancy was 28.7% **Elective and Non Elective Admissions:** Elective Admissions have decreased by approximately 15% in February (713) against January (840). Non Elective admission numbers have slightly decreased to 847 compared to 853 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.

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

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



Reporting Date	Performance	Op. Plan #
Mar-24	16,619	QC11

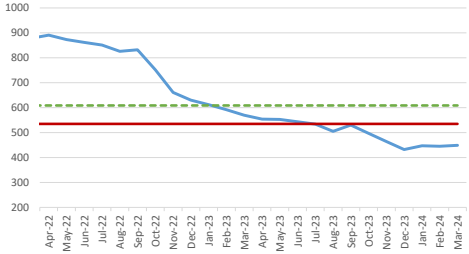
Threshold	YTD Mean	Benchmark
< 15,431	16,268	15,465

(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
5,600

RTT - No. patients waiting for Inpatient procedures



Reporting Date	Performance	Op. Plan #
Mar-24	449	QC11

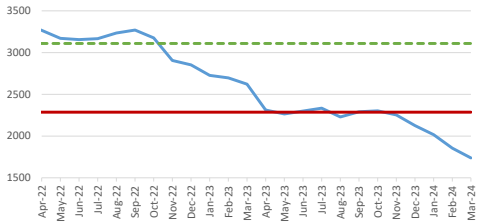
Threshold	YTD Mean	Benchmark
< 535	497	554

(Lower value represents better performance)

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

No. patients waiting 52+ weeks from Decision to Treat
75

RTT - No. patients waiting for Daycase procedures



Reporting Date	Performance	Op. Plan #
Mar-24	1,738	QC11

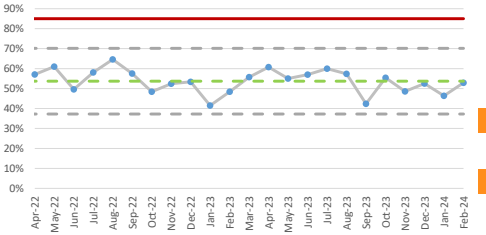
Threshold	YTD Mean	Benchmark
< 2,286	2,174	2,311

(Lower value represents better performance)

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

No. patients waiting 52+ weeks from Decision to Treat
387

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



Reporting Date	Performance	Op. Plan #
Feb-24	52.9%	QC13

Threshold	YTD Mean	Benchmark
85.0%	53.5%	54.0%

(Higher value represents better performance)

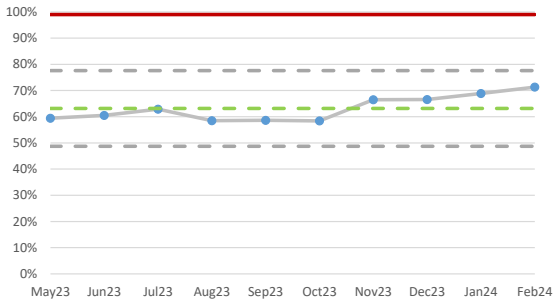
- Variation Description
Common cause

- Assurance Description
Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• 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.	• R&R delivery (Nov'21 to Feb '24); 2,150 Ophthalmology procs in total; 955 Orthopaedic procs in total; 18 GSU procs in Feb (501 in total); Other surgical specialties – 54 in total; 1,224 outpatient attendances in total; Radiology – 93 Ultrasound scans in Feb (1,367 radiology scans in total); Mental Health – 313 referrals in total; 458 endoscopic procedures. o Overall R&R has delivered about a 77% reduction in the Ophth daycase waiting list. o Overall R&R has delivered about a 43% reduction in orthopaedic daycase/inpatient waiting lists. o Overall there's been about a 61% reduction in the General Surgery daycase/inpatient waiting lists. • Dedicated waiting list validation team established and programme of waiting list validation commenced in October '22. To date over 24,200 referrals have been through technical validation and over 13,000 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 21% reduction in the outpatient waiting list. No patient is removed from the waiting list without clinical oversight. • The programme of clinical validation has continued across a number of specialties, with over 5,200 referrals reviewed to date, with over 1,700 (33%) identified as being approprate to either be 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, radiology and Community Mental Health Services for Adults(CMHSA).	• General Surgery R&R activity commenced in November '22. • Enhanced Waiting List Management programme established to implement procedural and operational improvements to embed Access policy and improve waiting list management. This includes: - Waiting List Validation; started in October '22. - Patient Tracking List (PTL) meetings (non Cancer); - Referral & Booking (initial focus on partial booking and patient initiated follow ups) - Referral To Treatment (RTT) Rules and System implementation; - Reducing patient Did Not Attend (DNA) rates; - Harm Review Note - Benchmark for '% Urgent GP referrals seen for 1st Outpatient' is the Manx Care monthly average for 2022/23. The benchmarks for the OP, IP and DC waiting lists are currently the waiting list sizes in Apr '23. In future reporting the benchmark will be a comparison to UK waiting list sizes using the numbers waiting per 1,000 population.

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

Diagnostics - % patients waiting 26 weeks or less



Reporting Date	Performance	Op. Plan #
Feb-24	71.3%	QC37b

Threshold	YTD Mean	Benchmark
99.0%	63.2%	-

(higher value represents better performance)

+ Variation Description

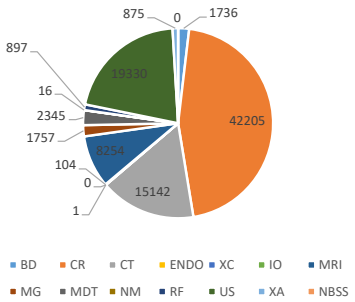
Common cause

- Assurance Description

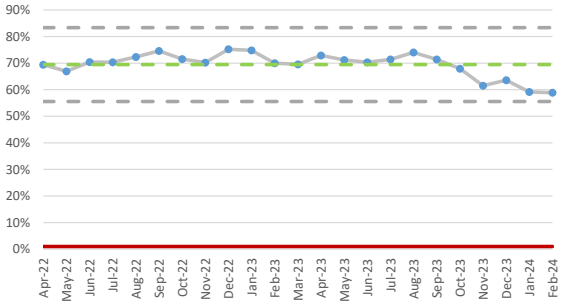
Consistently fail target

Modality	Feb-24		
	WL	>6 wks	% >6 wks
Bone Densitometry	159	31	19%
Computed Tomography	633	223	35%
Magnetic Resonance Imaging	375	96	26%
Ultrasound Non Obs	2,704	1,928	71%
Total	**3,871**	**2,278**	**59%**

YTD Demand by Modality: 2023/24



Diagnostics - % of Patients waiting over 6 weeks



Reporting Date	Performance	Op. Plan #
Feb-24	58.8%	QC37

Threshold	YTD Mean	Benchmark
1%	67.5%	26.2%

(lower value represents better performance)

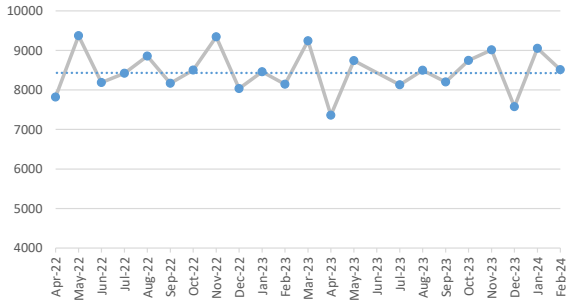
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

Diagnostics - No. of requests received



Reporting Date	Performance	Op. Plan #
Feb-24	92,662	

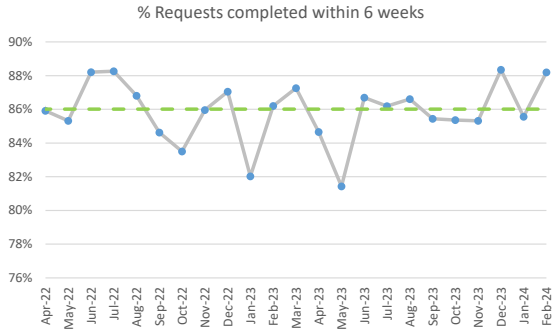
Threshold	YTD Mean	Benchmark
-	8,424	8,546

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• Overall demand continues to exceed capacity. Demand was 26.3% higher than capacity in February. • Emergency Department (ED) 24.2%, Outpatient Department (OPD) 35.9% and General Practitioner (GP) 23% remain the primary source of referrals, and there has been no significant change on the distribution compared to last month. • Inpatient Referrals (794). This equated to 11.8% of all requests. • 57.5% of exams were reported within 2 hours, 5.3% have taken 97 hours or longer which is an improvement on last month. • Of the 6,736 exams, 46.4% were turned around on the same day, and a further 37.1% in 1- 28 days.	• 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 times. 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.	• 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 January 2024. Benchmarks for '% Requests < 6 Weeks' and 'No. of requests received' are the Manx Care monthly average for 2022/23.

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



Reporting Date	Performance	Op. Plan #
Feb-24	88.2%	
Threshold	**YTD Mean**	**Benchmark**
-	85.8%	85.9%

+ Variation Description

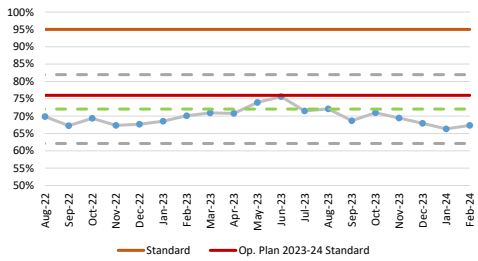
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% Requests completed within 6 weeks: 88.2% of requests completed in February were undertaken within 6 weeks. This aligns with the average of 85.8% for the year so far.		

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

A&E - % 4 Hour performance



Reporting Date	Performance	Op. Plan #
Feb-24	67.3%	QC23
	Admitted 19.6%	
	Non-Admitted 77.8%	

Threshold	YTD Mean	Benchmark
76% (95%)	70.4%	70.9%

(Higher value represents better performance)

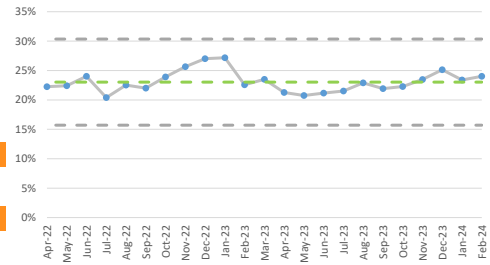
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

A&E - Admission Rate : Noble's Hospital



Reporting Date	Performance	Op. Plan #
Feb-24	24.0%	QC24

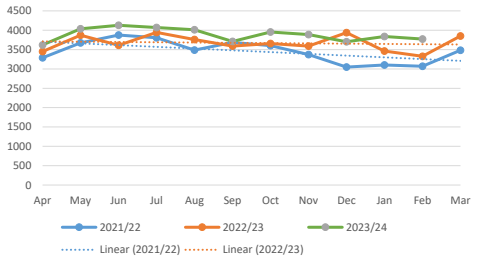
Threshold	YTD Mean	Benchmark
-	22.5%	28.4%

Variation Description

Common cause

Assurance Description

ED - Total Attendances : Manx Care



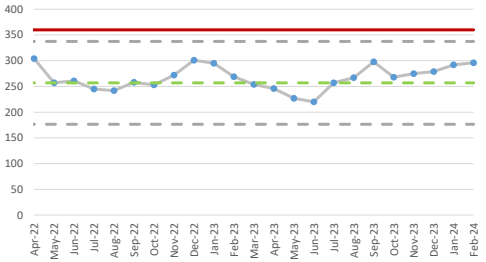
Reporting Date	Performance	Op. Plan #
Feb-24	3,774	

Threshold	YTD Mean	Benchmark
-	3,885	3,671

Variation Description

Assurance Description

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



Reporting Date	Performance	Op. Plan #
Feb-24	296	QC150

Threshold	YTD Mean	Benchmark
360 mins	266	268

(Lower value represents better performance)

- Variation Description

Common cause

+ Assurance Description

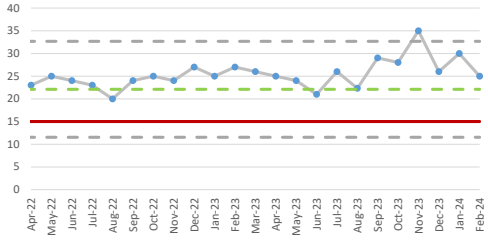
Consistently hit target

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

• ED Attendances YTD are 6.3% higher than same period last year.
• February's performance of 67.3% remained below the 95% threshold but slightly lower the UK's performance of 70.9%.
  • Admitted Performance: 19.6%;
  • Non Admitted Performance: 77.8%;
• 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 February, the average admission rate from Noble's ED of 24%, slightly higher than 23.4% in January, and was lower than that of the UK (28.4%).
 	
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.
	• Further embedding of Ambulatory Emergency Care and MACU to divert patients away from the main ED department for practitioner led and ambulatory treatment that would normally require inpatient admission such as IV therapy or deep vein thrombosis treatment.
	• Work on accuracy of time stamps for triage and treatment at briefings.
	• Development of Rapid Assessment by senior clinical staff
	• Review of GIRFT Programme National Specialty Report (Emergency Medicine) and potential for alignment with current processes and metrics.
	• Two current non-emergency workstreams should also contribute to the improvement of performance within ED:
	- Work streams around time of discharge
	- Other work streams around exit block
		• Average total time in department remains within the required 360 minute standard.
		• Expectation that performance will remain in line with the UK, but it should be noted that as expected the position has remained challenging over the period due to the additional seasonal pressures.
		• 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 February' 24.
		Benchmarks for 'Total Attendances' and 'Average time in ED' are the Manx Care monthly averages for 2022/23.

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

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



Reporting Date	Performance	Op. Plan #
Feb-24	25	QC26

Threshold	YTD Mean	Benchmark
15 mins	26	24

(Lower value represents better performance)

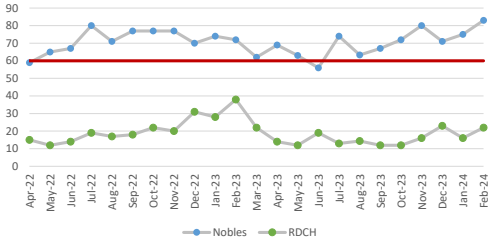
+	Variation Description

Special Cause of Concerning variation (High)

-	Assurance Description

Consistently fail target

ED-Average number of minutes between arrival to clinical assessment



Reporting Date	Performance		Op. Plan #
Feb-24	Nobles	83	
	RDCH	22	

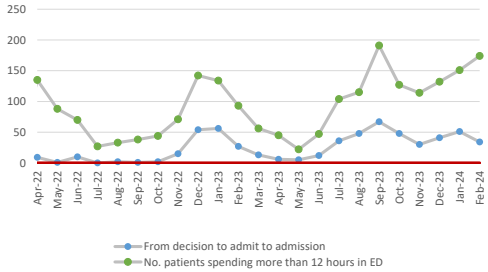
Threshold	YTD Mean	Benchmark
60 mins		-

(Lower value represents better performance)

Variation Description

Assurance Description

A&E - 12 Hours waits



Reporting Date	Performance		Op. Plan #
	%Trolley 12h Wait	0.9%	QC78
	% ED 12h Wait	4.6%	

Threshold	YTD Mean	Benchmark
0		-

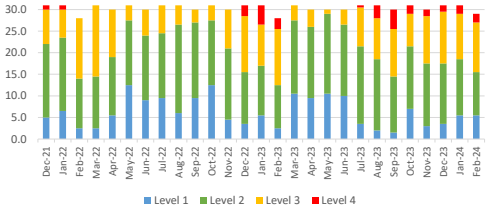
(Lower value represents better performance)

-	Variation Description

-	Assurance Description

Consistently fail target

Operational Pressures Escalation Level (OPEL) (Days)



Reporting Date	Performance	Op. Plan #

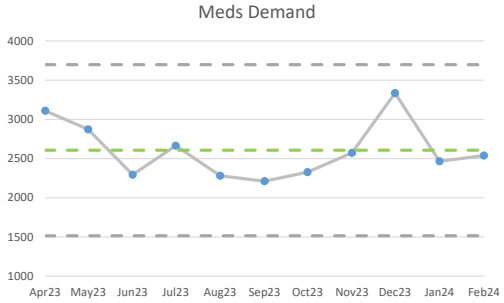
Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The service was on the highest Operational Pressures Escalation Level (OPEL), Level 4, for 2 days in February. • The number of 12 Hour Trolley Waits was 34 (0.9% of attendances; UK 2.1%) • 174 patients had a stay of more than 12 hours in ED in February. That equated to 4.6% of attendances.		Note - Benchmark for 'Average number of minutes between Arrival and Triage' is the Manx Care monthly average for 2022/23.

Responsive	MEDs Demand	Executive Lead	Oliver Radford	Lead	Mark Cox



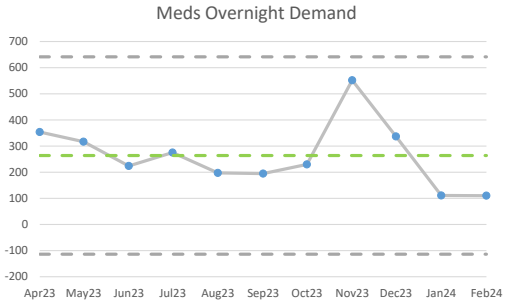
Reporting Date	Performance	Op. Plan #
Feb-24	**2539**	-

Threshold	YTD Mean	Benchmark
-	2607	-

Variation Description

Common cause

Assurance Description



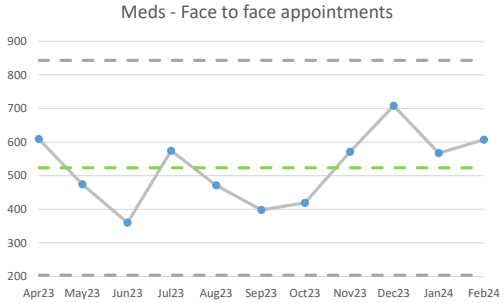
Reporting Date	Performance	Op. Plan #
Feb-24	**110**	-

Threshold	YTD Mean	Benchmark
-	264	-

Variation Description

Common cause

Assurance Description



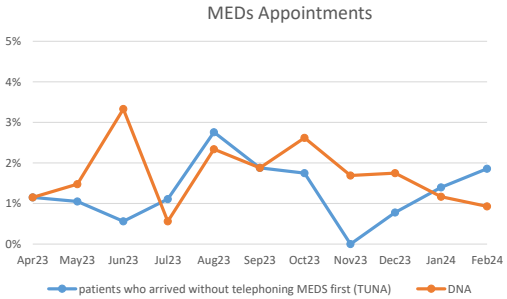
Reporting Date	Performance	Op. Plan #
Feb-24	**607**	-

Threshold	YTD Mean	Benchmark
-	523	-

Variation Description

Common cause

Assurance Description



Reporting Date	Performance		Op. Plan #
Feb-24	**TUNA**	**1.9%**	-
	DNA	**0.9%**	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

Variation Description

Assurance Description

Issues / Performance Summary

- In February 2024 MEDS provided 2539 patient interactions. This number is up from January by 75, even though February is a smaller month.

- In February 2024 MEDS offered a total of 607 Face to face appointments either at base or in the community. This was 32.39% of the total telephone contacts for this period.

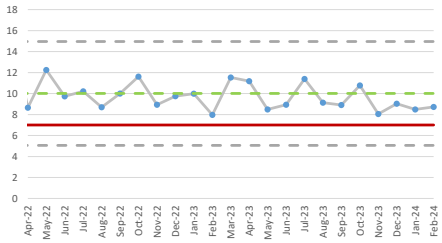
- Of the 607 face to face appointments 8 were patients who arrived without telephoning MEDS first and 4 of the patients failed to attend given appointment.

Planned / Mitigation Actions

Assurance / Recovery Trajectory

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

Ambulance - Category 1 Average (Mean) Response Time



Reporting Date	Performance	Op. Plan #
Feb-24	00:08:43	QC20

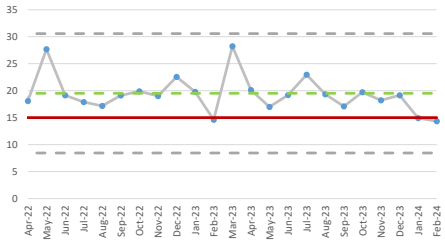
Threshold	YTD Mean	Benchmark
7 mins	00:09:22	00:08:25

(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 #
Feb-24	00:14:21	QC21

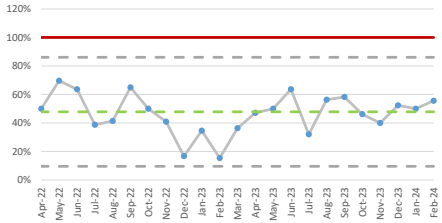
Threshold	YTD Mean	Benchmark
15 mins	00:18:22	00:14:56

(Lower value represents better performance)

+ Variation Description: Common cause

+ Assurance Description: Inconsistently passing and falling short of target

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



Reporting Date	Performance	Op. Plan #
Feb-24	55.6%	

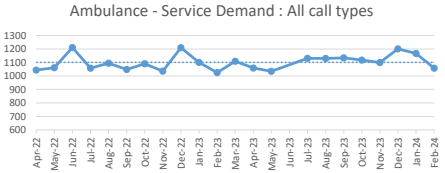
Threshold	YTD Mean	Benchmark
100.0%	50.1%	43.5%

(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 #
Feb-24	1,058	

Threshold	YTD Mean	Benchmark
-	1,112	1,090

Variation Description

Assurance Description

Feb-24	East	North	South	West	Total
Category 1 Calls	13	4	6	3	26
No. reached within 15 mins	13	2	4	3	22
% response within 15 mins	100.0%	50.0%	66.7%	100.0%	84.6%

Issues / Performance Summary

• February has seen demand for the service remain at high levels. There has again been a month on month increase in discharge and inter hospital transfer requests. Nobles ED handover delays and associated loss of response availability continues to present challenges. 29th of February is of particular note with 17 delays at ED over 30 mins. This is very high. We continue to work hard with Nobles Teams to assist as much as we can. Category 1 performance has stabilised but remains adrift of national standards. We have however seen an improvement in Category 2 performance well below (faster than) the national standard.

• Hear and Treat activity is lower than previous months due to short notice sickness within the team. The frontline service whilst maintaining mandated service levels, has not been able to provide as many "extra" resources this month. This will be the same situation as we move into spring so there is potential for performance to be adversely effected.
• Hear and Treat conducted 149 patient triages. This resulted in in 63 cases being downgraded (improving demand management) and 13 patients being directed to service that didn't require an ambulance response. In addition, 22 Hear and Treat triages were upgraded <1h to face to face assessment and 38 triages were upgraded to a Category 2 response with a conveyance rate of 71% which represents significant patient safety improvements.

• 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).

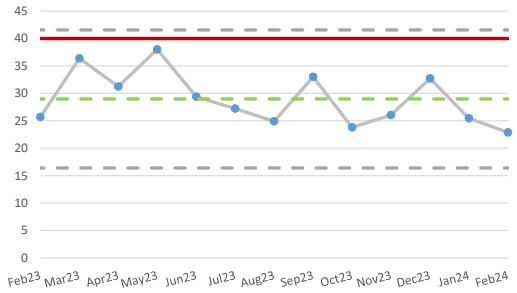
Assurance / Recovery Trajectory

• 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 February'24.
Benchmarks for 'CVA/Stroke' and 'Service Demand' are the Manx Care monthly averages for 2022/23.

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

Ambulance - Category 2 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Feb-24	00:22:54	QC136

Threshold	YTD Mean	Benchmark
40 mins	00:28:37	01:17:39

(Lower value represents better performance)

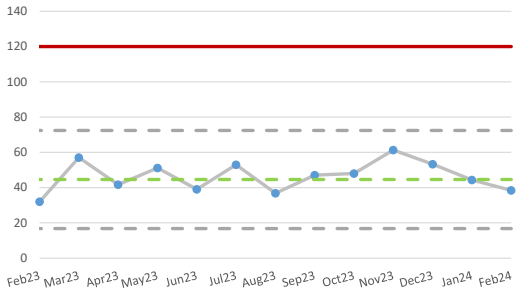
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Ambulance - Category 3 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Feb-24	00:38:24	QC138

Threshold	YTD Mean	Benchmark
120 mins	00:46:45	04:51:59

(Lower value represents better performance)

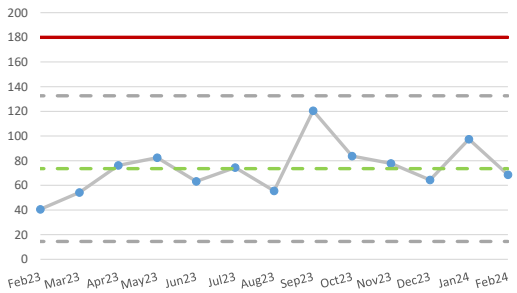
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Ambulance - Category 4 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Feb-24	01:08:34	QC140

Threshold	YTD Mean	Benchmark
180 mins	01:18:34	05:56:23

(Lower value represents better performance)

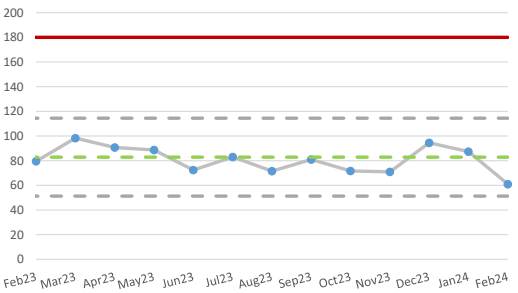
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Ambulance - Category 5 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Feb-24	01:00:59	QC142

Threshold	YTD Mean	Benchmark
180 mins	01:19:20	-

(Lower value represents better performance)

+ Variation Description

Common cause

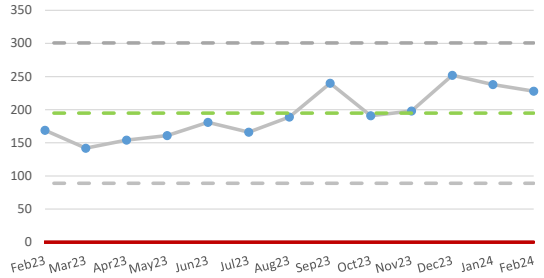
+ Assurance Description

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 = 00:22:54 - Category 3; Standard < 120 mins; 90th percentile = 00:38:24 - Category 4; Standard < 180 mins; 90th percentile = 01:08:34 - Category 5; Standard < 180 mins; 90th percentile = 01:00:59		Note - Benchmarks for Category 2,3,4 'Response time at 90th Percentile' are UK NHSE performance figures for February'24.

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

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



Reporting Date	Performance	Op. Plan #
Feb-24	228	QC85

Threshold	YTD Mean	Benchmark
0	200	177

(Lower value represents better performance)

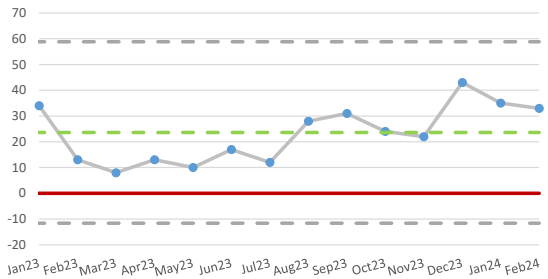
+ Variation Description

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 #
Feb-24	33	QC86

Threshold	YTD Mean	Benchmark
0	24	22

(Lower value represents better performance)

+ Variation Description

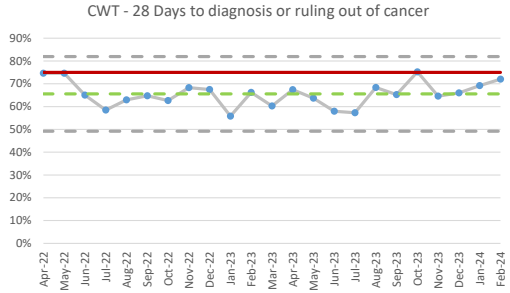
Common cause

- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• There were 33 instances where handover Turnaround Times were greater than 60 mins, and 228 where greater than 30 mins.		

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



Reporting Date	Performance	Op. Plan #
Feb-24	72.0% (236 of 328)	QC31

Threshold	YTD Mean	Benchmark
75.0%	66.1%	70.9%

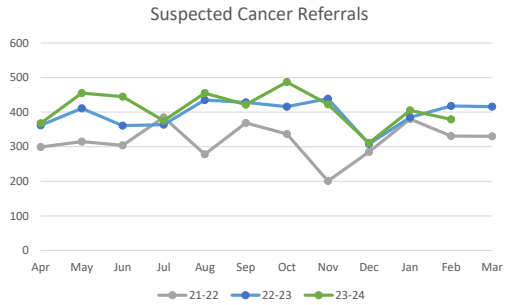
(Higher value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target



Reporting Date	Performance	Op. Plan #
Feb-24	379	

Threshold	YTD Mean	Benchmark

- Variation Description

Common cause

Assurance Description

Tumour Group	Suspected Cancer Referrals								
	Feb-24	Apr 23 - Feb 24	Apr 22 - Feb 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	55	726	576	26.0%	66	53	792	635	24.7%
Colorectal	72	814	845	-3.7%	74	72	888	913	-2.7%
Dermatology	57	960	903	6.3%	87	87	1,047	995	5.3%
Gynaecology	47	495	428	15.7%	45	39	540	476	13.4%
Haematology	1	58	66	-12.1%	5	5	63	72	-12.1%
Head & Neck	36	396	388	2.1%	36	36	432	422	2.4%
Lung	18	132	113	16.8%	12	11	144	120	20.0%
Other	3	18	28	-	2	4	20	29	-32.3%
Upper GI	33	371	373	-0.5%	34	34	405	406	-0.3%
Urology	35	397	363	9.4%	36	36	433	432	0.3%
Sub-Total	**357**	**4,367**	**4,083**	**7.0%**	**397**	**378**	**4,764**	**4,500**	**5.9%**

**Tumour Group	Monthly number of	
	Feb-24	12 month Avg.
Breast symptomatic (non-suspected cancer)	21	9

*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

- Performance for the 28 Day FDS target has improved since November 2023 and however is still remaining below the 75% threshold at 72%. The mean wait time is currently 27 days and the median waiting time is currently 20 days.
- 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 escalated in line with the Cancer Escalation Policy
- 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
- 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

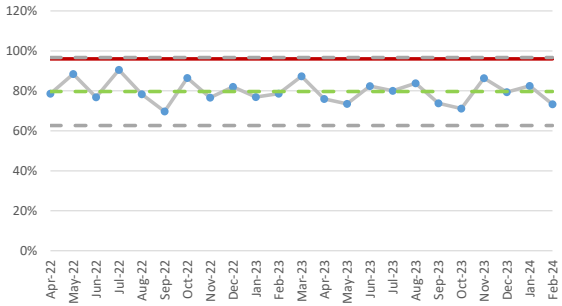
Assurance / Recovery Trajectory

- 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 Jan'24.

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

CWT - 31 Day Diagnosis to Treatment



Reporting Date	Performance	Op. Plan #
Feb-24	73.3% (44 of 60)	QC35

Threshold	YTD Mean	Benchmark
96.0%	78.4%	87.5%

(Higher value represents better performance)

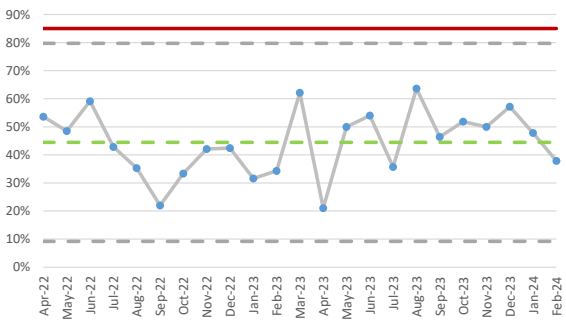
Variation Description

Common cause

Assurance Description

Consistently fail target

CWT - 62 Day Referral to Treatment



Reporting Date	Performance	Op. Plan #
Feb-24	37.8% (14 of 37)	QC34

Threshold	YTD Mean	Benchmark
85.0%	46.9%	62.3%

(Higher value represents better performance)

Variation Description

Common cause

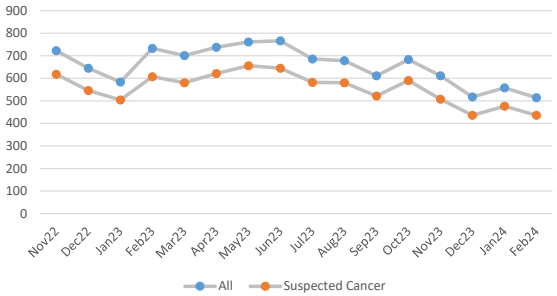
Assurance Description

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 Jan'24

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

Number of patients on Cancer Pathway



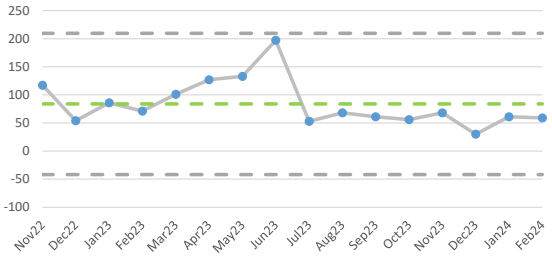
Reporting Date	Performance	Op. Plan #
Feb-24	514	

Threshold	YTD Mean	Benchmark
-	648	677

Variation Description

Assurance Description

Cancer - Total number of patients waiting for first appointment



Reporting Date	Performance	Op. Plan #
Feb-24	59	

Threshold	YTD Mean	Benchmark
	83	86

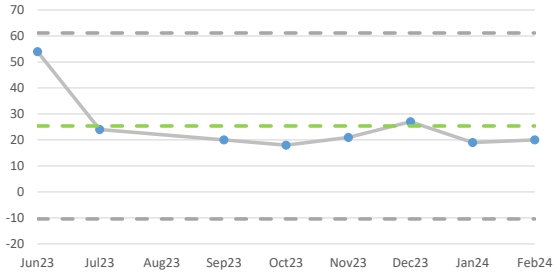
(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description

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



Reporting Date	Performance	Op. Plan #
Feb-24	20	

Threshold	YTD Mean	Benchmark

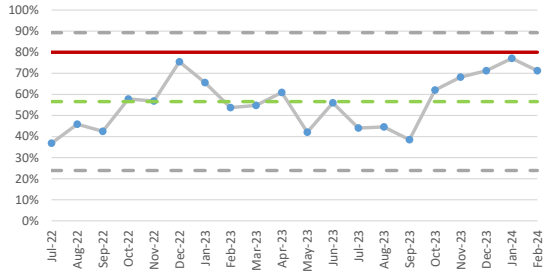
- **Variation Description**

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.		

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



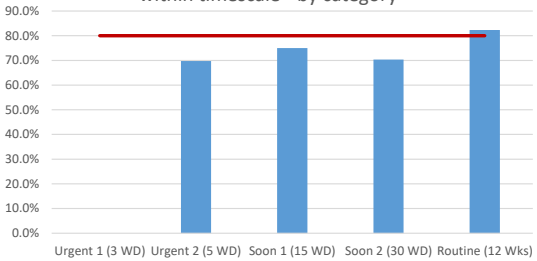
Reporting Date	Performance	Op. Plan #
Feb-24	71.2%	QC62

Threshold	YTD Mean	Benchmark
80.0%	57.8%	54.4%

(Higher value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target



Reporting Date	Performance	Op. Plan #
Feb-24	-	

Threshold	YTD Mean	Benchmark
80%	-	-

(Higher value represents better performance)

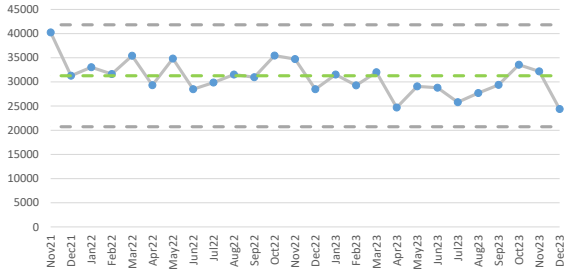
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Community Adult Therapy: • The team hold heavy caseloads of patients with complex and changing needs requiring regular input and reviews making it more difficult to respond to new referrals.	**Community Adult Therapy:** • Team have reviewed triage priorities and the Mandate 2024/25 has reflected this with the new metrics (starting April-24) simplified 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.	- Note: Benchmark for '% patients seen by CAT' is the Manx Care monthly averages for 2022/23.

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

Number of GP Appointments



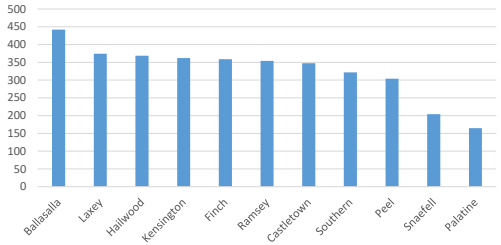
Reporting Date	Performance	Op. Plan #
Dec-23	**24384**	-
Threshold	**YTD Mean**	**Benchmark**
-	28397	31375

Variation Description

Common cause

Assurance Description

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



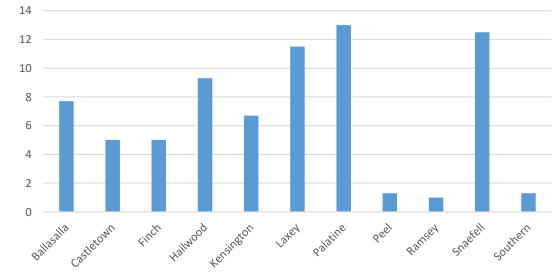
Reporting Date	Performance	Op. Plan #
Dec-23	-	
Threshold	**YTD Mean**	**Benchmark**
	-	-

-

- **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	-

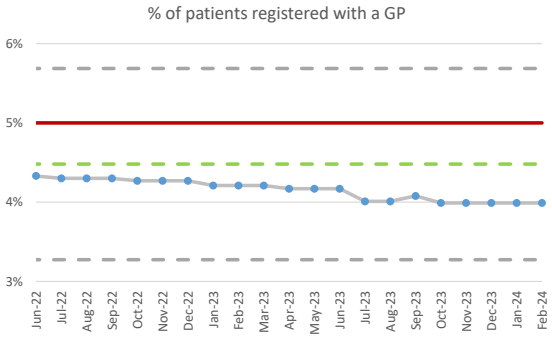
(Lower value represents better performance)

Variation Description

Assurance Description

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

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



Reporting Date	Performance	Op. Plan #
Feb-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

% of patients registered with a GP:

- % tolerance is currently in line with requirements.

Planned / Mitigation Actions

% of patients registered with a GP:

- List cleansing is conducted monthly / quarterly and annually. An additional validation is conducted with practices by the Primary Care GP registrations team to ensure that practices patient lists match the GP registration system.
- The GP Contracts manager, at the contract review meetings discusses list sizes, 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.

Assurance / Recovery Trajectory

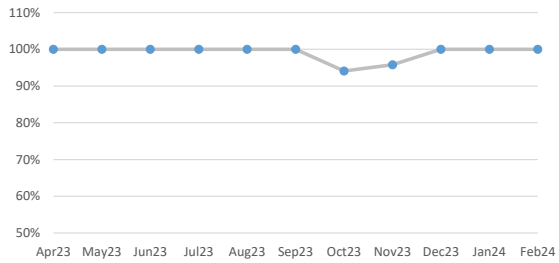
% of patients registered with a GP:

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

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

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



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

Threshold	YTD Mean	Benchmark
-	99.1%	-

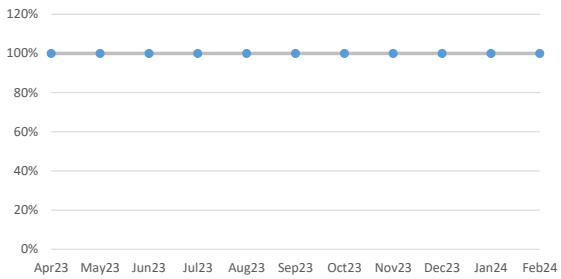
(Higher value represents better performance)

+ Variation Description

Common cause

Assurance Description

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



Reporting Date	Performance	Op. Plan #
Feb-24	**100.0%**	QC62

Threshold	YTD Mean	Benchmark
-	100%	-

(Higher value represents better performance)

+ Variation Description

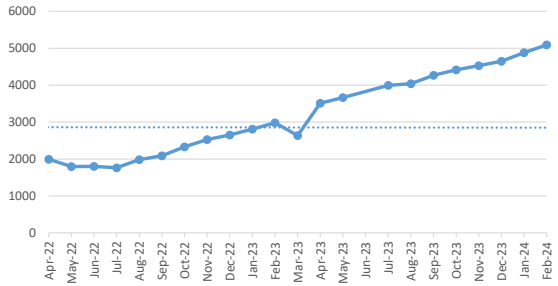
Common cause

Assurance Description

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

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

No. patients waiting for a Dentist (GDP)



Reporting Date	Performance	Op. Plan #
Feb-24	5092	

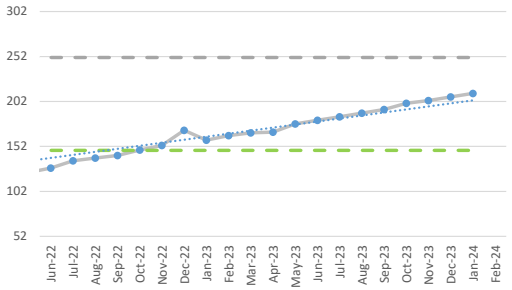
Threshold	YTD Mean	Benchmark
-	4265	826

(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

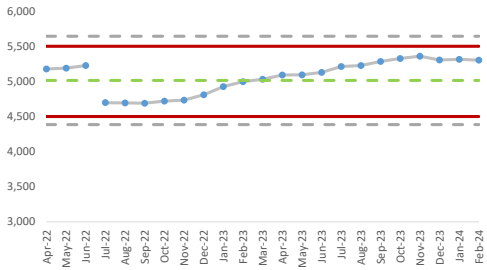
Variation Description
Special Cause of Concerning variation (High)

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Dental: • Of the 5,092 patients waiting for allocation on the dental waiting list, 3,489 are adults, 1,601 are children and there are 2 showing as unknown as DOB not given.	**Dental:** • Dental Team will follow up on unknown age of patients	Note - Benchmark for 'No. patients waiting for dentist' is the number waiting in Apr '23.

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

MH - No. service users on Current Caseload



Reporting Date	Performance	Op. Plan #
Feb-24	5302	QC73

Threshold	YTD Mean	Benchmark
4500 - 5500	5240	4907

(Value within range represents better performance)

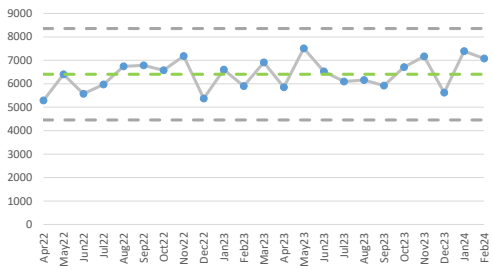
+	Variation Description

Common cause

+	Assurance Description

Consistently hit target

MH- Appointments



Reporting Date	Performance	Op. Plan #
Feb-24	7077	

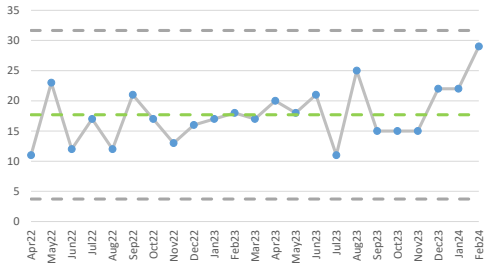
Threshold	YTD Mean	Benchmark
-	6549	6276

+	Variation Description

Common cause

Assurance Description

MH- Admissions



Reporting Date	Performance	Op. Plan #
Feb-24	29	

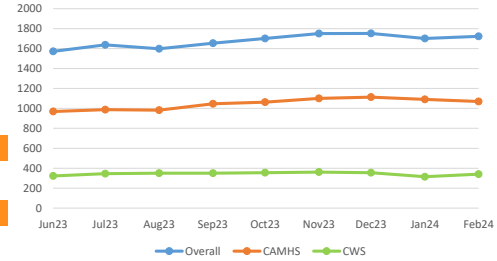
Threshold	YTD Mean	Benchmark
-	19	16

-	Variation Description

Common cause

Assurance Description

Mental Health Waiting Lists



Reporting Date	Performance	Op. Plan #
Feb-24	**1723**	

Threshold	YTD Mean	Benchmark
-	1677	

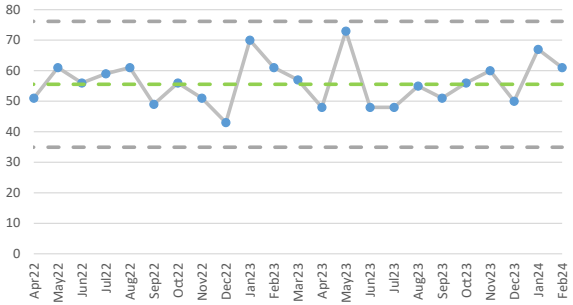
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Current Caseload: Caseload remains within the expected range with a decrease of 15 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 February increased to 29, this has now stabalised and relates to one individual whom the Senior Leadership Team are assured received appropriate treatment.	**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'	**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 waits for low to moderate psychological therapies will be greatly reduced during 2024

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

Maternity Bookings



Reporting Date	Performance	Op. Plan #
Feb-24	**61**	

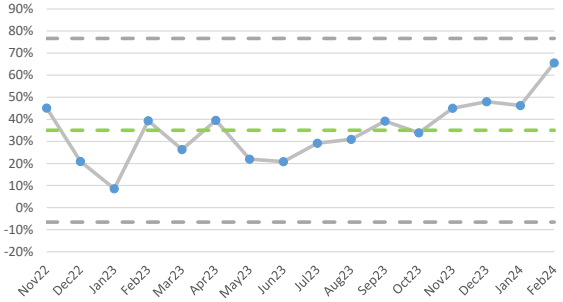
Threshold	YTD Mean	Benchmark
-	813	56

Variation Description

Common cause

Assurance Description

Gestation At Booking <10 Weeks



Reporting Date	Performance	Op. Plan #
Feb-24	**66%**	

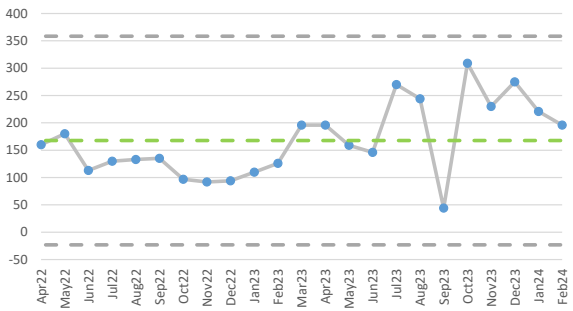
Threshold	YTD Mean	Benchmark
-	38%	28.0%

Variation Description

Common cause

Assurance Description

Ward Attenders



Reporting Date	Performance	Op. Plan #
Feb-24	**196**	

Threshold	YTD Mean	Benchmark
-	-	131

Variation Description

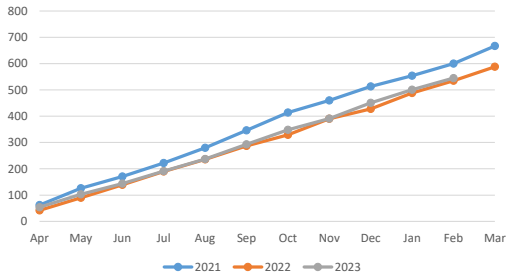
Common cause

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 66% of booked women booking before 10 weeks. **Booking:** A total of 61 women have booked for care in February (61 in February 23).		

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

Births per annum



Reporting Date	Performance	Op. plan #
Feb-24	**545**	
Threshold	**YTD Mean**	**Benchmark**
-	296	-

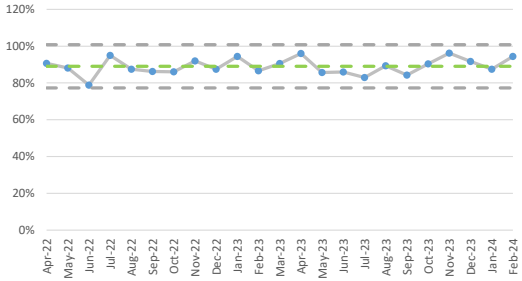
(Higher value represents better performance)

+	Variation Description

Common cause

Assurance Description

% New Birth Visits within timescale



Reporting Date	Performance	Op. Plan #
Feb-24	**94%**	QC133
Threshold	**YTD Mean**	**Benchmark**
-	90%	89%

-	Variation Description

Common cause

Assurance Description

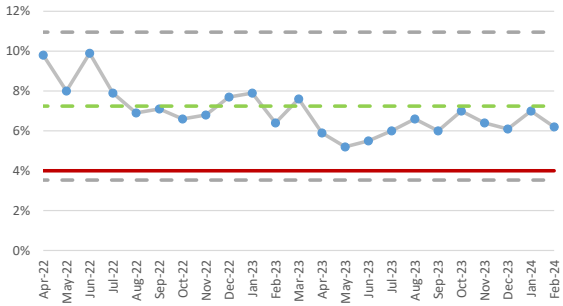
Issues / Performance Summary	Planned / Mitigation Actions	
In February 2024 we received 51 Antenatal referrals into the department. **New Birth Visits** The Health Visiting Team completed a total of 36 visits. Out of these visits, 34 were completed within the timeframe of 14 days and 2 were not completed within timeframe. Our overall compliance was 100 %. There was 2 exceptions and 0 breaches.		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	Feb-24		6.2%	6.2%	-	4.0%		
WP002		Workforce - Number of staff on long term sickness	Feb-24	-	68	82	-	-		
WP004		Workforce - Number of staff leavers	Feb-24	-	18	23	254	-		
WP005		Workforce - Number of staff on disciplinary measures	Feb-24	-	6	9	94	-		
WP006		Workforce - Number of suspended staff	Feb-24	-	3	3	32	-		
WP013		Staff 12 months turnover rate	Feb-24		10.0%	10.1%	-	10%		
WP014		Training Attendance rate	Feb-24		63.0%	61.8%	-	90%		
WP007		Governance - Number of Data Breaches	Feb-24		14	12	131	0		
WP008		Governance - Number of Data Subject Access Requests (DSAR)	Feb-24	-	57	56	620	-		
WP009		Governance - Number of Access to Health Record Requests (AHR)	Feb-24	-	5	3	30	-		
WP010		Governance - Number of Freedom of Information (FOI) Requests	Feb-24	-	13	10	112	-		
WP011		Governance - Number of Enforcement Notices from the ICO	Feb-24	-	0	0	0	-		
WP012		Governance - Number of SAR, AHR and FOI's not completed within their target	Feb-24		47	39	425	0		
WP015		Number of DSAR, AHR and FOI's overdue at month end	Feb-24		27	36	398	-		

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

% Hours lost to staff sickness absence



Reporting Date	Performance	Op. plan #
Feb-24	6.2%	P1

Threshold	YTD Mean	Benchmark
4.0%	6.2%	7.7%

(Lower value represents better performance)

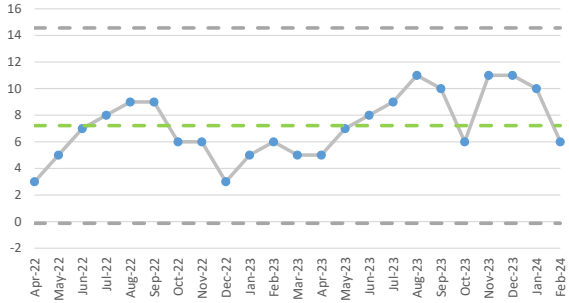
+ Variation Description

Special Cause of Improving variation (Low)

- Assurance Description

Consistently fail target

Number of staff on disciplinary measures : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	6	P5

Threshold	YTD Mean	Benchmark
-	9	-

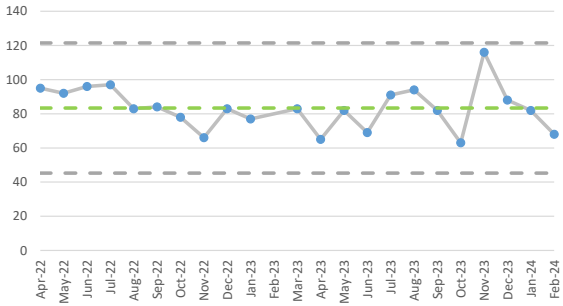
(Lower value represents better performance)

+ Variation Description

Common cause

Assurance Description

Number of staff on long term sickness : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	68	P4

Threshold	YTD Mean	Benchmark
-	82	-

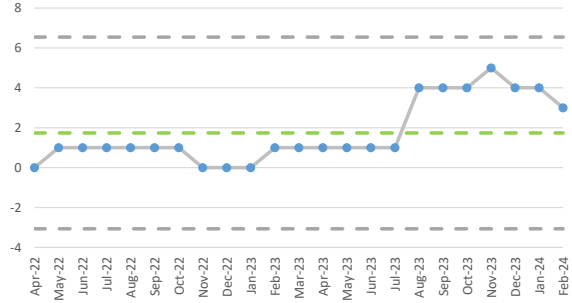
(Lower value represents better performance)

+ Variation Description

Common cause

Assurance Description

Number of suspended staff : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	3	P6

Threshold	YTD Mean	Benchmark
-	3	-

(Lower value represents better performance)

+ Variation Description

Common cause

Assurance Description

Issues / Performance Summary

• Worktime lost in February 24 by sickness category:

Stress, Anxiety & Depression	- 1.3%
Cough, Cold & Flu	- 1.1%
Musculoskeletal	- 1.0%
Covid-19	- 0.3%
Other sickness	- 2.5%

• Worktime lost in February 24 by Area:

Integrated Social Care Services	- 6.9%
Medicine, Urgent Care & Ambulance Services	- 5.4%
Integrated Mental Health Services	-
Infrastructure	- 6.2%
Integrated Primary & Community Care Services	- 5.5%
Integrated Cancer & Diagnostic Services	- 5.5%
Women, Children & Families	- 7.0%
Surgery, Theatres, Critical Care & Anaesthetics	- 6.6%

Planned / Mitigation Actions

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

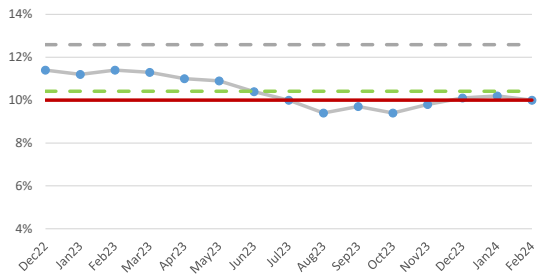
• The decision to suspend staff which may occasionally be necessary is normally taken in consultation with HR to ensure the measures are appropriate and proportionate.

Assurance / Recovery Trajectory

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

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

Staff 12 months turnover rate



Reporting Date	Performance	Op. plan #
Feb-24	10.0%	P2

Threshold	YTD Mean	Benchmark
10.0%	10.1%	11.3%

(Lower value represents better performance)

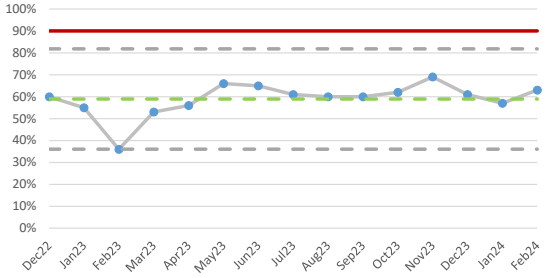
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

Instructor-led training sessions attendance rate



Reporting Date	Performance	Op. plan #
Feb-24	63%	P7

Threshold	YTD Mean	Benchmark
90%	62%	51%

(Higher value represents better performance)

+	Variation Description

Common cause

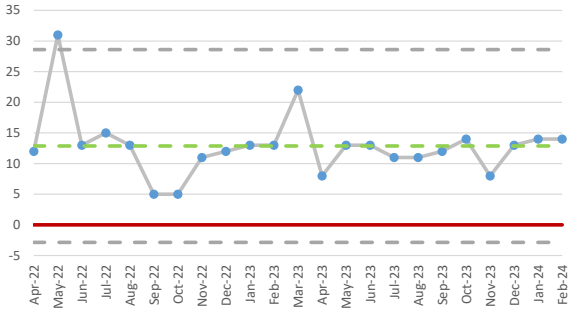
-	Assurance Description

Consistently fail target

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

Well Led	Governance	Executive Lead	Simon Collins	Lead	Jennifer Maynard

Governance - Number of Data Breaches : Manx Care



Reporting Date	Performance	Op. plan #
Feb-24	14	L1

Threshold	YTD Mean	Benchmark
0	12	-

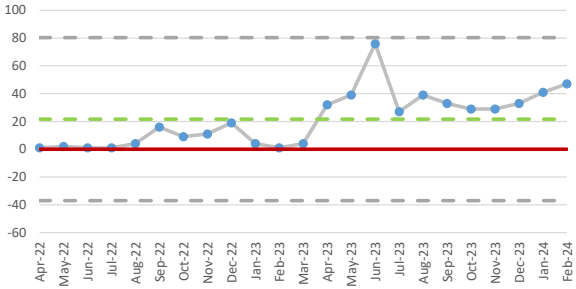
-	Variation Description

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 #
Feb-24	47	L6

Threshold	YTD Mean	Benchmark
0	39	-

(Lower value represents better performance)

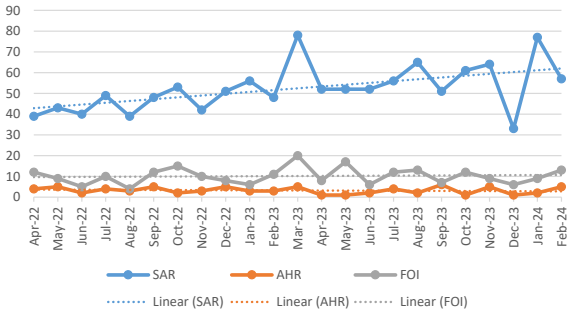
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Governance - Information requests by type : Manx Care



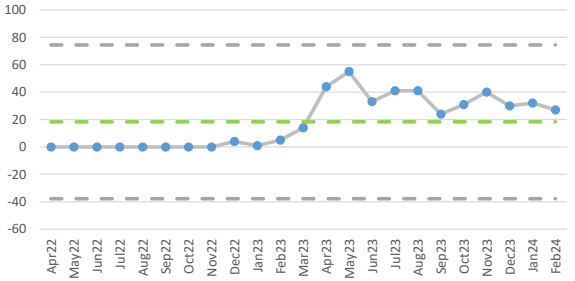
Reporting Date	Performance	Op. plan #
Feb-24	-	L2-3-4

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 #
Feb-24	27	-

Threshold	YTD Mean	Benchmark
-	36	18

(Lower value represents better performance)

+	Variation Description

Common cause

	Assurance Description

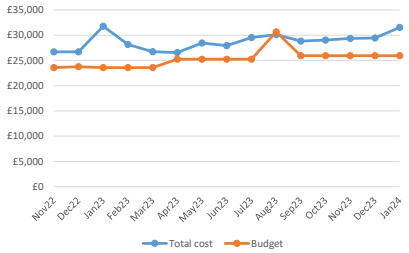
Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Total: 14 Reported to the Commissioner: 1 Data Subjects informed: 3 Data Subjects Not Informed: 11 (1 x legal advice not to inform, 1 x currently being investigated / assessed 9 x low risk to data subject) Types of breach Email: 8 Technology: 3 Confidentiality: 3	• Manx Care notifies to the ICO all breaches which they are required to notify. All breaches (and suspected breaches) are fully investigated by the Manx Care DPO. The DPO will conduct a full internal investigations with the relevant service areas to establish the details of the breach and conduct a root cause analysis exercise. Recommended improvements and changes will be identified and the DPO and IG Risk and Quality Assurance Manager will work together with relevant service areas to ensure any improvements and remedial actions identified are progressed. • 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. Evidence indicates that staff across Manx Care are confident to report data breaches and that such events are used as an opportunity to learn, 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, FOI, Police and Court 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. Additionally, there is a significant impact on resources in care groups and service areas due to their involvement in providing clinical redaction reviews and information for FOI requests.

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)	Jan-24		122%	-	567%	100% (equiv. 1%)		
WF002		Total income (£)	Jan-24	-	-£1,290,650	-£1,238,717	-£13,102,898	-		
WF003		Total staff costs (£)	Jan-24	-	£21,371,002	£16,177,273	£181,103,104	-		
WF004		Total other costs (£)	Jan-24	-	£12,928,918	£11,886,589	£129,301,665	-		
WF005		Agency staff costs (proportion %)	Jan-24	-	3.0%	5.5%	-	-		
WF009		Actual performance against Budget	Jan-24		-5,586	-£4,401	-£29,292	-		

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

Actual Performance against Budget

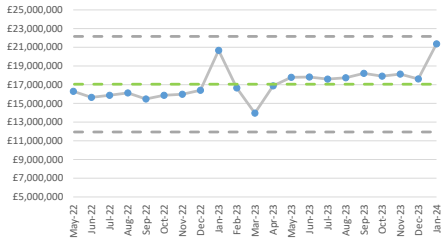


Reporting Date	Performance	Op. plan #
Jan-24		
Threshold	**YTD Mean**	**Benchmark**

Variation Description

Assurance Description

Total staff costs (£)



Reporting Date	Performance	Op. plan #
Jan-24	£21,371,002	F4
Threshold	**YTD Mean**	**Benchmark**
-	£16,177,273	-

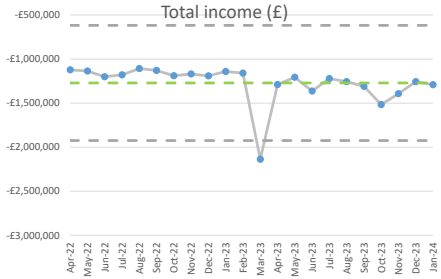
(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description

Total income (£)



Reporting Date	Performance	Op. plan #
Jan-24	-£1,290,650	F3
Threshold	**YTD Mean**	**Benchmark**
-	-£1,238,717	-

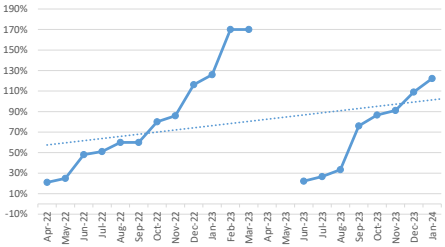
(Higher value represents better performance)

- **Variation Description**

Common cause

Assurance Description

% Progress towards Cost Improvement Target (CIP)



Reporting Date	Performance	Op. plan #
Jan-24	122.2%	F1
Threshold	**YTD Mean**	**Benchmark**
100% (equiv. 1%)	-	-

(Higher value represents better performance)

+ **Variation Description**

Assurance Description

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

% Progress towards Cost Improvement Target (CIP):

• To date, the CIP plan has delivered £6.7m in savings, of which £5.5m 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 January stands at 90% 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 £33.6m compared to the prior year, whilst funding has increased by just £20m creating a gap of £13.6m. The year-end position for 22/23 was an overspend of £8.9m which also contributes to the predicted operational overspend of £22.7m.

Total income (£):

• The operational result for January is an overspend of (£5.2m). The increase in spend in the month is due to payment of the MPTC & NJC 2022/23 pay award arrears (backdated to Apr-22).

Total staff costs (£):

•YTD employee costs are (£7.6m) 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 £9.5m is broken down across Care Groups below. The Care Groups with the largest spend are Medicine (£1.9m), Social Care (£1.8m) and Mental Health (£1.3m), where spend is primarily incurred to cover existing vacancies in those areas.

% 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.

• The Commercial Opportunities target is unlikely to be met in this year but is expected to deliver in full in 24/25. Infrastructure savings are now recovering. Tertiary savings are expected to deliver during Q4. The efficiency target of £825k has now been exceeded with delivery of £1.3m to date.

Total income (£):

• Spend is expected to increase by £33.6m compared to the prior year, whilst funding has increased by just £20m creating a gap of £13.6m. The year-end position for 22/23 was an overspend of £8.9m which also contributes to the predicted operational overspend of £22.7m.

• If Reserve Funding is available for the remaining request of £0.5m this would reduce the operational forecast to (£30.0m).

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 in January increased due to arrears payments for MPTC & NJC. 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.

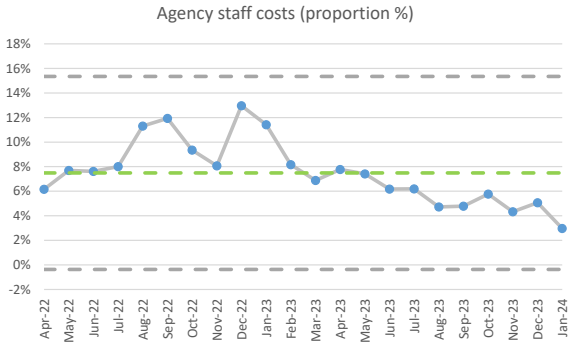
% Progress towards Cost Improvement Target (CIP):

• To date, £5.5m in CIP cash out savings have been delivered, which have been reflected in the forecast. £1.3m 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.

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



Reporting Date	Performance	Op. plan #
Jan-24	3.0%	

Threshold	YTD Mean	Benchmark
	5.5%	5.5%

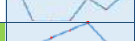
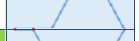
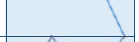
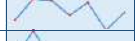
(Lower value represents better performance)

+	Variation Description
	Common cause

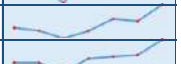
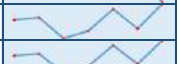
Assurance Description

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

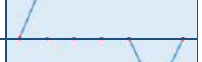
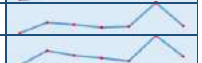
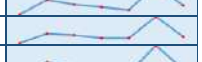
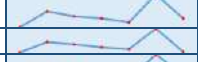
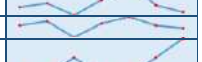
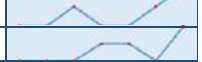
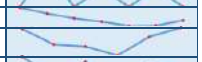
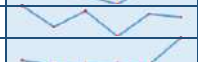
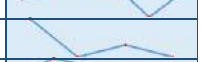
Performance Scorecard 1

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD 2023-24	YTD Performance
SAFE	SA001	Serious Incidents declared	<3 < 36 PA	0	2	2	1	1	3	4	1	5	5	0	3	2	27	
	SA002	Duty of Candour letter has been sent within 10 days of incident	80%	N/A	N/A	80.00%	75.00%	50.00%	75.00%	100.00%	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	100.00%	100.00%	50.00%	75.00%	100.00%	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%	97.85%	95.06%	90.41%	84.73%	89.60%	87.30%	88.89%	91.00%	94.50%	92.50%	93.00%	98.00%	92.00%		
	SA004	% Adult Patients (within general hospital) who had VTE prophylaxis prescribed if appropriate	95%	99.17%	97.00%	91.87%	95.87%	97.40%	100.00%	98.00%	96.00%	99.00%	99.00%	96.00%	99.00%	99.00%		
	SA005	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
	SA006	Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	<2	0.35	0.54	0.63	0.16	0.16	0.17	0.45	0.31	0.49	0.5	0.17	0.3	0.2		
	SA019	Pressure Ulcers - Total incidence - Grade 2 and above	<= 17 (204 PA)	11	13	15	13	19	24	29	16	11	17	2	14	7	167	
	SA007	Clostridium Difficile - Total number of acquired infections	< 30 PA	3	2	4	4	4	4	2	1	1	3	0	1	3	27	
	SA008	MRSA - Total number of acquired infections	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	
	SA009	E-Coli - Total number of acquired infections	< 72 PA	4	0	5	8	6	10	4	9	8	11	7	8	9	85	
	SA010	No. confirmed cases of Klebsiella spp	-	0	0	0	3	1	2	2	2	0	2	2	2	1	17	
	SA011	No. confirmed cases of Pseudomonas aeruginosa	-	0	0	0	0	0	1	1	1	0	0	2	0	0	5	
	SA012	Number of Medication Errors (with Harm)	< 25 PA	0	0	1	1	0	0	0	0	1	0	0	0	0	3	
	SA013	Harm Free Care Score (Safety Thermometer) - Adult	95%	98.5%	96.9%	96.8%	97.4%	98.0%	97.5%	96.8%	97.0%	97.7%	97.0%	95.5%	97.0%	98.0%		
	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%	89.0%	100.0%	100.0%	100.0%	100.0%		
	SA015	Harm Free Care Score (Safety Thermometer) - Children	95%	95.2%	99.0%	82.3%	99.8%	95.2%	96.2%	100.0%	99.0%	100.0%	100.0%	98.5%	99.0%	99.0%		
	SA016	Hand Hygiene Compliance	96%	97.0%	92.0%	98.0%	96.0%	99.0%	97.0%	97.0%	97.0%	99.0%	97.0%	98.0%	96.0%	98.0%		
	SA017	48-72 hr review of antibiotic prescription complete	98%	58.0%	81.0%	80.0%	70.0%	79.0%	70.0%	74.0%	88.0%	82.0%	88.0%	78.0%	90.0%	85.0%		
EFFECTIVE	EF067	Planned Care - DNA - Hospital	5%	N/A	N/A	N/A	N/A	N/A	8.7%	12.2%	10.2%	9.4%	11.0%	11.9%	12.2%	11.1%		
	EF001	Planned Care - DNA Rate (Consultant Led outpatient appointments)	5%	7.9%	12.0%	11.9%	11.1%	10.4%	11.9%	14.8%	11.5%	11.2%	13.3%	16.7%	15.2%	14.0%		
		Planned Care - DNA Rate (Nurse Led outpatient appointments)		4.8%	6.0%	7.4%	7.1%	4.8%	5.1%	8.2%	6.6%	5.4%	6.8%	5.8%	8.2%	7.7%		
		Planned Care - DNA Rate (AHP Led outpatient appointments)		9.4%	11.0%	11.3%	9.5%	10.1%	9.0%	11.4%	10.2%	10.0%	9.8%	10.4%	9.8%	8.6%		
	EF002	Planned Care - Total Number of Cancelled Operations		317	396	236	344	284	337	268	371	367	348	355	390	320	3620	
		Hospital cancelled		179	229	109	196	138	200	140	223	239	156	167	204	155	1927	
		Patient cancelled		138	167	127	148	146	137	128	148	128	192	188	186	165	1693	
	EF005	Length of Stay (LOS) - No. patients with LOS greater than 21 days	-	125	88	112	121	114	140	103	105	94	81	91	115	103	1179	
		Average Length of Stay (ALOS) - Nobles	-	5	6	5	5	5	5	5	5	5	5	5	5	4		
		Average Length of Stay (ALOS) - RDCH	-	50	41	38	130	38	31	36	40	44	34	35	35	43		
		Total Number of discharges	-	866	1008	907	960	906	985	1009	938	971	1033	949	960	989	4767	
	EF050	Total Number of Inpatient discharges-Nobles	-	826	976	882	924	866	946	968	904	928	995	902	920	946	4586	
	EF051	Total Number of inpatient discharges-RDCH	-	40	32	25	36	40	39	41	34	43	38	47	40	43	181	

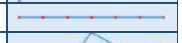
Performance Scorecard 2

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD 2023-24	YTD Performance
EFFECTIVE	EF003	Theatres - Number of Cancelled Operations on Day		39	48	36	40	28	51	27	33	46	31	24	44	35	395	
		Theatres - Number of Cancelled Operations on Day - Clinical		10	19	12	14	16	7	8	14	16	13	7	16	13	136	
		Theatres - Number of Cancelled Operations on Day - Non clinical - Patient		5	11	5	6	5	14	5	6	10	6	7	3	8	75	
		Theatres - Number of Cancelled Operations on Day - Non clinical - Hospital		24	18	19	20	7	30	14	13	20	12	10	25	14	184	
	EF004	Theatres - Theatre Utilisation %	85%	82.5%	75.8%	73.3%	76.2%	67.8%	79.7%	82.4%	80.6%	79.8%	76.2%	72.3%	76.1%	81.8%		
	EF006	Crude Mortality Rate		20.23	24.24	16.47	15.37	12.75	15.25	19.63	18.81	24.68	19	21.76	38.07	31.71		
	EF007	Total Hospital Deaths		23	27	18	18	13	20	21	22	30	27	20	41	39	269	
	EF024	Mortality - Hospitals LFD (Learning from Death reviews)	80.00%	92%	94%	93%	93%	98%	98%	98%	97%	97%	99%	99%	98%	98%		
	EF008	West Wellbeing Contribution to reduction in ED attendance	10% per 12 months	7.3%	25.3%	6.7%	5.8%	-6.4%	24.9%	14.2%	7.1%	6.6%	6.2%	6.3%	0.4%	-3.5%		
	EF009	West Wellbeing Reduction in admission to hospital from locality	5% per 12 months	-6.4%	89.2%	-10.9%	-1.8%	-25.3%	-25.6%	-1.8%	-14.3%	1.6%	66.7%	32.7%	28.3%	32.7%		
	EF011	MH - Average Length of Stay (LOS) in MH Acute Inpatient Service (Discharged)	-	72	26	30	33	83	21	51	20	8	39	24	31	7		
	EF013	MH - % service users discharged from MH inpatient to have follow up appointment	90%	94.0%	100.0%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.4%	88.0%		
	EF064	Number of patients with a length of stay - 0 days (Mental Health)	-	3	0	2	1	1	0	1	1	0	1	1	0	1	9	
	EF065	MH - Number of patients aged 18-64 with a length of stay - > 60 days	-	5	1	3	4	3	0	2	1	0	1	0	1	0	15	
	EF066	MH - Number of patients aged 65+ with a length of stay - > 90 days	-	0	0	2	0	1	1	3	0	0	1	2	2	0	12	
	EF047	% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	75%	100%	100%	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%	100%	100%	50%	100%	100%	50%	100%	-	-	-	100%	-	-		
	EF026	Crisis Team one hour response to referral from ED	75%	75%	91%	94%	94%	100%	96%	84%	90%	77%	90%	85%	91%	91%		
	EF015	ASC - % of Re-referrals	<15%	4.6%	1.3%	3.9%	3.8%	1.7%	4.5%	1.2%	0.0%	3.3%	4.1%	5.1%	6.1%	16%		
	EF063	ASC - No. of referrals		65	77	76	78	59	66	86	68	91	74	59	82	74	813	
	EF016	ASC - % of all Wellbeing Partnership Assessments completed in Agreed Timescales	80%	33%	27%	39%	39%	29%	42%	27%	23%	40%	30%	24%	28%	20%		
	EF017	ASC - % of individuals (or carers) receiving a copy of their Wellbeing Partnership Assessment	100%	0%	27%	22%	48%	100%	100%	100%	96%	100%	96%	95%	96%	100%		

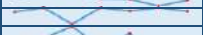
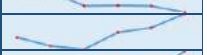
Performance Scorecard 3

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD 2023-24	YTD Performance
EFFECTIVE	EF019	CFSC - % Complex Needs Reviews held on time	85%	35.7%	75.0%	100.0%	75.0%	65.5%	54.6%	50.0%	48.0%	56.0%	43.5%	66.7%	34.0%	29.4%		
	EF021	CFSC - % Total Initial Child Protection Conferences held on time	90%	50.0%	100.0%	100.0%	100.0%	33.3%	80.0%	71.4%	80.0%	76.9%	100.0%	0.0%	80.0%	72.7%		
	EF022	CFSC - % Child Protection Reviews held on time	90%	85.7%	77.8%	88.9%	100.0%	100.0%	88.9%	95.8%	95.7%	80.0%	100.0%	100.0%	75.0%	88.9%		
	EF023	CFSC - % Looked After Children reviews held on time	90%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	90.5%	90.0%	88.0%	100.0%	100.0%	76.0%	92.9%		
	EF049	C&F -Number of referrals - Children & Families		N/A	N/A	116	172	144	133	121	168	141	199	188	230	95	1707	
	EF044	C&F -Children (of age) participating in, or contributing to, their Child Protection review	90%	N/A	N/A	0.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	67.0%		
	EF045	C&F -Children (of age) participating in, or contributing to, their Looked After Child review	90%	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	95.0%		
	EF046	C&F -Children (of age) participating in, or contributing to, their Complex Review	79%	N/A	N/A	36.0%	34.0%	42.0%	41.0%	100.0%	36.0%	35.0%	71.0%	21.0%	55.0%	63.0%		
	EF025	Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	95%	89%	96%	97%	96%	99%	99%	97%	92%	96%	95%	93%	95%	96%		
	EF010	% Dental contractors on target to meet UDA's	96%	75%	72%	3%	10%	17%	25%	35%	38%	46%	53%	55%				
	EF068	Pharmacy - Total Prescriptions (No. of fees)		N/A	N/A	131397	140744	139132	136305	137200	158757	137848	146299	131619			£1,259,301	
	EF069	Pharmacy - Chargable Prescriptions		N/A	N/A	16509	19236	18377	17909	17376	22055	18211	19690	18137			£167,500	
	EF070	Pharmacy - Total Exempt Item		N/A	N/A	129409	139125	137291	134446	134685	155968	135824	143793	129776			£1,240,317	
	EF071	Pharmacy - Chargeable Items		N/A	N/A	16410	19108	18266	17909	17224	21924	17940	19273	17758			£165,812	
	EF072	Pharmacy - Net cost		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	£1,287,033			£12,836,187	
	EF073	Pharmacy - Charges Collected		N/A	N/A	£63,586	£73,816	£70,832	£68,792	£66,370	£84,646	£69,092	£74,520	£68,322			£639,976	
	EF030	Caesarean Deliveries (not Robson Classified)		26%	21%	39%	43%	32%	46%	61%	41%	35%	43%	47%	39%	37%		
	EF031	Induction of Labour	< 30%	36%	34%	29%	36%	11%	33%	44%	30%	25%	40%	29%	47%	37%		
	EF032	3rd/4th Degree Tear Overall Rate	< 3.5%	0%	0%	0%	0%	1%	0%	0%	1%	2%	0%	2%	2%	0%		
	EF033	Obstetric Haemorrhage >1.5L	< 2.6%	0%	0%	0%	0%	0%	1%	1%	0%	2%	0%	2%	4%	0%		
	EF034	Unplanned Term Admissions To NNU		0%	0%	0%	0%	12%	4%	4%	13%	15%	5%	5%	10%	9%		
	EF035	Stillbirth Number / Rate		0	1	0	0	0	1	0	0	0	0	0	0	0	1	
	EF036	Unplanned Admission To ITU – Level 3 Care		0	0	0	2	0	1	0	1	0	0	0	1	0	5	
	EF037	% Smoking At Booking		9%	9%	15%	11%	8%	6%	4%	4%	7%	12%	16%	10%	16%		
	EF038	% Of Women Smoking At Time Of Delivery	< 18%	6%	11%	14%	6%	5%	0%	10%	14%	3%	12%	6%	8%	2%		
	EF039	First Feed Breast Milk (Initiation Rate)	> 80%	83%	70%	76%	63%	73%	56%	71%	69%	76%	71%	67%	63%	58%		
	EF040	Breast Feeding Rate At Transfer Home		36%	34%	37%	29%	31%	32%	30%	72%	69%	76%	73%	78%	77%		
	EF041	Neonatal Mortality rate/1000		0	0	0	0	0	0	0	0	0	0	0	1	0	1	
	EF059	W&C - Paediatrics- Total Admissions		N/A	N/A	N/A	N/A	119	131	117	133	162	197	164	169	179	1371	
	EF060	W&C - NNU - Total number of Admissions		N/A	N/A	6	7	8	8	3	7	11	5	5	5	5	70	
	EF061	W&C - NNU - Avg. Length of Stay		N/A	N/A	N/A	N/A	8.5	3.4	5.0	3.4	6.5	21.2	12.5	4.4	7.8		
	EF062	W&C - Community follow up		N/A	N/A	4	8	6	2	1	3	0	9	8	8	3	52	

Performance Scorecard 4

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-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	
	CA002	Complaints - Total number of complaints received	-	27	30	28	24	27	24	22	26	29	27	28	24	30	289	
	CA012	FFT - How was your experience? No. of responses	-	620	739	571	718	2096	1161	1311	1187	1682	1650	943	1403	1503	14225	
	CA013	FFT - Experience was Very Good or Good	80%	87.0%	87.0%	92.0%	87.0%	85.0%	87.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%		
	CA014	FFT - Experience was neither Good or Poor	10%	10.0%	5.0%	2.0%	4.0%	6.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.0%		
	CA015	FFT - Experience was Poor or Very Poor	<10%	4.0%	8.0%	6.0%	8.0%	9.0%	9.0%	6.0%	5.0%	5.0%	5.0%	5.0%	6.0%	5.0%		
	CA016	Manx Care Advice and Liaison Service contacts	-	770	839	589	636	517	649	621	655	704	958	620	880	689	7518	
	CA017	Manx Care Advice and Liaison Service same day response	80%	90.0%	88.0%	89.0%	87.0%	91.0%	90.0%	91.0%	90.0%	89.0%	90.0%	91.0%	90.0%	93.0%		
	CA007	Complaint acknowledged within 5 working days	98%	100.0%	100.0%	100.0%	86.0%	100.0%	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%	85.7%	100.0%	98.3%	100.0%	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	
	CA011	No. complaints referred to HSCOB	-	0	0	0	0	0	7	4	1	4	2	4	2	1	25	
RESPONSIVE	RE058	Cons Led- OP Referrals		3056	3502	2867	2887	3075	2846	2986	2812	3041	2857	2200	2864	2585	31020	
	RE059	Nurse Led- OP Referrals		559	717	729	594	850	889	741	824	794	1056	640	1002	923	9042	
	RE060	AHP- OP Referrals		508	840	684	736	906	846	770	853	866	962	640	966	863	9092	
		RTT - Number of patients waiting for first hospital appointment		21025	20618	20406	20189	20480	20191	20367	21180	21042	21335	20810	20452	20512		
	RE001	No. patients waiting for first Consultant outpatient	< 15465	15119	15380	15465	15500	15718	15703	15846	16562	16744	16973	16861	16610	16620		
		No. waiting Over 52 weeks - to start consultant-led treatment	0	5006	4792	4890	4927	5016	5247	5089	5289	5432	5602	5487	5361	5406		
		Average Wait (weeks) - Ref to OP		51	49	47	47	47	49	48	48	48	49	47	48	48		
		Max wait (weeks) - Ref to OP		790	794	799	846	836	817	816	840	844	1017	1021	1025	1030		
	RE0011	No. patients waiting for Nurse outpatient		2218	1927	1519	1385	1540	1512	1449	1643	1623	1802	1657	1663	1744		
	RE00111	No. patients waiting for AHP		3688	3311	3422	3304	3222	2976	3072	2975	2675	2560	2292	2179	2148		
	RE002	Number of patients waiting for Daycase procedure	< 2311	2697	2622	2311	2264	2372	2334	2229	2291	2303	2254	2126	2016	1854		
		Average Wait (weeks) - Daycase		42	40	41	42	43	43	45	43	44	45	45	49	46		
		Max wait (weeks) - Daycase		295	299	304	308	312	316	320	293	297	301	301	305	310		
		No. waiting Over 52 weeks - Inpatient (Daycase only)		787	717	624	609	635	617	602	607	601	604	580	573	496		
	RE003	Number of patients waiting for Inpatient procedure	< 554	592	570	554	553	551	534	505	530	497	464	432	447	445		
		Average Wait (weeks) - Inpatient		38	40	39	40	41	40	38	38	35	33	33	34	31		
		Max wait (weeks) - Inpatient		312	316	321	325	329	333	337	342	235	212	217	221	215		
		No. waiting Over 52 weeks - Inpatient (IP pathway only)		155	142	143	144	149	134	124	129	106	95	78	79	73		
	RE004	% Urgent GP referrals seen for first appointment within 6 weeks	85%	48.4%	55.7%	60.8%	55.0%	57.0%	60.0%	57.4%	42.4%	55.4%	48.6%	52.5%	46.4%	52.9%		
	RE005	Diagnostics - % requests completed within 6 weeks		86.2%	87.3%	84.7%	81.4%	86.7%	86.2%	86.6%	85.4%	85.4%	85.3%	88.4%	85.6%	88.2%		
	RE006	Diagnostics - % Current wait > 6 weeks		70%	70%	73%	71%	70%	71%	74%	71%	68%	61%	64%	59%	59%		
		Diagnostics - Total Waiting List Size (exc. Scheduled & On Hold)		8089	8481	8256	7719	7545	7291	3541	4544	3846	3622	3955	3883	3871		
		Diagnostics - % Current wait <= 6 weeks	99%	30%	30%	27%	29%	30%	29%	26%	29%	32%	39%	36%	41%	41%		
	RE061	Diagnostics-% patients waiting 26 weeks or less	99%	N/A	N/A	N/A	59%	61%	63%	59%	59%	58%	67%	67%	69%	71%		

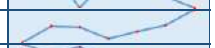
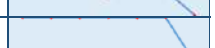
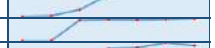
Performance Scorecard 5

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-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%	70.1%	71.0%	70.8%	73.9%	75.7%	71.5%	72.1%	68.7%	71.0%	69.5%	68.0%	66.3%	67.3%		
		A&E - 4 Hour Performance - Nobles		58.5%	59.6%	61.7%	64.5%	66.5%	61.1%	60.8%	57.9%	60.6%	58.7%	57.2%	55.2%	56.3%		
		A&E - 4 Hour Performance - RDCH		99.6%	99.8%	99.9%	100.0%	99.6%	100.0%	99.9%	100.0%	99.9%	100.1%	99.7%	99.7%	100.0%		
	RE008	A&E - 4 Hour Performance (Non Admitted)	95%	79.6%	80.8%	79.6%	82.1%	84.0%	80.6%	82.9%	78.8%	80.4%	79.3%	79.1%	76.6%	77.8%		
	RE009	A&E - 4 Hour Performance (Admitted)	95%	21.4%	22.5%	25.3%	29.0%	29.4%	23.2%	16.8%	16.9%	22.8%	22.6%	20.0%	18.0%	19.6%		
		A&E - Admission Rate		16.1%	16.8%	16.1%	15.2%	15.3%	15.7%	16.3%	16.3%	16.4%	17.4%	18.8%	17.6%	17.9%		
	RE0072	A&E - Admission Rate - Nobles		22.6%	23.5%	21.3%	20.8%	21.2%	21.5%	22.9%	21.9%	22.3%	23.5%	25.1%	23.4%	24.0%		
		A&E - Admission Rate - RDCH		0.3%	0.2%	0.2%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%		
	RE010	A&E - Average Total Time in Emergency Department	360 mins	269	254	246	227	220	257	267	298	268	275	279	292	296		
	RE011	A&E - Average number of minutes between Arrival and Triage (Noble's)	15 mins	27	26	25	24	21	26	22	29	28	35	26	30	25		
	RE012	Average number of minutes between arrival to clinical assessment-Nobles	60 mins	72	62	69	63	56	74	63	67	72	80	71	75	83		
	RE033	ED - Average number of minutes between arrival to clinical assessment-Ramsey	60 mins	38	22	14	12	19	13	14	12	12	16	23	16	22		
	RE013	A&E - Patients Waiting Over 12 Hours From Decision to Admit to Admission to a Ward (12 Hour Trolley Waits)	0	27	13	6	5	12	36	48	67	48	30	41	51	34	378	
	RE0131	Number of patients exceeding 12 hours in Nobles Emergency Department	0	93	56	45	22	47	104	115	191	127	114	132	151	174	1222	
	RE080	ED- Emergency Care Time (Average Number of minutes between arrival and referral to speciality OR discharge)	180 min	176	177	177	175	161	178	168	182	179	181	177	183	186		
	RE014	Ambulance - Category 1 Response Time at 90th Percentile	15 mins	15	28	20	17	19	23	19	17	20	18	19	15	14		
	RE0141	Total Number of Emergency Calls		1025	1109	1059	1035	1105	1131	1130	1134	1118	1099	1201	1167	1058	12237	
	RE0142	Number of Category 1 Calls		32	33	25	46	43	41	38	46	24	28	31	37	26	385	
	RE015	Ambulance - Category 1 Mean Response Time	7 mins	8	12	11	8	9	11	9	9	11	8	9	8	9		
	RE016	Ambulance - % patients with CVA/Stroke symptoms arriving at hospital within 60 mins of call	100%	15.4%	36.4%	47.1%	50.0%	63.6%	32.0%	56.3%	58.3%	46.2%	40.0%	52.4%	50.0%	55.6%		
		Category 2 Mean Response Time	18 mins	12	16	14	16	13	13	11	16	12	13	15	12	11		
	RE034	Category 2 Response Time at 90th Percentile	40 mins	26	36	31	38	29	27	25	33	24	26	33	25	23		
		Category 3 Mean Response Time	Monitor	16	22	20	20	19	24	17	20	22	24	22	19	17		
	RE035	Category 3 Response Time at 90th Percentile	120 mins	32	57	42	51	39	53	37	47	48	61	53	44	38		
		Category 4 Mean Response Time	Monitor	19	25	30	35	20	37	26	44	33	36	32	37	29		
	RE036	Category 4 Response Time at 90th Percentile	180 mins	41	54	76	82	63	74	56	121	84	78	64	97	69		
		Category 5 Mean Response Time	Monitor	31	42	40	36	31	35	32	35	33	30	46	34	30		
		Category 5 Response Time at 90th Percentile	180 mins	80	98	91	89	72	83	72	81	72	71	95	87	61		
		Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	0	169	142	154	161	181	166	189	240	191	198	252	238	228	2198	
		Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	0	13	8	13	10	17	12	28	31	24	22	43	35	33	268	
	RE043	OPEL level 4 (Days)		3	0	0	0	0	1	3	5	2	2	2	2	2	17	
	RE082	Meds Demand - N.patient interactions		N/A	N/A	3111	2872	2295	2664	2281	2211	2326	2574	3335	2464	2539	28672	
	RE083	Meds Overnight Demand		N/A	N/A	354	317	224	275	197	195	230	552	337	111	110	2902	
	RE084	Meds - Face to face appointments		N/A	N/A	609	474	360	574	471	398	419	571	708	567	607	5758	
	RE086	Meds - TUNA%		N/A	N/A	1.2%	1.1%	0.6%	1.1%	2.8%	1.9%	1.8%	1,27%	0.8%	1.4%	1.9%		
	RE088	Meds- DNA%		N/A	N/A	1.2%	1.5%	3.3%	0.6%	2.3%	1.9%	2.6%	1.7%	1.8%	1.2%	0.9%		

Performance Scorecard 6

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD 2023-24	YTD Performance
RESPONSIVE	RE0171	Referrals received for all suspected cancers		418	416	368	455	445	375	455	422	487	423	311	405	379	4525	
	RE018	CWT - % patients decision to treat to first definitive treatment within 31 days	96%	78.6%	87.3%	76.0%	73.5%	82.4%	80.0%	83.8%	73.8%	71.2%	86.4%	79.4%	82.5%	73.3%		
	RE019	CWT - Maximum 62 days from referral for suspected cancer to first treatment	85%	34.3%	62.2%	21.1%	50.0%	54.0%	35.7%	63.6%	46.4%	51.9%	50.0%	57.1%	47.8%	37.8%		
	RE025	CWT - Maximum 28 days from referral for suspected cancer (via 2WW or Cancer Screening) to date of diagnosis	75%	66.2%	60.3%	67.4%	63.7%	58.0%	57.3%	68.4%	65.3%	75.3%	64.6%	66.0%	69.2%	72.0%		
	RE057	All Referrals received for all suspected cancers		489	502	434	537	514	460	558	502	599	501	364	472	443	5384	
	RE026	IPCC - % patients seen by Community Adult Therapy Services within timescales	80%	53.7%	54.8%	60.9%	42.1%	56.0%	44.0%	44.6%	38.5%	62.1%	68.2%	71.2%	77.1%	71.2%		
		% Urgent 1 - seen within 3 working days	80%	86.7%	74.2%	69.8%	50.0%	71.5%	65.6%	54.1%	42.4%	50.0%	100.0%	NaN	100.0%	NaN		
		% Urgent 2 - seen within 5 working days	80%	68.4%	61.8%	73.7%	54.0%	67.7%	39.3%	50.0%	52.2%	69.8%	82.1%	89.2%	81.7%	69.7%		
		% Soon 1 - seen within 15 working days	80%	26.7%	34.9%	38.7%	21.7%	23.9%	32.6%	39.6%	16.4%	0.0%	0.0%	0.0%	0.0%	75.0%		
		% Soon 2 - seen within 30 working days	80%	9.1%	38.5%	70.0%	0.0%	100.0%	0.0%	0.0%	51.9%	69.5%	70.5%	70.1%	75.6%	70.4%		
		% Routine - seen within 12 weeks	80%	62.5%	40.0%	70.0%	87.5%	79.0%	50.0%	34.8%	42.9%	66.7%	56.0%	42.9%	73.2%	82.4%		

Performance Scorecard 7

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD 2023-24	YTD Performance
RESPOSIVE		IPCC - No. patients waiting for a dentist		2983	2638	3509	3666	3872	3993	4042	4268	4415	4528	4648	4878	5092		
	RE0271	IPCC - Longest time waiting for a dentist (weeks)		164	167	168	177	181	185	189	193	200	203	207	211			
		IPCC - Number patients seen by dentist within the year		54924	53892	53697	53829	53089	53628	53778	54084	54025	53151	41895	57005	0		
	RE031	The % of patients registered with a GP (PERMANENT REGISTRATION)		4.2%	4.2%	4.2%	4.2%	4.2%	4.0%	4.0%	4.1%	4.0%	4.0%	4.0%	4.0%			
		Average of Days to next GP appt - Ballasalla		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		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		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		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		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		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		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		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	1.3	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0				
		Average of Days to next GP appt - Snaefell		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		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		29280	31998	24715	29084	28790	25807	27687	29379	33554	32174	24384			255574	
	RE054	Did Not Attend Rate (GP Appointment)	-	3%	3%	3%	3%	3%	2%	3%	3%	2%	3%	3%				
	RE074	Response by Community Nursing to Urgent / Non routine		N/A	N/A	100%	100%	100%	100%	100%	100%	94%	96%	100%	100%	100%		
	RE075	Community Nursing Service response target met - Routine		N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	RE028	MH - No. service users on Current Caseload	4500 - 5500	4995	5030	5090	5093	5129	5211	5226	5285	5325	5359	5305	5315	5302	57640	
	RE044	MH- Waiting list		N/A	N/A	N/A	N/A	1572	1637	1598	1654	1701	1750	1752	1702	1723		
	RE071	Average caseload per social worker-Adult Generic Team	16 to 18	N/A	N/A	N/A	N/A	13.3	19.0	19.3	21.7	20.3	21.6	20.4	25.9	17.1		
	RE078	Average caseload per social worker-Adult Learning Disabilities	17 to 18	N/A	N/A	N/A	N/A	18.7	20.3	21.1	23.4	27.1	28.1	23.4	20.0	17.6		
	RE079	Average caseload per social worker-Older Persons Community Team	18 to 18	N/A	N/A	N/A	N/A	10.8	11.7	11.3	14.7	17.2	19.8	19.8	14.4	17.2		

Performance Scorecard 8

	KPI ID	Indicator	OP. Plan Threshold	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD 2023-24	YTD Performance
RESPONSIVE	RE030	W&C - % New Birth Visits within timescale		86.7%	90.6%	96.0%	85.7%	86.0%	83.0%	89.4%	84.3%	90.4%	96.2%	91.7%	87.5%	94.4%		
	RE032	Births per annum		535	588	54	103	144	191	237	293	348	391	451	501	545		
	RE051	Maternity Bookings		61	57	48	73	48	48	55	51	56	60	50	67	61	617	
	RE052	Ward Attenders		126	196	196	159	146	270	244	44	309	230	275	221	196	2290	
	RE053	Gestation At Booking <10 Weeks		39.3%	26.3%	39.6%	21.9%	20.8%	29.2%	30.9%	39.2%	33.9%	45.0%	48.0%	46.3%	65.6%		
	RE056	Adult General and Acute (G&A) bed occupancy	<=92%	N/A	N/A	N/A	N/A	N/A	60.1%	64.2%	61.6%	63.2%	68.3%	64.8%	65.4%	61.9%		
	RE069	ASC - % of all Residential Beds Occupied	85% - 100%	68%	84%	83%	83%	71%	69%	68%	52%	59%	48%	70%	59%	0%		
	RE070	Respite bed occupancy	>= 90%	81%	79%	92%	80%	69%	70%	81%	65%	58%	73%	88%	48%	0%		
		Total number of Service Users		204	262	250	250	212	134	134	162	181	153	220	176	0		
	RE068	ASC-% of Service users with a PCP in Place	95.00%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%		
WELL LED (PEOPLE)	WP001	% Hours lost to staff sickness absence	4.0%	6.4%	7.6%	5.9%	5.2%	5.5%	6.0%	6.6%	6.0%	7.0%	6.4%	6.1%	7.0%	6.2%		
	WP002	Number of staff on long term sickness		0	83	65	82	69	91	94	82	63	116	88	82	68		
	WP004	Number of staff leavers		17	19	22	22	24	22	34	34	19	21	22	16	18	254	
	WP005	Number of staff on disciplinary measures		6	5	5	7	8	9	11	10	6	11	11	10	6	94	
	WP006	Number of suspended staff		1	1	1	1	1	1	4	4	4	5	4	4	3	32	
	WP007	Number of Data Breaches	0	13	22	8	13	13	11	11	12	14	8	13	14	14	131	
		Reported to ICO		13	21	8	13	13	13	11	11	4	4	1	2	0	80	
	WP011	Number of Enforcement Notices from the ICO	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	1	4	32	39	76	27	39	33	29	29	33	41	47	425	
	WP013	Staff 12 months turnover rate	10%	11.4%	11.3%	11.0%	10.9%	10.4%	10.0%	9.4%	9.7%	9.4%	9.8%	10.1%	10.2%	10.0%		
	WP015	Number of DSAR, AHR and FOI's overdue at month end		5	14	44	55	33	41	41	24	31	40	30	32	27	398	
		Number of DSAR, AHR and FOI's Breaches		6	18	76	94	109	68	80	57	60	69	63	73	74	823	
WELL LED (FINANCE)	WF001	% Progress towards Cost Improvement Target (CIP)	1.5%	170.0%	170.0%	N/A	N/A	22.2%	26.7%	33.3%	76.0%	86.7%	91.1%	109.0%	122.2%			
	WF002	Total income (£)		-£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	-£1,290,649.95		-£13,102,898	
	WF003	Total staff costs (£)		£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	£21,371,001.58		£181,103,104	
	WF004	Total other costs (£)		£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	£12,928,918.18		£129,301,665	
	WF005	Agency staff costs (proportion %)		8.2%	6.9%	7.8%	7.4%	6.2%	6.2%	4.7%	4.8%	5.8%	4.3%	5.1%	3.0%			
	WF007	Actual performance (£ 000)		£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	£31,534.0			
	WF008	budget (£ 000)		£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	£25,948.0			
	WF009	Actual performance against Budget (£ 000)		-£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	-£5,586.0			