Integrated Performance Report

Apr-24

Version: Final v2.0

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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 2024/25.The Performance & Business Intelligence Team 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 in April-24 include:

- **Re-structure of layout to align with Care Groups and other reporting areas**
- **Addition of Tertiary data**
- **Inclusion of Mandate objective summaries**

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

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

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

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

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

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

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

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

• 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

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

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

Therefore, the benchmarks included in this month's report should be treated as indicative only until such time as the alignment of the methodologies used has been reconciled and confirmed.
Work to identify appropriate peer organisations and metrics to benchmark Manx Care's performance against is ongoing, and currently many of the benchmark figures within this report use Manx Care's 2023/24 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.

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	

Executive Summary

	Going Well	Cause for Concern
Care Quality & Safety	• 0 cases of C.Diff reported, the annual threshold is <30. • Zero Medication Error with Harm across Manx Care in April, there was one was listed with moderate harm; however, this involved a private pharmacy. • Numbers of Falls that resulted in Harm remained low and within the expected threshold. • Positive achievement against Safety Thermometer for Adults, Maternity and Children. • Performance of VTE prophylaxis and VTE risk assessment within 12 hours exceeded the thresholds. • There were no cases of MRSA but one case of Pseudomonas aeruginosa in March. • 100% of letters were sent in accordance with Duty of Candour Regulations. • There were 0 Never Events in April.	• There have been ten cases of E.coli bacteraemia this month all of which were community associated. Potential sources of infection include urinary tract infections and biliary disease. No patients had a long-term catheter in situ. Case numbers are in line with UK trends. • 48-72 hr senior medical review of antibiotic prescription remains below the 98% threshold at 89% in April from 83% in March.
Patient Experience	• Manx Care has consistently met gender appropriate accommodation standards. • MCALS is responding to a high proportion of queries within the same day (89%) • Service user satisfaction remains high with 88% 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 April was 100%.	• There were 52 complaints overall for April which is an increase of 20 from March.
People & Governance	High levels of contact from staff across Manx Care to provide advice and guidance on a wide range of subjects. The level of engagement is very encouraging, demonstrating the continuing commitment of staff across Manx Care to handling data correctly and to 'do the right thing in the right way.' Staff turnover rate remains within target.	In April the number of FOI requests received was the highest in a single month for the past year. The number of Subject Access Requests was the second highest month in the last year.
Primary & Community	• The response by Community Nursing to Urgent / Non routine within 24h and Routine (7 days) was 100% in April. • GP Practice DNA Rate was 3.5%, within the threshold of 5%	Number of patients awaiting allocation to a dental practice remains above 5000, though decreased by 121 in April.
Hospital Care	Number of patients waiting for Inpatient procedure continues to decrease	• Access to surgical bed base continues to challenge theatre efficiency and utilisation. • Consultant anaesthetic staffing and theatre staffing position remains a challenge.
Diagnostics & Cancer	• Cancer 28 Day performance in April was slightly below the 75% threshold at 73%.	
Women, Children & Families	Majority of indicator remains within thresholds with Smoking at booking and delivery continuing to decrease.	• Induction of labour was slightly above the national standard (30%) at 38%.
Emergency Care	•New metric 'Emergency readmissions within 30 days of discharge from hospital ' now reported. •Phase 1 of AATU started in April 2024, with new metrics now reported. •Ambulance Category 2-5 at 90th percentile responses within targets. • The 6 hour Average Total Time in Emergency Department standard continues to be achieved. • The service was on the highest Operational Pressures Escalation Level (OPEL), Level 4, for 0 days in April.	• Patients spending more than 12 hours in ED remains high (150), and 40 12-Hour Trolley Waits. • The ED Performance against the 4 hour standard slightly decreased to 67.9% in April but remained below the required target. • Emergency care demand remains high (6.9% increase comparing to same period last 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 14 breaches of the 60 minute ambulance turnaround time, though this was an improvement compared to 23 in March. • Ambulance - Category 1 Response Time at 90th Percentile increased to 18:45 mins in April 2024.
Tertiary Providers	New area of reporting. Work ongoing to develop.	
Mental Health	• Caseloads remain within target range. • Thresholds achievement for performance metrics.	
Social Care	• 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 April.	• Complex Needs Reviews held on time was 47% in April below the threshold of 85%.
Finance	• Progress towards Cost Improvement Target (CIP) was 156% in March.	• The full year operational result was an overspend of (£31.1m) with further spend of (£6.3m) being covered by the DHSC reserve. Additional costs of £4.2m (not shown in the table above) were covered by fund claims. • FY employee costs are (£10.7m) over budget.

Mandate Objectives: Corporate Overview

Objective No.	Objective	Status	Progress / Risks	Lead
1 a	Cost of care			
1b	Urgent care provision		Project plans updated through the Transformation Oversight Group. 'See, Treat and Leave', 'Intermediate Care', and 'Ambulatory Assessment and Treatment Unit (AATU)' have started.	MC
1c	Primary Care at Scale (PCAS)			AC
2a	Multi-agency strategies			TH
2b	Foster carers			
2c	Oral health in children actions			AC, MP
2 d	Health visiting and school nursing			
2 e	Equitable access to services			
3 a	Financial envelope		Management accounts regulalry provided to DHSC.	JL
3 b	Understanding demand		Data regularly reported in IPR for requested metrics.	AH
3 c	Life changing diagnosis			
3 d	NICE Technology Appraisals			MB
4 a	Home first			
4 b	Planning for an ageing population		On-going monthly meetings with Public Health. Intermediate Care started in late March 2024.	
4 c	COVID review		Manx Care has accepted the recommendations of the covid review and progress into implementation of the recommendations, in conjunction with Cabinet Office, underway. A number of recommendations will require financial support and we will work with the Cabinet Office to secure funding to enable us to implement the recommendations.	
5 a	Contracts		The Team continue to work on implementation of the Contract Management Framework.	LR
5 b	Data Security and Information Governance			JM
5 c	Estates review			AP
5d	Manx Care Record		Project details updated through the Transformation Oversight Group.	SC
5 e	Workforce - support and grow		Data regulalry reported in IPR on requested metrics: vacancy rates, staff turnover and % spend on agency staff.	MH
5 f	Quality assurance			

Care Quality & Safety

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC01	Mandate	Exposure to Serious Incidents	Safe	Apr-24		4	4	4	< 36 PA		
QC07	Operational Plan	Duty of Candour Letter sent within 10 days of the application	Safe	Apr-24		100%	100%	-	80%		
	Operational Plan	Compliance with the Duty of Candour Regulations	Safe	Apr-24		100%	100%	-	100%		
QC08	Operational Plan	% Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe	Apr-24		95%	95%	-	95%		
QC09	Operational Plan	% Adult Patients (within general hospital) with VTE prophylaxis prescribed	Safe	Apr-24		96%	96%	-	95%		
QC02	Mandate	Number of Never Events	Safe	Apr-24		0	0	0	0		
QC03	Mandate	Number of Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	Safe	Apr-24		1	0.5	-	< 2		
SA03	Supporting	Total number of Inpatient Falls per 1,000 bed days	Safe	Apr-24		8.9	8.9	-	-		
QC10	Operational Plan	Clostridium Difficile - Total number of acquired infections	Safe	Apr-24		0	0	0	< 30 PA		
QC06	Mandate	MRSA - Total number of acquired infections	Safe	Apr-24		0	0	0	0		
QC11	Operational Plan	E-Coli - Total number of acquired infections	Safe	Apr-24		10	10	10	< 72 PA		

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC12	Operational Plan	No. confirmed cases of Klebsiella spp	Safe	Apr-24		5	5	5	< 20 PA		
QC13	Operational Plan	No. confirmed cases of Pseudomonas aeruginosa	Safe	Apr-24		0	0	0	< 6 PA		
QC04	Mandate	Exposure to medication incidents resulting in harm	Safe	Apr-24		0	0	0	< 25 PA		
QC14	Operational Plan	Harm Free Care Score (Safety Thermometer) - Adult	Safe	Apr-24		98%	98%	-	95%		
QC15	Operational Plan	Harm Free Care Score (Safety Thermometer) - Maternity	Safe	Apr-24		100%	100%	-	95%		
QC16	Operational Plan	Harm Free Care Score (Safety Thermometer) - Children	Safe	Apr-24		100%	100%	-	95%		
QC17	Operational Plan	Hand Hygiene Compliance	Safe	Apr-24		98%	98%	-	96%		
QC18	Operational Plan	48-72 hr review of antibiotic prescription complete	Safe	Apr-24		89%	89%	-	>= 98%		
QC05	Operational Plan	Pressure Ulcers - Total incidence - Grade 2 and above	Safe	Apr-24		9	9	9	< 204 PA		
QC21	Operational Plan	Mortality - Hospitals LFD (Learning from Death reviews)	Effective	Apr-24		98%	98%	-	80%		
QC19	Operational Plan	Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	Effective	Apr-24		96%	96%	-	95%		
QC20	Operational Plan	Mixed Sex Accommodation - No. of Breaches	Effective	Apr-24		0	0	0	0		

GOING WELL

There were 0 Never Events in April.

- 0 cases of C.Diff reported, the annual threshold is <30.
- Zero Medication Error with Harm across Manx Care in April, there was one was listed with moderate harm; however, this involved a private pharmacy.

100% of letters were sent in accordance with Duty of Candour Regulations.

CAUSE FOR CONCERN

QC 01 Serious Incidents (SIs): All serious incidents undergo a rigorous process of validation, assurance, and acceptance. A breakdown of the cases is as follows:
1. This case was a very complex clinical presentation involving a rare abdominal pathology.
2. A case involving a delayed diagnosis of ophthalmic cancer.
3. A case involving venous thromboembolism thromboprophylaxis.
4. A fall resulting in significant trauma.

All cases are under investigation. Staff are being supported with a focus on vital sign measurement, recording assessments of risk in ophthalmic outpatients, and referrals to specialist pathways. Additionally, efforts are centered on guidelines for anticoagulation in obesity, examining environmental changes to minimise fall risk, implementing anti-slip friction flooring, and medicines optimisation. The rigorous investigation of serious incidents is vital in reducing patient harm and ensuring continual improvement in healthcare delivery. By thoroughly examining each incident, we can identify underlying issues, implement corrective actions, and enhance overall patient safety. This process fosters a culture of learning and accountability, ultimately leading to better health outcomes.

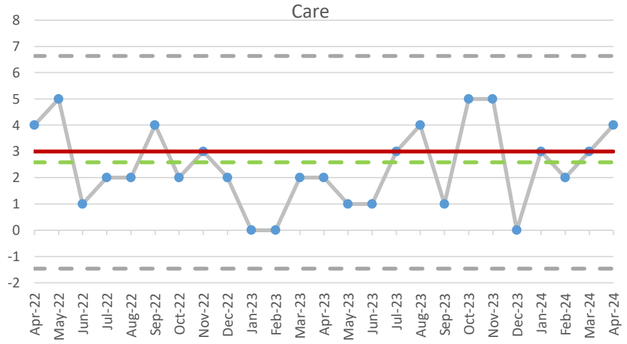
QC11 E. coli Bacteraemia: Effectively addressing E. coli bacteraemia is paramount. Recent cases have been community-associated, stemming primarily from urinary tract infections and biliary disease, with no links to catheter use. Notably, the Isle of Man reports significantly fewer cases compared to the UKHSA average of 26 cases in March. Ongoing efforts include rigorous monitoring and reinforcement of infection control protocols. Comprehensive tracking and targeted interventions are in place to mitigate risks. The lower incidence rate on the Isle of Man underscores the effectiveness of our proactive healthcare practices, offering reassurance to patients and stakeholders alike.

Mandate Objectives: Care Quality & Safety

Objective No.	Objective	Status	Progress / Risks	Lead
5 f	During 2024-25, Manx Care will support the Quality, Safety and Engagement Team of the Department in agreeing the processes and mechanisms by which matters of a clinical, safety and patient engagement nature are shared, assessed and monitored. Quality Assurance Framework is operational before the end of the Service Year with a date for review scheduled.			

Care Quality & Safety	Serious Incidents	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Serious Incidents - Exposure to Serious Incidents : Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	4	QC01

Threshold	YTD Mean	Benchmark
< 36 PA	4	3

(Lower value represents better performance)

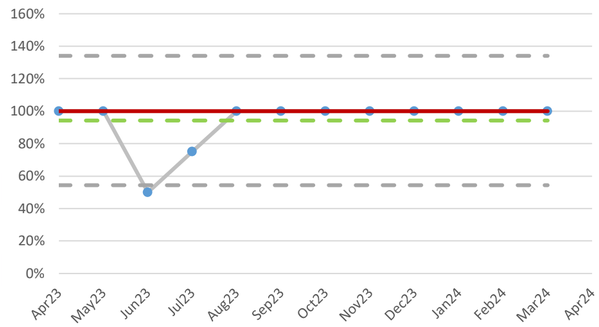
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

Compliance with the Duty of Candour Regulations



Reporting Date	Performance	Op. plan #
Apr-24	100.0%	QC07

Threshold	YTD Mean	Benchmark
100.0%	100.0%	93.8%

(Higher value represents better performance)

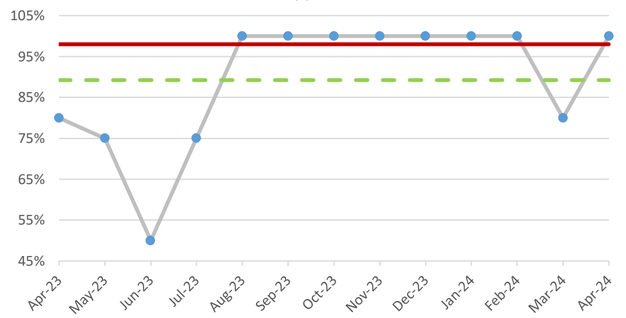
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Duty of Candour Letter sent within 10 days of the application



Reporting Date	Performance	Op. plan #
Apr-24	100.0%	QC07

Threshold	YTD Mean	Benchmark
80%	100.0%	88.33%

(Higher value represents better performance)

+ Variation Description

Common cause

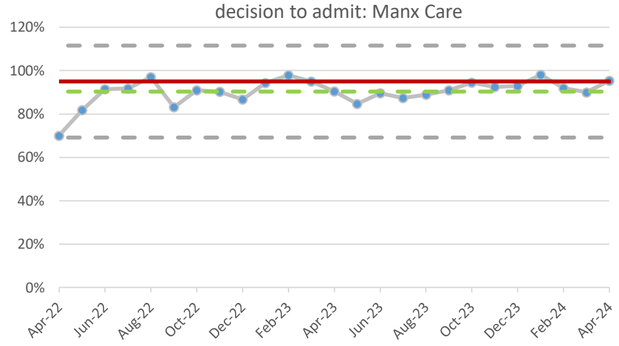
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Serious Incidents: 4 serious incidents declared in April.	**Serious Incidents:** Continue to monitor via SIRG.	**Serious Incidents:** Reasonable assurance yearly target <36 will be met.
Letter has been sent in accordance with Duty of Candour Regulations: 100% compliance.	**Letter has been sent in accordance with Duty of Candour Regulations:** Continue to monitor.	**Letter has been sent in accordance with Duty of Candour Regulations:** Confident of continued compliance. Note - Benchmarks are the Manx Care monthly averages for 2023/24

Care Quality & Safety	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 #
Apr-24	95.4%	QC08

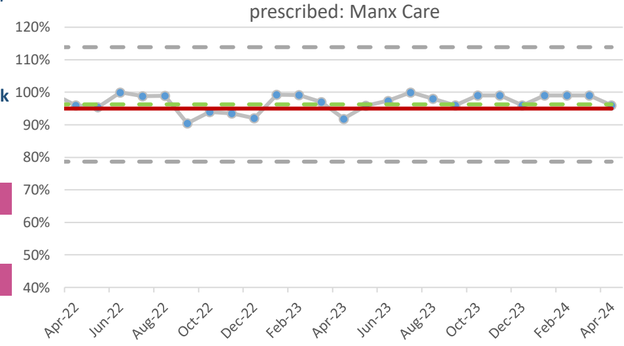
Threshold	YTD Mean	Benchmark
95.0%	95.4%	91.0%

(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 #
Apr-24	96.0%	QC09

Threshold	YTD Mean	Benchmark
95.0%	96.0%	97.5%

(Higher value represents better performance)

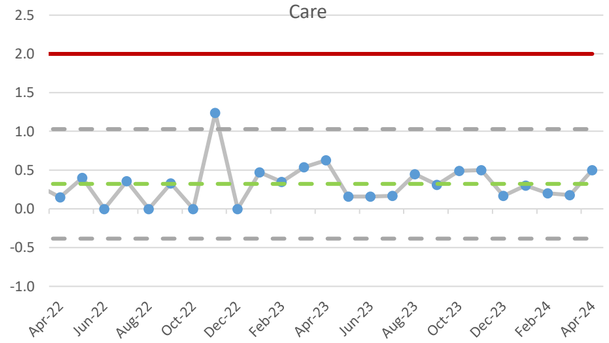
+	Variation Description
	Common cause

+	Assurance Description
	Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
VTE risk assessment within 12 hours: 98.4% for April which is only the second time in 13 months that this target has been achieved. **VTE Prophylaxis:** 98% - remains above target.	**VTE risk assessment within 12 hours:** Poor compliance highlighted to QSE. CDs tasked with exploring actions to make improvements. CQS to feedback weekly via governance meetings and to ward staff when performance is below target. **VTE Prophylaxis:** Continue to maintain compliance.	**VTE risk assessment within 12 hours:** Low level of confidence that performance will improve unless CDs take robust action that will affect a change. **VTE Prophylaxis:** High level of confidence. Performance is positive and remains consistent. Note - Benchmarks are the Manx Care monthly averages for 2023/24

Care Quality & Safety	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 #
Apr-24	0.5	QC03

Threshold	YTD Mean	Benchmark
< 2	0.5	0.3

(Lower value represents better performance)

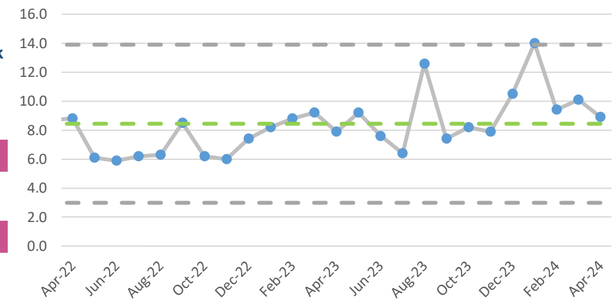
-	Variation Description

Common cause

+	Assurance Description

Consistently hit target

Total number of Inpatient Falls per 1,000 bed days : Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	9	

Threshold	YTD Mean	Benchmark
-	9	9

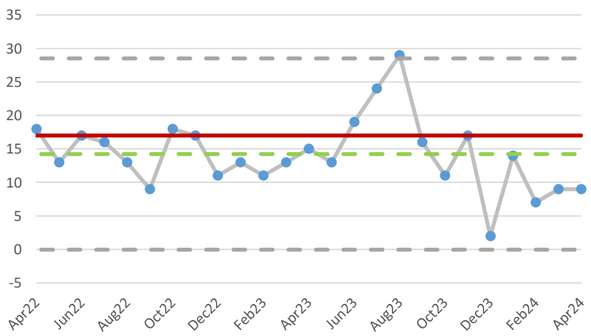
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Pressure Ulcers - Total incidence - Grade 2 and above



Reporting Date	Performance	Op. plan #
Apr-24	9.0	QC05

Threshold	YTD Mean	Benchmark
< 204 PA	9.0	14.7

(Lower value represents better performance)

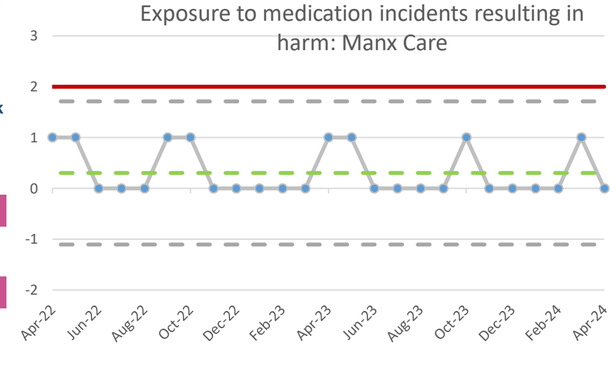
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

Exposure to medication incidents resulting in harm: Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	0	QC04

Threshold	YTD Mean	Benchmark
< 25 PA	0	0

(Lower value represents better performance)

+	Variation Description

Common cause

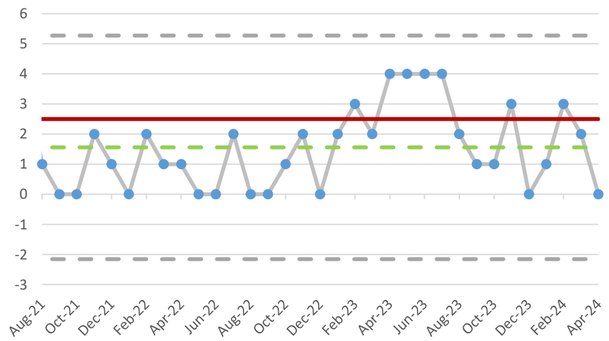
+	Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Inpatient Health Service Falls (with harm) per 1000 occupied bed days: 0.50 per thousand bed days which remains under the target of <2. This figure is higher than last month but less when compared to April 2023. **Medication Errors (with Harm):** There was one was listed with moderate harm; however, this involved a private pharmacy. **Pressure Ulcer incidence:** Nine pressure ulcers (PU) were recorded as new or having deteriorated under Manx Care services, eight were new incidents whilst one had deteriorated. The majority were community acquired: Six occurred in patients' own homes, one occurred in an older persons' residential setting.	**Inpatient Health Service Falls (with harm) per 1000 occupied bed days:** All inpatient falls are reviewed to ensure that a suitable risk assessment is in place. **Medication Errors (with Harm):** No omissions from Manx Care but a new process has been implemented in the Pharmacy to mitigate the risk of this happening again and to reduce distraction for the Pharmacist. The Pharmacist has also completed a self-reflection for development and learning. Continued high vigilance and monitoring in this area to ensure that the numbers continue to remain low and below the annual target. Medication Group continues to monitor trends, foresee issues and identify where improvements can be made. **Pressure Ulcer incidence:** TV continue to investigate category 3 and above incidents to identify any care delivery/ education deficits. Ward leads to maintain oversight that risk assessments and care plans are completed within expected timeframes via Patientrack.	**Inpatient Health Service Falls (with harm) per 1000 occupied bed days:** Consistently remained below target and monitoring will continue. **Medication Errors (with Harm):** Good level of confidence yearly target. **Pressure Ulcer incidence:** Pressure ulcer figures remain consistent in incidence rate and distribution across community/ acute. In-patient incidence is particularly low. Note - Benchmarks are the Manx Care monthly averages for 2023/24

Care Quality & Safety	Infection Control	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis	

C.Diff - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	0	QC10

Threshold	YTD Mean	Benchmark
< 30 PA	0	2

(Lower value represents better performance)

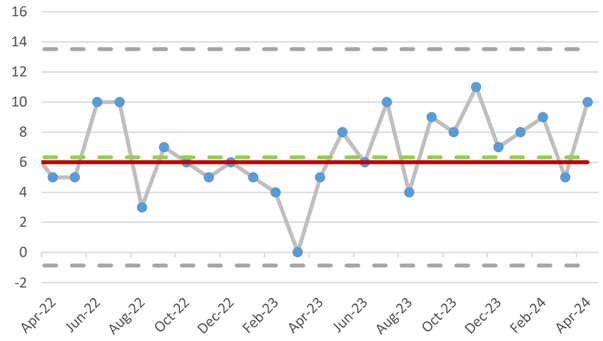
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

E.Coli - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	10	QC11

Threshold	YTD Mean	Benchmark
< 72 PA	10	8

(Lower value represents better performance)

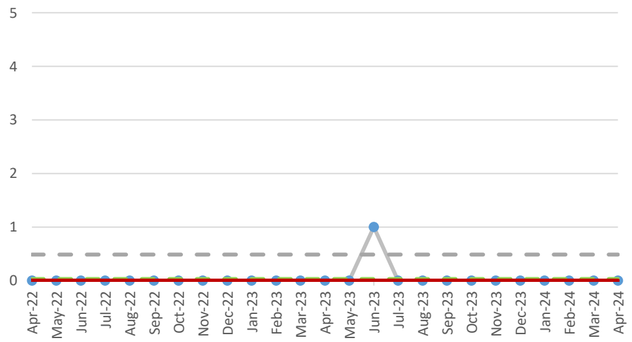
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

MRSA - Actual Cases : Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	0	QC06

Threshold	YTD Mean	Benchmark
0	0	0

(Lower value represents better performance)

+ Variation Description

Common cause

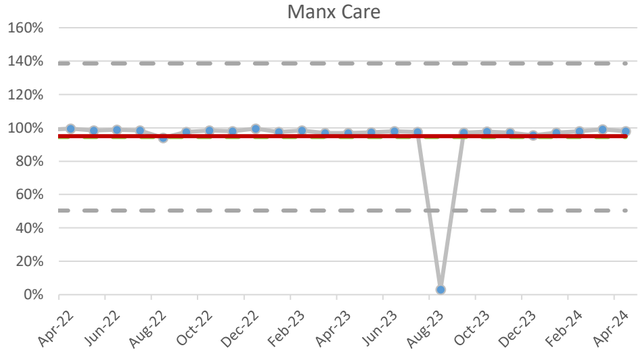
+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
C.Diff: There have been no cases this month.	**C.Diff:** To continue to undertake surveillance, promote appropriate sampling of specimens and isolation of symptomatic patients	**C.Diff:** Reasonable assurance that cases will below the yearly target <30.
E.Coli: There have been ten cases this month all of which were community associated. Potential sources of infection include urinary tract infections and biliary disease. No patients had a long-term catheter in situ. Case numbers are in line with UK trends.	**E.Coli:** To continue to monitor trends and provide surveillance to identify any links between cases. There are no links identified.	**E.Coli:** The increase in cases is mirrored in the UK. Cases at present do not indicate that numbers will exceed last years or exceed the yearly target.
MRSA: There have been no cases this month	**MRSA:** To continue to undertake routine surveillance.	**MRSA:** The zero case this month provides assurance that the yearly target is on track
Pseudomonas aeruginosa: There have been no cases this month.	**Pseudomonas aeruginosa:** To continue to undertake surveillance and monitor trends.	**Pseudomonas aeruginosa:** There is no national threshold set. Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Care Quality & Safety	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 #
Apr-24	98.0%	QC14

Threshold	YTD Mean	Benchmark
< 6 PA	98.0%	89.5%

(Higher value represents better performance)

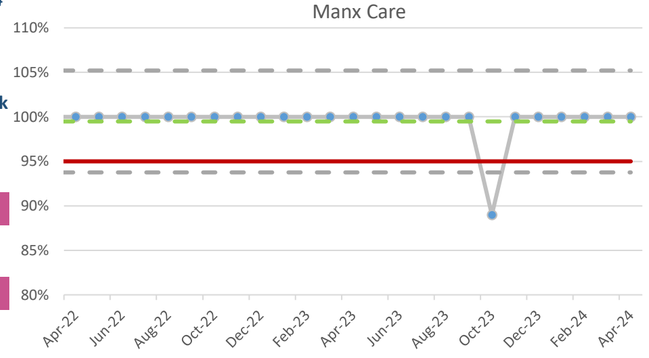
-	Variation Description

Common cause

+	Assurance Description

Consistently hit target

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



Reporting Date	Performance	Op. plan #
Apr-24	100.0%	QC15

Threshold	YTD Mean	Benchmark
< 25 PA	100.0%	99.1%

(Higher value represents better performance)

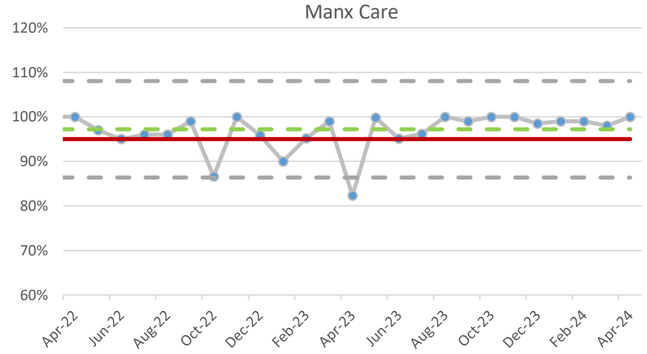
+	Variation Description

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 #
Apr-24	100.0%	QC16

Threshold	YTD Mean	Benchmark
95.0%	100.0%	97.2%

(Higher value represents better performance)

+	Variation Description

Common cause

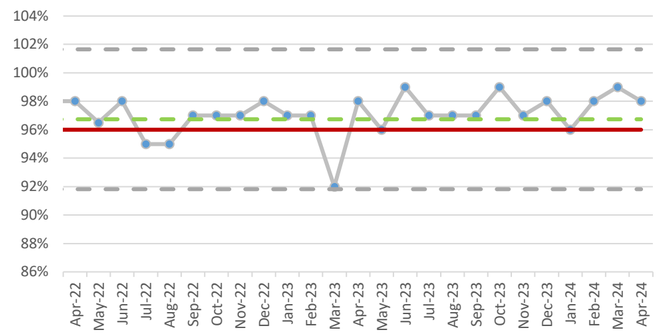
+	Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Adult: 98% for this month exceeding the target of 95%. **Maternity:** 100% compliance against the Maternity Safety Thermometer. **Children:** 99% compliance against the Children's Safety Thermometer.	**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 2023/24.

Care Quality & Safety	Hand Hygiene; Antibiotic Review	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis

Hand Hygiene Compliance: Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	98.0%	QC17

Threshold	YTD Mean	Benchmark
95.0%	98.0%	97.6%

(Higher value represents better performance)

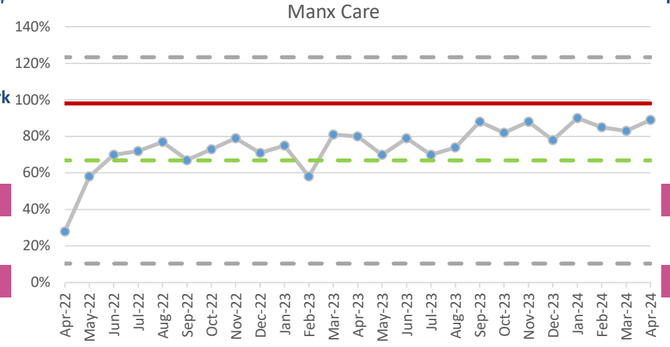
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

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



Reporting Date	Performance	Op. plan #
Apr-24	89.0%	QC18

Threshold	YTD Mean	Benchmark
95.0%	89.0%	80.6%

(Higher value represents better performance)

+ Variation Description

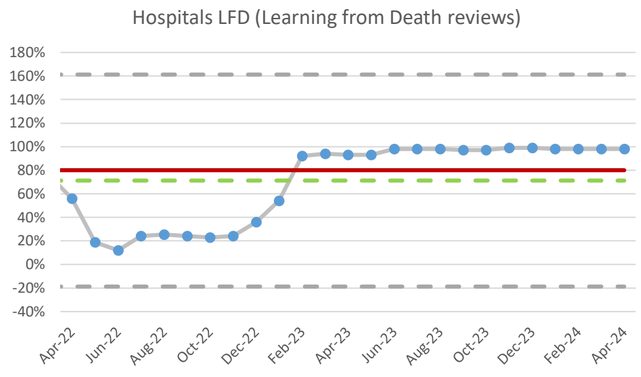
Special Cause of Improving variation (High)

- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hand Hygiene: The overall hand hygiene audit was 98%. **Review of Antibiotic Prescribing:** 89% up from 83%.	**Hand Hygiene:** To continue to undertake monthly hand hygiene audits and provide training where appropriate **Review of Antibiotic Prescribing:** To continue to monitor.	**Hand Hygiene:** There is reasonable confidence that the rates will remain compliant across Manx Care. **Review of Antibiotic Prescribing:** AMS ward rounds – Consultant Microbiologist reviewing all prescriptions. Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Care Quality & Safety	Mortality	Executive Lead	Marina Hudson	Lead	David Hedley; Alison Hool	



Reporting Date	Performance	Op. Plan #
Apr-24	98.0%	QC21

Threshold	YTD Mean	Benchmark
>= 98%	98.0%	97.1%

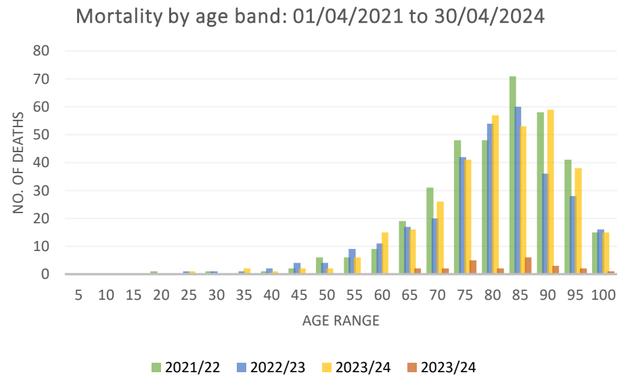
(Higher value represents better performance)

+ 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	**294**	

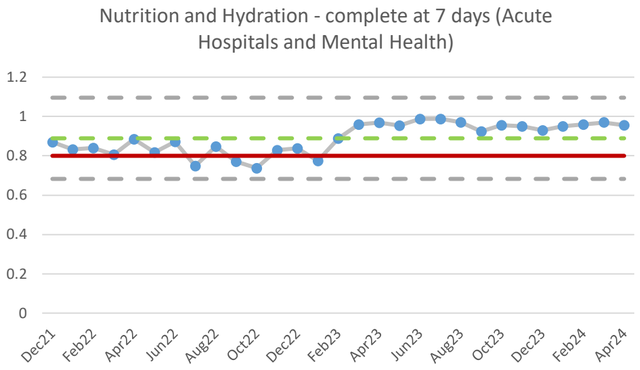
Threshold	YTD Mean	Benchmark
-	-	-

+ Variation Description

- Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Hospitals LFD (Learning from Death) Reviews: 98% level one forms completed. All were completed within 5 days of death.	**Hospitals LFD (Learning from Death) Reviews:** Continue to monitor and encourage more care group attendance at Mortality Review Meeting. Work continuing to increase number of level 2 reviews.	**Hospitals LFD (Learning from Death) Reviews:** Reasonable Assurance the target of 80% will continue to be reached. Note - Benchmarks are the Manx Care monthly average for 2023/24.

Care Quality & Safety	Nutrition & Hydration	Executive Lead	Paul Moore	Lead	Paul Hurst, Sue Davis



Reporting Date	Performance	Op. Plan #
Apr-24	95.6%	QC19

Threshold	YTD Mean	Benchmark
95.0%	95.6%	96.2%

(Higher value represents better performance)

- Variation Description

Special Cause of Improving variation (High)

+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Nutrition & Hydration: 95.6% across all inpatients within Manx Care. This is 1.4% lower than last month but remains above the target of 95%.	**Nutrition & Hydration:** Continue to ensure staff are provided with feedback to improve performance and maintain consistently above target.	**Nutrition & Hydration:** Continue to monitor compliance and feedback to service areas where further improvements can be made. Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Care Quality Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
QC01	Serious Incidents declared	<3 (<36 PA)	2	1	1	3	4	1	5	5	0	3	2	3	4	4	
QC07	Duty of Candour letter has been sent within 10 days of incident	80%	80.00%	75.00%	50.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%	100.00%		
QC007	Letter has been sent in accordance with Duty of Candour Regulations	100%	100.00%	100.00%	50.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
QC08	Eligible patients having VTE risk assessment within 12 hours of decision to admit	95%	90.41%	84.73%	89.60%	87.30%	88.89%	91.00%	94.50%	92.50%	93.00%	98.00%	92.00%	90.00%	95.40%		
QC09	% Adult Patients (within general hospital) who had VTE prophylaxis prescribed if appropriate	95%	91.87%	95.87%	97.40%	100.00%	98.00%	96.00%	99.00%	99.00%	96.00%	99.00%	99.00%	99.00%	96.00%		
QC02	Never Events	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
QC03	Inpatient Health Service Falls (with Harm) per 1,000 occupied bed days reported on Datix	<2	0.63	0.16	0.16	0.17	0.45	0.31	0.49	0.5	0.17	0.3	0.2	0.18	0.5		
QC05	Pressure Ulcers - Total incidence - Grade 2 and above	<= 17 (204 PA)	15	13	19	24	29	16	11	17	2	14	7	9	9	9	
QC10	Clostridium Difficile - Total number of acquired infections	< 30 PA	4	4	4	4	2	1	1	3	0	1	3	2	0	0	
QC06	MRSA - Total number of acquired infections	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
QC11	E-Coli - Total number of acquired infections	< 72 PA	5	8	6	10	4	9	8	11	7	8	9	5	10	10	
QC12	No. confirmed cases of Klebsiella spp	-	0	3	1	2	2	2	0	2	2	2	1	3	5	5	
QC13	No. confirmed cases of Pseudomonas aeruginosa	-	0	0	0	1	1	1	0	0	2	0	0	1	0	0	
QC04	Number of Medication Errors (with Harm)	< 25 PA	1	1	0	0	0	0	1	0	0	0	0	1	0	0	
QC14	Harm Free Care Score (Safety Thermometer) - Adult	95%	96.8%	97.4%	98.0%	97.5%	3.0%	97.0%	97.7%	97.0%	95.5%	97.0%	98.0%	99.0%	98.0%		
QC15	Harm Free Care Score (Safety Thermometer) - Maternity	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
QC16	Harm Free Care Score (Safety Thermometer) - Children	95%	82.3%	99.8%	95.2%	96.2%	100.0%	99.0%	100.0%	100.0%	98.5%	99.0%	99.0%	98.0%	100.0%		
QC17	Hand Hygiene Compliance	96%	98.0%	96.0%	99.0%	97.0%	97.0%	97.0%	99.0%	97.0%	98.0%	96.0%	98.0%	99.0%	98.0%		
QC18	48-72 hr review of antibiotic prescription complete	98%	80.0%	70.0%	79.0%	70.0%	74.0%	88.0%	82.0%	88.0%	78.0%	90.0%	85.0%	83.0%	89.0%		
	Crude Mortality Rate	-	16.5	15.4	12.8	15.3	19.6	18.8	24.7	19.0	21.8	38.1	31.7	22.4	23.6		
	Total Hospital Deaths	-	18	18	13	20	21	22	30	27	20	41	39	25	23	23	
QC21	Mortality - Hospitals LFD (Learning from Death reviews)	80%	93%	93%	98%	98%	98%	97%	97%	99%	99%	98%	98%	98%	98%		
QC19	Nutrition and Hydration - complete at 7 days (Acute Hospitals and Mental Health)	95%	97%	96%	99%	99%	97%	92%	96%	95%	93%	95%	96%	97%	96%		

Service User Experience Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
L07	Mandate	Number of complaints received	Caring	Apr-24		52	52	52	<= 450 PA		
L08	Mandate	Percentage of complaints acknowledged within 5 working days	Caring	Apr-24		100%	100%	-	98%		
L09	Mandate	Written response to complaint within 20 days	Caring	Apr-24		100%	100%	-	98%		
L10	Mandate	No. complaints exceeding 6 months	Caring	Apr-24		0	0	0	0		
L11	Mandate	No. complaints referred to HSCOB	Caring	Apr-24	-	3	3	3	-		

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC22	Operating Plan	FFT - How was your experience? No. of responses	Caring	Apr-24	-	1,345	1,345	1,345	-		
QC23	Operating Plan	FFT - Experience was Very Good or Good	Caring	Apr-24		88.0%	88.00%	-	80%		
QC24	Operating Plan	FFT - Experience was neither Good or Poor	Caring	Apr-24		4.0%	4.0%	-	10%		
QC25	Operating Plan	FFT - Experience was Poor or Very Poor	Caring	Apr-24		8.0%	8.0%	-	<10%		
QC26	Operating Plan	Manx Care Advice and Liaison Service contacts	Caring	Apr-24	-	838	838	838	-		
QC27	Operating Plan	Manx Care Advice and Liaison Service same day response	Caring	Apr-24		89.0%	89.0%	-	80%		

GOING WELL

Complaint response rates continues to remain high and above threshold

FFT - Experience was Very Good or Good - remains above threshold

Manx Care Advice and Liaison Service same day response continues to be high and above threshold

CAUSE FOR CONCERN

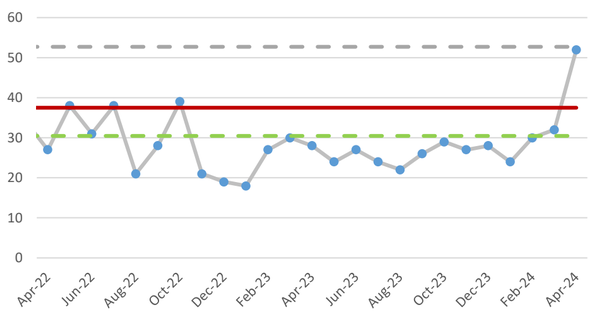
Acknowledgement of Rising Complaints - While not yet a major concern, Manx Care acknowledges receiving 52 complaints over the past month, including those from GPs. The primary issues raised were related to access to treatment or drugs, clinical treatment, delays in diagnosis, and staff values and behaviours. Importantly, all complaints were acknowledged within five working days, demonstrating our commitment to responsiveness and transparency. Several factors have contributed to the rise in complaints, as articulated by the complainants, such as long waiting lists and delays in care, which overall impact patient satisfaction. Ensuring timely and clear communication remains a challenge, and variations in staffing can affect service quality. In response, we are enhancing communication strategies to ensure patients receive timely, accurate information. Efforts are ongoing to optimize service delivery and reduce waiting times. Additionally, continuous staff training focuses on improving patient interactions and addressing concerns promptly. Our goal is to maintain high standards of care and continually improve patient satisfaction.
Breakdown of complaints recieved by Care Group
Integrated Diagnostic and Cancer Services 1
Integrated Mental Health Services 3
Integrated Primary and Community Care Services 18
Integrated Women's, Children's, and Families' Services 4
Medicine, Urgent Care and Ambulance Services 13
Social Care Services 1
Surgery, Theatres, Critical Care and Anaesthetics 12

Mandate Objectives: Service User Experience

Objective No.	Objective	Status	Progress / Risks	Lead
2 e	Manx Care will share with the Department the results of Manx Care's public consultation on services for women and jointly work to understand the drivers for change, focussing particularly on feasibility of an early pregnancy service, services for menopause and reproductive disorders. Results of Manx Care's public consultation on services for women shared through the Mandate Development Meetings			
3	Service Users experience of accessing care is understood and this is used to drive service delivery changes for the future. Friends and family testing is routinely used to understand both individual needs and identify improvements for cohorts of people.			

Service User Experience	Complaints	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis	

Complaints - Number of complaints: Manx care



Reporting Date	Performance	Op. plan #
Apr-24	52	L07

Threshold	YTD Mean	Benchmark
<= 450 PA	52	27

(Lower value represents better performance)

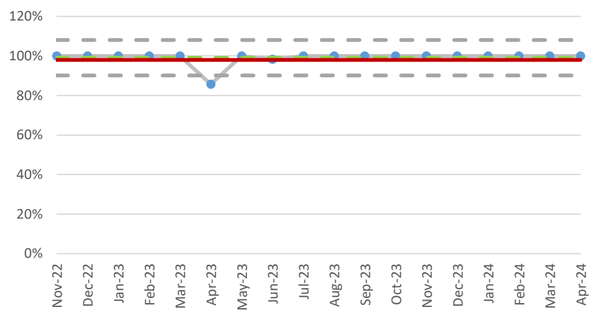
- Variation Description

Special Cause of Improving variation (Low)

- Assurance Description

Inconsistently passing and falling short of target

Complaint - Written response within 20 days: Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	100%	L09

Threshold	YTD Mean	Benchmark
98.0%	100.0%	98.7%

(Higher value represents better performance)

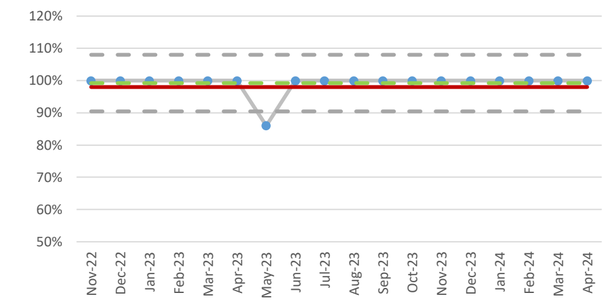
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Complaint acknowledged within 5 working days: Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	100%	L08

Threshold	YTD Mean	Benchmark
98%	100.0%	98.8%

(Higher value represents better performance)

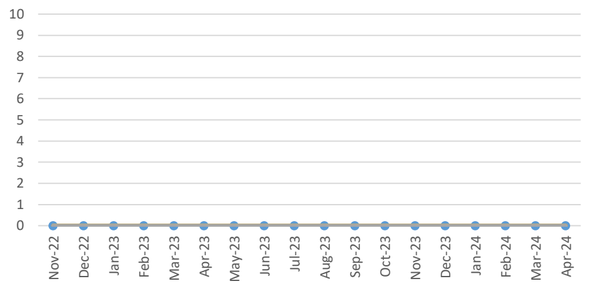
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Complaint - No. complaints exceeding 6 months: Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	0	L10

Threshold	YTD Mean	Benchmark
0	0	0

(Lower value represents better performance)

+ Variation Description

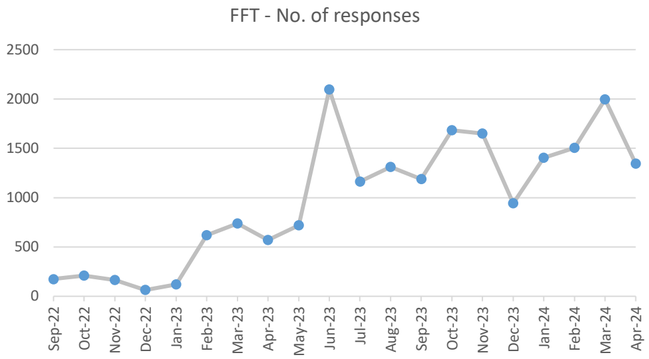
Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Number of Complaints: There were 37 complaints overall for April which is an increase of 5 (16%) from March. Two were withdrawn within the process as they were happy their concerns had been addressed. This is the highest figure received within the last 12 months. The care groups with the largest percentage this month were M&UC 33%, Surgery 28% and Integrated Women and Children's 11%. **Acknowledged within 5 Days:** 100% compliance with all complaints being acknowledged within 5 working days. **Written Response within 20 days:** 100% of compliance in April. **No. Complaints Exceeding 6 Months:** None **No. complaints referred to HSCOB:** 3 complaints referred to HSCOB in April. This figure is inclusive of requests for information and decision notices (where HSCOB have accepted the case for investigation). One was regarding Ward 9 (Medicine), One was regarding ED (Urgent Care) and one regarding ENT (Surgery). The latter was previously an IRB case, which has now been transferred to be handled by HSCOB.	**Number of Complaints:** Continued support from MCALS helps to reduce the number of formal complaints. Continue to monitor and highlight trends to service areas. **Acknowledged within 5 Days:** Continue to monitor compliance. **Written Response within 20 days:** Continue to monitor. **No. Complaints Exceeding 6 Months:** Continue to monitor. **No. complaints referred to HSCOB:** Continue to ensure all concerns are addressed in resolution letters, which will help to reduce referrals to HSCOB.	**Number of Complaints:** Reasonable level of confidence target annual target will be met. **Acknowledged within 5 Days:** Consistency has continued meeting this target. High degree of confidence this will continue. **Written Response within 20 days:** Good level of confidence target will continue to be met. **No. Complaints Exceeding 6 Months:** Reasonable level of confidence target will be met. **No. complaints referred to HSCOB:** No target set at present, continue to monitor and provide information as required when requested from HSCOB. Note - Benchmarks are the Manx Care monthly averages for 2023/24.

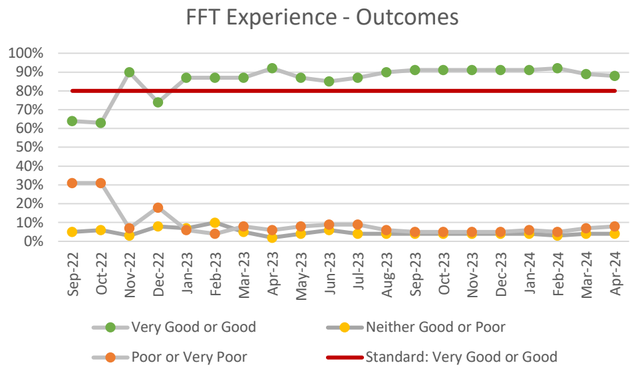
Service User Experience	Friends & Family Test	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis	



Reporting Date	Performance	Op. plan #
Apr-24	1,345	QC22
Threshold	**YTD Mean**	**Benchmark**
-	1,345	1,352

- **Variation Description**

Assurance Description



Reporting Date	Performance	Op. plan #
Apr-24	88.0%	QC23-24-25
Threshold	**YTD Mean**	**Benchmark**
80.0%	88.0%	-

(Higher value represents better performance)

+ **Variation Description**

Common cause

+ **Assurance Description**

Consistently hit target

Issues / Performance Summary

FFT Total number of responses:
A total of 1345 surveys completed in April 2024.

• FFT – Experience was very good or good:
1183 completed surveys rated experience as Very Good or Good equating to 88% against a target of 80%. Target exceeded for every month YTD.

• FFT – Experience was neither good or poor:
62 completed surveys rated experience as Neither Good nor Poor equating to 4% against a target of 10% or less.

• FFT – Experience was poor or very poor:
101 completed surveys rated experience as Poor or Very Poor, equating to 8% against a target of 10% or less.

Planned / Mitigation Actions

FFT Total number of responses:
Continue to promote / encourage feedback – outpatient departments and GP Practices continue to deliver consistent feedback via the survey – uptake from inpatient settings is still relatively low by comparison and work continues to
promote engagement with teams and senior nursing leads to encourage feedback via the survey.

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

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

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

Assurance / Recovery Trajectory

FFT Total number of responses:
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. Survey can be accessed via QR code available on posters, stickers, leaflets and flyers across Manx Care sites. Easy read version of survey launched in November and text message reminder service launched in March 2024. There is a reasonable degree of confidence in increasing survey returns.

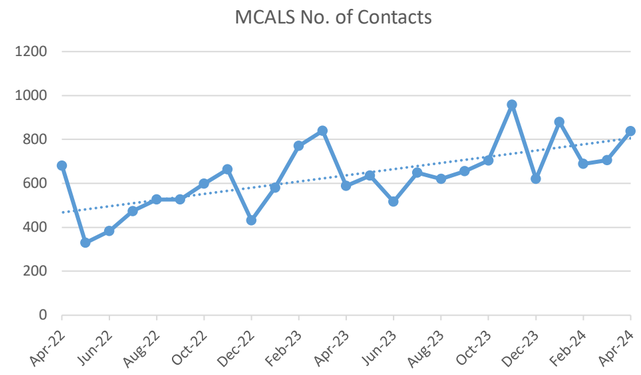
• FFT – Experience was very good or good:
Reasonable degree of confidence that reporting targets will continue to be met.

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

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

Note -
Benchmarks are the Manx Care monthly averages for 2023/24.

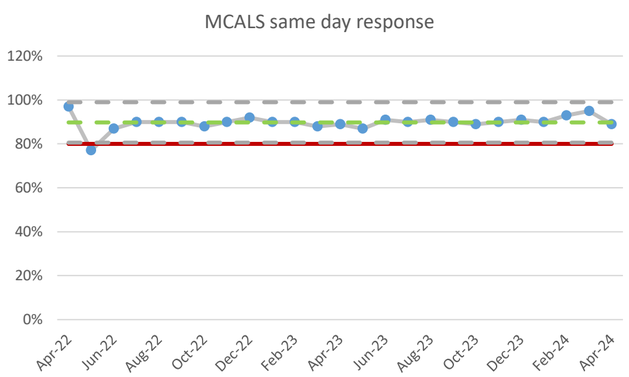
Service User Experience	MCALS	Executive Lead	Paul Moore	Lead	Paul Hurst; Sue Davis	



Reporting Date	Performance	Op. plan #
Apr-24	838	QC26
Threshold	**YTD Mean**	**Benchmark**
-	838	685

+ Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Apr-24	89.0%	QC27
Threshold	**YTD Mean**	**Benchmark**
80.0%	89.0%	91%

(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: 838 contacts received in April 2024, increase of 16% compared to March 2024. Access to appointments within ophthalmology orthopaedics, GP and Dental services and cardiology were the dominant themes. In person contacts during April reduced to 130 to contacts due a reduction in the number of drop-in sessions. **Same Day Response:** In April, MCALS had resolved all contacts within 24 hours 89% 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. Drop-in sessions will be increased from July 2024 as we have actively recruited x 4 more MCALS Volunteers to support the hubs across the island to help to reach seldom heard voices and to offer a face-to-face option when expressing concerns or enquiries. **Same Day Response:** Continued good performance in dealing with service user contacts. Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Service User Experience Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
QC20	Mixed Sex Accomodation - No. of Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
L07	Complaints - Total number of complaints received	-	28	24	27	24	22	26	29	27	28	24	30	32	52	52	
QC22	FFT - How was your experience? No. of responses	-	571	718	2096	1161	1311	1187	1682	1650	943	1403	1503	1994	1345	1345	
QC23	FFT - Experience was Very Good or Good	80%	92.0%	87.0%	85.0%	87.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%	89.0%	88.0%		
QC24	FFT - Experience was neither Good or Poor	10%	2.0%	4.0%	6.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.0%	4.0%	4.0%		
QC25	FFT - Experience was Poor or Very Poor	<10%	6.0%	8.0%	9.0%	9.0%	6.0%	5.0%	5.0%	5.0%	5.0%	6.0%	5.0%	7.0%	8.0%		
QC26	Manx Care Advice and Liaison Service contacts	-	589	636	517	649	621	655	704	958	620	880	689	705	838	838	
QC27	Manx Care Advice and Liaison Service same day response	80%	89.0%	87.0%	91.0%	90.0%	91.0%	90.0%	89.0%	90.0%	91.0%	90.0%	93.0%	95.0%	89.0%		
L08	Complaint acknowledged within 5 working days	98%	100.0%	86.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
L09	Written response within 20 days	98%	85.7%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
L10	No. complaints exceeding 6 months	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
L11	No. complaints referred to HSCOB	-	0	0	0	7	4	1	4	2	4	2	1	2	3	3	

People Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
P01	Mandate	Percentage of working hours lost to staff sickness absence	Well Led	Apr-24		5.7%	5.7%	-	4%		
P02	Mandate	Staff 12 months turnover rate	Well Led	Apr-24		9.8%	9.8%	-	10%		
P03	Mandate	Training Attendance rate	Well Led	Apr-24		64.0%	64.0%	-	90%		
P04	Mandate	Staff vacancy rate	Well Led	Apr-24		19.1%	19.1%	-	15%		

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
L01	Mandate	Governance - Number of Data Breaches	Well Led	Apr-24	-	10	10	10	-		
L02	Mandate	Governance - Number of Data Subject Access Requests (DSAR)	Well Led	Apr-24	-	72	72	72	-		
L03	Mandate	Governance - Number of Access to Health Access (AHR) Requests	Well Led	Apr-24	-	2	2	2	-		
L04	Mandate	Governance - Number of Freedom of Information (FOI) Requests	Well Led	Apr-24	-	18	18	18	-		
L05	Mandate	Governance - Number of Enforcement Notices from the ICO	Well Led	Apr-24		0	0	0	0		
L06	Mandate	Governance - Number of SAR, AHR and FOI's not completed within their target	Well Led	Apr-24		40	40	40	0		

GOING WELL

Turnover rate remains within target

The Information Governance team continues to be very busy and is regularly contacted by staff from across Manx Care to provide advice and guidance on a wide range of subjects.
This level of engagement is very encouraging, demonstrating as it does the continuing commitment of staff across Manx Care to handling data correctly and to 'do the right thing in the right way'.

Instructor-led training sessions attendance rate reported as surrogate due to OHR reporting issues.

The volume of requests for information, particularly Data Subject Access Requests remains high and presents a significant challenge for the Information Governance Team.

In April the number of FOI requests received was the highest in a single month for the past year. The number of Subject Access Requests was the second highest month in the last year.

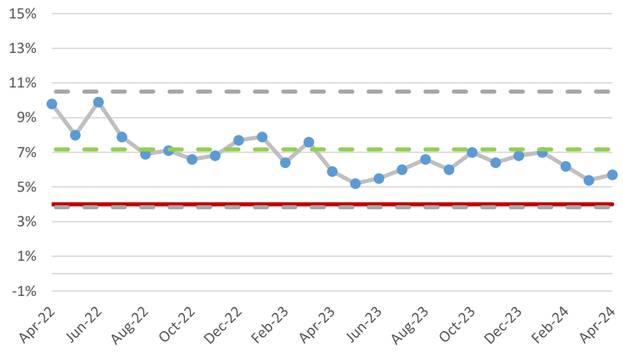
Staff shortages in March and April have impacted the ability of the team to respond to requests within the required timescales.
There were 10 Data Breaches in April. All breaches are fully investigated in order that Manx Care can identify 'lessons learned' and improve our processes going forward.

Mandate Objectives: People & Governance

Objective No.	Objective	Status	Progress / Risks	Lead
5 b	By the end of the Service Year, Manx Care will be able to demonstrate having achieved standards met in a majority of months (at least 7 of 12) against the Data Security and Protection Toolkit ('DSPT'), level 3.		In-year analysis of data will be undertaken to assess achievement. In support of DSPT submission enhanced GDPR and Data Protection training is being scheduled for senior leaders across Manx Care.	JM
5 b	Minutes of the IGAB demonstrate clear lines of escalation		Boards papers with IGAB documentation supplied to Department on regular basis.	JM
5 b	Progress update against the KPMG recommendations brought through a Manx Care Board or sub-committee no less than quarterly.			JM
5 e	Manx Care will continue with progress against their People, Culture and Engagement strategy 2023-2026 which aims to not only support and develop existing staff but also to recruit and retain new ones.			MH
5 e i	Following completion of initial integrated workforce reviews, Manx Care will provide the Department with a milestone plan for this work to be carried out for all areas of Manx Care, including career pathways, skills audit and workforce planning.			MH
5e ii	Development and implementation of a workforce Equality, Diversity and Inclusion (EDI) charter and strategy will be a priority, covering all levels of the organisation and with board level accountability.		A new Equality, Diversity and Inclusion Forum has been set up to meet monthly, which include EDI Champions, Staff Network Leads and allies. This forum will be used to share issues and concerns, generate ideas and development and input into the EDI strategy development. Further Equality, Diversity and Inclusion workshops are due to be held with champions with a view to mapping out the deliverables which will sit underneath the Strategy, which is in development.	MH
5e iii	During the Service Year, Manx Care will launch their Recruitment and Retention strategy (developed by the transformation Workforce and Culture Team – but to be implemented by Manx Care). Manx Care's implementation plan will include succession planning in order to reduce spend on agency staff and drive a stable workforce, therefore enabling consistency of care.		The Recruitment & Retention Strategy has been ratified by the People Committee and a thorough implementation plan has been drafted for review with the Director for People in May.	MH
Overall measures	PULSE surveys achieve at least a 50% completion rate and an overall positive response to work undertaken under integrated workforce reviews.		In-year analysis of data will be undertaken to assess achievement. Manx Care Staff survey 2024 due in Septermber 2024.	
Overall measures	Increase in the number of vacancies (other than entry level) filled internally following improvement in career pathways and workforce planning.		In-year analysis of data will be undertaken to assess achievement.	
Overall measures	Target of <=10% for staff turnover rate consistently (In at least 10 of 12 calendar months) met during 2024-25.		Data published monthly in IPR. In-year analysis of data will be undertaken to assess achievement.	
Overall measures	Overall vacancy level across Manx Care of <= 15% during 2024-25.		Data published monthly in IPR. In-year analysis of data will be undertaken to assess achievement.	
Overall measures	Percentage of staff who have undertaken mandatory training regarding substance misuse, brought to the Substance Misuse Steering Group, which demonstrates a gradual increase to 100% by the end of the Service Year.		In-year analysis of data will be undertaken to assess achievement.	

People	OHR	Executive Lead	Anne Corkill	Lead	Hannah Leighton	

% Hours lost to staff sickness absence



Reporting Date	Performance	Op. plan #
Apr-24	5.7%	P01

Threshold	YTD Mean	Benchmark
4.0%	5.7%	6.2%

(Lower value represents better performance)

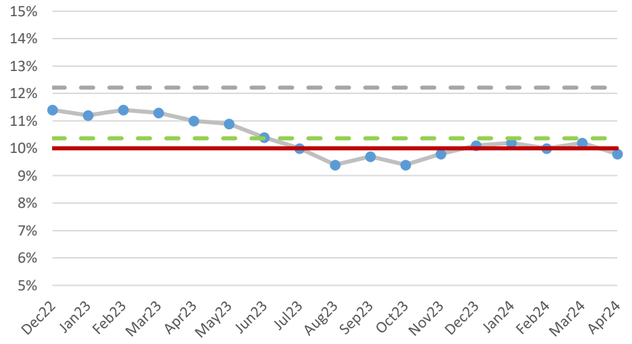
+ Variation Description

Special Cause of Improving variation (Low)

- Assurance Description

Consistently fail target

Staff 12 months turnover rate



Reporting Date	Performance	Op. plan #
Apr-24	9.8%	P02

Threshold	YTD Mean	Benchmark
10.0%	9.8%	10.1%

(Lower value represents better performance)

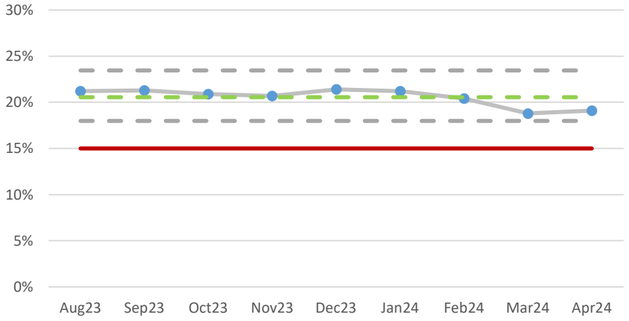
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Instructor-led training sessions attendance rate



Reporting Date	Performance	Op. plan #
Apr-24	64%	P03

Threshold	YTD Mean	Benchmark
80%	64%	62%

(Higher value represents better performance)

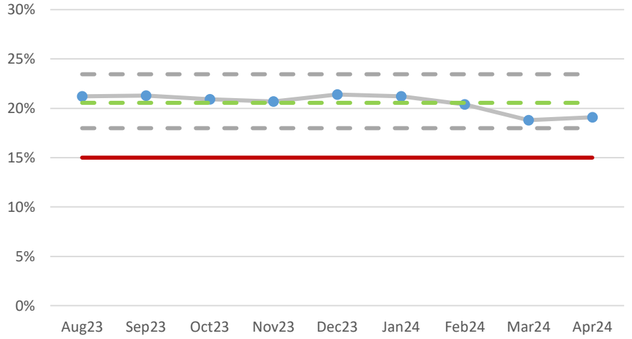
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

Vacancy rate %



Reporting Date	Performance	Op. plan #
Apr-24	19%	P04

Threshold	YTD Mean	Benchmark
15%	19%	21%

(Higher value represents better performance)

+ Variation Description

Common cause

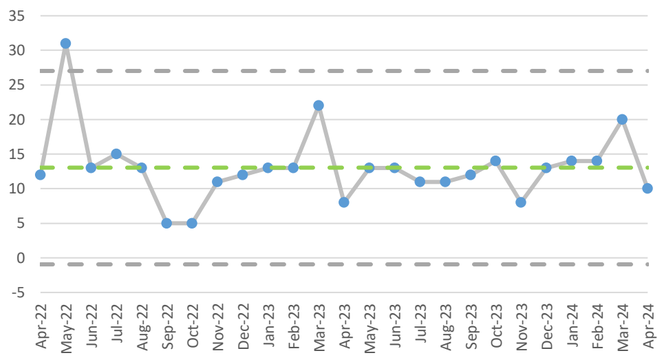
- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• % of hours lost to staff sickness absence	• % of hours lost to staff sickness absence	• % of hours lost to staff sickness absence
• Staff 12 month turnover rate	• Staff 12 month turnover rate	• Staff 12 month turnover rate
• Vacancy rate	• Vacancy rate	• Vacancy rate
• Instructor-led training sessions attendance rate	• Instructor-led training sessions attendance rate	• Instructor-led training sessions attendance rate
		Note - Benchmarks are the Manx Care monthly averages for 2023/24

People	Governance	Executive Lead	Simon Collins	Lead	Jennifer Maynard	

Number of Data Breaches : Manx Care



Reporting Date	Performance	Op. plan #
Apr-24	10	L01

Threshold	YTD Mean	Benchmark
-	0	13

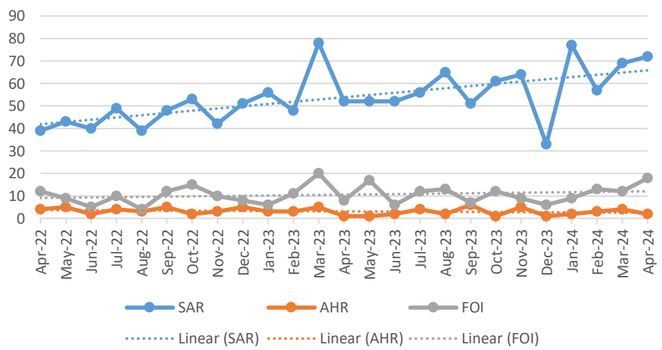
- Variation Description

Common cause

- Assurance Description

Consistently fail target

Information requests by type : Manx Care



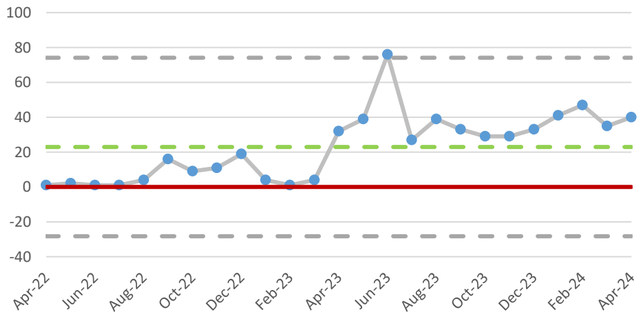
Reporting Date	Performance	Op. plan #
Apr-24	-	L02-03-04

Threshold	YTD Mean	Benchmark
-	-	-

Variation Description

Assurance Description

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



Reporting Date	Performance	Op. plan #
Apr-24	40	L06

Threshold	YTD Mean	Benchmark
0	40	38

(Lower value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• **Breaches –** Total: 10 Reported to the Commissioner: 1 Data Subjects informed: 4 Data Subjects Not Informed: 6 (low risk to data subject) Types of breach Email: 4 Written Communication: 1 Confidentiality: 5 • **Enforcement Notices from the ICO** None	Manx Care notifies to the ICO all breaches which they are required to notify or which appear to meet the criteria of notification. Subsequently, after investigation a breach which was reported may be found not to have met the criteria. However, if the initial information indicates a reportable breach that is the action Manx Care will take. All breaches (and suspected breaches) are fully investigated by the Manx Care DPO who will conduct a full internal investigations with the relevant service areas to establish the details of the breach / suspected breach and conduct a root cause analysis exercise to establish the full circumstances. Any recommended improvements and process changes will be identified and documented. 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 by staff from across the organisation. Evidence indicates that staff are confident to report data breaches. Breaches or suspected breaches 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. Manx Care continues to review policies and processes. It is recognised that an effective governance structure is based on continual improvements and reviews. Note - Benchmarks are the Manx Care monthly averages for 2023/24

People Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
P01	Percentage of hours lost to staff sickness absence	4%	5.9%	5.2%	5.5%	6.0%	6.6%	6.0%	7.0%	6.4%	6.8%	7.0%	6.2%	5.4%	5.7%		
P02	Staff Turnover rate	10%	11.0%	10.9%	10.4%	10.0%	9.4%	9.7%	9.4%	9.8%	10.1%	10.2%	10.0%	10.2%	9.8%		
P03	Training Attendance	80%	56.0%	66.0%	65.0%	61.0%	60.0%	60.0%	62.0%	69.0%	61.0%	57.0%	63.0%	58.0%	64.0%		
P04	Staff vacancy rate	15%						21.3%	20.9%	20.7%	21.4%	21.2%	20.4%	18.8%	19.1%		
L01	Number of Data Breaches	Monitor	8	13	13	11	11	12	14	8	13	14	14	20	10	10	
L02	Number of Subject Access Requests (SAR)	Monitor	52	52	52	56	65	51	61	64	33	77	57	69	72	72	
L03	Number of Access to Health Record Requests (AHR)	Monitor	1	1	2	4	2	6	1	5	1	2	3	4	2	2	
L04	Number of Freedom of Information (FOI) Requests	Monitor	8	17	6	12	13	7	12	9	6	9	13	12	18	18	
L05	Number of Enforcement Notices from the ICO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
L06	Number of DSAR, AHR and FOI's not completed within their target	0	32	39	76	27	39	33	29	29	33	41	47	35	40	40	

Integrated Primary & Community Care (IPCC) Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD
QC123	Mandate	Average wait time (in days) to next GP Practice appointment	Responsive	Mar-24	-	8	-	-
QC131	Mandate	Number of clinical appointments delivered by GP practice (per 1,000 population)	Responsive	Mar-24	-	277	272	-
QC134	Mandate	GP Practice Did Not Attend Rate	Responsive	Mar-24		3.5%	3.7%	-
	Supporting	Number of GP Practice appointments	Responsive	Mar-24		35577	33768	405214
QC130	Operating Plan	% of patients registered with a GP	Responsive	Apr-24		4.0%	4.0%	-
QC124	Mandate	Average waiting time (days) for patients allocated to a dental practice	Responsive	Apr-24	-	1131	1131	-
QC135	Mandate	Number of patients waiting allocation to a dentist	Responsive	Apr-24	-	5013	5013	-
QC136	Mandate	% Dental contractors on target to meet UDA's*	Responsive	Apr-24	-	6%	6%	-
	Supporting	Number of additions to dental allocation list	Responsive	Mar-24	-	228	228	2,241
	Supporting	Number of allocations to a dental practise	Responsive	Apr-24	-	4	4	672

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
	Supporting	Pharmacy - Total Prescriptions (No. of fees)	Effective	Feb-24	-	139,393	140,122	0	-		
	Supporting	Pharmacy - Chargable Prescriptions	Effective	Feb-24	-	18,605	18,634		-		
	Supporting	Pharmacy - Total Exempt Item	Effective	Feb-24	-	137,180	138,013	0	-		
	Supporting	Pharmacy - Chargeable Items	Effective	Feb-24	-	18,140	18,398		-		
	Supporting	Pharmacy - Net cost	Effective	Feb-24	-	£1,370,221	£1,415,933	£0	-		
	Supporting	Pharmacy - Charges Collected	Effective	Feb-24	-	£70,012	£71,032		-		
	Supporting	Number of Sight Test	Effective	Mar-24	-	2567	2240	0	-		
QC118	Mandate	Community Nursing Service response target met: Urgent/non-routine (24 hours)	Responsive	Apr-24		100%	100%	-	100%		
QC119	Mandate	Community Nursing Service response target met: Routine (7 days)	Responsive	Apr-24		100%	100%	-	100%		

GOING WELL

Overall GP Practice DNA Rate was within the threshold of 5%

Community Nursing targets continue to achieve threshold

CAUSE FOR CONCERN

In April, there was a decrease of 121 from March 2024 for the number of patients awaiting allocation to a dental practice.

Ongoing validation work should further reduce the total number

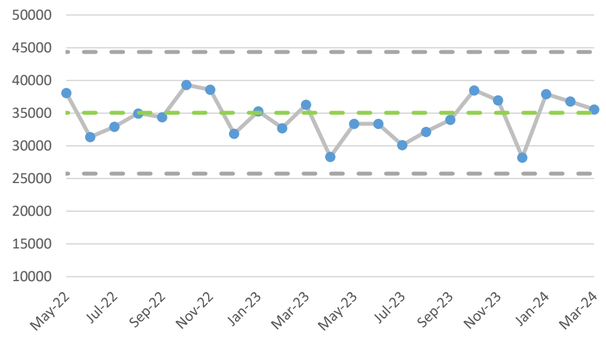
*Threshold applies at year end only.

Mandate Objectives: Integrated Primary & Community Care (IPCC)

Objective No.	Objective	Status	Progress / Risks	Lead
1 c	Medication reviews reporting routinely brought through a Manx Care Board subcommittee agenda detailing the number of reviews completed, resulting cost savings and associated reduction in accessing services due to medicines optimisation.			
1 c	Salaried model and service shift - Manx Care will confirm the details of a salaried GP offering by 31 May 2024		11.04.24 Proposal for the Salaried Model drafted and is currently being consulted. Input has been received by the Cabinet Office and the PCN. We have commissioned the PCC to undertake a piece of work on the salaried option and due to meet to discuss the GP salaried model and benchmarking on 19.04.24. 01.05.24 PCC meeting has been postponed. On track for producing details on salaried GP model by end of May. Risks: Affordability - model tweaking for realistic affordability. Time & Resources - constraints due to the complexities and unknowns for the model and reliance on consultation/ responses from key stakeholders.	AC
1 c	Details of the commissioning of a virtual GP service to support the service during times of pressure will be undertaken and assessed in time to be relevant for the next period of winter pressures		11.04.24 RFI process completed, looking at options for contracting. RFI responses reviewed and summarised and with Care Group now for consideration. 01.05.24 Interviews took place this week - awaiting outcome. Risks: PCN buy in to the model (early indications demonstrate a reluctance to agree to a virtual service but have agreed to trial it as a concept idea initially). IT - could be a UK-based provided and we will need to work with GTS to ensure links and access electronically is available and IG covered. Electronic prescribing - GPs have indicated this needs to be in place otherwise it will create workload and requests for GPs to prescribe for patients they have not seen.	AC
1 c	Hubs - By the end of the Service Year, Manx Care will have wellbeing partnerships and hubs operating in all geographies of the Island		Currently in discussions with RGP to etablish the Northern Hub, creation of the board and structure. Wellbeing partnerships already operating in W/N/S will be working at integrating with other relevant services for the hub, commencing in the North. Once the North is established, this will then be rolled out to other areas. Risks: Timeframe - once the Northern hub is set up it will take time to embed and ensure the model is operating as it needs to be, before we roll out the same structure to the other areas. Physical resource availability (staffing and buildings). Contractor engagement and support from AGs & DHSC in terms in legislation.	
1 c	Pharmacy services – Manx Care will continue to support the Department in scoping future models for pharmacy. By the end of the Service Year 2024-25, Manx Care will have completed and started to deliver against an options appraisal for delivery and contracting of community pharmacy, including a plan to recruit and support junior pharmacists, with a development plan to increase first contact pharmacist provision across all GP practices and the established wellbeing partnerships.		This objective has been split into 4 key areas. 1. Overarching Strategy & community pharmacy into PCAS. 2. The recruitment of new pharmacists - this is already underway. No funding for additional pharmacists - clarity required on whether this objective is for Meds Optimisation i.e. recruiting junior pharmacists OR it's for Nobles Pharmacy. 3. First Contact Pharmacists is a PCN objective (money and roles have been transferred to the PCN). 4. Electronic prescribing. Risks: Key Stakeholders involvment & Project pause for number 1 from DHSC. PCN delivering on requirements for number 3.	MB
1 c	First contact practitioners – Manx Care will review the pilot model of first contact practitioners in musculoskeletal, mental health and dermatology with a view to expanding geographical coverage.		Pilot work is been reviewed. Model has been operating out of Ballasalla, now looking at expanding these services.	
1 c	Frailty - Manx Care will bring together all the work-streams related to frailty to ensure that there is a documented holistic and consistent approach across all services.		Pharmacy are contributing to the frailty clinics in the Northern wellbeing hub already and in care home MDT reviews across the Island. Therapies report running a clinic pilot every Tuesday with the community PT and OT, frailty practitioner and consultant, for fallers discharged home from ED who have been identified as at-risk of further falls. This is an MDT clinic which can then refer patients on to eg Falls programme or for other areas such as Medicaiton review etc. We have doubled the numbers of Falls Clinic assessments within the Community Adult Team (Typically of course these individuals are also frail). We plan to review results.	
1 c	Average wait time for a GP appointment, broken down by practice.		The new suite of dashboards and reports have been signed off in May 2024, with reporting of GP service performance to recommence in next month's reporting cycle.	AC
2 c	Implementation reporting for the Social Affairs Policy Review Committee (SAPRC) report into oral health in children (led by Public Health).		Work on-going with Public Health.	
2 c	Dental waiting list information regularly available.		Progress: Dental waiting list dashboard readily available and reported monthly into the via the IPR. Risk: Resource - single dedicated bank staff member who works on data for IPCC dashboards, therefore, single point of failure.	AC

IPCC	GP - All Professionals	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon	

Number of Practice Appointments



Reporting Date	Performance	Op. Plan #
Mar-24	**35577**	-

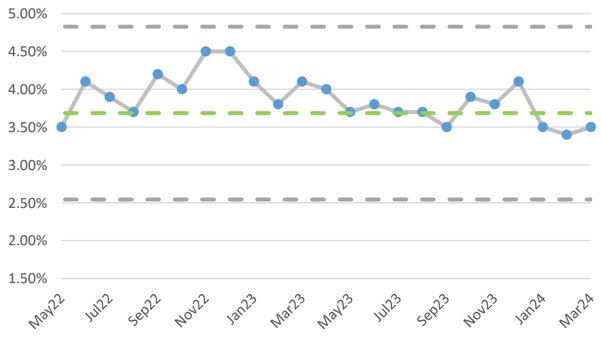
Threshold	YTD Mean	Benchmark
-	33768	33768

Variation Description

Common cause

Assurance Description

DNA Rate - Practice Appointments



Reporting Date	Performance	Op. Plan #
Mar-24	**3.5%**	QC134

Threshold	YTD Mean	Benchmark
<5%	3.7%	3.7%

(Lower value represents better performance)

- **Variation Description**

Common cause

Assurance Description

Average of Days to next Practice appointment - March'24

Reporting Date	Performance	Op. Plan #
Mar-24	-	QC123

Threshold	YTD Mean	Benchmark
-	7.2	-

(Lower value represents better performance)

Variation Description

Assurance Description

Number of appointments per 1000 registered patients - March'24

Reporting Date	Performance	Op. Plan #
Mar-24	-	QC131

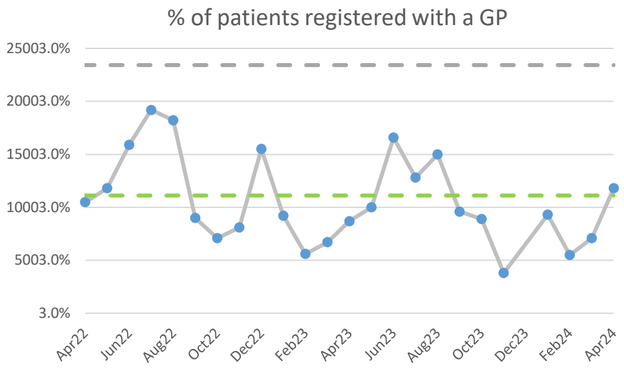
Threshold	YTD Mean	Benchmark
-	-	

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Number of appointments	**Number of appointments**	**Number of appointments**
DNA Rate	**DNA Rate**	**DNA Rate**
Average days to appointment	**Average days to appointment**	**Average days to appointment**
April data not yet available.		**Note:** **- Reporting all professionals at practise (e.g. Doctor, Nurse, Advanced Nursing Practitioners).** **- Benchmarks are the Manx Care monthly averages for 2023/**24

IPCC	GP	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon	



Reporting Date	Performance	Op. Plan #
Apr-24	4.0%	QC130

Threshold	YTD Mean	Benchmark
4.0%	4.0%	4.0%

(Lower value represents better performance)

Variation Description

Special Cause of Improving variation (Low)

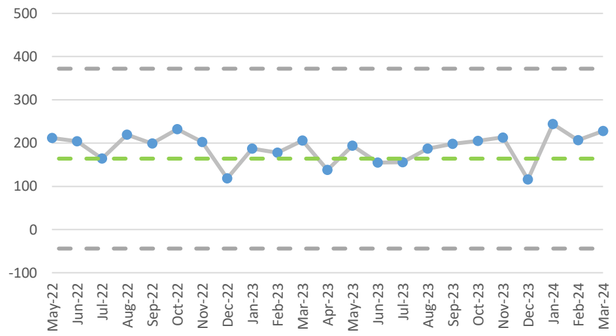
Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% of patients registered with a GP:	**% of patients registered with a GP:**	**% of patients registered with a GP:**
		Note - Benchmarks are the Manx Care monthly averages for 2023/24

IPCC	Dental allocations and additions	Executive Lead	Oliver Radford	Lead	Rebecca Dawson	

Number of additions to the Dental Waiting list

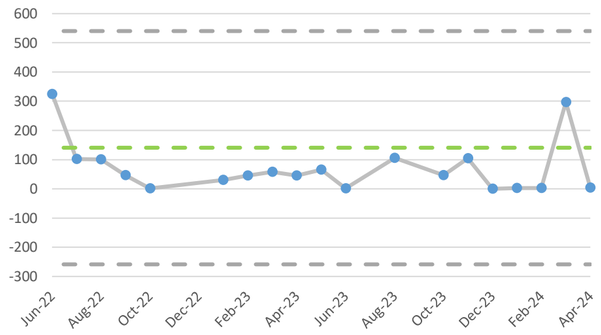


Reporting Date	Performance	Op. Plan #
Mar-24	**228**	-
Threshold	**YTD Mean**	**Benchmark**
	228	

Variation Description

Assurance Description

Patients Allocations to Dental Practices

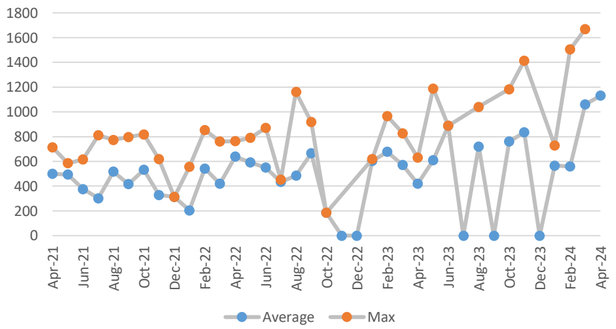


Reporting Date	Performance	Op. Plan #
Apr-24	**4**	QC137
Threshold	**YTD Mean**	**Benchmark**
-	4	-

Variation Description

Assurance Description

Waiting time for patients allocated to a Dental Practice



Reporting Date	Performance	Op. Plan #
Apr-24		QC124
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

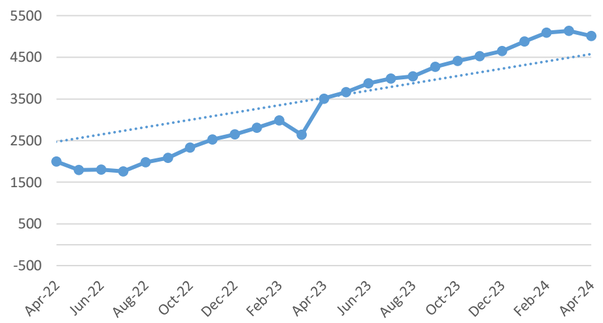
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
		Note - Benchmarks are the Manx Care monthly averages for 2023/24

IPCC	Dental waiting time	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon	

Number of patients waiting allocation to a dentist



Reporting Date	Performance	Op. Plan #
Apr-24	5013	QC135

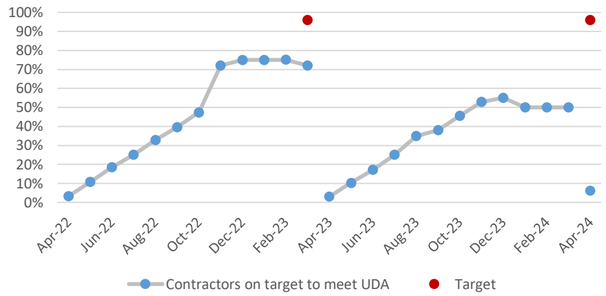
Threshold	YTD Mean	Benchmark
	0	4337

(Lower value represents better performance)

-	Variation Description

Assurance Description

% Dental contractors on target to meet Units of Dental Activity (UDA's)



Reporting Date	Performance	Op. Plan #
	6.00%	QC136

Threshold	YTD Mean	Benchmark
	6.00%	

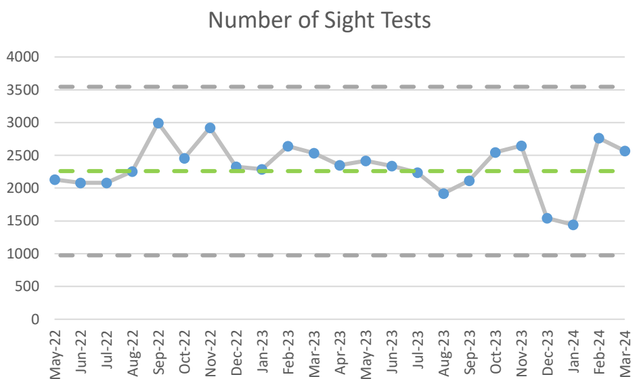
(Lower value represents better performance)

-	Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
No. patients waiting for a Dentist: In April, there was a decrease of 121 from March 2024. Following waiting list sweep letters, 1,039 patients failed to respond and are currently being removed from the waiting list. Therefore, the total number should continue to decrease. **% Dental contractors on target to meet Units of Dental Activity (UDA's)** 4 contractors are on target to meet UDA's for this month.	**No. patients waiting for a Dentist:** Waiting list validation work on going which will result in a further reduction in numbers **% Dental contractors on target to meet Units of Dental Activity (UDA's)**	**No. patients waiting for a Dentist:** Waiting list validation work on going which will result in a further reduction in numbers **% Dental contractors on target to meet Units of Dental Activity (UDA's)** Note - Benchmarks are the Manx Care monthly averages for 2023/24

IPCC	Eye Care	Executive Lead	Oliver Radford	Lead	



Reporting Date	Performance	Op. Plan #
Mar-24	**2567**	-
Threshold	**YTD Mean**	**Benchmark**
-	2240	2240

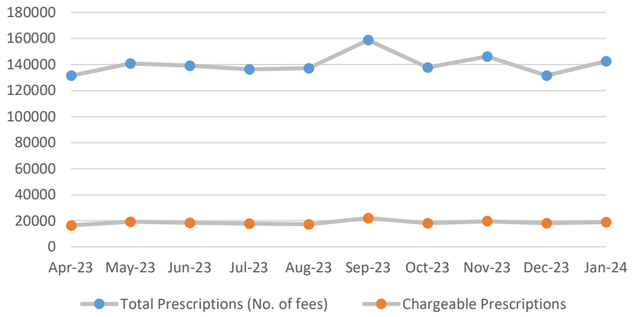
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
		Note - Benchmarks are the Manx Care monthly averages for 2023/24

IPCC	Community Pharmacy	Executive Lead	Oliver Radford	Lead	Maria Bell

Pharmacy - Number of Prescriptions

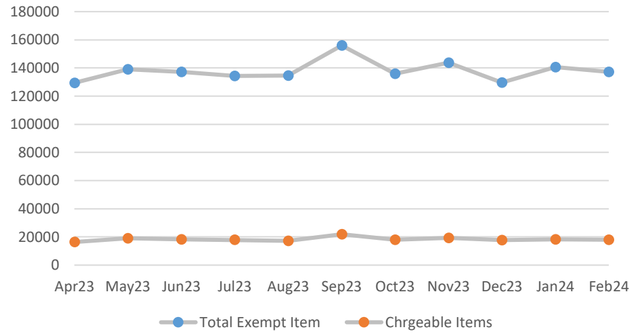


Reporting Date	Performance	Op. Plan #
Feb-24	-	-
Threshold	**YTD Mean**	**Benchmark**

Variation Description

Assurance Description

Pharmacy - Number of Items

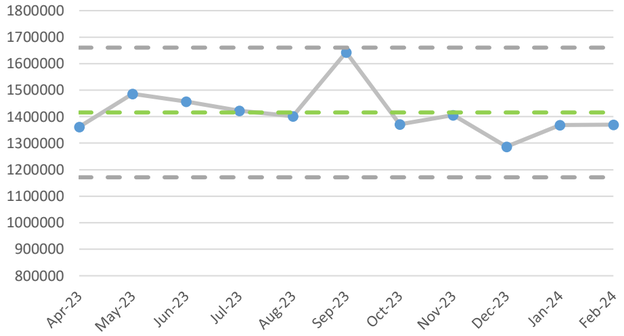


Reporting Date	Performance	Op. Plan #
Feb-24	-	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

/ariation Descriptio

ssurance Descriptio

Pharmacy - Net cost



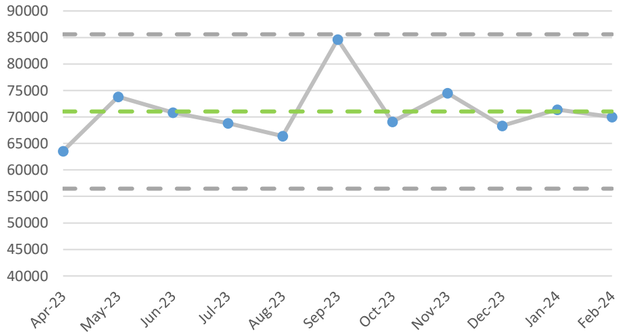
Reporting Date	Performance	Op. Plan #
Feb-24	**£1,370,221**	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

Variation Description

Common cause

Assurance Description

Pharmacy - Charges Collected



Reporting Date	Performance	Op. Plan #
Feb-24	**£70,012**	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

/ariation Descriptio

Common cause

ssurance Descriptio

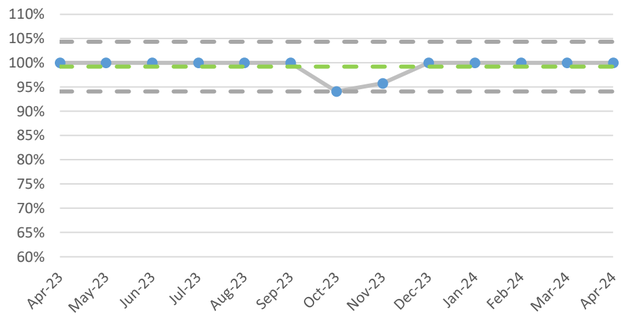
Issues / Performance Summary

Planned / Mitigation Actions

Assurance / Recovery Trajectory

IPCC	Community Nursing	Executive Lead	Oliver Radford	Lead	Annmarie Cubbon	

Community Nursing Service response target met: Urgent/non-routine (24 hours)



Reporting Date	Performance	Op. Plan #
Apr-24	100%	QC118

Threshold	YTD Mean	Benchmark
100.0%	100.0%	99%

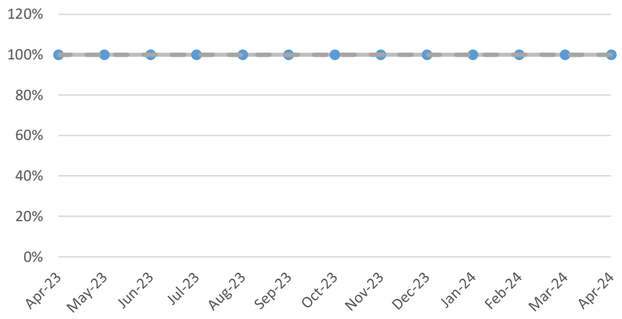
(Higher value represents better performance)

+ Variation Description

Common cause

Assurance Description

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



Reporting Date	Performance	Op. Plan #
Apr-24	100.0%	QC119

Threshold	YTD Mean	Benchmark
100.0%	100%	100.0%

(Higher value represents better performance)

+ Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Urgent Continues to achieve the threshold of 100% **Routine** Continues to achieve the threshold of 100%		Note - Benchmarks are the Manx Care monthly averages for 2023/24

Integrated Primary & Community Care Performance

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
QC124	Average waiting time for patients allocated to a dental practice (days)		420	609	889		720		759	834		566	558	1060	1131		
QC135	Number of patients waiting allocation to a dentist		3509	3666	3872	3993	4042	4268	4415	4528	4648	4878	5092	5134	5013		
QC136	% Dental contractors on target to meet UDA's	96%	3%	10%	17%	25%	35%	38%	46%	53%	55%	50%	50%	50%	6%		
	IPCC - Number patients seen by dentist within the year		53697	53829	53089	53628	53778	54084	54025	53151	41895	57005	51622	50794	51908	51908	
QC131	Number of clinical appointments delivered by GP practice (per 1,000 population)						257	252	280	293	233	300	280	277			
QC130	The % of patients registered with a GP (PERMANENT REGISTRATION)	4%	4.2%	4.2%	4.2%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%		
QC123	Average of Days to next GP practice appt - Ballasalla		5	3	3	4	3	4	4	4	4	3	3	4			
QC123	Average of Days to next GP practice appt - Castletown		6	6	6	5	5	6	9	7	8	7	7	8			
QC123	Average of Days to next GP practice appt - Finch		10	9	8	10	9	9	12	8	9	8	8	8			
QC123	Average of Days to next GP appt - Hailwood		12	13	14	14	13	12	11	14	16	15	16	18			
QC123	Average of Days to next GP practice appt - Kensington		10	11	11	9	11	10	14	10	8	11	7	8			
QC123	Average of Days to next GP practice appt - Laxey		11	12	14	12	16	16	15	11	10	11	10	10			
QC123	Average of Days to next GP practice appt - Palatine		3	4	4	3	3	5	7	6	4	3	4	4			
QC123	Average of Days to next GP practice appt - Peel		7	7	7	7	6	7	6	8	9	7	8	11			
QC123	Average of Days to next GP practice appt - Ramsey		4	4	4	4	5	4	3	4	3	4	5	4			
QC123	Average of Days to next GP practice appt - Snaefell		13	13	11	12	9	10	8	8	9	7	5	7			
QC123	Average of Days to next GP practice appt - Southern		8	9	9	9	9	8	8	7	8	7	8	9			
	IPCC - Number of GP practice appointments		28297	33346	33369	30107	32159	33962	38498	36950	28219	37925	36805	35577		0	
QC134	Did Not Attend Rate (GP practice)	5%	4.0%	3.7%	3.8%	3.7%	3.7%	3.5%	3.9%	3.8%	4.1%	3.5%	3.4%	3.5%			
QC118	Community Nursing Service response target met: Urgent/non-routine (24 hours)	100%	100%	100%	100%	100%	100%	100%	94%	96%	100%	100%	100%	100%	100%		
QC119	Community Nursing Service response target met: Routine (7 days)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		

Hospital Based Care Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC49	Mandate	Planned Care - DNA Rate - Hospital	Effective	Apr-24		10.4%	10.4%	-	<=7.6%		
QC50	Mandate	Planned Care - DNA Rate (Consultant Led outpatient appointments)	Effective	Apr-24		12.8%	12.8%	-	<=7.6%		
QC51	Mandate	Planned Care - DNA Rate (Nurse)	Effective	Apr-24		5.9%	5.9%	-	<=7.6%		
QC52	Mandate	Planned Care - DNA Rate (Allied Health)	Effective	Apr-24		9.7%	9.7%	-	<=7.6%		
QC59	Supperting	Planned Care - Total Number of Cancelled Operations	Effective	Apr-24	-	308	308	308	-		
QC30	Mandate	Number of patients (inpatient only) with a length of stay = 0 days	Effective	Apr-24	-	630	630	630	-		
QC31	Mandate	Number of patients (inpatient only) with a length of stay > 7 days	Effective	Apr-24	-	215	215	215	-		
QC32	Mandate	Number of patients (inpatient only) with a length of stay > 21 days	Effective	Apr-24	-	96	96	96	-		
	Supporting	Referrals for first OP Attendance (Consultant)	Responsive	Apr-24	-	2750	2750	2750	-		
QC85	Operating Plan	Adult General and Acute (G&A) bed Occupancy	Responsive	Apr-24		91.1%	62.1%	-	92%		
	Mandate	Number of patients waiting for first hospital appointment	Responsive	May-24	-	20250	-	-	-		
QC33	Mandate	Number of patients waiting for first Consultant Led Outpatient appointment	Responsive	May-24		16612	16580	-	< 16,547		
QC34	Mandate	Number of patients waiting for Daycase procedure	Responsive	May-24		1859	1830	-	< 2311		
QC35	Mandate	Number ofpatients waiting for Inpatient procedure	Responsive	May-24		422	431	-	< 440		

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC36	Mandate	Number of patients waiting more than 52 weeks for first consultant-led outpatient appointment	Responsive	Apr-24	-	5671	5698	-	-		
	Supporting	Theatres - Number of Cancelled Operations	Effective	Apr-24		25	25	25	-		
QC47	Mandate	Theatre Utilisation– percentage of planned sessions delivered	Effective	Apr-24		83%	83%	-	85%		
QC44	Mandate	Number of theatre cancellations on the day, shown as a total for the month: clinical	Effective	Apr-24	-	11	11	11	-		
QC45	Mandate	Number of theatre cancellations on the day, shown as a total for the month: Hospital non-clinical	Effective	Apr-24	-	5	9	9	-		
QC46	Mandate	Number of theatre cancellations on the day, shown as a total for the month: Patient related	Effective	Apr-24	-	9	5	5	-		
QC37	Mandate	% Urgent GP referrals seen for first appointment within 6 weeks	Responsive	Apr-24		54%	54%	-	85%		
	Supporting	Total Number of Inpatient discharges-Nobles	Effective	Apr-24	-	854	854	854	-		
	Supporting	Total Number of inpatient discharges-RDCH	Effective	Apr-24	-	37	37	37	-		
QC53	Mandate	Number of discharges: Pre-10:00	Effective	Apr-24	-	89	89	89	-		
QC54	Mandate	Number of discharges: Pre-16:00	Effective	Apr-24	-	737	737	737	-		
QC55	Mandate	Number of discharges: Weekend	Effective	Apr-24	-	161	161	161	-		
QC56	Mandate	Delayed transfers of care	Effective	Apr-24	-	18	18	18	-		

GOING WELL

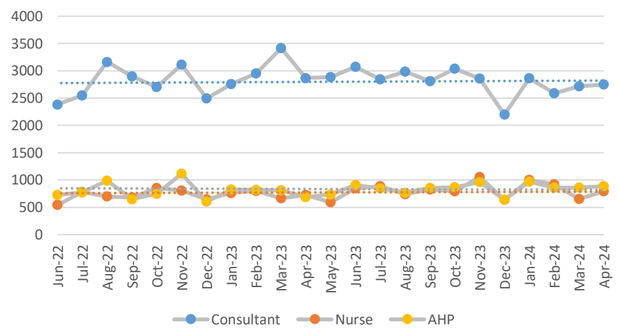
CAUSE FOR CONCERN

Mandate Objectives: Hospital Care

Objective No.	Objective	Status	Progress / Risks	Lead
3 b	Agreed acceptable waiting times across all services and specialties are publicly available, regularly reviewed and performance reported against.		Data is reported monthly in IPR and on waiting list webpage.	AH
3 b	D&C report regarding acute services presented to the October 2024 Mandate Development Meeting.		Work underway and on track for October 2024.	AH
3 b	Milestone plan for expanding D&C assessments presented to the March 2025 Mandate Development Meeting.		Work underway and on track for March 2025.	AH
3 b	Restoration and recovery maintenance reporting for general surgery, ophthalmology and orthopaedics provided to the Department through the Mandate Development Meetings on a quarterly basis.		Reports supplied to Department when requested.	AH
3 c	Terminal cancer and vision loss support review and recommendations shared with the Department through the Mandate Development Meetings by 30 September 2024		Cancer Services continues to expand establishment of Cancer Support Workers and Cancer Care Co-ordinators. These roles include providing Holistic Needs Assessments (HNA's) to patients with cancer diagnoses to develop a Personalised Care Plan and actively support them through their diagnosis and treatment. This is done in conjunction with the Oncology Day Unit and the CNS for the specific site of disease. A wider review of existing mechanisms with commence in early summer 2024. (Also reported in IDCS)	
Overall measures	Reduction in average length of stay in secondary care (towards the agreed 21-day target) through proactive pathways, enabling early discharge planning and activation to promote efficient patient flow, so that by 31 March 2025, the total number of patients with a length of stay in Noble's Hospital > 21 days has not breached 100 in any given month.		In-year analysis of data will be undertaken to assess trend.	OR
Overall measures	By 31 December 2024, Manx Care will have provided a forecast of when all agreed waiting times can be achieved and regularly reported through the IPR. Where milestones are in doubt, Manx Care will provide early identification to the Performance Technical Group meeting		Work underway and on track for end of year completion.	AH
Overall measures	Reduction in delayed discharges from Noble's Hospital.		Data is reported monthly in IPR. In-year analysis of data will be undertaken to assess trend.	AH

Hospital Based Care	Demand	Executive Lead		Lead	

Referrals for First Outpatient Appointment



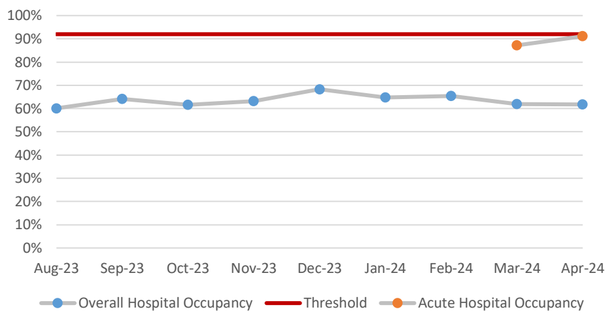
Reporting Date	Performance		Op. Plan #
Apr-24	Consultant	2750	

Threshold	YTD Mean	Benchmark
-	2750	2811

Variation Description

Assurance Description

Adult General and Acute (G&A) bed occupancy



Reporting Date	Performance	Op. Plan #
Apr-24	91.1%	QC85

Threshold	YTD Mean	Benchmark
92.0%	62.1%	87.2%

(Lower value represents better performance)

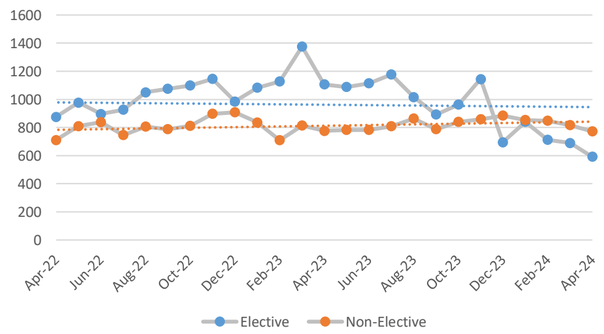
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

Elective and Non Elective Admissions



Reporting Date	Performance	
Apr-24	Elective	591
	Non Elective	773

Threshold	YTD Mean	Benchmark
-	-	-

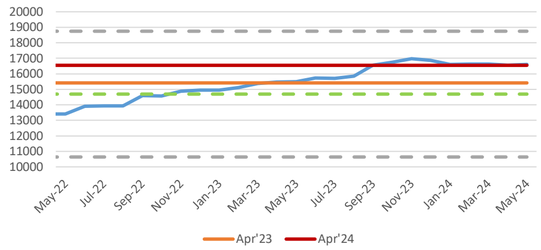
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals for First Outpatient Appointment: Referral levels for Consultant led services increased in April to 2750, compared to 2715 in March. **Hospital Bed Occupancy** Overall Hospital occupancy is 62% Acute Adult Occupancy was 91.1% and Non Acute **Elective and Non Elective Admissions:** Elective Admissions have decreased by approximately 14.4% in April (591) against March (690) Non Elective admission numbers have slightly decreased to 773 compared to 816 last month.		Note - Benchmarks are the Manx Care monthly averages for 2023/24

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

Number of patients waiting for first Consultant Led Outpatient appointment



Reporting Date	Performance	Op. Plan #
May-24	**16,612**	QC33

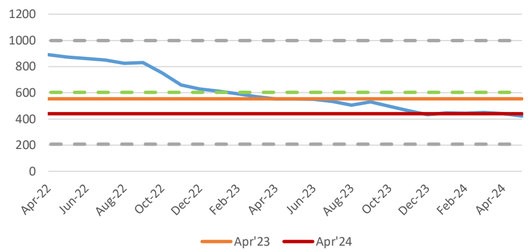
Threshold	YTD Mean	Benchmark
< 16,547	16,580	15,465

(Lower value represents better performance)

Avg Wait Time (Referral to 1st Cons Led OP Appt.)
49

No. patients waiting 52 weeks or more for 1st OP
5,725

Number ofpatients waiting for Inpatient procedure



Reporting Date	Performance	Op. Plan #
May-24	**422**	QC35

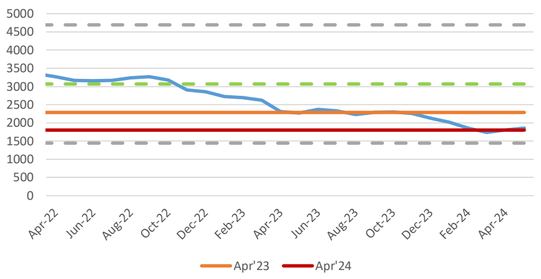
Threshold	YTD Mean	Benchmark
< 440	431	554

(Lower value represents better performance)

Avg Wait Time (Decision to Treat to Treatment - IP)
26

No. patients waiting 52+ weeks from Decision to Treat
60

Number of patients waiting for Daycase procedure



Reporting Date	Performance	Op. Plan #
May-24	**1,859**	QC34

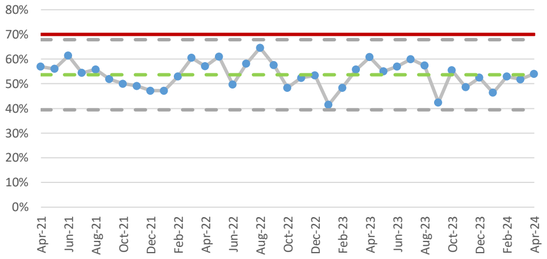
Threshold	YTD Mean	Benchmark
< 1,801	1,830	2,311

(Lower value represents better performance)

Avg Wait Time (Decision to Treat to Treatment - DC)
35

No. patients waiting 52+ weeks from Decision to Treat
350

% Urgent GP referrals seen for first appointment within 6 weeks



Reporting Date	Performance	Op. Plan #
Apr-24	**54.0%**	QC37

Threshold	YTD Mean	Benchmark
85.0%	54.0%	53.4%

(Higher value represents better performance)

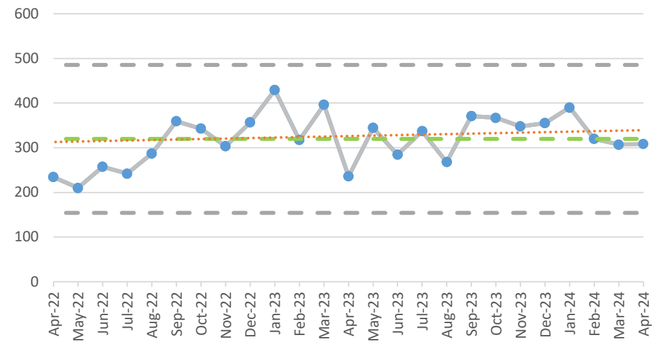
- Variation Description
Common cause

- 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.	• Phase 2 of the Restoration & Recovery programme concluded at the end of March 2024. • R&R delivery (November '21 to March '24); 2,150 Ophthalmology procedures in total; 955 Orthopaedic procedures in total; 515 GSU procedures in total; Other surgical specialties – 54 procedures in total; 1,224 outpatient attendances in total; 1,470 radiology scans in total; Mental Health – 320 referrals in total; 458 endoscopic procedures. o Overall R&R has delivered about a 83% reduction in the Ophthalmology daycase waiting list. o Overall R&R has delivered about a 47% reduction in orthopaedic daycase/inpatient waiting lists. o Overall there's been about a 60% 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 26,100 referrals have been through technical validation and over 14,000 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 5% 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 1,700 referrals reviewed to date, with over 1,000 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). This phase of the programme is intended to address the significant volume of patients awaiting outpatient appointments.	• 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.

Hospital Based Care	Planned Care operations and DNA	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson	

Planned Care - Total No. Cancelled Operations



Reporting Date	Performance	Op. Plan #
Apr-24	308	QC59

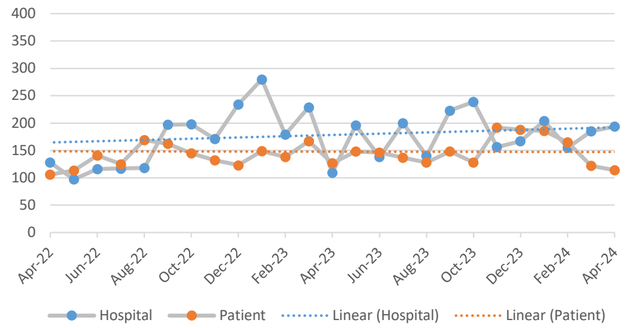
Threshold	YTD Mean	Benchmark
-	308	327

(Lower value represents better performance)

+	Variation Description
	Common cause

Assurance Description

Planned Care - Cancelled Operations by source



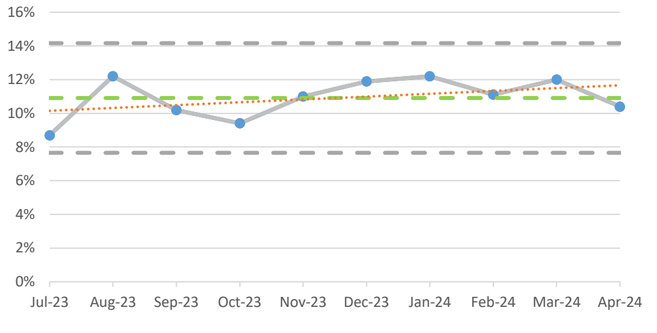
Reporting Date	Performance	Op. Plan #
Apr-24	-	QC44-46

Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Planned Care - DNA Rate - Hospital



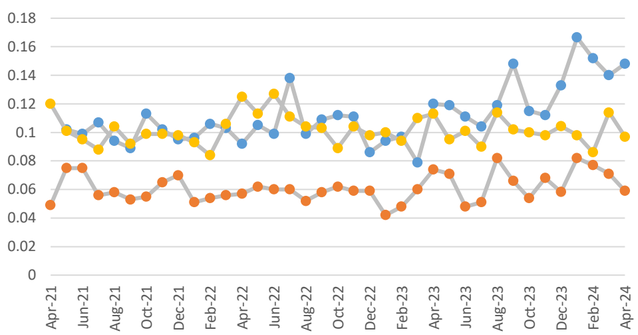
Reporting Date	Performance	Op. Plan #
Apr-24	10.4%	QC49

Threshold	YTD Mean	Benchmark
<=7.6%	0	11.0%

Variation Description

Assurance Description

Planned Care - DNA Rate



Reporting Date	Performance		Op. Plan #
Apr-24	Cons.	12.8%	QC50-52
	Nurse	5.9%	
	AHP	9.7%	

Threshold	YTD Mean	Benchmark
<=7.6%	-	-

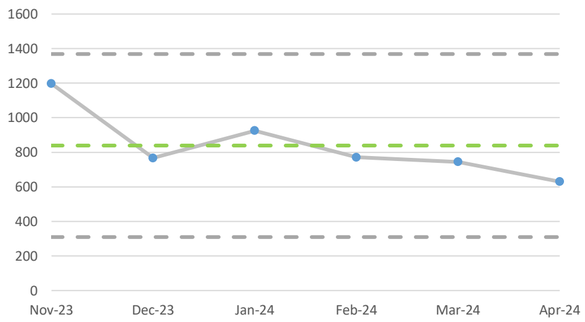
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Cancelled Operations: The number of cancelled operations in March was 308. **DNA Hospital** 10.4% in April	**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 2023/24

Hospital Based C	Length of Stay	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson	

Number of patients with a length of stay = 0 days



Reporting Date	Performance	Op. Plan #
Apr-24	630	QC30
Threshold	**YTD Mean**	**Benchmark**
-	630	881

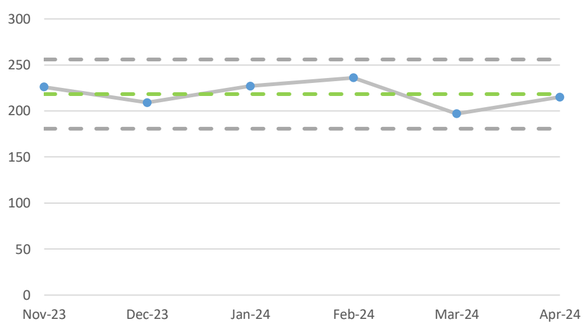
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Number of patients with a length of stay > 7 days

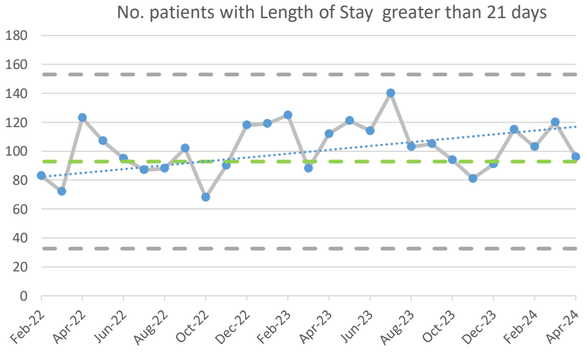


Reporting Date	Performance	Op. Plan #
Apr-24	215	QC31
Threshold	**YTD Mean**	**Benchmark**
-	215	219

-	Variation Description

Assurance Description

No. patients with Length of Stay greater than 21 days



Reporting Date	Performance	Op. Plan #
Apr-24	96	QC32
Threshold	**YTD Mean**	**Benchmark**
-	96	108

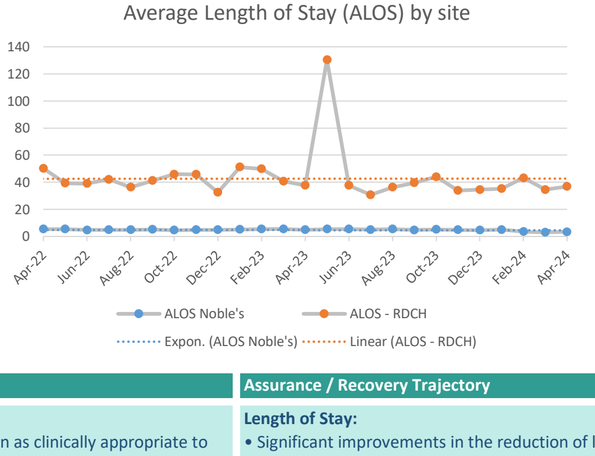
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Average Length of Stay (ALOS) by site



Reporting Date	Performance	Op. Plan #
Apr-24		QC58
Threshold	**YTD Mean**	**Benchmark**

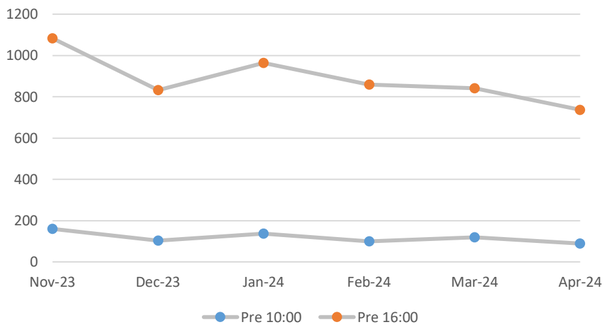
-	Description

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 April split for the metric is: No. discharged patients who had a LOS > 21 days =56 No. patients still admitted with a LOS > 21 days = 40 • 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.	**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 1.7 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.

Hospital Based	Discharges	Executive Lead	Oliver Radford	Lead	J.Watson; M.Cox; L.Thompson	

Number of discharges



Reporting Date	Performance	Op. Plan #
Apr-24	630	QC53-54

Threshold	YTD Mean	Benchmark
-	630	101

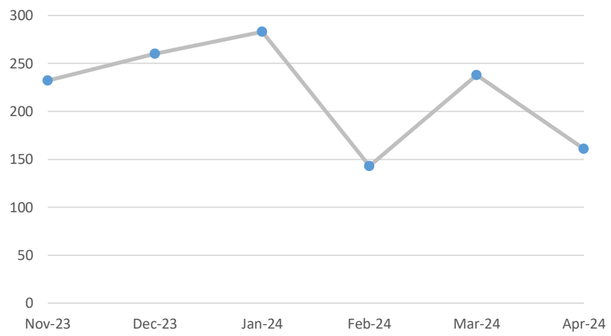
(Lower value represents better performance)

+ Variation Description

Common cause

Assurance Description

Number of Discharges - Weekend



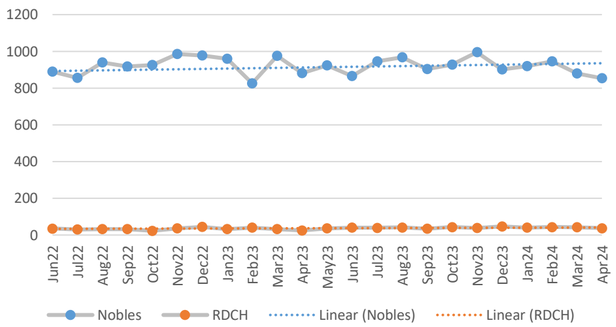
Reporting Date	Performance	Op. Plan #
Apr-24		QC55

Threshold	YTD Mean	Benchmark

- Variation Description

Assurance Description

Inpatient Discharges



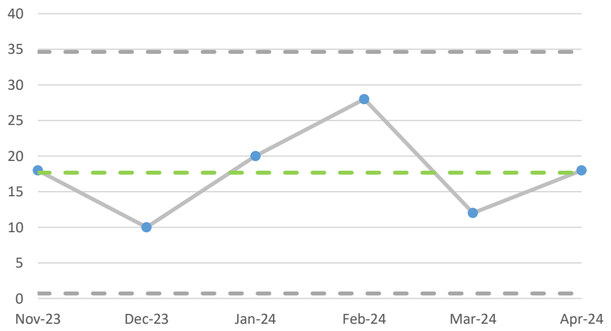
Reporting Date	Performance		Op. Plan #
Apr-24	Nobles	854	
	RDCH	37	

Threshold	YTD Mean		Benchmark
	Nobles	927	916
	RDCH	37	33

Variation Description

Assurance Description

Delayed transfers of care (Hospital)



Reporting Date	Performance	Op. Plan #
Apr-24	18	QC56

Threshold	YTD Mean	Benchmark

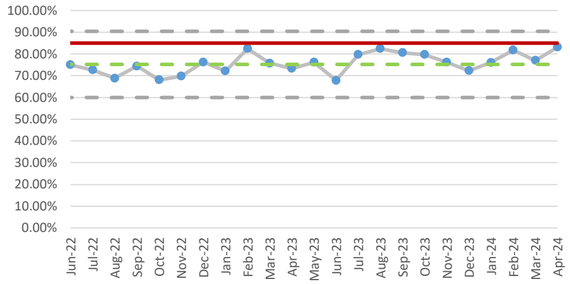
- Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Inpatient Discharges: There were 891 discharges in April.		Note - Benchmarks are the Manx Care monthly average for 2022/23.

Hospital Based C	Theatres	Executive Lead	Oliver Radford	Lead	James Watson	

Theatre Utilisation - % of planned sessions delivered



Reporting Date	Performance	Op. Plan #
Apr-24	83.1%	QC47

Threshold	YTD Mean	Benchmark
85.0%	83.1%	76.9%

(Higher value represents better performance)

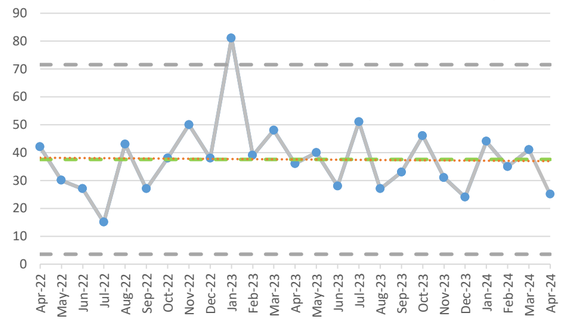
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

Theatres - No. of Cancelled Operations on Day



Reporting Date	Performance	Op. Plan #
Apr-24	25	

Threshold	YTD Mean	Benchmark
-	25	36

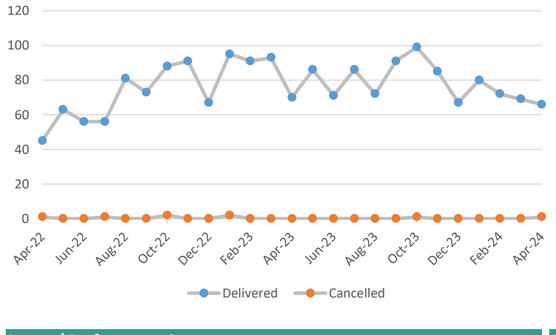
(Lower value represents better performance)

+	Variation Description

Common cause

Assurance Description

Theatres - Delivered (vs Cancelled Sessions)



Reporting Date	Performance	Op. Plan #
Apr-24	66	

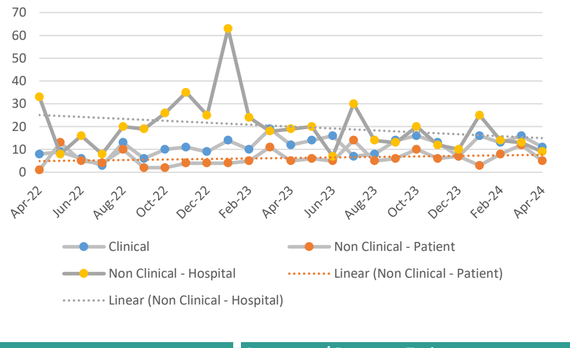
Threshold	YTD Mean	Benchmark
-	66	79

(Higher value represents better performance)

+	Variation Description

Assurance Description

Theatres - Cancelled Operations on Day by source



Reporting Date	Performance	Op. Plan #
Apr-24	-	QC44-46

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 April was 66. •The number of cancelled operations decreased to 25 in Apri. Most common reasons were "Unfit for Surgery-Acute illness" (7). • 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.	• The implementation of a surgical admissions lounge which is in the project stages. • Reinforced 48 Hour call out pathway with the rebooking of short notice cancellations into slots where patient has cancelled. • 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 2023/24.

Hospital Based Care Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD 2024-25	YTD Performance
	Cons Led- OP Referrals		2867	2887	3075	2846	2986	2812	3041	2857	2200	2864	2585	2715	2750		2750	
	Nurse Led- OP Referrals		729	594	850	889	741	824	794	1056	640	1002	923	655	794		794	
	AHP- OP Referrals		684	736	906	846	770	853	866	962	640	966	863	860	890		890	
QC33	No. patients waiting for first Consultant outpatient		15465	15500	15718	15703	15846	16562	16744	16973	16861	16610	16620	16619	16547	16612		
	No. waiting Over 52 weeks - to start consultant-led treatment		4890	4927	5016	5247	5089	5289	5432	5602	5487	5361	5406	5600	5671	5725		
	Average Wait (weeks) - Ref to OP		47	47	47	49	48	48	48	49	47	48	48	49	50	49		
	Max wait (weeks) - Ref to OP		799	846	836	817	816	840	844	1017	1021	1025	1030	1034	1038	1043		
	No. patients waiting for Nurse outpatient		1519	1385	1540	1512	1449	1643	1623	1802	1657	1663	1744	1722	1658	1616		
	No. patients waiting for AHP		3422	3304	3222	2976	3072	2975	2675	2560	2292	2179	2148	2031	1984	2022		
QC34	Number of patients waiting for Daycase procedure		2311	2264	2372	2334	2229	2291	2303	2254	2126	2016	1854	1738	1801	1859		
	Average Wait (weeks) - Daycase		41	42	43	43	45	43	44	45	45	49	46	39	36	35		
	Max wait (weeks) - Daycase		304	308	312	316	320	293	297	301	301	305	310	312	304	308		
	No. waiting Over 52 weeks - Inpatient (Daycase only)		624	609	635	617	602	607	601	604	580	573	496	387	359	350		
QC35	Number of patients waiting for Inpatient procedure		554	553	551	534	505	530	497	464	432	447	445	449	440	422		
	Average Wait (weeks) - Inpatient		39	40	41	40	38	38	35	33	33	34	31	30	26	26		
	Max wait (weeks) - Inpatient		321	325	329	333	337	342	235	212	217	221	215	223	194	198		
	No. waiting Over 52 weeks - Inpatient (IP pathway only)		143	144	149	134	124	129	106	95	78	79	73	75	62	60		
QC37	% Urgent GP referrals seen for first appointment within 6 weeks	85.0%	60.8%	55.0%	57.0%	60.0%	57.4%	42.4%	55.4%	48.6%	52.5%	46.4%	52.9%	51.8%	54.0%			
QC49	Planned Care - DNA - Hospital	7.6%	N/A	N/A	N/A	8.7%	12.2%	10.2%	9.4%	11.0%	11.9%	12.2%	11.1%	12.0%	10.4%			
QC50	Planned Care - DNA Rate (Consultant Led outpatient appointments)	7.6%	11.9%	11.1%	10.4%	11.9%	14.8%	11.5%	11.2%	13.3%	16.7%	15.2%	14.0%	14.8%	12.8%			
QC51	Planned Care - DNA Rate (Nurse Led outpatient appointments)	7.6%	7.4%	7.1%	4.8%	5.1%	8.2%	6.6%	5.4%	6.8%	5.8%	8.2%	7.7%	7.1%	5.9%			
QC52	Planned Care - DNA Rate (AHP Led outpatient appointments)	7.6%	11.3%	9.5%	10.1%	9.0%	11.4%	10.2%	10.0%	9.8%	10.4%	9.8%	8.6%	11.4%	9.7%			
QC59	Planned Care - Total Number of Cancelled Operations		236	344	284	337	268	371	367	348	355	390	320	307	308		308	
	Hospital cancelled		109	196	138	200	140	223	239	156	167	204	155	185	194		194	
	Patient cancelled		127	148	146	137	128	148	128	192	188	186	165	122	114		114	
QC30	Number of patients with a length of stay = 0 days									1197	767	925	771	744	630			
QC31	Number of patients with a length of stay > 7 days									226	209	227	236	197	215			
QC32	Number of patients with a length of stay > 21 days	-	112	121	114	140	103	105	94	81	91	115	103	120	96		96	
QC58	Average Length of Stay (ALOS) - Nobles	-	5	5	5	5	5	5	5	5	5	5	4	3	3			
QC58	Average Length of Stay (ALOS) - RDCH	-	38	130	38	31	36	40	44	34	35	35	43	35	37			
	Total Number of discharges	-	907	960	906	985	1009	938	971	1033	949	960	989	902	891		891	
	Total Number of Inpatient discharges-Nobles	-	882	924	866	946	968	904	928	995	902	920	946	880	854		854	
	Total Number of inpatient discharges-RDCH	-	25	36	40	39	41	34	43	38	47	40	43	42	37		37	
QC44-6	Theatres - Number of Cancelled Operations on Day		36	40	28	51	27	33	46	31	24	44	35	41	25		25	
QC44	Theatres - Number of Cancelled Operations on Day - Clinical		12	14	16	7	8	14	16	13	7	16	13	16	11		11	
QC45	Theatres - Number of Cancelled Operations on Day - Non clinical - Patient		5	6	5	14	5	6	10	6	7	3	8	12	5		5	
QC46	Theatres - Number of Cancelled Operations on Day - Non clinical - Hospital		19	20	7	30	14	13	20	12	10	25	14	13	9		9	
QC47	Theatres - Theatre Utilisation %	85%	73.3%	76.2%	67.8%	79.7%	82.4%	80.6%	79.8%	76.2%	72.3%	76.1%	81.8%	77.0%	83.1%			
QC53	Number of discharges: Pre-10:00									160	104	137	99	120	89		89	
QC54	Number of discharges: Pre-16:00									1083	832	963	859	841	737		737	
QC55	Number of discharges: Weekend									232	260	283	143	238	161		161	
QC56	Delayed transfers of care									18	10	20	28	12	18		18	

Integrated Diagnostics & Cancer Services Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC91	Mandate	CWT - % 28 Days to diagnosis or ruling out of cancer	Responsive	Apr-24		73%	73%	-	75%		
QC92	Mandate	CWT - % patients decision to treat to first definitive treatment within 31 days	Responsive	Apr-24		92%	92%	-	96%		
QC93	Mandate	CWT - % patients urgent referral for suspected cancer to first treatment within 62 days	Responsive	Apr-24		46%	46%	-	85%		
	Supporting	Number on Cancer Pathway (All)	Responsive	Apr-24	-	561	561	-	-		
	Supporting	Total number of patients Waiting for 1st cancer OP	Responsive	Apr-24	-	72	72	-	-		
	Supporting	Cancer - Median Wait Time from the Referral Date to the Diagosis Date	Responsive	Apr-24	-	19	19	-	-		
QC97	Mandate	Diagnostics - Percentage of patients waiting 6 weeks or more for a diagnostics test	Responsive	Apr-24		59.3%	59.3%	-	<=1%		

GOING WELL

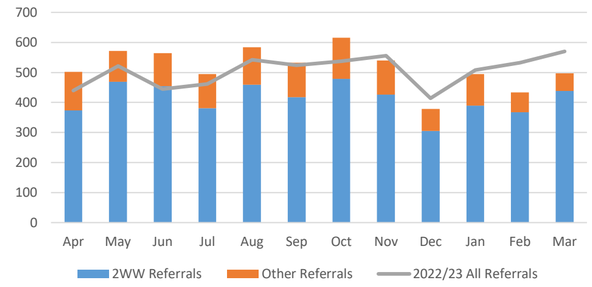
CAUSE FOR CONCERN

Mandate Objectives: Integrated Diagnostics & Cancer Services

Objective No.	Objective	Status	Progress / Risks	Lead
3 b	Manx Care will consistently (*In at least 10 out of 12 calendar months) meet the following: i. The 28-day faster diagnosis standard (FDS). ii. The 62-day referral to treatment standard (noting the reliance on tertiary providers for some elements of some pathways). iii. A 31-day decision to treat to treatment standard		Data published monthly in IPR. In-year analysis of data will be undertaken to assess target achievement. Proactive review of patients who have been on a Cancer pathway for 100+ days ongoing. These reviews and validation work will support the expedition of patient care and proactively improve our Cancer Waiting Times.	LA
3 c	Terminal cancer and vision loss support review and recommendations shared with the Department through the Mandate Development Meetings by 30 September 2024		Cancer Services continues to expand establishment of Cancer Support Workers and Cancer Care Co-ordinators. These roles include providing Holistic Needs Assessments (HNA's) to patients with cancer diagnoses to develop a Personalised Care Plan and actively support them through their diagnosis and treatment. This is done in conjunction with the Oncology Day Unit and the CNS for the specific site of disease. A wider review of existing mechanisms with commence in early summer 2024. (Also reporting in Hosp. Care Page)	LA

IDCS	Cancer Wait Times	Executive Lead	Oliver Radford	Lead	Lisa Airey	

Referrals to Cancer Pathway - Suspected Cancer (2WW) & Other (Screening/Upgraded)



Reporting Date	Performance	Op. Plan #
Apr-24	376	

Threshold	YTD Mean	Benchmark

(Higher value represents better performance)

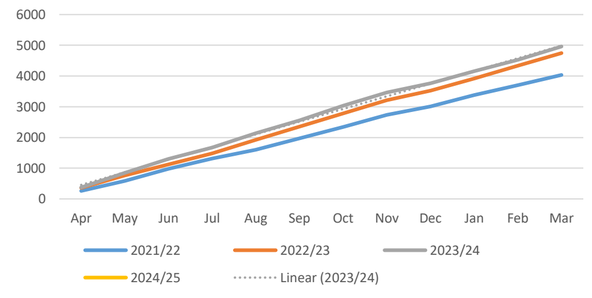
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

Referrals to Cancer Pathway - Suspected Cancer (2WW) only - Cumulative YTD



Reporting Date	Performance	Op. Plan #
Apr-24	485	

Threshold	YTD Mean	Benchmark

(Higher value represents better performance)

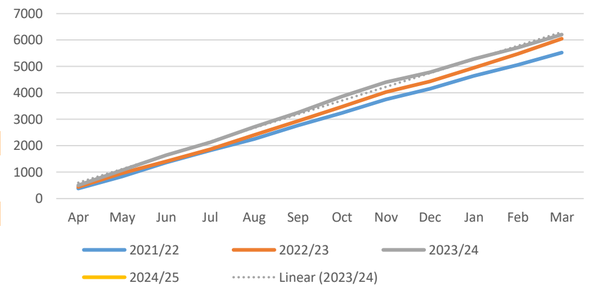
+	Variation Description

Common cause

+	Assurance Description

Inconsistently passing and falling short of target

Referrals to Cancer Pathway (All Referral Types) - Cumulative YTD



Reporting Date	Performance	Op. Plan #
Apr-24	423	

Threshold	YTD Mean	Benchmark

-	Variation Description

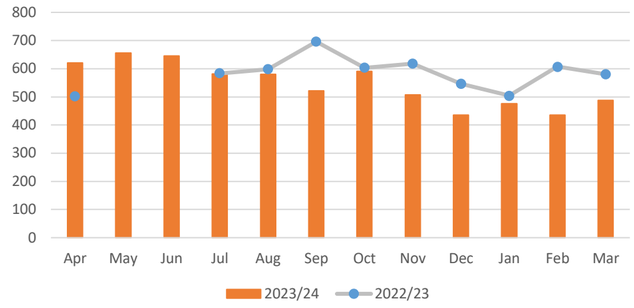
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• There are different types of referral onto a cancer pathway. The most common is a suspected cancer referral from a GP (or Dentist or Optomotrist) - this previously was known as a 2 week wait or 2WW referral. Other types of referral onto a cancer pathway can come from screening services or an upgraded referral.	• The ongoing review of our existing suspected cancer (GP referral) proformas with our specialist teams against the current Cheshire and Merseyside Cancer Alliance templates is reaching it's conclusion. Further to successfully reviewing and implementing revised forms for Gynaecology, Skin, and Sarcoma, we have now reviewed and implemented Breast, Lung, Haematology, Upper GI, Colorectal, ENT, Oral, and Urology. Remaining specialist teams are currently reviewing their forms, and our ambition is to implement the remaining revised forms by close of May 2024. • On Wednesday 13 March, Primary Care and Cancer Services jointly held an education session for the Island's GP's and Primary Care clinicians. This session was solely dedicated to Cancer, with a focus on the roll out of the new Urgent Suspected Cancer Referral (2WW) forms. Presentations were provided by clinicians from Noble's Hospital, the Cancer Services team and the Primary Care Network - not only in relation to the roll out of the new forms but also the Acute Oncology Advice and Guidance Service, GP Safety-netting, The Cancer Academy and the 28-Day Faster Diagnosis Standard (FDS). • 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	• 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 • Revised suspected cancer proformas now implemented for Gynaecology, Skin and Sarcoma Breast, Lung, Haematology, Upper GI, Colorectal, ENT, Oral, and Urology

IDCS	Cancer Wait Times	Executive Lead	Oliver Radford	Lead	Lisa Airey

Monthly Snapshot of number of patients on Cancer PTL
(Open cancer pathway, referred on 2WW/Suspected Cancer only)



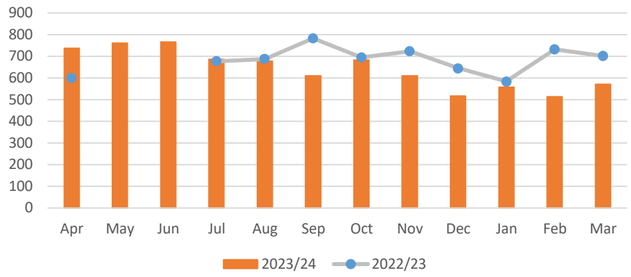
Reporting Date	Performance	Op. Plan #
Apr-24	561	

Threshold	YTD Mean	Benchmark
-	563	677

Variation Description

Assurance Description

Monthly Snapshot of number of patients on Cancer PTL
(Open cancer pathway, all referral types)



Reporting Date	Performance	Op. Plan #
Jan-00	0	

Threshold	YTD Mean	Benchmark
-	665	685

Variation Description

Assurance Description

Monthly Snapshot of number of patients waiting over 62 days on Cancer PTL (RTT Pathway)

Reporting Date	Performance	Op. Plan #
Apr-24		

Threshold	YTD Mean	Benchmark
	130	

+ Variation Description

Common cause

Assurance Description

Monthly Snapshot of number of patients on PTL awaiting 1st appointment
(Open cancer pathway, all referral types)

Reporting Date	Performance	Op. Plan #
Apr-24	72	

Threshold	YTD Mean	Benchmark
	87	86

(Lower value represents better performance)

+ Variation Description

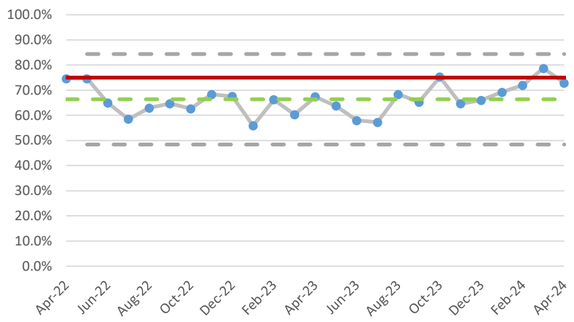
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• As per the last Operational PTL (Priority Tracking List) meeting of April 2024 (26/04/24), there are 561 patients awaititing a cancer or non-cancer diagnosis or, if diagnosed, awaiting treatment. • The median wait time for diagnosis in April 2024 is 19 days. • 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	• 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	• 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

IDCS	Cancer Wait Times	Executive Lead	Oliver Radford	Lead	Lisa Airey	

CWT - 28 Day Faster Diagnosis Standard (FDS)



Reporting Date	Performance	Op. Plan #
Apr-24	72.8%	QC91
	(284 of 390)	

Threshold	YTD Mean	Benchmark
75.0%	72.8%	77.3%

(Higher value represents better performance)

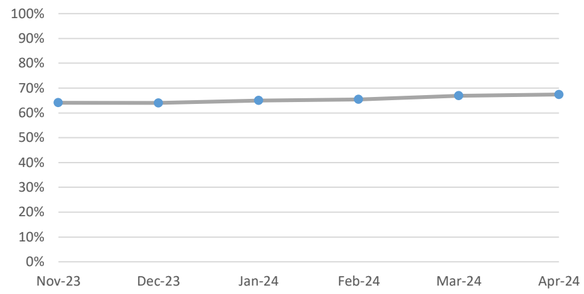
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

CWT - 28 Day Faster Diagnosis Standard (FDS) - Rolling 12 Month performance



Reporting Date	Performance	Op. Plan #
Apr-24	67.4%	-
	(3013 of 4469)	

Threshold	YTD Mean	Benchmark

(Higher value represents better performance)

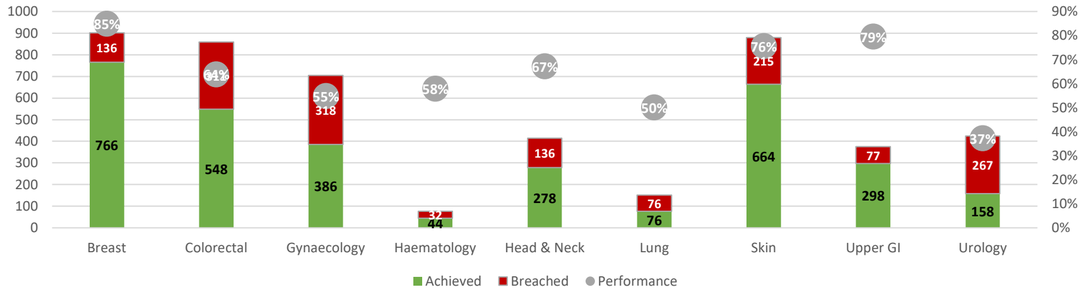
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

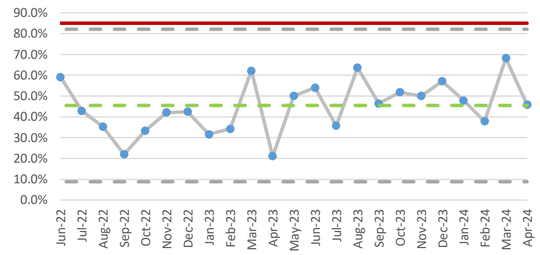
CWT - 28 Day Faster Diagnosis Standard - Rolling 12 Month Summary by Tumour Group



Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• This metric is based the target of maximum of 28 days from receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer. • 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	• 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	• 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 Note - Benchmarks for 28 day FDS are taken from UK NHSE performance figures for March 2024 (https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-data-and-summaries/2023-24-monthly-cancer-waiting-times-statistics/)

IDCS	Cancer Wait Times	Executive Lead	Oliver Radford	Lead	Lisa Airey	

CWT - 62 Day Referral to Treatment (RTT)



Reporting Date	Performance	Op. Plan #
Apr-24	45.8% (15 of 22)	QC93

Threshold	YTD Mean	Benchmark
85.0%	45.8%	68.7%

(Higher value represents better performance)

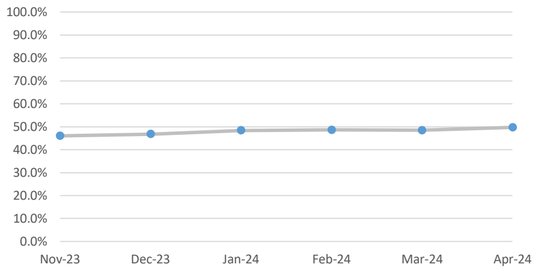
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

CWT - 62 Day Faster Diagnosis Standard (FDS) - Rolling 12 Month performance



Reporting Date	Performance	Op. Plan #
Apr-24	49.7% (179 of 360)	-

Threshold	YTD Mean	Benchmark
85.0%	-	-

(Higher value represents better performance)

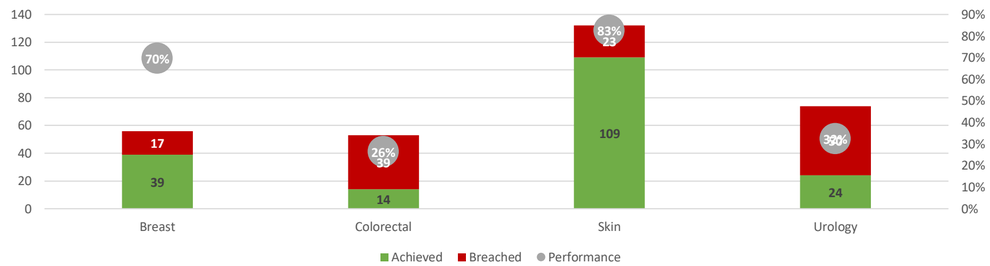
+	Variation Description

Common cause

-	Assurance Description

Consistently fail target

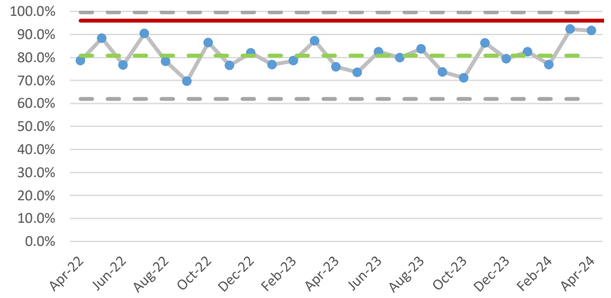
CWT - 62 Day Referral to Treatment (RTT) - Rolling 12 Month Summary by Tumour Group



Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• This metric is based the target of maximum of 62 days from receipt of an urgent GP referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer • The current reporting of the 62 day process does not include the breach allocation in line with the UK National Cancer Waiting Times Guidance. At present all breaches of the 62 day pathway are included in the current performance reported above. • All patients on a RTT cancer pathway are monitored by the various cancer PTLs to ensure that any potential delays in their pathway are minimised wherever possible. Any organisational delays are escalated in line with the Cancer Escalation Policy. • The monthly percentage performance of RTT is expected to be volatile due to the small number of patients who are treated for cancer per month. A tumour group breakdown of RTT is provided for those with a larger activity only based on a 12 month summary of performance. This is to show the smaller numbers from which the monthly RTT performance is calculated, and give more details on the performance for these tumour group. Other tumour groups have data that is less than 10 patients so are excluded for publication to avoid potential for patient identification.	• Work continues within the Cancer Services Team and BI to build the breach allocation into the 62 day reporting process. This is to ensure that only breaches that Manx Care are responsible for are reported into the 62 day RTT performance. This change will align us with the UK National Cancer Waiting Times Guidance. It will also assist with a better understanding where the issues are in the pathway, which could support Tertiary service level discussions for the future. • Ongoing training within the Cancer MDT team to accurately capture breach allocation reasons on the Somerset Cancer Register (SCR), including the date in which a patient is referred to a Tertiary Centre for investigation or treatment.	• 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 Data updates: • Cancer Outcomes and Services Dataset (COSD) has now transitioned to electronic portal submission, and away from e-mail submissions, in-line with UK Trusts. • Data towards the 2020 Cancer Intelligence Report published by the Public Health Directorate has now started to be transmistted to the team from the National Disease Registration Service (NDRS). • 2024 COSD Dataviews Data Quality Review is now live and regular COSD compliance checks have now commenced for 2024. Note - Benchmarks for 62 day RTT are taken from UK NHSE performance figures for March 2024 (https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-data-and-summaries/2023-24-monthly-cancer-waiting-times-statistics/)

IDCS	Cancer Wait Times	Executive Lead	Oliver Radford	Lead	Lisa Airey	

CWT - 31 Day Decision to Treat to Treatment (DTT)



Reporting Date	Performance	Op. Plan #
Apr-24	91.7%	QC92
	(44 of 48)	

Threshold	YTD Mean	Benchmark
96.0%	91.7%	91.1%

(Higher value represents better performance)

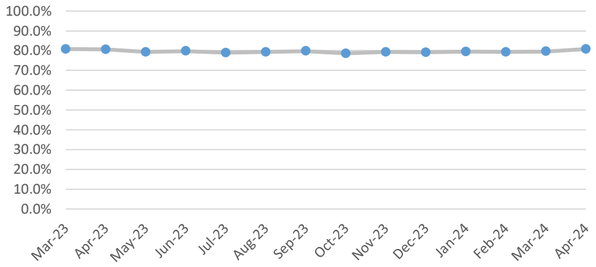
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

CWT - 31 Day Decision to Treat to Treatment (DTT) - Rolling 12 Month Summary by Tumour Group



Reporting Date	Performance	Op. Plan #
Apr-24	80.7%	-
	(541 of 670)	

Threshold	YTD Mean	Benchmark
96.0%	-	-

(Higher value represents better performance)

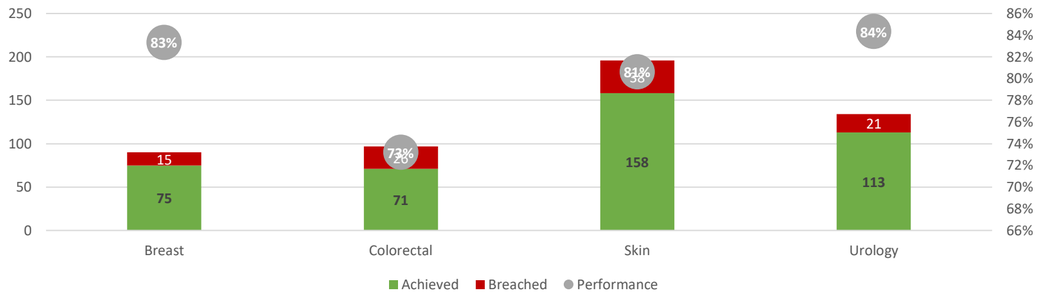
+ Variation Description

Common cause

- Assurance Description

Consistently fail target

CWT - 31 Day Decision to Treat to Treatment (DTT) - Rolling 12 Month Summary by Tumour Group



Issues / Performance Summary

• This metric is based the target of maximum of 31 days from From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer. This is for all cancer treatments, including subsequent treatments

• All patients on a DTT cancer pathway are monitored by the various cancer PTLs to ensure that any potential delays in their pathway are minimised wherever possible. Any organisational delays are escalated in line with the Cancer Escalation Policy.

• The monthly percentage performance of DTT is expected to be volatile due to the small number of patients who are treated for cancer per month.

Planned / Mitigation Actions

• Work continues within the Cancer Services Team and BI to build the breach allocation into the 62 day reporting process. This is to ensure that only breaches that Manx Care are responsible for are reported into the 62 day RTT performance. This change will align us with the UK National Cancer Waiting Times Guidance. It will also assist with a better understanding where the issues are in the pathway, which could support Tertiary service level discussions for the future.

Assurance / Recovery Trajectory

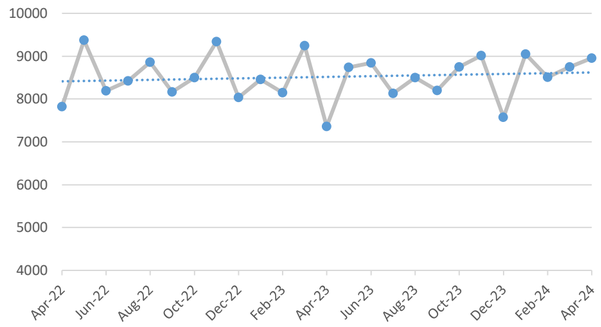
• Reporting data now taken directly from the Somerset Cancer Registry (SCR) and is automated

• KPIs and performance management governance brought in line with the National Cancer Waiting Times Monitoring Dataset Guidance

Note -
Benchmarks for 31 day DTT are taken from UK NHSE performance figures for December 2023 (https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-data-and-summaries/2023-24-monthly-cancer-waiting-times-statistics/)

IDCS	Diagnostics Wait Times	Executive Lead	Oliver Radford	Lead	Lisa Airey

Diagnostics - No. of requests received



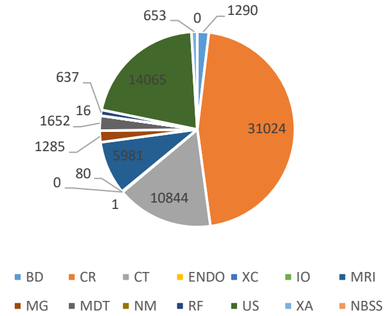
Reporting Date	Performance	Op. Plan #
Apr-24	8,957	
Threshold	**YTD Mean**	**Benchmark**
-	8,957	8,451

Variation Description

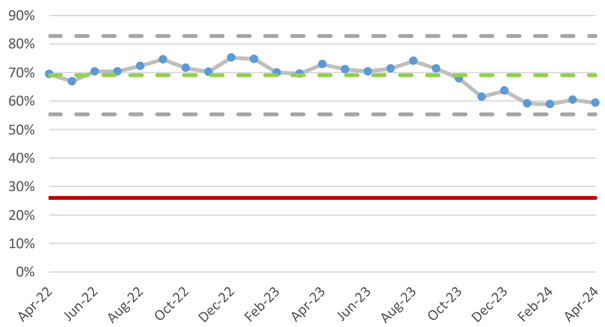
Assurance Description

Modality	Apr-24		
	WL	>6 wks	% >6 wks
Bone Densitometry	167	47	28%
Computed Tomography	797	324	41%
Magnetic Resonance Imaging	451	115	25%
Ultrasound Non Obs	2,835	2,036	72%
Total	**4,250**	**2,522**	**59%**

YTD Demand by Modality: 2023/24



Diagnostics - % of Patients waiting over 6 weeks



Reporting Date	Performance	Op. Plan #
Apr-24	59.3%	QC97
Threshold	**YTD Mean**	**Benchmark**
<=1%	59.3%	21.8%

(lower value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• Overall demand continues to exceed capacity. Demand was 31.5% higher than capacity in April. • Emergency Department (ED) 23.9%, Outpatient Department (OPD) 39.1% and General Practitioner (GP) 20.8% remain the primary source of referrals, and there has been no significant change on the distribution compared to last month. • Inpatient Referrals (760). This equated to 11.2% of all requests. • 43.6% of exams were reported within 2 hours, 15.6% have taken 97 hours or longer. • Of the 6,814 exams, 46.5% were turned around on the same day, and a further 36.5% 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. • 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. Note - Benchmark for '% Patients Waiting over 6 Weeks' is the UK NHSE performance figures for March 2024.

Integrated Diagnostics & Cancer Services Performance Scorecard

	KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
	QC93	Decision to treat to first definitive treatment within 31 days	96%	76.0%	73.5%	82.4%	80.0%	83.8%	73.8%	71.2%	86.4%	79.4%	82.5%	76.9%	92.3%	91.7%		
	QC92	Maximum 62 days from referral for suspected cancer to first treatment	85%	21.1%	50.0%	54.0%	35.7%	63.6%	46.4%	51.9%	50.0%	57.1%	47.8%	37.8%	68.2%	45.8%		
	QC91	Maximum 28 days from referral for suspected cancer to date of diagnosis	75%	67.4%	63.7%	58.0%	57.3%	68.3%	65.3%	75.3%	64.6%	66.0%	69.2%	72.0%	78.7%	72.8%		
		All Referrals received for all suspected cancers		502	572	564	495	584	532	615	540	378	495	433	497	466	466	
	QC97	Diagnostics - % Current wait > 6 weeks	1%	73%	71%	70%	71%	74%	71%	68%	61%	64%	59%	59%	60%	59%		
		Diagnostics - Total Waiting List Size (exc. Scheduled & On Hold)		8256	7719	7545	7291	3541	4544	3846	3622	3955	3883	3871	4130	4250		

Integrated Care Women Children & Families Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
	Supprting	Maternity Bookings	Responsive	Apr-24	-	50	50	50	-		
	Supprting	Ward Attenders	Responsive	Apr-24	-	282	282	282	-		
	Supprting	Gestation At Booking <10 Weeks	Responsive	Apr-24	-	70%	70%	-	-		
QC155	Operating Plan	W&C - % New Birth Visits within timescale	Responsive	Apr-24	-	89%	89%	-	-		
	Supprting	Births per annum	Responsive	Apr-24	-	47	-	47	-		
QC156	Operating Plan	Maternity - % Of Women Smoking At Time Of Delivery	Effective	Apr-24		2%	2%	-	< 18%		
QC157	Operating Plan	Maternity - First Feed Breast Milk (Initiation Rate)	Effective	Apr-24		74%	74%	-	> 80%		
	Supprting	Maternity - Breast Feeding Rate At Transfer Home	Effective	Apr-24	-	81%	81%	-	-		
	Supprting	Maternity - Neonatal Mortality rate/1000	Effective	Apr-24	-	0	0.0%	-	-		-
	Supprting	W&C - Paediatrics- Total Admissions	Effective	Apr-24	-	145	145	145	-		-
	Supprting	W&C - NNU - Total number of Admissions	Effective	Apr-24	-	12	12	12	-		-

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
	Supprting	W&C - NNU - Avg. Length of Stay	Effective	Apr-24		7	7	-	-		-
	Supprting	W&C - NNU -Community follow up	Effective	Apr-24		13	13	13	-		-
	Supprting	Maternity - Caesarean Deliveries (not Robson Classified)	Effective	Apr-24	-	45%	45%	-	-		
QC158	Operating Plan	Maternity - Induction of Labour	Effective	Apr-24		38%	38%	-	< 30%		
QC159	Operating Plan	Maternity - 3rd/4th Degree Tear Overall Rate	Effective	Apr-24		0%	0%	-	< 3.5%		
QC160	Operating Plan	Maternity - Obstetric Haemorrhage >1.5L	Effective	Apr-24		0%	0%	-	< 2.6%		
	Supprting	Maternity - Unplanned Term Admissions To NNU	Effective	Apr-24	-	13%	13%	-	-		
QC161	Operating Plan	Maternity - Stillbirth Number / Rate	Effective	Apr-24		0	0%	-	<4.4/1000		
	Supprting	Maternity - Unplanned Admission To ITU – Level 3 Care	Effective	Apr-24	-	0	0%	0	-		
	Supprting	Maternity - % Smoking At Booking	Effective	Apr-24	-	9%	9%	-	-		

GOING WELL

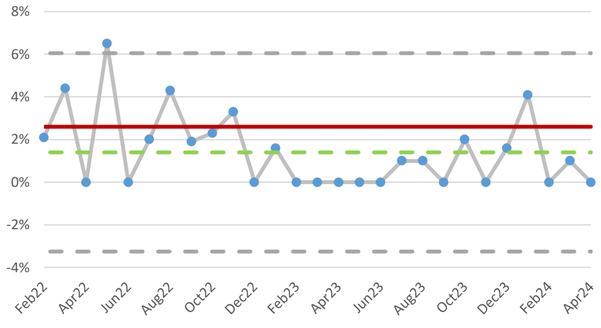
CAUSE FOR CONCERN

Mandate Objectives: Integrated Care Women Children & Families

Objective No.	Objective	Status	Progress / Risks	Lead
2 d	Manx Care will continue to develop the local offering of the 0-19 programme through the health visiting and school nursing teams, commencing with exploration and recommendations for: i. An infant feeding team with contact offered to every family before 4 months of age (including 'starting solids'). ii. Special education needs and disability (SEND) health visitor role. iii. Training offering for health visitors around domestic abuse, in line with local domestic abuse legislation and consideration of a health visiting role specifically skilled in this area			LT
2 d	Recommendations and implementation options for the development of the 0-19 programme, shared with the Mandate Development Meetings by 30 September 2024.		Families' hub which was piloted in Ramsey has proved to be a huge success, this blueprint is now going to be piloted in the south of the island. This is in response to staffing challenges and adopting the 0-19 Public Health model	LT

ICWC&F	Maternity	Executive Lead	Oliver Radford	Lead	Linda Thompson	

Obstetric Haemorrhage >1.5L



Reporting Date	Performance	Op. Plan #
Apr-24	0%	QC160

Threshold	YTD Mean	Benchmark
< 2.6%	0.00%	0.9%

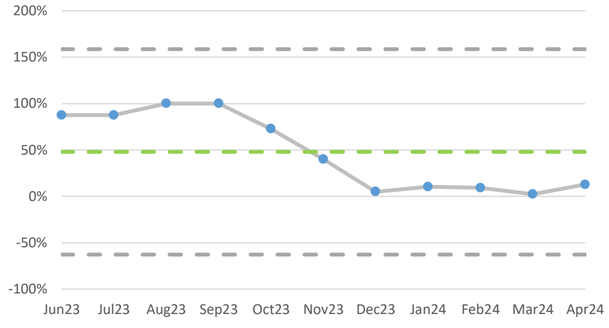
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Unplanned Term Admissions To NNU



Reporting Date	Performance	Op. Plan #
Apr-24	**12.8%**	

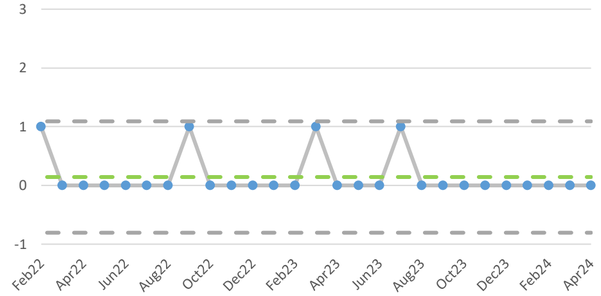
Threshold	YTD Mean	Benchmark
-	12.8%	51.4%

Variation Description

Common cause

Assurance Description

Stillbirth Number / Rate



Reporting Date	Performance	Op. Plan #
Apr-24	0	QC161

Threshold	YTD Mean	Benchmark
<4.4/1000	0.0	0

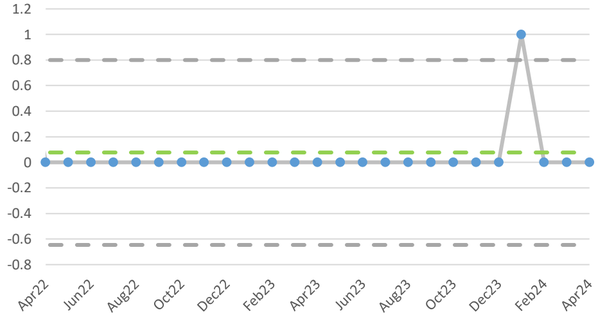
+ Variation Description

Common cause

+ Assurance Description

Inconsistently passing and falling short of target

Neonatal Mortality rate/1000



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

Threshold	YTD Mean	Benchmark
-	0	0

+ Variation Description

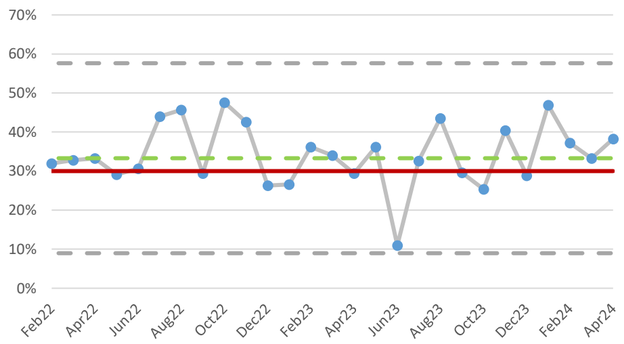
Special Cause of Improving variation (Low)

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Obstetric haemorrhage >1.5 litre: No PPH's occurred in April, down from 1 in March. **Unplanned Term Admissions To NNU** 6 unplanned term admissions to NNU, which could have impacted the First Feed Breast Milk which was down to 59.6% in April from 76.1% in March. **Stillbirth number / rate** **Neonatal mortality rate**		Note - Benchmarks are the Manx Care monthly averages for 2023/24

ICWC&F	Delivery	Executive Lead	Oliver Radford	Lead	Linda Thompson	

Induction of Labour



Reporting Date	Performance	Op. Plan #
Apr-24	38.2%	QC15

Threshold	YTD Mean	Benchmark
< 30%	38.2%	32.9%

(Lower value represents better performance)

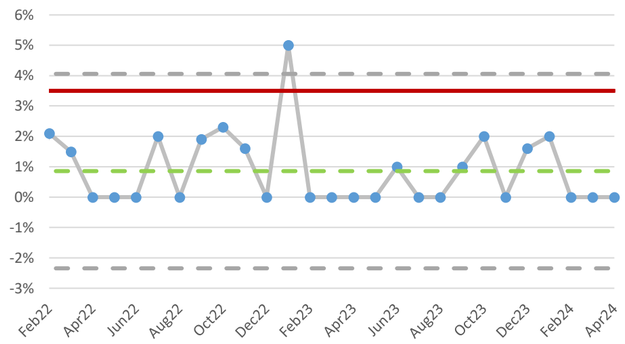
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

3rd/4th Degree Tear Overall Rate



Reporting Date	Performance	Op. Plan #
Apr-24	0%	QC159

Threshold	YTD Mean	Benchmark
< 3.5%	0.0%	0.6%

(Lower value represents better performance)

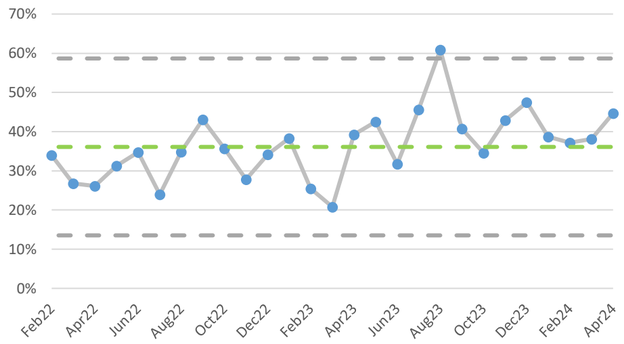
+ Variation Description

Common cause

Assurance Description

Consistently hit target

Caesarean Deliveries (not Robson Classified)



Reporting Date	Performance	Op. Plan #
Apr-24	44.7%	

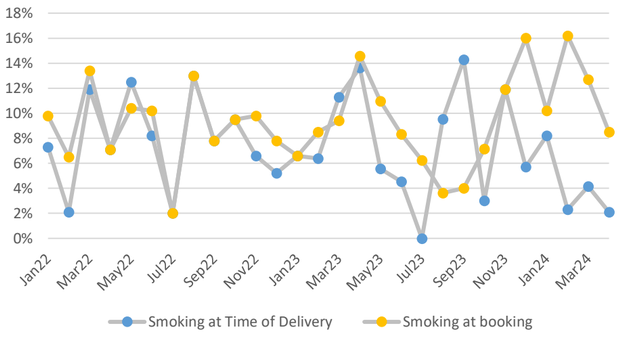
Threshold	YTD Mean	Benchmark
-	44.7%	41.6%

+ Variation Description

Common cause

Assurance Description

% Smoking



Reporting Date	Performance		Op. Plan #
Apr-24	Booking	8.5%	QC156
	Delivery	2.1%	

Threshold	YTD Mean	Benchmark
-	-	-

(Lower value represents better performance)

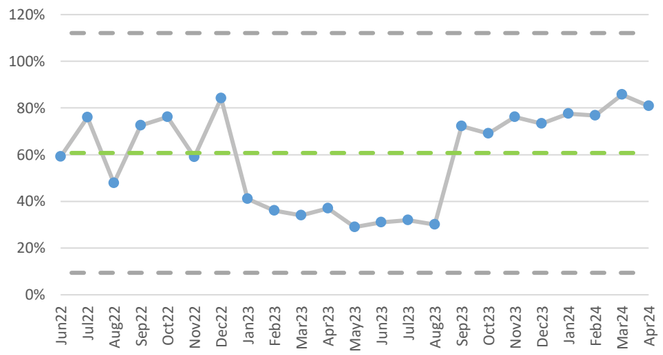
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Total caesarean deliveries: **Induction of labour:** 38.2% in April, up from 33.3% in March and is out of national standard. Audit is being undertaken regarding reason for induction. Percentage of inductions are undertaken for large or small for gestational age as both of these present a risk to an ongoing pregnancy at term +. However, we do not have any objective evidence that these babies are larger or smaller as we are not able to plot growth against a personalised growth chart. We are currently looking at the feasibility of introducing personalised growth charts from the perinatal institute. **Third and fourth degree tear rates:** **Smoking at booking and delivery:** Down to 2.1% from 2.3% last month.		Note - Benchmarks are the Manx Care monthly averages for 2023/24

ICWC&F	Breast Feeding	Executive Lead	Oliver Radford	Lead	Linda Thompson	

Breast Feeding Rate At Transfer Home



Reporting Date	Performance	Op. Plan #
Apr-24	80.9%	

Threshold	YTD Mean	Benchmark
-	80.9%	57.5%

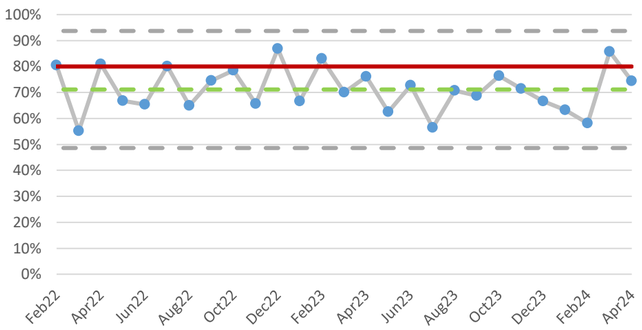
(Higher value represents better performance)

+ Variation Description

Common cause

Assurance Description

First Feed Breast Milk (Initiation Rate)



Reporting Date	Performance	Op. Plan #
Apr-24	74.4%	

Threshold	YTD Mean	Benchmark
> 80%	74.4%	69.1%

(Higher value represents better performance)

- Variation Description

Common cause

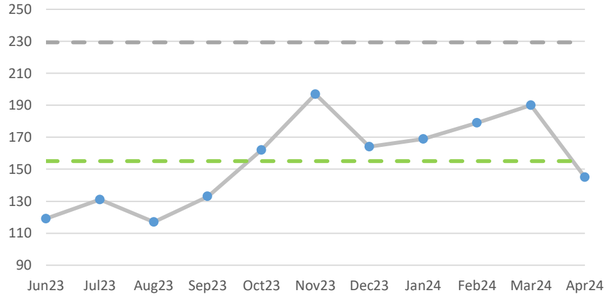
- Assurance Description

Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Breastfeeding Intention 74.4% of women intended to breastfeed, with 80.9% discharged home breastfeeding.		Note - Benchmarks are the Manx Care monthly averages for 2023/24

ICWC&F	NNU	Executive Lead	Oliver Radford	Lead	Linda Thompson	

Paediatrics- Total Admissions



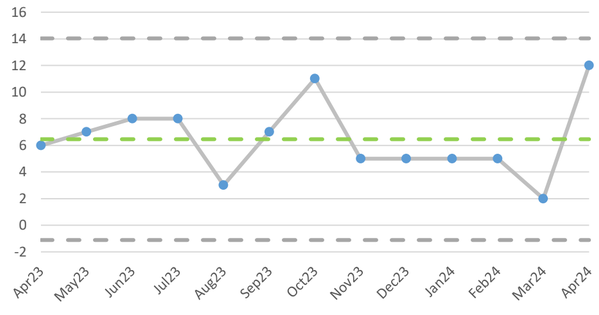
Reporting Date	Performance	Op. Plan #
Apr-24	**145**	
Threshold	**YTD Mean**	**Benchmark**
-	145	156

+ Variation Description

Common cause

Assurance Description

NNU - Total number of Admissions



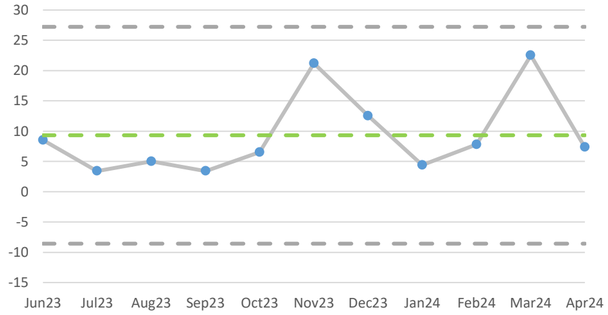
Reporting Date	Performance	Op. Plan #
Apr-24	**12**	
Threshold	**YTD Mean**	**Benchmark**
-	12	6

- Variation Description

Common cause

Assurance Description

NNU - Avg. Length of Stay



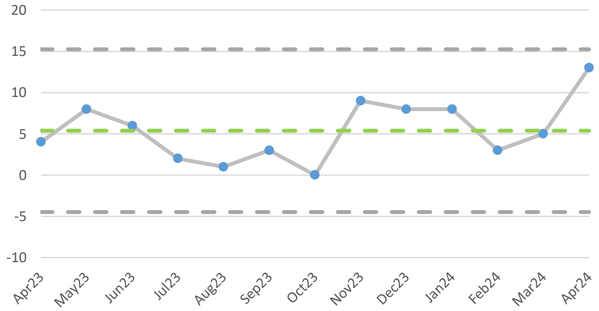
Reporting Date	Performance	Op. Plan #
Apr-24	**7**	-
Threshold	**YTD Mean**	**Benchmark**
-	7.3	10

+ Variation Description

Common cause

Assurance Description

NNU - Community follow up



Reporting Date	Performance	Op. Plan #
Apr-24	13	
Threshold	**YTD Mean**	**Benchmark**
-	13	5

Variation Description

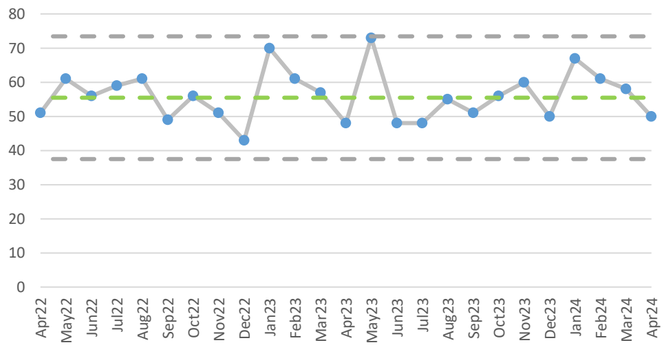
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• 6 babies were below 37/40 (34+2- 36+2) weeks gestation (preterm), admission with prematurity/ respiratory symptoms/ suspected / hypoglycaemia/ hypothermia. • 1 x baby required intubation & ventilation (ITU). • 1 baby was unplanned admissions at 37/40 + weeks (term) with respiratory symptoms/suspected infection/hypoglycaemia/suspected fracture. • 1 x baby was admitted from home with jaundice requiring treatment. • 11 x babies were admitted from theatre/labour ward/postnatal ward between 17 mins and 23hrs of age. • 6 x babies required intravenous antibiotics. • Staffing -3 members of staff had sickness absence (1x WTE long term) Nursery nurse support staff 0.2WTE. Staff working extra hours to fill gaps, especially in April with the increase activity and dependency level. • Band 6 neonatal nurse 2.2 x WTE agency required to maintain minimum staffing.	• 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 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).	• 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 2023/24

ICWC&F	Maternity Activity	Executive Lead	Oliver Radford	Lead	Linda Thompson	

Maternity Bookings



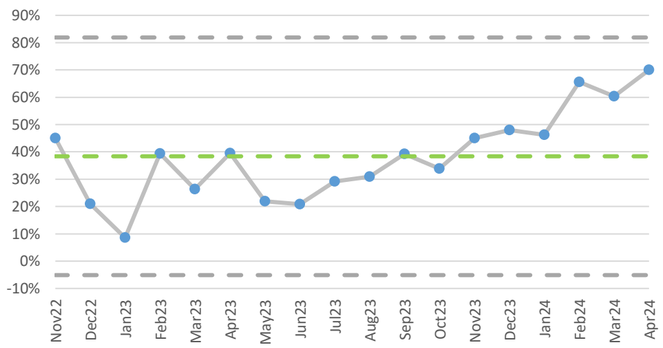
Reporting Date	Performance	Op. Plan #
Apr-24	**50**	
Threshold	**YTD Mean**	**Benchmark**
-	50	56

Variation Description

Common cause

Assurance Description

Gestation At Booking <10 Weeks



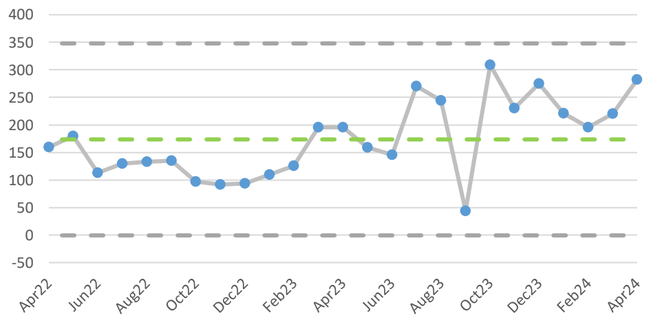
Reporting Date	Performance	Op. Plan #
Apr-24	**70%**	
Threshold	**YTD Mean**	**Benchmark**
-	70%	40.1%

Variation Description

Common cause

Assurance Description

Ward Attenders



Reporting Date	Performance	Op. Plan #
Apr-24	**282**	
Threshold	**YTD Mean**	**Benchmark**
-	282	209

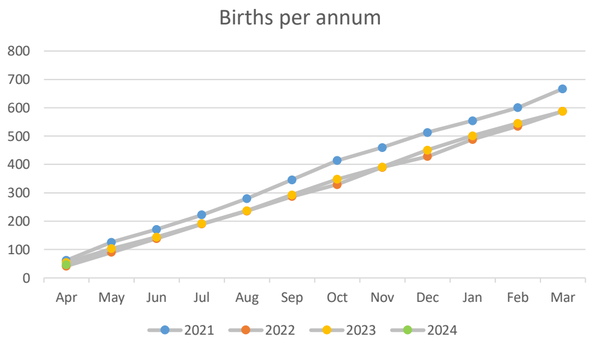
Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
		Note - Benchmarks are the Manx Care monthly averages for 2023/24

ICWC&F	Births	Executive Lead	Oliver Radford	Lead	Linda Thompson	

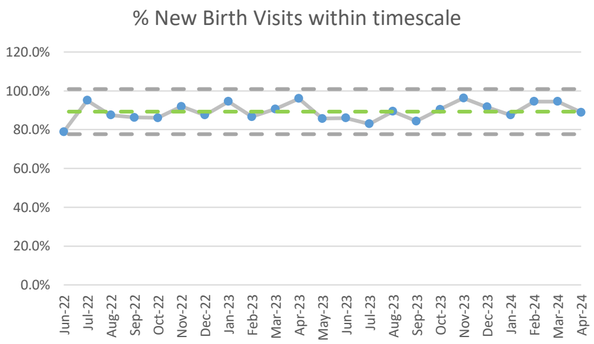


Reporting Date	Performance	Op. plan #
Apr-24	**47**	
Threshold	**YTD Mean**	**Benchmark**
-	-	-

(Higher value represents better performance)

+	Variation Description
	Common cause

Assurance Description



Reporting Date	Performance	Op. Plan #
Apr-24	**89%**	QC155
Threshold	**YTD Mean**	**Benchmark**
-	89%	90%

-	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	
In April 2024 we received 51 Antenatal referrals into the department. **New Birth Visits** The Health Visiting Team completed a total of 45 visits. Out of these visits, 40 were completed within the timeframe of 14 days and 5 were not completed within timeframe during April. Our overall compliance was 95 % There were 3 exceptions and 2 breaches.		Note - Benchmarks are the Manx Care monthly averages for 2023/24

Integrated Care Women Children & Families Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
	Caesarean Deliveries (not Robson Classified)		39%	43%	32%	46%	61%	41%	35%	43%	47%	39%	37%	38%	45%		
QC158	Induction of Labour	< 30%	29%	36%	11%	33%	44%	30%	25%	40%	29%	47%	37%	33%	38%		
QC159	3rd/4th Degree Tear Overall Rate	< 3.5%	0%	0%	1%	0%	0%	1%	2%	0%	2%	2%	0%	0%	0%		
QC160	Obstetric Haemorrhage >1.5L	< 2.6%	0%	0%	0%	1%	1%	0%	2%	0%	2%	4%	0%	1%	0%		
	Unplanned Term Admissions To NNU		0%	0%	88%	88%	100%	100%	73%	40%	5%	10%	9%	2%	13%		
QC161	Stillbirth Number / Rate		0	1	0	0	0	0	0	0	0	0	0	0	0	0	
	Unplanned Admission To ITU – Level 3 Care		0	1	0	1	0	0	0	1	0	0	0	0	0	0	
QC156	% Smoking At Booking		15%	11%	8%	6%	4%	4%	7%	12%	16%	10%	16%	13%	9%		
	% Of Women Smoking At Time Of Delivery	< 18%	14%	6%	5%	0%	10%	14%	3%	12%	6%	8%	2%	4%	2%		
QC157	First Feed Breast Milk (Initiation Rate)	> 80%	76%	63%	73%	56%	71%	69%	76%	71%	67%	63%	58%	86%	74%		
	Breast Feeding Rate At Transfer Home		37%	29%	31%	32%	30%	72%	69%	76%	73%	78%	77%	86%	81%		
	Neonatal Mortality rate/1000		0	0	0	0	0	0	0	0	0	1	0	0	0	0	
	W&C - Paediatrics- Total Admissions		0	0	119	131	117	133	162	197	164	169	179	190	145	145	
	W&C - NNU - Total number of Admissions		6	7	8	8	3	7	11	5	5	5	5	2	12	12	
	W&C - NNU - Avg. Length of Stay		0	0	9	3	5	3	7	21	13	4	8	23	7		
	W&C - Community follow up		4	8	6	2	1	3	0	9	8	8	3	5	13	13	
QC155	W&C - % New Birth Visits within timescale		96.0%	85.7%	86.0%	83.0%	89.4%	84.3%	90.4%	96.2%	91.7%	87.5%	94.4%	94.4%	88.9%		
	Births per annum		54	103	144	191	237	293	348	391	451	501	545	587	47		

Emergency Care Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC75	Mandate	ED - % 4 Hour Performance	Responsive	Apr-24		68%	68%	-	76% (95%)		
QC86	Operating Plan	ED - % 4 Hour Performance (Non Admitted)	Responsive	Apr-24	-	77%	77%	-	-		
QC87	Operating Plan	ED - % 4 Hour Performance (Admitted)	Responsive	Apr-24	-	18%	18%	-	-		
QC88	Operating Plan	ED - Average Total Time in Emergency Department - Nobles	Responsive	Apr-24		292	292	-	360 mins		
QC80	Mandate	ED - Average number of minutes between Arrival and Triage (Noble's)	Responsive	Apr-24		25	25	-	15 mins		
QC81	Mandate	ED - Average number of minutes between arrival to clinical assessment - Nobles	Responsive	Apr-24		83	83	-	60 mins		
QC81	Operating Plan	ED - Average number of minutes between arrival to clinical assessment - RDCH	Responsive	Apr-24		17	17	-	60 mins		
QC84	Operating Plan	ED - 12 Hour Trolley Waits	Responsive	Apr-24		44	44	44	0		
QC78	Mandate	Number of persons choosing to leave ED without being seen	Responsive	Apr-24	-	3.2%	3.2%	-	-		
QC79	Mandate	Number of patients spending more than 12 hours in ED (Nobles)	Responsive	Apr-24		150	150	-	0		
QC83	Mandate	Emergency readmissions within 30 days of discharge from hospital	Responsive	Apr-24	-	39	39	-	-		
QC76	Mandate	ED admission rate - Nobles	Responsive	Apr-24	-	21.5%	21.5%	-	-		

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC61	Mandate	Ambulance - Category 1 Response Time at 90th Percentile	Responsive	Apr-24		19	19	-	15 mins		
QC60	Mandate	Ambulance - Category 1 Mean Response Time	Responsive	Apr-24		8	8	-	7 mins		
QC62	Mandate	Ambulance - Category 2 Mean Response Time	Responsive	Apr-24		13	13	-	18 mins		
QC63	Mandate	Category 2 Response Time at 90th Percentile	Responsive	Apr-24		28	28	-	40 mins		
QC64	Operating Plan	Ambulance - Category 3 Response Time at 90th Percentile	Responsive	Apr-24		32	32	-	120 mins		
QC67	Operating Plan	Ambulance - Category 4 Response Time at 90th Percentile	Responsive	Apr-24		89	89	-	180 mins		
QC69	Operating Plan	Ambulance - Category 5 Response Time at 90th Percentile	Responsive	Apr-24		85	85	-	180 mins		
QC71	Mandate	Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	Responsive	Apr-24		182	182	182	0		
QC73	Mandate	Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	Responsive	Apr-24		14	14	14	0		
	Supporting	MEDS Demand - N.patient interactions	Responsive	Apr-24	-	2484	2484	2484	-		
	Supporting	MEDS Overnight Demand	Responsive	Apr-24	-	102	102	102	-		
	Supporting	MEDS - Face to face appointments	Responsive	Apr-24	-	537	537	537	-		
	Supporting	MEDS - TUNA%	Responsive	Apr-24	-	2%	2%	-	-		
QC90	Mandate	MEDS- DNA%	Responsive	Apr-24		1%	1%	-	<5%		
RE044	Transformation	Number of referrals into AATU	Responsive	Apr-24	-	219	219	219	-		
RE045	Transformation	Number of patients accepted into AATU	Responsive	Apr-24	-	188	188	188	-		
RE046	Transformation	Hear&Treat - Number of 999 ambulance calls dealt with by Clinical Navigator	Responsive	Apr-24	-	165	165	0	-		

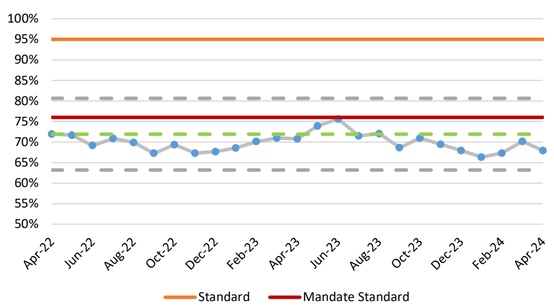
GOING WELL	CAUSE FOR CONCERN
Data now reported for 'Emergency readmissions within 30 days of discharge from hospital ' 'AATU referrals and accepted' and 'Hear & Treat'	
Ambulance Category 2-5 response times remain within thresholds	

Mandate Objectives: Emergency Care

Objective No.	Objective	Status	Progress / Risks	Lead
1 b	Responsibility for delivery and service implementation of the 'See, Treat and Leave', 'Intermediate Care', 'Hear and Treat' and 'Ambulatory Assessment and Treatment Unit (AATU)' projects of the transformation programme for Urgent and Emergency Integrated Care (UEIC), and the associated services, will be assumed by Manx Care. Regular project status reporting and detailed implementation plans of UEIC projects to the Transformation Oversight Group.		TOG pack reporting regulary provided to Department. 'See, Treat and Leave', 'Intermediate Care', and 'AATU' have started. AATU is currently operating 4 chairs and facilitating admission avoidance and early discharge, currently seeing approximately 40-50 patients per week during phase one (the service opened with 10 condition pathways in place). Work on the second phase of AATU has begun in order to identify and address current unmet need.	
3 b	Manx Care will consistently (*In at least 10 out of 12 calendar months) meet emergency department targets. Where targets are to be set based on performance data for the 2023-24 Service Year, they will be documented in writing at the first joint Performance Technical Group meeting of the 2024-25 Service Year).		Data published monthly in IPR. In-year analysis of data will be undertaken to assess achievement.	
Overall measures	Data is available to understand the numbers of patients referred into, and accepted by, the AATU service, by the end of the Service Year.		AATU started April 2024. Reporting dashboard to be developed.	
Overall measures	Upward trend in ambulance calls handled by a clinical navigator leading to an 11% reduction in unnecessary ambulance call outs by the end of 2025-26.		Reporting dashboard being developed and awaiting service area sign-off. Data is being collected and assessment will be completed at the requested date at year end 2025-26.	
Overall measures	Downward trend in the proportion of unheralded attendances versus predicted attendances at Noble's Hospital emergency department (target to be agreed at the first Performance Technical Group meeting of the Service Year).		Awaiting DHSC clarification on target.	
Overall measures	Downward trend in readmission rates.		Data published monthly in IPR. In-year analysis of data will be undertaken to assess trend.	

Emergency Care	Emergency Department (1 of 3)	Executive Lead	Oliver Radford	Lead	Mark Cox	

ED - % 4 Hour performance



Reporting Date	Performance		Op. Plan #
Apr-24	67.9%		QC75
	Admitted	18.1%	
	Non-Admitted	77.1%	
Threshold	**YTD Mean**		**Benchmark**
76% (95%)	67.9%		74.4%

(Higher value represents better performance)

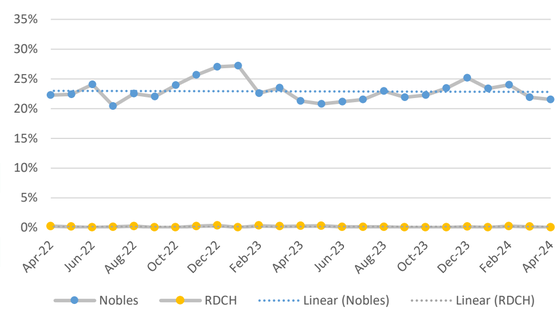
-	Variation Description

Common cause

-	Assurance Description

Consistently fail target

ED - Admission Rate



Reporting Date	Performance	Op. Plan #
Apr-24	21.5%	QC76
Threshold	**YTD Mean**	**Benchmark**
-	21.5%	29.0%

Variation Description

Common cause

Assurance Description

ED - Total Attendances : Manx Care

Reporting Date	Performance	Op. Plan #
Apr-24	3,869	
Threshold	**YTD Mean**	**Benchmark**
-	3,869	3,893

Variation Description

Assurance Description

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

Reporting Date	Performance	Op. Plan #
Apr-24	292	QC88
Threshold	**YTD Mean**	**Benchmark**
360 mins	292	266

(Lower value represents better performance)

-	Variation Description

Common cause

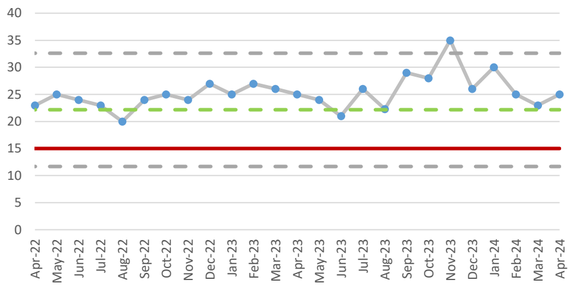
+	Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• ED Attendances YTD are 6.9% higher than same period last year. • April's performance of 67.9% remained below the 95% threshold but slightly lower the UK's performance of 74.4%. • Admitted Performance: 18.1%; • Non Admitted Performance: 77.1%; • 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 April, the average admission rate from Noble's ED of 21.5%, slightly lower than 21.9% in March, and was lower than that of the UK (29%). Performance due to: • Lack of ED observation space (Clinical Decision Unit space) • Lack of physical space to see patients • 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.	• 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	• The Ambulatory Assessment and Treatment Unit (AATU) was established in April 2024. • Average total time in department remains within the required 360 minute standard. • Expectation that performance will remain in line with the UK. • Work is ongoing regarding the Healthcare Transformation Funding and the development of diversionary pathways away from ED and investment in community services. • 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 April' 24. Benchmarks for 'Total Attendances' and 'Average time in ED' are the Manx Care monthly averages for 2022/23.

Emergency Care	Emergency Department (2 of 3)	Executive Lead	Oliver Radford	Lead	Mark Cox	

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



Reporting Date	Performance	Op. Plan #
Apr-24	25	QC80

Threshold	YTD Mean	Benchmark
15 mins	25	26

(Lower value represents better performance)

Variation Description

-

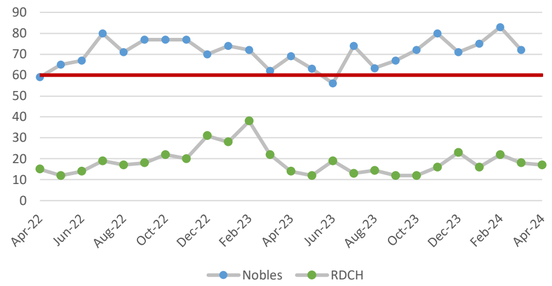
Special Cause of Concerning variation (High)

Assurance Description

-

Consistently fail target

ED-Average number of minutes between arrival to clinical assessment



Reporting Date	Performance		Op. Plan #
Apr-24	Nobles	83	QC81
	RDCH	17	

Threshold	YTD Mean	Benchmark
60 mins		-

(Lower value represents better performance)

Variation Description

Assurance Description

A&E - 12 Hours wait

Reporting Date	Performance		Op. Plan #
Apr-24	%Trolley 12h Wait	1.1%	QC84
	% ED 12h Wait	3.9%	QC79

Threshold	YTD Mean	Benchmark
0		-

(Lower value represents better performance)

Variation Description

-

Assurance Description

-

Consistently fail target

Operational Pressures Escalation Level (OPEL)

Reporting Date	Performance	Op. Plan #

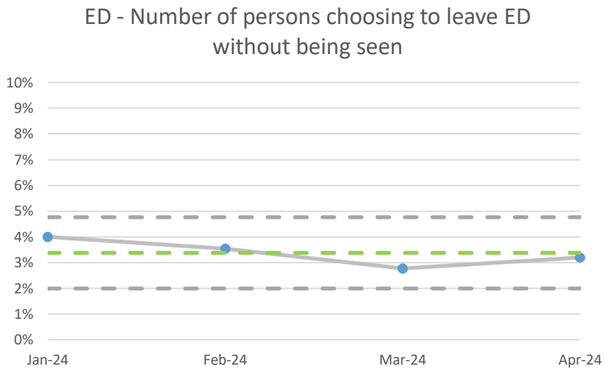
Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The service was on the highest Operational Pressures Escalation Level (OPEL), Level 4, for 0 days in April • The number of 12 Hour Trolley Waits was 44 (1.1% of attendances; UK 1.9%) • 150 patients had a stay of more than 12 hours in ED in April. That equated to 3.9% of attendances.		Note - Benchmark for 'Average number of minutes between Arrival and Triage' is the Manx Care monthly average for 2023/24.

Emergency Care	Emergency Department (3 of 3)	Executive Lead	Oliver Radford	Lead	Mark Cox	



Reporting Date	Performance	Op. Plan #
Apr-24	**3.2%**	QC78

Threshold	YTD Mean	Benchmark
-	3.2%	3.4%

(Lower value represents better performance)

-	Variation Description

Special Cause of Concerning variation (High)

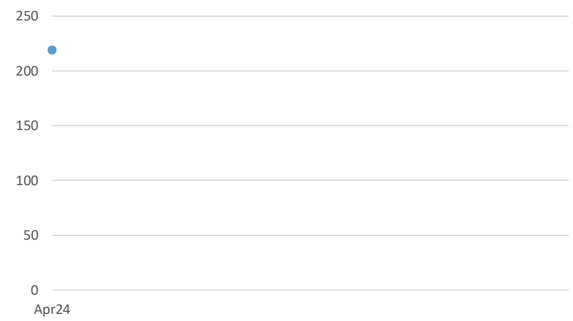
-	Assurance Description

Consistently fail target

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

Emergency Care	AATU	Executive Lead	Oliver Radford	Lead	Mark Cox	

Number of referrals into AATU



Reporting Date	Performance	Op. Plan #
Apr-24	**219**	-

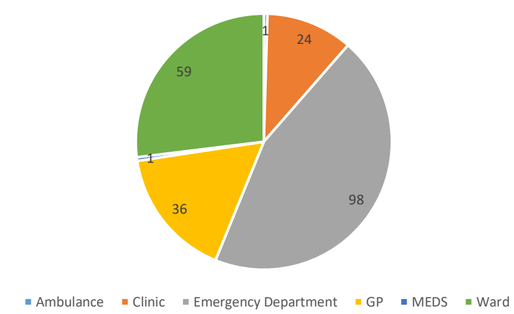
Threshold	YTD Mean	Benchmark
-	219	-

Variation Description

Common cause

Assurance Description

Source of AATU Referral - Year to Date



Reporting Date	Performance	Op. Plan #
Apr-24	**219**	-

Threshold	YTD Mean	Benchmark
-	219	-

Variation Description

Common cause

Assurance Description

Number of patients accepted into AATU

Reporting Date	Performance	Op. Plan #
Apr-24	**188**	-

Threshold	YTD Mean	Benchmark
-	188	-

Variation Description

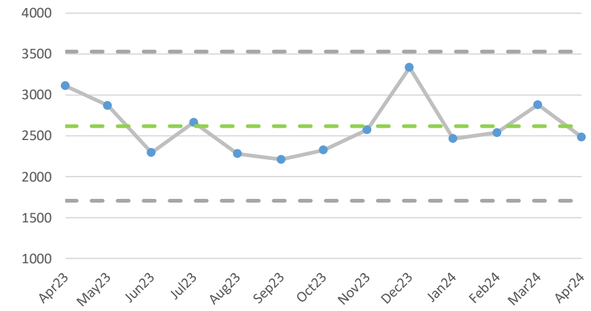
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
New service started in April 2024. There will be a 2 week suspense to the AATU service during the TT fortnight		

Emergency Care	MEDS Demand	Executive Lead	Oliver Radford	Lead	Mark Cox	

Meds Demand



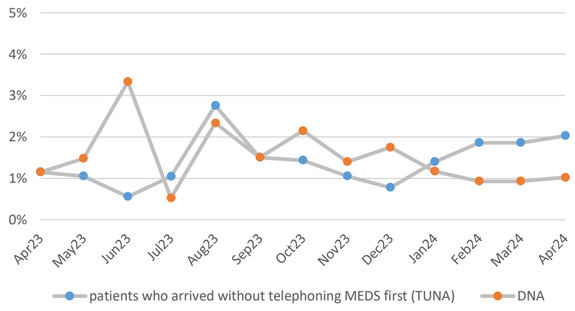
Reporting Date	Performance	Op. Plan #
Apr-24	**102**	-
Threshold	**YTD Mean**	**Benchmark**
-	102	-

Variation Description

Common cause

Assurance Description

MEDs Appointments



Reporting Date	Performance		Op. Plan #
Apr-24	**TUNA**	**2.0%**	-
	DNA	**1.0%**	QC90
Threshold	**YTD Mean**		**Benchmark**
-	-		-

(Lower value represents better performance)

Variation Description

Assurance Description

Meds - Face to face appointments

Reporting Date	Performance	Op. Plan #
Apr-24	**537**	-
Threshold	**YTD Mean**	**Benchmark**
-	537	-

Variation Description

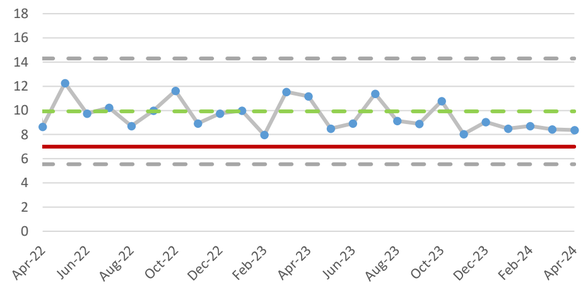
Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
In April 2024 MEDS provided 2484 patient interactions. In April 2024 MEDS had 102 patient interactions overnight. 3 were Monday to Friday and 99 Saturday and Sunday. In April 2024 MEDS offered a total of 537 Face to face appointments either at base or in the community. This was 28.58% of the total telephone contacts for this period. Of the 394 face to face appointments (not including UCA appointments) 8 were patients who arrived without telephoning MEDS first and 4 of the patients failed to attend given appointment.		

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

Ambulance - Category 1 Average (Mean) Response Time **(min)**



Reporting Date	Performance	Op. Plan #
Apr-24	00:08:23	QC60

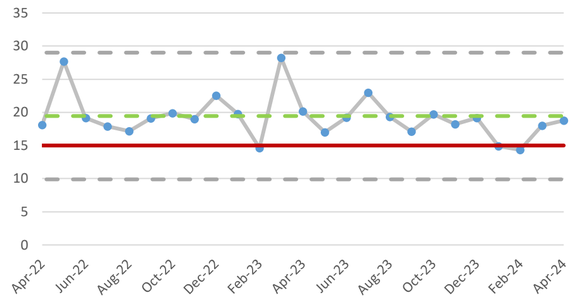
Threshold	YTD Mean	Benchmark
7 mins	00:08:23	00:08:10

(Lower value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Ambulance - Category 1 Response Time at 90th Percentile **(min)**



Reporting Date	Performance	Op. Plan #
Apr-24	00:18:45	QC61

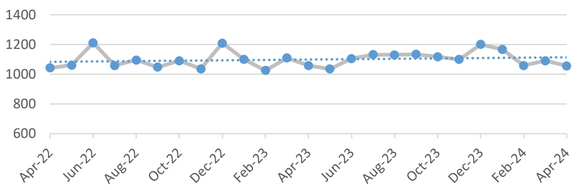
Threshold	YTD Mean	Benchmark
15 mins	00:18:45	00:14:33

(Lower value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Ambulance - Service Demand : All call types



Reporting Date	Performance	Op. Plan #
Apr-24	**1,056**	

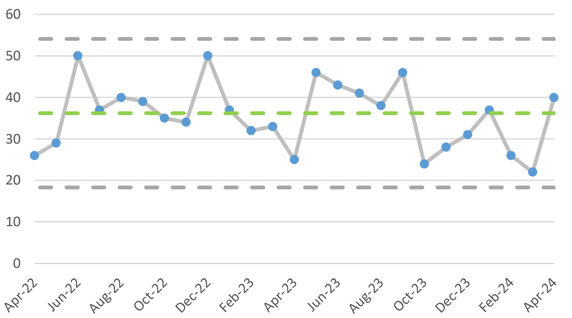
Threshold	YTD Mean	Benchmark
-	1,056	1,111

Variation Description

Assurance Description

Apr-24	East	North	South	West	Total
Category 1 Calls	24	9	5	2	**40**
Reached within 15 mins	22	5	5	1	**33**
Response within 15 mins	91.7%	55.6%	100%	50.0%	**82.5%**

Ambulance - Service Demand : Category 1



Reporting Date	Performance	Op. Plan #
Apr-24	**40**	-

Threshold	YTD Mean	Benchmark
-	40	34

(Lower value represents better performance)

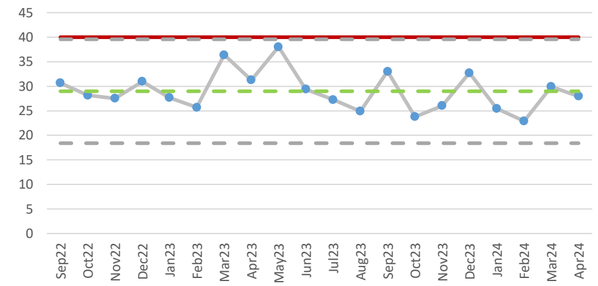
+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
April has seen a maintenance of Category 1 and Category 2 response standards with a small improvement in both. Category 1 numbers however where higher for the month than previous so it was good to see us able to at least, maintain performance level. Challenges this month have been high levels of staff sickness and ongoing update training adversely effecting staffing levels. The end of the Urgent Transport Service contract has placed additional pressures on staffing level whilst we attempt to provide this vehicle from current staffing cohort. Recruitment is ongoing to fill these vacancies. On a positive note, ED delays over 1 hour have improved significantly this month which aids resource availability.	• 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 2024/25 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).	• 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 forApril'24.

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

Ambulance - Category 2 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Apr-24	00:27:58	QC63

Threshold	YTD Mean	Benchmark
40 mins	00:32:17	01:04:12

(Lower value represents better performance)

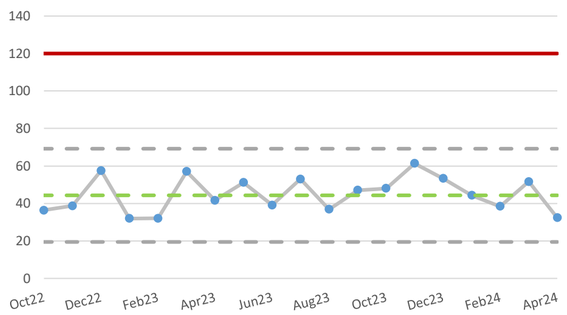
\- Variation Description

Common cause

\+ Assurance Description

Consistently hit target

Ambulance - Category 3 Response Time at 90th Percentile



Reporting Date	Performance	Op. Plan #
Apr-24	00:32:17	QC65

Threshold	YTD Mean	Benchmark
120 mins	01:29:18	03:55:40

(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 #
Apr-24	01:29:18	QC67

Threshold	YTD Mean	Benchmark
180 mins	01:24:32	04:31:31

(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 #
Apr-24	01:24:32	QC69

Threshold	YTD Mean	Benchmark
180 mins	03:02:00	-

(Lower value represents better performance)

\+ Variation Description

Common cause

\+ Assurance Description

Consistently hit target

Issues / Performance Summary

• We remain bench marking well against the categories (2,3,4 and 5) standards:
- Category 2; Standard < 40 mins; 90th percentile = 00:27:58
- Category 3; Standard < 120 mins; 90th percentile = 00:32:17
- Category 4; Standard < 180 mins; 90th percentile = 01:29:18
- Category 5; Standard < 180 mins; 90th percentile = 01:24:32

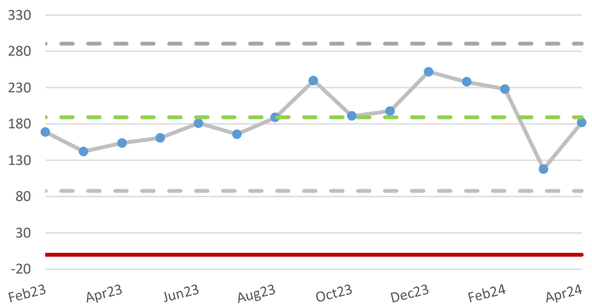
Planned / Mitigation Actions

Assurance / Recovery Trajectory

Note -
Benchmarks for Category 2,3,4 'Response time at 90th Percentile' are UK NHSE performance figures for April 2024.

Emergency Care	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 #
Apr-24	182	QC71

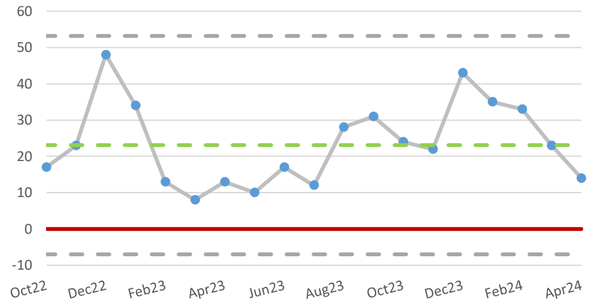
Threshold	YTD Mean	Benchmark
-	14	177

(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 #
Apr-24	14	QC73

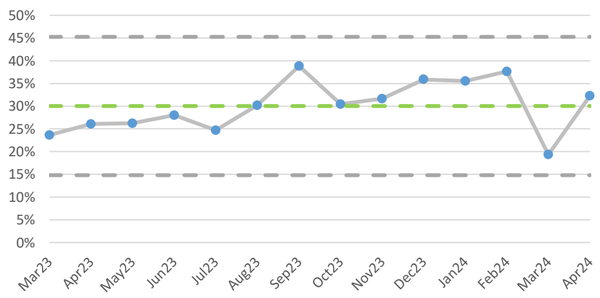
Threshold	YTD Mean	Benchmark
-	2484	22

(Lower value represents better performance)

+	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

% of Ambulance crew turnaround times from arrival to clear longer than 30 minutes.



Reporting Date	Performance	Op. Plan #
Apr-24	32.3%	QC72

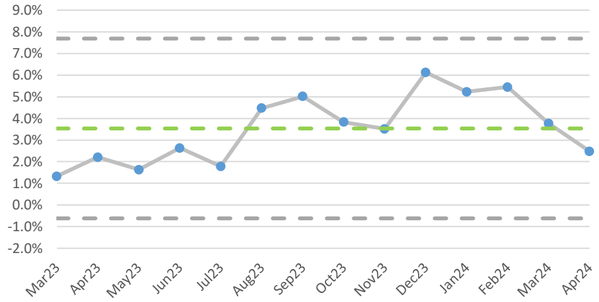
Threshold	YTD Mean	Benchmark
-	32.3%	30.4%

(Lower value represents better performance)

-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

% of Ambulance crew turnaround times from arrival to clear longer than 60 minutes.



Reporting Date	Performance	Op. Plan #
Apr-24	2.5%	QC74

Threshold	YTD Mean	Benchmark
-	2.5%	3.8%

(Lower value represents better performance)

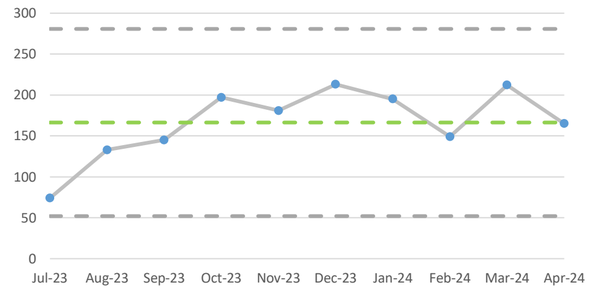
-	Variation Description
	Common cause

-	Assurance Description
	Consistently fail target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• There were 14 instances where handover Turnaround Times were greater than 60 mins, and 182 where greater than 30 mins.		Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Emergency Care	Hear & Treat	Executive Lead	Oliver Radford	Lead	Mark Cox	

Hear&Treat - Number of 999 ambulance calls dealt with by Clinical Navigator



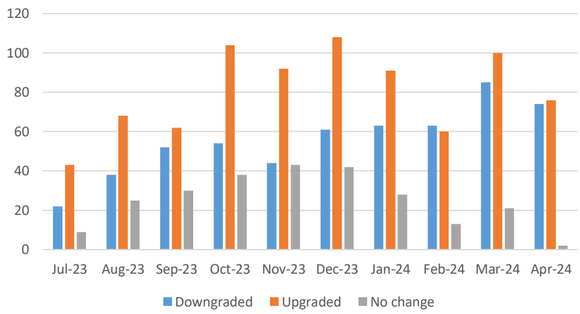
Reporting Date	Performance	Op. Plan #
Apr-24	165	-
Threshold	**YTD Mean**	**Benchmark**
-		-

Variation Description

Common cause

Assurance Description

Hear&Treat - Clinical Navigator Outcome



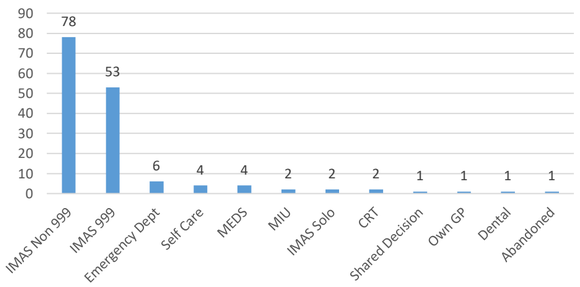
Reporting Date	Performance	Op. Plan #
Apr-24		-
Threshold	**YTD Mean**	**Benchmark**
-		-

Variation Description

Common cause

Assurance Description

Hear&Treat - Clinical Navigator Outcome Desintation - April 2024



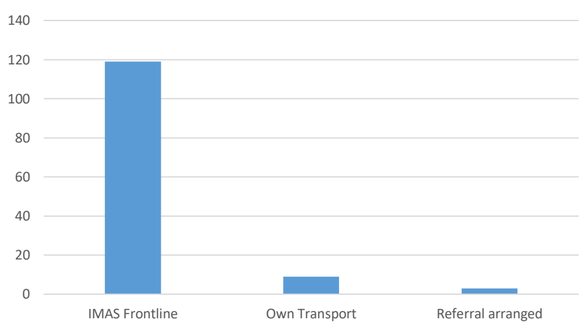
Reporting Date	Performance	Op. Plan #
Apr-24		-
Threshold	**YTD Mean**	**Benchmark**
-		-

Variation Description

Common cause

Assurance Description

Hear&Treat - Transport mode



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

Variation Description

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
We have seen Hear and Treat activities continue to benefit service delivery with the new de-escalated response timeframes in place since 1st April 24 bringing about a greater impact. This has led to a larger proportion of cases being “Downgraded” which assists with service demand management whilst providing appropriate patient care and response.		

Emergency Care Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
QC75	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%	70.8%	73.9%	75.7%	71.5%	72.1%	68.7%	71.0%	69.5%	68.0%	66.3%	67.3%	70.2%	67.9%		
	A&E - 4 Hour Performance - Nobles		61.7%	64.5%	66.5%	61.1%	60.8%	57.9%	60.6%	58.7%	57.2%	55.2%	56.3%	59.5%	55.7%		
	A&E - 4 Hour Performance - RDCH		99.9%	100.0%	99.6%	100.0%	99.9%	100.0%	99.9%	100.1%	99.7%	99.7%	100.0%	99.8%	100.0%		
QC86	A&E - 4 Hour Performance (Non Admitted)	95.0%	79.6%	82.1%	84.0%	80.6%	82.9%	78.8%	80.4%	79.3%	79.1%	76.6%	77.8%	79.6%	77.1%		
QC87	A&E - 4 Hour Performance (Admitted)	95.0%	25.3%	29.0%	29.4%	23.2%	16.8%	16.9%	22.8%	22.6%	20.0%	18.0%	19.6%	21.5%	18.1%		
QC76	A&E - Admission Rate		16.1%	15.2%	15.3%	15.7%	16.3%	16.3%	16.4%	17.4%	18.8%	17.6%	17.9%	16.1%	15.6%		
	A&E - Admission Rate - Nobles		21.3%	20.8%	21.2%	21.5%	22.9%	21.9%	22.3%	23.5%	25.1%	23.4%	24.0%	21.9%	21.5%		
	A&E - Admission Rate - RDCH		0.2%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%	0.1%	0.0%		
QC88	A&E - Average Total Time in Emergency Department	360 mins	246	227	220	257	267	298	268	275	279	292	296	265	292		
QC80	A&E - Average number of minutes between Arrival and Triage (Noble's)	15 mins	25	24	21	26	22	29	28	35	26	30	25	23	25		
QC81	Average number of minutes between arrival to clinical assessment-Nobles	60 mins	69	63	56	74	63	67	72	80	71	75	83	72	83		
QC81	ED - Average number of minutes between arrival to clinical assessment-Ramsey	60 mins	14	12	19	13	14	12	12	16	23	16	22	18	17		
QC84	A&E - Patients Waiting Over 12 Hours From Decision to Admit to Admission to a Ward (12 Hour Trolley Waits)	0	6	5	12	36	48	67	48	30	41	51	34	43	44	44	
QC79	Number of patients exceeding 12 hours in Nobles Emergency Department	0	45	22	47	104	115	191	127	114	132	151	174	111	150	150	
QC61	Ambulance - Category 1 Response Time at 90th Percentile	15 mins	20	17	19	23	19	17	20	18	19	15	14	18	19		
	Total Number of Emergency Calls		1059	1035	1105	1131	1130	1134	1118	1099	1201	1167	1058	1090	1056	1056	
	Number of Category 1 Calls		25	46	43	41	38	46	24	28	31	37	26	22	40	40	
QC60	Ambulance - Category 1 Mean Response Time	7 mins	11	8	9	11	9	9	11	8	9	8	9	8	8		
QC62	Category 2 Mean Response Time	18 mins	14	16	13	13	11	16	12	13	15	12	11	13	13		
QC63	Category 2 Response Time at 90th Percentile	40 mins	31	38	29	27	25	33	24	26	33	25	23	30	28		
QC64	Category 3 Mean Response Time	Monitor	20	20	19	24	17	20	22	24	22	19	17	24	16		
QC65	Category 3 Response Time at 90th Percentile	120 mins	42	51	39	53	37	47	48	61	53	44	38	52	32		
QC66	Category 4 Mean Response Time	Monitor	30	35	20	37	26	44	33	36	32	37	29	47	39		
QC67	Category 4 Response Time at 90th Percentile	180 mins	76	82	63	74	56	121	84	78	64	97	69	93	89		
QC68	Category 5 Mean Response Time	Monitor	40	36	31	35	32	35	33	30	46	34	30	39	32		
QC69	Category 5 Response Time at 90th Percentile	180 mins	91	89	72	83	72	81	72	71	95	87	61	79	85		
QC71	Ambulance crew turnaround times from arrival to clear should be no longer than 30 minutes.	0	154	161	181	166	189	240	191	198	252	238	228	118	182	182	
QC73	Ambulance crew turnaround times from arrival to clear should be no longer than 60 minutes.	0	13	10	17	12	28	31	24	22	43	35	33	23	14	14	
	OPEL level 4 (Days)		0.0	0.0	0.0	0.5	3.0	4.5	2.0	1.5	1.5	2.0	2.0	1.5	0.0	0	
	Meds Demand - N.patient interactions		3111	2872	2295	2664	2281	2211	2326	2574	3335	2464	2539	2881	2484	2484	
	Meds Overnight Demand		354	317	224	275	197	195	230	552	337	111	110	119	102	102	
	Meds - Face to face appointments		609	474	360	574	471	398	419	571	708	567	607	699	537	537	
	Meds - TUNA%		1.1%	1.1%	0.6%	1.0%	2.8%	1.5%	1.4%	1.1%	0.8%	1.4%	1.9%	1.9%	2.0%		
QC90	Meds- DNA%		1.1%	1.5%	3.3%	0.5%	2.3%	1.5%	2.1%	1.4%	1.8%	1.2%	0.9%	0.9%	1.0%		

Tertiary Provider Activity & Finance Performance Summary

Off-Island Services to Tertiary Centres

The Isle of Man is fortunate in that it has a modern hospital setting that is able to offer good quality care across a number of specialities. However, there are certain procedures which we are not able to offer on Island due to the following factors:
We do not employ a specialist who is able to treat people on Island;
Where evidence suggests that patients treated in regional centres of excellence receive significantly better outcomes than if treated in a small district general hospital (for example, major trauma, cardiac surgery, transplantation and specialist cancer surgery);
The number of cases requiring intervention means that local provision could not offer a safe and affordable service.
The Isle of Man has relationships with a number of healthcare organisations in the North West of England, with annual activity values in the region of £22m.

Provider	Main Specialist Area(s)
Alder Hey Children's NHS Foundation Trust	Paediatrics
The Christie NHS Foundation Trust	Cancer
Liverpool Heart Liverpool Heart and Chest Hospital NHS Foundation Trust	Cardiology, Respiratory Medicine
Liverpool Women's NHS Foundation Trust	Trauma & Orthopaedics and General Specialties
Manchester University NHS Foundation Trust	Gynaecology, Gynaecology Oncology, Obstetrics and Clinical Genetics
Mersey and West Lancashire Teaching Hospitals NHS Trust	Plastic Surgery, Spinal
The Clatterbridge Cancer Centre NHS Foundation Trust	Cancer
The Walton Centre NHS Foundation Trust	Neurology and Pain Management
Wirral University Teaching Hospital NHS Foundation Trust	General Specialties
Wrightington, Wigan and Leigh NHS Foundation Trust	Orthopaedics

FINANCE

ID	KPI Description	Latest Date	Reporting Month			Year to Date (YTD)				Year End Forecast		
			Plan	Actual	Variance	Plan	Actual	Variance	Mean	Plan	Finance	Variance
	Alder Hey Children's NHS Foundation Trust	Mar-24	£217,953	£199,080	£18,872	£2,615,431	£3,097,407	-£481,976				
	Christies Hospital NHS Foundation Trust	Mar-24	£47,241	£47,241	£0	£566,886	£566,886	£0				
	Clatterbridge Cancer Centre NHS Foundation Trust	Mar-24	£244,911	£277,545	-£32,634	£2,938,935	£3,166,041	-£227,106				
	Liverpool Heart & Chest Hospital NHS Foundation Trust	Mar-24	£559,384	£470,963	£88,421	£6,712,613	£5,237,217	£1,475,396				
	Liverpool Women's NHS Foundation Trust	Mar-24	£28,745	£26,004	£2,740	£344,936	£434,545	-£89,609				
	Liverpool University Hospitals NHS Foundation Trust	Mar-24	£460,866	£482,718	-£21,852	£5,530,396	£5,473,543	£56,853				
	Manchester University NHS Foundation Trust	Mar-24	£16,998	£16,998	£0	£203,976	£203,976	£0				
	Southport & Ormskirk Hospital NHS Trust	Mar-24	£7,730	£7,730	£0	£92,755	£92,755	£0				
	St Helens & Knowsley Hospitals NHS Trust	Mar-24	£43,663	£43,663	£0	£523,951	£523,951	£0				
	Walton Centre NHS Trust	Mar-24	£186,414	£186,414	£0	£2,236,964	£2,236,964	£0				
	Wirral University Teaching Hospital NHS Foundation Trust	Mar-24	£36,158	£36,158	£0	£433,900	£433,900	£0				
	Wrightington Wigan & Leigh NHS Foundation Trust	Mar-24	£34,867	£34,867	£0	£418,399	£418,399	£0				
	Total		**£1,884,928**	**£1,829,380**	**£55,548**	**£22,619,142**	**£21,885,584**	**£733,558**				

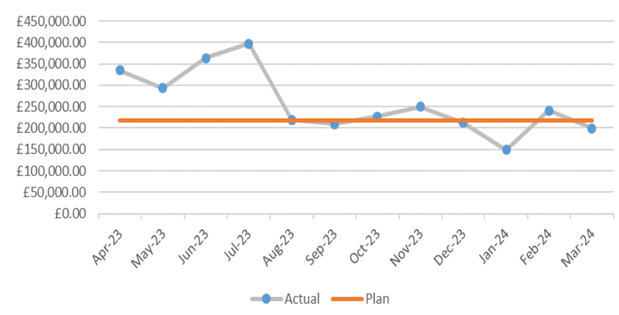
GOING WELL	CAUSE FOR CONCERN
Tertiary activity and their financial spends are in the main within scope of our plans. 24/25 plans are being agreed with the tertiary providers and will further bring some assurance once all the providers have confirmed or amended any projections for the rest of the year.	Some providers have been slow in agreeing the contract plans, which will potentially hamper the accuracy and control of the forthcoming activity and their resulting spend.
Partnership developments are progressing well, with some pathways being co-developed to bring efficiencies, reduce patient travelling and improve experience and quality. E.g. Ophthalmology, Ortho Pre-Op Assessment, Neurology Telemedcine.	A phase of work is being planned to look at the tertiary non-contracted activty (NCA) and how re-direction or development of respective pathways at non-contracted providers may impact activity and partnership with our main tertiary providers. This is dependent on the forthcoming implentation of new referrals management software to help track and analyse the NCA referrals actvity.
Transfers of patient referrals to the UK are continuing steadily and broadly in line with historical rates for transport. Progressing new sofware for Referrals Management, which will centrally provide governance and assurance in tracking and monitoring UK referrals actvity, maximisng care on-island or at the appropriate centre where possible, and help optimse travel and contratual pathways.	Currently not tracking care performance KPIs related to tertiary specialities (with exception of the cancer pathways given there's good integration between secondary and tertiary with that). Currently no dashboard for the Patient Transfers to and from UK to monitor by proxy RTT performance and discharge performance into our community or other services. Until the new software is launched (Sept 24), we will be limited in monitoring these as well as managing referrals and controlling unwarrented cost variations that may be associated with sub-optimal referral practices or pathways.

Mandate Objectives: Tertiary Providers

Objective No.	Objective	R.A.G.	Progress / Risks	Lead
5	Strongly governed relationships with third party providers, through actively managed contracts which promote strong governance, high quality services and continuous improvement. A commissioning dataset which supports meaningful analysis of secondary and tertiary activity.		• Internal monthly meetings established between contract and performance teams. • Establishing regular contract meetings between Manx Care and third party providers at a minimum of quarterly, some monthly, to review SLAM performance and risks and issues and developments affecting activity plans and service outputs. • 23% contracts agreed, with remaining under review with 24/25 activity and financial plans. Risk – Contracts for northwest providers are progressing well, but Non-contracted activity (NCA) will require another phase of work. • For Commissioning dataset, we're awaiting implementation of a Central Referrals Management system within Patient Transfers, which will provide approximate RTT indicators and follow-up indicators that we can performance manage 3rd parties against.	AH / KDF / LR
5 a	Quarterly contract reporting and timeline updates in line with section 3.3.2 of this Mandate, via the Mandate Development Meetings.		• 23% contracts agreed. The remaining under review with the proposed 24/25 Activity and Financial plans, a with a number already agreeing the plans for 24/25.	KDF / LR
Overall measures	By the end of the Service Year, a contract management framework is in place covering primary and secondary care.		• Contract management framework has been drafted. In addition to Primary and Secondary, care will also include Tertiary Care.	KDF / LR

Tertiary Providers	Finance	Executive Lead	Jackie Lawless	Lead	Lisa Rea	

Alder Hey

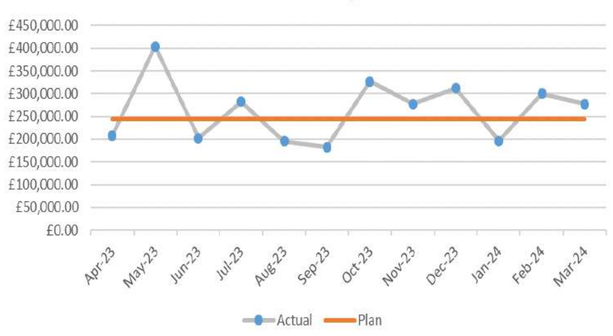


Reporting Date Mar-24	Performance	Op. Plan #
Threshold	YTD Mean	Benchmark

Variation Description

Assurance Description

Clatterbridge



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

Variation Description

Assurance Description

Liverpool Heart & Chest

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

Variation Description

Assurance Description

Liverpool University

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

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Off-Island Services to Tertiary Centres The Isle of Man is fortunate in that it has a modern hospital setting that is able to offer good quality care across a number of specialities. However, there are certain procedures which we are not able to offer on Island due to the following factors: • We do not employ a specialist who is able to treat people on Island; • Where evidence suggests that patients treated in regional centres of excellence receive significantly better outcomes than if treated in a small district general hospital (for example, major trauma, cardiac surgery, transplantation and specialist cancer surgery); • The number of cases requiring intervention means that local provision could not offer a safe and affordable service. The Isle of Man has relationships with a number of healthcare organisations in the North West of England, with annual activity values in the region of £22m.	**Repatriation of tertiary activty where possible** Work is underway to review pathways and service to optimise provision and where appropriate, repatriate some tertiary activity (and thus costs) to the island. (e.g. Ophthalmology, Neurology- Telemedicine, Gatro- ERCP, Renal) **Collecting data;** We're working on improving the data from providers to help with our service developments and making pathways more efficient. We are also aiming to collect data from Patient Tranfers new Referrals Managmenet System (Sept 24), to help in identifiying opportunities to optimse care pathways and referrals practices, reducing tertiary provider spending and activity. **Regular Contracting Meetings** Establishing regular contract meetings between Manx Care and third party providers at a minimum of quarterly, some monthly, to review SLAM performance and risks and issues and developments affecting activity plans and service outputs.	**Repatriation and managing tertiary activity** A range of programmes are supporting aims of reducing costs and improving care pathways (e.g. CIP, Care Pathways Transformation, Central Referrals Management Function within Patient Transfers.) **Data and monitoring** Regular monitoring of SLAM data of Tertiary activity is on-going on a monthly basis. This will continue to be improved as more or better data comes on-stream, as well as integrating Referrals and Patient Travel data into this IPR to provide additional indicators of tertiary activity and potential risks and opporunities. **Contract Meetings** Contrually required regular meetings with providers and Manx Care are in place, to review or challenge the provider's SLAM performance reports, and raise risks and issues and developments affecting activity plans and service outputs.

Integrated Mental Health Service (IMHS) Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC151	Supporting	Total waiting list	Responsive	Apr-24	-	1871	1871	-	-		
	Supporting	Number of Appointments	Responsive	Apr-24	-	7490	7490	7490	-		
	Supporting	Number of Admissions	Responsive	Apr-24	-	24	24	24	-		
QC144	Mandate	Number of service users on current caseload	Responsive	Apr-24		5352	5,352	-	4500 - 5500		
QC145	Mandate	Number of service users on CAMHS caseload	Responsive	Apr-24	-	9	9	-	-		
QC153	Operating Plan	Average Length of Stay (LOS) in MH Acute Inpatient Service	Effective	Apr-24	-	16	16	-	-		
QC146	Mandate	Percentage of re-referrals within 6 months	Effective	Apr-24	-	30%	30%	-	-		
QC147	Mandate	Mental Health Service did not attend rate	Effective	Apr-24		9%	9%	-	<=7.6%		

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC148	Operating Plan	Number of patients with a length of stay - 0 days	Effective	Apr-24	-	1	1	1	-		
QC149	Operating Plan	Number of patients aged 18-64 with a length of stay - > 60 days	Effective	Apr-24	-	0	0	0	-		-
QC150	Operating Plan	Number of patients aged 65+ with a length of stay - > 90 days	Effective	Apr-24	-	1	1	1	-		-
QC143	Mandate	% Service users on a CPA followed up in 3 days, discharged from inpatient care	Effective	Apr-24		91%	91%	-	90%		
QC140	Mandate	% Patients admitted to physical health wards requiring a Mental Health assessment, seen within 24 hours	Effective	Apr-24		100%	100%	-	75%		
QC141	Mandate	% Patients with a first episode of psychosis treated with recommended care package within two weeks of referral	Effective	Apr-24		-	-	-	75%		
QC139	Mandate	Crisis Team one hour response to referral from ED	Effective	Apr-24		81%	81%	-	75%		

GOING WELL

Performance incidicators all achieved threshold performance.

Caseload numbers remain consitsent and with the threshold range,

CAUSE FOR CONCERN

Overall DNA rate was sllightly above the threshold

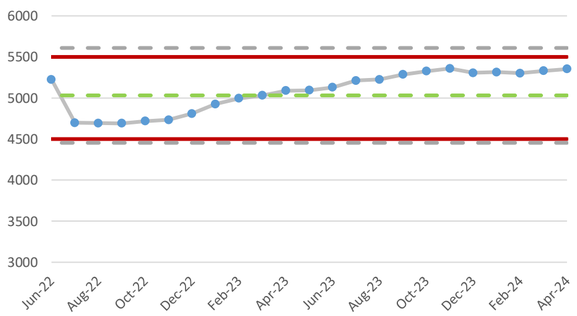
Re-referral numbers remain high, though until on-going data validation work is complete, the exact numbers are unknown and expected to be lower

Mandate Objectives: Integrated Mental Health Service

Objective No.	Objective	Status	Progress / Risks	Lead
2 b	An application to join the National Confidential Inquiry into Suicide and Safety in Mental Health ('NCISH') supported by local psychiatrists.		The participation agreement has been signed. Public Health are now in the process of progressing on boarding.	RB
2 b	Following approval of the Child and Adolescent Mental Health Service business case, changes will be implemented to ensure those with low to moderate mental health needs are offered timely access to community-based support, advice or, where appropriate, courses of psychological therapy through the THRIVE model. An implementation plan for the early intervention model (iThrive) will be shared with the Department by 30 September 2024 and first actions underway by the end of the Service Year.		Funding considered and approved by Treasury on 24/04/24. Work on this project can now begin and the contracting process for the commissioning piece has already commenced.	RB
2 b	Manx Care will complete review of the clinical pathways for all major mental health conditions for all patients, and use this to implement changes for future delivery, starting with depression, in order to assess where capacity can be created in the system.		All services have this action incorporated within their service delivery plans. It should be noted that there may not be opportunity to create capacity as part of this review, for example a recent review of the MH urgent and emergency care pathway has identified a significant lack of funding in the service which leaves IMHS provision on island significantly less than minimum expectations in the UK.	RB
2 b	Continued development of the drug death indicator data provided to Public Health as part of the Public Health Outcomes Framework (PHOF)		Regular meetings on-going between Performance & Business Intellegence Team with Public Health.	AH/SM
2 b	Milestone plan for reviewing clinical pathways for all major mental health conditions provided to the Department by 30 September 2024 through the Mandate Development Meetings, with quarterly progress updates thereafter		This is a measure of the review of clinical pathways above – therefore feedback as above	RB
Overall measures	Following the review of clinical pathways for all major mental health conditions, the creation of capacity will result in a reduction in waiting times for adult mental health services, to be forecast during 2024-25 and realised during 2025-26.		This is a measure of the review of clinical pathways above – therefore feedback as above	RB
Overall measures	Overall improvement (downward trend) in mental health outpatient waiting times and total waitlist volume.		Data reported monthly in IPR. In-year analysis of data will be undertaken to assess trend.	RB

IMHS	Caseloads / Waiting Lists	Executive Lead	Tim O'Neill	Lead	Ross Bailey	

Number of service users on Current Caseload



Reporting Date	Performance	Op. Plan #
Apr-24	5352	QC145

Threshold	YTD Mean	Benchmark
4500 - 5500	5352	4907

(Value within range represents better performance)

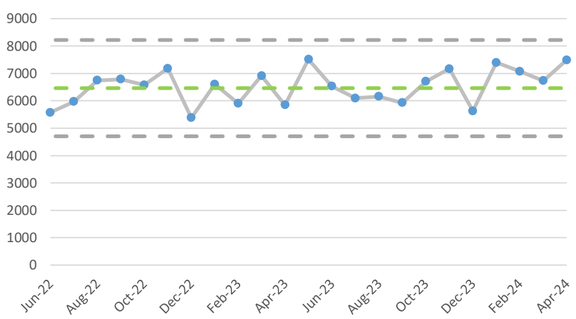
- Variation Description

Common cause

+ Assurance Description

Consistently hit target

MH- Appointments



Reporting Date	Performance	Op. Plan #
Apr-24	7490	

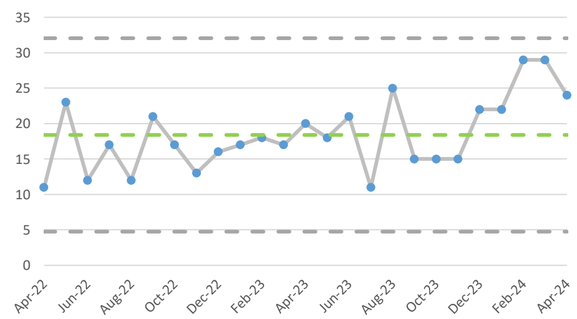
Threshold	YTD Mean	Benchmark
-	7490	6276

- Variation Description

Common cause

Assurance Description

MH- Admissions



Reporting Date	Performance	Op. Plan #
Apr-24	24	

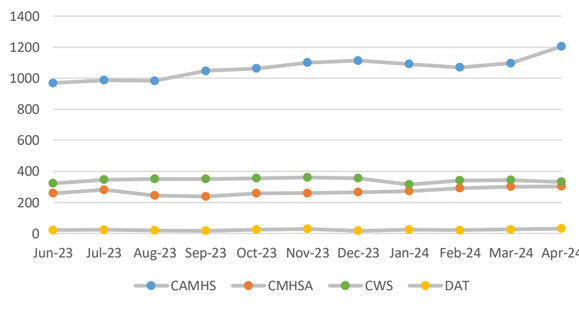
Threshold	YTD Mean	Benchmark
-	24	16

+ Variation Description

Common cause

Assurance Description

Mental Health Waiting Lists



Reporting Date	Performance	Op. Plan #
Apr-24	**1871**	QC151/2

Threshold	YTD Mean	Benchmark
-	1871	

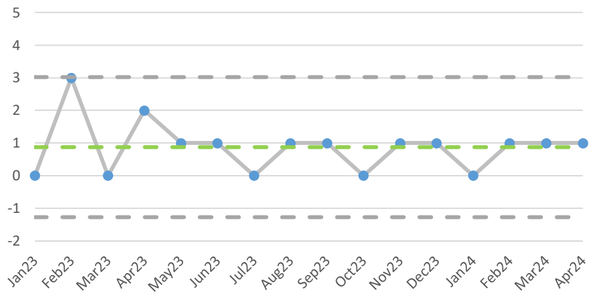
Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Current Caseload: Caseload remains within the expected range 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 April decreased to 24.	**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 Note - Benchmarks are the Manx Care monthly averages for 2023/24.

IMHS	Length of Stay	Executive Lead	Tim O'Neill	Lead	Ross Bailey	

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



Reporting Date	Performance	Op. Plan #
Apr-24	1	QC148

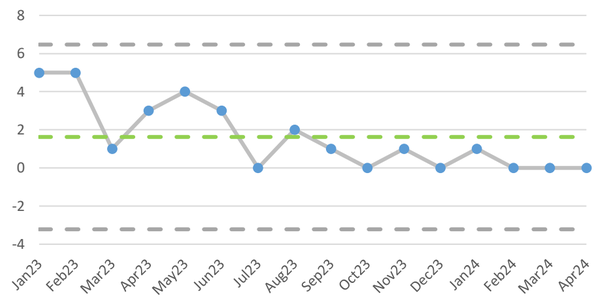
Threshold	YTD Mean	Benchmark
-	1	1

+ 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 #
Apr-24	1	QC149

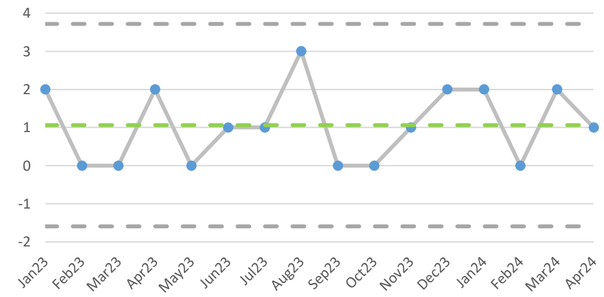
Threshold	YTD Mean	Benchmark
-	1	4

+ 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 #
Apr-24	0	QC150

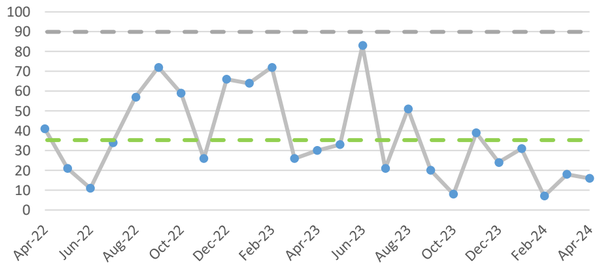
Threshold	YTD Mean	Benchmark
-	0.0	0.7

+ Variation Description

Common cause

Assurance Description

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



Reporting Date	Performance	Op. Plan #
Apr-24	9	QC154

Threshold	YTD Mean	Benchmark
-	9	46

- Variation Description

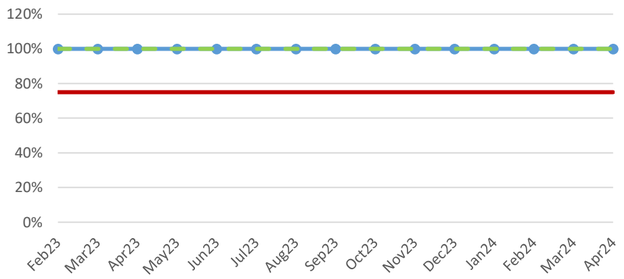
Common cause

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 2023/24.

IMHS	Seen within Timeframe %	Executive Lead	Tim O'Neill	Lead	Ross Bailey	

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



Reporting Date	Performance	Op. Plan #
Apr-24	91%	QC140

Threshold	YTD Mean	Benchmark
90%	91%	100%

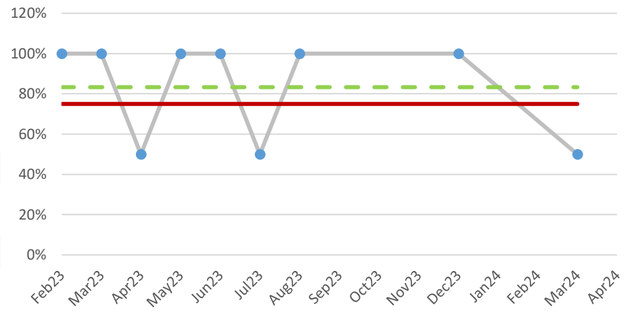
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

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



Reporting Date	Performance	Op. Plan #
Apr-24		QC141

Threshold	YTD Mean	Benchmark
75%	100%	100%

+ Variation Description

Common cause

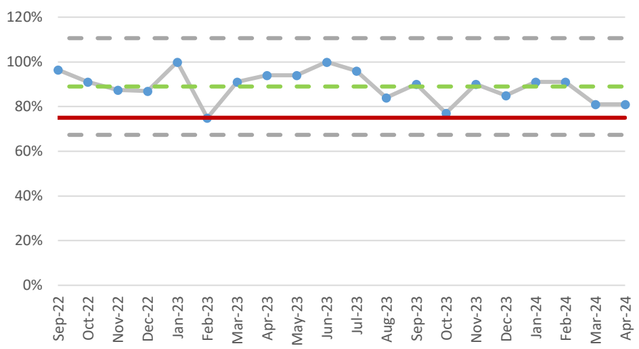
+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Patients Admitted to Physical Health Wards: The 24 hour response to Nobles Hospital (non ED) in April was 100%. **First Episode of Psychosis Treated with care package:** No patients to see in April. *NB. Small numbers affect % values. E.g. Two patients referred, 1 patient seen results in 50% performance.*	These indicators are both consistently above targets and are of no cause for concern within the care group. They are being regularly monitored. Small numbers (single figures) can distort % values.	Note - Benchmarks are the Manx Care monthly averages for 2023/24.

IMHS	DNA, Re-referrals	Executive Lead	Tim O'Neill	Lead	Ross Bailey	

Crisis Team one hour response to referral from ED



Reporting Date	Performance	Op. Plan #
Apr-24	81.0%	QC139

Threshold	YTD Mean	Benchmark
75.0%	81.0%	91.2%

(Higher value represents better performance)

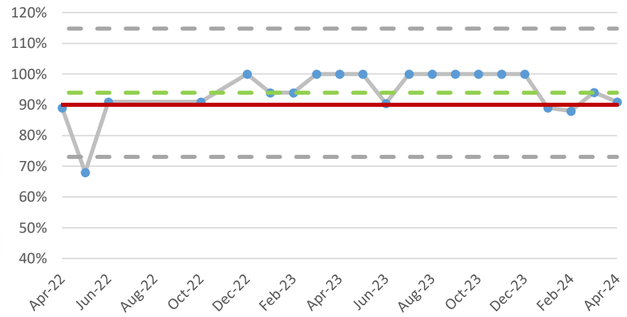
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

% service users on CPA discharged from inpatient that have follow up appointment within 3 days



Reporting Date	Performance	Op. Plan #
Apr-24	91.0%	QC143

Threshold	YTD Mean	Benchmark
90.0%	100.0%	90.9%

(Higher value represents better performance)

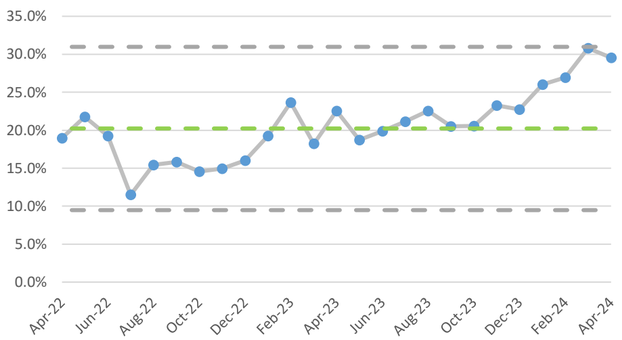
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

% Re-referrals within 6 months



Reporting Date	Performance	Op. Plan #
Apr-24	29.5%	QC146

Threshold	YTD Mean	Benchmark
-	29.5%	23.0%

(Higher value represents better performance)

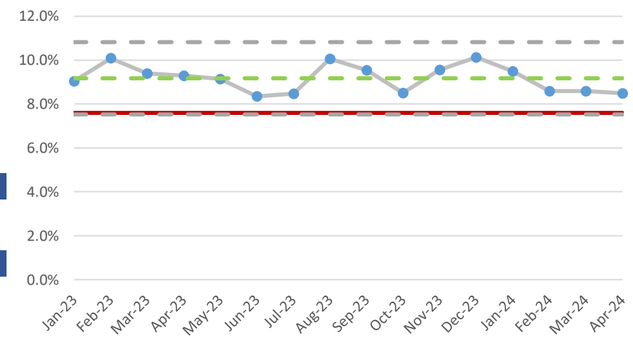
+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

DNA Rate %



Reporting Date	Performance	Op. Plan #
Apr-24	8.5%	QC147

Threshold	YTD Mean	Benchmark
<=7.6%	8.5%	9.1%

(Higher value represents better performance)

+ Variation Description

Common cause

+ Assurance Description

Consistently hit target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Crisis Team: • 81% for April which matches the figure for the previous month. **3 Day follow up:** • Threshold achieved with 91% for April. **% Re-referrals within 6 months** • ongoing validation work within service area. **DNA Rate %** •Remains stable and slighlty above threshold of 7.6%	**Crisis Team:** Continue to monitor.	Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Integrated Mental Health Service Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
QC144	Number of service users on Current Caseload	4500 - 5500	5090	5093	5129	5211	5226	5285	5325	5359	5305	5315	5302	5330	5352	5352	
QC145	CAMHS Current Caseload		10	10	8	8	8	8	8	8	8	9	8	10	9	9	
QC151/2	MH- Waiting list		N/A	N/A	1572	1637	1598	1654	1701	1750	1752	1702	1723	1768	1871	1871	
QC154	MH - Average Length of Stay (LOS) in MH Acute Inpatient Service (Discharged)	-	30	33	83	21	51	20	8	39	24	31	7	18	16	16	
QC148	Number of patients with a length of stay - 0 days (Mental Health)	-	2	1	1	0	1	1	0	1	1	0	1	1	1	1	
QC149	MH - Number of patients aged 18-64 with a length of stay - > 60 days	-	3	4	3	0	2	1	0	1	0	1	0	0	0	0	
QC150	MH - Number of patients aged 65+ with a length of stay - > 90 days	-	2	0	1	1	3	0	0	1	2	2	0	2	1	1	
QC139	Crisis Team one hour response to referral from ED	75%	94%	94%	100%	96%	84%	90%	77%	90%	85%	91%	91%	81%	81%		
QC140	% 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%		
QC141	% Patients with a first episode of psychosis treated with recommended care package within two weeks of referral	75%	50%	100%	100%	50%	100%				100%	-	-	-	-		
QC143	MH - % service users discharged from MH inpatient to have follow up appointment	90%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.0%	88.0%	94.1%	91.0%		
QC146	Percentage of re-referrals within 6 months		22.6%	18.7%	19.9%	21.1%	22.5%	20.5%	20.5%	23.2%	22.7%	26.0%	26.9%	30.8%	29.5%		
QC147	Mental Health Service did not attend rate	<=7.6%	9.3%	9.2%	8.4%	8.5%	10.1%	9.5%	8.5%	9.6%	10.1%	9.5%	8.6%	8.6%	8.5%		

Social Care Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC99	Operating Plan	ASC - No. of referrals	Effective	Apr-24	-	80	80	80	-		-
QC100	Mandate	ASC - % of Re-referrals	Effective	Apr-24		4%	4%	-	<15%		
QC103	Mandate	Wellbeing Partnership Assessments completed in agreed timescales.	Effective	Apr-24		19%	19%	-	80%		
QC105	Mandate	ASC - % of individuals (or carers) receiving a copy of their Wellbeing Partnership Assessment	Effective	Apr-24		100%	100%	-	100%		
QC106	Mandate	Residential bed occupancy	Responsive	Apr-24		60%	60%	-	>=85%		
QC107	Mandate	Respite bed occupancy	Responsive	Apr-24		54%	54%	-	>=90%		
QC108	Mandate	Service Users with a Person-Centred Plan in place	Responsive	Apr-24		100%	100%	-	>=95%		
QC116	Operating Plan	Number of Safeguarding inquiries to Adult Social Care	Responsive	Apr-24	-	86	86	86	-		-
QC117	Operating Plan	Number of reported Safeguarding alerts in care homes	Responsive	Apr-24	-	60	60	60	-		-
EE054	Supporting	Discharges from Adult Safeguarding Team	Responsive	Apr-24	-	63	63	63	-		-
	Supporting	Re-referrals to Adult Safeguarding Team	Responsive	Apr-24	-	12	12	12	-		-
	Supporting	% MARFs Completed by Adult Safeguarding Team	Responsive	Apr-24	-	100%	100%	-	-		-

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
QC101	Operating Plan	C&F -Number of referrals - Children & Families	Effective	Apr-24	-	100	100	100	-		
QC109	Mandate	CFSC - % Complex Needs Reviews held on time	Effective	Apr-24		47%	47%	-	85%		
QC110	Mandate	CFSC - % Total Initial Child Protection Conferences held on time	Effective	Apr-24		82%	82%	-	90%		
QC111	Mandate	CFSC - % Child Protection Reviews held on time	Effective	Apr-24		100%	100%	-	90%		
QC112	Mandate	CFSC - % Looked After Children reviews held on time	Effective	Apr-24		100%	100%	-	90%		
QC113	Mandate	C&F -Children (of age) participating in, or contributing to, their Child Protection review	Effective	Apr-24		96%	96%	-	90%		
QC114	Mandate	C&F -Children (of age) participating in, or contributing to, their Looked After Child review	Effective	Apr-24		100%	100%	-	90%		
QC115	Mandate	C&F -Children (of age) participating in, or contributing to, their Complex Review	Effective	Apr-24		54%	54%	-	79%		

GOING WELL

ASC referrals and wre-referrals remain within threshold.

% of individuals (or carers) receiving a copy of their Wellbeing Partnership Assessment achieved the 100% threshold

CAUSE FOR CONCERN

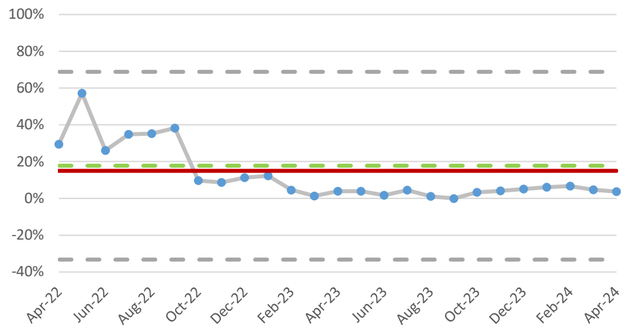
Wellbeing Partnership Assessments completed in agreed timescales - work ongoing to develop new methodology for 6 weeks which will improve performance

Mandate Objectives: Social Care

Objective No.	Objective	Status	Progress / Risks	Lead
2 b	Manx Care will continue to build and support the foster carer network through recruitment and retention activity and supportive processes, increasing the total number of fostering households by 4 by the end of the 2024-25 Service Year, with a plan to continue to increase and maintain this in subsequent years, including a focus on promoting kinship (friends and family) arrangements.		Recruitment continues, with the campaign continuining and significant visibility of marketing material around the Island. Fatima Whitbread's recent visit to the Island was intended to further raise the profile. Family Placement have a number of events organised for Fostering Fortnight during May 2024. The current package of financial support is being reviewed, with an aim of remvoing any fiscal disincentives to foster.	JG
2 b	Plan for increasing and retaining foster carers shared with the Department by 30 September 2024.			JG
2 b	Number of foster carers in place as of 01 April 2024 and 31 March 2025, and the number recruited in the 2024-25 Service Year, provided to the Department.		The April figures were 21 Mainstream Foster Carers, and 9 Family & Friends (kinship).	JG
2 e	Carers Strategy implementation reporting including numbers of carers assessments being completed.			
4 b	Social Care capacity and utilisation data provided to the Department no less than quarterly via the Performance Technical Group meeting.		Work being progress in line with the timescales discussed in the Performance Technical Group meetings and will be updated via this forum.	AH
Overall measures	All fostering assessments completed within 9 months of the time of application.		Data will be shared after Quarter 1, once a new Family Placement Panel Administrator has been recruited, on-boarded and is on track with suporting Panel.	JG

Social Care	Adult Social Work (1 of 2)	Executive Lead	Tim O'Neill	Lead	Bradley Chambers/Samantha Murphy	

ASC - % of Re-referrals



Reporting Date	Performance	Op. Plan #
Apr-24	3.8%	QC100

Threshold	YTD Mean	Benchmark
<15%	3.8%	3.8%

(Lower value represents better performance)

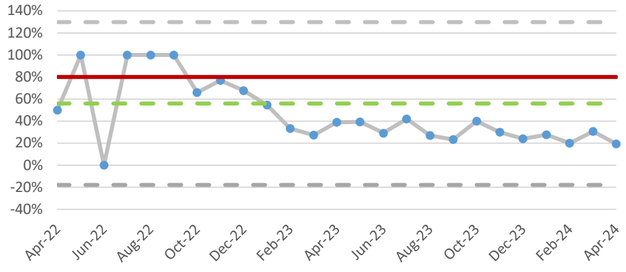
- Variation Description

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 #
Apr-24	19.2%	QC103

Threshold	YTD Mean	Benchmark
80.0%	19.2%	31.0%

(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 #
Apr-24	80	QC99

Threshold	YTD Mean	Benchmark
-	80	77

- Variation Description

Common cause

Assurance Description

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

Reporting Date	Performance	Op. Plan #
Apr-24	100.0%	QC105

Threshold	YTD Mean	Benchmark
100.0%	100.0%	87.2%

(Higher value represents better performance)

+ Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary

Referrals:
The number of new referrals received in April decreased to 80 from 105 in March. 5 were homeless referrals, 5 were for review rather than assessment and 7 referrals were received from the Older Peoples Mental Health Service - their only Social Worker was away for 6-8 weeks, meaning that more referrals came to Adult Social Work.

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 April remained below the required threshold.

Individuals receiving copy of Assessment:
• The assessment sharing level was 92.6% during April, slightly below the threshold.

Planned / Mitigation Actions

Assessments completed within timescales:-
The BI Team and Adult Social Work have completed work on improving the dashboard pull-throughts, with assessments and re-assessments now clarified to provide a more accurate performance picture. This should lead to an improvement in assessments being completed within timescale. Internal audit checks highlighted that 2 assessments shown as not being shared were in fact shared, some minor teething issues with the dashboard are being worked through with BI colleauges and closely monitored.

The completion of assessments in Learning Disabilities now has a target of 42 days for completion rather than 28. Whilst this may assist with assessments being completed to timescale, much of the work is long-term and therefore re-assessments.
The low completion rate of assessments to timescale is a cause for concern, now that the dashboard improvement work is largely complete, efforts will now focus on the bottlenecks and root cause for delays. A number of these cases have a complexity element, performance will be closely tracked in this area.

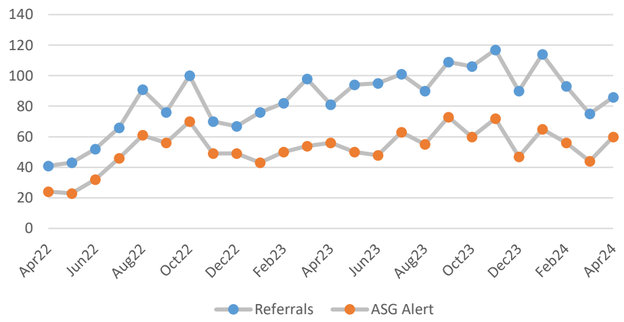
Assurance / Recovery Trajectory

Assessments completed within Timescales:
• Areas of Adult Social Work have experienced staffing pressures, which are in the early stages of being relieved by both agency recruitment and secondments.
• The waiting list for the Older Peoples Community Team has decreased from >70 to >30 in recent weeks, this is a result of agency backfill of 2 vacancies. It is anticipated that the waiting list will decrease further in the coming weeks. Once the waiting list is cleared, achievement of the 28 day target is expected. • 2 OPCT
Social Workers have integrated within the Northern Wellbeing Partnership as part of a pilot scheme, designed to improve assessments being completed to timescale. The allocation from Partnership to allocated professional will be smoother, leading to hopefully an improved service user experience.

Note -
Benchmarks are the Manx Care monthly averages for 2023/24

Social Care	Adult Social Work (2 of 2)	Executive Lead	Tim O'Neill	Lead	Bradley Chambers/Samantha Murphy	

Adult Safeguarding

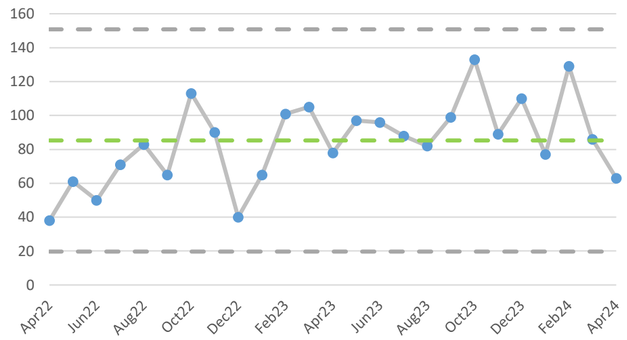


Reporting Date	Performance		Op. Plan #
Apr-24	Referrals	86	
	Alert	60	
Threshold	**YTD Mean**		**Benchmark**
-	-		-

Variation Description

Assurance Description

Discharges from Adult Safeguarding Team



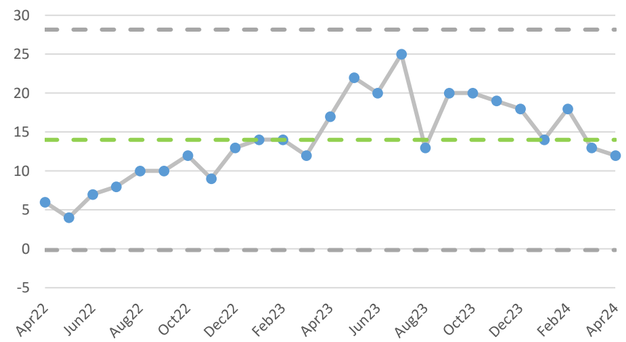
Reporting Date	Performance	Op. Plan #
Apr-24	63	
Threshold	**YTD Mean**	**Benchmark**
-	63	97

Variation Description

Common cause

Assurance Description

Re-referrals to Adult Safeguarding Team



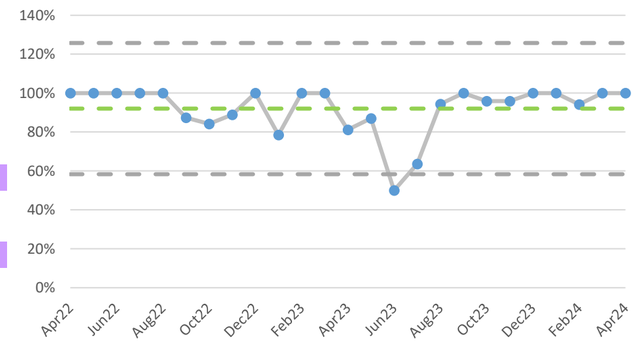
Reporting Date	Performance	Op. Plan #
Apr-24	12	
Threshold	**YTD Mean**	**Benchmark**
-	12	18

Variation Description

Common cause

Assurance Description

% MARFs Completed by Adult Safeguarding Team



Reporting Date	Performance	Op. Plan #
Apr-24	100.0%	
Threshold	**YTD Mean**	**Benchmark**
-	100.0%	88.5%

(Higher value represents better performance)

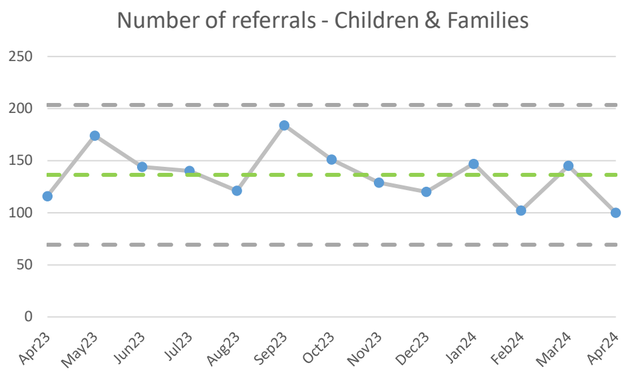
- **Variation Description**

Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
• The number of alerts received continues to be high and increasing. The team can demonstrate a 30% increase in alerts when comparing 2022 to 2023 (to date). • The Adult Safeguarding Team continues with a heavy caseload compared to available resource. The business case submitted for an additional Safeguarding Officer has not translated into additional resource allocation for 2024/25, so the funding for this may need to be found within the existing envelope or filled by agency staff. There is also a high level of demand from the Safeguarding Board, who require regular input from Manx Care to meet their statutory obligations. • 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. • 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. • 24 out of 24 MARFs were completed within timescale during April 2024	• Referrals and ASG alerts methodology will be discussed with the B.I team. • A Business Case for additional staffing resources was considered, this has not yet translated into additional funding for the 2024/25 service year.	• The post of Senior Practitioner recently went to advert and has been recruited to. The new recruit is likely to commence in post within the next 6 weeks. Note - Benchmarks are the Manx Care monthly averages for 2023/24

Social Care	Social Work (Children & Families) 1 of 3	Executive Lead	Tim O'Neill	Lead	Julie Gibney



Reporting Date	Performance	Op. Plan #
Apr-24	**100**	QC101

Threshold	YTD Mean	Benchmark
-	100	139

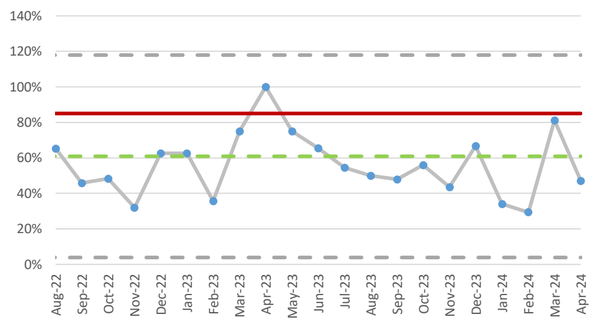
-	Variation Description
	Common cause

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Referrals: Referral levels have decreased to 100 in April.		**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 2023/24.

Social Care	Social Work (Children & Families) 2 of 3	Executive Lead	Tim O'Neill	Lead	Julie Gibney

CFSC - % Complex Needs Reviews held on time



Reporting Date	Performance	Op. Plan #
Apr-24	47.1%	QC109

Threshold	YTD Mean	Benchmark
85.0%	47.1%	58.6%

(Higher value represents better performance)

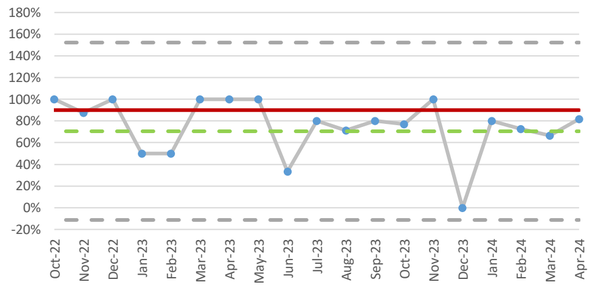
\- Variation Description

Common cause

\- Assurance Description

Inconsistently passing and falling short of target

CFSC - % Total Initial Child Protection Conferences held on time



Reporting Date	Performance	Op. Plan #
Apr-24	81.8%	QC110

Threshold	YTD Mean	Benchmark
90.0%	81.8%	71.8%

(Higher value represents better performance)

\+ Variation Description

Common cause

\- Assurance Description

Inconsistently passing and falling short of target

CFSC - % Child Protection Reviews held on time

Reporting Date	Performance	Op. Plan #
Apr-24	100.0%	QC111

Threshold	YTD Mean	Benchmark
90.0%	100.0%	92.8%

(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 #
Apr-24	100.0%	QC112

Threshold	YTD Mean	Benchmark
90.0%	100.0%	94.4%

(Higher value represents better performance)

\+ Variation Description

Common cause

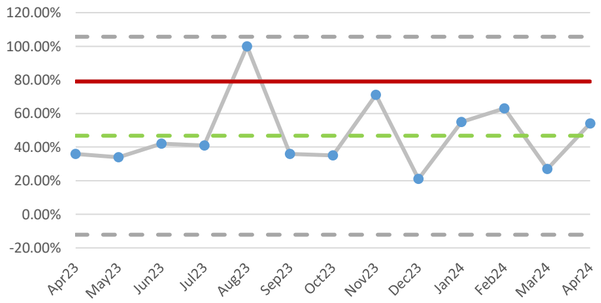
\+ Assurance Description

Inconsistently passing and falling short of target

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
Complex Needs Reviews held on time: 17 Reviews held and 8 were in timescale and 9 were out of timescale Reasons for delayed meetings: Family Unavailable – 1 Chairperson Unavailable - 3 Notification by Social Work Staff out of time scales – 3 Relevant Professional/Agency unavailable - 2 **Initial Child Protection Conferences held on time:** 11 meetings were due and 9 were held in time and 2 were out of timescale Reasons for delayed meetings: Family Unavailable - 2 (one family) **Child Protection Review Conferences held on time:** 14 RCPC's were held and 14 were on time **Looked After Children reviews held on time:** 100% of reviews were held within the timescales in April.	The Complex Needs Reviews are undertaken by the Children with Disabilities Team, the CWD has 107 children shared between 4 Social Workers. The Initial Response Team and Out of Hours Social Work Team also hold Child With Complex Needs cases, there are significant pressures on these service areas who have to balance CWCN with Child Protection priorities for newly referred cases and emergency situations. A watching brief is being kept on capacity generally within these teams, as the opening of the MASH in June 2023 has added pressures with no additional resource factored in. The current caseloads 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 C&F as a mitigation to the workload of the service generally. Note - Benchmarks are the Manx Care monthly averages for 2022/23.

Social Care	Social Work (Children & Families) 3 of 3	Executive Lead	Tim O'Neill	Lead	Julie Gibney

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



Reporting Date	Performance	Op. Plan #
Apr-24	54%	QC115

Threshold	YTD Mean	Benchmark
79%	54%	47%

(Higher value represents better performance)

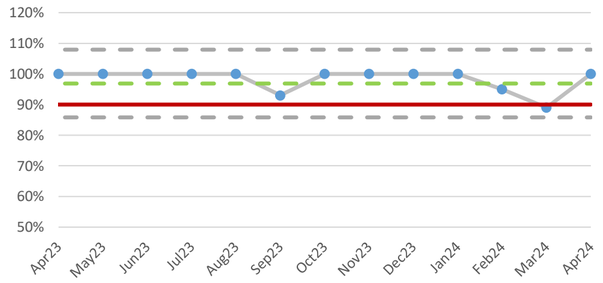
- Variation Description

Common cause

- Assurance Description

Inconsistently passing and falling short of target

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



Reporting Date	Performance	Op. Plan #
Apr-24	100%	QC114

Threshold	YTD Mean	Benchmark
90%	100%	98%

(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 #
Apr-24	96%	QC113

Threshold	YTD Mean	Benchmark
90%	96%	82%

(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 Issues / Performance Summary for supporting narrative.	Please see Issues / Performance Summary for supporting narrative. Note - Benchmarks are the Manx Care monthly averages for 2023/24.

Social Care Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
QC99	ASC - % of Re-referrals	<15%	3.9%	3.8%	1.7%	4.5%	1.2%	0.0%	3.3%	4.1%	5.1%	6.1%	6.8%	4.8%	3.8%		
QC100	ASC - No. of referrals	Monitor	76	78	59	66	86	68	91	74	59	82	74	105	80	80	
QC102	C&F- No. of referrals	Monitor	116	174	144	140	121	184	151	129	120	147	102	145	100	100	
QC103	ASC - % of all Wellbeing Partnership Assessments completed in timeframes	80%	39%	39%	29%	42%	27%	23.3%	40.0%	30.0%	24.1%	27.6%	20.0%	30.8%	19.2%		
QC105	ASC - % of individuals (or carers) receiving a copy of their Wellbeing Partnership Assessment	100%	22%	48%	100%	100%	100%	96.0%	100.0%	96.3%	95.5%	95.7%	100.0%	92.3%	100.0%		
QC106	Residential Beds Occupancy	85% - 100%	83%	83%	71%	69%	68%	52.0%	59.0%	48.0%	70.0%	59.0%	70.0%	73.0%	60.0%		
QC107	Respite bed occupancy	>= 90%	81%	79%	92%	80%	69%	70.0%	81.0%	65.0%	58.0%	73.0%	88.0%	48.0%	65.0%		
QC108	ASC-% of Service users with a PCP in Place	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
QC109	Complex Needs Reviews held on time	85%	100.0%	75.0%	65.5%	54.6%	50.0%	48.0%	56.0%	43.5%	66.7%	34.0%	29.4%	81.1%	47.1%		
QC110	CFSC - % Total Initial Child Protection Conferences held on time	90%	100.0%	100.0%	33.3%	80.0%	71.4%	80.0%	76.9%	100.0%	0.0%	80.0%	72.7%	66.7%	81.8%		
QC111	CFSC - % Child Protection Reviews held on time	90%	88.9%	100.0%	100.0%	88.9%	95.8%	95.7%	80.0%	100.0%	100.0%	75.0%	88.9%	100%	100%		
QC112	CFSC - % Looked After Children reviews held on time	90%	100.0%	100.0%	100.0%	100.0%	90.5%	90.0%	88.0%	100.0%	100.0%	76.0%	92.9%	95.5%	100%		
QC113	C&F -Children (of age) participating in, or contributing to, their Child Protection review	90%	0.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	67.0%	33.0%	96.0%		
QC114	C&F -Children (of age) participating in, or contributing to, their Looked After Child review	90%	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	95.0%	89.0%	100%		
QC115	C&F -Children (of age) participating in, or contributing to, their Complex Review	79%	36.0%	34.0%	42.0%	41.0%	100.0%	36.0%	35.0%	71.0%	21.0%	55.0%	63.0%	27.0%	54.0%		
QC116	Number of Safeguarding inquiries to Adult Social Care	Monitor	81	94	95	101	90	109	106	117	90	114	93	75	86	86	
QC117	Number of reported Safeguarding alerts in care homes	Monitor	56	50	48	63	55	73	60	72	47	65	56	44	60	60	
	% MARFs Completed by Adult Safeguarding Team	Monitor	81.3%	87.0%	50.0%	63.6%	94.4%	100.0%	95.8%	95.8%	100.0%	100.0%	94.1%	100.0%	100.0%		

Finance Performance Summary

KPI ID	Source	KPI Description	Domain	Latest Date	R.A.G.	Value	Mean	YTD	Threshold	Variation	Assurance
F01	Mandate	% Progress towards Cost Improvement Target (CIP)	Well Led	Mar-24	-	156%			100% (equiv. 2%)		
F02	Mandate	Performance against Budget	Well Led	Mar-24	-	-2,536	-£2,860	-£34,321	£0 variance		
F03	Mandate	Agency staff costs (proportion %)	Well Led	Mar-24	-	4%	£0		5%		

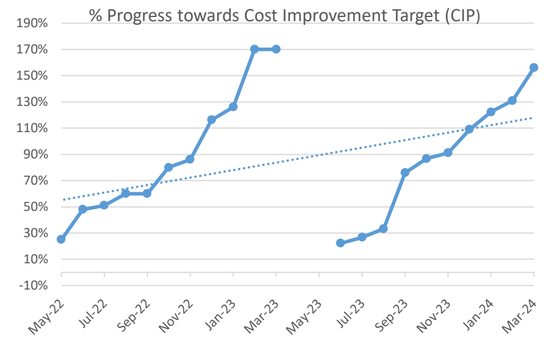
GOING WELL

CAUSE FOR CONCERN

Mandate Objectives: Finance

Objective No.	Objective	Status	Progress / Risks	Lead
1a	Manx Care will continue Activity Based Costing (ABC) in earnest, using 2024-25 to understand the work required to drive this work in a timely way. Following handover of the artefacts from the external partner, Manx Care will establish the next phase of work to enable service line reporting (SLR).			
1 a	SLR system implementation plan agreed by the Manx Care Board and shared through the Mandate Development Meetings during the second half of the year			
1a	Reporting from the new SLR platform routinely (no less than quarterly) brought through a Manx Care Board sub-committee in the latter quarters of 2025-26			
1 a	Outputs and analysis of repeat costing activity for the acute setting brought to the final Mandate Development Meeting of the Service Year of 2025-26			
1a	Regular management accounts scrutinised by a Manx Care Board sub-committee.		Manx Care board papers regularly provided to DHSC.	
3 a	Provision of regular management accounts (shared monthly with the Department through the Department's Finance Business Partner)		Regularly provided to DHSC.	
3 a	Financial assurance brought through a Manx Care Board or sub-committee agenda on a monthly basis.			
3 b	Costed implementation plan and proposed timeline for NICE TAs agreed through a Manx Care Board sub-committee agenda and submitted to the Department by 31 July 2024.			
3 b	Provision of regular management accounts (shared monthly with the Department through the financial governance mechanisms), reflecting savings achieved through the introduction of NICE TAs.			
Overall measures	Financial balance achieved - need for supplementary vote minimised			

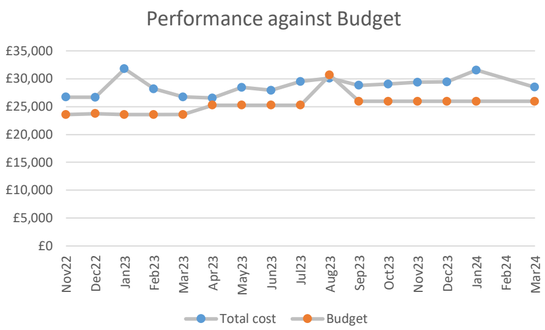
Finance	Finance	Executive Lead	Jackie Lawless	Lead	Samantha Allibone	



Reporting Date	Performance	Op. plan #
Mar-24	**156.0%**	F01
Threshold	**YTD Mean**	**Benchmark**

Variation Description

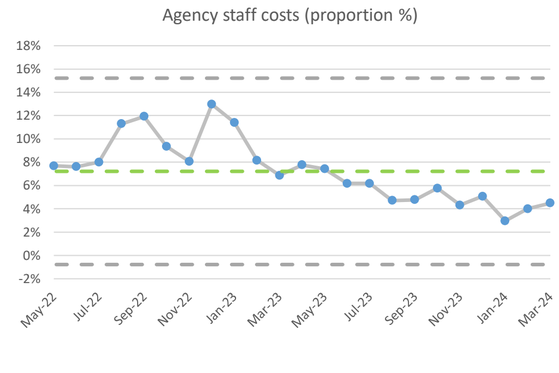
Assurance Description



Reporting Date	Performance	Op. plan #
Mar-24		F02
Threshold	**YTD Mean**	**Benchmark**

Variation Description

Assurance Description



Reporting Date	Performance	Op. plan #
Mar-24	**4.5%**	F03
Threshold	**YTD Mean**	**Benchmark**
5.0%		

Variation Description

Assurance Description

Issues / Performance Summary	Planned / Mitigation Actions	Assurance / Recovery Trajectory
% Progress towards Cost Improvement Target (CIP): • To date, £7m in CIP cash out savings have been delivered, which have been reflected in the forecast. £1.5m in efficiencies have also been delivered but these do not impact the forecast. • Spend increased by £34.7m 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 contributed to the operational overspend of £22.7m. **Budget Performance** • The full year operational result was an overspend of (£31.1m) with further spend of (£6.3m) being covered by the DHSC reserve. Additional costs of £4.2m (not shown in the table above) were covered by fund claims. • The final position was an improvement of £0.3m to last month's forecast where some of the risks around the year-end stock take and pay award arrears didnot materialise. **Agency staff costs** • FY employee costs are (£10.7m) over budget. Agency spend contributed to this overspend and reducing it was a factor in improving the financial position. The total agency spend YTD of £11.1m is broken down across Care Groups below. The Care Groups with the largest spend are Social Care (£2.3m), Medicine (£2.2m) and Mental Health (£1.4m), where spend is primarily incurred to cover existing vacancies in those areas.	**Budget Performance** • Fund claim applications for the Legal Fee Reserve & the HTF are still to be approved by Treasury, but for the purposes of these accounts it is assumed that these costs are recovered from the relevant fund. • Spend increased by £34.7m 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 contributed to the operational overspend of £22.7m. **Agency staff costs** • Although agency costs reduced bank costs gradually increased although there was not a spike in March which has been seen in previous years. Overall costs tracked 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, £7m in CIP cash out savings have been delivered, which have been reflected in the forecast. £1.5m in efficiencies have also been delivered but these do not impact the forecast. • The efficiency target of £825k has now been exceeded with delivery of £1.5m to date.

Finance Performance Scorecard

KPI ID	Indicator	OP. Plan Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD 2024-25	YTD Performance
F01	% Progress towards Cost Improvement Target (CIP)	2%	N/A	N/A	22.2%	26.7%	33.3%	76.0%	86.7%	91.1%	109.0%	122.2%	131.0%	156.0%			
F02	Actual performance against Budget (£ 000)	£0 variance	-£1,301	-£3,187	-£2,663	-£4,261	£548	-£2,866	-£3,082	-£3,403	-£3,491	-£5,586	-£2,493	-£2,536			
F03	Agency staff costs (proportion %)	5%	7.8%	7.4%	6.2%	6.2%	4.7%	4.8%	5.8%	4.3%	5.1%	3.0%	4.0%	4.5%			