How are we doing?

Board Annual Delivery Plan Performance Report Quarter 2 2024/2025

Content

Introduction

NHS Grampian's Plan for the Future sets out the direction for 2022-2028 and provides a framework for other key plans to be aligned to, ensuring that our strategic intent becomes a reality. To help us get there, the fulfilment of our outcomes will be delivered through our Integrated Performance Assurance and Reporting Framework.

Our Vision and Strategic Intent

Integrated Performance Assurance and Reporting Framework

The Board Performance Report is designed as part of the Framework to provide NHS Grampian with a balanced summary of the Board's position including all key areas outlined in our strategic plan on a quarterly basis. To achieve this, NHS Grampian has identified Key Performance Indicators and Deliverables within each of the categories in our strategic intent above as agreed in the Delivery Plan, which are considered to drive the overall performance of the organisation towards our vision and outcomes.

The report highlights key areas of achievement or concern, with narratives from Executive Leads to provide a wider perspective.

Alignment of our Plan for the Future and Performance

A

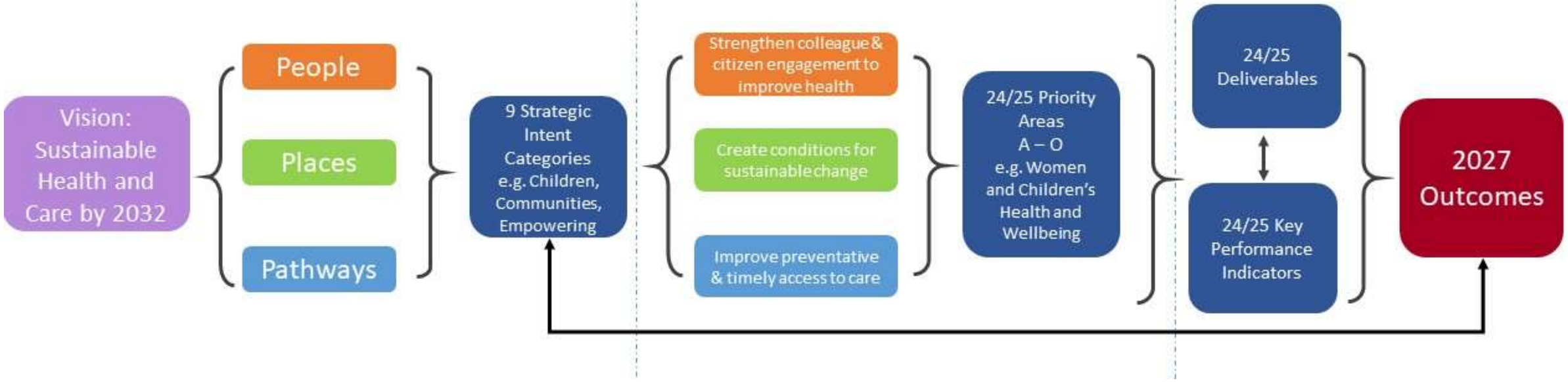
Strategic Intent

B

24/25 ADP Objectives and Priority Areas

C

How we measure, track our performance against objectives and priority areas through KPIs, supported by deliverables to achieve our 2027 outcomes

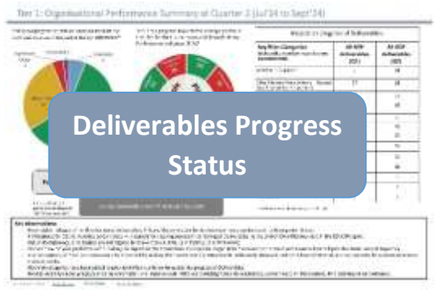


Reading Guide

The format of this report supports a tiered approach on how we review performance information. The purpose of the reading guide is to help you navigate the sections in this report. These are intended to flow, enabling you the flexibility to view high level or drill down data.

(Tier 1)
Our Organisational Performance Summary
(High level overview of "How we are doing" as an NHS Board across our strategic intent)

Performance Wheel



Deliverables Progress Status

This section covers two key areas of focus:

1) Our Board Performance Summary across our strategic intent:

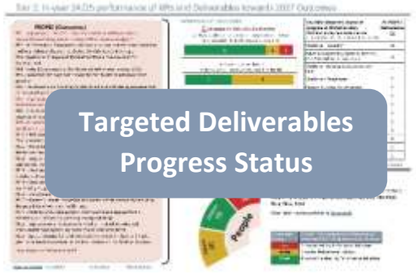
The Performance Wheel and Deliverables above indicate a high level overview of our performance as a Board across each of our strategic intent set out in People, Places and Pathways. The Red, Amber, Green (RAG) rating assessment criteria for the Key Performance Indicators (KPIs) and progress status of our Deliverables can be found on the next page.

2) Our Board Performance Summary across key critical areas of our organisation:

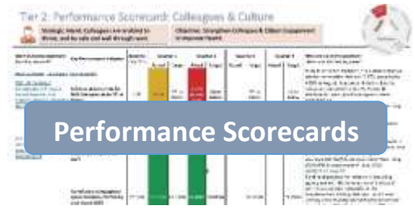
A high level overview to provide a wider landscape not specifically covered via People, Places and Pathways but critically important for the organisation will be included here.

(Tier 2)
Our Performance Scorecards and Deliverables
(Summary of Key Performance Indicators and Deliverables across categories in strategic intent)

Performance Wheel



Targeted Deliverables Progress Status



Performance Scorecards

In this section, the Performance Wheel will feature throughout and apply a focus on each of the strategic intent illustrated by its RAG rating. You will be presented with Performance Scorecards and targeted Deliverables aligned to the strategic intent, objectives and priority areas set out in the Delivery Plan.

This section will expand its overall RAG rating e.g. Access into the next level of information showing performance against those Key Performance Indicators considered to be most important measures as agreed by the Board and status reporting of the Deliverables as per the Annual Delivery Plan.

Definitions of the key headings on the Performance Scorecards and Deliverables can be found in the next page.

(Tier 3)
Performance Spotlights
(Detailed focus on adverse or favourable performance with detailed commentaries)

Performance Wheel

Performance Spotlights

In this section, our Performance Spotlights will provide more drilled down data highlighting areas of favourable and adverse performance from the Performance Scorecards and Deliverables.

The detailed commentaries from Executive Leads cover:

- Our Story so far
- Our Key Risks, Challenges and Impacts
- Our Mitigations and Recovery Actions
- What have we learnt?
- Our Oversight and Assurance

Key spotlight components will be subject to change depending on the areas of focus for the period of reporting.

KEY

(A) Overall RAG Ratings for Board Performance Summary:

Each category of our strategic intent within the Performance Wheel is given an overall RAG rating. These are based on the ratings of the Key Performance Indicators (KPI) within each category highlighted in the Performance Scorecards.

Assessment Rating	Criteria*
Red	2 or more red Key Performance Indicators
Amber	1 red Key Performance Indicator
Green	0 red and 1 amber Key Performance Indicators

*Where a category only has one KPI, the RAG rating for that category will be the same as for its KPI

(B) RAG Ratings for the Performance Scorecards:

The ratings of the Key Performance Indicators within each category highlighted in the Performance Scorecards are based on the criteria below, unless otherwise stated:

Assessment Rating	Criteria
Red	Current performance is outwith the standard/target by more than 5%
Amber	Current performance is within 5% of the standard/target
Green	Current performance is meeting/exceeding the standard/target

(C) Each KPI also has a marker to indicate the direction of performance from the previous quarter, in relation to current target:

Marker	Description
●	Improvement in performance from previous quarter
●	Decline in performance from previous quarter
●	There has been no change between previous and current quarter

(D) Performance status reporting of our Deliverables through Quarterly Milestones

- Complete
- On Track
- Minor Delay
- Significant Delay
- Proposal

DEFINITIONS

The following definitions will support you in your understanding of the various key words found throughout the report.

Strategic Intent and its categories
This means People, Places and Pathways with categories such as Empowering, Access etc.

Priority Areas
These are the priorities that set out in our delivery plan that helps to align our performance, activities to meet our objectives and strategic intent.

Key Performance Indicator (KPI)
A KPI is a carefully selected metric, directly linked to our strategic objectives and indicative of overall performance. KPIs are chosen to provide actionable insights into the progress and success of specific goals and objectives, and help assess performance and drive decision-making.

Deliverables
A key deliverable is an outcome of a task or project activities taking place. Typically outlined at the outset, key deliverables are quantifiable and linked to quarterly milestones for monitoring progress. Milestones serve as markers in time to track and measure progress

Outcomes
Outcomes are the specific, immediate or intermediate, tangible and measurable results or changes resulting directly from a project's activities or interventions. They reflect changes in behaviour, knowledge, skills, attitudes, or conditions and are used to assess progress towards long-term goals and impact. Examples include increased self-esteem and more items recycled.

Baseline
This indicates the level of performance against each indicator at the end of 2024/25, serving as a reference point against which progress or change can be evaluated.

Targets
These indicate the performance we are seeking to achieve for the KPIs each quarter as we progress towards the overall objective by March 2025. Each KPI will have quarterly targets, some which will be level throughout the year and some will be cumulative. There may be seasonal adjustment applied to quarterly targets if applicable for the KPI.

Trend Graphs

Each KPI has a trend graph which summarises performance from the last 12 months, where data is available.

Executive Summary

The Quarter 2 performance report provides a transparent and balanced assessment of our progress and challenges in delivering the Annual Delivery Plan. Workforce capacity, financial constraints, and infrastructure limitations continue to place significant pressures on the system, impacting short-term deliverables and influencing our trajectory toward 2027 outcomes. Despite these challenges, our teams remain focused on learning, adapting, and driving meaningful progress.

This quarter, 40% of Key Performance Indicators (KPIs) showed improvement, while 55% experienced a decline compared to the previous quarter; and 50% remain rated Red. Additionally, 94 Deliverables missed their milestones. The Performance Wheel reflects these pressures, with one less strategic intent category rated Green and another now rated Red. These changes highlight the complexity of balancing system-wide demands while driving forward our strategic priorities. Performance against national waiting time standards remains mixed, with capacity and funding challenges affecting key areas, though CAMHS and IVF consistently exceed targets.

To support decision-making and improve clarity, we have strengthened our performance assurance approach in the report by enhancing linkages between in-year KPIs, Deliverables, and longer-term Outcomes in the Plan for the Future. The revised spotlights offer a comprehensive view of performance, integrating qualitative insights with quantitative data to provide transparency, assurance, and actionable focus for sustained progress.

The new “Key Organisational Enablers” section, this quarter focused on Digital, highlights the critical role of technology in improving patient access, safety, and system efficiency. This addition emphasises the interdependencies that drive performance and align with our strategic goals.

Listening to our workforce and citizens remains central to our approach. This quarter, the "Voice of Our Citizens" highlights complaint trends and service improvements, while the "Voice of Our Colleagues" focuses on the Trickle App, enabling Doctors in Training to share concerns and ideas. These tools ensure feedback drives accountability, compassion, and meaningful change.

Looking ahead, we aim to further enhance performance insights by highlighting collaborative works and shared outcomes across Health and Social Care.

Adam Coldwells, Interim Chief Executive NHS Grampian

Q1 Performance Wheel
April 2024 – June 2024

Voice of our Colleagues via Trickle

Colleague experience:

- Trickle App launched August with invitations sent to approx. 800 Doctors in Training (DiT) in NHS Grampian.
- This is with the aim of providing a space to raise concerns, ideas and make suggestions for workplace improvements.
- Trickle is being trialed with DiTs because experience in NHS Lothian indicates it has the potential to provide a voice to DiTs- a digitally active group - by encouraging participation and promoting a sense of organisational belonging.
- Currently there are 178 users signed up. Work is ongoing with trainee leads to encourage further sign ups. The ability to post anonymously is being highlighted.
- There have been 6 Trickles raised, 2 of which have been completed and 4 remain open. Topics raised include wellbeing, rotas, social and payroll
- A Champions Group including the Scottish Clinical Leadership Fellow, Director of Medical Education and colleagues from Wellbeing, Culture and Development meets fortnightly to review trickles and identify owners in the system.

Our key risks, challenges and opportunities:

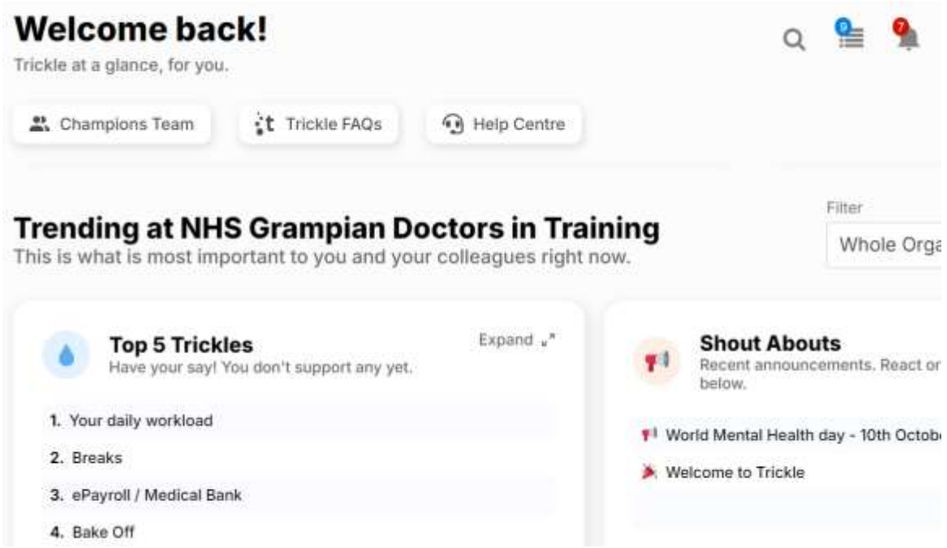
- Meaningful responses are required to ensure staff engagement is given appropriate focus, with timely responses generated to ensure closed loop communication and feedback.
- Challenge of maintaining growth in user numbers amongst a busy and transient cohort of staff.
- With the appointment of new Trainee leads it is anticipated that Trickle will have actively engaged Champion Team which should drive further engagement with the app.

trickle™

Our actions to date…

Preparatory:

- Formation and induction of Champions Team including People & Culture Team representative, Director of Medical Education Team, Scottish Clinical Leadership Fellow, Trainee Leads. Champions have all attended specific training delivered by Trickle
- Trickle App introduced at five departmental teaching sessions
- Trickle App introduced at Consultant Sub-committee and Clinical Interface Group
- Social Media communication strategy developed and implemented via X
- Standard Operating Procedure for management of inappropriate Trickles developed
- Bi-weekly Champion Meetings established



What Next…?

1. Incoming Trainee Leads to receive Champion training. Proposal to re-establish the Trainees Forum with output from this being used to generate further Trickles and disseminate outcomes of forum amongst Trainees
2. Tea and Trickle event planned to be held in the Mess to further promote the role of Trickle and to introduce new Trainee Leads
3. Trickle output about IT issues to be presented to EPR Steering Group to try and address IT user experience for Trainees
4. Trickle to be introduced at Foundation Year teaching to encourage further sign ups

Voice of our Citizens

Complaints received Quarters 1 & 2 2024/25

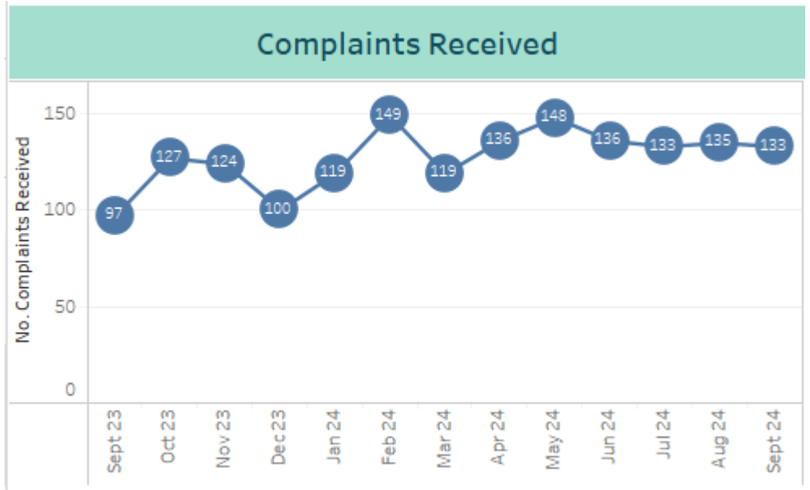
In the first 6 months of the year 2024/2025, NHS Grampian received 821 complaints; the Integrated Specialist Care Portfolio accounted for 31% of these.

We received an average of 31 complaints per week

- Complaints received increased by 14% from the same period in 2023/2024.
- The majority of complaints (63%) were received by email, which is a slight increase on last year.
- Complaints via email are encouraged as this ensures the complaint is accurately captured in the complainant's own words, and gives space for stories to be shared. Other available methods include via telephone, letter or feedback card, with access to Language Line where required. In addition, the Patient Advice and Support Service Scotland (PASS) is available to provide support to anyone wishing to make a complaint.
- The number of complaints open at month end has been trending up over the last year. There is a noted dip in the complaints closed in April, which contributed to a higher complaints open trend to August; an increase in complaints closed in September has resulted in a reduction in complaints open at the end of quarter 2

63% of complaints were received by email

Compliments continue to be received via feedback cards as well as Care Opinion, and work is planned to encourage use of Care Opinion to record feedback in real time.



Timescales

Performance in meeting timescales has reduced compared with the same period in the previous year.

13% of complaints were closed by early resolution

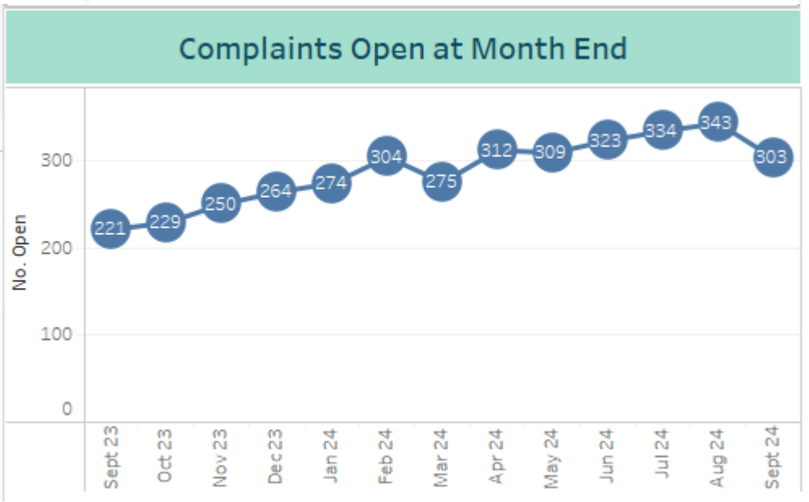
- 13% of complaints were resolved via early resolution – with an average response time of 4.8 working days.
- 36% were closed within the Model Complaints Handling Procedure target of 20 days, a reduction of 3% compared to the previous year.

The Feedback Service is revising processes to support improved response times, and plans for the second half of the year include providing a named officer to support each service, aiming to foster closer working and more tailored support.

Average time to respond by early resolution was 4.8 working days

There was a significant increase in complaints closed in September 2024. A short piece of work was undertaken with a service which had an opportunity to dedicate an additional resource which was available for a short period of time, and this joint work with the Feedback Service contributed to this boost in performance.

Improved performance in timescales is hoped will positively impact complainant satisfaction with the complaints process.



Voice of our Citizens

Staffing is the most common complaint theme

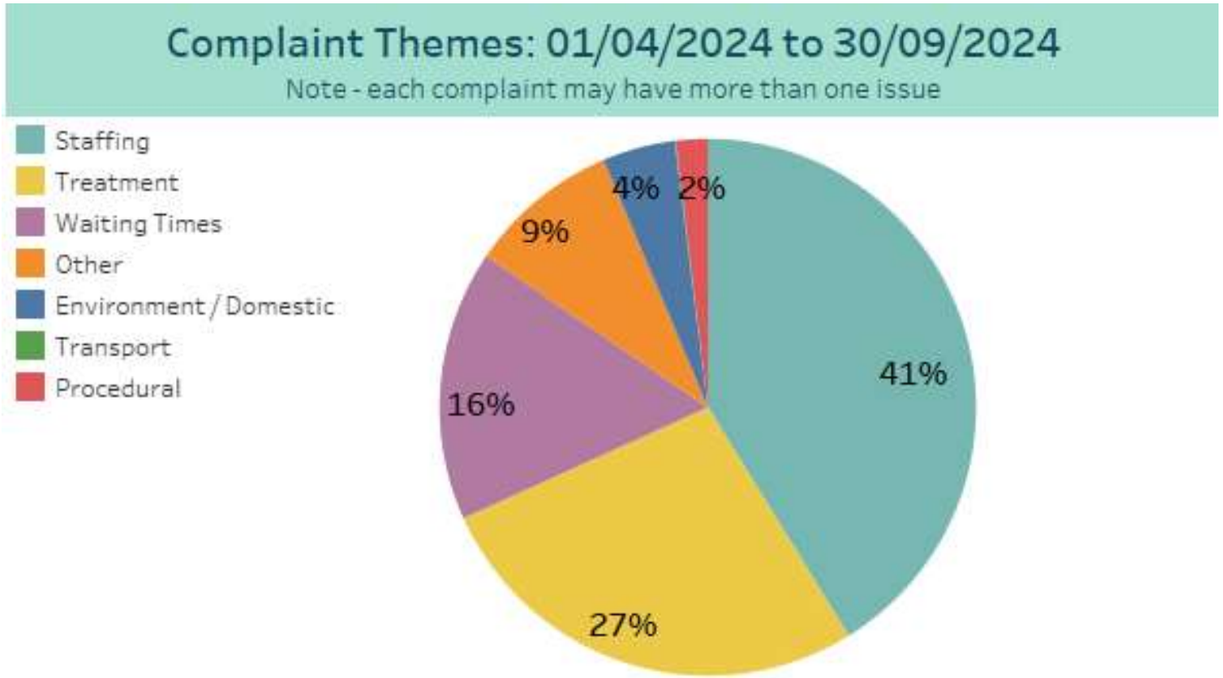
Themes

The themes raised in the complaints remained fairly static, with staffing remaining the most common theme of complaints received at 41% - an increase of 2% from the same period last year. Breaking this down, the main themes for complaints regarding staffing were oral communication (37%) and staff attitude and behaviour (25%).

We are holding our first system wide critical thinking session in November with the proposed topic of communication. The opportunity to get some key stakeholders together, collect views and perspectives, hear lived experience and consider how we can share and embed learning better within our system has been welcomed by colleagues.

In correlation with this, of actions taken following complaints, actions to improve communication were the most common at 18%. However, not all cases have actions completed against them, and there is work to be done on ensuring that actions and learning are correctly recorded.

Analysis of complaints regarding communication indicates that apologies are given locally and staff encouraged to reflect on their communication skills, but as seen below, there is an opportunity for a more coherent and system wide approach to improve the systems and processes that directly influence communications.



Communication - related complaint

Actions taken to improve communication

Mother complained on behalf of her disabled son who was very distressed being left for a long period when he presented to hospital.

Quality Improvement project on equality and diversity being completed within the department, and staff met with family to gain understanding of information to support future admissions.

Patient complained of not being able to get through on appointment line.

Service has requested call monitoring software to properly monitor calls and gather data on calls which have attempted to come through to support service improvement.

Complaint regarding cancellation of local vaccination appointments following change in eligible groups. Local team were unaware that a communication had been sent out via the national booking system and did not reflect the eligibility change. The local team cancelled appointments on the local system unaware that text messages would already have been sent to some patients.

A new step has been added to the process for cancelling bookings of this nature so the team have assurance that no letters or texts have been sent from the national system, and any uncertainty around this is also followed up with a phonecall.

Key Organisational Enablers - Digital

Background and situation:

- In April 2024 we took the decision to start a process of modernising our digital support across NHS Grampian and this started with the decision to change the name from eHealth to Digital Directorate and to further enhance this modern approach by creating Chief Digital Officer and Chief Clinical Digital Officer roles to align with other national and territorial boards.
- We took the decision to make these changes to reflect the impact, demand and change in digital services across NHS Grampian and the wider health and social care economy and support the digital transformation across NHS Grampian
- Digital is often seen as purely IT and all about computers. However, over the years this has evolved at a NHS Grampian the Digital Directorate covers:
    - Switchboard
    - Libraries
    - Medical Records
    - Digital Applications
    - Information Technology
    - Project Planning
    - National Virtual Consultation
- Digital Directorate supports every colleague and every citizen with their digital journey across our health Care. Our Switchboard and Telecoms colleagues support over 2.4 million calls per month.
- Our Networks team ensures that all colleagues and citizens have access to Wi-Fi to connect their devices, whether that's the latest medical equipment or to their phone to allow patients and families stay connected. Digital is the key partner across your experience and journey.
- Our Cyber Security Team support the protection of all our data through management of policies and ensuring we have the latest protections across our networks, infrastructure and applications.
- As a modern health and social care provider we are much more reliant on digital solutions from appointment booking to electronic patient records and all the way to modern 3D printing devices to support more effective patient care. Our digital solutions have already changed the way our citizens can access support and this will only increase in future years with the ability of citizens to use their own connected smart devices to supply real-time information to our systems.

What makes Digital a key enabler? What is its Strategic Impact?

The NHS Grampian Plan for the Future digital strategy focusses on the changing patterns of service delivery, care pathways and the emphasis on technology based on best alignment with our 'quadruple aim' of simultaneously achieving:

1. **Better health and social care outcomes** – longer, healthier, more contented lives.
2. **A better experience of health and social care for citizens** – less stress, easier interactions.
3. **A better experience for staff** – supporting people to work to the best of their abilities.
4. **Affordable health and care services** – sustainable long-term financial planning.

Digital is a key enabler across NHS Grampian, all our opportunities for a sustainable future from reducing carbon footprint to improving resource utilisation and rostering come from a requirement of digital enablement. Without digital we are not able to provide text messages or online portals to support colleagues and citizens, without digital our students don't have access to the latest textbooks and online training portals supplied by our knowledge services teams.

Our actions to date… Delivering on Digital: Achievements and Progress

- Due to the impact of COVID19 on the ways we work and engage with citizens we saw and continue to see a rapid growth in the number of digital solutions across NHS Grampian and the wider community. As part of our strategy to deliver a modern digital service for the betterment of all our colleagues and citizens it was vital that we undertook a review of all our planned digital activity and recent additions to understand how we can maximise the output and learn any lessons on deployment and engagement.
- Over the last 6 months (May to October 2024) we have undertaken a pause in the roll out or development of non-critical digital solutions to allow us to undertake these new products and also support a review of how digital should look and support key services going forward.
- The pause has provided significant benefit bit our support to the business continued:
- **Book Blethers**: Our Library team has support staff welfare through the successful roll out of "book blethers" all staff to be able to indulge in reading for pleasure. Initially launched to support colleagues who were shielding during COVID19 to ensure they weren't alone during the pandemic and has now continued and expended to more than one group and recently having an Author Session as part of Black History Month with Staff Equalities Network
- **GP IT Re-provisioning:** We have led the role out of a new GP Clinical application that will improve access to information, improve the ability to access the information outside of GP practices through web enabled systems and free up clinical time to support more citizens. So far we have successful migrated to the modern hosted environment for 57 of our GP Practices with the remainder due to go live next year.
- **Value and sustainability**: Digital have supported the wider NHS Grampian drive on efficiency through targeted initiatives including a review and rationalisation of printing across the organisation to support an overall reduction in the number of printers and replacement of older costly printers with energy and cost efficient models where appropriate.
- **National Virtual Consultation Service**: Delivered the roll out of Virtual Consultation product "Near Me" supporting 84,000 consultations across NHS Grampian and thus providing our citizens with greater access to clinical support
- **Implementation of HEPMA:** Successfully rolled out digital pharmacy solution "HEPMA" across NHS Grampian as part of a regional strategy led by NHS Grampian, enhancing medication safety and clinical workflow efficiency, thereby significantly reducing the risk of errors in prescription and administration, providing a better service to our citizens.

How does Digital help support the Plan for the Future? Do your own KPIs show this?

- The plan for the future and the digital strategy demonstrate the key part digital will play in creating a modern health and social care service, form the enhancement of diagnostics through AI and Robotics to providing citizens with the ability to have consultations form the comfort of their own home.
- This means that we must create a modern digital service that can support these aims with clear KPIs around delivery. This is something that has not previously been routinely created or supported and as part of our modernisation agenda, we will be developing and publishing our KPIs to demonstrate the impact of digital transformation and provide greater governance and assurance.
- The "once for Scotland" national procurements such as Microsoft365 provides us with the opportunity to work as a connected Scottish Health and Social Care economy and build universal solutions that will provide colleagues and citizens with a standardised digital experience, whether that's through building applications that allow a quicker recruitment of bank colleagues meaning that we have greater ability to support critical care through a national bank manged through digital solutions or standardised pre-appointment assessment and consent forms which citizens can access from comfort of their own home with support from colleagues.
- Digital provides the opportunity to break down barriers to allow cross board care. This is best highlighted in the work we are doing with NHS Highland to support better access to maternity care for citizens of Moray. We have supported targeted investment to understand how clinical colleagues from either board can have ease of access to critical patient information without the technical barriers such as being unable to log onto systems or needing a separate account for the electronic patient record. This work will take time but will break down the technical barriers and support greater regional working that will only benefit our citizens.
- Our hosting of National Virtual Consultation team has supported improvements to our pathways with in excess of 80,000 virtual appointments for citizens of Grampian meaning that they get access to clinical support earlier and in manner that supports their individual needs, placing our citizens at the heart of our digital and technological solutions.

How does it link to and help to facilitate our 2024/25 Deliverables?

- Digital is the key enabler in 5 non digital objectives within our Annual Delivery plan including *"Scoping an Urgent Care Hub that encompasses care home provision and flow navigation and optimises and expands on existing arrangements including additional pathways to prevent hospital admissions and allow patients to remain in their own homes, such as Hospital @ Home and other virtual capabilities."*
- To enable this objective within the ADP requires digital leadership and project expertise to ensure that the service can be provided. This includes reviewing the technology requirement, how the applications would be accessed on our networks, creating KPIs and SLAs to reflect the demand. Our dedicated Service Desk colleagues will offer support to colleagues where technical issues are identified.
- The Digital Directorate supports every colleague and every citizen on their journey across our Health and Social Care journey and thus all actions within our ADP requires the support and enablement of digital.

How does it help improve organisational performance?

- NHS Grampian has over 6000 differing pieces of software across the organisation ranging from Business and Payroll to clinical equipment. Each of these pieces of software provides critical support to our organisation and without these areas we would not be able to operate.
- We have recently supported colleagues with the procurement of software to support 3D printing of insoles for patients. This not only allowed patients to get access to the support quicker but reduced the overall cost of producing insoles, allowing time and money to be redirected to other areas within the department to support care.

Our impacts, Challenges and Risks

Digital faces similar financial challenges as other parts of NHS Grampian. The push for efficiency requires digital to modernize infrastructure while facing budget constraints. Key challenges include:

- **Financial Pressures**: Balancing modernization with maintaining current infrastructure. Service contracts have seen a 20% cost increase.

- **Prioritisation and Governance**: We rely on a prioritization framework led by the Digital Board to ensure strategic goals are met despite limited resources. The Digital Board oversees decisions on prioritization of work, managing risk through regular reporting, and development of operational delivery plans.

- **Health Records Management**: We currently manage and store approximately 1,000,000 paper records both onsite and offsite. Rising costs for storage will continue to increase due to restrictions on the safe destruction of medical records owing to ongoing national public inquiries. We have developed a new record scanning strategy to digitize records and reduce the need for offsite storage, thereby cutting costs and allowing easier access to information for citizens.

- **Cyber Security and Compliance**: NHS Grampian complies with regulatory and legal requirements, including the annual Network & Information Systems (NIS) Audit and Review process. We have recently completed our post-audit yearly review, which has shown improvements in governance and risk management around cybersecurity. Education and training around digital security are also ongoing, aiming to mitigate the risks posed to the organization, colleagues, and citizens.

- **Performance Gaps**: We continue to work to ensure we can support cross-sharing of information between primary and secondary care to support the roll-out of national and regional products such as the 'digital front door.' This will improve how citizens engage with our services and support a reduction in administrative costs, contributing to better patient care.

- **Strategic Impact of Applications**: Ongoing efforts to review processes, develop the Electronic Patient Record (EPR), and integrate existing systems aim to streamline workflows, enabling clinical staff to focus more on patient care rather than administrative tasks and improve citizen access to their information.

How Are We Managing Risks Around Digital:

- Continuous Governance Improvements: Whilst it was pleasing to demonstrate the improvements we have made in our NIS compliance, we are actively working to further improve governance and enhance visibility of the challenges, risks, and opportunities within digital.

- Cybersecurity Education and Training: Supporting education around digital security is a key focus, both for the organization and citizens. We have recently launched an updated training course for colleagues within NHS Grampian and plan to introduce a citizen awareness pack in the next financial year.

- Digital Board Oversight: The newly introduced Digital Board provides opportunities for service-wide decisions on digital, from prioritising work to managing risk through regular reporting and development of our operational delivery plans.

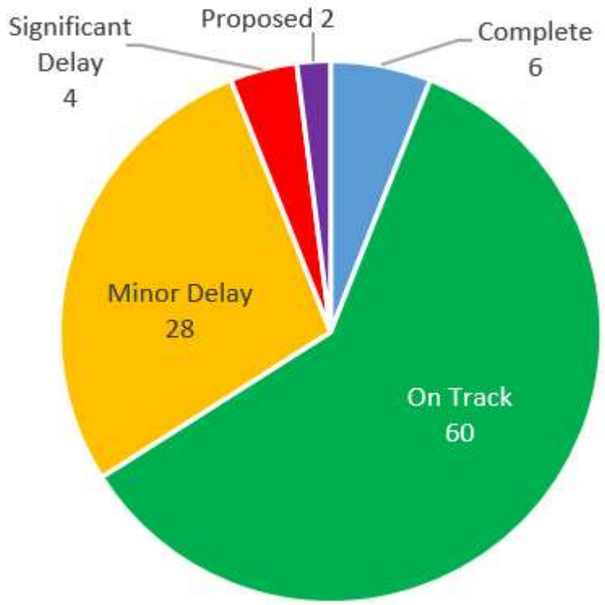
- Review of Digital Strategy: The impact of financial challenges and digital demands means that our digital strategy and timelines require review to ensure they are achievable or need amendment. We will work with our colleagues, citizens, and stakeholders to ensure that our digital strategy and journey meet the needs for our future ways of working.

What Next…?

- As was seen through the pandemic, digital will become the driving force to support citizens and their journey through our services. We will see increased utilisation of connected devices that provide live information on citizen health and also reducing the need for citizens to attend site. Not only will this improve the care we can offer but will support our role as an anchor organisation and our commitments to reducing carbon footprint.
- **Book Blethers:** Our Library team will look to build upon the support of our “book blethers” and extend it to our citizens, enabling support
- **Digital Front Door:** Our teams will work with regional and national colleagues to support the national “once for Scotland” digital front door solution that will provide greater access to digital records for all citizens.
- **Creating a modern Digital service**: The requirement for increased digital support means that we need to create a modern digital service that can maintain the increasing digital infrastructure whilst providing the ability to create new digital solutions. This will be achieved through investment in colleagues and engagement with our citizens through roadshows and town hall events where our citizens can have their say and help shape our digital future.
- **Review of our digital strategy**: Our digital strategy was reviewed last year but this now needs to be revisited and reflect the changes caused by the current financial challenges and also the national requirements. Colleagues and citizens will be asked to support this review through workshops and feedback.

Tier 1: Our Board Performance Summary at Quarter 2 (Jul'24 to Sept'24)

This is our progress on 100 deliverables towards the 2027 outcomes as of the end of the Q2 milestone*



This is our progress towards the strategic intents in the Plan for the Future, measured through 38 Key Performance Indicators (KPIs)*

*Data accurate as at 28/11/2024, subject to change
Performance wheel based on 37 of 38 KPIs for which data has been provided

People (19 Outcomes)

Places (12 Outcomes)

Pathways (14 Outcomes)

Impact of current performance towards 2027 Outcomes (45)

Vision: Sustainable Health and Care by 2032

Impact on progress of Deliverables		
Key Risks Categories **(Deliverables may have more than one associated risks)**	**All ADP deliverables (Q1)**	**All ADP deliverables (Q2)**
Workforce – Capacity*	-	**53**
Other (National Policy, Systems – National, Data & Modelling, Engagement)	57	29
Finance - Funding not yet agreed	29	25
Workforce - Training, Development and Skills	31	22
Workforce - Recruitment	25	21
Finance - Non-recurrent funding	21	19
Workforce - Retention	11	17
Finance – Insufficient Funding*	-	15
Infrastructure - Estates	10	11
Workforce - Absence	9	10
Workforce - Wellbeing	9	9
Infrastructure – Digital*	-	3
Procurement	2	1

*Indicates new risk category added for Q2

Key observations:

- More visible linkages of the flow between Deliverables, KPIs and Outcomes but further improvements can be made to show golden thread
- 6 milestones for Q2 are reported as Complete. A prognosis for tracking success in achieving all Deliverables by the end of Q4 will be included in the Q3 ADP report.
- Out of 45 Outcomes, 6 Outcomes are not aligned to Deliverables or KPIs. (3 in PEOPLE, 3 in PATHWAYS)
- Unclear how "in year performance" is making an impact on 2027 Outcomes. Incorporate longer term measures with annual performance data will provide clearer view of trajectory.
- The descriptions of most Outcomes could be improved by making them more Specific, Measurable, Achievable, Relevant, and Time-bound (SMART), as they currently focus more on actions than on results.
- New risk categories have been added to provide further clarity on impact to the progress of Deliverables.
- Provide visibility on the progress of all transformation and improvement initiatives to highlight interdependencies, performance on Deliverables, KPIs and impact on Outcomes.

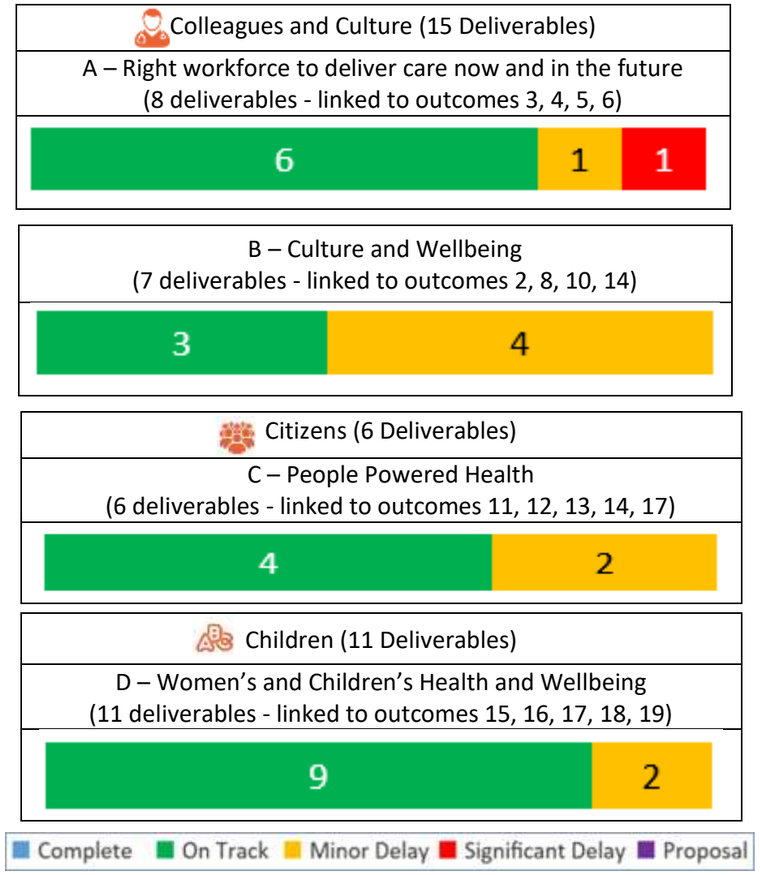
Tier 2: In-year 24/25 performance of KPIs and Deliverables towards 2027 Outcomes

PEOPLE (Outcomes)

PE1 - Implemented plans for reshaping workforce will have reduced substantive workforce spend to below 60% of revenue budgets*
PE2 - All Portfolios / Directorates will have an annual workforce turnover rate and total sickness absence rate below the NHS Scotland average.
PE3 - Agenda for Change and Medical Workforce non-pay reforms implemented.
PE4 - Value & Sustainability Plan delivered with annual savings of 3%.
PE5 - Increased participation in research contributing to evidence based practice.
PE6 - Health and Care (Staffing) (Scotland) Act and e-Rostering implemented across all relevant professions.
PE7 - Organisation iMatter scores re: confidence in leadership, involvement in decisions and performance management =/>70%*
PE8 - 70% of colleagues in all Portfolios / Directorates report the organisation supports their health and wellbeing at work.
PE9 - All services using a real-time feedback loop to support improved workforce engagement and change*
PE10 - NHS Grampian meeting requirements of published Protected Learning Time commitments under Agenda for Change reform.
PE11 - We will deliver good quality care and sustainable health services in the future through the active participation of our staff, citizens and partners.
PE12 - Insights of colleagues and citizens will be reflected in our planning approaches to reduce inequality of access to services.
PE13 - Creation of a culture where volunteers are embedded as valued members of our teams, and their contribution is recognised.
PE14 - Creation of a culture of engagement and empowerment, as part of our Putting People First approach.
PE15 - Moray Maternity Services Plan for Model 6 implemented & evaluated.
PE16 - Women's Health - scope the best access within community including the possibility of women's health hubs.
PE17 - Children and young people's participation and engagement is informing and influencing service planning and design.
PE18 - Improvement in outcomes for children realised & evidenced, measured through agreed key performance indicators (KPIs).
PE19 - Agreed strategy for paediatric tertiary services in place, to include plan for critical care services for children resident in the North of Scotland

*Not aligned to Deliverable or KPI

Performance of Deliverables



Key Risk Categories: Impact on progress of 32 Deliverables (Deliverables may have more than one associated risk therefore total will exceed 32)	All PEOPLE Deliverables Q2
Workforce – Capacity*	19
Other (National Policy, Systems – National, Data & Modelling, Engagement)	15
Workforce - Training, Development and Skills	7
Workforce - Recruitment	7
Finance - Funding not yet agreed	7
Finance – Insufficient Funding*	5
Finance - Non-recurrent funding	4
Workforce - Retention	4
Infrastructure – Estates	2
Workforce - Wellbeing	2
Workforce - Absence	1
Procurement	0
Infrastructure – Digital*	0

*Indicates new risk category added for Q2

Performance of Key Performance Indicators

Performance against 11 People KPIs across Colleagues and Culture, Children, and Citizens – linked to Outcomes PE2, PE3, PE4, PE10, PE11, PE14, PE18

More information available in Scorecards

Assessment Rating	Criteria* Each category in the Performance Wheel has a RAG rating based on its KPI scores
Red	2 or more red Key Performance Indicators
Amber	1 red Key Performance Indicator
Green	0 red and 1 amber Key Performance Indicators

Tier 2: Performance Scorecard: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

2027 Outcome alignment linked outcome ID	**Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?** *When was this last reported?*
			Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
PE2 - All Portfolio/ Directorates will have an annual turnover and sickness absence rate below the NHS Scotland average	**Sickness absence rate for NHS Grampian to be 5% or below**	5.0%	5.25%	5% or below	**5.37% (to end Aug)**	**5% or below**		5% or below		5% or below	From 01/04/24 to 30/08/24, the sickness absence rate for substantive staff was 5.37%, dropping to 4.95% in August. September data is subject to validation, but currently 4.97%. Power BI dashboards now support managers in areas exceeding 5%. *Last reported: Staff Governance Committee - Aug 2024; Chief Executive Team - Sept 2024* spotlight on page 18
PE3 - Agenda for Change and Medical Workforce non-pay reforms implemented	**100% of AFC staff have reduced their hours to 37hrs per week or pro-rata equivalent for part time staff**	0%	41%	40%	**71%**	**70%**		100%		100%	Good engagement across non-rostered services with implementation of initial 30 minute reduction. Note that year to date costs for transitional overtime and additional bank work to end Aug are in the region of £2.7m. – National data delay issue preventing accurate figure *Last reported: Staff Governance Committee – 31st Oct 2024* spotlight on page 19
PA4 - Value & Sustainability Plan delivered with annual savings of 3%	**To reduce nursing agency spend to below £9.75m by end March 2025**	£2.62m	£2.350m	£2.437m	**£4.468m**	**£4.875m**		£7.312m		£9.750m	Continued progress for reductions in nursing agency use with the introduction of increased controls as outlined nationally by the Supplementary Staffing Task and Finish Group *Last reported: Nursing and Midwifery Workforce Council – 30th October 2024, Briefing paper to CET under Value & Sustainability 06/08/24* spotlight on page 20
	To reduce junior doctor banding/medical locums spend to below £17.789m by end March 2025	£6.121m	£5.610m	£4.447m	**£9.969m**	**£8.895m**		£13.342m		£17.789m	Savings achievement now ahead of target during quarter 2, although still an over reliance on non-recurring savings which are one off (35% recurring / 65% non-recurring). *Last reported: Chief Executive Team 22/10/2024* spotlight on page 21

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Colleagues & Culture

2027 Outcome alignment linked outcome ID	**Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1** Actual	**Quarter 1** Target	**Quarter 2** Actual	**Quarter 2** Target	**Quarter 3** Actual	**Quarter 3** Target	**Quarter 4** Actual	**Quarter 4** Target	**Why are we in this position?** *When was this last reported?*
PE10 - NHS Grampian meeting requirements of published Protected Learning Time commitments under Agenda for Change reform	**Compliance with mandatory training will increase to 80% for all new starts and 60% for all other colleagues (70% overall)**	58.9%	61%	70%	**63%**	**70%**		70%		70%	Q2 improvements reflect ongoing efforts to raise the profile and increased awareness from the Protected Learning Time elements of the Agenda for Change non-pay reform. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 22
	Compliance with statutory training will increase to 90% for all new starts and 70% for all other colleagues (80% overall)	67.5%	69%	80%	**64%**	**80%**		80%		80%	The Q2 drop in compliance aligns with the 63-65% achievement range seen over the past year. Ongoing operational pressures complicate improvement efforts, but early signs suggest that sharing data with the CE Team is positively influencing senior management's achievement modelling. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 23
PE14 - Creation of a culture of engagement and empowerment	**50% of all staff have current appraisal on Turas or SOAR**	13%	15%	20%	**15.1%**	**30%**		40%		50%	Operational pressures hinder achievement improvements. A review and re-launch of the leadership framework and appraisal guidance in 24/25, alongside national TURAS proxy reporting, aim to enhance awareness and local appraisal reporting. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 24
	Reduce time to hire in support of addressing workforce shortages	116 days	110 days	<105 days	**No Data for Q2**	**<105 days**		<95 days		<95 days	The increase in vacancies is due to vacancy control processes and limited Jobtrain reporting, especially for bulk recruitment (e.g., Band 2 HCSW and NGNs), which account for a larger share of overall vacancies. Issues with data have only just become apparent, but go back some time. JobTrain working on a national fix, together with supplying historical data to enable re-reporting of the TTH for the last 12 months. *Last reported: Chief Executive Team - Aug 2024 and PAFIC - Aug 2024*

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Citizens

Strategic Intent: No citizen in Grampian will be left behind

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

2027 Outcome alignment linked outcome ID	**Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?** *When was this last reported?*
			Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
PE11 - We will deliver good quality care and sustainable health services in the future through the active participation of our staff, citizens and partners.	**To increase the total membership of the Public Involvement Network by 15% (6 members) by 31 March 2025 (from 38 to 44)**	38	41	38	**39**	**41**		42		44	Two members have left the PIN over the previous quarter. Fluctuation of leavers/joiners is to be expected and does not yet jeopardise achievement of the overall target. *Last reported: PIN membership monitored by the Public Engagement Team and reported through Comms Leadership Team meetings (last meeting held 19/08/24)* spotlight on page 25
PE13 - Creation of a culture where volunteers are embedded as valued members of our teams, and their contribution is recognised.	**To increase the total number of volunteers by 25% by 31 March 2025 (from 191 to 239)**	191	223	211	**224**	**231**		235		239	Volunteer numbers have fluctuated between 235 and 217 during Q2 reflecting the variable availability of this resource. Mean availability for quarter is 224. *Last reported: Q1 HAWD 12/09/24 Spotlight, Volunteer Oversight Group 09/10/24* spotlight on page 26

Tier 2: Performance Scorecard: Children

Strategic Intent: Children are given the best start, to live happy, healthy lives

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

2027 Outcome alignment linked outcome ID	**Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?** *When was this last reported?*
			Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
PE18 - Improvement in outcomes for children realised & evidenced, measured through agreed key performance indicators (KPIs).	**Reduce backlog unbooked TTG RACH patients (including Paediatric Dentistry) to 400 patients by March 2025**	592	507	<500	**372**	**<500**		<450		<400	The impact of 21 days of theatre downtime and CDU closures was mitigated through progress in paediatric dental validation, non-GA circumcision, and MRI efficiency. A service manager is reviewing outpatient lists and conversion rates to improve capacity planning. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 27

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): Sickness absence rate for NHS Grampian to be 5% or below

Q2 actual: 5.37%
Q2 Target: <5%

Outcome: All Portfolio/Directorates will have an annual turnover and sickness absence rate below the NHS Scotland average

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- The Scottish Government required Boards to reduce sickness absence as part of delivery planning requirements of Boards for 2024/25.
- Based on historical and current performance, CE Team agreed this reduction should be to an average rate for the organisation below 5%.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- The monthly rate for August 2024 had dropped to 4.95%. It was 4.73% at the same point last year. September data is subject to validation, but currently 4.97%.
- Whole FY to date is 5.14% and the rolling year 5.09%. Corresponding rates in 23/24 were 4.95% and 4.90% respectively
- A SLWG led by the Head of Occupational Health has been established as part of the Value and Sustainability programme.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?

- This will support areas with high absence rates already undertaking targeted work (Facilities, Mental Health, Nursing) and provide additional supports where needed

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Managers' capacity to manage absence and follow policy, this may include understanding of process and good practice
- Capacity of Occupational Nurse Advisors to support increasing demand of referrals given other competing service priorities
- Lack of access to real time information via Power BI that can by analysed to identify absence hotspots and patterns for services or professions
- Impact of vacancy control creating more pressure on staff and services and the potential to raise sickness absence.
- Seasonal variations / outbreaks increasing absence from a slightly higher position this year than 2023/24

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- There is a potential link relating to completion Statutory and mandatory learning in areas relating to Infection Control, Moving and Handing and Violence and Aggression

Commentary from

Tom Power,
Director of People & Culture

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Cross system SLWG (Short Life Working Group) has met, and looked at absence data in Power BI, shared intelligence around the areas where there are specific projects to support the reduction of absence. Tests of change were planned for one clinical and one non-clinical area
- Ongoing good practice is being promoted, including, Return to work interviews, referral (self and management to OHS), and support return to work programmes, signposting to policies.

The targeted projects include:

- Domestic Services – a number of small tests of change through a project with Domestic staff as an internal Anchors approach.
- Mental Health – a small scale test of change by offering an experienced Clinical Psychologist providing Cognitive Therapy pro-actively for staff, who are identified by senior ward management as may potentially benefitting from an earlier therapeutic intervention. The offer would be open to all MDT staff working across the in-patient acute wards at RCH.
- Healthcare Support Workers – a project initiated through value and sustainability identified sickness absence as area for deep dive as contribution to agency & Health care support workers overspend

b) How will we measure the expected impact, and what could prevent success?

Using the information provided by the Workforce Intelligence Unit to understand the areas where there is enduring high absence rates and the overall % rate. This will also be supported by themed information from Occupational Health Services. To increase the chance of success, access to information (PowerBI) for mangers and understanding how to use the dashboard. Other potential factors that could decrease success include outbreaks of illness across teams

c) If something hasn't worked, what alternative course of action will be taken?

Support and application of the local and national workforce policies available to staff and managers

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Strategic Intent?

- There is a proactive approach already being taken in NHS Grampian, which is mitigating upward pressure in some higher absence areas.
- It will be important to compare performance across years and months to establish any new post pandemic patterns.
- Additional information will be added regarding OHS referral rates, to understand how absence is being managed
- There is an opportunity for the V&S linked to SLWG to pull learning from projects and test of change work and support application across other services

b) What needs to change? Is further support needed, if so from where and in what form?

Learning from projects and test of change work and its application across other services.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Value and Sustainability SLWG providing oversight of work across system, reporting to Chief Executive Team quarterly and Scottish Government on 15 Box Grid targets.

Related ADP deliverable and milestones progress reported to occupational Health, Safety and Wellbeing Committee, with six monthly updates to Staff Governance Committee (SGC)

b) When was this last reported?

Last update to SGC was in August 2024.

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): 100% of AFC staff have reduced their hours to 37hrs per week or pro-rata equivalent for part time staff

Q2 actual: 71%
Q2 Target: 70%

Outcome: Agenda for Change and Medical Workforce non-pay reforms implemented

Our story so far….

a) What is the background to the current position, and how are we performing against target?

National requirement as part of non-pay reforms to Agenda for Change effective 1st April 2024 to reduce the working week to 37h for all 14,913 AfC staff by end November 2024, with a further hour's reduction to follow by 2026

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Month on month increase in number of staff reducing the working week as evidenced by corresponding decrease in RWW (Reduced Working Week) Transitional Allowance (overtime) payment for those working 37.5 hours after 1st April pending agreement of approach to reduce, noting that this is paid monthly in arrears

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

This KPI measures 1 of three deliverables connected to Agenda for Change Reform, which have a linked 3 year outcome. Whilst progress is supporting achievement of the reduced working week and linked three year outcome, it presents a challenge in respect of other 24/25 deliverables – both the Agenda for Change reform priority of implementing Protected Learning Time – and other wider deliverables such as implementing Health and Care Staffing Act and reducing Supplementary Staffing spend.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Formal risk register to be developed now Programme Manager is in post. Content expected to be:

- Capacity of 24/7 services to reduce to 37 hours
- Level of funding available from national allocation vs demand for backfill
- Impact of arrangements on staff morale
- Difficulty of implementing further reduction to 36 hours

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

There is potentially a consequence for the delivery of Health and Care Staffing Act compliance and Supplementary Staffing reductions from reduced workforce capacity. KPIs on Statutory and Mandatory Training and Appraisal take up are also likely to be impacted by demands of implementation and overall capacity levels reducing. It remains to be seen what impact this has on clinical and other service delivery, however this is expected to be more significant when the reduction to 36 hours is implemented.

Commentary from

Tom Power,
Director of People & Culture

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Governance process in place to provide backfill funding for services who are unable to introduce the working week. Part of the governance process will consider a balanced risk assessment of clinical, financial and staff governance risks, alongside consideration of whether the services are within those defined as emergency/essential and/or required to operate 24/7

b) How will we measure the expected impact, and what could prevent success?

Monitoring the number of formal submissions to reduce the working week, number of submissions for backfill funding and monthly costs of the RWW transitional allowance

c) If something hasn't worked, what alternative course of action will be taken?

Programme Manager starting work on lessons learned to inform what the opportunities are for improvements when it comes to the further reduction down to a standard 36 hour working week

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Strategic Intent?

In addition to the work being undertaken by the Programme Manager regarding the lessons learned as noted in recovery actions, there is also national work led by NHS Education for Scotland that the Programme Board have fed in to in October 2024. This will be used to inform the approach being taken to reducing to 36 hours, alongside inputs to national Scottish Government and Employer discussions that took place in September

b) ***What needs to change? Is further support needed, if so from where and in what form?***

Current actions proving successful in progress towards our current goals.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Reduced Working Week sub group, Chaired in Partnership reports to Agenda for Change Reform Programme Board, also Chaired in Partnership
Programme Board provides monthly updates to Chief Executive Team and Quarterly to Sustainable Workforce Oversight Group
KPI updates provided to PAFIC each quarter

b) When was this last reported?

Updates provided bi-monthly to Staff Governance Committee – last report 31st October - and via ADP deliverable updates every 6 months in deeper dive format under Sustainable Workforce hearing – last report June 2024

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): To reduce nursing agency spend to below £9.75m by end March 2025

Q2 actual: £4.468m
Q2 Target: £4.875m

Outcome: To deliver the V&S Plan with savings of 3% annually up to 2028

Our story so far….

a) What is the background to the current position, and how are we performing against target?

NHSG has a target to reduce nursing agency spend by £3.6M on the last financial year. To meet this target spend requires to be below £888K per month. NHSG is progressing this work through the Value and Sustainability (V&S) programme and through the implementation of national directives under the Nursing Agency- Supplementary Staffing task and finish group (SSTFG). In 23/24 NHSG stopped the use of high cost off framework agency and removed HCSW agency from April 2024. Agency use is driven, primarily, by vacancy and additional activity above funded establishment in the form of additional beds to support flow and capacity on the acute sites. Improved sourcing and over recruitment of newly graduated nurses is there strategic plan however operational plans are required to reduce overall demand.

- In Q2 there has been a further reduction in agency use with a downward trend on monthly spend
- NHSG is on track to meet the financial savings on Nursing and Midwifery Agency as set out in the Value and sustainability programme
- NHSG has implemented all requirement of the national controls through SSTFG

b) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

The use of agency is controlled through appropriate governance and authorisation following professional review. Improvement in agency spend relate to alternative sourcing through substantive employment and supporting a market change whereby it is preferential for an agency worker to seek employment with a health board and not a reduction in staffing requirements. As such agency continues to be used where there is a clearly defined risk to a breach of patient safety, service failure or an inability to meet legislative requirements.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?

The performance of this KPI is supporting progress towards achieving the 3% annual reduction in spend under the value and sustainability programme.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Where improvement continues in staff recruitment and agency controls, there is a risk that increases in demand for additional staffing due to winter pressure and additional beds will see agency use overall staffing spend increase including agency requirement

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

The performance of this KPI is supporting the 3% annual reduction in spend under the V & S programme

Commentary from

June Brown, Executive Nurse Director & Interim Deputy Chief Executive

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Over recruitment of Newly Graduated Nurses (NGN)
- Improved governance over rostering and authorisation of agency shift

Real-time staffing process are in place across all clinical sites that use agency allowing for the assessment or staffing risk, recording of mitigation and escalation of safety concerns. Standard operating procedures allow for the forward planning or staffing based on planned staffing and predicted clinical activity in the preceding 72 hour period. Agency process are responsive where there is a requirement for agency

b) How will we measure the expected impact, and what could prevent success?

Impact of agency reduction process is measured through agency use within the bank system and the through spend analysis. Over recruitment of NGNs to cover vacancy and unfunded activity will significantly reduce supplementary demand, however due to challenges in recruiting out with the NGN cohort and to keep up with turnover and investment, it is possible that agency use could increase where vacancies begin to rise

c) If something hasn't worked, what alternative course of action will be taken?

The positive performance of the actions currently being undertaken has not necessitated a change of direction at time of reporting.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Through the value and Sustainability Programme there have been engagement workshops with stakeholders to support the development of efficiencies and consult of plans for improved governance and grip and control.

There are a large range of initiatives within the V&S programme to support the delivery of the nursing workforce using test of change methodology and shared learning. These initiatives are discussed at the N&M Workforce Council which has pan Grampian representation

b) What needs to change? Is further support needed, if so from where and in what form?

Improvements in operational governance for managing workforce risk and outcomes of workforce planning would support nursing and midwifery teams to deliver sustainable change, support redesign and ensure professional teams understand how workforce risks are being managed.

Senior Nurses have been requested to engage with Portfolio management teams to develop clear, transparent and robust governance routes for the outputs of nursing Staffing Level Tools and Common Staffing Methodology which is a legislative requirement.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Nursing and Midwifery Workforce Council and Value and Sustainability Programme

b) When was this KPI last reported?

Nursing and Midwifery Workforce Council – 30th October 2024

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): To reduce junior doctor banding/medical locums spend to below £17.789m by end March 2025

Q2 actual: £9.969m
Q2 Target: £8.895m

Outcome: To deliver the V&S Plan with savings of 3% annually up to 2028

Our story so far….

a) What is the background to the current position, and how are we performing against target?

Prior to the August rotation there had been an increase in the number of non-compliant rotas (predominantly due to doctors not taking breaks) to a peak of 39. NHS Grampian were an outlier across Scotland with more non-compliant rotas than any other are. All rotas are compliant on paper however 31 were re-written to reduce the likelihood of breaks being missed, through redesign such as shorter shifts negating need for second break. In addition the CET invested in additional Clinical Fellow posts to fill gaps and strengthen rotas also to support breaks. Monitoring has commenced.

Medical Agency Locum spend has decreased through improving compliance with Direct Engagement and utilisation of tier 1 doctors as well as reducing on call payments to 50% rate from 00:00-08:00, unless the doctor is called. This has led to a reduction in spend by £1M to date.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Spend in rota banding has reduced as a result of the re-written rotas, however there is a risk this will increase, and be backdated to the start of the rotation, should the rotas convert to non-compliant.

Medical Agency Locum use continues to reduce. This has increased as a result of all doctors (out with Mental Health which is out of scope of the work) now being on Direct Engagement.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

Progress is being made towards KPI; this KPI has a direct effect on the ability to achieve our Value & Sustainability Outcome.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

The Doctor Contract will not be reviewed until 2026 therefore any change in break taking activity, and hence spend associated with non-compliant rotas, will rely on culture change.

Service models and reliance on locums to fill gaps continue to impact on ability to decrease reliance on locums.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

This KPI directly affects the financial savings KPI, although that KPI is currently on track.

Commentary from

Paul Bachoo,
Executive Lead,
Integrated Specialist Care Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Ongoing focus on break taking with introduction of a team to support break planning, escalation of issues, reporting when not taken and support for services to mitigate and prevent recurrence. A new reporting mechanism for missed/late breaks and late finishes has been introduced

Decrease in commission rates for long standing locums has also been introduced and will contribute to the reduction in spend.

b) How will we measure the expected impact, and what could prevent success?

Impact will be measured by reviewing spend associated with medical staff and locums. Success could be prevented if doctors do not comply with contractual obligations and take their breaks on time.

c) If something hasn't worked, what alternative course of action will be taken?

The project continually reviews success and learns from performance and engagement. In addition a further workshop is being planned in December to review the action plan, what it has delivered and what amendments are required.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Progress is being evaluated through monitoring outcomes, and spend associated with medical budgets including locum use.

Feedback is also shared from medical leadership, operational management and DDiT Monitoring Team to review impact of activity and adapt and strengthen our approach as needed.

b) What needs to change? Is further support needed, if so from where and in what form?

The culture change around break taking is beginning to have an impact, however progress may be limited in some areas.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Through regular reports to the Chief Executive Team

b) When was this KPI last reported?

22nd October 2024

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Priority Area: A - Right workforce to deliver care now and in the future

Key Performance Indicator (KPI): Compliance with mandatory training will increase to 80% for all new starts and 60% for all other colleagues (70% overall)

Q2 actual: 63%

Q2 Target: 70%

Our story so far….

As at end Q2, 2024/25, 63% of all staff have completed mandatory training, an improvement of 2% from Q1, and 4.5% from Q4 of 23/24. This represents a steady increase in completion rates over the summer period.

Mandatory Training for NHS Grampian has 13 agreed modules including a refresher module and welcome and orientation pack. More than 70% (target) of staff are up to date with training in 3 of the 13 modules.

There are 2 training areas requiring significant improvement, *Public Protection* –a new module combining adult and child protection, launched earlier in 2024 - and *Equality & Diversity – for which a new module is in development by NES.*

Our key risks, challenges and impacts…

Ensuring proactive compliance with mandatory training remains a challenge for NHS Grampian. Risks include:

- Service demands on participating colleagues who need to complete / update mandatory training
- Impact of broader Agenda for Change Reform programme (reduced working week) on capacity, and thus ability to meet Protected Learning Time requirements.
- National work to move forward Protected Learning Time work streams impacting on local changes
- Impact of vacancy controls on capacity of specialist Wellbeing, Culture and Development team supporting improvement work

This KPI is more likely to be impacted by others that prioritise the delivery of services.

Commentary from
Tom Power

Director of People & Culture

Our mitigation and recovery actions

- Wellbeing, Culture and Development (WCD) team continue supporting managers by running regular reports pending NES Turas Learn development work to help understand gaps and areas for improvement
- For 2024/25 it was agreed to move to a single KPI for all staff (70%) for Mandatory Training.
- Amalgamation of Statutory and Mandatory Training compliance SLWG and implementing Protected Learning Time Sub Group of Agenda for Change Reform.
- Continued improvement and visibility of compliance data through production of Workforce Intelligence PowerBI Dashboards, and production of bespoke reports (such as on CE Team compliance for Chief Executive to support role modelling) where necessary
- Wellbeing, Culture & Development Team continue to signpost staff to the Statutory & Mandatory training that are the responsibility of all via the Daily Brief, WCD Wednesday updates.
- Representations from NHS Grampian will support the national workstreams designing NHS Scotland core modules and consider the system modifications and reporting requirements for implementation.

What have we learnt?

- Resource from NHS Grampian will be required to support national work streams around Protected Learning Time
- Protected time for learning remains an issue for staff and managers
- Where targeted work is undertaken, improvement has been seen
- Vacancy controls are increasing risk of insufficient specialist capacity to support staff development.

Oversight and assurance

- Staff Governance Committee
- Short Life Working Group reporting to Sustainable Workforce Oversight Group
- Monthly data on uptake is shared with portfolio/operational management levels and issues can be escalated to Chief Executive Team where required

When was this KPI last reported?

- Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Priority Area: A - Right workforce to deliver care now and in the future

Key Performance Indicator (KPI): Compliance with statutory training will increase to 90% for all new starts and 70% all other colleagues. (80% overall)

Q2 actual: 64%

Q2 Target: 80%

Our story so far….

NHS Grampian is committed to ensuring that all staff are appropriately trained for their role. This KPI reflects a 2024/25 deliverable around improving statutory and mandatory training and introducing Protected Learning Time. It reflects compliance requirements and national policy.

Statutory training compliance relates solely to fire safety training, with all other topics mandatory as they are not required by law to be completed.

Statutory training compliance relates solely to Fire Safety training and the current 24/25 target for this is 80%. Whilst there are pockets of notable improvement – particularly in Facilities and Corporate Services - we continue to see unmet targets around this training module, and over the last 12 months, with an average completion rate of 64.6%.

Our key risks, challenges and impacts…

Ensuring colleagues working in a pressured system prioritise this training in a way that ensures significant improvement in compliance for existing staff, and sustaining highest levels of compliance for new starts. Current demands on colleagues are cited as a barrier to prioritising the completion of learning.

The risk specific to statutory training is a lack of compliance with legal requirements, adverse scrutiny from regulatory bodies (Health and Safety Executive, Scottish Fire and Rescue Service) and inadequately trained staff who cannot respond in an appropriate manner when a fire incident occurs, risking the safety of themselves and others.

There is also a risk connected to the impact of vacancy controls on the capacity of specialist Wellbeing, Culture and Development team to support targeted improvement work.

Commentary from
Tom Power

Director of People & Culture

Our mitigations:

- Ongoing reminders via various networks and communication channels to target improvement in statutory learning requirements
- Pending completion of NES TURAS Learn reporting by proxy development work, Wellbeing, Culture & Development team supporting managers by running regular reports to help understand gaps and areas for improvement.
- Representation on national working groups has enhanced understanding of national direction of travel for the implementation of Protected Learning Time
- Introduction of a single KPI for all staff (80%) for Statutory Training rather than separate targets for existing staff and new starts to simplify monitoring and reporting.
- Further improving visibility of completion data for all levels of staff through Workforce Intelligence PowerBI Dashboards, and bespoke reports where required

What have we learnt?

- Protected Time for Learning remains an issue - implementing agreed Agenda for Change reforms in this area are key.
- There may be a need to prioritise within Mandatory topics according to profession or level of compliance, and direct completion in that order.
- This work carries a risk of temporary compliance before levels fall back again, and is not the preferred improvement approach.
- A Human Learning Systems approach may be beneficial to promoting greater ownership by staff.

Oversight and assurance:

- SLWG reporting to Sustainable Workforce Oversight Group
- Data shared at Chief Executive Team quarterly performance meetings
- Discussion of data and steps to improve position with Portfolios/Directorates at Staff Governance Committee
- Monthly data on uptake shared with Portfolio management teams.
- Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Colleagues & Culture

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Priority Area: B – Culture and Wellbeing

Key Performance Indicator (KPI): 50% of all staff have current appraisal on Turas or SOAR

Q2 actual: 15.1%

Q2 Target: 20%

Our story so far….

Over the last year, there has been a slow but steady increase in the number of Agenda for Change staff having their appraisal signed off with the current completion rate being 15.10%. This data is based on those who have access to the TURAS Appraisal system. **On average, 23% of staff have engaged in the appraisal process** but have not yet have signed off their agreed objectives or undertaken a formal meeting to support this.

We currently do not have access to NHS Education for Scotland's SOAR data (medical staff) to confirm engagement and completion rates. Executive and Senior Managers require to have appraisals completed to be eligible for the annual pay award. These are at 100% for 2023/24 performance reviews and 100% for 2024/25 objectives.

A revised national Personal Development and Review Policy is due to be launched in 2024 as part of the Once for Scotland Workforce Policies programme. It is understood that a soft launch will take place in October 2024 with a hard launch in January 2025.

Our key risks, challenges and impacts…

Employees need to understand what is expected of them, how to be successful in their roles and what supports are available to help them improve and develop. However, if appraisal is not done well this can also create a negative experience for an employee and a manager leading to damaged working relationships, disengaged staff and low morale.

Key risks to achieving high engagement with the appraisal process are:

- Changes to expectations with new national updated Personnel Development and Performance Review (PDPR) guidance
- The level of resource required to navigate the current data reporting systems and provide monthly updates is significant
- Poor or inconsistent experience of appraisal, for both staff and managers, deters them from prioritising the process.
- Large spans of responsibility within some staff groups make the workload associated with appraisal challenging for already busy managers.
- Competing demands affecting time, including from statutory and mandatory training and other CPD requirements, and reduction in working week.
- The impact of vacancy controls on staffing levels and capacity in the specialist Wellbeing, Culture and Development team supporting improvement work.

Commentary from

Tom Power
Director of People & Culture

Our mitigation and recovery actions

- Preparing for Appraisal sessions have been delivered to the Managers Development Programme providing an overview of the importance of appraisals.
- This is also now featured through discussion in the 'Supporting My Wellbeing' intervention delivered by Wellbeing, Culture and Development (WCD), highlighting the need for high quality appraisal in support of staff wellbeing and expectations
- Soft launch of national PDPR guidance will be reviewed by WCD to consider best approach to trial and fully implement this between October 2024 and January 2025.
- Develop and test report of Director level compliance rates for Appraisal recorded with direct reports in order to inform leadership role modelling in support of improvement.
- Gather information to understand current staff experience, focusing energies on areas of low engagement and building on good practice.
- Use national Agenda for Change Protected Learning Time and Once for Scotland Personal Development Planning and Review Policy implementation as an opportunity to increase organisational focus.

What have we learnt?

- New national expectations will help us relaunch and reset expectations around engagement with the professional review and development process
- Strong professional review and development planning practices can improve staff morale, staff engagement and staff performance – this must be prioritised
- Improved communication and clear expectations being set around the value, importance and impact of professional review and development will improve engagement
- Vacancy controls create risk in terms of sustaining capacity to support staff development.

Oversight and assurance

- Appraisal data is reported monthly by the Wellbeing, Culture & Development Team, to all divisions/operational Units of NHS Grampian.
- Updates will be provided to the Culture and Staff Experience Oversight Group and data also made available to Chief Executive Team performance meetings.
- Reporting will be closely aligned to the work undertaken by the Protected Learning Time sub-group and form part of local monitoring arrangements
- Staff Governance Committee assurance reporting on deliverable
- Last reported Q1 PAFIC 28/08/24 and HAWD 12/09/24

Tier 3 - Our Performance Spotlights: Citizens

Strategic Intent: No citizen in Grampian will be left behind impact
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): To increase the total membership of the Public Involvement Network by 15% (6 members) by 31 March 2025 (from 38 to 44)

Q2 actual: 39
Q2 Target: 41

Outcome: We will deliver good quality care and sustainable health services in the future through the active participation of our staff, citizens and partners.

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- NHS Grampian's Public Involvement Network (PIN) offers members a range of ways to engage with NHS Grampian
- The Public Involvement Network is open to anyone in Grampian who has an interest in health related services.
- Members of the Public Involvement Network receive regular NHS Grampian updates and information about opportunities to be involved - from taking part in focus groups and attending local events to participating in surveys which inform decision making through active participation

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- We had 2 new members joining and one member left during Q2

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?

- Fluctuation of leavers/joiners as well as how many members are 'active' at any one point is to be expected and does not jeopardise achievement of the overall target

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Reductions/departures results in PIN becoming less representative of the Grampian Population
- Limited capacity/competing priorities within the Public Involvement Team limit the resource that can be deployed to attend to this KPI

b) Are there any unintended consequences or impacts on other KPIs, or other areas (e.g. workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- This KPI also supports achievement of the following deliverables:
  - Develop and embed mechanisms through which children and young people's voices can be heard
  - Achieve the objectives set out in Horizon 1 of the Putting People First (PPF) Plan

Commentary from

Stuart Humphreys, Director of Marketing & Corporate Communications

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Regular opportunities are sought and created for the PIN to ensure the relationship between members and NHSG is mutually rewarding

Opportunities to join the PIN are regularly promoted via public events, social media and our corporate website as well as through word of mouth from existing members

Structures and processes that support recruitment and retention of PIN members are offered. These include a corporate induction and appropriate training

b) How will we measure the expected impact, and what could prevent success?

Impact and ongoing performance is monitored through monthly meetings of Public Involvement Team and monthly meetings of the PIN

Limited capacity/competing priorities within the Public Involvement Team limit the resource that can be deployed to attend to this KPI

c) If something hasn't worked, what alternative course of action will be taken?

Currently not applicable

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Strategic Intent?

- Quality of interaction/contribution and not just membership numbers is an equally important success measure

b) What needs to change? Is further support needed, if so from where and in what form?

- At present there is one PIN for Grampian made up of both very active and less active members. Going forward the intention is to split these into two so that 'active' members can be even more involved (e.g. in-person events/group discussion) and less active members are able to contribute in a way that is less demanding on their time

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Monthly meeting of Public Involvement Team
- Monthly meetings of the PIN

b) When was this last reported?

- Quarterly reporting via HAWD report – last reported to September Board meeting

Tier 3 - Our Performance Spotlights: Citizens

Strategic Intent: No citizen in Grampian will be left behind
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): To increase the total number of volunteers by 25% by 31 March 2025 (from 191 to 239)

Q2 actual: 224
Q2 Target: 231

Outcome: Create an effective welcoming environment where volunteers are embedded as valued members of our teams and their contribution is recognized.

Our story so far….

a) What is the background to the current position, and how are we performing against target?

Quarterly reporting to Scottish Government between July-September shows fluctuation between 235 (exceeding target) and 217 active volunteers per month. Whilst the mean number of volunteers this quarter is below target, we were ahead of target in Q1 and also for the month of July.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

As previously reported, volunteer availability is influenced by holidays, exam periods etc. Since the Q2 period includes the main summer/school holidays period, August and September figures fell below target, hence we are reporting a mean number of 224 volunteers. However, this is not indicative of a trend that jeopardises meeting the ADP target for 2024/5.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

This strategic background work does not materially affect service delivery or the day-to-day contribution that volunteering continues to makes across Grampian. Over 5,100 hours were donated by volunteers during quarter 2

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Limited capacity/competing priorities within the Public Involvement/Volunteering Team limit the amount of time that can be dedicated to this work.

A backlog of staff policies requiring consultation mean that the volunteering policy is currently awaiting an allocated timeslot for progression by the Grampian Area Partnership Forum (GAPF) Policy sub-group (currently anticipated to be January)

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

Absence of a clear volunteer policy is likely to i) reduce willingness of services to engaging with volunteers (representing a missed opportunity) and ii) lead to unfortunate confrontations between fatigued staff (resulting in volunteers leaving, having been made to feel unwelcome and unappreciated) due to lack of clarity & understanding of their role.

Absence of a Volunteer Plan for NHSG means there is currently no agreed long-term approach to how/where volunteers can deliver greatest benefit in enhancing the quality of patient journey/providing support to staff.

Commentary from

Stuart Humphreys, Director of Marketing & Corporate Communications

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

SLAs have been created to support the recruitment of new volunteer posts recruited by Charity partners including the Jak Foundation and Charlie House. These posts are not included within NHSG reporting numbers, which only reflect volunteers directly engaged by the Health Board.

In Q2 NHS Grampian became the first Health Board to sign-up to Volunteer Scotland's Charter, recognising the significant contribution that volunteers make across Grampian every single day – supporting both retention and recruitment.

b) How will we measure the expected impact, and what could prevent success?

Monitoring of volunteer numbers and hours donated is recorded by the Volunteer Coordination Group, reported monthly to the Volunteers Across Grampian Oversight Group and reported quarterly to the Scottish Government*

*Q2 Figures reported to SG:

Month	Volunteers	Hours
Jul 2024	235	1827
Aug 2024	221	1652.25
Sep 2024	217	1656.75

c) If something hasn't worked, what alternative course of action will be taken?

Not applicable.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Monthly monitoring and reporting at meetings of the Volunteers Coordination Group and Volunteers Across Grampian Oversight Group capture both data relating to volunteering as well as opportunities and issues.

b) What needs to change? Is further support needed, if so from where and in what form?

No change or support is currently required.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Day-to-day volunteer monitoring and management via Public Involvement Team / Volunteer Coordination Group
- Monthly monitoring via Volunteers Across Grampian Oversight Group
- Reporting and assurance structure aligned to Population Health Committee and Staff Governance Committee

b) When was this KPI last reported?

- Last reported: Q1 HAWD 12/09/24 Spotlight, Volunteer Oversight Group 09/10/24

Tier 3 - Our Performance Spotlights: Children

Strategic Intent: Children are given the best start, to live happy, healthy lives

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

Key Performance Indicator (KPI): Reduce backlog unbooked TTG RACH patients (including Paediatric Dentistry) to 400 patients by March 2025

Q2 actual: 372
Q2 Target: <500

Outcome: Improvement in outcomes for children being realised & evidenced, measured through agreed KPI's and working with CPP colleagues in City, Shire & Moray to create the next 3 year Integrated Children's Services Plans

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- A restriction of elective activity during the pandemic combined with staffing challenges has resulted in a backlog of elective patients awaiting their surgical procedure.
- At present, we are overachieving against the target, having managed to reduce the number of unbooked patients to 372.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- The trajectory has been predominantly headed in a positive direction during the last quarter with a slight adverse trajectory as a result of the October holiday weeks.
- This should not affect the future performance but is predicted to have a similar downturn in activity during the festive period.
- During this quarter there was essential theatre work undertaken that resulted in a reduction of 50% of elective activity for 21 days. This was predicted to result in a loss of 113 cases, however, a review has identified that the mitigation strategies employed by the operational team resulting in loss of 37 cases.
- Further theatre work will need to take place in Q4 and this will result in further activity.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

- The performance is supporting the deliverable and increasing the likelihood of achieving the related 2027 outcome.
- This will not have an adverse effect of any other aspect of the service.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Vulnerability relating to consultant paediatric anaesthetist workforce – this may result in cancellations and a reduction in the capacity for patients <3 years old.
- High Dependency Unit (HDU) capacity challenges – this will result in the inability to prioritise complex patients who may require an inpatient stay in HDU following the procedure.
- Vulnerable nurse staffing workforce for Daycase Unit (DCU) – during the winter period there will be an increase in staff sickness and if this drops below a threshold it will result in the closure of DCU. Recently, this resulted in 23 cases being cancelled in one week.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- An unintended consequence would be a reduction in outpatient clinic capacity as a result of additional lists being offered to surgeons in order to maximise activity inpatient activity. This impacts both TTG Waits and Outpatient Waits KPIs

Commentary from Geraldine Fraser

Executive Lead
Integrated Families Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Ongoing validation of paediatric dental lists.
- Ongoing work to finalise setting up a non-GA circumcision service.
- Further consultant anaesthetist posts to be advertised.
- Work commenced to improve theatre utilisation.
- Work ongoing to model conversion rates from outpatient clinics in order to predict additions/demand on the IPWL.

b) How will we measure the expected impact, and what could prevent success?

- The impact will be measured by the KPI and associated reduction in the number of unbooked patients.
- Significant staff sickness/absence will have a significant reduction in elective activity and may prevent success.
- Any significant downtime in theatres as a result of CDU downtime, essential theatre repairs etc. will contribute to preventing success.
- A significant addition to the IPWL over a short space of time will have an adverse impact on the number of patients waiting over 12 weeks.

c) If something hasn't worked, what alternative course of action will be taken?

- Many of the scenarios that would prevent success are unable to be predicted or prevented. However, in the event that one of those scenarios were to happen then action would be taken to mitigate the impact.
- In the event that the KPI was under achieving and was not explained by one of the scenarios listed above then a review of all theatre Demand, Capacity, Activity and Queue (DCAQ) would be undertaken to identify the cause and possible solutions.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- Continual monitoring and feedback of activity required to maintain engagement and motivation.
- Our current data associated with efficiency requires improvement.
- The impact associated with dental validation.
- The effectiveness of the mitigation plans during the theatre works.

b) What needs to change? Is further support needed, if so from where and in what form?

- Improvements to the nursing workforce in RACH to improve resilience of DCU and increase HDU capacity.
- Once work has been completed to identify the requirement then support will be required.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Performance analysed and areas for improvement identified and addressed as part of an on-going continuous improvement process.
- Monthly waiting time data is shared with portfolio/operational management level
- Paediatric anaesthetic SLWG
- Theatre User Group

b) When was this KPI last reported?

Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 2: In-year 24/25 performance of Deliverables towards 2027 Outcomes

PLACES (Outcomes)

PL1 - NHS Grampian's strategic approach to being an Anchor organisation embedded.
PL2 - Investment and management plan aligned to Net Zero Route Map, as part of climate emergency and sustainability framework.
PL3 - Whole system infrastructure plan with 25-30 year outlook and clear (backlog) maintenance, development and disinvestment priorities.
PL4 - Stable and sustainable workforce in critical service areas.
PL5 - Positive reputation for education and training.
PL6 - Functional infrastructure to support sustainable service delivery.
PL7 - Clear local and networked pathways delivering high quality services.
PL8 - Building on the success of condition specific projects to robustly demonstrate practical and measurable ways of implementing value-based health and care.
PL9 - Consistent, system wide approach to maximise reach and impact of connected workstreams.
PL10 - Sustained and enhanced recycling performance.
PL11 - Sustained and enhanced clinical waste reduction performance.
PL12 - Increase and interaction of greenspace for all users

Performance of Deliverables

Anchor (8)

E – Employment, Procurement, Physical Assets (3 deliverables - linked to outcome 1)	F – Infrastructure (5 deliverables - linked to outcomes 3, 6)
3	2, 3

Communities (15)

G – Population based approach to health (9 deliverables - linked to outcomes 7, 9)	H – Dr Grays (6 deliverables - linked to outcomes 4, 5, 6, 7, 9)
7, 2	1, 2, 3

Environment (11)

I – Greening Health Systems (6 deliverables - linked to outcomes 2, 10, 11)	J – Value based Health and Care (5 deliverables - linked to outcomes 8, 9)
4, 2	1, 3, 1

Complete | On Track | Minor Delay | Significant Delay | Proposal

Key Risk Categories: Impact on progress of 34 Deliverables (Deliverables may have more than one associated risk therefore total will exceed 100%)	All PLACES Deliverables Q2
Workforce – Capacity*	23
Other (National Policy, Systems – National, Data & Modelling, Engagement)	12
Finance - Funding not yet agreed	5
Workforce - Training, Development and Skills	5
Finance – Insufficient Funding*	4
Finance - Non-recurrent funding	3
Workforce – Recruitment	3
Workforce – Retention	3
Workforce – Absence	2
Workforce – Wellbeing	1
Infrastructure - Estates	0
Procurement	0
Infrastructure – Digital*	0

*Indicates new risk category added for Q2

Performance of Key Performance Indicators

Performance against 15 Places KPIs across Colleagues and Culture, Children, and Citizens – linked to Outcomes PL1, PL2, PL4, PL6, PL7, PL8, PL10, PL11, PE3, PE16

More information available in Scorecards

Assessment Rating	Criteria* Each category in the Performance Wheel has a RAG rating based on its KPI scores
Red	2 or more red Key Performance Indicators
Amber	1 red Key Performance Indicator
Green	0 red and 1 amber Key Performance Indicators

Tier 2: Performance Scorecard: Anchor

Strategic Intent: We have social responsibility, beyond healthcare

Objective: Create the conditions for sustainable change

2027 Outcome alignment linked Places outcome ID	2024/25 Key Performance Indicator	Baseline (Mar'24)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Why are we in this position? *When was this last reported?*
			Actual	Target	Actual	Target	Actual	Target	Actual	Target	
PL1 - NHS Grampian's strategic approach to being an Anchor organisation embedded.	**Completion of Year 1 actions in the Anchor Strategic Workplan by 31st March 2025**	0%	0%	0%	**27%**	**25%**		50%		100%	Collaboration among the three anchor pillars and Public Health led to a strategic anchor endorsed by NHS Grampian on July 19. Baselining was completed, and partnerships were formed across the North East to improve collaboration and communication. Last reported: Population Health Committee 27/09/24; Chief Executive Team 11/10/24
PL6 - Functional infrastructure to support sustainable service delivery	**To improve domestics performance within the Facilities Monitoring Tool for A1 Hospitals to be above 95% by end March 2025**	92.9%	93.3%	93.4%	**93.0%**	**93.9%**		94.4%		95.0%	The domestics scoring reflects the daily derogations which are implemented due to high staff absence and increased cleaning required to support corridor care. *Last reported: Q2 figures published October 2024; to be reported via Facilities & Estates HAI Workplan Group.* spotlight on page 33
	To improve estates performance within the Facilities Monitoring Tool for A1 Hospitals to be above 95% by end March 2025	94.9%	94.7%	93.4%	**95.0%**	**93.9%**		94.4%		95.0%	Facilities scores on track, with improvement as a result of dedicated HAI handyman. *Last reported: Q2 figures published October 2024; to be reported via Facilities & Estates HAI Workplan Group.*

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Communities

Strategic Intent: Playing our role with partners for flourishing communities

Objective: Create the conditions for sustainable change

2027 Outcome alignment linked outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?** *When was this last reported?*
			Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
PL1 - NHS Grampian's strategic approach to being an Anchor organisation embedded	**Waiting Well Service to be delivered to an additional 8000 patients by end March 2025**	14609	16568	16609	**18623**	**18609**		20609		22609	18,623 patients in receipt of service since start in June 2022 with 99% of patients engaging with service and 5,877 requiring specific wellbeing advice/support *Last reported: Reports to Public Health Monitoring and Governance Group 24th September 2024* spotlight on page 34
PL4 - Stable and sustainable workforce in critical service areas.	**100% of hospital teams will have produced workforce plans to support safe and effective staffing (Dr Gray's)**	0%	5%	0%	**10%**	**50%**		100%		100%	Spotlight reporting on the two DGH KPIs is delayed due to limited programme capacity and recent operational management gaps, impacting the review and statistical feedback on workforce planning. Steps are underway to resolve these issue *Last reported: September Programme Board cancelled, November Programme Board next date.*
PL6 - Functional infrastructure to support sustainable service delivery	**Reduction of very high and high infrastructure risk by 10% to sustain critical service delivery (Dr Gray's)**	0%	10%	0%	**10%**	**5%**		5%		10%	
PL7 - Clear local and networked pathways delivering high quality services	**100% completion of project tasks for implementation of new model for Theatres and Surgery (Dr Gray's)**	0%	25%	25%	**50%**	**50%**		90%		100%	On track for timeline for Theatres Redesign Project *Last reported: via Programme Manager's Report to Programme Board August 2024*
PE16 - Women's Health - scope the best access within community including the possibility of women's health hubs.	**100% of individuals are offered an abortion care assessment within 1 week of contact with services**	82%	99%	100%	**96%**	**100%**		100%		100%	Continues to be close to being met due to continued flex in service however with ongoing impact on other service delivery *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 35
	100% individuals are offered a date for an abortion procedure within 1 week of assessment	70%	77%	100%	**57%**	**100%**		100%		100%	Reduced due to time to scan and inpatient/surgical procedure. Work is ongoing in service regarding scanning pathway improvement *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 36

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact

Objective: Create the conditions for sustainable change

2027 Outcome alignment linked outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1** Actual	**Quarter 1** Target	**Quarter 2** Actual	**Quarter 2** Target	**Quarter 3** Actual	**Quarter 3** Target	**Quarter 4** Actual	**Quarter 4** Target	**Why are we in this position?** *When was this last reported?*
PL2 - Investment and management plan aligned to Net Zero Route Map	**25% Actions from Action Plan for NHSG Climate Emergency & Sustainability Framework RAG Status Green by end March 2025**	0%	4.20%	6.25%	**4.16%**	**12.50%**		18.75%		25%	The actions are long term, and there has been a shift in the available funding streams from within the Government which several of the actions was dependent upon, as evidenced in the action plan *Last reported: Heat & Power Meeting 11/11/24* spotlight on page 37
	Reduce gas emissions in line with required reduction compared to UK-ETS Target (Foresterhill Campus, RCH, Cornhill)	29316 tCO2e	7853.26 tCO2e	5260 tCO2e	**13308.54 tCO2e**	**10520 tCO2e**		15779 tCO2e		21039 tCO2e	Reduced output of the Biomass boiler which will in turn have a knock on impact for the coming months (e.g. we used 55% more Natural Gas in May 2024 compared to May 2023); additionally there is increased heating load with new buildings brought on line. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 38
PE4 - To deliver the V&S Plan with savings of 3% annually up to 2027	**To achieve a savings target of £34.9m for FY24/25**	0	£3.73m (end of May)	£5.38m (end of May)	**£19.62m**	**£17.45m**		£26.15m		£34.9m	Main savings achieved in agency nursing, locum direct engagement, reduced overtime levels, vacancy control, non-carry forward of earmarked slippage and freeing up of Board Reserves. *Last reported: Separate Q1 finance update to PAFIC 25/09/24 and Board 12/09/24* spotlight on page 39
PL8 - Building on the success of condition specific projects to robustly demonstrate practical and measurable ways of implementing value-based health and care.	**An increase of 200 in completion of Turas module on Shared Decision Making by end March 2025**	1024	1076	1074	**1113**	**1124**		1174		1224	Slight drop off in engagements compared to previous momentum, likely due to competing pressures and lack of large events linked to this during this quarter *Last reported: Realistic Medicine Flash Report 30/08/24* spotlight on page 40

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Environment

2027 Outcome alignment linked outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?** *When was this last reported?*
			Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
PL10 - Sustained and enhanced recycling performance	**Increase percentage of recycled waste by weight to 55% by March 2025**	45.10%	46.49%	47.60%	**46.0%**	**50%**		52.5%		55%	Despite ongoing communications, there is still a lack of "on-the-ground" support. Meetings in STM resulted in removing desk bins and purchasing 150 additional recycling bins. *Last reported: Quarterly Waste Meeting 24/10/24* spotlight on page 41
PL11 - Sustained and enhanced clinical waste reduction performance	**Reduction in clinical waste by 5% (aligned to national targets) by March 2025**	1797T	460.597T	<426.78T	**880T**	**<853.58T**		<1280.36T		<1707T	There is no control over clinical waste weight; metrics per patient episode need defined. Introducing 150 recycling bins will help reduce waste through proper segregation. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 42

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 3 - Our Performance Spotlights: Anchor

Strategic Intent: We have social responsibility, beyond healthcare

Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): To improve domestics performance within the Facilities Monitoring Tool for A1 Hospitals to be above 95% by end March 2025

Q2 actual: 93.0%
Q2 Target: 93.9%

Outcome: Functional infrastructure to support sustainable service delivery

Our story so far….

a) What is the background to the current position, and how are we performing against target?

-The Domestic Supervisors undertake monthly audits for all areas and submit into the NHS Scotland benchmarking system. The scores are then published quarterly by NHS Assure in the "National Cleaning Compliance Report". Boards are considered as 'compliant' where their cleaning and facilities management scores are >90%.

- Domestic Services and Maintenance had targeted to be >95% by Q4 24/25 at Aberdeen Royal Infirmary. Maintenance services achieved 95% in Q2. However, the Domestic Service audits indicate a decrease from 93.3% Q1 to 93% for Q2 for Aberdeen Royal Infirmary which is classed as our A1 site.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Changes or trends which have contributed to this quarter include ongoing challenges around

- absence levels; currently at 9% for domestics overall compared to 5.28% for NHS Grampian overall
- corridor care and additional beds increasing domestic workload
- reducing overtime to achieve financial compliance.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

- Q2 results indicate a risk to achieving our 24/25 target of >95% by Q4.
- However, our results indicate that our hospitals are clean and our target was to challenge ourselves to improve further.
- Cleaning standards themselves are not the issue, instead we need to target to improve workforce stability and reduce absence which are factors which impact on achieving our targets.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- workforce related; namely recruitment, retention, stability and absence factors.
- The team comprises 95% part time staff, which can often indicate that employees have out of the workplace responsibilities.
- Majority of the workforce are Band 2 and 3s, so are possibly more likely to experience financial challenges in their day to day lives.
- Staff group experience health inequalities across all aspects of live; physical, mental, emotional, social and financial
- Key absence reasons relate to anxiety/mental health and musculoskeletal reasons which would align with the staffing demographic, and work being manual

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- Unintended consequences on domestic service delivery come from corridor care, boarding and increased patient flow movements.
- Financial restraints such as overtime controls have further impacted the achieving of targets.

One of the risks in attaining our targets is the higher than the Board average sickness absence in domestic services. This means that when we are short staffed we need to derogate from cleaning scheduled in order to prioritise the available workforce. The Staff Absence KPI therefore has the potential to influence this KPI.

Commentary from Alan Wilson

Director of Infrastructure & Sustainability

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- We are working closely with Public Health colleagues to address health inequalities in the team; this includes strategies to recruit to 'team fit' to improve stability, and also improve access to recruitment.

-We have a further piece of work progressing around effective absence management where we are working closely with Occupational Health Services.

-A final piece of work is progressing which is a 'deep dive' into domestic services and includes factors such as rota's, shift times and recruitment. This is to assure ourselves that we have the right numbers of staff, in the right place at the right time.

- In terms of reducing harm the team are structured and take a risk based approach when they have to derogate from cleaning schedule. In the first instance they derogate from non-clinical areas where they are short staffed to mitigate the impacts on clinical areas.

b) How will we measure the expected impact, and what could prevent success?

We will measure the impact from data collected around team:

- Stability, vacancies, turnover and absence reporting.
- Close monitoring of monthly audit scores to ensure we maintain clean hospital sites.

c) If something hasn't worked, what alternative course of action will be taken?

-Our current cleaning scores do not raise cause for concern.
-A recent change in rota indicated a slight reduction in absence, data such as this will continue to be used to ensure that initiatives for improvement do not have an adverse impact.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

We are evaluating progress by:

- critically analysing our data sources
- undertaking a deep dive into domestic service delivery.
- We have a new Head of Service coming into post on 18 November who will also bring a fresh view to the Service.
- seeking to understand processes in Boards which are achieving >95% so we can learn from their experiences.

b) What needs to change? Is further support needed, if so from where and in what form?

- We anticipate that an improvement in absence rates could impact the statistics positively.

-Through the deep dive we are also looking at shift times and anticipate some degree of organisational change in the future.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Facilities & Estates HAI Workplan Group, and Annual Delivery Plan

b) When was this KPI last reported?

Q2 figures published October 2024; to be reported via Facilities & Estates HAI Workplan Group.

Tier 3 - Our Performance Spotlights: Communities

Strategic Intent: Playing our role with partners for flourishing communities

Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): Waiting Well Service to be delivered to an additional 8000 patients by end March 2025

Q2 actual: 18623
Q2 Target: 18609

Outcome: NHS Grampian's strategic approach to being an Anchor organisation embedded

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- Waiting Well was introduced in June 22 to support patients to wait well for NHS Grampian procedures. It provides support to patients to minimise or avoid any reduction in wellbeing whilst waiting.
- The Healthpoint team contact each patient by telephone and have a 'wellbeing' conversation where they listen to the patient, identify their wellbeing concerns and look at practical ways to support the patients to 'wait well' using their expertise in motivational interviewing and behaviour change techniques. These person led discussions include supporting and encouraging patients to access local services to make positive lifestyle changes, address financial concerns and social isolation. All advisors are able to provide specialist smoking cessation support. A follow up call is offered to patients by the team. To help ensure that patients are best prepared for their procedure the Advisors discuss vaccinations and screening services and encourage uptake. For patients who disclose that their symptoms have significantly deteriorated, a Nurse contacts the patient to provide support and escalate to clinical teams if necessary.
- By 30.09.24 18,623 patients had received the service, achieving Q2 target (18,609)

b) What changes or trends have occurred this quarter, and how might they affect future performance?

The Q2 target has been achieved. It is expected that the service will continue to deliver the current level of service for the duration of 24-25.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

21 planned care specialties had been supported at the beginning of September 24.The service has since been widened to support further service cohorts. Waiting Well is practically embedding prevention within healthcare pathways.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Introduction of the NECU(National Elective Coordination Unit) text message service resulted in Waiting Well calls being paused in Q1 to patients on orthopaedic and endoscopy waiting lists. These services were concerned that receiving both services would cause confusion to patients and that waiting well was no longer required. There is a risk that there is a misconception that simply delivering the NECU text messaging service will deliver waiting well which is not the case.

3 WTE fixed term posts provide the current level of waiting well service delivery. The service is at full capacity. Current contracts are due to end 31st March 25. The current vacancy control measures / criteria do don't allow for these fixed term contracts to be extended - this will result in the entire service being at risk from March 2025.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

Effective waiting well support may have positive impacts on other KPIs such as average length of stay and waiting times. Evidence has shown that supporting patients to take simple steps before surgery / treatment can help patients' recover more quickly and reduce re-admissions. In NHSG, Waiting Well has resulted in 4.8% of patients contacted being removed from lists and 18% of patients confirming unavailability dates to allow effective scheduling of procedures.

Commentary from Susan Webb

Director of Public Health

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Advanced engagement and planning with services to agree waiting list / pathway cohorts to receive Waiting Well calls. This ensures adequate lead in time to address service queries / concerns before start dates to avoid any delays and reduction in service provision. This includes addressing any concerns raised with respect of NECU text messaging. National and local discussions are ongoing to consider how NECU and waiting well can be streamlined and targeted to ensure those most in need still receive support to 'wait well'.
- Highlighting impact of current vacancy control measures as part of forthcoming vacancy control criteria review.

b) How will we measure the expected impact, and what could prevent success?

- Further service concerns in relation to NECU / Waiting Well could disrupt service continuity resulting in reduced service provision/ delivery of the KPI.
- If vacancy control policy does not allow for the posts to be extended beyond March 2025 this will severely impact service delivery

c) If something hasn't worked, what alternative course of action will be taken?

- Extending the reach of the Waiting Well service to a wider range of services has resulted in a continuous pipeline being established. It is not anticipated that the current service level will change - there is continued demand and the service is at maximum capacity for the staffing available to deliver the service.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- Patient feedback embedded in Waiting Well service calls. This informs service continuous improvement
- Point in time evaluations completed quantifying service impact. 85% of responders found the information they received helpful, 22% advised they had made changes contributing to their health, 27% were planning / thinking about making changes, 9% advised the information received had led to improvements in their life.

b) What needs to change? Is further support needed, if so from where and in what form?

- There has been instances where services have declined the Waiting Well service for their patients on waiting lists due to a perception that this will increase service workload. Further understanding of the patient benefits are required to ensure this patient centred approach is adopted by services.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Public Health Monitoring and Governance Group

b) when was this KPI last reported?

Reported to Public Health Monitoring and Governance Group 24th September 2024

Tier 3 - Our Performance Spotlights: Communities

Strategic Intent: Playing our role with partners for flourishing communities
Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): 100% of individuals are offered an abortion care assessment within 1 week of self-referral to services.

Q2 actual: 96%
Q2 Target: 100%

Outcome: Women's Health - Scope the best access within community including the possibility of women's health hubs

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- Abortion care is a time dependent service and regarded as urgent care.
- Healthcare Improvement Scotland (HIS) Standards for Sexual Health states that *'NHS Board and Integrated Joint Boards offer an abortion assessment appointment that takes place one week of self-referral to abortion services.'*
- The target is that 100% of those seeking an abortion care assessment receive this within one week.
- Q2 (96%) position shows a decline from Q1 (99%).

b) What changes or trends have occurred this quarter, and how might they affect future performance?

A small decrease in proportion of women undergoing first assessment has been noted however this remains close to the 100%.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

- The achievement of the KPI at 96% reflects the continued adaptability of the service.
- There is ongoing concern of the impact to aligned care provision. From July-September, 70 hours of additional clinician time was diverted to abortion care to meet demand. There continues to be no additional resource in service to meet demand.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Increased flexibility in the sexual health service to meet the demands of abortion care mean decreased opportunities for long-acting reversible contraceptive provision (preventative action).

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- Performance of this KPI has a direct effect on the Abortion Procedure Times KPI, through increased delays or reduced times to procedure.

Commentary from
Geraldine Fraser

Executive Lead
Medicine & Unscheduled Care (MUSC) Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- NHS Grampian Sexual Health remains flexible to demand, adjusting the rota as necessary on a day-to-day basis to ensure individuals as assessed within 1 week.
- Data intelligence will be used to try and predict any potential increases/fluctuations.
- Increasing opportunities for contraception to reduce the need for abortion is being prioritised within NHS Grampian Sexual Health, with ongoing support for primary care and other service recovery.
- Learning from recent workshop is being taken forward locally.

b) How will we measure the expected impact, and what could prevent success?

- Monitor KPI performance; remain flexible in service.
- Lack of investment to cope with increased demand; failure to invest in primary prevention.
- Unable to replace colleagues with vacancy controls in place.

c) If something hasn't worked, what alternative course of action will be taken?

- Review process and adjust service delivery.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- A target of 100% of assessments completed in one week is representative of 'gold standard' care. This should be deliverable with increased intelligence re abortion demand and continued service review - an area for local improvement against a backdrop of numbers of abortion increasing locally and nationally.

b) What needs to change? Is further support needed, if so from where and in what form?

- Demand needs to be met via increased staffing/resource but also preventative action is required. There is an opportunity to increase conversations around contraceptive use in other areas of the health and social care system which would help women make informed choices RE postnatally.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Oversight and assurance for the operational delivery is through Aberdeen Health and Social Care Partnership.
- Performance discussed within Management Meetings and shared with the Senior Leadership Team.
- Strategic delivery of abortion care in Grampian is discussed within the Managed Care Network for Sexual Health and Blood Borne Viruses (via Public Health) with a link to the Integrated Families Portfolio (Women's Board).

b) When was this KPI last reported?

- Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Communities

Strategic Intent: Playing our role with partners for flourishing communities
Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): 100% individuals are offered a date for an abortion procedure within 1 week of assessment

Q2 actual: 57%
Q2 Target: 100%

Outcome: Women's Health - Scope the best access within community including the possibility of women's health hubs

Our story so far….

a) What is the background to the current position, and how are we performing against 'get?

- Abortion care is a time dependent service and regarded as urgent care.
- Healthcare Improvement Scotland (HIS) Standards for Sexual Health states that *'NHS Board and Integrated Joint Boards offer an abortion procedure that takes place one week of the abortion assessment appointment.'*
- The target is that 100% of those seeking an abortion receive this within one week.
- Q2 (57%) position shows a decline from Q1 (77%).

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- Achievement against the KPI target fluctuates.
- The challenges described below will continue to make it difficult to achieve target in the next quarter (or beyond).

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

- The challenges described below will make it difficult to achieve the target by the end of the reporting period.
- Increased flexibility in the sexual health service to meet the demands of abortion care mean decreased opportunities for long-acting reversible contraceptive provision (preventative action).

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Availability of scan/face-to-face appointment in Aberdeen health village due to staffing resource. A new scan pathway has been in place from September 2024 to aid clinic cover as not wholly dependent on staff with scanning competencies. A formal test of change assessment is in progress. There is however concerns ongoing regarding retirements of specialist, experienced staff over next year.
- There also continues to be issues regarding Elgin scan availability with 37.5% of scanning clinic lists not running due to annual/sick leave or no staff cover.
- Availability of inpatient beds for patients over 11+6 weeks or for medical reasons or performance. A delay in scan appointment increases % of patients who require inpatient procedure if the time limit for home procedure is exceeded.
- Availability of theatre capacity for surgical abortion. This can impact on procedure choice as if over 12 weeks gestation surgical procedure if not available locally.

b) Are there any unintended consequences or impacts on other KPIs, or other areas (e.g. workforce, infrastructure)?

- The Abortion Assessment KPI 1 (for Abortion) is nearer to target; however, this KPI is subject to more fluctuation.

Commentary from Geraldine Fraser

Executive Lead Medicine & Unscheduled Care (MUSC) Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Continue to offer early assessment, reaching 100% of assessments completed within a week (see other KPI).

- Increase opportunities staff training in scanning.
- Increase capacity by reviewing current processes/pathways.
- Additional resource being sought to support improvements in abortion pathway and to reduce variation/delays.
- Work towards scans being offered at the earliest opportunity (note some people may choose to delay); consider best possible care option and offer an appointment within one week of completed scan/face-to-face appointment (if required).

b) How will we measure the expected impact, and what could prevent success?

- Monitor KPI performance; remain flexible in service.
- Lack of investment to cope with increased demand; failure to invest in primary prevention.
- Unable to resolve bed space/theatre space with system colleagues.
- Unable to replace colleagues with vacancy controls in place.

c) If something hasn't worked, what alternative course of action will be taken?

- Review process and adjust service delivery.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- A target of 100% of procedures in one week is representative of 'gold standard' care. Where this is not met, or cannot be met, there are health and wellbeing consequences for patients plus an impact on service delivery. Scanning is the first step of the process; where this cannot be delivered in a timely manner, this impacts the abortion care pathways overall.
- Using monitoring to 'flex' in service to meet demands within resource but this is becoming increasingly difficult to manage.

b) What needs to change? Is further support needed, if so from where and in what form?

- Require to increase workforce so gaps are not apparent when staff are absent. This will require additional funding.
- Adequate bed space/theatre space – ARI/DGH.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Oversight and assurance for the operational delivery is through Aberdeen Health and Social Care Partnership.
- Performance discussed within Management Meetings and shared with the Senior Leadership Team.
- Strategic delivery of abortion care in Grampian is discussed within the Managed Care Network for Sexual Health and Blood Borne Viruses (via Public Health) with a link to the Integrated Families Portfolio (Women's Board).

b) when was this KPI last reported?

- Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact
Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): 25% Actions from Action Plan for NHSG Climate Emergency & Sustainability Framework RAG Status GREEN by end March 2025 (+6.25% per quarter)

Q2 actual: 4.16%
Q2 Target: 12.50%

Outcome: Investment and management plan aligned to Net Zero Route Map

Our story so far….

a) What is the background to the current position, and how are we performing against target?

This KPI, is made up of several key actions relating to the Heat and Power infrastructure within the NHSG estate, for many of the actions there are long term pieces of work which are being developed and others require significant levels of investment.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

The Heat and Power Group continues to meet on a quarterly basis with the actions being developed and worked through, due both the funding restrictions both from the Scottish government and internally and that of the timescale of the actions within the strategy the movement is going to appear to not be at the targeted rate of movement. Additionally the chair will be discussing in the next meeting to consolidate several of the disparate actions and bring them under the same headings.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?

The Outcome is driving the deliverables, in so far as the investment is the main key driver to the actions and therefore deliverables within this KPI.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Lack of funding from the Scottish Government and arms-length governmental organisations.
- Many of the projects are long term so unlikely to change on a quarterly basis

b) Are there any unintended consequences or impacts on other KPIs, or other areas (e.g. workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

The consequence of achieving all of the KPI's would be at the expense of other pieces of work taking place through over resource representation/prioritisation and that of the need for significant financial investment taking away from other prioritised areas within the Health Board.

Commentary from Alan Wilson

Director of Infrastructure & Sustainability

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

In order to push forwards the actions in the Heat and Power strategy in a meaningful way, there is a planned Foresterhill focussed decarbonisation workshop due to take place in November which will include both NHSG and external partners

b) How will we measure the expected impact, and what could prevent success?

We ensure continual progressions through:

- Maintaining a comprehensive perspective on decarbonisation technologies.
- Prioritising the implementation of established technologies.
- Integrating backlog maintenance projects with energy and carbon reduction goals.
- Ensuring continuous updates from involved parties are communicated to relevant groups.

c) If something hasn't worked, what alternative course of action will be taken?

The mitigation measures mentioned above are not static and are constantly in development and changing accordingly within the dynamic work flow, therefore there will be a constant evolution of several of the mitigation measures on an ongoing basis

What have we learnt?

a) *How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?*

- The Speed of Change: This area encompasses emerging technologies that are undergoing rapid development, which in turn affects their viability for implementation in the healthcare setting.

b) *What needs to change? Is further support needed, if so from where and in what form?*

- Significant Investment Gap: There is a clear and substantial disparity between the level of investment required for comprehensive decarbonisation efforts and the current funding available from governmental sources.
- Enhanced Focus on Co-Benefits**:** The ancillary benefits of decarbonizing the estate, such as reduced financial penalties and improved operational efficiency, must be emphasized more robustly when addressing backlog maintenance.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Sustainability Governance Group
- Asset Management Group

b) When was this last reported

The Heat and power meetings occur on a rolling two monthly basis, last reported 11/11/2024

Tier 3 - Our Performance Spotlights: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact
Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): Reduce gas emissions in line with required reduction compared to UK-ETS Target (Foresterhill Campus, RCH, Cornhill)

Q2 actual: 13308.54 tCO2e
Q2 Target: 10520 tCO2e

Outcome: Investment and management plan aligned to Net Zero Route Map

Our story so far….

a) What is the background to the current position, and how are we performing against target?

The UK-ETS (UK Emissions Trading Scheme) target reduces year on year to incentivise those who are part of the scheme which NHSG is through the small emitter/opt out scheme. NHSG has to purchase additional allowances since 2018 due to exceeding its CO_2 allowances. Due to a decreasing CO_2 allowance the degree to which NHSG has exceeded, which would naturally take place even if our emissions were to stay static. This has resulted in the increased cost associated with the purchase of additional allowances which is further compounded on the backdrop of the cost of allowances having increased 1300% from 2018 to 2023 per tCO_2

b) What changes or trends have occurred this quarter, and how might they affect future performance?

With regards to the Q2 target having not been achieved this is in part due to increased Biomass boiler downtime and the both the Anchor family hospital coming online for heating thus increasing the base heat load demand therefore resulting in increased energy use visa vee being further away from the actual target.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?

The Outcome is driving the Deliverables, in so far as the investment is the main key driver to the actions and therefore deliverables within this KPI.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- The only current investment aimed at reducing emissions at the Foresterhill site is the consequential energy reduction from backlog investments in buildings and engineering plants. These investments are relatively small in scale and do not contribute significantly to the overall emissions reduction.
- The health board exceeding its emissions allowance results in substantial financial penalties. For the year 2022-23, this penalty amounted to £635,594.65
- It is imperative to develop a robust mechanism that facilitates the necessary level of investment to reduce emissions at the Foresterhill site, ensuring alignment with UK-ETS targets.

b) Are there any unintended consequences or impacts on other KPIs, or other areas (e.g. workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

The consequence of achieving all of the KPI's would be at the expense of other pieces of work taking place through over resource representation/prioritisation and that of the need for significant financial investment taken away from other prioritised areas within the Health Board

Commentary from Alan Wilson

Director of Infrastructure & Sustainability

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Sustained Advancement of the Heat and Power Strategy Action Plan: Maintaining momentum in implementing the comprehensive plan to improve energy efficiency and reduce emissions.
- Collaboration with External Private Organizations: Partnering with private sector entities to explore and secure investment opportunities aimed at mitigating on-site emissions.
- Grant and Proposal Writing to Governmental and Non-Governmental Organizations: Actively pursuing funding through detailed grant applications
- Integrating backlog maintenance projects with energy and carbon reduction goals.

b) How will we measure the expected impact, and what could prevent success?

Success would be measured/assessed if we were to look at it purely within the envelope of UK-ETS target and not the level of activity which has taken place within the produced emissions, through the end of year external validation of emissions produced and wherever this is within the allowance. The drivers of success prevention are the mechanism of which we provide heat and power to the Foresterhill health campus not being decarbonised and the need for this in addition to increased efficiency of energy based equipment by the onsite users would reduce energy consumption and therefore aid in the achievement of the overall UK-ETS target.

c) If something hasn't worked, what alternative course of action will be taken?

The mitigation measures mentioned above are not static and are constantly in development and changing accordingly within the dynamic work flow, therefore there will be a constant evolution of several of the mitigation measures on an ongoing basis

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- Significant Investment Gap: There is a clear and substantial disparity between the level of investment required for comprehensive decarbonisation efforts and the current funding available from governmental sources.
- Enhanced Focus on Co-Benefits: The ancillary benefits of decarbonizing the estate, such as reduced financial penalties and improved operational efficiency, must be emphasized more robustly when addressing backlog maintenance.

b) What needs to change? Is further support needed, if so from where and in what form?

- Need for additional investment and for the longer term co-benefits of achieving the target.
- Leveraging Behaviour Change: Behaviour change can significantly impact energy usage and emissions reduction. Opportunities exist through mandated eLearning initiatives and the utilization of sustainability champions to foster a culture of energy efficiency and environmental responsibility.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Emissions levels for the UK-ETS are verified by an external consultancy annually before validation by SEPA.
- The emissions levels are presently reported under KPI's for the Infrastructure and sustainability group.
- Information provided to the Board an integrated into the PBCCD report as well as the Annual climate emergency report

b) When was this last reported?

Q1 PAFIC 28/08/24 and HAWD 12/09/24 *Spotlights*

Tier 3 - Our Performance Spotlights: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact
Objective: Create Conditions for Sustainable Change

Key Performance Indicator (KPI):

To achieve a savings target of £34.9m for FY24/25

Q2 actual: £19.62m
Q2 Target: £17.45m

Outcome: To deliver the V&S Plan with savings of 3% annually up to 2027

Our story so far….

a) What is the background to the current position, and how are we performing against target?

NHS Grampian's financial plan for 2024/25 submitted to the Scottish Government in March 2024 projected a deficit in the region of £59 million for the year after assuming achievement of savings of £35 million.

This Spotlight report details progress against the £35m savings target. Savings achievement is now ahead of target at the end of the second quarter. This reflects the effort that has gone into identifying and realising savings within the Value & Sustainability Plan.

Despite the good progress in the achievement of savings targets, NHS Grampian's end of year forecast is still above the £59m expected of the Board by the Scottish Government. This is largely due to the inclusion of funding contributions to meet expected deficits in two of the Integrated Joint Boards (IJBs). Both IJBs set balanced budgets at the start of the year so overspend contributions from NHS Grampian were not built into the Board's opening financial plan.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

The level of savings achievement has improved in Quarter 2 compared Quarter 1, as more schemes have commenced and schemes that started during Quarter 1 have gained momentum. At the end of Quarter 1 savings achievement was behind target, it is now ahead of target.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

Financial decisions are always taken in the context of the "Finding Balance" approach, which means that their potential impact is weighed against expected impacts on operational performance, staff wellbeing and prevention. Decisions to achieve savings are not taken in isolation.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

New cost pressures wiping out the good work carried out on Value & Sustainability, resulting in more savings to be achieved in order to stabilise the financial position.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

There are trade-offs in many areas between different KPIs. For example, the Reduced Time to Hire KPI needs to be balanced against the target to achieve savings through the implementation of vacancy control criteria.

Commentary from

Alex Stephen
Director of Finance

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- "Finding Balance" approach to taking financial decisions.
- Chief Executive Team sign off of Value & Sustainability Programme.
- Regular reporting of progress against Value & Sustainability programme to different stakeholders.

b) How will we measure the expected impact, and what could prevent success?

- Expected impact measured by monthly reporting of savings achieved versus target.
- Barriers include planned schemes not progressing as expected, which then requires alternative savings schemes to be developed.

c) If something hasn't worked, what alternative course of action will be taken?

- Initial approach is to understand why savings haven't been delivered as planned.
- If this is not reversible, alternative savings schemes require to be developed.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- Progress is evaluated by monthly reporting of savings achieved against target.
- The experience and learning points from the 2024/25 will be used in the development of the 2025/26 Value & Sustainability Programme.

b) What needs to change? Is further support needed, if so from where and in what form?

- Better linkage of efficiency plans from all stakeholders (i.e. NHSG, IJBs and Councils) in order to avoid unintended consequences and cost shunting.
- Timelier implementation of some plans with schemes being developed prior to the start of the financial year.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Regular reporting to Scottish Government, NHSG Board, PAFIC and chief Executive Team.

b) when was this KPI last reported?

Separate Q1 finance update to PAFIC 25/09/24 and Board 12/09/24; September 2024 to Scottish Government

Tier 3 - Our Performance Spotlights: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact
Objective: Create the Conditions for Sustainable Change

Key Performance Indicator (KPI): An increase of 200 in completion of Turas module on Shared Decision Making by end March 2025

Q2 actual: 1113
Q2 Target: 1124

Outcome: Building on the success of condition specific projects to robustly demonstrate practical and measurable ways of implementing value based health and care.

Our story so far….

a) What is the background to the current position, and how are we performing against target?

We continue to connect the Turas module (Shared Decision Making) as a key resource, linking to relevant workstreams and so support communication and awareness raising. Q2 showed a slight drop off in relation to KPI.

However, it is notable that NHS Grampian has been very successful in relation to the KPI. The Board has significantly outperformed other territorial Boards, and this has been reported nationally and commended by the Realistic Medicine policy team. Not only in relation to the Turas module engagement, but NHS Grampian's approach to Realistic Medicine has also been highlighted as exemplary.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Q2 included more focused staff engagement (small numbers piloted shared decision making simulated conversation training) and more public / patient engagement. The Turas KPI is a high level measure but of staff engagement only (it's not accessible by public).

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

Overall, we continue to make inroads in understanding barriers and enablers to shared decision making. The KPI provides a crude measure of engagement, but the Realistic Medicine programme has a robust range of measures, recently shared with governance channels including CET as part of the 6 monthly reporting period. Shared decision making is a long-term culture change so measurement is challenging.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Culture change, particularly in the resource-challenged landscape, and associated time / capacity issues continue to be the key challenges to Realistic Medicine and embedding shared decision making.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

None identified at time of reporting

Commentary from

Paul Bachoo,
Executive Lead,
Integrated Specialist Care Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Culture change, particularly in the resource-challenged landscape, and associated time / capacity issues continue to be the key challenges to Realistic Medicine and embedding shared decision making.

b) How will we measure the expected impact, and what could prevent success?

A range of qualitative and quantitative measures are incorporated into all Realistic Medicine workstreams. Resource scarcity and capacity are threats to success, however projects are sized to fit accordingly.

c) If something hasn't worked, what alternative course of action will be taken?

Workstreams are continually evaluated and refreshed to ensure the best use of the capacity and skill.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Future Care Planning:
% of Treatment Escalation Plan (TEPs) completion: Rate has exceeded Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) rate. Capturing stories of lived experience and evaluation of shared decision making. Reach and engagement with key resources where data analytics are available (SharePoint site, social media). 100% positive feedback from simulated conversation training; clinician stories of positive impact on patient interactions. Feedback included: "Fantastic session which will be very worthwhile for all grades of doctors and the multi professional team". "This has helped me not just in TEPs discussions but everyday patient conversations".

Value Based Evaluation and Decision Making:
Research is helping to more robustly explore anecdotal evidence of referral/vetting decision making. Outputs include will include qualitative and quantitative data around key themes. People First Communication: In development, evaluation TBC.

Innovative Pathway Redesign: Migraine 340 eLearning engagements to date (across 13 territorial boards / 2 special boards / 4 HEIs). 226 attendees have attended live training to date / 142 have watched recorded training 453 live attendees at patient information webinar / 1335 views since upload to YouTube We continue to gather patient and clinician stories. Highlights include how this work is helping supported self-management and helping patients take a more active role in appointments, such as preparing with headache diaries. Furthermore, we have patient stories showing improved management of their condition as a direct result of this work.

b) What needs to change? Is further support needed, if so from where and in what form?

Continue to work responsively and flexibly to make the best use of resource available, and opportunities available

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Reported through the Accountability and Assurance pack shared with the transformation Programme Board 6 weekly and through the monthly Realistic Medicine flash reports.

b) when was this KPI last reported?

Realistic Medicine Flash Report 30/08/24

Tier 3 - Our Performance Spotlights: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact
Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): Increase percentage of recycled waste by weight to 55% by March 2025

Q2 actual: 46%
Q2 Target: 50%

Outcome: Sustained and enhanced recycling performance

Our story so far….

a) What is the background to the current position, and how are we performing against target?

NHS Grampian recognises the moral obligation as waste producer to reduce both the total amount of waste it produces as well as working towards achieving the national target of 70% recycling rate by end of 2025.
Our recycling rate has remained fairly static at around 45% for the past few years as the focus has been on addressing healthcare waste issues.
National reports indicate that NHS Grampian has one of the highest recycling rates among territorial boards.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

NHSG has made the eLearning module for waste mandatory, to ensure that all staff should have a minimum level of understanding regarding the segregation of the different waste streams therefore leading to increased recycling rate.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?

NHS Grampian is constantly working towards the outcome and the achievement of the KPI is delivered through the method detailed in the outcome.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Under-achievement on the annual projection towards the final target will compromise the outcome
- Biggest challenge is lack of dedicated staff resource available to monitor and support changes to waste streaming and recycling across a distributed system and substantial geography
- Funding for additional recycling receptacles/bins to encourage staff
- Staff not following protocols for waste segregation and disposal leading to increased disposal costs

b) Are there any unintended consequences or impacts on other KPIs, or other areas (e.g. workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

There is a clear need to improve the opportunity of waste bins being made available which requires investment, however current levels of investment are targeted elsewhere and if we were to have all the funds required, that would be passing on risks to other areas. Waste recycling is also directly linked to success in the Clinical Waste reduction KPI.

Commentary from

Alan Wilson
Director of
Infrastructure & Sustainability

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Changes and improvements in recycling options have been introduced across several sites in Aberdeen City Health and Social Care Partnership (HSCP) across Q3 & Q4
- Step-up messaging to build ward-level knowledge and enthusiasm and recognise local team progress through the new Green Star awards
- Collaboration with Domestic Services to reduce numbers of general waste bins and site communal bin points to encourage recycling
- Recycling bins have been supplied to all ward kitchens across ARI
- Identifying number of recycling bins required across all sites
- Purchasing recycling bins for identified wards within current budget restrictions.
- Global communication due in November informing all staff that there are to be no office bins
- Increased number of recycling bins made available

b) How will we measure the expected impact, and what could prevent success?

The measurement of the impact will be seen through the increased proportional amount of recycled waste being within the recycled waste category as a measurable; the success of this is in the control of the same group that create the waste, and their activities in relation to correct waste segregation. Therefore there are both behavioural and educational aspects, in addition to an enabling activity through the increase number of waste bins being provided requiring investment.

An audit is to be carried out audit of Maternity hospital which has been supplied with extra recycling bins to investigate the degree of impact on the recycling rate, for this model to then be shared across the board.

c) If something hasn't worked, what alternative course of action will be taken?

There is ongoing dialogue between the relevant parties to constantly look at the mitigation measures which are in place and see what areas are progressing and what is not. In short, the mitigation measures mentioned above are not static and are constantly in development and changing accordingly within the dynamic work flow, therefore there will be a constant evolution of several of the mitigation measures on an ongoing basis

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- Staff and departments are generally keen to reduce waste and improve recycling options at their place of work
- Providing the facilities (e.g. bins) to collect and manage recycling empowers local teams to implementation and increased recycling rates
- There is a need to be able to have case studies to the share this evidence with other staff groups.

b) What needs to change? Is further support needed, if so from where and in what form?

- Many sites, even when keen to improve, feel the need for additional guidance and support to initiate and implement changes
- There is a need to have ward level waste champions, working alongside domestics; however, there is a shortage of staffing capacity.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- Waste weights are included in the Public Bodies Climate Change Duties Report to Scottish Government and the NHSG Sustainability Governance Group
- Quarterly waste reports and KPIs are supplied to NHSG Waste Management group

b) When was this last reported?

- Last Quarterly waste meeting was on 24th October 2024

Tier 3 - Our Performance Spotlights: Environment

Strategic Intent: We are leaders in sustainability, minimising our environmental impact
Objective: Create the conditions for sustainable change

Key Performance Indicator (KPI): Reduction in clinical waste by 5% by March 2025

Q2 actual: 880T
Q2 Target: <853.58T

Outcome: Sustained and enhanced clinical waste reduction performance

Our story so far….

a) *What is the background to the current position, and how are we performing against target?*

NHS Grampian recognises the moral obligation as waste producer to reduce the amount of clinical waste which we produce both through the front end of the equipment used and through the constant drive to increase the level of correct waste segregation

b) *What changes or trends have occurred this quarter, and how might they affect future performance?*

The reason as to why we appear to not be aligned with the quarterly target is due to the fact that the target is in actual fact an annual target, this is because of inter-annual variations in the amount of clinical waste produced on an ongoing basis.

We are likely to see an increase in the amount of clinical waste in the coming months, this is due to entering the vaccination "season".

With regards to the amount of clinical waste being produced per patient, this remains a piece national work which is still outstanding, as the waste per patient episode would allow for the inference of real terms reduction in the amount of clinical waste being produced per patient. This is currently no achievable, with periods of both more patients and or "complicated" patient episodes increasing the amount of clinical waste being produced, which shows up as the targets not being achieved, when the waste per patient type could in real terms be reducing

c) *How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?*

NHS Grampian is constantly increasing its level of clinical waste segregation, however the measurement of this is being looked into, to avoid masking of improvement through patient episode data skewing the output.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Staff not following protocols for waste segregation and disposal leading to increased disposal costs
- Biggest challenge is lack of dedicated staff resource available to monitor and support changes to waste streaming across a distributed system and substantial geography.
- Funding for additional recycling receptacles/bins to encourage staff

b) Are there any unintended consequences or impacts on other KPIs, or other areas (e.g. workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

Successfully reducing levels of Clinical Waste will have a direct impact on improvements in Waste Recycling levels, as a reduction of clinical waste production will lead to a reduction in waste production as a whole, and an increase in the proportion of recyclable waste.

Commentary from

Alan Wilson
Director of
Infrastructure & Sustainability

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- Identifying number of recycling bins required across all sites for diverting materials out of clinical waste bags
- Purchasing recycling bins for identified wards within current budget restrictions
- Step-up messaging to build ward-level knowledge.
- Green Theatre group identifying locations where additional bins can be placed to reduce waste entering the clinical waste stream.
- We have supplied 53 recycling bins to date (25.10.2024)

b) How will we measure the expected impact, and what could prevent success?

- Planning to undertake an audit on clinical waste segregation for those areas at ward level which have been supplied with additional recycling bins
- Work is continually taking place with meetings across all related sectors from domestic staff and with direct ward level waste producers to increase both source segregation and accessibility of the correct waste bins.

c) If something hasn't worked, what alternative course of action will be taken?

There is ongoing dialogue between the relevant parties to constantly look at the mitigation measures which are in place and see what areas are progressing and what is not. In short, the mitigation measures mentioned above are not static and are constantly in development and changing accordingly within the dynamic work flow, therefore there will be a constant evolution of several of the mitigation measures on an ongoing basis

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

The level of resolution available is not conducive to enabling to identifying specific areas of improvement as NHSG is subdivided into 3 sites (Woodend, Dr Gray's and Foresterhil) with Foresterhill also being the proxy for all other sites outwith the aforementioned across Grampian.

- The positioning of the clinical waste bins plays a key role in determining what ends up within each respective waste stream (i.e. people will put waste into first bin they come to rather than correct waste segregation)
- Providing the facilities to collect and manage waste empowers local team implementation

b) What needs to change? Is further support needed, if so from where and in what form?

There is a need for a new method of calculating the level of clinical waste being produced per patient episode, which requires national work to be undertaken, as to allow for better internal and external progress to be developed.

- The majority of staff do want to have a positive impact, however the facilities to do this do not always exist (e.g. not enough bins)
- Many sites are keen to improve and have signalled they feel additional guidance and support to initiate and implement changes would be beneficial

Oversight and assurance

a) *What is the assurance and governance oversight arrangements?*

- NHS Grampian undertakes Pre Assessment Audits (PAA's) for all clinical waste producing sites to ensure segregation compliance.
- Operational Waste Management Group
- OHS
- Waste weights are included in the Public Bodies Climate Change Duties Report to Scottish Government.

b) *When was this last reported?*

The PAA's is a rolling piece of work, which is then reported to SEPA accordingly, with the Operational meetings taking place on a quarterly basis.

Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 2: In-year 24/25 performance of KPIs and Deliverables towards 2027 Outcomes

PATHWAYS (Outcomes)

PA1 - Evaluation of the two redesigned care pathways (Adult General Mental Health & Frailty) demonstrates an improved person-centred approach.

PA2 - There is clarity among all partners within the two redesigned pathways about governance & performance reporting while demonstrating a systems leadership approach to delivery*

PA3 - Specialities will have a clear recurring capacity and demand gap analysis. Where there is a gap, a plan will exist to close the gap through redesign / regionalisation. Alternatively, a case will be presented to the Board to consider service cessation.

PA4 - Services will be monitored and in a continuous improvement loop to maximise all possible efficiencies.

PA5 -Improvements in unplanned care performance will remove the diversion of resources from planned care allowing full use of planned care assets for planned care*

PA6 - We will plan elective care on a North of Scotland (NoS) basis and repurpose territorial assets against this NoS plan.

PA7 - Services will be benchmarked across Scotland in terms of efficiencies and upper quartile performance expected, monitored and delivered.

PA8 - We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take account of demographics, peoples' experiences & outcomes, the increasing demand/need & long-term gains.

PA9 - We will have continued to improve access to unscheduled and planned care pathways. We will have moved towards admission avoidance, improve primary care based response to illness and ensure citizens of Grampian are empowered to participate in their own healthcare promoting preventative measures, self-care strategies and overall wellbeing.

PA10 - Achieve mental health outcomes in concordance with national strategy.

PA11 - Fully integrated national electronic record between citizen, health, local government and third sector.

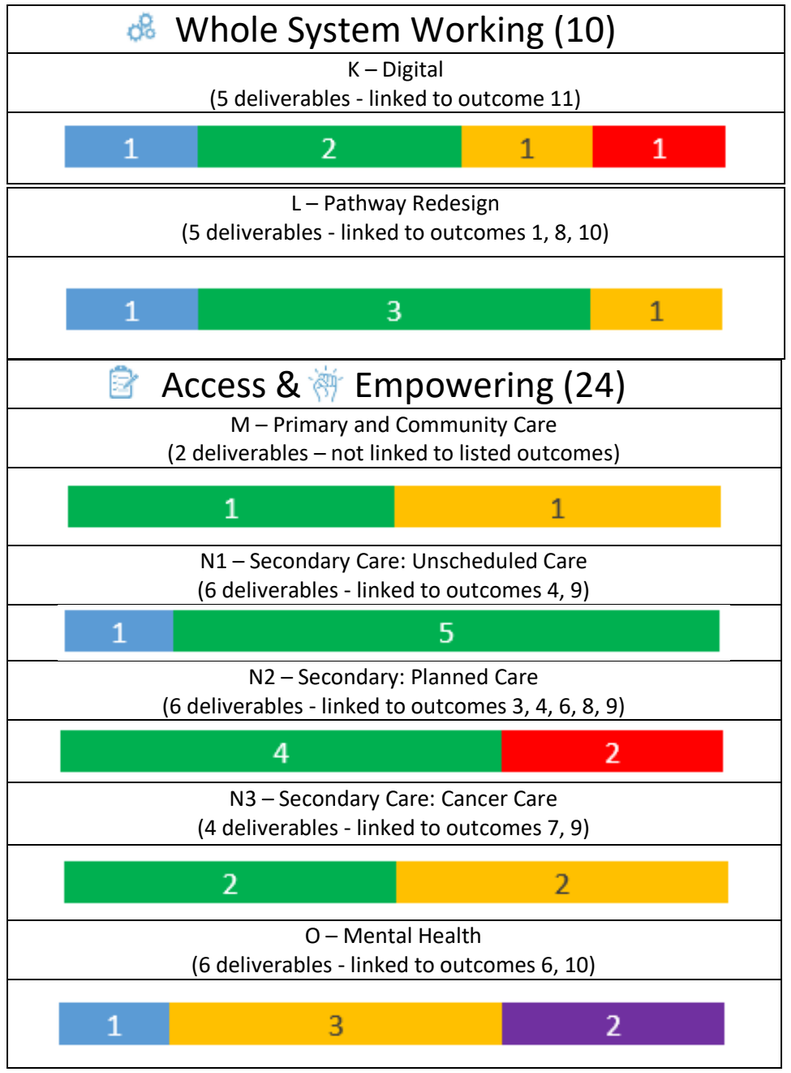
PA12 - Extend citizen access to records to add notes and data*

PA13 - Deliver good quality care and sustainable health services in the future through active participation of our staff, citizens and partners

PA14 - Create a more equitable and responsive oral health care system with a focus on prevention, supported self-care and management, and access to dental services to improve oral health outcomes.

*Not aligned to Deliverable or KPI

Performance of Deliverables



Key Risk Categories: Impact on progress of 34 Deliverables (Deliverables may have more than one associated risk therefore total will exceed 100%)	**All PATHWAYS Deliverables Q2**
Finance – Funding not yet agreed	13
Finance – Non recurrent funding	12
Workforce – Recruitment	11
Workforce – Capacity*	11
Workforce – Retention	10
Workforce – Training, Development and Skills	10
Infrastructure - Estates	9
Workforce – Absence	7
Workforce – Wellbeing	6
Finance – Insufficient Funding*	6
Infrastructure – Digital*	3
Other (National Policy, Systems – National, Data & Modelling, Engagement)	2
Procurement	1

*Indicates new risk category added for Q2

Performance of Key Performance Indicators

Performance against 12 Pathways KPIs across Colleagues and Culture, Children, and Citizens – linked to Outcomes PA8, PA9, PA10, PE18

More information available in Scorecards

Assessment Rating	Red	Amber	Green
Criteria (Where a category only has one KPI, the RAG rating for that category will be the same as for its KPI)	2 or more red Key Performance Indicators	1 red Key Performance Indicator	0 red and 1 amber Key Performance Indicators

Tier 2: Performance Scorecard: Access & Empowering

Strategic Intent: Patients are able to access the right care at the right time

Strategic Intent: Grampian's population is enabled to live healthier for longer

Objective: Improve Preventative & Timely Access to Care

2027 Outcome alignment linked outcome ID	2024/25 Key Performance Indicator	Baseline (Mar'24)	Quarter 1 Actual	Quarter 1 Target	Quarter 2 Actual	Quarter 2 Target	Quarter 3 Actual	Quarter 3 Target	Quarter 4 Actual	Quarter 4 Target	Trend (12 months to Sep'24)	Benchmarking (11 mainland Boards: 1st = best performing)	Why are we in this position? *When was this last reported?*
PA8 - We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take account of demographics, peoples' experiences & outcomes, the increasing demand/ need & long-term gains.	**We will minimise the number of waits over 104 weeks for TTG patients**	2031	1961	<2100	**1999**	**<1800**		<1500		<1400		11th (Jun 24 census point)	We are slightly over trajectory but generally static due to CDU downturn and slower private contract activity on hold for financial reasons. The key issue is the lack of SSU capacity. *Last reported: Formal reporting to Scottish Government weekly* Note: targets updated in Q2, in line with revised agreement with SG spotlight on page 48
	We will minimise the number of waits over 104 weeks for a new outpatient appointment	625	829	<700	**1426**	**<700**		<900		<1000		11th (Jun 24 census point)	Capacity in key specialties is prioritised for urgent cases, affecting the routine queue, while some planned capacity is withheld due to financial considerations. *Last reported: Formal reporting to Scottish Government weekly* spotlight on page 49
	Average monthly delayed discharges to be no greater than Q4 2023/24	254	274	<255	**283**	**<255**		<255		<255		comparative benchmarking not available	Delays remain high due to increasing complexity and demand for care homes exceeding capacity, with financial challenges impacting options. Weekly meetings continue to share learning and connect with other HSCPs, supported by HIS for MHLD and Aberdeenshire. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 50

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Access & Empowering

2027 Outcome alignment linked outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1** Actual	**Quarter 1** Target	**Quarter 2** Actual	**Quarter 2** Target	**Quarter 3** Actual	**Quarter 3** Target	**Quarter 4** Actual	**Quarter 4** Target	**Trend** (12 months to Sep'24)	**Benchmarking** (11 mainland Boards: 1st = best performing)	**Why are we in this position?** *When was this last reported?*
PA8 - We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take account of demographics, peoples' experiences & outcomes, the increasing demand/ need & long-term gains.	**Proportion of delayed discharges waiting over 4 weeks to be no greater than Q4 2023/24**	32.5%	32.1%	<32.6%	**34.2%**	**<32.6%**		<32.6%		<32.6%		comparative benchmarking not available	Monitoring by HSCP's continues and working with Foresterhill campus & Dr Gray's on appropriate additions to delayed list. *Last reported: October 2024 Delayed Discharge Improvement Group* spotlight on page 51
	72% of citizens will receive first treatment within 62 days of urgent suspected cancer referral	55.0%	60.65%	72%	**53.9%**	**72%**		72%		72%		10th (quarter end Jun 24)	Backlog activity was delayed in mobilisation, and equipment and infrastructure issues have stalled progress in backlog clearance. Active recovery efforts may lead to a decline in performance *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 52
	95% of citizens will receive first cancer treatment within 31 days of decision to treat	89.9%	89.96%	95%	**88.4%**	**95%**		95%		95%		11th (quarter end Jun 24)	Backlog activity was delayed in mobilisation, and equipment and infrastructure issues have stalled progress in backlog clearance. Active recovery efforts may lead to a decline in performance *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 53
PA9 - We will have continued to improve access to unscheduled and planned care pathways	**Reduce NHSG 90th percentile SAS turnaround times to 110 minutes by quarter 4 2024/25**	203	196	160	**210**	**145**		135		110		11th (quarter end Jun 24)	AMIA starts the day with limited admitting capacity, causing SAS resources to stack. Late afternoon patient inflow is affected by acute ward occupancy over 100%, increased delayed discharges, and higher summer demand compared to previous years. *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 54

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Access & Empowering

2027 Outcome alignment linked outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1** Actual	Target	**Quarter 2** Actual	Target	**Quarter 3** Actual	Target	**Quarter 4** Actual	Target	**Trend** (12 months to Sep'24)	**Benchmarking** (11 mainland Boards: 1st = best performing)	**Why are we in this position?** *When was this last reported?*
PA9 - We will have continued to improve access to unscheduled and planned care pathways	**70% of citizens will be seen within 4 hours in NHSG Emergency Departments**	60.7%	60.8%	70%	**61.0%**	**70%**		70%		70%		9th (quarter end Jun 24)	Exit block from ED remains a key issue, with Acute ward occupancy consistently over 100%. Delayed discharges have slightly increased, and summer demand is higher than previous years *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 56
	Average length of stay for elective and non-elective patients (NHSG MUSC only) to be no higher than Q4 2023/24	6.53 days	6.42 days	<6.54 days	**6.33 days**	**<6.54 days**		<6.54 days		<6.54 days		comparative benchmarking not available	Despite a largely unchanged DD/DTOC picture, MUSC Length of Stay has reduced slightly as focus has shifted to discharge efficiency and long stays not in delay. *Last reported: Formal reporting to Scottish Government weekly* spotlight on page 58
PA10 - Achieve mental health outcomes in concordance with national strategy.	**90% of children and young people referred to Mental Health Services will be seen within 18 weeks of referral**	97.4%	96.7%	90%	**98.0%**	**90%**		90%		90%		4th (quarter end Jun 24)	CAMHS Continues to meet the Scottish Government National Waiting Times Standard of 90%. There continues to be a growing demand for children requiring access to specialist CAMHS services nationally and the compliance in Grampian has decreased with both an increase in demand and a reduced workforce, however CAMHS Grampian are working hard to ensure that there is timely access to patients waiting for their 1st Clinical Assessment with routine contact every 12 weeks for those that are waiting for a 2nd appointment *Last reported: MHLDS Governance Meeting 31/10/24, H&SC Clinical Governance Group 30/10/24*

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 2: Performance Scorecard: Access & Empowering

2027 Outcome alignment linked outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1** Actual	**Quarter 1** Target	**Quarter 2** Actual	**Quarter 2** Target	**Quarter 3** Actual	**Quarter 3** Target	**Quarter 4** Actual	**Quarter 4** Target	**Trend** (12 months to Sep'24)	**Benchmarking** (11 mainland Boards: 1st = best performing)	**Why are we in this position?** *When was this last reported?*
PA10 - Achieve mental health outcomes in concordance with national strategy.	**70% of people referred to psychological therapies will be seen within 18 weeks of referral**	75.5%	81.7%	70%	**80.5%**	**70%**		70%		70%		5th (quarter end Jun 24)	We are continuing to maintain our performance for the referral to treatment standard of 18 weeks, for September 2024 this was 83%. Maintenance of performance will be challenging given current financial constraints/resource reduction, so should remain at current level *Last reported: MHLDS Governance Meeting 31/10/24, H&SC Clinical Governance Group 30/10/24, Psychological Therapies Programme Board 09/10/24*

Tier 2: Performance Scorecard: Whole System Working

Strategic Intent: Joined up and connected, with and around people

Objective: Improve Preventative & Timely Access to Care

2027 Outcome alignment linked Pathways outcome ID	**2024/25 Key Performance Indicator**	**Baseline** (Mar'24)	**Quarter 1** Actual	**Quarter 1** Target	**Quarter 2** Actual	**Quarter 2** Target	**Quarter 3** Actual	**Quarter 3** Target	**Quarter 4** Actual	**Quarter 4** Target	**Why are we in this position?** *When was this last reported?*
PA9 - We will have continued to improve access to unscheduled and planned care pathways, using performance measures that also take account of demographics, people's experiences and outcomes, the increasing demand/need & long term gains	**Completion of 6 workstreams within the Grampian Frailty Programme Plan by 31st March 2025 in order to achieve collaboration across all 3 HSCPs and NHSG**	0%	25%	25%	**50%**	**50%**		75%		100%	Due to financial challenges and additional cost it has been agreed not to progress an MCN but to ensure a network continues through the frailty board. Dr Gray's considering what it would take to become a Centre of Excellence for Frailty. Ongoing work to progress priorities and recent update given to North East Partnership Steering Group. *Last reported: Frailty Board reports to Unscheduled Care Programme Board on progress; Reported 12th November* spotlight on page 59

Assessment Rating	Red	Amber	Green
Criteria	Performance is outwith the target by more than 5%	Performance is within 5% of the target	Performance is meeting/exceeding the target

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): We will minimise the number of waits over 104 weeks for TTG patients

Q2 actual: 1999
Q2 Target: <1800

Outcome: We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take into account demographics, people's experiences and outcomes, the increasing demand/need and long term gains

Our story so far….

a) What is the background to the current position, and how are we performing against target?
Although we are above target the position has stabilised. It remains our analysis that the majority of these long wait patients now require to be operated on in ARI rather than in our available peripheral capacity. Out main theatre capacity within ARI remains heavily weighted towards delivering emergency surgery, cancer and Elective Surgical Categorisation System (ESCatS) 1 care with the short stay unit remaining non-operational for short stay surgery. Work continues along with estates colleagues to bring a minimum of one short stay theatre back into commission for short stay surgery which is the key action to begin to address our longest waiting patients. The best case estimate for this currently is within Quarter 4 but there is not a firm date as yet.

b) What changes or trends have occurred this quarter, and how might they affect future performance?
We suffered a downturn in activity due to the scheduled and then unscheduled downtime of the Central Decontamination Unit. Significant effort went into a business continuity exercise to minimise the disruption this caused but the priority of this exercise was to maintain emergency and critical care services so the longest waiting patients were the cohort who were impacted the most. The fragility of our infrastructure remains an overall concern which is likely to continue to impact on service delivery. The Orthopaedic downturn at Dr Gray's has not yet fed into this cohort of patients but will in time unless this can be mitigated in the medium to longer term. There is a suggestion that planned care funding which is diverted towards the bottom line financial position. If this occurs then our ADP will need to be re-profiled.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?
Reducing the Treatment Time Guarantee (TTG) backlog to at a minimum ESCatS complaint timescales is vital for our 2027 vision. Although the TTG position is broadly stable we have not managed to systematically move it to an improving picture.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?
Infrastructure issues continue to pose a risk of short-term service disruptions. Reactivating the short-stay theatres is critical to systematically addressing the longest-waiting patients. The financial situation may impact this, whether through diverting planned care funds or other cost-saving measures. The impact of the 10% service reduction will need modelling once specifics are available. The orthopaedics suspension at Dr Gray's isn't yet reflected in performance measures, and capacity is currently being reallocated to other services. A stable elective plan for Dr Gray's is needed to assess medium-term impacts.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?
The constrained resources of the Digital Directorate reduces the ability to and speed of adopting potential solutions to improve efficiency. This is more a risk for TTG then a current issue (although nationally we are being pushed to adopt the Infix Theatre Scheduling System our assessment is that it will not lead to a significant efficiency improvement locally). The infrastructure issue (both buildings and equipment) are more likely currently to lead to an inability to deliver our planned care programme. The consequences of the financial situation are not currently known but is likely to have an overall negative impact on planned care delivery.

Commentary from

Paul Bachoo, Executive Lead, Integrated Specialist Care Portfolio (ISCP)

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?
We continue to respond to escalations around deteriorating patients and utilise the ESCatS risk management system, however it is working with timescales far outwith its design parameters. We continue to clinically review all deaths on the waiting list to determine if anywhere likely casual to their length of wait and this overall remains reassuring in its findings. We are however very aware of the harm caused to patients during this prolonged waiting time. Support and advice remains available via the Waiting Well team and others, although this team is shrinking.

b) How will we measure the expected impact, and what could prevent success?
This is one of many metrics in the overall elective care plan which are monitored and reported on closely. The key risks have been outlined in this paper.

c) If something hasn't worked, what alternative course of action will be taken?
It remains our intent to reach a plan to achieve capacity-demand balance within an ESCatS compliant timescale. We continue to operate tactically to achieve maximum capacity and efficiency though fundamental redesign is likely to be required to achieve this ambition. We continue to work regionally and nationally around how this might be achieved on a collaborative basis given the workforce, financial and infrastructure challenges us and the wider NHS Scotland face.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?
All elements of the elective care plan are quantified, measured and reported closely. This however is the in-year tactical plan which predicted (and is seeing) an overall deterioration in the position. In general however we remain content with our overall efficiency of the use of the assets we do have within the constraints we are operating under.

We were supportive of an approach to pilot for closer delivery of elective care on a regional working; but this work has been paused by the North of Scotland Chief Executives at present pending further guidance from the Scottish Government around regional working.

b) What needs to change? Is further support needed, if so from where and in what form?
In the short term we need financial clarity for in year funding redirection as this will have a direct impact if progressed and we require a start date for the short stay theatre complex to be confirmed as that will also have the most immediate impact.

In the longer term we need to understand the impact of the 10% service reduction ask and the consequences of this, along with a stable vision for the role Dr Gray's Hospital will play in elective operating for NHS Grampian in the future.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?
- *Performance Assurance, Finance & Infrastructure Committee*
- *Weekly operational performance management*
- *ISCP Programme Board*
- *SG Access Support Team*

b) When was this KPI last reported?
There is formal reporting of the position to Scottish Government on a weekly basis

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): We will minimise the number of waits over 104 weeks for a new outpatient appointment

Q2 actual: 1426
Q2 Target: <700

Outcome: We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take into account demographics, people's experiences and outcomes, the increasing demand/need and long term gains

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- The largest volume of patients sits within Urology and Dermatology. We believe the Dermatology position should improve gradually as two substantive trainees are going into new consultant posts but there is no identified recovery solution to the Urology capacity issues to date. Items have been identified which would increase efficiency but these are held given the funding situation outlined above.
- The Dermatology position could potentially be improved by the adoption of digital solutions being advocated by the Centre for Sustainable Delivery (CfSD). At present the Digital Directorate has advised that they are not in a position to support the rollout of this product amongst other priorities.
- In general the shift top more urgent new referrals continues which is diverting substantial capacity towards the urgent front of the queue leaving limited capacity in many specialties for the longest waiting routine patients.
- Substantial capacity continues to be delivered via additionality, in the main via waiting list initiatives, but also via some bespoke independent sector contracts. A formal plan is now ready to reinvest a proportion of the recurring WLI budget into core capacity posts, but is being held pending financial approval.

b) What changes or trends have occurred this quarter, and how might they affect future performance?
The trends previously visible have continued with the 104 and 78 week lines extending above trajectory and likely to remain so in the Q3 position, whilst the 52 week position remains below trajectory.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?
We continue to build a long backlog of patients putting the 2027 outcome of timely care at risk

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?
The key challenges remain around the available workforce, the changing disease profile and urgency shift and available finances. The referral priority shift and available resources have been described previously. The financial picture is emerging both in terms of the potential for direct removal of planned care funding and the knock on consequences of other efficiency savings all of which are likely to have direct or indirect impact on planned care to an extent. The position of Dr Gray's hospital and the impact of service suspension will also short term knock on consequences until they can be formally mitigated. Risk ID: 3065.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

The Finance recovery plan and controls being introduced are having and will continue to have a direct impact on planned care performance. The Digital Directorate firebreak and limited resources to support emerging innovations that may improve services will have a direct impact. There remains a risk that unscheduled care demands will reduce the availability of staff to provide routine outpatient services.

Commentary from

Paul Bachoo,
Executive Lead,
Integrated Specialist Care Portfolio (ISCP)

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?
We continue to prioritise on a clinical basis and respond to escalations around deteriorating patients. We continue to engage with the CfSD around service efficiencies and redesign and are exploring as a whole system the consequences and health consumption associated with waiting to determine if this would allow targeted intervention to achieve whole system benefit.

b) How will we measure the expected impact, and what could prevent success?

This metric is one metric out of numerous quantified outcomes in the elective care plan that is formally tracked and reported on.

c) If something hasn't worked, what alternative course of action will be taken?

It is clear we have a recurring demand and capacity gap in a number of services along with substantial backlogs which is matched with a challenging financial picture that makes service expansion to meet the demand a non-viable option. Significant service redesign a radical sharing of resources on a regional basis will be required to balance these competing priorities. We continue to engage and work towards this.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Actual performance is measured closely and analysed. Although longest waiting trajectories are above where we would like we are over delivering in terms of the total activity in the plan. Although there will be various reasons for this across specialities and conditions the top level view remains that insufficient capacity remains to address the longest waiting patients given the relative proportion of urgent patients being referred. The strategic intent is to achieve sustainable demand and capacity balance within a tolerable waiting times performance. Our current board level Planned Care strategic risk is graded as being intolerable and this is inclusive of the Outpatient position. As substantial service expansion to meet the demand is not a viable option given our current financial situation this suggests a fundamental service redesign is required within a number of specialities

b) What needs to change? Is further support needed, if so from where and in what form?

In the short term clarity is required on whether planned care funding is being diverted to other uses; this question is currently being resolved by the Chief Executive Team. In the medium term we both need to understand the consequences of the whole system service reduction plan (the 10% reduction ask) to meet the financial resources available to the board and the planned care performance consequences of this. Alongside this fundamental service redesign is required in several specialities to design an outpatient system that can meet demand on a sustainable basis with in the resources available to us.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?
There are weekly operational performance meetings which track key projects and identifies key variances. These feed into monthly Scottish Government Performance Reviews along with formal performance overview at the ISCP Programme Board which feeds into PAFIC. All operational teams will also monitor their local performance as part of their core role.

b) When was this KPI last reported?
There is formal reporting every week to Scottish Government

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Patients are able to access the right care at the right time
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): Average monthly delayed discharges to be no greater than Q4 2023/24

Q2 actual: 283
Q2 Target: <255

Outcome: We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take account of demographics, peoples' experiences & outcomes, the increasing demand/need & long-term gains.

Our story so far….

a) ***What is the background to the current position, and how are we performing against target?***

Delayed Discharges are a jointly held responsibility shared by Aberdeenshire, Moray & Aberdeen City Integrated Joint Boards (IJBs) resulting in differing experiences across the NHS Grampian region.

Aberdeenshire saw an increase in the number of delays in Q2 2024 as compared with 2023, while City's delays reduced during the year and in Q2 the census date figure was 36 demonstrating good performance despite the significant challenges. In Moray, delays slowly increased but have stabilised, remaining at an average of 35 for this quarter; they remain lower than the 2022 March position of 52.

b) ***What changes or trends have occurred this quarter, and how might they affect future performance?***

Initial improvement support session with Scottish Government in June 2024. This led to the development of the Collaborative Response & Assurance Group (CRAG) with subsequent improvement targets set collaboratively. The target by end of October 2024 is to reach a maximum of 34.6 delays per 100,000 adults in Grampian. The initial focus has been on rapid improvement, then embedding sustainable change. This target has been supported by joint working via the Discharge Without Delay Group for NHSG, alongside improvement workshops held in collaboration with Scottish Government colleagues.

c) ***How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?***

HSCP activity is overseen by IJBs and comes through their Strategic Plans, implemented through their Strategic Delivery Plans, rather than the Plan for the Future/ADP. The KPI performance demonstrates that the achievement of the 2027 outcome remains challenging and should be seen in the context of activity in the community to prevent hospital admission such as virtual community wards. All KPIs relating to patient flow are interrelated, particularly those recorded under Pathways – improve preventative and timely access to care. Monitoring of KPIs by HSCP's continues alongside working with Foresterhill campus & Dr Gray's on appropriate additions to delayed list.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Number of delays remain high. Complexity and level of need for people are increasing. Many people waiting for care homes and demand exceeds capacity. Financial challenges impact on other options.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

This KPI has significant interrelationships with the Proportional Delayed Discharges KPI, and also the Length of Stay, Ambulance Turnaround, and Emergency Department Wait KPIs.

Commentary from
Pam Milliken, Chief Officer, Aberdeenshire Health & Social Care Partnership (HSCP)
Judith Proctor, Interim Chief Officer, Moray Health & Social Care Partnership (HSCP)
Fiona Mitchelhill, Chief Officer, Aberdeen City Health & Social Care Partnership (HSCP)

Our mitigation and recovery actions

Aberdeenshire:

- Daily operational meetings to discuss progress of all delays and identify barriers
- Scrutiny to ensure that reported delays are appropriate, added to the system timeously and coded accordingly
- Weekly meetings to review the Aberdeenshire delayed discharge position and identify key themes, challenges, actions and escalations
- An Aberdeenshire Care Management Team is based in the ARI hub to increase efficiency and ensure new referrals are picked up promptly

Aberdeen City:

- Daily/weekly meetings to review client group in hospital settings, those at highest
- risk are prioritised
- continue to deliver initiatives to help support and maintain staff health and wellbeing
- Increase in collaborative working between clinical teams and hospital social work teams

Moray:

- Daily monitoring of flow, weekly review of all discharges that are delayed. Review of each delay, shared decision making to promote discharge with the resources available
- Operational team engagement in preventing delayed discharges
- Self- assessment against a set of KPI's
- Priority patient management in Moray developed to ensure that resource is allocated to those most in need, this is reviewed weekly but daily if required

b) How will we measure the expected impact, and what could prevent success?

Full review of current Delayed Discharges in City, Shire & Moray with incident reporting of delays over 90 days.

c) If something hasn't worked, what alternative course of action will be taken?

Consistent review of HSCPs recovery actions. Opportunities for learning and sharing from existing practice in each IJB.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Aberdeenshire:

- The test of change for TrakCare access has had a positive impact on flow and will be embedded in practice for Care Managers
- Step Up opportunities should be increased

Aberdeen City:

- Increasing amount of Technology Enabled Care (TEC) enabling timely discharge and new ways of working
- It is key to keep close collaboration with providers to seek solutions and capacity for emergency care and timely care packages being in place
- Having a dedicated post to focus on delays and create pathways for more streamlined discharges

Moray:

- That daily operational engagement with shared decision making will generate creative solutions to reducing delays, encourage the flow of patient's through the system and reduce the need for system wide crisis

b) What needs to change? Is further support needed, if so from where and in what form?

Health Intelligence Scotland working closely to support Shire & Mental Health Learning and Disability (MHLD).

Scottish Government colleagues supporting Shire HSCP via several Discharge Without Delay

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Weekly Discharge without Delay meeting continues in sharing learning and opportunities with other HSCP's. Health Improvement Scotland supporting MHLD and Aberdeenshire.

b) When was this KPI last reported?

Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Patients are able to access the right care at the right time
Strategic Intent: Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): Proportion of delayed discharges waiting over 4 weeks to be no greater than Q4 2023/24

Q2 actual: 34.2%
Q2 Target: 32.6%

Outcome: Building on the success of condition specific projects to robustly demonstrate practical and measurable ways of implementing value based health and care.

Our story so far….

a) What is the background to the current position, and how are we performing against target?

Delayed Discharges are a jointly held responsibility shared by Aberdeenshire, Moray & Aberdeen City Integrated Joint Boards (IJBs) resulting in differing experiences across the NHS Grampian region. Aberdeenshire saw an increase in the number of delays in Q2 2024 as compared with 2023, while City's delays reduced during the year and in Q2 the census date figure was 36 demonstrating good performance despite the significant challenges. In Moray, delays slowly increased but have stabilised, remaining at an average of 35 for this quarter; they remain lower than the 2022 March position of 52.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Initial improvement support session with Scottish Government in June 2024. This led to the development of the Collaborative Response & Assurance Group (CRAG) with subsequent improvement targets set collaboratively. The target by end of October 2024 is to reach a maximum of 34.6 delays per 100,000 adults in Grampian. The initial focus has been on rapid improvement, then embedding sustainable change. This target has been supported by joint working via the Discharge Without Delay Group for NHSG, alongside improvement workshops held in collaboration with Scottish Government colleagues. Weekly attendance and follow up meeting with Convention of Scottish Local Authorities (COSLA) about rural care homes and mental health.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

HSCP activity is overseen by IJBs and comes through their Strategic Plans, implemented through their Strategic Delivery Plans, rather than the Plan for the Future/ADP. The KPI performance demonstrates that the achievement of the 2027 outcome remains challenging and should be seen in the context of activity in the community to prevent hospital admission such as virtual community wards. HSCPS Initial focus is on rapid improvement then subsequently embedding sustainable change.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Demand for health and social care services continues to increase in line with a growing population of older people, people with complex needs and guardianship
- Focus on delayed discharge leads to longer waiting times for new referrals to Adult Social Work to be assessed and a growing list of unmet need
- Delayed discharge results in risks to patients including treatment in wrong setting, increased risk of infection, loss of mobility & cognitive function, and delays to onward care
- Performance in City is expected to deteriorate as interim beds have been closed due to lack of recurring funding
- Increase risks in the community with unmet need
- Reduction in available care home beds

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

This KPI has significant interrelationships with the Proportional Delayed Discharges KPI, and also the Length of Stay, Ambulance Turnaround, and Emergency Department Wait KPIs.

Commentary from
Pam Milliken, Chief Officer, Aberdeenshire Health & Social Care Partnership (HSCP)
Judith Proctor, Interim Chief Officer, Moray Health & Social Care Partnership (HSCP)
Fiona Mitchelhill, Chief Officer, Aberdeen City Health & Social Care Partnership (HSCP)

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Aberdeenshire - Increasing care home capacity through engagement with commissioned providers to reopen empty beds
Facilitation of care home placements for people with complex needs by the Care Home Collaboration Nursing Team
SDS option 2 Care at Home provider established targeting people who are delayed waiting for care home in Central Buchan following a tender
Increase use of 13Za of the Social Work (Scotland) Act 1968 to ensure principle of minimum intervention is being achieved
Community Hospital Frailty Review to optimise access to community hospitals and identify barriers and solutions to achieve consistent and effective MDT working across Aberdeenshire.
Moray - Risk Enablement Toolkit used for complex discharges
Progressing Proportional Care Programme - train the trainers
START and D2A process mapping
Realistic Medicine Progressing Shared Decision Masterclasses - frailty focus
Polypharmacy reviews - shown to reduce care provision
City - Embed criteria led discharge
Review Discharge to Assess including learning from others
Understand improved Guardianship processes in Moray and share learning
Scale up alternative to admission work via use of technology enabled care
Expediting discharge via use of technology enabled care

b) How will we measure the expected impact, and what could prevent success?

Full review of current Delayed Discharges with incident reporting of delays over 90 days.

c) If something hasn't worked, what alternative course of action will be taken?

Continue to seek support and review via NHSGs Collaborative Response & Assurance Group (CRAG.) Health Improvement Scotland continue to assist both Shire & MHLDs where additional support is needed.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Joint working across City, Shire & Moray IJBs on the following key issues -

Planned Date of Discharge

Multidisciplinary Team (MDT) guidance

Discharge to Assess

Criteria Led Discharge

Risk enabled care

Technology Enabled Care (TEC)

Discharge Without Delay Group – overseeing work towards targets

Representation from across Grampian and reports through the local HSCPs and the Chief Executive Team.

b) What needs to change? Is further support needed, if so from where and in what form?

Health Intelligence Scotland working closely to support Shire & Mental Health and Learning Disability (MHLD).
Scottish Government colleagues supporting Shire HSCP via several Discharge Without Delay workshops.
Opportunities for learning and sharing from existing

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Weekly Delayed Discharge Improvement Group meeting established to have oversight of improvement plan. Development of Grampian Wide Short Life Working Group which will meet weekly

b) when was this KPI last reported?

October 2024 Delayed Discharge Improvement Group

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): 72% of citizens will receive first treatment within 62 days of urgent suspected cancer referral

Q2 actual: 53.9%
Q2 Target: 72%

Outcome: We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take into account demographics, people's experiences and outcomes, the increasing demand/need and long term gains

Our story so far….

a) What is the background to the current position, and how are we performing against target?

Cancer care relating to the tracked pathways continues to compete for resources with many other unscheduled or urgent high priority non-cancer pathways.

An increased rate of both Urgent Suspected Cancer (USC) referrals and backlog in Urology & Colorectal pathways continues to be seen in Grampian as mirrored by the overall national picture.

Whilst efforts continue to reduce the high number of backlog patients, this will result in a negat impact to the cancer performance and in turn the projected Q1 target of 72% is not being met.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- Additional activity was delivered, following Q1&Q2 backlog clearance funding
- Resulted in a small decline in the diagnostic backlog
- Efforts to reduce backlog will result in a negative impact to the cancer performance until such time that the backlog is cleared

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

This KPI is a tactical in-year measure of performance and heavily influenced via additional capacity. Therefore they offer limited direct relevance to the 2027 outcomes relating to planned care.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Unscheduled care demands
- Funding levels and limitations
- Workforce resource, retention and recruitment
- Workforce planned and unplanned leave
    - Significant access funding reductions have already realised these risks
- Increasing diagnostic backlog driven by continued high referral rates and inability to match capacity with demand
- Radiotherapy and Oncology capacity does not meet demand
- Theatre capacity does not meet demand across a number of areas, combined with access to pre-operative assessment and post-operative beds

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

There is considerable interlinking relationships with a number of other Access and Community KPIs and Deliverables, particularly the 31 Day Cancer Treatment KPI.

Commentary from
Paul Bachoo,
Executive Lead,
Integrated Specialist Care Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Local, Regional and National level co-operation and discussion to share challenges and issues

- Cancer Manager's Forum to share best practice and learning opportunities
- North Cancer Alliance (NCA) have an oversight of regional activity and through an operational delivery group are seeking to formalise escalation for support or mutual aid requests.
- Use of Golden Jubilee Hospital for Colorectal surgery
- Collaboration with Planned Care team to co-ordinate allocation of resource
- Plans to re-purpose Urology Diagnostic Hub in ward 211
- Harnessing innovation to support pathway efficiencies

b) How will we measure the expected impact, and what could prevent success?

Impact is measured through cancer waiting times performance metrics and the number of patients breaching on a quarterly basis. Measurement of improvement can also be monitored through average and longest waits on the pathway from USC referral to treatment. In the latest reporting quarter these have increased which has prevented the success of reaching the KPI.

c) If something hasn't worked, what alternative course of action will be taken?

Collaborative work continues regionally and nationally in efforts to level up cancer waiting time performance. The key priorities of the National Cancer Performance Delivery Board are Diagnostic Backlog, Pathology and Urology diagnostics, these areas are consistent with the known 'pinch-points' on cancer pathways in NHS Grampian.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Learning from breach analysis, pathways improvements and the allocation of backlog clearance additionality will continue to demonstrate the key areas of focus required to achieve the deliverable. The KPI will continue to indicate the impact of mitigations put in place to resolve "pinch points" in meeting performance for cancer diagnosis and time to first treatment.

b) What needs to change? Is further support needed, if so from where and in what form?

- Maximisation of cold elective capacity in the clearance of cancer backlogs with support from Scottish Government in the allocation of NTC activity
- Appropriate level of core funding directed to diagnostics and treatment modalities on the cancer pathways
- Regional and national escalation to support capacity for pathways of high clinical priority

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

• Weekly breach escalation meetings and performance reporting
• Weekly tracking meetings
• Weekly Data validation reports
• Fortnightly portfolio meetings
• Fortnightly board calls with Scottish Government Cancer Delivery Team
• Monthly breach analysis patient summary reports completed by service and clinical teams
• Visual breach analysis showing pathway "pinch points"
• Monthly meetings with diagnostic services
• Monthly Cancer Performance Delivery Board
• Quarterly action plan meetings with service and clinical teams
• Quarterly Cancer Managers Forum

b) when was this KPI last reported?

Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Colleagues are enabled to thrive, and be safe and well through work
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): 95% of citizens will receive first cancer treatment within 31 days of decision to treat

Q2 actual: 88.4%
Q2 Target: 95%

Outcome: We will have improved the time to access in unscheduled and planned care pathways, using performance measures that also take into account demographics, people's experiences and outcomes, the increasing demand/need and long term gains

Our story so far….

a) What is the background to the current position, and how are we performing against target?

Urgent Suspected Cancer (USC) referrals continue to be 50-60% higher than pre-pandemic levels. There are shortfalls in capacity across multiple areas with insufficient resource available to meet the increase in demand. Backlogs in the high-volume Urology & Colorectal pathways continue to be seen in Grampian as mirrored by the overall national picture. Efforts continue to reduce the number of patients within cancer diagnosis and treatment backlogs. There are anticipated improvements to performance for some pathways but maintained or reduced performance in others. Whilst efforts continue to reduce the high number of backlog patients, this will result in a negative impact to the cancer performance until such time that the backlog is cleared.

b) ***What changes or trends have occurred this quarter, and how might they affect future performance?***

Decrease in the number of patients treated against the 31-day standard in the last reporting quarter (Jul – Sept 2024). This can be attributed to some loss of activity over the summer holiday period. There were further challenges with theatre capacity due to ongoing issues with the Central Decontamination Unit (CDU).

c) ***How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?***

This KPI is a tactical in-year measure of performance and heavily influenced via additional capacity. Therefore they offer limited direct relevance to the 2027 outcomes relating to planned care.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

Oncology Mutual Aid being provided to neighbouring health boards

- Radiotherapy and Oncology capacity does not meet demand
- Unscheduled care demands
- Funding levels and limitations
- Workforce resource, retention and recruitment
- Workforce planned and unplanned leave
- Increasing diagnostic backlog driven by continued high referral rates and inability to match capacity with demand
- Theatre capacity does not meet demand across a number of areas, combined with access to pre-operative assessment and post-operative be

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

There is considerable interlinking relationships with a number of other Access and Community KPIs and Deliverables, particularly the 62 Day Cancer Treatment KPI.

Commentary from

Paul Bachoo,
Executive Lead,
Integrated Specialist Care Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Local, Regional and National level co-operation and discussion to share challenges and issues

- Cancer Manager's Forum to share best practice and learning opportunities
- North Cancer Alliance (NCA) have an oversight of regional activity and through an operational delivery group are seeking to formalise escalation for support or mutual aid requests.
- Use of Golden Jubilee Hospital for Colorectal surgery
- Plans to increase theatre capacity through short stay theatres

b) How will we measure the expected impact, and what could prevent success?

Impact is measured through cancer waiting times performance metrics and the number of patients breaching on a quarterly basis. Measurement of improvement can also be monitored through average and longest waits on the pathway from decision to treat to treatment. In the latest reporting quarter these have increased which has prevented the success of reaching the KPI.

c) If something hasn't worked, what alternative course of action will be taken?

Collaborative work continues regionally and nationally in efforts to level up cancer waiting time performance. The key priorities of the National Cancer Performance Delivery Board are Diagnostic Backlog, Pathology and Urology diagnostics, these areas are consistent with the known 'pinch-points' on cancer pathways in NHS Grampian.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Learning from breach analysis, pathways improvements and the allocation of backlog clearance additionality will continue to demonstrate the key areas of focus required to achieve the deliverable. The KPI will continue to indicate the impact of mitigations put in place to resolve "pinch points" in meeting performance for cancer diagnosis and time to first treatment.

b) What needs to change? Is further support needed, if so from where and in what form?

- Maximisation of cold elective capacity in the clearance of cancer backlogs with support from Scottish Government in the allocation of NTC activity
- Appropriate level of core funding directed to diagnostics and treatment modalities on the cancer pathways
- Regional and national escalation to support capacity for pathways of high clinical priority

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

- *Weekly breach escalation meetings and performance reporting*
- *Weekly tracking meetings*
- *Weekly Data validation reports*
- *Fortnightly portfolio meetings*
- *Fortnightly board calls with Scottish Government Cancer Delivery Team*
- *Monthly breach analysis patient summary reports completed by service and clinical teams*
- *Visual breach analysis showing pathway "pinch points"*
- *Monthly meetings with diagnostic services*
- *Monthly Cancer Performance Delivery Board*
- *Quarterly action plan meetings with service and clinical teams*
- *Quarterly Cancer Managers Forum*

b) When was this KPI last reported?

Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Patients are able to access the right care at the right time
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): Reduce NHSG 90th percentile SAS turnaround times to 110 minutes by quarter 4 2024/25

Q2 actual: 210
Q2 Target: 145

Outcome: We will have continued to improve access to unscheduled and planned care pathways. We will have moved towards admission avoidance, improve primary care based respond to illness and ensure citizens of Grampian are empowered to participate in their own healthcare promoting preventative measures, self-care strategies and overall wellbeing.

Commentary from
Geraldine Fraser
Executive Lead
Medicine & Unscheduled Care (MUSC) Portfolio

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- NHS Grampian remains challenged in relation to the 90th percentile ambulance turnaround time.
- The positon has attracted continued attention from NHS Scotland and senior Scottish Ambulance Service (SAS) personnel, resulting in a Test if Change with Acute Medical Initial Assessment (AMIA) beginning on 29 October.
- Ambulance turnaround time is directly linked to 4 hour access performance KPI. Addressing ambulance waits through additional measures is only required if the through flow from front door areas is constrained, or there are very specific peaks in demand.
- A continuation of the winter 2024 challenges around occupancy and level of demand have caused an increase in variability on performance against the 90th percentile metric.
- Extended waits occur when bed capacity in the hospital is exhausted. Movement of the ambulance 'stack' is then dependent on patients being discharged. Within this scenario, the volume of daily discharges and the time in the day when they occur become crucial.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- The trend continues to move in the wrong direction and this is likely to worsen further over the winter as occupancy pressure increases.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

- The current level of performance severely compromises our ability to improve access to unscheduled care pathways, impacting both on patient safety and, too often, patient outcomes.

Our key risks, challenges and impacts…

a) What are the key risk and challenges affecting performance?

- AMIA Flow - admission rates vary between Emergency Department (ED) (c28%) and AMIA (c75%). As such, when ambulances begin to stack outside of AMIA, they tend to wait for longer.
- Footprint – Assessment spaces are low in number.
- Staffing capacity - medical staffing require to provide cover across ED overspill, RESUS, majors/minors, paediatrics as well as triage. This has improved over the quarter.
- Patient experience - patients arriving at ARI by ambulance experiencing delay in hand over from SAS to NHSG may have a poorer experience, resulting in an increasing number of complaints.
- Patient safety - delays to transferring patients to ARI may negatively impact patient care
- Reputation - An inability to reduce 90th percentile ambulance waits negatively effects both confidence in the Health Board on the part of NHS Scotland and Scottish Ambulance Service.

We are working towards our flow improvement Deliverable through ongoing scope of works. Performance represents current challenges of demand outweighing capacity, with process improvements having only marginal impact; 2027 Outcome aims to have reduced demand through admission avoidance, improved primary and community care responses and citizens empowered to participate in their own healthcare promotion, preventative measures and overall wellbeing. Average number of delayed discharges and proportion of delayed discharges both impact on this KPI by reducing admitting capacity to beds from ED.

b) Are there any unintended consequences or impacts on other KPIs or areas?

- Stacking impacts on 4 hour access performance, and potential deterioration while waiting for assessment can increase length of stay.

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

- NHS Grampian's Unscheduled Care Improvement Plan aims to address some of the key challenges highlighted. It coheres operational improvement actions to reduce admissions, improve hospital flow, and reduce occupancy with Unscheduled Care Programme Board (USCPB) initiatives and wider system programmes such as the G-OPES (Grampian Operational Pressure Escalation System), and Bed Base, Reviews.
- Many of the operational improvement actions are focused towards preservation of daytime assessment capacity in ED and AMIA. Immediate mitigations were extended to include a step-down area next to AMIA between 1700-0700 daily to provide greater assessment capacity at the time of peak stacking.
- **Managing Front Door Risk**. Improvement work within ED to further improve 'time to first assessment' to reduce SAS risk by reducing ambulance waits, and reducing the number of admissions into ARI.
- **Reduction in ED/AMIA occupancy at 0800hrs**. Utilisation of capacity out with the MUSC portfolio footprint overnight to create admitting capacity from ED and, particularly, AMIA.
- **Avoiding conveyance**. Continued focus on Flow Navigation Centre (FNC) staffing robustness, service expansion (mental health and paediatrics), and connections with other upstream services (NHS24, Primary Care, G-Med).
- **Increasing discharge volume**. The preferred alternative to boarding patients elsewhere is to achieve a discharge profile which equals the rate of admissions. Addressing the volume of delayed discharges enables bed turnover rate to be increased, and specific focus on reducing length of stay for those not in delay will further support that effort.

b) How will we measure the expected impact, and what could prevent success?

- Ambulance wait performance is reviewed fortnightly by the SAS/NHSG Tactical Group and the respective Chief Executives. The largest risk to success of the post-assessment stepdown initiative are the fact that it is dual use and therefore must be emptied each morning, which limits criteria for use to be only patients which have a receiving bed identified. The second issue is the general lack of hospital-wide capacity which is likely to preclude identification of receiving beds for potential W401 patients.

c) If something hasn't worked, what alternative course of action will be taken?

- The Test of Change is designed to be adaptable to respond to emerging learning over the period it runs and it will be evaluated based on agreed success criteria in February 2025. One of the limiting factors is the availability of the 8 beds only during out of hours: a 24/7 area would be much more impactful.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

- Reflections on last quarter's performance reinforces the impact of occupancy levels on our ability to manage ambulance waits. This has brought focus onto the volume and timing of patient movements from our admitting wards.

b) What needs to change? Is further support needed, if so from where and in what form?

- Working jointly with SAS to mitigate risks and enable an improved shared care model at our front doors is essential. A Joint Tactical Group has been created to provide routine management oversight to the full range of relevant issues (including the AMIA Test of Change), as well as to enable enhanced information sharing on improvement activities and risk.
- A whole system Unscheduled Care Improvement Plan has been submitted to Scottish Government in November 2024, with the aim of removing ambulance queuing. Investment into downstream capacity would be required to enable significant change and improvement to happen.

Oversight and assurance

b) What is the assurance and governance oversight arrangements?

- Weekly performance information is received on ambulance turnaround times and is reported and discussed via joint SAS and NHSG meetings.

b) When was this KPI last reported?

- Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Patients are able to access the right care at the right time
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): 70% of citizens will be seen within 4 hours in NHSG Emergency Departments

Q2 actual: 61%
Q2 Target: 70%

Outcome: We will have continued to improve access to unscheduled and planned care pathways. We will have moved towards admission avoidance, improve primary care based respond to illness and ensure citizens of Grampian are empowered to participate in their own healthcare promoting preventative measures, self-care strategies and overall wellbeing.

Commentary from
Geraldine Fraser
Executive Lead
Medicine & Unscheduled Care (MUSC) Portfolio

Our story so far….

a) What is the background to the current position, and how are we performing against target?

NHS Grampian's performance in meeting the 4-hour access target remains poor compared with the many other Health Boards, and has attracted continued attention from NHS Scotland.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Extension of winter challenges over much of the summer have reduced the capacity of operational teams to maximise improvement opportunities. Given the influence of bed volume on performance and our challenges in generating additional capacity, little meaningful performance improvement was seen over the last quarter, and performance over the next quarter is likely to decrease in the face of increased demand and an inability to address the fundamental imbalances in system capacity compared with the patient need.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

The performance in this KPI hinders progress in improving access to unscheduled care pathways, including Delayed Discharges and Length of Stay.

Our key risks, challenges and impacts…
a) What are the key risks and challenges affecting performance?

- General Medicine (GenMed) and Frailty services' capacity and throughput remain challenged and often account for 40-50% of bed waits. The volume of delays within both pathways is a key factor in their efforts to maintain admitting capacity, and any decrease in downstream bed availability will have an immediate and significant impact on 4 hour access performance.
- The fragility of the medical workforce in ED and GenMed has constrained performance less often over the last quarter. Notwithstanding the fiscal implications, our ability to recruit and retain such cohorts in sufficient number as not been proved in the last 24 months.
- 4 hour access performance is a whole system measure; it takes system-wide action to have a sustained effect on 'exit block'. Notwithstanding the inherent complexity of system working, financial constraints are likely to curtail short-term capacity adjustments to increase bed turnover rate in acute settings.
- Key impacts are in patient experience, patient safety, reputation, and staff wellbeing.
- We are working towards our flow improvement Deliverable through the ongoing scope of works. Performance represents the current challenges of demand outweighing capacity, with process improvements having only marginal impact; the 2027 Outcome aims to have reduced demand through admission avoidance, improved primary and community care responses and citizens empowered to participate in their own healthcare promotion, preventative measures and overall wellbeing.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- Delayed access to assessment may lead to increased Length of Stay due to deterioration in condition.
- Average number of delayed discharges and proportion of delayed discharges both impact on this KPI by reducing admitting capacity to beds from ED.

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

Unscheduled Care Programme initiatives in NHS Grampian 2024:

1. Urgent Care Hub (Admission Avoidance) – Further develop professional-to-professional decision support line for Care Homes; expand the Flow Navigation Centre (FNC) to include mental health and paediatrics; enhance the coordination between Primary Care, NHS24, G-Med, FNC, and ED/AMIA (Acute Medical Initial Assessment)
2. Discharge Without Delay - **ARI**: remodel Discharge Lounge. Invest in discharge champions to advance discharge planning and enhance connections with downstream agencies. City/Shire: support establishment of Virtual Community Wards (Shire) and a Discharge to Assess capability (City).
3. Length of Stay – Seeking to reduce long stays in admitting areas, which increase overall length of stay in hospital, and addressing extended lengths of stay (7 days+) of patients not in delay to enhance bed turnover rate.
4. GenMed Pathway Redesign - review and seek to improve the manner in which GenMed patients are allocated to in-patient areas. This aims to reduce bed waits in ED (exit block) through creation of a larger admitting footprint for this service.

The Unscheduled Care Programme Board (USCPB) activities for this year are wrapped into a wider Unscheduled Care Improvement Plan, as agreed by Chief Executive Team (CET) in June 2024. The plan coheres operational improvement actions to reduce admissions, improve hospital flow, and reduce occupancy with USCPB initiatives and wider system programmes such as the G-OPES (Grampian Operational Pressure Escalation System) Review and the Bed Base Review.

b) How will we measure the expected impact, and what could prevent success?

- 4 Hr Access performance is reviewed by MUSC SLT weekly and length of stay data/delayed discharges are reviewed by the MUSC Portfolio Board monthly. USCPB will monitor change initiative progress.

c) If something hasn't worked, what alternative course of action will be taken?

- If Delayed Discharge/transfers of care do not reduce, or if demand surges, we will advise that the system capacity contingency plan be activated.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Reflections on last quarter's performance centre on potential for only short-lived gains to be achieved through enhancements to efficiency of internal process in the ED/AMIA and in-patient areas within ARI. Close monitoring of occupancy and performance trends show a close correlation, though encouraging to note pace of recovery has increased over previous periods when occupancy pressure is reduced. With increased resilience in ED staffing over the coming quarter, we anticipate this being amplified when conditions in the wider hospital allow.

b) What needs to change? Is further support needed, if so from where and in what form?

We are working towards our flow improvement Deliverable through the ongoing scope of works. Performance represents the current challenges of demand outweighing capacity, with process improvements having only marginal impact; the 2027 Outcome aims to have reduced demand through admission avoidance, improved primary and community care responses and citizens empowered to participate in their own healthcare promotion, preventative measures and overall wellbeing. Average number of delayed discharges and proportion of delayed discharges both impact on this KPI by reducing admitting capacity to beds from ED.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Executive Lead for the Medicine & Unscheduled Care (MUSC) Portfolio is accountable for ED and AMIA performance, sustainability, and development, and is also Executive Sponsor of the NHS Grampian Unscheduled Care Programme Board. This board reports routinely to the CET and NHS Grampian Board.

MUSC Portfolio Senior Leadership Team takes primary responsibility for performance monitoring, holding to account, and assurance to the wider organisation.

Management of the Unscheduled Care Improvement Plan is undertaken via the MUSC Portfolio Board for operational improvement measures, and the USCPB for wider improvement measures. Whole system actions are monitored and reported to CET via the USCPB.

Outwith routine reporting to the NHSG Board described above, significant scrutiny of our 4 hour access performance is undertaken by the following:

NHS Grampian Chief Executive – briefed weekly on ED performance and 4 hour access improvement trajectory.

NHS Scotland Unscheduled Care Team – updated routinely on the Unscheduled Care Improvement Plan.

b) When was this KPI last reported?

Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights

Tier 3 - Our Performance Spotlights: Access & Empowering

Strategic Intent: Patients are able to access the right care at the right time
Grampian's population is enabled to live healthier for longer
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): Average length of stay for elective and non-elective patients (NHSG MUSC only) to be no higher than Q4 2023/24

Q2 actual: 6.3 days
Q2 Target: <6.54 days

Outcome: We will have continued to improve access to unscheduled and planned care pathways. We will have moved towards admission avoidance, improve primary care based respond to illness and ensure citizens of Grampian are empowered to participate in their own healthcare promoting preventative measures, self-care strategies and overall wellbeing.

Our story so far….

a) What is the background to the current position, and how are we performing against target?

- Grampian's small bed-to-population ratio demands that Length of Stay (LoS) is optimised to increase bed turnover rate and maintain admitting capacity.
- Length of Stay is an overall measure including time needed for a patient to achieve sufficient recovery to as to be clinically fit for discharge as well as, often, delays in achieving discharge once sufficiently well. In more vulnerable patients, extended stays in hospital are often the cause of a subsequent in health if discharge is not achieved soon after clinical fitness is achieved.
- Post-surgical recovery is easier to predict than that of medical patients and this is reflected in the respective LoS. The latter group within the MUSC portfolio, occupy beds which account for c69% of the flow from ED and Acute Medical Initial Assessment (AMIA).

b) What changes or trends have occurred this quarter, and how might they affect future performance?

- The overall picture remains largely stable, with reductions in elective LoS offsetting the general increase in non-elective LoS. However, focus should remain on medical non-elective LoS as this relates to the majority of beds from which admissions from ED and AMIA (Acute Medical Initial Assessment) occur, and therefore are crucial to Acute sustainability. They are also the cohort which is trending in the wrong direction.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

- The performance of this KPI is currently making the 2027 outcome more achievable overall by increasing NHSG bed turnover rate, though the areas under greatest operational pressure are not recording in line with the wider organisational picture. This means that a greater proportion of those patients will be in the wrong place as bed capacity in the wider site is utilised.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- GenMed and Frailty. These specialties are the largest volume pathways who are routinely under the greatest pressure. Ideally, these two pathways would have the lowest LoS to maximise bed turnover, though the complexity and vulnerability of the patients in these areas is particularly high (c77% of GenMed inpatients are over 70 years of age). They certainly should be the most efficient pathways in terms of achieving timely discharges.
- Balance of Risk. Reducing LoS incurs a risk calculation around both fitness for discharge at the individual level, and around the volume of care being provided in specific settings at the organisational level. While c57% of patients leave ARI to go directly home with no further input from NHS Grampian or its associated HSCPs, the system must balance the risk for those who remain within it.

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

- Patient safety. There are two main patient safety risks associated with the current position: first, the impact on patients of an unnecessarily long stay in hospital and, second, the risk borne by those who cannot access Acute care as a result of lack of admitting capacity.

Commentary from
Geraldine Fraser

Executive Lead
Medicine & Unscheduled Care (MUSC) Portfolio

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

The NHS Grampian Unscheduled Care Improvement Plan efforts to improve discharge planning within Acute teams continues, as does the system-wide focus on Discharge Without Delay. Centre for Sustainable Development (CfSD) focus and support around capacity planning will also be increased in the coming quarter.

Priorities for Q3 2024:

Reducing 7 & 14 day LoS. The MUSC portfolio has embarked on a programme of work to better scrutinise and prioritise patients with the longest stays to ensure that clinical fitness is the factor which keeps those patients in hospital. This work is linking with the weekly Delayed Discharge focus work with HSCPs.

Discharge Planning. Ward-level planning and improvement work focused at timely identification of patients for discharge, improving discharge workflows and interactions with support services, and balancing resource availability with times of peak demand. Better utilising the Planned Discharge Date (PDD) is central to this work.

Discharge Champions. An opportunistic move to embedding the Discharge Lounge Team within core wards 104/8/10/110 has seen a positive improvement in discharge volume and indeed time distribution. Discussions are underway as to how this can be scaled up to support greater demand of this team to support in ward discharging processes.

Multi-Disciplinary Team Working. Linked with better exploitation of the PDD, is the need to maximise concurrent planning for discharge for both Acute and HSCP teams. Correct representation at Multi-Disciplinary Team meetings, and agreed priorities and criteria for discharge are key components of the programme.

GenMed redesign. The MUSC Leadership Team will embark on a programme of work to enhance the provision for GenMed patients within this FY.

b) How will we measure the expected impact, and what could prevent success?

LoS performance and long stays are reviewed monthly by the MUSC Portfolio Board. PDD accuracy (output of multi-agency discharge planning) is used to measure impact of other measures above. There are some cultural issues to overcome with ward teams; funding availability for GenMed redesign.

c) If something hasn't worked, what alternative course of action will be taken?

We are looking for CfSD support on some of our more challenging initiatives.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

Reflection on the first measured quarter's performance bears out a need for an approach which avoids generalisations, as the unique nature and challenges of each service, as well as the pathways that support them, present different challenges. Most importantly, in the first instance, is the need to embed an understanding of the impact of LoS on performance and the management of risk within the front line teams in the portfolio and across the wider organisation.

b) What needs to change? Is further support needed, if so from where and in what form?

We are working towards our flow improvement Deliverable through the ongoing scope of works. Performance represents the current challenges of demand outweighing capacity, with process improvements having only marginal impact; the 2027 Outcome aims to have reduced demand through admission avoidance, improved primary and community care responses and citizens empowered to participate in their own healthcare promotion, preventative measures and overall wellbeing.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Weekly performance data is submitted to Scottish Government and the Centre for Sustainable Delivery; this is also reported to the MUSC Portfolio Board regularly.

b) when was this KPI last reported?

Weekly performance data is submitted to Scottish Government

Tier 3 - Our Performance Spotlights: Whole Systems Working

Strategic Intent: Joined up and connected, with and around people
Objective: Improve Preventative & Timely Access to Care

Key Performance Indicator (KPI): Completion of 6 workstreams within the Grampian Frailty Programme Plan by 31st March 2025 in order to achieve collaboration across all 3 HSCPs and NHSG

Q2 actual: 50%
Q2 Target: 50%

Outcome: We will have continued to improve access to unscheduled and planned care pathways, using performance measures that also take account of demographics, people's experiences and outcomes, the increasing demand/need & long term gains

Our story so far….

a) What is the background to the current position, and how are we performing against target?

The Grampian Frailty Programme was implemented to ensure there is a Grampian wide whole-system focus to Frailty. Progress against the 6 workstreams remains mainly on target in Quarter 2 with key collaboration across the 3 partnerships taking place regularly at the 6 weekly frailty board meetings.

b) What changes or trends have occurred this quarter, and how might they affect future performance?

Frailty pathway development across the 3 partnerships continues, priorities remain around the development of a whole system approach to transforming services to meet the demands of our patients. The first community appointments day took place in Moray, Aberdeenshire local frailty group has been reinvigorated, continued development of Shire Virtual wards, City is developing a Discharge to Assess Pathway and work is ongoing with sport Aberdeen to help with frailty prevention. Additionally development work across the 3 partnership areas for a frailty icon to identify frail patients in the system is taking place.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes? Is it at the expense of other aspects of the service?

This deliverable remains on track to ensure collaboration and shared learning around frailty across the 3 partnerships and this firmly aligns with the achievement of the 2027 outcomes. The lack of funding for a frailty Managed Clinical Network (MCN) is a concern but mitigations are in place to deal with this situation.

Note – HSCP activity is also overseen by the IJBs and is implemented and monitored by their Strategic Delivery Plans.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance?

- Increased demand – The demand for frailty due to the aging population continues to grow
- Funding – In the current financial climate we are having to do more with less
- Workforce – Pressures on the staff continue to grow and the implementation of the reduced working hours are challenging to ensure safe staffing levels
- Rosewell Review – The review and decision on the future of this key service within the frailty pathway will have an impact on the frailty programme

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)? For example, does the Reduce Time to Hire KPI in People affect your reported KPI?

None identified

Commentary from

Fiona Mitchelhill,
Chief Officer,
Aberdeen City HSCP

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

The lack of funding to support the development of a frailty MCN is disappointing however the frailty board are developing a network within its remit to ensure frailty learning is widely communicated and shared.

Regular meetings of the frailty board ensure actions and mitigations are identified to improve performance and reduce hard. The development of the frailty dashboard on illuminate allows performance across the frailty pathway to be easily monitored.

Moray's engagement with the Healthcare Improvement Scotland (HIS) frailty work is enabling them to consider what it would take to become a Centre of Excellence for Frailty, this learning can be shared across the system.

b) How will we measure the expected impact, and what could prevent success?

The new frailty standards are expected in November 2024 and they will be mapped against the current position of the frailty programme in NHS Grampian. The outcome of this exercise will provide greater clarity around the progress made in NHS Grampian in meeting the requirements in delivering a high standard of care for those patients on the frailty pathway. The risks identified are the key potential impacts on the success of delivering the frailty programme in NHS Grampian.

c) If something hasn't worked, what alternative course of action will be taken?

The frailty board meets on a 6 weekly basis to discuss progress and identify solutions to areas of insufficient progress / concern.

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?

The frailty board meets 6 weekly to review the progress made on the frailty programme plan. As stated earlier learning is shared and actions and mitigations are identified where progress is not taking place.

The development of Discharge to Assess is a priority and how this can function within the system given the limited finance and resource. Linking this in with the already established ECS (Enhanced Community Support) and communicating its role wider will support this development of discharge to assess.

b) What needs to change? Is further support needed, if so from where and in what form?

The structure of the board needs to be developed. The aim is to develop the board with key workstreams and ownership, this will help mitigate the lack of implementation of a frailty MCN.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

Frailty Board reports to Unscheduled Care Programme Board on progress

b) when was this KPI last reported?

Reported 12th November

Appendix: National Waiting Times Standards

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Jun 2023**	**Quarter end Sep 2023**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Benchmarking** (of 11 mainland Boards quarter end Jun 2024: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
95% of unplanned A&E attendances to wait no longer than 4 hours from arrival to admission, discharge or transfer *(% admitted, discharged or transferred within 4 hours of arrival at an Emergency Department or Minor Injury Unit)*	95%	70.2%	70.7%	66.5%	**66.7%**	**67.9%**	6th Scotland: 69.1%	Overall A&E performance increased over the three quarters to June 2024, to a level slightly lower than at the same time last year. We remain below the overall Scotland level. *This performance recovery is surprising, given the increased proportion of Delayed Discharge (DD)/Delayed Transfer of Care (DTOC) in Acute wards. Close scrutiny remains from SG in terms of our ability to reduce ambulance stacking. Bed waits in ED/AMIA continue to outnumber ambulance waits on a daily basis. The key constraint remains admitting capacity over ED/AMIA performance at this time.*
All patients requiring one of the 8 key diagnostic tests will wait no longer than 6 weeks *(% of waits of 6 weeks or less at quarter end)*	100%	38.7%	37.5%	33.8%	**39.4%**	**42.2%**	9th Scotland: 50.0%	Performance had decreased each quarter through 2023/24, but improved for the quarter to June 2024. We have remained below the overall Scotland level for the last year. *Our elective care plan does not target this metric directly. However the Radiology service is showing sustained improvement and this is likely to persist to the end of the financial year given the financial funding associated with it. Endoscopy is showing a small level of improvement but is likely to reverse as significant capacity will cease to be provided at the end of Dec 2024 as the funding will cease*
95% of New Outpatients should be seen within 12 weeks of referral *(% of waits where patient was seen at a new appointment within 12 weeks of referral)*	95%	70.3%	66.6%	64.2%	**61.8%**	**65.9%**	7th Scotland: 65.5%	Performance improved for the quarter to June 2024, following three quarterly decreases. A similar trend has been observed at Scotland level over the last year; we have remained above the overall Scotland level for the last two years. *Our elective care plan does not directly address this metric. Our longest waits to continue to grow above trajectory though the lower waiting trajectories are over performing demonstrating a split between specialities.*

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Jun 2023**	**Quarter end Sep 2023**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Benchmarking** (of 11 mainland Boards quarter end Jun 2024: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
All TTG patients should be seen within 12 weeks of decision to treat *(% of waits where patient was admitted for treatment within 12 weeks of decision to treat)*	100%	45.7%	45.9%	47.3%	**43.9%**	**46.2%**	11th Scotland: 58.4%	Following a decrease for the first quarter of 2024, performance increased for the quarter to June 2024. We remain consistently below the overall Scotland level. *Our elective care plan does not directly address this metric. Our longest waits have broadly stabilised although above trajectory. The situation is not likely to improve until short stay surgical capacity is brought online which currently best case will be Q4. The reduction in surgery and actual and potential changes of case mix in DGH is not yet stable enough to predict the overall impact this will have*
95% of patients should wait no more than 31 days from decision to treat to first cancer treatment *(% of waits where patient was treated within 31 days of decision to treat)*	95%	93.78%	89.6%	90.5%	**89.5%**	**89.2%**	11th Scotland: 95.5%	Performance decreased through the first two quarters of 2024. We have been below the overall Scotland level for the last year. *We are not where we had have hoped to be, Capacity issues as well as infrastructure issues has slowed progress.*
95% of patients receive first treatment within 62 days of urgent suspicion of cancer referral *(% of waits where patient was treated within 62 days of urgent suspected cancer referral)*	95%	70.63%	57.0%	54.4%	**55.0%**	**60.6%**	10th Scotland 73.2%	Following a decrease through the second half of 2023, performance improved through the two quarters to June 2024. We remain consistently below the overall Scotland level. *This is not where we would want to be but Q2 end June 2024 did meet the projected target for the period. Capacity issues, particularly in diagnostics, as well as infrastructure issues has slowed progress.*
90% of children and young people should start treatment within 18 weeks of referral to CAMHS *(% of waits where patient started treatment within 18 weeks of referral)*	90%	96.1%	84.7%	96.7%	**97.4%**	**96.5%**	4th Scotland: 84.2%	After improving for the last two quarters in 2023/24, performance decreased for the quarter to June 2024. We remain above the overall Scotland level, and have returned to achieving the national target for the last three quarters. *The service continues to work extremely hard to maintain a high level of performance, aiming to maintain this in the forthcoming quarter, in the context of significant challenges including growing demand, reduced capacity and reduction in funding allocations.*

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Jun 2023**	**Quarter end Sep 2023**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Benchmarking** (of 11 mainland Boards quarter end Jun 2024: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
90% of people should start their treatment within 18 weeks of referral to psychological therapies *(% of waits where patient started treatment within 18 weeks of referral)*	90%	63.8%	74.3%	76.4%	**75.4%**	**81.7%**	5th Scotland: 80.3%	Following a decrease for the first quarter of 2024, performance improved for the quarter to June 2024. We are above the Scotland level for the first time in over two years. *The service continues to work extremely hard to maintain a high level of performance, aiming to maintain this in the forthcoming quarter, in the context of significant challenges including growing demand, reduced capacity and reduction in funding allocations.*
90% of patients will commence IVF treatment within 52 weeks *(% of waits for patients screened at an IVF centre within 52 weeks of a referral from secondary care to one of the four specialist tertiary care centres)*	90%	100%	100%	100%	**100%**	**100%**	Scotland: 100.0%	We continue to consistently achieve the target *Our service prioritises patient safety and patient care above anything else. The fact that we are surpassing the NHS Scotland guidelines for waiting times from referral to treatment speaks in magnitude the hard working and committed team ethos we have here at Aberdeen Centre for reproductive medicine.*

From national waiting times publications