Board Meeting
10.04.25
Open Session
Item 9

How are we doing?

Board Annual Delivery Plan Performance Report Quarter 3 2024/2025

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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.

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

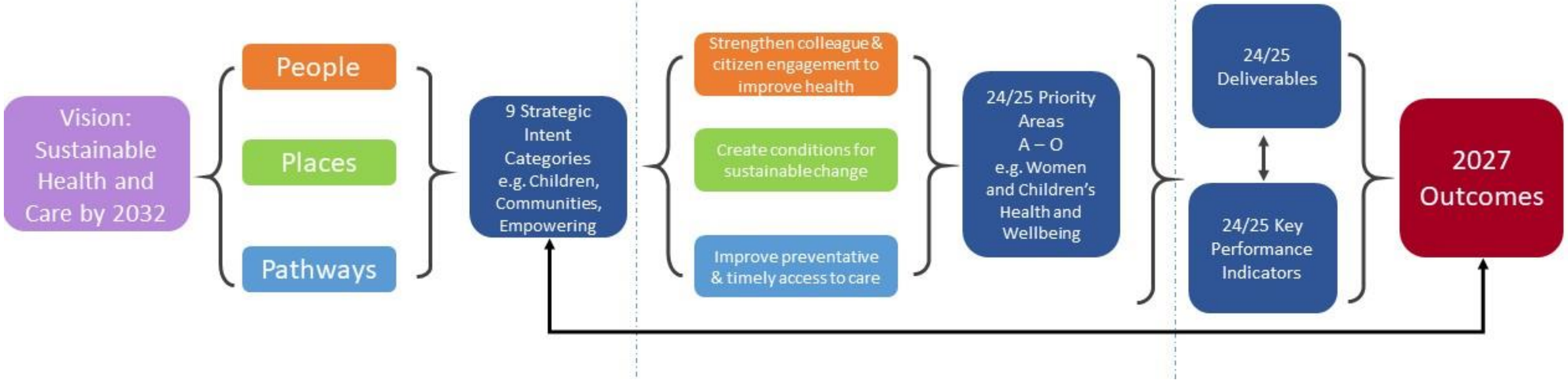
Strategic Intent

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



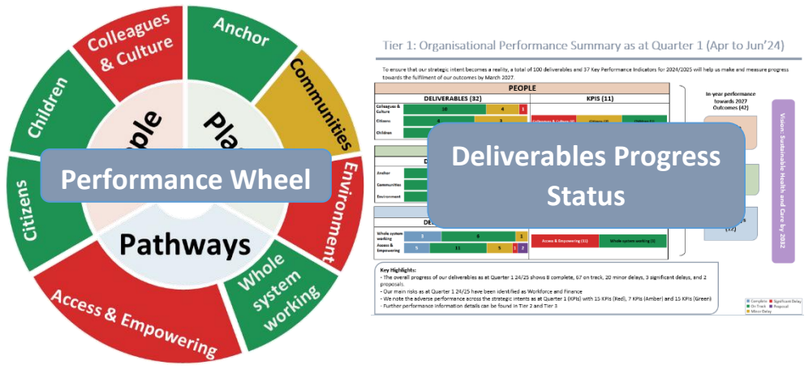
Reading Guide

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)

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

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



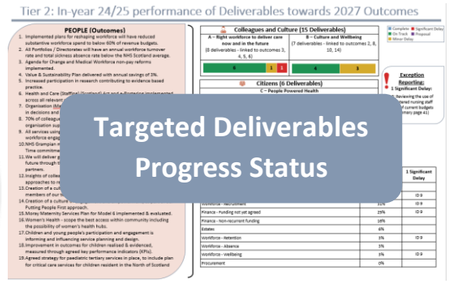
This section covers two key areas of focus:

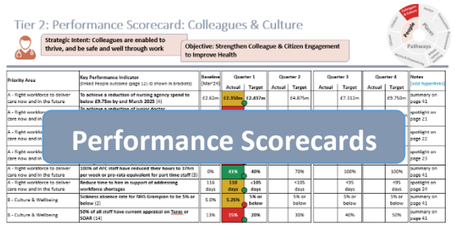
1) Our Board Performance Summary across our strategic intent:

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.





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.

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 Minor Delay Significant Delay Postponed

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 3 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, 37% of Key Performance Indicators (KPIs) showed improvement, while 55% experienced a decline compared to the previous quarter; 61% rated Red, an increase of 11%. Additionally, 53 of 100 Deliverables achieved their milestones. The Performance Wheel reflects these pressures, with one strategic intent category rated Green and 2 categories now rated Red compared to the last quarter. 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. Continuing to strengthen and improve the value of our reporting, this quarter sees the addition of a more forward looking approach. Comprising both a current picture of completed quarterly Milestones and a prognosis for the final status of our annual Deliverables for the end of the 2024/25 Annual Delivery Plan. This provides early visibility of areas that may benefit from further attention or intervention to enhance progress before year end. 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.

Continuing our “Key Organisational Enablers” section, this quarter focuses on the “Putting People First” approach, which aims to place Grampian citizens at the heart of how we collaboratively provide and develop our healthcare services as a key part of our community.

Listening to our workforce and citizens remains central to our approach. This quarter, the "Voice of Our Citizens" returns to Care Opinion with a focus on the Minor Injury Unit in ARI, while the "Voice of Our Colleagues" looks at the Review of the Portfolios Approach in response to colleague concerns, and the Staff Welfare experience survey. These tools ensure that feedback drives accountability, compassion, and meaningful change.

Adam Coldwells, Interim Chief Executive NHS Grampian

Q1 Performance Wheel
April 2024 – June 2024

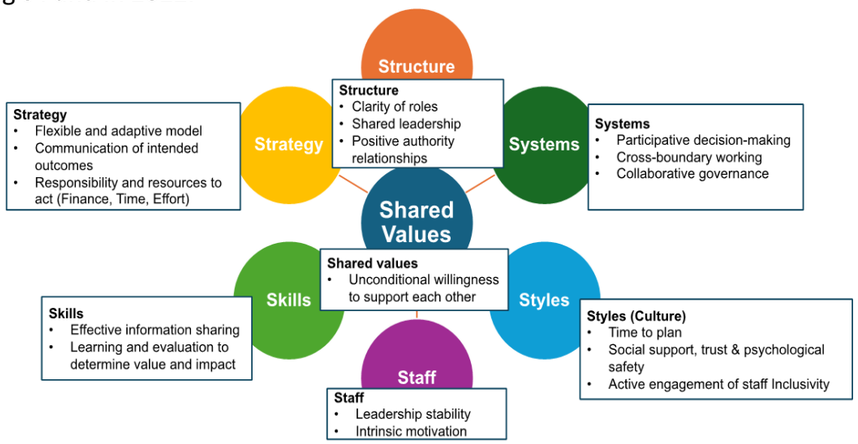
Q2 Performance Wheel
July 2024 – Sept 2024

Voice of our Colleagues

We have continued to seek to understand and have responded to colleagues experience in the following ways:

Review of the Portfolios Approach

- A review of the approach to cross system working, adopted during 2021, was undertaken in response to colleague concerns that it had not been effective.
- This included extensive consultation with over 200 members of the Wider System Leadership Team, Area Clinical Forum and Grampian Are Partnership Forum (GAPF).
- An analysis was undertaken using the McKinsey 7s Framework and our research on the leadership levers for cross system working done with the King's Fund in 2022.



- Changes are now being progressed in respect of three primary recommendations:
  - To agree in Partnership the most appropriate title/identity for and clearly describe the main elements of our organisation
  - To reinforce our commitment to cross system working, and to support colleagues in adopting the values and behaviours that support it
  - Introduce a single non clinical leadership role alongside Medical, Nursing and AHP equivalents for Acute and Tertiary services, incl. Dr Gray's.
- Work to progress the organisational change required to establish the new leadership role is underway. The Strategic Change Board will shortly receive proposals for the integration of Acute services in Dr Gray's with ARI.

Staff Welfare experience survey

- Following concerns raised at GAPF re- deteriorating staff experience, a short-life working group was commissioned in December to consider possible actions.
- The group has agreed to explore 3 key factors affecting workforce wellbeing across 2 hospitals (ARI & Dr Gray's) initially.
  - Access to suitable changing facilities
  - Access to personal belonging secure storage
  - Access to space to take breaks/lunch
- Focussing on these two sites is intended to speed up the process of understanding the baseline situation and enable solutions to be identified and delivered.
- The data will be gathered per team and operational unit in order to ensure a connection to operational management arrangements to support leadership from local management teams.
- This work is being undertaken by support teams to enable the use of existing data on team structures and previous audits of facilities such as those described above.

Our key risks, challenges and opportunities:

- Continued levels of operational and financial pressures continues to adversely impact staff experience at all levels of our system.
- The nature of change required and these pressured will impact on bandwidth for the changes recommended in the Portfolios Review.
- The staff welfare survey is an opportunity to quantify the current position re: concerns raised via Partnership Fora, and address staff experience impacts that are more readily actionable in a short timescale.
- Meaningful action is required at all levels to ensure staff experience and engagement is given appropriate focus, with continued focus on team level iMatter action planning a key area for improvement.

Our actions to date…

- Drafting of the survey to be used in understanding the three welfare factors identified is underway and expected to be agreed mid-February 2025.
- Planning for the 2025 national iMatter staff experience survey. Developed communications plan to highlight 2025 survey and opportunities through action planning with teams.
- Connecting and learning from other Health Boards demonstrating improvements in engagement, response and action planning trends.
- Chief Executive Team members planned at least one site/location/team visit per month to support senior team visibility.

What Next…?

- Implement the 2025 iMatter survey; with a focus on capturing ONE action in the action plan, recognising the ongoing workload pressures.
- Undertake survey of welfare arrangements in ARI and DGH as an initial test of identifying and addressing gaps in staff experience.
- Ensure good cross-system representation and engagement in the Staff Health and Wellbeing Steering Group to ensure activity prioritised meets the needs of the system.
- Ensure good cross-system representation and engagement with the Culture Matters Steering Group to ensure activity prioritised meets the needs of the system.
- Support from Wellbeing, Culture and Development (WCD) to parts of our system attending to staff experience and organisational culture challenges.
- Continue to offer WCD-led analysis of results per operational units (portfolios/directorates) to allow more nuanced identification of differences across the system thereby influencing organisation action planning.
- Further development of our values based approach as recommended by Review of Portfolios approach; with plans to reflect this in 2025/26 Annual Delivery Plan.

Voice of our Citizens

Care Opinion stories July-December 2024

271 stories in Jul-Dec 2024

99% of stories have a response

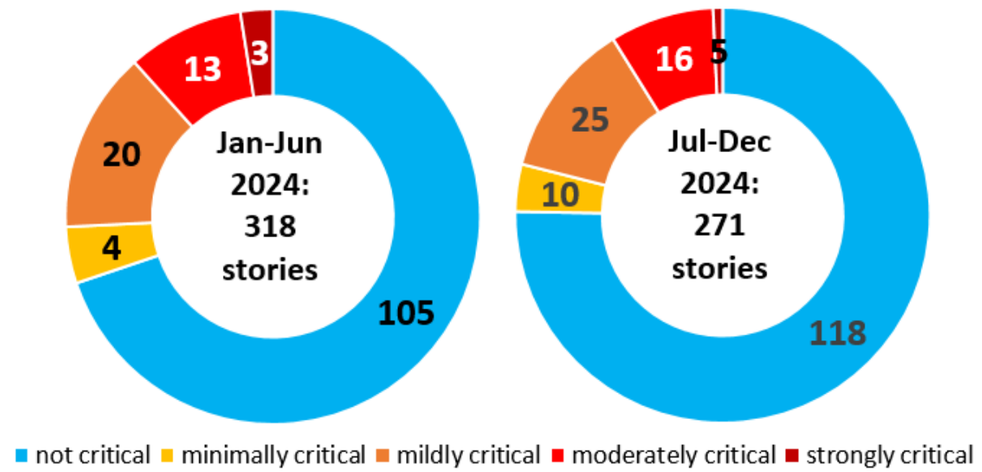
3 stories have changes planned

1 story has had a change made

The 271 stories submitted to Care Opinion in the period July-December 2024 represent a 15% increase from the previous six-month period, and a 9% decrease in comparison to the same period the previous year.

- The proportion of 'not critical' (or 'positive') stories increased from 70% in the first half of 2024, to 75% in the second half of the year.
- The proportion of 'mildly', 'moderately', and 'strongly critical' stories has decreased.
  - 2 stories were rated as 'strongly critical', a decrease from 8 in the previous six months. For both of these stories the service areas responded within one day, requesting the story authors contact them to discuss in more detail.
- Overall initial responsiveness continues at a very high level, at 99% for the period.

How moderators have rated the criticality of stories



Criticality scores in relation to the most negatives statements within the story are assigned by moderators to support the alerting service in identifying issues which might need urgent response, action or escalation

Contributing to change

Sharing their experiences through Care Opinion stories allows citizens to acknowledge good practice as well as contributing to change.

- For the July-December 2024 period, 4 of these stories' responses show a change has been planned or made (see next page for further detail), 2 fewer than the previous six-month period.

Governance

Care Opinion (along with feedback and complaints) data is regularly provided to the Clinical Risk Management meeting.

It is important to note that Care Opinion stories are representative of a small sample of our population who choose to provide feedback through this method.

Other feedback routes are available, including compliments, complaints and patient surveys. The first overview of complaints was included in the December 2024 'How are we Doing' report, with the next update planned for the June 2025 report.

Key risk: are we missing an opportunity to build trust in our services

- Where areas for improvement are identified, completing the feedback loop with the story's author can help build trust and inspire confidence in our services.
- It also enables sharing of improvements with other service areas.

There are occasions where changes made are communicated directly with the story author and not recorded on Care Opinion. Responders receive an email reminder to complete the online feedback loop by sharing actions taken on the Care Opinion platform.

The majority of stories we receive are completely positive (not critical), these stories are shared with the relevant teams and no change is required within the service.

Ongoing actions to improve recording on Care Opinion:

- During Care Opinion training, the value of recording changes is being highlighted, together with the importance of ensuring responses to stories are person-centred.
- Service-specific links are being provided to all services for them to share, making it easier for citizens to provide feedback (see Minor Injuries Unit example on page 11).
- Work is ongoing to establish citizens' and colleagues' level of awareness of Care Opinion, with an increase in the number of stories in the latest quarter.
- Raising awareness through the Quality Improvement and Assurance Team newsletter, shared with all colleagues through the Daily Brief.

Voice of our Citizens

Citizens stories via Care Opinion July-December 2024

Changes planned

[Lovely childbirth team, but breastfeeding support was lacking]
I gave birth to my second daughter at Dr Gray's maternity unit in Elgin in May 2024. I had a fantastic experience!...
…If I have anything constructive to say it would be that there seems to be a lack of feeding support. I deliberately stayed overnight as I wanted breastfeeding support after I had been unable to feed my first daughter but I did feel a bit left to my own devices.
www.careopinion.org.uk

CHANGE PLANNED

Response from Senior Charge Midwife, Dr Gray's Hospital (October 2024):

First of all congratulations on the birth of your second baby. It sounds like you had a lovely, calm, safe birth, and I am delighted to see you mention the staff who you feel particularly helped and supported you at this time.
Sorry to hear that you feel that breastfeeding support could have been increased during your overnight stay in the hospital. We will discuss this as a team to see how we could offer increased support to other women in the future. That said, I am glad to hear that the staff who attended you overnight were lovely and offered you help when you requested assistance by pressing the call buzzer.
As a team we wish you and your family well as your new baby grows.

[Missed ectopic pregnancy]
I had phoned Aberdeen Early Pregnancy Unit four times with bleeding and abdominal pain and was told to wait 5 days until when I had an early scan booked. The last phone call was particularly frustrating as I had told them the abdominal pain was getting worse and that I was wakening through the night with pain and that bleeding had started. When I was told I could not be seen I asked if there were any cancellations could they please phone me but was told that they don't get cancellations, everyone had abdominal pain or bleeding like me that they are scanning. I felt as if I was being a nuisance phoning and that they thought my abdominal pain and bleeding was not serious…
www.careopinion.org.uk

CHANGE PLANNED

Response from Midwifery Manager, Aberdeen Maternity Hospital (October 2024):

I am very sorry to hear of your experience contacting the early pregnancy unit and I apologise that you felt you were not listened to. I will feed your experience back to the staff working within the unit and the senior nurse. I appreciate this is an anonymous feedback service, but if you wish to contact *(email)* with your contact information this can be directed to myself and I can look further into the care you experienced.

[After finding it everything has been fine]
There is no signposting anywhere to find RAAC. Even the staff we encountered didn't know where I needed to be. The cardiac ward tried to help and even called to find out where we should go. It needs to be on the signs or detailed instructions given when you are discharged. After finding it everything has been fine and the staff are competent, compassionate and utterly fantastic. Even the lunch was good.
www.careopinion.org.uk

CHANGE PLANNED

Response from Advanced Nurse Practitioner, Ambulatory Emergency Care (December 2024):

Many thanks for taking the time to provide feedback on your experience in the RAAC area. It is really helpful to have feedback regarding wayfinding to RAAC. This is definitely something we will look into as a department to see how we can provide better signage for the area as I appreciate coming into hospital is a distressing experience without then struggling to find where you are meant to be.
I will pass on your feedback regarding the staff, they will appreciate hearing your experience once on the ward. I hope you are recovering well, and if you have any further comments relating to your experience in RAAC then please don't hesitate to get in contact, my email address is *(email)*

[New Needles for bloods]
I attended an outpatient's appointment at Clinic G, Purple Zone, Aberdeen Royal Infirmary this week. At this appointment I had bloods taken at the outpatients department. The nurse was fantastic, which is more than can be said about the new needles being used. This is the third time I have had to suffer these needles and honestly, I don't think they should be allowed to be used. I have been attending clinics for over 25 years and I have never had so much bruising after bloods being taken…
www.careopinion.org.uk

CHANGE MADE

Response from Senior Charge Nurse, Maxillofacial Outpatient Department (October 2024):

Thank you for sharing your experience of having bloods taken at Aberdeen Royal Infirmary. I'm really sorry it has taken me a while to reply, I wanted to make sure I had confirmation of a change before sharing a response. Starting with the positive feedback for the nursing staff – thank you! As Senior Charge Nurse in Clinic G it means a lot to me, and the team, to know that the nurse you saw was fantastic. We all work as hard as we can to make patients time with us as easy as possible but sometimes, as you have mentioned, equipment lets us down. I'm sorry to hear you came away with bruising (and not for the first time) due to the needles. I am pleased to confirm that new needles were released at the end of September. The team have viewed prototypes of these and are much happier with the design as they seem very similar to the needles used previously. Sometimes new orders can take a wee while to reach the teams but we are working as quickly as we can to ensure they are available in the clinic soon. Thanks again for sharing your feedback which has helped to ensure a change was made for the benefit of both patients and staff.

Voice of our Citizens

Themes from Care Opinion Feedback (July-December 2024)

The Care Opinion platform lets our citizens attach brief tags to their stories, providing a summary of what was good and what could be improved about their experience.

What's good?

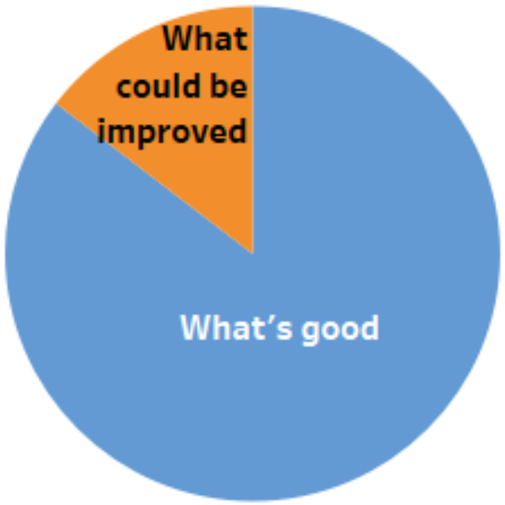
Feedback is predominantly positive, with "nurse" continuing to trend as the most frequently used positive tag, alongside "professional" and "helpful"

What could be improved?

There are some areas where our citizens' stories suggest improvement can be made. Once again, "communication" was the most frequently tagged area for improvement, followed by "staff"

These word clouds provide a visual representation of the tags from citizens' stories: the larger and darker the word, the more frequently it was used as a tag

Tag categorisation Jul 2024-Dec 2024
based on 271 stories submitted



There were 23 stories in the period July-December 2024 where "communication" has been tagged as an area for improvement; the themes include:

- Bedside manner and staff attitude
- Missed opportunities to communicate
- Poor explanations

It is recognised the local Clinical Governance Meetings regularly review complaints as one of the meeting agenda items, and encouragement is provided for staff within Portfolios to undertake the training modules available, with the theme of communication remaining an area of focus.

In the last Cross System Quality, Safety and Assurance Group it was agreed by the Chair to dedicate the October meeting to a Critical Thinking Session on how we share and embed learning, which will include complaints and feedback amongst other items. It is hoped this opportunity will provide time across a range of Portfolios to explore options to support colleagues across the system with making an impact on our collective themes.

Tags are added by story authors to help summarise what was important to them at the time of writing. The content of stories may highlight themes which have not been tagged. To maintain the authenticity of the story, tags are not altered.

Voice of our Citizens

Care Opinion in action: Minor Injuries Unit

Jill Reid, Lead Emergency Nurse Practitioner:

We've been using Care Opinion actively for about 6 months now. At the beginning of our Care Opinion journey we placed posters on the walls, but we found no-one really noticed them. We soon realised we would need to be more proactive with encouraging patients to give feedback and moved on to handing the Direct Ask Flyers (example on the right), with QR codes, to patients along with their patient advice leaflet.

We found it was important to directly highlight the need for feedback to patients, for example we'll say 'If you would like to give us some feedback, it would be really appreciated' or 'if you would like to tell us a bit about your journey today it will help us improve the system'. It wasn't something everyone felt completely comfortable with initially, so we held a bit of a competition with a cake reward.

The first person to get a mention on Care Opinion won. Making it fun and little bit competitive really helped staff engage and it was something everyone could get involved with.

Minor Injuries Unit Stats: September-December 2024

We found that by opening up a conversation about why feedback was important to us, patients felt comfortable to bring up any issues they had had so far in their journey. We found that some walk-in patients were unaware they could phone 111 and make an appointment and were frustrated when they saw patients being seen immediately on arrival. The conversation about letting us know what went well, or what didn't go well, gave us the opportunity to provide an explanation there and then – and hopefully prevent any frustration being taken home or shared wider.

Receiving regular positive feedback has been a great morale boost and staff are genuinely pleased for each other when a colleagues name is mentioned in a story. We have a staff Teams channel where I share a link to each story as it arrives. This helps make sure that, even though shift work often prevents us being all together at once, we still have the opportunity to read the stories our patients and their families have shared. Highlighting personal mentions gives staff the opportunity to use the story later in their revalidations too.

At the moment, I write all the feedback responses, but in future I'd like to involve staff more directly with this, giving them the opportunity to write a personal thank you, which I think would be meaningful for both the staff and the story author.

I would highly recommend using Care Opinion, it's been easy for us to use, it's a great prompt for conversation with our patients and helps foster an openness around the care we provide.

The Minor Injury Unit (MIU), although part of the Emergency Department at ARI, runs a separate service for patients who attend. Assessing a variety of injuries from wounds, burns, bites, to dislocations and broken bones, it is open from 8am – 8pm, 7 days a week for patients aged 16 and over. Patients attend through two different streams; walk-ins -who self-present to the ED, and those who schedule an appointment after calling 111.Calling and scheduling an appointment means any waiting time is spent at home – rather than in the hospital waiting room.

Key Organisational Enablers – Putting People First

What is Putting People First?

Plan for the Future outlines our intent for the Grampian health and care system to listen to what is important to people and work in collaboration with people to build the best system possible. This is about how services are designed but also about working as a system which connects with community supports and assets to enable people to take an active role in their own health and wellbeing.

To achieve this ambition, based on extensive engagement and best practice, Putting People First, is our agreed approach to listening to and involving everyone living in the local area. This is endorsed by the NHS Grampian board and is a long term commitment to changing how we do things. Read the full framework here: putting-people-first-approach-may-2024-2.pdf

Putting People First as a Key Enabler: Supporting and Guiding the Organisation's Strategic Delivery

Putting People First is about building trust and relationships through dialogue so people (colleagues and citizens) feel valued, heard, included, motivated and supported. This is not a one size fits all approach but about collaborating within existing networks in our system and using a range of ways to ensure we hear from our diverse population. We want to support staff to feel confident and supported in working in this way, creating the conditions where we value the expertise of lived experience equally alongside service expertise and developing a shared narrative to enable us to collaborate honestly and transparently with members of the public to address the challenges we all see and feel every day in our health and care system.

Strategic Alignment: Embedding Putting People First in Our Organisational Goals

Putting People First offers the opportunity for colleagues to co-produce with citizens' service improvements and new ways of doing things which increase people's ability to take ownership over their health. Whilst this makes common sense, this is also supported by a strong evidence base that empowered and engaged colleagues leads to more effective services and that co-production with communities can create more effective approaches to helping people live well. As a result, the approach is connected to the following strategic outcomes:

- Improved patient satisfaction
- Increased staff satisfaction
- Designing more effective models of care which are preventative and sustainable

Our actions to date

For the People First approach and principles to be embedded across the organisation, this requires a long term commitment to begin to do things differently. The next two years focuses on setting the foundations, building on existing good practice and creating cross system collaborations to test and spread effective novel approaches to involving people in how we do things.

Working within existing resources, an action plan has been developed using a logic model approach to track progress in setting the foundations for Putting People First. A Core Group meets monthly where people responsible for agreed actions in the plan raise issues/report on progress. A wider whole system Oversight Group receives updates on the delivery plan every 2-3 months, providing constructive challenge and support.

Despite working within existing resources, we are making progress across all priorities in the delivery plan. However, this has become more challenging in recent months due to financial pressures impacting on capacity within teams. The delivery plan covers 4 agreed priority areas of activities, with progress status as outlined in the table on the right:

Putting People First – Priority Areas from 24/25 Action Plan **Q3 Progress Status (Oct-Dec 2024)**	
1. Supporting People's Skills and Confidence *Outcome: Increased confidence and skills in people to listen well and act on feedback* **Priority Areas:** - Develop resources to support teams improve how they involve the public - Toolkits training developed and being tested **RAG Action Status:** 4 – On Track 1 – Minor Delay 1 – Significant Delay*	**2. Developing community led health responses** *Outcome: a shared approach for testing and developing community led health approaches such as CADs* **Priority Areas:** - Community Appointment Day (CAD) – testing underway across multiple localities **RAG Action Status:** 4 – On Track 2 - Complete
3. Grow a network *Outcome: Improved use of public feedback to develop effective services and sustainable models of care* **Priority Areas:** - Communities of practice established - Leadership support in place - Cross system engagement and oversight group established **RAG Action Status:** 4 – On Track 1 - Complete	**4. Increase public voice in public services** *Outcome: a visible network and infrastructure which supports a relationship building approach to involving and listening to people* **Priority Areas:** - Test real time feedback loops - plan in place - Create our own learning loops and develop our existing processes - areas identified **RAG Action Status:** 2 – On Track 1 – Minor Delay

*Q3 action plan not progressed due to capacity within Wellbeing, Culture and Development. Leadership and Management development framework paused to ensure alignment with portfolio review. To mitigate this, a cross-system working group was formed to map existing training and support, despite initial delays due to staff capacity. The group is now meeting regularly and aims to simplify and make training accessible, while exploring opportunities for streamlining and collaboration in learning and support.

The following highlights what has been achieved in priority area 2 above, developing community led health responses. Future reports will spotlight activities from the other three delivery priorities areas.

Developing community led health responses – testing Community Appointment Days Moray Community Appointment Day - Full Video

Community Appointment Days (CADs) approaches are a new way of working which bring clinical services into non-clinical settings and offers under one roof a wide range of third sector, peer support, wider public sector and community based support.

This approach provides unhurried person centred, holistic care and support, promoting prevention & self-management and wraps care and support around the whole person, seeing beyond their presenting condition. It brings clinical services out into communities and enables better connections to be made with community based supports which can help people take a more active role in their own health and wellbeing.

Integral to this approach is that the sessions are co-designed with people with lived experience. In addition, each person who attends has the opportunity to have a 'What Matters to You' conversation to help each person get the most from the session based on their unique situation.

To date we have had 3 Community Appointment Days in Grampian, one in Elgin focusing on Musculoskeletal Physiotherapy and Podiatry and two in Aberdeen focusing on Chronic Pain, with further CADs planned for 2025 across a range of conditions and populations. To date, over 370 people have attended a CAD in Grampian.

A priority for testing the Community Appointment Day approaches is to evaluate impact both in the short, medium and longer term. Whilst there has been lots of ideas from improvements which are helping shape each future CADs, overall themes from initial evaluations are:

Patient Experience - **high level of satisfaction around key themes:**
Having Time - people were not rushed and had time to talk about their concerns.
Being Listened to – people fed back that they felt truly listened to.
One-stop-shop – people spoke positively of having services all in one place, learning what support was available in their community.
Patient Centred – advice was specific to each person, looked at as a whole person, not just one ailment.
Motivational - people expressed intent to become more active as a result of attending.

Staff Experience – learning and positive feedback around key themes
Operational – really positive about working this way and using these events going forward.
Consultations – really good to have a more holistic conversation with patients.
Preparation and support – staff taken out of 'what they know' can cause anxiety, also highlighted importance of scheduling breaks and debriefing after intense conversations.
Waiting Lists – staff talked of how this way of working could help to reduce waiting lists/improve uptake of prevention/self-management advice. This will feature in future evaluation activity.
Stakeholder feedback – positive feedback from partner organisations who attended, highly valued feeling an equal partner with the NHS and keen to participate in future sessions

"Really positive experience. I've felt "written off" by NHS and government, and today really helped me see a way forward."

Person Living with Chronic Pain

"To do things differently that supports our population and enable them to take an active part in their care AND support them with what matters most to them"

Staff member

"It was an extremely useful day from our point of view. Hopefully it was also very useful for your patients and staff. It would be something that we would be delighted to participate in again should the opportunity arise" – Versus Arthritis

"To be heard, listened to and understood" I am so happy to be part of this group, to help share my "lived experience of long term chronic pain", to promote a better understanding for the CAD professionals to assess the best and safest way to share all the help that they can, to the people that matter the most. It is so debilitating living with long term chronic pain and events such as these, give everyone "hope" for the future. A huge THANK YOU to everyone for caring and for wanting to make this a regular event in the future and I for one, am so grateful!

Member of Chronic Pain Service User Reference Group

Learning and Impact to date

In this initial phase, Putting People First provides opportunities to shine a light on how ready the system is for reform and what are the barriers to successful change.

To date, the learning specifically from Community Appointment Days has shown the following positive signs:

Positive Signals of success in the system learning from our CAD experiences

- ✓ There is an appetite from many staff, stakeholders and the public to work in a more collaborative way.
- ✓ The public are aware of the pressures in the NHS and are willing partners when invited to participate and are realistic and aware of the pressures facing the NHS.
- ✓ Staff involved to date in Community Appointment Days have found the experience positive and motivating.
- ✓ Key stakeholders including third and wider public sector have valued working collaboratively and want to continue to develop this type of collaborative approach.

Risks and challenges- learning from our CAD experiences

- ➢ Staff capacity to develop and test new approaches due to current here and now pressures is a limiting factor.
- ➢ The focus on secondary care performance metrics in some areas can make it difficult to use resource to work more upstream.
- ➢ Services often work in silos so it is challenging to find capacity to coordinate whole system approaches which go beyond the boundary of an individual service or organisation.
- ➢ Preventative approaches need time to develop and demonstrate impact – it can be challenging to gather support and capacity to test given the focus on immediate financial pressures.
- ➢ Culture is king. NHS Grampian has a diverse range of cultures and micro cultures – leaders at all levels have a role to play in creating cultures which are empowering, make clear on what is within our gift to change and gives colleagues permission and support to innovate.

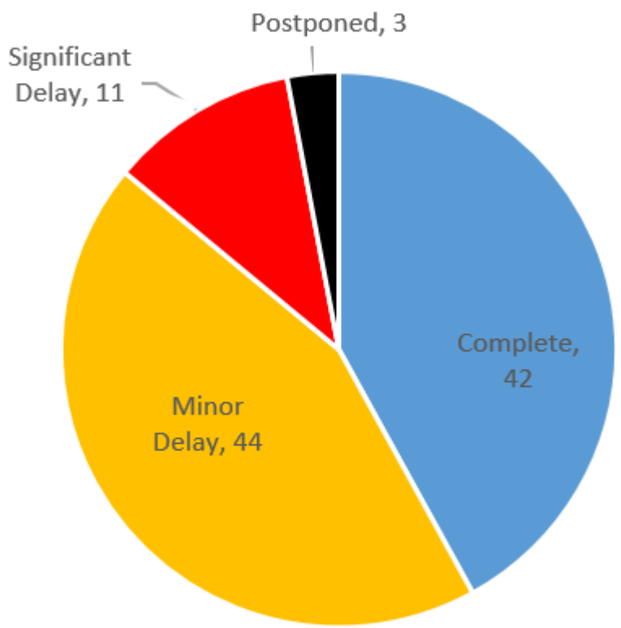
What Next for Putting People First…?

We will continue to evolve Putting People First, placing co-production, putting building trust and relationships and co-production at the centre of this work we will:

- ✓ Further develop Community Appointment Days and other community led health responses which are co-produced with community members.
- ✓ Support colleagues to test and learn from real time feedback loops, lived experience panels and other relational approaches to engagement.
- ✓ Support the development of the Strategic Route Map to ensure Putting People First approach is embedded in how we do change.
- ✓ Develop research, monitoring and evaluation to demonstrate impact of new relational approaches with a strong focus on lived experience, using a Human Learning System Approach.
- ✓ Further develop cross system collaborations with GIRFE, Values Based Medicine, Trauma Informed Care, Human Learning Systems and other relational approaches which see people as the experts in their own lives.

Tier 1: Our Board Performance Summary at Quarter 3 (October to December 2024)

This is our prognosis of completion of 100 deliverables at end March 2025 at the end of the Q3 milestone*



*Data accurate as at 12/02/2025

At the end Q3 (December 2024), below table shows our current breakdown of performance of 38* KPIs across People, Places and Pathways. We are seeing an increase of 4 KPIs totalling 23 KPIs showing adverse performance and a decline in positive performance from 13 to 11 KPIs in comparison to Q2.

Places	People*	Pathways	Total KPIs (38*) Q3
6	8	9	23 (61%)
3	0	0	3 (8%)
6	2	3	11 (29%)
	1* (not rated)		1 (2%)

*Actual Q3 figure not available for KPI: Reduce time to hire in support of addressing workforce shortages. This is due to issues with data and JobTrain nationally. Ongoing progress to address this and provide historical data to support re-reporting of this KPI.

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

Prognosis for the performance of Key Performance Indicators into Q4:

Circle markers against each of our KPIs provides an indication of a direction in performance. We can see that 21 of the KPIs have shown a decline in performance in Q3, with 14 KPIs showing an improvement from the previous quarter and 3 KPIs showing no change between quarters. Analysis using the circle markers to monitor performance will be useful in capturing early warnings to ensure we make improvements or maintain improved performance in meeting our targets.

Marker	Direction of performance	Places	People	Pathways	Total KPIs (38)
🔴	**Declining**	**7**	**5**	**9**	21 (55%)
🟢	**Improvement**	**7**	**4**	**3**	14 (37%)
⚫	**No change**	**1**	**2**	**0**	3 (8%)

People (20 Outcomes)

Places (12 Outcomes)

Pathways (14 Outcomes)

Impact of current performance towards 2027 Outcomes (46)

Vision: Sustainable Health and Care by 2032

Key observations:

- 57 of 100 Q3 Milestones reported as Achieved
- Prognosis of Deliverable completion by end of Q4 included to provide more forward-looking view of progress
- Out of 46 Outcomes, 6 Outcomes are not aligned to Deliverables or KPIs. (3 in PEOPLE, 3 in PATHWAYS)
- "In year performance" impact on 2027 Outcomes provided by services as first steps to incorporating longer term measures with annual performance data.
- 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.

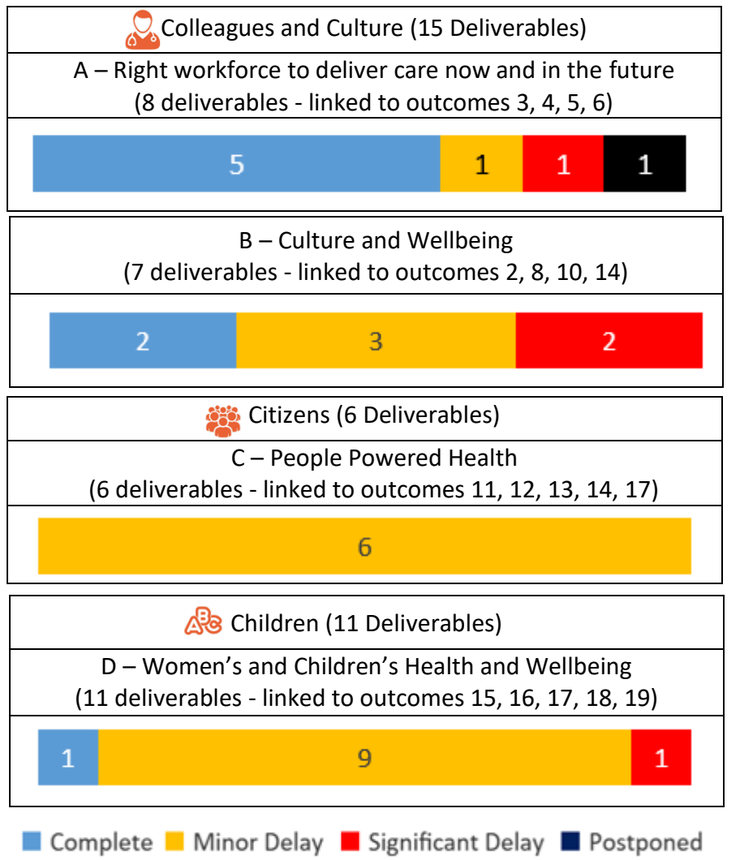
Tier 2: In-year 24/25 performance of KPIs and Deliverables towards 2027 Outcomes

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
PE20 - Implement the Best Start Strategy in Grampian to become Business As Usual (BAU)
*Not aligned to Deliverable or KPI

Performance of Deliverables



Key Risk Categories: Impact of progress of 32 Deliverables (Deliverables may have more than one associated risk therefore total will exceed 32)	All PEOPLE Deliverables Q3
Workforce – Capacity	27
Other (National Policy, Systems – National, Data & Modelling, Engagement)	11
Workforce - Recruitment	10
Finance – Insufficient Funding	9
Workforce - Training, Development and Skills	5
Workforce - Wellbeing	5
Finance - Funding not yet agreed	4
Finance - Non-recurrent funding	4
Workforce - Retention	4
Workforce - Absence	4
Infrastructure – Estates	1
Infrastructure – Digital	1
Procurement	0

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	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: 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** (Mar2024)	**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%	5% or below	**5.37%** (to Nov 24)	**5% or below**		5% or below	The figure from 01/09/24 - 30/11/24 (Substantive Staff only) was 5.37%, monthly sickness absence increased in September to 5.6% however has decreased to 5.1% in November. Power BI dashboards now in place to support work with managers in areas over 5%. *Last reported: Staff Governance Committee December 2024* spotlight on page 20
PE3 - Agenda for Change (AfC) 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%	**93%**	**100%**		100%	Plans in place for 93% of all AfC staff to reduce their working week. Backfill Funding agreed for a number of services based on a risk assessment criteria prioritising services which were both 24/7 and Emergency/Essential. To reflect system pressure, agreed by Programme Board to extend implementation date for those services to the end of the next rostering period (Feb). Work underway to identify and support small number of services who have not made formal Reduced Working Week (RWW) submissions *Last reported: Sustainable Workforce Hearing December 2024* spotlight on page 21
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	**£6.064m**	**£7.312m**		£9.750m	The over recruitment has support continued reductions in agency spend with continued performance against target. *Last reported: Nursing and Midwifery Workforce Council – 30th October 2024*
	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	**£14.219m**	**£13.342m**		£17.789m	Medical locum spend continues to reduce with spend in December being at the lowest level since June 2022 and above the savings target set. 100% of locums (Excluding Mental Health) are now engaged through Direct Engagement. Junior Doctor Non Compliance remains high due to Banding payments paid on rotas that have been monitored as non-compliant; in addition the 2024/25 pay award of cc10% has been paid on banding payments in December which we do not receive funding for. *Last reported: Chief Executive Team 14/01/25* spotlight on page 22

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** (Mar2024)	**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**	
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%	**65%**	**70%**		70%	Continued improvement trajectory as per continuity of Q2 update *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 23
	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%	**63%**	**80%**		80%	Further reduction by 1% compared to Q2. This continues on a consistent range of performance going back in excess of 1 year where 63-65% achievement is the consistent level of performance. Continued operational and financial pressures are having an ongoing impact on the progress we seek to make. The Protect Learning Time elements of the Agenda for Change 2022/23 non-pay elements are expected to impact favourably on this as we move into 2025/26. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 24
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%	**22.82%** (Turas and secondary care SOAR)	**40%**		50%	Some improvement in AfC position though not yet at target due to workload pressures impacting recording on systems. Addition of some SOAR data is continuing to build overall picture for all of NHSG. Primary care medical staff data being sought on a regular basis to enable true whole system picture to be reported. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 25
	Reduce time to hire in support of addressing workforce shortages	116 days	110 days	<105 days	No Data for Q2	<105 days	**No Data for Q3**	**<95 days**		<95 days	National JobTrain Reporting unable to accurately report Time to Hire. Work underway to simultaneously influence national reporting via the Reporting Sub Group of the National JobTrain Governance Group, and develop local reporting to enable accurate reporting of our Time to Hire *Last reported: Q1 PAFIC 28/08/24 and HAWD 12/09/24 Spotlights* spotlight on page 26

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 (Mar2024)	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?*
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	**39**	**42**		44	Whilst existing PIN is an engaged group that meets regularly, the capacity within the team to grow and evolve its membership to include underrepresented groups remains constrained. *Last reported: Communications Leadership Team meeting 18/11/24, Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 27
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	**210**	**235**		239	Overall number of volunteers remains stable, with modest growth overall when including SLAs with charity partners. However, nationally reported numbers reflect only those directly engaged by NHSG and which have been 'active' during the quarter - which continues to show high variability. This is influenced by both holiday periods and the demographic of our volunteers which tend to be older and have other commitments including caring responsibilities *Last reported: Volunteers Across Grampian Strategic Group 02/12/24* spotlight on page 28

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: 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** (Mar2024)	**Quarter 1** Actual	Target	**Quarter 2** Actual	Target	**Quarter 3** Actual	Target	**Quarter 4** Actual	Target	**Why are we in this position?** *When was this last reported?*
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	**444**	**<450**		<400	Recent worsening of the workforce challenges in the paediatric anaesthetic workforce resulting in a reduction of capacity in addition to a reduction of capacity for patients under 3 years old. Increase in number of theatre lists handed back by some specialties due to the competing demand on the outpatient service. Increase in emergency cases (CEPOD) over winter has resulted in a number of cancelled lists. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights*

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

Q3 actual: 5.37%
Q3 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 have included the reduction in absence as part of Boards' sustainability and value requirements for 2024/25. As the mainland territorial health board with the lowest recorded sickness absence rate, NHS Grampian committed to reducing absence to below 5%, an improvement of 0.5% or circa £8m productive gain on 2023/24.

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

- There are early indications that the absence level is moving towards 5%. However, we require to track the information over the rest of the year to establish if this indicates a downward trend, given the normal increase into winter months.
- The monthly rate for December 2024 is 5.98%, resulting in a quarterly figure of 5.55%. Corresponding Year to Date (YTD) in 23/24 was 5.11%. It is likely that the Q3 figure has been inflated by the relatively early onset of high levels of flu and other respiratory viruses

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

- There is no specific three year deliverable linked to this KPI, though it has implications for value and sustainability / financial balance. A 1% change in sickness absence is estimated to equate to approximately £8m revenue costs.

Our key risks, challenges and impacts…

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

- Staff absences due to mental health issues such as stress, anxiety and depression continue to be the main reason for long term absence. This could be related to the ongoing system pressures that staff which has an impact staff morale and wellbeing
- Winter period increase in patients and staff with Flu cases and coughs and colds in December was significant in relation to short term absences in end of Q3 was 25.90%
- Impact of vacancy control creating more pressure on staff and services and the potential to raise sickness absence
- Manager capacity to manage absence and follow policy, this may include understanding of process and good practice
- Capacity of OHS to support increasing demand of referrals given other competing service priorities

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

- Fluctuation of this KPI has implications in relation to costs of replacement staff such as locums, agency bank, additional hours and overtime.

Commentary from

Philip Shipman,
Interim Director of People & Culture

Our mitigation and recovery actions

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

- Work across NHSG to raise the profile of OHS and the role OHS has in supporting the mangers to actively manage absences and access to Occupational Health Service (OHS) and signposting on to Wellbeing resources
- Work continues across Facilities and the HCSW cohort with updates pending. MHLD exploring access to Psychologists to support staff in remaining in workplace as part of response to above average absence rates. Steering Group scheduled to review progress mid Feb and identify good practice for shared learning

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, improve access to absence information (via 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?

- Discussion and shared learning opportunities with other NHS Boards across Scotland who have implemented alternative measures to support absenteeism

What have we learnt?

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

Progress will be tracked over years and months and data compared to establish any new post pandemic patterns. Managers' access to Power BI Absence dashboard will provide relevant, comparable and up to date absence information supporting insight into services and professional groups. Additional information will be added regarding OHS referral rates

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

Work alongside Wellbeing Culture and Development and HR teams and identify opportunities for target support around keeping our staff well at work. Manager's development on managing short term absences and how to implement policies and manage return to work plans

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

- Value and Sustainability Short Life Working Group (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 December 2024.
Reported to PAFIC via Q2 KPIs in Dec 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

Q3 actual: 93%
Q3 Target: 100%

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 (AfC) 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. The AfC Reform Programme Board agreed an extension for services seeking backfill funding to enable implementation in line with Roster change dates in February that is minimally disruptive to services, so the Q3 position is that 93% of services have either reduced the working week, or have an approved plan in place to do so.

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 the month on month decrease in Reduced Working Week (RWW) 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. Work is underway to identify and support services who have not yet reduced to 37 hours based on identifying and contacting all rosters which are still paying the RWW Transitional Allowance.

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

This KPI measures 1 of three deliverables connected to Agenda for Change Reform, which have a linked 3 year outcome. Current progress on this deliverable is not putting three year outcome at significant risk.

Our key risks, challenges and impacts…

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

- Impact of arrangements on staff morale when system pressures are significant
- Difficulty of implementing further reduction to 36 hours given impact in capacity and current financial challenges

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

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

Philip Shipman, Interim Director of People & Culture

Our mitigation and recovery actions

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

Backfill funding agreed for services unable to safely introduce the working week without it. Based on a balanced risk assessment of clinical, financial and staff governance risks, alongside consideration of whether services within definition of emergency / essential and/or required to operate 24/7.

A review of SSTS rosters for those services who have submitted a RWW proposal and those with no submission is underway. Once identified, services can be contacted directly to support a move to a 37 hour week.

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.

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. Clarity is required nationally on timelines for implementing 36 hour working week.

Oversight and assurance

a) What are 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 quarterly updates to Sustainable Workforce Oversight Group with escalation to Chief Executive Team if required.

KPI updates provided to PAFIC each quarter and flash Report to SGC bi-monthly.

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 deep dive format under Sustainable Workforce hearing – last report December 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

Q3 Actual: £14.219m
Q3 Target: £13.342m

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?

In advance of the August rotation most rota's had been re-written with the aim to support compliance with breaks, reducing band 3 payments. There has been a reduction from the peak of 39 non-compliant rotas at last cycle to 32, a reduction of 18%. Focused efforts are having the desired impact as 10 rotas that were non-compliant at last cycle are now compliant, however three new rotas have become non-compliant. The impact of the project has been significantly impacted by the 10.8% pay award that is not within project influence and is significantly impacting on ability to meet the target.

The Medical Agency Locum (MAL) project which is currently exceeding, and predicted to continue to exceed, target. This is due to combined efforts of mandated Direct Engagement and Tier 1 framework, reduced commission rates and on call payments 00:00-08:00. Risks include use of locums for additional surge bed space.

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 and conversion of some high cost (large number and senior grade) rotas to compliant. This is not at the rate required to meet the target.

MAL 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?

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?

There is a risk flow could be impacted on therefore break and discharge planning is essential.

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 embedding 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.

Locum Desk scrutiny and process around MAL engagement has enabled transition from non-Direct Engagement to Direct Engagement and has led to engagement on lower rates than previously seen..

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 Doctors and Dentists in Training (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 are the assurance and governance oversight arrangements?

Through regular reports to the Chief Executive Team

b) When was this KPI last reported?

14 January 2025

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

Q3 actual: 65%
Q3 Target: 70%

Outcome: NHS Grampian meeting requirements of published Protected Learning Time commitments under Agenda for Change reform.

Our story so far….

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

As at end Q3, 2024/25, 65% of all staff have completed mandatory training, an improvement of 1% from Q2, and 5.5% from Q4 of 2023/24. This represents a steady increase in completion rates from February to December 2024.

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

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, the majority of the remainder are above 65%.

The 2 training areas requiring significant improvement in the last report, *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 have shown a 5% increase and fairly static trend respectively.*

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

This KPI is more likely to be impacted by others that prioritise the delivery of services. No significant impacts currently on 3 Year Outcomes.

Our key risks, challenges and impacts…

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

Ensuring proactive compliance with mandatory training remains a challenge due to:

- 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

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

Commentary from

Philip Shipman, Interim Director of People & Culture

Our mitigation and recovery actions

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

- 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
- Amalgamation of Statutory and Mandatory Training compliance Short Life Working Group (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.

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

- Monitoring progress with take up of required online training by new starts, following corporate induction attendance and offer of support

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

- Escalate to Chief Executive Team to seek stronger direction to prioritise completion.

What have we learnt?

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

- Protected time for learning remains an issue for staff and managers
- Where targeted work is undertaken, improvement has been seen, but specialist support resource is scarce.

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

- Transferability of core statutory and mandatory training between Boards and reduced frequency of refresh periods – via national Protected Learning Time work
- 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

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

- 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

b) When was this KPI last reported?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 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

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

Q3 actual: 63%
Q3 Target: 80%

Outcome: NHS Grampian meeting requirements of published Protected Learning Time commitments under Agenda for Change reform.

Our story so far….

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

Compliance relates solely to fire safety training, with all other topics mandatory as they are not required by law to be completed. Whilst there are pockets of notable improvement – particularly in Facilities and Corporate Services - we continue to see unmet targets around this training module.

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

There has been a deterioration in performance through the course of the year, with the current level of 63% below the level for the year to date (64.4%).

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

This KPI is more likely to be impacted by others that prioritise the delivery of services. No significant impacts currently on 3 Year Outcomes.

Our key risks, challenges and impacts…

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

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.

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

None

Commentary from

Philip Shipman,
Interim Director of People & Culture

Our mitigation and recovery actions

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

- 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, 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
- Creation of anonymised CET reports to enable conversations about role modelling – resulting in significant improvement in compliance. (42 to 86% since May 24)

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

- Trend charts showing performance as a system and per operational unit.

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

- Escalation to Chief Executive Team for stronger direction and oversight in Portfolios/Directorates to improve completion rates.

What have we learnt?

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

- Protected Time for Learning remains an issue - implementing agreed Agenda for Change reforms in this area are key.
- 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.

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

- Improved responsibility taken by colleagues and managers for ensuring compliance.
- Stronger monitoring and oversight in Portfolios/Directorates to improve completion rates.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

- 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.

b) When was this KPI last reported?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 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

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

Q3 actual: 22.82% (Turas and secondary care SOAR)
Q3 Target: 40%

Outcome: Creation of a culture of engagement and empowerment

Our story so far….

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

Over the last year, the average of all staff including Agenda for Change recorded on TURAS Appraisal has been a consistent achievement of overall appraisal at or around 22%. In this spotlight report for the first time some of the staff recorded on SOAR are also included in this and the retrospective trend data, in addition to data relating to Agenda for Change staff only via TURAS Appraisal. We continue to seek access to data for the remaining group on SOAR; all primary care medical staff, ensuring future reporting will cover the full deliverable.

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

Over the last year the average of all staff including Agenda for Change recorded on TURAS Appraisal has improved from 18% to 22%. This quarter, for the first time **some** staff recorded on SOAR are included in the figures and retrospective trend data. (i.e. all secondary care medical staff, with primary care medical staff data remaining to be accessed and incorporated into this spotlight).

A revised national Personal Development and Review Policy was 'soft' launched in Oct 2024 as part of the Once for Scotland Workforce Policies programme, with formal launch expected in February.

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

This KPI reflects a 2024/25 deliverable around improving appraisal uptake. It has a bearing on the colleagues and culture element of the Plan for the Future outcomes linked to an 'engaged workforce'. By investing in the learning and development of staff, both individually and as teams, we facilitate the development of services so that they are better equipped to meet the needs of service users. 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.

Our key risks, challenges and impacts…

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

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 Continuous Professional Development (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.

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?

Our workforce will be adversely affected by continued below target performance of this KPI. This is because regular performance appraisal via quality conversations are directly linked to levels of staff engagement and better team performance.

Commentary from

Philip Shipman, Interim Director of People & Culture

Our mitigation and recovery actions

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

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 has been reviewed by WCD to consider any action required between soft launch and implementation in Jan 25.
- 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.

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

Continued trend data showing appraisals completed, whilst ensuring a full dataset is accessed and reported on (e.g. including SOAR data alongside the well-established TURAS data reporting).

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

No alternative courses of action available

What have we learnt?

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

- 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

a) What are the assurance and governance oversight arrangements?

- 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 Colleagues and Culture 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

b) When was this KPI last reported?

Q2 PAFIC 27/11/24 and HAWD 12/12/24

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): Reduce time to hire in support of addressing workforce shortages

Q3 actual: Unavailable
Q3 Target: <95 days

Outcome: N/A

Our story so far….

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

The National KPI for Time to Hire (TTH) is 117 days, with a locally agreed stretch target of <95 days. Cost pressure funding was allocated to the Recruitment Team to enable them to achieve the local KPI target. To assist with the administrative overhead and reduce the TTH within services with high volumes of recruitment (e.g. Facilities and Estates), NHS Grampian use the "Bulk Recruitment" functionality within JobTrain. Bulk Recruitment is effectively an "always open" job advert to which potential applicants can apply. If deemed appointable after interview, the applicants are appointed to the next available position that is approved through vacancy controls. As a consequence, the TTH for Bulk Recruitment applicants is based upon the date the Bulk Advert went live, rather than their specific post. This artificially extends the TTH for Bulk Recruitment, which has a knock-on effect of artificially extending the overall TTH – making the overall TTH unreliable.

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

Without accurate TTH data, it has not been possible to identify trends or changes in trends.

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

Without accurate TTH data, it has not been possible to identify trends or changes in trends.

Our key risks, challenges and impacts…

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

The most significant determinant of future performance will be the impact of the confirmation that the Cost Pressure Funding allocated for reducing the TTH has been identified as an agreed Service Reduction to assist NHS Grampian achieve financial balance. Without this Cost Pressure Funding, it will not be possible to achieve the target KPI nor will it be possible to mitigate for that Service Reduction whilst operating within the confines of our current National Recruitment System.

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 may be positive and negative unintended consequences of the inability to achieve the KPI in future. A positive consequence of an extended KPI is the potential for financial savings caused by vacancies going unfilled for longer. Conversely, vacancies going unfilled for longer can increase costs due to increased costs of Bank/Agency to fill those gaps. Our workforce systems are not currently sufficiently sophisticated to accurately identify either positive or negative consequences.

Commentary from

Philip Shipman,
Interim Director of People & Culture

Our mitigation and recovery actions

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

Actions in place to recover and resolve the situation are as follows:

- Escalation within national recruitment structures: Alongside raising service calls directly with JobTrain, NHS Grampian representatives are escalating the TTH reporting issues within the JobTrain Reporting Sub Group and the National JobTrain Governance Group
- Develop local reporting: As the national routes are not currently able to effectively resolve the issue, NHS Grampian is developing local TTH Reporting. This requires software development skills, there is a requirement to schedule and prioritise that development. It is however hoped that this will be available for initial testing by end February
- Influence Recruitment System replacements: JobTrain is one of the HR business systems within the scope of the national Business Services Transformation Programme. NHS Grampian representatives are actively involved in developing the specification for the JobTrain replacement, which will include the requirement for accurate and timely reporting

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

Impact will be measured by a simple Yes/No regarding the availability of accurate reporting. Taking actions both nationally and locally to recover the situation has spread the risk of success being prevented.

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

No alternative courses of action available

What have we learnt?

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

With reference to availability of alternative reporting approach, in order to enable us to re-evaluate our TTH positions for bulk and non-bulk recruitment activity.

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

At a fundamental level, the reporting from JobTrain is seen to be unreliable. There therefore needs to be a fundamental change in the way business systems are evaluated and procured to ensure real time and accurate reporting is an essential requirement that is available within the core system without requiring additional software development skills. Representatives from NHS Grampian are actively involved is seeking to influence that change.

Notwithstanding the above, NHS Grampian's recruitment fill rates are generally good, reflected in a workforce headcount and WTE that is higher than pre-pandemic levels.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Chief Executive Team Operational performance Meetings

PAFIC – No linked deliverable for SGC review.

b) When was this KPI last reported?

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

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 membership of the Public Involvement Network by 15% (6 members) by 31 March 2025 (from 38 to 44)

Q3 actual: 39
Q3 Target: 42

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.
- Fluctuation of leavers/joiners is usual and does not represent a trend

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

- There have been regular meetings and opportunities for the PIN to get involved and ensure the relationship between members and NHSG is mutually rewarding
- Recruitment to the PIN was put on hold from mid-December 2024 to allow for the development of a new, two-tier structure. This new structure is intended to harness digital resources to enable NHS Grampian to involve and engage with a wider and more diverse group of people living in the Grampian region.
- A survey has gone out to existing PIN members and feedback is currently being analysed. This will inform an in-person focus-group discussion with the PIN members scheduled for February 2025.

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 PIN members are 'active' is to be expected. This does not material affect the outcome sought– which remains 'delivery good quality care and sustainable health services in the future through the active participation of our staff, citizens and partners'.

Our key risks, challenges and impacts…

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

- Significant reductions/departures would result in PIN becoming less representative of the Grampian Population

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 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?

- The new two-tier structure is intended to enable a wider and more diverse group of people living in the Grampian region to be engaged with by making participation easier and more flexible.
- Members of the Public Involvement Network continue to 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) 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?

- N/A

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
- Progress is monitored through monthly meetings of Public Involvement Team

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 are the assurance and governance oversight arrangements?

Impact and ongoing performance is monitored through monthly meetings of Public Involvement Team and monthly meetings of the PIN. Progress is reported via monthly meetings of the Communications Leadership Team and quarterly HAWD reports

b) When was this last reported?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights

Tier 3 - Our Performance Spotlights: Citizens

Strategic Intent: No citizen in Grampian will be left behind

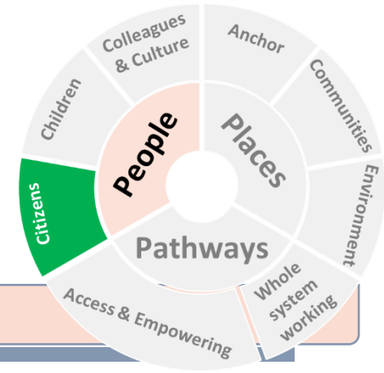
Objective: Strengthen Colleague & Citizen Engagement to Improve Health

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

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

Q3 actual: 210

Q3 Target: 235



Our story so far….

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

The Scottish Government's commitment to voluntary action requires Health Boards to have a policy statement on volunteering and to co-ordinate, monitor and support the development of volunteer services.

In recognition that a formal volunteer policy is needed and would underpin a future-focussed volunteer plan, regular meetings with representatives of the Grampian Area Partnership Forum (GAPF) policy sub-group took place throughout 2024. A draft Volunteer policy has been produced and is awaiting approval prior to staff consultation.

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

Quarterly reporting to Scottish Government* between October-December shows fluctuation between 218 and 202 active volunteers per month.

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

This strategic background work does not materially affect service delivery or the day-to-day contribution that volunteering continues to makes across Grampian

Our key risks, challenges and impacts…

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

- Capacity constraints within the Public Involvement Team which is responsible for Volunteering is a limiting factor with regard to the pace with which this work can progress.
- Busy and fatigued staff are less likely to be receptive to utilising volunteers in the short-term despite the potential longer-term benefits.

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.

Commentary from
Stuart Humphreys

Director of Marketing & Corporate Communications

Our mitigation and recovery actions

- In addition to including both October half-term and the festive period, this quarter figures have been impacted by the stand down of ARI volunteers whilst critical infrastructure works were carried out by facilities and estates. Recruitment also had to pause over a two month period during which two applicants who had been ready to begin training decided to leave and volunteer elsewhere due to the delay.

- 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*

*Q3 Figures reports to SG:

Month	Volunteers	Hours
Oct 2024	218	1794.25
Nov 2024	210	1536.25
Dec 2024	202	1250.25

What have we learnt?

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

Nationally reported numbers reflect only those volunteers directly engaged by NHSG and which have been 'active' during the quarter. However, when including those volunteers covered in SLAs with charity partners, overall numbers are increased. Work is underway to capture these unreported numbers in order that they can be shared in future reports to provide a fuller picture.

The Volunteer Policy will give staff further confidence and support wider acceptance/use of volunteering across the organisation.

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 are the assurance and governance oversight arrangements?

- Day-to-day volunteer management via Public Involvement Team / Volunteer Coordinator Group
- Volunteer strategy via monthly Volunteers Across Grampian Group
- Reporting and assurance structure aligned to Population Health Committee and Staff Governance Committee

b) When was this last reported?

- Volunteers Across Grampian Strategic Group 02/12/24

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)
2 | 1	2 | 2 | 1

Communities (15)

G – Population based approach to health (9 deliverables - linked to outcomes 7, 9)	H – Dr Gray's (6 deliverables - linked to outcomes 4, 5, 6, 7, 9)
8 | 1	3 | 2 | 1

Environment (11)

I – Greening Health Systems (6 deliverables - linked to outcomes 2, 10, 11, 12)	J – Value based Health and Care (5 deliverables - linked to outcomes 8, 9)
3 | 2 | 1	4 | 1

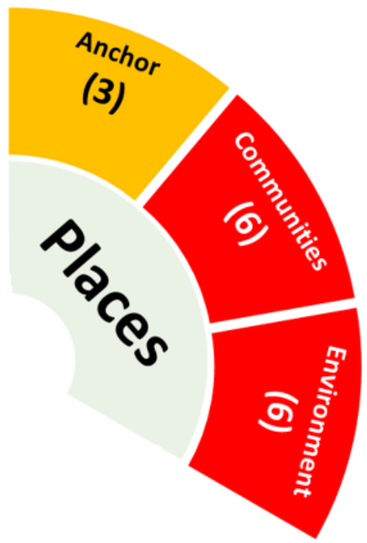
Complete | Minor Delay | Significant Delay | Postponed

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 Q3**
Workforce – Capacity	24
Other (National Policy, Systems – National, Data & Modelling, Engagement)	15
Finance – Insufficient Funding	10
Finance - Non-recurrent funding	7
Workforce – Absence	5
Workforce – Wellbeing	5
Finance - Funding not yet agreed	4
Infrastructure - Estates	3
Workforce – Recruitment	2
Workforce – Retention	1
Workforce - Training, Development and Skills	1
Procurement	1
Infrastructure – Digital	1

Performance of Key Performance Indicators

Performance against 14 Places KPIs across Anchor, Communities and Environment – linked to Outcomes PL1, PL2, PL4, PL6, PL7, PL8, PL10, PL11, PE3, PE16

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: 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 (Mar2024)	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%**	**47%**	50%		100%	Collaboration between the leads for the three anchors pillars and Public Health led to a strategic 5-year anchor workplan endorsed by NHS Grampian on 19th July. Initial baselining has been undertaken and partnerships developed with partners across the North East to identify opportunities for collaborative approaches Last reported: Population Health Committee 27/09/24; Chief Executive Team 11/10/24 spotlight on page 34
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%**	**92.3%**	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.*
	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%**	**95.0%**	94.4%		95.0%	Facilities scores on track, with improvement as a result of dedicated HAI handyman. *Last reported: When published Q2 figures will 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 (Mar2024)	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	
	Waiting Well Service to be delivered to an additional 8000 patients by end March 2025	14609	16568	16609	18623	18609	**21135**	**20609**		22609	Staff in Healthpoint work flexibly to deliver several services, including Waiting Well. They plan workload to ensure targets are achieved. *Last reported: Public Health Performance, Monitoring and Governance Group 09.01.25*
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%	**10%**	**100%**		100%	Limited progress in Strategy Programme due to limited resource. Gaps in leadership resource resolved in December 2024 *Last reported: Triumvirate GM January 2025* Spotlight on page 35
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%	**10%**	**5%**		10%	Whole system infrastructure plan in development including DGH site, will help to inform DGH priorities *Last reported: DGH Programme Board August 2024*
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%	**75%**	**90%**		100%	Progress achieved in tasks but not at desired rate due to lack of capacity in project, leadership and operational resource. *Last reported: Local Triumvirate 13/01/25* spotlight on page 36
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%	**98%**	**100%**		100%	The number of people accessing abortion has remained high as per previous quarters; NHS Grampian sexual health service is working flexibly and increasing appointment availability. An additional 271 appointments over the quarter were dedicated to abortion care, again diverting care from other workstreams. Less staff absence (annual leave etc.) in this quarter has contributed. Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights
	100% individuals are offered a date for an abortion procedure within 1 week of assessment	70%	77%	100%	57%	100%	**62%**	**100%**		100%	Performance has also improved for KPI 2 with the service and partners working towards further improvements. Similarly to KPI 1 for Abortion, increased staffing and flexibility has contributed to the increase. It should be noted that for both KPIs that flexibility does mean other sexual health activity is decreased to accommodate the demand in abortion care. Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights spotlight on page 37

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** (Mar2024)	**Quarter 1** Actual	Target	**Quarter 2** Actual	Target	**Quarter 3** Actual	Target	**Quarter 4** Actual	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%	**26.30%**	**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 38
	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	**23280.06 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: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 39
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	**£34.4m**	**£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: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights*
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	**1178**	**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 Accountability & Assurance Pack January 2025* 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** (Mar2024)	**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%	**47.20%**	**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: 30th January 2025, and F&E SLT 28th January 2025* 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	**1302.5T**	**<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:* 30th January 2025, and F&E SLT 28th 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):
Completion of Year 1 actions in the Anchor Strategic Workplan by 31st March 2025

Q3 actual: 47%
Q3 Target: 50%

Outcome: NHSG 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?

We have made good progress on year 1 of our actions in the Anchors workplan. We have:

- Developed a regional procurement group
- Started to work with Domestic Services to apply an anchors lens to improve health and reduce absence
- Started implementing our communication strategy to embed anchors within the organisation.
- Continuing work with partner health boards and use national networks to learn and share areas of good practice
- Positive feedback on our anchors workplan nationally, some NHS Grampian's work highlighted as examples of good practice
- achieved 47% of our actions, against a target of 50% by end Q3

This has been a developmental year for us to assess our anchors progress to allow future improved priority setting. This process allowed us to identify opportunities to further develop our plans, including being more targeted in our actions to vulnerable/ priority populations, further developing our relationships with Local Employability Partnerships and consideration of the supplier development programme, although there is a financial cost associated with this. Other health boards with dedicated anchors resource highlighted the importance of this in progressing both partnership and local NHS progress in Anchors actions.

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

We acknowledged the importance of understanding our current position for year 1. This was supported by multiple tools, including using a national framework and local data. We have been unable to complete 2 key actions in Q3 which have interdependencies with national and local pieces of work:

- Procurement- "Map influenceable and non-influenceable spend". Due to limited resource and competing staff and financial pressures National data received at end November could not be analysed and Grampian data extracted for review. Planned for Q4 to inform priority setting for 25/26.
- Asset based review- "Understand what land and buildings NHS Grampian has at each stage of the lifecycle framework to identify opportunities for anchors activity to maximise environmental and social impacts." Outcome of the NHS Grampian Asset Based Review being undertaken that will provide this information anticipated for the end of Q4.

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

We may be delayed in achieving all of our year 1 actions by the end of Q4. Once the baselining data is available and analysed, this will enable us to review and refine actions. This should not impact our ability to achieve our 2027 outcomes.

Our key risks, challenges and impacts…

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

- **Interdependencies with other pieces of work and organisations**
- **Limited capacity of staff with anchors within their remit**.
- **Financial decision making**- recruitment controls on entry level jobs
- **Vacancy Controls**- posts funded from external funding not able to progress through previous vacancy control measures. This has now been resolved, although funding is not guaranteed as recurring.

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

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?

- Continue to engage nationally and locally with co-dependent pieces of work.
- Use the other tools to support us in future planning and priority setting. This will mitigate a delay in future planning due to the delay in baselining. Future planning can be reviewed and refined as information becomes available.
- Continue to focus our efforts on the actions we can progress in the interim.

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

Measurement through completion of actions and deliverable by end of Q4. The prevention of success will be the delayed delivery of the inter-dependent pieces of work as outlined above.

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

If we do not receive output of the inter-dependent work in Q4, the baselining activity for anchors will need to progress in 2025/26. We will continue to set priorities using the best information we have available at the time and then review and refine this as more data becomes available through our baselining activity.

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 through:

1. National annual reporting metrics to Scottish Government (due for submission March 2025)
2. Public Health Scotland Baselining toolkit (completed for each pillar)
3. Local Baselining- progress delayed due to interdependencies as outlined above.
4. Evaluation of specific projects

By using these tools, we can monitor progress of our strategic intent to embed our approach to being an anchor organisation. We are using these tools to identify areas of focus to strengthen our approach and inform planning.

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

As we continue to implement our communications strategy, we need engagement from senior managers and budget holders to work with us to identify areas where we can apply and embed anchors principles.

There is strong engagement across the pillars with good evidence of leadership being provided. However, due to system pressures and no additional resource there is limited capacity to progress actions within timescales set out in the Anchors strategic plan due to competing priorities. A lack of resilience within each of the pillars can also result in delays to work being progressed. In 2025/26 we plan to reduce our priority areas and be more focussed in our actions.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Report to Public Health Monitoring and Governance and then to Population Health Committee.

b) When was this KPI last reported?

Population Health Committee 27/09/24; Chief Executive Team 11/10/24

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 hospital teams will have produced workforce plans to support safe and effective staffing

Q3 actual: 10%
Q3 Target: 100%

Outcome: Stable and sustainable workforce in critical service areas.

Our story so far….

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

- **Theatres** – plan produced in Jan 2024, requires further update. Update delayed by lack of operational capacity at leadership level, including a vacant post since summer 2024.
- **General Surgery** – plan updated early 2024, requires further update. Planned updated April - June 2025
- **Orthopaedics** – plan updated in early 2024, requires further update. Orthopaedic service in DGH altered in May 2024 with most activity transferred to Aberdeen. Workforce plan delayed by full clinical review of service planned Spring 2025, to include recommendations for the service model and supporting workforce necessary; expected later 2025.
- **Emergency and Unscheduled Care** – significant team time spent of workforce planning in last 4 months including preparing data and training for the 6 Steps approach. Usefulness of the data hampered by complexity of providing medical cover in DGH where there are 7.5 long term medical consultant vacancies and specialist cover is included but does not deliver ward based care. Further work is planned to progress the workforce plan in March 2025.

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

Recent changes in local triumvirate leadership highlighted need for operational activity in workforce planning including development of the Moray Workforce Plan to Scottish Government by March 2025. At service level, orthopaedic service has a barrier to updating plans as detailed above.

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 production of service level workforce plans has some limited impact of the overall deliverables as there is already a broad understanding of the challenges, risks and mitigating actions in place to ensure workforce for sustainable services. This understanding is described in narrative in the Moray Workforce Plan.

Our key risks, challenges and impacts…

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

- In the medical service, a recent vacancy as Clinical Lead will cause delay
- Limited workforce and management capacity
- Orthopaedic service clinical review

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?

Lack of an updated workforce plan in Theatres Nursing has hindered an immediately available understanding of the theatres nursing workforce for the Theatres project, however this has been addressed by additional work within that project.

Commentary from

Judith Proctor,
Chief Officer, Moray H&SCP

Our mitigation and recovery actions

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

- Local Triumvirate management are communicating and supporting service teams and management with the approach to workforce planning and contributing to the Moray Workforce Plan.
- Workforce Planning is now scheduled for the first quarter of 2025 in the Surgical Directorate.
- Ongoing support from corporate Workforce Planning team in Medicine, scheduled for further input in early March.

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

- Services will produce Workforce Plans for the local Triumvirate and the Moray Workforce Plan.
- Lack of operational capacity is the key risk to undertaking and completing regular workforce planning.

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

- Workforce Plans are a Business as Usual requirement as part of operational management and will be an area reported and managed as part of the Portfolio.

What have we learnt?

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

- Workforce planning has been highlighted as a priority requirement for service management, with support from the local Triumvirate. This will be managed through operational governance structures.
- This highlight has enabled workforce planning to be prioritised for early 2025.

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

- Support is already in place from colleagues in Workforce Planning and further support may be sought from Workforce Planning colleagues in the future if required.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Production of workforce plans is assured through operational governance structures and will be further measured as part of the DGH Strategy Programme.

b) When was this KPI last reported?

- Hospital Triumvirate GM Jan 2025

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% completion of project tasks for implementation of new model for Theatres and Surgery

Q3 actual: 75%
Q3 Target: 90%

Outcome: Clear local and networked pathways delivering high quality services

Our story so far….

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

- The- Dr Gray's Hospital (DGH) Theatres project is part of the DGH Strategy
- Planned milestones included an agreed model by January with embedding of Business as Usual (BAU) by March.
- Significant progress has been made against deliverables but milestone deliverables are delayed.

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

- Workforce capacity issues as highlighted as risks in previous reports.
- Project, operational and leadership roles.

The rate of progress is slower because of lack of protected time for the project.

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 is not likely to affect 2027 Deliverables, as mitigating project actions are already underway (revised project plan).

Our key risks, challenges and impacts…

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

- Very limited project resource or funding
- Temporary loss of Senior Responsible Officer (SRO) and Hospital General Manager
- Very limited capacity of senior leadership for project
- Lack of protected time for workforce and management roles

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?

Successful completion of the project will result in a theatres function at DGH that will support capacity and productivity across the whole system, improving the rate of elective activity and waiting list performance for NHSG. Delays in completion of the project impacts on the system's ability to operate in this way.

Commentary from

Judith Proctor,
Chief Officer, Moray H&SCP

Our mitigation and recovery actions

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

- Revised project plan has been developed
- Triumvirate to reconfirm support

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

- Weekly Project Leadership meetings cover reporting of progress and delays, helping to identify the barriers to success early and ask for senior input to resolve where possible
- Lack of capacity may be a barrier to success

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

- Escalation of project risk through the local project governance structure initially

What have we learnt?

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

- Weekly Project Leadership meetings monitor progress
- Learning from the impacts of lack of dedicated time has led to revised project plan.
- The limitations in progress which arise from lack of capacity across projects is a theme in other areas of the DGH Strategy, this learning has led to risks being identified and plans for mitigation where possible

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

- Project capacity and protected time for local workforce - revised project plan has been developed which acknowledges this

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

DGH Programme Board

b) When was this KPI last reported?

Local Triumvirate 13/01/25

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

Q3 actual: 62%
Q3 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 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.
- Q3 (62%) position shows an improvement from Q2 (57%).

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

- Achievement against the KPI target fluctuates; recovery to baseline of 70% has not yet been achieved nor had the target been met. 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?

- 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 appointments in NHS Grampian Sexual heath/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.
- Concerns are on ongoing regarding retirements of specialist, experienced staff over next year; succession planning is in process.
- For several years Moray patients needing inpatient abortion have had to travel to Aberdeen twice, once for a scan and consultation by Sexual Health and again for the procedure at ARI. Some Moray women choosing home abortion have been scanned by the DGH radiology department with follow up teleconsultation with Sexual Health and medication supply by DGH pharmacy. There are ongoing discussions regarding increasing DGH capacity for abortion care assessment and procedure management.
- 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).

- The Moray Women's Health team are working with NHSG Sexual Health to offer all Moray patients a scan at DGH with telemed consultation with Sexual Health. Patients therefore will only need to travel to Aberdeen if they are having inpatient procedure at ARI. This is due to be implemented mid-march.
- Increase opportunities staff training in scanning; succession planning for staff leaving the service, escalation of risk and need to advertise posts in good time.
- 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; consider best possible care option and offer an appointment within one week of completed scan/face-to-face appointment (if required).
- Work ongoing to understand barriers to contraceptive delivery in primary care/postpartum and with women (lived experience).

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 are 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: Q2 PAFIC 27/11/24 and HAWD 12/12/24 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)

Q3 actual: 26.3%
Q3 Target: 18.75%

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 decarbonisation of Heat and Power within the NHSG estate. Topics covered include sources of funding for capital and pre-capital projects, collaboration between NHS Grampian and local authorities and specific actions for Foresterhill which is responsible for over 80% of the organisations emissions for heat and power. Green Public Sector Estates Decarbonisation Scheme which is the primary funding source for NHS decarbonisation project is Scotland is currently closed with no plans to reopen.

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. Pre capital funding has been secured to progress a feasibility study to look at Deep Geothermal heat for Foresterhill. Communications between NHS Grampian and all three local authorities have been positive and all parties involved are keen to progress partnership working where possible. There is currently no dedicated funding available for decarbonisation projects from Scottish Government or NHS Grampian to progress infrastructure projects.

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 investment is the main key driver to the actions and therefore deliverables within this KPI. Despite lack of funding the group has progressed action areas particularly around the procurement of Power purchase agreements that would see the board using renewable energy from known sources and partnership working with local authorities completing a study with Moray council looking at a district heating network in Elgin. While these actions are required beneficial in our transition to net zero they have not had a direct impact on our emissions.

Our key risks, challenges and impacts…

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

- Lack of funding from the Scottish Government and arm's length governmental organisations.
- NHS Grampian's emissions negatively impact the environment our patients live, reducing our emission creates a healthier environment.
- If capital funding was made available would we have the resource to utilise it.

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. NHS Scotland has committed to achieving net zero emissions in by 2040 of earlier if possible in "A Policy for NHS Scotland on the Climate Emergency and Sustainable Development" (DL (2021) 38) and sets a tighter deadline for building emissions all owned buildings be heated from renewable sources by 2038.

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?

- With an absence of dedicated funding toward energy efficiency and decarbonisation these factors are being pushed into backlog maintenance work.
- The Sustainability e-Learning module to educate staff on behavioural change they can make while at work and home has been released to promote good practice.
- A Sustainability Champions network has been established to share ideas and promote sustainable working.
- NHS Grampian Green Theatres program is running looking at making changes in theatres such as the reduction in waste through innovative disposal methods and reduction in energy consumption by switching off plant when not in use.

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?

- **Complex requirements of healthcare:** This area encompasses emerging technologies that are undergoing rapid development, which in turn affects their viability for implementation in the healthcare setting. Electrifying heat sources would be a simple way to decarbonise heating but the operational costs would be significantly higher and resilience is an issue as highlighted in the new mortuary project where there electric boiler are not back up by the emergency generator due to the load required. Alternative heat supplies must be investigated such as heat recovery from waste water or deep geothermal.

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 decarbonising the estate, such as reduced financial penalties such as the civil penalty the board paid SEPA for breaching our UK Emission Trading Scheme emission allowance and improved operational efficiency of our infrastructure with measure such as window replacement and insulation must be emphasised more robustly when addressing backlog maintenance.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

- Sustainability Governance Group
- Asset Management Group

b) When was this last reported?
Heat & Power Meeting 09/12/24

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

Q3 actual: 23280.06 tCO2e
Q3 Target: 15779 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 target reduces year-on-year to incentivise those who are part of the scheme. NHSG has purchased additional allowances since 2018 due to exceeding its continually decreasing CO2 allowances. This has resulted in increased cost associated with the purchase of additional allowances further compounded by 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?

In Q3, several challenges contributed to us falling further from the target:

- increased downtime of the biomass boiler led to a higher reliance on carbon intense heating methods.
- Baird and Anchor buildings are now both taking heat from the energy centre, increasing the base heat load demand and overall energy use.

However, there are positive developments. Utilising local contractors we plan to restart the biomass boiler, expected to happen in the New Year. This will help reduce reliance on gas fired heating. Long term, grant funding for a feasibility study on the use of deep geothermal heat at Foresterhill was secured. If the study yields positive results, new opportunities for decarbonising heat on the site could result, significantly impacting our future performance.

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

Performance of this KPI is crucial as it directly influences our deliverables and the achievement of our 2027 Outcomes. The primary driver for our actions and deliverables within this KPI is investment. Without significant investment in decarbonisation efforts at Foresterhill or an increase in allowances under the UKETS permit, achieving this KPI will remain challenging.

Our key risks, challenges and impacts…

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

- 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.
- Exceeding our emissions allowance results in substantial financial penalties. For the year 2023, this penalty amounted to £635,594.65 and 2024 is forecast to be similar.
- Imperative to develop a robust mechanism that facilitates necessary level of investment to reduce emissions at Foresterhill.

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?

Performance of this KPI is crucial as it directly influences our deliverables and the achievement of our 2027 Outcomes. The primary driver for our actions and deliverables within this KPI is investment. Without significant investment in decarbonisation efforts at Foresterhill or an increase in allowances under the UKETS permit, achieving this KPI will remain challenging.

The current performance highlights the need for continued and increased investment in sustainable technologies and infrastructure. This investment is essential to drive the necessary actions and deliverables that will enable us to meet our 2027 Outcomes. Until we secure this investment or see an increase in allowances, our progress towards achieving this KPI will be hindered, impacting our overall sustainability goals.

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 decarbonising the estate, such as reduced financial penalties and improved operational efficiency, must be emphasised 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

b) What are 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 Public Bodies Climate Change Duty (PBCCD) report as well as the Annual climate emergency report

c) When was this last reported?

Q2 PAFIC 27/11/24 and HAWD 12/12/24

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): An increase of 200 in completion of Turas module on Shared Decision Making by end March 2025

Q3 actual: 1178
Q3 Target: 1174

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 to support communication and awareness raising. Q2 showed a slight drop off in relation to KPI, however the programme's flexible approach has ensured that this has recovered and back on track for Q3, and therefore the target for the year.

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).

In Q3, we have had some key events with large audiences to promote the module and make it relevant to these groups (medical education conference, respiratory MCN winter event). Furthermore, the programme's continued communication plan on Treatment Escalation Planning has connected the module also, as well as established induction routes (such as flying start).

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

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 and a suite of additional evaluation methods are written into the programme to look at a range of perspectives.

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?

The programme continues to connect the KPI in meaningful ways. Continue to evaluate shared decision making through a range of methods, and use the KPI as a high level indicatory.

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. This is evidenced in the recovery of the KPI in Q3.

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 increased from 7% to 11% since the launch event and continued communication plan since August 2024. 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 underway 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 406 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 / 1400 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 are 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 Accountability and Assurance pack January 2025 (sway resource)

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

Q3 actual: 47.2%
Q3 Target: 52.5%

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 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. While this KPI has been positive affected by the introduction of comms and bin availability, it is still reliant on patient episode clinical waste production, which will continue to contribute to the Board embodied and operation emissions.

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
- There is a clear disconnect between the waste producers and the impact they are having both financial and environmentally,
- There is a need for the waste producers to see the impact they are having and have a greater responsibility of their actions as their current mal-practice has no direct impact upon their activities or outputs on a direct basis, meaning staff are too separated for a change to be made through current practices. Highlighting the need for a change in staff behaviour through direct examples.

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?

- Changes and improvements in recycling options have been introduced across several sites in Aberdeen City Health and Social Care Partnership (HSCP) across Q3, to continue in 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
- We have supplied 130 recycling bins to date, budget limited.
- 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. Also looking to increase face-to-face interaction and linking in with Pre-Assessment Audits for waste.

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 are the assurance and governance oversight arrangements?

- Waste weights are included in the Public Bodies Climate Change Duties (PBCCD) 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?

Operational meetings taking place on a quarterly basis, last reported 30th January 2025, and F&E SLT 28th January 2025

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

Q3 Actual: 1302.5T
Q3 Target: <1280.36T

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 what equipment is 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?***

We appear to not be aligned with the quarterly target 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.

Measuring the amount of clinical waste being produced per patient remains an ongoing national work, 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 not 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. While this KPI has been positive affected by the introduction of comms and bin availability, it is still reliant on patient episode clinical waste production, which will continue to contribute to the Board embodied and operation emissions.

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?

- Ongoing identification of number of recycling bins required across all sites for diverting materials out of clinical waste bags.
- Purchasing recycling bins for identified wards completed 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; planned creation of an "exemplar" theatre.
- We have supplied 130 recycling bins to date, budget limited.
- There is a new Sustainability campaign including waste all set out for 2025, including particular target dates linking to legislative targets.
- Workshops for F&E managers within Domestics, Portering and Maintenance and Technical Service (MaTs).

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. Also looking to increase face-to-

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 Foresterhill) 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 access to Recycling bins and on the ground staffing would be beneficial.

Oversight and assurance

a) ***What are 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
- Occupational Health Service (OHS)
- Waste weights are included in the Public Bodies Climate Change Duties Report to Scottish Government.

b) ***When was this last reported?***

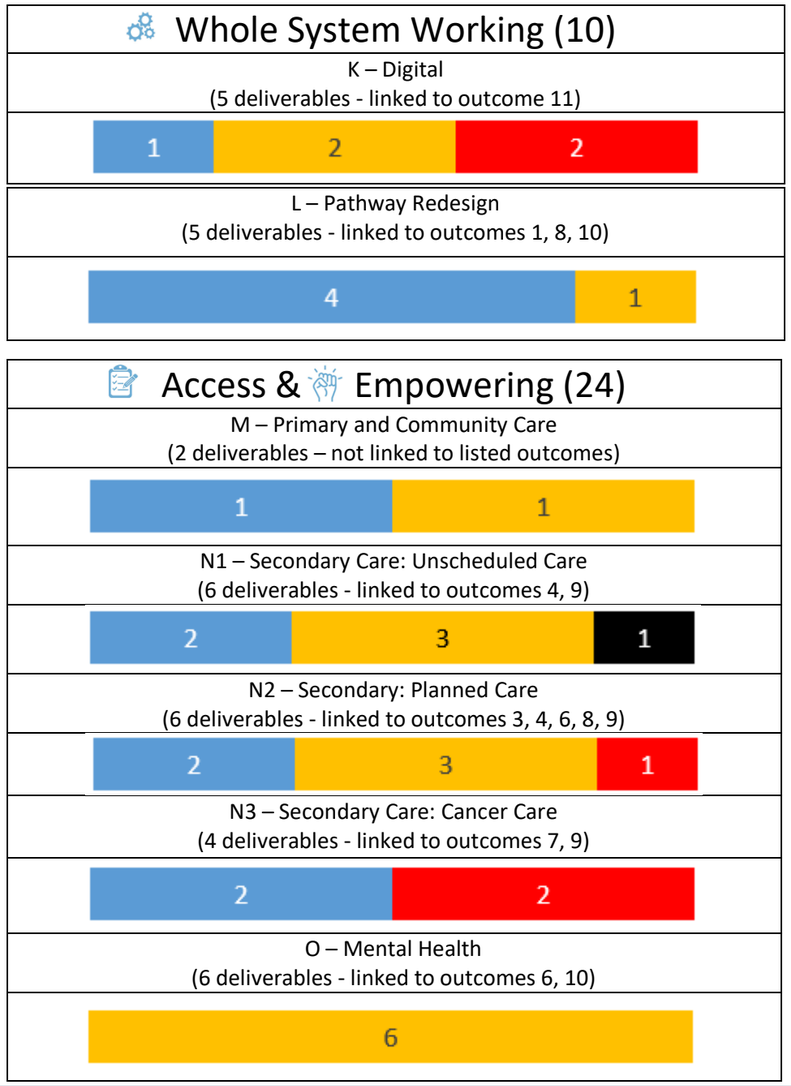
Operational meetings taking place on a quarterly basis last reported 30th January 2025, and F&E SLT 28th

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 Q3**
Finance – Funding not yet agreed	18
Workforce – Capacity	13
Workforce – Recruitment	12
Infrastructure - Estates	11
Finance – Non recurrent funding	9
Finance – Insufficient Funding	9
Workforce – Retention	7
Workforce – Training, Development and Skills	7
Workforce – Absence	6
Workforce – Wellbeing	6
Infrastructure – Digital	2
Other (National Policy, Systems – National, Data & Modelling, Engagement)	2
Procurement	1

Complete Minor Delay Significant Delay Postponed

Performance of Key Performance Indicators

Performance against 12 Pathways KPIs across Whole System Working, and Access and Empowering – linked to Outcomes PA8, PA9, PA10, PE18

More information available in Scorecards

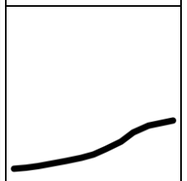
Assessment Rating	Red	Amber	Green
Criteria (Where a category only has one KPI, the RAG rating for that category will be the same as for its KPI)	2 or more red Key Performance Indicators	1 red Key Performance Indicator	0 red and 1 amber Key Performance Indicators

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 (Mar2024)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend (12 months to Dec 2024)	Benchmarking (11 mainland Boards: 1st = best performing)	Why are we in this position? *When was this last reported?*
			Actual	Target	Actual	Target	Actual	Target	Actual	Target			
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	**2070**	**<1500**		<1400		11th (Sep 24 census point)	Primarily due to inability to re-open short stay theatres and some impact from Central Decontamination Unit (CDU) issues *Last reported: Formal reporting to Scottish Government on a weekly basis* Note: targets updated in Q2, in line with revised agreement with SG spotlight on page 49
	We will minimise the number of waits over 104 weeks for a new outpatient appointment	625	829	<700	1426	<700	**1747**	**<900**		<1000		11th (Sep 24 census point)	Continuous challenge in key specialities and with proportion of urgent and USC patients being referred. Full elective care plan not implemented due to funding constraints *Last reported: Formal reporting to Scottish Government on a weekly basis* spotlight on page 50
	Average monthly delayed discharges to be no greater than Q4 2023/24	254	274	<255	283	<255	**282.3**	**<255**		<255		comparative benchmarking not available	Complexity of need remains high for delayed discharges. There is limited capacity for care homes across the region, with demand outstripping capacity with providers being able to select self-funders or people with lower needs. Financial positions of HSCPs are impacting on what opportunities are available. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 51

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** (Mar2024)	**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 Dec 2024)	**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%	**34.1%**	**<32.6%**		<32.6%		comparative benchmarking not available	Complexity of need remains high for delayed discharges. There is limited capacity for care homes across the region, with demand outstripping capacity with providers being able to select self-funders or people with lower needs. Financial positions of HSCPs are impacting on what opportunities are available. *Last reported: December 2024 Discharge without Delay Improvement Group* spotlight on page 52
	72% of citizens will receive first treatment within 62 days of urgent suspected cancer referral	55.0%	60.65%	72%	53.9%	72%	**60.3%**	**72%**		72%		11th (quarter end Sep 24)	Backlog clearance activity in Q1 & Q2 reduced backlog in some areas however, overall the backlog of cancer patients awaiting diagnosis and treatment have remained static and therefore performance has only marginally improved since Q2. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 53
	95% of citizens will receive first cancer treatment within 31 days of decision to treat	89.9%	89.96%	95%	88.4%	95%	**87.3%**	**95%**		95%		11th (quarter end Sep 24)	Competing demands have impacted time to treatment. This includes regional mutual aid in oncology and surgical treatments. Hospital flow continues to be a challenge and further infrastructure issues such as the shutdown of CDU has impacted capacity. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 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** (Mar2024)	**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 Dec 2024)	**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. 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.	**Reduce NHSG 90th percentile SAS turnaround times to 110 minutes by quarter 4 2024/25**	203	196	160	210	145	**241**	**135**		110		11th (quarter end Sep 24)	Ambulance turnaround times continue to increase as a result of insufficient flow within and out of the Acute setting. While it is well established that the NHSG bed base is a constraining factor, the data suggests that there are nearly always more bed waits in Emergency Department (ED) and Acute Medical Initial Assessment (AMIA) than there are ambulances stacking, and there are always significantly more delayed discharges in ARI than there are bed waits in ED and AMIA. This suggests that the majority of the challenge lies in downstream capacity as the pathways in the hospital are sufficient to manage the level of front door demand. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 55
	70% of citizens will be seen within 4 hours in NHSG Emergency Departments	60.7%	60.8%	70%	61.0%	70%	**57.9%**	**70%**		70%		9th (quarter end Sep 24)	While it is well established that the NHSG bed base is a constraining factor in allowing timely admissions from ED, and the data suggests that there are nearly always more bed waits in ED and AMIA than there are ambulances stacking, and there are always significantly more delayed discharges in ARI than there are bed waits in ED and AMIA. There are predictable periods within the operations cycle where flow out of ED is not the factor which impacts on 4 hour performance. Reduced staffing levels in the ED overnight and at weekends, regularly compromises the pace of assessment, and this is exacerbated when RESUS is in high demand. *Last reported: Q2 PAFIC 27/11/24 and HAWD 12/12/24 Spotlights* spotlight on page 57

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** (Mar2024)	**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 Dec 2024)	**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. 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.	**Average length of stay (LoS) 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	**6.38 days**	**<6.54 days**		<6.54 days		comparative benchmarking not available	Focus within clinical areas round discharge processes and a greater volume of clinical decision-making as a result of the formation of the boarder team has largely offset the anticipated rise in LoS through the winter period. While the volume of Delayed Discharge and Delayed Transfer of Care (DTOC) have not decreased, the proportion of very long delays have reduced through more stringent review and system-wide coordination to facilitate complex patient moves. *Last reported: Weekly performance data is submitted to Scottish Government* spotlight on page 59
PA10 - Achieve mental health outcomes in concordance with national strategy. PE18 - Improvement in outcomes for children realised & evidenced, measured through agreed key performance indicators (KPIs).	**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%	**97.7%**	**90%**		90%		5th (quarter end Sep 24)	CAMHS Grampian continues to me the Scottish Government Waiting Times standards for those children and young people being referred to specialist mental health services within 18 weeks of referral. With the average waiting time being 8 weeks from referral to treatment. *Last reported: MHLDS Governance Monthly Assurance Group Jan 2025*
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%	**80.3%**	**70%**		70%		5th (quarter end Sep 24)	The PT and CAMHS performance data has been combined over recent months which is the main reason for improvement in overall performance seen. However maintenance of the 80% 18 week Referral to Treatment (RTT) is testament to the continued hard work of the staff given current financial challenges *Last reported: PT Improvement & Governance Board Jan 2025*

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: 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 (Mar2024)	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	
PA8 - 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%	**65%**	**75%**		100%	The lack of funding for the development of a frailty Managed Critical Network (MCN) has impacted on the delivery in Q3 but this is being addressed by the redevelopment of the frailty board, work is taking place in early 2025. The process mapping and link to the new frailty standards has also been delayed but is due to be worked on in Q1 2025. *Last reported: Frailty Programme Board 16/12/24* spotlight on page 60

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

Q3 actual: 2070
Q3 Target: <1500

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. Our 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. This is now unlikely to occur before 2025/26.

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. The full use of the planned care funding has been agreed so there is investment in core staffing that will assist the position from around mid-2025.

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 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 remain an issue with the potential for short term service interruption. Our ability to bring the short stay theatres back into operation remains the crucial step to begin to have an ability to begin to systematically address the longest waiting patients. The consequences of the 10% service reduction ask require to be modelled for their planned care impacts when they are known. The Orthopaedics suspension at Dr Gray's is not yet visible in this performance measure and available capacity is being reallocated towards other services at present. A stable elective plan for Dr Gray's needs to be formed and the impacts of this can then be assessed in the medium term. Datix Risk ID 3065 is recorded against this risk.

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 deliverv.

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 we, 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?
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 are 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

Q3 actual: 1747
Q3 Target: <900

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).
- 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.

b) What changes or trends have occurred this quarter, and how might they affect future performance?
The trends previously visible have continued though the commencement of Independent sector contracts has impacted positively on the 104 week position. 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 consequences of efficiency savings is as yet unknown on their impact on planned care. 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. Datix Risk ID: 3065 applies.

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 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 are 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

Q3 actual: 282.3
Q3 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?

Discharge without delay are a jointly held responsibility, shared by Aberdeenshire, Moray, and Aberdeen City Integrated Joint Boards (IJBs). As a result, the performance picture is comprised of differing experiences across the NHS Grampian region.
Aberdeenshire and Moray saw a decrease in the number of delays in Q3 2024-2025.
Aberdeen City have seen an increase in delays in Q3 due to impact on closure of interim beds as were funded with non-recurring money. Significant work is being undertaken to balance the Aberdeen City IJB budget and difficult decisions will be required which will impact on our performance in this area.
Mental Health and Learning Disability (MHLD) have seen a 26% reduction in discharges without delay, this has been achieved through reviewing systems and processes.

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

There has been a slight increase in patients in NHSG waiting for Guardianship, an increase in patients awaiting care home place and an increase in patients waiting for care, this will impact on the flow of patients through the system. In response, surge capacity has been identified and deployed during high risk periods for acute. Place availability and care arrangements continue to be the main reasons for standard delays in Aberdeenshire, whilst progress in relation to Adults with Incapacity (AWI) processes continue to be a factor in most complex delays, followed by place availability.

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 Delivery Plans, in conjunction with NHS Grampian's 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?

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. Workforce Capacity limitations.

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 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
- An Aberdeenshire Care Management Team is based in the ARI hub to increase efficiency and ensure new referrals are picked up promptly
- Delayed discharge data is fed into Daily Situation Update meetings, chaired by the Senior Manager on Call
- Teams work with the Care Home Assurance Team to support transition to a care home for people with complex needs
- Senior management oversight and scrutiny of delayed discharges is led by a Partnership Manager, supported by the Location and Service Managers who lead on delayed discharges for their areas/sector

City

- People are allocated care manager on the day of referral.
- Daily meeting with Provider to prioritise care at home capacity, balancing risk for need within hospital and community.
- Considering reallocation of bed based system to community focus for prevention and early intervention and reducing need for hospital admission

Moray

- Continual monitoring of data to help inform service improvement. Workshops and daily meetings continue to support this.
- 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?

• 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.
• We continue to review the delays due to adaptations and seek to find solutions to move people to more appropriate environment. We also make use of Sheltered or Very Sheltered accommodation as an interim solution where available and relevant, these will continue as interim beds reduce.
• Daily oversight of available resource with senior managers from community and acute, collective decision making around the allocation of available resource in line with Grampian Operational Pressure Escalation (GOPES)

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

Consistent review of each HSCPs recovery actions. Opportunities for learning and sharing from existing practice in each IJB via Weekly Discharge without Delay meeting for NHSG. 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?

Aberdeenshire:

- Test of change for TrakCare access had positive impact on flow. To be embedded in practice for Care Managers
- Step Up opportunities should be increased

Aberdeen City:

- Minor readjustment of case allocation to hospital social work team allowed greater focus on discharges
- Discharge to Assess team increasing confidence of clinical teams to consider this option
- Raising awareness of Technology Enabled Care across population to enable discharges

Moray:

- Daily operational engagement with shared decision making will generate creative solutions to reducing delays, encourage flow 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 & MHLD. Scottish Government colleagues supporting Shire HSCP via several Discharge Without Delay workshops.
Weekly Discharge without Delay meeting & CRAG continue in sharing learning and opportunities with other HSCP's.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

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

b) When was this KPI last reported?

Q2 PAFIC 27/11/24 and HAWD 12/12/24

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

Q3 actual: 34.1%
Q3 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?

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 was to reach a maximum of 34.6 delays per 100,000 adults in Grampian. Delayed Discharges are a jointly held responsibility shared by Aberdeenshire, Moray & Aberdeen City Integrated Joint Boards (IJBs). At Q3's CRAG data NHS Grampian had 31.7 standard delays per 100,000 adults.

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

The numbers continue to vary on a daily basis, we have seen an increase across Grampian this year. With the financial pressures experienced across the system we are seeing an impact on people who are delayed. There have been a reduction in delays in Moray and Aberdeenshire in this quarter. Aberdeenshire were down to less than 100 delays for the first time this year. HIS are continuing to work with Mental Health & Learning Disability (MHLD) service where they have seen a 26% reduction in delays. Health Improvement Scotland (HIS) are continuing to work with Aberdeenshire. This target has been supported by joint working via the Discharge Without Delay Group for NHSG.

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

HSCP activity is overseen by IJBs and comes through their Strategic Plans, implemented through their 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. HSCP's continued 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
- Increase risks in the community with unmet need
- Capacity 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, 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 – Working with SG Rapid Peer Review & Support Team (RPRST) and current priority areas of focus are development of D2A and community hospital discharge SOP for Aberdeenshire Community Hospitals.
Community Hospital Frailty Review to optimise access to community hospitals and identify barriers and solutions to achieve consistent and effective MDT working across Aberdeenshire, linked to above.
Care Home Collaboration Nursing Team continue to try to support facilitation of care home placements for people with complex needs. *IMPORTANT NOTE – the AHSCP have had to implement an interim operational change to our existing process for care home allocation/funding to bring spend into line but mitigations are in place and detailed in briefings already issued to the system via the CET. This is not a service or policy change at present.*
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.
Focus on Planned Discharge Dates (PDDs) and learning from best practice to spread to MDTs, linked to above – one Aberdeenshire ward significantly higher than all other wards consistently.
Moray – Testing the combination of AHP D2A with the START team (enablement care at home team) to encourage early discharge. Continue with daily wide system operational meeting to ensure full use of all available resource to support flow through patient flow through our systems. Work is ongoing to ensure effective MDT decision making with the roll out of "How good is our MDT" and supportive decision-making tools.
City – Restructure of hospital social work team to oversee only hospital patients with community teams involved only once discharged.
Testing Discharge to Assess team with a provider.
Secured funding and third sector partner to progress supporting Power of Attorney earlier in the process.
Technology Enabled Care considered first for all care needs
Greater scrutiny on PDD compliance.

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 monitor via NHSGs fortnightly DWD meeting. Health Improvement Scotland continue to assist both Aberdeenshire & MHLDs

What have we learnt?

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

Shared learning locally and nationally at the fortnightly Discharge without Delay meeting.

Weekly system meeting looking at finance and flow with PEL & Chief Officers (COs).

Quarterly reporting to Clinical Care Governance Committees on progress and reporting to PEL monthly meeting. Each HSCP has internal monitoring of progress.

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

Good support from HIS and sharing that with wider system.

Acknowledgement of the financial challenges faced by the wider system and the difficult decisions that are associated and potential impact.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Fortnightly Discharge without Delay Improvement Group meeting established to have oversight of improvement plan. Established reporting mechanisms in place. COs continue to attend weekly national CRAG meeting.

b) When was this KPI last reported?

December 2024 Discharge without Delay 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

Q3 actual: 60.3%
Q3 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 negati 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 following Q1 & Q2 backlog clearance funding has ended
- The diagnostic backlog is increasing once again
- 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?

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 are 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 National Treatment Centre (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 are 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?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 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

Q3 actual: 87.3%
Q3 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?

The number of patients treated against the 31-day standard in the last reporting quarter (Oct – Dec 2024) has resumed to consistent levels. Despite the increase in activity, performance has remained below target.

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

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 are 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 are 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?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 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

Q3 actual: 241
Q3 Target: 135

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?

- 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, and submission of an urgent improvement plan to NHS Scotland in mid-November.
- Ambulance turnaround time is directly linked to 4 hour access performance KPI. Addressing ambulance waits through additional measures is only required if the flow from front door areas is constrained, or there are very specific peaks in demand.
- Further flow pressures linked with increased presentations, patient acuity, and constrained discharge pathways over this quarter have increased hospital occupancy and a decrease in 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 be sustained over the remainder of winter as occupancy pressure increases.

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

- 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.

Commentary from
Geraldine Fraser

Executive Lead
Medicine & Unscheduled Care (MUSC) Portfolio

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 again over this 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. A recent Test of Change relating to triaging in ambulances outside ED has shown a marked improvement in patients being accelerated into the department. This will be implemented permanently.
- **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 AMIA 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 was 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. Support from CfSD in implementing their recommendations of Jan 2025 has been offered.

Oversight and assurance

b) What are 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?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 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

Q3 actual: 57.9%
Q3 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 and increasing pressure from Scottish Ambulance Service.

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

Occupancy challenges which persisted over much of the summer have further increased. Given the influence of bed volume on performance and our challenges, performance over the last quarter has decreased. Additional capacity for General Medicine patients has been created in W308, which has eased pressure on the most challenged specialty in terms of demand, and this has potential to increase the pace of recovery when seasonal demand and acuity lessen.

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

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 Emergency Department (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, and a reoccurrence of trainee shortages remains likely.
- 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. Recent feedback from the Centre for Sustainable Delivery (CfSD) includes a number of medium term measures which will improve efficiency within the acute setting – these will be incorporated into the plan going forward.

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 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 are 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?

Q2 PAFIC 27/11/24 and HAWD 12/12/24 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

Q3 actual: 6.38 days
Q3 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 decline in health if discharge is not achieved soon after clinical fitness is achieved.
- The MUSC portfolio operates 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 a slight increase in overall LoS for the MUSC portfolio over this quarter. Seasonal variation usually delivers a larger increase through the winter. Further, the volume of Delayed Discharges remains high which also pushes LoS up. LoS to the point of being clinically fit for discharge remains very stable at 6.2 days.

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

- 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.

<u>Priorities for Q4 2024:</u>

<u>Reducing 7 & 14 day LoS.</u> The MUSC portfolio continues 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, including better utilising the Planned Discharge Date (PDD).

<u>Discharge Champions.</u> 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. Formal evaluation reports in March 2025.

<u>Multi-Disciplinary Team Working.</u> 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. Following the opening of W308 for GenMed, the MUSC Leadership Team will continue 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

b) What are 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

Q3 actual: 65%
Q3 Target: 75%

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 some workstreams within the Grampian Frailty Programme has not progressed as anticipated due system pressures.

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. Moray HSCP has completed their involvement in the Health Improvement Scotland (HIS) Focus on Frailty Programme with the focus on the early identification of frailty being a priority. High level mapping of the frailty pathway has taken place but further work is required particularly in connection to the new frailty standards that were published in late Nov 24. In City, work has progressed with the Geriatricians to develop a liaison service with a trial scheduled to commence in Jan 25, a trial for Discharge to Assess has already commenced. Collaboration between hospital and community services continues to be a focus supporting alternative to admission, this has seen an increase in referrals to the Enhanced Care huddles. In Aberdeenshire, work has been completed around the Review of the Virtual Community Wards & primary care teams are now to be working to the new Service Level Agreement (SLA) that has been shared with GP practices alongside a Standard Operating Procedure (SOP). The Community Hospital Review around the pathway for patients with frailty is nearing completion & a paper is expected to be shared with the Aberdeenshire SMT Q1 25.

c) How is the performance of this KPI impacting your Deliverables and the achievement of our 2027 Outcomes?
The performance of this KPI has had a minor setback due to capacity of staff but the work continues to be progressed and should not impact of the achievement of the 2027 outcomes. 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 – looking to seek balance between finances, performance and improvement
- Workforce – Recruitment and retention challenges persist and the implementation of the reduced working hours are challenging to ensure appropriate staffing levels
- Rosewell Review – The review and decision on the future of this key service within the frailty pathway is being considered

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 progress of the Grampian Frailty Programme plan has the potential to impact on the front door, due to the high level of older adult admissions. Links with the Unscheduled Care (USC) board are in place and any areas of concern are shared and discussed.

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 frailty board are developing a network within its remit to ensure frailty learning is widely communicated and shared. Work is scheduled to take place Q1 2025 to develop the board to enable this.
Regular meetings of the frailty board ensure actions and mitigations are identified to improve performance and reduce harm. The frailty dashboard on illuminate allows performance across the frailty pathway to be easily monitored.
Moray's participation within the HIS frailty programme has enabled this learning to be shared and the Board are keen to take forward the development of the frailty icon to help support the identification of frail patients across Grampian.
The development of the Liaison and the Discharge to Assess services have the potential to mitigate and reduced the risks listed as these services aim to reduce patient length of stay, improve flow and offer better outcomes for the patients. (In Aberdeenshire – discharge to assess has been considered, but is not possible without new funding to support at this time.

b) How will we measure the expected impact, and what could prevent success?
The new frailty standards were released in late Nov 24, evaluation against these is being undertaken by each of the partnerships to understand gaps and identify key areas for development within the frailty system. The identified risks are the key areas that could impact on the success of delivery of this work.

c) If something hasn't worked, what alternative course of action will be taken? The Frailty Programme Board meets to discuss progress and identify solutions to areas of insufficient progress / concern. Updates are also provided to the USC Board.

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 regularly to review and evaluate the progress made on the frailty programme plan, learning is shared and actions and mitigations are identified where progress is not taking place. A frailty workshop is planned in Q1 2025 to review the programme board and ensure key areas of work are being progressed in line with the recently published frailty standards.

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, with the aim to ensure the board provides the role of a frailty Managed Clinical Network (MCN) alongside the progression of key pieces of work e.g. early identification of frailty (frailty icon) ensuring compliance with the new frailty standards across the system. This work will take place in Q1 2025.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Frailty Board reports to Unscheduled Care Programme Board on progress

b) When was this KPI last reported?
Frailty Programme Board 16/12/24

Appendix: National Waiting Times Standards

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2023**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Quarter end Sep 2024**	**Benchmarking** (of 11 mainland Boards quarter end Sep 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%	70.7%	66.5%	66.7%	67.9%	**67.6%**	7th Scotland: 69.5%	Overall A&E performance increased over the three quarters to June 2024, before a fractional decrease to September 2024. The level remains lower than at the same time the previous year. We have moved from 6th to 7th position of the mainland Boards (with Ayrshire & Arran improving); we remain below the overall Scotland level. *This performance recovery is surprising, given the increased proportion of DD/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%	37.5%	33.8%	39.4%	42.2%	**48.3%**	8th Scotland: 53.6%	Performance had decreased each quarter through 2023/24, before improving for the first two quarters in 2024/25. We have moved from 9th to 8th position of the mainland Boards (with a decrease at Lothian); 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. The rate of improvement in Endoscopy is likely to deteriorate as significant capacity ceased at the end of Dec 2024.*
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%	66.6%	64.2%	61.8%	65.9%	**64.0%**	7th Scotland: 63.9%	Performance decreased for the quarter to September 2024, following an increase the previous quarter. This pattern was also observed at Greater Glasgow & Clyde, Highland, and Lanarkshire, as well as Scotland overall. We have remained above the overall Scotland level for the last three years. *Our elective care plan does not directly address this metric. Our longest waits to continue to be above trajectory though the lower waiting trajectories are over performing demonstrating a split between specialities. There has been a positive downward trend in the longer waits throughout January*

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2023**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Quarter end Sep 2024**	**Benchmarking** (of 11 mainland Boards quarter end Sep 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%	45.9%	47.3%	43.9%	46.2%	**46.1%**	9th Scotland: 57.7%	There was a fractional decrease in performance for the quarter to September 2024, following an increase the previous quarter. We have moved from 11th to 9th position of the mainland Boards (with decreases at Forth Valley and Lanarkshire); 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 will not now be this financial year. 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%	89.6%	90.5%	89.5%	89.2%	**88.4%**	11th Scotland: 94.3%	Performance decreased for the third consecutive quarter, to September 2024. We have been below the overall Scotland level for the last year and a half. *We are not where we had have hoped to be, Capacity issues as well as infrastructure issues has slowed progress. Despite poor performance, levels of activity in the number of cancer treatments delivered have remained high.*
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%	57.0%	54.4%	55.0%	60.6%	**53.9%**	11th Scotland 72.1%	Following an improvement through the first two quarters of 2024, performance decreased to September 2024. We have moved from 10th to 11th position of the mainland Boards (with improvement at Tayside); we remain consistently below the overall Scotland level. *This is not where we would want to be, but the Q end June 2024 did meet the projected target for the period. Capacity issues, particularly in diagnostics, as well as infrastructure issues has slowed progress. Despite poor performance, levels of activity have remained high. The demand in referrals to cancer pathways have also remained high and outweigh available capacity which generates a backlog and thus any efforts to reduce the backlog results in a reduction in the performance and does not translate the work of the system to maintain or recover.*

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2023**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Quarter end Sep 2024**	**Benchmarking** (of 11 mainland Boards quarter end Sep 2024: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
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%	84.7%	96.7%	97.4%	96.5%	**97.9%**	5th Scotland: 89.1%	After decreasing for the first quarter of 2024/25, performance improved for the quarter to September 2024. We have moved from 4th to 5th position of the mainland Boards (with improvement at Fife); we remain above the overall Scotland level, and have returned to achieving the national target for the last year. *The services continue to operate with reduced capacity due to various financial/funding challenges impacting recruitment and retention of staff over the previous 2 quarters. Nonetheless, our performance to waiting times standards has remained relatively stable which we aim to maintain over the coming quarter.*
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%	74.3%	76.4%	75.4%	81.7%	**80.4%**	5th Scotland: 80.0%	Performance decreased for the quarter to September 2024, following an increase the previous quarter. We are above the Scotland level for the second consecutive quarter for the first time in over two years. *The services continue to operate with reduced capacity due to various financial/funding challenges impacting recruitment and retention of staff over the previous 2 quarters. Nonetheless, our performance to waiting times standards has remained relatively stable which we aim to maintain over the coming quarter.*
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 *We are performing comfortably at our targeted goal. Many of our patients are being brought through the pathway from referral to commencing of treatment on a much smaller timeline. It is again thanks to our brilliant team here at Aberdeen centre for reproductive medicine that are focused on providing the highest level of care for our patients.*

From national waiting times publications