How are we doing?

Q4 and End of Year 2024/25 Annual Delivery Plan
Board Performance Report

June 2025

Content

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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.

Our Vision and Strategic Intent

Integrated Performance Assurance and Reporting Framework

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

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

Alignment of our Plan for the Future and Performance

A

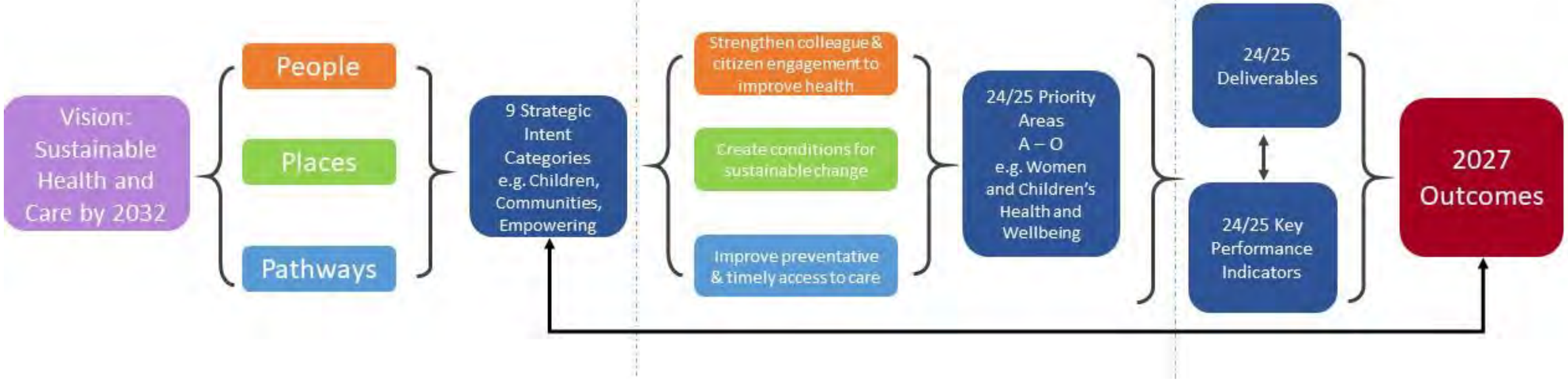
Strategic Intent

B

24/25 ADP Objectives and Priority Areas

C

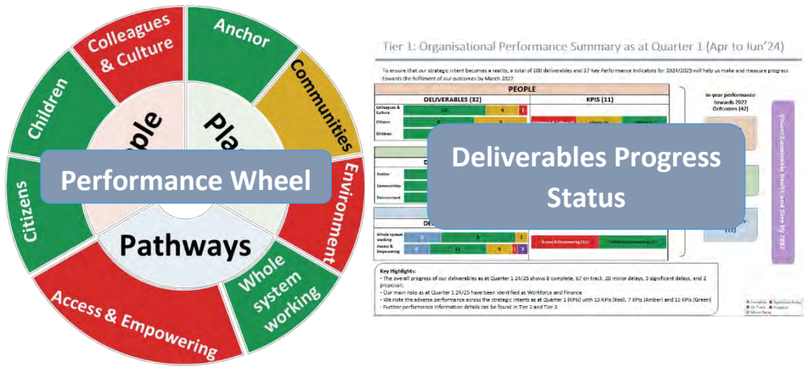
How we measure, track our performance against objectives and priority areas through KPIs, supported by deliverables to achieve our 2027 outcomes



Reading Guide

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

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



This section covers two key areas of focus:

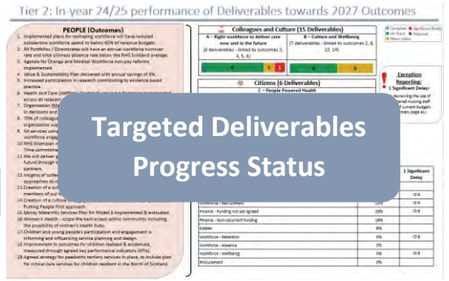
1) Our Board Performance Summary across our strategic intent:

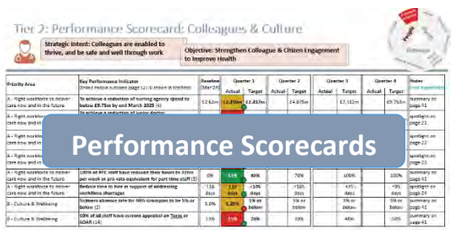
The Performance Wheel and Deliverables above indicate a high level overview of our performance as a Board across each of our strategic intent set out in People, Places and Pathways. The Red, Amber, Green (RAG) rating assessment criteria for the Key Performance Indicators (KPIs) and progress status of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

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

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

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





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

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

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

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

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
Postponed
Minor Delay
Significant Delay

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 4 and End of Year 2024/25 HAWD Report presents NHS Grampian's performance against the annual Deliverables and KPI targets set out in the 2024/25 Annual Delivery Plan (ADP). It also marks the formal end-of-year position, highlighting the progress made throughout the year while recognising the impact of financial constraints, workforce capacity challenges, and infrastructure limitations, factors that have influenced both our short-term deliverables and targets, as well as our trajectory toward 2027 outcomes. Despite these challenges, our teams remained focused on learning, adapting, and driving meaningful progress.

Of the 100 Deliverables targeted for completion this year, 45 have been completed, with the remaining 55 progressing under appropriate system oversight arrangements across the organisation. In Q4, 60 Deliverables met their milestones, an improvement of 3 compared to Q3. Our performance metrics show mixed results where 32% of Key Performance Indicators (KPIs) improved, while 55% declined. Notably, 55% of KPIs were rated Red, representing a 6% decrease compared to the last quarter at 61%. To support a more holistic understanding of progress, the revised spotlights integrate both quantitative measures and qualitative insights, enhancing transparency and providing assurance on areas of strength and those requiring further attention.

The Performance Wheel reflects this slight improvement, with 2 strategic intent categories now rated Green and 5 categories rated Red compared to the previous quarter. These shifts continue to highlight the complexity of balancing system-wide demands while advancing our strategic priorities in the face of ongoing challenges. Performance against national waiting time standards remains mixed, with capacity and funding constraints impacting key areas, though CAMHS and IVF continue to consistently exceed targets.

The end of year offers an opportunity to reflect on our delivery, performance, and the improvements achieved during 2024/25, while continuing to evolve our reporting approach as we look ahead to the 2025/26 ADP. Strengthening our ability to assess the effectiveness of actions, and the contribution to outcomes and medium term priorities, will be essential to maintaining confidence and ensure sustained added value in what we do across NHS Grampian.

The implementation of the NHS Scotland Operational Improvement Plan will also influence our reporting approach for the coming year. Initial updates are included in this report, alongside progress against the Scottish Government Waiting Times Standards.

Listening to our workforce and citizens remains central to our approach. This quarter, the "Voice of Our Citizens" returns to complaints received through Care Opinion, while the "Voice of Our Colleagues" looks at the use of the Trickle App by Doctors in Training. These tools ensure that feedback drives accountability, compassion, and positive change.

Adam Coldwells, Interim Chief Executive NHS Grampian

Q1 Performance Wheel April 2024 – June 2024

Q2 Performance Wheel July 2024 – Sept 2024

Q3 Performance Wheel Oct 2024 – Dec 2024

Voice of our Colleagues via Trickle

Colleague experience:

- Trickle App was launched in September 2024 with invitations sent to approx. 800 Doctors in Training (DiT) in NHS Grampian.
- This is with the aim of providing a space to raise concerns, ideas and make suggestions for workplace improvements.
- Trickle is being trialed with DiTs because experience in NHS Lothian indicates it has the potential to provide a voice to DiTs - a digitally active group - by encouraging participation and promoting a sense of organisational belonging.
- Currently there are 211 users signed up. Work is ongoing with trainee leads to encourage further sign ups. The ability to post anonymously was highlighted.
- In total there have been 19 Trickles raised, 1 in the last week, 6 of which have been completed, 6 remain open and 7 have been abandoned. Topics raised recently include NHS Grampian Financial Crisis, Work Life Balance, and Doctor's mess, invitation to participate in Inter-Company Row event and Cycling to work.
- A Champions Group including the previous Scottish Clinical Leadership Fellow, Director of Medical Education and colleagues from Wellbeing, Culture and Development meets on a regular to review trickles and identify owners in the system.

Our key risks, challenges and opportunities:

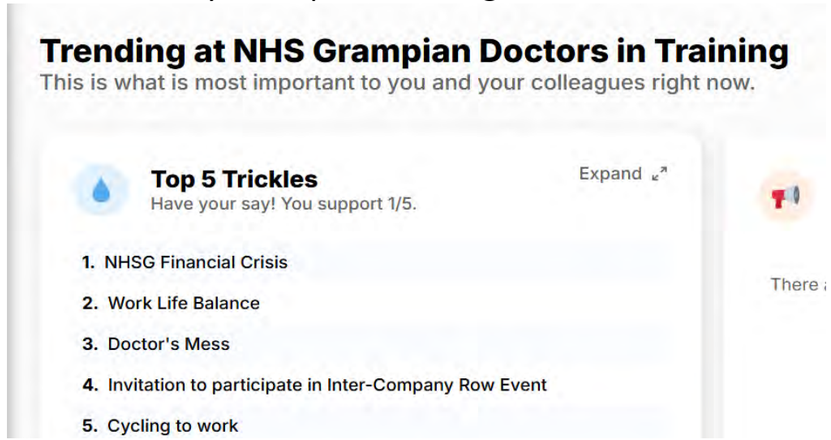
- Meaningful responses from identified champions are required, to ensure staff engagement is given appropriate focus, with timely and factually correct responses generated to ensure closed loop communication and feedback.
- Challenge of maintaining growth in user numbers amongst a busy and transient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

trickle™

Our actions to date…

At initial launch: preparatory work:

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



What Next…?

1. Consideration to be given if continuing with the platform after end of initial pilot, due to cost and low numbers of engagement.
2. Continue incoming Trainee leads to receive Champion training. Proposal to re-establish the Trainees Forum with output from this being used to generate further Trickles and disseminate outcomes of forum amongst Trainees
3. Looking to other boards for activity levels and awareness of topics raised.
4. Trickle output about IT issues to be presented to EPR Steering Group to try and address IT user experience for Trainees
5. Trickle to be introduced at Foundation Year teaching to encourage further sign ups.
6. Consider how to evaluate and measure impact for this pilot.

Voice of our Citizens

Complaints received Quarters 3 and 4 2024/25

In the second half of 2024/25, NHS Grampian received 793 complaints; the Integrated Specialist Care Portfolio accounted for 27% of these, we continue to receive a high proportion of complaints in relation to waiting times.

We received an average of 31 complaints per week

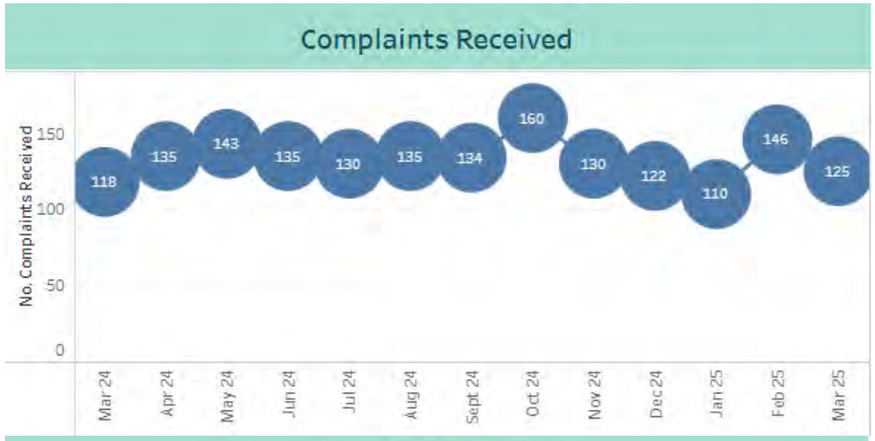
- Complaints received decreased by 2% compared to the first half of 2024/25 and increased by 8% from the same period in 2023/24.
- Of the 793 complaints received Advocacy services were used by complainants in only 8 complaints. MSP/MP supported 53 complainants, on several occasions more than 1 MP/MSP was involved in the same complaint. Complaints raised by MP/MSP follow the same process as all other complaints. The Scottish Government followed up on 3 complaints they set a deadline for response, the feedback service collates the response which is sent directly from the Chief Executive support team.

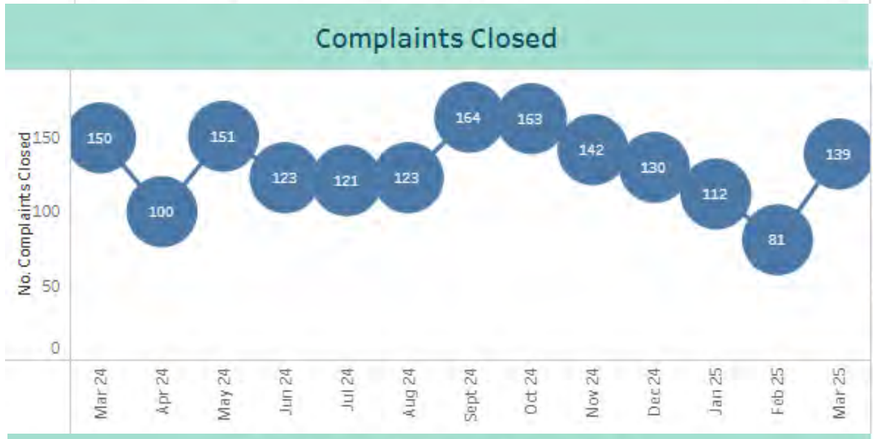
complaints received equate to 0.1% of activity*

- The number of complaints open at month end had been trending up in the year to August 2024, before decreasing to January 2025. An increase in the number of complaints received in February, together with a low number of complaint closures in that month has resulted in an increase in the number of complaints open at month end.

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

*Inpatient, Outpatient, Emergency Department activity for the period 01/10/24-31/03/25





Timescales

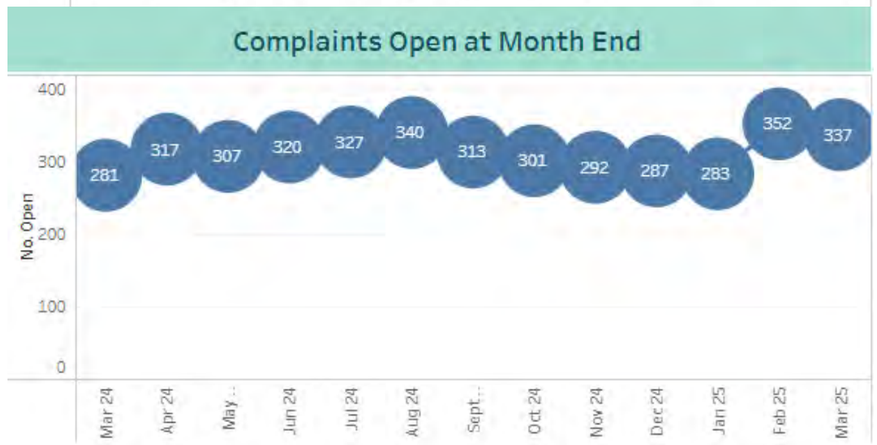
Performance in meeting timescales has improved compared with the same period in the previous year.

24% of complaints were closed by early resolution

- 24% of complaints were resolved via early resolution (compared to 16% in the previous six months), with an average response time of 7.1 working days.
- 43% were closed within the Model Complaints Handling Procedure target of 20 days, an improvement from 35% for the same period the previous year.

It is best practice to make contact be telephone with a complainant at the earliest opportunity. We have up to 5 working days, or up to 10 if an extension is requested to resolve a complaint under early resolution. This is the best outcome for the complainant as they feel listened to and can expand on the points raised if necessary. It is also of benefit to staff as it allows them to focus on patient care delivery. Sometimes it is possible to agree with the complainant at the initial call what it is that they want us to do and resolve the complaint at that point. Regardless the early contact helps the staff member investigating the complaint to fully understand the most important issues and agree what will be investigated.

Average time to respond by early resolution was 7.1 working days



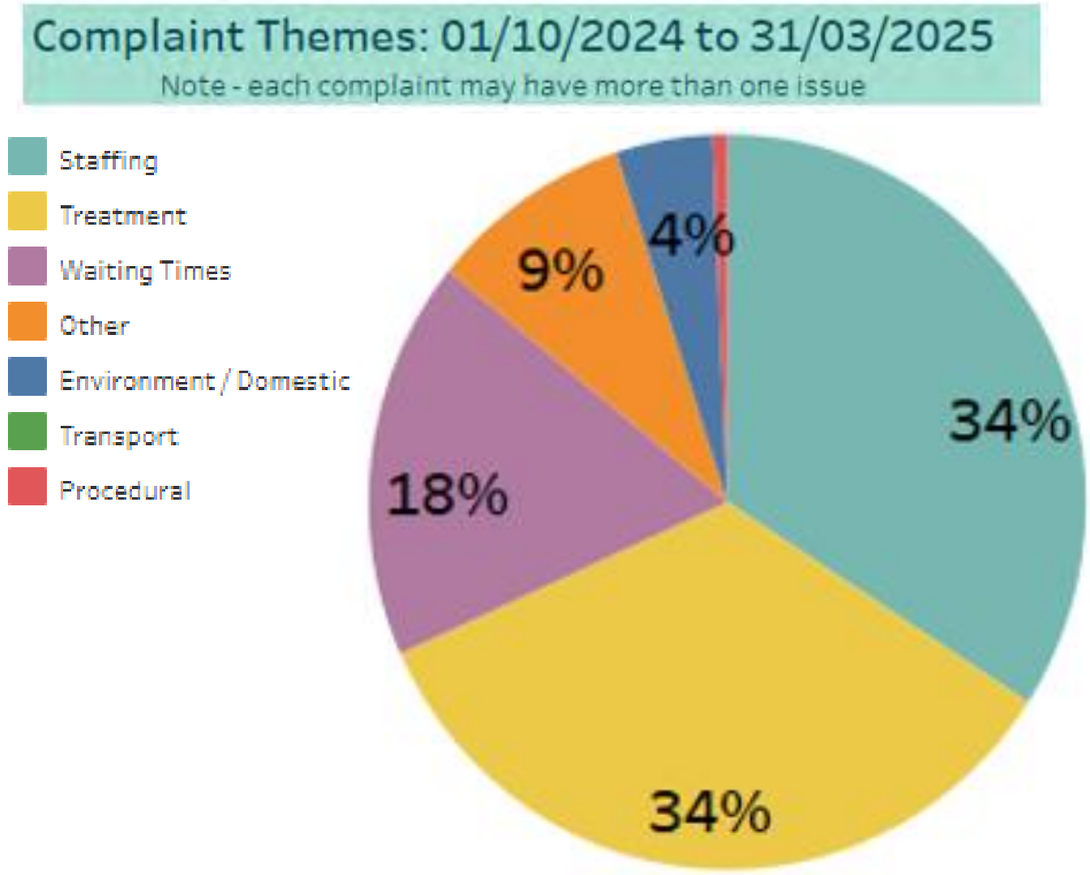
Voice of our Citizens

Themes

Staffing and Clinical Treatment are the most common complaint themes

For the latest six months, staffing and treatment have been the primary themes of complaints, with 34% of complaints attributable to each. Previously staffing was the most common theme, accounting for 41% of complaints.
Breaking this down, the main sub-themes for complaints regarding staffing were oral communication (40%) and staff attitude and behaviour (29%); for treatment, all complaints came under the sub-theme of clinical treatment (100%).

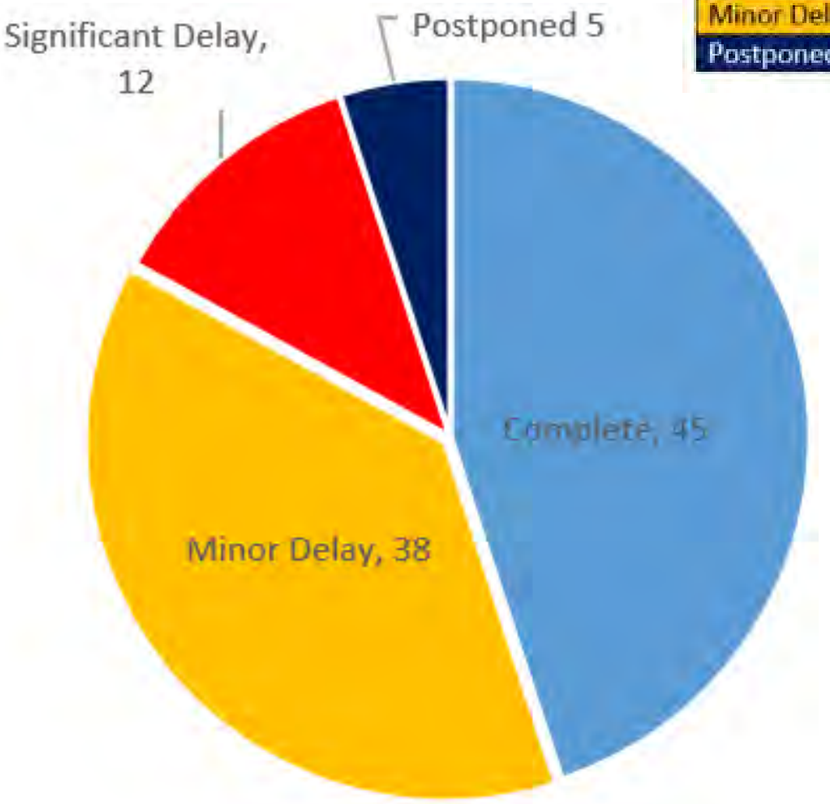
We held a 2-hour critical thinking session in November focusing on communication, which provided the opportunity for Quality Improvement trained colleagues across our system to facilitate and challenge us to explore fresh approaches and bold ideas to this persistent issue. Approximately 50 colleagues of varying roles across NHS Grampian were in attendance. We had ambitious aims for our session to build a movement of colleagues across our system on one shared purpose and project, provide colleagues with a chance to share their ideas, hear lived experience and gather ideas and agreed an overall project aim. 83% of colleagues said they had opportunity to share your ideas and be listened to, 67% expanded their network as result of this session, and 83% found the session helpful. Key themes from our good examples included kindness, living to our NHS Grampian values, and open, honest and approachable, clarity with action focus, and acknowledging learning in encouraging active listening and checking more on understanding.



Communication - related complaint	Lack of suitable specialist equipment for patient to manage personal hygiene.	Patient complained of lengthy delays in receiving a course of daily chemotherapy	Patient advised where to wait for their outpatient appointment, was not called in for appointment. Waited for an hour and then let reception know they were leaving. Received a letter saying removed from list
Actions taken to improve communication	Equipment located and agreement that it will be available for loan on future in patient stays.	It was identified that there were simple administrative errors. The Aseptic team has implemented a revised electronic worklist system, and also introduced a label which is applied to prescriptions to highlight they are multiday.	Service called patient and apologised. A new appointment was made during the call. The patient should have been asked to wait in a smaller dedicated area, not the main waiting room. Complaint shared with the team who now have a board to check to ensure patients are in the correct area.

Tier 1: Organisational Performance Summary End of Year (April 2024 to March 2025)

This is the final position of our 100 deliverables at close of the 2024/25 ADP on March 31st 2025.
45 Deliverables were completed, and 55 Deliverables were not completed during the 2024/25 ADP.



Disposition of Incomplete Deliverables Post 31st March 2025

Status	Carried forward to 2025/26 ADP	Continue within Portfolio or Directorate Work	Stop or Postponed
Significant Delay (12)	5	6	1
Minor Delay (38)	19	16	3
Postponed (5)	1	3	1

Factors contributing towards 55 Incomplete Deliverables	Deliverables Impacted
Workforce – Capacity	33
Finance – Insufficient Funding	17
Finance - Funding not yet agreed	11
Workforce - Recruitment	12
Infrastructure - Estates	11
Workforce - Training, Development and Skills	9
Workforce - Absence	8
Workforce - Wellbeing	7
Finance - Non-recurrent funding	5
Other	5
Infrastructure – Digital	5
Workforce - Retention	5
Procurement	1

Overall KPI Performance:

At the end of Q4 (March 2025), below table shows our end of year breakdown of performance of 38* KPIs across People, Places and Pathways. We are seeing a decrease of 2 KPIs totalling 21 KPIs showing adverse performance, with positive performance increased by 1 to 12 KPIs in comparison to Q3.

Places	People*	Pathways	Total KPIs (38*) Q4
6	7	8	21 (55%)
3	0	1	4 (11%)
6	3	3	12 (32%)
	1* (not rated)		1 (2%)

*Actual Q4 figure remains unavailable for KPI: Reduce time to hire in support of addressing workforce shortages. This is due to continuing issues with data and JobTrain nationally. Ongoing progress to address this and provide historical data to support re-reporting of this KPI continues.

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

Key highlights:

- The overall impact of completed Deliverables is not fully clear or aligned to achieving our Outcomes, emphasising the need to have well-defined measures that demonstrates tangible impact of in-year to longer term performance.
- 60 of 100 Q4 Milestones reported as Achieved, an improvement of 3 from Q3.
- Of those *postponed*, 3 were due to a move to a regional approach, 1 reduced scope and absorbed into an existing work plan, and 1 de-prioritised.
- Of 55 Deliverables not complete, 25 have been carried forward to the 2025/26 ADP, 25 continued into Portfolio/Directorate workscopes, and 5 have been de-prioritised for 2025/26.
- Of 12 Significant Delays, 10 are reliant on additional resource to progress, and 2 dependent on resolution of national delays.
- Performance metrics show mixed results where 32% of Key Performance Indicators (KPIs) improved, while 55% declined. Notably, 55% of KPIs were rated Red, representing a 6% decrease compared to the last quarter at 61%.

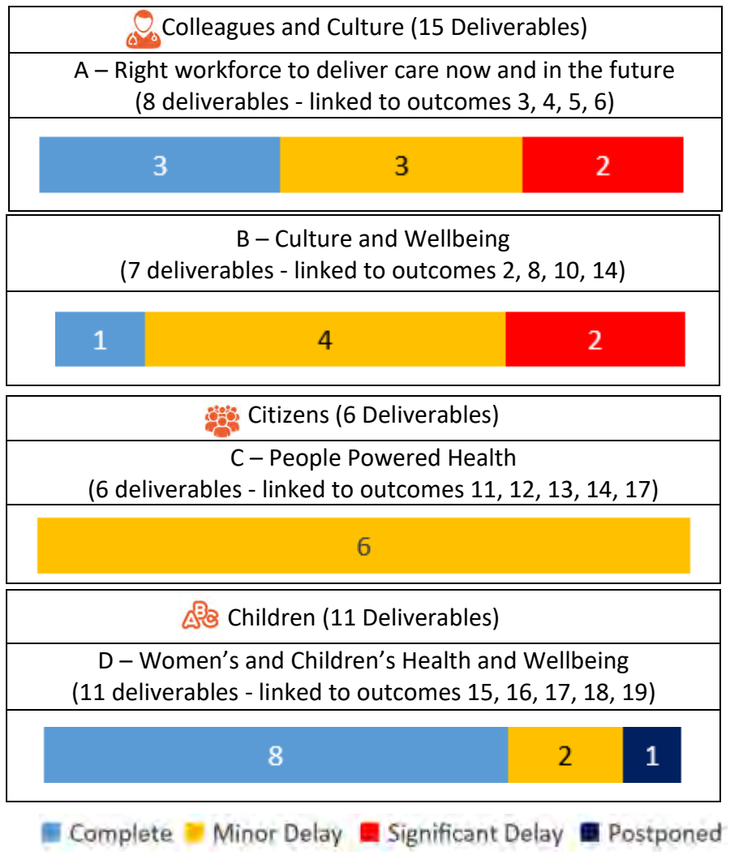
Tier 2: In-year 24/25 performance of KPIs and Deliverables towards 2027 Outcomes

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 Q4
Workforce – Capacity	24
Workforce - Recruitment	10
Finance – Insufficient Funding	9
Workforce - Training, Development and Skills	5
Finance - Non-recurrent funding	5
Workforce - Wellbeing	4
Workforce - Absence	4
Infrastructure – Digital	4
Finance - Funding not yet agreed	3
Infrastructure – Estates	3
Workforce - Retention	2
Other	2
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**	**5.5%**	**5% or below**	The figure from 01/12/24 - 28/02/25 (Substantive Staff only) was 5.78%, with monthly sickness absence having increased by 0.41% from the last reporting period 01/09/24-30/11/24. PowerBI dashboards now in place to support work with managers in areas over 5%. A short-life sickness & absence working group has been established to take steps to reduce absence in areas that are above average in NHS Grampian, with the aim of reducing the overall sickness absence level below 5% *Last reported: Staff Governance Committee Feb 2025* spotlight on page 15
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%**	**100%**	Remaining staff migrated to compliant rosters and SSTS authorisers reminded that Reduced Working Week Transitional Allowance can no longer be paid as of 31st March 2025 *Last reported: Sustainable Workforce Hearing December 2024* spotlight on page 16
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**	**£7.732m**	**£9.750m**	Embedded controls remain in place and effective. Over recruitment has reduced vacancies and supported the reduction in agency use. This impact is partially hidden due to increased agency use for increasing unfunded activity relating to maintaining bed capacity *Last reported: 26.03.2025 Nursing and Midwifery Council. 17.03.2025 V&S Nursing Operational Group*
	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**	**£19.409m**	**£17.789m**	Resident Doctor banding payments continue to be challenging due to various factors with spend of £7.625m in 24/25. Whilst this is an increase from 23/24, progress has been made with the number of Band 3 rotas at March 2025 sitting at 24 compared to 39 at the start of the year, resulting in an estimated saving of cc£820k compared to if no action had been taken. This saving has been offset in part by the impact of the pay award. *Last reported: Chief Executive Team 14/01/25* spotlight on page 17

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%	**65%**	**70%**	Sustained in-year improvement trajectory. Continued financial and operational pressures impacting ability to undertake mandatory training. *Last reported: Q3 PAFIC and Board HAWD April 2024* spotlight on page 18
	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%	**62%**	**80%**	A further 1% reduction in Q4 (up to end Feb25) represents the 3rd month in a row with a 1% reduction in compliance from 65 to now 62%. Continued financial and operational pressures are adversely affecting this KPI. *Last reported:Q3 PAFIC and Board HAWD April 2024* spotlight on page 19
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%	**24.65% (excluding nurse bank)**	**50%**	Slight decrease in AfC staff achievement, with a 10% improvement for medical staff on SOAR (now includes both secondary and primary care). Dental staff on SOAR still being followed up - as yet not included in this data. Continued financial and operational pressures are adversely affecting this KPI. *Last reported: Q3 PAFIC and Board HAWD April 2024* spotlight on page 20
	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	**No Data for Q4**	**<95 days**	National JobTrain Reporting still unable to accurately report Time to Hire as Bulk Recruitment still impacts on the overall figure. Vacancy Dashboard being developed by Workforce to enable accurate reporting of our Time to Hire. Last reported: Chief Executive Team - Aug 2024 and PAFIC - Aug 2024

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

Tier 2: Performance Scorecard: Citizens

Strategic Intent: No citizen in Grampian will be left behind

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

2027 Outcome alignment linked outcome ID	**Key Performance Indicator**	**Baseline** (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**	
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**	**39**	44	Recruitment is on hold while we make the transition to the new two-tier structure. We have been undertaking some engagement with the existing members re our proposals and asking them if they want to remain as a Public Rep and/or be included in the new, larger PIN database. *Last reported: Monthly CET Performance meeting, Q3 HAWD Report to Public Board meeting on 10/04/25* spotlight on page 21
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**	**207**	239	Annual growth in volunteer numbers impacted by necessary pause (as reported in Q3). Numbers are a provisional estimate pending receipt of confirmed figures for national reporting w/c 21 April *Last reported: Monthly CET Performance meeting, Q3 HAWD Report to Public Board meeting on 10/04/25* spotlight on page 22

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**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?** *When was this last reported?*
			Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
PE18 - Improvement in outcomes for children realised & evidenced, measured through agreed key performance indicators (KPIs).	**Reduce backlog unbooked TTG RACH patients (including Paediatric Dentistry) to 400 patients by March 2025**	592	507	<500	372	<500	444	<450	**293**	**<400**	Successful mitigation against risks by using validation, effective planning at 6/4/2 meetings and data informed decisions. *Last reported: Q3 PAFIC 26/02/25 and HAWD 10/04/25 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

Q4 actual: 5.5%
Q4 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 ongoing indications that the absence level is moving towards 5%. We will continue to track the information and make comparisons across quarters to establish if this indicates a downward trend, given the normal increase into winter months. Quarter 4 rate is 5.5% compared to 5.37% in quarter 3
- The monthly rate for December 2024 was 5.98%, the March 2025 comparative rate is 4.9%. Corresponding Year to Date (YTD) in 23/24 was 5.1%, this is the same for 24/5.

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. Analysis of reason for bank and agency use is required to determine the related cost savings.

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 and its impact on staff and their morale and wellbeing
- Impact of vacancy control may be 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 and the use of 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 Occupational Health Service (OHS) and the role OHS has in supporting the mangers to actively manage absences and access to OHS.
- The sickness/absence working group have oversight around what work is taking place across the organisation based on the data that is available, and will identify what support can be offered from the Wellbeing, Culture and Development teams. They will also determine what work should be prioritised based using this data, identifying individuals to take this forward within teams.
- Work continues across Facilities as part of an Anchors approach and with a cohort of HCSW, with updates pending. MHLD continue to explore access to Psychologists to support staff in remaining in workplace as part of response to above average absence rates.
- Wider teams are interested in looking at what data is available in their individual areas.
- Work is ongoing to triangulate sickness absence data with vacancies and supplementary staffing usage. Looking at sickness absence reasons, specifically musculoskeletal and back problems. This data is being compared with compliance for the manual handling statutory/mandatory training.

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

- The PowerBI absence dashboard is progressing and with Information Governance support access will be given to managers in the coming months to support their management of absence within teams. This will require roll out and appropriate training
- Focussed work on improving reporting of absence reason given, e.g. Categorised as not known
- This will also be supported by themed information from Occupational Health Services.

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 Staff Governance Committee was in December 2024 as cycle of 6 monthly updates. Reported to PAFIC via Q3 KPIs in 26th February 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): 100% of AfC staff have reduced their hours to 37hrs per week or pro-rata equivalent for part time staff

Q4 actual: 100%
Q4 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 to reduce the working week for all 14,913 Agenda for Change (AfC) staff by 30 minutes to 37h by end November 2024, followed by a further hour's reduction by 1st April 2026. The initial reduction of 30 minutes has been fully implemented.

Following the publication of a recent circular from the Scottish Government regarding the further reduction from 37hrs to 36hrs, the AfC Reform Programme Board, CET and Grampian Area Partnership Reform (GAPF) have agreed an outline plan to meet the requirements of this circular. A detailed implementation plan will be developed for approval by October 2025.

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

Work to cease use of the Reduced Working Week (RWW) Transitional Allowance (overtime) payment for those working 37.5 hours after 1st April 2025 was finalised which led to the full implementation of the first 30 minute reduction.

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
- Reducing a further hour on 1st April 2026 will result in NHG Grampian losing equivalent of 334 WTE out of the system

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.

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

Completion of a lessons learned exercise to understand the impacts of the initial reduction, and identify what changes might be needed for the subsequent reduction. This will need to encompass perspectives from the RWW Sub Groups, Services and affected staff and include the impact on Staff Wellbeing.

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

To review the current standard RWW options against the intent of the DL and recommend any changes to those standard options, with particular reference to TOIL and confirm the implementation approach

What have we learnt?

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

To review and recommend changes to the governance process in light of the number of late adopters, including consideration of whether submissions should be by roster rather than/as well as by Staff Group

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 implementation approach for going to 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 Colleagues and Oversight Group and in turn to Staff Governance Committee. Escalation to Chief Executive Team if required.

Monthly updates provided to GAPF.

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 – being reported on the 1st May 2025 - and via ADP deliverable updates every 6 months in deep dive format under Sustainable Workforce heading – 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

Q4 actual: £19.409m
Q4 Target: £17.789m

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?

Initially there were 39 non-compliant rotas this improved to 32 in Aug 2024-Feb 2025 rotation, a reduction of 18%. By the February 2025 – August 2025 rotation this had reduced further to 23 non-compliant rotas, almost a 40% reduction from baseline. The impact of the project was significantly impacted by the 10.8% pay award that was not within project influence and significantly impacted on ability to meet the target.

The Medical Agency Locum (MAL) project exceeded the savings target. This was due to combined efforts of mandated Direct Engagement and Tier 1 framework, reduced commission rates and on call payments 00:00-08:00. There were risks around use of locums for additional surge bed space as the service have been unable to progress to internal posts.

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, however there has been significant progress not only through redesigning rotas but through addressing behaviours around break taking.

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 is currently under review therefore any change in break taking activity, and hence spend associated with non-compliant rotas, will rely on culture change. Impact is starting to be seen through the project work and medical leadership.

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,
Medical Director,
Acute Services

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. Data from the reporting mechanism for missed/late breaks and late finishes is being used to pinpoint required changes and impact of activity.

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. Due to pay protection when rotas become compliant the financial savings are not immediate therefore the actual numbers of compliant rotas are key metrics.

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.

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 (the number of non-compliant rotas), and spend associated with medical budgets including both non-compliant rota banding payments and locum use.

Feedback is also shared from medical leadership, operational management and Doctors 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.

Approval has been given to replace the vacant Programme Manager post to ensure there is ongoing activity and oversight to deliver this complex culture change.

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?

11/02 at CET and 25/02 CET quarter 4 performance meeting

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)

Q4 actual: 65%
Q4 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 the end of Q3 2024/25, 65% of all staff have maintained completing all core mandatory training requirements. This represents a sustained improvement from 59% at end of the March 2024. This also returns our performance to a slight improvement (of 1%) in relation to the previous 4 year high of 64% achieved in December 2024.

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

The mandatory training requirement consists of 13 agreed modules across 9 core topic areas including a refresher module and welcome and orientation pack. More than 70% (target) of staff are up to date with training in 7 of the 13 modules (up from 3 modules at last report), the majority of the remainder are above 65%, with all modules showing an upwards trend in completion rates with a notable exception of hand hygiene and the hand hygiene assessment.

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 consistent improvement over the year of 24/25. Equality and Diversity improving from 24 to 31% and an impressive growth for Public Protection in improving from 0% to 55%.

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 Protected Learning Time Sub Group of Agenda for Change Reform Program Board, ensuring focus on all NHSG staff.
- Continued improvement and visibility of compliance data through production of Workforce Intelligence PowerBI Dashboards, and production of bespoke reports (such as 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 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.
- Agreement at CET to include mandatory training compliance as an objective for all CET members and in turn their direct reports in order to role model.

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
- 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
- Protected Learning Time sub-group – reporting to Agenda for Change Non-Pay Reform Program board.
- 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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 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)

Q4 actual: 62%
Q4 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 (where in Sept and Oct 2024 the target was exceeded) 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 pattern of normal variation in performance through the course of the year, with the current level of 63% continuing a trend of relatively static performance over the last 4 years with an average growth of 1% over this time period.

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 a role modelling approach. This has resulted in significant improvement in compliance of CET members. (From 42% to 86% from May to September 2024)
- Agreement in CET in April 2025 to include completion of statutory training in objectives of CET members and in turn direct reports.
- Specific improvement work commissioned by the Colleagues and Culture Oversight Board in March 2025, currently being scoped by Wellbeing, Culture and Development department.

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?

- Regular reporting at Colleagues and Culture 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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 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

Q4 actual: 24.65% (excl. nurse bank)
Q4 Target: 50%

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 consistently at or around 20%. In this spotlight report for the first time all medical staff recorded on SOAR are included (previously this was only secondary care doctors as overall datasets are monitored in different organisational structures within NHS Grampian). The Scottish Online Appraisal Resource (SOAR) is an administration tool, designed to support and facilitate the appraisal process for doctors working in Scotland. This combined dataset more accurately reflects the organisational KPI and is now included in the retrospective trend data. In this report, we also now have records relating to 63 dental officers included who also use the SOAR system. We continue to seek access to data for the remaining group on SOAR; any remaining dental staff, ensuring future reporting will cover the full KPI.

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 recorded on TURAS Appraisal is 20.6% if we look at all AfC staff excluding nurse bank or 15.2% if nurse bank included. When combined with SOAR data this means an end March 2025 compliance of 20% for all staff including nurse bank, or 26.5% for all staff with nurse bank excluded.

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 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. February 2025 session had 120 managers attending; with an increase in appraisal preparation sessions since.

- 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 Q1 25/26.
- Agreement of CET to include completed appraisal in objectives of all team members with these built into objectives of direct reports too.
- 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.
- Specific improvement work on completed appraisal rates commissioned by Colleagues and Culture Oversight Group.
- 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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 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)

Q4 actual: 39
Q4 Target: 44

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?

- The Public Involvement Network is open to anyone in Grampian who has an interest in health related services.
- PIN Members are usually also members of other forums and groups. Consequently they have finite capacity and must balance competing demand on their time

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

- 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.
- Engagement has been undertaken with existing members to shape the structure being developed.
  - 15 responses received (approx. 39%) to survey. Feedback supported the proposals for new two-tiered structure and (80%) would choose to be on both tiers
  - More detailed discussion held with seven current PIN members about how the new two-tiered structure will work. Positive support from all for change and recognition of benefits

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

- This does not materially 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?

- Unless efforts are made to support the continued contribution of members, the competing demands on their time may result in lower levels of contribution/participation. This 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

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 in development and, once launched, is intended to enable a wider and more diverse group of people living in the Grampian region to be engaged with by making PIN 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?

- Qualitative feedback on new structure from existing members through monthly meetings of Public Involvement Team and PIN
- Factors that could limit success are;
  - New structure in development fails to address issue raised leading to reduced participation
  - The availability of willing people to join the PIN is lower than anticipated

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. The development of a two-tier structure has been done collaboratively with PIN members and is scheduled to be rolled-out by the end of May. This will enable the PIN to contribute to future strategic development work where appropriate
- Progress will be 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?

- PIN participation needs to be nurtured by reconfiguring structures and mechanisms in a way that provides flexibility, so that members can contribute as much or as little as their capacity allows.

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?

Monthly CET Performance meeting, Q3 HAWD Report to Public Board meeting on 10/04/25

Tier 3 - Our Performance Spotlights: Citizens

Strategic Intent: No citizen in Grampian will be left behind

Objective: Strengthen Colleague & Citizen Engagement to Improve Health

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

Q4 actual: 207

Q4 Target: 239

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?

The Scottish Government's commitment to voluntary action requires Health Boards to have a policy statement on volunteering.

Quarterly reporting to Scottish Government* between January-March shows fluctuation between 210 and 203 active volunteers per month.

Volunteer numbers reported to SG only include 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.

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

- Recruitment is paused in several areas due to volunteer and coordinator capacity (NHS Grampian has 1WTE Volunteer Coordinator role).
- Some volunteers have indicated a need to seek paid employment for economic reasons. This is likely to lead to a reduction in numbers over the coming months.

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 across the system are less likely to be receptive to utilising volunteers in the short-term (due to need for supervision whilst learning) despite the long-term benefits (freeing-up clinical capacity, improved patient experience etc.)

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?

Indirectly. The use of volunteers has the potential to free up staff time spent undertaking non-clinical duties – leading to capacity gains and/or efficiencies and supporting staff to take breaks.

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?

Opportunities for efficiency within the Public Involvement Team are being explored as a means of modestly increasing capacity dedicated to volunteering.

Once approved and published, the Volunteer Policy will be used to encourage staff to consider whether a volunteer could benefit their department or service.

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

Measurement of volunteer numbers is now supplemented by hours volunteered:

Between Jan-March 5.094 total hours were volunteered and the ARI Wayfinding service alone surpassed over 10,000 volunteering hours since the service began in October 2023.

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?

Work is underway to capture unreported volunteer numbers in order that they can be shared in future reports to provide a more representative picture.

There has been an increase in younger people enquiring about short term volunteering or work experience placements.

During Q4 several enquiries have been received from people looking to volunteering as a means of gaining ward experience following unsuccessful applications for employment.

How these opportunities might be accommodated given team resource constraints is being considered.

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

Staff consultation of the Volunteer Policy should be expedited in order to mitigate this potential barrier to volunteer use among staff.

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?

- Monthly CET Performance meeting, Q3 HAWD Report to Public Board meeting on 10/04/25

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

PLACES (Outcomes)

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

Performance of Deliverables

Anchor (8)

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

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	3, 1, 1

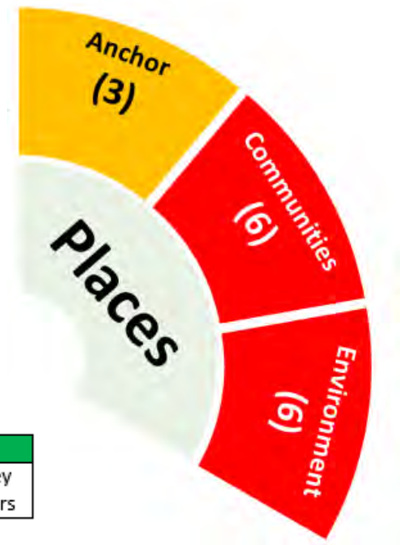
Complete | Minor Delay | Significant Delay | Postponed

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 Q4
Workforce – Capacity	16
Finance – Insufficient Funding	7
Other (National Policy, Systems – National, Data & Modelling, Engagement)	4
Infrastructure – Digital	4
Finance - Non-recurrent funding	3
Workforce – Absence	3
Finance - Funding not yet agreed	3
Infrastructure - Estates	3
Workforce – Wellbeing	2
Workforce - Training, Development and Skills	2
Workforce – Recruitment	1
Workforce – Retention	1
Procurement	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%	**84%**	**100%**	Delays in some of the data from partners to allow us to use it. Capacity within the organisation to prioritise anchors-related work. *Last reported: Population health portfolio board 04/04/25* spotlight on page 28
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%	**93.4%**	**95.0%**	Domestic absences, low stability workforce, derogations have all contributed to prevent reaching full target. *Last reported: Q4 data only available 31/3/25 so will be reported via F&E HAI Workplan Group & IS&SS SLT w/c 31/3/25* spotlight on page 29
	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%	95.4%	**95.0%**	Target reached as a result of campaign maintenance approach which has seen a reduction of circa 10% of painting related FMT issues, flooring issues also reduced. *Last reported: Q4 data only available 31/3/25 so will be reported via F&E HAI Workplan Group & IS&SS SLT w/c 31/3/25.* spotlight on page 30

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	**22669**	**22609**	Waiting Well service exceeded number of wellbeing over the Q4 KPI target whilst also supporting an additional 143 Warm Home calls in quarter 4. *Last reported: Public Health Monitoring and Governance Performance meeting on 1 April*
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%	**10%**	**100%**	Lack of capacity from operational teams and awareness of need to contribute to whole system workforce planning, rather than site based plans. *Last reported: Triumvirate GM January 2025* Spotlight on page 31
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%**	**10%**	Site infrastructure priorities fully mapped and articulated and prioritised as part of wider system assessment for backlog maintenance costs. Prioritised infrastructure work undertaken including installation of new fire detection system. *Last reported: Triumvirate GM January 2025* Spotlight on page 32
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%	**75%**	**100%**	Limited dedicated project support has focused on key priorities for delivery within the current year yielding positive results across a range of objectives however, reduced theatre project support in Q4 and lack of leadership capacity has limited total completion of all improvement actions *Last reported: DGH Theatre Project Group weekly update meetings* spotlight on page 33
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%	**98%**	**100%**	Demand for abortion care had continued to increase in 24/25. The 100% target is ambitious. 98% is an improved position from the baseline of 82% in 2024. This is due to the continued increase in flexibility from the specialist sexual health service team. *Last reported: Public Health Monitoring and Governance Performance meeting on 1st April 2025*
	100% individuals are offered a date for an abortion procedure within 1 week of assessment	70%	77%	100%	57%	100%	62%	100%	**77%**	**100%**	Demand for abortion care had continued to increase in 24/25. The 100% target is ambitious. 77% is an improved position from the baseline of 70% in 2024. This is due to the continued increase in flexibility from the specialist sexual health service team *Last reported: Public Health Monitoring and Governance Performance meeting on 1st April 2025* spotlight on page 34

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%**	**26.30%**	**25%**	Continued development of topics from this forum is seeing good work progressed. Format of recording and topic areas covered have changed and will require an update for coming year. *Last reported: Heat and power group 14/04/2025*
	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**	**31458.66 tCO2e**	**21039 tCO2e**	This target is set by SEPA and is reduced annually to encourage the organisation to invest in emission reduction projects. Without significant investment to transition away from fossil fuels to reduce emissions from combustion plant we will not achieve this target. *Last reported: Heat and Power group 12/05/2025* spotlight on page 35
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**	**£50.5m**	**£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: Q3 PAFIC 26/02/25 and HAWD 10/04/25 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**	**1270**	**1224**	We have successfully continued to keep a focus on Realistic Medicine, linking promotion of the Shared Decision Making module (KPI) to relevant communications and events. This is reflected in continued engagement with the module. *Last reported: Transformation Programme Board - 25/03/2025* *Realistic Medicine Policy Team - 14/03/2025*

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: 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%	**46.07%**	**55%**	December & January are historically poorer months for recycling; however we also had major structural issues around Phase 2 loading bay in February which meant general waste being disposed of in both of our mixed recycling compactors, resulting in very low level of waste being classed as recycling. New waste contracts started on 1st February, and one contractor is still having major issues with the supply of accurate waste data - figures for mixed recycling for February from Shire & Moray are estimates. *Last reported: Update to Waste Management Group during February 2024* spotlight on page 36
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	**1722.7T**	**<1707T**	Reduction of 4.2% achieved against annual target of 5%. High levels of staff involvement in diverting recyclable materials out of orange bags across the year, but no control over numbers of patients treated and therefore clinical waste produced *Last reported: Update to Waste Management Group during February 2024*

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

Tier 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

Q4 actual: 84%
Q4 Target: 100%

Outcome: NHSG strategic approach to being an Anchor organisation embedded

Our story so far….

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 our strategy, workplan and have made good progress on implementing the year 1 actions. We have:

- Developed a regional procurement group, with an aim to identify opportunities for collaborative approaches to procurement, share learning and data
- Started to work with Domestic Services to apply an anchors lens to improve health and reduce absence within this sector of our workforce. We have reviewed the workforce data and have identified potential areas for development around recruitment (processes, working hours/ patterns) and career development opportunities and undertaken a number of workshops to engage with staff (took place in Q1 in 25/26).
- Implemented Phase 1 of our communication strategy to embed anchors within the organisation.

We set out to implement 100% of the year 1 actions in the Anchors workplan. We have fully completed 84% of our actions, with progress towards all of them.

- This has been a developmental year to measure where we are in our anchors progress as an organisation to allow more informed priority setting in future years.
- We continue to work with partner health boards and use national networks to share areas of good practice. In the national review of Anchors strategic plans and progress, we received positive feedback on our anchors workplan and some of the work in NHS Grampian was highlighted as examples of good practice (outlined above).

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

As anchors is a relatively new workstream, for year 1 we acknowledged the importance of understanding our current position through baselining. We have been unable to complete 2 key actions which had interdependencies with national and local pieces of work:

- Procurement- "Map influenceable and non-influenceable spend". National data has now been received which is required to be analysed and Grampian data extracted for review. This was not possible by the end of Q4 due to limited dedicated anchors resource and competing staff and financial pressures taking priority. We plan to progress this as part of our wider data plans for 25/26.
- Work and jobs- "Undertake baselining to understand our workforce, how they represent the population and identify target groups." Workforce data dashboard that has been in development will be available for analysis. To review this data from an anchors lens as part of 25/26 data plans.

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

We have been delayed in achieving all of our year 1 actions. Once the baselining data is available and analysed, this will enable us to review and refine actions in future years. This should not impact our ability to achieve our 2027 outcomes overall but the pace and scale of future years' work towards this will be impacted as the actions from year one that are partially completed will carry over to year 2.

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.

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 the co-dependent pieces of work.
- Use other tools we have listed above to support us in future planning and priority setting. This will mitigate a delay in future planning due to the delay in baselining.
- Continue to focus our efforts on the actions we can progress in the interim.
- Include delayed actions in 25/26 workplan.

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

Measurement through progress towards wider data plans in 25/26. 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?

We will continue to set priorities using the best information we have available and review and refine this as more data becomes available through our 25/26 data plans.
Other actions not completed have minor delays and will be included in the 25/26 workplan. These delays are attributable to resource constraints and competing priorities in the organisation.

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 (submitted 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 25/26 we have reduced our priority areas to be more focussed in our actions.

Oversight and assurance

a) What is 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?

Public Health Monitoring and Governance group 18th March 2025; reported to Population Health Portfolio Board 4th April 2025. On agenda for PHC 2nd May 2025.

Tier 3 - Our Performance Spotlights: Anchor

Strategic Intent: We have social responsibility, beyond healthcare

Objective: Create the conditions for sustainable change

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

Q4 actual: 93.4%
Q4 Target: 95%

Outcome: Functional infrastructure to support sustainable service delivery

Our story so far….

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

The Facilities Management Tool is the measure of how Estates and Domestics are providing patients with a clean environment. The tool measures aspects such as internal building conditions (fabric of the room), as well as the cleanliness during the audit.

This target unmet due to a number of mitigating factors, discussed below. The National Cleaning Standards Scotland compliance target is >90% which we are well within.

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

High staff turnover and high absence rate meaning low stability

- Unfunded demand; such as increasing Non Standard Patient Area and high numbers of terminal cleans (patients moving from ward to ward; meaning multiple cleans of same bed space in a single day)
- Domestic Services have worked hard to achieve financial balance in 2024/25 which has had an impact on staff backfilling absence and vacant posts.
- Reduction in the Working Week meaning we have lost half an hour for each 1.0WTE which has not been backfilled
- Ongoing daily derogations which means high risk clinical areas always prioritised.

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

In terms of our deliverable whilst we are short of target, despite this we are well within national compliance. This deliverable will not prevent us from providing a clean and safe care environment for Grampian's hospital population.

Our key risks, challenges and impacts…

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

- Low Staff stability
- High Staff absence
- Aging estate non-optimum for cleaning
- Underfunded resource; historic budgets where absence factors (annual leave, sickness) not built in
- Times of service delivery non-optimum for 24/7 service
- Newly introduced PVG/Disclosure Checks which could delay recruitment/impact those already in post.
- Reduction in the working week, both the legacy of the ½ reduction in 2024/25 and the forthcoming 1 hour.
- Increasing and unfunded demand; use of non-standard patient areas and increasing patient movements requiring terminal cleans
- Closed areas re-opening to address bed capacity issues.

d) 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?

Staff morale

Derogations to cleaning in other areas such as non-clinical spaces.

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?

Daily derogations to ensure clinical areas are maintained to be clean & safe

Daily huddles to move staff to most high risk areas

Talent pool approach to recruitment to mitigate time to hire (this is where staff are recruited and offered next available post)

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

Ongoing measurement via benchmarking

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

In the event an area fails to achieve >90% on Facilities Management Tool (FMT) audit. An immediate action plan would be put in place to address the deficiencies.

What have we learnt?

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

We continue to remain compliant which demonstrates we are a safe and clean hospital. This is important for how we deliver our services in NHS Grampian, but also for public perception.

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

Ongoing work around recruitment, stability and absence.

Service is looking at models for service delivery and shift patterns.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Infection Prevention & Control Strategic Committee (IPCSC), Facilities & Estates Compliance Meeting and Facilities & Estates HAI Workplan Group

b) When was this KPI last reported?

Reported via IPCSC Report on 20 May 2025

Tier 3 - Our Performance Spotlights: Anchor

Strategic Intent: We have social responsibility, beyond healthcare

Objective: Create the conditions for sustainable change

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

Q4 actual: 95.4%
Q4 Target: 95%

Outcome: Functional infrastructure to support sustainable service delivery

Our story so far….

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

Estates have achieved their target through a change in approach. This means we are improving the environment in which patient care is being delivered.

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

The 'campaign approach' to maintenance is becoming embedded with the achieved target illustrating this is a successful approach to managing the aesthetic elements (flooring/painting) of the healthcare environment. Campaign maintenance is a systematic approach to optimising limited resources for maintenance. It is a planned, rather than reactive process where staff are deployed to paint working through areas in a pre-agreed way, e.g. going from room to room. This is in contrast to an approach where painters would react to calls to paint specific rooms. In the approach, clinical areas are prioritised.

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

This provides a basis/benchmark for sustaining this level of quality performance and also to consider planned service reductions in a controlled fashion to meet other organisational targets (financial)

Our key risks, challenges and impacts…

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

- Aging Estate across Grampian which increases budgetary requirement
- Under funded staffing resource provision in Estates service
- High numbers of vacancies held for to achieve financial balance
- Access to clinical areas
- Challenges in recruiting to trades role which could be further compounded by future likelihood of removal of RRP in NHS Boards in Scotland
- Staff recruitment & staff stability; retaining Trades staff in Aberdeen is closely linked to buoyancy of Oil Industry.
- Reduction in the Working Week without any backfill will reduce 'time on the tools' which could impact our ability to maintain our target.

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 writing

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?

Continue with campaign maintenance approach in 2025/6 in ARI.

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

The Facilities Management Tool (FMT) audits measure the expected impact. The aging estate could prevent success as further deterioration in estate condition.

Risk that IPC control measures could prolong length and complexity of roles meaning Estates issues mount up.

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

Not applicable. However, in event that the FMT audit reports that an area is non-compliant (<90%) then an immediate action plan is put in place to address emerging deficiencies.

What have we learnt?

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

The Campaign approach has been successful to in addressing painting in a cyclical way at ARI

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

Going forward the campaign approach to Maintenance should be extended to other areas across Grampian. This could reduce reactive calls, and non-productive time from travelling. However, the staffing numbers in other areas is insufficient for the approach to fully work.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Infection Prevention & Control Strategic Committee (IPCSC), Facilities & Estates Compliance Meeting and Facilities & Estates HAI Workplan Group

b) When was this KPI last reported?

Reported via IPCSC Report on 20 May 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% of hospital teams will have produced workforce plans to support safe and effective staffing

Q4 actual: 10%
Q4 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 Dr Gray's Hospital (DGH) altered in May 2024 with most activity transferred to Aberdeen. Workforce plan now an integral element of Acute Integration Pathway Re-deign which was commissioned by CET in March 025. Spring 2025. This include recommendations for the service model and supporting workforce necessary by July 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. The Emergency Care Practitioner workforce tool was completed in March 2025 to inform the next iteration of the ED plan.

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.
- Ongoing support from corporate Workforce Planning team in Medicine, scheduled for further input in early March.
- Prioritised capacity to contribute to Acute Integration Pathway re-design, including workforce aspects

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.

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 31/03/25

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): Reduction of very high and high infrastructure risk by 10% to sustain critical service delivery

Q4 actual: 10%
Q4 Target: 10%

Outcome: Functional infrastructure to support sustainable service delivery

Our story so far….

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

In 2024/25, the funding available for infrastructure across Grampian has been very limited and this has necessitated a system wide approach to prioritising the most urgent of infrastructure maintenance issues. Dr Gray's Hospital (DGH) risks are now assessed on a system basis rather than a site basis. The focus has therefore been on assessing and identifying the highest priorities for DGH within a broader overview and this has been achieved.

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

Interim site management arrangements have now reverted and there will be a dedicated focus on infrastructure in 2025 onwards. This focus is likely to form part of revised DGH site plan which will be developed to maintain local strategic priorities while system wide pathway integration is progressed.

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?

Performance in this KPI is not likely to negatively impact other Deliverables directly, except where theatre infrastructure limits theatre capacity and this is an enabling project within the DGH Programme. However this is being managed by the theatre redesign itself to ensure optimal theatre service within existing space, and may also be mitigated by the ongoing work to integrate the endoscopy pathways across Grampian.

Our key risks, challenges and impacts…

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

Very limited funding available for backlog maintenance to manage infrastructure risks

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?

Reduced ability to upgrade doctors' accommodation forces use of ward adjacent rooms which should be used for safe storage and H&S compliance

Potential future limitation on ability to provide sufficient theatre capacity for Maternity Model

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?

With limited funding available to address infrastructure works on the site, the focus has been to work with colleagues across the system to fully assess the site's maintenance needs and develop a thorough and prioritised understanding. A site visit and review has helped to produce this detail and the highest priority works related to fire safety works is underway.

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

The work already completed sets out the local infrastructure priorities according to risk level which will provide the basis for monitoring and oversight. Ongoing and further limitation of available budget is a pressure on managing infrastructure risks.

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

Local infrastructure priorities will be included in a site plan encompassing local strategic priorities. An integrated service planning approach will ensure there is an understanding of the service impacts of any infrastructure risks which will be managed and escalated appropriately.

What have we learnt?

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

Infrastructure risks have significant impact on the delivery of services and should be assessed not solely on the basis of physical condition but on the current and future impact on service delivery and patient experience.

Ongoing and future limitations around funding for the maintenance of physical estate means that a whole system approach is necessary to ensure priorities are viewed for the whole of the Board area. The impact of this approach for DGH is shaped by the comparatively lower risks on the site.

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

Changes in the availability of funding for infrastructure maintenance is not within the Board's scope to change, however the recent approach does ensure an equitable way to manage the highest risks which is transparent and fair.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

NHSG Physical Infrastructure Programme Board manages infrastructure risk reporting
From 2025/26 local infrastructure priorities will be overseen as part of a revised DGH site plan

b) When was this KPI last reported?

NHSG Backlog Maintenance Plan AMG January 2025
DGH extract reported to DGH GM May 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

Q4 actual: 75%
Q4 Target: 100%

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
- Formal 'commission' of revised theatre schedule to clarify expectation for operational teams

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
- Escalation via Accountability & Assurance Frameworks

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

b) What are the assurance and governance oversight arrangements?

DGH Programme Board

b) When was this KPI last reported?

Local Triumvirate 31/03/25

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

Q4 actual: 77%
Q4 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.
- Q4 (77%) position shows an improvement from Q2 (62%).

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

- Achievement against the KPI target fluctuates; the Q4 position is above baseline (70%). The challenges described below continue to make it difficult to achieve target.

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

- 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). In 2024/25 an additional 413.5hrs of staff time (776 appointments) were needed to meet demand.

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.
- 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 (98%); however, this KPI is subject to more fluctuation.

Commentary from

Geraldine Fraser
Chief Officer,
Acute Services

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.
- 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 and requires a sustainable approach. Funding for out of Board abortions also needs to be considered.

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?

- Public Health Monitoring and Governance Performance meeting on 1 April/Sexual Health Management Meetings

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)

Q4 actual: 31458.66 tCO2e
Q4 Target: 21039 tCO_2e

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.

A feasibility study has been undertaken to investigate the potential utilisation of deep geothermal heat for the Foresterhill health campus (FHC). Funding has been secured for a detailed decarbonisation and energy efficiency study for the FHC from which a phased approach can be used to decarbonise the site in line with the overall backlog maintenance and site masterplan.

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 2024, this penalty amounted to £676,253.93.
- 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 UK-ETS 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.
- Investigation into novel technologies including that of Deep Geothermal and Hydrotreated Vegetable Oil (HVO) for the FHC heating makeup

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 utilisation of sustainability champions to foster a culture of energy efficiency and environmental responsibility.

Oversight and assurance

a) 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

b) When was this last reported?

Q3 14/04/2025 H&P, 22/04/2025 F&E SLT.

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

Q4 actual: 46.07%
Q4 Target: 55%

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.

Phase II loading bay was out of action for a prolonged period which had a significant impact on the recycling rate, due to black bags being disposed of into the recycling compactors.

Historically December and January have always been poor for recycling rates across all boards.

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?

Appropriate segregating 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
- Waste recycling videos going live in April
- Updated waste eLearning modules
- Updating of waste posters to reflect new general waste contracts

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.

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 and appropriate receptacles.

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?

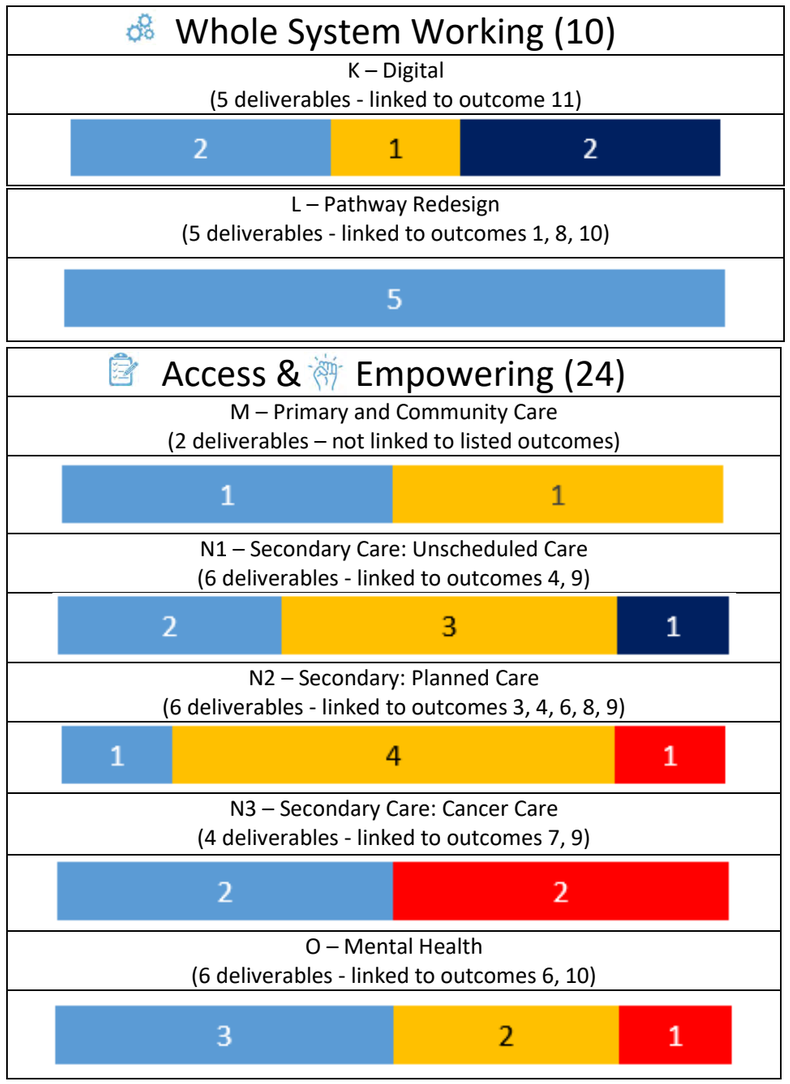
Operational meetings taking place on a quarterly basis, last reported 24th April 2025, and F&E SLT 22nd April 2025

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 Q4**
Finance – Funding not yet agreed	15
Workforce – Capacity	14
Workforce – Recruitment	8
Infrastructure - Estates	8
Finance – Insufficient Funding	6
Workforce – Training, Development and Skills	5
Finance – Non recurrent funding	4
Workforce – Retention	4
Workforce – Absence	3
Workforce – Wellbeing	2
Infrastructure – Digital	1
Other (National Policy, Systems – National, Data & Modelling, Engagement)	1
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	**1948**	**<1400**		11th (Dec 2024 census point)	Acuity and difficulty securing appropriate operating capacity for longest waiters. Short stay complex remains shut Note: targets updated in Q2, in line with revised agreement with SG *Last reported: Formal reporting to Scottish Government on a weekly basis* spotlight on page 43
	We will minimise the number of waits over 104 weeks for a new outpatient appointment	625	829	<700	1426	<700	1747	<900	**1739**	**<1000**		11th (Dec 2024 census point)	Patient referral acuity shift. Challenges in key specialities such as Urology *Last reported: Formal reporting to Scottish Government on a weekly basis* spotlight on page 44
	Average monthly delayed discharges to be no greater than Q4 2023/24	254	274	<255	283	<255	282.3	<255	**294.7**	**<255**		comparative benchmarking not available	CO's continue to attend weekly national CRAG meeting where DD data is monitored and there is opportunity for shared learning. The Grampian meeting has continued to meet fortnightly and is transitioning to be the oversight for the national Discharge without Delay collaborative. *Last reported: to IJB's through HSCP governance routes (Feb 2025).* spotlight on page 45

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%	**33.1%**	**<32.6%**		comparative benchmarking not available	CO's continue to attend weekly national CRAG meeting where DD data is monitored and there is opportunity for shared learning. The Grampian meeting has continued to meet fortnightly and is transitioning to be the oversight for the national Discharge without Delay collaborative. *Last reported: to IJB's through HSCP governance routes (Feb 2025)* spotlight on page 46
	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%	**52.5%**	**72%**		11th (Dec 2024 census point)	Continued increase in USC referral demand. Not all plans to increase capacity have been realised such as opening of short stay theatres. *Last reported: Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights; weekly SG reporting* spotlight on page 47
	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%	**90.0%**	**95%**		11th (Dec 2024 census point)	Continued increase in USC referral demand. Not all plans to increase capacity have been realised such as opening of short stay theatres. *Last reported: Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights; weekly SG reporting* spotlight on page 48

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	**254**	**110**		11th (quarter end Dec 2024)	Acute occupancy levels at midnight remain over 100%, with daytime occupancy routinely 20% higher. This means that ED/AMIA occupancy is also extremely high as bed waits are slow to move to admitting areas (routinely waiting on discharges). With assessment areas either at or above capacity, ambulances have to stack until an assessment space becomes available *Last reported: Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights* spotlight on page 49
	70% of citizens will be seen within 4 hours in NHSG Emergency Departments	60.7%	60.8%	70%	61.0%	70%	57.9%	70%	**57.4%**	**70%**		9th (quarter end Dec 2024)	Acute occupancy levels at midnight remain over 100%, with daytime occupancy routinely 20% higher. This means that ED/AMIA occupancy is also extremely high as bed waits are slow to move to admitting areas (routinely waiting on discharges). *Last reported: Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights* spotlight on page 51
	Average length of stay for elective and non-elective patients (NHSG MUSC only) to be no higher than Q4 2023/24	6.53 days	6.42 days	<6.54 days	6.33 days	<6.54 days	6.38 days	<6.54 days	**7.02 days**	**<6.54 days**		comparative benchmarking not available	The volume of respiratory and flu admissions increase over winter and Length of Stay always increases as a result. The volume of delayed discharges has also increased. *Last reported: Weekly performance data is submitted to Scottish Government* spotlight on page 53

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**		**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**			
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%	**97.7%**	**90%**		3rd (quarter end Dec 2024)	CAMHS Continues to meet the Referral to Treatment National Standard of 90%, demand for access continues to increase along with the complexity of those requiring to be seen. *Last reported: MHLDS Clinical Governance Group and the ACH&SP Clinical Governance Group. February 2025* Spotlight on page 54
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%	**77.8%**	**70%**		6th (quarter end Dec 2024)	Adult PT services continue to maintain performance against waiting times standard this quarter with 78% of people receiving treatment within the 18 week waiting time's standard. Demand and capacity planning remains our priority with a maintenance and improvement focus *Last reported: all 4 cross system HSCP clinical governance groups. Also reported to Scottish Government on monthly basis* Spotlight on page 55

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%**	100%	The six key workstreams identified in 24/25 for the frailty programme have been progressed to a finish point. 1. Programme Governance - Completed 2. Performance Monitoring - Dashboards on illuminate 3. Communication - Completed 4. Developing a Sustainable Workforce - the workforce supports the current system, this will be reviewed as the DWD work progresses in line with reduced working week hours for staff. 5. Learning Network / Managed Clinical & Care Network - No funding for MCN however a shared learning culture across the three partnerships is embedded and continues across the Frailty Programme Board. 6. Grampian-wide Overview of all Aspects of the Frailty Pathway - key elements of this remain however these will be taken forward via the Discharge Without Delay Programme of work. *Last reported: Frailty Programme Board 10/02/2025* spotlight on page 58

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

Q4 actual: 1948
Q4 Target: <1400

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 objective was not achieved within 24/25.

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.

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 financial savings asks is yet to be modelled for their planned care impacts when they are known. 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 infrastructure issue (both buildings and equipment) is most likely currently to lead to an inability to deliver our planned care programme. The consequences of the financial situation are not currently known but is likely to have an overall negative impact on planned care delivery.

Commentary from

Paul Bachoo, Medical Director, Acute Services

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 remain supportive of an approach for closer delivery of elective care as a region but there has been limited progress on this to date.

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 financial constraints 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

Q4 actual: 1739
Q4 Target: <1000

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.
- The Dermatology position could potentially be improved by the adoption of digital solutions being advocated by the Centre for Sustainable Delivery and these have been submitted for consideration of SG funding for 2025/26.
- 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.

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, 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 have 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,
Medical Director,
Acute Services

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 Centre for Sustainable Delivery (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 how we can redesign services to be financially sustainable and also deliver an improved performance; this will require fundamental service redesign in several specialties

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

Q4 actual: 294.7
Q4 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 (DwD) 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 saw an increase in delays in Q4 2024-2025, a contributing factor was controls put on social care spending in response to increased care home placements and spending in the first three quarters of the year. Aberdeen City have seen a decrease in delays in Q4, they are back to similar numbers from a year ago when interim beds were open. Moray have seen a recent reduction but numbers have remained stable.

Mental Health and Learning Disability (MHLD) have sustained the 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, community hospital surge capacity has been identified and deployed during high risk periods for acute. Place availability, funding and care arrangements were 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.

Our key risks, challenges and impacts…

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

Number of delays demonstrate people in wrong part of system. Complexity and level of need for people are increasing. Many people waiting for care homes and demand exceeds capacity. Financial challenges impact on other options.

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

This KPI has significant interrelationships with Length of Stay, Ambulance Turnaround, and Emergency Department Wait KPIs.

Commentary from
Leigh Jolly, 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

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 meeting of HSCP Chief Officers, MUSC Portfolio Lead and Dr Gray's Lead to review the system pressures and identify key themes, challenges, actions and mitigations.

• We continue to review the delays due to adaptations and seek to find solutions to move people to more appropriate environment.

• 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?

Monitoring progress via the Fortnightly Discharge without Delay meeting for NHSG. Continue to have national support in Aberdeenshire & MHLD.

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

Monitoring of data. Competing demands and financial resources could prevent success.

What have we learnt?

Aberdeenshire:

- A draft Standard Operating Procedure for Community Hospital Discharges and a plan for implementing this has been developed in collaboration with Scottish Government colleagues.

Aberdeen City:

- 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?

Clinicians should refrain from prescribing care while people are in hospital. Early engagement with care management. National support continues in MHLD & Aberdeenshire. NHS Grampian are now part of the national DwD collaborative. Fortnightly Discharge without Delay meeting gives support to the wider system.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

Fortnightly Discharge without Delay meeting continues linking with national collaborative. Existing Clinical & Care Governance routes.

b) When was this KPI last reported?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights

Tier 3 - Our Performance Spotlights: Access & Empowering

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

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

Q4 actual: 33.1%
Q4 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 Q4's CRAG data NHS Grampian had 35.5 standard delays per 100,000 adults. At the end of March 2025, Aberdeenshire had 107, Aberdeen had 47, and Moray had 32 individuals delayed most of whom were in community hospitals.

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 has been an increase in delays in Aberdeenshire in this quarter. In Aberdeenshire the main reasons for delays were assessments, care arrangements, place availability and funding. The figures in Moray have remained stable and there has been a reduction in Aberdeen.

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
- Requirement to control the increasing cost of meeting the level of demand for social care
- 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 in the community
- 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
- 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
Leigh Jolly, 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?

Three HSCPs have signed up to the national **Discharge without Delay Collaborative** with planned progression of 4 workstreams:

- Workstream 1: Planned Date of Discharge/Integrated Discharge Hub.
- Workstream 2: Discharge to Assess/Home First.
- Workstream 3: Community Hospitals/Step Down Rehab Units.
- Workstream 4: Frailty @the Front Door.

Grampian wide bid submitted to the Scottish Government's Whole System Planning Commission 2025-26

Aberdeenshire – Tight review of individuals delayed by Care Managers and Location Managers and Professional Oversight Group for Care Homes and Care at Home meets weekly to monitor and mitigate risk across the social care system in Aberdeenshire.
Delayed Discharge Improvement Group: meets weekly with action plan updated following the Scottish Government Rapid Review & Support Team recommendations. A draft Standard Operating Procedure for Community Hospital Discharges and a plan for implementing this has been developed in collaboration with SG colleagues.
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.
Implemented an interim operational change to our existing process for care home allocation/funding has been in place to reduce place to the position in January 2024.
SDS option 2 Care at Home provider established targeting people who are delayed waiting for care home in Central Buchan following a tender
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 – Hospital social work team oversee individuals during hospital stay.
Promotion of 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 Discharge without Delay (DwD) meeting.

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 through IJB's. 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 Delivery Group meeting to monitor progress with national collaborative. Established reporting mechanisms in place. COs continue to attend weekly national CRAG meeting.

b) When was this KPI last reported?

March 2025 Discharge without Delay Grampian Group update

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

Q4 actual: 52.5%
Q4 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 negative 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?

- The diagnostic backlog has increased 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 ou 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,
Medical Director,
Acute Services

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 develop the SURE unit Urology Diagnostic Hub
- Harnessing innovation to support pathway efficiencies
- Business cases have been presented to Scottish Government for additional funding

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.

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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights; weekly reporting to SG

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

Q4 actual: 90.0%
Q4 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?

There has been an increase in performance in the last reporting quarter which has narrowly missed the national performance target of 95%.

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,
Medical Director,
Acute Services

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
- Business cases have been presented to Scottish Government for additional funding

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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 Spotlights; weekly reporting to SG

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

Q4 actual: 254
Q4 Target: 110

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.
- 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 has begun to reverse slightly in 2025 despite occupancy pressure increasing.

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

Chief Officer, Acute Services

Our key risks, challenges and impacts…

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

- Cute Medical Initial Assessment (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 has submitted an Unscheduled Care Whole System Plan 25/26 to the Scottish Government in March outlining the improvement measures required to shift the balance of care from acute hospitals to communities. We continue to liaise with Scottish Government Policy Team in relation to the potential for approval of the plan and whether there will be release of implementation funding.
- 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.
- **In-Ambulance Triage**. Since January NHSG has undertaken initial triage for ambulance patients awaiting access to the ED. This was initiated to improve patient safety, and has been successful in doing so, but has also refined some patient pathways and reduced waits.
- **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 (ToC) 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. We intend to relocate and extend the ToC to increase staffing resilience over the next 8 weeks.

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 Centre for Sustainable Delivery (CfSD) in implementing their recommendations of Jan 2025 has been offered.

Oversight and assurance

a) 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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 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

Q4 actual: 57.4%
Q4 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
Chief Officer,
Acute Services

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 Ward 308, 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 is increasingly 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 2025:

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. Increased focus to reverse a recent increase in GenMed Length of Stay.
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 March 2025 which has been submitted to the Scottish Government in March and for which we awaiting feedback. 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 Discharge Without Delay programme. 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. Early focus points for this work will be the Urgent Care Hub and multi-disciplinary / multi-specialty decision making at the front doors.

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?

Q3 PAFIC 26/02/25 and HAWD 10/04/25 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

Q4 actual: 7.02 days
Q4 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.
- Complexity. There are indications that the number of transfers of care within our pathways is negatively impacting on LoS. GenMed LoS proved to be 20% higher than over the previous 12 months. In the absence of a clear drive, this is being investigated as a matter of priority.

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
Chief Officer,
Acute Services

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 Delivery (CfSD) focus and support around capacity planning will also be increased in the coming quarter.

Priorities for 2025:

Reducing 7 & 14 day LoS. 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).

Discharge Champions. An opportunistic move to embedding the Discharge Lounge Team within core wards 104/8/10/110 has seen a positive improvement in discharge volume and indeed time distribution. Discussions are underway as to how this can be scaled up to support greater demand of this team to support in ward discharging processes. Formal evaluation reports in May 2025.

Multi-Disciplinary Team Working. Linked with better exploitation of the PDD, is the need to maximise concurrent planning for discharge for both Acute and HSCP teams. Correct representation at Multi-Disciplinary Team meetings, and agreed priorities and criteria for discharge are key components of the programme.

GenMed redesign. 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: Access & Empowering

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

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

Key Performance Indicator (KPI): 90% of children and young people referred to Mental Health Services will be seen within 18 weeks

Q4 actual: 97.7%
Q4 Target: 90%

Outcome: Achieve Mental Health outcomes in concordance with national strategy/Improvement in outcomes for children realised and evidenced, measured through agreed key performance indicators

Our story so far….

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

NHS Grampian CAMHS continues to meet this KPI, underpinned by the Referral to Treatment (RTT) Scottish Government national waiting times standard for CAMHS stating that 90% of children and young people should start psychological intervention within 18 weeks of referral.

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

This position has been consistent for the past 18 months. Performance continues to be affected by an ongoing need to prioritise and see patients where risk is identified.

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

This KPI performance is a significant milestone, positively impacting deliverables and achievement of the 2027 outcomes of improving timely access to mental health services for children and adolescents. However, meeting this target has required substantial resources and focus, which has impacted other aspects of the service.

NHS Grampian follow national waiting times guidance from Public Health Scotland (PHS) regarding recording and defining RTT times. All referrals to CAMHS that meet nationally set referral criteria are offered assessment or consultation, depending on clinical need, to ascertain whether further psychological treatment or intervention is recommended or wanted. At the point of assessment or consultation (first contact / appointment / consultation); clinicians are asked to use their clinical judgement, based on the above PHS guidance, to decide whether this initial contact warrants an assessment only, or also constitutes the start of treatment; entering an outcome code accordingly. NHS Grampian have consistently and transparently highlighted that (for the CHOICE and Partnership clinical care pathway which is approximately 70% of clinical demand) the wait for a first (CHOICE) appointment is generally within 8 – 12 weeks (meeting <18 week RTT target), however the wait for a second (PARTNERSHIP) treatment appointment, is significantly higher than we would like it to be. The median wait in days between an initial contact and the second appointment in 2025 (to date) is 126 days. We are working hard to address this. To ensure balanced progress towards the 2027 outcomes, it is essential to continue investing in all areas of CAMHS, including those that may not directly contribute to the 18 week target but are crucial for providing comprehensive mental health care and treatment.

Our key risks, challenges and impacts…

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

Alongside increasing demand, there has also been an increase in both mental health severity / acuity and complexity of presentations. Meeting the 18 week referral to treatment target requires significant resources which can strain other areas of service. Balancing resources to ensure comprehensive care across all aspects of CAMHS is a continuous challenge. The focus on meeting the 18 week target diverts attention from other critical areas such as reducing wait to second appointment. The need to achieve substantial financial savings while maintaining service quality presents a significant challenge. Budgetary pressures can impact the ability to invest in necessary areas to sustain long-term improvements. A number of temporary staff have been lost due to the fragility of the EMHOF allocation. Increasing demand for mental health services coupled with limited capacity, can lead to longer waiting times and pressure on existing services. Managing this demand effectively is crucial to maintaining performance.

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 inter-relationships with

- Workforce, Culture and Wellbeing - intense focus on meeting this target increased pressure on staff, leading to higher levels of burnout and absenteeism, impacting overall staff morale and retention. This has also necessitated rapid recruitment, sometimes resulting in less experienced staff being hired. This can impact the quality of care and increase the need for additional training and support.
- Infrastructure, Finance - required significant investment in infrastructure, including clinic spaces and equipment; alongside workforce. This can strain budgets.
- Population based Health - The current population of children and adolescents and the world they are living in is markedly different to that of ten years ago, with ever increasing demand in terms of mental health issues. Focus on the 18-week target may lead to disruptions in other services, such as early or crisis intervention. Balancing these needs is crucial to avoid compromising comprehensive care. While the 18-week target has been met, there has been an increase in waiting times for other elements of care, such as 2nd appointment and neurodevelopmental assessments. This can impact overall service delivery, result in poor outcomes and impact patient satisfaction.

Commentary from

- Fiona Mitchelhill, Chief Officer, Aberdeen City, Health & Social Care Partnership (HSCP)
- Leigh Jolly, Chief Officer, Aberdeenshire

Our mitigation and recovery actions

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

- Weekly CAMHS Leadership Team Meetings focussed on performance. Oversight and scrutiny through wider MHLDS and HSCP clinical governance structures.
- Monthly Scottish Government reporting.
- We continue to prioritise seeing all urgent and emergency referrals.
- Demand, Capacity, Activity and Queue modelling takes place regularly for clinical pathways.
- Job plans continue to be reviewed regularly to identify opportunities to manage and direct clinical capacity.
- We are working with CSSDT and our finance colleagues to aim to reinstate a significant number of clinical posts / capacity lost due to the fragility of the EMHOF funding.

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

CAMHS Grampian is the lowest staffed Board in Scotland with 16.5 Whole Time Equivalent (wte) per 100,000 per population. This compares to the national average of 28.1 wte per 100,000 per population, with at least 19.4 wte per 100,000 at all other Boards.

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

Continue to monitor. Opportunity for learning and sharing through various national and regional forums.

What have we learnt?

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

Monthly data continuously reviewed within the Leadership Team to monitor trends and changes, which allows focussed time for the cause of any changes to be identified – this ensures patient experience is at the forefront of decision making

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

Acknowledgement of the significant internal wait for a second treatment appointment.

Further investment in workforce to move away from being the lowest staffed Board in Scotland.

Investment in digital solutions such as text reminders, to maximise efficient use of available appointments and decrease wasted clinical time.

Acknowledgement of the financial challenges faced and the difficult decisions that are associated and potential impact if workforce is not increased.

Oversight and assurance

b) What is the assurance and governance oversight arrangements?

Monthly MHLDS Clinical Governance Group and the Aberdeen City Health and Social Care Partnership Clinical Governance Group. Monthly reporting to Scottish Government and PHS.

b) When was this KPI last reported?

Monthly

Tier 3 - Our Performance Spotlights: Access & Empowering

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

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

Key Performance Indicator (KPI): 70% of people referred to psychological therapies will be seen within 18 weeks of referral

Q4 actual: 77.8%
Q4 Target: 70%

Outcome: Achieve Mental Health outcomes in concordance with national strategy

Our story so far….

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

We have been working for approximately 3 years on a PT improvement programme of work in line with Scottish Government access standards for Psychological therapies
Referral to treatment times standard performance has been maintained at above 70% this year despite risks identified below. Referral numbers, treatment starts and the waiting list have remained stable in 2024/25. Number of patients waiting over 36 weeks and over 52 weeks have reduced. Digital service activity has increased by more than 50%. All but one of the PT specification implementation criteria have been met either fully or partially.

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

The PT referral to treatment time standard has ensured a focus and prioritisation of evidence based psychological treatments which is welcomed by patients and reflected in high demand for our services. Given we take a cross system and service wide approach to the delivery of PT the performance standard/KPI should not be at the expense of deliveries for other aspects of the service. We continue to highlight at national level the need to develop ways of valuing and measuring wider applied psychology activity, for example preventative working models, which have subsequently become more present in national agendas within Psychology and in engagement with Scottish Government mental health leads.

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

We continue to work hard to manage our resource across the system as effectively as possible using Demand Capacity Activity and Queue analysis at the centre of our work for PT delivery. We have been able to maintain above 70% compliance to the 18 week referral to treatment standard for PT, however there remain significant waiting lists in certain very high volume services where demand currently outstrips resource, specifically Adult Mental Health services.

Our key risks, challenges and impacts…

a) What are the key risks and challenges affecting performance? The biggest risks related to continuing our improvement work relates firstly to the general financial position where savings are required to be made across the system. This has resulted in temporary posts being discontinued and all posts taking longer than usual to progress to recruitment. In addition the Enhanced Mental Health Outcomes Framework (EMHOF) allocation was received very late for 2024/25 which has meant that Finance have not been able to hold risk attached to posts funded under this framework which are substantial in number. More widely the allocation of funding for PTs into the IJBs has meant that it is extremely challenging to manage deliverables across the system in an equitable way and that IJBs have major savings to make compromising further PT resource maintenance

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?
As described above the delays in recruitment are impacting significantly on PT performance. The other unintended consequence is that staff can experience a sense of overwhelm and burnout associated with the persistent weight of lengthy waiting lists for PT

Commentary from

June Brown, Executive Nurse Director & Interim Deputy Chief Executive

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?
We continue to engage with Scottish Government in our regular enhanced support meetings where mutual feedback and scrutiny is focussed on continued improvement. We also have a comprehensive assessment of the implementation of the PT specification which allows us further focus on areas of improvement, all of which is central to our key PT governance forum, the Psychological Practice Improvement and Governance Board (PPIGB).

We also continue to work closely with our colleagues across the IJB's to identify further resource to mitigate against lost capacity identified over the last 12 months. This will be dependant largely on when the 2025/26 EMHOF allocation is received. This will be baselined which will help with further future service planning. We also continue our work with DCAQ and trajectory planning which will help identify with further certainly where we need to apply resource when the opportunity arises

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

We have clear measurement of impact with the regular monthly waiting times reporting for PT. Continued improvement is primarily contingent on further resource identification for recruitment of PT staff specifically on the EMHOF allocation as described above.

c) If something hasn't worked, what alternative course of action will be taken? If we do not receive further funding it will be challenging to continue improvements, however we will continue to use all of the tools at our disposal to maintain current performance

What have we learnt?

a) How are we evaluating progress, and how is learning being applied to support delivery of the Outcome?
Data is reviewed monthly and longest waits constantly targeted as priority. We monitor trends and changes to ensure a patient focussed approach is central to our work.

b) What needs to change? Is further support needed, if so from where and in what form?
We need further support to recruit sufficient PT staff to resolve backlog and meet demand moving forward in line with waiting times standard. We are continuing to work up a clear analysis of resource required for this longer term.

Oversight and assurance

a) What is the assurance and governance oversight arrangements?

PT performance is reported through each of the partnership governance forums. Performance is also reported to Scottish Government on a monthly basis and forms the basis of our enhanced support meetings and also provides the agenda for improvement element of our Psychological Services Improvement and governance Board.

b) When was this KPI last reported?

Monthly

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

Q4 actual: 100%
Q4 Target: 100%

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. The six identified key workstreams for 24/25 have been progressed to a finish point.

1. Programme Governance - Completed
2. Performance Monitoring - Dashboards on illuminate
3. Communication - Completed
4. Developing a Sustainable Workforce - the workforce supports the current system, this will be reviewed as the Discharge Without Delay (DWD) work progresses in line with reduced working week hours for staff.
5. Learning Network / Managed Clinical & Care Network - No funding for MCN however a shared learning culture across the three partnerships is embedded and continues across the Frailty Programme Board.
6. Grampian-wide Overview of all Aspects of the Frailty Pathway - key elements of this remain however these will be taken forward via the DWD Programme of work.

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

Frailty process mapping and review against best practice / new frailty standards across the three health and social care partnerships is now complete. From this exercise assurances are in place that improvements to frailty across the system will come from the DWD programme of work whilst also ensuring progress continues to be made around prevention, particularly around early identification.

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

The performance of this KPI has reached a finish point and this supports 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. In Aberdeenshire there are ongoing challenges with medical support from geriatrician team.

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 - note the links frailty has with the wider system. Key elements of further development for frailty will be taken forward as part of the Discharge with Delay Programme of work.

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 focus and development around the four workstreams of the Discharge Without Delay Programme (DWD)

- Discharge to Assess / Home First
- Community Hospital and Step Down Rehabilitation Units
- Frailty at the Front Door
- Planned Date of Discharge (PDD) and Integrated Hubs

The DWD programme will help support and manage the identified risks for Frailty. The workforce issue in particular will be an evolving process with potential for extra money coming from Scottish Government for the DWD work.

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

The DWD programme has key deliverables with specific measures to demonstrate the meeting of these. 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 governance of the DWD work will be via the Unscheduled Care Programme Board, with the progress and any issues raised around this work dealt with in that Forum.

What have we learnt?

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

Progress against this KPI in 24/25 has been via the Frailty Programme Board which 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.

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

The structure / remit of the Frailty Programme Board needs to be developed in line with the DWD work and governance structures around this, whilst ensuring prevention and frailty learning (MCN – Managed Clinical Network) are part of the remit. An understanding of the prevention and early intervention within primary care and the community settings and the alignment with the DWD work is key.

Oversight and assurance

a) What are the assurance and governance oversight arrangements?

The governance for Frailty Programme Board is through the Unscheduled Care (USC) Programme Board. The priority for frailty work going forward will be the DWD work, the governance of this will be through the USC Programme Board.

b) When was this KPI last reported?

Last Frailty Programme Board 10th February, next meeting scheduled for 19th May.

Operational Improvement Plan-2025/26

The NHS Scotland Operational Improvement Plan is intended as a short term, realistic support to local health boards existing planning, and is the first part of a longer term commitment of reform and renewal to ensure long-term sustainability, reduce health inequalities, further harness the benefits of digital technology, and improve population health outcomes in Scotland, while focussing on the following 4 critical areas:

Improving access to treatment	**Improving access to health and social care services through digital and technological innovation**
Shifting the balance of care	**Prevention – ensuring we work with people to prevent illness and more proactively meet their needs**

At this initial stage of reporting, selected updates of early work towards the OIP is included, with further development due over the lifespan of the OIP.

Improving access to treatment - Expand the Rapid Cancer Diagnostic Services - Cancer Management Framework

Scottish Government (SG) re-launched the Framework for Effective Cancer Management (FECM) in March 2025, incorporating ten key elements to guide NHS boards in planning and delivering cancer services. These elements, including corporate responsibility and pathway management, are designed to support the achievement of national cancer standards and improve patient outcomes. The refreshed framework has been expanded to include data collection to monitor demand and capacity as well as incorporating patient experience feedback as standard practice in cancer service planning. It is anticipated that self-assessment of NHSG's compliance in the delivery of the FECM will be reported to SG on a regular basis with defined outcome measures.

One of the elements in the framework focusses on effective breach analysis processes, in collaboration with management teams and clinicians, to support data validation when a breach of cancer waiting times target occurs, governance around escalation of cancer pathway 'pinch points' as well as providing an opportunity for shared learning to mitigate future breaches. Ongoing work to gather validated data throughout the continual breach analysis process has been used to inform performance trajectories and develop the annual cancer improvement plan along with business case bids submitted to SG with aim to improve 62-day cancer waiting times performance by March 2026. Most of the cancer bids submitted for financial year 25/26 have been funded and are in the process of being operationalised to increase capacity.

NHS Grampian have an operational pathway in place for GP's to refer patients with non-specific cancer symptoms directly for a CT scan. Work is underway to streamline the management of these patients, in collaboration with the single point of contact service, in order to redesign the pathway in line with the Rapid Cancer Diagnostic Services (RCDS) model by March 2026.

Improving access to health and social care services through digital and technological innovation - Digital Dermatology Pathway

As of the week beginning 17 March 2025, five GP practices successfully went live with the digital dermatology application. Building on this initial implementation, a wider rollout across the Grampian region commenced during the week beginning 20 April 2025. To date, a total of 296 primary care colleagues across 24 practices now have access to the application. This group includes clinicians, doctors in training, and administrative staff involved in the referral process.

To ensure continued progress and alignment, weekly meetings are held between the NHS Grampian Planned Care Redesign Programme Manager and the CfSD Project Manager. These meetings focus on advancing the rollout across the region and exploring opportunities for benefits realisation.

A dedicated local project team has also been established, comprising representatives from Dermatology, Primary Care, Health Intelligence, and Digital Services. This team is tasked with embedding the use of digital dermatology within NHS Grampian, supporting the submission of progress updates to CfSD, and working towards achieving the Scottish Government's target of ensuring that 90% of dermatology referrals include a triage-suitable image by September 2025.

At present, there are no issues of concern reported. Furthermore, the digital dermatology project is anticipated to positively impact other areas aligned with the operational improvement plan, such as reducing waiting lists—particularly those exceeding 52 weeks. These potential benefits will be further explored and documented as part of the planned benefits realisation work.

Improving access to health and social care services through digital and technological innovation - An Operating Theatre Scheduling Tool

We have commenced the process of discovery to support the role out of Theatre Scheduling with planned delivery to two specialities by October 2025. As yet, we have not been able to quantify the level of efficiency this will bring to the services, but initial work has indicated that the organisation will benefit from a standardisation of coding from local codes to OPCS4 which will contribute to improvements in managing our waiting lists and support our plans for an overall reduction.

Shifting the balance of care - Primary Care Optometry - Community Glaucoma

NHS Grampian has made strong progress in implementing the Community Glaucoma Service (CGS), which enables the discharge of stable glaucoma patients from hospital eye services (HES) to NESGAT-trained community optometrists. This supports the wider ambition to reduce waiting times and move services closer to home. A key milestone has been the resolution of digital data transfer from Medisight to OpenEyes, now approved by Information Governance and expected to go live in the coming weeks. This will allow the first tranche of patient discharges by mid-summer, with a fully integrated pathway in place by March 2026. The work is aligned to NHS Grampian's Route Map and national priorities to embed sustainable community eye care.

Positive outcomes include early service streamlining through clinical risk stratification, reduced pressure on hospital services, and successful training of five NESGAT optometrists across two regions — with further expansion planned to ensure equitable access. The work directly supports two operational areas in the request: Community Glaucoma, as the primary focus of this initiative, and reducing waiting lists (including 52-week waits) by shifting appropriate care from hospitals to community optometry, thereby increasing hospital capacity and responsiveness.

Improving access to treatment - Waiting lists, reducing 52 day waits

All services continue to follow the Access Policy, applying processes around DNA (Did Not Attend) and CNA (Cannot Attend) to reduce wasted appointments and theatre time. Established practices such as Active Clinical Referral Triage (ACRT), Patient-Initiated Reviews (PIR), and Enhanced Recovery After Surgery (ERAS) remain in place where implemented, with support provided to services still onboarding. Scottish Government has confirmed additional funding to target patients waiting over 52 weeks for outpatient appointments or surgery. Services receiving this funding are progressing recruitment for medical, nursing, administrative staff, and necessary equipment, with many posts already advertised or at interview stage. Plans using additional hours from existing staff are also on track.

Weekend operating sessions and outpatient clinics for ENT and Orthopaedics continue through external providers to treat long-waiting patients, alongside clinics and surgeries run by local teams, although the latter may scale back in July due to limited funding. Services without additional funding are still prioritising their longest waits and exploring internal efficiencies. Pre-assessment for surgical patients remains ongoing, though limited financial resources constrain the ability to scale up. Activity tracking and performance trajectories are reviewed weekly at the Long Waiters Meeting, with monthly submission of overall planned versus actual activity. Targeted work with individual services continues, including exploration of capacity across Scotland via NECU, and collaboration with CfSD to develop the national Perioperative Services Framework aimed at improving theatre efficiency and reducing waiting times.

Use of National Treatment Centres

NHS Grampian have allocations to various external hospitals for patients to undergo elective procedures. There are occasions where NHS Grampian will seek or are given ad hoc allocations but this can differ from year to year depending on demand and capacity. Our known and confirmed allocations for the 2025/26 financial year are as below and are given as numbers of procedures.

- National Treatment Centre Highland – Cataracts 1753, Orthopaedic Joints 600, Orthopaedic Foot and Ankle 30.
- Golden Jubilee National Hospital Glasgow – Orthopaedic Joints 389, Orthopaedic Soft Tissue Knees 37 General Surgery 190, Major Colorectal 118, Minor Colorectal 48, Lower Colonoscopy 1540.

Additionally NHS Grampian has access to 2 main theatre suites per day Monday to Friday within Stracathro Regional Treatment Centre, the theatre nursing team and anaesthetists are supplied by NHS Tayside but procedures are carried out on NHS Grampian patients by NHS Grampian Surgeon's.

Improving access to treatment - Validation processes for waiting lists

All patients on a new outpatient waiting list and in-patient or day case waiting list should be administratively validated after waiting for 6 months and every 6 months thereafter. There are 2 mechanisms we have for doing this, either by accessing the National Elective Co-ordination Unit (NECU) who have digital means to contact large volumes of patients via text message. They will then follow up via telephone any patients who have not responded, patients without a mobile number or patients who have chosen "unsure" or "No I do not require my appointment/admission" as a response to the text message. On completion of a validation campaign the information collated is sent back to NHS Grampians administration groups so that trakcare can be updated for each patient as per the patient response.

The second mechanism for administrative validation is via NHS Grampian's administrative staff, who will validate the patients either at the point of a patient calling in or a proactive call to the patient for the purpose of validation. In either type of validation the questions are the same, checking the patient's details, asking if the patient still require their admission/appointment, and also allowing an opportunity for the patient to raise a comment or query. This ensures that patients on our waiting list have all appropriate information recorded and still plan to attend for their appointment or admission.

Improving access to treatment - Diagnostics: Reducing the backlog – Process in Radiology

Last year, NHSG Grampian received non-recurring funding to support reduction in the waiting time for diagnostic imaging across the three main modalities, CT, MRI and Ultrasound. This funding allowed provision of a Mobile CT Unit, Mobile MRI Unit and a Locum Sonographer. A proportion of funding was aligned to outsourcing of reporting to support increased activity and ensure timely reporting of imaging. Additional workforce provision within MRI allowed partial extension of the service.
Radiology is a pan Grampian service, delivering activity across eight locations across the region. There is also provision for the island boards, both in terms of remote support for clinical teams based in Orkney and Shetland and the delivery of care to residents transferred to Aberdeen. Key improvement actions delivered across 2024/25 include; enhanced collaborative working and a move towards improved equity of wait across sites within Grampian, regular review of demand and capacity with a focus on problematic imaging sub-groups, targeting of additional activity to areas of longest wait and centralisation of outsourcing allocation to improve equity of reporting timescales across Grampian. This facilitated a decrease in total list size across all three modalities (23% combined reduction) and a reduction in over 6 week waits across all three modalities (43% combined reduction). Pathways improved included reduction in waits for diagnostics in USC, Paediatrics, Cardiology, primary care.
This year Radiology has been fortunate in receiving confirmation of both recurring and non-recurring funding to the sum of £5.4m. Within CT and MRI, non-recurring funding will support the continuation of increased levels of activity through mobile units to reduce the backlog, whilst the recurring funding will enable expansion of the CT and MRI service. Service expansion will support the long-term objective of a self-reliant sustainable service. A locum sonographer and additional evening and weekend sessions within ultrasound will support a reduction in backlog and waiting time. Overall activity delivered as a direct result of this funding is projected to be around 35,000. Continuation of insourcing and outsourcing of reporting will ensure reporting of imaging remains within recommended timescales. Recurring funding to increase our consultant radiologist establishment again ensures a long-term, maintainable solution, which should allow the reduction, but not the elimination, of the need for external reporting. At the end of March, the objective is 95% achievement of diagnostic imaging within 6 weeks. In addition a major capital improvement piece continues to be driven forward. Last FY, a replacement of a Trauma CT scanner in the ED FHC was successfully undertaken with no negative impact on patient safety, no mean feat given the pressured environment of the ED. In recent years the entire Children's hospital Radiology service has been completely upgraded, this work has just completed, bring higher quality images and lower doses of radiation to your youngest population. This year's commitment is to deliver a safe and sustainable MRI service on the FHC and advanced planning is underway. Work is also progressing to deliver a new radiology information system (project costs circa £1.1 million) in November and the National PACS program of work is on target for summer of 2026.

Improving access to treatment - Diagnostics: Reducing the backlog – Process in Endoscopy

The endoscopy service continue to rely on non-recurring investment to bolster its activity and have been successful in a number of bids that will continue to ensure we maximise capacity through utilisation of both external providers and internal recruitment.
Through the majority of 2024/25 our Aberdeen service were able to add a further 120 slots per week through use of external providers as well as utilise NHS Scotland support for a further 25 slots per week through a supporting health board.
Further internal redesign enabled the Aberdeen service to reduce some reliance on external providers to use substantive staff to support delivery of further activity at the Aberdeen Royal Infirmary site. This also included specialty personnel to support with additional General Anaesthetic clinics to support a small number of patients who clinically require this additional support.
The endoscopy service have again benefitted from further funding support into 2025/26 to support recruiting to a number of posts based at Aberdeen, some of which are appointed to, others at advert, for further skilled practitioners to support delivery of endoscopy activity.
Further continuous service improvement work continues to ensure the service operates as efficient as possible. This includes but is not limited to, review of vetting and booking guidance and compliance, themed review of not attended appointments, review of clinic templates and room utilisation, waiting list re-validation and patient focused booking.
The endoscopy service in NHS Grampian is working towards integrating the endoscopy service to a single service versus the current delivery model based at acute hospital sites (Aberdeen and Elgin). Within this piece of work a key objective is to transition away from reliance on non-recurring funding to deliver the service and develop core capacity to improve access to this service.

Appendix: National Waiting Times Standards

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Benchmarking** (of 11 mainland Boards quarter end Dec 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%	66.5%	66.7%	67.9%	67.6%	**64.3%**	7th Scotland: 65.1%	Overall A&E performance increased over the first two quarters of 2024, before decreasing through the second two quarters to December 2024. The level remains lower than at the same time the previous year. We remain 7th of the mainland Boards for the second consecutive quarter (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. – Q4 Update Pending*
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%	33.8%	39.4%	42.2%	48.3%	**50.1%**	8th Scotland: 53.1%	Performance has improved each quarter through 2024. We remain 8th of the mainland Boards for the second consecutive quarter; we have been 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%	64.2%	61.8%	65.9%	64.0%	**62.0%**	7th Scotland: 63.2%	Performance decreased for the second consecutive quarter, to December 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 remain 7th of the mainland Boards, but have dropped below the overall Scotland level for the first time since quarter ending June 2021. *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 Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Benchmarking** (of 11 mainland Boards quarter end Dec 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%	47.3%	43.9%	46.2%	46.1%	**48.1%**	8th Scotland: 57.0%	There was an improvement in performance for the quarter to December 2024, following a fractional decrease the previous quarter. We have moved from 9th to 8th position of the mainland Boards (with a decreases at Dumfries & Galloway); 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%	90.5%	89.5%	89.2%	88.4%	**87.3%**	11th Scotland: 94.8%	Performance decreased for each quarter through 2024. We remain with the lowest performance of the mainland Boards, and have been below the overall Scotland level since quarter ending June 2023. *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%	54.4%	55.0%	60.6%	53.9%	**60.3%**	11th Scotland 73.5%	Following a decrease to September 2024, performance improved to December 2024. We remain with the lowest performance of the mainland Boards, and 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 Dec 2023**	**Quarter end Mar 2024**	**Quarter end Jun 2024**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Benchmarking** (of 11 mainland Boards quarter end Dec 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%	96.7%	97.4%	96.5%	97.9%	**97.8%**	3rd Scotland: 89.1%	Performance decreased fractionally for the quarter to December 2024. We have moved from 5th to 3rd position of the mainland Boards (with decreases at Forth Valley and Tayside); 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%	76.4%	75.4%	81.7%	80.4%	**80.4%**	6th Scotland: 80.5%	Performance decreased for the quarter to September 2024, following an increase the previous quarter. We have moved from 5th to 6th position of the mainland Boards (with improvement at Fife), and we have dropped just below the overall Scotland level. *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 continuing to perform 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. We are managing outliers with delayed treatment for various reasons appropriately.*

From national waiting times publications