**Agenda Item 4**

# NHS Highland

| | |
|---|---|
| **Meeting:** | **NHS Highland Board** |
| **Meeting date:** | **17 May 2024** |
| **Title:** | **Integrated Performance and Quality Report** |
| **Responsible Executive/Non-Executive:** | **David Park, Deputy Chief Executive** |
| **Report Author:** | **Lorraine Cowie, Head of Strategy & Transformation** |

## 1 Purpose

**This is presented to the Board for:**

- Assurance

**This report relates to:**

Quality and Performance across NHS Highland

**This report will align to the following NHSScotland quality ambition(s):**

Safe, Effective and Person Centred

**This report relates to the following Strategic Outcome(s)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Start Well | | Thrive Well | | Stay Well | | Anchor Well | |
| Grow Well | | Listen Well | | Nurture Well | | Plan Well | |
| Care Well | | Live Well | | Respond Well | | Treat Well | |
| Journey Well | | Age Well | | End Well | | Value Well | |
| Perform well | | Progress well | | All Well Themes | X | | |

## 2 Report summary

The NHS Highland Board Integrated Performance & Quality Report (IPQR) is aimed at providing a bi-monthly update on performance based on the latest information available.

Moving forward the Argyll & Bute Integrated Performance Management Framework intelligence will be included for the Board for information only. This has been previously presented through the governance structure within Argyll & Bute.

### 2.1 Situation

In order to allow full scrutiny of the intelligence presented in the IPQR, Board is asked to review the intelligence presented so that a recommendation on level of assurance can be given.

The outcomes and priority areas have been incorporated for this Board are aligned with Together We Care and the Annual Delivery Plan.

As part of Blueprint for Good Governance we have a spotlight on patient experience of radiology and endoscopy included in this month's report.

Planned care trajectories will be included in the next version of IPQR and they are currently being agreed internally and with Scottish Government in line with the additional funding becoming available.

As done in previous IPQRs, Discovery data has been utilised for benchmarking comparator purposes to further examine the NHSH performance position against that of other Boards.

The committee-approved Finance, Resources and Performance Committee, Clinical Governance Committee and Staff Governance Committee IPQR slides have been included in this report to produce a full Board IPQR.

### 2.2 Background

The IPQR is an agreed set of performance indicators across the health and social care system. The background to the IPQR has been previously discussed in this forum.

### 2.3 Assessment

A review of these indicators will continue to take place as business as usual and through the agreed Performance Framework.

## 2.4 Proposed level of Assurance

This report proposes the following level of assurance:

| | | | |
|---|---|---|---|
| Substantial | | Moderate | |
| Limited | x | None | |

The level of assurance has been proposed as limited due to the current pressures faced by HHSCP in Acute and Community care delivery. The agreed processes for strategic transformation and efficiency will help drive continuous improvement and support improved performance.

# 3 Impact Analysis

### 3.1 Quality/ Patient Care

The Board IPQR provides a summary of quality and patient care across the system.

### 3.2 Workforce

The Board IPQR gives a summary of our related performance indicators relating to staff governance across our system.

### 3.3 Financial

Financial analysis is not included in this report.

### 3.4 Risk Assessment/Management

The information contained in this report is managed operationally and overseen through the appropriate Programme Boards and Governance Committees. It allows consideration of the intelligence presented as a whole system.

### 3.5 Data Protection

The report does not contain personally identifiable data.

### 3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

### 3.7 Other impacts

None.

### 3.8 Communication, involvement, engagement, and consultation

This is a publicly available document.

### 3.9 Route to the Meeting

Through the relevant Governance Committees.

## 4 Recommendation

The Board is asked:

- To note limited assurance and the continued and sustained pressures facing both NHS and commissioned care services.
- To consider the level of performance across the system.

### 4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – May 2024
- Argyll & Bute HSCP Integrated Performance Management Framework - FQ2 (23/24)

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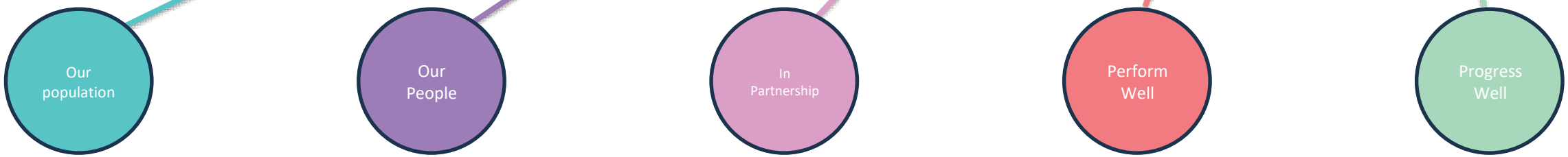
# Integrated Performance Report

## NHS Highland Board
## May 2024



# Executive Summary of Performance

| Well Theme | Area | Current Performance | National Target | ADP Trajectory Met | Performance Rating |
|---|---|---|---|---|---|
| Stay Well | COVID Vaccinations | 56.6% | | | |
| Stay Well | Smoking Cessation | 130 | | Not met (336 target) | Not meeting target |
| Stay Well | Drug & Alcohol Waiting Times | 93.4% | 90% | | Target met –2 months of increased performance |
| Thrive Well | CAMHS | 67.5% | 90% | | Not meeting target |
| Respond Well | Emergency Access | 75.7% | 95% | Not met | 4 months of decreased performance |
| Care Well | Delayed Discharges | 186 | 95 (local) | Not met | Improving – 3 months of improved performance |
| Treat Well | Treatment Time Guarantee | 56.6% | 100% | ADP and long waits not met | Improving – 3 month of improved performance |
| Treat Well | Outpatients | 41.2% | 100% | ADP and long waits not met | Variation – 1 month of improved performance |
| Treat Well | Diagnostics - Radiology | 63.3% | 80% (Mar 24) | Not met | Variation – 1 month of decreased performance |
| Treat Well | Diagnostics – Endoscopy | 71.4% | 80% (Mar 24) | Met | Not meeting target but stable around current performance |
| Journey Well | 31 Day Cancer Target | 95.5% | 95% | Met | Target met – 1 month of improved performance |
| Journey Well | 62 Day Cancer Target | 79.3% | 95% | Not Met | Variation – 5 months of decreased performance |
| Live Well | Psychological Therapies | 89.2% | 90% | | Improving – 5 months of improved performance |

**Guide to Performance Rating**

Improving is 2/3 months of improved performance
Decreasing – 2/3 months of decreased performance
Variation – Inconsistent pattern of performance/not meeting target

## Notes for Highlighting

Where applicable upper and lower control limits have been added to the graphs as well as an average mean of performance.

Additional detail has been added in each performance section on when the target was last met and how many times. If target was not met an indication has been given of the highest performance over the previous 24 months.

Within TTG and Outpatients there are 3 targets at present and these have been highlighted individually.

ADP trajectories will be added for the next IPQR.

Within the narrative section areas where action was highlighted in the previous IPQR all Exec Leads have been asked for assurance of progress and next steps for improvement by July 2024.

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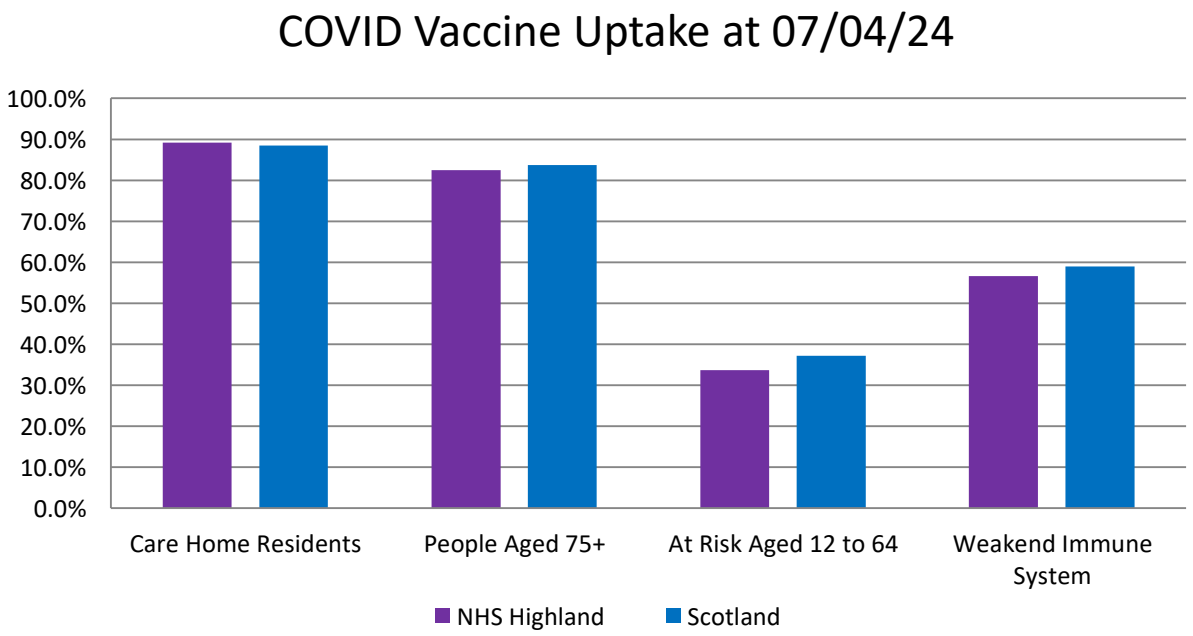
**Exec Lead**
**Dr. Tim Allison,**
**Director of Public Health**

# Vaccination Performance

| Progress Made | Next Steps | Timescale |
|---|---|---|
| •The autumn/winter COVID and 'Flu vaccination programme has now finished. It was delivered by Board staff except for some islands where there has been practice delivery. This programme was designed to reach those more at risk of illness.<br>•Overall COVID & 'Flu uptake has been reasonable, but the quality of performance delivery needs to be improved as does uptake in these programmes and for children's vaccination. | • Scottish Government is working with Highland HSCP in level 2 of its performance framework and Public Health Scotland is acting as a critical friend.<br>• The spring COVID vaccination programme has started for people aged 75+ and those more vulnerable. Other adult and child programmes also continue.<br>• Options are being considered for delivery models in Highland HSCP. | • Ongoing |

| PERFORMANCE OVERVIEW<br>Strategic Objective: Our Population<br>Outcome Area: Stay Well | |
|---|---|
| **Latest Performance** | 56.7% |
| **ADP Trajectory Agreed** | n/a |
| **ADP Trajectory** | n/a |
| **Performance Guide** | Ongoing depending on campaign |
| **National Benchmarking** | 34% |
| **National Target** | n/a |
| **National Target Achievement** | n/a |




## Benchmarking with Other Boards

Comparative Covid vaccine uptake for all eligible people at 07/04/24:

| NHS Board | Covid |
|---|---|
| Ayrshire & Arran | 60.5% |
| Dumfries & Galloway | 64.0% |
| Fife | 56.6% |
| Grampian | 58.5% |
| Highland | 56.7% |
| Tayside | 60.9% |

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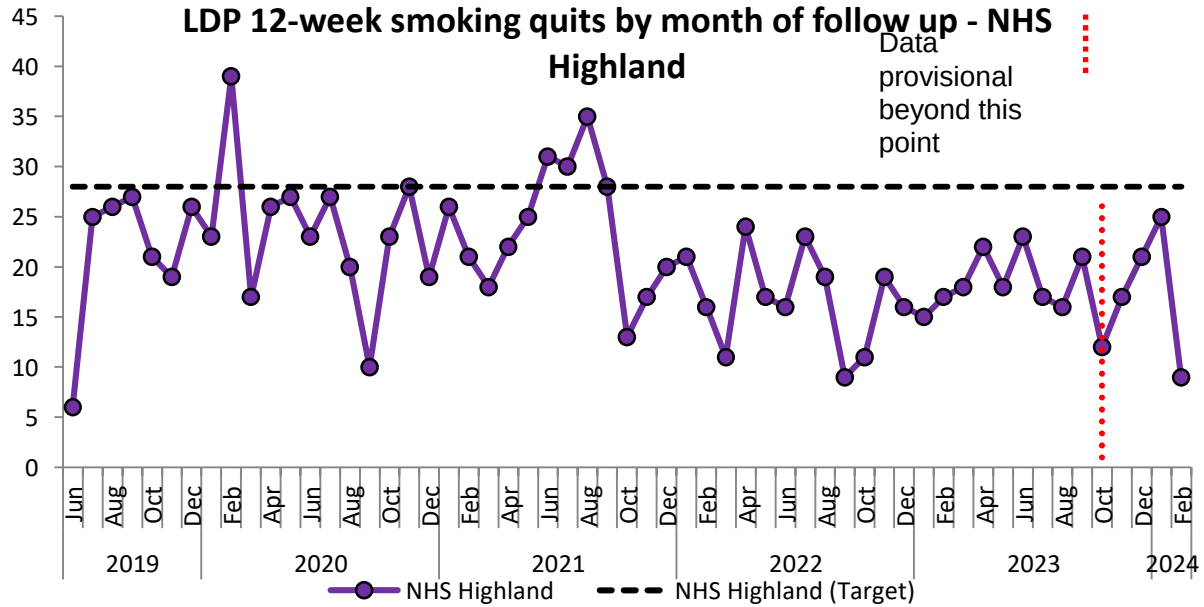
**Exec Lead**
**Dr. Tim Allison, Director of Public Health**

# Smoking Cessation

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • SOP training to remaining advisers<br>• Promote additional service in outpatients at Raigmore Hospital, set up meetings with clinical staff.<br>• Roll out training to Community Pharmacies.<br>• Review ABI targets by end of March 2024<br>• The current target is to deliver 336 successful quits at 12 weeks in the 40% most deprived within board SIMD areas. Of those setting a quit date from 1st April 2023 to 31st October 2023, there were 130 successful quits in the 40% most deprived.<br>• Mapping of smoking cessation services to NICE guidance.<br>• Mapping of smoking cessation services to recommendations from Review of Smoking Cessation Services in Scotland and Scottish Government 2-year Tobacco Action Plan | • Training on the SOPs to improve Community Pharmacy data has been delivered to most of our advisers.<br>• Advisers working closely with assigned Community Pharmacies and relationships are being built. Delivery of training is challenging due to capacity issues within Community Pharmacy.<br>• Additional adviser capacity in outpatients Raigmore and training with pre-assessment being planned. | Review end of June 2024 |

| PERFORMANCE OVERVIEW<br>Strategic Objective: Our Population<br>Outcome Area: Stay Well | |
|---|---|
| **ADP Trajectory Agreed** | Yes |
| **ADP Trajectory** | Below Target |
| **Performance Guide** | Decreasing |



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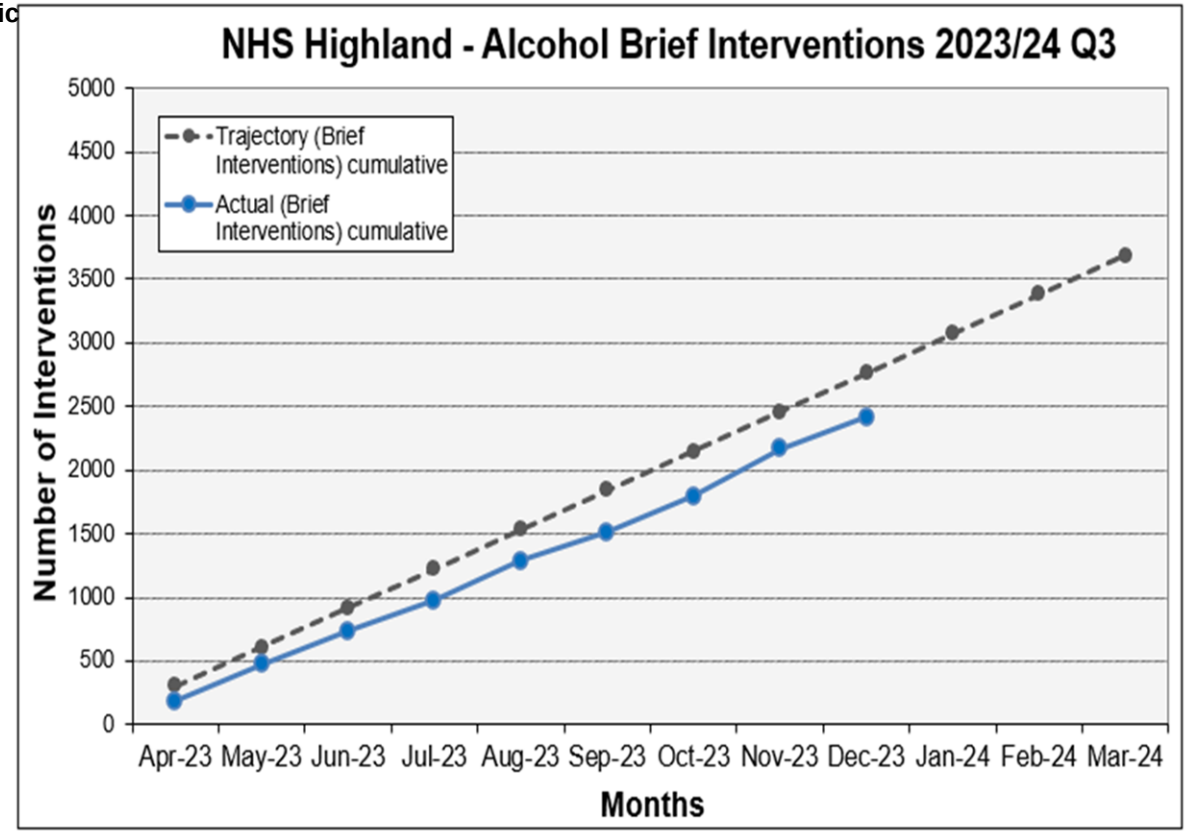
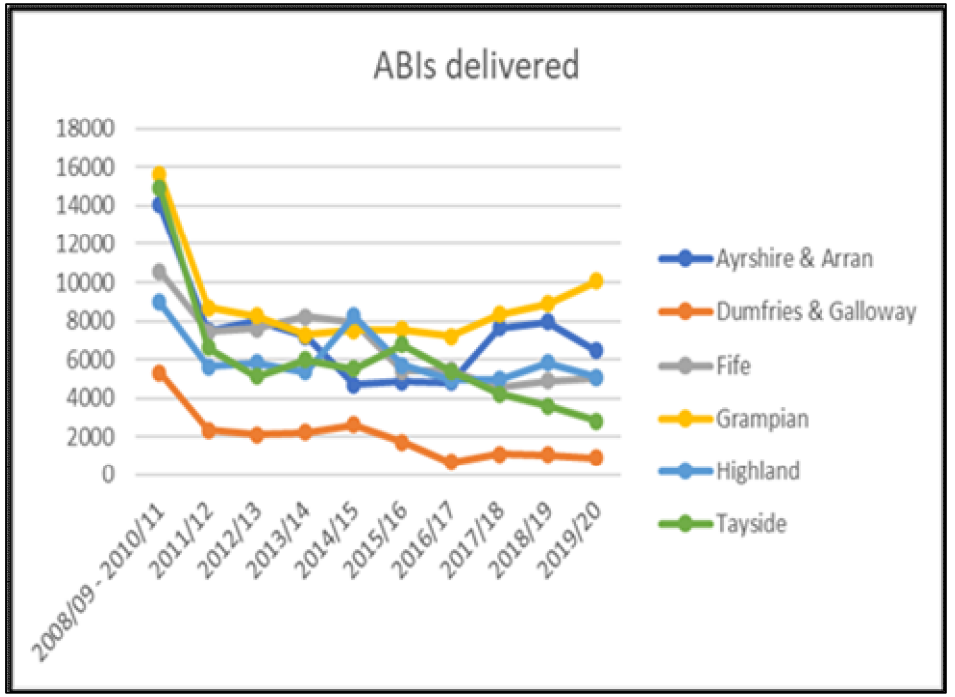
**Exec Lead**
**Dr. Tim Allison, Director of Public Health**

# Alcohol Brief Interventions

| Progress Made | Next Steps | Timescale |
|---|---|---|
| • ABI training calendar available on Turas for 2023/2024 with courses being well attended; 129 participants in 19 deliveries. Wider Settings reporting form live since November and used 160 times in 2023/2024. | • Progress with updating LES. Develop 2024/2025 plan. Continue further evaluation of training to determine practical application. Plan for trainers' development session. | • Review end June 2024. |

| PERFORMANCE OVERVIEW<br>Strategic Objective: Our Population<br>Outcome Area: Stay Well | |
|---|---|
| **Latest Performance** | n/a |
| **ADP Trajectory Agreed** | n/a |
| **ADP Trajectory** | n/a |
| **Performance Guide** | Just commenced |
| **National Benchmarking** | n/a |
| **National Target** | n/a |
| **National Target Achievement** | n/a |



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**Exec Lead**
**Pamela Cremin**
**Chief Officer**
**HHSCP**

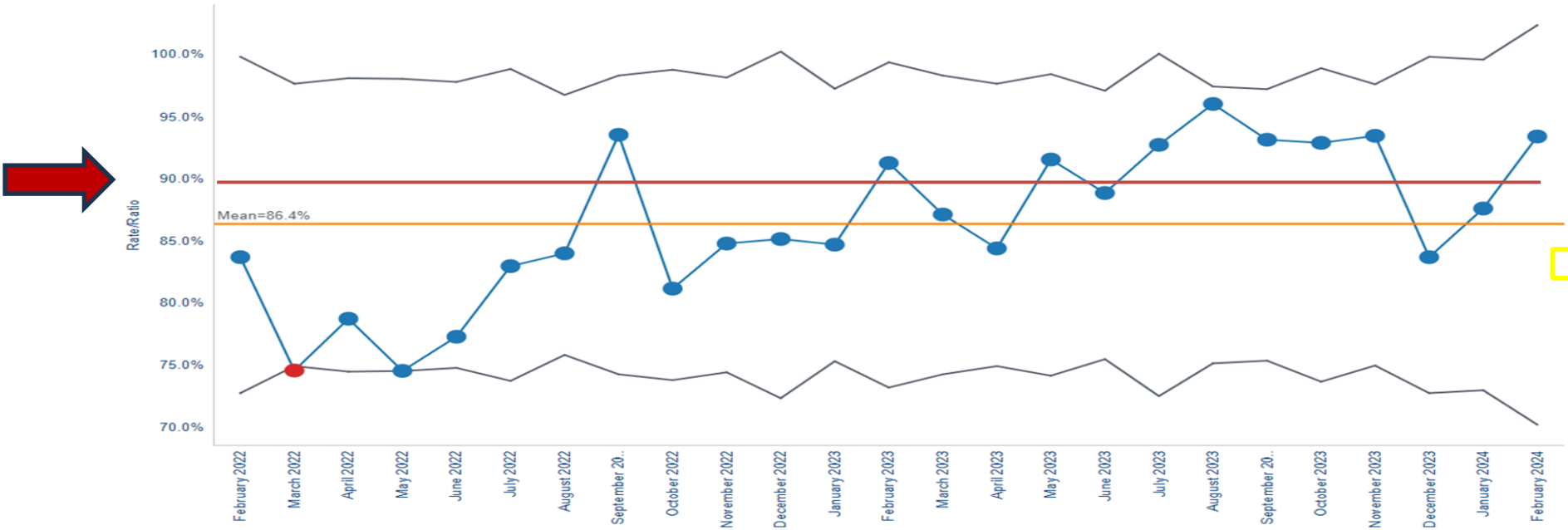
# Drug & Alcohol Waiting Times

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| Work is being undertaken with SG MIST team to improve the wating times in HHSCP.<br><br>Previous improvements achieved. | •Work completed with MIST who have provisionally provided green RAGB score in relation to NHS Highland processes are in place to meet waiting times<br>•Staff shortages and inability to progress with recruitment have resulted in inability to sustain treatment time targets.<br>•There is confidence that a return to staffing establishment will result in ability to achieve RTT targets | • Waiting list initiatives are being explored and will be initiated<br>• Additional financial support is being provided to enable recruitment to progress<br>• Confirmation of MAT allocation for 2024-25 will also support recruitment to additional posts |

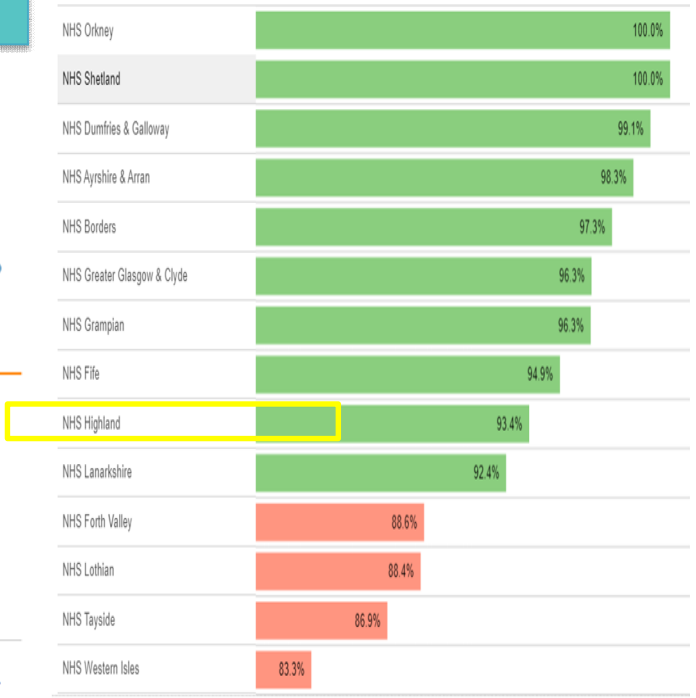
**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Stay Well**

| | |
|---|---|
| **Latest Performance** | **93.4%** |
| **Scottish Average** | **90%** |
| **NHSS Target** | **90%** |
| **Performance Rating** | **Target met for 1 month** |
| **When was target last met? Target met in last 24 months** | **November 2023 6 times** |
| **Benchmarking** | **9h out of 14 Boards** |

**Drug & Alcohol Waiting Times Less Than 3 Weeks From Referral to Treatment**




## Benchmarking with Other Boards



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

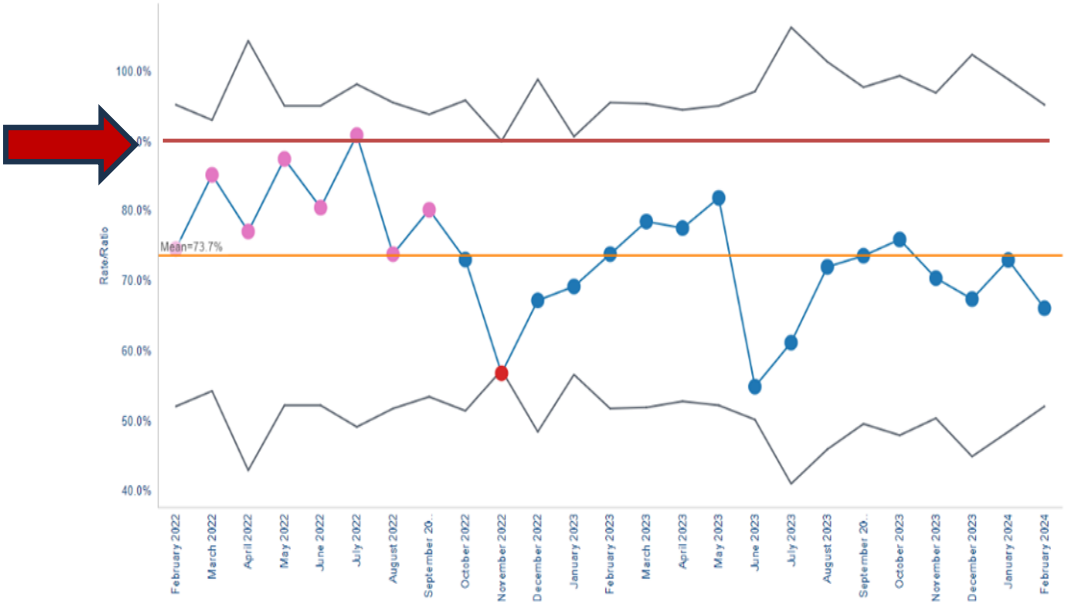
# Child & Adolescent Mental Health Services

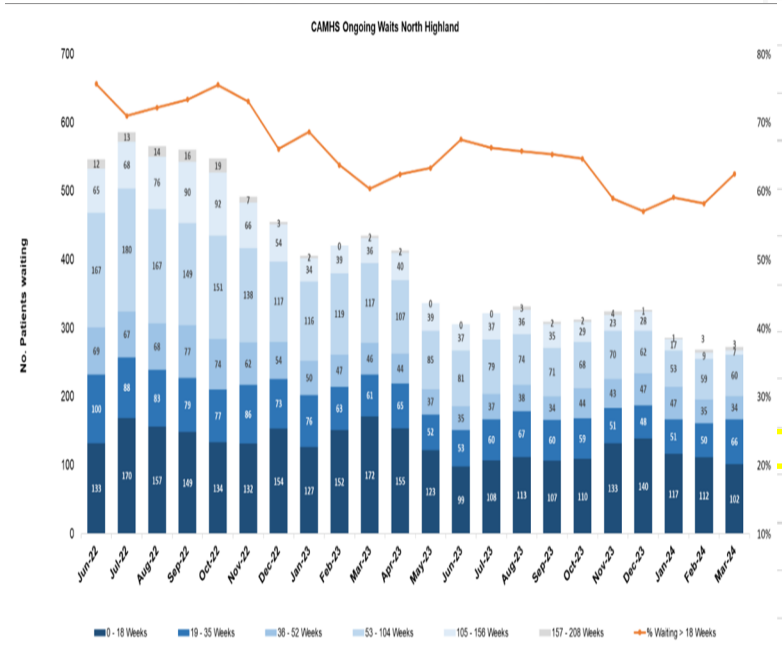
| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Core Team model & systems change continuing, increased efficiency and flow, wait list scrutiny. Requires changes to Trak care. Accurate data is an issue that the team continue to work on.<br>• Modelling for intensive home treatment continues. Requires additional workforce to implement.<br>• Efficiency and systems improvements will deliver some additional capacity. NHSH CAMHS still remains one of the lowest levels of staff WTE per population rate. Additional staff resource is required to implement full national service specification. | • Core team workgroup progressing, reconfiguration of wait list structure into single CAMHS wait list, update referral c riteria, MDT vetting & implementation o f engagement/assessment appts by April '24.<br>• Significant progress in Intensive Home Treatment Team modelling by workgroup progressing workforce and clinical model.<br>• Liaison service implemented initial elements of service delivery. Engagement ongoing with paed and GA wards.<br>• Continued reduction in numbers waiting in NH. | • Engagement appointments commencing for all new referrals from 3rd May. Excess capacity directed to waiting list cases.<br>• Further recruitment required to implement and support further improvement; delayed due to uncertainty over mental health framework budget allocation. |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Thrive Well**

| | |
|---|---|
| **Latest Performance** | **66.2%** |
| **Scottish Average** | **84.8%** |
| **NHSS Target** | **90%** |
| **Performance Rating** | **Target not met Below mean for 4 months.** |
| **When was target last met? Target met in last 24 months** | **July 2022 1 time** |
| **Benchmarking** | **10th out of 14 Boards** |

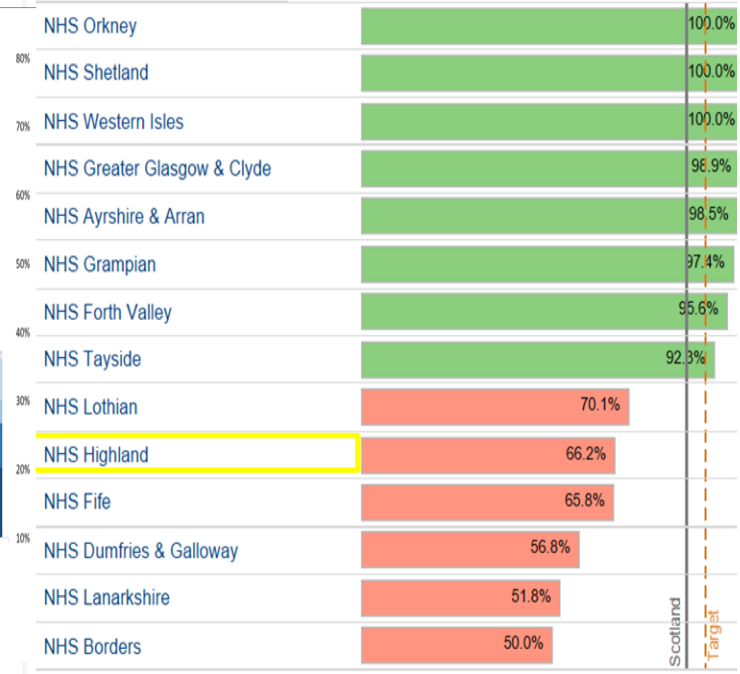
## <18 Weeks CAMHS Treatment




## Benchmarking with Other Boards

**Selected Time Period: February 2024**
(click on a circle in timetrend to change the selected time period)



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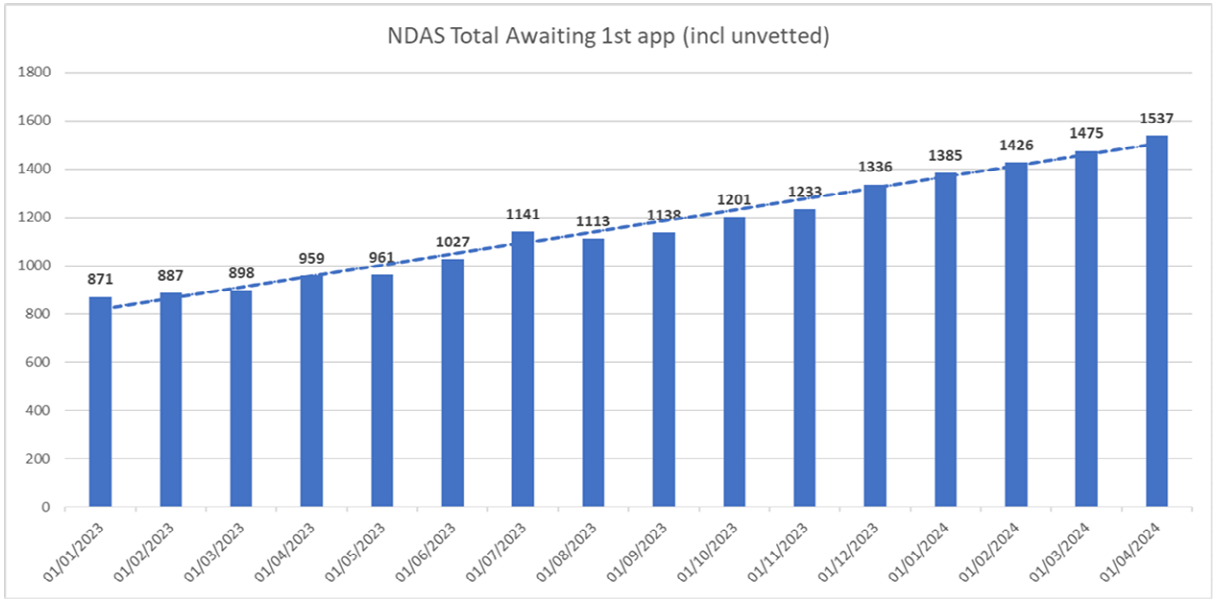
**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

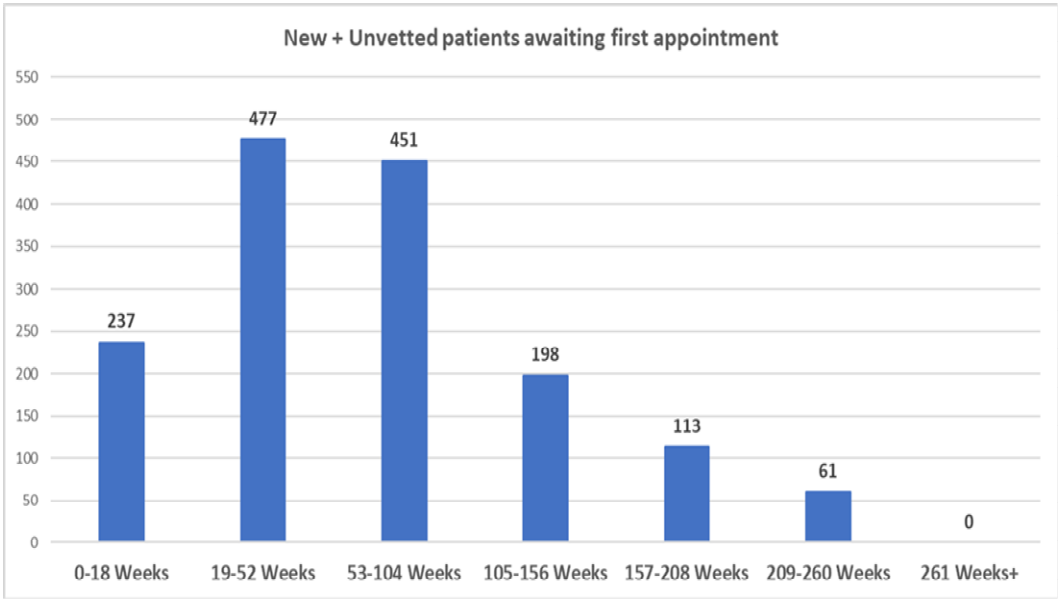
# Neurodevelopmental Assessment Service

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 24 |
|---|---|---|
| • Authority Framework is in place.<br>• Scottish Approach for Service Design is adopted at an ICSP level.<br>• ICSP ND Programme .Board is established and has met.<br>• NDAS Model update completed and in practice.<br>• NDAS Eligibility Criteria reviewed, updated and in practice.<br>• Waiting list cleansing exercise is completed.<br>• ICSP GIRFEC and Child Planning training for MDT`s rolled out. | Waiting list validation and data cleansing ongoing. Working with community paediatrics to map out clinical capacity required to complete the assessments for the CYP identified as waiting for medical review<br><br>Education colleagues are progressing with a QRR Group to streamline the staged assessment by named persons | Neurodevelopmental future planning to consider and agree on:<br><br>• Inter-agency Authority Framework<br>• Governance mechanisms<br>• NDAS Model<br>• Eligibility Criteria<br>• Clinical leadership<br>• Engagement and coproduction with service users<br><br>There is acknowledgement that these were previously committed to be completed by June 2024 however these have been reviewed and a new direction has been established to support GIRFEC. |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Thrive Well**

| | |
|---|---|
| **Performance Rating** | Decreasing |
| **National Benchmarking** | n/a |
| **National Target** | Full compliance to the Nat ND Service Spec by end March 2026. |
| **National Target Achievement** | n/a |



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

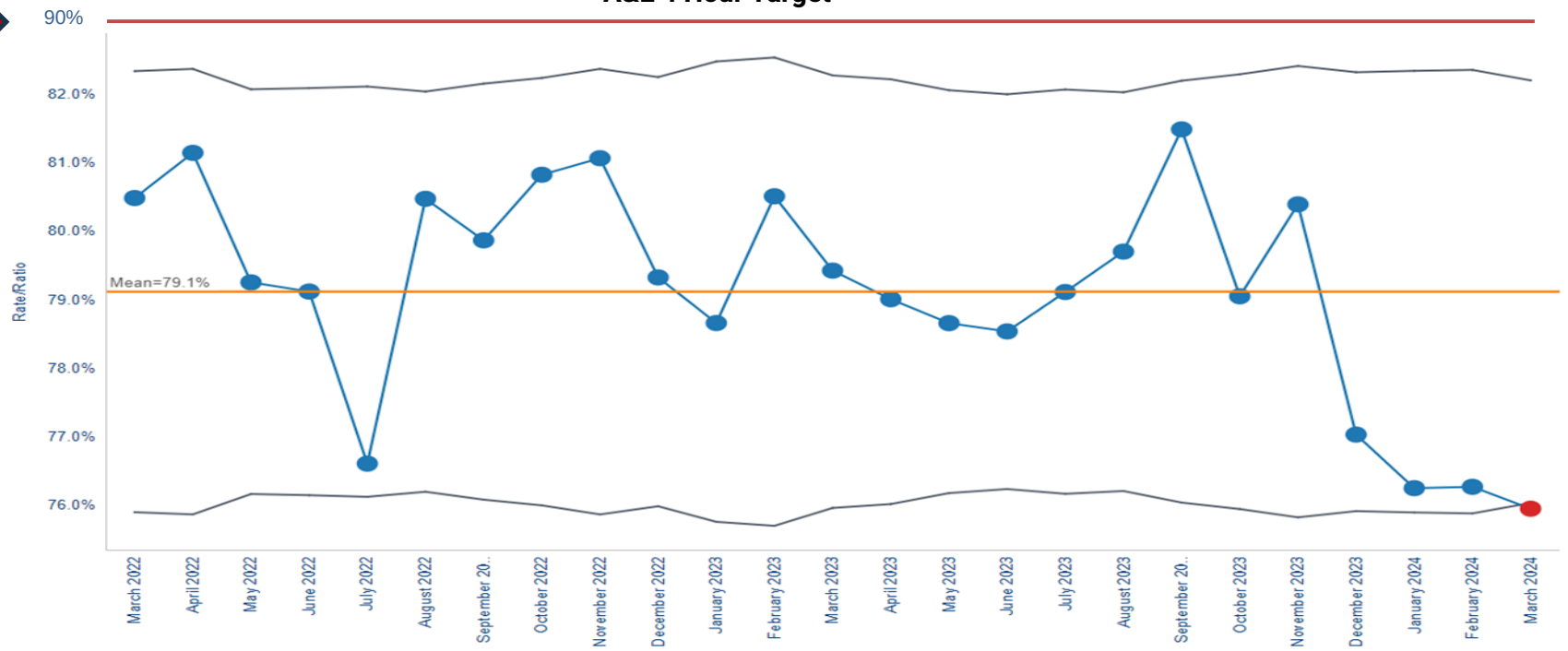
# Emergency Department Access

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Discharge Lounge staffed and open 6 days per week SAS median turnaround maintained under 60 minutes<br>• SAS off load with 60 minutes = 79.2% (Aim 90%)<br>• 24/7 Flow cover in place<br>• No ED wait over 18hrs<br>• No SAS wait over 3 hours<br>• Discharge Lounge on Trak to collect data<br>• Phased Flow extended to 5pm | • Sustained performance<br>• Supported by Phased Flow/Discharge Lounge and 24/7<br>• Escalation process being tested when patient hits 17hrs or SAS hits 2.5hrs<br>• Awaiting ED Trak<br>• For OPEL levels 4 and 5 | • New version of OPEL tool (V14) being tested to reflect unstaffed surge capacity<br>• New version of OPEL score/Level 4 actions to provided a more structured response to capacity pressures for Raigmore<br>• 3 PDSAs taking place to improve TAT of patient transfers from ED to downstream areas (adapted safe to sit model, enhanced handover) |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Respond Well**

| | |
|---|---|
| **Latest Performance** | **75.7%** |
| **Scottish Average** | **80%** |
| **NHSS Target** | **90%** |
| **Performance Rating** | **Below mean**<br>**4 months of decreasing performance** |
| **When was target last met?**<br>**No of times in last 24 months** | **July 2020**<br>**0** |
| **Benchmarking** | **6th out of 14 Boards** |

## A&E 4 Hour Target




## Benchmarking with Other Boards

Selected Time Period: March 2024
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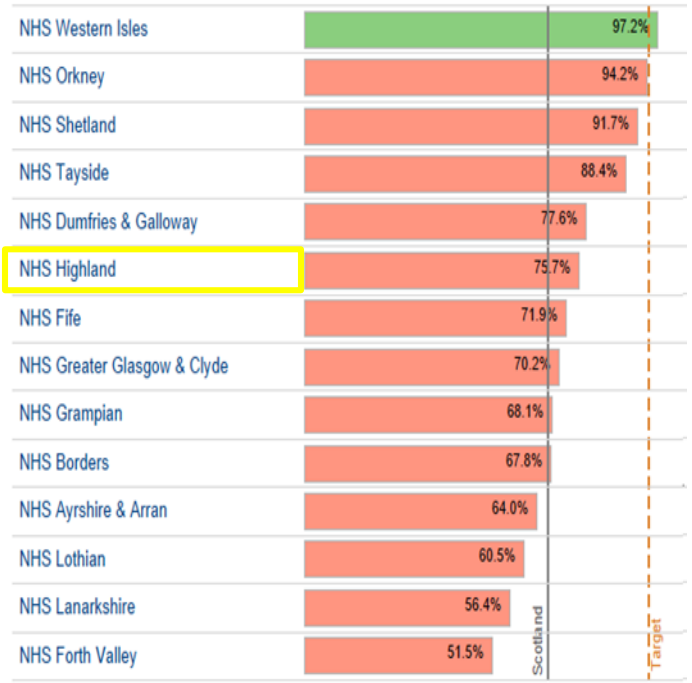

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**Exec Lead**
**Pam Cremin**
**Chief Officer, HHSCP**

# Delayed Discharges

## Previous IPQR Actions

- NHS Highland Board to monitor impact of Choice Guidance implementation.
- To develop and deliver capacity within the community to enable improved timeous response to need for urgent care.
- Discussions ongoing with District colleagues re opportunities for strengthening community response.
- Improve use of technology enabled care.
- Focused work ongoing in CAH to ensure maximisation and most efficient targeting of limited resources.
- Embed use of app and monitor impact in terms of communication.
- Development of standard work for pause, stop and restart of care following hospital admission.

## Assurance of Completion

- Choice guidance implemented
- Mapping of community capacity in progress. Adult Social Care capacity planning tool developed and informing Adult Social Care Plan
- Value and Efficiency workstream developed and being refocussed on priorities for rapid progression for TEC roll out.
- Exercise targeting review CAH resources to reduce delay in hospital trialled in Inverness successfully.
- Roll out of App ongoing with training plan in place for Raigmore and across districts.
- Pause, stop and restart standard work being tested

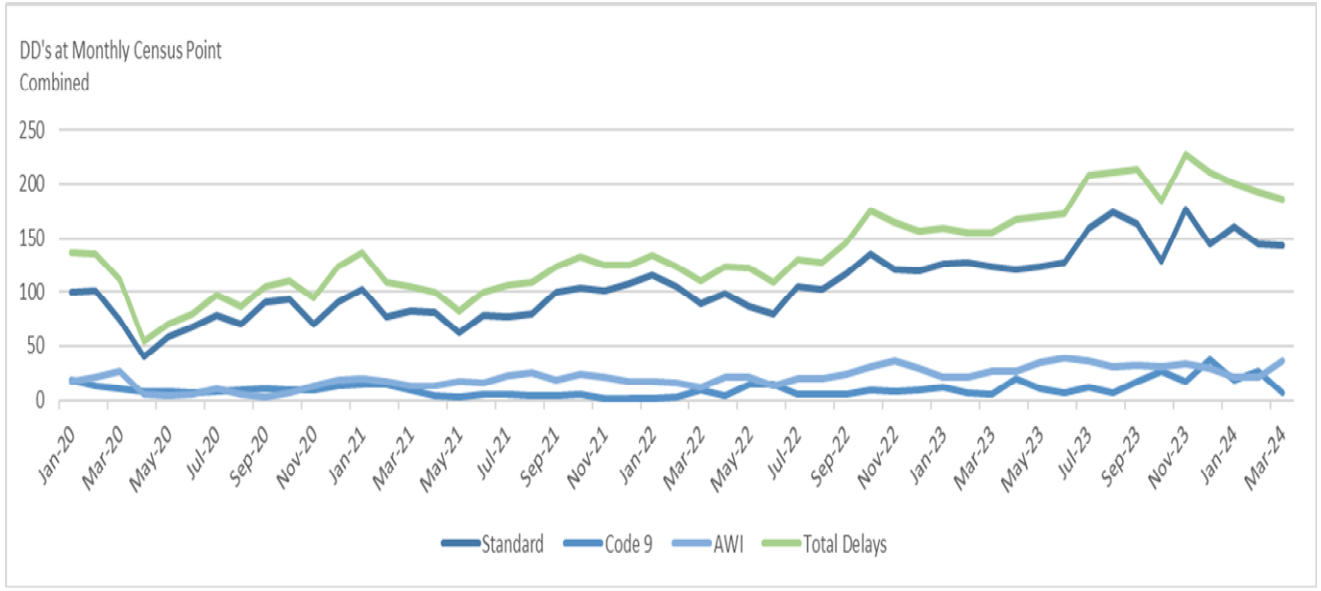
## Improvements to be made by July 2024

- Prioritisation of unscheduled care plan for 24/25
- DDs identified as CfSD leverage point – plan submitted and integral to the unscheduled care plan.
- Targeted CAH methodology in Inverness to be rolled out.
- Extend use of App in New Craigs and RGHs
- Pause, stop and restart standard work implemented.

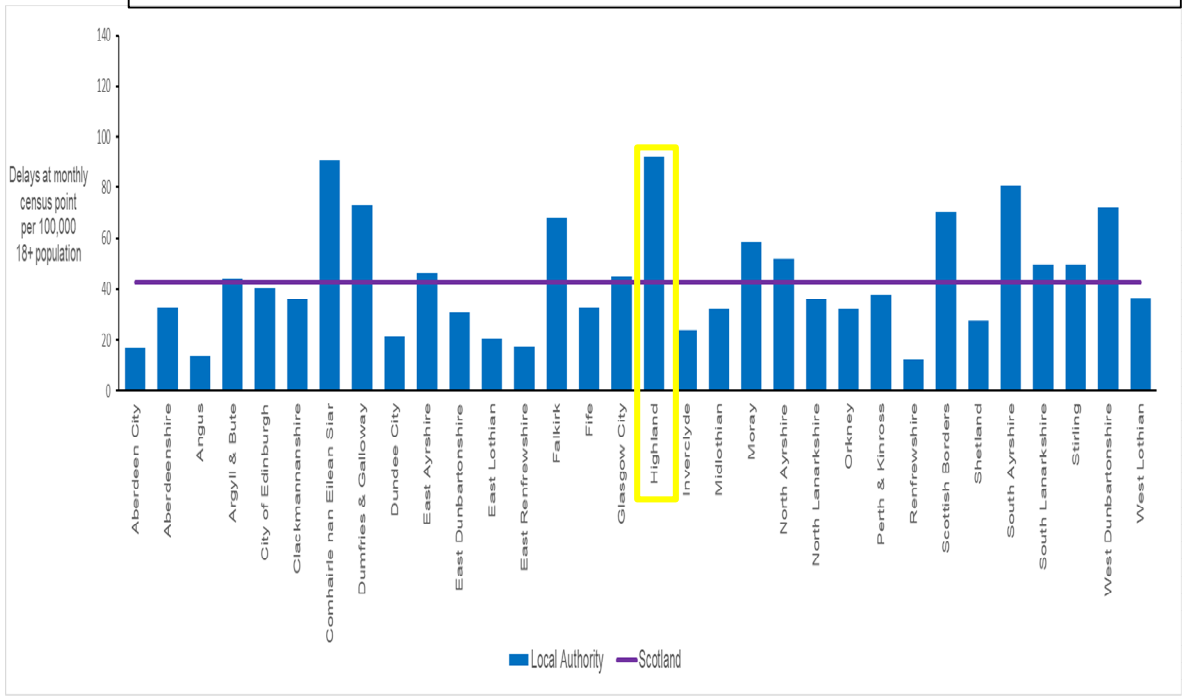
## PERFORMANCE OVERVIEW
**Strategic Objective: In Partnership**
**Outcome Area: Care Well**

| | |
|---|---|
| **Latest Performance** | 186 at Census Point 6026 bed days lost |
| **NHSH Target** | 95 DDs |
| **Target Achievement** | Not Met |
| **Performance Rating** | Decreasing DDs |
| **Performance Benchmarking** | 14th out of 14 Boards |

## Delayed Discharges at Monthly Census Point




## Benchmarking with Other Boards/Local Authorities



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

# Outpatients (NOP Seen/12 week target) – Target 1

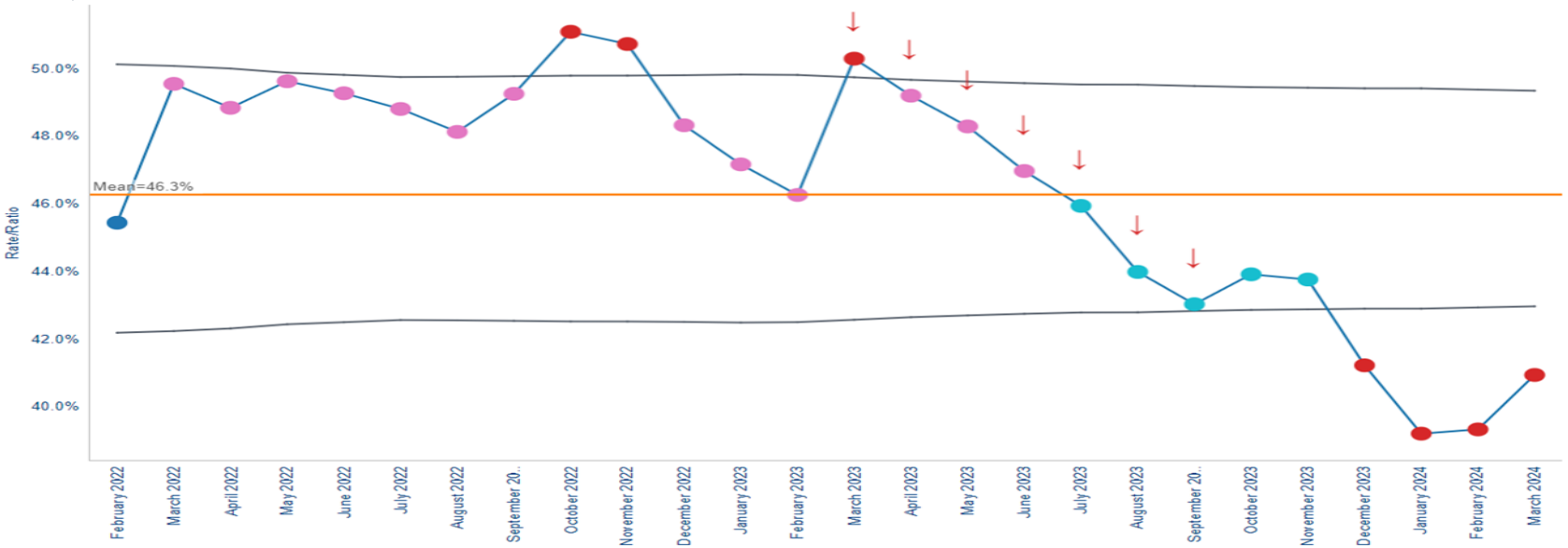
| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Identify specialities with increases in patient referral and ensure Patient Hub live and review ACRT processes against best practice<br>• Re-evaluate patient and clinician satisfaction with Near Me<br>• Maximise use of virtual activity<br>• Clinic utilisation reporting to be made available to specialties to reduce DNAs/cancellations and unfilled appointments<br>• Improve booking practices<br>• ACRT and PIR full implementation in appropriate specialties.<br>• ISP plans activity have been agreed for 2024/25.<br>• Capacity planning to ensure sustainable staffing solutions in place to deliver planned care.<br>• Continue with implementation of all efficiency measures | • ENT rolling out ACRT on 10 conditions, monitor additions to the waiting list for reductions<br>• Continue to review actions and efficiency measures for positive results and roll out to high volume specialties<br>• Monitor actual activity against ISP Plans<br>• Monitor clinic utilisation and efficiency | • Reduction of patients being added to the waiting list due to the implementation of the CFSD initiatives<br>• Waiting times reduced<br>• Workshop with key stakeholders mid May to ascertain future options for Outpatients across NHS Highland<br>• PID and strategic assessment completion |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

| | |
|---|---|
| **Latest Performance** | 40.9% |
| **Scottish Average** | 43.2% |
| **NHSS Target** | 95% |
| **Performance Rating** | Target not met Below lower control limit |
| **When was target last met? Highest performance** | Never been met 80% in January 2020 |
| **Benchmarking** | 11th out of 14 Boards |

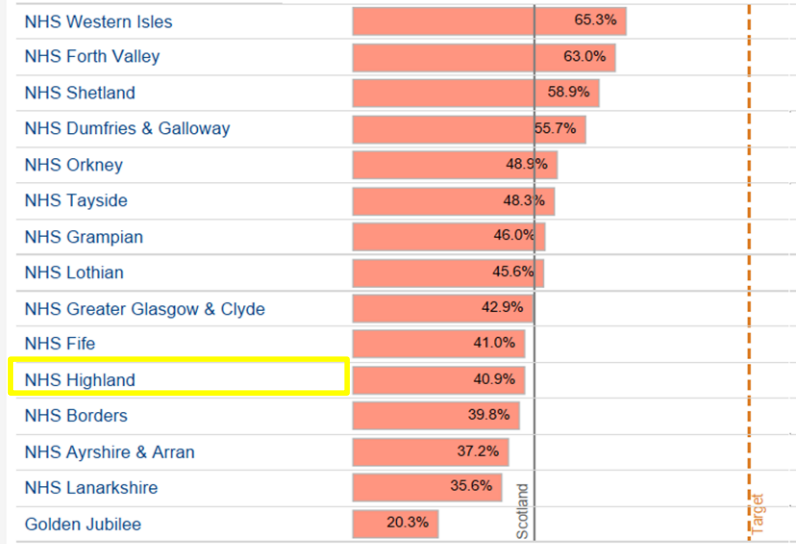
95%

## New Outpatients 12 Week Waiting Times




## Benchmarking with Other Boards

**Selected Time Period: March 2024**
(click on a circle in timetrend to change the selected time period)



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

# Outpatients (ADP – Target 2 / Long Waits – Target 3)

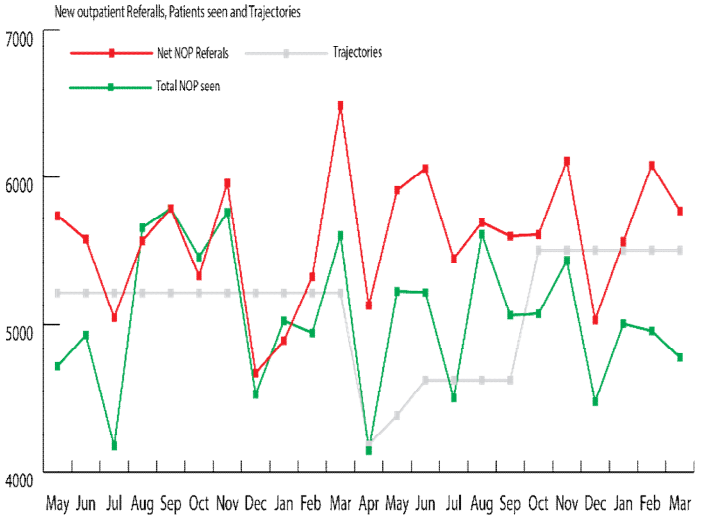
| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Use of CFSD initiatives as no further financial support is possible<br>• Use of ISP to address OP efficiency barriers to maximisation<br>• Bids have been submitted to SG for funding to provide additional activity for high volume specialties, Urology, Gynaecology, Dermatology and Gastroenterology | • Should additional funding be provided monitor activity, finance against agreed plan | Reduction of patients waiting for an outpatient appointment, particularly patients waiting over 52 weeks<br>Implementation of CfSD initiatives<br>Progress development of Local Access Policy and implementation of new Waiting Times Guidance |

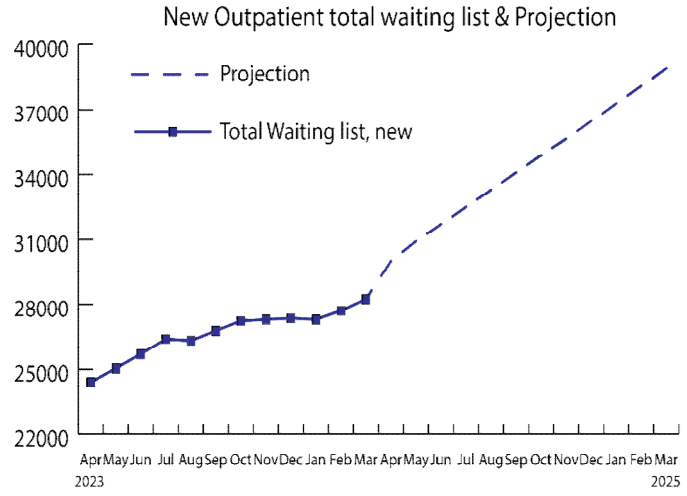
**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

| | |
|---|---|
| **ADP Target** | Not met<br>1% below |
| **Long Waits Target** | Not met<br>3200 > 52 weeks |

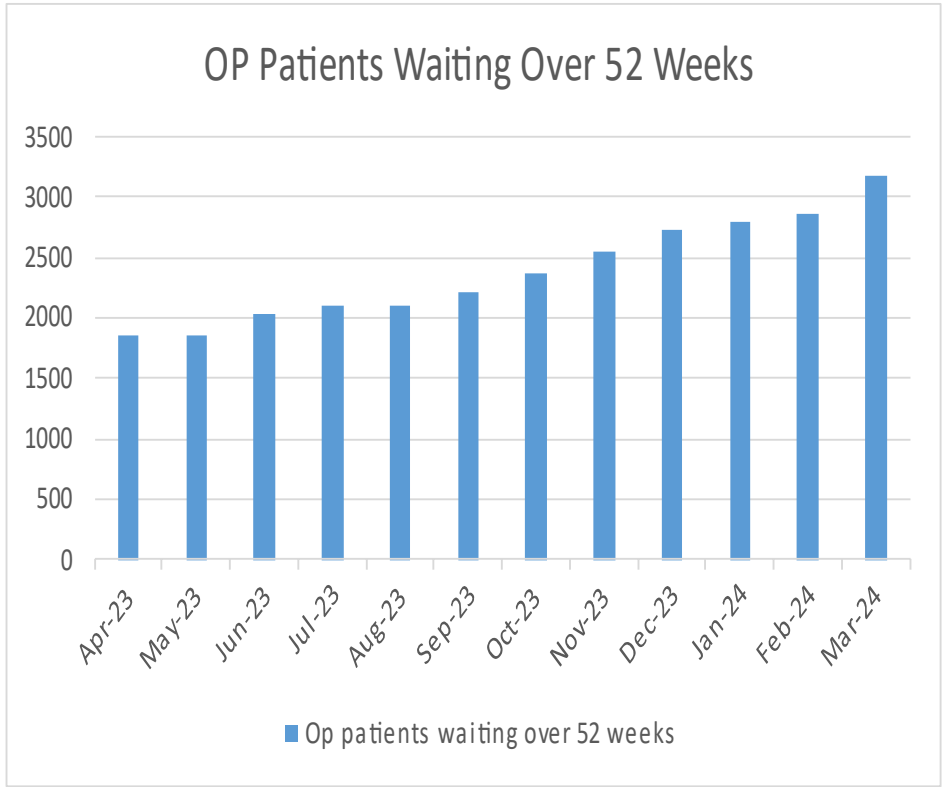
## Target 2 – ADP Target

| Yearly Trajectory | YTD Performance | Patients Seen- March 24 | Overall |
|---|---|---|---|
| 60,070 | 60,070 (100%) | 59474 (99%) | 1% below target |




## Target 3 – Long Wait (None by March 2024)



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

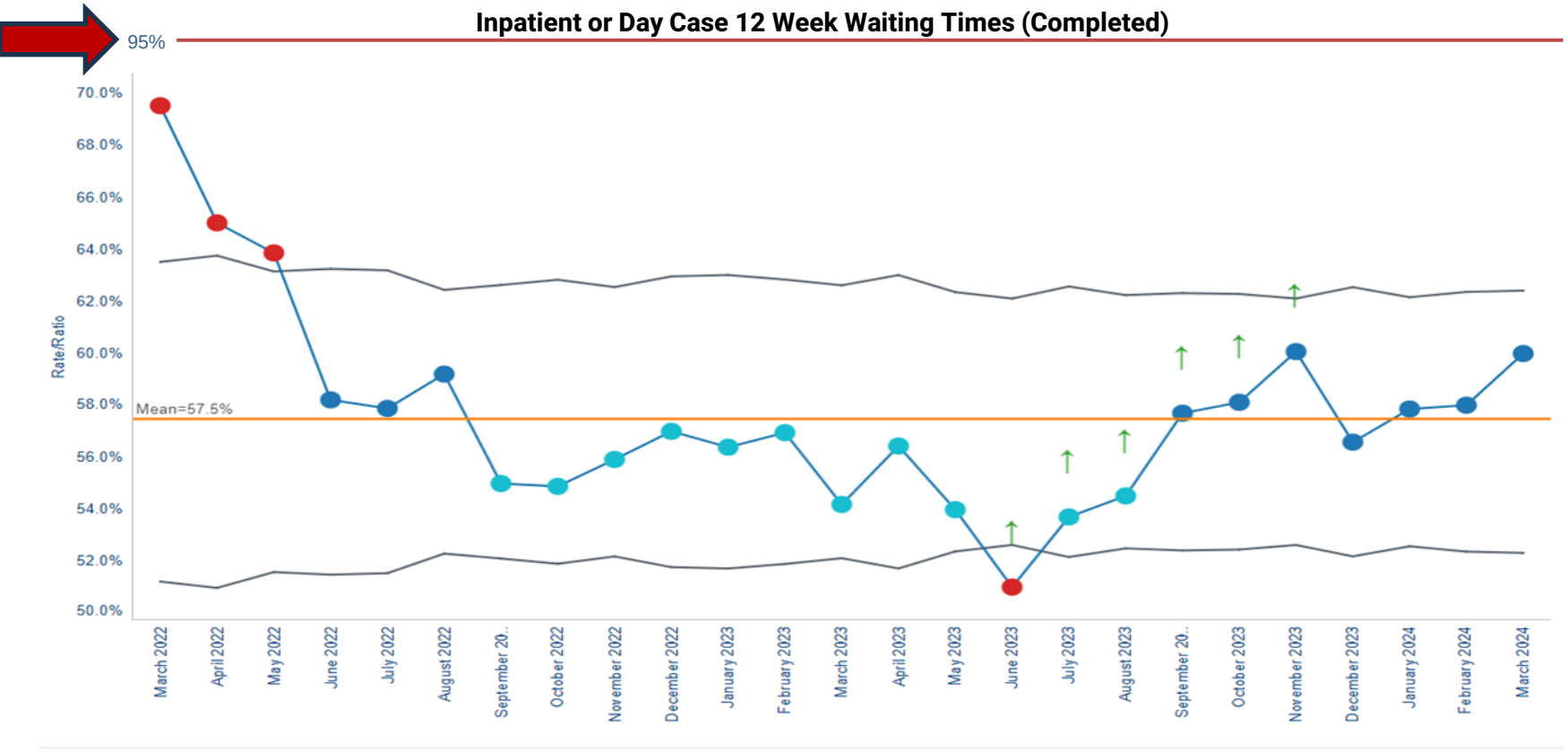
# Treatment Time Guarantee (Target 1 - TTG 12 week target)

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Local Patient Access Policy adherence<br>• Implement InFix.<br>• Ensure only patients fit for surgery are on the waiting list, data and clinical cleanse of waiting lists<br>• Ward reconfiguration continue<br>• Theatre efficiency to be owned at service and speciality level.<br>• Submission to SG for additional funding to open another theatre, this will be for Orthopaedics and ENT mainly with a view to including Gynaecology and General Surgery later in the year | • Monitor efficiencies against number of patients waiting<br>• Monitor number of long waiting patients | • **Reduction of the number of patients in particular patients waiting over 52 weeks** |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

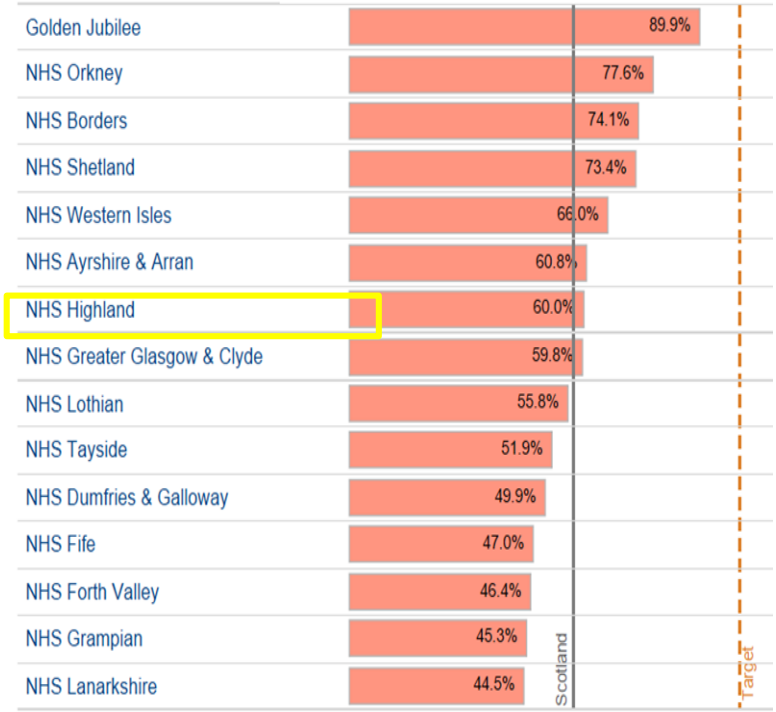
| | |
|---|---|
| **Latest Performance** | 60% |
| **Scottish Average** | 57.2% |
| **NHSS Target** | 95% |
| **Performance Rating** | Target Not Met; Above mean for 3 months |
| **When was target last met? Highest performance** | Never been met 69.5% in Mar 2022 |
| **Benchmarking** | 11th out of 14 Boards |

## Inpatient or Day Case 12 Week Waiting Times (Completed)




## Benchmarking with Other Boards

**Selected Time Period: March 2024**
(click on a circle in timetrend to change the selected time period)



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

# Treatment Time Guarantee (TTG Seen/TTG Target)

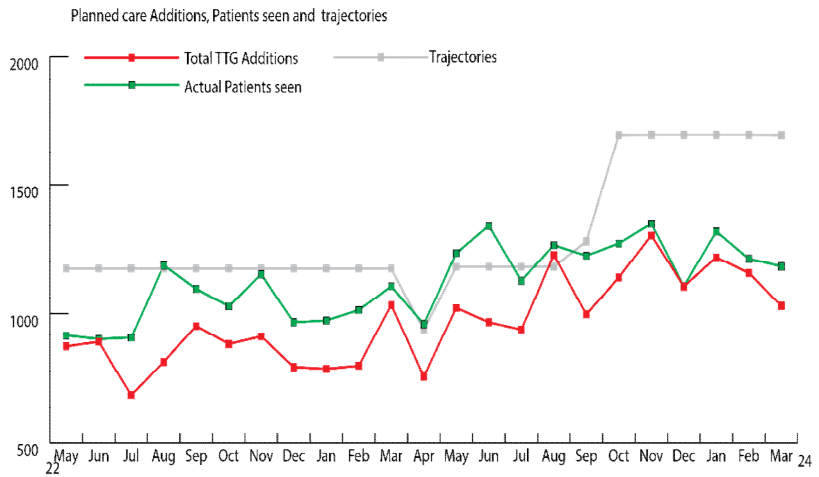
| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Continue to ensure waiting lists are cleansed and patients are being clinically prioritised<br>• Improve utilisation of NHS Highland theatre capacity across all sites.<br>• Implement CfSD initiatives<br>• Bid submitted to SG for additional funding to support the opening of another theatre capacity in Raigmore and NTC | • TTG activity will be monitored weekly at Specialty level<br>• Theatre utilisation figures will be displayed in theatres and improvements will be ongoing | • Reduction in the number of patients waiting for surgery.<br>• Reduction in the time patients are waiting for their surgery |

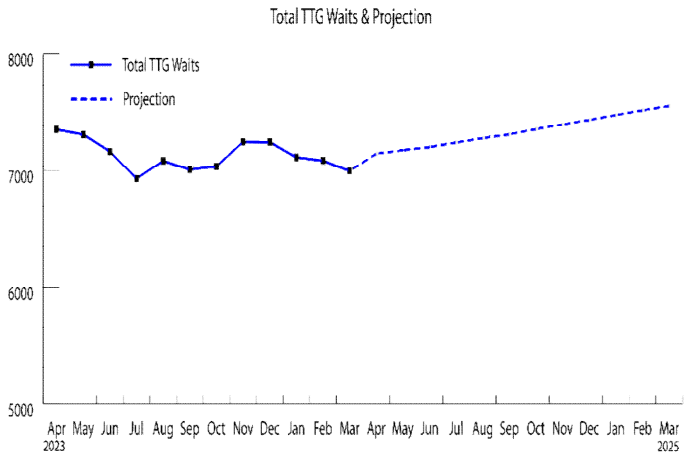
**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

| | |
|---|---|
| **ADP Target** | Not met<br>15% below |
| **Long Waits Target** | Not met<br>390 >104 weeks<br>780 > 78 weeks |

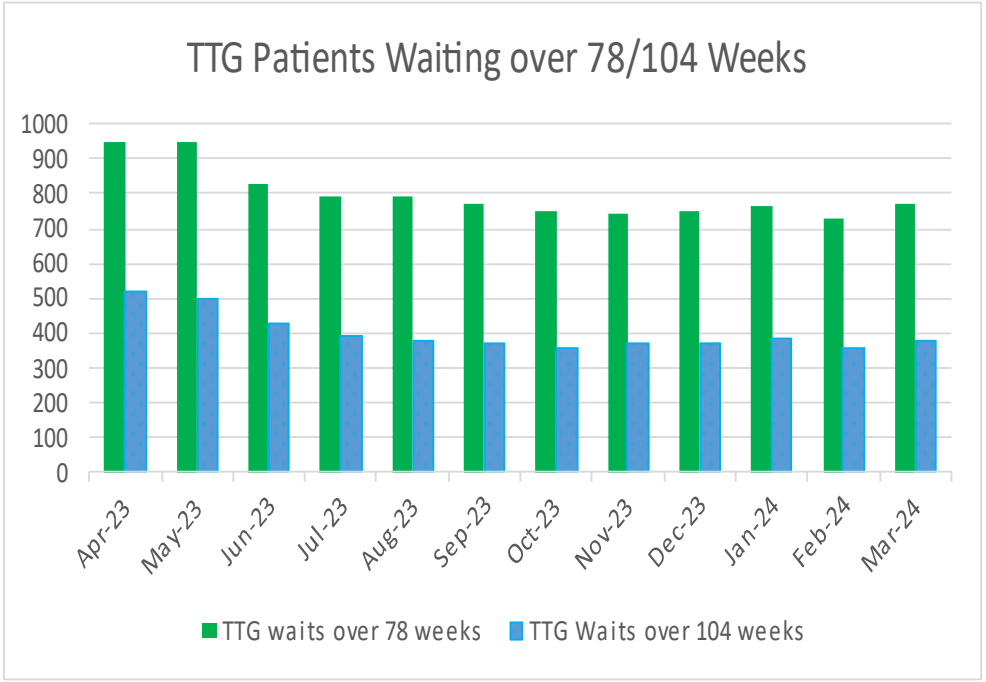
## Target 2 – ADP Target

| Yearly Trajectory | YTD Performance | Patients Seen- Mar 24 | Overall |
|---|---|---|---|
| 17,114 | 17,114 (100%) | 14,589 (85%) | 15% behind target |




## Target 3 – Long Wait (None by March 2024)



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

# Diagnostics - Radiology

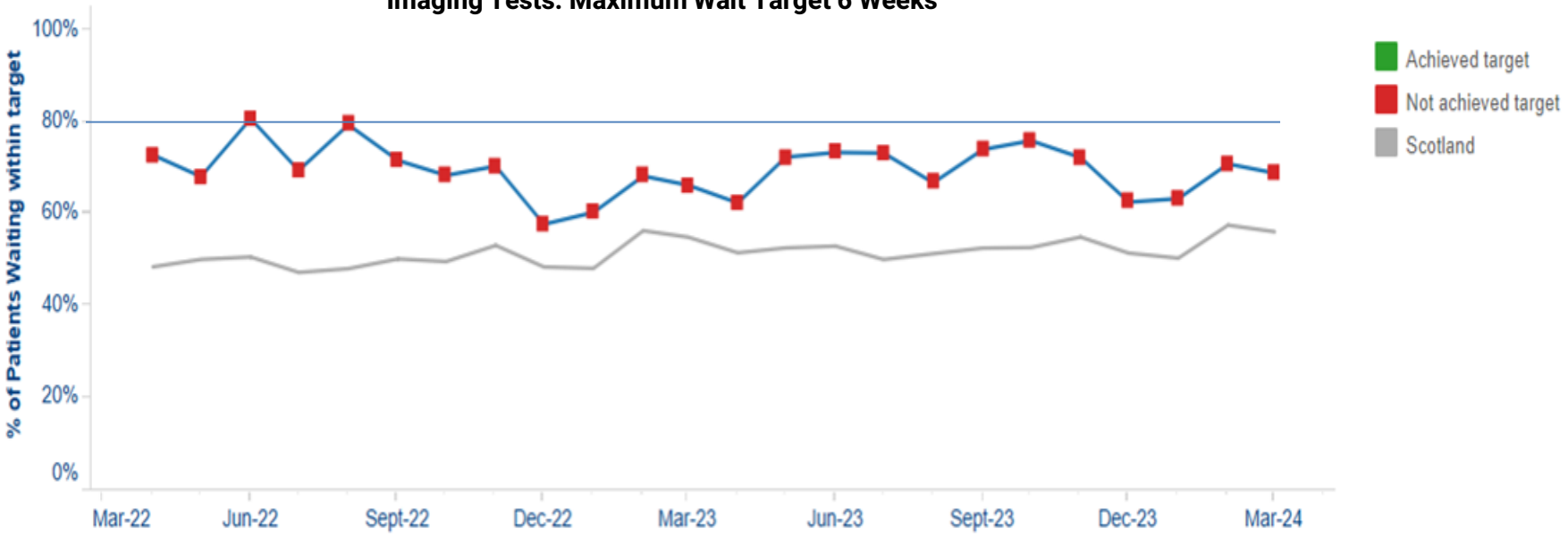
| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Continued to manage within capacity available<br>• Modelling regarding MRI is continuing<br>• Further work required to develop the Board wide Diagnostic Strategy.<br>• Go live with "ReconDL" AI system to provide increased throughput of MRI imaging. Significant reduction in prostate exam time<br>• Recruitment of shared Radiographer posts between main Dept and Breast Service | • Recruitment of Consultant for Oban<br>• 3 trainees now passed CESR<br>• Mobile MRI Unit funded for remainder of 24/25 - additional 15 days each month<br>• Continued workforce planning for all modalities in progress | • Utilisation of the additional capacity |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

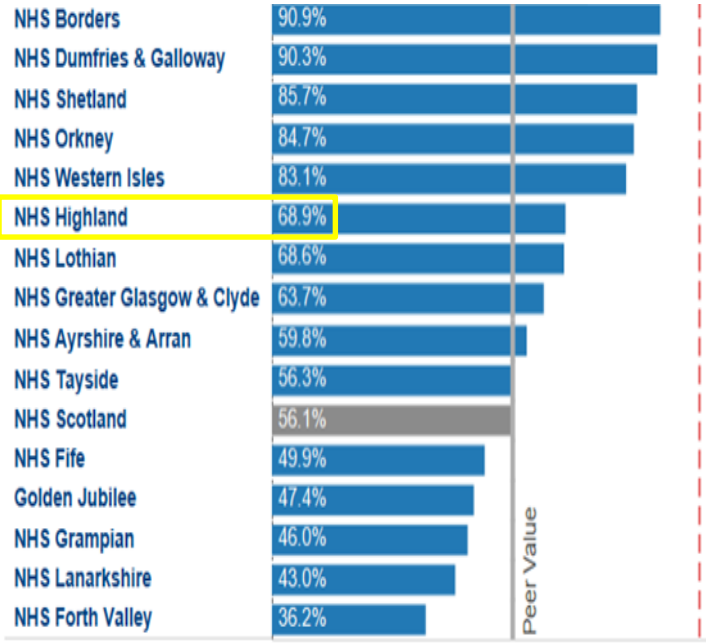
| | |
|---|---|
| **Latest Performance** | 68.9% |
| **Scottish Average** | |
| **NHSS Interim Target**<br>**NHSS Overall Target** | 80%<br>90% |
| **Performance Rating** | Target Not Met<br>Variation but lower over last 4 months |
| **When was target last met?**<br>**Highest performance** | August 2022<br>81% |
| **Benchmarking** | 6th out of 14 Boards |

| Yearly Trajectory | YTD Target | Patients Seen-Nov | Overall |
|---|---|---|---|
| 34,632 | 34,632 (100%) | 33,229 (95.95%) | 4.05% below target |

**Imaging Tests: Maximum Wait Target 6 Weeks**




**Benchmarking with Other Boards**



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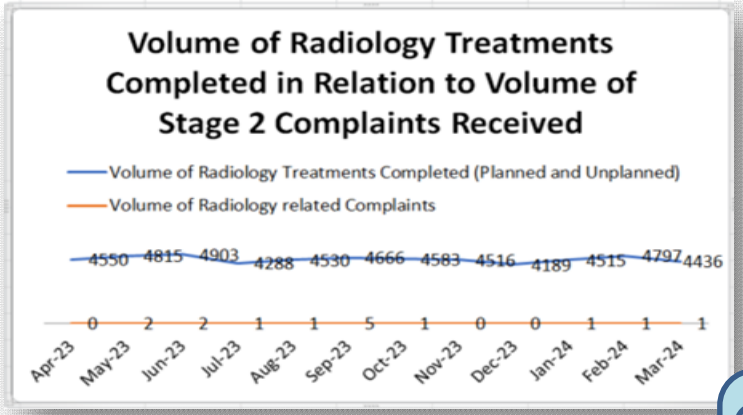
## 12 Month View of Complaint and Feedback Activity: Diagnostics - Radiology

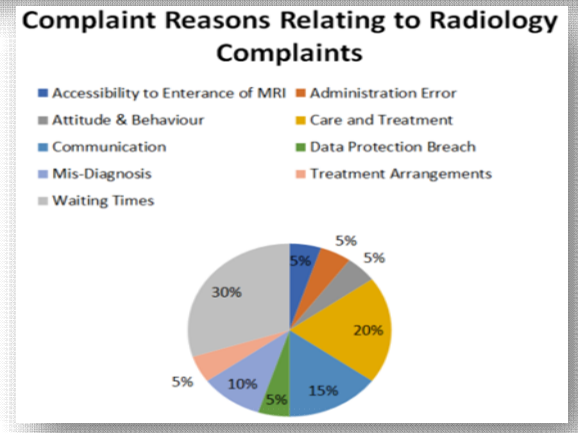
| Progress Made | Next Steps | Timescale |
|---|---|---|
| • Care Opinion (CO) is now being facilitated by the Feedback Team, and the aim is to promote and share the outcomes of feedback | • Run monthly reports from services and distribute the reports from CO more widely | • End of May 2024 |

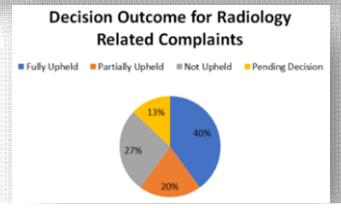
Over 12 months, 3 compliments have been registered in Datix for Radiology

Executive Lead Boyd Peters

**Total of 54788 Radiology procedures were carried out in last 12 months with 15 formal Stage 2 complaints raised – 0.027%**




# NHS Highland – Listening and Responding to our Patients

Care Opinion

**In 12 months, Care Opinion have received 56 Radiology stories, with a response rate of 93%**

**Out of a Rating of 5, Radiology Care Opinion Scores are:**

- Treated with Respect & Dignity – 4.62
- Information and Decision Making Shared Appropriately – 4.12
- Service Punctuality – 4.31
- Clear Information – 4.19
- Clean, Safe & Friendly Place – 4.62
- Being Listened To – 4.42


**The Patient Said..**
She was concerned for the delay in MRI results for her son.

**What We Did..**
Apologised for the delay, explained the administrative error which caused the delay and advised on actions for sharing the complaint internally with the team to provide learning and development to improve

**The Patient Said..**
The first set of scans were not conclusive and a further set are required but unhappy with the wait time and lack of information

**What We Did..**
Apologised for lack of clarity, explained the first set of scans and what the second set were for, whilst clarifying an appointment time

**Over the last 12 months 2 Stage 2 complaints have been logged where actions have been taken for improvement.**

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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

# Diagnostics - Endoscopy

## Previous IPQR Actions

- Communication with patients; from 1st March we propose to send NHS Inform leaflet explaining national waiting times guidance (to be agreed to business meeting on 29th Feb)
- Submitted request to have TrakCare PMS waiting times target updated from local 28-day target to national 42-day target (waiting timescale from Ehealth).
- JAG accreditation assessment on 21st March 2024. Impact: recognition of quality measures being achieved
- Updated version of formstream request sent to Ehealth on 30th January to enable referrers to send referrals electronically
- National polyp detection rate benchmarking shows NHS Highland has the highest percentage in Scotland which is a measurement of the quality in endoscopic practice

## Assurance of Completion

- We are now sending all patients the NHS leaflet with the PFB letter
- JAG accreditation received - we agreed that the provisional report received is accurate we have 6/12 to action, some of the actions already in process.
- Our electronic Formstream request was already in situ they will honour request we are awaiting an update as to when this will be completed.

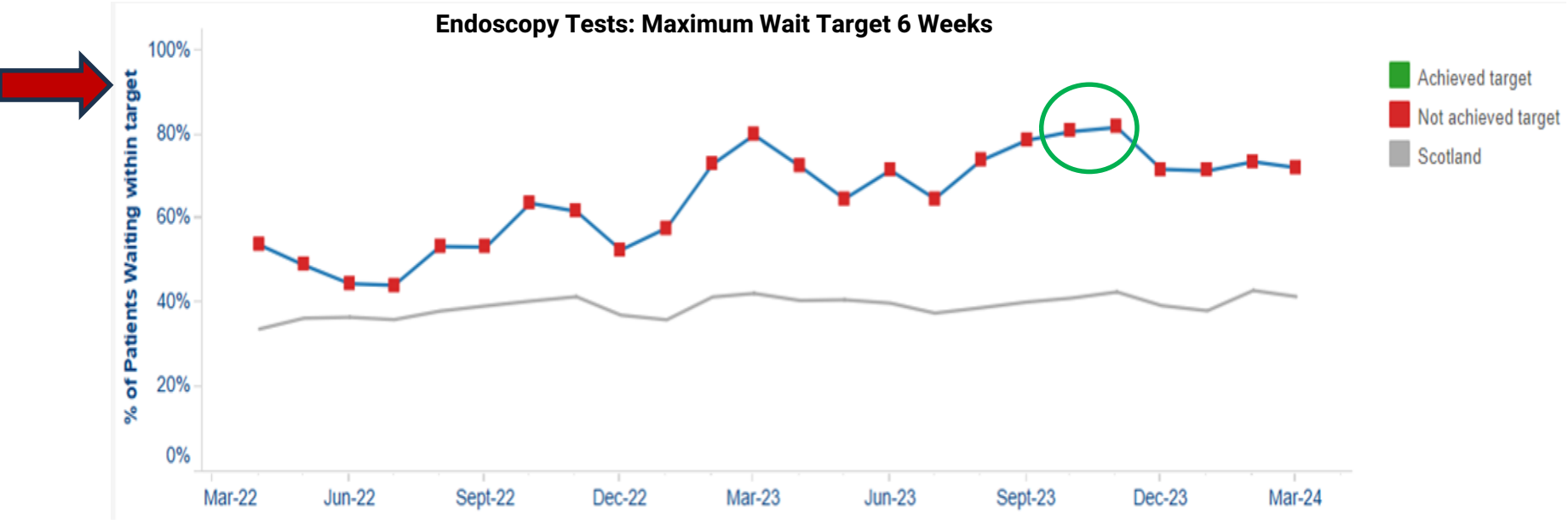
## Improvements to be made by July 2024

- **Continue to sustain quality metrics**
- **Complete the JAG actions**

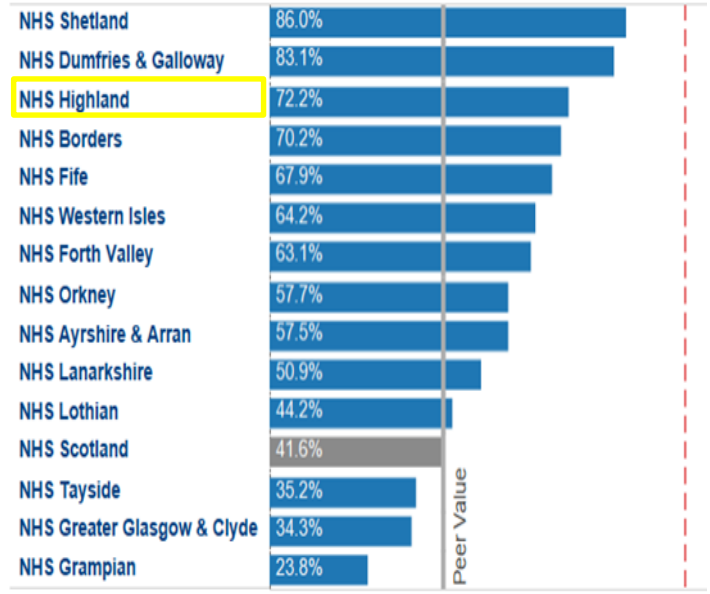
| Yearly Trajectory | YTD Target | Patients Seen | Overall |
|---|---|---|---|
| 5,892 | 5,892 (100%) | 6,521 (110.68%) | 10.68% over target |

## PERFORMANCE OVERVIEW
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

| | |
|---|---|
| **Latest Performance** | 72.2% |
| **Scottish Average** | 41.6% |
| **NHSS Target**<br>**Interim Target** | 90%<br>80% |
| **Performance Rating** | Target Not Met<br>Above mean for 3 months |
| **When was target last met?**<br>**Highest performance** | Nov 2023<br>2 times |
| **Benchmarking** | 3rd out of 14 Boards |
| **ADP Target** | Met<br>10.68% Over |




## Benchmarking with Other Boards



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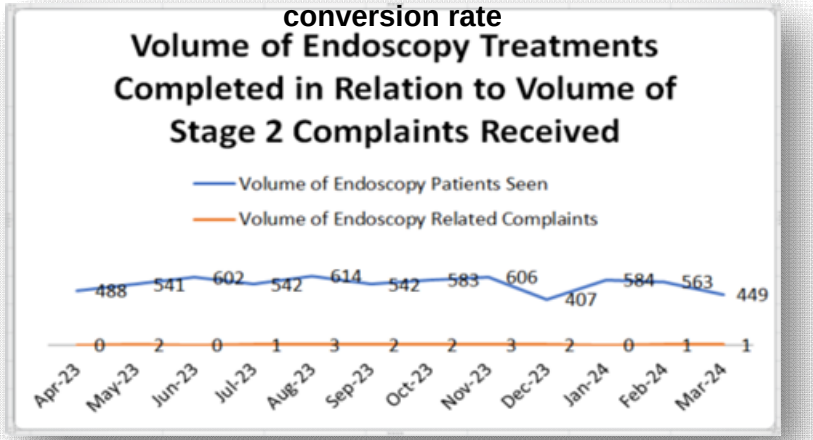
# 12 Month View of Complaint and Feedback Activity: Diagnostics - Endoscopy

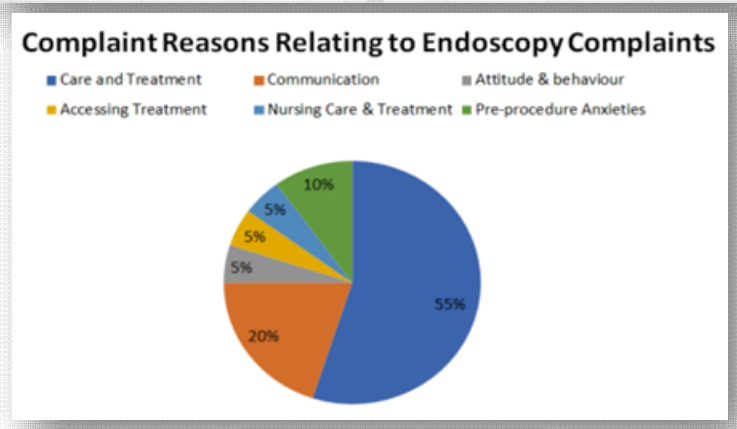
| Progress Made | Next Steps | Timescale |
|---|---|---|
| • Care Opinion (CO) is now being facilitated by the Feedback Team, and the aim is to promote and share the outcomes of feedback | • To engage with the Endoscopy Service and share the benefits of Care Opinion in hope they sign up to the service | • End of May 2024 |

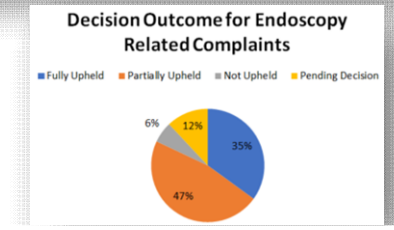
Over 12 months, 3 compliments have been registered in Datix for Endoscopy

Executive Lead Boyd Peters

**Total of 6521 Endoscopy procedures were carried out in last 12 months with 17 formal Stage 2 complaints raised – 0.26% conversion rate**




## NHS Highland – Listening and Responding to our

**The Patient Said..**
To their MSP, that they are concerned with the late cancellation of their endoscopy procedure and lack of communication

**What We Did..**
Apologised, explained cancellation and ensured an appointment would be expedited. Staff have been advised to improve their communication when handling cancellations, and giving reassurance of next appointments where possible.


**The Patient Said..**
That offering an endoscopy appointment elsewhere is not suitable for him, and feels the service is not considering the individual needs of the patient

**What We Did..**
Explained the options given and the reasons for offering the appointment elsewhere. Assured more two-way communication would be given when agreeing appointments with patients where possible.

**The Patient Said..**
they had a traumatic experience regarding their Nasal Jejunal (NJ) feeding tube, they felt staff were untrained and using incorrect equipment.

**What We Did..**
Apologised, reassured that Endoscopists have been reminded to fully explain difficult therapeutic endoscopy procedures with patients prior to proceeding. Offered a meeting.

**Over the last 12 months 3 Stage 2 complaints have been logged where actions have been taken for improvement.**

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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

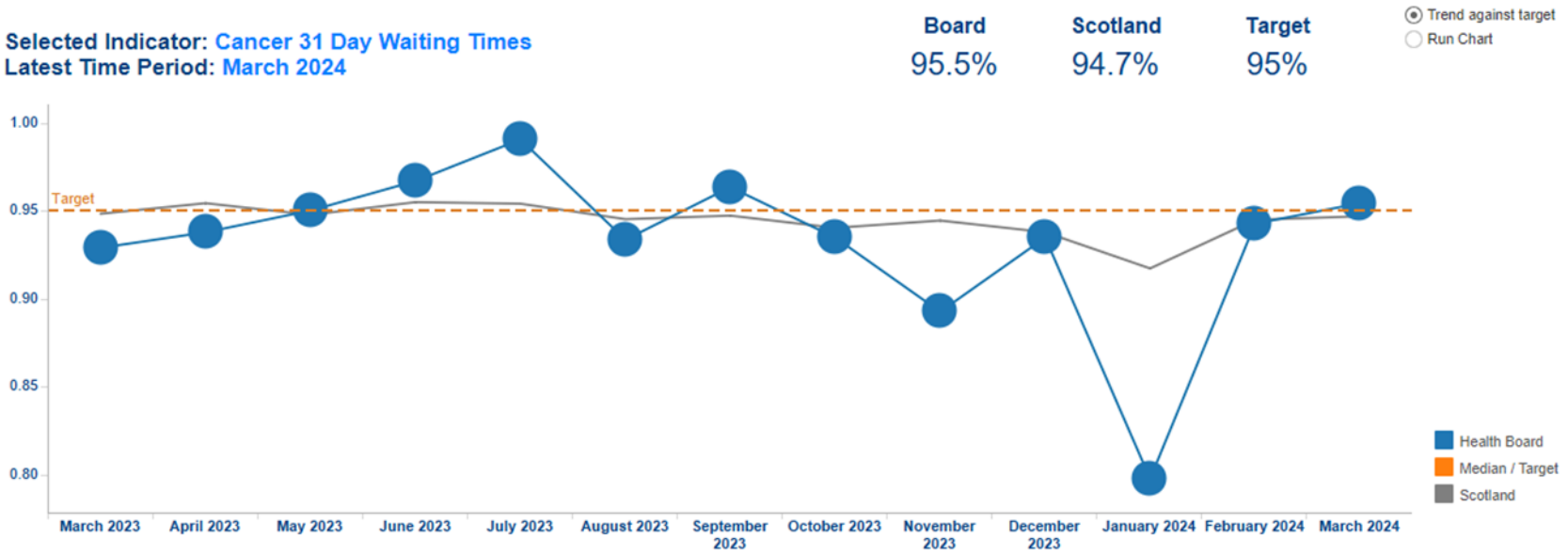
# 31 Day Cancer Waiting Times

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • Overall recruitment and retention of key Consultant Oncology posts is a significant challenge and different models of working will need to be established for sustainable and resilient services<br>• Cancer Performance Oversight Board being established chaired by Deputy Medical Director by Jan 24<br>• Programme of recovery with regards to urology and colorectal which will have specific improvement plans developed and target milestones by Jan 24<br>• Complete review of oncology in NHSH | • Continued prioritisation of Cancer patients for theatre access including High volume cancer specialties such as Urology and Breast<br>• Oncology Workshop to review baseline Service Model to both manage and treat<br>patients complete. Agreed minimum requirement to care for 5 "big tumours" = 75% of new patients. | • Review of theatre schedule to maximise capacity in tumour types at greatest risk<br>• Further renewed efforts to recruit to vacant posts.<br>• Development of contingencies involving regional and national centres to provide Consultant management capacity<br>• Recruit to vacant and additional service treatment staff eg Nurse Specialists/Con. Radiotherapists |

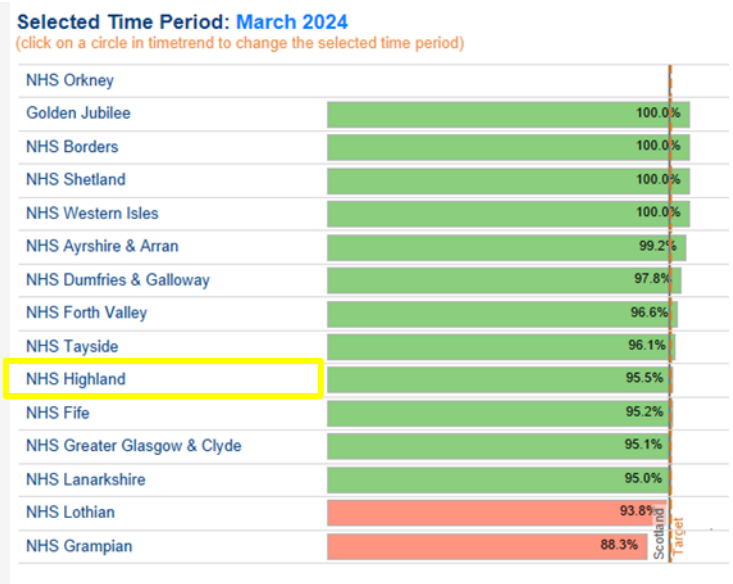
**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

| | |
|---|---|
| **Latest Performance** | 95.5% (March 24) |
| **Scottish Average** | 94.7% |
| **NHSS Target** | 95% |
| **Performance Rating** | Target Met – 1 month only |
| **When was target last met?**<br>**No of times in last 24 months** | September 2023<br>7 times |
| **Benchmarking** | 9th out of 15 Boards |

NATIONAL TARGET 95%




**31 Day Benchmarking with Other Boards**



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**Exec Lead**
**Katherine Sutton**
**Chief Officer, Acute**

# 62 Day Cancer Waiting Times

| Previous IPQR Actions | Assurance of Completion | Improvements to be made by July 2024 |
|---|---|---|
| • As per 31 day<br>• Continued adherence to Framework for Effective Cancer Management principles | • Continued reduction in backlogs of patients breach and not diagnosed and breached and not treated<br>• Prioritisation of patients to be seen within 14 days of referral<br>• See next Slide | • As per 31 Day<br>• Continued compliance with FECM |

**PERFORMANCE OVERVIEW**
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

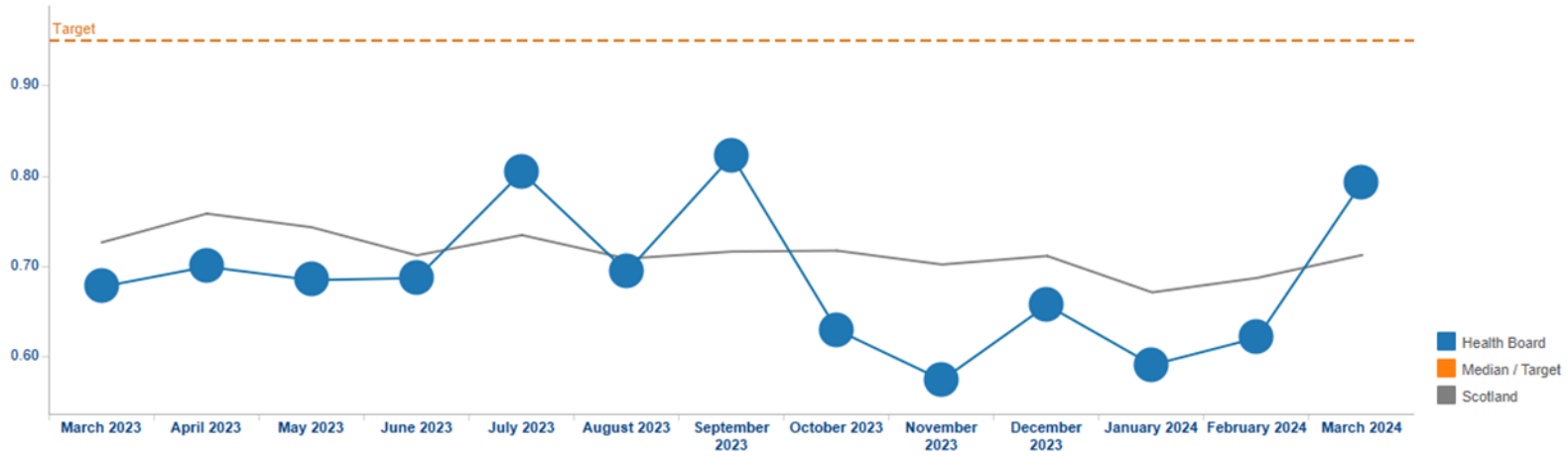
| | |
|---|---|
| **Latest Performance** | 79.3% |
| **Scottish Average** | 71.3 |
| **NHSS Target** | 95% |
| **Performance Rating** | Target Not Met<br>11 points above mean |
| **When was target last met?**<br>**Highest Performance** | Never Met<br>82.2% Sept 2023 |
| **Benchmarking** | 7th out of 14 Boards |

NATIONAL TARGET 95%

**Selected Indicator:** Cancer 62 Day Waiting Times
**Latest Time Period:** March 2024

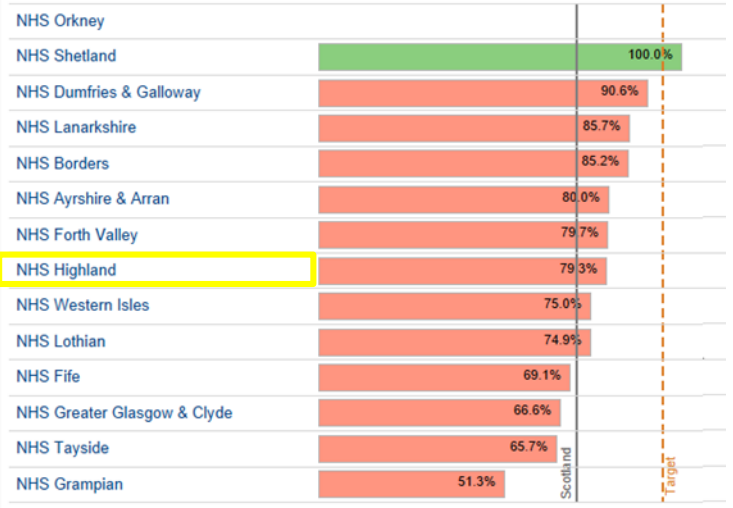
| Board | Scotland | Target |
|---|---|---|
| 79.3% | 71.3% | 95% |

Trend against target
Run Chart




**62 Day Benchmarking with Other Boards**

**Selected Time Period:** March 2024
(click on a circle in timetrend to change the selected time period)



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**Exec Lead**
**Pamela Cremin**
**Chief Officer, HHSCP**

# Psychology Waiting Times

## Previous IPQR Actions

- CAPTND questionnaire installation by eHealth
- CAPTND existing data fields assessed for quality and improvements identified
- SG self-assessment completion
- Reduced wait times
- Recruitment in line with SG recommendations for net workforce increase through the MH Outcomes Framework funding

## Assurance of Completion

- Before eHealth can complete the questionnaire implementation, they need to receive a software patch from InterSystems, which is estimated to be sent around 06/06/2024
- Existing data fields identified for data quality improvement as part of going process
- We have completed the SG assessment as we are part of the pilot. We are still refining how we improve engagement and quality of performance. We are working with SG to make improvements to the usability of the tool nationally
- Waiting times are continuing to reduce
- Workforce recruitment is part of an on-going process. We have identified gaps within our service provision related to our workforce structure

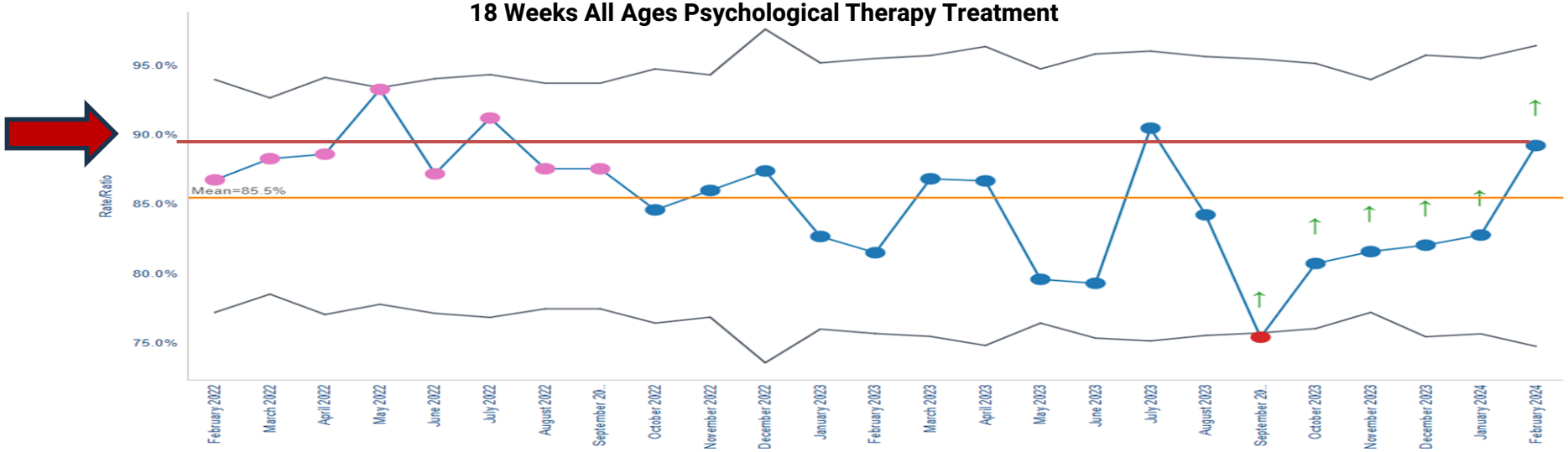
## Improvements to be made by July 2024

- We are in regular dialogue with the CAPTND national team and have alerted NHS Highland eHealth of the estimated software patch release dates
- Data field is an ongoing process and will update in July 2024
- SG Assessment is an on-going process, and we are in dialogue with SG regarding improvements to the national tool.
- Waiting times are continually monitored for reduction in our wait times and then focus on RTT 18 weeks regarding our performance
- Workforce is on-going and we will forward our requests for increase as part of the mental health outcomes framework
- We will be exploring if there more collaborative alliance with other Scottish Health Boards to address inequities in service

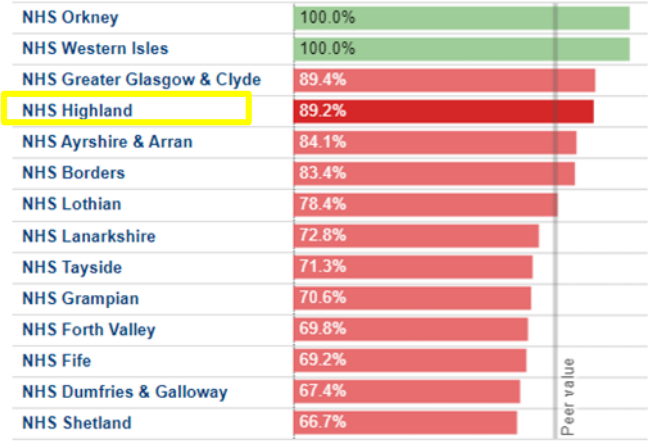
## PERFORMANCE OVERVIEW
**Strategic Objective: Our Population**
**Outcome Area: Treat Well**

| | |
|---|---|
| **Latest Performance** | 89.2% |
| **Scottish Average** | 77.7% |
| **NHSS Target** | 90% |
| **Performance Rating** | Target Not Met Improving for 5 months |
| **When was target last met? No of times in <24 months** | July 2023 1 time |
| **Benchmarking** | 4th out of 14 Boards |
| **ADP Target** | Not applicable |

## 18 Weeks All Ages Psychological Therapy Treatment




## Benchmarking with Other Boards



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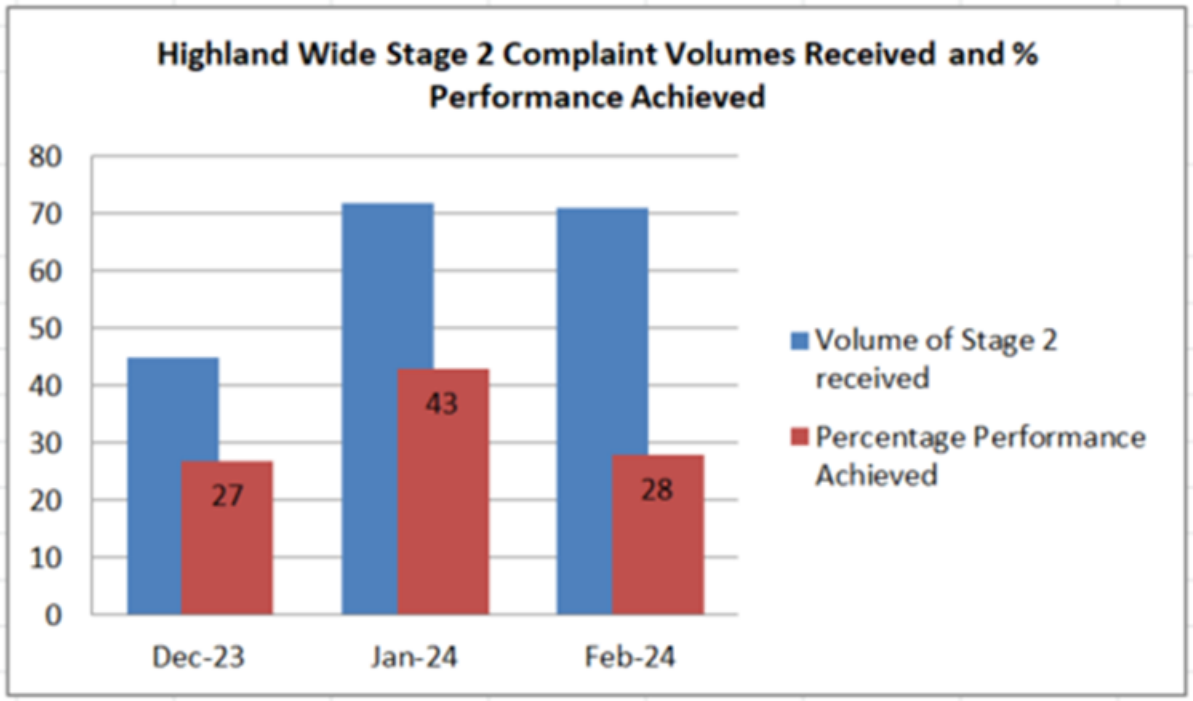
**Exec Lead**
**Boyd Peters**

## Complaint Activity: Last 3 months

| Progress Made | Next Steps | Timescale |
|---|---|---|
| • Continue to develop spotlight reports whilst working in partnership with Strategy & Transformation<br>• Preparing for the SPSO Child Friendly Complaint Handling Procedure | • To agree the agenda of topics for deep-dive analysis<br>• To work with Public Health and contribute to the progression of the UNCRC framework as well as reviewing requirements to prepare for the new Child Friendly CPH in FT | • May 2023<br>• June 2023 |




**PEFORMANCE OVERVIEW**
**Strategic Objective:**
**Outcome Area:**

| | |
|---|---|
| **Latest Performance (Target 60%)** | February 28% |

| NHS Boards | Performance % Achieved as reported in Annual reports 2022/2023 |
|---|---|
| NHS F.V | 43% |
| NHS Lothian | 27% |

**Factors which influenced complaint volumes has been:**

- CAMHS & NDAS - wait times for service
- Lack of Adult Social Care provision
- Access to treatment at Minor Injury units in community hospitals
- Shingles Vaccinations – patients are sent appointments but when they arrive they are told they are not eligible

**Factors which influenced performance has been:**

- A second consecutive month of high Stage 2 complaint volumes
- Administrative delays in case progressions
- Staff availability for progression of investigations

**Top 3 Complaint themes**

- Care and treatment - Relating to delays in diagnosis, miss-diagnosis, level of nursing care and issues with treatments
- Communication – Contact with Social Services, discharges from hospital, vaccination service, cancelled appointments
- Waiting Times – ENT appointments, ADHD assessments, adult psychiatry, NDAS assessments

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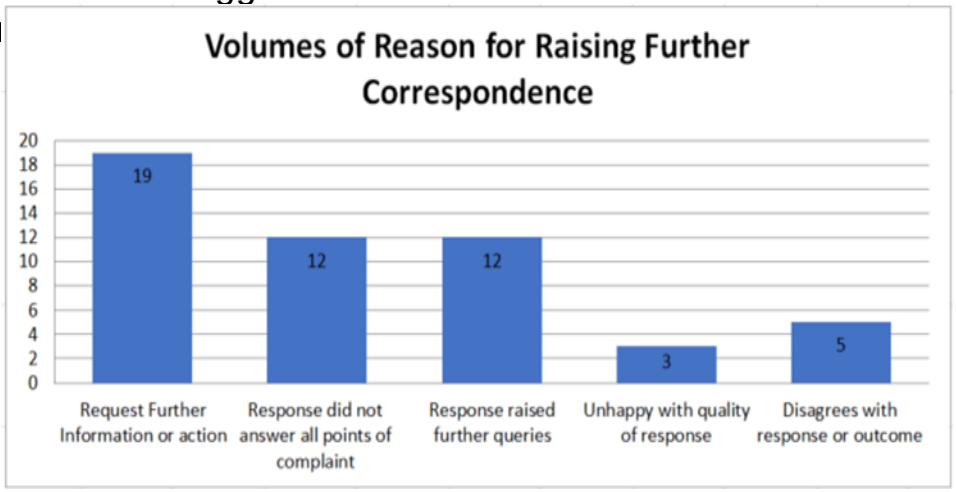
# Quality and Impacts: Review of SPSO and Further Correspondence Returns

**The aim of this slide is to review aspects of Feedback Team workstreams which may give indication on the standards of NHS Highland complaint handling.**

**Exec Lead**
**Boyd Peters**

## Further Correspondence Activity:

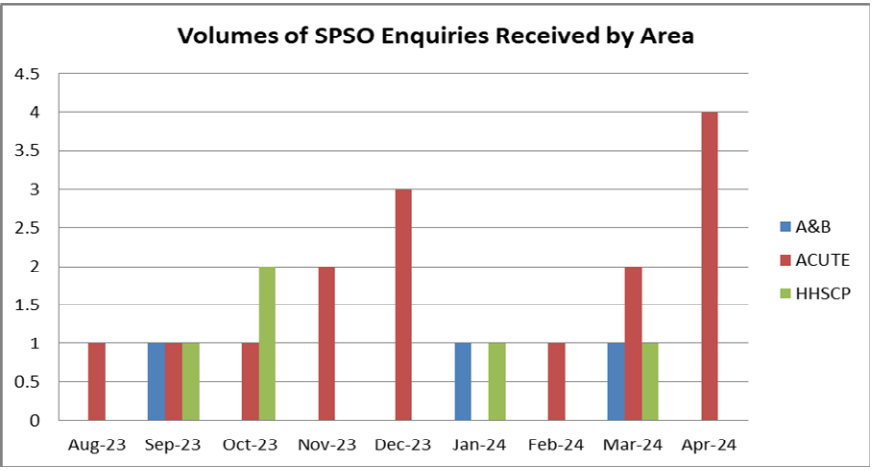
Since August 2023 total of 550 Stage 2 have been logged and 34 of those became a Further Correspondei




## Quality Improvement Recommendations for Complaint Handling

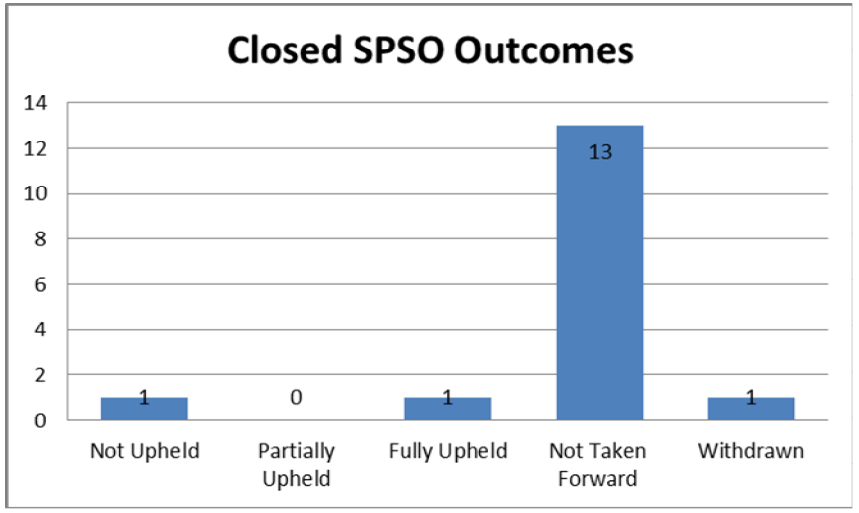
- Mandatory contact made with complainant when the complaint is received
- To not enter the complaint handling process until contact is made and clarifications on the complaint have been secured with full understanding and expectations given to complainant
- More meetings with complainants/families to explain outcomes of investigations
- Training on drafting a quality response
- Quality Management System with audits and structured feedback for continuous improvement
- Improved contacts lists for ensuring Professional Leads are involved at earlier stages of the complaint process

## SPSO Activity




**Since August 2023 23 SPSO cases have been logged**

- Increase In SPSO activity during March and April with a focus on enquiries on standard of care and treatment in respect of nursing practices, diagnosis and timeliness of treatments.
- A further focus is regarding communication on diagnosis decisions and any delays in treatment and impacts to a patient because of delays




**In the last 13 months 16 cases have been closed.**

- 2 enquiries have progressed to formal stage, where others are not taken forward on the basis the Board's responses have been deemed reasonable.
- It is reassuring to find that out of the 16 SPSO reviewed, 1 was

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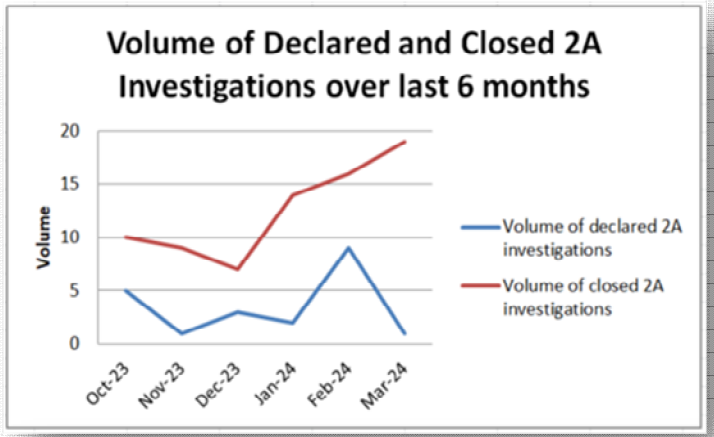
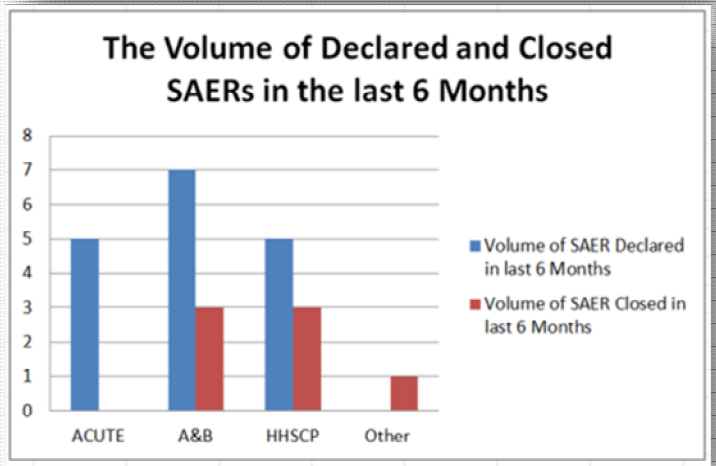
## SAER and Level 2A (Case Reviews): Last 13 months

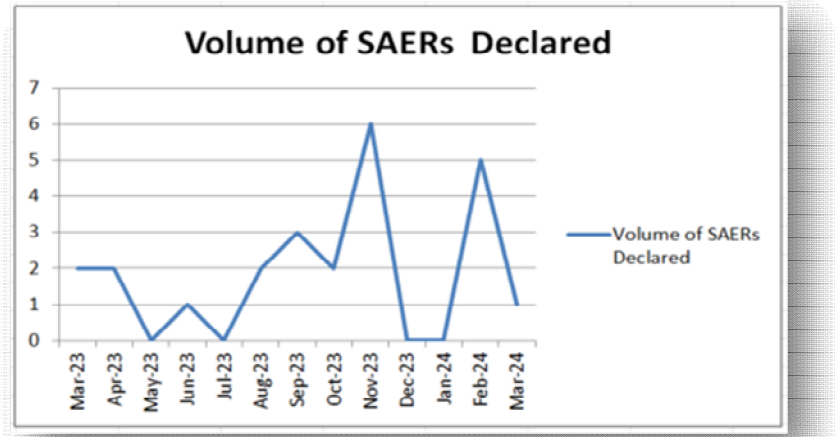
| Progress Made | Next Steps | Timescale |
|---|---|---|
| • Undertaken refresher SAER training for Lead Reviewers in HHSCP | • Reviewing and updating SAER resources following feedback from training<br>• Acute and HHSCP Interface Group is identifying ways to share learning and will be holding a learning event in September 2024<br>• SAER training will be delivered to Argyll & Bute HSPC in next 3 months | • August 2024<br>• By end of September 2024<br><br>• July 2024 |

**Exec Lead**
**Boyd Peters**




**All adverse events reported on Datix are reviewed through the Quality and Patient safety structure. In the 6 month period 5925 adverse events were reported. We declared 17 SAERs (0.28%conversion rate) and 22 Level 2A reviews (0.37% conversion rate)**




**Examples of SAERs Declared**:

- Care and treatment of young child
- Self harming behaviour
- Missed diagnosis

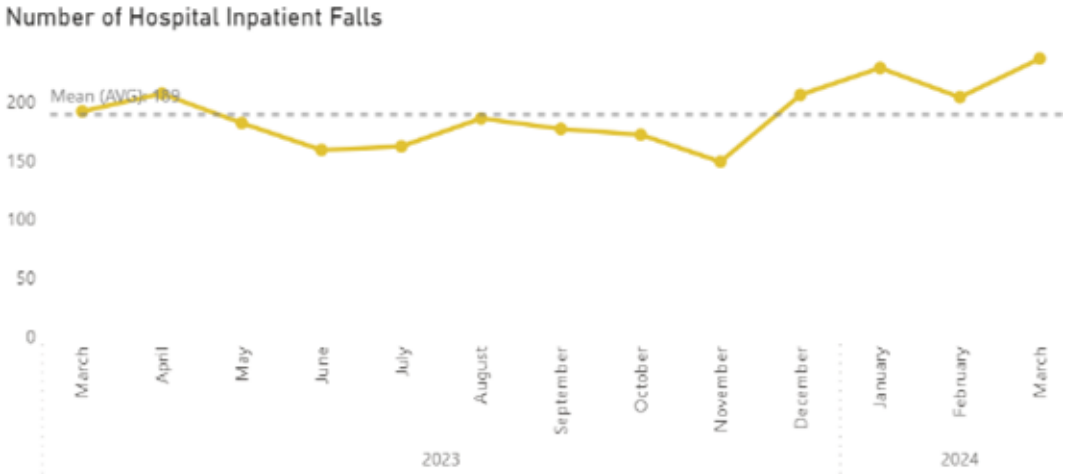
**Clinical Governance Support Team continues to help ensure investigations are efficient and the correct people are involved at the earliest opportunity**

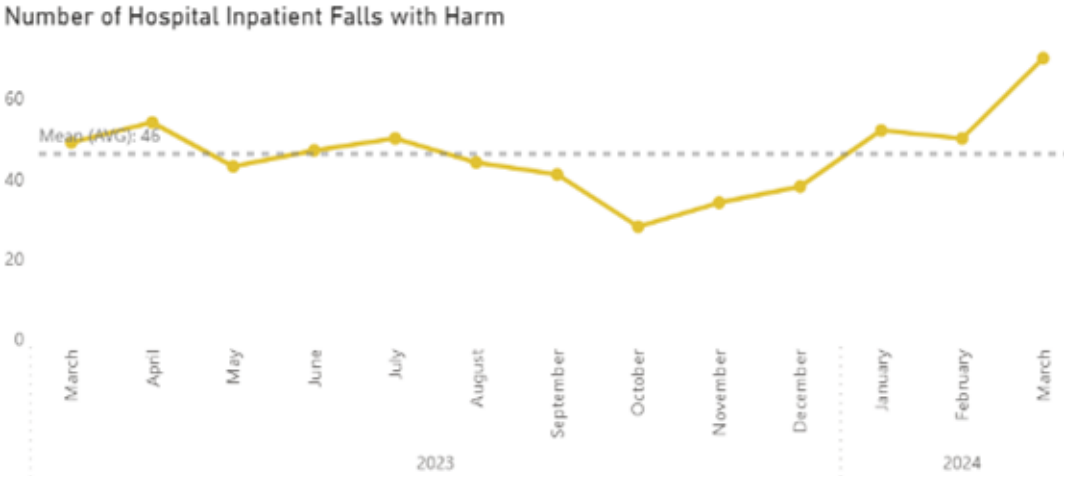
# Clinical Governance

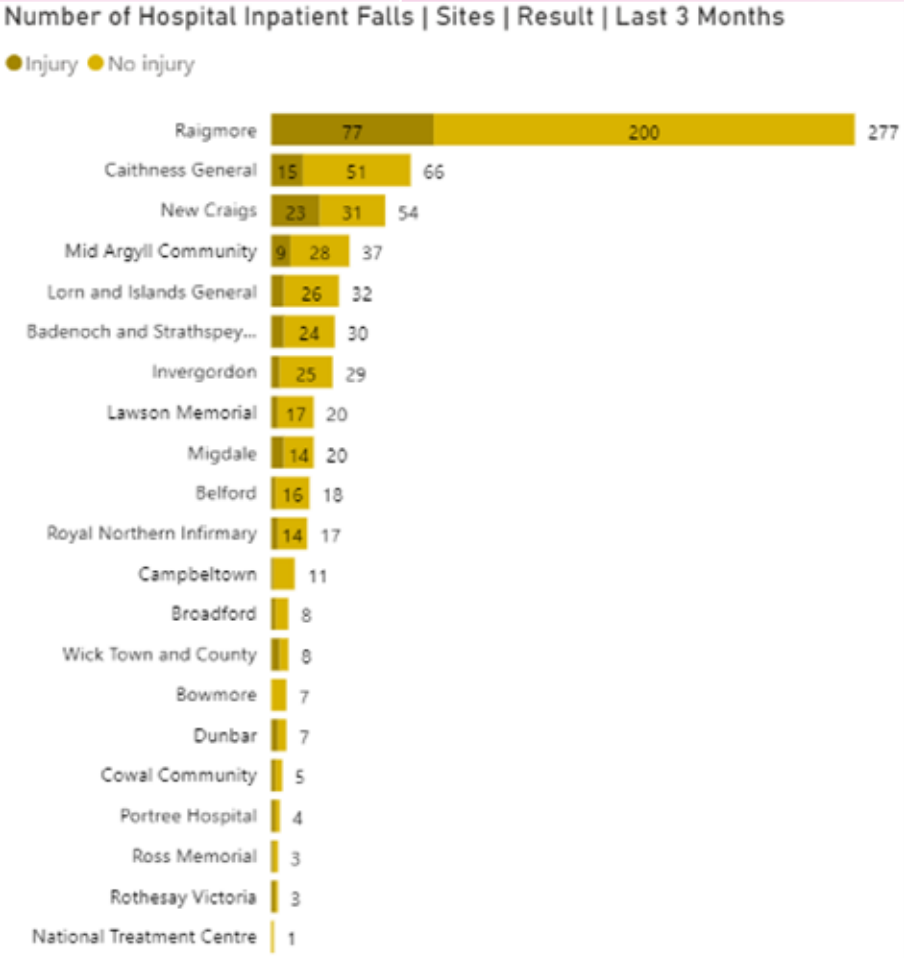
## Hospital Inpatient Falls | Run Chart and Site Harm/No Harm Outcome

**Executive Lead**
**Louise Bussell**

| Progress Made | Next Steps | Timescale |
|---|---|---|
| • Increasing falls and falls with harm across all areas, possibly linked to number of surge beds in use in Acute Hospitals, surge beds in B&S<br>• Falls audit tool has been updated<br>• Testing of MDT post fall sticker across 2nd floor Raigmore<br>• List of red flag medications developed to support post fall review | • Falls audit tool to be used in areas with highest falls to inform future improvement work in these areas<br>• Single page prompt sheet to be developed aligned to SPSP driver diagram | 30/4/24<br><br>31/5/24 |



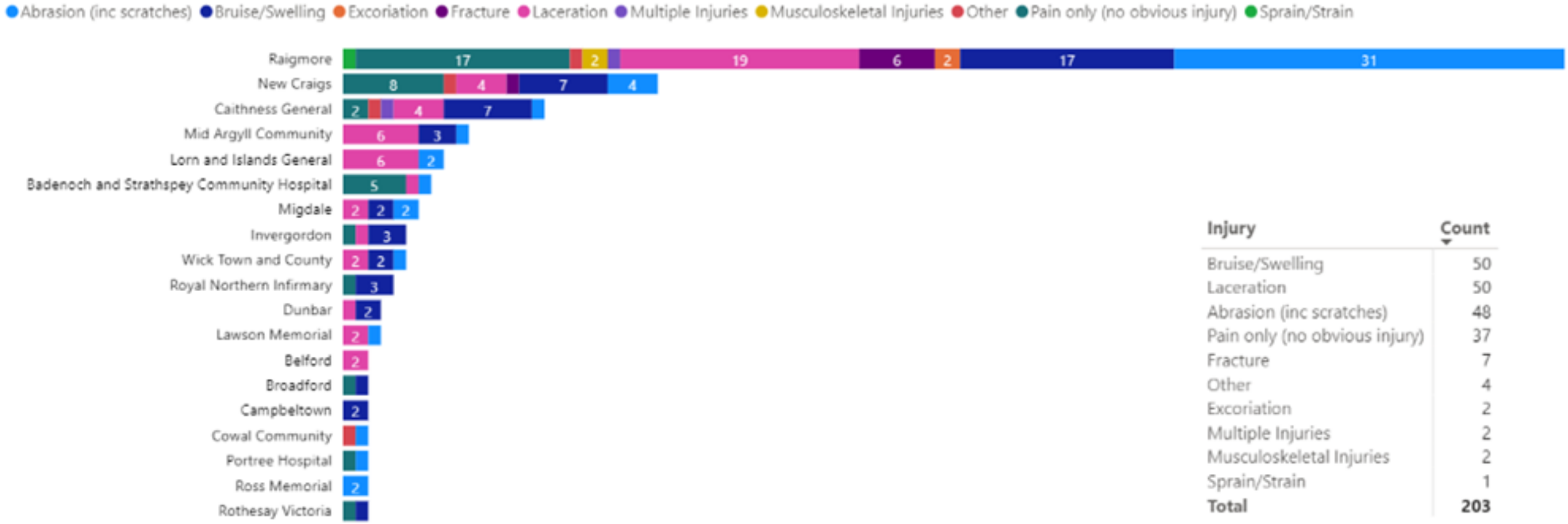



# Clinical Governance

## Hospital Inpatient Falls | Falls with Harm Site and Injury Type Detail

**Executive Lead**
**Louise Bussell**

### Number of Hospital Inpatient Falls | Sites | Injury Type | Last 3 Months



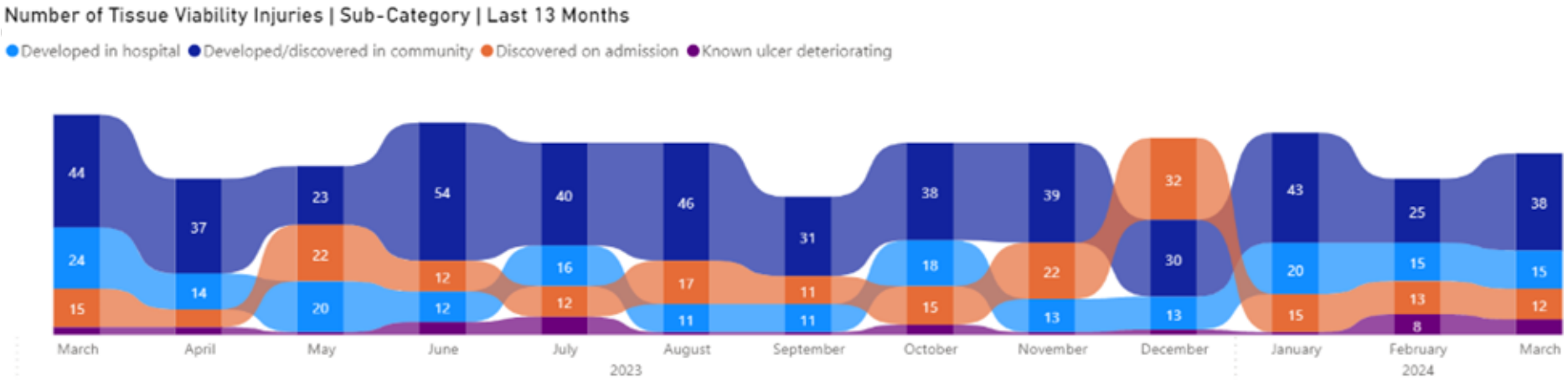

| Injury | Count |
|---|---|
| Bruise/Swelling | 50 |
| Laceration | 50 |
| Abrasion (inc scratches) | 48 |
| Pain only (no obvious injury) | 37 |
| Fracture | 7 |
| Other | 4 |
| Excoriation | 2 |
| Multiple Injuries | 2 |
| Musculoskeletal Injuries | 2 |
| Sprain/Strain | 1 |
| **Total** | **203** |

# Clinical Governance

## Tissue Viability Injuries | Grade 2/3/4 | Overall and Subcategory Detail

**Executive Lead**
**Louise Bussell**

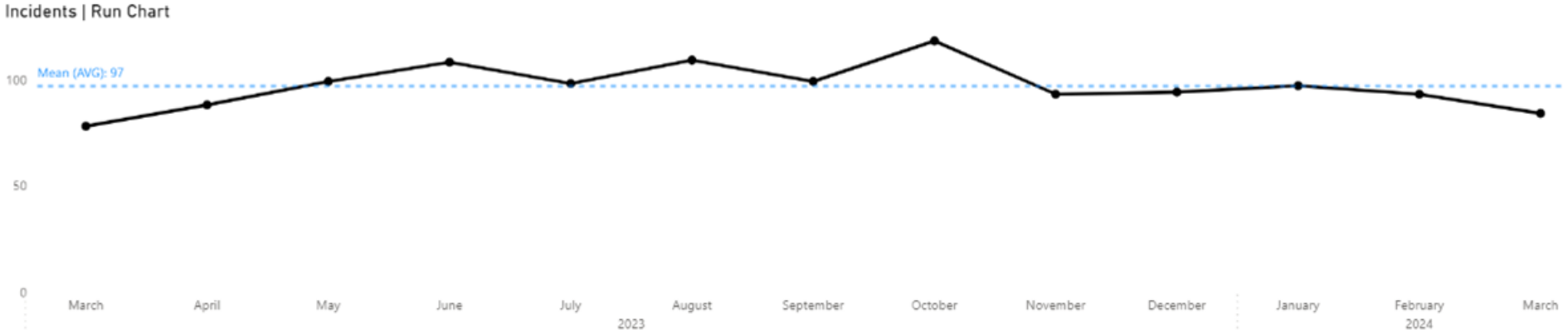
| Progress Made | Next Steps | Timescale |
|---|---|---|
| • Target aim to reduce pressure ulcers agreed | • Reduction of hospital acquired PUs by 20% | • June 2024 |
| • Discussions undertaken with SAS re pilot pressure damage risk assessment and implementation of risk reduction measures for patients delayed waiting in ambulances. | • SAS investigating options to access pressure relieving equipment. | • June 2024 |
| | • Consideration of including pressure damage risk assessment in SAS triage tool. | • June 2024 |
| • aSSKINg model - have commenced trials on some Raigmore wards. | • Development of an aide memoir for all users for aSSKINg | • August 2024 |
| • Identified potential improvements to patient care from the standardisation of the Red Day Tool (HIS document) across acute and community settings - potential to improve compliance, interventions and communication across patient journey. | • Plan community team trial to commence aSSKINg | • May 2024 |
| | • Evaluate acute trial with QI team for Hybrid mattress in progress | • May 2024 |
| | • TV Lead to liaise with HIS re potential to make changes and next steps after trial of aSSKINg tool | • May 2024 |
| • aSSKINg model to be trialled in community | • ELearning for Pressure ulcers with updated tools | • June 2024 |
| • ELearning for pressure ulcers in progress | | |
| • Hybrid mattress evaluation and results being compiled | | |

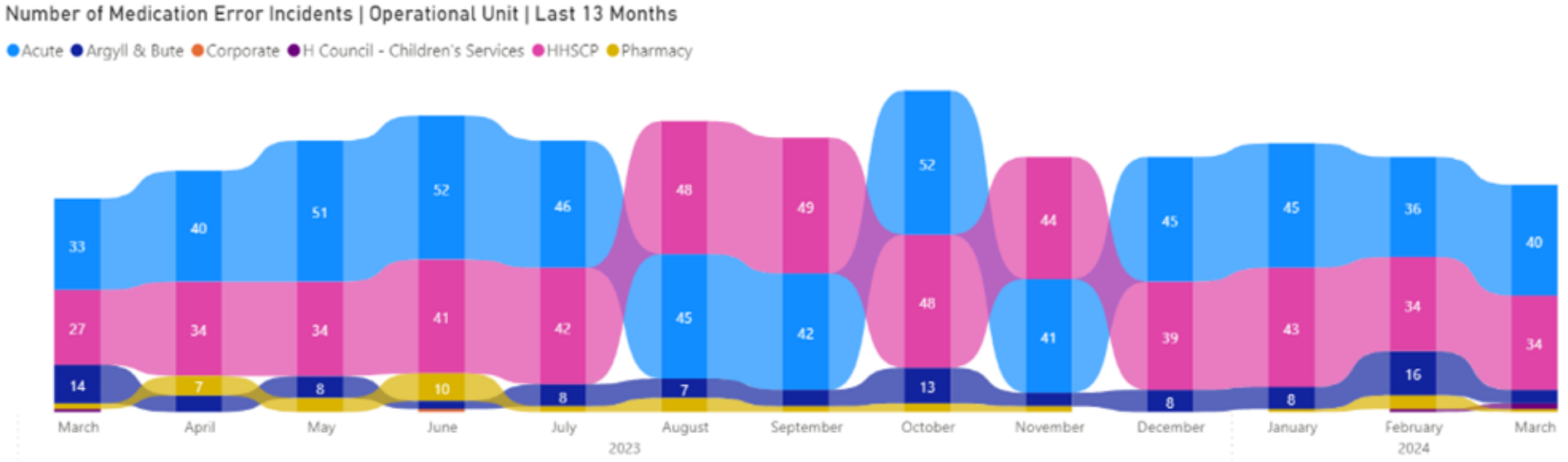



# Medication Errors

## Clinical Only Errors | Overall and Operational Unit Detail

| Progress Made | Next Steps | Timescale |
|---|---|---|
| •Agreement to review role, remit and membership of Medicines Safety Subgroup (MSS) of ADTC<br>•Ongoing roll out of HEPMA<br>•Short life working group established to review medicines management policies in social care settings<br>•Agreement to establish multiprofessional Controlled Drugs Governance Group | •Update and broaden membership of MSS<br>•Develop medicines governance strategy and action plan for MSS<br>•Controlled Drugs Governance Group to be established<br>•Launch updates of medicines management in social care settings policies, including developing education and training resources<br>•SLWG to establish and assure actions in line with sodium valproate National Patient Safety Alert | • May 2024<br>• May 2024<br>• May 2024<br>• June 2024<br>• June 2024 |



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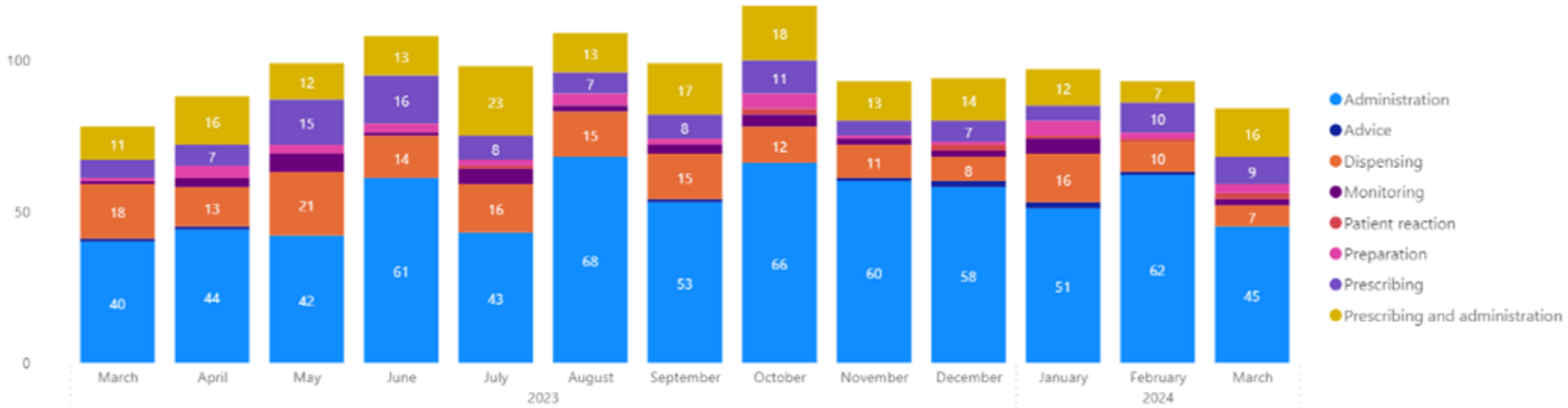
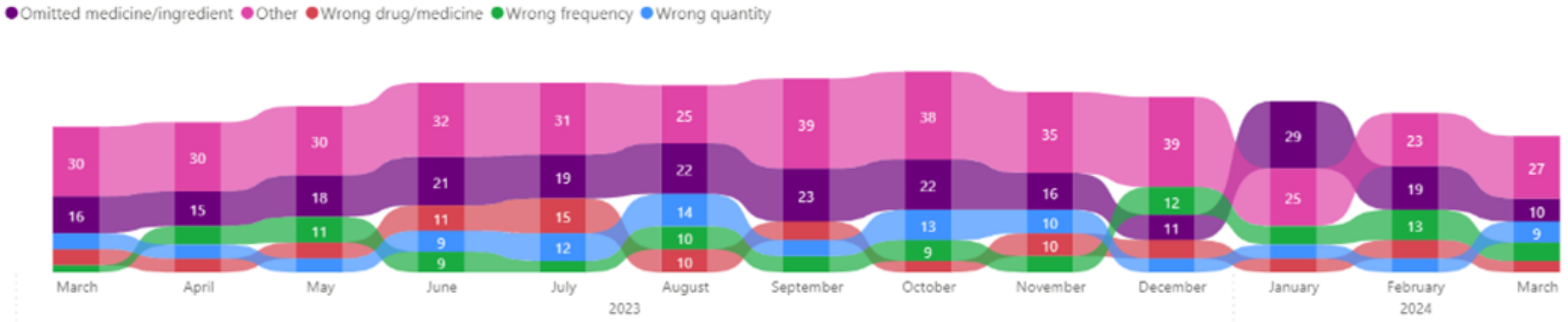
# Medication Errors

## Clinical Only Errors | Subcategory and Error Type Detail

### Number of Medication Error Incidents | Subcategory | Last 13 Months




### Number of Medication Error Incidents | Error Type (Top 5 recorded) | Last 13 Months



# Infection Control | SAB, CDIFF and ECOLI

## Table Overview

**Executive Lead**
**Louise Bussell**

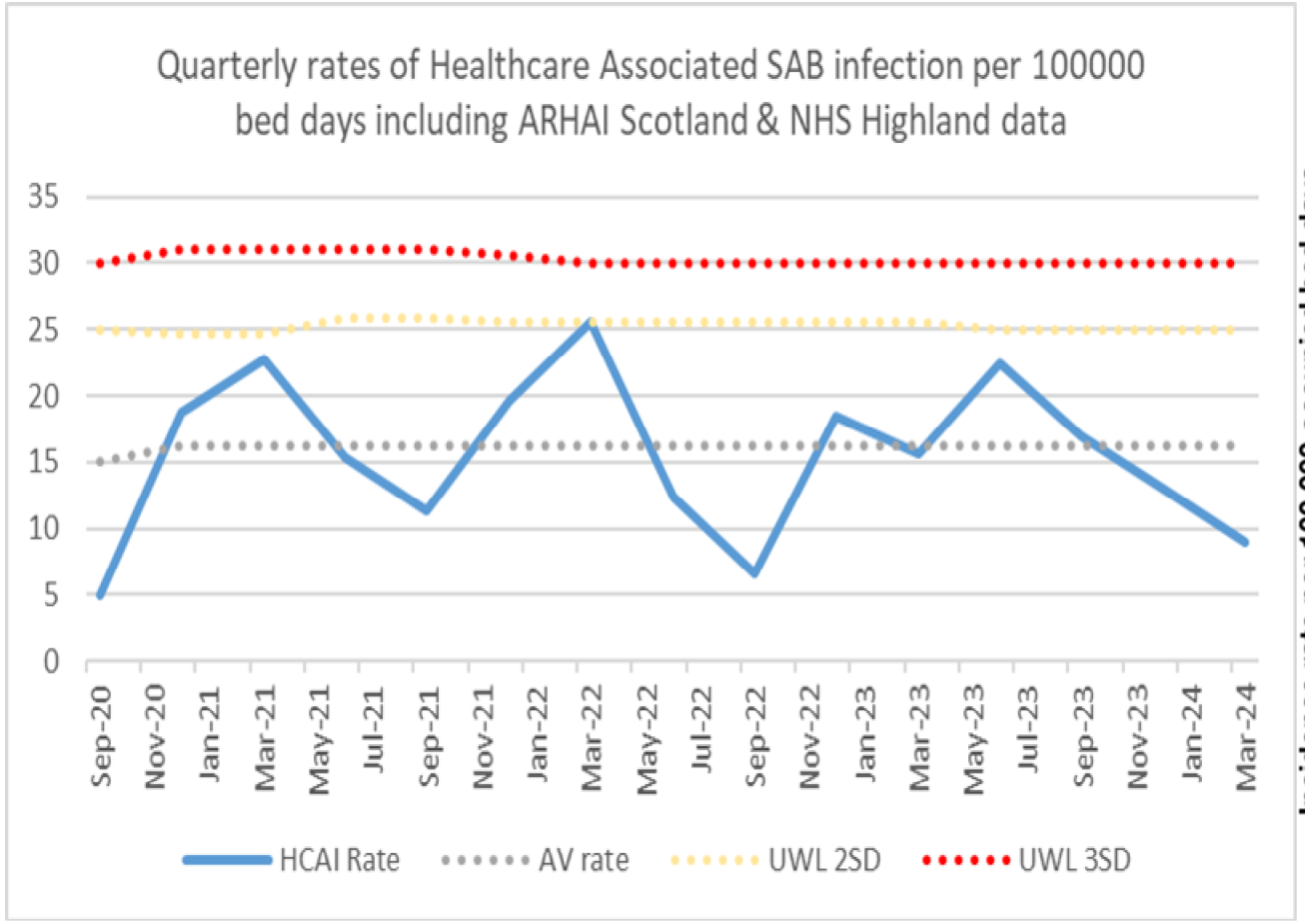
| Progress Made | Next Steps | Timescale |
|---|---|---|
| • The current reduction aims are: Clostridioides difficile healthcare associated infection rate of 15.6 per 100,000 total occupied bed days by April 2024. Staphylococcus aureus bacteraemia rate of 15.3; and EColi bacteraemia rate of 17.1<br>• Current NHS Highland and published PHS data identifies a rate of 24 (75 cases) for CDI 2023/24. This reduction aim will not be met<br>• Current NHS Highland and published PHS data identifies a rate of 15.2 (47 cases) for SAB 2023/24. This reduction aim may be met<br>• Current NHS Highland and published PHS data identifies a rate of 23 (74 cases) for EColi 2023/24. This reduction aim will not be met.<br>• NHS Highland was not above normal variation when analysing trends over the past three years and remains within predicted limits. | • The Infection Prevention and Control Team actively monitor each patient with a reported episode of infection for learning and to prevent future occurrences. Information is disseminated to the wider teams.<br>• IPC annual work plan continues to be monitored, and a detailed report is submitted to Clinical Governance Committee for assurance.<br>• Await confirmation of future reduction aims for 2024/2025<br>• A review of CDIFF cases and their management is being conducted with various clinical colleagues and representatives from ARHAI to identify any learning and future actions due to increase reported in July-September and the reporting of CDIFF outbreaks. | • Review end of year validated position validated position July 2024<br>• Local review of the management of CDIFF cases in Acute Care settings to commence May 2024<br>• Await forthcoming publication of reduction aims for 2024/25 |

**Quarterly Infection Control Infection Rates per 100,000 Occupied Bed Days (OBD) for 2023/2024**
**Includes validated and published data by Public Health Scotland (PHS), and NHS Highland unvalidated data when unavailable**

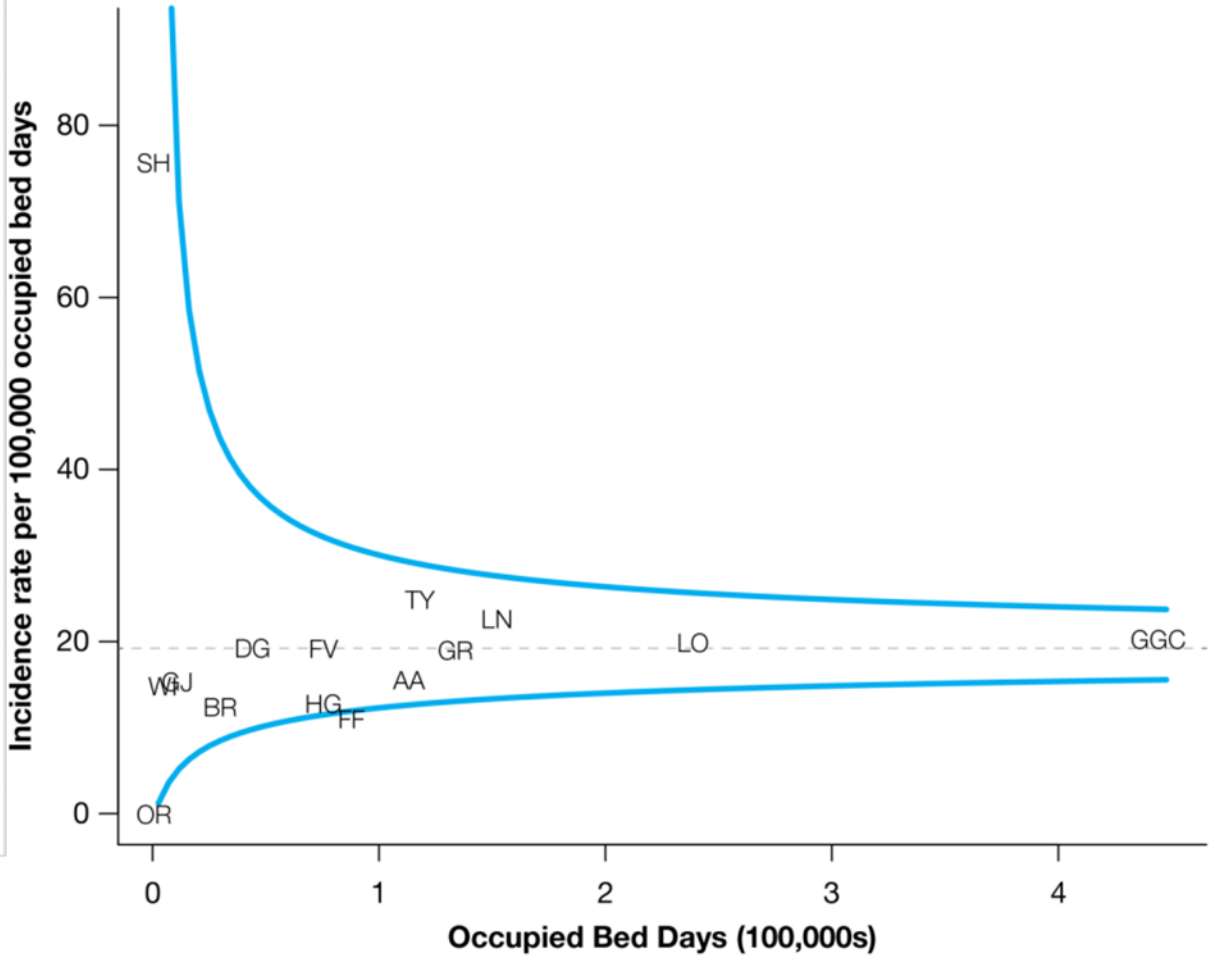
| Period | Apr-Jun 2023 Q1 | Jul-Sep 2023 Q2 | Oct-Dec 2023 Q3 | Jan-Mar 2024 Q4 (NHS HIGHLAND DATA – NOT VALIDATED) |
|---|---|---|---|---|
| **SAB** | HCAI | HCAI | HCAI | HCAI |
| NHS HIGHLAND | 22.4 | 16.9 | 12.8 | 9 |
| SCOTLAND | 18.3 | 18.1 | 19.2 | n/a |
| **C. DIFFICILE** | | | | |
| NHS HIGHLAND | 18.5 | 31.2 | 21.8 | 25 |
| SCOTLAND | 15.8 | 15.5 | 14.3 | n/a |
| **E.COLI** | | | | |
| NHS HIGHLAND | 23.8 | 31.2 | 27.0 | 14 |
| SCOTLAND | 37.6 | 37.8 | 34.7 | n/a |

# Infection Control

## Staphylococcus Aureus Bacteraemias (SABs)

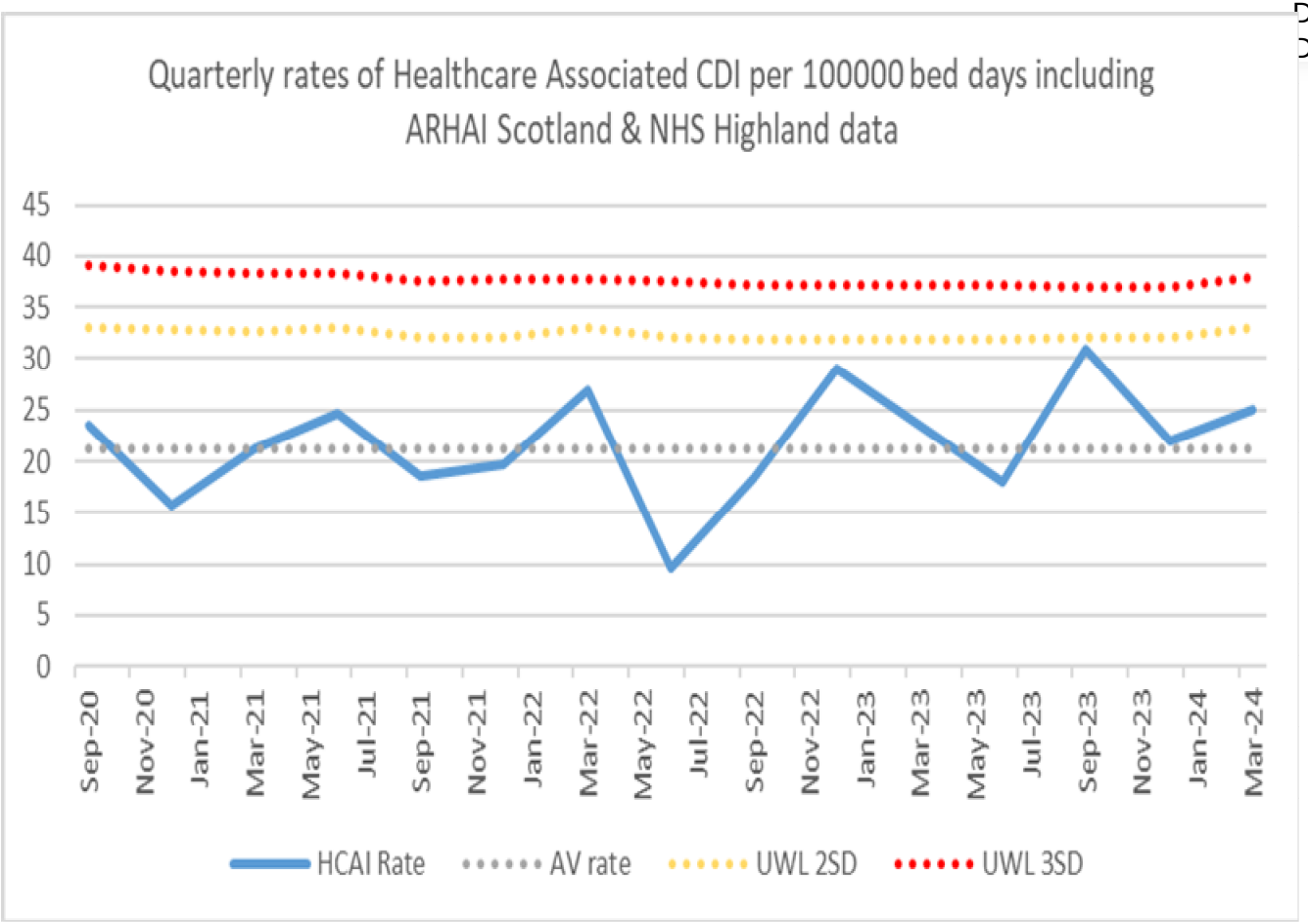



Discovery data | Infection rate per 100,000 bed days | NHS Highland quarter ending December 2023 HG – NHS Highland

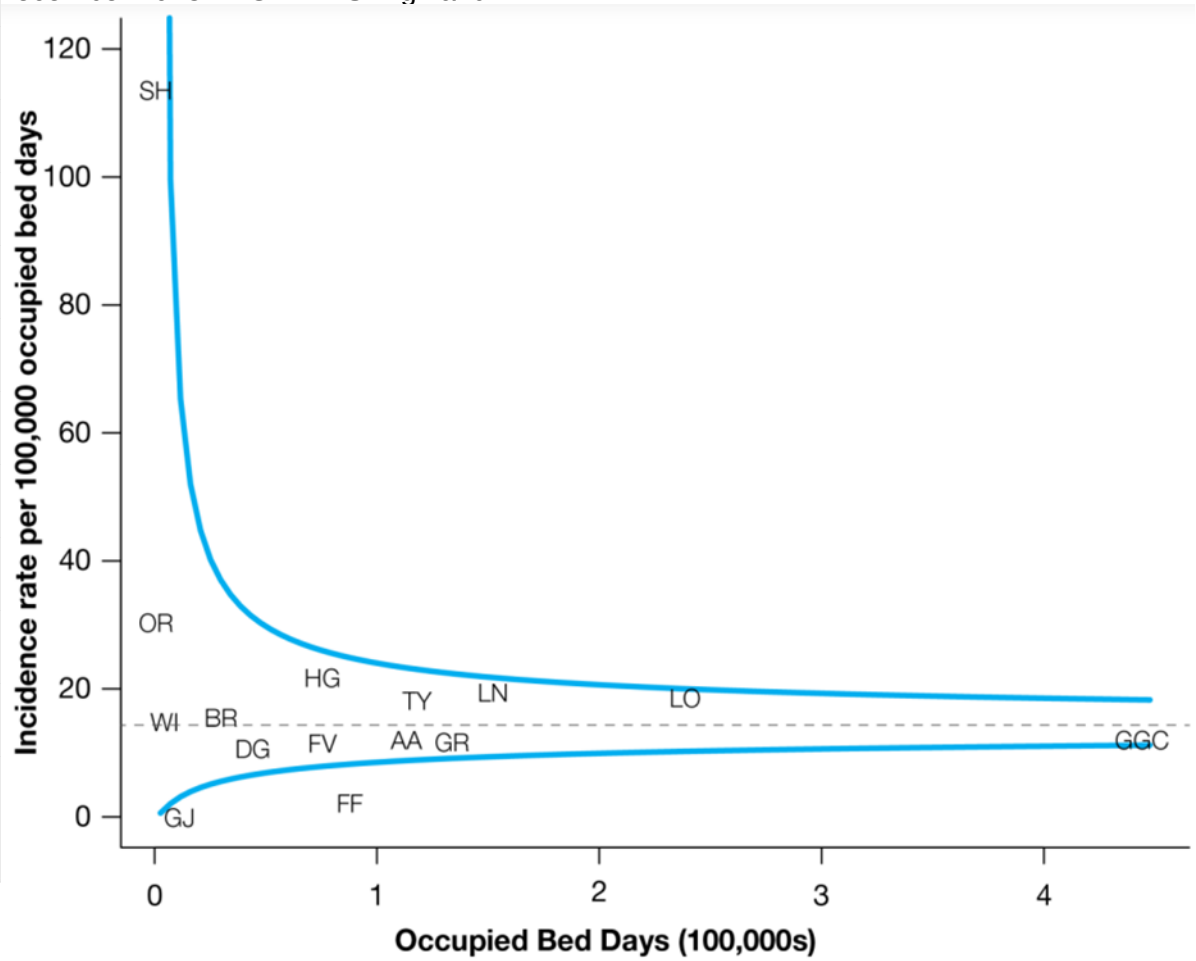


# Infection Control

## Clostridioides difficile infection (CDIFF)

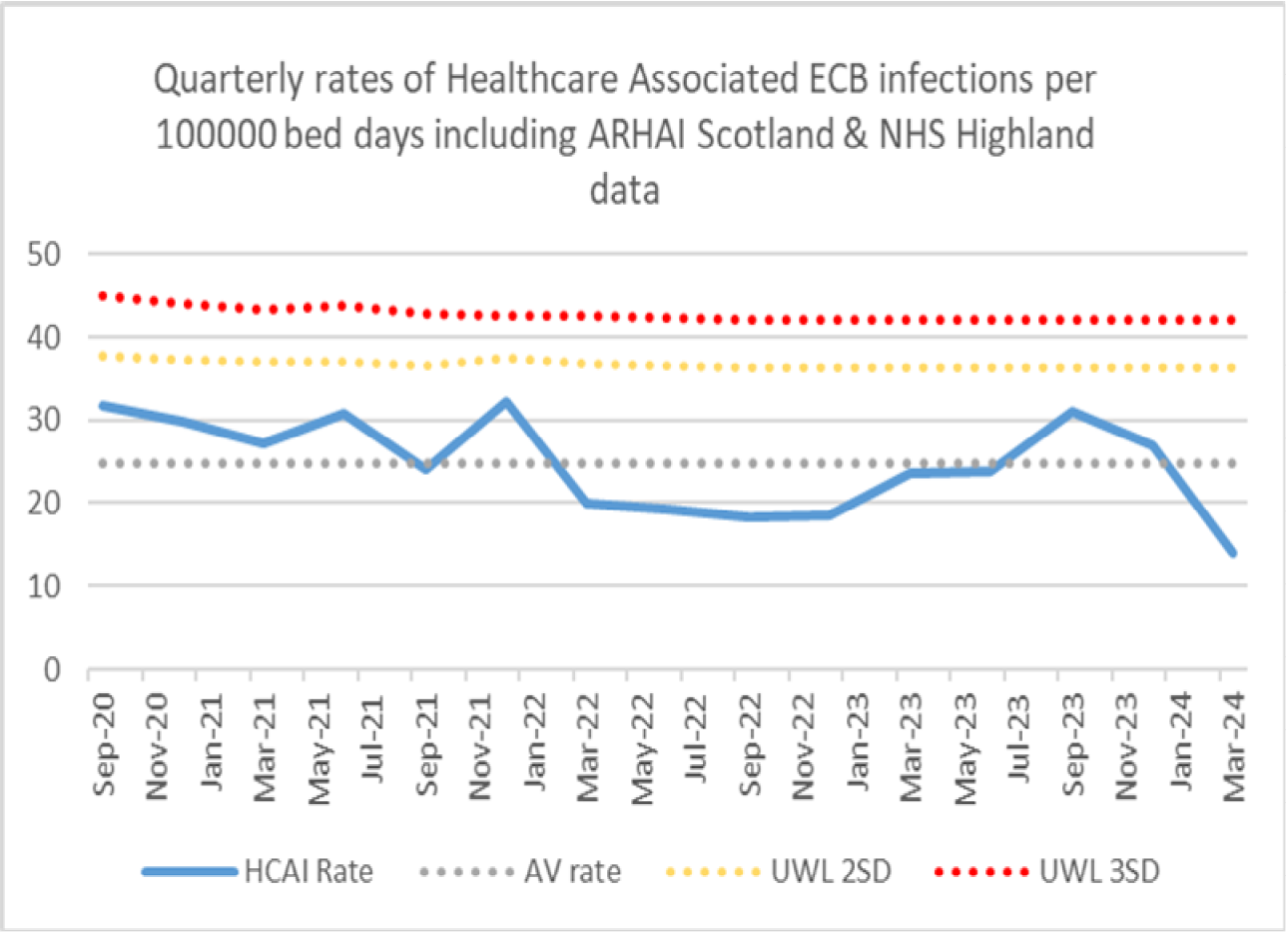



Discovery data | Infection rate per 100,000 bed days | NHS Highland quarter ending December 2023 HG – NHS Highland

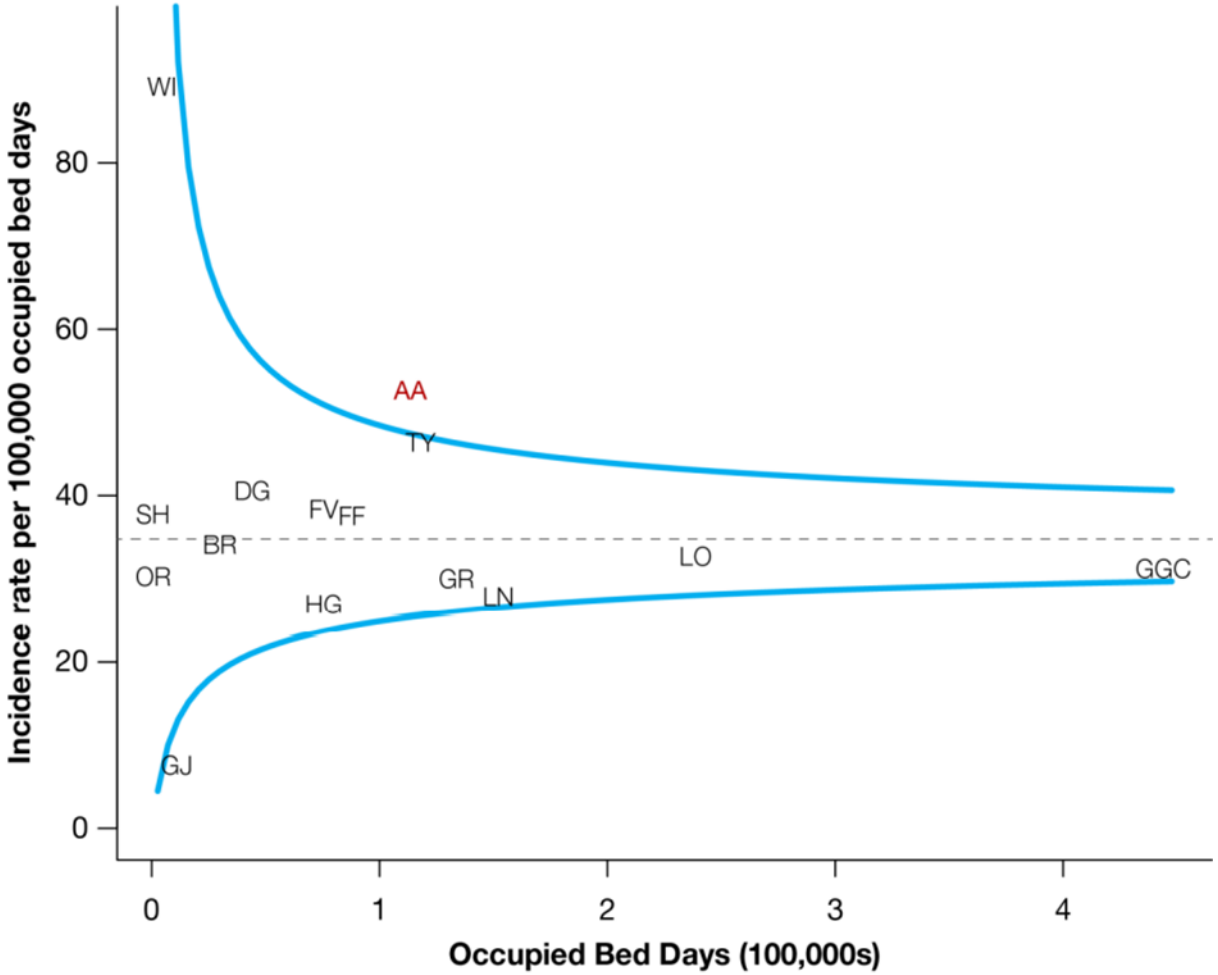


# Infection Control

## E.coli bacteraemia (ECOLI)




Discovery data | Infection rate per 100,000 bed days | NHS Highland Quarter ending December 2023 HG – NHS Highland



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# Integrated Performance & Quality Report

## Objective 3 Our People

Gareth Adkins
Director of People & Culture

NHS Highland absence remains above the national 4% target and over 6% for February and March 2024 . The absence rate has increased each year since 2022. Long term absences remain high in musculoskeletal problems (7%) and anxiety/stress (23%) which contributes to staffing pressures within teams however with high levels of unknown causes being recorded the information is incomplete (more than 30%). Short term absences in Cold, Cough, Flu (19% of absences) remain high as well as gastro-intestinal problems (14% of absences) but again high levels of absence with no reason recorded (25%).

Absences with no reason recorded with an unknown cause/not specified remain an area for improvement (approx. 30%). Highlight reports are shared with SLTs and People Partners are engaging with SMTs in their areas to encourage Managers to ensure that an appropriate reason is recorded and continuously updated. The People Services Team continue to work closely with managers of long-term absent employees. Awareness of attendance management processes remains low and attendance on Once for Scotland courses for managers is low. To raise awareness reports are now distributed to SLTs, via the People Partners to demonstrate attendance at the Once for Scotland courses, both online and elearning.

Sickness absence workstream is being established to focus on areas with high sickness absence rates. Targeted support will be planned to enable changes which may see a reduction in the level of absence

The NHS Highland Health and Wellbeing Strategy is out for consultation for a period of 4 weeks. The feedback will be considered and the Strategy lauched over the summer. The Strategy details our commitment to supporting health and wellbeing but also what resources and support is already available to our workforce. An action plan detailing the short, medium and long term actions is being progressed by the Health & Wellbeing Group.

The average time to fill vacancies has increased to 134 days. The time to fill NHS Scotland KPI is 116 days. Within this data vacancies approved at a vacancy management group are counted and the count doesn't reflect those pre vacancy management group approvals or where staff have left post and the manager hasn't started the replacement process. To support the progression of vacancies in the system, hiring managers can help by ensuring that they have time arranged to review applications and undertake the process of shortlisting as soon after the closing date as possible and interview dates are arranged well in advance. An Executive Vacancy Monitoring group has been established to consider all vacancies across North Highland

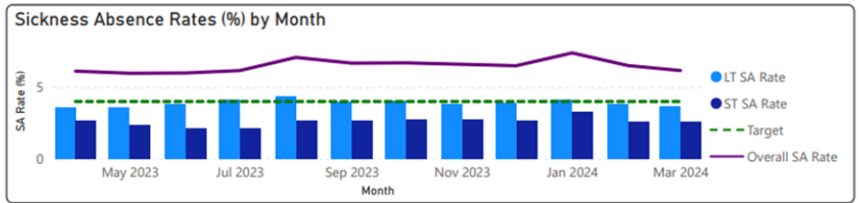
The recruitment improvement plan continues to be progressed with many of the actions completed. An interim Onboarding survey was launched mid Jan 2024 which aimed to survey all new starts from 1st May - 31st Dec 23. The survey was issued to 598 employees, employed during this period. 173 returns were received; therefore the participation rate was 29%. Key results:85% of respondents said their overall onboarding experience was favourable. 12% was neutral and 3% was unfavourable. Of the 173 returns; 55 returns were received from employees in Acute, 50 from HSCP, 36 from Argyll and Bute and 32 from Corporate Services. 86% said they would recommend NHS Highland as a great place to work. 52% moved to NHS from outwith, 28% moved from another Healthboard.

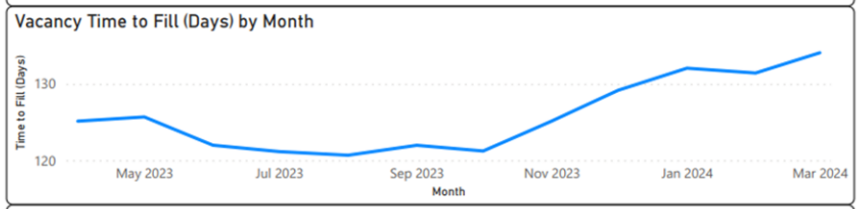
We continue to see high levels of leavers related to retirement (41%) and voluntary resignation (23%) and we see high levels of leavers with the reason recorded as 'other' which accounts for 16% of our leavers. 9% of our workforce have left to move to new NHS Employment. Further encouragement is required to capture leaving reasons. An interim Exit feedback Survey has now closed. 50 leavers completed a return out of 840 leavers in that period. Key results: 61% of respondents said their overall experience was favourable. 17% were neutral and 22% was unfavourable.20% of the returns related to retirement, 16% were moving to a different role externally, 12% were moving role internally. 28% were leaving for reasons unrelated to their role, 22% were moving for challenge/job growth.48% of the respondent worked in the NHS for over 10 years.

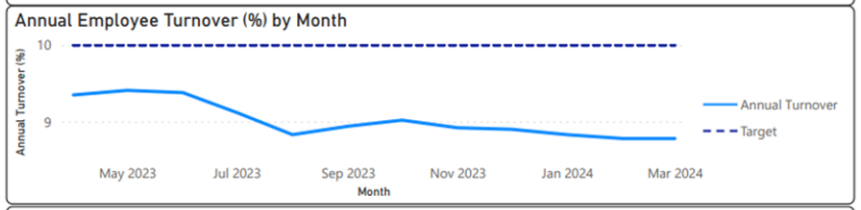
NHS Highland's turnover remains stable in line with the other Boards across Scotland. The National Turnover rate is 9.4% as at March 2022, and was 8.1% as at March 2021. Although turnover remains stable, we aim to to gather valuable information to better understand staff experiences from onboarding to exiting to help identify improvements

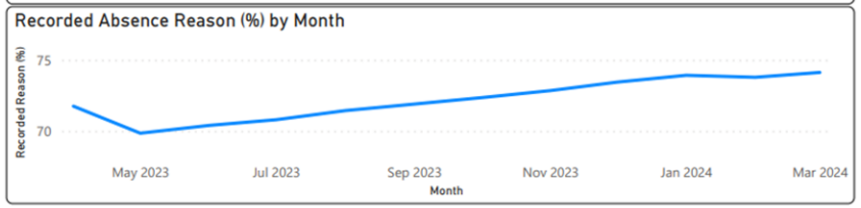
### Organisational Metrics Mar 2024

| | |
|---|---|
| Sickness Absence Rate (%) | 6.16 |
| Long Term SA Rate (%) | 3.64 |
| Short Term SA Rate (%) | 2.59 |
| Recorded Absence Reason (%) | 74.13 |
| Vacancy Time to Fill (Days) | 134.08 |
| Annual Employee Turnover (%) | 8.78 |



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# Integrated Performance & Quality Report

## Objective 3 Our People

Gareth Adkins
Director of People & Culture

Refreshed awareness sessions for managing PDP&R has been launched in the organisation; monitoring of attendance is in place. This will provide information on how to successfully and meaningfully undertake a PDP&R with individuals. The content of the sessions will be regularly reviewed to ensure alignment with policy and good practice. The People Partners will work with the senior leadership teams in ensuring that plans exist for increase in the amount of PDPs undertaken. As part of the Culture and Leadership Framework, new PDP&R training will be offered to all colleagues to improve understanding of the benefits and reasons for regular feedback and development and to increase completion rates. In addition an improvement plan is being progressed regarding the completion of PDPs commencing with senior managers.

A 6 month monitoring period has commenced from end of January for statutory and mandatory training. Each month reports are sent to EDG and their direct reports on the compliance levels aginst the agreed improvement trajectory for the core elearning modules. An oversight group is established reporting to EDG. Overall improvements are being made in this area

## Training Metrics Mar 2024

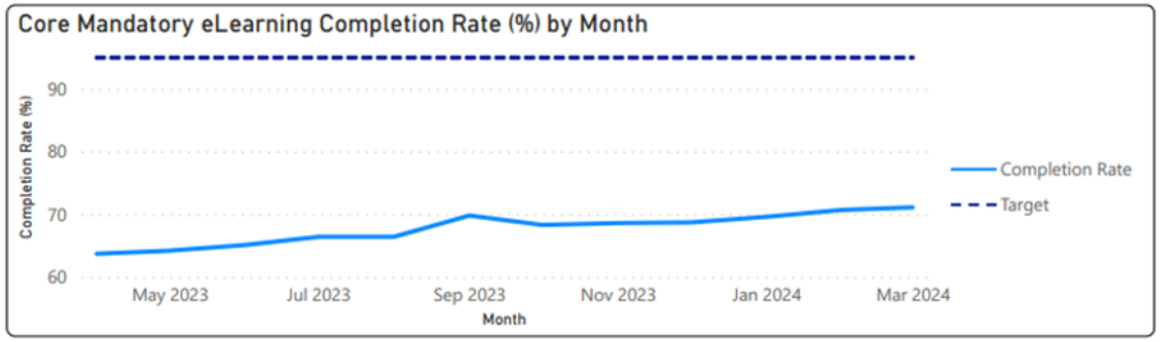
**Mandatory eLearning Completion (%)**
**71.1**

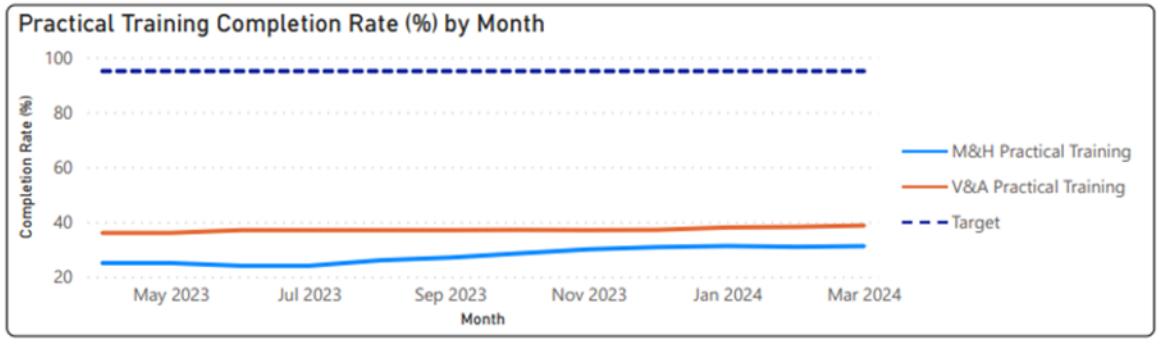
Note that from Feb 2024 V&A e-Learning module has been excluded from Mandatory Training compliance figures until new course is launched in June for all Job Families.

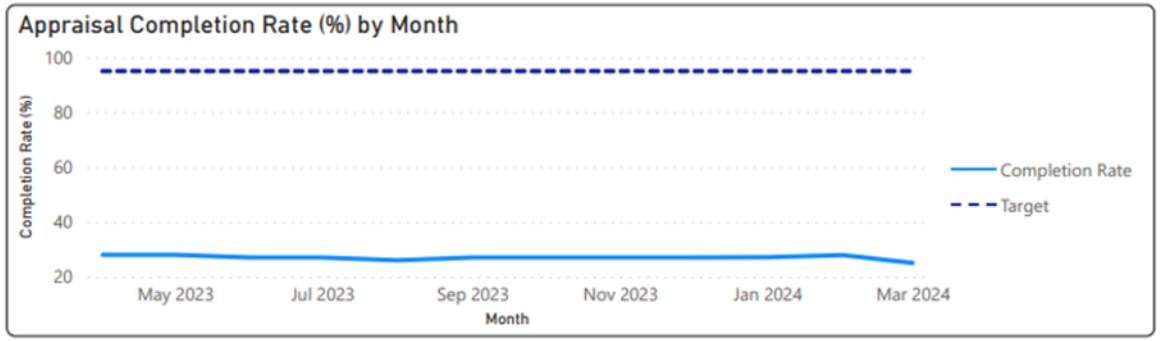
**V&A Practical Training Completion Rate (%)**
**38.7**

**M&H Practical Training Completion Rate (%)**
**31.2**

**Appraisal Completion Rate (%)**
**25.0**



# Appendix: IPQR Contents

| Slide # | Report | Frequency of Update | Last Presented | Next Published on IPQR |
|---|---|---|---|---|
| 3 | Covid Vaccine Uptake | Monthly | May 2024 | July 2024 |
| 3 | Board Comparison % Covid Vaccine Uptake | Monthly | May 2024 | July 2024 |
| 4 | LDP 12-week smoking quits by month of follow up-NHS Highland | Monthly | May 2024 | July 2024 |
| 5 | NHS Highland-Alcohol brief interventions 2023/24 Q2 | Quarterly | March 2024 | July 2024 |
| 5 | ABIs delivered | 6 monthly | November 2023 | July 2024 |
| 6 | Drug and Alcohol Wait Times | Monthly | May 2024 | July 2024 |
| 6 | Board Comparison % | Monthly | May 2024 | July 2024 |
| 7 | 18 Weeks CAMH Services Treatment | Monthly | May 2024 | July 2024 |
| 7 | Board comparison % Met Waiting time standard | Monthly | May 2024 | July 2024 |

| Slide # | Report | Frequency of Update | Last Presented | Next Published on IPQR |
|---|---|---|---|---|
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| 8 | Board Comparison % meeting Waiting time standard | Monthly | May 2024 | July 2024 |
| 9 | Delayed Discharges at Monthly Census Point | Monthly | May 2024 | July 2024 |
| 9 | Delayed Discharge Benchmarking | Monthly | May 2024 | July 2024 |
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| 11 | New Outpatients Referrals, Patients seen and Trajectories | Monthly | May 2024 | July 2024 |
| 11 | New Outpatient Total Waiting List & Projection | Monthly | May 2024 | July 2024 |
| 11 | OP Patients Waiting Over 52 Weeks | Monthly | May 2024 | July 2024 |
| 12 | Inpatient or Day Case 12 Week Waiting Times (Completed) | Monthly | May 2024 | July 2024 |
| 12 | Board Comparison % Met waiting time standard | Monthly | May 2024 | July 2024 |
| 13 | Planned Care Additions, Patients seen and trajectories | Monthly | May 2024 | July 2024 |
| 13 | Total TTG Waits & Projection | Monthly | May 2024 | July 2024 |
| 13 | TTG Patients waiting over 78/104 weeks | Monthly | May 2024 | July 2024 |

| Slide # | Report | Frequency of Update | Last Presented | Next Published on IPQR |
|---|---|---|---|---|
| 14 | Imaging Tests: Maximum Wait Target 6 weeks | Monthly | May 2024 | July 2024 |
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| 16 | Board Comparison % Met waiting time standard | Monthly | May 2024 | July 2024 |
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| 17 | Board Comparison % Met waiting time standard | Monthly | May 2024 | July 2024 |
| 18 | 18 Weeks All Ages Psychological Therapy Treatment | Monthly | May 2024 | July 2024 |
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| 19 | Volume of Radiology Treatments Completed in Relation to Volume of Stage 2 Complaints Received | Monthly | May 2024 | July 2024 |
| 19 | Complaint Reasons Relating to Radiology Complaints | Monthly | May 2024 | July 2024 |
| 19 | Decision Outcome for Radiology Related Complaints | Monthly | May 2024 | July 2024 |
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| 20 | Complaint Reasons Relating to Endoscopy Complaints | Monthly | May 2024 | July 2024 |
| 20 | Decision Outcome for Endoscopy Related Complaints | Monthly | May 2024 | July 2024 |

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# Argyll & Bute Health & Social Care Partnership

## Integrated Performance Management Framework FQ2 (23/24)

# 2023/24- FQ2 Performance Overview

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| ARGYLL & BUTE TOTAL | |
|---|---|
| ON TRACK | 51 |
| OFF TRACK | 42 |


PERFORMANCE ACROSS ARGYLL & BUTE

Overall performance for FQ2 notes that 55% of KPI's are scoring against target, with 51 reporting as on-track and 42 off-track, this is an improvement against previous FQ1 performance. The KPI's report performance against the target and include the target, actual and variance and is a mix of both quantitative and qualitative indicators.

**CHILDREN & FAMILIES**


| | |
|---|---|
| ON TRACK | 2 |
| OFF TRACK | 9 |

**TELECARE / DIGITAL**


| | |
|---|---|
| ON TRACK | 5 |
| OFF TRACK | 3 |

**PUBLIC HEALTH / PRIMARY CARE**


| | |
|---|---|
| ON TRACK | 13 |
| OFF TRACK | 0 |

**HOSPITAL CARE / DELAYED DISCHARGES**


| | |
|---|---|
| ON TRACK | 7 |
| OFF TRACK | 10 |

**FINANCE**


| | |
|---|---|
| ON TRACK | 1 |
| OFF TRACK | 4 |

**CARERS / AHP**


| | |
|---|---|
| ON TRACK | 7 |
| OFF TRACK | 4 |

**CARE AT HOME / CARE HOMES**


| | |
|---|---|
| ON TRACK | 2 |
| OFF TRACK | 5 |

**LEARNING DISABILITY / MENTAL HEALTH**


| | |
|---|---|
| ON TRACK | 14 |
| OFF TRACK | 7 |

# Children & Families

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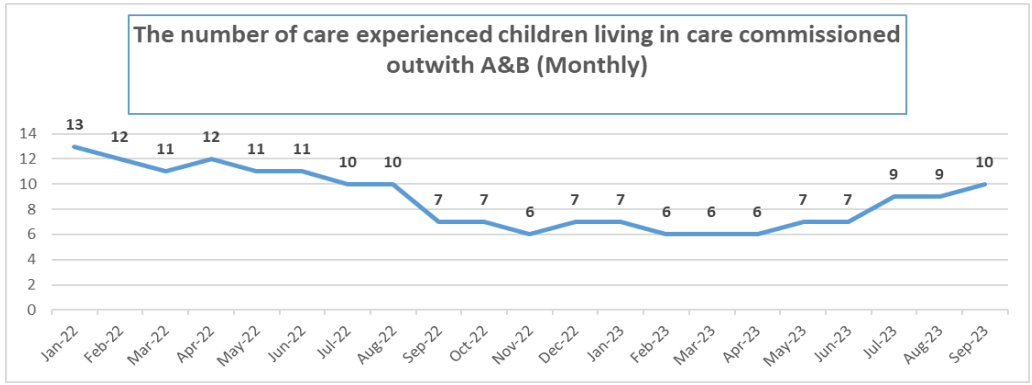
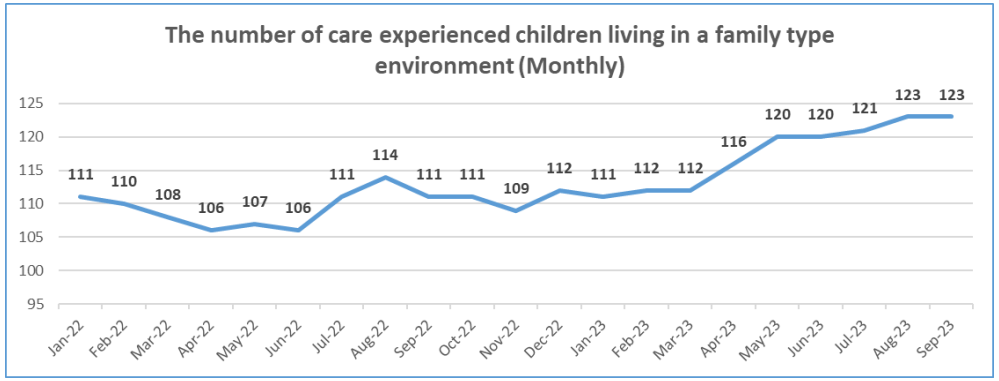
**Across 11 KPI, C&F services performance notes 2 (18%) on track, with 9 (82%) off track against the targets set in Q2 23/24. This is a decrease from 27% on track reported (-9%) variance on the previous quarter performance.**




**Performance on or above target**:

- Number of care experienced children placed at home or in Kinship or Fostering Care is on track, noting 17% above target performance.
- The percentage of panel Reports completed for Scottish Children's Reporter Administration (SCRA) with 28 Days noted an increase to 100% against 80% target

**Performance below target & areas for improvement:**

- Performance around reducing numbers of care experience children looked after living in residential care commissioned out with A&B has declined due to noted increased this quarter from 5% to 7% of all children looked after. The number of children cared for in 'external placements' is small and as such consideration must be given when reviewing a percentage shift across a small population.
- With regards to the number of children seen within 18 weeks for Child & Adolescent Mental Health Services remains off track, with FQ2 noting 79.3% against a 90% target. This is however an increase of 17.2% on previous quarter's performance and demonstrates steady longer-term progress in this area.

# Telecare & Digital

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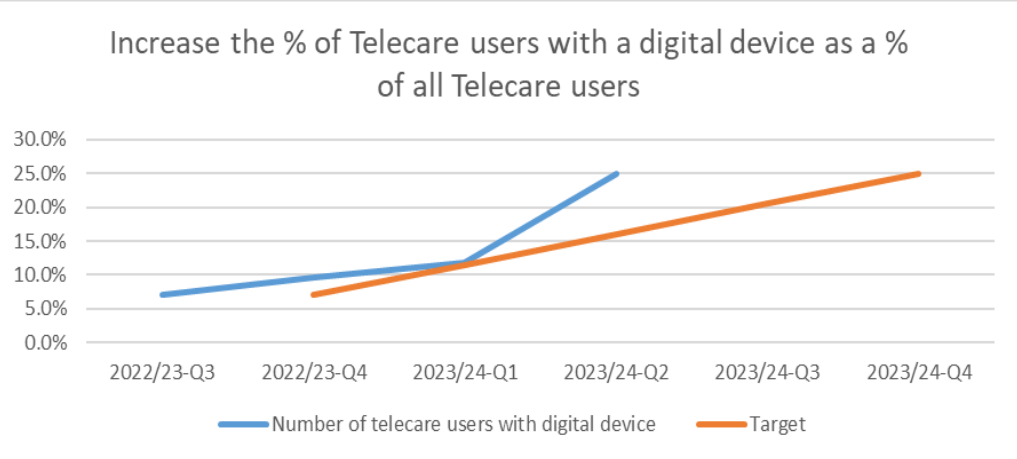
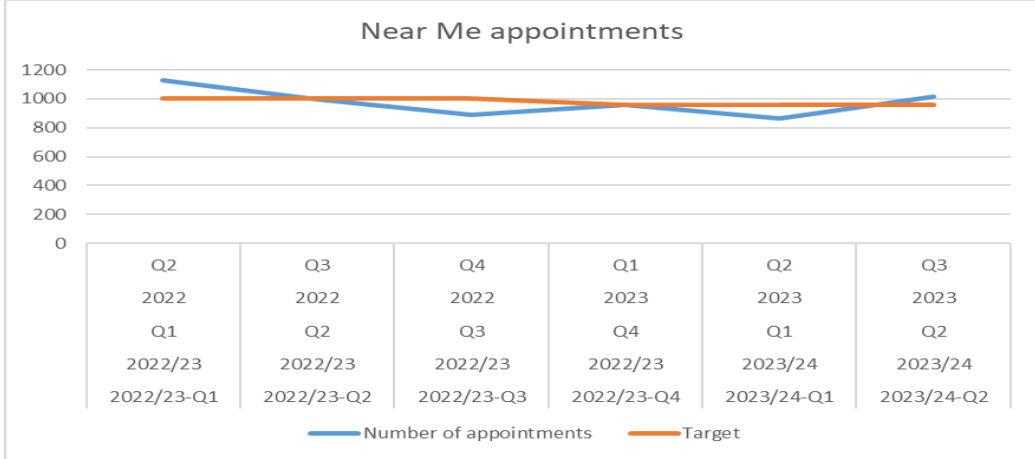
**Benchmarked performance across the 8 Key Performance Indicators against target notes a significant increase in the number of KPI's reporting on-track with Q1 noting (3) 37.5% on track against FQ2 reporting (5) 62.5% on-track and increase of (25%) 3 KPI's remain off –track against target for FQ2.**




**Performance on or above target**:

- Digitalisation of Telecare Devices: Substantial progress has been made and the 25% end-of-year target has almost been achieved in FQ2.
- 'Near Me' Clinics: A significant 18% increase from the last quarter suggests that virtual appointments are becoming more widely accepted and may be a lasting trend beyond the decline post-COVID.
- SilverCloud: referrals remain on target with a 6% increase in referrals from last Quarter

**Performance below target & areas for improvement:**

- There has been an issue surrounding licensing of Just Checking equipment which has prevented new equipment going out during Q2. There has also been no new Buddi equipment issued.
- Telecare referrals being completed on time is an ongoing issue, the ability to keep track of outstanding referrals via a CMS has been lost during the migration to Eclipse

# Public Health & Primary Care

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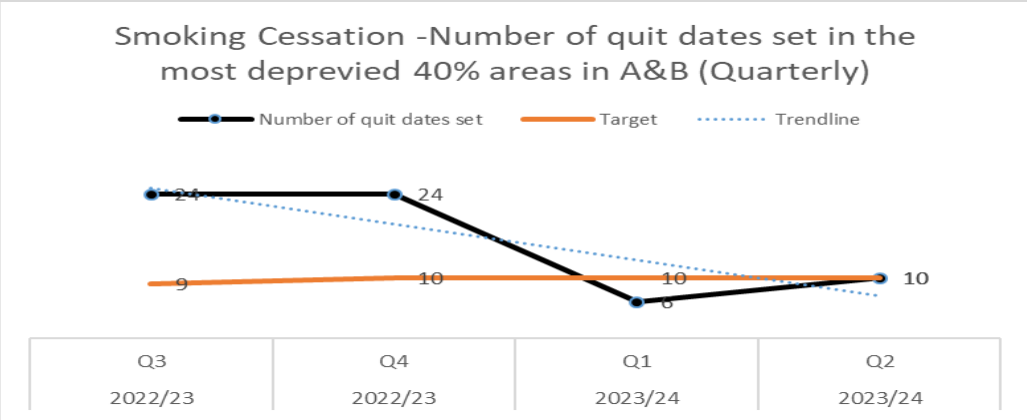
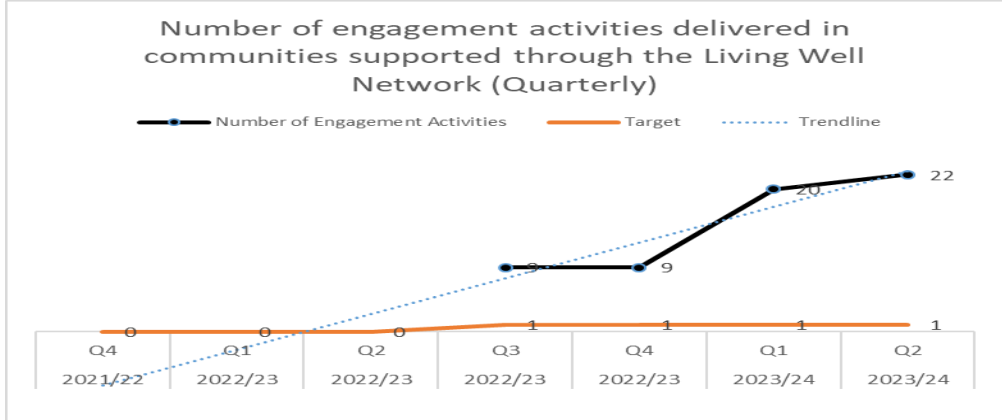
**Benchmarked performance across the 13 Key Performance Indicators against target notes a sustained increase in the number of KPI's reporting on-track with Q2 noting (13) on track against FQ1 reporting (11) on-track. Across 5 KPI's, Public Health performance notes 5 (100%) are on track set against the targets in Q2 2023/24. This is an increase of 20% on the previous quarter performance**




**Performance on or above target**:

- Increasing the monthly number of quit dates is on target in Q2. There is a variance of 67%. It is noted that the "actual" reported in Q1 was incomplete as only had 1 months data.
- Monitoring contracts and KPIs of all PH commissioned contracts is 100% on track in Q2. This follows a 100% trend from Q3 of 2022/23.
- Increasing the number of engagement activities delivered in communities is on target in Q2 and shows an increase in performance each quarter. There is a variance of 10% in Q2 from Q1.
- In the current fiscal year, primary care in Argyll and Bute has effectively introduced several new services, achieving notable success.
- In the five most deprived areas—Helensburgh, Campbeltown, Dunoon, Rothesay, and Oban—GP practices now can refer their patients to a community link worker for either in-person or remote appointments.

**Performance below target & areas for improvement:**

- Quarter 2 reported no KPI below target and all Public Health & Primary Care KPI's recorded as on or above target

# Hospital & Delayed Discharges

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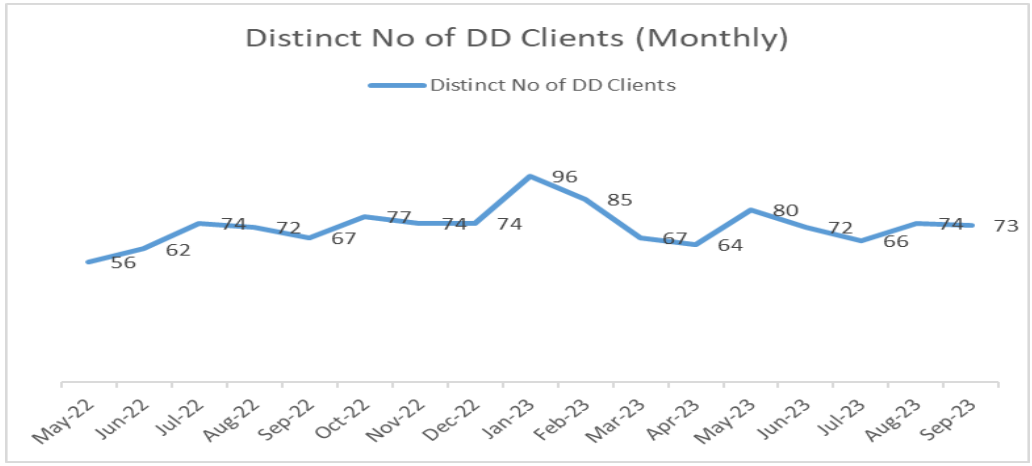
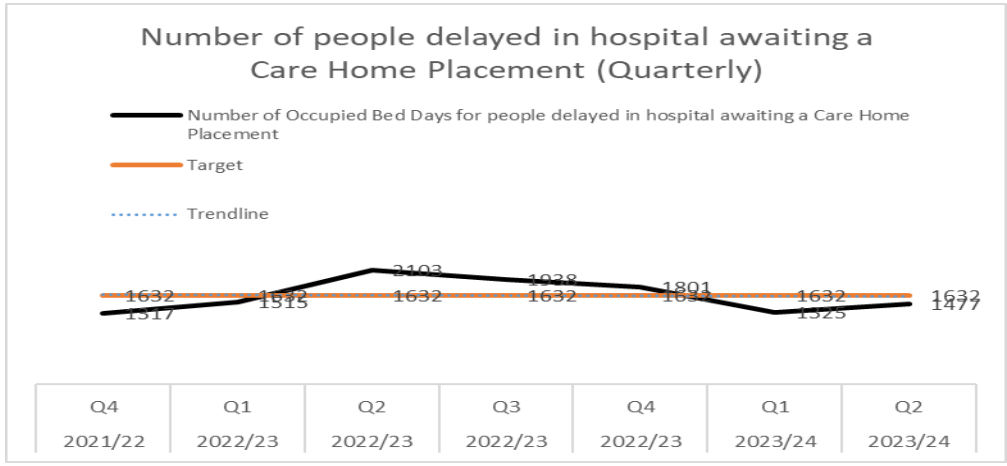
**Across 17 KPI's, Hospital Care performance notes 7 (41%) on track, with 10 (59%) off track against the targets set in Q2 23/24. This is an increase from 27% on track reported (+14%) variance on the previous quarter performance. Discharge performance notes 3 (50%) on track, with 3 (50%) off track against the targets set in Q2 23/24. There is no variance from (50%) reported on track on the previous quarter performance.**




**Performance on or above target**:

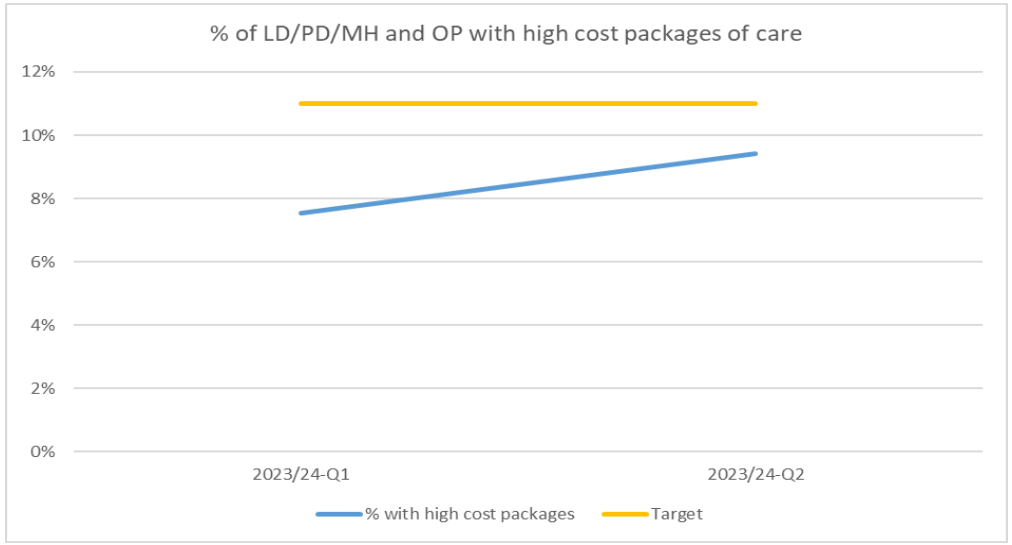
- Reducing the number of people delayed in hospital is on track, with a (-11%) variance on Q1. We are 100% on target on this quarter performance.
- Reducing the number of occupied bed days for people delayed in hospital awaiting a care home placement is on track. Note an increase of (11%) bed days on previous quarter performance.
- The number of inpatients 18+ who are discharged without delay is on track, with a (-1%) variance on Q1.
- Reducing the average Length of Stay for inpatients in A&B hospitals is on track, having dropped by 25% since Q1, and is exactly on target.

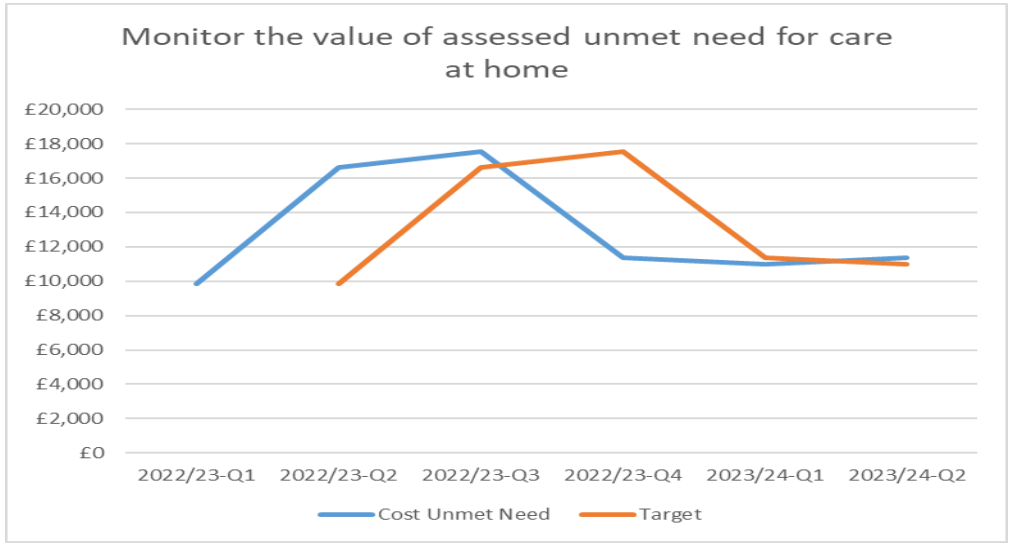
**Performance below target & areas for improvement:**

- Overall length of stay (bed days) in hospital is below target and showing a (14%) increase from Q1. (37%) below Q2 target.
- Reducing the number of people delayed in hospital due to care at home availability has slightly improved since Q1 (-14%). (16%) above Q2 target. Unplanned admissions to hospital for 65+ remain slightly above target and showing a 2% increase on Q1.

# Finance

**Across 5 KPIs, Financial services performance notes 1 (20%) on track, with 4 (80%) off track against the targets set in Q2 23/24. This is a decrease from 40% on track reported (-20%) variance on the previous quarter performance.**




**Performance on or above target**:

- The performance on reducing the percentage of clients with high-cost packages of care KPI is improving at 3% above target performance.

**Performance below target & areas for improvement:**

- Reduction in value of assessed unmet need for care at home remains off track with costs increased this quarter on previous quarter.
- Performance with regards to reducing the cost of hospital stays as a result of delayed discharge remains off track, with FQ2 noting 24% above the target, and an increase of 13% on previous quarter's performance.
- The cost on pharmacy expenditure remains off track, with FQ2 noting 16% above target, matching 16% above target on the previous quarter.

# Carers & Allied Health Professionals

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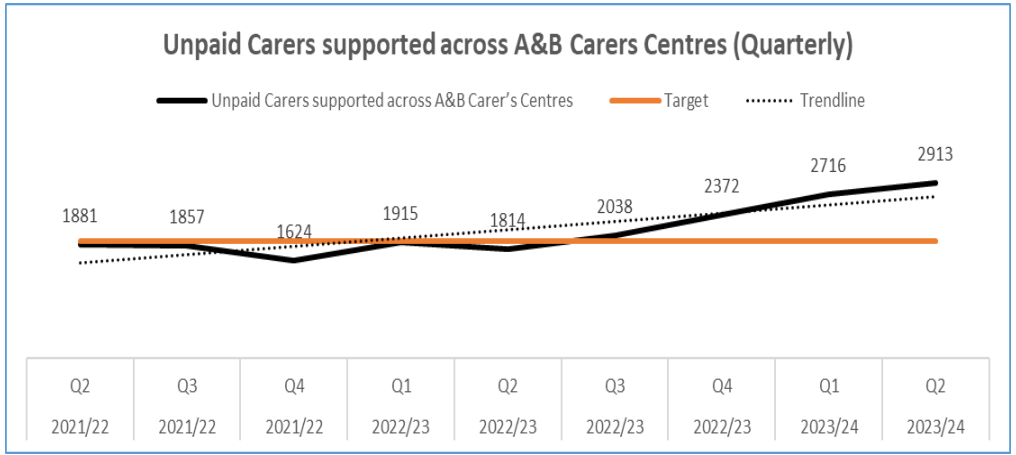
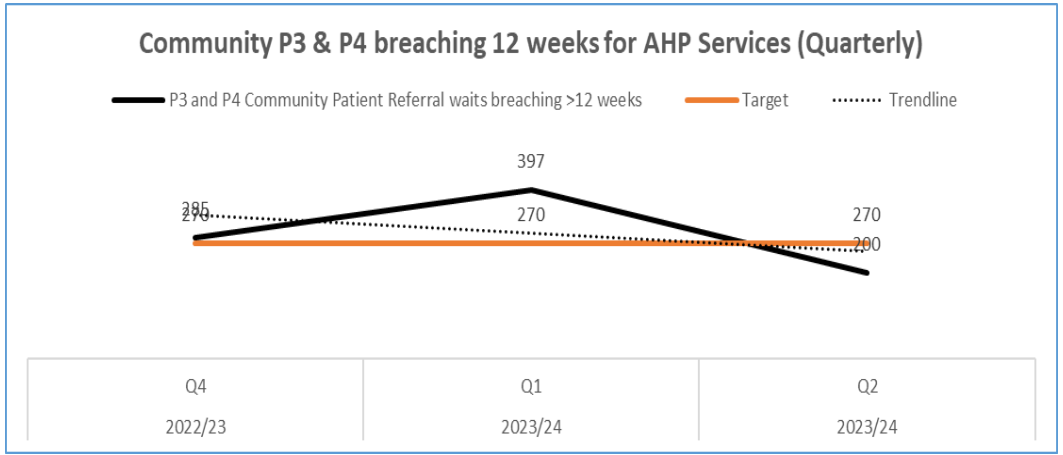
**Across 11 KPI, Carers / AHP services performance notes 7 (64%) on track, with 4 (36%) off track against the targets set. This is an increase from 36% on track reported (+28%) variance on the previous quarter performance.**




**Performance on or above target**:

- The number of Unpaid Carers Supported / Registered across A&B's Carers Centres continues to increase. As reported last quarter, there has been a change to the data collection from the Carers Centres. For consistency the numbers used to define performance are those that are currently registered by the Carers Centres. In the new financial year the Target will be revised to reflect this change in reporting.
- There has been a slight increase in the number of completed Adult Carer Support Plans this quarter and this is now on target.
- AHP Outpatient Completed Waits have increased 5% this quarter.
- The rate of New Outpatient AHP referrals seen as a proportion of all referrals seen continues to be on track. The current rate of 30% well above target set (25%).

**Performance below target & areas for improvement:**

- Young Carers Statements Completed have decreased recently although up on last quarter. Relative to retrospective quarterly data in 2021/22 and 2022/23 the current quarterly figure is consistent or slightly higher. This target will need to be revised due to the unique aspects of gathering information from Young Carers.
- AHP Outpatient Referral Waits breaching 4 weeks for MSK (Muscular Skeletal) have increased again this quarter – up 19% from last quarter. Those breaching 12 weeks is also off-track this quarter.

# Care at Home & Care Homes

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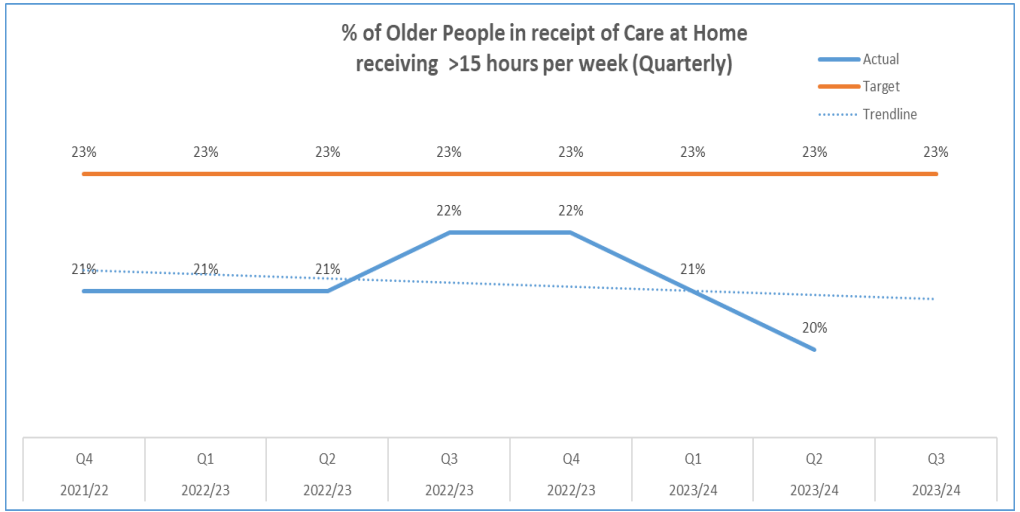
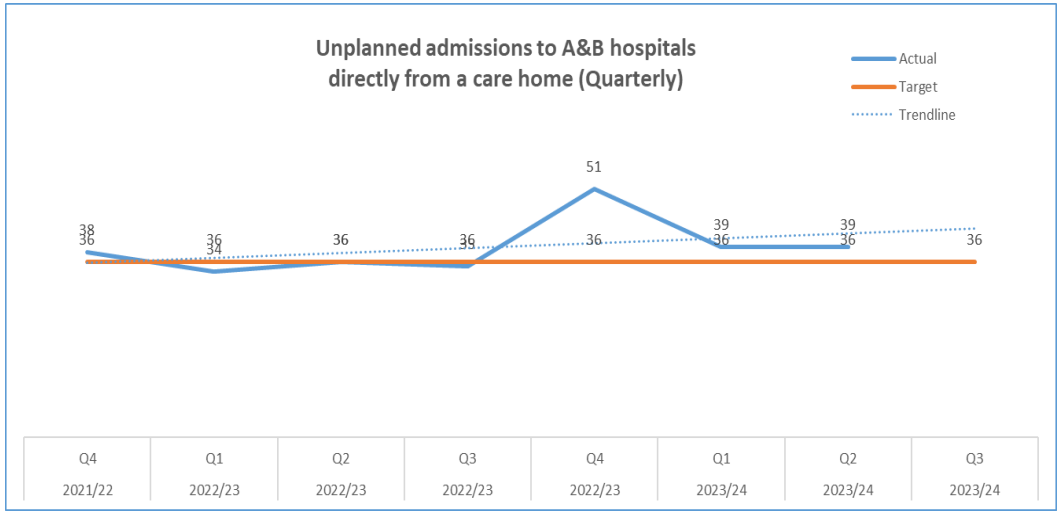
**Across 7 KPIs, Care at Home/Care Homes performance notes 2 on track, with 5 off track against the targets set in Q2 23/24. This is an overall increase of 29% as all KPI in Q1 were reported as off track.**




**Performance on or above target**:

- Percentage of Priority 1 & 2 referrals for a Care at Home service completed within the target response timescales
- Percentage of Older people in receipt of a Care at Home service with a Universal Adult Assessment competed at their 6 week point **(Please note that both these indicators will be further developed as part of the annual KPI review process, this is a result of the move to Eclipse Case Management and a different process to count and record assessments and referrals. The annual KPI review will begin in FQ3 2023/24)**

**Performance below target & areas for improvement:**

- The % of Older People who waited > 6 months for their homecare monitoring review to be completed has continued to increase slightly – Q2 is 2% up on Q1 – and is now 22% above target.
- Performance on % of Older People receiving nursing care home service has remained static over a year and is still 9% below target
- Occupancy rates across A&B care homes continue to improve (4% up on Q1) but still 5% below target.

# Learning Disability & Mental Health

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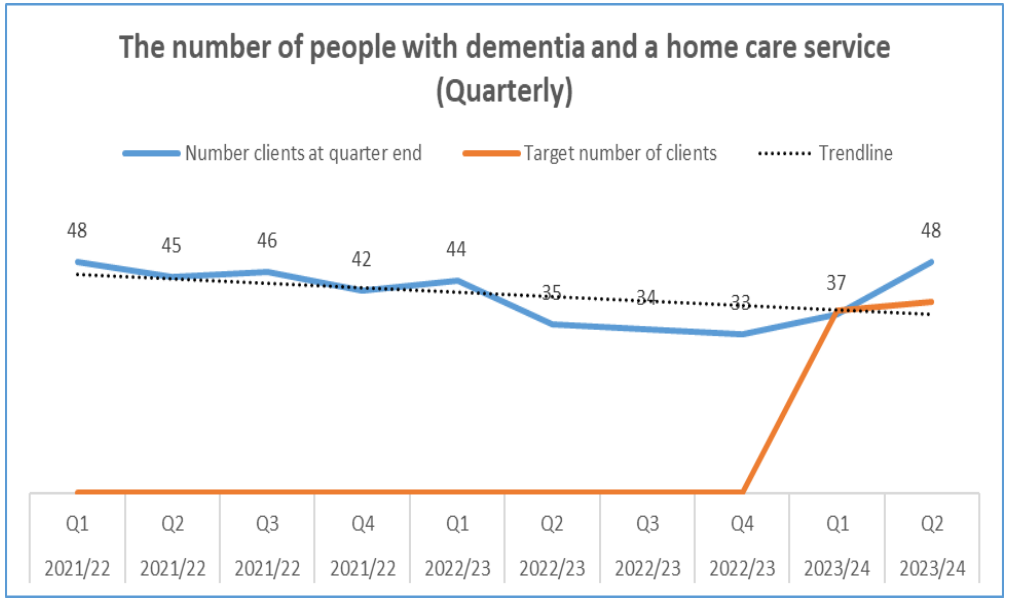
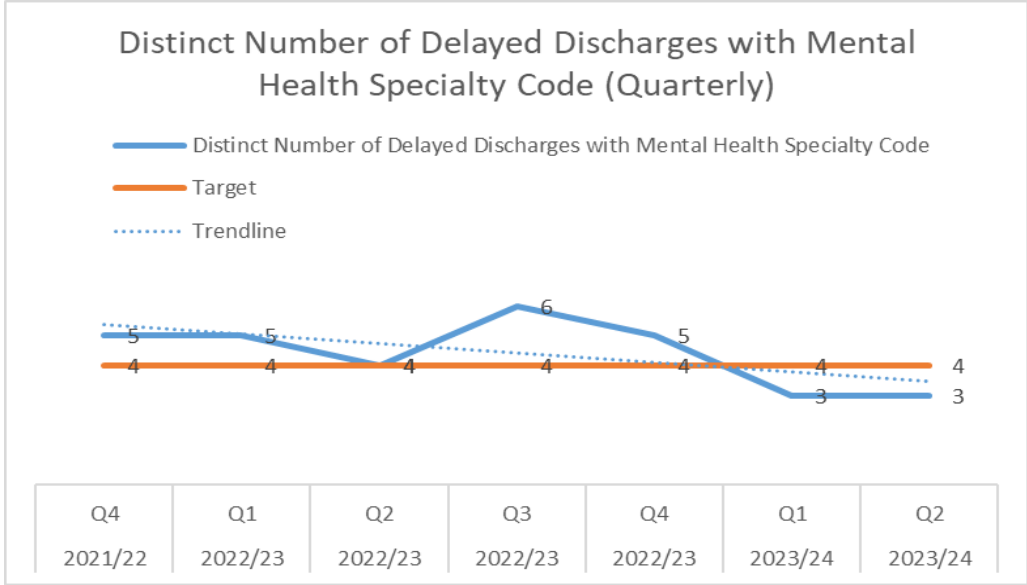
Argyll & Bute Health & Social Care Partnership

**Across 21 KPI, Learning Disability / Mental Health/ ASP (Adult Support and Protection) / ADP performance notes 14 (67%) on track, with 7 (33%) off track against the targets set. This is an increase from 52% on track reported (+15%) variance on the previous quarter's performance.**




**Performance on or above target:**

- There has been a gradual increase recently in the number of people with dementia supported by a Care at Home service. Since the last quarter it has risen by 11 (30%) to 48.
- The Dementia teams have also increased the number of people with needs assessed via Universal Adult Assessments. This has increased from 15 to 24 over the quarter (+60%).
- The number of referrals received for Post Diagnostic Support has also significantly increased this quarter rising from 26 to 62 (+138%).

**Performance below target & areas for improvement:**

- The number of people waiting more than 12 weeks for a new Mental Health Outpatient service has been increasing slightly over recent quarters. At Q2 2023/24 there were 440 waiting, an increase of 5% on previous quarter.

# Health & Wellbeing Outcome Indicators & Ministerial Steering Group Integration Indicators

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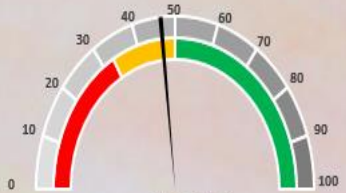
**The latest data in relation to 26 HWBOI and MSG Indicators reports 46% on track, with 12 on track and 14 off track.**

| ARGYLL & BUTE TOTAL | |
|---|---|
| ON TRACK | 12 |
| OFF TRACK | 14 |
| Awaiting Data | 0 |




46%

PERFORMANCE ACROSS ARGYLL & BUTE