Agenda Item 3

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**26 March 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 the performance, quality and workforce metrics based on the latest information available.

- The performance information is presented to the Finance, Resources and Performance Committee for consideration before being presented in the Board IPQR.
- The Clinical Governance information is presented to the Clinical Governance Committee for consideration before being presented in the Board IPQR.
- The workforce information is presented to the Staff Governance Committee for consideration before being presented to the Board.

2.1 Situation

In order to allow full scrutiny of the intelligence presented in the IPQR the 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. The Local Delivery Plan standards have also been included.

For Board consideration, we have incorporated a test of change as agreed through the Blueprint for Good Governance bringing patient experience into the IPQR, starting with Cancer services. Moving forward we will spotlight some key areas through this approach if agreed.

2.2 Background

The IPQR is an agreed set of 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	

Given the number of areas where performance has decreased and the impact on outcomes for our population then limited assurance is proposed.

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

The Board IPQR, of which this is a subset, 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 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 accept limited assurance and to note the decreased performance across most areas of our system.
- To consider the newly incorporated patient experience slide as a test of change with regards to information displayed for consideration in other areas of interest for future Boards.

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – March 2024

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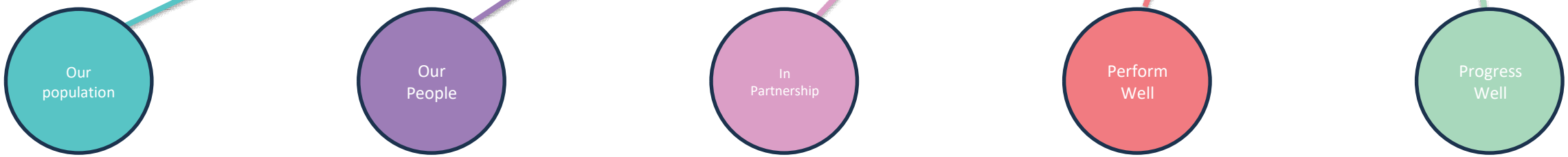
Integrated Performance & Quality Report

NHS Highland Board
26th March 2024



Executive Summary of Performance

Area	Current Performance	ADP Trajectory Met	Performance Rating	National Target	National Target Met/Not Met
Vaccination Performance	56.6%				
Smoking Cessation			Decreasing – 2 months of decreased performance	n/a	Not met <10%
CAMHS	67.5%	No target agreed	Decreasing – 2 months of decreased performance	90%	Not met >10%
Emergency Access	79.3%	Not met	Stable	95%	Not met >10%
Treatment Time Guarantee	56.6%	ADP and long waits not met	Variation – 1 month of increased performance	100%	Not met >10%
Outpatients	41.2%	ADP trajectory met but long waits increasing	Decreasing – 2 months of decreased performance	100%	Not met >10%
Diagnostics - Radiology	63.3%	Met	Variation – 1 month of decreased performance	80% (Mar 24)	Not met <10%
Diagnostics – Endoscopy	71.4%	Met	Stable	80% (Mar 24)	Met
31 Day Cancer Target	93.2%	Not Met	Variation – 1 month of improved performance	95%	Not Met <10%
62 Day Cancer Target	65.7%	Not Met	Variation – 1 month of improved performance	95%	Not Met >10%
Psychological Therapies	81.6%	No target agreed	Improving – 2 months of improved performance	90%	Not met <10%
Delayed Discharges	213 at Census	Not met	Decreasing – 3 months of decreased performance	n/a	n/a

Guide to Performance Rating

- Stable if no improvement or decrease has been seen but overall positive performance
- Improving is 2/3 months of improved performance
- Decreasing – 2/3 months of decreased performance
- Variation – Inconsistent pattern of performance/not meeting target

The above is a summary of performance where national target or ADP trajectories are agreed and do not cover the full content of this Integrated Performance and Quality Report

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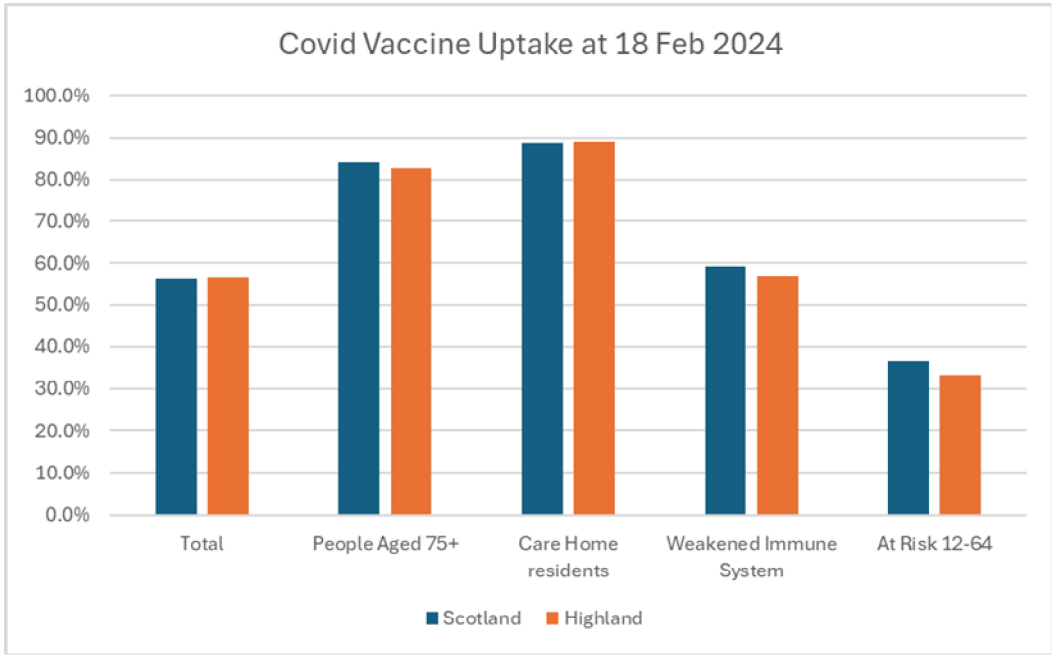
Exec Lead
Dr. Tim Allison, Director of Public Health

Vaccination Performance

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
•The autumn/winter COVID and 'Flu vaccination programme has been delivered by Board staff except for some islands where there has been practice delivery. This programme is designed to reach those more at risk of illness. •Overall COVID & 'Flu uptake has been reasonable, but the quality of service requires improvement in Highland HSCP regarding issues including workforce and access. This is also the case for other vaccination programmes.	• Work is being undertaken with Scottish Government and Public Health Scotland to improve the quality of delivery in Highland HSCP. Changes include consideration of the design of a service based on district teams. • Preparations need to be made for new vaccine programmes.	• Implementation of spring COVID vaccination programme • Improvement in uptake of childhood vaccination

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

Latest Performance	56.6%
National Benchmarking	55%



Comparative Covid vaccine uptake for all eligible people at 18/02/24:

NHS Board	Covid
Ayrshire & Arran	60.5%
Dumfries & Galloway	64.0%
Fife	56.6%
Grampian	58.5%
Highland	56.6%
Tayside	60.8%

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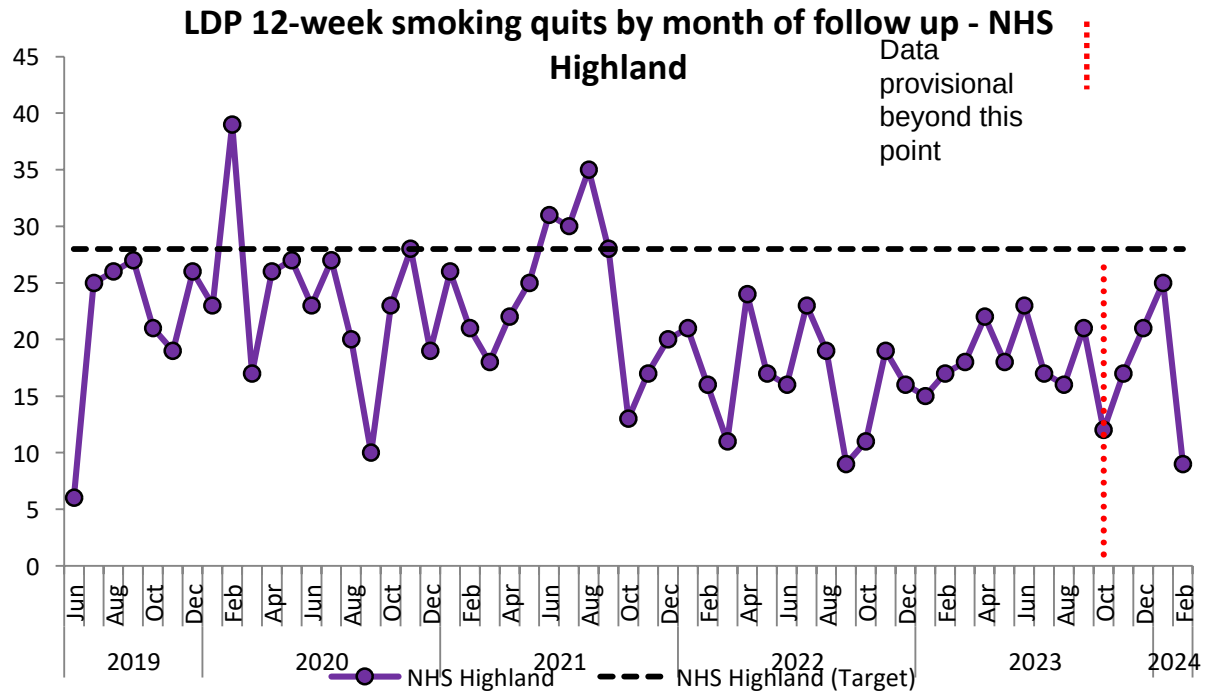
Dr Tim Allison, Director of Public Health

Smoking Cessation

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Training on the SOPs to improve Community Pharmacy data has been delivered to 56% of advisers. • Advisers have now visited all assigned Community Pharmacies and relationships are being built. Community Pharmacy training has been piloted with 3 Community Pharmacies and this can now be rolled out. • Additional adviser capacity in outpatients Raigmore and training with pre-assessment being planned.	• SOP training to remaining advisers • Promote additional service in outpatients at Raigmore Hospital, set up meetings with clinical staff. • Roll out training to Community Pharmacies.	• Review end of March 2024 • 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. • Mapping of smoking cessation services to NICE guidance. • Mapping of smoking cessation services to recommendations from Review of Smoking Cessation Services in Scotland and Scottish Government 2-year Tobacco Action Plan

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
ADP Trajectory Agreed	Yes
ADP Trajectory	Below Target
Performance Guide	Decreasing



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Exec Lead
Katherine Sutton
Chief Officer, Acute

Child & Adolescent Mental Health Services

What we said in December IPQR?

- Ongoing recruitment to substantive posts, additional nursing and psychiatry staff looking for employment.
- Recruit psychology workforce from current trainees with expected start date of October 2024
- Workforce diversification whilst protecting discipline specific critical floor
- Finalise workforce/finance plan
- CAPTND data set capture system to work with eHealth as currently delayed

What we have completed and impact?

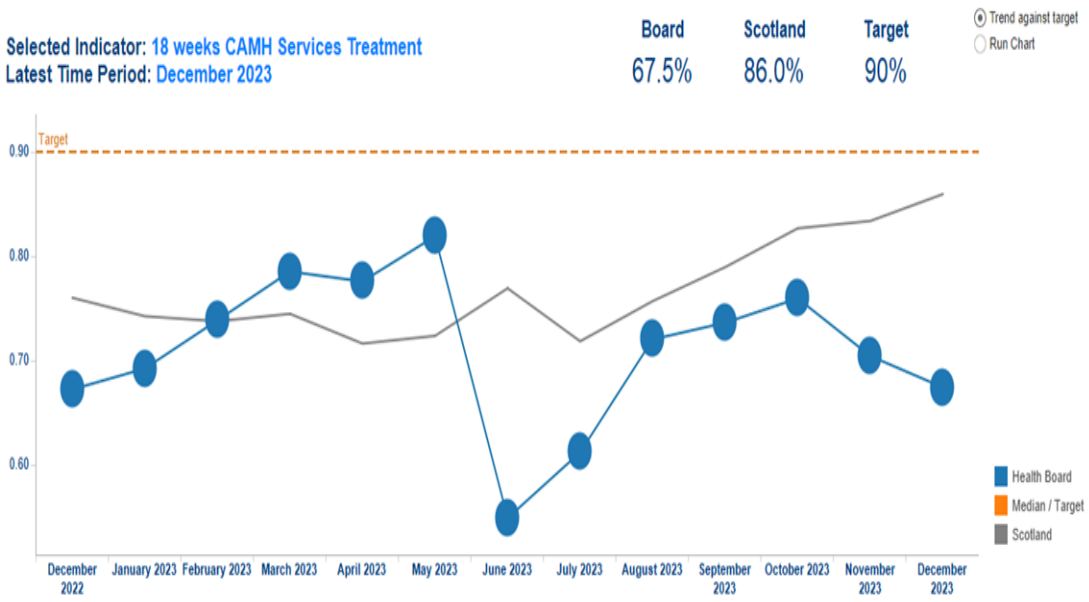
- Recruitment paused due to late allocation of MHOF and NHSH financial position. Slows rate of reduction in long waits.
- Loss of psychiatrist within team, no locum cover. Slows rate of reduction in long waits.
- Group interventions commenced, greater efficiency in treatment delivery.
- Improved leadership and systems in core wait list management resulting in increased flow and lower waiting times.
- Impact of previous actions continuing with reductions in longest waits (9% reduction from December to January)
- Wait times in A & B continue to rise and will impact on total NHSH waiting times position.

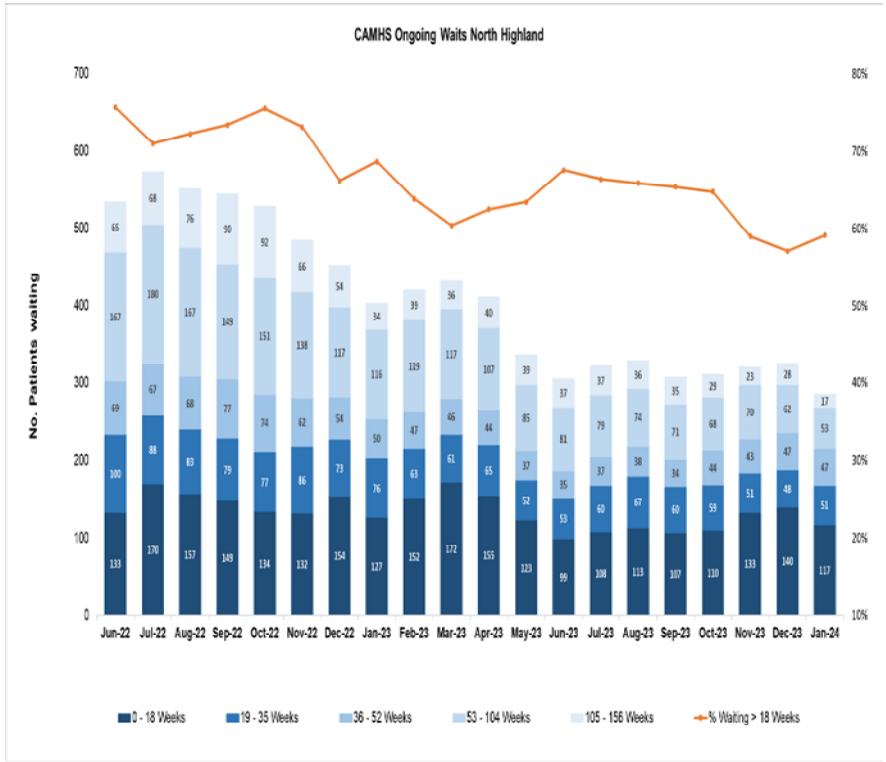
Next Steps to Improve by June 24

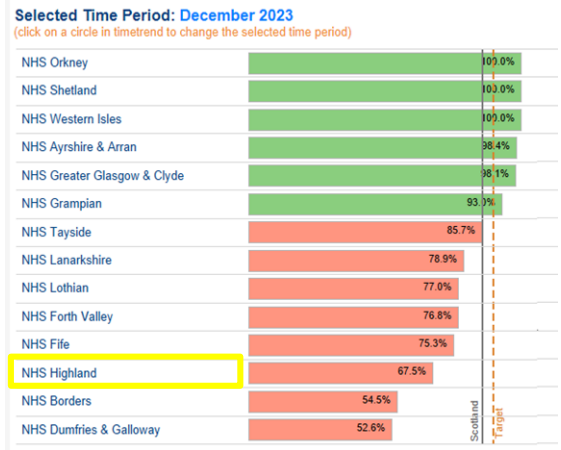
- Core Team model & systems change continuing, increased efficiency and flow, wait list scrutiny. Requires changes to Trak care. Accurate data is an issue that the team continue to work on.
- Modelling for intensive home treatment continues. Requires additional workforce to implement.
- Efficiency and 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.

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

Latest Performance	67.5%
ADP Trajectory Agreed	To be agreed
Performance Rating	Treatment time not met but 9% decrease in long waits, Dec to Jan
National Benchmarking	Lower than Scottish Average >10%
National Target	90%
National Target Achievement	Not Met >10% 12th out of 14 Boards







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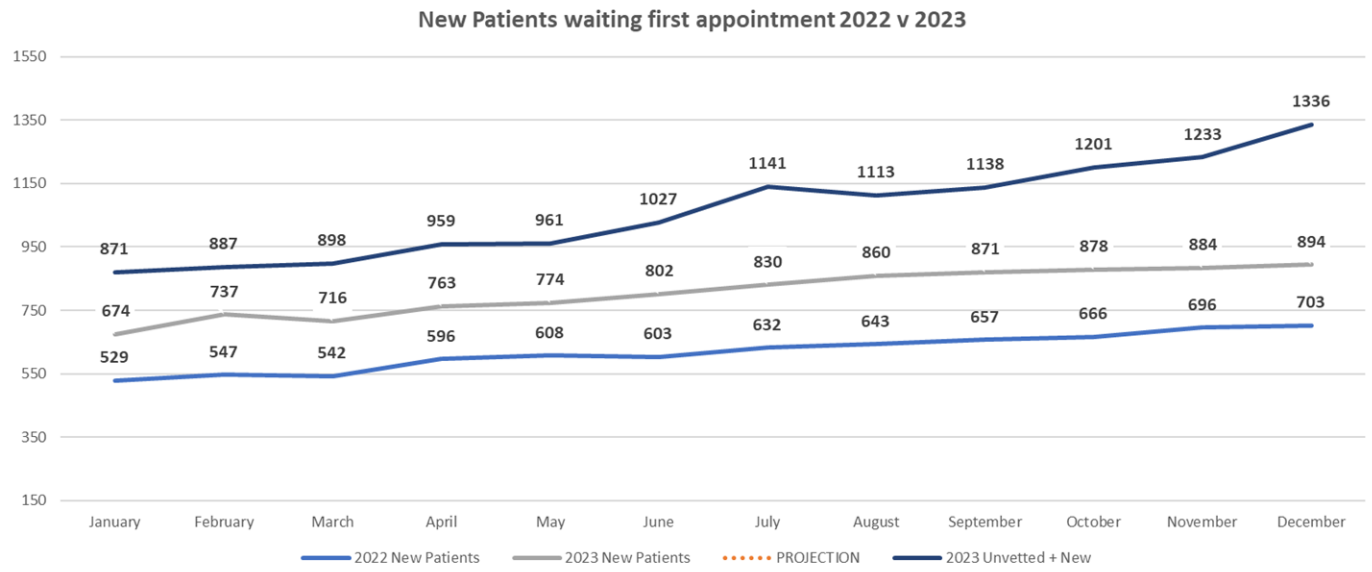
Exec Lead
Katherine Sutton
Chief Officer, Acute

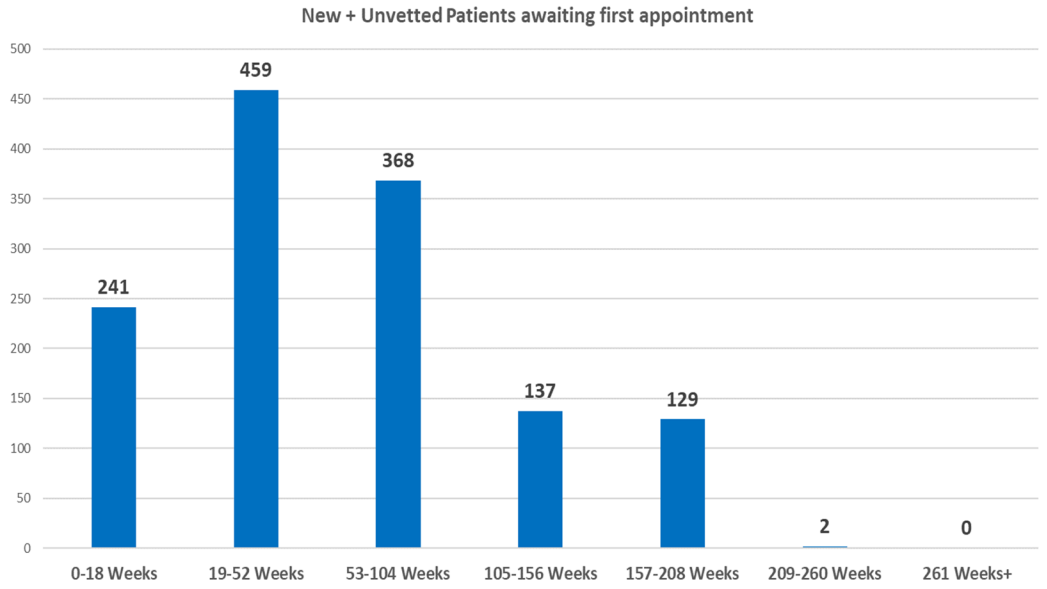
Neurodevelopmental Assessment Service

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Develop plan based on the report with clear milestones, roles and responsibility • Interim strategic clinical leadership to be appointed until requirements are clear to be compliant with the national spec • Development of integrated arrangements to support child planning to support early access with a family support plan • Working with Public Health, GPs and Secondary care to address wider holistic support to healthy living for children including sleep and nutrition • Adopt the Scottish Approach to service design as a solid framework to develop the plan towards safe and sustainable services for Children	•MDT meeting 18/12/13. Education and Learning now aware of the challenge/risk and committed to contribute to improvement activity. •Improvement Plan reviewed and updated to incorporate new ICSP level actions.. •Interim Head of Psychology CAMHS to provide strategic clinical leadership , working in partnership with CAMHS leadership, Community Paediatrics Leadership and Paediatric AHP Lead. •NDAS Model – recommendations for change confirmed. •Waiting list cleansing exercise mapping of CYP referred by N.P, with school rolls completed. •Clinical dashboard to support clinical modelling developed and tested.	•Authority Framework is in place. Scottish Approach for Service Design is adopted at an ICSP level. •Programme Lead is confirmed. •Programme Manager resource is in place. •Discovery Phase is completed. •ICSP ND Programme .Board is established and has met. •NDAS Model update completed and in practice. •NDAS Eligibility Criteria reviewed, updated and in practice. •Waiting list cleansing exercise is completed. •ICSP GIRFEC and Child Planning training for MDT`s rolled out.

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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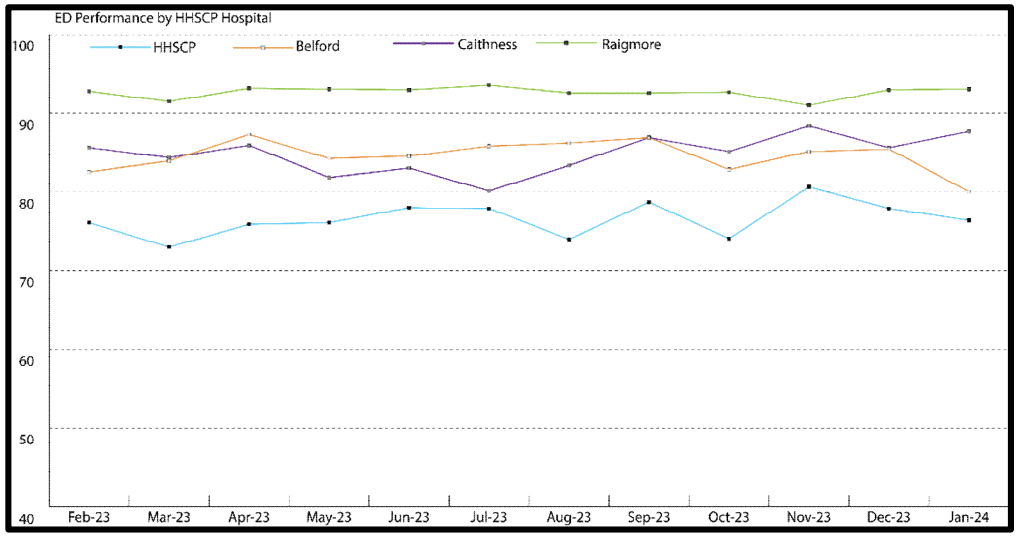
Exec Lead
Katherine Sutton
Chief Officer, Acute

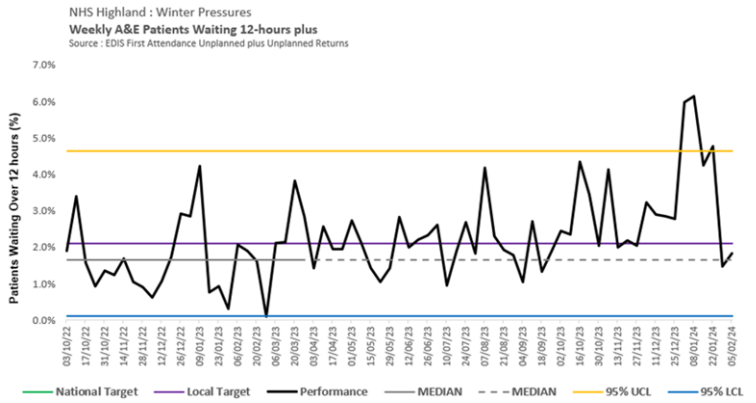
Emergency Department Access

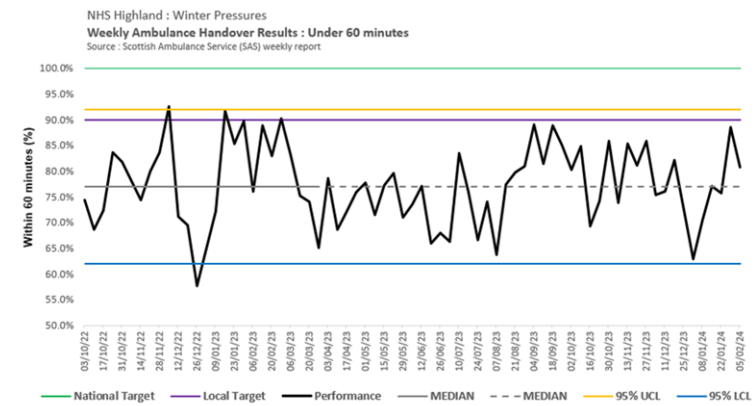
What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Improve the 4-hour access standard by optimising patient flow in MIU, increasing Flow Group 1 performance from 90% to >95% (currently 91%) (ongoing) • Extended test (4 weeks) to be agreed for Safe Transfer Hospital • 24/7 patient Flow cover • 7/7/ Discharge Lounge	Discharge Lounge staffed and open 6 days per week SAS median turnaround maintained under 60 minutes 24/7 Flow cover in place This has supported the reduction of SAS waits over 3hrs, the median SAS TAT and has reduced the average time for a Phased Flow patient receiving corridor care to 20 minutes.	• No ED wait over 18hrs • No SAS wait over 3 hours • Discharge Lounge on Trak to collect data • Phased Flow extended to 5pm

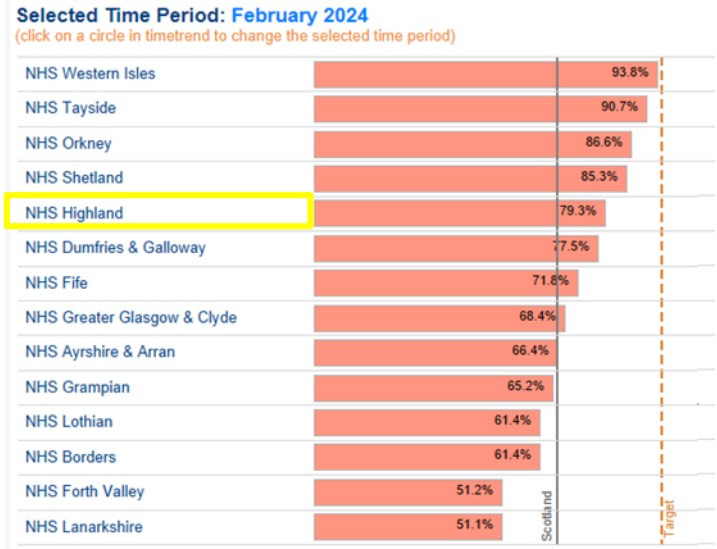
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Latest Performance	79.3%
ADP Trajectory Agreed	80%
ADP Trajectory	n/a
Performance Rating	Stable
National Benchmarking	Higher than Scottish Average >5%
National Target	95%
National Target Achievement	Not Met >10%









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Exec Lead
Pam Cremin
Chief Officer, HHSCP

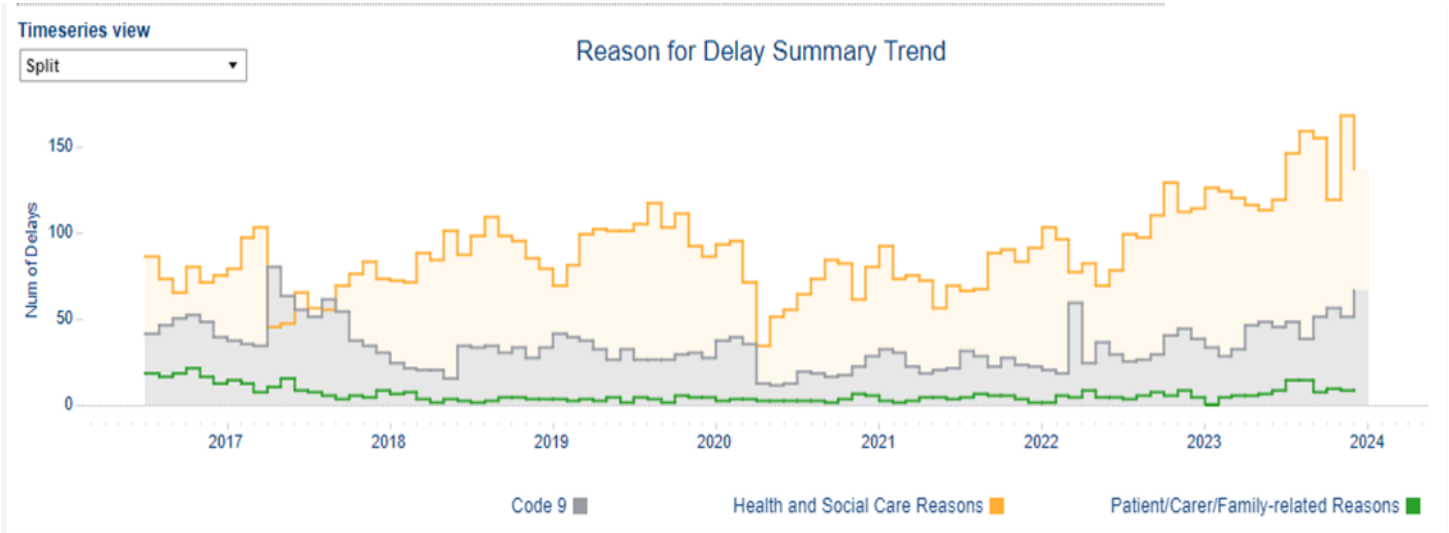
Delayed Discharges

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Implementation of Choice Guidance • Number of Intermediate care beds within AAE to be extended to 6 • Roll out of agreed pathway to all Districts to ensure enhanced working between ED and community • Roll out learning from Inverness Wrap Around Care developments • Continued development of the Discharge App, with the next version ready for final testing in wards 2C and 7A and all Districts in community commencing on 11th Jan 24. • Further roll out of the Discharge App	• Choice Guidance launched week beginning 19th Feb. • 4 intermediate care beds in AAE regularly utilised with additional 2 being planned for urgent admissions and planned respite when staffing permits. • Limited progress on rollout of learning from Wrap Around Care developments due to staffing pressures within the Districts • Communication pathway established between Raigmore ED and Single Point of Access within the Districts. The impact is releasing ED staff time to concentrate on direct care delivery and to reduce unnecessary social admissions • Testing of version 1.5 complete. Rollout Plan in place. Implementation date to be agreed. Anticipated impact is improved communication between acute and community and Mental Health. • Standard work for DHD identification, monitoring and coding in place.	• 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.

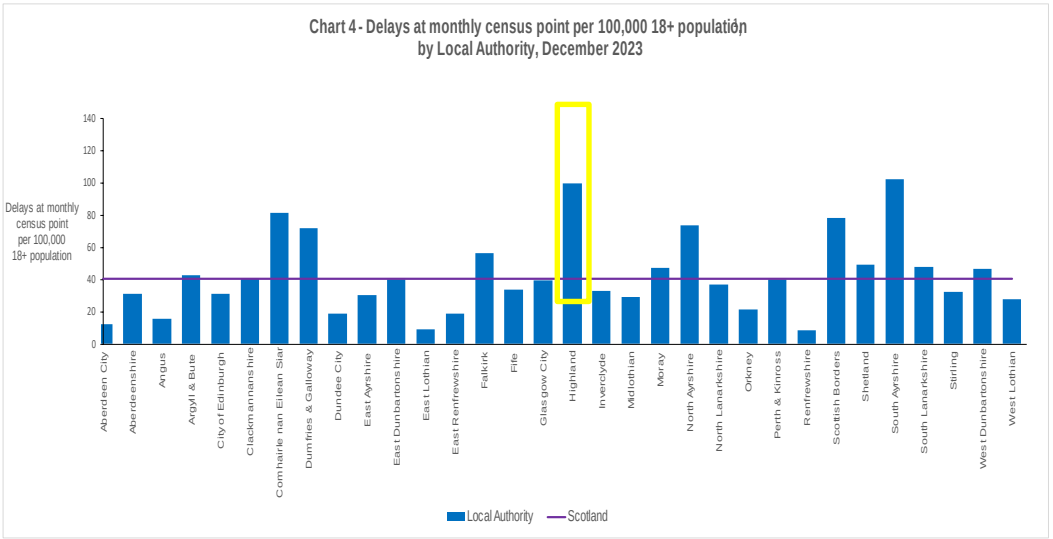
PERFORMANCE OVERVIEW
Strategic Objective: In Partnership
Outcome Area: Care Well

Latest Performance	213 at Census Point 6213 bed days lost
Target	95 DDs
Target Achievement	Not Met
Performance Rating	Overall we have increasing DDs
Performance Benchmarking	Highest in Scotland for DDs

Delayed Discharges in NHS Highland



Delayed Discharge - Benchmarking



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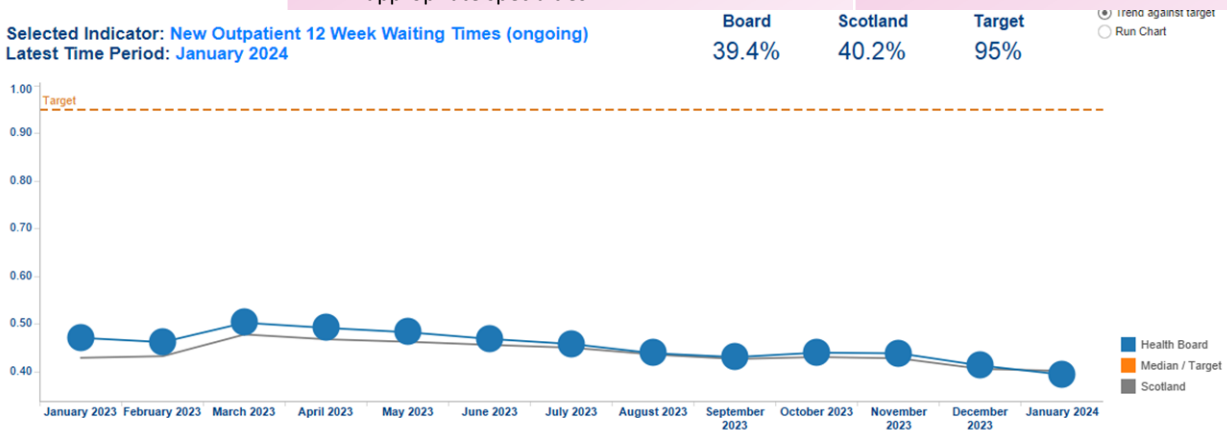
Exec Lead
Katherine Sutton
Chief Officer, Acute

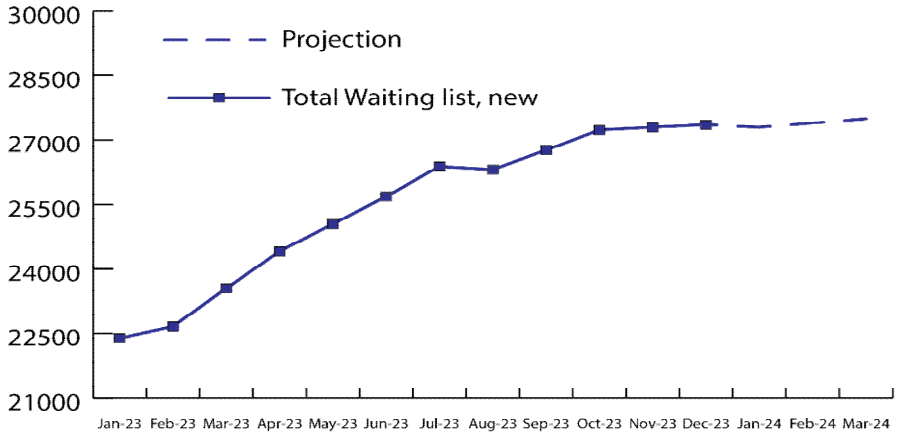
Outpatients (NOP Seen/12 week target)

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Identify specialities with increases in patient referral and ensure Patient Hub live and review ACRT processes against best practice • Re-evaluate patient and clinician satisfaction with Near Me • Maximise use of virtual activity • Clinic utilisation reporting to be made available to specialties to reduce DNAs/cancellations and unfilled appointments • Improve booking practices • ACRT and PIR full implementation by Mar 24 in appropriate specialties.	• Value and efficiency workstreams being developed • ISP in progress	• Agree ISP plans with activity for 2024/25. • Capacity planning to ensure sustainable staffing solutions in place to deliver planned care. • Continue with implementation of all efficiency measures

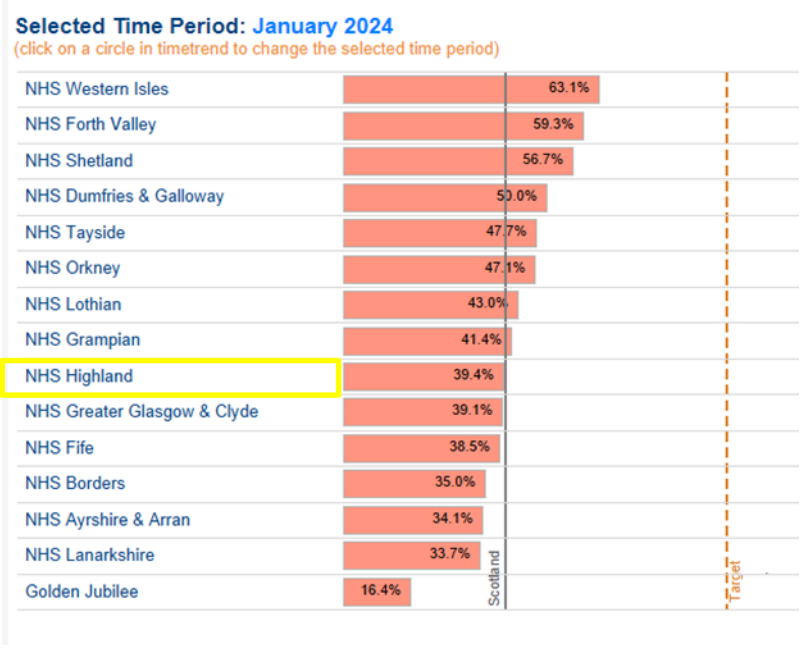
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	39.4%
ADP Trajectory Agreed	Yes
ADP Trajectory (NOP Seen)	Met
Performance Rating 12 Week Waiting Time	Decreasing
National Benchmarking	At Scottish average
National Target	95%
National Target Achievement	Not Met >10%





There are 3 areas reviewed by Scottish Government at present in terms of performance. These are 12 week WT, long waits and overall waiting list



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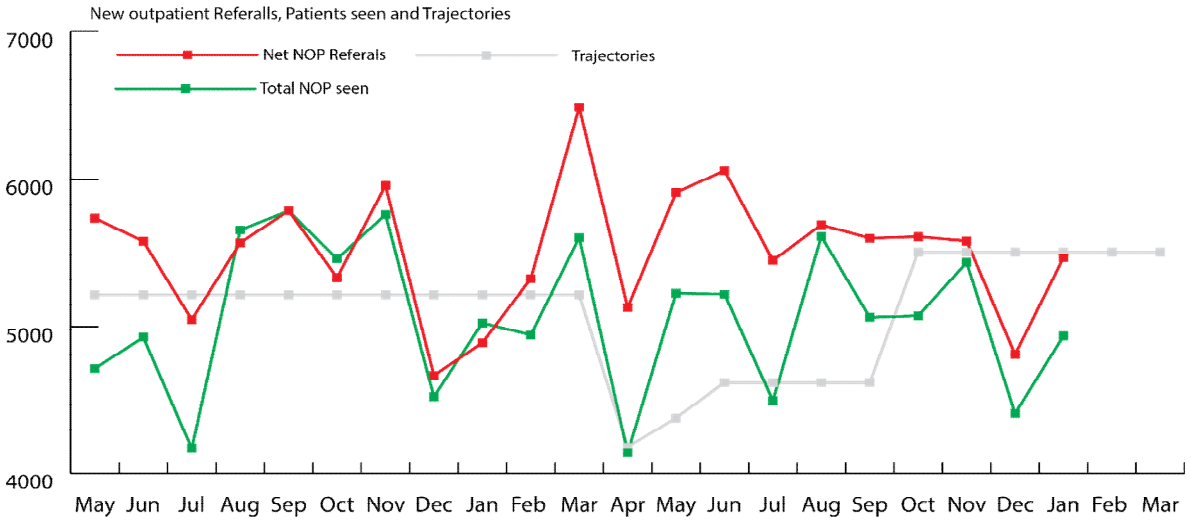
Exec Lead
Katherine Sutton
Chief Officer, Acute

Outpatients (ADP/Long Waits Target)

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Cumulative activity ahead of schedule • ACRT/PIR best practice processes developed • Patient Hub waiting list validation roll out on going • Specialties identified to improve Near Me use • Clinic timetable drafted • Outpatient workstream in place and working towards the above aims.	• Continue to work to deliver ADP trajectory • Patient Hub implemented, comms plan in progress. • Value and Efficiency Workstream commissioned and will support increased Near Me use	• Use of CFSD initiatives as no further financial support is possible • Use of ISP to address OP efficiency barriers to maximisation

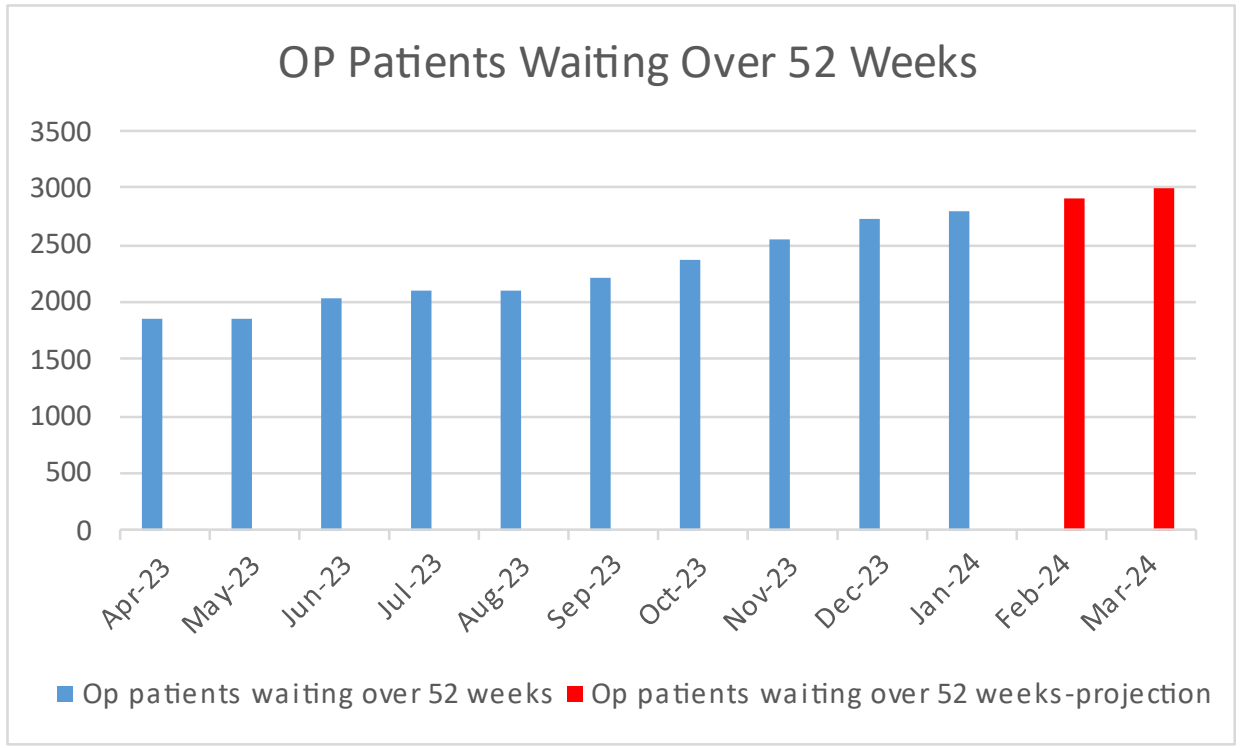
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	65%
ADP Trajectory Agreed	Yes
ADP Trajectory	Met
Performance Rating (ADP/Long Waits)	Decreasing as long waits will not be met
National Benchmarking	Higher than Scottish Average <5%



Yearly Trajectory	YTD Performance	Patients Seen- Jan 24	Overall
60,070	49,060 (82%)	49,615 (83%)	1% above target

The target for March 2024 is that no patient will wait longer than 1 year for an outpatient. This is forecasted to not be met



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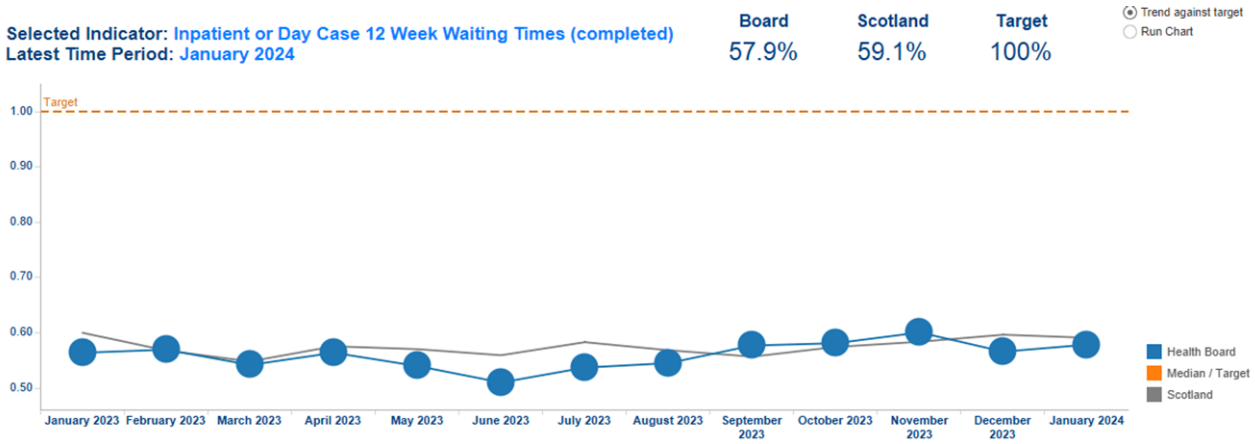
Exec Lead
Katherine Sutton
Chief Officer, Acute

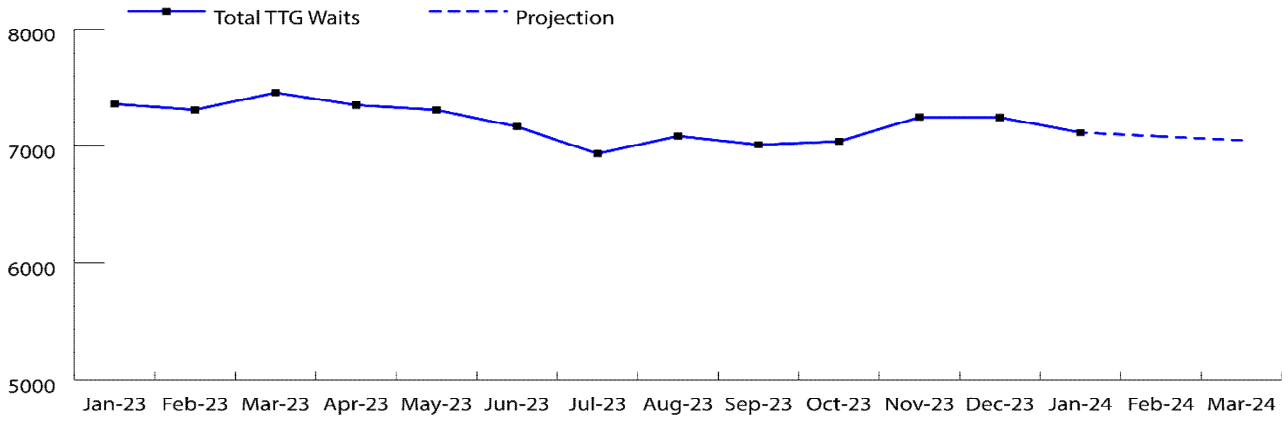
Treatment Time Guarantee (TTG 12 week target)

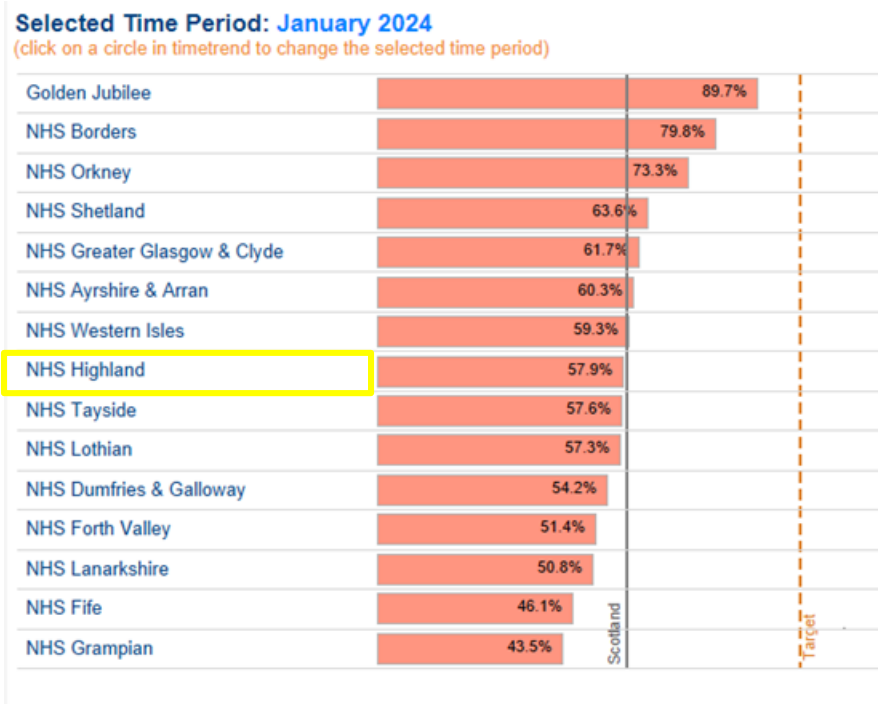
What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Communicate need for adherence to Local Patient Access Policy. • Redo local access policy • Need to improve standard work for booking practice. • Implement InFix. • Coded lists – Mar24 • Patient Hub rolled out Mar24	• Communicate need for adherence to Local Patient Access Policy. • Redo local access policy • Need to improve standard work for booking practice. • Implement InFix. • Undertake ISP planning process at a specialty level • Theatre efficiency activity	• Ward reconfiguration at Raigmore with dedicated day surgery area. • Ring fenced surgical beds in certain wards • Theatre efficiency to be owned at service and speciality level.

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

Latest Performance	57.9%
ADP Trajectory Agreed	Yes
ADP Trajectory	Not met
Performance Rating 12 week waiting time	1 month of improvement
National Benchmarking	Lower than Scottish Average <5%
National Target	100%
National Target Achievement	Not Met >10%







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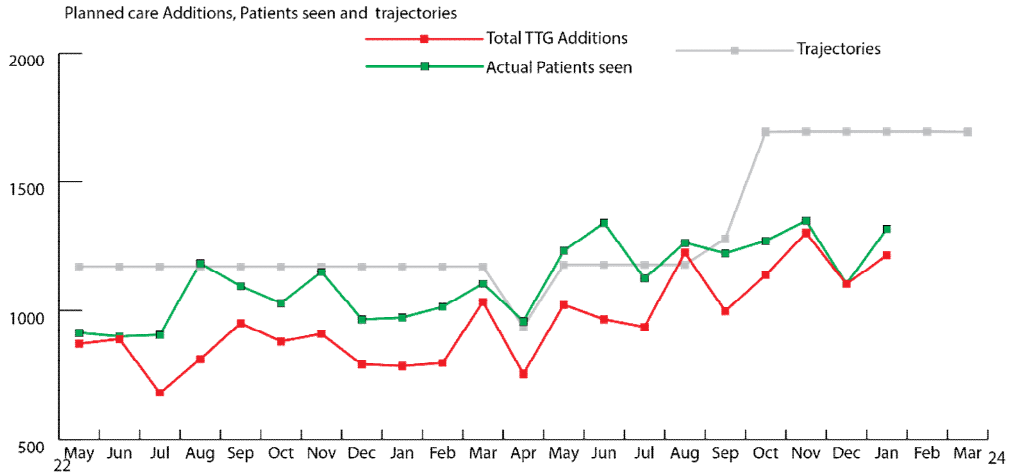
Exec Lead
Katherine Sutton
Chief Officer, Acute

Treatment Time Guarantee (TTG Seen/TTG Target)

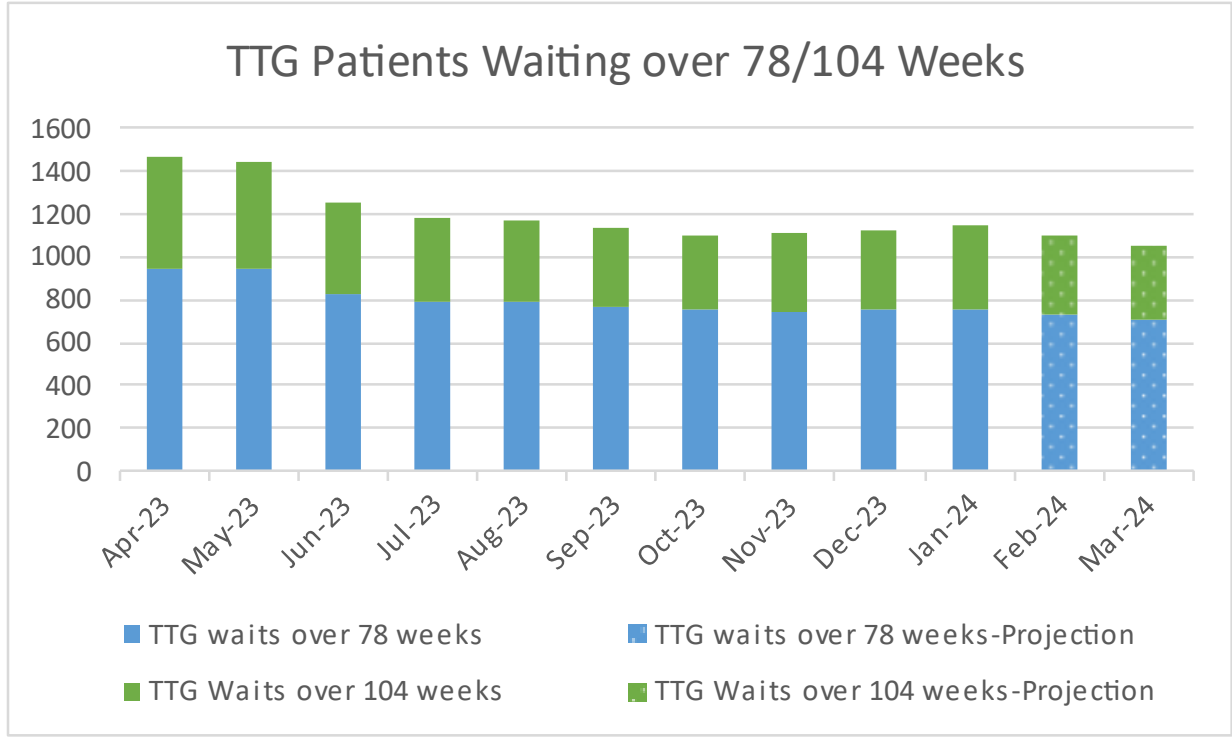
What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
We would continue to aim to reduce the numbers of patients waiting over 78 / 104 weeks to access service. Apply access policy and access capacity at RGHs. Due to financial constraints we would have to reduce overall theatre capacity available in Raigmore.	• We have seen a total of **12179** TTG patients from April until January of which **3775** were inpatients and **8404** Day Cases. In January **1217** patients were added to the TTG waiting list in January and we have seen **1318** showing a reduction on the overall waiting list of **129** patients to 7114 patients waiting.	• Continue to ensure waiting lists are cleansed and patients are being clinically prioritised • Improve utilisation of NHS Highland theatre capacity across all sites.

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

Latest Performance	57%
ADP Trajectory Agreed	Yes
ADP Trajectory	Met
Performance Rating (ADP/Long Waits)	Decreasing as long waits will not be met



Yearly Trajectory	YTD Performance	Patients Seen- Jan 24	Overall
17,114	13,722 (80%)	12,179 (71%)	9% behind target



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Exec Lead
Katherine Sutton
Chief Officer, Acute

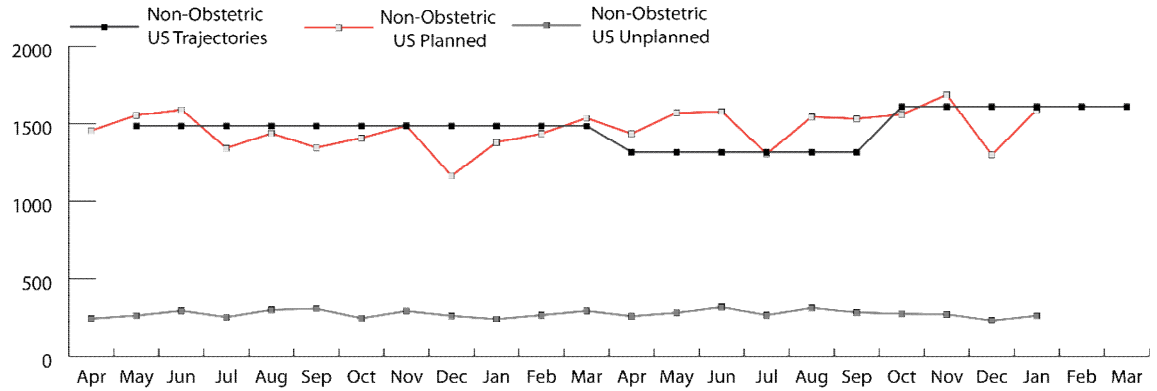
Diagnostics - Radiology

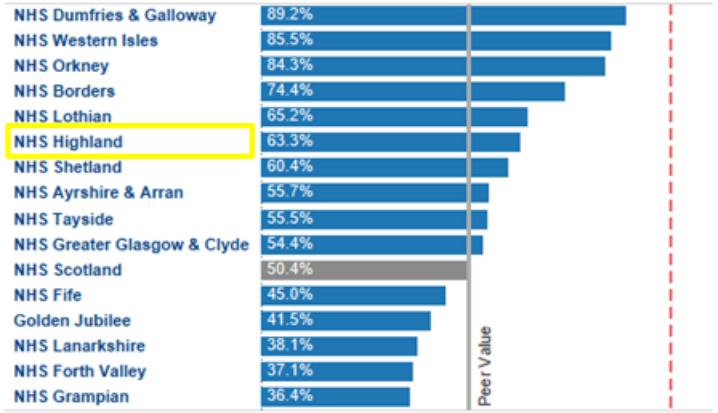
What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Continued review of inpatient/emergency access to radiology balanced with planned care • Modelling on MRI being collaboratively done with the Research, Development and Innovation Directorate • Development of Board wide diagnostics strategy	• Continued to manage within capacity available • Modelling regarding MRI is continuing • Further work required to develop the Board wide Diagnostic Strategy. • Go live with "ReconDL" AI system to provide increased throughput of MRI imaging • Recruitment of shared Radiographer posts between main Dept and Breast Service	• ISP will progress and assess the potential capacity available to deliver within financial constraints.

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

Latest Performance	63.3%
ADP Trajectory Agreed	Yes
ADP Trajectory	Met – 68.6%
Performance Rating	Decreased since previous IPQR
National Benchmarking	Higher than Scottish Average
National Target	80% by March 2024
National Target Achievement	Not Met >10%

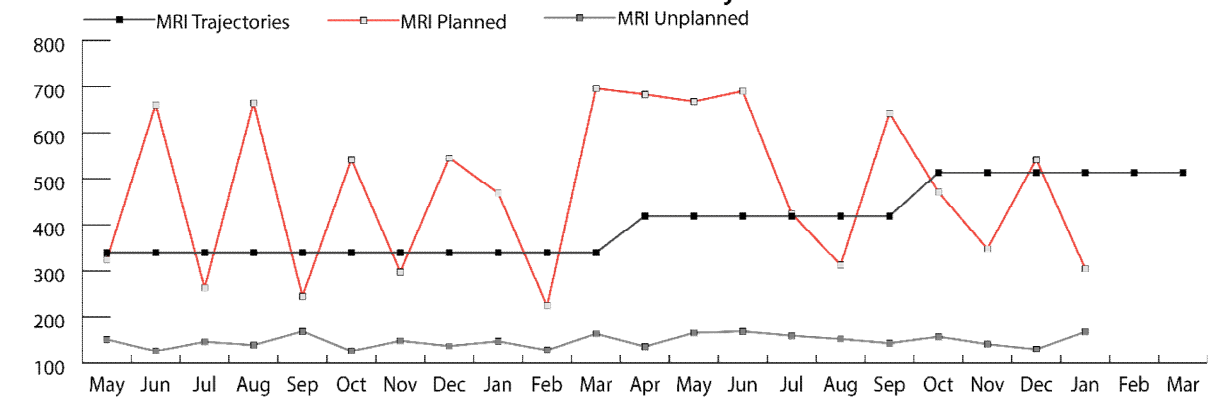
Non-Obstetric Patients Seen & Trajectories



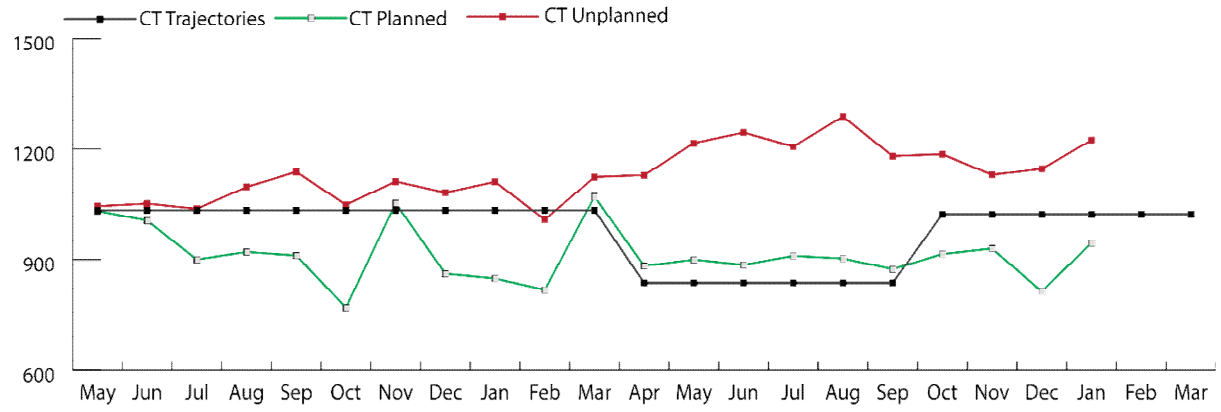


Yearly Trajectory	YTD Target	Patients Seen-Nov	Overall
34,632	28,282 (81.66%)	29,308 (84.63%)	2.96% over target

MRI Patients Seen and Trajectories



CT Patients Seen and Trajectories



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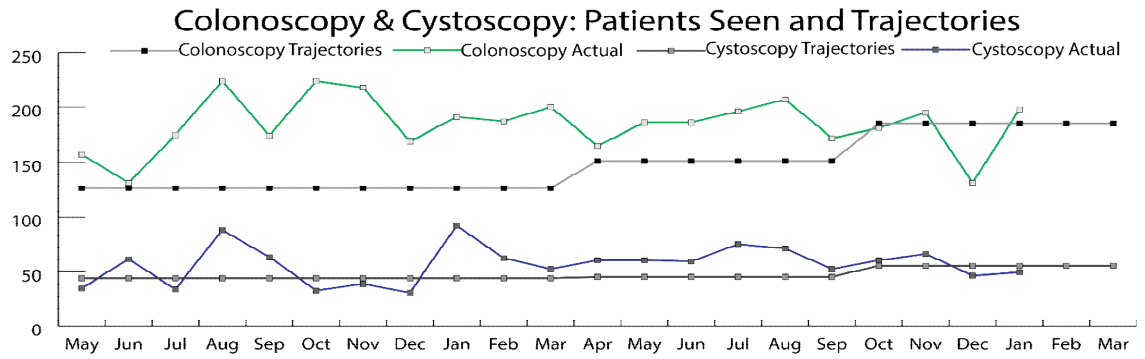
Exec Lead
Katherine Sutton
Chief Officer, Acute

Diagnostics - Endoscopy

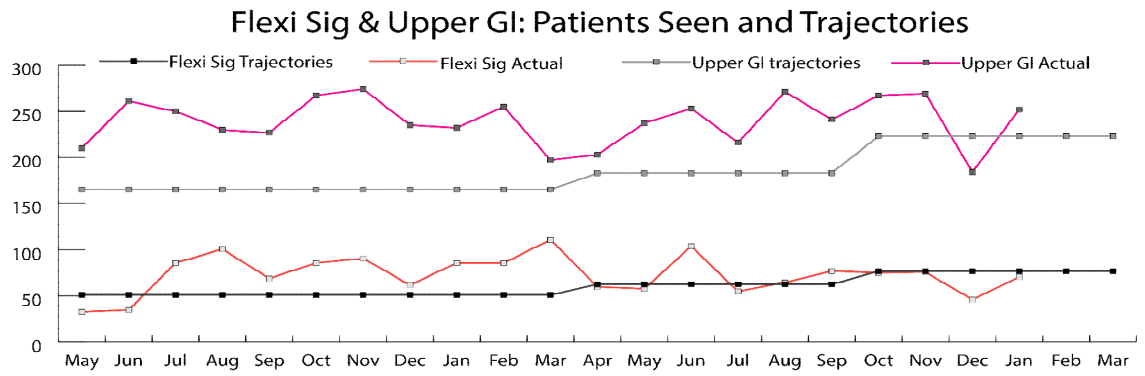
What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• JAG Accreditation assessment in Feb 24	• JAG accreditation assessment on 21st March 2024. Impact: recognition of quality measures being achieved • Updated version of formstream request sent to Ehealth 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	• 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). **Please note this when benchmarking.**

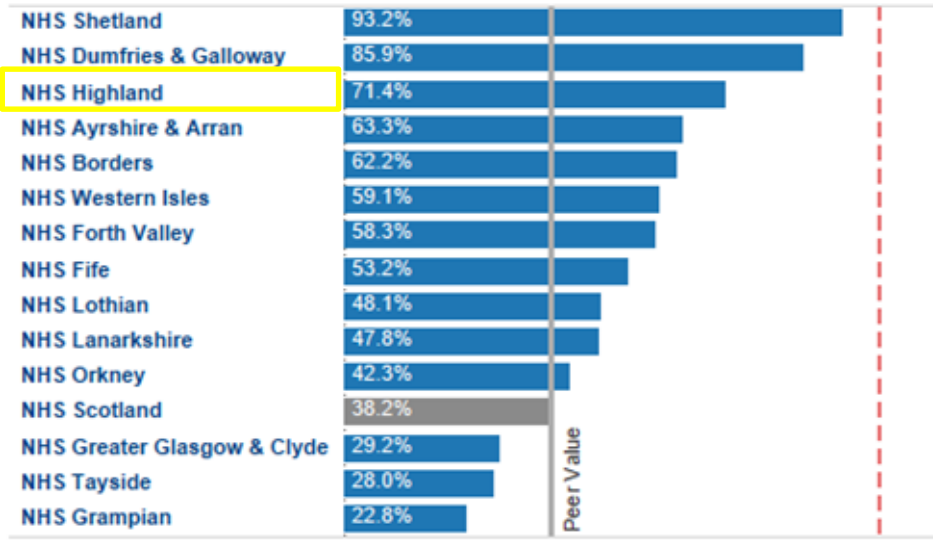
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	71.4%
ADP Trajectory Agreed	Yes
ADP Trajectory	Met – 56.2%
Performance Rating	Stable
National Benchmarking	Higher than Scottish Average
National Target	80% by March 2024
National Target Achievement	Not Met <10%



Yearly Trajectory	YTD Target	Patients Seen-Nov	Overall
5,892	4,812 (81.67%)	5,495 (93.26%)	11.59% over target





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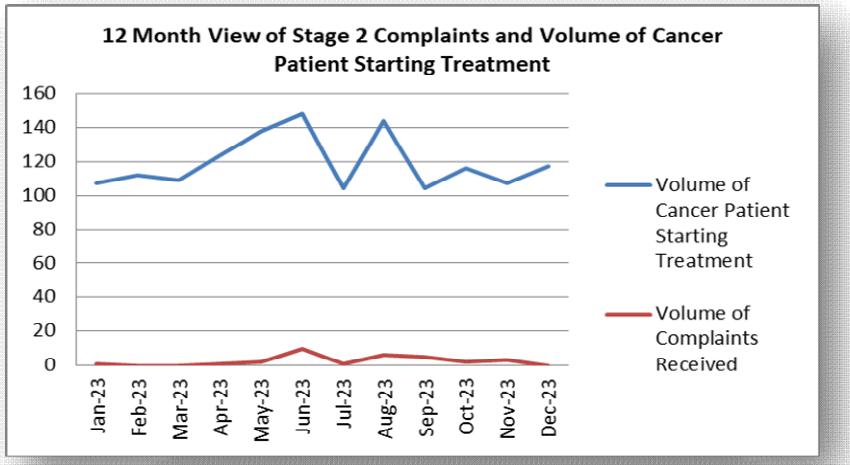
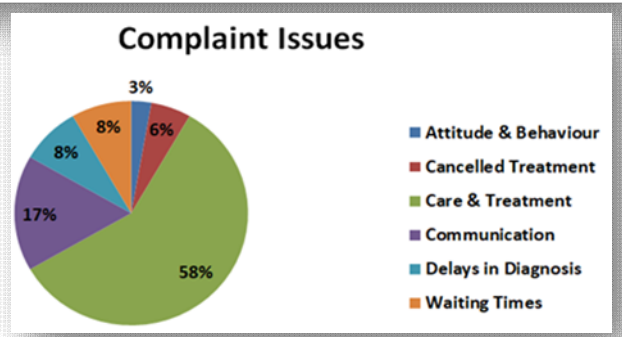
12 Month View of Complaint and Feedback Activity: Patient Experience

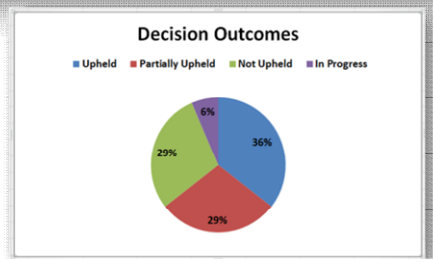
Progress Made	Next Steps	Timescale
• Bespoke complaints area of QPS Dashboard near completion	• Analysis on Actions and impacts	• April 2024

Over 12 months, 6 compliments have been registered in Datix

Over the 12 month period 1430 patients started cancer treatments. 2% of patients submitted a complaint. 42% of complaints were responded to in the 20 working day target.







NHS Highland – Taking Action To Drive Continuous Improvement

The Patient Said..
There has been poor communication regarding fathers treatment, and too long a wait time for appointment in clinic.

What We Did..
Apologised, reviewed process for sharing information between departments and reduced the time frame for when patients are asked to wait prior to their appointment

The Patient Said..
Poor patient experience for a breast screening appointment. Confusion regarding where appointment would take place.

What We Did..
Apologised for the service, increased pre-appointment communication with parking and location information. Shared complaint as a learning development aid for staff.

The Patient Said..
They had concerns regarding delays in treatment, and lack of consideration for patients travelling from Caithness to Raigmore.

What We Did..
Met with patient, gave clarity and reassurance on care pathway. In addition, gave info on how SAS could support with safe travel.

The Patient Said..
To the SPSO that patient X-Rays were incorrectly interpreted, leading to a delay in diagnosis.

What We Did..
Apologised, raised a DOC and implemented a process to audit X-Ray results.

Over the last 12 months 5 complaints have been identified with Actions taken to resolve or improve. 2 of these complaints progressed to the SPSO where actions were recommended. 1 of these complaint resulted in Organisational Duty of Candour (DOC) being called.

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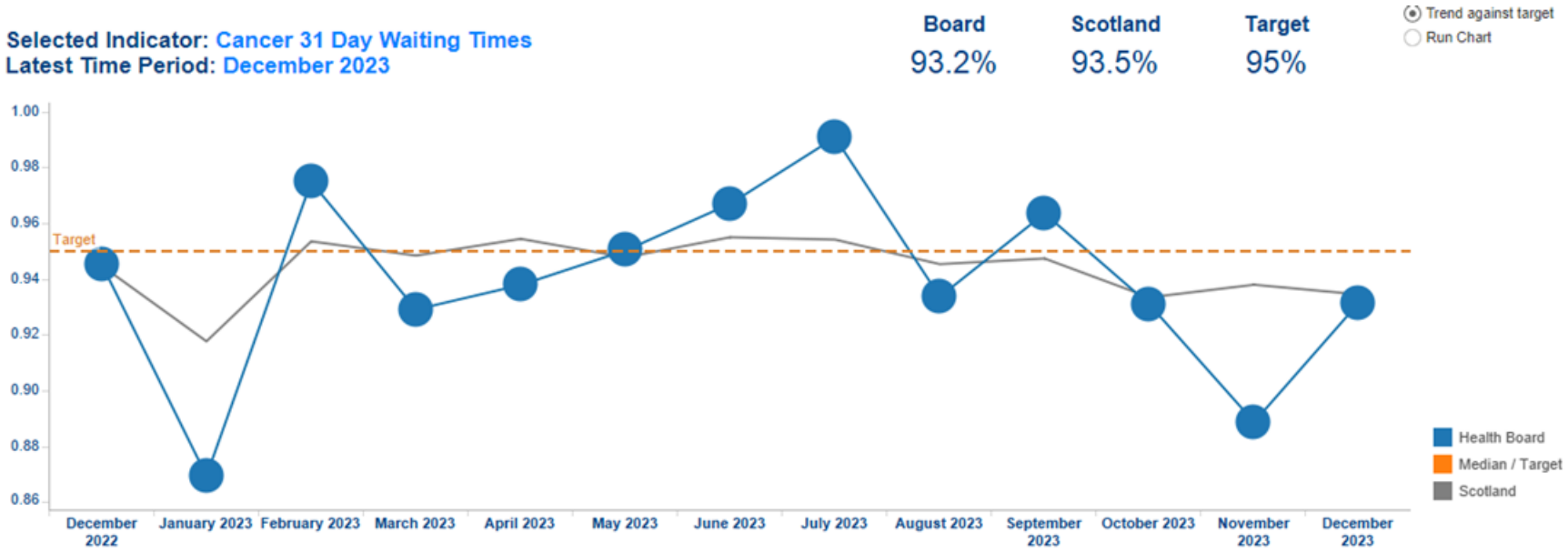
Exec Lead
Katherine Sutton
Chief Officer, Acute

31 Day Cancer Waiting Times

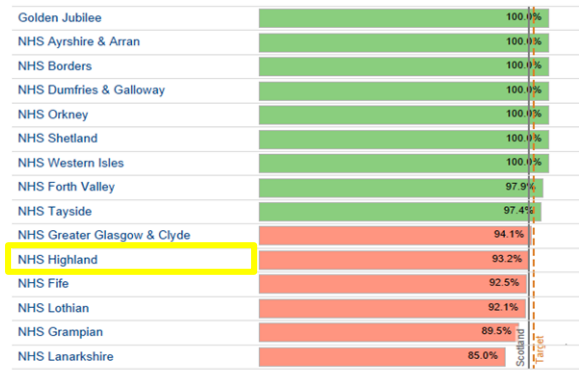
What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• Overall recruitment and retention of key Consultant Oncology posts is a significant challenge and different models of working will need to be established for sustainable and resilient services • Cancer Performance Oversight Board being established chaired by Deputy Medical Director by Jan 24 • Programme of recovery with regards to urology and colorectal which will have specific improvement plans developed and target milestones by Jan 24	• Additional Locum Oncologist have been appointed to address gaps in Urology and UGI Radiotherapy Oncology for the immediate term. • The gaps within Radiology have been filled. This is a key element of the challenge to assessment and diagnose the increasing number of USC patients. • The backlog of breached patients continues to impact upon performance although it is reducing	• Redouble our efforts to appoint to the Breast Radiologist vacancies • Complete a review of options for the future provision of Oncology within NHS Highland.

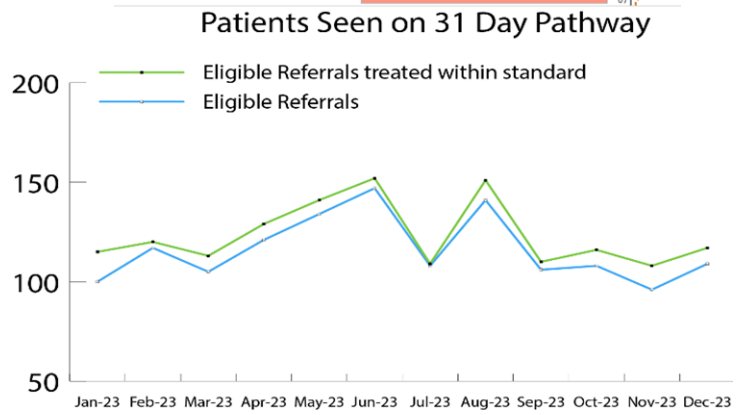
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	93.2%
ADP Trajectory Agreed	Yes
ADP Trajectory	Not Met
Performance Rating	1 month of improvement
National Benchmarking	Below Average
National Target	95%
National Target Achievement	Not Met



31 Day Benchmarking with Other Board





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Exec Lead
Katherine Sutton
Chief Officer, Acute

62 Day Cancer Waiting Times

What we said in December IPQR?	What we have completed and impact?	Next Steps to Improve by June 24
• 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 • Cancer Performance Oversight Board being established chaired by Deputy Medical Director by Jan 24 • Programme of recovery with regards to urology and colorectal which will have specific improvement plans developed and target milestones by Jan 24	• Additional Locum Oncologist appointed to address gaps in Urology and UGI Radiotherapy for the immediate term. • Some gaps within Radiology have been filled. This is a key element of the challenge to assessment and diagnose the increasing number of USC patients. • The backlog of breached patients continues to impact upon performance although it is now reducing	• As per 31 Day Cancer Waiting Times • Continued compliance with the national Framework for Effective Cancer Management.

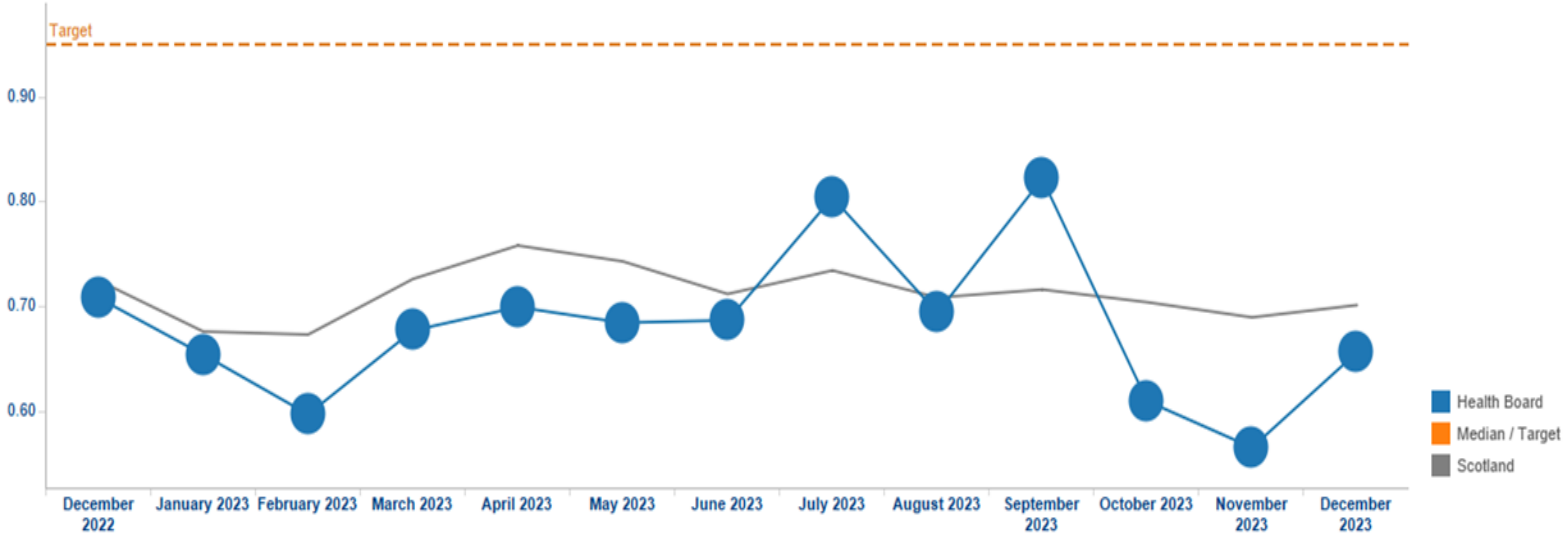
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	65.7%
ADP Trajectory Agreed	Yes
ADP Trajectory	Met
Performance Rating	Decreasing
National Benchmarking	Below Scottish Average <10%
National Target	95%
National Target Achievement	Not Met >10%

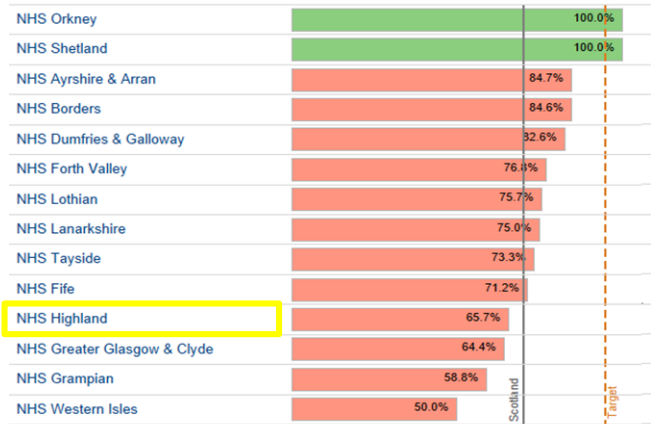
Selected Indicator: Cancer 62 Day Waiting Times
Latest Time Period: December 2023

Board	Scotland	Target
65.7%	70.2%	95%

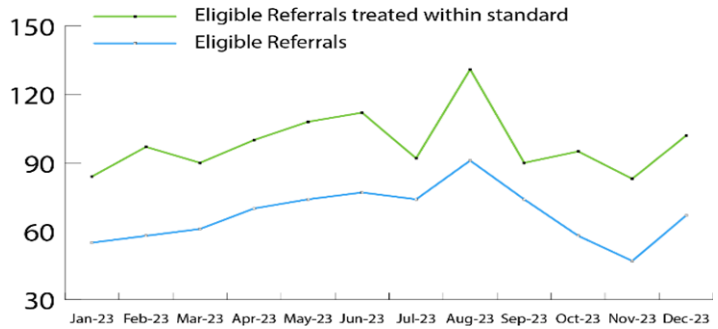
Trend against target
Run Chart



62 Day Benchmarking with Other Boards



Patients Seen on 62 Day Pathway



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Exec Lead
Pamela Cremin
Chief Officer, HHSCP

Psychology Waiting Times

What we said in December IPQR?

- CAPTND data set capture system to work with eHealth as currently delayed
- Implementation of PT specification 2024
- NHS Highland pilot test site for SG for the PT specification and Core Mental Health Standards self- assessment tool
- Increase uptake and alternatives for digital therapies (Nov 23). Have SG new additional funding digital lead and patient engagement officer for increasing access to digital therapies
- Focus in line with Mental Health Outcomes framework to reduce longest waits

What we have completed and impact?

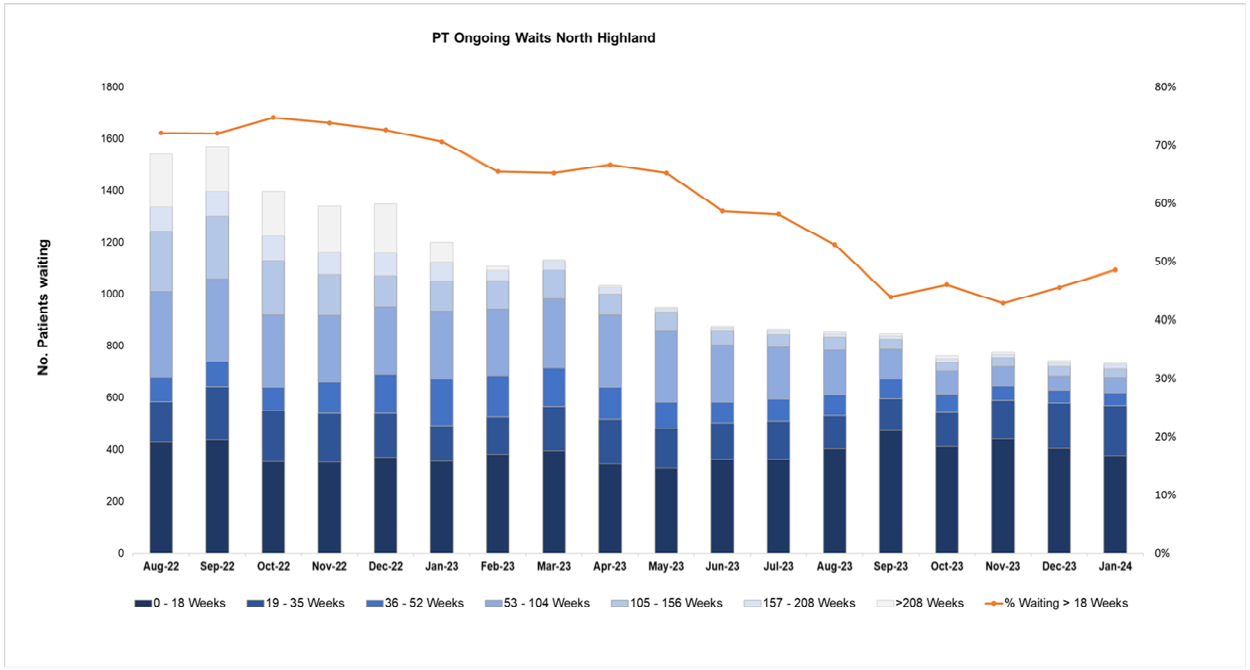
- CAPTND questionnaire has financial approval and will be made available to boards via a TrakCare software patch update. eHealth are still unable to commit to local installation timescales, contributing to planning delay.
- NHS Highland has started pilot for SG PT specification and Core Mental Health Standards self- assessment tool which will assure service delivery and highlight development areas.
- Digital post has no indication of SG commitment to funding being recurring. Meeting with NHSA&B on 29th Nov to discuss these posts if recurring funding confirmed.
- Now have 10 STEPPS groups running across pan-Highland.

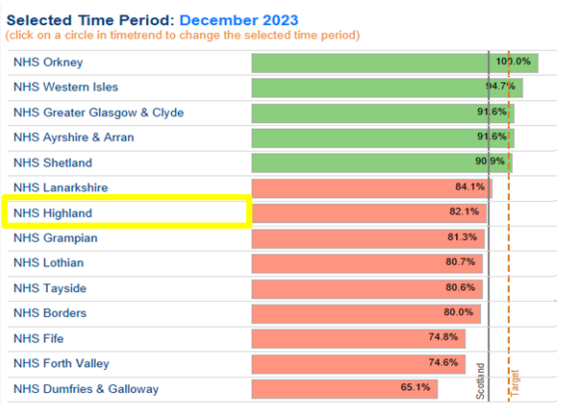
Next Steps to Improve by June 24

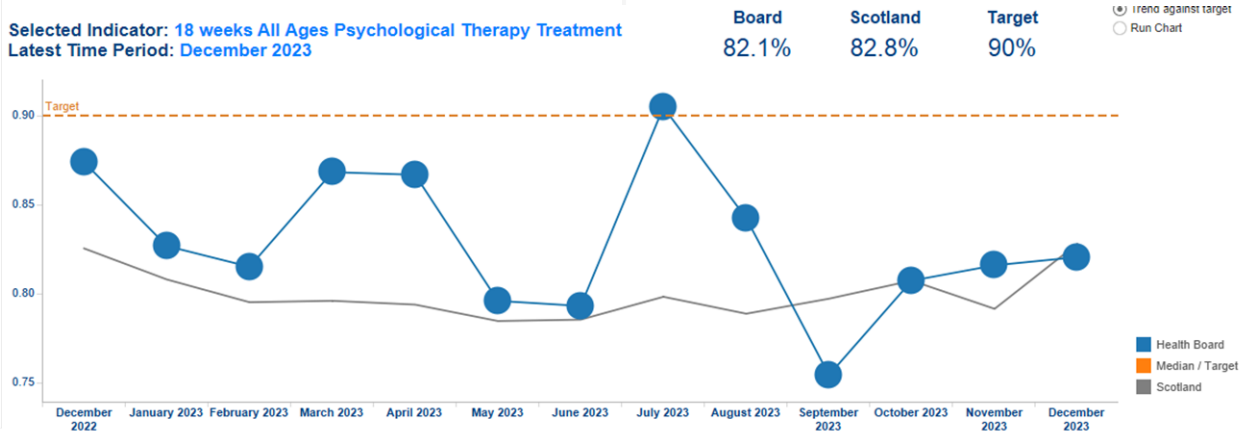
- CAPTND questionnaire installation by eHealth
- CAPTND existing data fields assessed for quality and improvements identified
- SG self-assessment completion
- Reduced wait times
- Recruitment in line with SG recommendations for net workforce increase through the MH Outcomes Framework funding.

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

Latest Performance	82.1%
ADP Trajectory Agreed	n/a
ADP Trajectory	n/a
Performance Rating	Improving
National Benchmarking	Below Scottish Average <5%
National Target	95%
National Target Achievement	Not Met >10%







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Exec Lead
Boyd Peters
Job Title

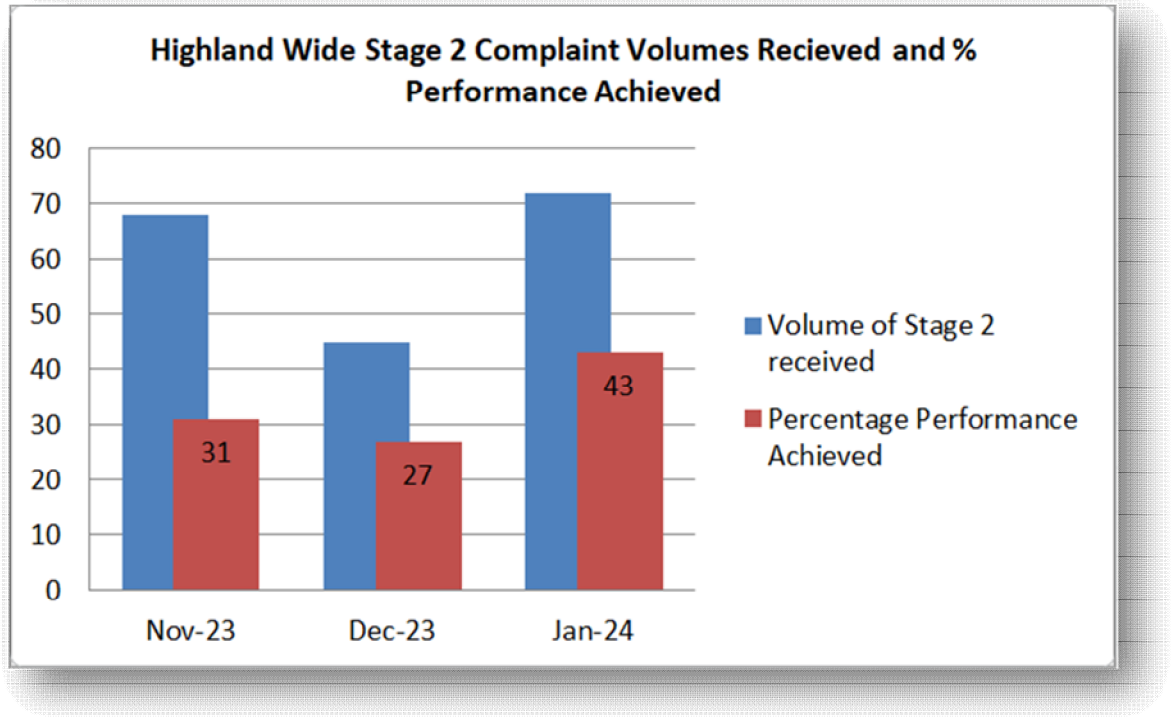
Complaint Activity: Last 13 months

Progress Made	Next Steps	Timescale
• Development in QPS Dashboard for bespoke complaint reporting • Working with Strategy & Transformation to develop patient experience reports in accordance with operational activity • Preparing for the SPSO Child Friendly Complaint Handling Procedure	• To refine the spotlight reports for other service area for IQR • HHSCP complaint management process reviews • Review our website, literature, training and communications	• March 2024 • March 2024 • End of March 2024

PEFORMANCE OVERVIEW
Strategic Objective:
Outcome Area:

Latest Performance (Target 60%)	January 43%

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



Factors which influenced performance has been:

- Front Line staffing pressures
- Administrative delays in case progressions
- Processing and allocation delays

Factors which influenced complaint volumes has been:

- Communication on poor discharges
- Waiting times for MRI scans
- Vaccinations
- Lack of maternity service for Skye

Top 3 Complaint themes

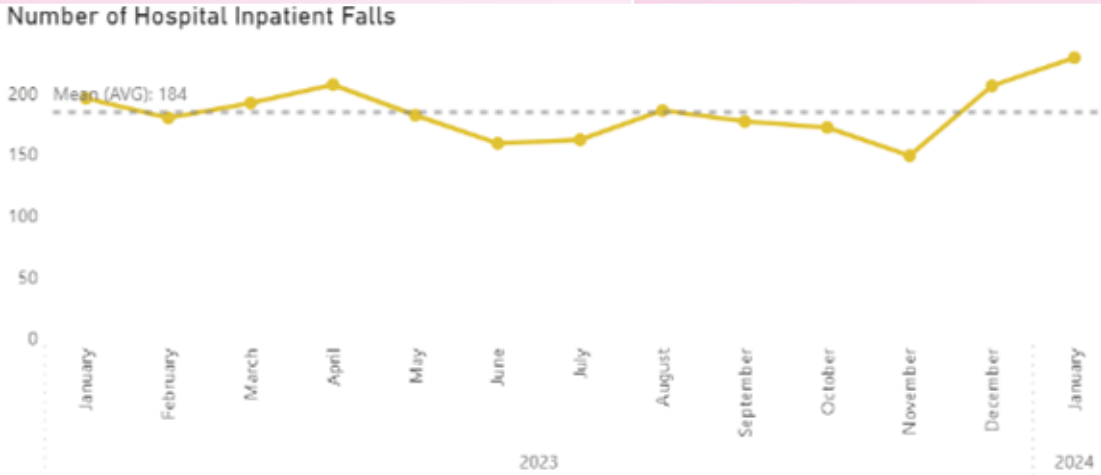
- Care and treatment - Relating to delays in diagnosis, miss-diagnosis, level of nursing care and issues with treatments
- Communication – Contact with Social Services, discharges from hospital, vaccination service, cancelled appointments
- Waiting Times – ENT appointments, ADHD assessments, adult psychiatry,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

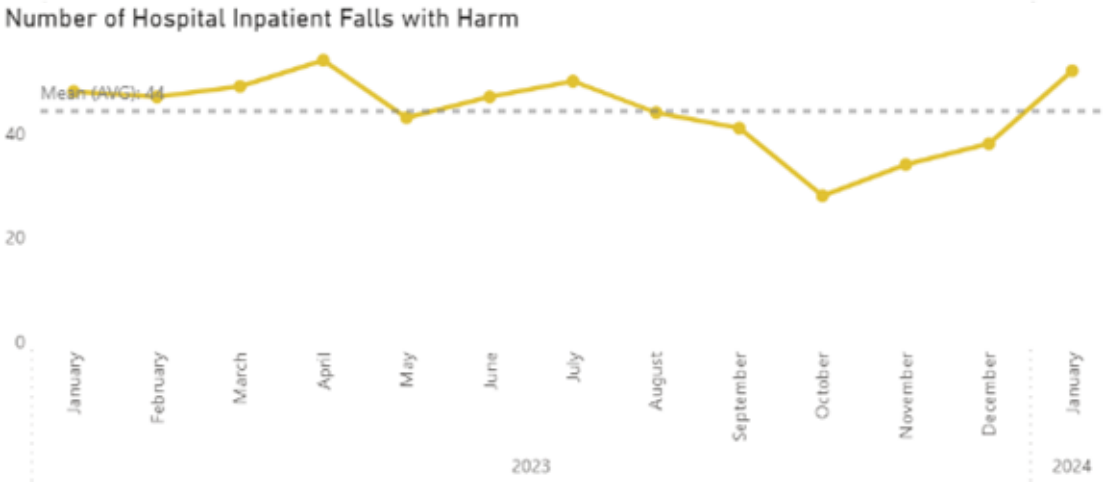
Clinical Governance

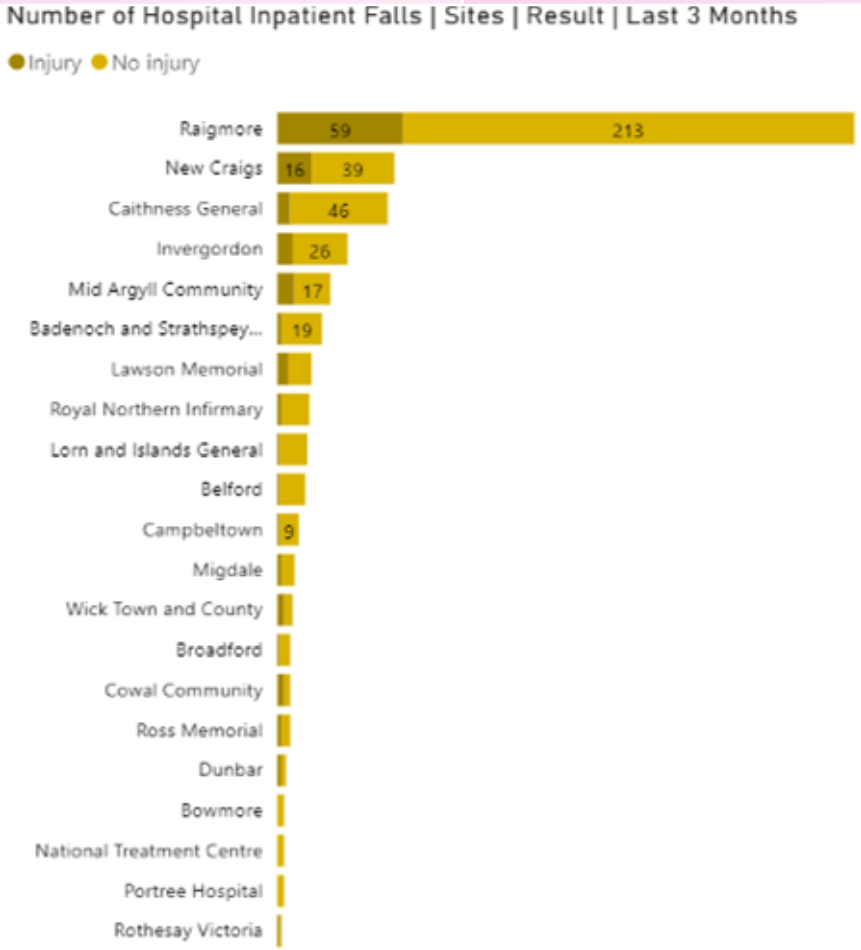
Hospital Inpatient Falls | Run Chart and Site Injury Detail (to be updated)

Executive Lead
Louise Bussell

Progress Made	Next Steps	Timescale
• HHSC falls with harm running close to 30% reduction • Acute- increase in falls, possible correlation with increase in beds • A&B – 20% decrease in falls and falls with harm last 3 months • Inpatient falls guidance draft submitted to HSE • Broons deconditioning resource launched across NHSH	Review overarching falls policy and Community and Care Home guidance Post fall guidance review	31/03/24 31/03/24







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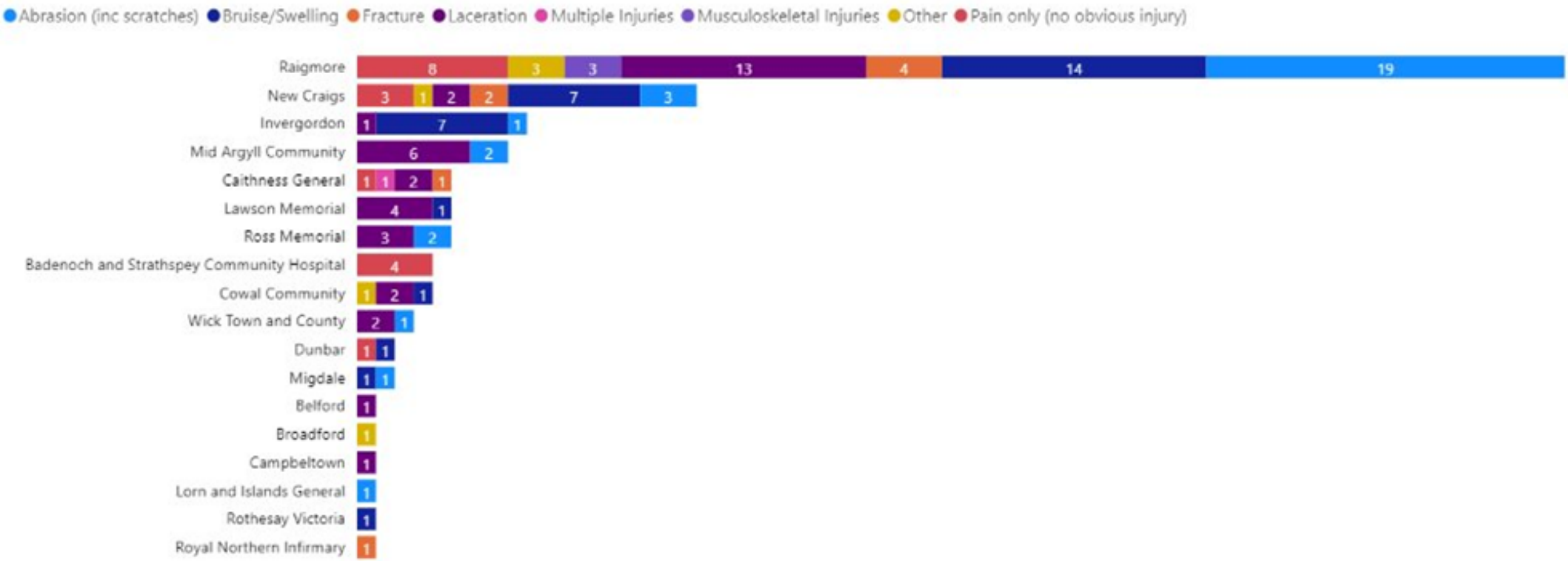
Clinical Governance

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

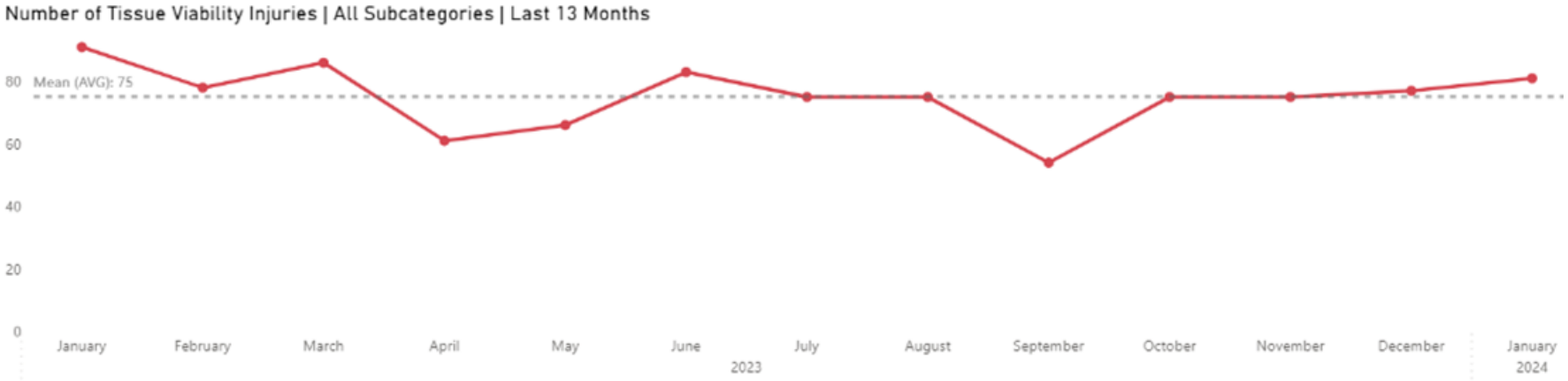


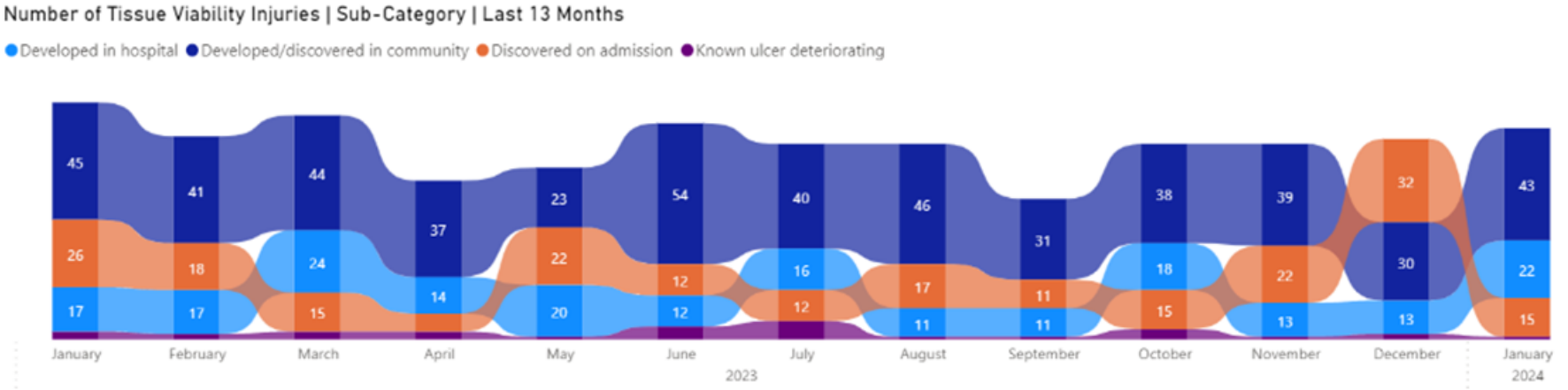
Clinical Governance

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
• aSSKINg model - have commenced trials on some Raigmore wards.	• Consideration of including pressure damage risk assessment in SAS triage tool.	• June 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.	• Development of an aide memoir for all users	• August 2024
	• Plan community team trial	• May 2024
	• Evaluate acute trial with QI team	• May 2024
	• TV Lead and TVNs to liaise with HIS re potential to make changes and next steps	





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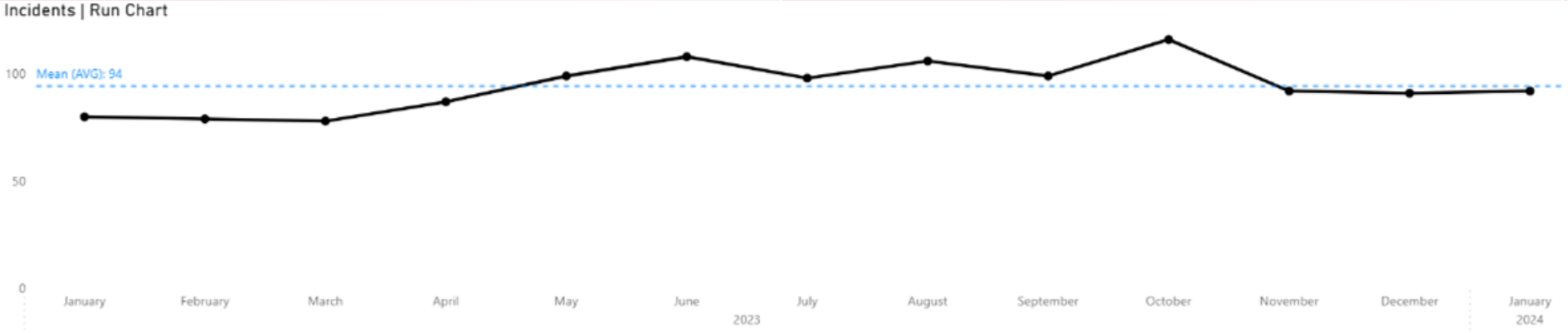
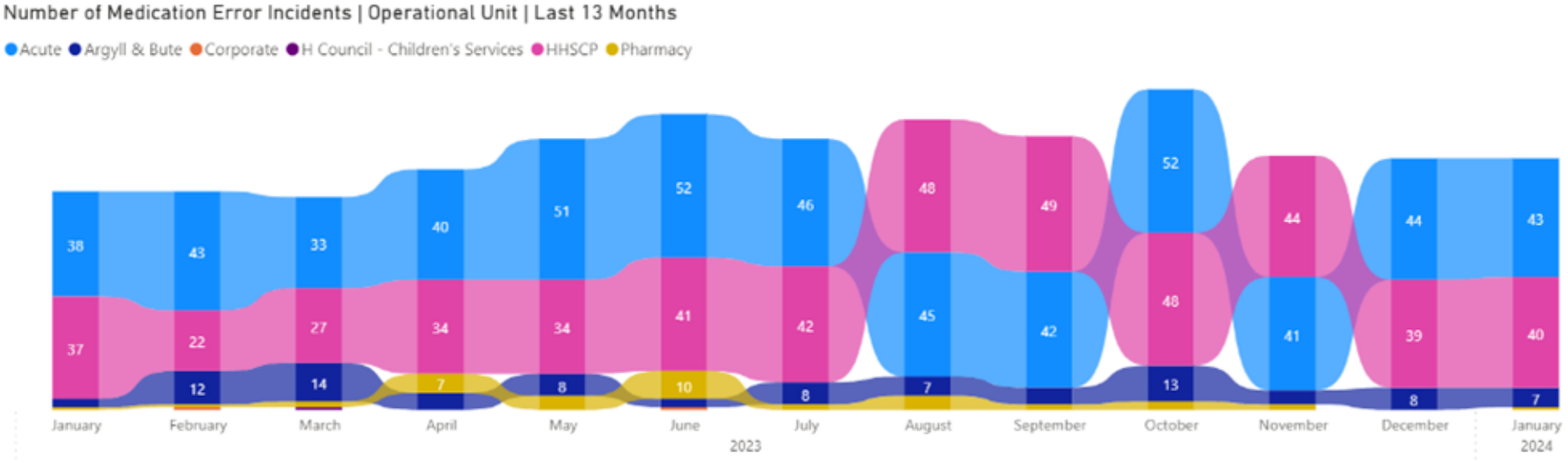
Medication Errors

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 •Ongoing roll out of HEPMA •Short life working group established to review medicines management policies in social care settings •Agreement to establish multiprofessional Controlled Drugs Governance Group	•Disseminate information on time critical medications •Launch of 'Back To Basics' prescribing and medicines administration initiative •Update and broaden membership of MSS •Develop medicines governance strategy and action plan for MSS •Controlled Drugs Governance Group to be established •Launch updates of medicines management in social care settings policies, including developing education and training resources	• March 2024 • March 2024 • May 2024 • May 2024 • May 2024 • June 2024





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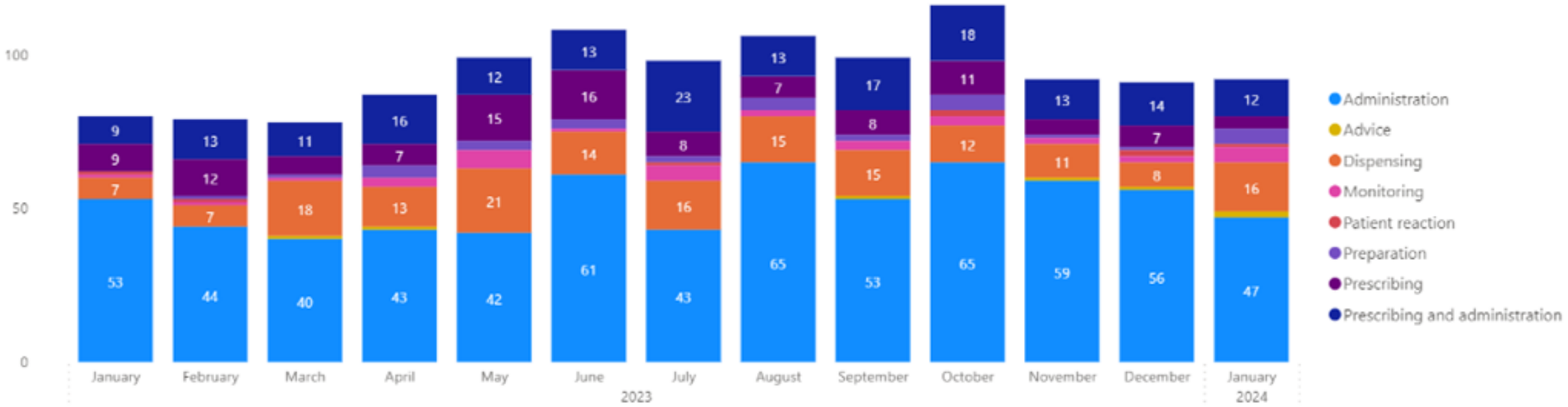
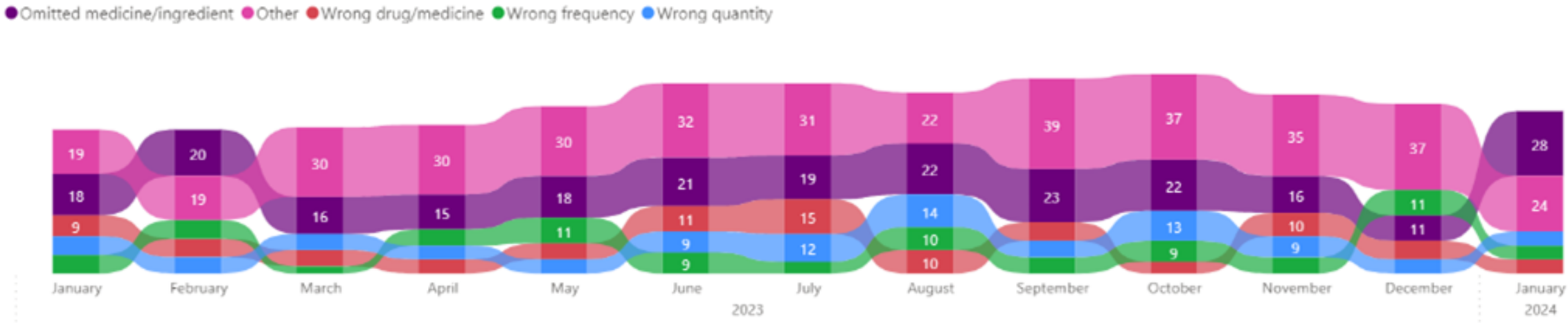
Medication Errors

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

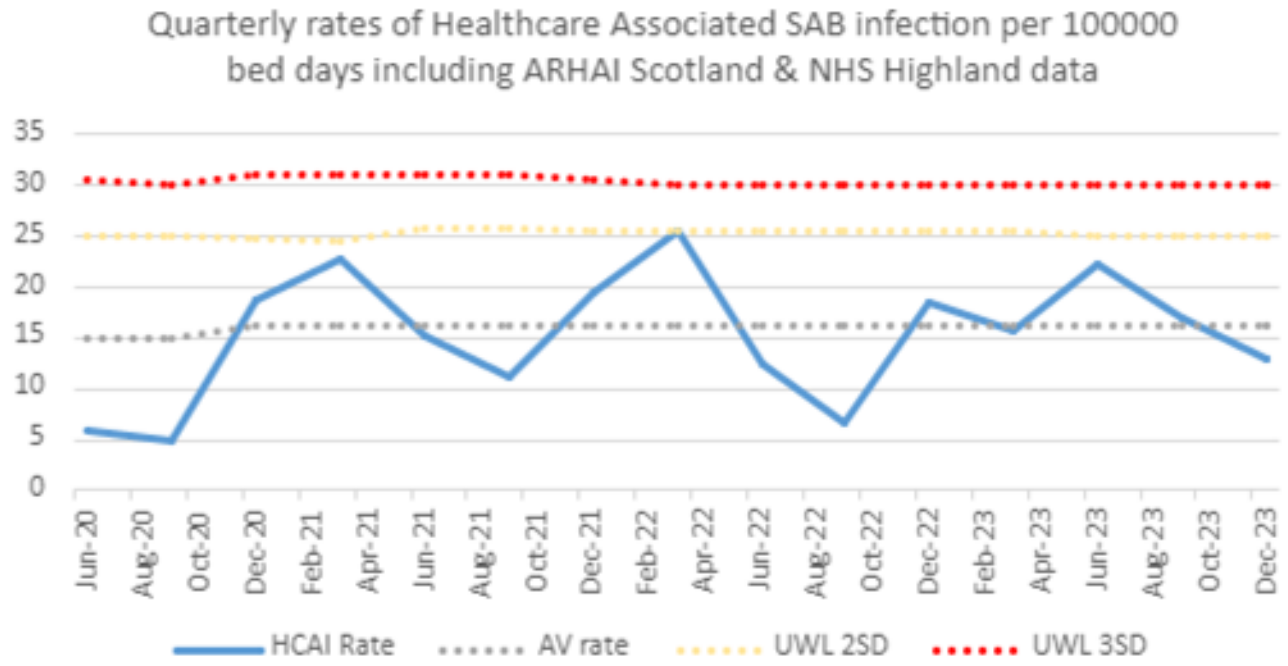
Progress Made	Next Steps	Timescale
• The current reduction aims are: Clostrididodes difficile healthcare associated infection rate of 15.6 per 100,000 total occupied bed days by April 2024. Staphylococcus aureus bacteraemia rate of 15.3; and EColi bacteraemia rate of 17.1 • Published data for July - Sept identified a rise in the expected rate of CDI as previously discussed. An increase in community associated ECOLIs was also identified.	• 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. • IPC annual work plan continues to be monitored, and a detailed report is submitted to Clinical Governance Committee for assurance. • Await confirmation of future reduction aims for 2024/2025 • A review of cases is being conducted with various clinical colleagues and representatives from ARHAI to identify any learning and future actions	• Review end of year position April 2024 • Validated position will be known July 2024 • Review to be submitted by 13/03/24

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

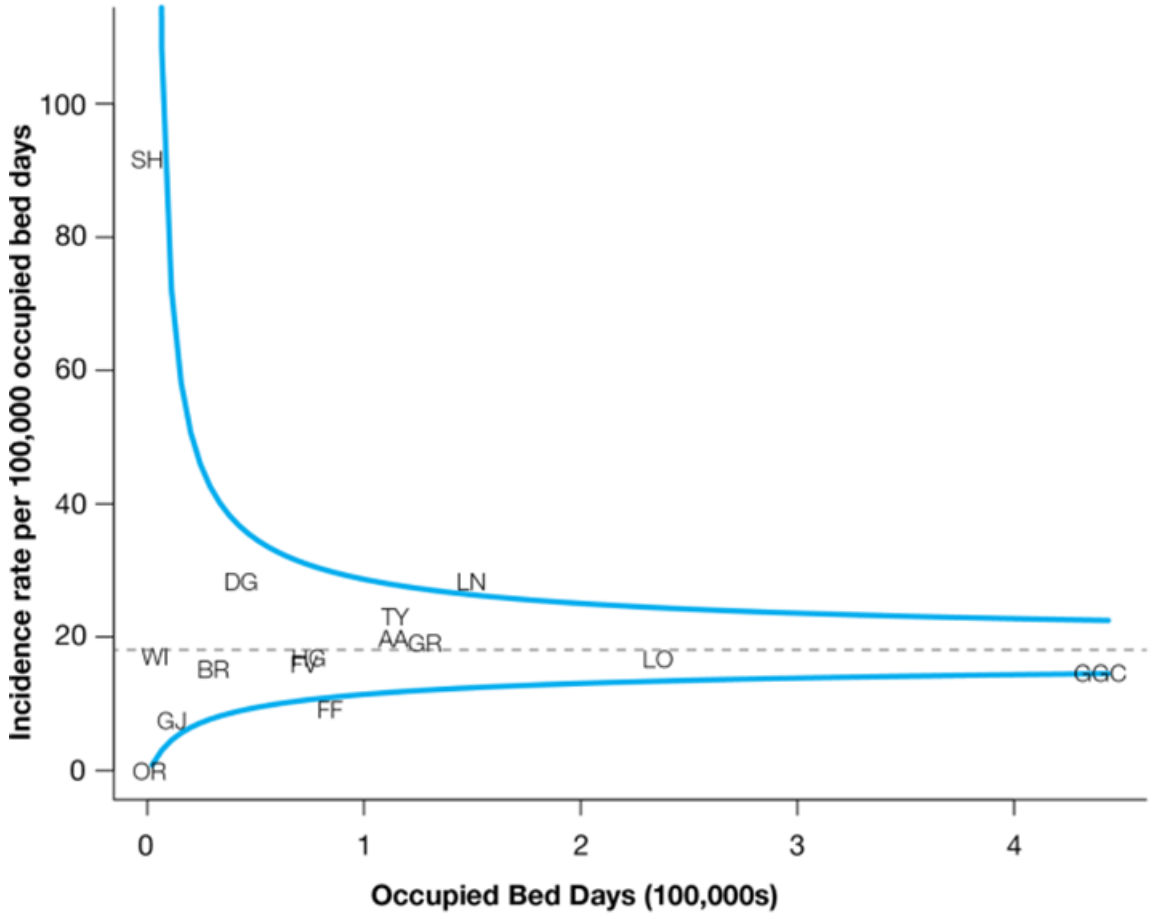
Period	Apr-Jun 2023 Q1	Jul-Sep 2023 Q2	Oct-Dec 2023 Q3	Jan-Mar 2024 Q4
SAB	HCAI	HCAI	HCAI	HCAI
NHS HIGHLAND	22.4	17	10	n/a
SCOTLAND	18.3	n/a	n/a	n/a
C. DIFFICILE				
NHS HIGHLAND	18.5	31	17	n/a
SCOTLAND	16.1	n/a	n/a	n/a
E.COLI				
NHS HIGHLAND	23.8	31	21	n/a
SCOTLAND	37.6	n/a	n/a	n/a

Infection Control

Staphylococcus Aureus Bacteraemias (SABs)

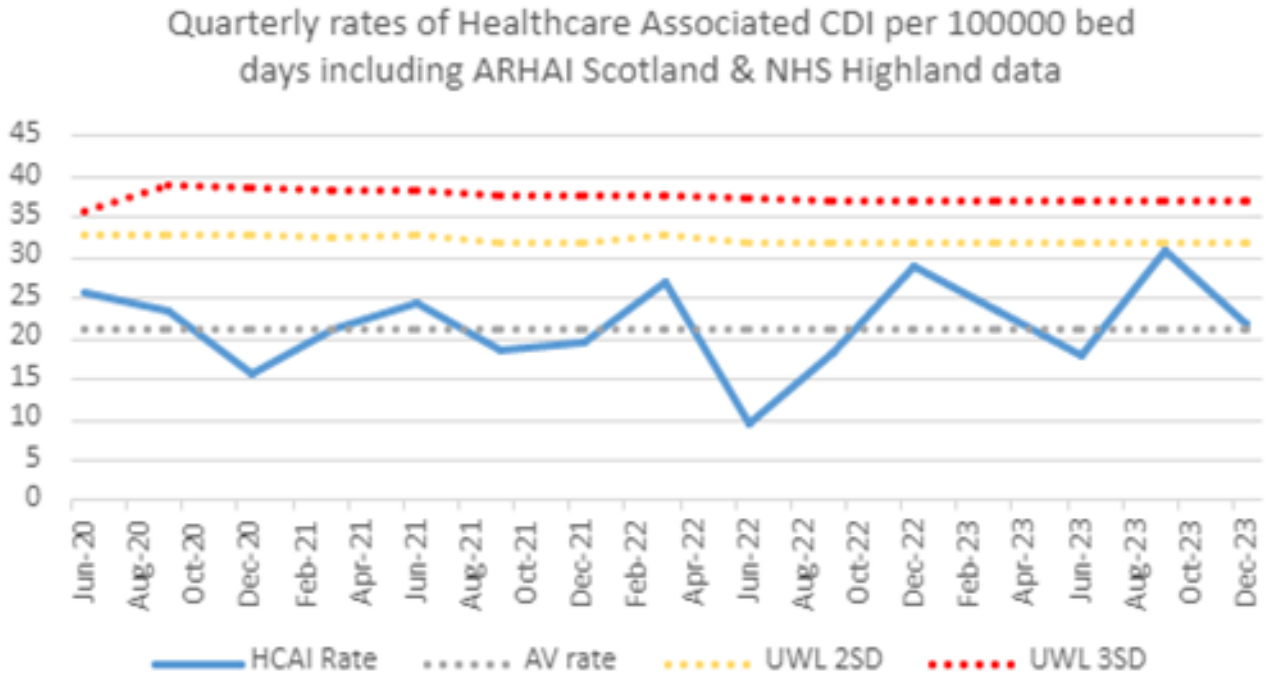


Discovery data | Infection rate per 100,000 bed days | NHS Highland quarter ending Se

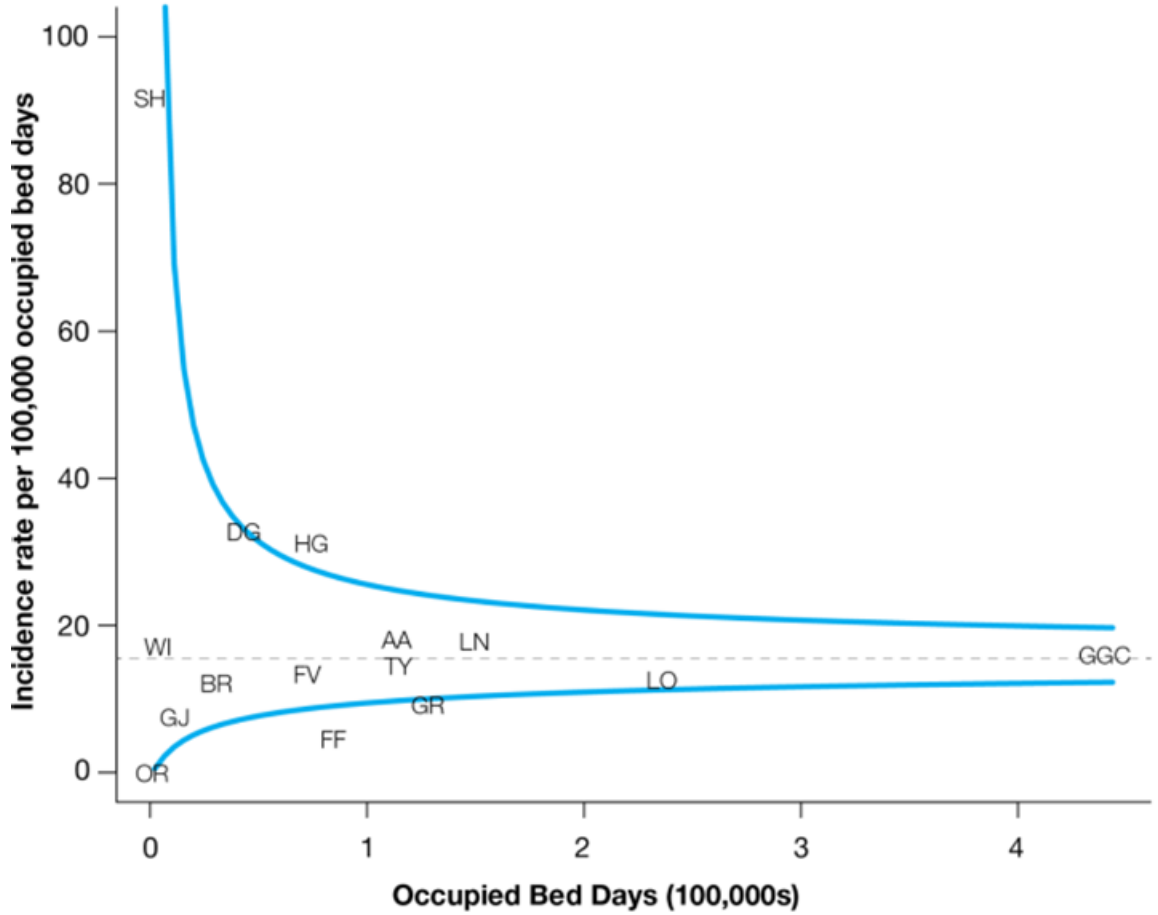


Infection Control

Clostridioides difficile infection (CDIFF)

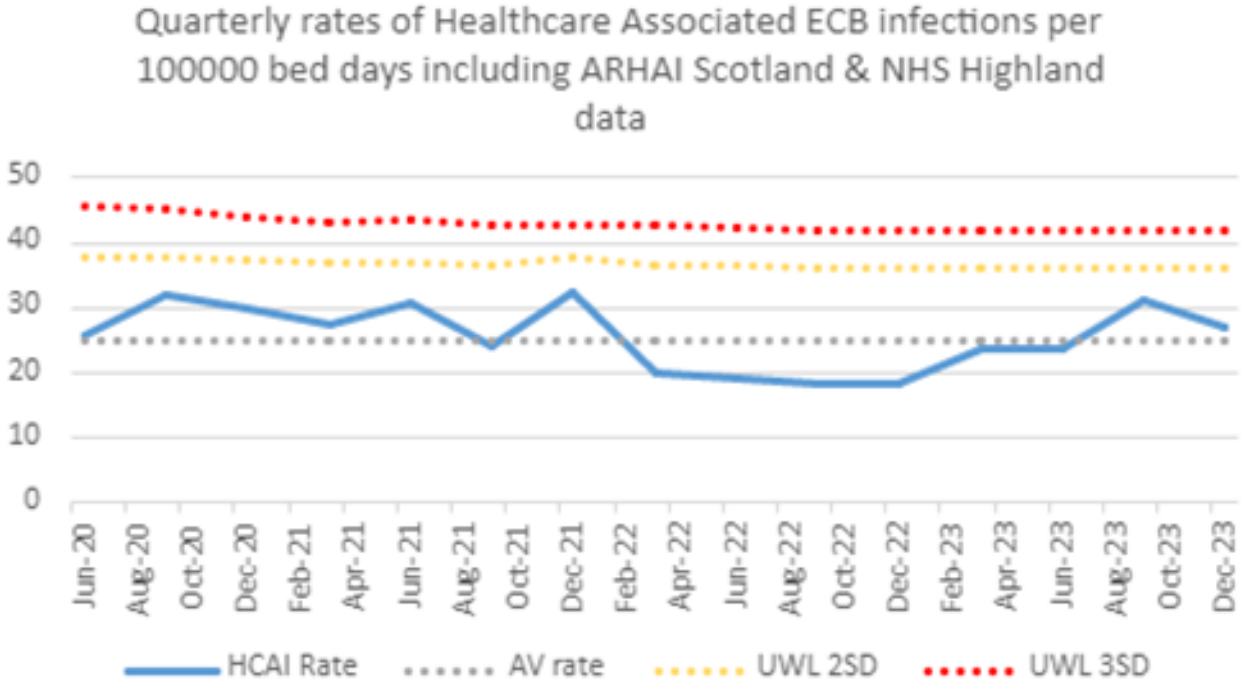


Discovery data | Infection rate per 100,000 bed days | NHS Highland quarter ending December 2023

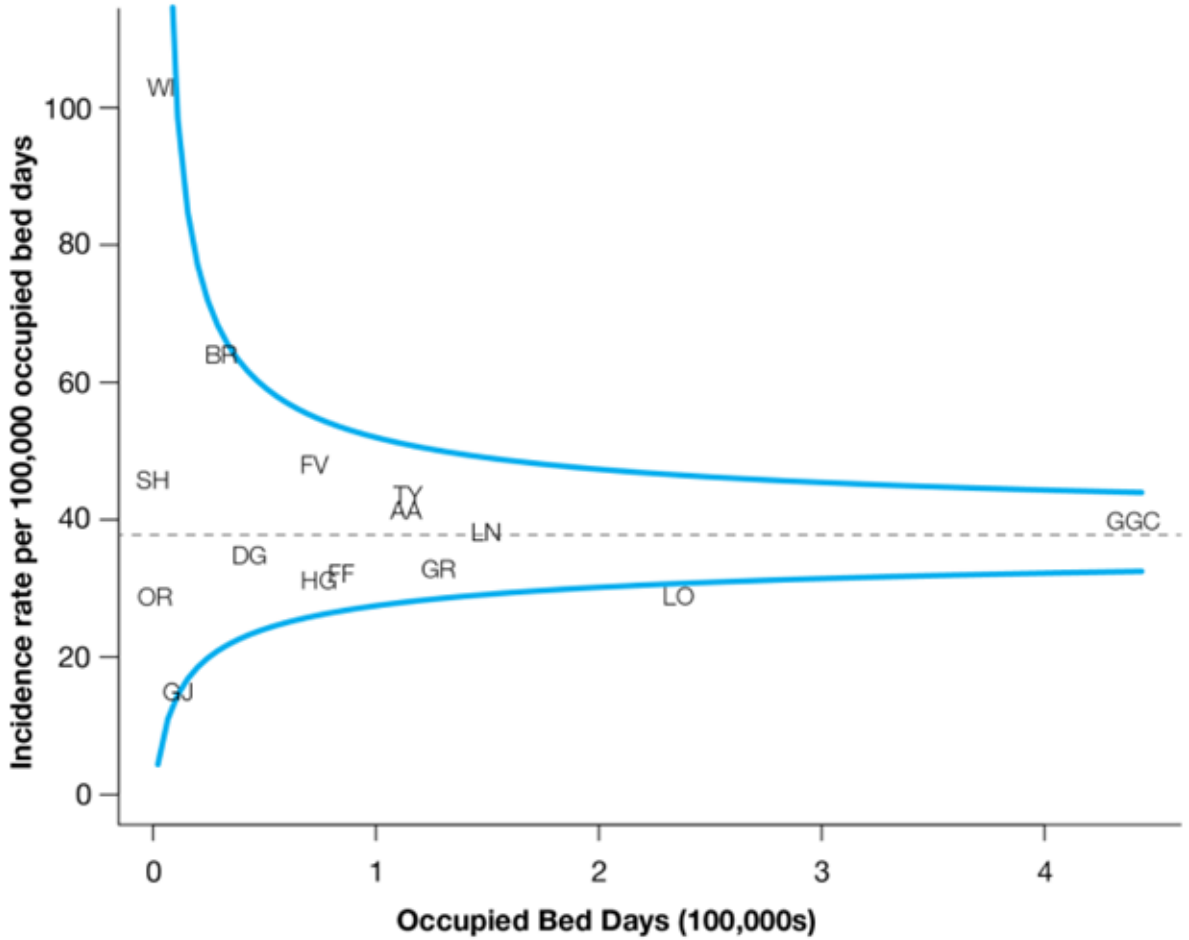


Infection Control

E.coli bacteraemia (ECOLI)



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



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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 for January reporting over 7% . Long term absences are mostly related to other musculoskeletal problems (13%) and anxiety/stress (25%) which contributes to staffing pressures within teams however with high levels of unknown causes being recorded the information is incomplete. Short term absences in Cold, Cough, Flu (31% of absences) remain high as well as gastro-intestinal problems (25% of absences).

Absences with no reason recorded with an unknown cause/not specified remain high (continues at 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 is still very 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.

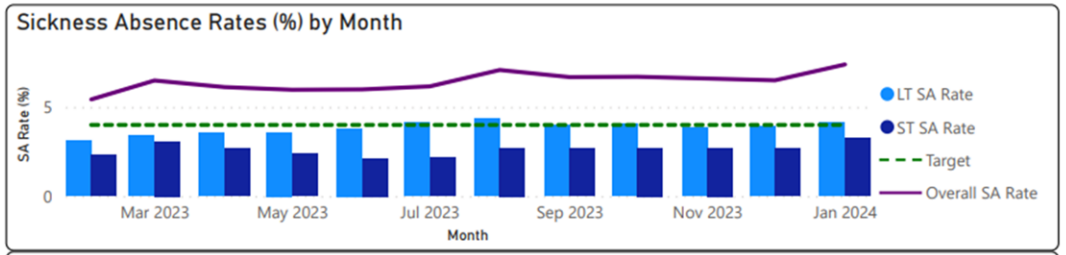
The NHS Highland Wellbeing Strategy is being progressed with a completion date of 31st March 2024. This document will describe our commitment to supporting health and wellbeing but also what resources and support is already available to our workforce

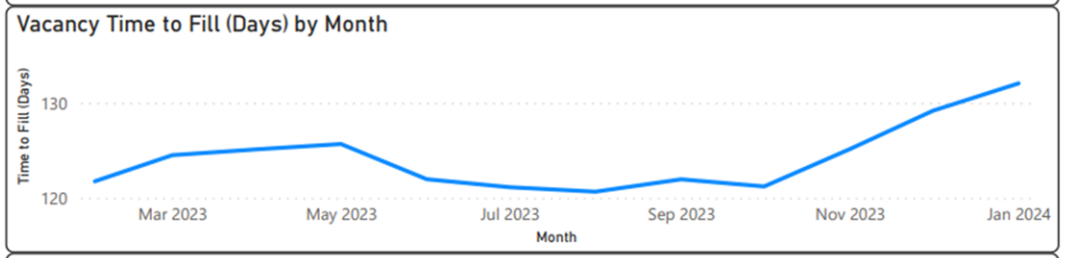
The average time to fill has peaked to 132 days with longer periods being recorded for professional positions and senior posts. The time to fill NHS Scotland KPI is 116 days. The improvement work associated with the recruitment process and roles and responsibilities is progressing. An interim Onboarding survey was launched mid Jan 2024 which aims to survey all new starts in the period 1st May - 31st Dec 23 which was approximately 600. Communication was shared directly with anyone who holds a Supervisor status and new starts received the survey link via email, as well as a communication in the Weekly Comms. The survey will close on the 1st of March and analysis will be completed by the end of March 2024. To date 53 employees have completed a return. The outcomes will inform further improvements required within our processes

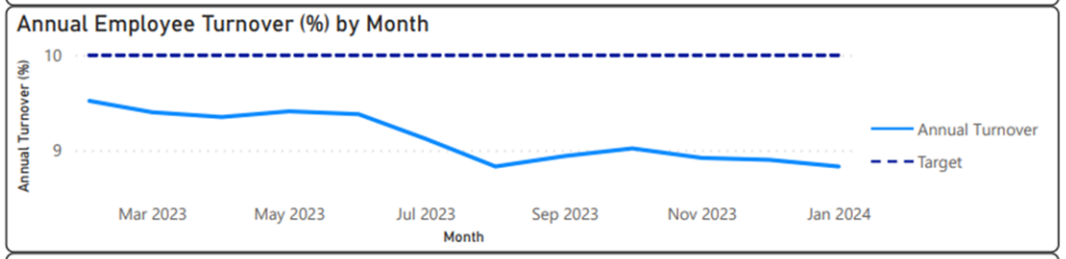
We continue to see high levels of leavers related to retirement (30%) and voluntary resignation (28%) and we see high levels of leavers with the reason recorded as 'other' which accounts for 21% of our leavers. 9% of our workforce have left to move to new NHS Employment. Further encouragement is required to capture leaving reasons. Our Exit Policy and Exit feedback survey launched in June. To date we have had 19 surveys (a 200% increase in exit surveys completed in the same period in 2022). Insights received from the surveys will be reviewed by Organisational Development. There have been over 300 leavers since June so the uptake of the Exit feedback survey is low. People partners are highlighting the Policy via SLTs and further work to promote the Policy from People Services is ongoing.

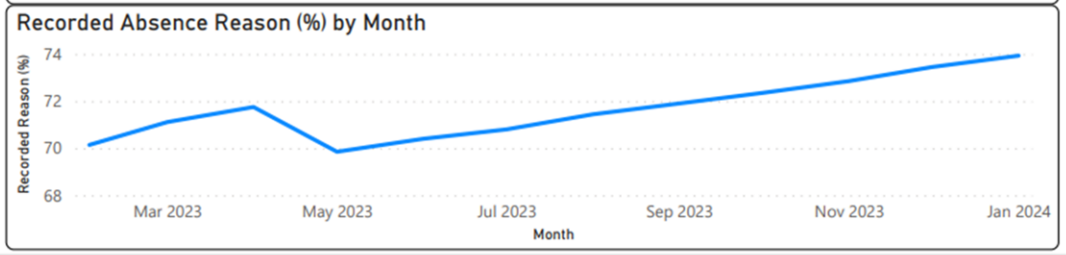
Organisational Metrics Jan 2024

Sickness Absence Rate (%)	7.39
Long Term SA Rate (%)	4.11
Short Term SA Rate (%)	3.25
Recorded Absence Reason (%)	73.93
Vacancy Time to Fill (Days)	132.06
Annual Employee Turnover (%)	8.83









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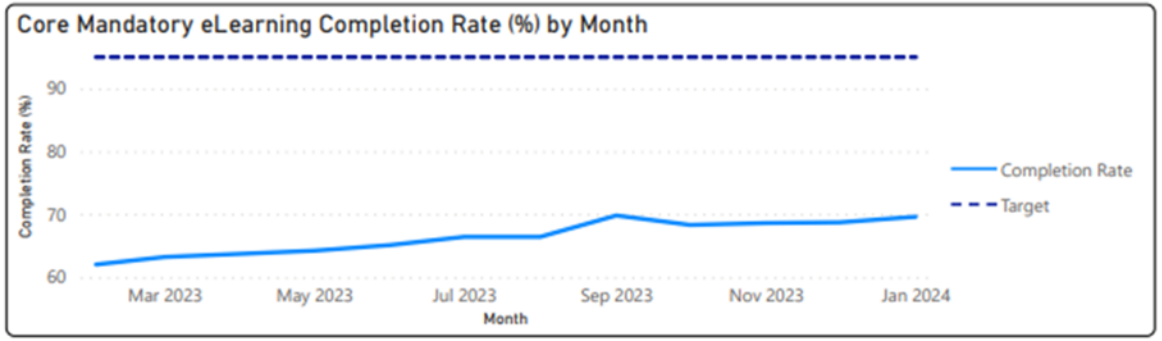
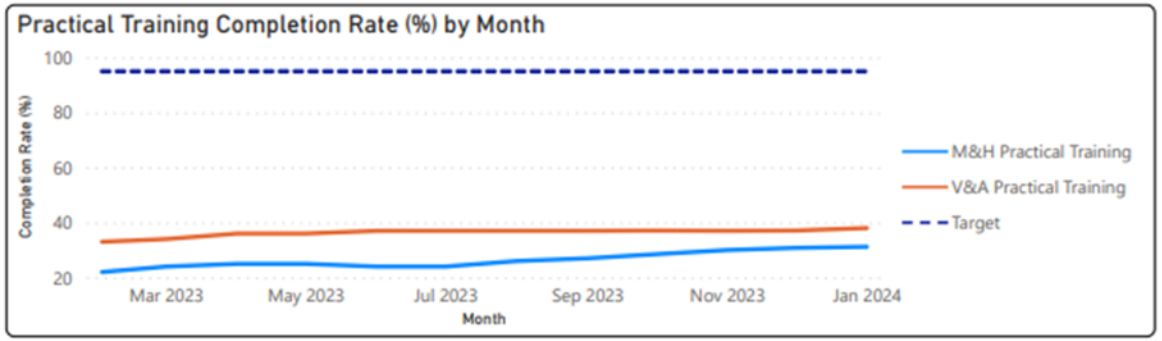
Refreshed awareness sessions for managing PDP&R has been launched in the organisation; monitoring of attendance is in place. This will provide information on how to successfully and meaningfully undertake a PDP&R with individuals. The content of the sessions will be regularly reviewed to ensure alignment 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.

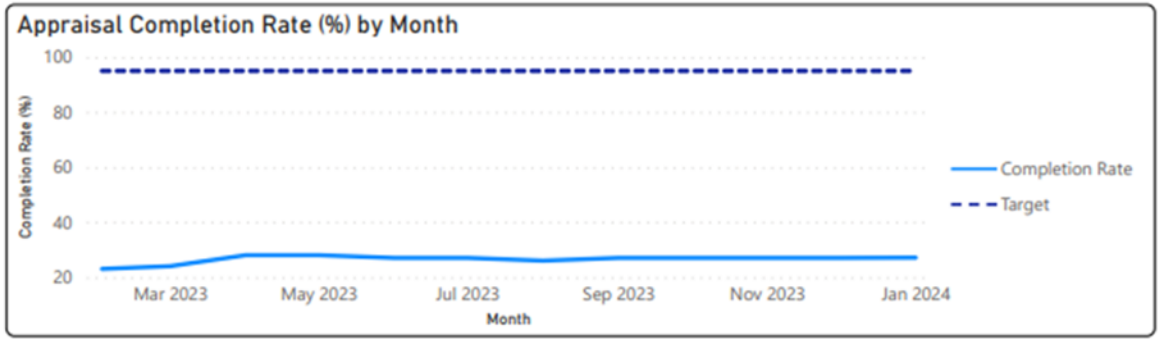
A 6 month monitoring period has commenced from end of January for statutory and mandatory training - monitoring the compliance of the core elearning modules. An oversight group is established reporting to EDG.

Training Metrics Jan 2024

Mandatory eLearning Completion (%)	69.6
V&A Practical Training Completion Rate (%)	38.0
M&H Practical Training Completion Rate (%)	31.2
Appraisal Completion Rate (%)	27.1







Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented	Next Published on IPQR
4	Covid Vaccine Uptake	Monthly	March 2024	May 2024
4	Board Comparison % Covid Vaccine Uptake	Monthly	March 2024	May 2024
5	NHS Highland-Alcohol brief interventions 2023/24 Q2	Quarterly	March 2024	May 2024
5	ABIs delivered	6 monthly	November 2023	May 2024
6	LDP smoking quit attempts by month of planned quit-NHS Highland	Monthly	March 2024	May 2024
6	LDP 12-week smoking quits by month of follow up-NHS Highland	Monthly	March 2024	May 2024
7	CAMHS 18 week treatment target	Monthly	March 2024	May 2024
7	CAMHS Ongoing waits	Monthly	March 2024	May 2024
7	Board comparison % Met Waiting time standard	Monthly	March 2024	May 2024
8	New patients waiting first appointment 2022v2023	Monthly	March 2024	May 2024
8	New and Unvetted patients awaiting first appointment	Monthly	March 2024	May 2024

Slide #	Report	Frequency of Update	Last Presented	Next Published on IPQR
9	ED 4 hr wait performance by HHSCP Hospital	Monthly	March 2024	May 2024
9	Weekly A&E patients waiting 12 hrs plus	Monthly	March 2024	May 2024
9	Weekly ambulance Handover results	Monthly	March 2024	May 2024
9	Board Comparison % meeting Waiting time standard	Monthly	March 2024	May 2024
10	Delayed Discharges in NHS Highland	Monthly	March 2024	May 2024
10	Delayed Discharge Benchmarking	Monthly	March 2024	May 2024
11	New outpatients 12 week waiting times	Monthly	March 2024	May 2024
11	New Outpatient total waiting list & Projection	Monthly	March 2024	May 2024
11	Board Comparison % Met waiting time standard	Monthly	March 2024	May 2024
12	New Outpatients Referrals, Patients seen and Trajectories	Monthly	March 2024	May 2024
12	OP Patients waiting over 52 weeks	Monthly	March 2024	May 2024
13	Inpatient or day case 12 Week waiting times	Monthly	March 2024	May 2024
13	Total TTG Waits & Projection	Monthly	March 2024	May 2024
13	Board Comparison % Met waiting time standard	Monthly	March 2024	May 2024
14	Planned Care Additions, Patients seen and trajectories	Monthly	March 2024	May 2024
14	TTG Patients waiting over 78/104 weeks	Monthly	March 2024	May 2024

Slide #	Report	Frequency of Update	Last Presented	Next Published on IPQR
15	Radiology Key tests Planned & Unplanned activity & Trajectories (3 Graphs)	Monthly	March 2024	May 2024
15	Board Comparison % met Waiting time standard	Monthly	March 2024	May 2024
16	Endoscopy Key tests Patients seen and Trajectories (2 Graphs)	Monthly	March 2024	May 2024
16	Board Comparison % met waiting time standard	Monthly	March 2024	May 2024
17	31 Day Cancer waiting times	Monthly	March 2024	May 2024
17	Board Comparison % Met waiting time standard	Monthly	March 2024	May 2024
17	Patients Seen on 31 Day Pathway	Monthly	New Graph	May 2024
18	62 Day Cancer waiting times	Monthly	March 2024	May 2024
18	Board Comparison % Met waiting time standard	Monthly	March 2024	May 2024
18	Patients Seen on 62 Day Pathway	Monthly	New Graph	May 2024
19	PT 18 week treatment target	Monthly	March 2024	May 2024
19	PT Ongoing waits	Monthly	March 2024	May 2024
19	Board comparison % Met Waiting time standard	Monthly	March 2024	May 2024
20	12 Month View of Stage 2 Complaints and Volume of Cancer Patient Starting Treatment	Monthly	New Graph	May 2024
20	Complaint Issues	Monthly	New Graph	May 2024
20	Decision Outcomes	Monthly	New Graph	May 2024