



Standards & Hospital Performance Report

Report for Qtr.4 2024-25

Contents

Standards & Hospital Performance Report	1
1. Target Performance: Trajectories and Local Delivery Plan	1
2. LDP STANDARD MEASURES 2024/25 (Qtr. 4)	5
Hospital Performance Section	16
3. Western Isles Hospital	16
A&E	16
Inpatient and Day Case Activity	18
Inpatient and Day Case – specialty breakdown	19
Number IP/DC on Waiting List	20
Number of New Outpatients on Waiting List	21
Hospital at Home Admissions	22
8 Key Tests	24
Theatre Utilisation	25
Hospital Beds (WIH)	27
Outpatient Appointments	32
4. Ospadal Uibhist agus Barraigh (OUAB)	35
A&E OUAB	35
Inpatient and Day Case Activity	37
Hospital Beds (OUAB)	38
5. St. Brendan’s Hospital (St. B)	42
Inpatient and Day Case Activity	42
6. Mainland Hospitals	46
Inpatient and Day Case Activity	46

1. Target Performance: Trajectories and Local Delivery Plan

Table 1 Current LDP Standards

Area	Standard	Associated Key Measures	Period	Status	Comments
Acute	<u>Suspicion-of-cancer referrals (62 days)</u>	<i>The maximum wait from urgent referral with a suspicion of cancer, to treatment is 62 days; the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer is 31 days.</i>	Mar-25	▼	Standard: 95%
	% of urgent referrals (inc. via A&E) with suspicion of cancer seen within 62 days of treatment starting.				Actual: 47%
					Variance: -50.7%
					15 of 32 seen within 62 days
	<u>All Cancer Treatment (31 days)</u>	<i>The maximum wait from urgent referral with a suspicion of cancer, to treatment is 62 days; the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer is 31 days.</i>	Mar-25	◀▶	Standard: 95%
	% of cancer patients treated within 31 days of diagnosis.				Actual: 100%
					Variance: 5.3%
					23 of 23 seen within 31 days
	<u>Emergency Department Waiting Times – 4 hours</u>	<i>Standard is 95% with stretch target of 98%</i>	Mar-25	▼	Standard: (95%) 98%
	The percentage of patients seen waiting no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.				Actual: 95%
					Variance: 0%
	<u>Early Access to Antenatal Services</u>	<i>Performance is calculated for each of the 5 quintiles and the lowest performing quintile will be reported.</i>	Mar-25	▼	Plan: 80%
	At least 80% of pregnant in each SIMD quintile will have booked for antenatal care by the 12 th week of gestation.				Actual: 83%
					Variance: 4.1%
					5 of 6 in quintile 2
	<u>IVF Treatment Waiting Times</u>	<i>A proportion of WI patients are treated in Glasgow and will be included in waiting times for GG&C.</i>	Mar-25	—	Plan: 90%
	Eligible patients will commence IVF treatment within 12 months. The target will be based on the proportion of patients who were screened at an IVF centre within 12 months of the decision to treat.				Actual: n/a
					Variance: n/a
					0 of 0

Area	Standard	Associated Key Measures	Period	Status	Comments
Acute	12 week Treatment Time Guarantee for Inpatients	100% compliance required.	Mar-25	▲	Standard: 100%
	The proportion of inpatient and day cases that were seen within the 12 week Treatment Time Guarantee.				Actual: 75%
					Variance: -25%
					91 of 364 seen within 12wks
	New Outpatients Waiting over 12 weeks	95% with stretch 100%.	Mar-25	▲	Plan: 95.0%
	The percentage of patients waiting no more than 12 weeks from referral (all sources) to a first outpatient appointment.				Actual: 74.1%
					Variance:-22.0%
					924 of 1247 seen within 12 wks
	New outpatients Waiting over 16 weeks	100% compliance required. Waits over 16 weeks must be eradicated.	Mar-25	▲	Plan: 100%
	Percentage of patients waiting no more than 16 weeks from referral (all sources) to a first outpatient appointment.				Actual: 79.5%
					Variance: -20.5%
					991 of 1247 pts seen in 16wks
	MRSA/MSSA Bacterium	Measure is flawed as it is looking for a 10% reduction based on a year with only 1 case	Mar-25	▲	Local Figure Qtr.4
	To further reduce healthcare associated infections of staphylococcus aureus bacteraemia (including MRSA) case Healthcare Associated (Rate per 100,000 Total Occupied Bed Days) and Community Associated (rate per 100000 population)	Target: 10% reduction on 2018/19 baseline by 2021/22			Target 3.2
		No update on target for 24/25 currently still using 21/22 target.			Healthcare Associated SAB :15.6 (1 Case)
					Target 16.8
	Clostridioides Difficile Infections	Board deemed an exception if incidence rate is above upper 95% confidence limit in current quarter OR above third standard deviation upper warning limit for current quarter of long term trend analysis.	Mar-25	▼	Local Figure Qtr.4
	To further reduce healthcare associated infections of Clostridium Difficile in patients aged 15 and over Healthcare Associated (Rate per 100,000 Total Occupied Bed Days) and Community Associated (rate per 100000 population)				Target Rate 3.2
					Healthcare Associated CDI : 15.55 (1 cases)
		No update on target for 24/25 currently still using 21/22 target.			Target Rate 3.4
					Community Associated CDI : 0 (0 cases)

Area	Standard	Associated Key Measures	Period	Status	Comments
Mental Health	<u>Faster access to specialist CaMHS</u>	90% of patients to be seen within 18 weeks.	Mar-25	◀▶	Standard:90%
	Deliver 18 weeks from referral to treatment for specialist CaMHS services.				Actual: 100%
					Variance: 11.1%
					25 of 25 pts seen within 18 weeks
	<u>Dementia: Diagnosed & Post-Diagnostic Support</u>	% of those referred for PDS who received a minimum of a year's support	Mar-25	▼	33 Newly diagnosed dementia cases per qtr. (133 annually)
	Newly diagnosed dementia cases in a performance year who are offered the service, as a percentage of the overall estimate of newly diagnosed dementia cases within that performance year.				Current Target: 133
					Actual: 63
					Variance: -52.6%
	No update from PHS on Projected diagnoses targets so still using 2021 target.	% of those referred for PDS who received a minimum of a year's support		◀▶	Percentage receiving PDS: 100%
Public Care	<u>Faster access to Psychological Therapies</u>	NHS Boards to achieve a rate of 90%.	Mar-25	▲	Standard: 90%
	Deliver 18 weeks referral to treatment for Psychological Therapies.				Actual: 68.8%
					Variance: -23.6%
					44 of 64 patients seen within 18 weeks
	<u>Referral to Treatment: Drugs and Alcohol</u>	90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	Mar-25	▼	Standard: 90%
					Actual: 82%
					Variance: -9.1%
					45 of 55 seen within 3 weeks
	<u>Smoking Cessation</u>	To achieve 30 successful quits at 12wks post-quit for people residing in the three most deprived local quintiles.	Feb-25	◀▶	Target 7
	Delivery of universal smoking cessation services to achieve a number of successful quits at 12 weeks post quit in the 60% most deprived within-island board SIMD areas.				Actual: 8
					Variance: 14.3%
					1 month in arrears

Area	Standard	Associated Key Measures	Period	Status	Comments
Primary Care	<u>Advance booking – GP</u>	<i>Able to book an appointment with a GP more than 48 days in advance</i>	<i>Mar-24 (Latest)</i>	▼	Standard: 90%
	Percentage of patients, who indicate that they were able to book an appointment with a GP more than 3 days ahead.				Actual: 76%
					Variance: -15.6%
	<u>Access to an appropriate care</u>	<i>Biennial patient satisfaction survey.</i>	<i>Mar-24 (Latest)</i>	▼	Standard: 90%
	Positive response to questions regarding access to an appropriate member of the GP Practice Team.	<i>Doctor</i>			83%
		<i>Nurse</i>			88%
		<i>Physiotherapist</i>			65%
		<i>Mental Health Professional</i>			56%
		<i>Another Healthcare Professional</i>			63%
Corporate	<u>Sickness Absence</u>	<i>NHS Boards to achieve a sickness absence rate of 4%.</i>	<i>Mar-25</i>	▼	Standard: 4.0%
	% Hrs lost due to sickness absence.				Actual: 5.55
					Variance: 38.8% Lost Hours:8230.11

2. LDP STANDARD MEASURES 2024/25 (Qtr. 4)

Exception report on KPMs not meeting latest planned trajectory.

Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25

WI Balanced Scorecard Indicator:

8: Cancer Waiting Times

Executive Lead:

Lachlan MacPherson
Hospital Manager

HEAT Target:

62-day standard from receipt of referral to start of treatment for newly diagnosed primary cancers.

Responsible Officer:

Ronnie Murray
Planning & Performance Manager

Trajectory Performance to date:

Supporting Analysis (where available):

Quarter Ending	Actual	Planned Value	Deviation (%)	Quarter Ending	Referral	Seen
Jun-24	73%	95%	-23.1%	Jun-24	26	19
Sep-24	77%	95%	-18.7%	Sep-24	22	17
Dec-24	72%	95%	-24.3%	Dec-24	32	23
Mar-25	47%	95%	-50.7%	Mar-25	32	15

1. Performance Narrative (include key reasons for underperformance status)

The Q4 performance of 48% related to 17 breaches out of 33 cases - these breaches were in Colorectal (x4), Head & Neck (x1), Lung (x1), Upper GI (x1) and Urology (x10), as per below.

	Q1-JAN-MAR			Q2-APR-JUN			Q3-JUL-SEP			Q4-OCT-DEC			2024 TOTAL		
62 DAYS (ALL)	❌	✓	Total	❌	✓	Total	❌	✓	Total	❌	✓	Total	❌	✓	Total
Breast		1	1			0			0			0	0	1	1
Cervical			0			0			0			0	0	0	0
Colorectal	4	4	8			0			0			0	4	4	8
Head & Neck	1		1			0			0			0	1	0	1
Lung	1	2	3			0			0			0	1	2	3
Lymphoma		2	2			0			0			0	0	2	2
Melanoma		1	1			0			0			0	0	1	1
Mesothelioma															
Multiple Myeloma															
Neurological															
Ovarian			0			0			0			0	0	0	0
Sarcoma															
Upper GI	1	4	5			0			0			0	1	4	5
Urological	10	2	12			0			0			0	10	2	12
Totals	17	16	33	0	0	0	0	0	0	0	0	0	17	16	33
	48.5%			#####			#DIV/0!			#DIV/0!			48%		

Cancer pathways for the majority of these specialities are through NHS Highland and so performance is dependent on performance at Highland (and Glasgow for selected specialities).

2. Planned Performance Improvements:

1. Breaches to be discussed by Cancer Steering Group.
2. A weekly report is submitted to Scottish Government and monthly calls with SG lead Rebekah MacQueen.
3. SLA meetings to be re-established with NHSH in order to address issues affecting performance.

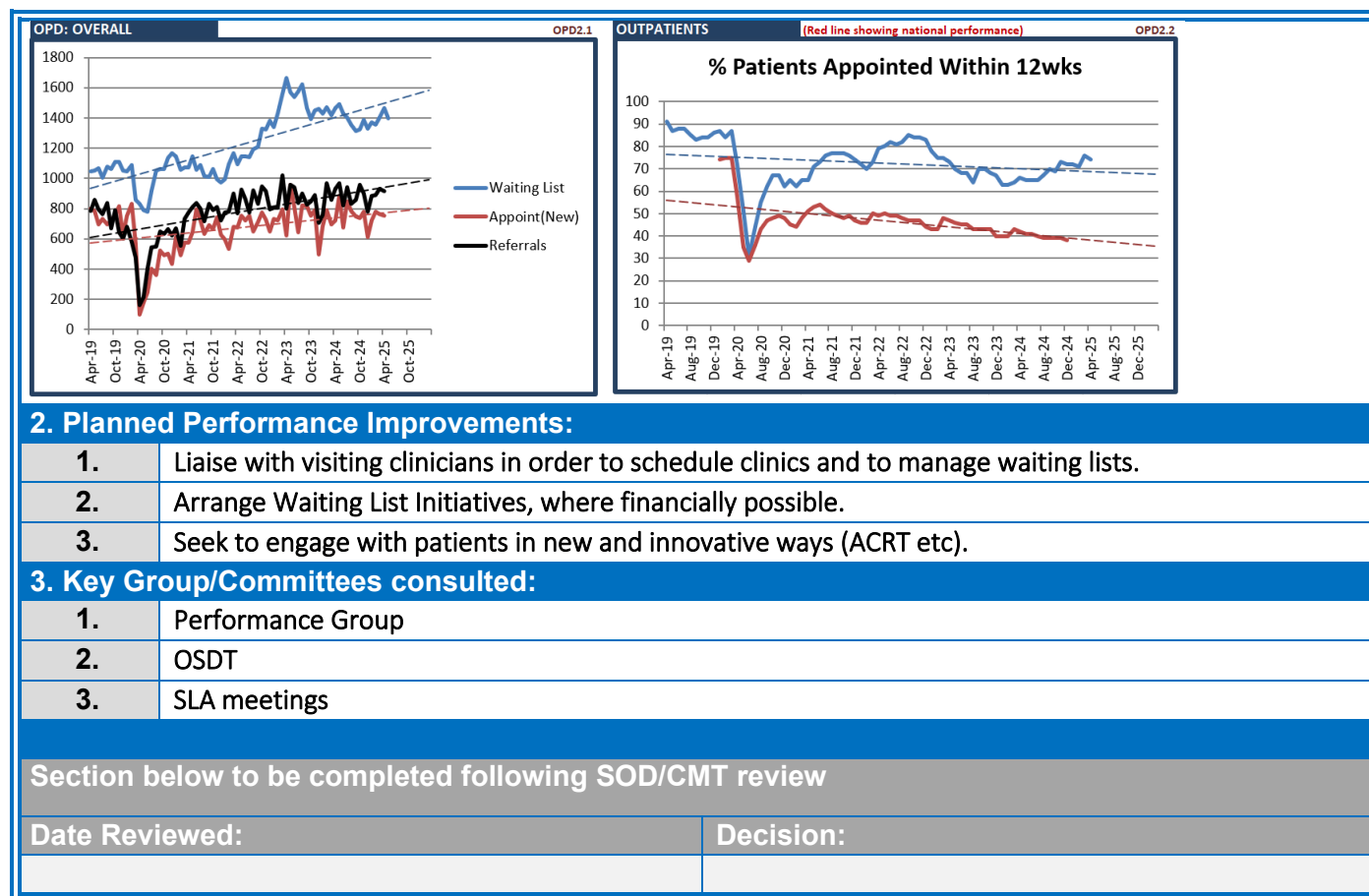
3. Key Group/Committees consulted:

1. Cancer Steering Group
2. Performance Group
3. OSDT

Section below to be completed following SOD/CMT review					
Date Reviewed:			Decision:		

Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25					
WI Balanced Scorecard Indicator:			Executive Lead:		
92a: New OP: maximum 12 weeks from referral (excluded from TTG)			Lachlan MacPherson Hospital Manager		
HEAT Target:			Responsible Officer:		
95% of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment			Ronnie Murray Planning & Performance Manager		
Trajectory Performance to date:			Supporting Analysis (where available):		
<u>Qtr. Ending</u>	<u>Actual</u>	<u>Planned Value against 12 week target</u>	<u>Deviation (%) against 12 week target</u>	<u>Month Ending</u>	<u>Patients Seen within 12wks</u>
Jun-24	63.5%	95%	-33.14%	Jan-25	827 of 1200
Sep-24	65.2%	95%	-31.34%	Feb-25	887 of 1221
Dec-24	70.0%	95%	-26.32%	Mar-25	924 of 1247
Mar-25	74.1%	95%	-22.00%	Last Qtr. by month	

1. Performance Narrative (include key reasons for underperformance status)
<p>Performance remains strong despite significant logistical and other challenges with visiting services.</p> <p>We hope to introduce opt-in letters in ENT to reduce the number of face-to-face appointments required.</p> <p>We are experiencing problems with Urology with NHS Highland not providing a visiting service in February or March, and again in May and June. NHS Highland have advised that the visiting service will be reduced to 2 visits per month. Clarification on the terms of the visiting service SLA is being sought.</p> <p>We continue to add capacity through Waiting List Initiatives as much as possible.</p> <p>We hope to implement the new waiting times guidance in Aug/Sep - and this will improve our performance with patients clocks being stopped for unavailability, DNAs etc after the initial 12-wk period - currently the clock just keeps ticking regardless.</p>



Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25

WI Balanced Scorecard Indicator:

92b: New OP: maximum 16 wks from referral (excluded from TTG)

HEAT Target:

100% of patients to wait no longer than 16 weeks from referral (all sources) to a first outpatient appointment

Executive Lead:

Lachlan MacPherson
Hospital Manager

Responsible Officer:

Ronnie Murray
Planning & Performance Manager

Trajectory Performance to date:

<u>Quarter Ending</u>	<u>Actual</u>	<u>Planned Value against 16 week target</u>	<u>Deviation (%) against 16 week target</u>
Jun-24	72.3%	100%	-27.7%
Sep-24	73.0%	100%	-27.0%
Dec-24	77.2%	100%	-22.8%
Mar-25	79.5%	100%	-20.5%

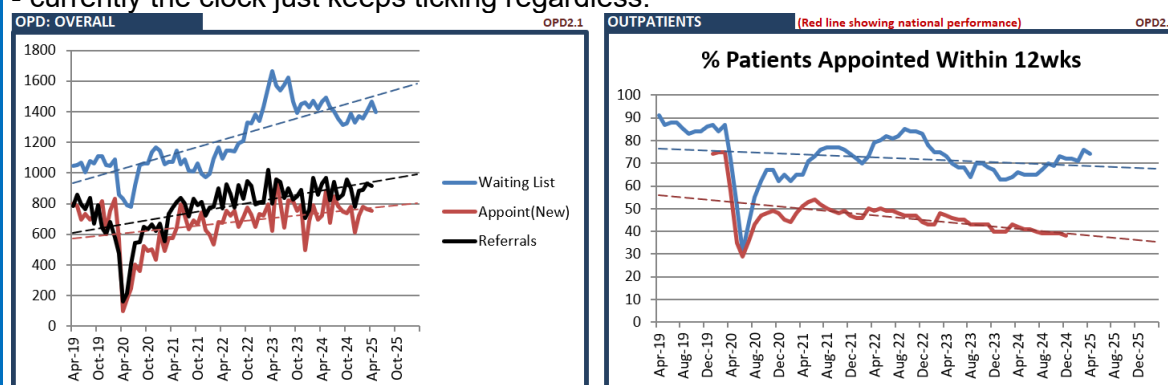
Supporting Analysis (where available):

<u>Month Ending</u>	<u>Patients Seen within 12wks</u>
Jan-25	77.8%
Feb-25	79.8%
Mar-25	79.5%

Last Qtr. by month

1. Performance Narrative (include key reasons for underperformance status)

Performance remains strong despite significant logistical and other challenges with visiting services. We hope to introduce opt-in letters in ENT to reduce the number of face-to-face appointments required. We are experiencing problems with Urology with NHS Highland not providing a visiting service in February or March, and again in May and June. NHS Highland have advised that the visiting service will be reduced to 2 visits per month. Clarification on the terms of the visiting service SLA is being sought. We continue to add capacity through Waiting List Initiatives as much as possible. We hope to implement the new waiting times guidance in Aug/Sep - and this will improve our performance with patients clocks being stopped for unavailability, DNAs etc after the initial 12-wk period - currently the clock just keeps ticking regardless.



2. Planned Performance Improvements:

1. Liaise with visiting clinicians in order to schedule clinics and to manage waiting lists.
2. Arrange Waiting List Initiatives, where financially possible.
3. Seek to engage with patients in new and innovative ways (ACRT etc).

3. Key Group/Committees consulted:

1. Performance Group
2. OSDT
3. SLA meetings

Corporate Management Team 17.06.2025

Agenda Item: 8.4.1

Purpose: For Assurance

Section below to be completed following SOD/CMT review	
Date Reviewed:	Decision:

Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25

WI Balanced Scorecard Indicator:

91: IP: maximum 12 week Treatment Time Guarantee

Executive Lead:

Lachlan MacPherson

Hospital Manager

HEAT Target:

Once planned inpatient and day case treatment has been agreed with the patient the patient must receive that treatment within 12 weeks.

Responsible Officer:

Ronnie Murray

Planning & Performance Manager

Trajectory Performance to date by Qtr end:

Quarter Ending	Actual	Planned Value	Deviation %
Jun-24	70.9%	100%	-29.1%
Sep-24	78.7%	100%	-21.3%
Dec-24	72.8%	100%	-27.2%
Mar-25	75.0%	100%	-25.0%

Supporting Analysis (where available):

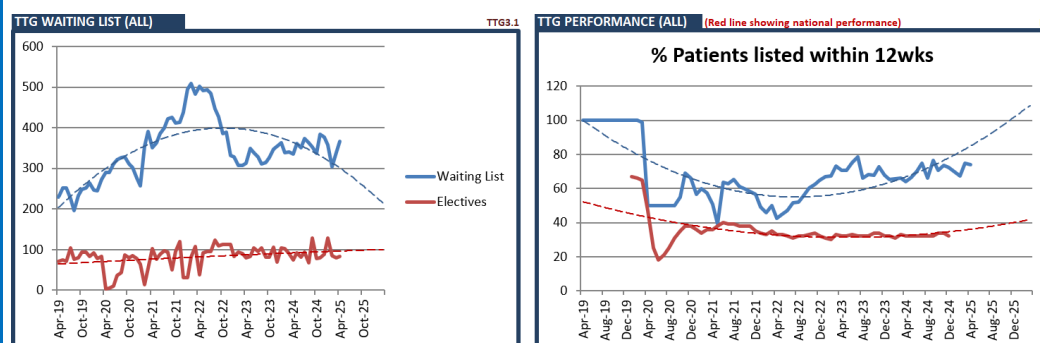
Month Ending	Patients waiting > 12wks
Jan-25	97 of 350
Feb-25	104 of 351
Mar-25	91 of 364

Last Qtr. by month

1. Performance Narrative (include key reasons for underperformance status)

Our TTG performance of 75% at the end of Q4 (Mar 25) remains very pleasing, particularly due to the ED refurb and the subsequent loss of day case elective activity, and increased bedding pressures which have led to the cancellation of arthroplasty procedures (Orthopaedics).

Ophthalmology is now the speciality with the highest number of patients waiting for planned surgery. There is a 3-day cataract visit next month which will reduce this number and further improve performance.



2. Planned Performance Improvements:

1. Weekly Theatre Scheduling meetings held to list patients appropriately.
2. Liaising with clinicians to ensure that waiting lists are correct.
3. Arrange Waiting List Initiatives where possible.

3. Key Group/Committees consulted:

1. Performance Group
2. Theatre Users Group
3. OSDT

Section below to be completed following SOD/CMT review**Date Reviewed:****Decision:****Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25****WI Balanced Scorecard Indicator:**

129a: Dementia - Diagnosed

Executive Lead:Frances Robertson
Nurse/AHP Director & Chief Operating Officer**HEAT Target:**

People newly diagnosed with dementia will be offered a minimum of one year's post-diagnostic support, coordinated by a named link worker.

Responsible Officer:Mike Hutchinson
Associate Director of Mental Health**Trajectory Performance to date:****Supporting Analysis (where available):**

<u>Qtr Ending</u>	<u>Actual Cumulative</u>	<u>Cumulative Estimate</u>	<u>Deviation (%)</u>
Jun-24	17	33	-48.5%
Sep-24	27	66	-59.2%
Dec-24	44	100	-55.8%
Mar-25	19	33	-42.4%

<u>Qtr Ending</u>	<u>Qtr totals</u>
Jun-24	17
Sep-24	10
Dec-24	17
Mar-25	19

1. Performance Narrative (include key reasons for underperformance status)

Referrals have continued to increase and again worth noting that we continue to receive referrals at an early stage to allow early detection and enhance the life of the individuals receiving PDS support. We continue with Locum Psychiatrist cover and have maintained the continuity of the weekly MDT meetings.

People with Dementia are supported through out assessment by the same Dementia Nurse who also provides Post Diagnostic Support ensuring continuity of care through the entire patient journey. Our current Locum Psychiatrist is pro-actively working jointly with the Community Dementia Nurses to ensure timely diagnosis is confirmed and PDS can be activated at the earliest opportunity. We continue to have full time equivalent Dementia Nurse on long term sick leave. Dementia Nurse Consultant post remains vacant but due for advertising.

2. Planned Performance Improvements:

- Continuation of good working links with partner agencies to include Alzheimer's Scotland, local care homes and joint working within the extended community Nursing Team's
- Dementia Nursing team are involved in discussions regarding the Read-Out dementia biomarkers research project, which is being led by Dr Russ, Via the University of Oxford, this will promote early detection and enhance good clinical practice. Currently at early stage. WI Health Board have been identified for this via Alzheimer's Research UK(funded)
- Training of dementia Team as and when required, also providing bespoke training within local care Ongoing homes in relation to stress and distress.

3. Key Group/Committees consulted:

- Alzheimer's Scotland**
- Mental Health Operational Management Meeting**
- GP Subcommittees as and when required.**

Corporate Management Team 17.06.2025

Agenda Item: 8.4.1

Purpose: For Assurance

Section below to be completed following SOD/CMT review	
Date Reviewed:	Decision:

Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25

WI Balanced Scorecard Indicator:

20: 18 weeks Referral to Treatment for Psychological Therapies

Executive Lead:Frances Robertson
Nurse/AHP Director & Chief Operating Officer**HEAT Target:**

90% of Psychological Therapies patients to start treatment within 18 weeks of referral.

Responsible Officer:Mike Hutchinson
Associate Director of Mental Health & Learning Disabilities**Trajectory Performance to date:****Supporting Analysis (where available):**

<u>Quarter Ending</u>	<u>Actual</u>	<u>Planned Value</u>	<u>Deviation (%)</u>
Jun-24	85.5%	90%	-5.1%
Sep-24	78.0%	90%	-13.4%
Dec-24	85.2%	90%	-5.3%
Mar-25	68.8%	90%	-23.6%

<u>Quarter Ending</u>	<u>Patients Seen within 18wks</u>
Jun-24	47 of 55
Sep-24	46 of 59
Dec-24	46 of 54
Mar-25	44 of 64

1. Performance Narrative (include key reasons for underperformance status)

We only recruited to the principal psychologist post 3 weeks ago and we are interviewing for the consultant psychologist post on 5/6/25. However, due to insufficient PT capacity across adult and children services NHS WI can not meet in full the 18 week target.

2. Planned Performance Improvements:

1. Working with PHS to develop a trajectory tool and reporting process that will incorporate DCAQ in its analysis. This will identify capacity needs to meet 18 week target
- 2.
- 3.

3. Key Group/Committees consulted:

- 1.
- 2.
- 3.

Section below to be completed following SOD/CMT review

Date Reviewed:

Decision:

Local Delivery Plan – HEAT Standard Performance Assessment Q4 2024/25

WI Balanced Scorecard Indicator:

27 Sickness Absence Rate

Executive Lead:
Diane Macdonald
HR Manager
HEAT Target:

Target Standard is 4% sickness absence level

Responsible Officer:
Christine Kennedy
Employee & Relations Officer
Trajectory Performance to date:
Supporting Analysis (where available):

<u>Month Ending</u>	<u>Actual</u>	<u>Planned Value</u>	<u>Deviation (%)</u>	<u>Month Ending</u>	<u>Lost Hors</u>
Jun-24	7.6	4.0	90.0%	Jan-25	9053.08
Sep-24	5.13	4.0	28.3%	Feb-25	8101.26
Dec-24	5.60	4.0	40.0%	Mar-25	8230.11
Mar-25	5.55	4.0	38.8%		

1. Performance Narrative (include key reasons for underperformance status)

There was a slight rise in absence during the winter months but early signs are that this is reducing with a reduction to 5.55% in March.

National data shows that NHS Western Isles has the 3rd lowest rate of absence of all territorial boards for the period 1st February 2024 to January 2025.

Employee Relations Officer's and Occupational Health continue to work closely to monitor absence and ensure all absences are being managed. A monthly meeting is held to analyse absence and follow up with managers on any absences that are not being managed appropriately.

Performance review of senior managers includes management of sickness absence. Increased data analysis of sickness absence by roster area is being reported to the Strategic Workforce Group and Corporate Management Team

The Director of HR and Workforce Development has met with managers for areas with the highest absence to ensure all possible actions are in place and that policy is being consistently applied. There is a high level of assurance that the attendance management process is being applied consistently to staff who have met triggers.

Managers who have input 'unknown' reasons for absence have been contacted with an instruction to input an absence category.

All managers have been invited to training on attendance management to ensure consistent application of policy and procedure across the organisation.

Staff communications on attendance management have been issued to highlight manager and employee responsibilities in the process.

2. Planned Performance Improvements:

1. All are being actively managed and employees supported appropriately with HR and OH working closely to monitor absences and ensure all absences are being managed in line with OfS policy. This is a continual process.
2. Along with ongoing training on attendance management to managers, staff communications have been issued to highlight both manager and employee responsibilities in the process.
3. The Wellbeing Group have agreed a Wellbeing Strategy and Action Plan which has a focus on mental wellbeing.

3. Key Group/Committees consulted:

1. Staff Governance
2. Partnership Forum (APF)
3. CMT/OSDT

Section below to be completed following SOD/CMT review

Date Reviewed:	Decision:

Hospital Performance Section

3. Western Isles Hospital

A&E

Figure 1 - No. A&E Attendances

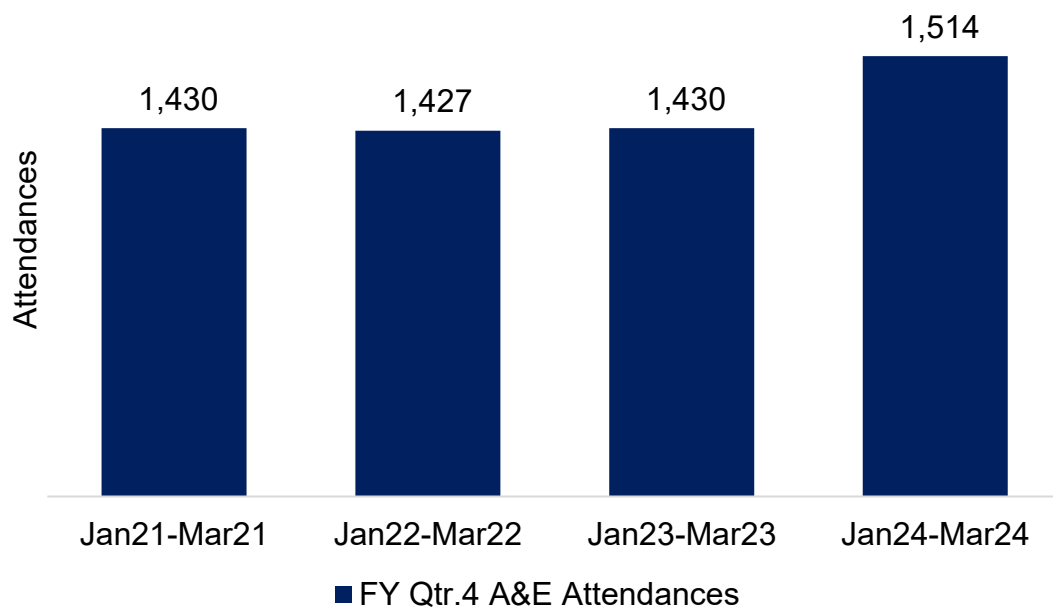


Figure 2 - % Attendances admitted

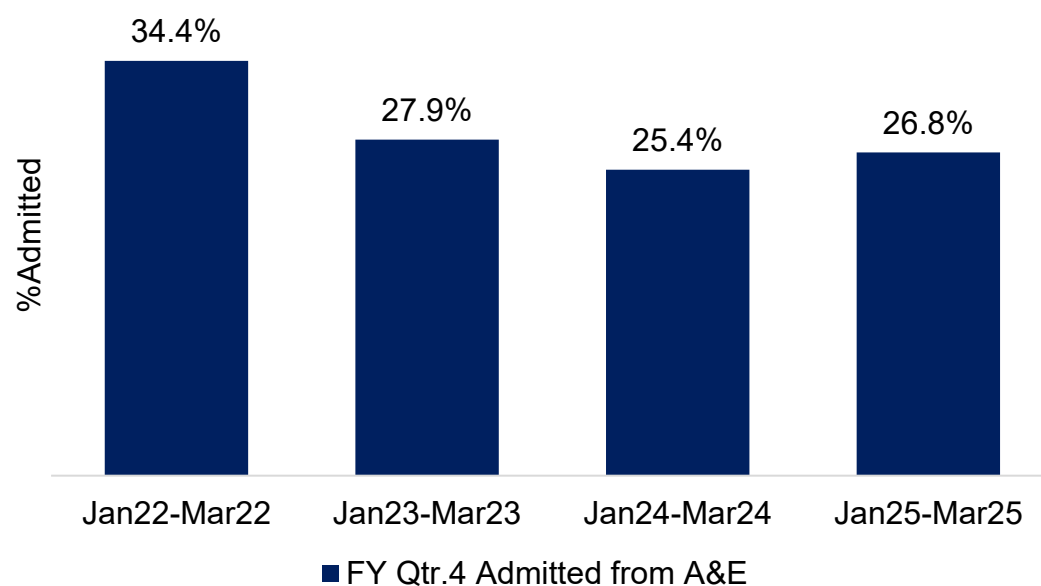


Table 2 - Outcome for WIH A&E Attendances

Disposition Description - (Jan-Mar)	2022	2023	2024	2025
Discharged With no follow up	36%	45%	43%	41%
Admitted	34%	28%	26%	27%
Discharged With referral	17%	17%	18%	18%
Discharged With follow up by primary team	9%	7%	9%	9%

Over 95% of attendances are included in these 4 descriptions

Table 3 - Referrals from WIH A&E Attendances

Referral from ED - (Jan-Mar)	2022	2023	2024	2025
No Follow Up Required	58%	66%	63%	61%
Other clinic	9%	13%	14%	12%
GP	14%	9%	10%	12%
A&E Clinic	5%	4%	4%	4%
Other	5%	1%	2%	2%
Other Healthcare professional/ service or organisation	1%	1%	1%	2%
Fracture clinic	2%	1%	2%	1%
Practice nurse	2%	2%	2%	1%

Over 95% of attendances are included in these 8 descriptions

Excludes patients that had an outcome of Admission

Table 4 - Flow of WIH A&E Attendances

Flow Type - (Jan-Mar)	2022	2023	2024	2025
Flow 1 (Minor Injury & Illness)	62%	68%	71%	70%
Flow 2 (Acute assessment)	3%	2%	2%	0.2%
Flow 3 (Medical Admissions)	25%	21%	19%	20%
Flow 4 (Surgical Admissions)	10%	7%	6%	7%
Flow 5 (Out of hospital Care)	1%	2%	2%	3%

Inpatient and Day Case Activity

Figure 3 - Inpatient and Day Case Activity (Episodes)

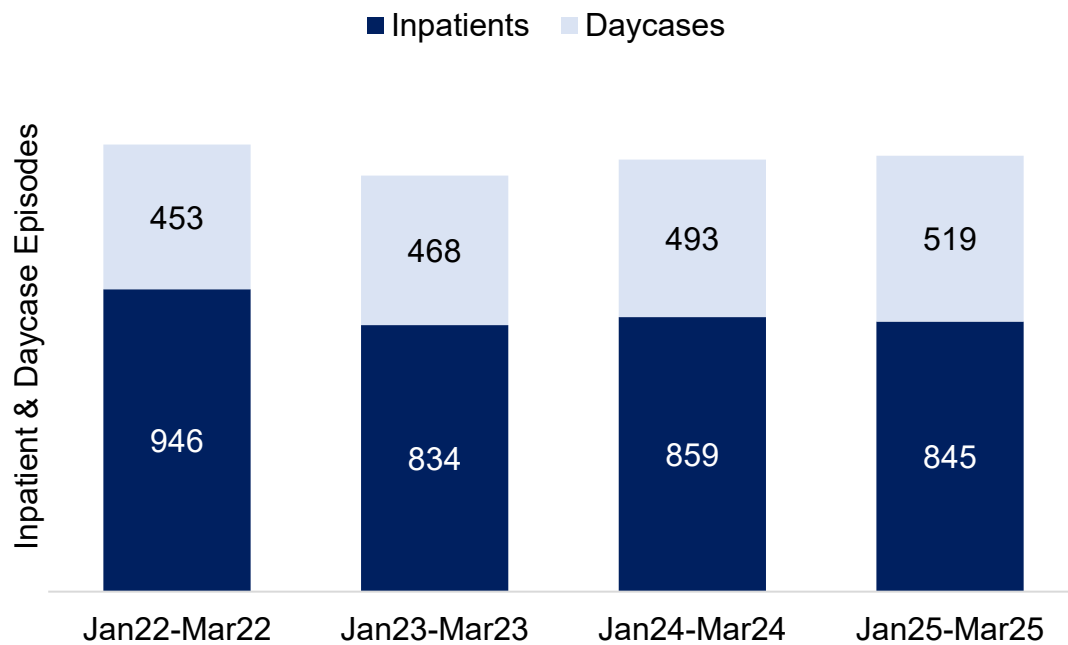
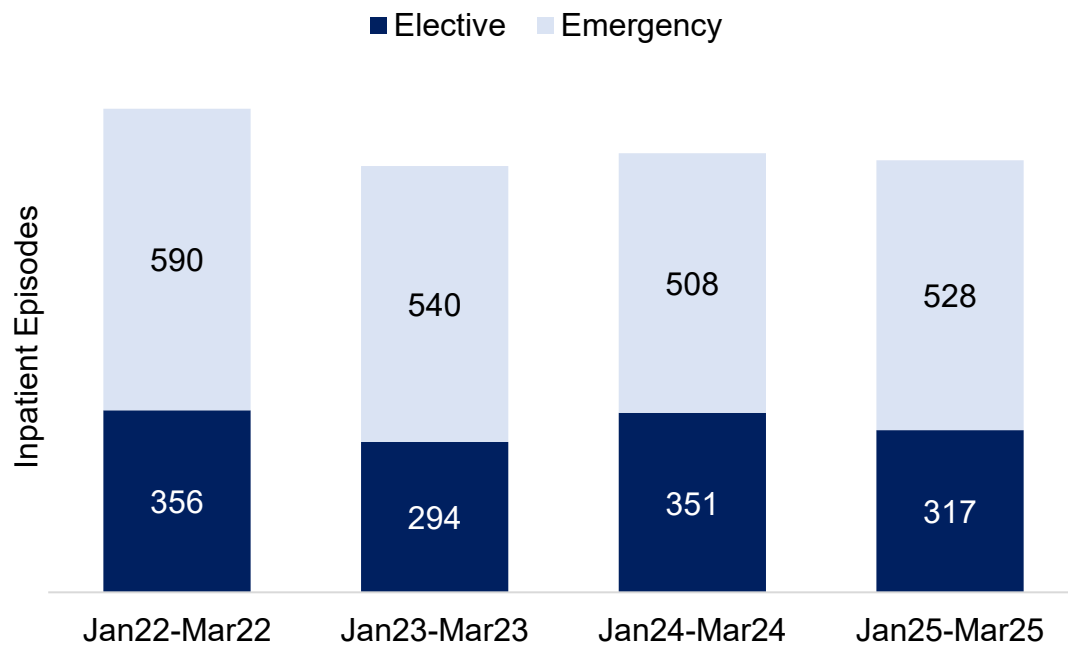


Figure 4 - Inpatient Activity by Type



Inpatient and Day Case – specialty breakdown

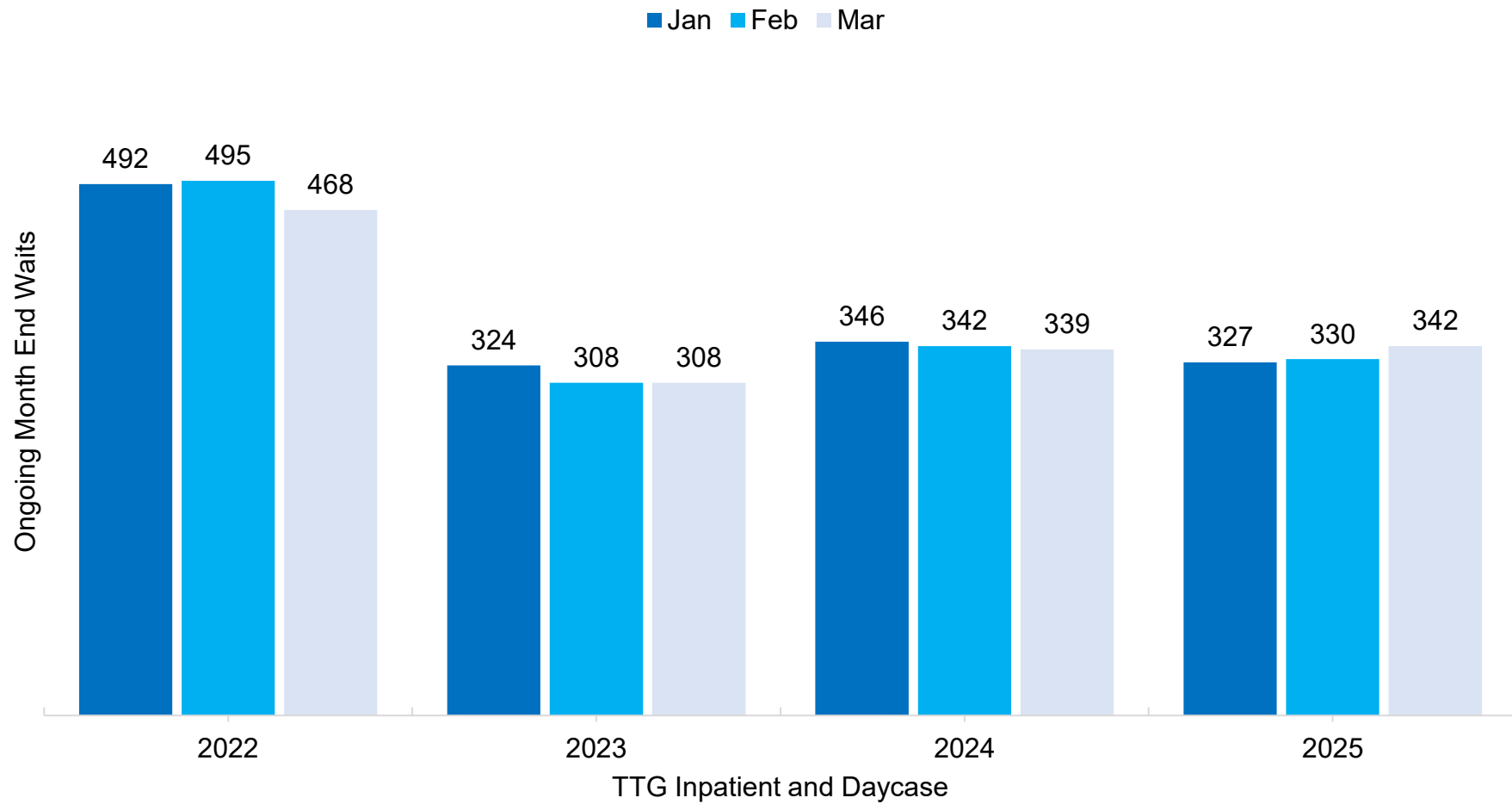
Table 5 - Western Isles Hospital only - all specialties excluding Obstetrics and Psychiatry

W107H ONLY	Inpatients					Daycase					IP & DC
Specialty	Jan22-Mar22	Jan23-Mar23	Jan24-Mar24	Jan25-Mar25	IP TOTAL	Jan22-Mar22	Jan23-Mar23	Jan24-Mar24	Jan25-Mar25	DC TOTAL	TOTAL
General Medicine	622	503	576	519	2220	0	1	1	3	5	2225
General Surgery	164	157	127	150	598	267	320	295	304	1186	1784
Trauma and Orthopaedic Surgery	98	106	111	130	445	61	48	50	34	193	638
Ophthalmology	0	0	0	2	2	60	64	91	114	329	331
Paediatrics	45	56	30	32	163	0	1	0	0	1	164
Gynaecology	15	11	15	12	53	11	15	22	28	76	129
Urology	0	0	0	0	0	45	14	26	28	113	113
Oral and Maxillofacial Surgery	2	0	0	0	2	9	5	8	8	30	32
Anaesthetics	0	1	0	0	1	0	0	0	0	0	1
Obstetrics & Gynaecology	0	0	0	1	1	0	0	0	0	0	1
Total	946	834	859	846	3485	453	468	493	519	1933	5418

Number IP/DC on Waiting List

*Note : *Acute and medical specialties only, also as appointment locations are not determined until they are scheduled, the waiting list is not split by island.*

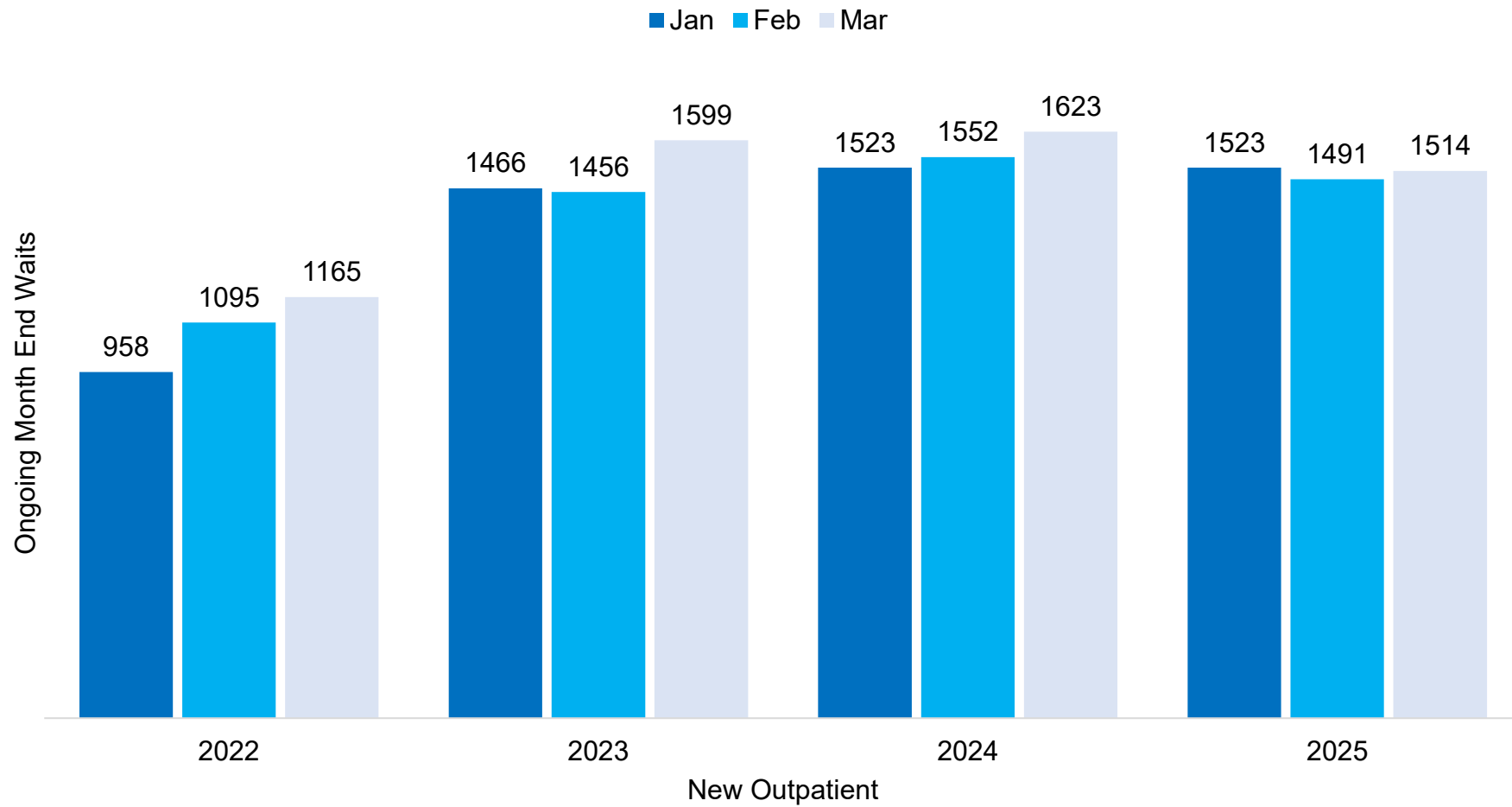
Figure 5 - TTG Inpatients and Daycases waiting list sizes



Number of New Outpatients on Waiting List

*Note : *Acute and medical specialties only, also as appointment locations are not determined until they are scheduled, the waiting list is not split by island.*

Figure 6 - New Outpatients on Waiting List



Corporate Management Team 17.06.2025

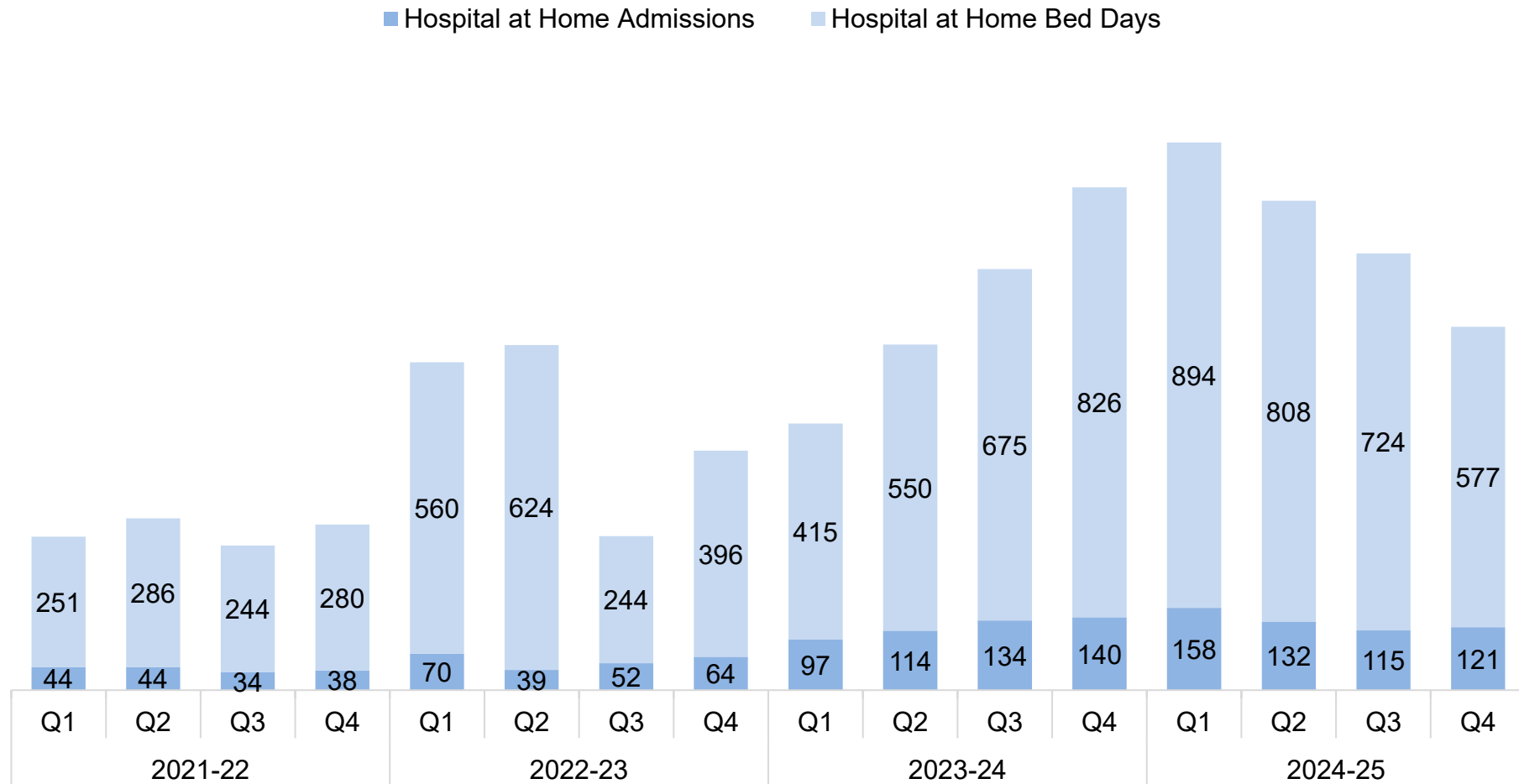
Agenda Item: 8.4.1

Purpose: For Assurance

Hospital at Home Admissions

Note: Includes admissions with LOS - some of these are CCE daycases under General Surgery but there are additional General Medicine and Orthopaedic patients too. 140 episodes with LOS = 0

Figure 7 - Hospital at Home Admissions



8 Key Tests

Endoscopy: Upper Endoscopy , Lower Endoscopy (excluding Colonoscopy) ,
Colonoscopy , Cystoscopy

Radiology: CT Scan , MRI Scan , Barium Studies ,
Non-obstetric ultrasound

Figure 8 - 8 Key Diagnostic Tests Waiting Times

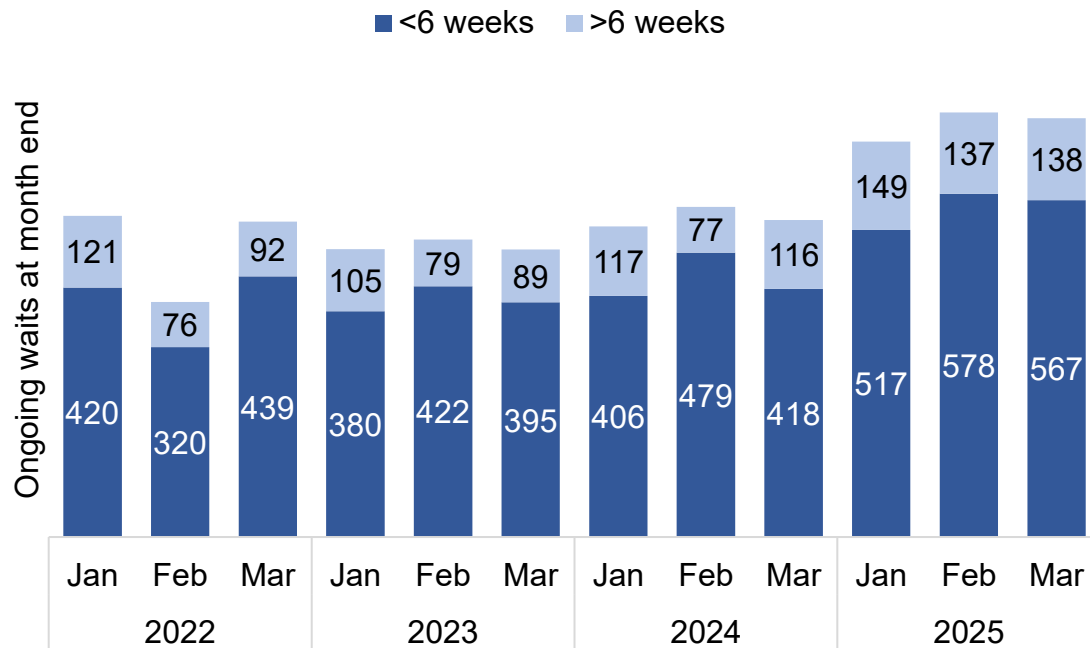
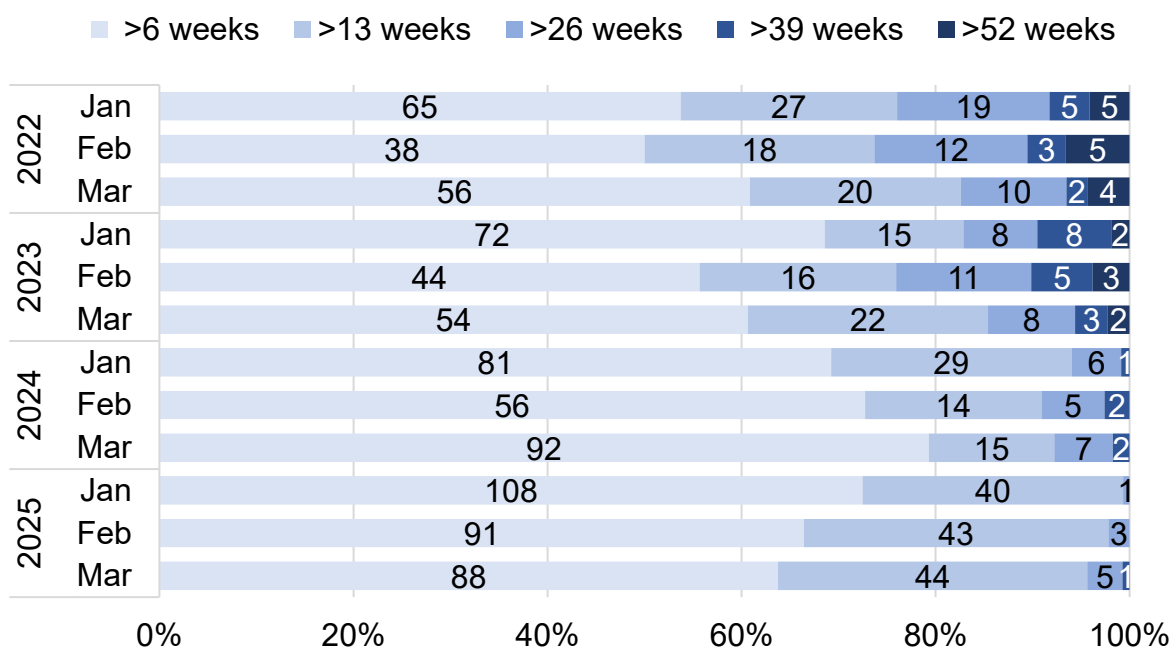
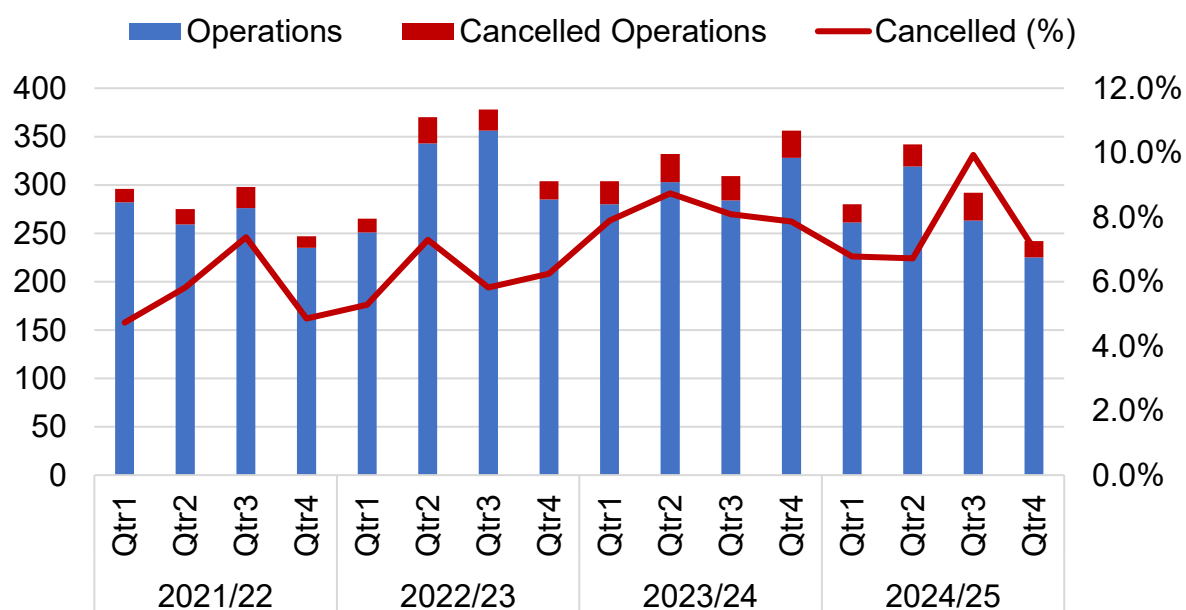


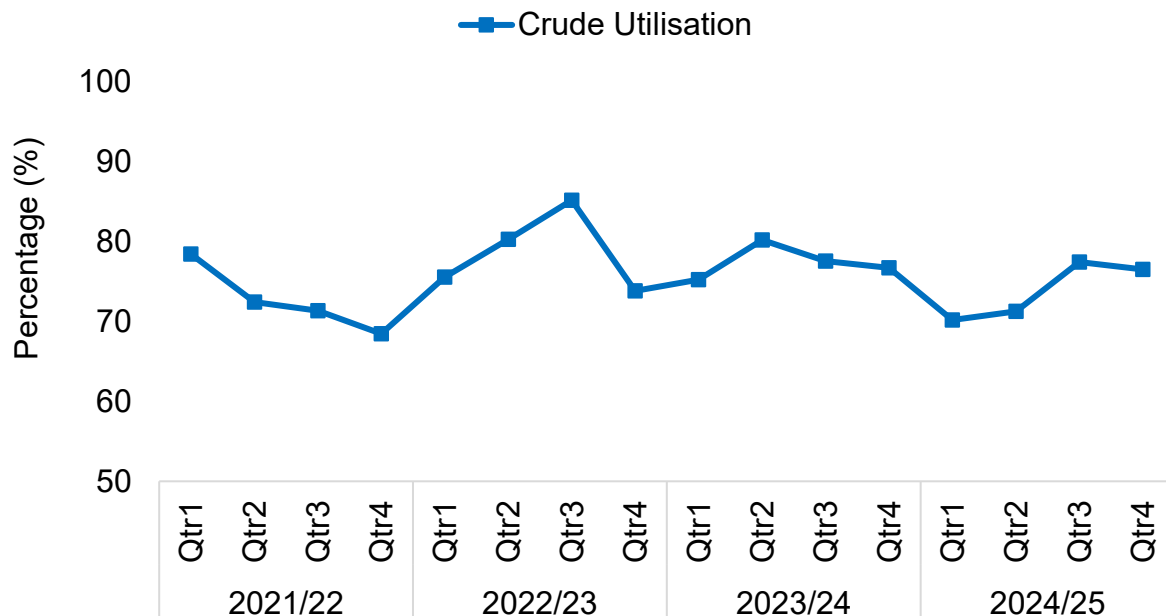
Figure 9 - Waits exceeding 6 weeks

Theatre Utilisation

Figure 10 - Cancelled Operations

Note : Data Includes Theatre 1 and Theatre 2 Only

Figure 11 - Theatre Utilisation (%)



Note : Crude utilization measures the efficiency of allocated working hours by comparing the planned (allocated) hours with the actual hours spent on tasks. A high crude utilization indicates that most of the assigned hours were effectively used, whereas a low value suggests inefficiencies or underutilization.

Hospital Beds (WIH)

Table 6 - Current Bed Complement (WIH)

Wards	Bed complement
Medical 1	8
Medical 2	22
Surgical Ward	18
HDU	4
APU	5
Maternity Ward	6
Children	3
WIH	66
*WIH (Acute)	52

**Acute beds include Medical 1, Medical 2, Surgical & HDU*

Table 7 - Percentage Occupancy Wards %

Wards	% Occupancy based on bed complement	% Occupancy based on staffed beds
Medical 1	**110.4%	97.1%
Medical 2	**113.9%	98%
Surgical Ward	86.2%	84.4%
APU	78.7%	78.7%
HDU	64.4%	64.3%
Children	35.6%	35.6%
Maternity Ward	24.3%	24.3%
WIH	88.6%	82.2%
WIH (*Acute)	100.0%	91.1%

**Acute beds include Medical 1, Medical 2, Surgical & HDU*

*** Where occupancy exceeds 100% this means the bed complement for that ward has been exceeded however contingency beds come into use and so staffed beds never exceeds 100%*

Figure 12 - Occupied Bed Days & Percentage Occupancy (All Beds)

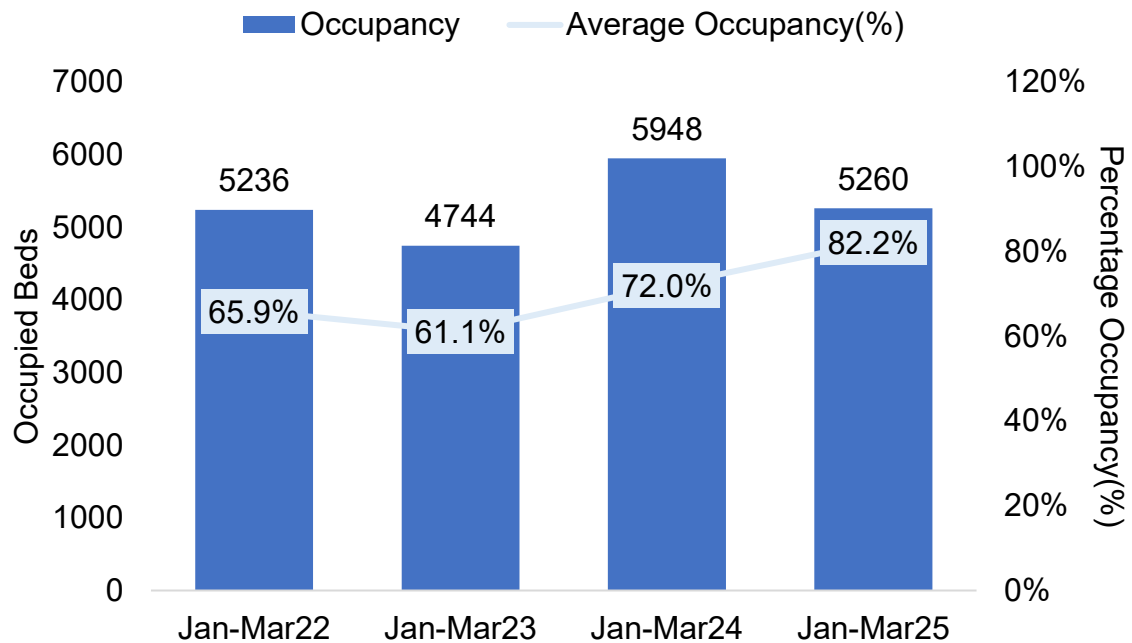
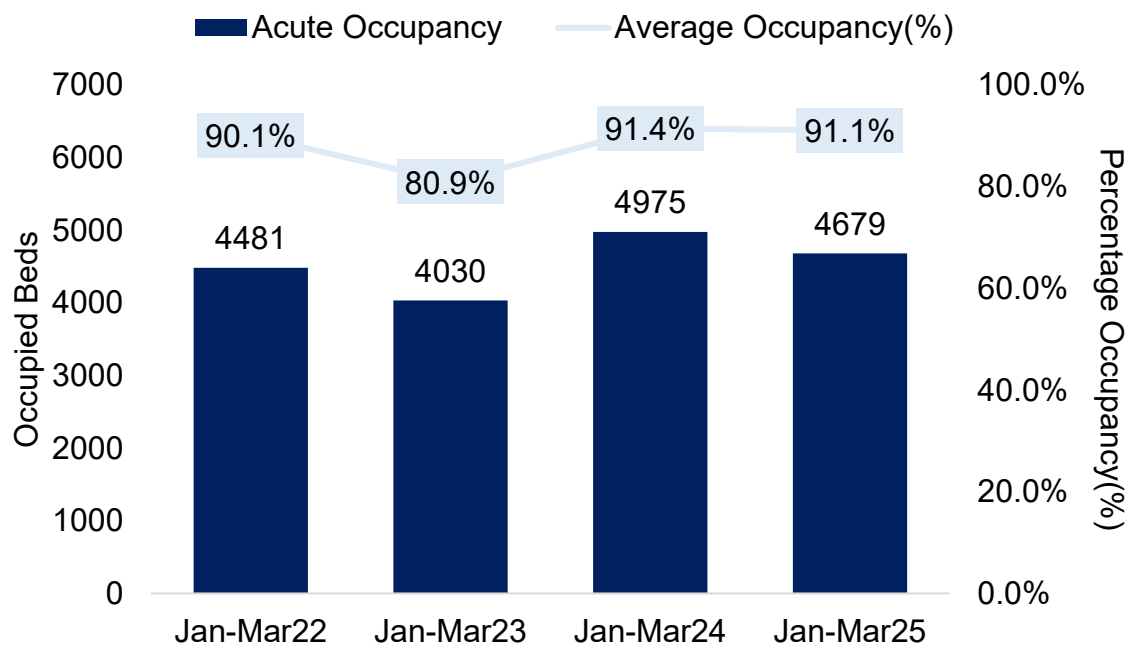


Figure 13 - Occupied Bed Days & Percentage Occupancy (Acute Beds Only)



Note: Acute Beds - include Medical 1, Medical 2, Surgical & HDU

Figure 14 - Number of Episodes and Average Length of Stay(ALOS)

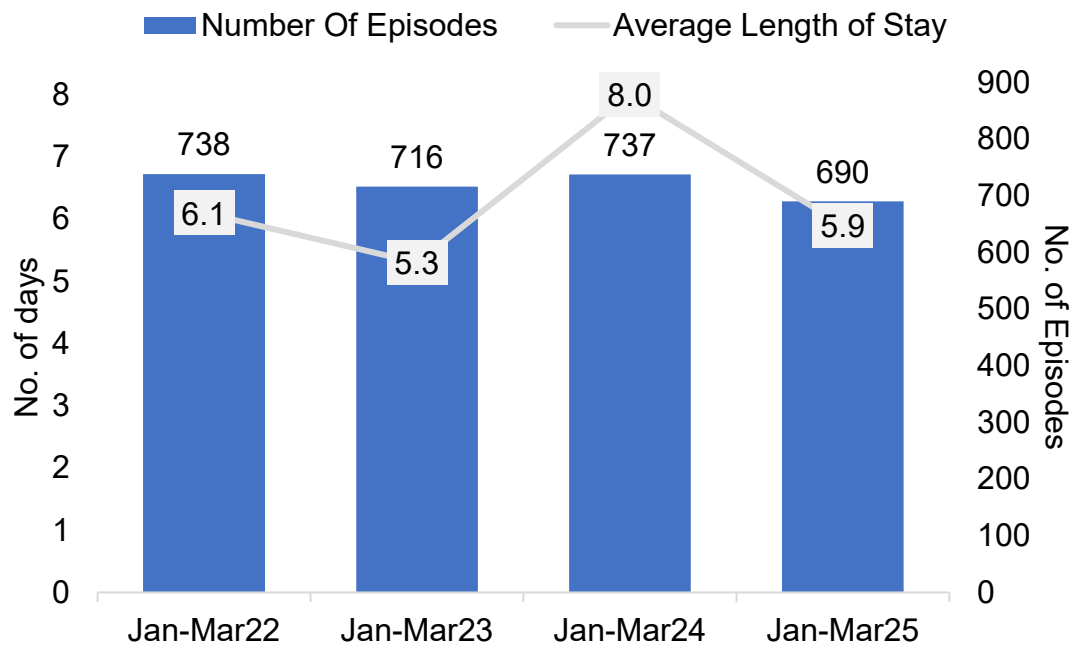


Figure 15 - Average Length of Stay by Speciality

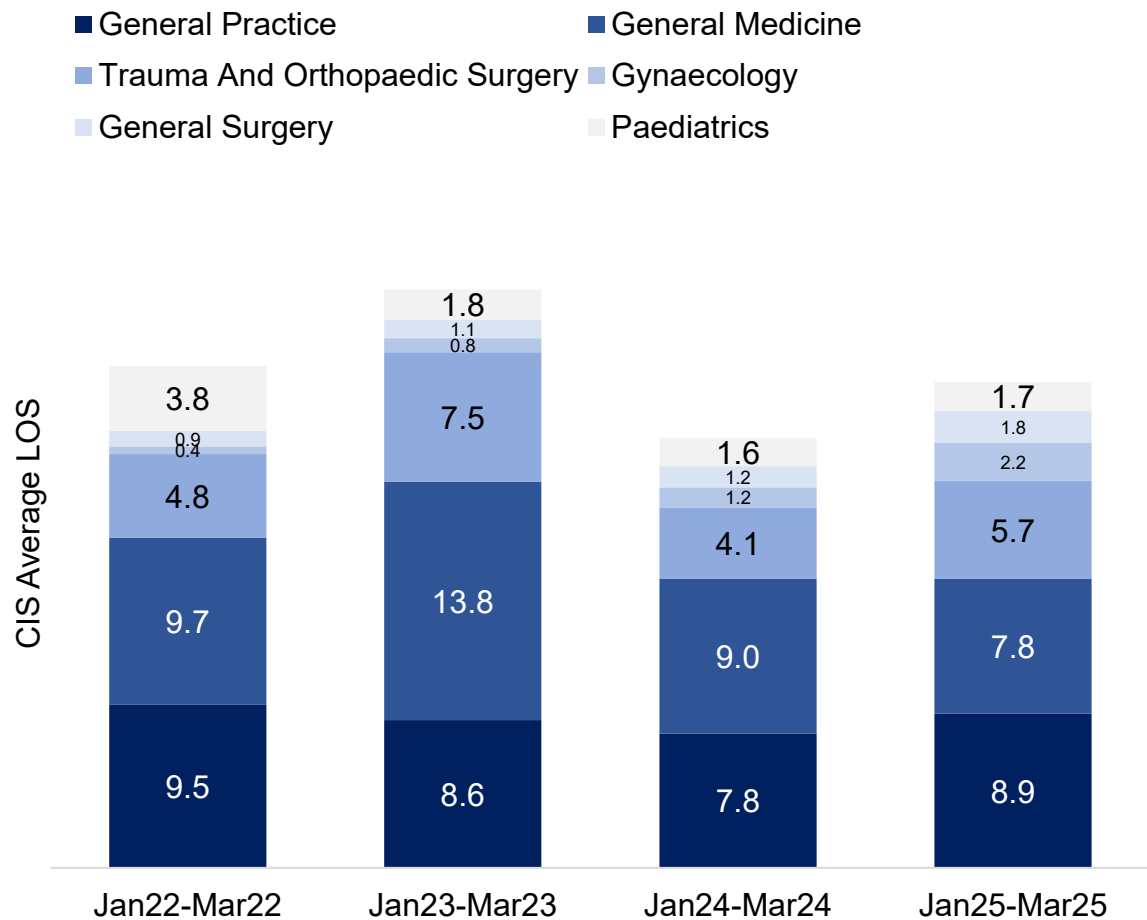


Table 8 - Daily Occupancy Bands

% Occupancy based on staffed beds	Number of days
	Jan to Mar 2025
100	-
95-99	8
90-94	31
85-89	19
80-84	21
75-79	10
70-74	1
65-69	-
60-64	-
<60	-

Table 9 - Daily Occupancy Bands

Ward	Number of days Jan to Mar 2025
Medical 1	71
Medical 2	71
APU	37
Surgical Ward	24
HDU	14
Children	5

Outpatient Appointments

Figure 16 - New and Repeat Outpatient Appointments

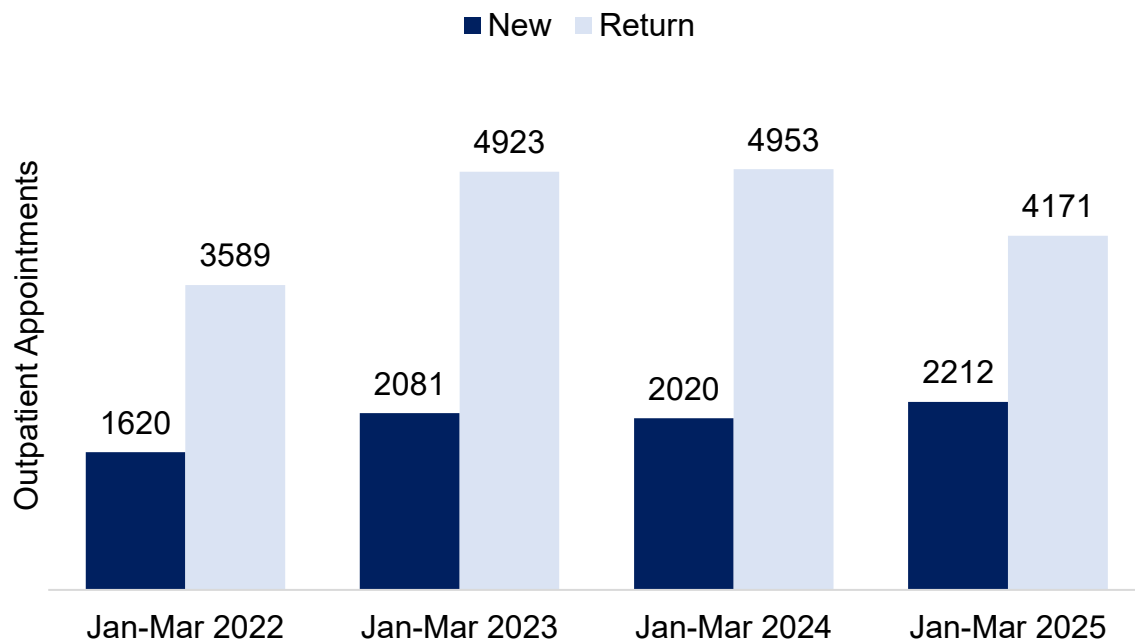


Figure 17 - Outpatients Return to New Ratio

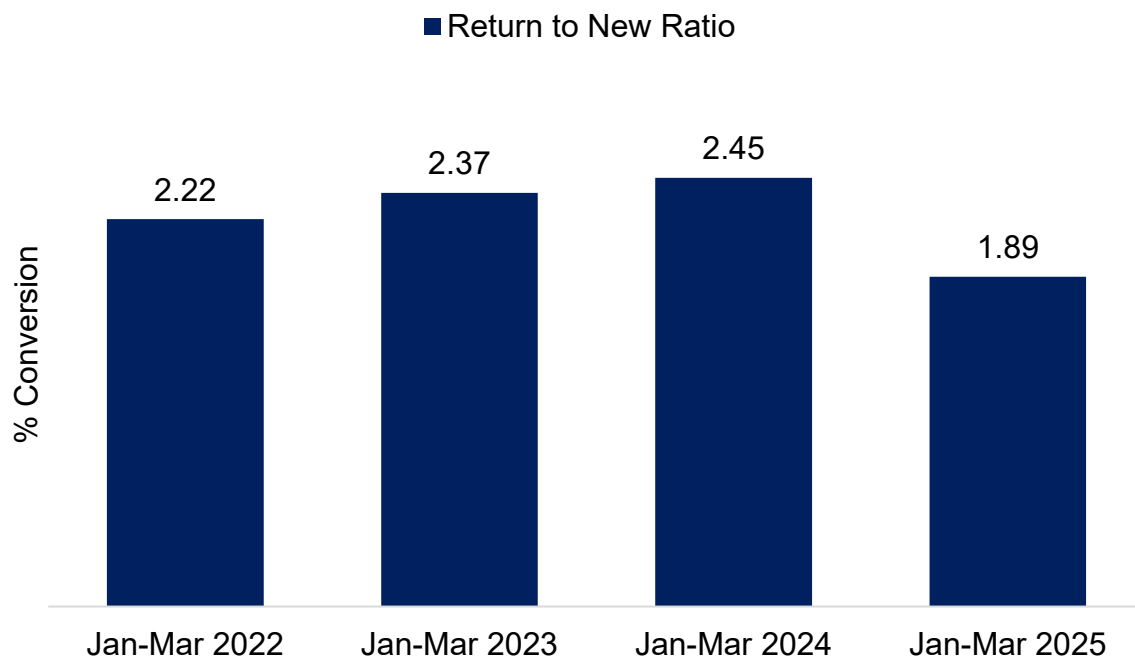


Figure 18 – Percentage Did Not Attend (% DNA)

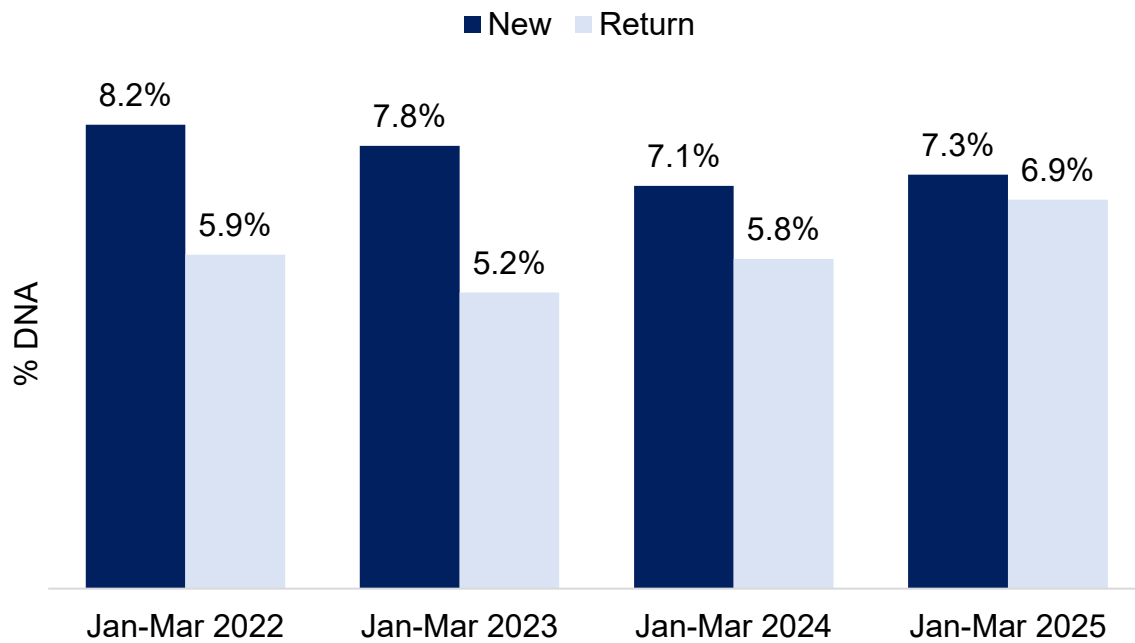


Figure 19 - Percentage Could Not Wait (CNW %)

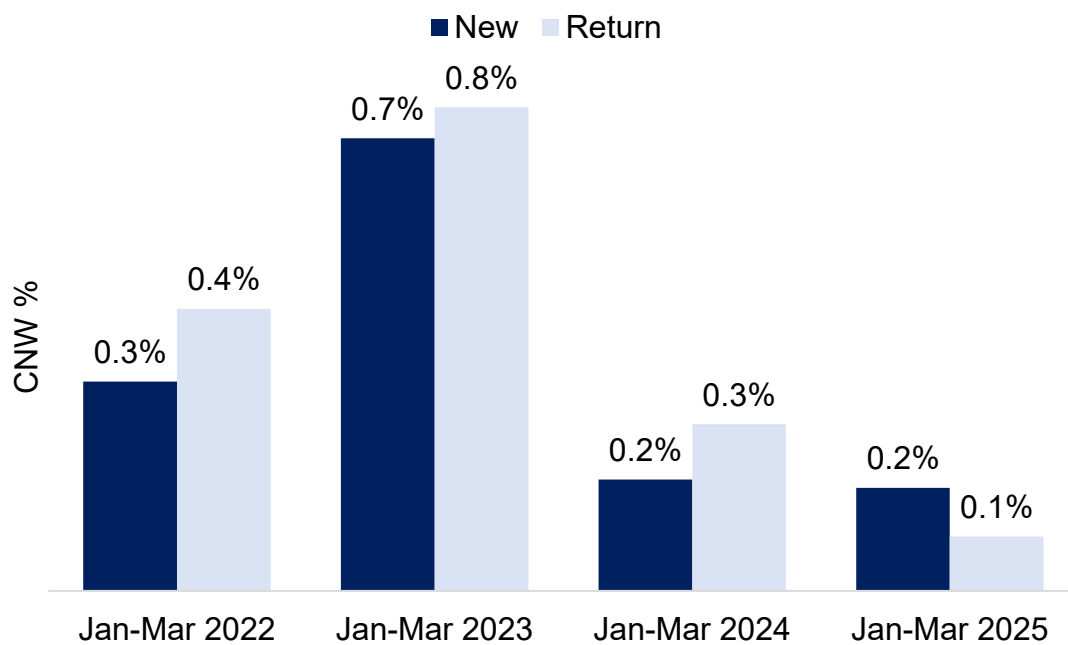


Figure 20 - Percentage Cancelled Appointments (%)

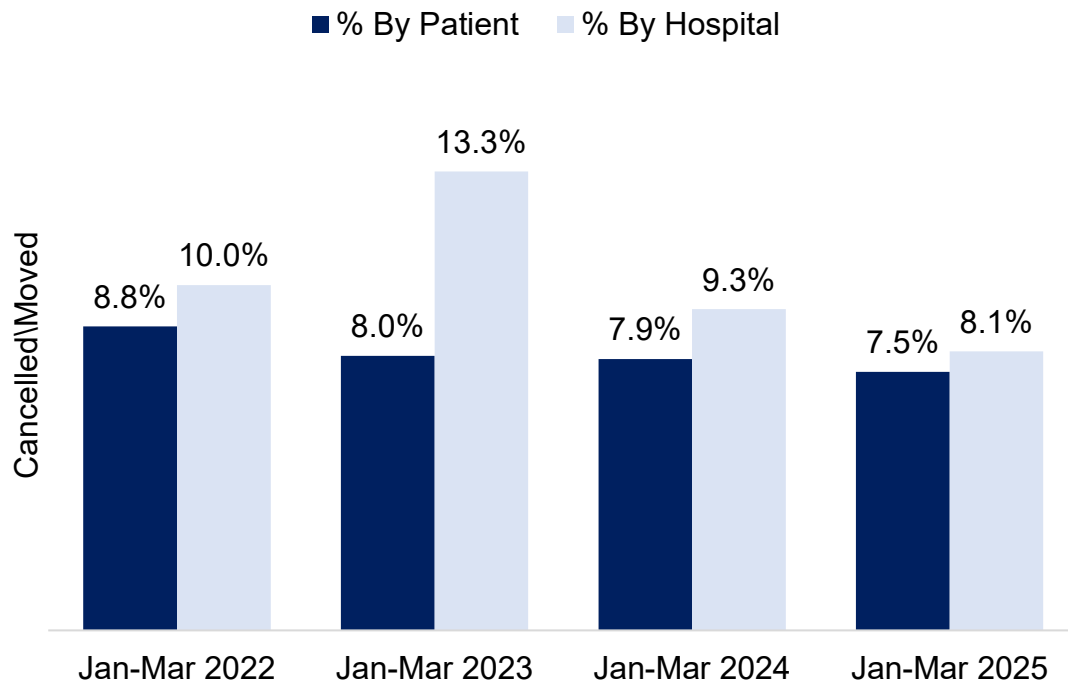
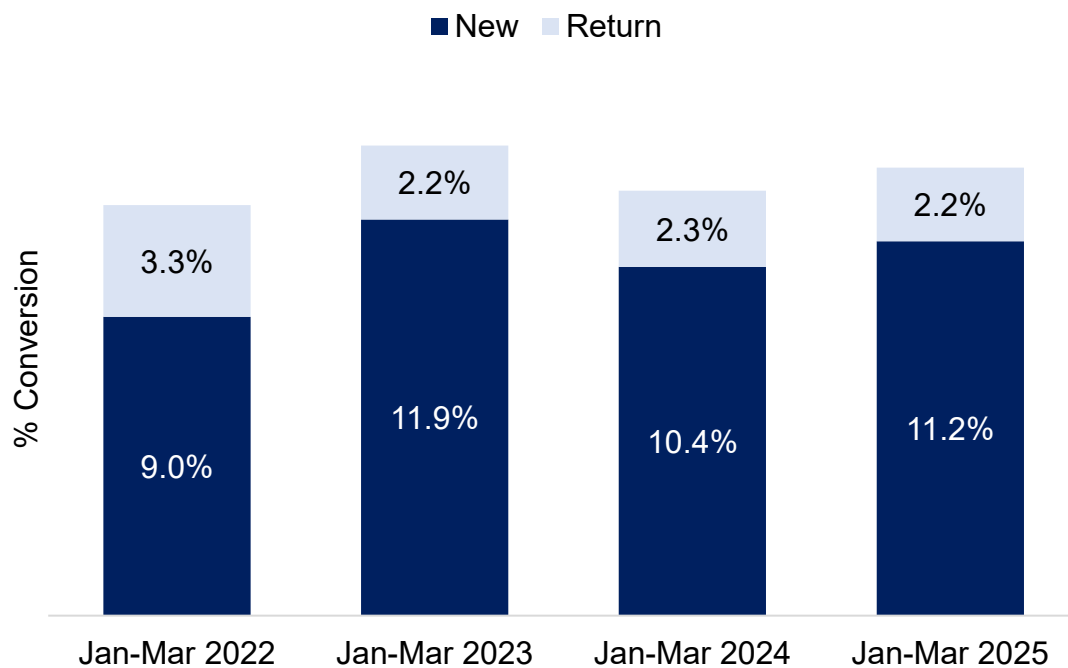


Figure 21 - Percentage Conversion to IP/DC



4. Ospadal Uibhist agus Barraigh (OUAB)

A&E OUAB

Figure 22 - No. A&E Attendances

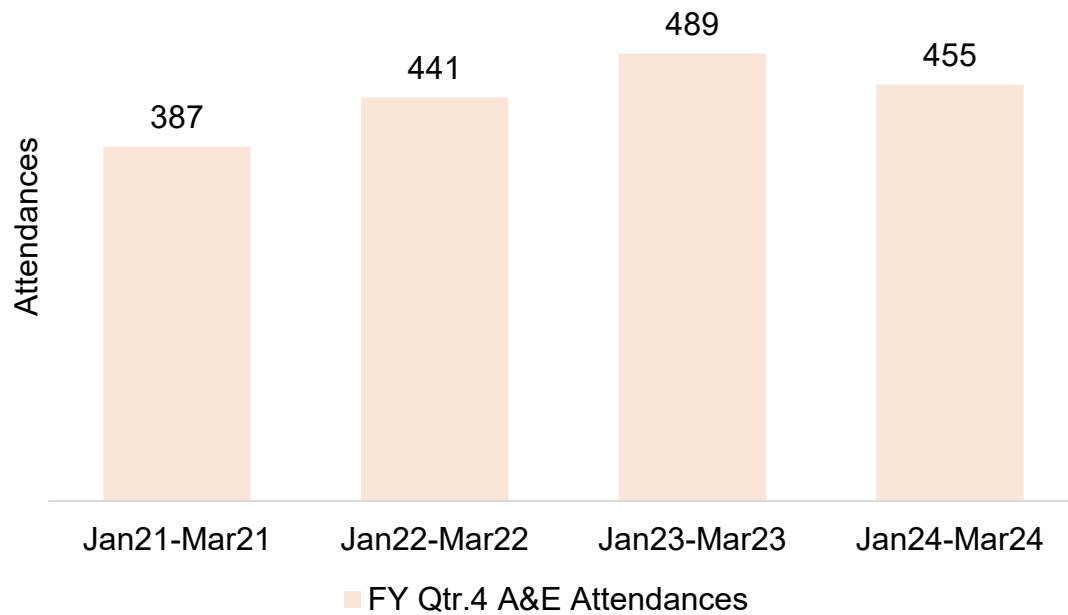


Figure 23 - % Attendances admitted

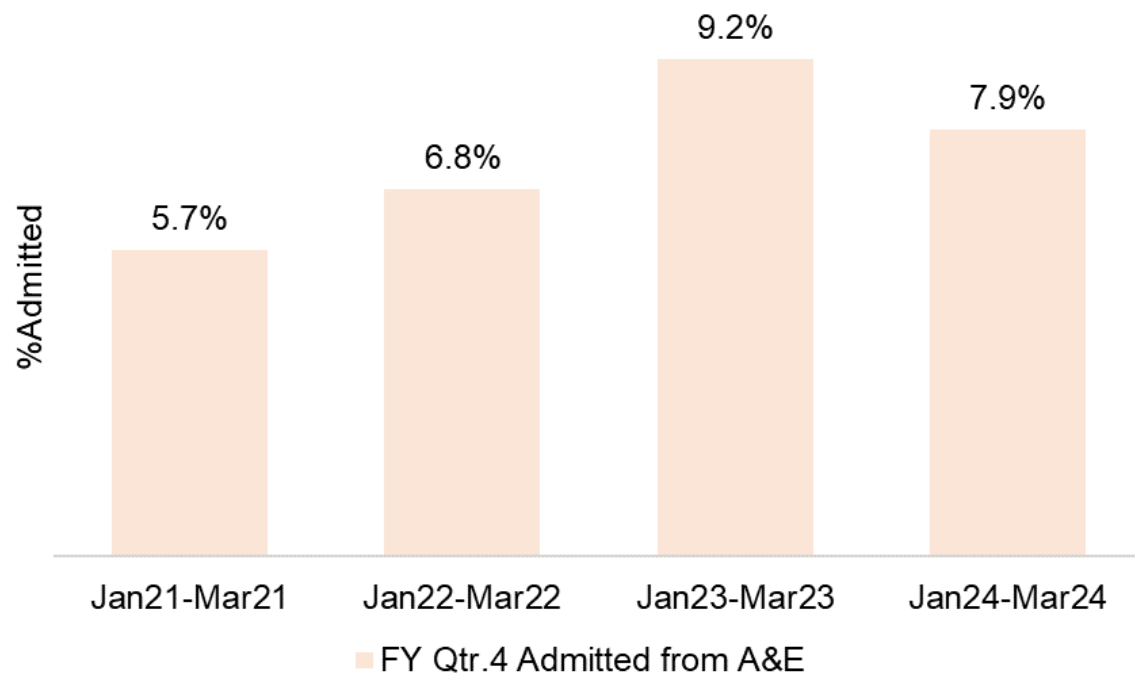


Table 10 - Outcome for OUAB A&E Attendances

Disposition Description - (Jan-Mar)	2022	2023	2024	2025
Discharged With no follow up	53%	55%	53%	52%
Discharged With follow up by primary team	22%	25%	27%	25%
Discharged With referral	17%	13%	10%	11%
Admitted	5%	7%	9%	7%

Table 11 - Referrals from OUAB A&E Attendances

Referral from ED - (Jan-Mar)	2022	2023	2024	2025
No Follow Up Required	60%	59%	58%	55%
GP	11%	16%	12%	17%
A&E Clinic	15%	13%	18%	16%
Other clinic	4%	4%	1%	3%
Other	3%	1%	2%	3%
Other Healthcare professional/ service or organisation	3%	2%	2%	2%
Physiotherapist	1%	0%	1%	1%
Community nurse	0%	1%	1%	0%

Table 12 - Referrals from OUAB A&E Attendances

Flow Type - (Jan-Mar)	2022	2023	2024	2025
Flow 1 (Minor Injury & Illness)	90%	90%	88%	90%
Flow 2 (Acute assessment)	4%	3%	3%	2%
Flow 3 (Medical Admissions)	6%	7%	9%	7%

Inpatient and Day Case Activity

Figure 24 - IP/DC Activity (episodes)

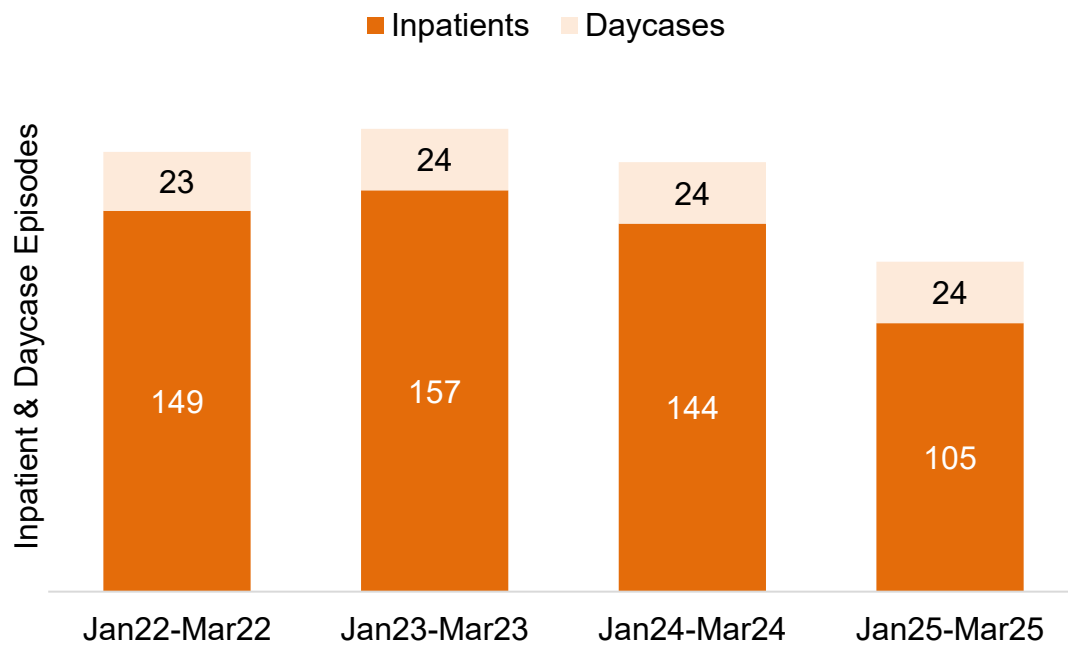
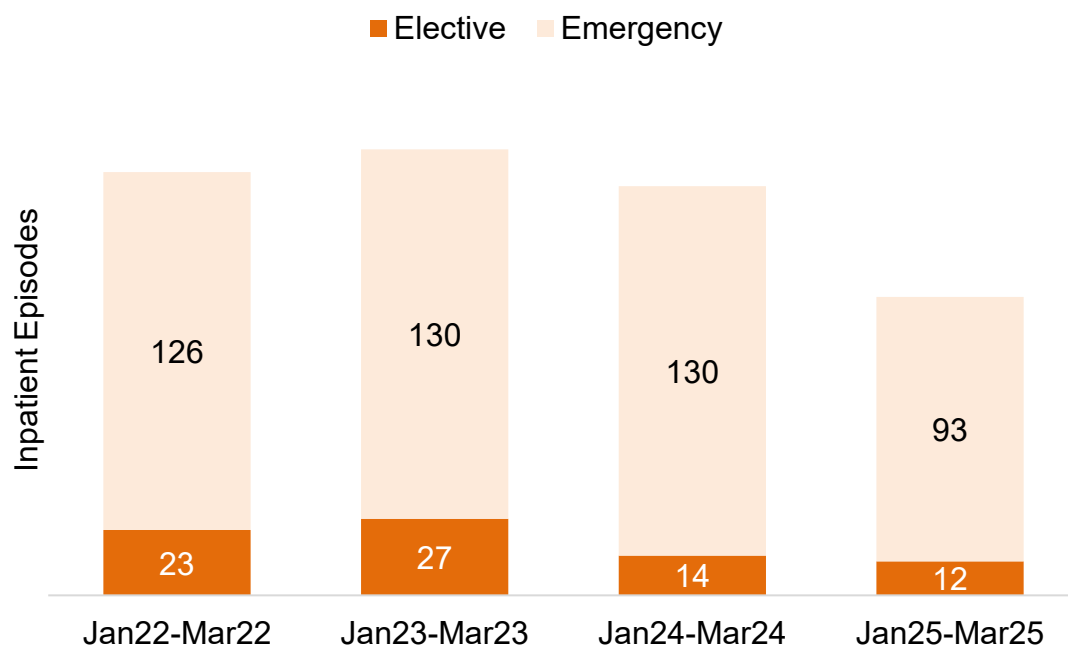


Figure 25 - Inpatients by Admission Type



Hospital Beds (OUAB)

Table 13 - Current Bed Complement

Ward/Location	Bed Complement
Uist and Barra	16

Figure 26 - Occupied Bed Days

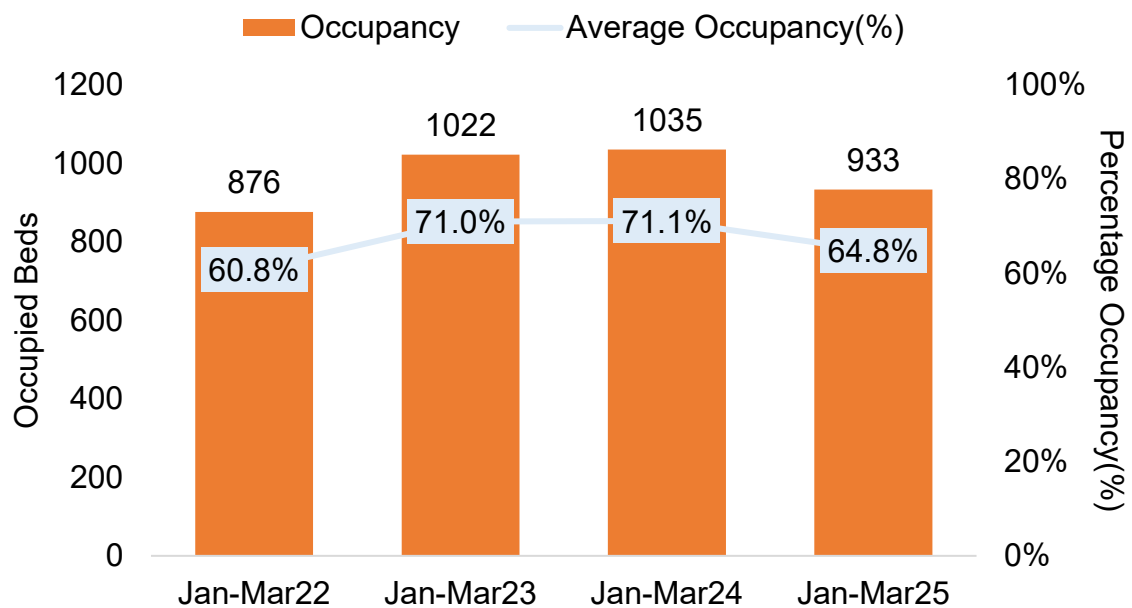


Figure 27 - Average Length of Stay

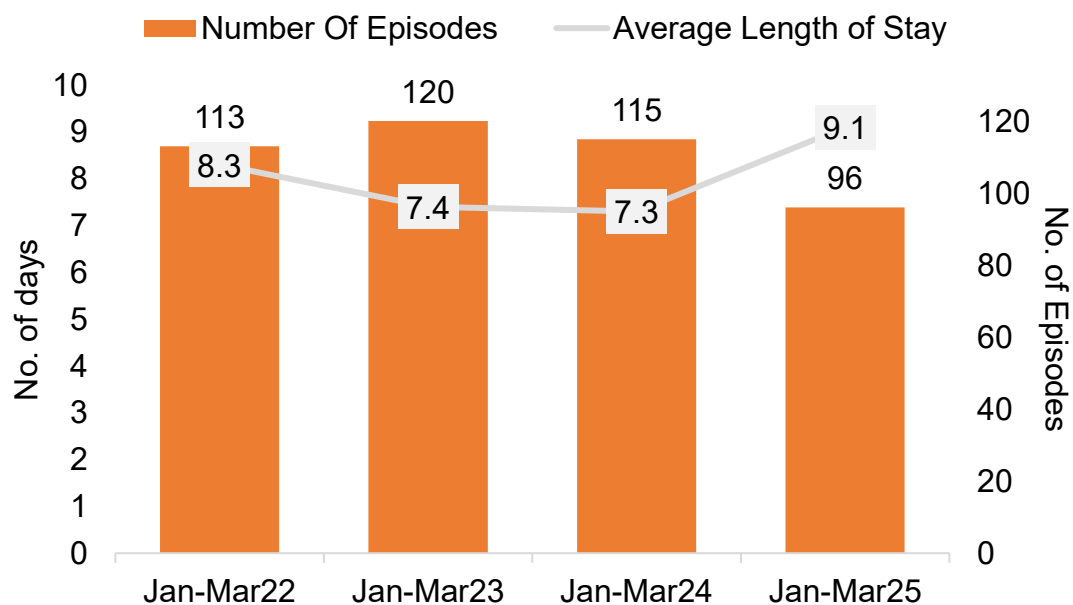


Table 14 - Daily Occupancy Bands

% Occupancy	Number of days
	Jan to Mar 2025
100	-
95-99	1
90-94	4
85-89	7
80-84	18
75-79	-
70-74	11
65-69	19
60-64	30
<60	-

Figure 28 - New and Repeat Outpatient attendances

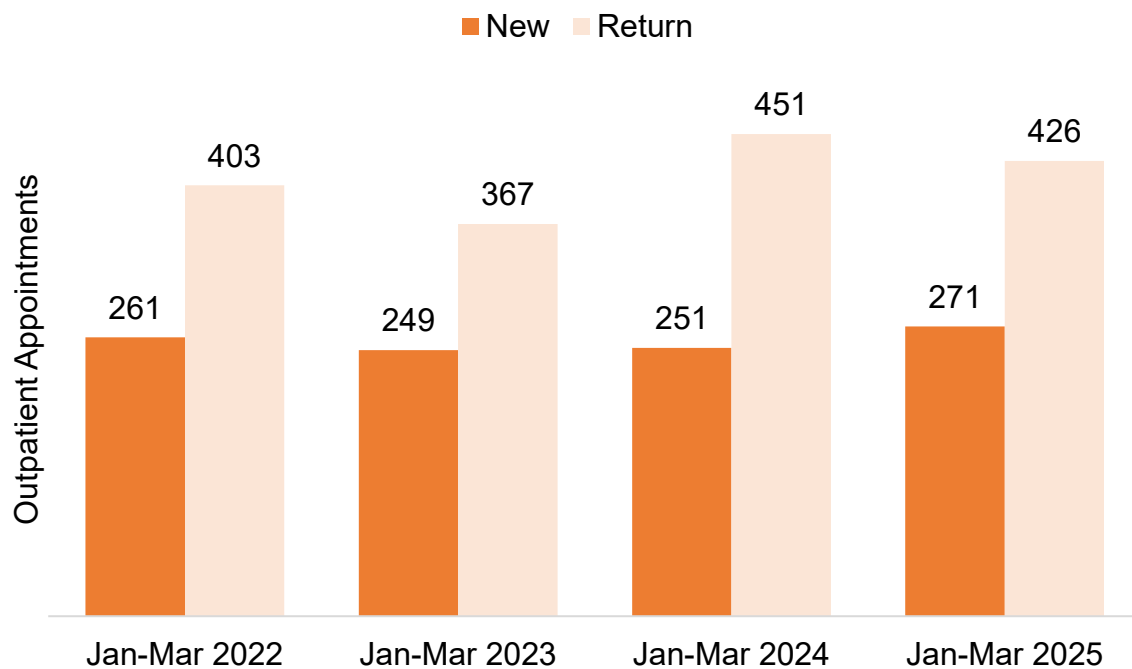


Figure 29 - Outpatient Return to New Ratio

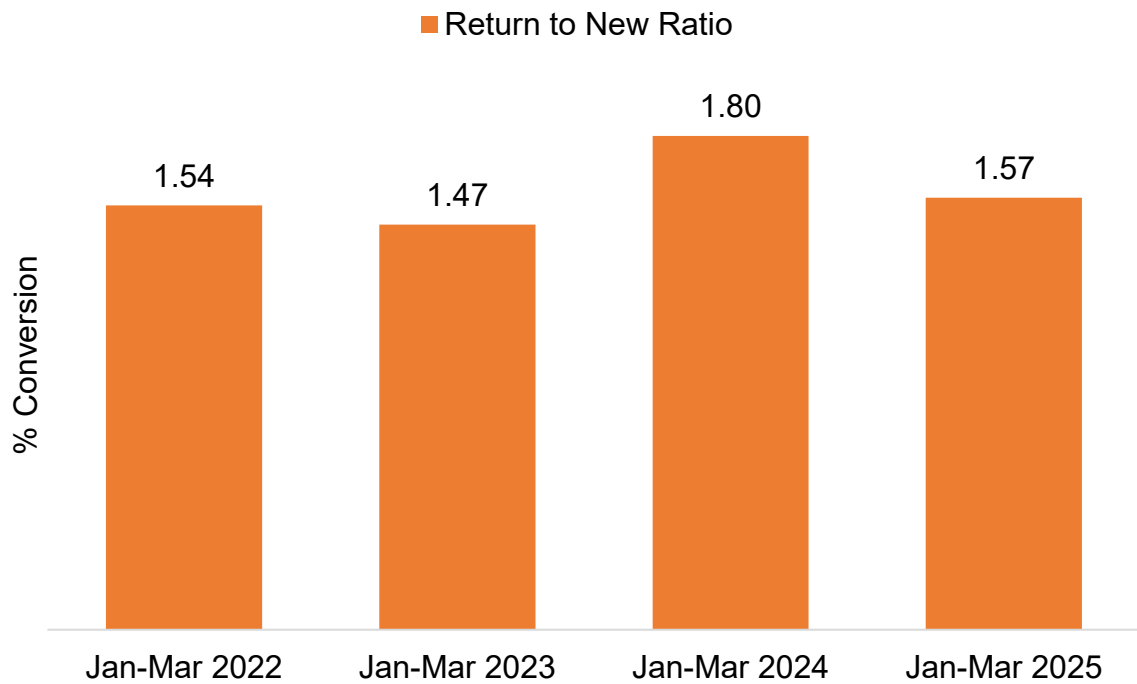


Figure 30 - Percentage Did Not Attend (% DNA)

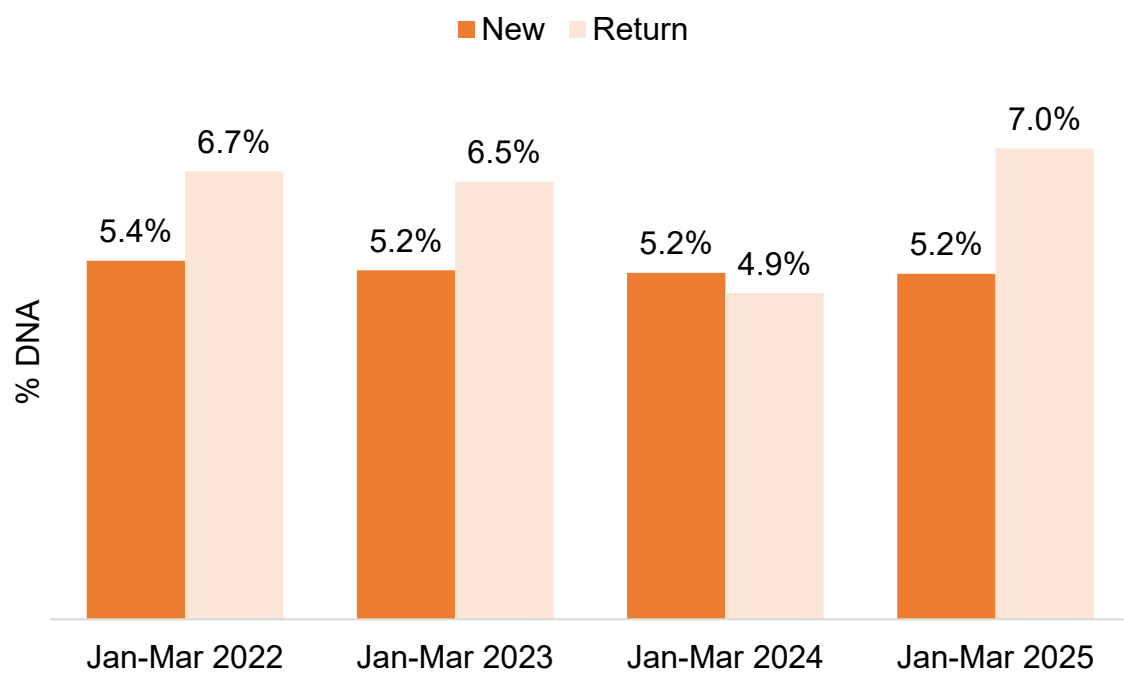


Figure 31 - Percentage Cancelled Appointments (%)

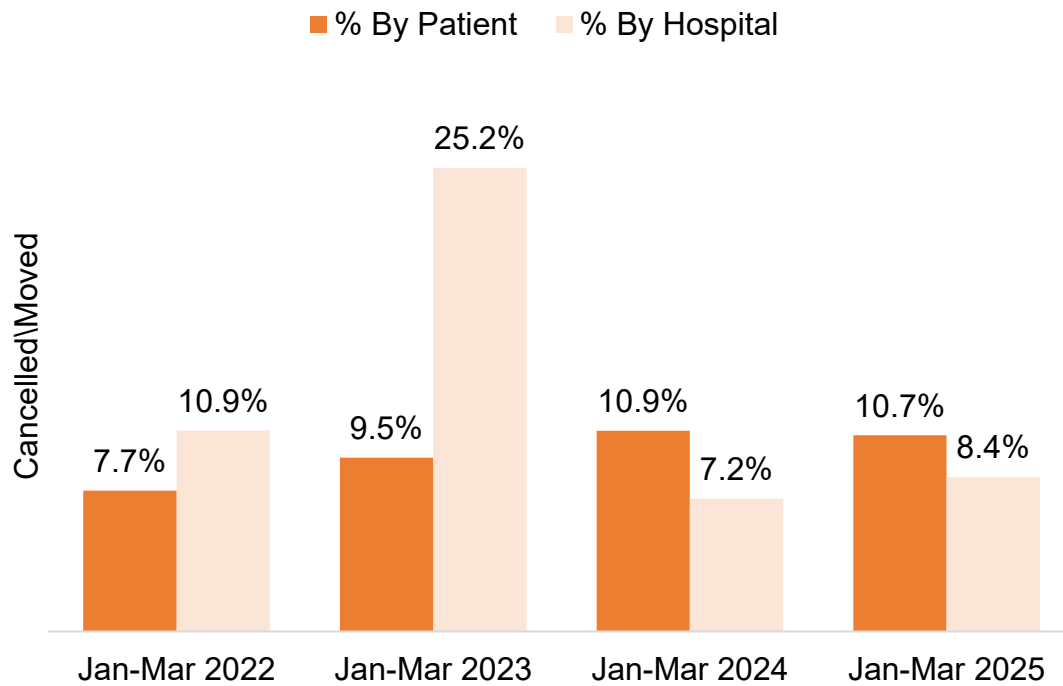
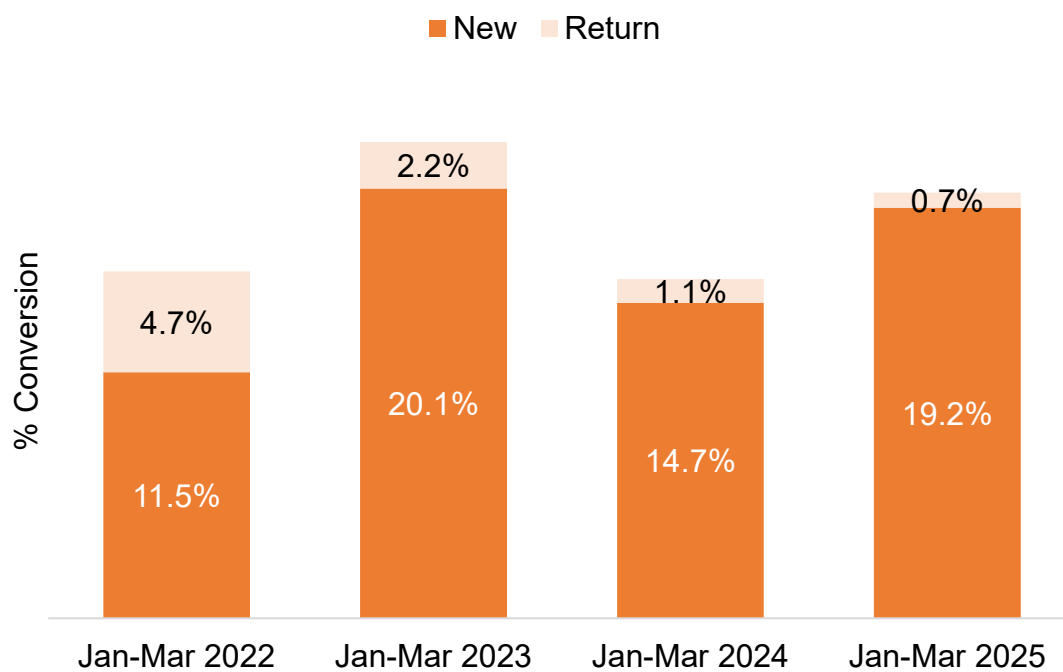


Figure 32. Percentage Conversion to IP/DC (%)



5. St. Brendan's Hospital (St. B)

Inpatient and Day Case Activity

Figure 33 - Inpatient and Day Case Activity St. B (episodes)

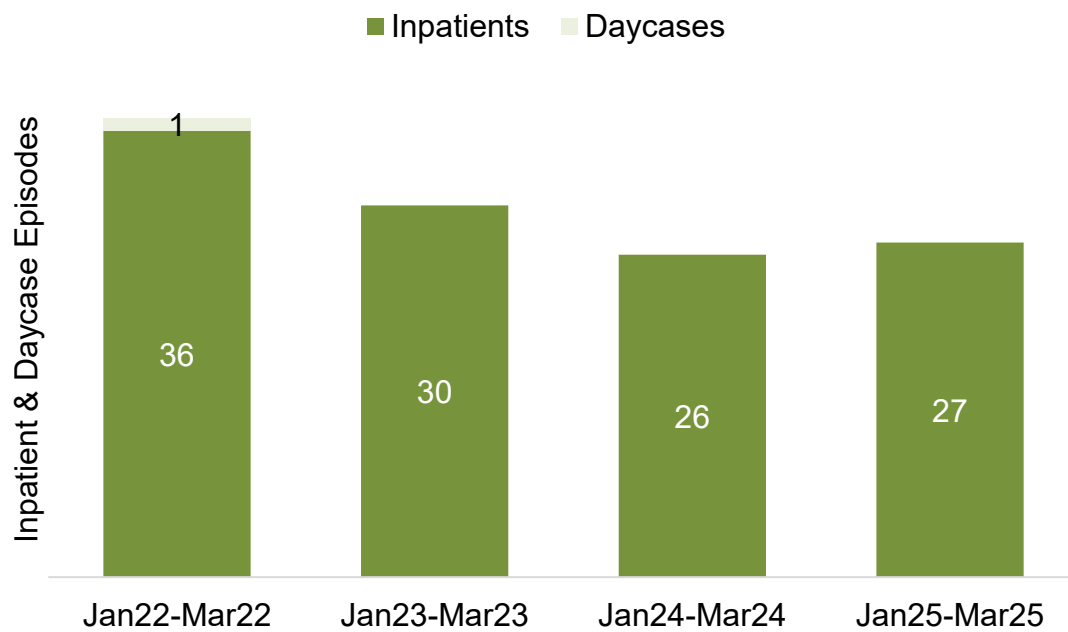


Figure 34 - St. B Inpatient Episodes by Admission Type

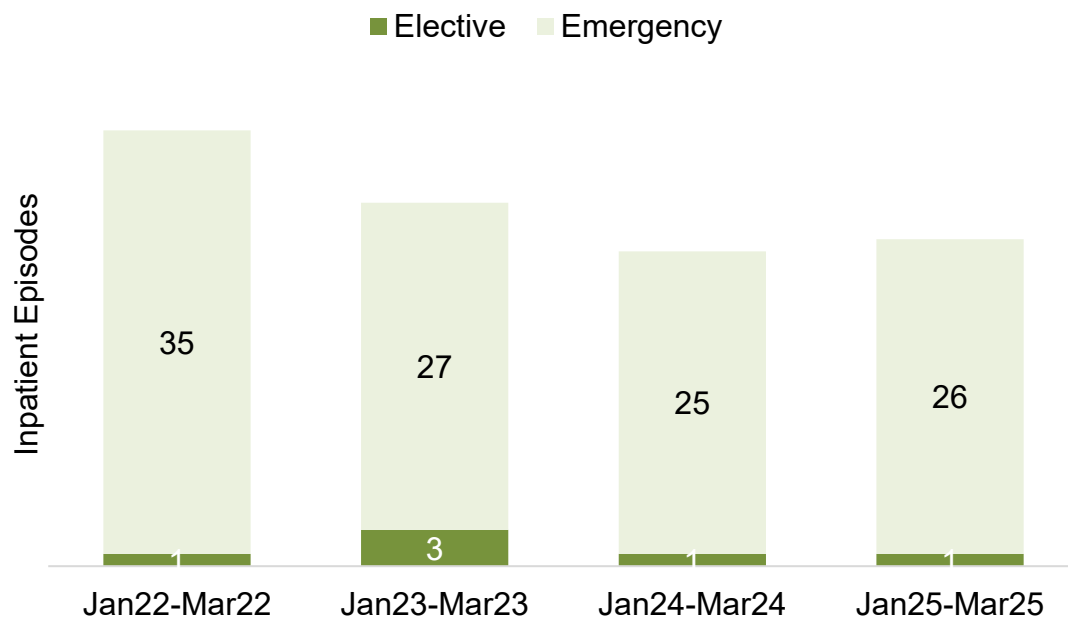


Table 15 - St. B Current Bed Complement

Ward/Location	Bed Complement
St Brendan's	3

Figure 35 - Occupied Bed Days

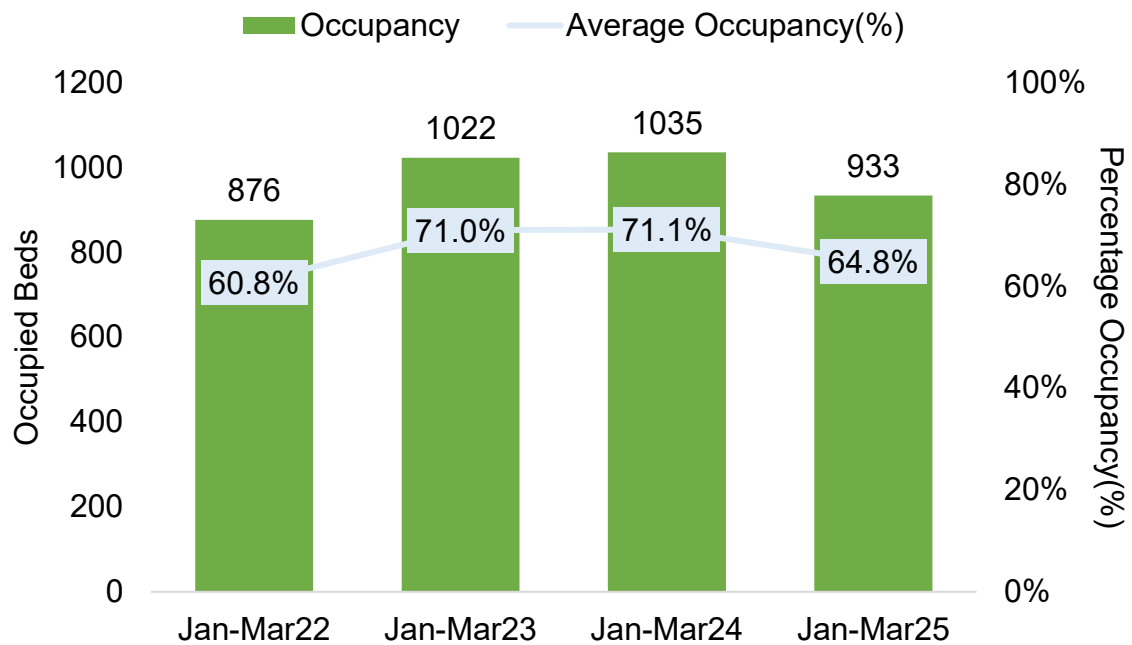


Figure 36 – Number of Episodes & Average Length of Stay

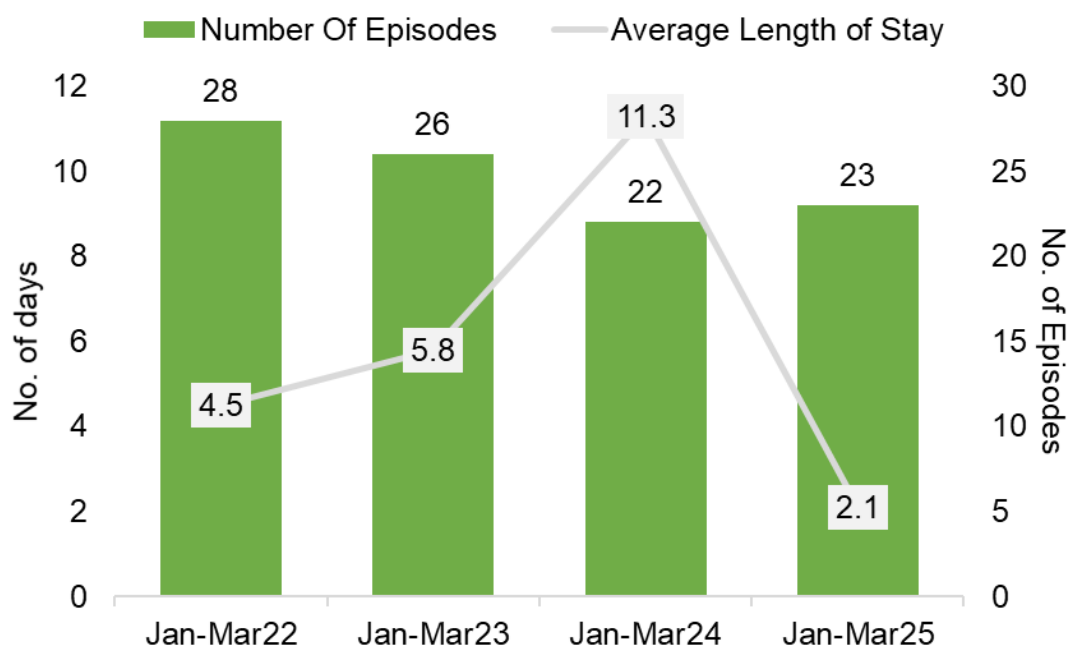


Table 16 - Daily Occupancy Bands

% Occupancy	Number of days
	Jan to Mar 2025
100	1
95-99	-
90-94	-
85-89	-
80-84	-
75-79	-
70-74	-
65-69	13
60-64	-
<60	76

6. Mainland Hospitals

Inpatient and Day Case Activity

Figure 37 - Mainland Inpatient & Daycase Episodes

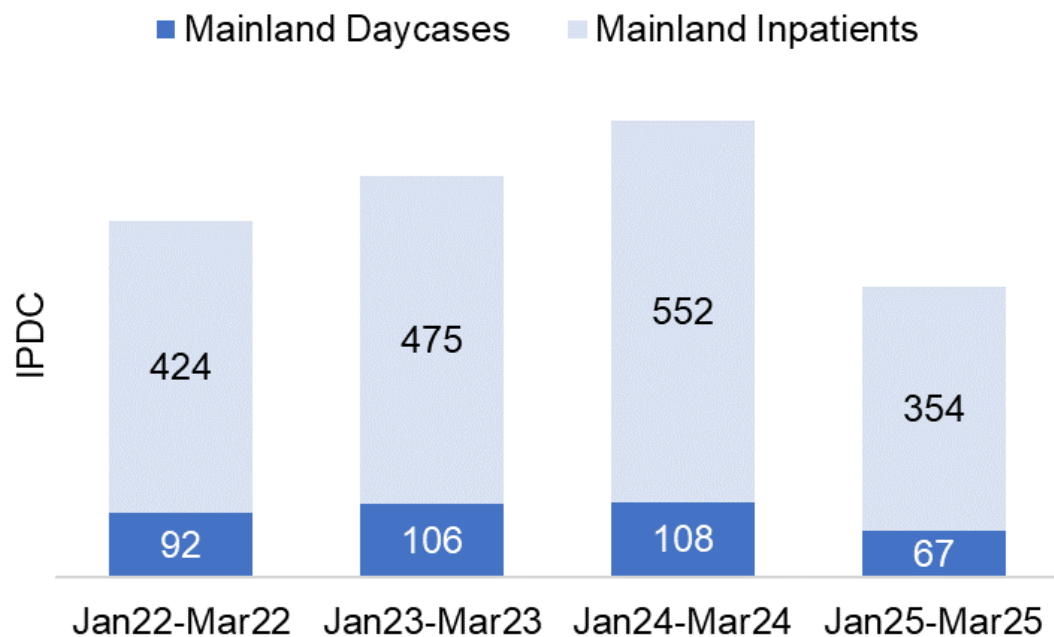


Figure 38 - Elective v Emergency Episodes

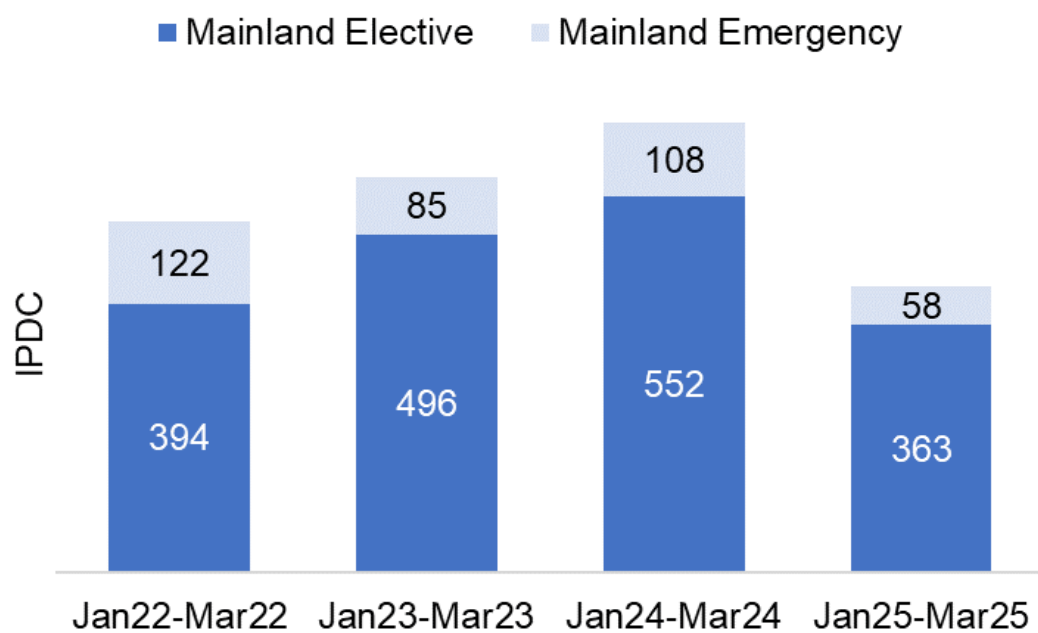


Figure 40 - Mainland Outpatients Appointments

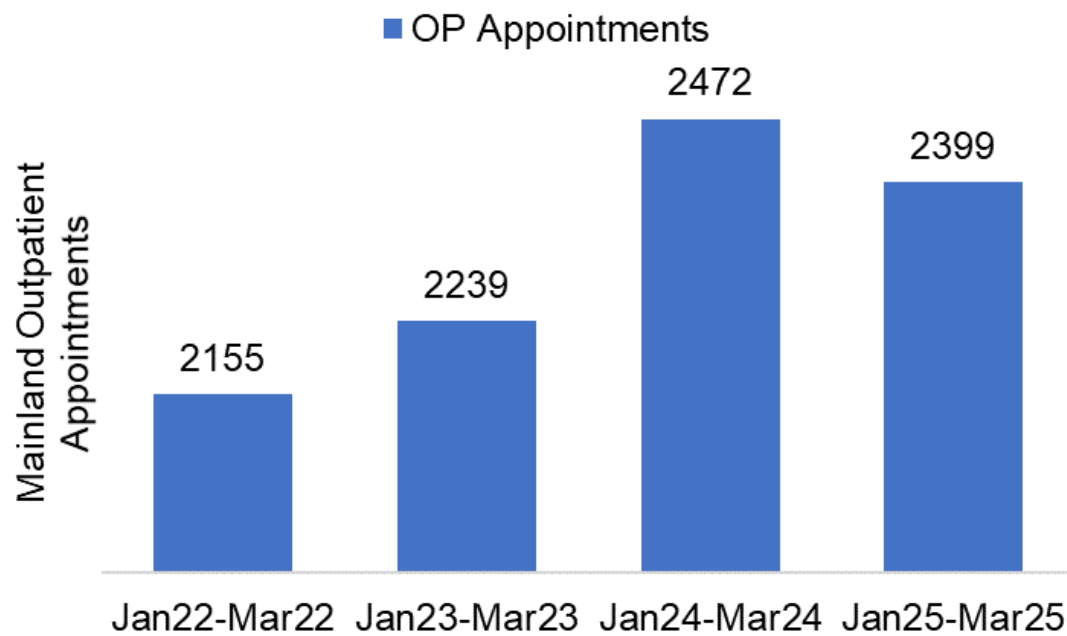


Figure 39 - Return to New Appointments Ratio

