NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**31st March 2026**
Title:	**Integrated Performance and Quality Report**
Responsible Executive/Non-Executive:	**David Park, Deputy Chief Executive (FPRC); Gareth Adkins (SGC); Louise Bussell, Director of Nursing & Dr Boyd Peters, Medical Director (CGC)**
Report Author:	**Sammy Clark, Performance Manager**

Report Recommendation: The Board is asked:

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

1 Purpose

Please select one item in each section ***and delete the others***.

This is presented to the Board for:

- Assurance

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.

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

2.1 Situation

The Integrated Performance & Quality Report (IPQR) contains an agreed set of measurable indicators across the health and social care system aimed at providing the Finance, Resource and Performance Committee, Clinical Governance Committee, Staff Governance Committee and the Health and Social Care Partnership Committee a bi-monthly update on performance and quality based on the latest information available.

A narrative summary table has been provided against each area to summarise the known issues and causes of current performance, how these issues and causes will be mitigated through improvements in the service, and what the anticipated impact of these improvements will be.

2.2 Background

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

2.3 Assessment

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

2.4 Proposed level of Assurance

Please describe what your report is providing assurance against and what level(s) is/are being proposed:

Substantial		Moderate	X
Limited		None	

NHS Highland Board is asked to take moderate assurance on performance reporting and note the continued and sustained pressures facing both NHS and commissioned care services.

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

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

3.3 Financial

Financial analysis is not included in this report.

3.4 Risk Assessment/Management

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

3.5 Data Protection

The report does not contain personally identifiable data.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

3.9 Route to the Meeting

Sections through the relevant Governance Committees;

- Staff Governance Committee – 3rd March 2026
- Clinical Governance Committee – 6th March 2026
- Finance Resource Performance Committee – 13th March 2026

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – March 2026 Board Meeting

Integrated Performance and Quality Report

Board Meeting

31st March 2026

Assuring NHS Highland Board on the delivery of the Board's 2 strategic objectives (Our Population and In Partnership) through our Well outcome themes.

Our Population

Deliver the best possible health and care outcomes

Our People

Be a great place to work

In Partnership

Create value by working collaboratively to transform the way we deliver health and care

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Executive Summary of Performance Indicators: Slide 1 of 2

Wells	Area	Current Performance (Date)	Previous Performance (Date)	Performance Trajectory	Local Target	National Target	Performance Rating
Thrive Well	**CAMHS <18-week referral-to-treatment**	96.7% (Dec 25)	87.4% (Oct 25)	↑	90%	90%	
Thrive Well	**NDAS Waiting List Size**	2138 (Dec 25)	2142 (Nov 25)	→	Reduce	N/A	
Stay Well	**Smoking Cessation Quits**	53 (Q2 25/26)	83 (Q1 25/26)	↓	84 per quarter	336 per annum	
Stay Well	**Breastfeeding**	27.7% (25/26 so far)	28.3% (24/25)	↓	25.4% by 2030/31	25.4% by 2030/31	
Stay Well	**Alcohol Brief Interventions (Number per Quarter)**	967 (Q2 25/26)	944 (Q1, 25/26)	↑	1841 (End of Q2)	1841 (End of Q2)	
Stay Well	**Drug & Alcohol Waiting Times <3-weeks**	87.4% (Q2 25/26)	83.7% (Q1 25/26)	↑	90%	90%	
Live Well	**Psychological Therapies < 18-week referral to treatment**	93.1% (Dec 25)	87.9% (Oct 25)	↑	90%	90%	
Respond Well	**Emergency Access (4 hour waits)**	78.5% (Dec 25)	80.6% (Oct 25)	↓	83% by 31/03/26	95%	
Respond Well	**Emergency Access (8 hour waits)**	7.5% (Nov 25)	9.0% (Oct 25)	↓	Reduce	Reduce	
Respond Well	**Emergency Access (12 hour waits)**	4.2% (Nov 25)	5.1 % (Oct 25)	↓	Reduce	Reduce	
Respond Well	**Delayed Discharges: All**	241 (Dec 25)	214 (Oct 25)	↑	Reduce	Reduce	
Respond Well	**Delayed Discharges: Standard Delays**	198 (Dec 25)	175 (Oct 25)	↑	151 by 31/03/26	Reduce	

Guide to Performance Rating

- Meeting Target
- <5% off target
- >5% off target
- >10% off target

Executive Summary of Performance Indicators: Slide 2 of 2

Wells	Area	Current Performance (Date)	Previous Performance (Date)	Performance Trajectory	Local Target	National Target	Performance Rating
Treat Well	New Outpatients (NOP) Cumulative Performance against Activity Plan	-5.6% (3116 behind plan) (Dec 25)	-3.2% (1386 behind plan) (Oct 25)	↓	N/A	55563 (Dec 25)	
Treat Well	New Outpatients (NOP) number of patients waiting >52 weeks	2013 (Dec 25)	2990 (Oct 25)	↓	N/A	55 by 31/03/26	
Treat Well	TTG Cumulative Performance against Activity Plan	0.0% (4 behind plan) (Dec 25)	1.4% (164 ahead of plan) (Oct 25)	↓	N/A	15295 (Dec 25)	
Treat Well	TTG number of patients waiting >52 weeks	354 (Dec 25)	475 (Oct 25)	↓	N/A	124 by 31/03/26	
Treat Well	Radiology: Cumulative Performance Against Activity Plan	21.54% (6276 ahead of plan) (Dec 25)	12.14% (3479 ahead of plan) (Sept 25)	↑	N/A	27677 (Dec 25)	
Treat Well	Radiology <6-week waiting time	66.8% (Nov 25)	60.5% (Sept 25)	↑	80% short term 90% long term	100%	
Treat Well	Endoscopy: Cumulative Performance Against Activity Plan	22.24% (1154 ahead of plan) (Dec 25)	10.97% (568 ahead of plan) (Sept 25)	↑	N/A	5040 (Dec 25)	
Treat Well	Endoscopy <6-week waiting time	67.9% (Nov 25)	70.3% (Sept 25)	↑	80% short term 90% long term	100%	
Journey Well	31-Day Cancer Target	89.9% (Dec 25)	96.1% (Oct 25)	↓	95%	95%	
Journey Well	62-Day Cancer Target	68.1% (Dec 25)	71.1% (Oct 25)	↓	80% by 31/03/26	95%	
Journey Well	SACT Access and Benchmarking (SACT as 1st Treatment) – Average Waiting Time	16-20 Days (Dec 25)	25 days (Sept 25)	↓	< 28 days	N/A	

Guide to Performance Rating

- Meeting Target
- <5% off target
- >5% off target
- >10% off target

Integrated Performance & Quality Report Guidance

The Integrated Performance & Quality Report (IPQR) contains an agreed set of Key Performance Indicators across the health and social care system aimed at providing the Finance, Resource and Performance Committee with assurance around the performance monitoring of the board and linkages to key deliverables described in our Annual Delivery Plan.

Throughout the IPQR, the BRAG rating of KPIs is assessed in terms of an assessment of latest performance in relation to meeting local and national targets in each Strategic Well theme.

Individual KPIs will also be BRAG rated with services providing narrative summary of current performance and highlighting current key risks to performance improvement.

Performance is reported for the NHS Highland board area and narrative to include both HSCP areas has been added where appropriate.

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

Performance relating to areas in Scottish Government's Operational Improvement Plan (OIP) are annotated with "OIP" for reference.

Guide to Performance Rating

- Meeting Target
- <5% off target
- >5% off target
- >10% off target

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Executive Lead
Louise Bussell,
Nurse Director

OIP

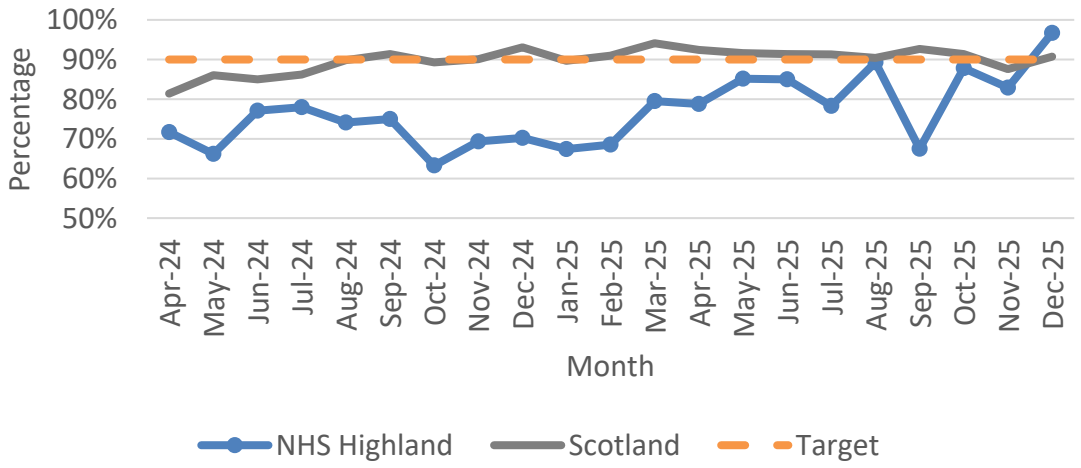
CAMHS (Child and Adolescent Mental Health Service)

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by December 2025 (Tier 3). Reduction of people who are currently on the Tier 3 CAMHS waiting list to <352 people by December 2025.	**Argyll & Bute** There has been considerable focus on compliance and interrogation of locality data ensuring action is taken as required, a focus on accuracy in data management and workforce activity. **Highland** The service continues to focus on the longest waits with no unbooked patients > 35 weeks.	Workforce across NHS Highland remains a vulnerability as the service look to build resilience for the future. **Argyll & Bute** Mitigations in place are the use of bank, temporary spend from reserves and pro-active recruitment. There has been a good response to recent advertisements. **Highland** 3 x newly qualified Clinical Psychologists case allocation in December. Additional capacity from Band 7 psychological therapist – temporarily reassigned to CAMHS. Exploring flexible cover ongoing (bank, secondments, additional hours).

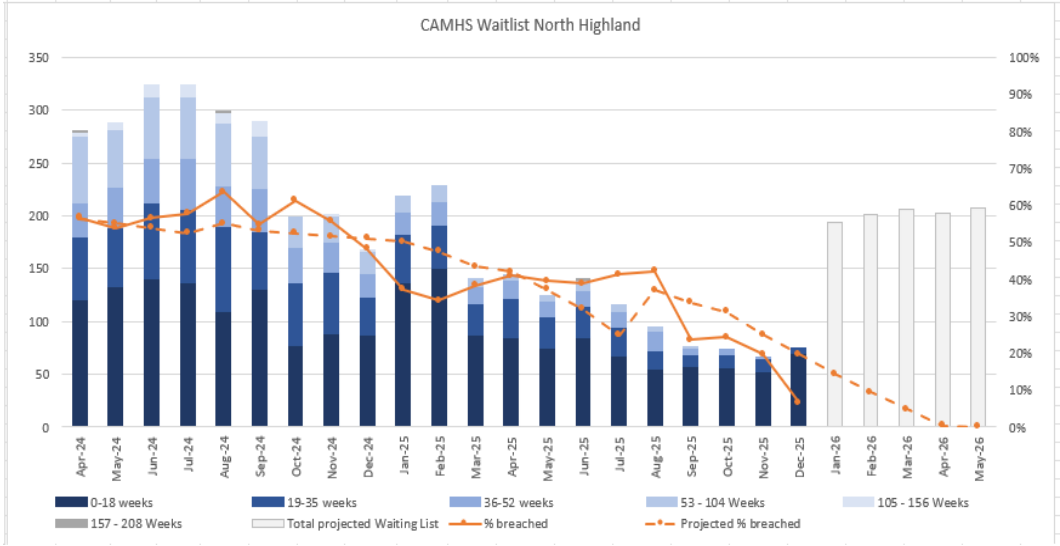
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	96.7%
National Average	90.7%
National Target	Full compliance to the National Service Specification by end of March 2026
National Target Achievement	n/a
Position	12th out of 14 Boards (note most boards achieved 100%)

CAMHS: Percentage of patients seen <18 weeks from referral



CAMHS Tier 3 Waiting List in Weeks



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Executive Lead
Katherine Sutton
Chief Officer, Acute

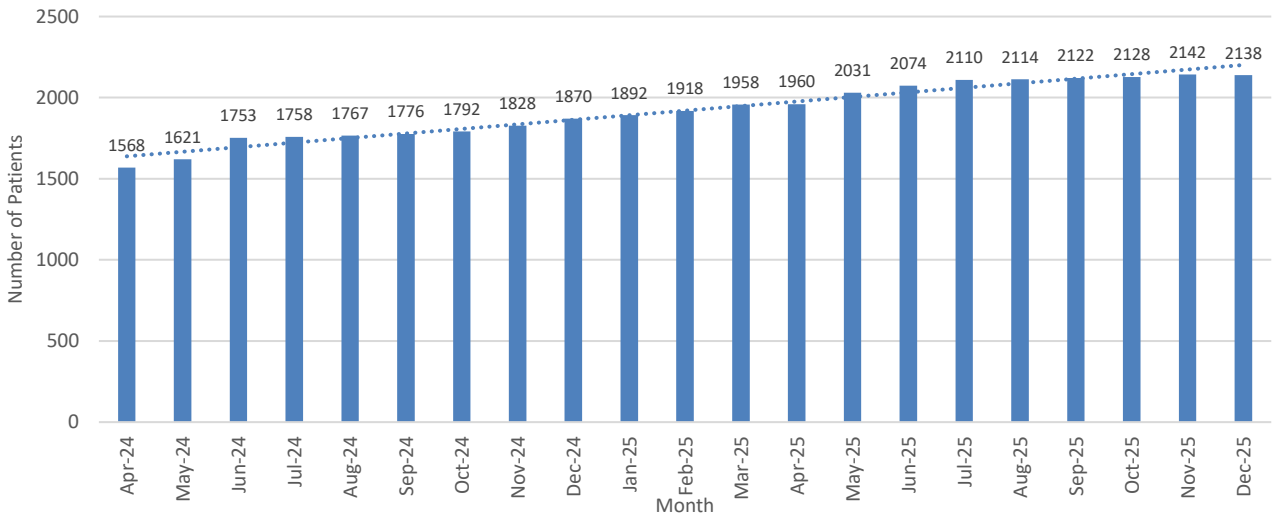
Neurodevelopmental Assessment Service (NDAS)

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Increasing percentage of NDAS patients seen within 18 weeks from referral, and towards meeting the national specification of greater than 95%.	There is extremely limited clinical capacity within the service to complete any assessments.	• Independent sector assessments funded equating to 65 patients. • Recruitment of a fixed term Neurodevelopment Practitioner - requires training and support to provide capacity. • Fixed term (to end of fiscal year) Psychologist recruitment to conclude any ongoing cases. • Development of the ND Hub website in collaboration with the 3rd Sector organisation to improve access to approved information for families, carers, and children. • New model test of change reviewing children, on the waitlist, from a single primary school, by THC and NHS Health teams.
Reduction in the total number of patients on the NDAS waiting list compared to the current baseline by March 2026.		

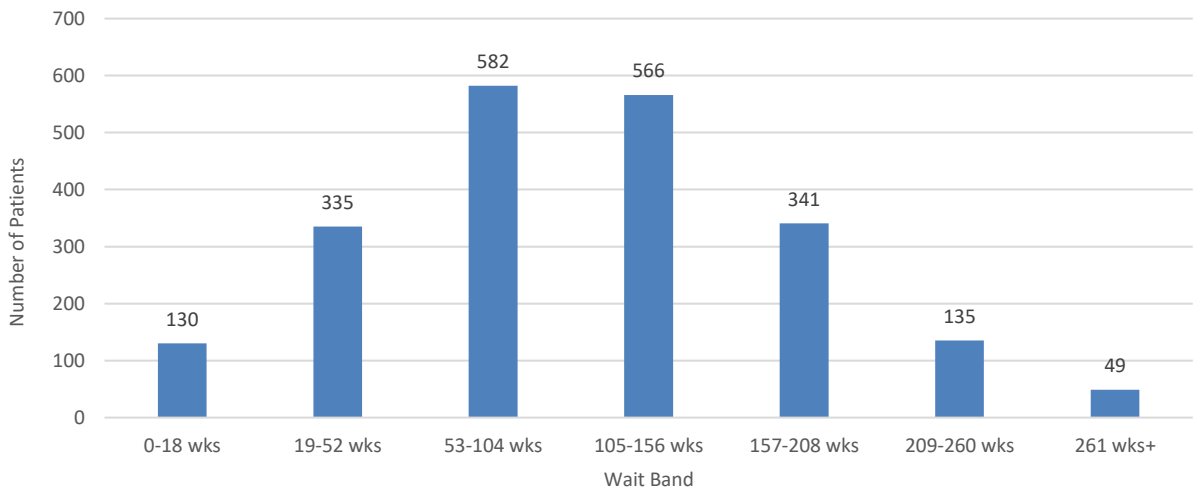
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	2138 on waiting list (Dec 2025)
National Average	n/a
National Target	Full compliance to the National NDAS Service Spec by end March 2026.
National Target Achievement	n/a
Position	n/a

NDAS Total Awaiting 1st Appointment (including unvetted)



NDAS New + Unvetted Patients Awaiting 1st Appointment by wait band



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Exec Lead
Jennifer Davies, Director of Public Health

Vaccinations

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Increased vaccination uptake – pertussis and RSV	**Winter vaccination programme:** Activity has now reduced significantly in relation to the delivery of the autumn/winter programme although flu vaccination continues to be promoted. The overall uptake for influenza vaccine for the 2025 season has exceeded the Scottish average (NHS Highland = 55.7%; Scotland = 55.5%). The staff vaccination programme has been particularly successful with NHS Highland achieving an uptake of 43.9% and ranked fifth across Scotland (Scotland = 41.9%). **Older adult RSV programme:** The uptake for the current RSV programme is equivalent to or has exceeded the Scottish average for each of the cohorts across Highland HSCP as detailed in the figure below. **Maternal programmes:** Uptake continues to be excellent across the board in relation to both pertussis and RSV maternal programmes. Both partnerships exceeded the national average in relation to vaccination uptake for both the RSV and pertussis vaccines. This is illustrated in the figure below.	Scottish Government is continuing to work with Highland HSCP in level 2 of its performance framework. A tripartite advisory group (SG, PHS, NHSH) is meeting to offer external support to NHS Highland as part of the implementation of the hybrid model of delivery in Highland HSCP. Work is ongoing in Argyll & Bute to maintain uptake rates and to support wider improvement work. Representation is provided at the national child health system meetings to support the effective rollout of the new child health system.

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

Performance Rating	
Latest position & performance	See charts
National Benchmarking	The overall performance for maternal vaccination uptake is above the Scottish average.
National Target	There is not a national target for the maternal campaign.

Figure 1: Vaccination uptake for the pertussis and RSV maternal vaccination programmes for both partnerships

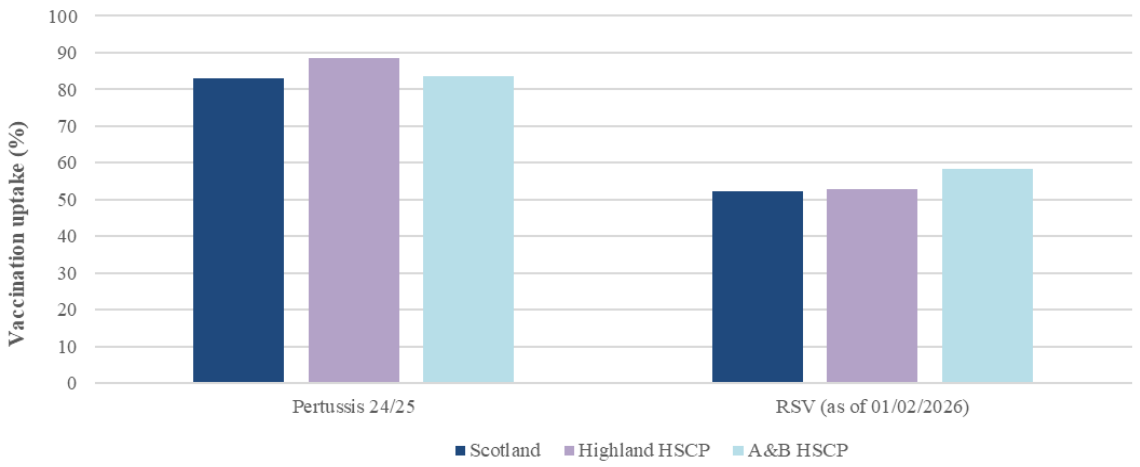
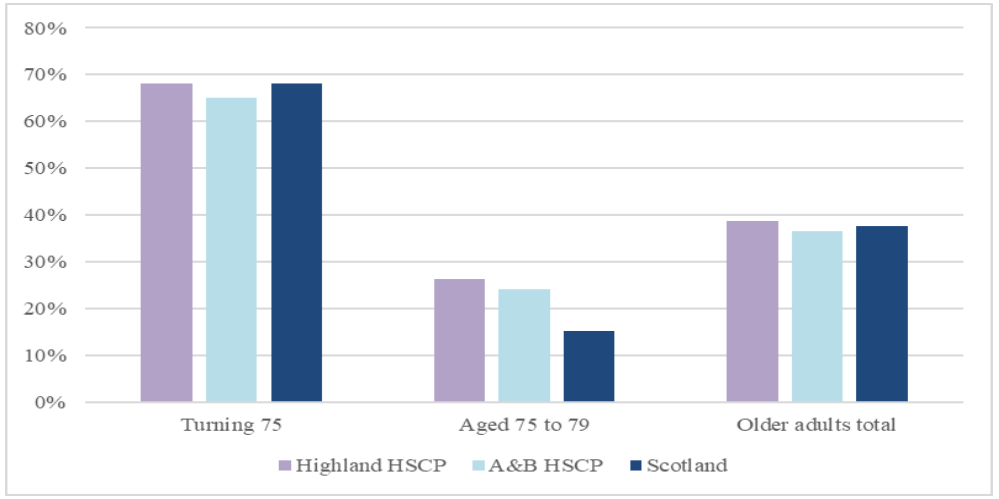


Figure 2: RSV vaccination uptake for older adults for the 2025/26 season (as of 1st February 2026)



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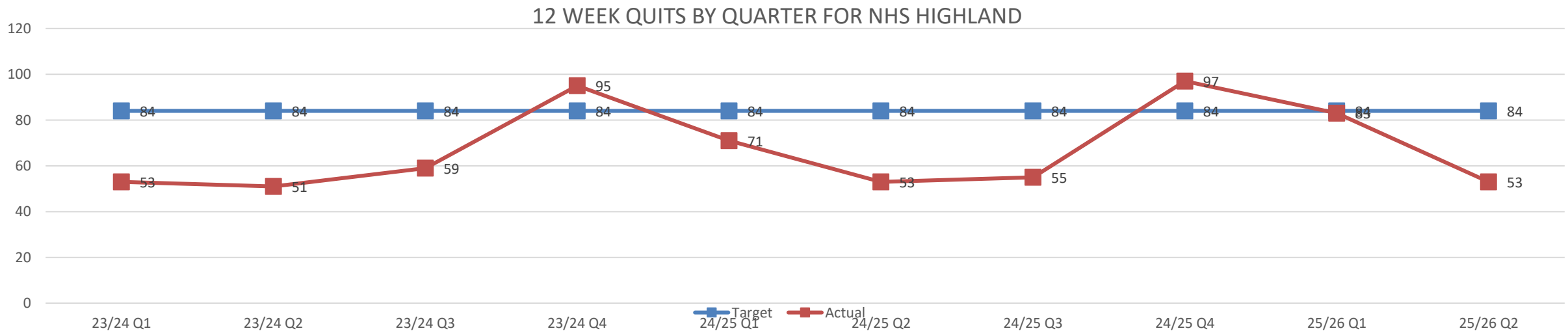
Exec Lead
Jennifer Davies, Director of Public Health

Smoking Cessation

Key Performance Indicators	Reasons for Current Performance (updated February 2026)	Plans, Mitigations and Actions
Delivery on national targets for Smoking Cessation interventions (12 week quits) >84 per quarter	• Poor follow up data within Community Pharmacy therefore many follow up outcomes have not been recorded. Capacity issues to complete these follow ups. • High incidence of smoking in young pregnant women. Services have struggled to engage this group in supporting them to quit • Limited support for patients within our acute setting. • Peak in Q4 is seen across Scotland and is likely due to individuals making plans about changes they want to make in their lives for a new year. • Q2 data is currently subject to validation.	•Missing data from quit dates set from 1st April 2025 – 1st September 2025 have been reviewed. 17.5% of individuals followed up had maintained a successful quit at 12 weeks and 11% of clients re-engaged with the service. Further missing data reviews have commenced. •Pilot to provide incentives for pregnant women commenced. So far, one woman is currently taking part, and another with her first appointment booked. Smoking Cessation Champions have been recruited in each community midwifery team and the Family Nurse Partnership team to aid communication and promote the pilot. •There has been 356 referrals for patients in Raigmore since the pilot began in May 2025, significantly higher than in the same period last year. A review of the pilot is currently being undertaken and due to be complete April 2026.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest Performance	53 quits in Q2 of 25/26 (unpublished data)
National Benchmarking	
National Target	336 successful quits in 12 weeks in 40 most deprived SIMD areas
National Target Achievement	136 quits delivered by end of Q2. This is 40% of the annual target
Position	Improved position compared to the same point in time in previous 2 years.



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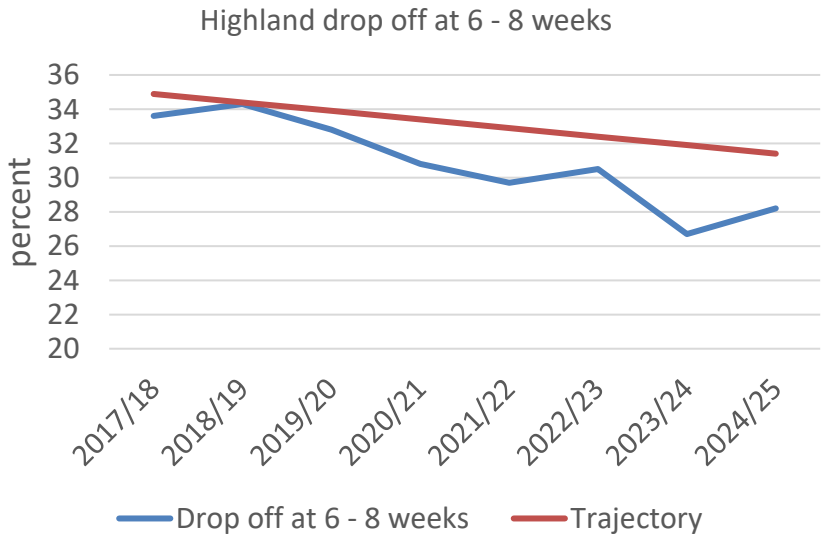
Exec Lead Jennifer Davies, Director of Public Health

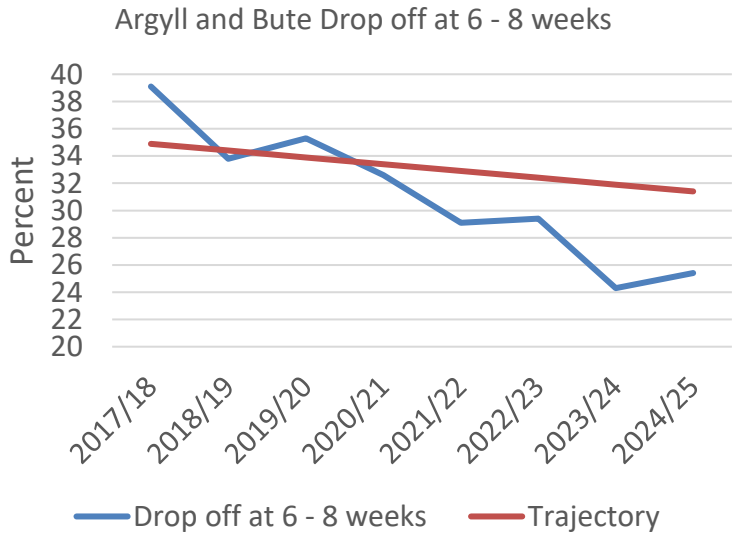
Breastfeeding

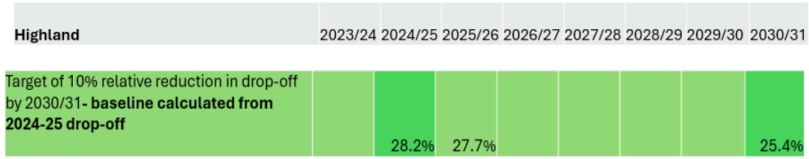
Key Performance Indicators		Reasons for Current Performance (Updated February 2026)	Plans, Mitigations & Actions
Reduce the attrition of any breastfeeding at 6 –8 weeks by 10% by 2030/1 (Provisional KPI: to be confirmed)		• National extension to breastfeeding stretch aim announced by Health Minister in November 2025. New trajectory to reduce attrition rates in any breastfeeding at 6 – 8 weeks by 10% by 2030/31. The baseline for NHS Highland for 23/24 is 26.1% meaning that the trajectory for 2030/2 is 23.5% and is an aspirational stretch aim for Highland. • Health in Early Years Scotland (HEYS) dashboard replaced the COVID child data in January 2024. This dashboard enables the timeliest breastfeeding data available. It is published quarterly, next quarterly report due in April 2026. • Infant feeding support worker recruitment funded by whole family wellbeing fund has been completed with new staff commencing posts in Fort William, Aviemore, Nairn and Raigmore. • A breastfeeding strategic group has been formed with the first meeting having taken place in December and includes representation from NHSH and Highland Council. Next meeting 10th of February • The breastfeeding key worker network has been reformed and pan Highland UNICEF BFI audits have been submitted to infant feeding lead for compilation • January and February breastfeeding training dates have been advertised to all staff; this includes an HIV masterclass run by HIV team and step by step guide to accessing ICON training • UNICEF portfolio due for North Highland community by end of February 2026	Work continues to drive improvements in all aspects of infant feeding workstreams. Publication of National Infant feeding strategy will support forward planning Breastfeeding and Infant Feeding Strategic Framework and Delivery Plan

PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Start well

Performance Rating	
Latest Performance	See chart
National Benchmarking	NHSH perform under the National Trajectory
National Target	Reduce breastfeeding attrition rates at 6-8 weeks by 10% by 2030/31
National Target Achievement	Currently achieving National Trajectory
Benchmarking	NHSH performs better than National trajectory







Public Health Scotland will publish trajectories in March 2026 – Trajectory for NHSH for **2030/1** likely to be: reduce attrition rates below **25.4%** at 6 – 8 weeks

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Exec Lead Jennifer Davies, Director of Public Health

Alcohol Brief Interventions (ABIs)

Key Performance Indicators	Insights to Current Performance	Plans and Mitigations
Deliver at least 100% of the planned Alcohol Brief Intervention (ABI) activity target by March 2026	Fig 1.Total no of ABIs delivered in Q2 is 967. This number is 3.8% above target for NHS Highland as set out in the Scottish Gov Local Delivery Plan (LDP). Fig. 2: Delivery is being met largely by GP Practices in Highland H&SCP (90.4%) with the remainder mainly being delivered in wider settings across NHS Highland.	A&E: Work underway to contact local A&E departments to promote ABI and reinvigorate recording. Antenatal: ABI 4 ABI's delivered to women reporting in-pregnancy alcohol consumption. -Badgernet section on alcohol is being reviewed nationally to make it easier for midwives to complete. -Antenatal staff training and advice/ support sessions ongoing. ABI training for health visiting team held in January and early Feb. Total no of 27 Health visitors trained, Resources created to support conversations.

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

Performance Rating	1911 vs. target of 1841 by end of Q2
Latest Performance	967 Q2
National Benchmarking	n/a
National Target	NHS Boards to sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.
National Target Achievement	1841 (End of Q2)
Position	n/a

Fig.1

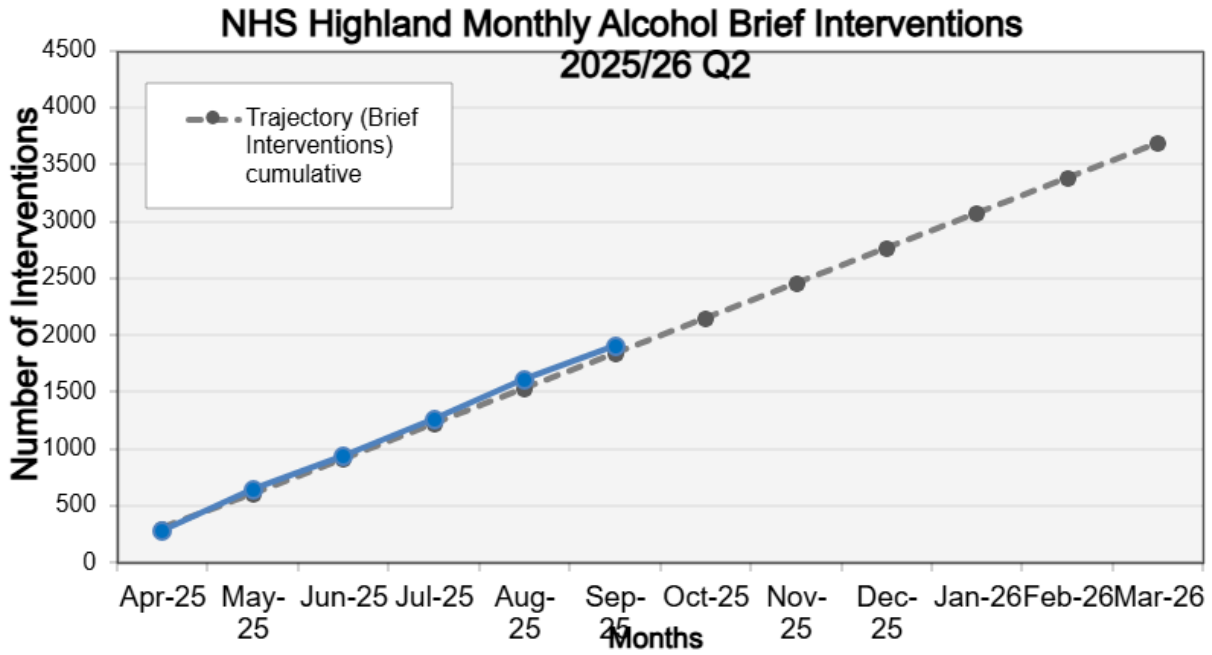
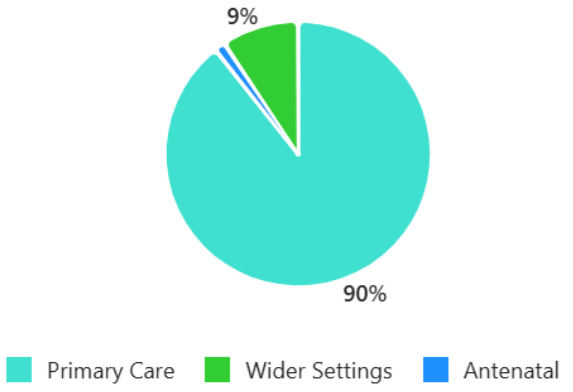


Fig.2 Setting Contribution 25/26 Q2

Primary Care	874	90.4%
Antenatal	4	0.4%
Wider Settings	89	9.2%
TOTAL	**967**	**100%**



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Executive Lead
Arlene Johnstone
Chief Officer, HHSCP

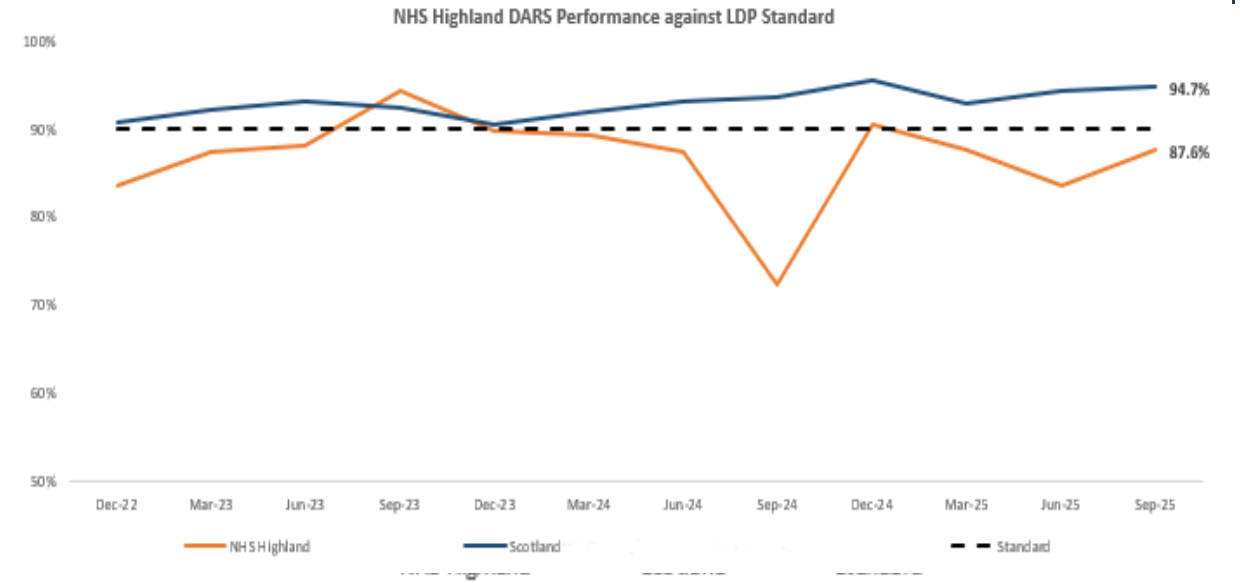
Drug & Alcohol Recovery (DARS)

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Achieve 90% of clients referred to DARS receiving a completed intervention or treatment plan within 3 weeks by March 2026.	Limited capacity versus demand has impacted waiting time targets. Recruitment difficulties are prevalent in some of the more rural areas across North Highland.	• Waiting list review processes are in place. • The recent commencement of a commissioned service for substance use will reduce referrals into the service. • Recruitment attempts are ongoing. • Some patients are being offered appointments in other areas outside of their immediate locality.

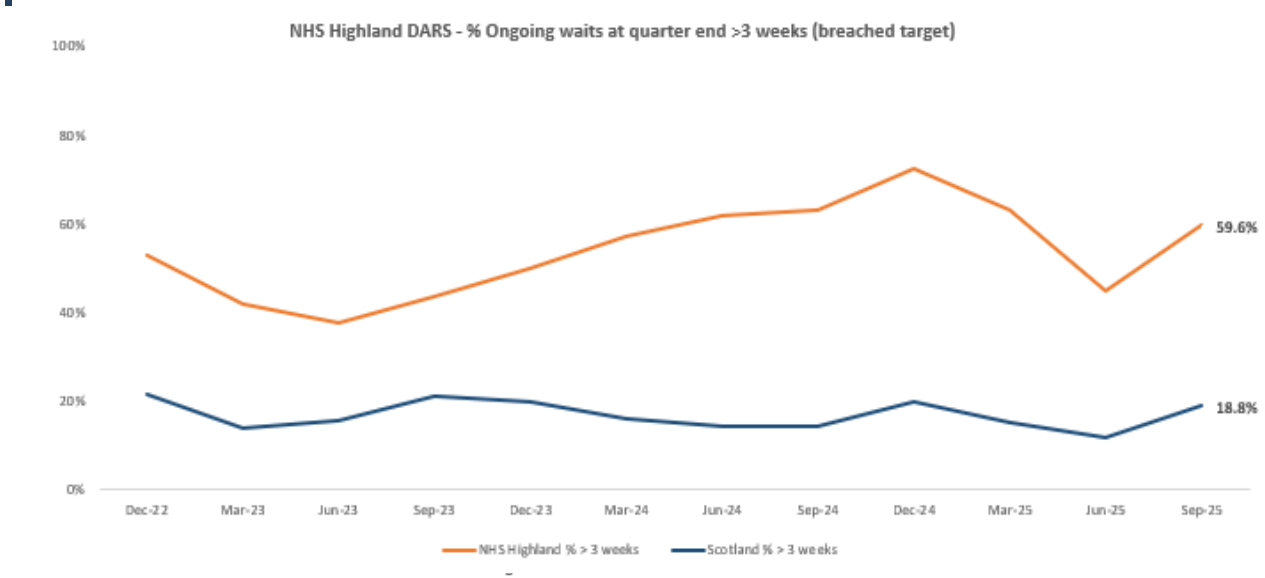
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	87.4% (Sep 25)
National Benchmarking	94.7% (Sep 25)
National Target	90% DARS referrals seen within 3 weeks
National Target Achievement	n/a
Position	n/a

NHS Highland DARS: Performance Against Standard for Completed Waits



NHS Highland DARS: % Ongoing Waits at Quarter End Waiting More than 3 Weeks (Breached Target)



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Executive Lead
Louise Bussell,
Nurse Director

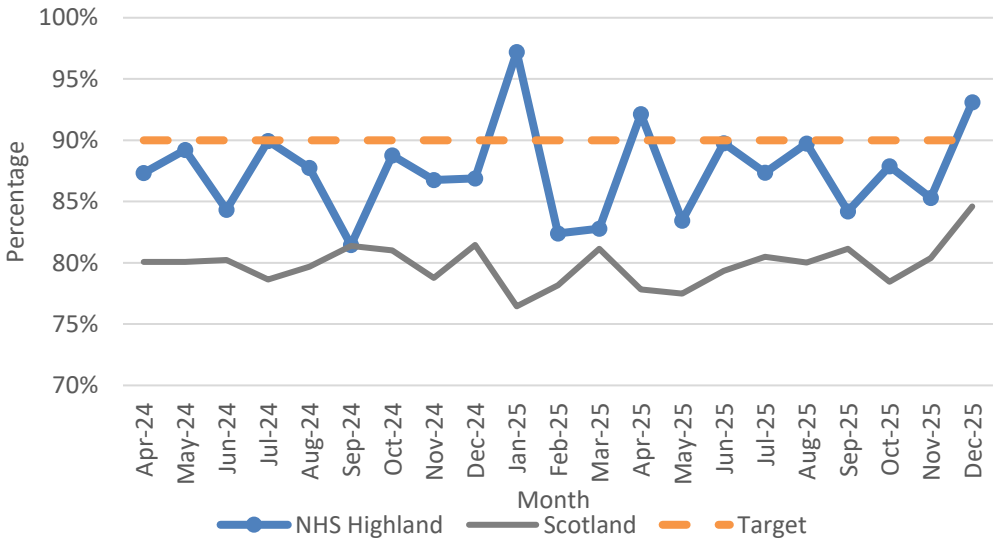
Psychological Therapies Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Ensure that at least 90% of patients referred to Psychological Therapy services are seen for their first appointment within 18 weeks of referral by March 2026. (pan-Highland)	**Highland** - There is a slight downturn in trend for referral to treatment time (RTT) and this is thought to be as a result of ongoing vacancy challenges and within the recruitment process itself. For the 12-month period December 2025 – Nov 2026 87.9% of people referred to the service were seen within 18 weeks. **Argyll & Bute - A**rgyll and Bute Adult Mental Health Psychological Therapies (AMHPT) service continues to make improvements in referral to treatment time (RTT). At the end of December 2025, average waiting times for CBT treatment were 17 weeks and 19 weeks for Psychology treatment.	**Highland –** Psychology services continues to work with departmental colleagues to address ongoing recruitment and financial challenges. Progress is being made with eHealth colleagues to incorporate subspecialties into reporting systems. This will help improve data quality and forecasting. **Argyll & Bute -** Waiting times continue to be impacted by resource limitations, especially for Psychology, but active recruitment to vacant posts is in progress. Like for North Highland, there are issues with data quality, but work is in progress with the Scottish Government to address this.
Increase number of completed PT waits (pan-Highland)		

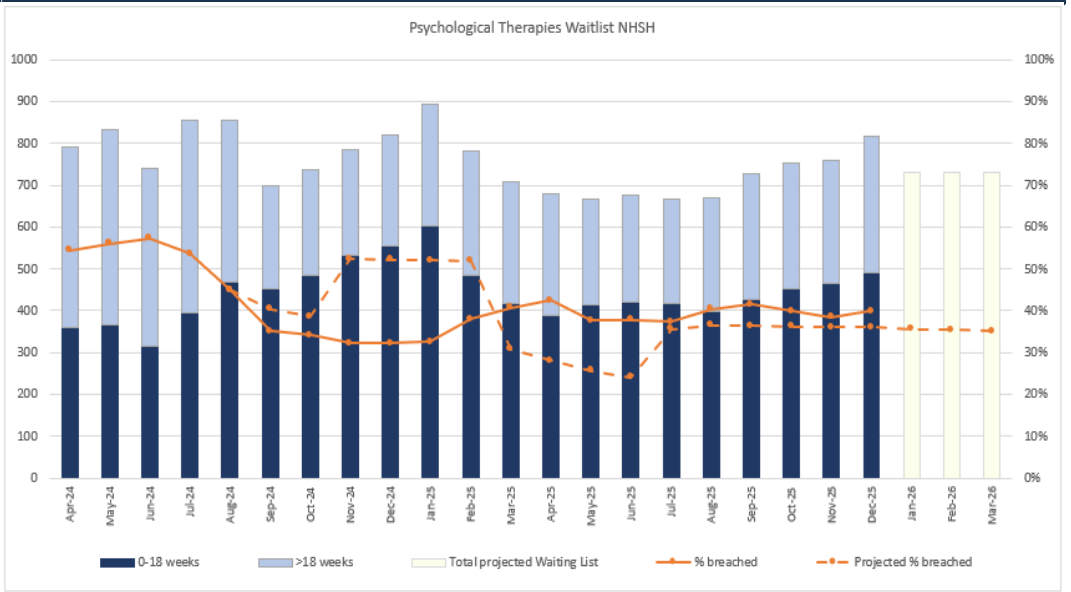
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	93.1%
National Average	84.6%
National Target	90%
National Target Achievement	Consistent improvements in targets
Position	3rd out of 14 Boards

Patient seen < 18 weeks



Waiting List Size



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Chief Officer, Acute

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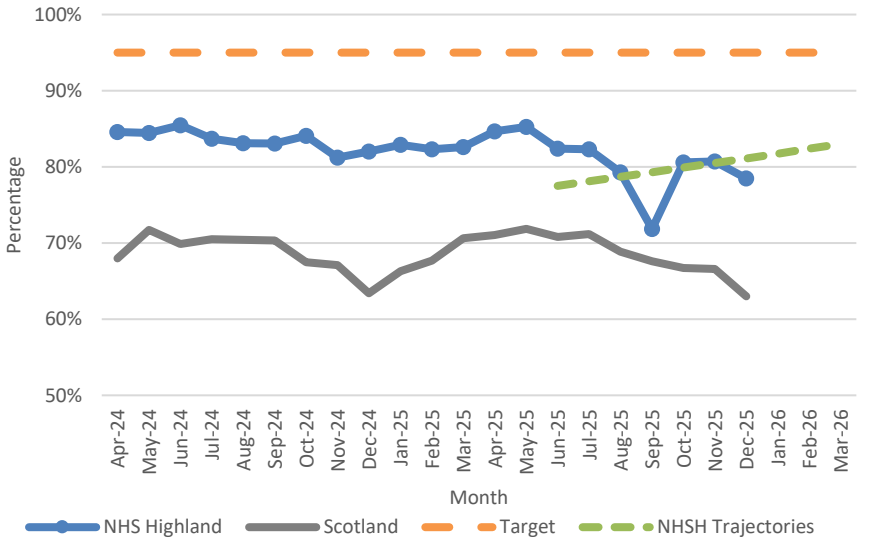
Emergency Department Access

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Achieve a 5% improvement in the number of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2026.	**Raigmore Hospital:** Pausing of the elective program to support capacity within Raigmore commenced 12 Jan 2026. Plans for full recommencement on 26 Jan 2026 are on track. Increase in LOS for the second week across NHSH H&SCP have supported the opening of extra capacity where possible to support movement out of the acute hospitals. This is being monitored and supported through the OPEL meeting framework. The placement of patients in non-standard bed spaces continues **Caithness Hospital (CGH):** Limited flow across the hospital and sustained delayed patients requiring patients to board in ED awaiting beds. 3 patients transferred out of area to Migdale hospital to support admissions **Belford Hospital (BH):** The year has started under significant pressure due to fragile staffing and constrained patient flow. Discharge delays have driven A&E bottlenecks, reflected in January's static 4-hour performance of 81%. **Lorn & Islands (LIH):** no exceptions to report – performance stable.	**Raigmore:** Leadership support provided for the unscheduled program work, predominantly Hospital at Home, Frailty and AHP at the front door. H&SCP have supported the opening of extra capacity where possible to support movement out of the acute hospitals. SAS HALO (Hospital Ambulance Liaison Officer) at Raigmore Hospital will be monitored for impact on hospital turn around times. **CGH:** Weekly Leadership meetings in place to monitor and support. Ongoing UUSC work progressing with system partners **BH:** Immediate focus remains on stabilising workforce resilience and improving patient flow. UUSC SLWG continues to progress alternative pathways to safely divert appropriate activity away from ED.
Reduce the number of A&E patients admitted, transferred, or discharged within 8 hours of arrival by March 2026, reducing extended waits and improving care quality.		
Reduce the number of patients waiting > 12 hours in A&E by March 2026, ensuring no patient experiences excessively prolonged waiting times.		

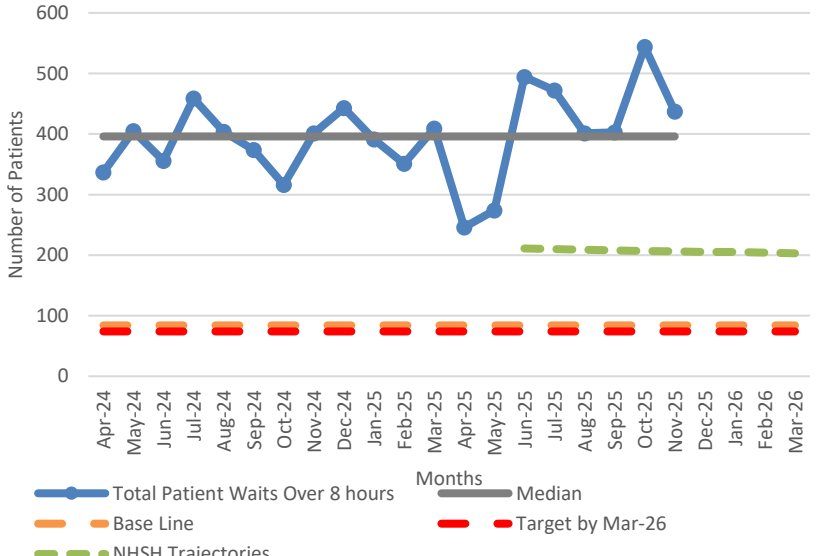
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	
Latest 4-hour Performance	78.5%
National 4-hour Average	63.0%
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	5th out of 14 Boards

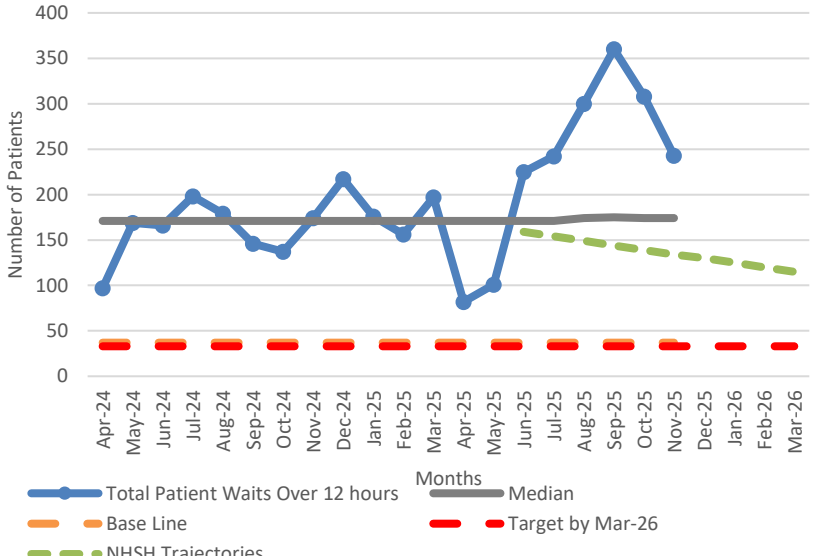
% of people seen in ED within < 4 hours per month



Total Patients waiting > 8 hours in ED per month



Total Patients waiting > 12 hours in ED per month



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Arlene Johnstone
Chief Officer, HHSCP

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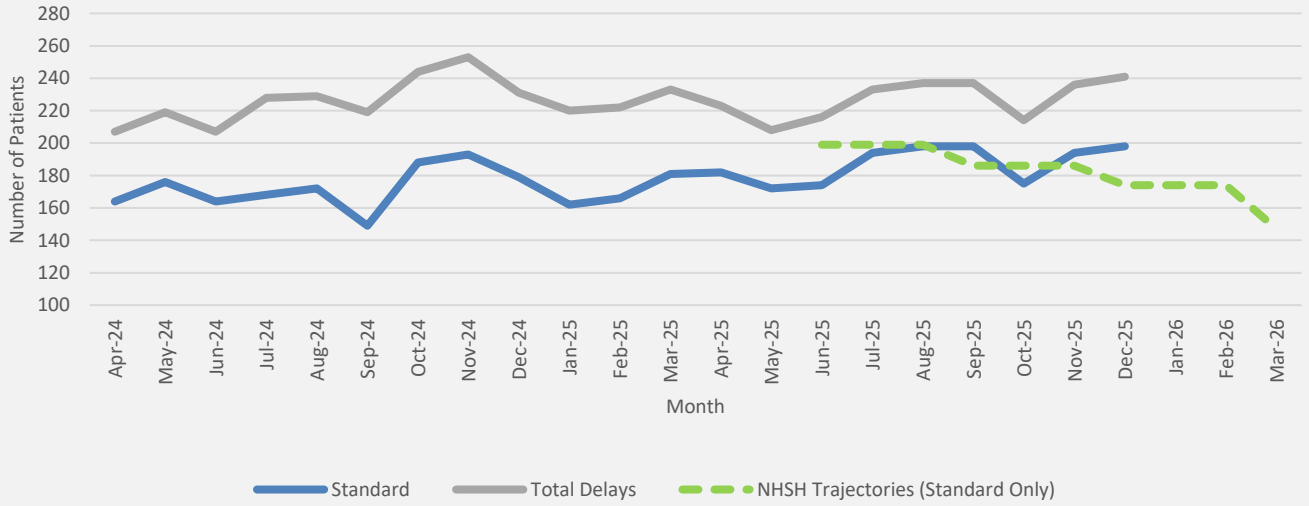
Delayed Discharges

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the total number of patients experiencing a standard delay in discharge from hospital across NHS Highland to agreed targets and trajectories. Target = 151 standard delays and 37 AWI by 31/03/26		There was an increase in standard delays in 2025 against our trajectory for reduction in standard delays. The reasons are multifactorial and are related to availability of care, complexity related to Adults with Incapacity legislation and process and coordination issues. Performance is subject to weekly oversight with EDG and further improvement plans are being instigated to respond to the recent deterioration in the overall position.	Pan-Highland workstreams are aligned to OIP in shifting the balance of care from acute to community services. **Highland HSCP** Links to the Adult Social Care Transformation Programme to provide alternative care for those with lower level of needs. Appointment of an Interface Manager to improve process and coordination issues in the discharge pathway. Pilot of Discharge to Assess programme is underway in East Ross which will impact 8 patients who are currently delayed, to be discharged home while awaiting assessment. It is hoped this model can be scaled across Highland. **Argyll & Bute** Actions to improve flow including interface with NHS GGC are underway, including additional governance around the allocation of care packages within the area. **Pan-Highland** Hospital at Home has now come on stream with capacity for 6 in Highland, while Argyll & Bute are moving forward with plans to expand from 12 to 16 available beds by 31/03.

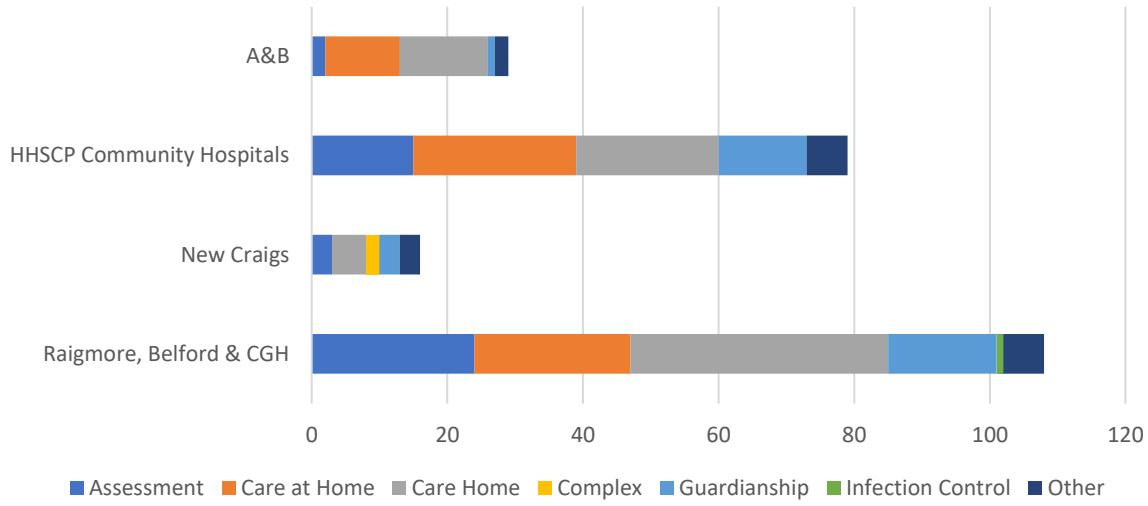
PERFORMANCE OVERVIEW
Strategic Objective: In Partnership
Outcome Area: Respond Well

Performance Rating	
Latest Performance	241 at Census Point
National Benchmarking	Engagement through national CRAG group and CfSD
National Target	Trajectories developed
National Target Achievement	Not Met
Position	14th of 14 Boards

Number of people delayed from hospital discharge at monthly census point NHS Highland (Highland and Argyll & Bute)



Number of people delayed from discharge – Location and Code



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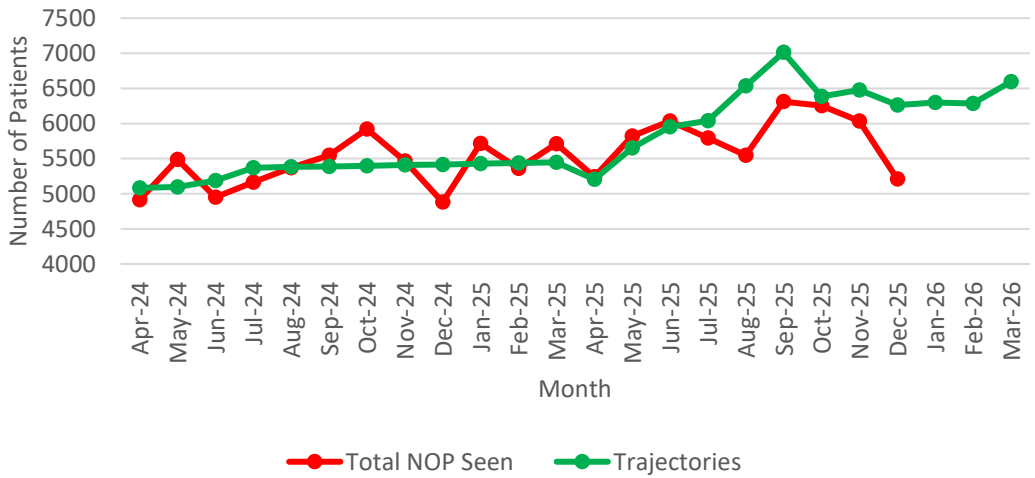
Outpatients (New Outpatients – NOP – seen within 12 week target) – Slide 1 of 3

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the number of new patients waiting over 52 weeks for a new outpatient appointment to 55 by March 2026.	**Highland** The number of people waiting over one year for their appointment continues to reduce across NHS Highland. This is due to increase in activity from last year and the continued implementation of best practice including clinical validation and new pathways such as "straight to test" prior to appointments. We are behind plan in some areas such as Ophthalmology and Gastroenterology and plans are in place to increase activity and reduce the gap. Some independent sector activity planned for the end of the year has been delayed into January, impacting the volume of activity. With the increase in activity there is a corresponding increase in the number of people added to the return waiting list. **Argyll & Bute** Argyll & Bute HSCP is on track to record <10 patients waiting longer than 1 year for a new appointment at end March 2026. Performance continues to improve due to additionality from the independent sector/in-house and targeted appointing and data quality work.	**Highland** Additional funding to support Gastroenterology increase validation, straight to test and activity. Recovery plan in place for Ophthalmology. **Argyll & Bute** Patients who are at risk of breaching are being flagged at an early stage and conversations had with both NHSGGC and NHS Highland to identify how they can be seen and progress.
The number of completed new outpatients appointments is equal to or exceeds the monthly target		
The number of completed new outpatients appointments is equal to or exceeds the cumulative target		
Increase the percentage of new outpatient referrals seen within 12 weeks of referral equal to or above 95%.		
Total number of patients currently waiting for return outpatient appointments to be equal to or less than previous year's monthly average		

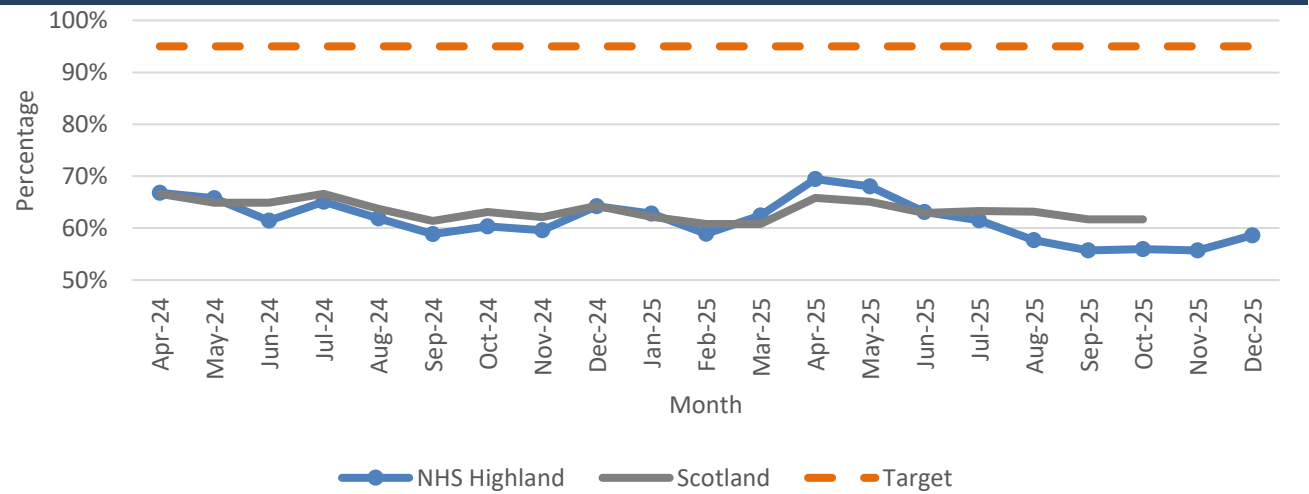
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating against Plan	
Latest Performance against Plan	5.6% behind target
National Benchmarking against 12 week performance	48.5% (Scotland 43.3%)
National Target against 12 week performance	95%
National Target Achievement against 12 week performance	Target not met Below lower control limit
Position against 12 week performance	6th out of 15 Boards

New Outpatients Seen & Trajectories



Outpatients Seen <12 Weeks *Including Consultant and Nurse Lead Activity*



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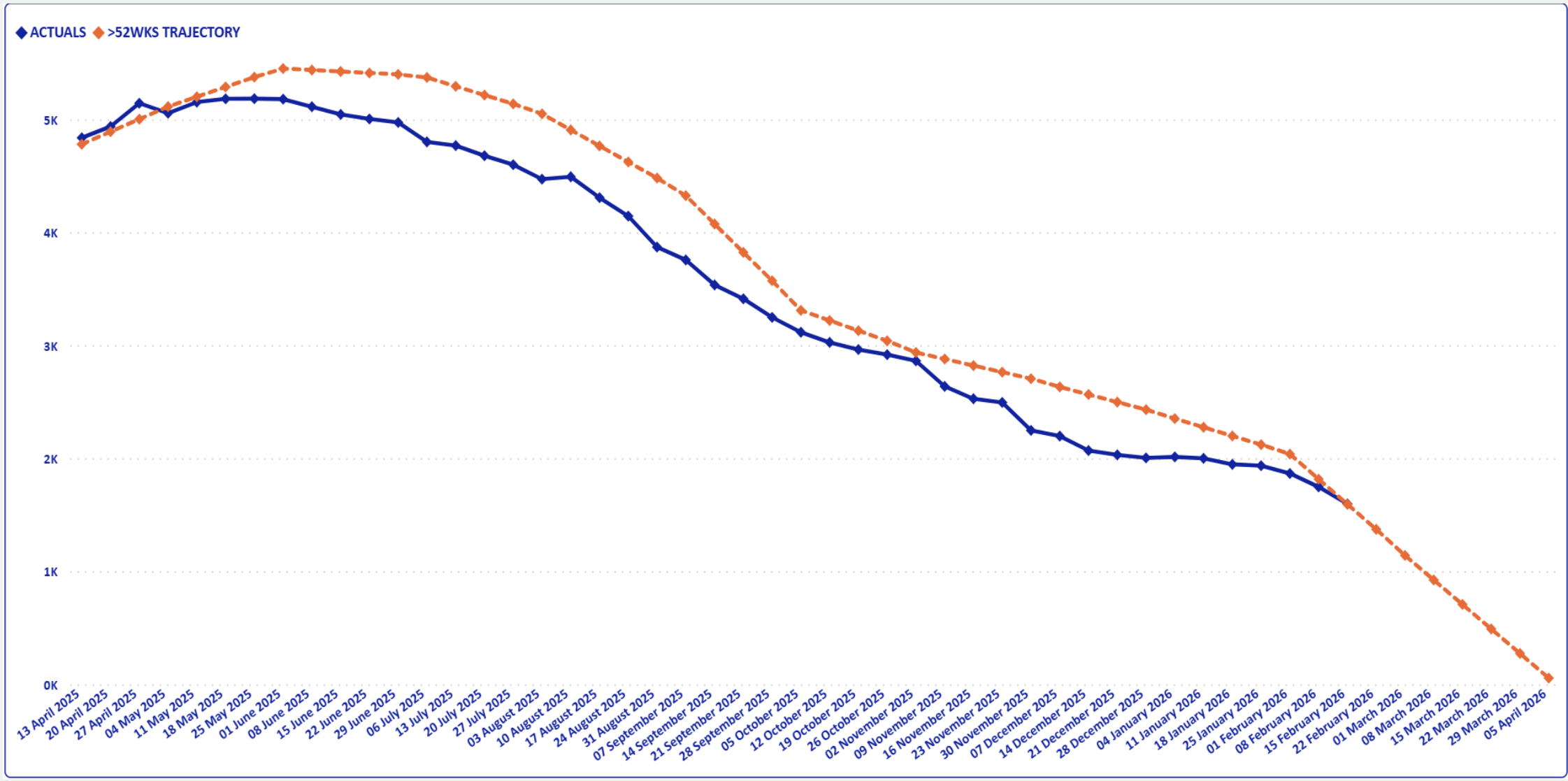
Outpatients (Long Waits) - Slide 2 of 3

NHS Highland remains positively ahead of trajectory in terms of reducing the number of patients waiting > 52 weeks to targets agreed with Scottish Government

Long Waits >52 weeks



Outpatients (Return Outpatients) - Slide 3 of 3

NHS Highland continues to monitor the level of return outpatients on our waiting lists, and since summer 2025 we observe an increase on the average of this time last year. This may be a consequence of our focus on ensuring outpatient activity is focused on reducing the total number of new outpatients > 52 weeks.

Executive Lead
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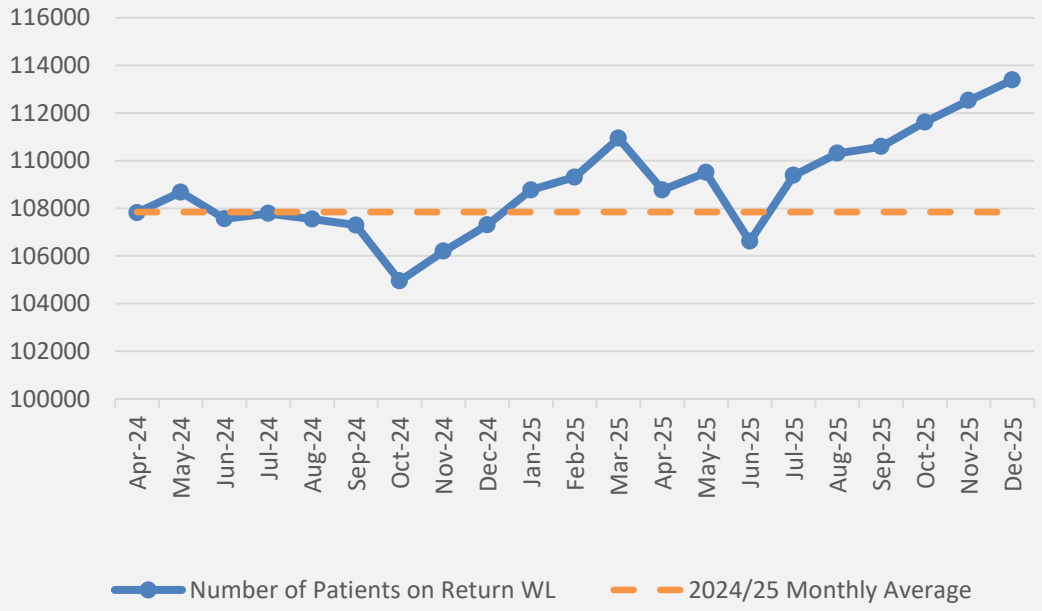
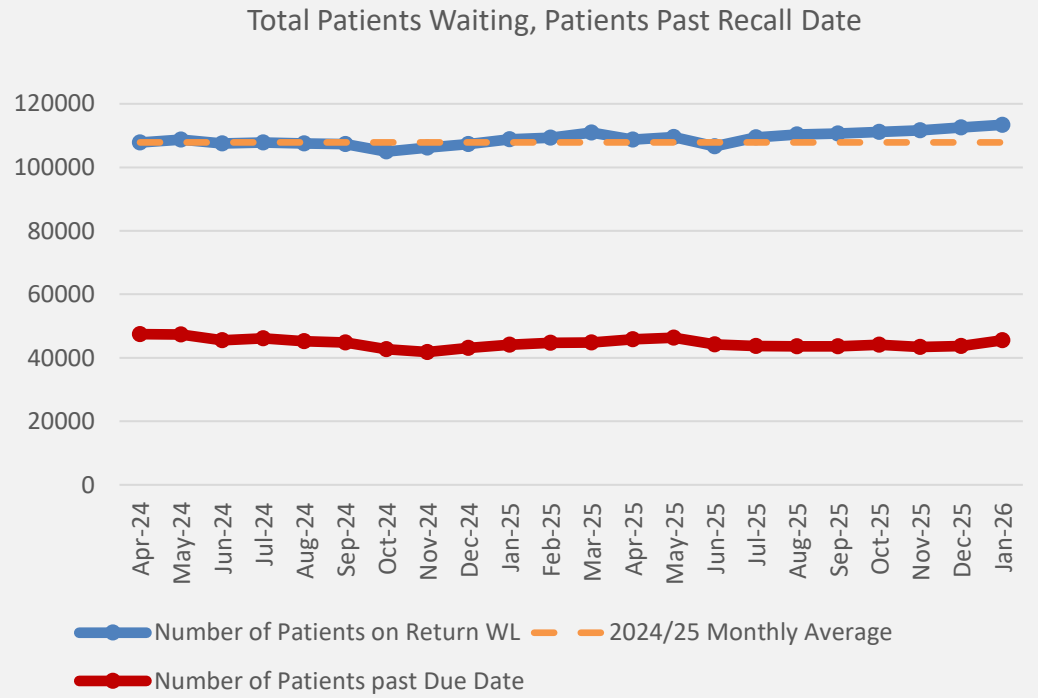
Chief Officer, Acute

Return Outpatients Wait List vs. 24/25 Average



Return Outpatients Wait List



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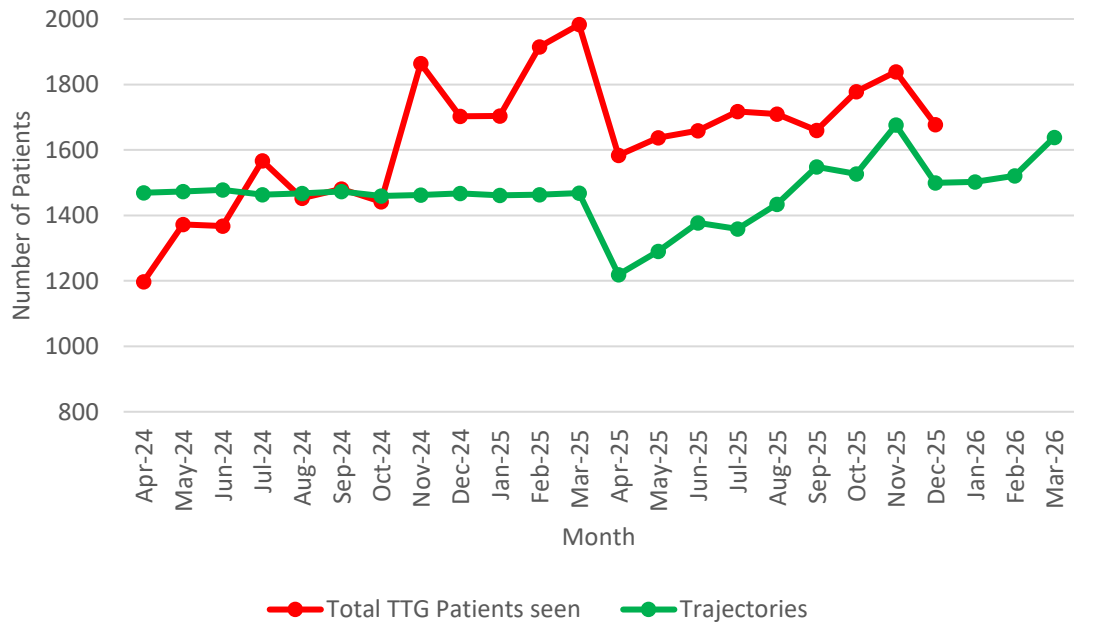
Treatment Time Guarantee (TTG) - Slide 1 of 2

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the number of TTG patients waiting over 52 weeks to 124 by March 2026	**Highland -** Activity is ahead of plan and the number of people waiting over 52 weeks continues to reduce at a rate above our target. This is attributed to our continued focus on performance and the robust clinical validation and application of waiting times guidance we have in place. **Argyll & Bute -** Performance continues to be on or around 12 weeks but we are mindful of the emerging Oral Surgery backlog.	**Highland –** Continue to monitor activity and progress across all acute sites to ensure delivery. **Argyll & Bute -** We expect a sharp increase in the number of patients waiting for Oral Surgery once the independent provider NOP activity is completed. Conversations around the future of the service are planned with NHS Highland.
The number of inpatient/day case procedures undertaken is equal to or exceeds the monthly target		
The number of inpatient/day case procedures undertaken is equal to or exceeds the cumulative target		
Percentage of TTG patients seen within 12 weeks of referral equal to or above 95% every month. within 12 weeks of referral equal to or above 95% every month.		

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

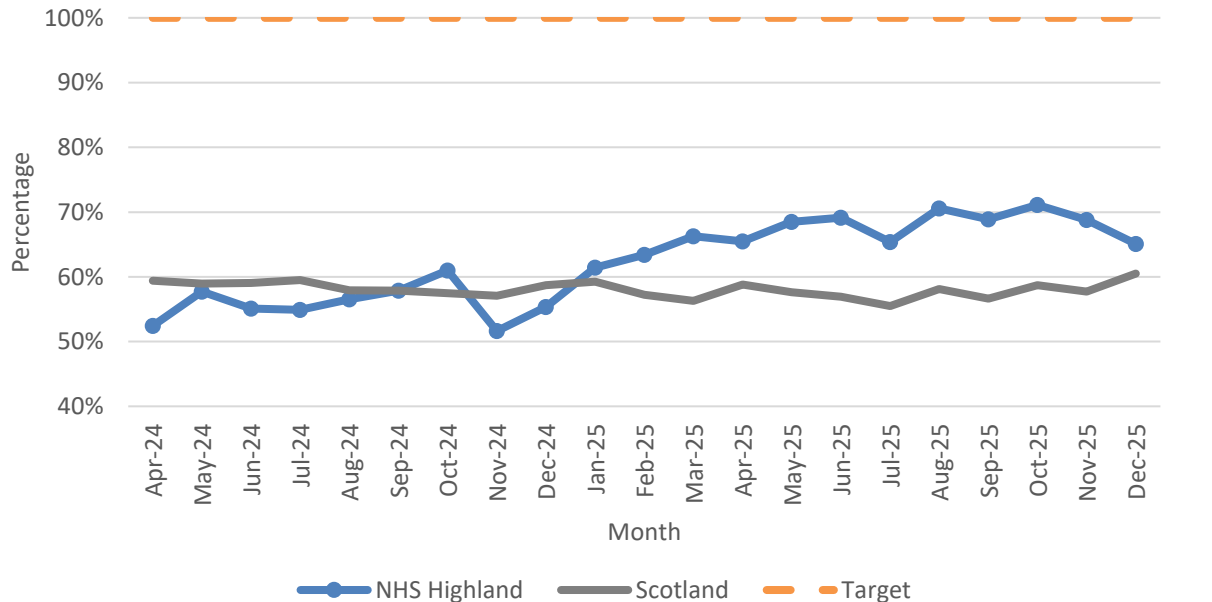
Performance Rating against Plan	
Latest Performance against Plan	On target
National Benchmarking against 12-week performance	65.1% (Scotland 60.5%)
National Target against 12-week performance	100%
National Target Achievement against 12-week performance	Target Not Met; But consistently above Scotland average
Benchmarking against 12-week performance	6th of out 15 Boards

Patients Seen & Trajectories



TTG Seen <12 Weeks

Consultant Only



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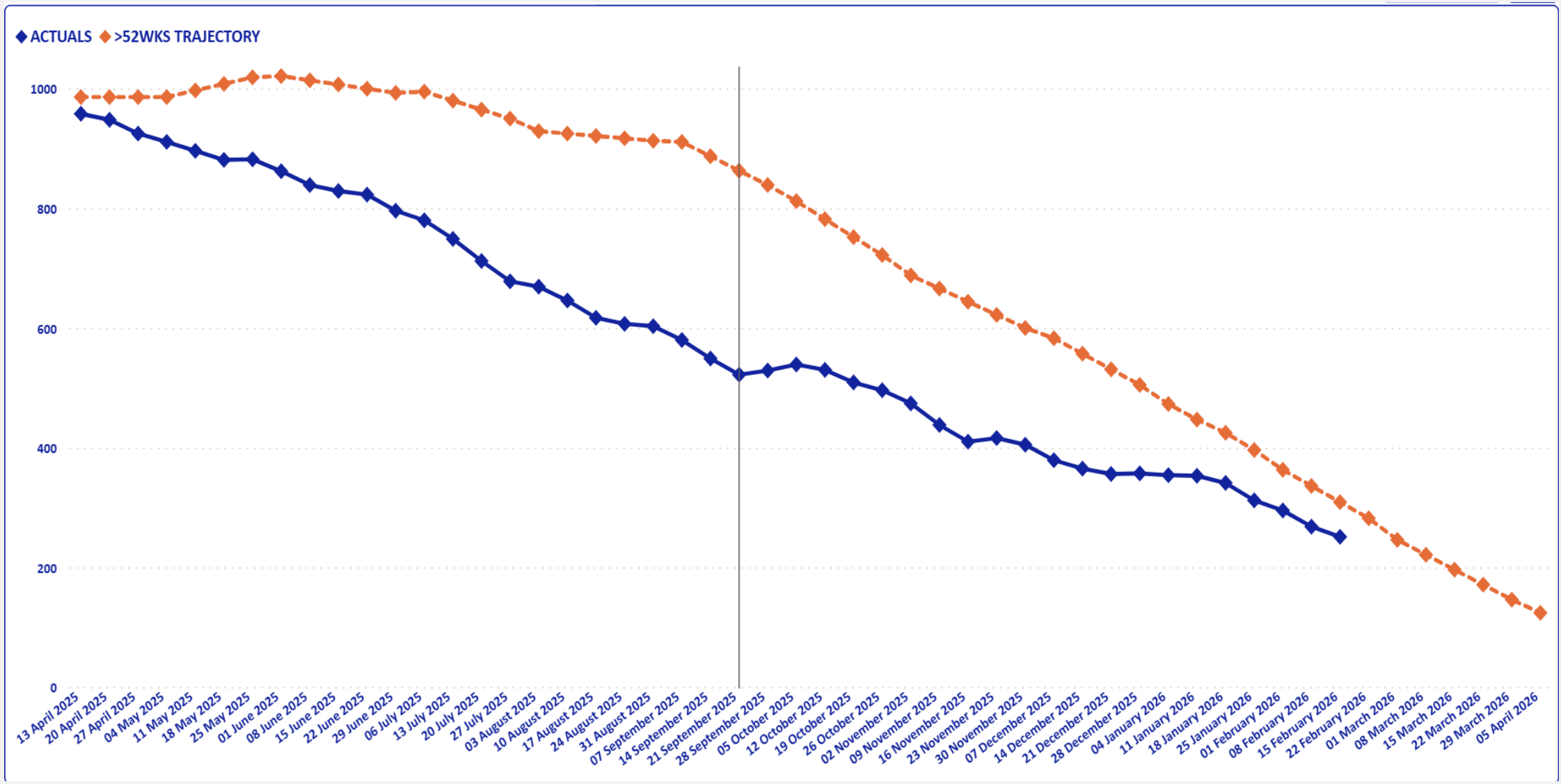
TTG (Long Waits) - Slide 2 of 2

NHS Highland continues to be ahead of trajectory and while it is expected the gap will narrow to March 2026 – as additional activity was front-loaded in 2025 – there is good confidence that the target levels will be met by end of March 2026.

Long Waits >52 Weeks



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Diagnostics – Radiology – Slide 1 of 2

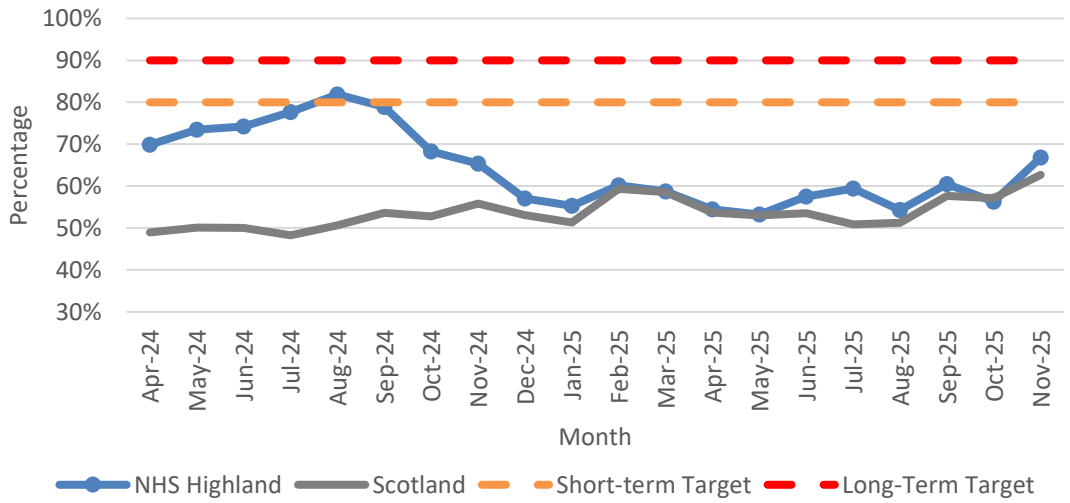
Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
The number of patients who receive imaging (all) is equal to or exceeds the trajectory every month		**Highland** 10% increase in CT scanning December versus November, outpatient scans static though. MRI van and OP activity lower in December due to public holidays and equipment breakdowns. Increase in USC referrals in December. High number of inpatient referrals (all modalities) at times impinges on outpatient capacity. **Argyll and Bute** Radiographer staffing is limited, with specialist services such as CT Cardiac and CT Colon experiencing the longest waiting times. Reduced radiologist FTE also restricts service development and continues to drive outsourcing costs.	**Highland** Recovery plan in discussion with SG, SBARS signed off by ASLT and submitted. **Argyll and Bute** Ongoing workforce establishment review, including activity analysis and professional planning. SBAR developed outlining the trajectory for service improvement and sustainable radiology services for the A&B population.
The number of patients who received a CT scan is equal to or exceeds the number of planned appointments every month			
Patients seen for non-obstetric ultrasound radiology testing is equal to or exceeds trajectory every month			
The number of patients who receive an MRI scan is equal to or exceeds the number of planned appointments every month			
Increase the number of patients receiving a key diagnostic test within 6 weeks from referral, in line with NHS Scotland guidance			

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

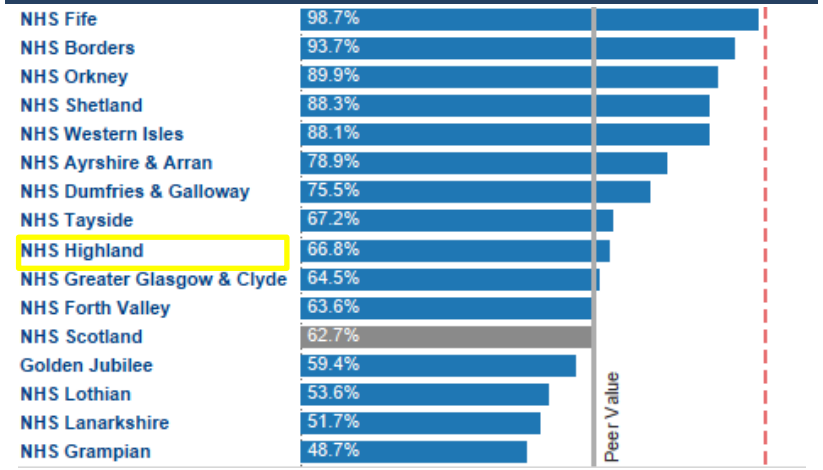
Performance Rating against Plan	
Latest Performance against 6-week target	66.8%
National Benchmark against 6-week target	62.7%
Local Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NHSH is above Scotland average
Benchmarking	9th out of 15 Boards

Imaging Tests: Maximum Wait Target 6 Weeks

Magnetic Resonance Imagine, Computer, Non-obstetric Ultrasound, Barium Studies Tomography



Benchmarking with Other Boards



Planned Activity

Yearly Trajectory	28,668
YTD Performance Trajectory	21,501 (75.0%)
Patients Seen – Dec 25	27,677 (96.54%)
Overall	21.54% above target

Diagnostics – Radiology – Slide 2 of 2

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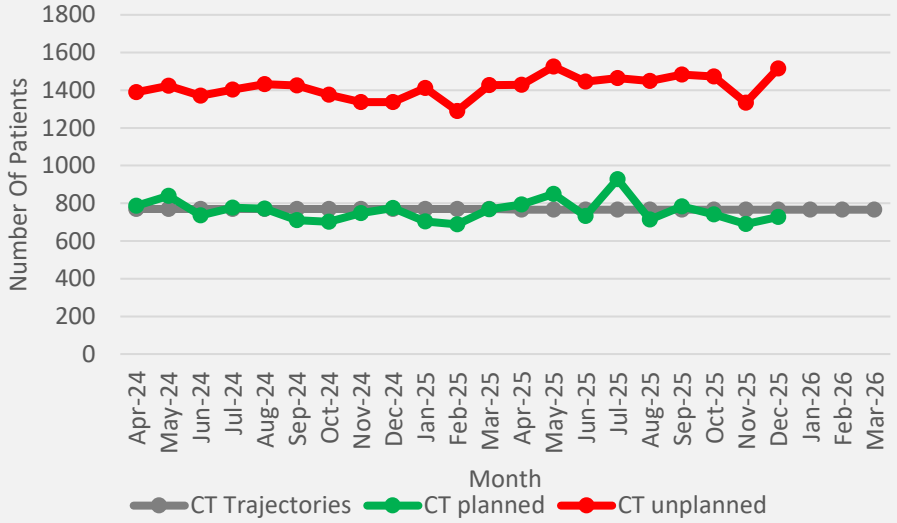
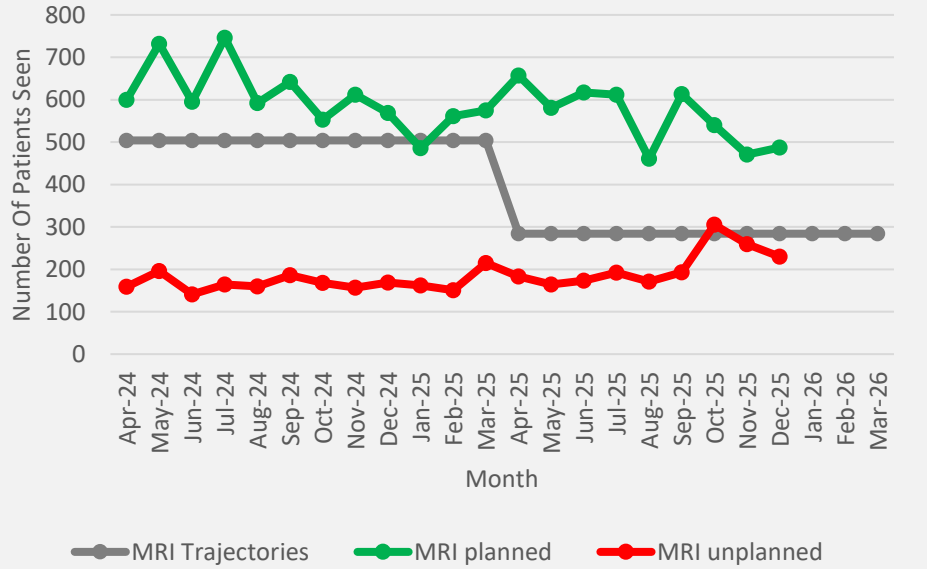
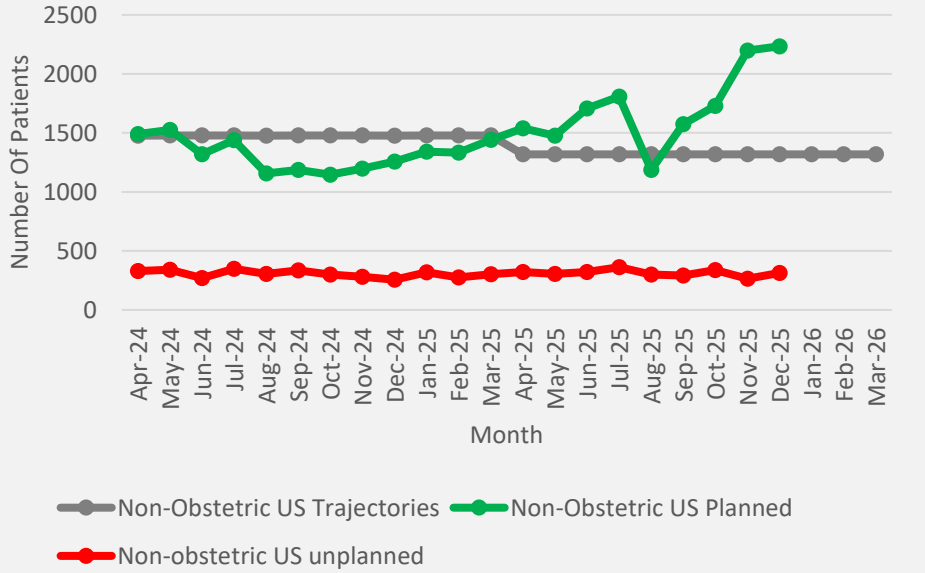
CT Patients Seen and Trajectories



MRI Patients Seen and Trajectories



Non-Obstetric Patients Seen and Trajectories



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Diagnostics – Endoscopy – Slide 1 of 2

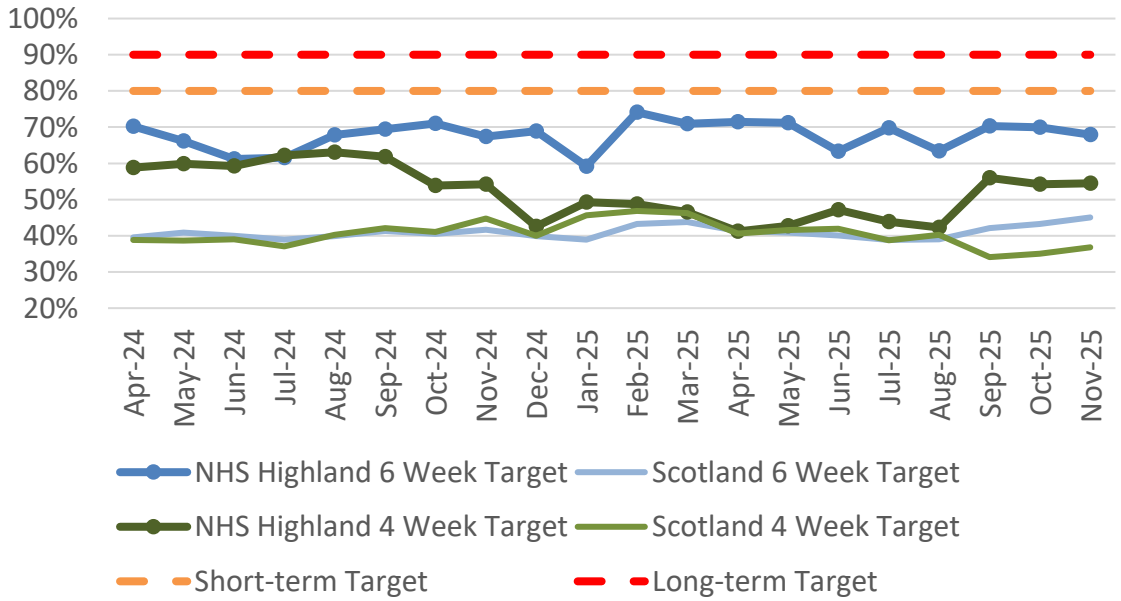
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
No patients waiting longer than 6 weeks for an endoscopy test (from referral to test) in line with Scottish Waiting Time Targets	**GI endoscopy:** Loss of colon capsule service is a challenge to performance, Maternity leave and other staffing challenges impact capacity, including challenges in RGH sites Belford, Wick and Oban sites. Significant waiting list initiative additionally in Gastroenterology and Gen Surgery causing demand pressures **Cystoscopy:** Reviewed staffing model to match demand and capacity underway.	**Overall:** raised PMS recording 28 days, rather than national 42 target. First raised 27/12/2023. Confirmation this is on digital delivery plan – can it be prioritised? **GI endoscopy:** Held meeting with Belford and Wick hospital managers to address loss of lower capacity at both sites. Awaiting mitigation plan Nurse endoscopists visiting Wick site in March to provide lower capacity **Cystoscopy:** Independent Sector and WLI running in Quarter 4 – data shows non-recurring demand/capacity gap
The number of patients seen for a new endoscopy appointment is equal to or exceeds the trajectory every month		
The number of patients seen for a new Colonoscopy, Cystoscopy, Flexi Sig and Upper GI is equal to or exceeds the number of planned appointments every month		

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

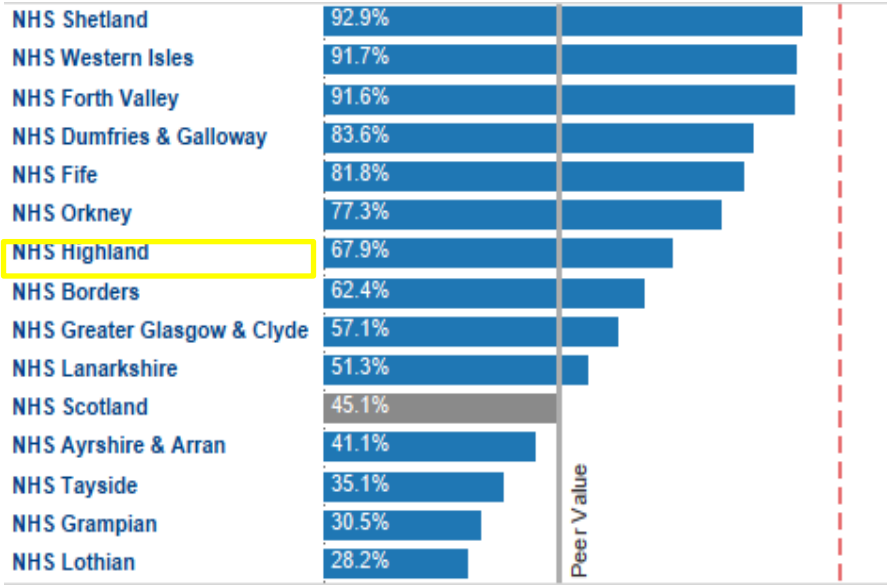
Performance Rating	
Latest Performance	67.9%
National Benchmark	45.1%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	While national target not met, performance in NHSH is ahead of Scotland average
Benchmarking	7th out of 15 Boards

Endoscopy Tests: Maximum Wait Target 4/6 Weeks

Colonoscopy, Cystoscopy, Flexi Sig, Upper GI



Benchmarking with Other Boards
6 Week National Target



Planned Activity

Yearly Trajectory	5,176
YTD Performance Trajectory	3,886 (75.08%)
Patients Seen – Dec 25	5,040 (97.31%)
Overall	22.24% above target

Diagnostics – Endoscopy – Slide 2 of 2

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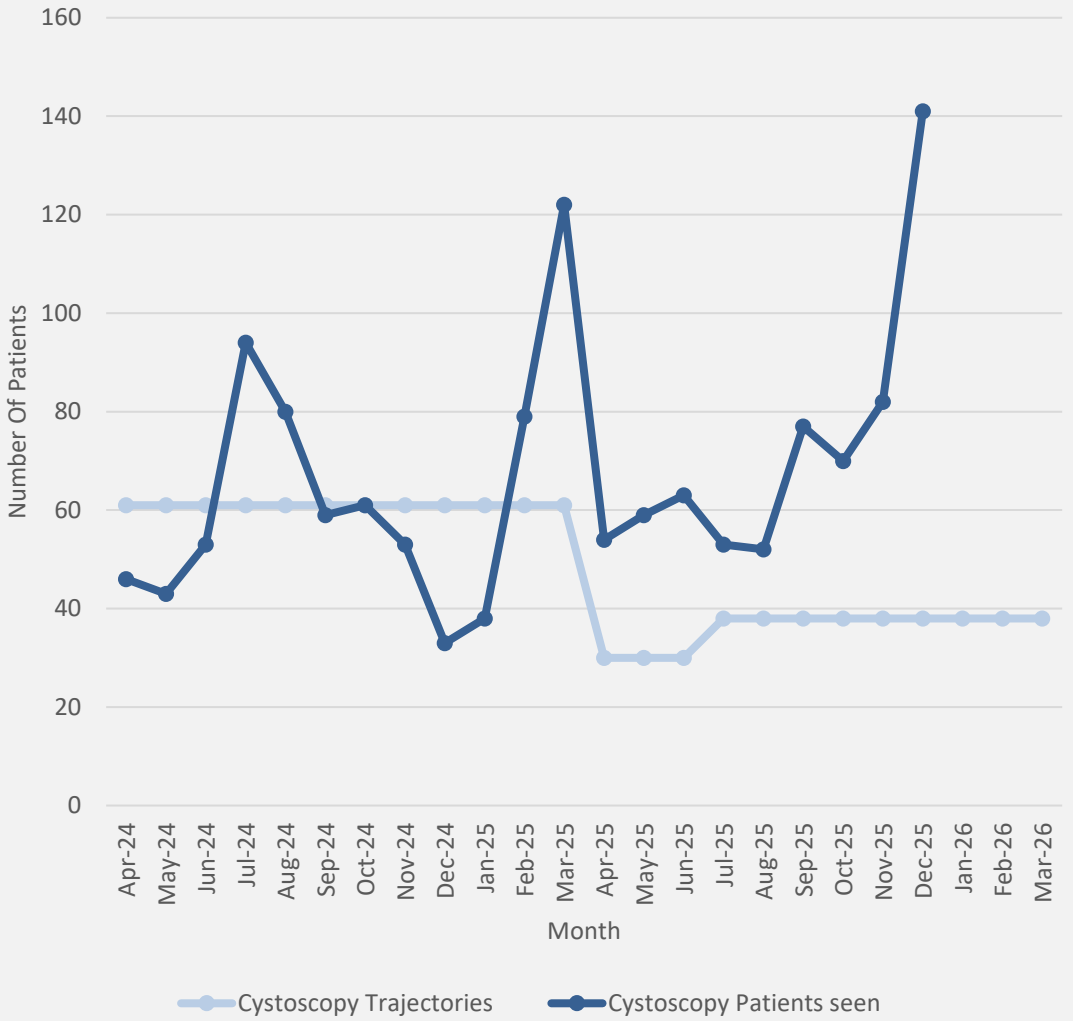
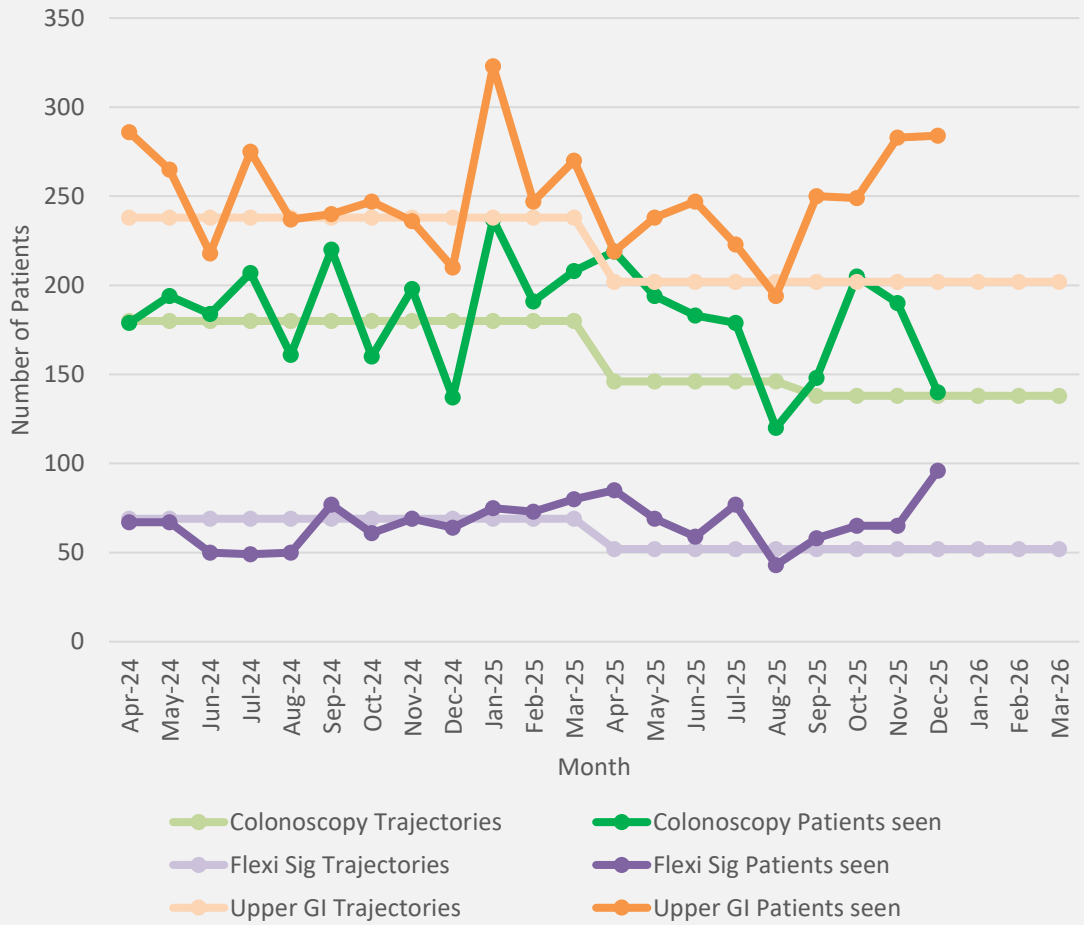
Patients Seen and Trajectories: *Cystoscopy*



Cystoscopy Patients Seen and Trajectories: *Colonoscopy, Flexi Sig & Upper GI*



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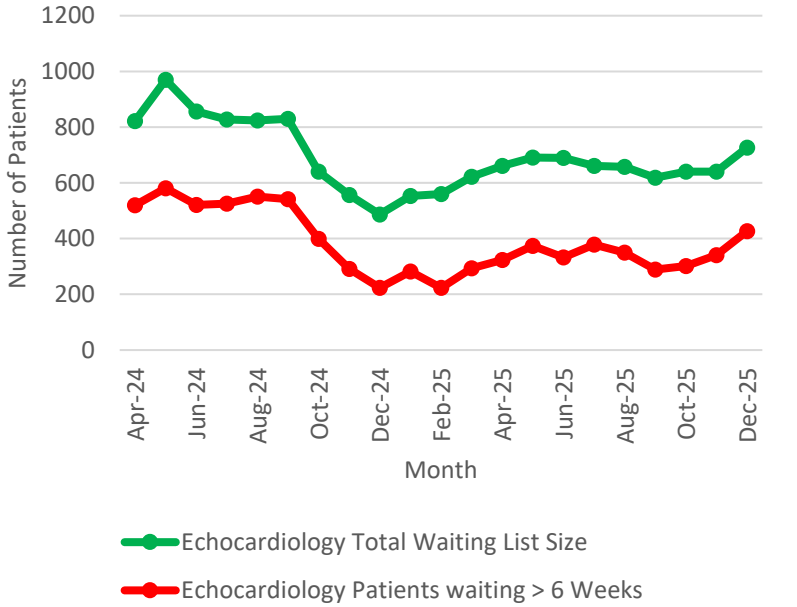
Diagnostics - Wait List Other

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Increase the number of patients waiting less than 6 weeks for an ECHO test (from referral to test) in line with Scottish Waiting Time Targets		**Ambulatory ECG & Blood Pressure (R-Tests/Holter):** -Some Cardiography post(s) vacated and in recruitment a considerable period from latter 2025 -Some equipment stock (R-Teat) limiting as numbers deplete and to be replenished **Echo-cardiography:** -Locum post closed in Oct 2025 -Long vacant Principal Post (now re-advertised) **Spirometry (Raigmore & Caithness):** -Stable, following significant improvement from 2nd staff member starting in mid-2024	• Posts in Vacancy Management Process • Paper to be at ASLT to renew R-Test stock • 4th Echo machine nationally funded and ordered • Key action to sustain improved situation
Increase the number of patients waiting less than 6 weeks for an R Test / 24 ECG (from referral to test) in line with Scottish Waiting Time Targets			
Increase the number of patients waiting less than 6 weeks for an spirometry test (from referral to test) in line with Scottish Waiting Time Targets			

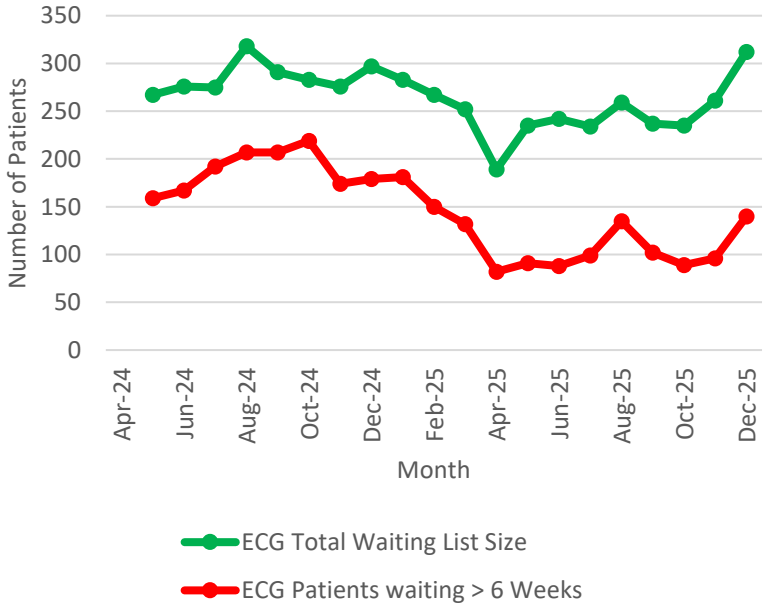
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	n/a
National Benchmark	n/a
National Target	n/a
National Target Achievement	n/a
Benchmarking	n/a

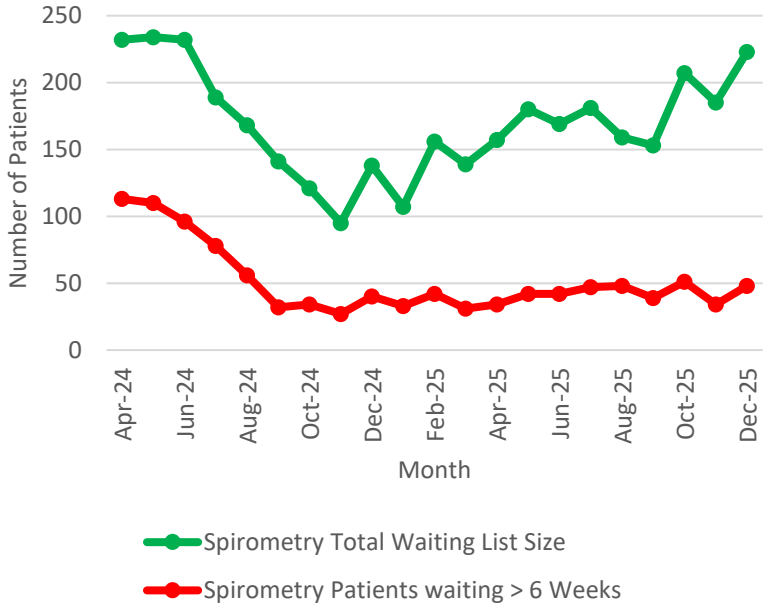
ECHO: Total Waiting List Size & Patients Waiting >6 Weeks



ECG: Total Waiting List Size & Patients Waiting >6 Weeks



Spirometry: Total Waiting List Size & Patients Waiting >6 Weeks



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Chief Officer, Acute

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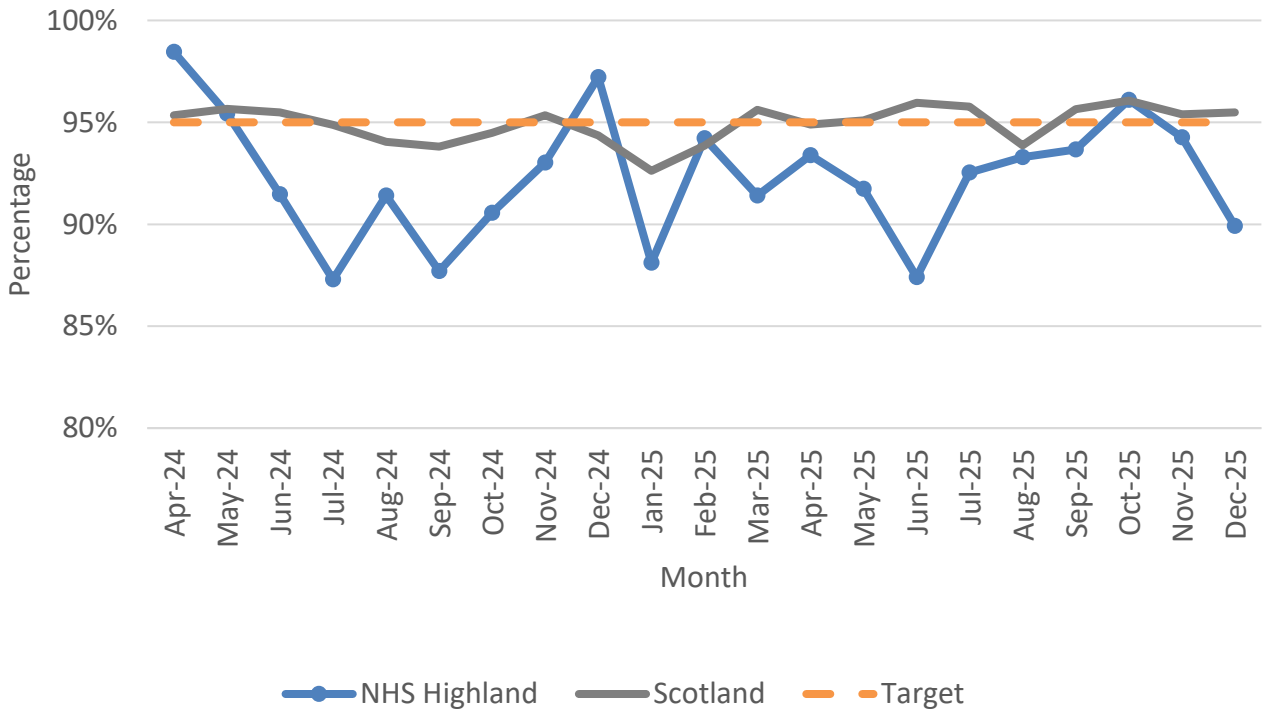
31 Day Cancer Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
95% of patients should begin treatment within 31 days of the decision to treat, regardless of the referral route	• The poor compliance is almost exclusively due to reduced capacity for Breast Surgery following changes in workforce owing to retirement and advertisement of replacement.	• Readvertisment of Breast Surgeon post with interviews scheduled for early March. • Support from NHS Forth Valley as interim measure. • Advancing locum appointment to increase capacity

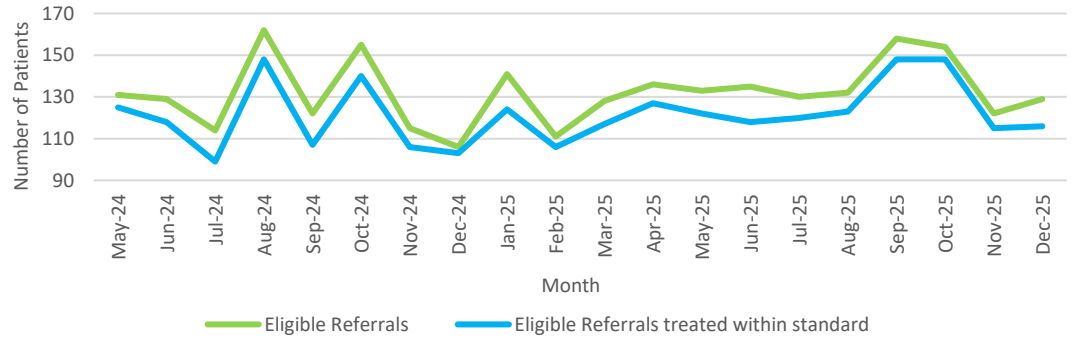
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	89.9%
National Benchmarking	95.5%
National Target Achievement	95%
Position	15th out of 15 Boards

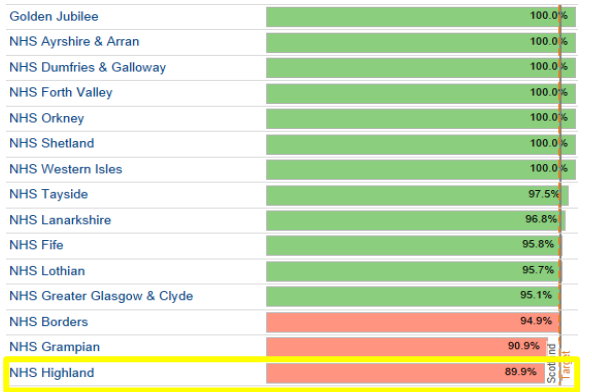
31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



31 Day Benchmarking with Other Boards



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Chief Officer, Acute

OIP

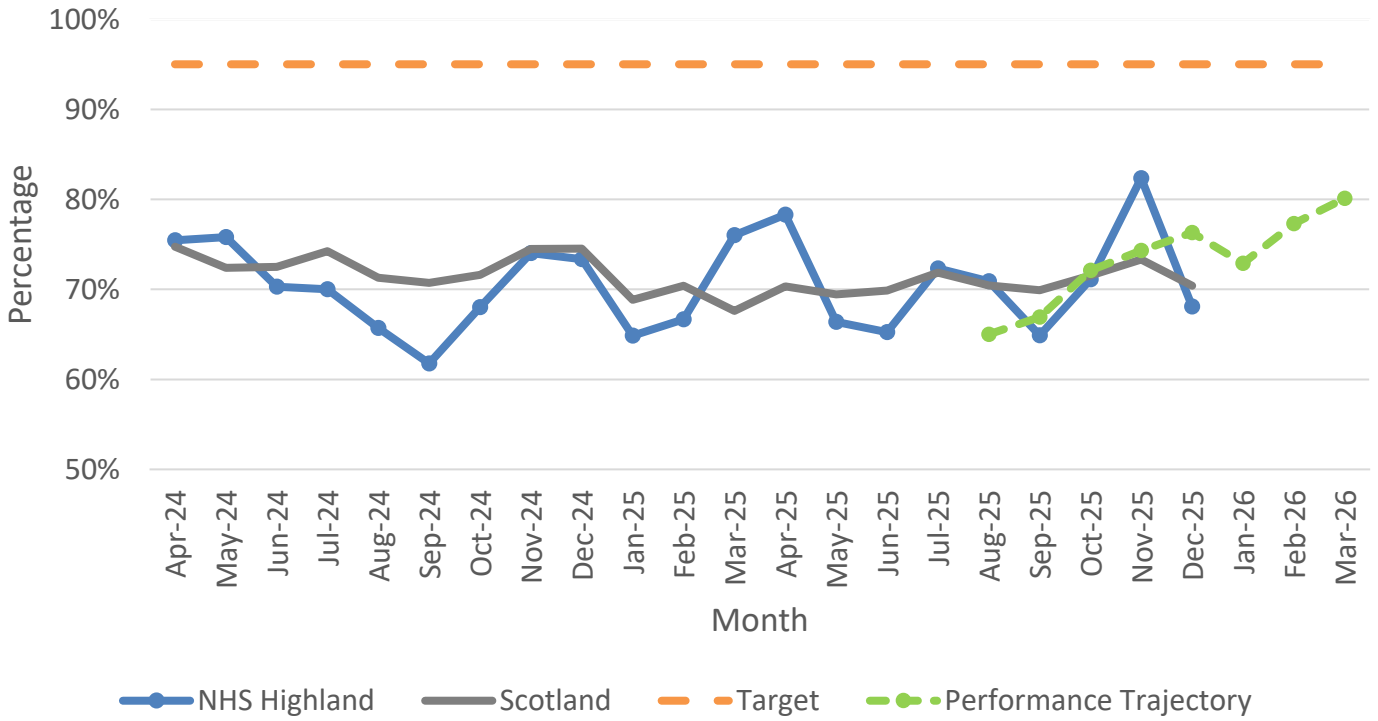
62 Day Cancer Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
95% of patients referred urgently with a suspicion of cancer (USC) - whether through a GP referral, national screening programme, should be their first cancer treatment within 62 days of receiving the referral.	• Compliance within Breast and Colorectal pathways timescales is the most challenged. • There is a lack of capacity for Assessment & Diagnostics in Breast within staffing gaps • There is a lack of staff to support a 2-week wait to scope in particular for Colorectal patients. • Most other patients are above the monthly declared trajectory which aims to be at 80% by 31 March 2026.	• Breast - Continued support from Forth Valley for See and Treat provision. • Breast – continued recruitment efforts to appoint to vacant posts, include appointment to alternate staffing models using non medical workforce. • Colorectal – as above with appointment of Nurse Endoscopists • Continued daily scrutiny and prioritisation of cancer activity to maintain and improve performance in every tumour type

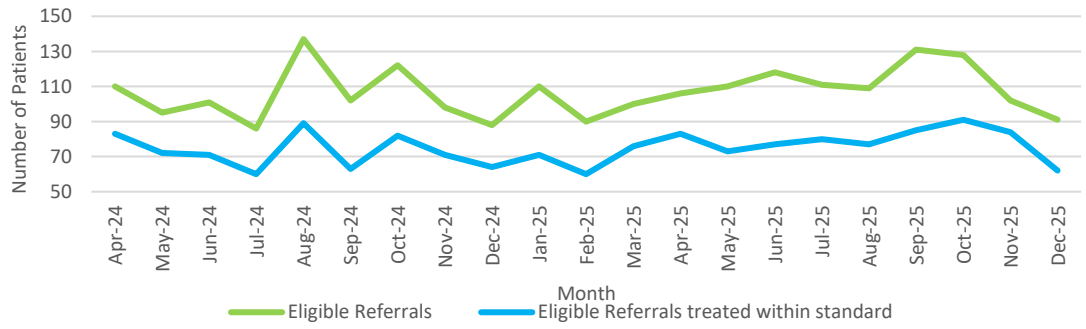
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	68.1%
National Benchmarking	70.4%
National Target	95%
National Target Achievement	Not Achieving
Position	9th Out of 14 Boards

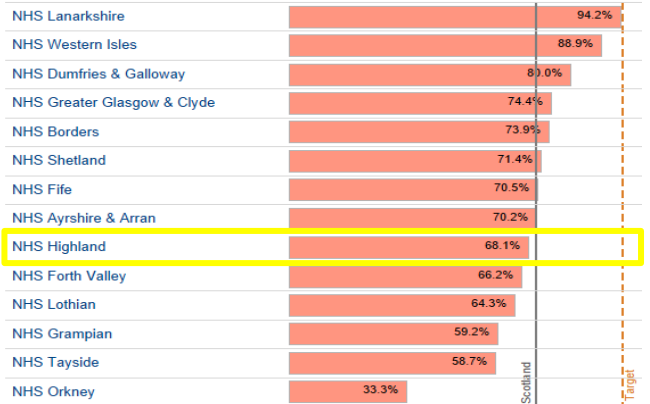
62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



62 Day Benchmarking with Other Boards



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Chief Officer, Acute

SACT (Systemic Anti Cancer Therapy) and Radiotherapy Access and Benchmarking

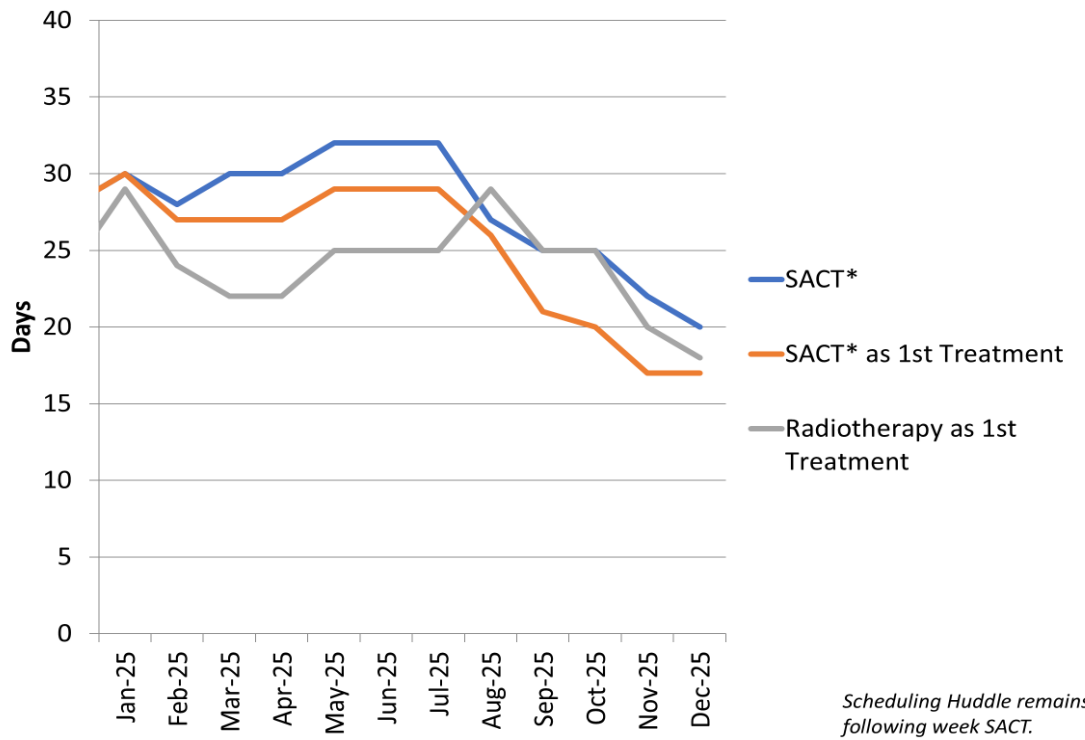
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
The average waiting times for SACT as 1st Treatment, Radiotherapy as First Treatment and ASCT patients overall (new and subsequent) will be no more than 28 days	This is a local standard only. It is expected to be adopted as a national benchmark within the next financial year. Performance is due to a variety of factors such as good prescribing staff capacity (medical and non-medical) together with optimal SACT Nursing staff to support SACT treatments.	We will continue to maximise the resources available to minimise the waiting times to commencement of SACT and Radiotherapy treatments.

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

Performance Rating	
Latest Performance	Average range = 16-20 days to start treatment
National Benchmarking	n/a
National Target	n/a
National Target Achievement	n/a
Position	NHS Highland activity matches national trends

Systemic Anti Cancer Therapy (SACT) and Radiotherapy
Average waiting times by month

ONCOLOGY



NHS Highland

Scheduling Huddle remains in place to ensure capacity for following week SACT.
Excludes all oral SACT.

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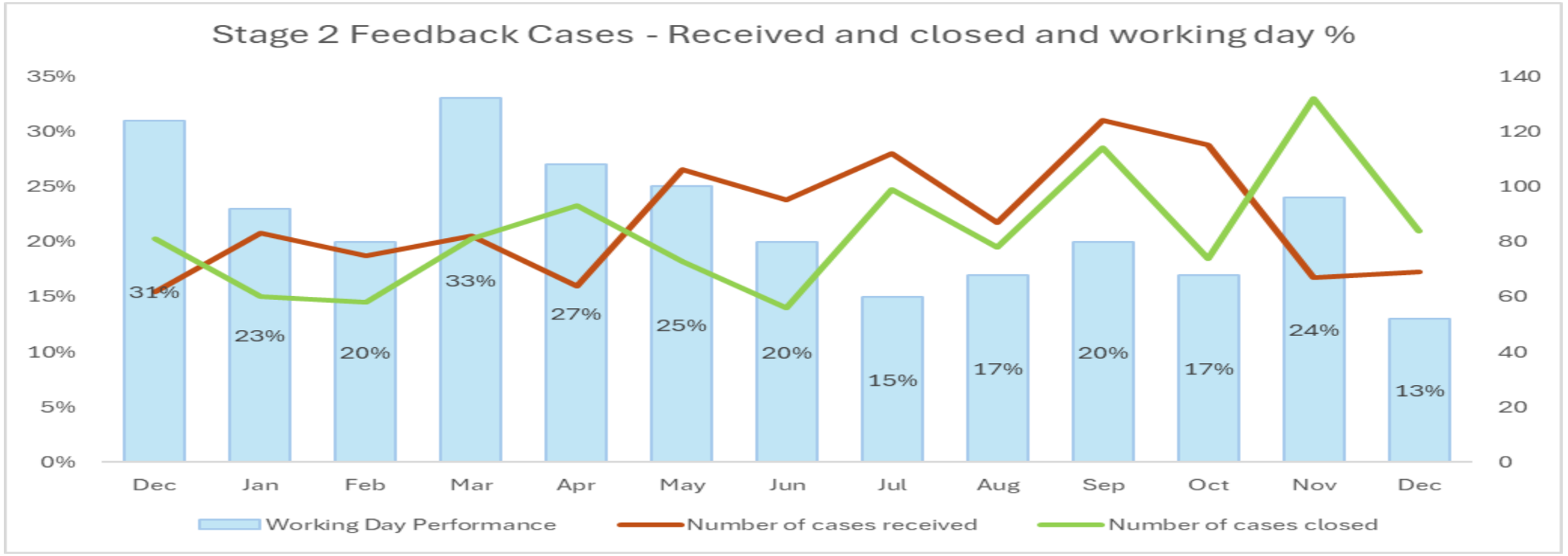
Stage 2 Complaint Activity (December 2024 – December 2025)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
N/A	Continued poor performance against the 20 day working target. This is due to investigations exceeding the expected time, routinely. Feedback Team continue to log and send responses within 24-48 hours of receipt. Whilst the number of complaints closed in November and December exceeded those opened, the previously identified reverse trend continues to reduce efficiency in the Feedback process affecting both Operational Units and the Clinical Governance Team.	Reporting to EDG and escalation to Board Medical Director where required. Weekly and bi-weekly reports to Operational Units. Meetings have been held with SLT. Investigations are the responsibility of the Operational Units.

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

Performance Rating	
Latest Performance	13%
National Benchmarking	None
National Target	60%
National Target Achievement	
Position	



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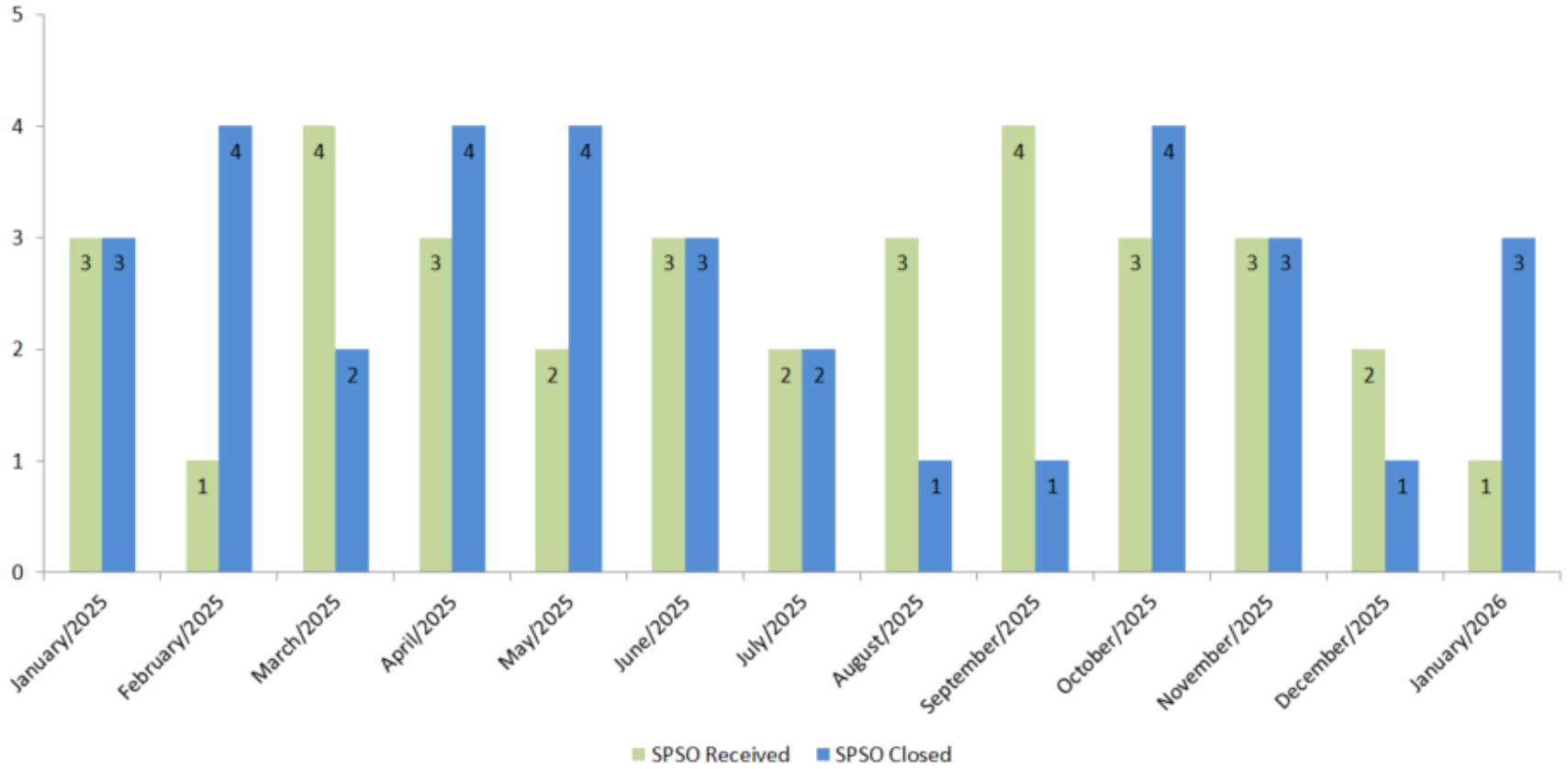
SPSO Activity (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	The number of cases opened by the SPSO has decreased in the last three months. All cases closed have not been taken forward.	SPSO cases continue to be monitored via the Quality and Patient Safety structure.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	
National Target Achievement	
Position	



SPSO cases received last 3 months:
6 received:

- 2 x Acute
- 1 x A&B
- 3 x HHSCP

These relate to Mental Health Services - Adult Psychiatry, Surgical - Orthopaedics, Surgical - Urology

SPSO cases closed last 3 months:
7 SPSO enquiries closed

- 7 x not taken forward

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Level 1 SAERs Declared and Status Overview (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	15 SAERs are over the 26 week target. There are 31 open SAERs. 51 SAER actions are overdue which is a decrease since the last reporting period. There is 69 open actions.	All operational areas have been actively reviewing their open SAERs to ensure that they are completed within the 26 week timeframe.

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	
National Target Achievement	
Position	

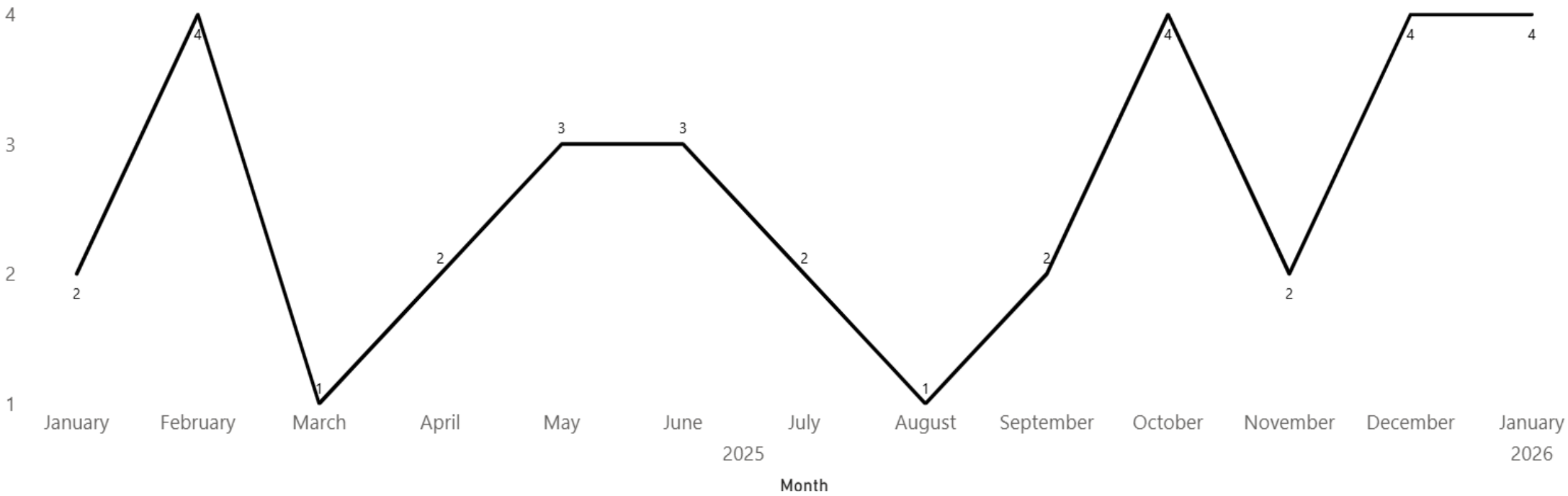
31
Open Level 1 (L1) Incidents

15
L1: Active more than 26 weeks

34
L1: SAER Declared Last 13 Months

0.19%
Incident | SAER Conversion Last 13 Months

SAER Level 1 Investigations Declared



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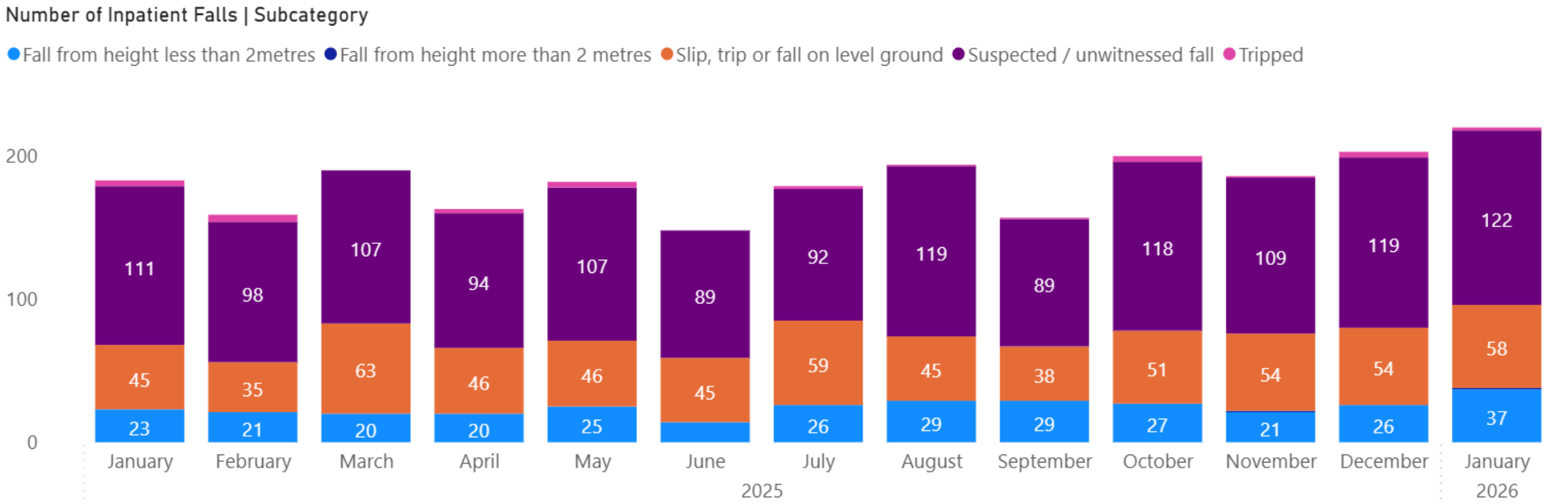
Hospital Inpatient Falls (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	There has been a slight overall increase in inpatient falls rates since last reporting period. Falls with harm rate static, averaging 40 per month across NHSH Multiple bays in Raigmore hospital have had an additional patient in them but this does not appear to have impacted rate of falls.	Improvement work continues at a local level. Good engagement with Falls awareness online event in November

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	
National Target	20% reduction (falls) 30% reduction (falls with harm)
National Target Achievement	
Position	



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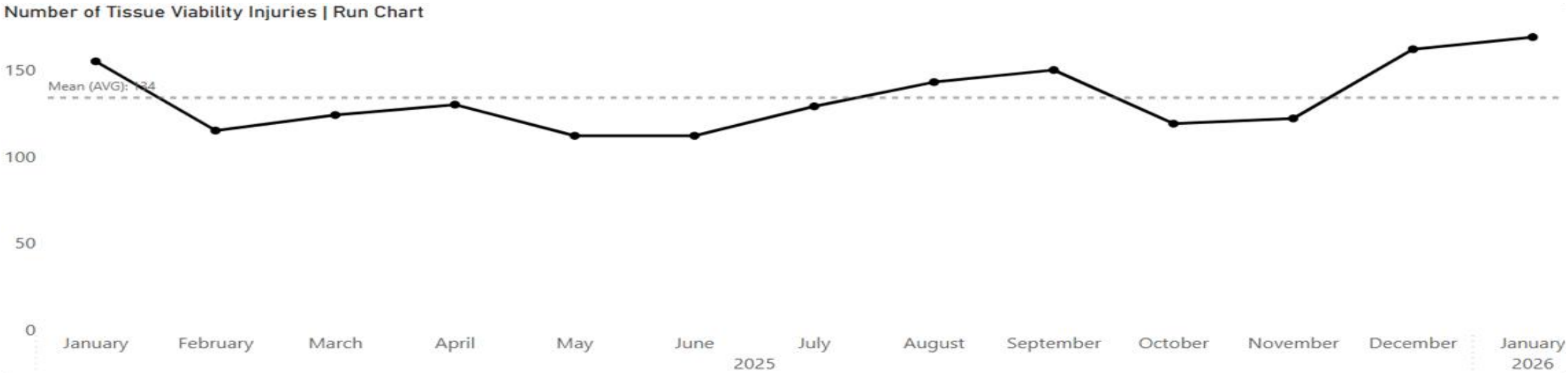
Tissue Viability Injuries (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
-MASD and PU Pathways complete via NATVNS- New Pressure Ulcer Grading Tool Training launched with dates via Teams. Training and Audit to target wards on Datix so that figures are accurate across acute key wards		- IPC unpublishing TURAS modules for Pressure Ulcers (PU). - PUs on feet adding to numbers - developed feet training - SAS discussions ongoing re: frailty pathway and in discussions with Clarie Copeland and Kate Watson from NHS Glasgow for QI - -NHS Grampian/SAS/NHSH PU launch - -MASD and PU Pathways complete via NATVNS-	- -Continue to implement support for high risk areas - -Develop training including for Feet - SLWG set up with NATVNS for pressure ulcer training materials as IPC will be publishing training slides on TURAS - PU Documents ongoing with NES support and NATVNS. Current modules shortened to 2,4,5 and 6 until updated - -There is still discrepancy on community figures due to the nature of the current system, which includes patients NOT known to DNS, but still captured under the headiing of 'developed in community'. Working with MB on this to drive change

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

Performance Rating	
Latest Performance	
National Benchmarking	HIS to confirm plans for future/ and how soon
National Target	20% reduction
National Target Achievement	Not available currently
Position	



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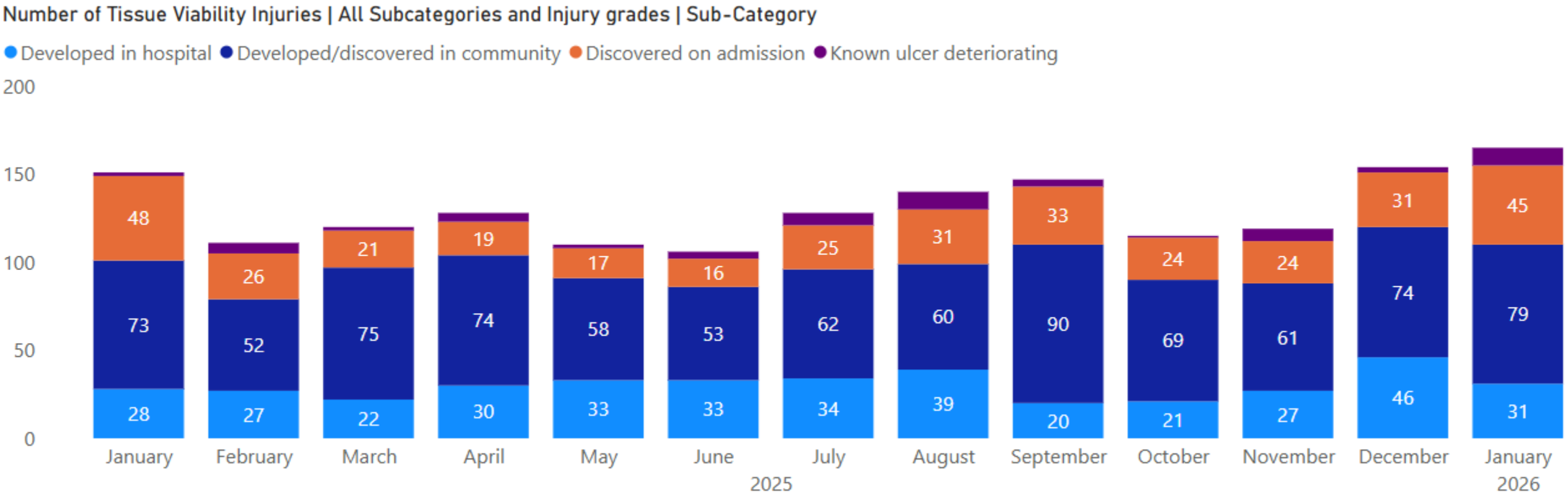
Tissue Viability Injuries | Subcategory (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
		• - QI project started - CPR Feet forms part of lower limb training - At risk ward shows improvement with PUs, but now has increase in number of PUs to feet- ongoing support, and include roll out of CPR Feet - Infection and Biofilm Pathway QI ongoing	- Wards 3A to start project with Podiatry - -Leg Ulcer Audit ongoing - Lower Limb training x1 more for the year successfully ongoing - Infection and Biofilm Pathway QI ongoing
		- Infection and Biofilm Pathway QI ongoing	

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	HIS to confirm plans for future/ and how soon
National Target	20% reduction
National Target Achievement	
Position	



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Tissue Viability Injuries | Subcategory by Injury Grade (January 2025 – January 2026)

ADP Deliverables Progress as at End of Q1 2025/26		Insights to Current Performance	Plans and Mitigations
Need to focus on Grade 2 and Grade 1 prevention as these 2 categories still account for the highest incidents of developed PUs.		• To discuss if Grade 1 can continue to be incident reported, as well as Grade 2	• There is a head to toe inspection video that will be used via NATVNS • Requested TURAS share and be made accessible to/including non NHS Highland care homes • Equipment guide being updated as a step up/step down guide for all clinicians across acute and community • Work underway to address Grade 1 and Grade 2 wounds acute/community

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	
National Benchmarking	HIS to confirm plans for future/ and how soon- ongoing
National Target	20% reduction
National Target Achievement	
Position	

Subcategory | Injury

Injury	Developed in hospital	Developed/discovered in community	Discovered on admission	Known ulcer deteriorating	**Total**
Mucosal Pressure Damage	10	4	12		**26**
Pressure Ulcer - combination lesions	4	8	7	2	**21**
Pressure Ulcer - deep tissue injury	27	96	9	10	**142**
Pressure Ulcer - ungradable	42	136	49	11	**238**
Pressure ulcer (grade not specified)	8	6	12	0	**26**
Pressure ulcer Grade 1	86	145	80	1	**312**
Pressure ulcer Grade 2	196	409	165	17	**787**
Pressure ulcer Grade 3	17	59	17	9	**102**
Pressure ulcer Grade 4	1	17	9	13	**40**
Ulcers	1	5	8	0	**14**
Total	**392**	**885**	**368**	**63**	**1708**

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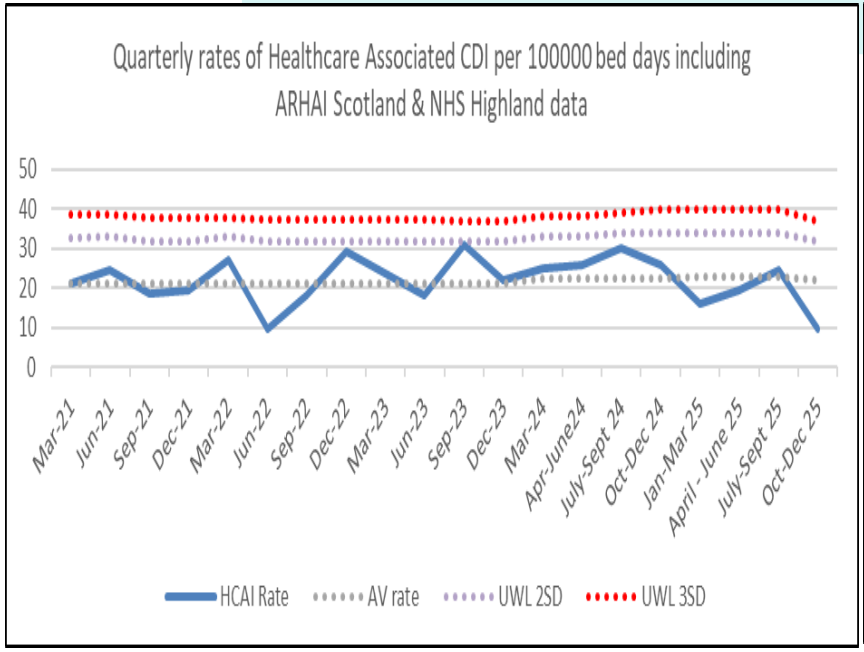
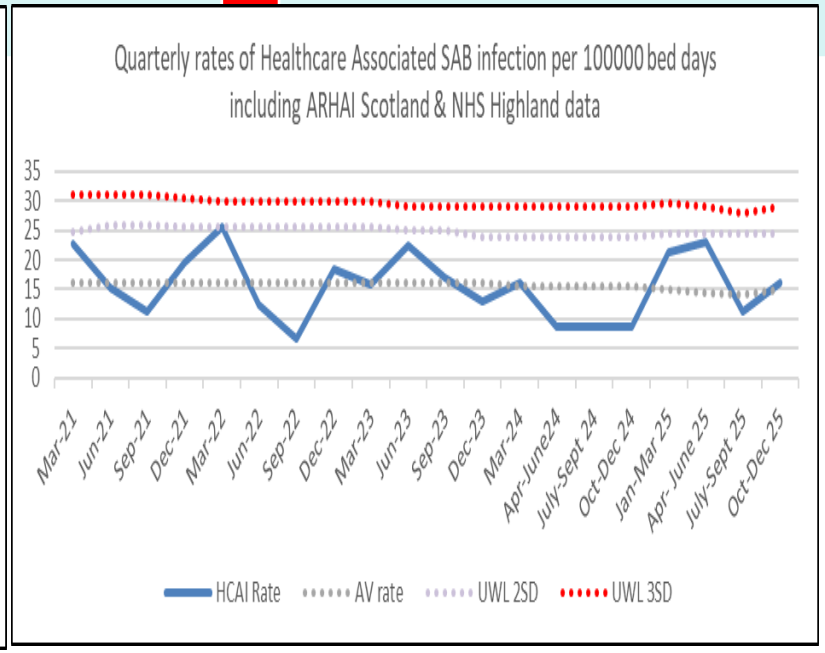
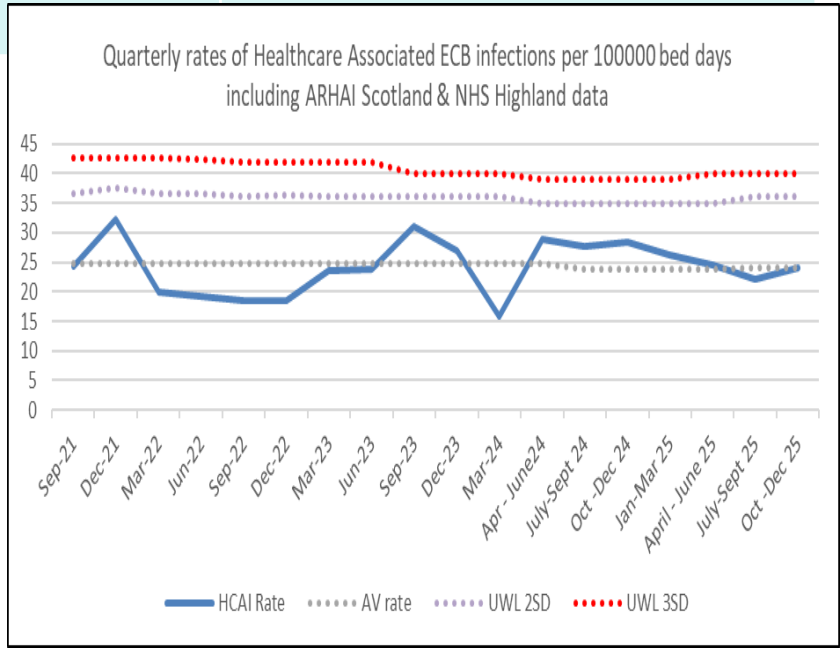
Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims 1st April 2025 to 31st December 2025

ADP Deliverables: Validated position for 2025/26 reduction aims The RAG ratings are calculated on the predicted monthly numbers.		Insights to Current Performance	Plans and Mitigations
Clostridioides difficile (CDI) 2025/2026 reduction aim is 75 HCAI cases. As of 31/12/2025 41 HCAI cases reported. Currently on track to meet aim (5 cases under trajectory)		On the 7th of January 2026 National Services Scotland published the report for the Quarterly Epidemiological data on Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland (July- Sept 2025 (Q3) 2025). This data reports that NHS Highland was within normal variation for healthcare associated SAB, CDI and EColi when analysing trends over the past three years, and was not above the 95% confidence interval upper limit in the funnel plot analysis. It should be noted that we were over the 95% confidence interval for CDI Community cases and have been asked to submit an exception report. These cases are not associated with clusters/outbreaks The following quarter shows the data has returned to within predicted limits. The next publication is expected April 2026	Continue to review individual cases for learning and any subsequent actions. Targeted work with antimicrobial prescribing continues, The use of faecal microbiota transplant therapy continues to be progressed as a treatment for chronic CDI. Continue to ensure adherence to national guidance for the management of infections. Submit the Community associated CDI exception report for Q3 (july-Sept 25) by 13th feb 2026
Staphylococcus aureus bacteria (SAB) 2025/26 reduction aim is 53 HCAI cases. As of 31/12/2025 41 HCAI cases reported. Currently on track to meet aim (13 case under trajectory)			
Escherichia Coli (ECB) 2025/2026 reduction aim is 75 HCAI cases. As of 31/12/2025 62 HCAI cases reported This is above predicted trajectory by 8 cases			







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Integrated Performance & Quality Report: Grow, Listen, Nurture & Plan Well

Key Performance Indicators (KPIs)		Feedback and Summary	Risks
Reduce sickness absence of all staff (long-term and short-term) across NHS Highland to less than 4% of staff being absent at all times.		Remains over 4% and has increased again to 6.9%. 24.9% of Long-term absences are related to anxiety/stress/depression.	Attendance is not managed robustly/consistently and rates remain higher than 4%. Training on policy and process continues. Toolkit and checklist being developed.
Ensure 95% Core Mandatory eLearning compliance across NHS Highland staff (measured through the Core Mandatory eLearning Completion Rate).		Statman compliance is 75.1%, action is required within each area to meet target of 95%	Risk to staff, patients and organisation as staff not appropriately trained. Reports available to managers on TURAS and statman dashboard.
Ensure the annual turnover rate of staff leaving NHS Highland remains below 10% of the total workforce.		Annual turnover decreased slightly this month to 6.89%	
Ensure the average Time to Fill rate for positions within NHS Highland remains below the 116 day national target.		Above the national target of 116 days at 121.6 and steadily rising.	Work continues with training for recruiting managers and sustaining lower time to fill period
Ensure 95% of the NHS Highland workforce has a completed TURAS Appraisal within the financial year 2025/26.		Appraisal rate of 29.8% is significantly short of the 95% target. There has been a decrease of 2.9% since last report.	Noncompliance with staff governance standards. All areas asked to develop plans to ensure each employee receives a PDP annually.

Guide to Performance Rating

Meeting Target

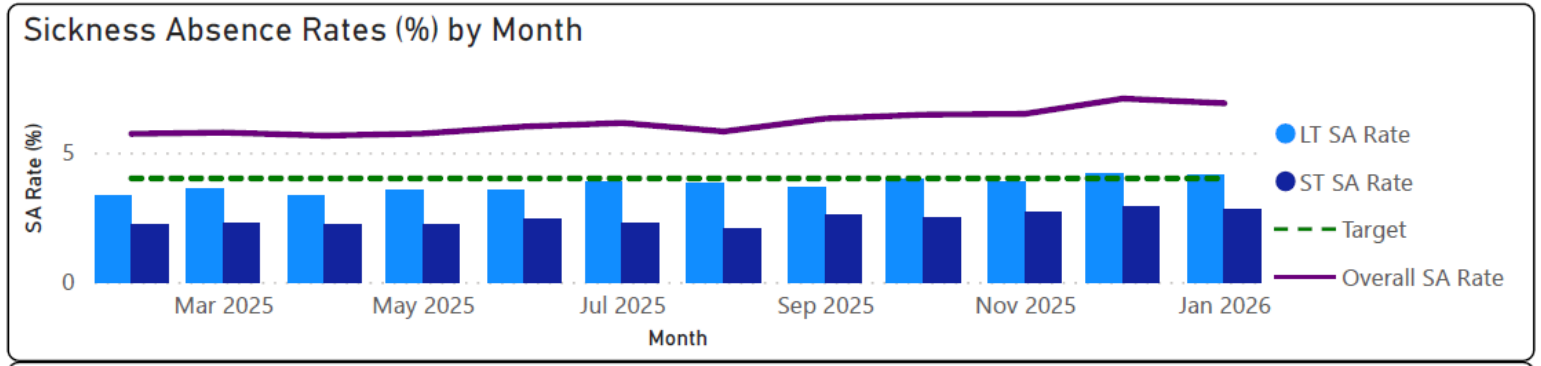
<5% off target

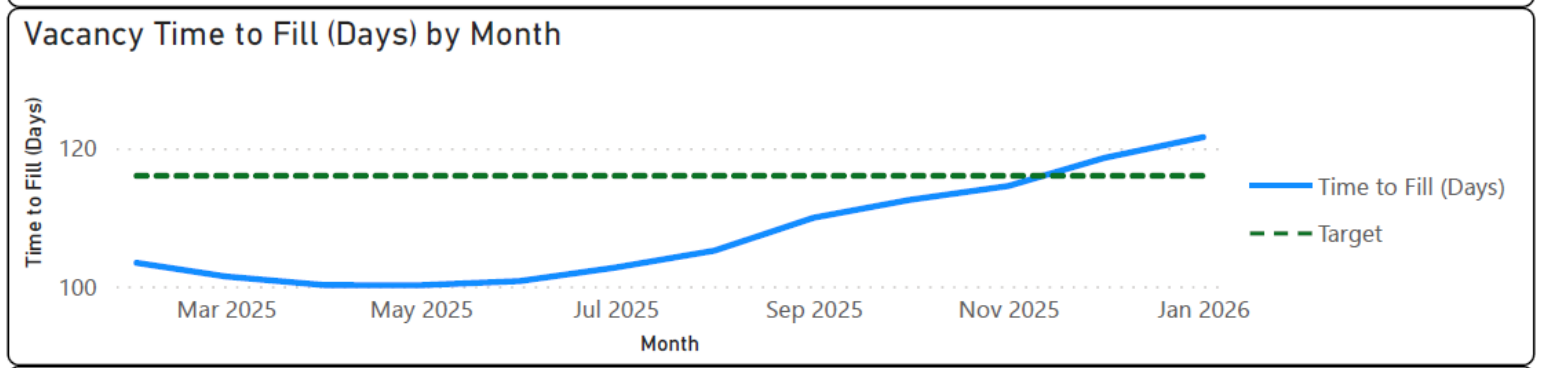
>5% off target

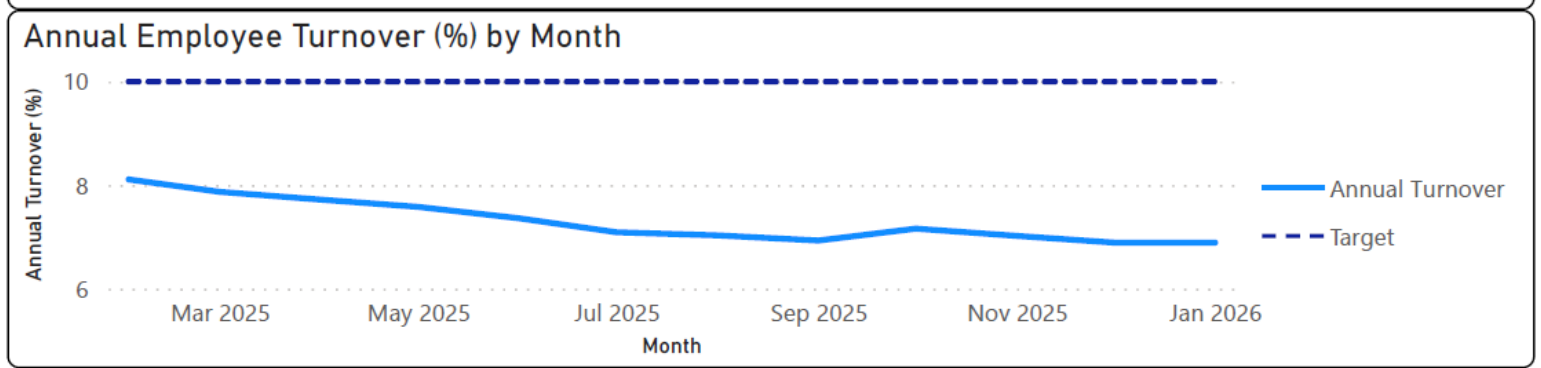
>10% off target

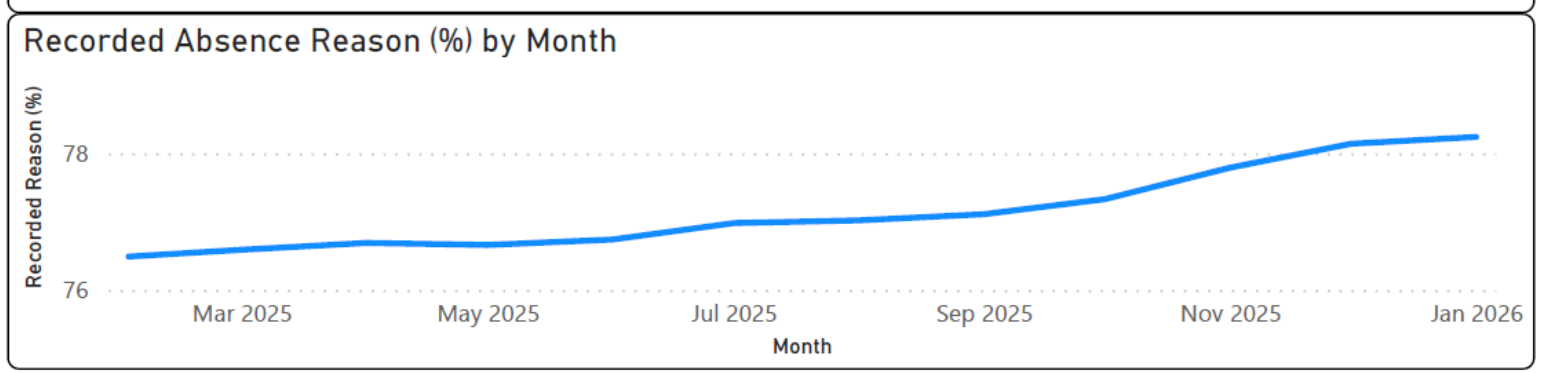
Organisational Metrics Jan 2026

Sickness Absence Rate (%)	6.90
Long Term SA Rate (%)	4.15
Short Term SA Rate (%)	2.81
Recorded Absence Reason (%)	78.24
Vacancy Time to Fill (Days)	121.60
Annual Employee Turnover (%)	6.89









Training Metrics Jan 2026

Bank eLearning Completion Rate (%)

50.9

Substantive eLearning Completion Rate (%)

79.9

Overall eLearning Completion Rate (%)

75.1

M&H Practical Training Completion Rate (%)

49.7

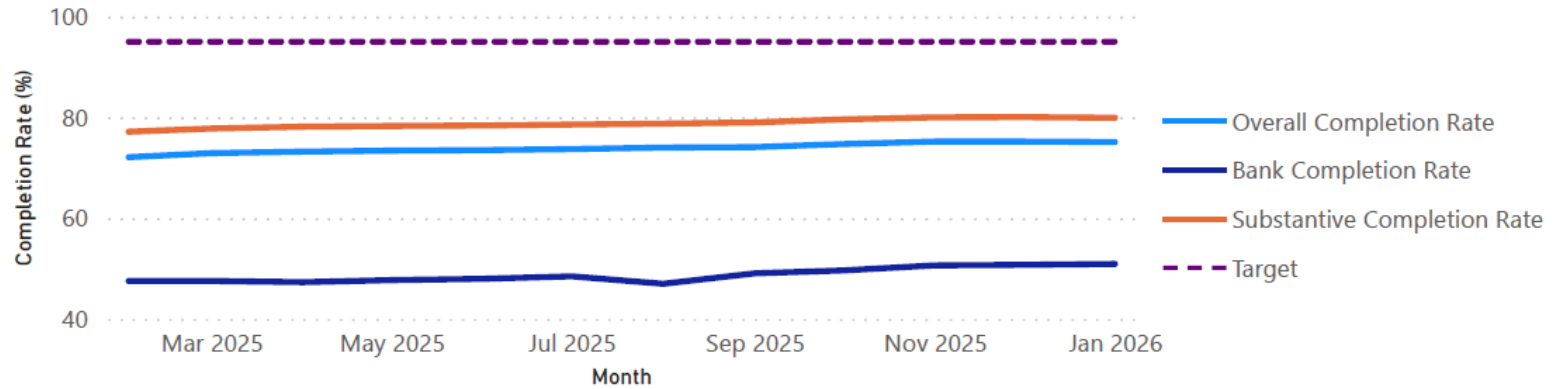
V&A Practical Training Completion Rate (%)

29.8

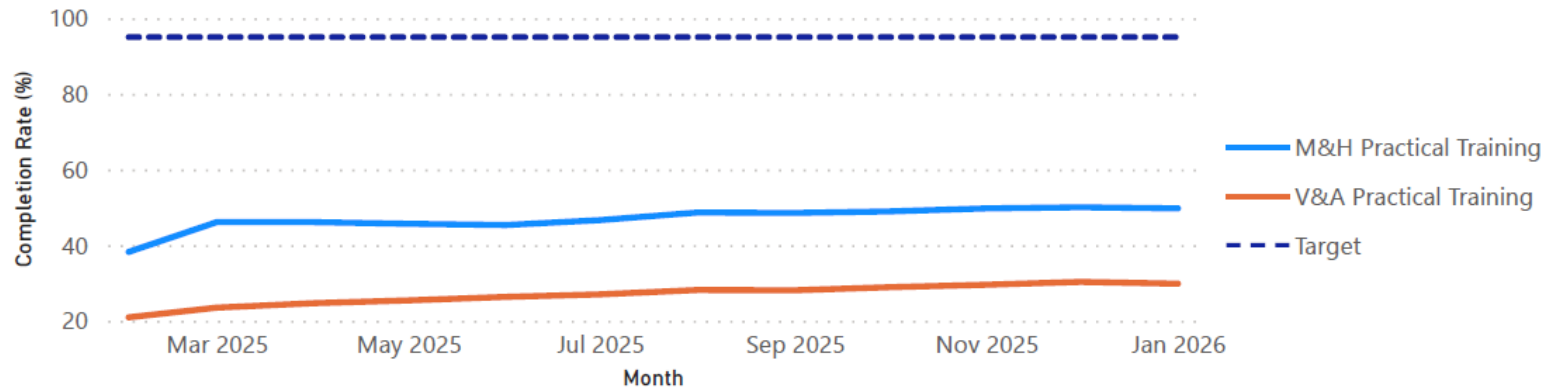
Appraisal Completion Rate (%)

29.8

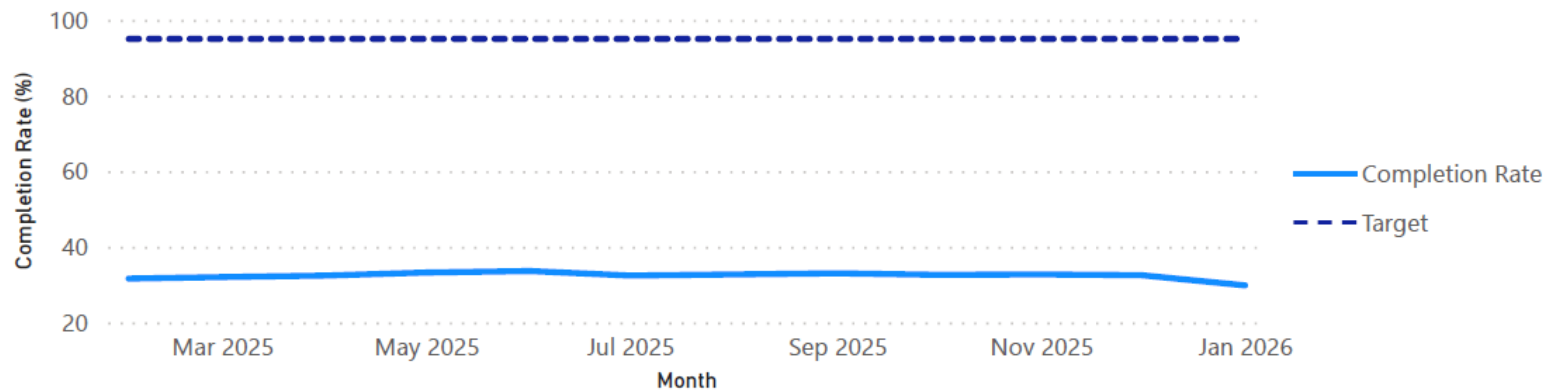
Core Mandatory eLearning Completion Rate (%) by Month



Practical Training Completion Rate (%) by Month



Appraisal Completion Rate (%) by Month



Organisational Metrics – Glossary

- **Sickness Absence Rate:** The sickness absence rate for the whole organisation, expressed as a percentage of hours lost / total contracted hours, for the specified month. Data is sourced from SWISS.
- **Long Term Sickness Absence Rate:** The long-term sickness absence rate for the whole organisation (long term is defined as 29 days or more), expressed as a percentage of hours lost / total contracted hours, for the specified month. Data is sourced from SWISS.
- **Short Term Sickness Absence Rate:** The short-term sickness absence rate for the whole organisation (short term is defined as 28 days or less), expressed as a percentage of hours lost / total contracted hours for the specified month. Data is sourced from SWISS.
- **Recorded Absence Reason:** This is the percentage of sickness absences where a reason other than 'unknown' is recorded i.e. 100% - the % of sickness absence recorded as 'unknown' reason. Data is sourced from Payroll and the period used is the past 12 months i.e. September 2025 would be looking at sickness absence recorded from Oct 2024 – Sep 2025.
- **Vacancy Time to Fill:** This is the average number of days to fill a vacancy (days between advert live date and candidate start date). Note this therefore does not include any time taken before the vacancy is advertised i.e. approval time, time to enter onto JobTrain etc. Data is sourced from Yellowfin and the period used is the past 12 months i.e. September 2025 would be looking at candidate start dates recorded from Oct 2024 – Sep 2025.
- **Annual Employee Turnover:** This is the turnover for a 12-month period i.e. September 2025 would be looking employee numbers as of 1st October 2024 and 30th September 2025, and the number of leavers during this period. The value is calculated as number of leavers / average number of employees * 100 to express as a percentage. The average number of employees is calculated using the number of employees at the start of the period and the number of employees at the end of the period. For example, 10800 employees as of 1st October 2024, 11400 employees as of 30th September 2025, 780 leavers during that period would give a turnover of 780 / ((10800+11400) / 2) * 100 = 7.03%. Note that Bank staff are excluded from this calculation. Data is sourced from eESS.

Organisational Metrics – Glossary

- **Overall eLearning Completion Rate:** This is the percentage completion rate for all staff for mandatory e-Learning courses within the required time period which varies by course. Courses included are Equality and Diversity, Fire Safety, Hand Hygiene, Information Governance, Moving and Handling Module A, Public Protection, Staying Safe Online, Violence and Aggression, and Why Infection Prevention Matters. Data is sourced from TURAS.
- **Bank eLearning Completion Rate:** As above, for Bank only staff. Data is sourced from TURAS.
- **Substantive eLearning Completion Rate:** As above, for staff who hold a substantive post. Data is sourced from TURAS.
- **M&H Practical Training Completion Rate:** This is the percentage of staff who have completed Moving and Handling (people) practical training within their required time period, which can be 1 year or 2 years depending on department. Only staff who are required to complete this training are included in the calculation. Data is sourced from TURAS.
- **V&A Practical Training Completion Rate:** This is the percentage of staff who have completed Violence and Aggression practical training within their required time period. Only staff who are required to complete this training are included in the calculation. Data is sourced from TURAS.
- **Appraisal Completion Rate:** This is the percentage of staff that have completed an appraisal within the past 12 months i.e. for September 2025, an appraisal with a completion date between 1st October 2024 – 30th September 2025 would be included. Note that Bank and Medical and Dental employees are excluded from this. Data is sourced from TURAS.

Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented
5	CAMHS Waitlist NHSH	Monthly	January 2026
6	NDAS Total Awaiting 1st App (incl unvetted)	Monthly	January 2026
6	NDAS New + Unvetted Patients Awaiting First Appointment by Wait Band	Monthly	January 2026
7	Vaccinations	Quarterly	January 2026
8	Smoking Cessation	Quarterly	January 2026
9	Breastfeeding	Monthly	January 2026
10	NHS Highland-Alcohol brief interventions 2025/26 Q2	Quarterly	January 2026
11	Drug and Alcohol Recovery Performance Against Standard for Completed Waits	Quarterly	January 2026
12	Psychological Therapy Waiting Times Patients seen <18 weeks.	Monthly	January 2026
13	% of People Seen in ED Within <4 hours Per Month	Quarterly	January 2026
13	Total Patients Waiting >8 hours in ED per Month	Quarterly	January 2026
13	Total Patients waiting >12 hours in ED per Month	Monthly	January 2026
14	Number of People Delayed from Hospital Discharge at Monthly Census Point NHSH	Monthly	January 2026
14	Number of People Delayed from Discharge – Location and Code.	Monthly	January 2026
15	Outpatients (NOP) Seen & Trajectories	Monthly	January 2026
15	Outpatients seen <12 weeks Including Consultant and Nurse Lead Activity	Monthly	January 2026

Slide #	Report	Frequency of Update	Last Presented
16	OP long waits >52 Weeks	Monthly	January 2026
17	Return Outpatients Wait List	Monthly	January 2026
18	TTG <12 Week Target Patients Seen & Trajectories	Monthly	January 2026
18	TTG Seen <12 Weeks (consultant Only).	Monthly	January 2026
19	TTG Long waits >52 Weeks.	Monthly	January 2026
20	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	January 2026
21	CT Patients Seen & Trajectories	Monthly	January 2026
21	MRI Patients Seen & Trajectories	Monthly	January 2026
21	Non Obstetric Patients Seen & Trajectories	Monthly	January 2026
22	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	January 2026
23	Patients Seen & Trajectories Cystoscopy	Monthly	January 2026
23	Patients Seen & Trajectories Colonoscopy, flexi sig & upper GI	Monthly	January 2026
24	ECHO: Total Waiting List Size & Patients waiting >6weeks	Monthly	January 2026
24	ECG Total Waiting List Size & Patients waiting >6weeks	Monthly	January 2026
24	Spirometry Total Waiting List Size & Patients waiting >6weeks	Monthly	January 2026
25	31 Day Cancer Waiting Times	Monthly	January 2026
25	Patients Seen on 31 Day Pathway	Monthly	January 2026

Slide #	Report	Frequency of Update	Last Presented
26	62 Day Cancer Waiting Times	Monthly	January 2026
26	Patients Seen on 62 Day Pathway	Monthly	January 2026
27	SACT Average Waiting Times by Month	Monthly	January 2026
28	Stage 2 Complaint Activity	Monthly	January 2026
29	Number of SPSO Cases Received/ Closed	Monthly	January 2026
30	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	January 2026
31	Number of Hospital Inpatient Falls by Subcategory	Monthly	January 2026
32	Number of Tissue Viability Injuries | Run Chart	Monthly	January 2026
33	Number of Tissue Viability Injuries | All Subcategories and Injury Grades | Sub-Category	Monthly	January 2026
34	Number of Tissue Viability Injuries | Subcategory by Injury Grade	Monthly	January 2026
35	Infection Control, CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction Aims	Monthly	January 2026
36	Integrated Performance & Quality Report : Grow, Nurture & Plan Well	Monthly	January 2026
37	Sickness Absence Rates % By Month	Monthly	January 2026
37	Vacancy Time to Fill Days by Month	Monthly	January 2026

Slide #	Report	Frequency of Update	Last Presented
37	Annual Employee Turnover % by Month	Quarterly	January 2026
37	Recorded Absence Reason % by Month	Quarterly	January 2026
38	Training Metrics January 2026	Quarterly	January 2026
39	Organisational Metrics - Glossary	Bi-monthly	January 2026
40	Organisational Metrics - Glossary	Bi-monthly	January 2026