**Agenda Item 6**

# NHS Highland

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| **Meeting:** | **NHS Highland Board** |
| **Meeting date:** | **27 January 2026** |
| **Title:** | **Operational Improvement Plan update** |
| **Responsible Executive/Non-Executive:** | **David Park, Deputy Chief Executive** |
| **Report Author:** | **Bryan McKellar, Whole System Transformation Manager** |

**Report Recommendation:**

NHS Highland Board are asked to take Substantial Assurance on NHS Highland's delivery against the Scottish Government Operational Improvement Plan (OIP) deliverables.

## 1 Purpose

**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)**

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|---|---|---|---|---|---|---|---|
| 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 requirements of Scottish Government's Operational Improvement Plan (OIP) are included within the Board's Annual Delivery Plan (ADP) across the

four areas of focus. FRPC receive bi-monthly reports on progress alongside the reporting of performance information in the Integrated Performance and Quality Report (IPQR).

This paper provides FRPC with assurance on the progress in NHS Highland with the Operational Improvement Plan deliverables to 9 December 2025.

## 2.2 Background

On 27th January 2025, the First Minister described plans to renew the health service and deliver the renewal of the NHS. The First Minister set out the Government's ambition for renewal to deliver more accessible, more person-centred care, trying to reduce immediate pressures across the NHS, shift the balance of care from acute services to the community, and use digital and technological innovation to improve access to care.

On 23 June 2025, the Government published three national frameworks, describing the reformation and renewal approach within NHS Scotland:

- Operational Improvement Plan
- Health and Social Care Service Renewal Framework
- Population Health Framework

The Operational Improvement Plan is described as the first component of 3 "products", the second product is the population health framework and the third the health and social care service renewal framework. Together these plans will focus on long-term sustainability, reducing health inequalities, the benefits of digital technology, and improving the population health outcomes in Scotland. They will set out how services for the whole population over the short, medium and longer term will be planned.

## 2.3 Assessment

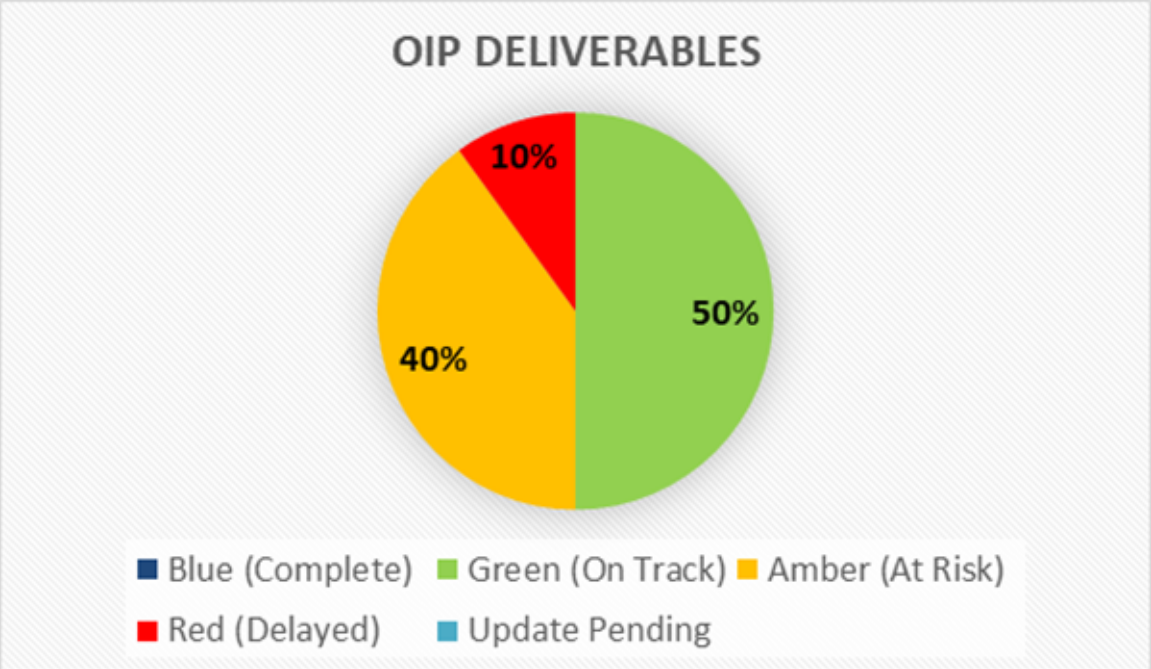
The development of the OIP followed the substantial development of the board's ADP, which represents a far wider set of objectives for all the services provided by NHS Highland. The OIP focusses on key policy directions which are fundamental to our key transformation and service improvement plans.

The OIP covers four broad goals which are aligned to the strategic outcomes of our own NHS Highland strategy, Together We Care, and well themes;

- Improving access to treatment
- Shifting the balance of care
- Improving access to health and social care services through digital and technological innovation

• Prevention – working with people to prevent illness and more proactively meet their needs.

Updates have been gathered through Strategy & Transformation working with Senior Responsible Officers (SROs) for each deliverable assessing progress to 22nd October 2025. A BRAG status has been assigned to each of the 20 deliverables assessing as follows:




Since this last update in October 2025, we have received an update on all deliverables, and there has been a positive shift overall from the last position on 30 October:

| CATEGORY | 30 October | 9 December | Change |
|---|---|---|---|
| Blue (Complete) | 0% | 0% | = |
| Green (On Track) | 40% | 50% | ↑ |
| Amber (At Risk) | 45% | 40% | ↓ |
| Red (Delayed) | 10% | 10% | = |
| Update Pending | 5% | 0% | ↓ |

Of the current deliverables assigned RED (Delayed) status at 9 December 2025, these are the explanations / escalations:

**Imaging – 95% of patients will receive imaging test within 6 weeks of referral**

An action plan to increase the percentage of patients receiving a radiology investigation within 6 weeks of referral is being progressed through Acute Senior Management, including weekly monitoring of performance information.

The key issue relates to CT and US capacity - engagement with Scottish Government and other health boards as to whether we can find collaborative solutions to manage current demand and available capacity in a different way that works towards meeting the 6-week target in radiology.

This remains an area of challenge within the board although NHS Highland remains above the national average for this KPI (NHS Highland = 60.5% vs. 57.7% national average, October 2025).

**AHP at the Front Door –** Following further consideration of the risks through EDG, a recruitment plan has been instigated in response to delay's to this project, and recruitment is now progressing for required posts in this service.

Of the current deliverables assigned AMBER (At Risk) Status, the following notes are provided for EDG for information:

- **Cancer**: Slightly below agreed 62-day performance improvement trajectory for October 2025, but actions to increase flow in Breast and Bladder pathways expected to achieve performance. Indicatively we are ahead of schedule for November 2025 data that is currently being verified.
- **CAMHS**: Performance in Highland has increased to 100% in some weeks, while there is targeted work in Argyll & Bute to see the longest waiting patients through waiting list initiatives. It is anticipated that A&B will start to improve performance towards the 95% target as the tail of the waiting list is cleared.
- **Hospital at Home (Highland HSCP):** This has moved from a red risk in the last report, as there has been progress made on recruitment with a partial go-live of the pilot in Inverness (for 1 patient space) from December 2025. Recruitment to allow full roll-out remains in progress.
- **FNC/OOH Integration:** Options appraisal on space assessment underway though Highland HSCP structures. Clinical pathways including Call-before-Convey developed and scheduled for go-live from December 2025. However sub-national discussions may require some adjustment to plans but is currently unknown.
- **Open Eyes:** Resourcing of the deployment of this service in Highland has been agreed and working towards the March 2026 go-live planned in Highland. Operational readiness activities underway through the programme.

- **Type 2 Diabetes:** This work is being defined by the national team and has limited patient scope (3,000 over 3 years).
- **Theatre Scheduling Tool:** Provider is focussing on bringing all NHS boards up to two specialities live with this tool – NHS Highland currently has this and therefore cannot proceed with an additional two specialities, until supplier resource becomes available. Preparatory in-house work is in progress around coding.
- **Frailty Enhanced Services:** Each GP practice must nominate a frailty lead who will have responsibility to co-ordinate frailty education and training. This will be to identify people with frailty in their local population. They must also collaborate with local frailty teams in the wider local system. The NHSH frailty lead will support Practices to do this and act as a central conduit of information sharing and support frailty attuned initiatives. This work is in progress.

Full details of the OIP delivery are included within Appendix 1 and the BRAG status for each deliverable.

**Reporting**

The next FRPC update on the OIP will be in March 2026. EDG will receive an update on progress in mid-February.

## 2.4 Proposed level of Assurance

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| Substantial | X | Moderate | |
| Limited | | None | |

**Comment on the level of assurance**

NHS Highland Board are asked to take Substantial Assurance on NHS Highland's delivery against the Operational Improvement Plan (OIP) deliverables.

# 3 Impact Analysis

## 3.1 Quality/ Patient Care

The strategic transformation of services across NHS Highland is required to support the delivery of sustainable services that meets the strategic outcomes of Together We Care.

## 3.2 Workforce

The OIP has been shared in board-wide communications on plans.

## 3.3 Financial

Benefits realisation remains a key area of programme management, specifically in relation to the shifting the balance of care and digital and innovation aspects of the OIP.

## 3.4 Risk Assessment/Management

Each programme will maintain a risk register. There are two Level 1 Corporate Risks relating to the delivery of our Annual Delivery Plan and Together We Care. This relates to resource and capacity to meet all the objectives required.

## 3.5 Data Protection

Each programme will require to consider Data Protection considerations accordingly.

## 3.6 Equality and Diversity, including health inequalities

Each programme will undergo an EQIA screening assessment to consider the impact to people with protected characteristics, and plan any mitigations / actions require

## 3.7 Other impacts

N/a

## 3.8 Communication, involvement, engagement and consultation

## 3.9 Route to the Meeting

EDG – Thursday 18th December
FRPC – Friday 9th January

# 4.1 List of appendices

The following appendices are included with this report:

- **Appendix 1, OIP Deliverables Dashboard as at 09/12/25**

| OIP | TWC Outcome | Area | Description | Exec Lead | Update (Escalations for EDG in RED) | BRAG at 09/12/25 |
|---|---|---|---|---|---|---|
| **PERFORMANCE IMPROVEMENT - ACCESS TO TREATMENT** | | | | | | |
| Improving Access to Treatment | Treat Well | Planned Care | Delivery of additional Planned Care activity (TTG and NOP) to reduce the longest waiting patients (target 0 >52 weeks by March 2026) across all specialities (or to target levels agreed with SG if 0 not possible) | Katherine Sutton | **25/11:** Long waiting NOP and TTG > 52 weeks remains ahead of trajectories. Gap has narrowed for NOP patients, but we remain on trajectory, TTG we are some way ahead of trajectory. Escalation monitoring in place. | |
| Improving Access to Treatment | Treat Well | Diagnostics | Drawing from the additional £100 million investment we will deliver additional MRI, CT, ultrasound, and endoscopy procedures to target the backlogs. This will support delivery of 95% of referrals to radiology being seen within six weeks by March 2026. | Katherine Sutton | **25/11:** An action plan to increase the percentage of patients receiving a radiology investigation within 6 weeks of referral is being progressed, including weekly monitoring of performance information. The key issue relates to CT and US capacity - engagement with SG and other health boards as to whether we can find collaborative solutions to manage demand and capacity. This remains an area of challenge within the board although NHSH remains above the national average for this KPI. | |
| Improving Access to Treatment | Journey Well | Cancer | Improving performance against the 31 and 62-day Cancer Waiting Times performance, improving access to cancer diagnosis and treatment | Katherine Sutton | **01/12:** Performance continues to miss the national waiting time standards for 62-day. With October reported at 68.9% vs. proposed trajectory of 72% (CE Performance report 17 November 2025) November's provisional performance is 76.8% V's trajectory of 74.3% actual, which is an improvement from October. | |

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| Improving Access to Treatment | Live Well | CAMHS | Continue to improve access to CAMHS services and meet the CAMHS waiting times standard of 90% starting treatment within 18 weeks of referral. | Katherine Sutton | **25/11:** We anticipate an impact on RTT performance as we continue to prioritise the longest waits within CAMHS. Service capacity remains constrained due to ongoing unplanned and planned staff leave. However, we expect improvement from December onwards, with four new staff in post in North Highland. Additionally, waiting list initiatives (WLI) are scheduled to commence in Argyll & Bute in October, which should further support waiting time recovery. | |
| **SHIFTING THE BALANCE OF CARE - NEW SERVICES / PATHWAYS** | | | | | | |
| Shifting the Balance of Care | Respond Well | Unscheduled Care | Expanding Same Day Emergency Care (SDEC) at Raigmore so more patients can be assessed, treated, and discharged on the same day – avoiding unnecessary overnight stays | Katherine Sutton | **09/12:** Digital infrastructure pending EPR resolution, but the new nursing rota has gone live as of 26/11 | |
| Shifting the Balance of Care | Respond Well | Unscheduled Care | An AHP service, including physiotherapists and occupational therapists, will be based at Raigmore ED and medical receiving units to assess older and more frail patients as early as possible | Katherine Sutton | **09/12:** Staffing: Some Band 5 posts still to be recruited. At risk is the ability to fully meet HIS model of frailty at the front door this FY due to recruitment delays. The go-live date of 1 November has now slipped. | |
| Shifting the Balance of Care | Respond Well | Unscheduled Care | A safe and consistent Discharge to Assess model – to be trialled in East Ross before rolling out across all districts – will enable patients to return home as soon as they are medically ready, with care needs assessed in the comfort of their own surroundings. | Katherine Sutton | **09/12:** Status: On track for the go-live date of 5th January 2026. Staffing: B4 posts recruited; B7 out to re-advert, however mitigations in place to meet the go-live date. | |
| Shifting the Balance of Care | Respond Well | Unscheduled Care | Hospital at Home services will be progressed, starting with Inverness in FY 25/26 with a view to implementing across other districts across the Highland area allowing more patients to receive hospital-level care in the comfort of their own home. | Katherine Sutton | **09/12:** Status: Partial readiness, with a go-live date for 1 patient on 8 December.<br>Staffing high risk: several posts remain in the recruitment pipeline.<br>Space: Requires additional work and team movement to base this service in the earmarked area. | |

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| Shifting the Balance of Care | Respond Well | Unscheduled Care | A dedicated Acute Frailty Assessment Area in Raigmore will give people identified as frail faster, specialist treatment, reducing the time they need to spend in hospital. | Katherine Sutton | **09/12:** Staffing recruitment pending, aiming to complete soon.<br>Model, space, and partnerships in place; no additional infrastructure needed. | |
| Shifting the Balance of Care | Respond Well | Unscheduled Care | There is additional planning work progressing to support developing a sustainable Flow Navigation Centre (FNC) and Out-Of-Hours (OOH) model that is integrated across primary and secondary care services and supporting patients to access care through more streamlined pathways. | Katherine Sutton | **09/12:** Staffing: One clinical lead recruited and exploring additional support.<br>Space: Options appraisal to be undertaken led by Khyber, per an action from the HHSCP UUC PDOG.<br>Model: SAS Call Before You Convey pathway developed, clinically validated and risk assessed and signed off. Go-live date for this pathway has been agreed as 8th December. | |
| Shifting the Balance of Care | Respond Well | Unscheduled Care | In Argyll & Bute, plans are progressing on redesigning and expanding its Extended Community Care Team (ECCT) to prevent deterioration, respond rapidly in the community, and deliver Discharge to Assess with a strong reablement focus. This enhanced service will see a significant rise in frailty screening and early clinical assessments, helping more people return home quickly with tailored support. | Evan Beswick | **09/12:** Launch of the Ambulatory Emergency Care Unit Pilot at Cowal Community Hospital by March 2026, supporting the “zero day” length of stay target and providing alternatives to admission for high-volume pathways.<br>Development of community frailty response models in Oban and Cowal, linking primary, secondary and community teams to provide proactive, preventative support and reduce avoidable admissions.<br>Expansion of Hospital at Home (Oban Model) to deliver 16 virtual beds (hub-and-spoke approach), including an Island Pilot, with enhanced seven-day coverage and strengthened training for community teams.<br>Ongoing integration of Flow Navigation Centre (FNC) with Out of Hours (OOH) services to improve triage, reduce unnecessary conveyance, and direct patients to the right care first time.<br>Scaling of Discharge to Assess (Home First) capacity in Oban and Cowal, supporting early supported discharge and reablement-based recover | |

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| Shifting the Balance of Care | Care Well | Primary Care Optometry | Expand the Community Glaucoma service in line with delivery of the national system Open Eyes, currently being led through NTC-Highland | Katherine Sutton | **9/12:** Focus on the implementation of the Open Eyes oEPR system for approved Community Glaucoma optometrist practices across NHS Highland - by end of March 2026. Scot Gov funding of £38,744 has been secured, and DPA governance approval with NES is in place. Operational readiness activities for CGS are underway. i.e.) generating patient cohorts, invitation processes, and provider lists. Integration work for PAS (TrakCare to Open Eyes) commenced by NHSH eHealth. Patient data migration still to take place as well as working with community optometrists, set up / access / training means it will be tight to meet the March 26 Go-Live date.<br>Operational readiness activities for CGS are underway. i.e.) patient cohorts, invitation processes, and provider lists.<br>Integration work for PAS (TrakCare to Open Eyes) commenced by NHSH eHealth, however we will need support from NES and Glasgow MDU to complete this work and aid migration of patient data to meet March 26 Go-Live date. | |
| **Digital and Technological Innovation** | | | | | | |
| Digital and Technological Innovation | Digital Delivery Plan | MyCare ( formally known as Digital Front Door) | Digital Front Door' app by the end of 2025 to improve access to health and social care services, starting with a pilot in Lanarkshire and expanding nationwide over five years, supported by integrated data sharing through the Community Health Index. | David Park | **03/12 - NHSH** awaiting feedback readiness assessments and the resulting work plans required to support this service. Although DFD will be launched in NHS Lanarkshire in December with a focus on Dermatology, this is not the offering that will be available to all citizens from April. As per the Health Ministers announcement in September, the wider national launch will include identify management (ability for citizens to log into the Mycare App), the ability to see core demographic information and some clinical information around medicines, allergies and | |

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| | | | | | vaccinations (information that is already held on national systems), and a service finder (a directory of health & social care services from NHS inform). | |
| Digital and Technological Innovation | Digital Delivery Plan | Digital Dermatology | A new Digital Dermatology Pathway, enabling GPs to attach skin images to referrals, is being rolled out across Scotland by spring 2025 to streamline diagnoses, reduce unnecessary consultant visits, and fast-track urgent cases, with impact tracked through usage and triage outcomes. | Katherine Sutton | **03/12** Digital Dermatology to be considered as next speciality for configuration.<br>To identify primary care lead in A&B. Revise the referral form to include a question regarding whether an image was attached; if not, please specify the reason. This section will offer drop-down options and open-ended text box for additional information. | |
| Digital and Technological Innovation | Digital Delivery Plan | Type 2 Diabetes Remission Programme | New national digital intensive weight management programme will support 3,000 newly diagnosed type 2 diabetes patients over three years from January 2026, aiming for significant weight loss and remission in up to 40% of participants, with outcomes tracked by recruitment, remission rates, and health improvements. | Katherine Sutton | **03/12 -** This work is being defined by the national team and has limited patient scope (3,000 over 3 years) | |
| Digital and Technological Innovation | Digital Delivery Plan | Genetic Testing | Introducing new genetic testing for stroke patients, newborn babies with bacterial infections, and new stroke patients | Katherine Sutton | **01/12:** The pathway for the stroke testing (CYP2C19 genetic test) is being finalised with a likely go live date of early 2026 - this will be performed by NHS Tayside for our patients. For the newborn gentamicin test we are not due to go live with that until late 2026 or early 2027 but there are no issues and all progressing as should be. | |
| Digital and Technological Innovation | Digital Delivery Plan | Theatre Scheduling | A theatre scheduling tool that boosts operating theatre productivity by up to 20% is being rolled out across all Scottish health boards by June 2025 to optimise theatre use, prioritise patients more effectively, and reduce treatment wait times. | Katherine Sutton | **28/11** - With new update<br>to TrakCare additional processes have been developed to add OPCS codes. Infix have responded to say that their priority is to roll out two specialties at every Board, so NHSH are not priority as already have two specialties set up. This is not a problem at present as still progress additional two specialties | |

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| | | | | | (Ophthalmology and Orthopaedics complete / General Surgery and ENT progressing). | |
| **PREVENTION - PATHWAYS / SERVICES** | | | | | | |
| Prevention | All Well Themes | Proactive Prevention | Preventative action at any stage of a person's health can significantly improve outcomes, with new investments in 2025–26 supporting proactive interventions for cardiovascular disease and frailty, including enhanced services and dedicated leads in general practice. | Jennifer Davies | **30/11**: the development of a refreshed NHS Highland strategy will put prevention at its core, alongside a population health focus and that will be done through the new Strategy Development Group and Population Health and Planning Committee | |
| Prevention | Care Well-Primary Care | Cardiovascular Disease (CVD) | A new General Practice enhanced service (DES) launching in spring 2025 will target key cardiovascular disease (CVD) risk factors—like high blood pressure and cholesterol—<br>by identifying those at highest risk and enabling early interventions to significantly reduce long-term health impacts. | Arlene Johnstone / Evan Beswick | **21/10:** 61/62 practices within HHSCP have signed up to participate in a CVD DES<br>**03/12:** of the 61 participating practices, as of end of October there are 33 practices actively participating in the CVD DES. In A&B there 22 participating practices, and 9 active. We are honouring our obligations under the DES and paying practices based on their activity claims. | |
| Prevention | Care Well-Primary Care | Frailty | A new Frailty Enhanced Service launching in April 2025 will support earlier identification and management of frailty in General Practice, with each practice appointing a Frailty Lead to improve care through training, data use, and collaboration. | Arlene Johnstone / Evan Beswick | **03/12** NHSH have appointed a Frailty Lead in Primary Care to coordinate across North Highland. The Frailty DES has a payment of £750 per practice.<br>59 out of 62 practices have signed up to participate.<br>Each practice must nominate a frailty lead who will have responsibility to co-ordinate frailty education and training. This will be to identify people with frailty in their local population. They must also collaborate with local frailty teams in the wider local system<br>The NHSH frailty lead will support Practices to do this and act as a central conduit of information sharing and support frailty attuned initiatives. | |