Agenda Item 7

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**25 November 2025**
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 **substantial 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	X	Thrive Well	X	Stay Well	X	Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well	X	Respond Well	X	Treat Well	X
Journey Well	X	Age Well		End Well		Value Well	
Perform well		Progress well		**All** Well Themes			

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	X	Moderate	
Limited		None	

NHS Highland Board is asked to take substantive 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 – 4th November 2025
- Clinical Governance Committee – 6th November 2025
- Finance Resource Performance Committee – 14th November 2025.

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – November 2025 Board Meeting

Integrated Performance and Quality Report

NHS Highland Board

25 November 2025

Assuring NHS Highland Board on the delivery of the Board's strategic objectives through our Well outcome themes.

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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 Summary of Performance Indicators: Page 1 of 2

Wells	Area	Current Performance	Performance Reported at last update	Performance Trajectory	Local Target	National Target	Performance Rating
Start Well (4)	**Breastfeeding**	N/A	N/A		N/A	N/A	
Thrive Well	**CAMHS <18RTT Performance**	89.3% (Aug 25)	85.0% (Jun 25)	↑	N/A	90%	
Thrive Well	**NDAS Waiting List Size**	2122 (Aug 25)	2074 (Jun 25)	↑	N/A	N/A	
Stay Well	**Screening – AAA**	87.3% (23/24)	71.4% (22/23)	↑	N/A	85%	
Stay Well	**Screening – Bowel**	70.4% (23/24)	69.1% (22/23)	↑	N/A	60%	
Stay Well	**Screening – Breast**	79.6% (22/23)	78.5% (21/22)	↑	N/A	80%	
Stay Well	**Screening – Cervical**	66.7% (23/24)	66.3% (22/23)	↑	N/A	80%	
Stay Well	**Pre-school Vaccinations**	93.9% (Jun 25)	93.0% (Mar 25)	↑	N/A	95%	
Stay Well	**Smoking Cessation Quits**	276	179	↑	N/A	336	
Stay Well	**Alcohol Brief Interventions**	944 (Q1)	1370 (Q4)	↓	N/A	N/A	
Stay Well	**Drug & Alcohol Waiting Times**	83.7% (Q1)	90.5% (Q4)	↓	N/A	90%	
Live Well	**Psychological Therapies**	87.4% (Jul 25)	89.8 (Jun 25)	↓	N/A	90%	
Respond Well	**Emergency Access (4 hour waits)**	71.8% (Aug 25)	82.3% (Jul 25)	↓	N/A	95%	
Respond Well	**Delayed Discharges**	237 (Aug 25)	234 (Jul 25)	↑	N/A	N/A	

Guide to Performance Rating

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

Executive Summary of Performance Indicators: Page 2 of 2

Wells	Area	Current Performance	Performance Reported at last update	Performance Trajectory	Local Target	National Target	Performance Rating
Treat Well	**NOP Cumulative Performance against Plan**	-5.1% (1859 behind plan) (Sept 25)	-3.2% (946 behind plan) (Aug 25)	↑	N/A	36392	
Treat Well	**NOP >52 week number of patients seen**	3116 (Sept 25)	3925 (Aug 25)	↓	N/A	3572	
Treat Well	**TTG Cumulative Performance against Plan**	2.0% (193 ahead of plan) (Sept 25)	4.6% (367 ahead of plan) (Aug 25)	↓	N/A	9772	
Treat Well	**TTG >52 week number of patients seen**	529 (Sept 25)	603 (Aug 25)	↓	N/A	839	
Treat Well	**Radiology 6wk performance against Plan**	12.14% (3479 ahead of plan) (Sep 25)	9.95% (2853 ahead of plan) (Jul 25)	↑	N/A	14334 (Sep 25)	
Treat Well	**Radiology 6wk waiting time**	57.5% (Jun 25)	56.8% (Mar 25)	↓	80% short term 90% long term	100%	
Treat Well	**Endoscopy 6wk performance against Plan**	10.97% (568 ahead of plan) (Sep 25)	9.52% (493 ahead of plan) (Jul 25)	↑	N/A	2596 (Sep 25)	
Treat Well	**Endoscopy 6wk waiting time**	63.4% (Jun 25)	70.9% (Mar 25)	↓	80% short term 90% long term	100%	
Journey Well	**31 Day Cancer Target**	93.2% (Aug 25)	86.1% (Jun 25)	↑	95%	95%	
Journey Well	**62 Day Cancer Target**	70.6% (Aug 25)	65.2% (Jun 25)	↑	Sept 25 66.9%	95%	
Journey Well	**SACT Access and Benchmarking**	25 days (Sept 25)	28 days (Aug 25)	↓	28 days	N/A	

Guide to Performance Rating

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

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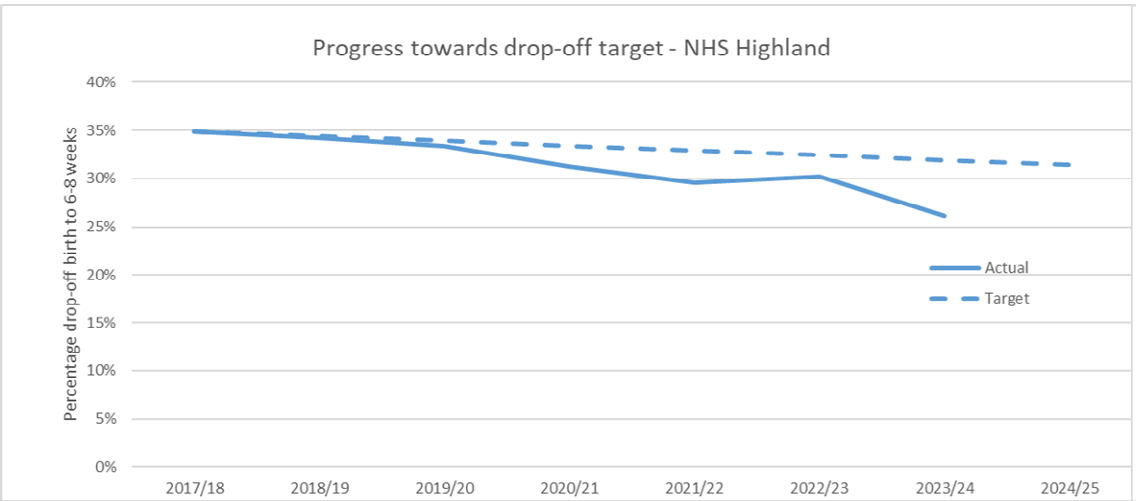
Exec Lead
Jennifer Davies, Director of Public Health

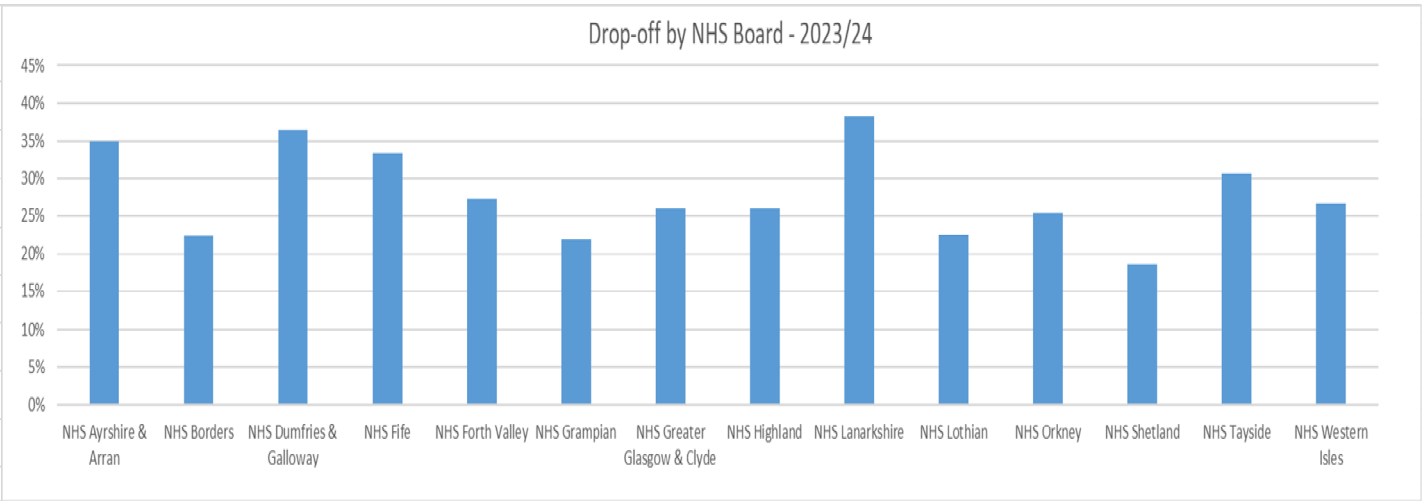
Breastfeeding

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the attrition of any breastfeeding at 6 –8 weeks by 10% by 2025		• National infant feeding statistics published annually in November • Breastfeeding scorecard distributed to boards in March by PHS providing data down to intermediate zone level to allow for planning and targeted intervention • Scorecard data demonstrates a need to support our Polish community where attrition rates have increased. • Unicef BFI Gold award has been achieved by all maternity and community (H.V and F.N.P) services in NHS Highland • The neonatal unit at Raigmore has achieved full accreditation • Recruitment in place to increase numbers of infant feeding support workers in North Highland through Whole Family Wellbeing Funding. This includes working in partnership with CALA to provide feeding groups which will commence in September. • Work with CALA to test the roll out of the National Early Learning Scheme where their nursery provision will become accredited as Breastfeeding Friendly Scotland • Initial scoping with A and B HSCP re: testing the Local Authority Breastfeeding Friendly Scheme • Recruitment of breastfeeding keyworkers in existing midwifery, health visiting, children's ward and FNPs services to support audit and specialist support in all areas of NHS Highland	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	See chart
National Target	See chart
National Target Achievement	See chart
Benchmarking	See chart





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Exec Lead
Katherine Sutton
Chief Officer, Acute

OIP

CAMHS (Child and Adolescent Mental Health Service)

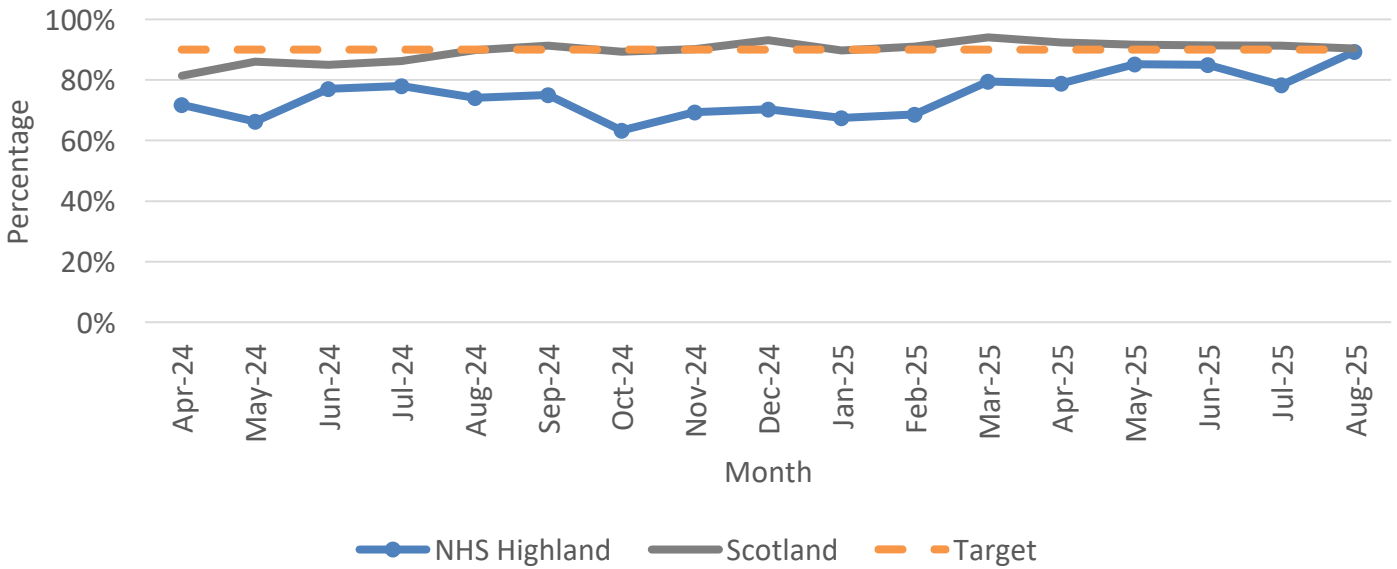
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by December 2025 (Tier 3).	**Argyll & Bute** Targeted focus on longest waits linked to planned waiting time initiative (WTI) commenced. Aim to achieve compliance within all localities (Helensburgh/Cowal & Bute / Mid Argyll-Oban) linked to KPI. **Highland** The service continues to focus on the longest waits with no unbooked patients > 52 weeks	**Argyll & Bute** • Reduced capacity due to ongoing vacancies • Changes to partner health capacity (Community Peads) • Recent reduction in beds Skye House (high risk young people, intensive support risk in system) workforce capacity/responsiveness • Joint focus with North Highland Trak upgrade • Whole system impact review (child, family & justice) **Highland** • Planned workforce additionality not delivered. • Losses from sickness, resignation and maternity leave reducing case allocation capacity across teams • Trakcare upgrade reconfiguration has commenced • Ongoing clinical and administrative validation of waitlist • Q4 boost expected with November Clinical Psychologist intake • Revision of trajectories completed
Reduction of people who are currently on the Tier 3 CAMHS waiting list to <352 people by December 2025.		

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

Performance Rating	
Latest Performance	89.3%
National Average	91.3%
National Target	Full compliance to the National Service Specification by end of March 2026
National Target Achievement	n/a
Position	13th out of 14 Boards*

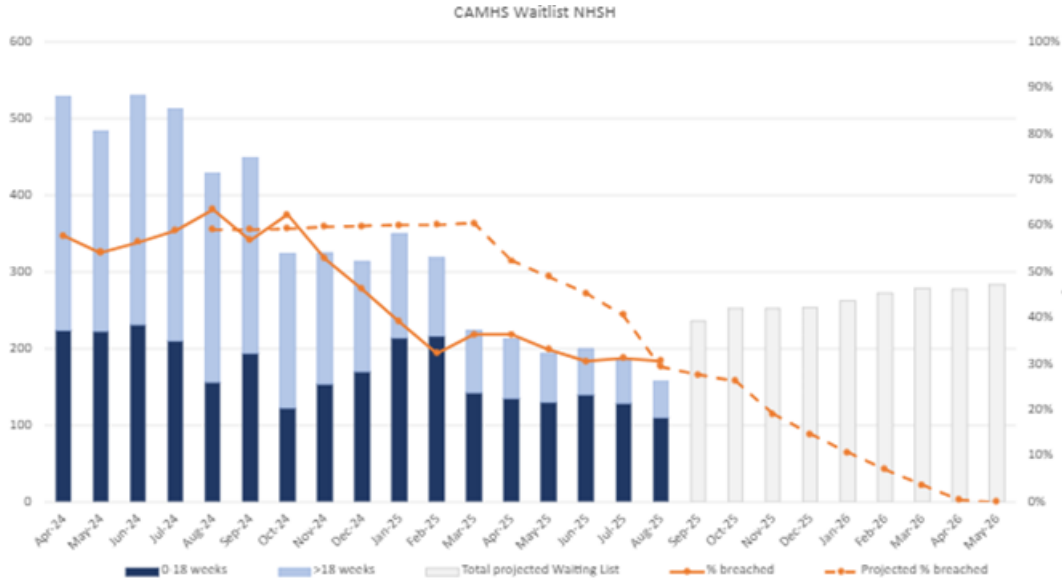
*as at July 2025 on Discovery

CAMHS: Percentage of patients seen <18 weeks from referral



CAMHS Tier 3 Waiting List in Weeks

(Draft trajectories currently being reviewed by service)



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Exec Lead
Katherine Sutton
Chief Officer, Acute

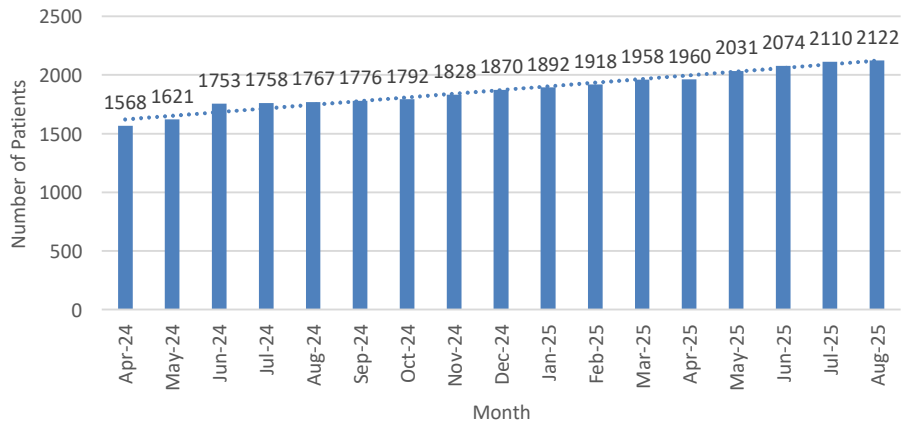
Neurodevelopmental Assessment Service (NDAS)

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%.	As there is no clinical capacity within the service to complete any assessments, a further 10 assessments will be completed via private provider. This will bring the total to 58 assessments.	A short-life working group who report into the Programme Board has been tasked with mapping out new strategies and pathways that will deliver earlier, more effective staged approach access to neurodevelopmental support, and where appropriate, diagnosis. As part of its remit, the group will consider the resource requirements needed to implement these changes in a sustainable way. The aim is to transform how children, young people, and families in the Highland region are supported, ensuring that services are accessible, coordinated, and aligned with both local needs and national expectations.
Reduction in the total number of patients on the NDAS waiting list compared to the current baseline by March 2026.		

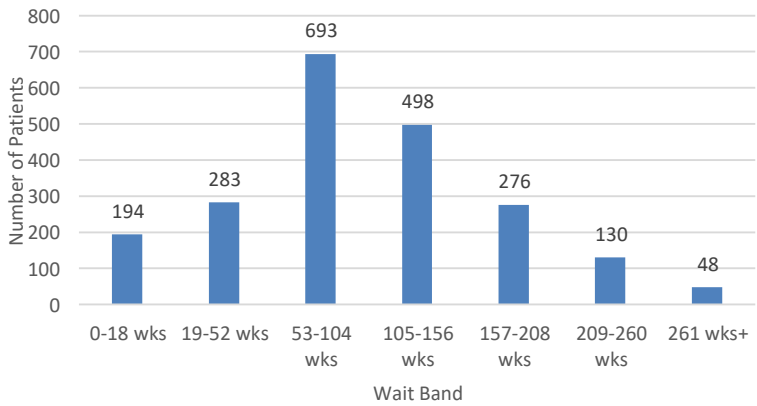
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	2122 on waiting list (Aug 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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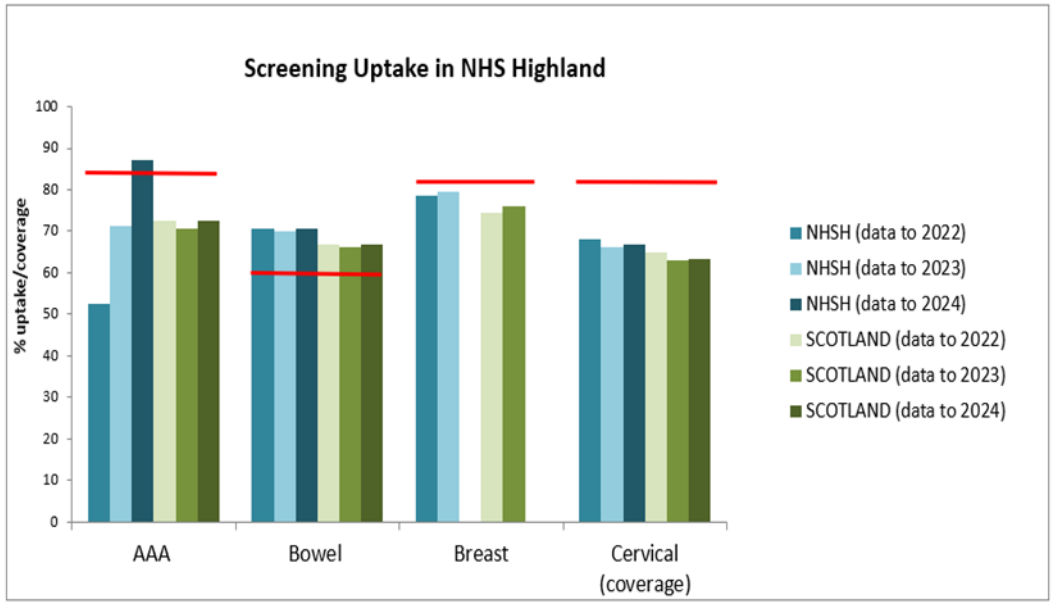
Jennifer Davies, Director of Public Health

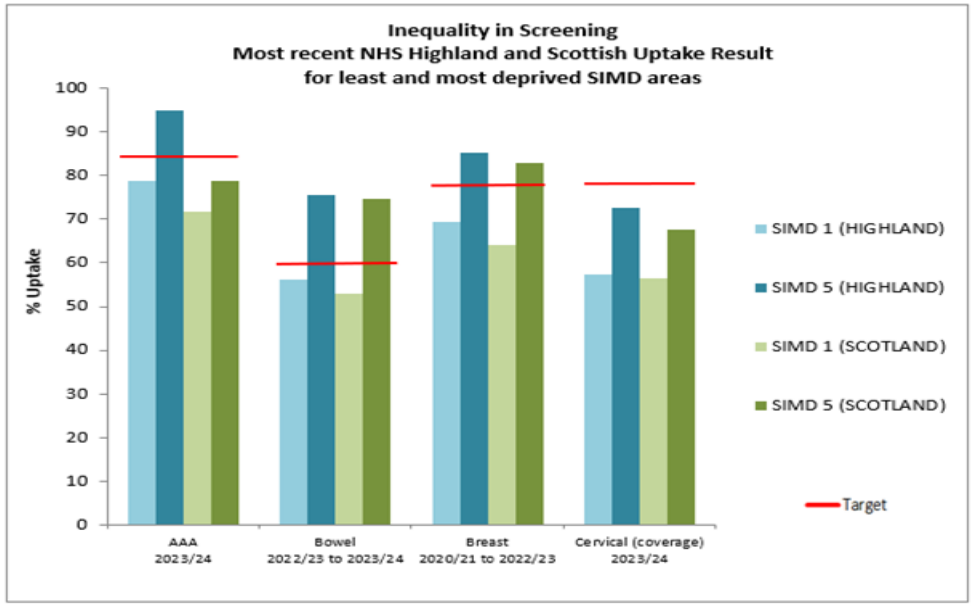
Screening

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Encourage and promote screening programmes and increase uptake across available screening programmes above national targets.		• Screening performance was compared against Scottish average benchmark levels using the most recent verified and published data by Public Health Scotland. The comparison shows that NHSH participation continues to be higher than average Scottish uptake levels for Bowel, Breast, Cervical and AAA screening programmes. • Official figures are typically published with 1 year delay at the beginning of each financial year. In 2025 (for reporting time periods up to 2024), the results for three of the above four programmes have been published. Statistics for Breast Screening are still pending. The cervical screening data was recently published in July 2025 after a long delay. Unfortunately, data quality issues had contributed to long delays in the publication of data, and correction of previously reported historical data. Refer to link for more information: https://publichealthscotland.scot/publications/scottish-cervical-screening-programme-statistics/scottish-cervical-screening-programme-statistics-annual-update-to-31-march-2022/. • Internal non-verified management data is also collected and used for management purposes and suggests similar findings for more recent time periods. • Performance data for Diabetic Eye Screening (DES) and Pregnancy & Newborn (P&N) screening programmes is not yet published by Public Health Scotland, so it is not possible to officially report on the performance of these programmes. However non-verified management data, used for internal monitoring purposes, indicates comparable performance with Scottish levels for these programmes too.	Work continues to drive improvements within screening programmes. The NHS Highland Screening Inequalities Plan 2023-26 outlines focused activities to specifically address equality gaps and widen access to screening.

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

Performance Rating	
Latest Performance	See chart
National Benchmark	See narrative
National Target	AAA – 85% Bowel – 60% Breast – 80% Cervical – 80%
National Target Achievement	See charts
Benchmark	See charts





NOTE: Within cervical screening, the % of eligible population screened within age-appropriate timeframe is now referred to as "coverage". Annual cervical screening statistics for Scotland published - News - Public Health Scotland

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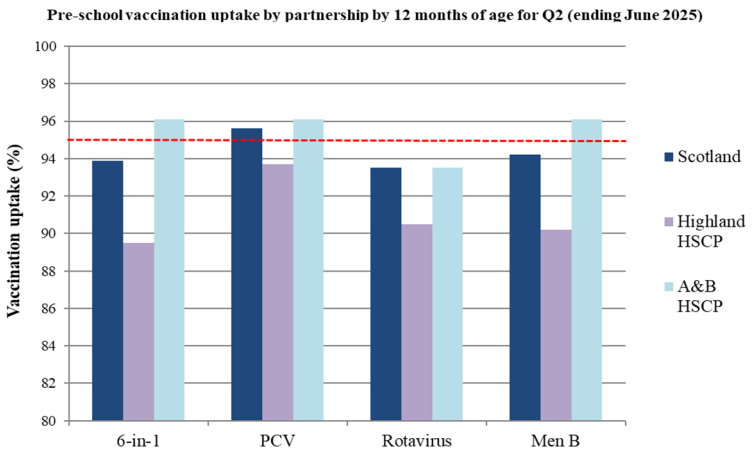
Exec Lead
Jennifer Davies, Director of Public Health

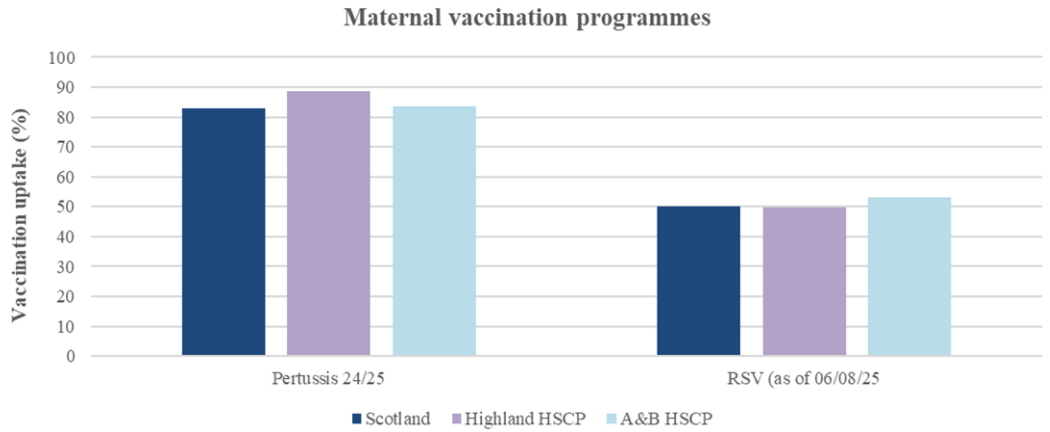
Vaccination

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Meet the 95% national target for the three children's vaccinations	Options are being progressed for the delivery of the collaborative hybrid model in Highland HSCP. Successful implementation of the first phase of the childhood schedule change with plans underway to implement the second phase. The winter vaccination campaign is underway across both partnerships in conjunction with wider winter preparedness. There is ongoing work to support the implementation of Scotland's 5-year vaccination and immunisation framework. **Medium-Term Plan priority:** Protection from vaccine preventable diseases and a reduction in health inequalities through the delivery of an effective, safe, person-centred and accessible vaccination service. **Pre-school vaccinations:** For three of the vaccines measured at 12 months, the vaccination uptake across A&B HSCP met the WHO 95% vaccination uptake target. None of the pre-school vaccine uptake rates for Highland HSCP measured at 12 months met the 95% WHO target. There continues to be improvement required in relation to both the uptake and timeliness of pre-school vaccinations. Improved performance across a range of metrics is a key aim of the delivery of the hybrid model. **Maternal vaccination programmes:** With respect to the maternal pertussis programme, both partnerships achieved uptake rates which exceeded the Scottish average (Highland HSCP= 88.5%, A&B HSCP= 83.5%, Scotland=83.0%). For the newly introduced Respiratory Syncytial Virus (RSV) programme, the uptake rates for both partnerships are close to the Scottish average (A&B HSCP=53.2%, Highland HSCP=49.6%, Scotland=50.0%).	Scottish Government is continuing to work with Highland HSCP in level 2 of its performance framework. The Vaccination Collaborative Implementation Group has been convened to support the delivery of the collaborative hybrid model across the partnership. 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.

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

Performance Rating (pre-school vaccinations)	
Latest position & performance	See charts
National Benchmarking	For pre-school vaccination, A&B uptake rates met or exceeded the national average for all vaccines measured at 12 months.
National Target	Vaccine uptake of 95% for pre-school vaccinations





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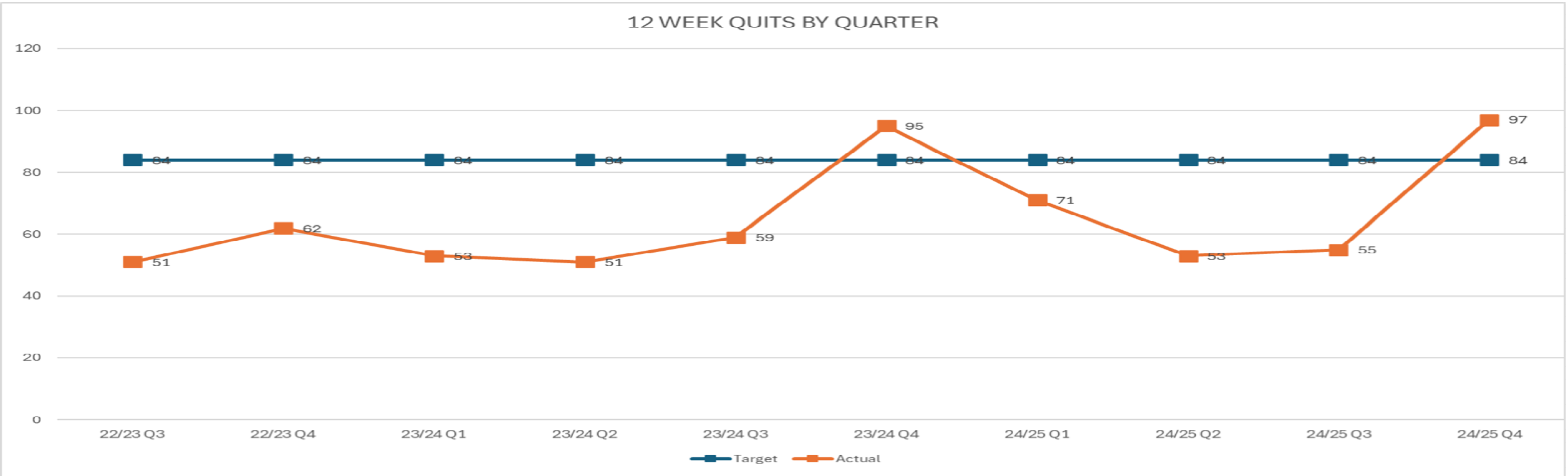
Exec Lead
Jennifer Davies, Director of Public Health

Smoking Cessation

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Respond to and deliver on national strategy and targets – including smoking cessation		• 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 within young pregnant women who are hard to reach. • Limited support for patients within our acute setting.	•Missing data from quit dates set from 1st April 2025 currently being reviewed – timeline for outcome will be 3 months •Pilot commenced 13 October •Early indication of pilot at Raigmore is positive, report to be developed November (6 months from pilot begun)

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest Performance	276 (24/25)
National Benchmarking	
National Target	336 successful quits in 12 weeks in 40 most deprived SIMD areas
National Target Achievement	N/A
Position	



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Exec Lead
Jennifer Davies, Director of Public Health

Alcohol Brief Interventions (ABIs)

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Health Improvement Delivery focused on: Alcohol Brief Interventions, Smoking Cessation, Breastfeeding, Suicide Prevention and Weight Management as target areas.		Fig 1.:Total no of ABIs delivered in Q1 is 944. This number is 3% 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 (90.5%) with the remainder mainly being delivered in wider settings across NHS Highland.	Q2 data for 25-26 expected next month and will be reported at next update. ABI skills training session participant numbers since last update: 28. ABI eLearning participant numbers since last update 104. Work underway to deliver bespoke ABI training to all health visitors in Highland HSCP, Whole family wellbeing approach Demand for training continues to be high, but the current attendance rate for is 57%
Embed MAT Standards within practice in NHS Highland.			

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest Performance	944 Q1
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	n/a
Position	n/a

Fig.1

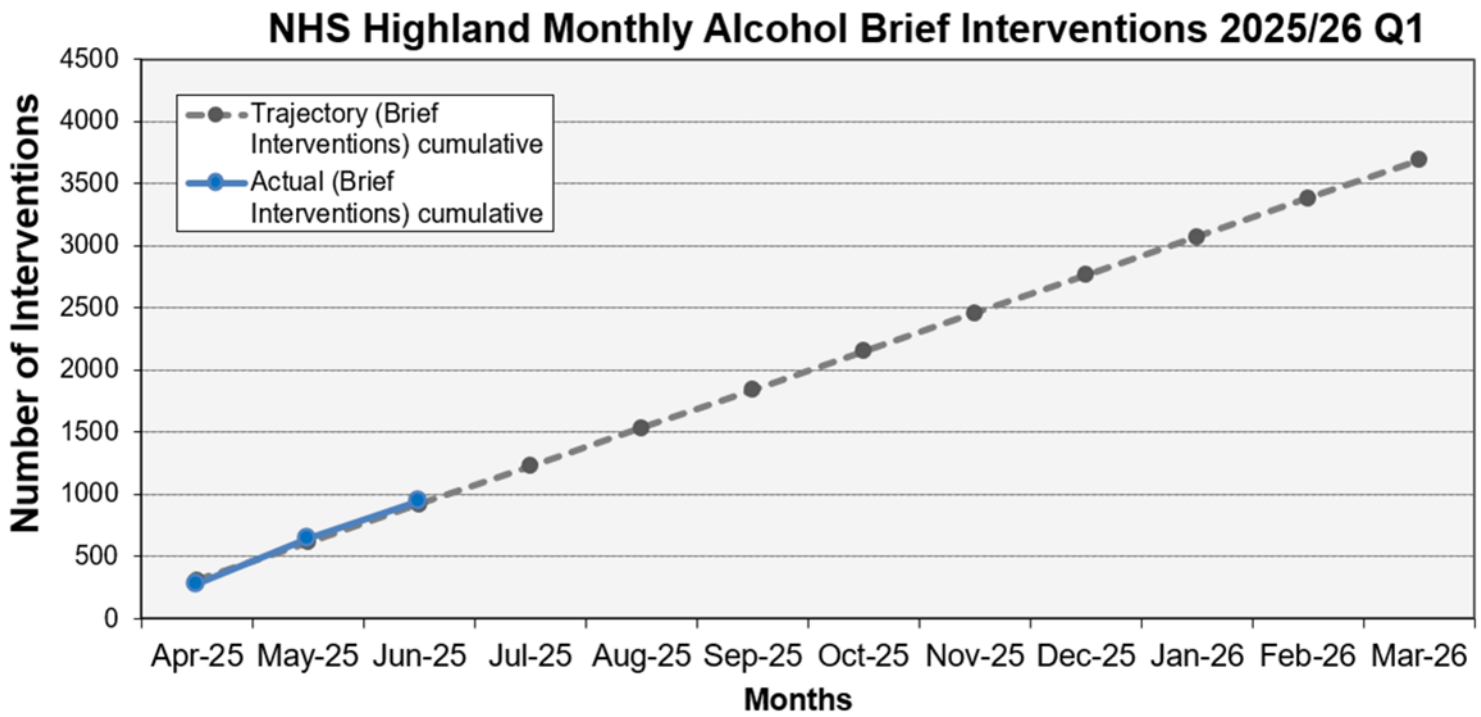

Fig.2 **Setting Contribution 25/26 Q1**

Primary Care	854	90.5%
Antenatal	4	0.4%
Wider Settings	86	9.1%
TOTAL	**944**	**100%**

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Exec Lead
Arlene Johnstone
Chief Officer, HHSCP

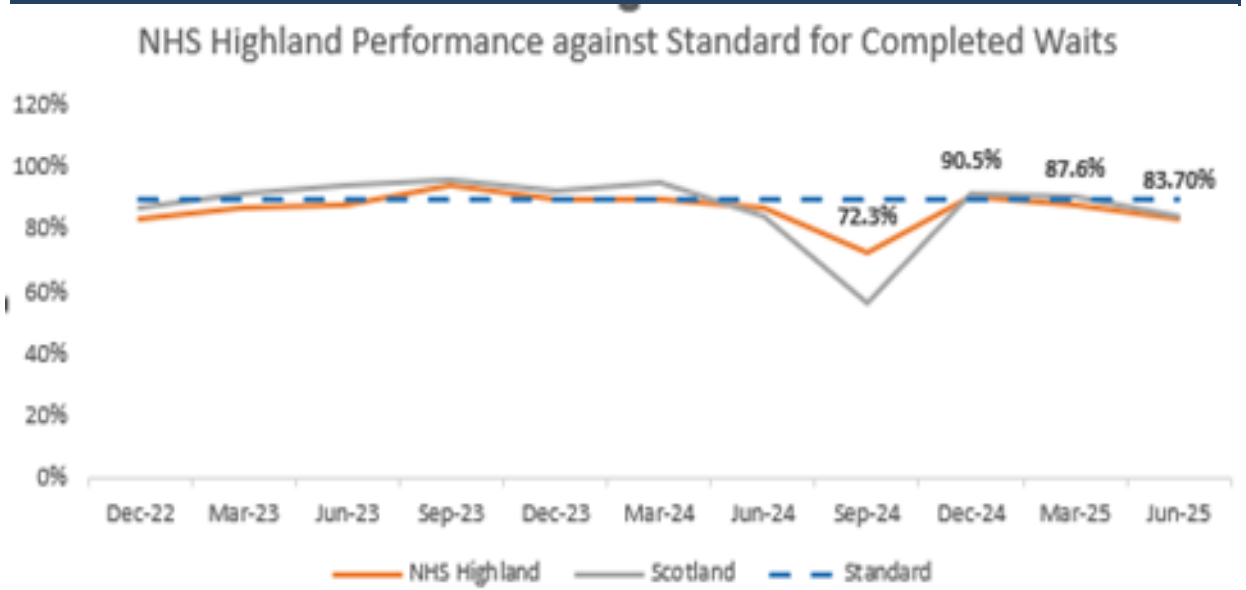
Drug & Alcohol Recovery (DARS)

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.		• There has been particular success and recruitment processes continue to fill vacancies. • A newly commissioned digital service "With You" commenced in August 20205. Data sharing arrangements are in the process of being confirmed which will support movement of patients between NHS and Third Sector, increasing capacity within the existing service. • Early plans for Quality Improvement approaches within individual service areas with the aim of reducing missed appointments (DNAs) are being explored which will increase capacity.	• Performance is related to staffing challenges, in particular vacancies and other absences.

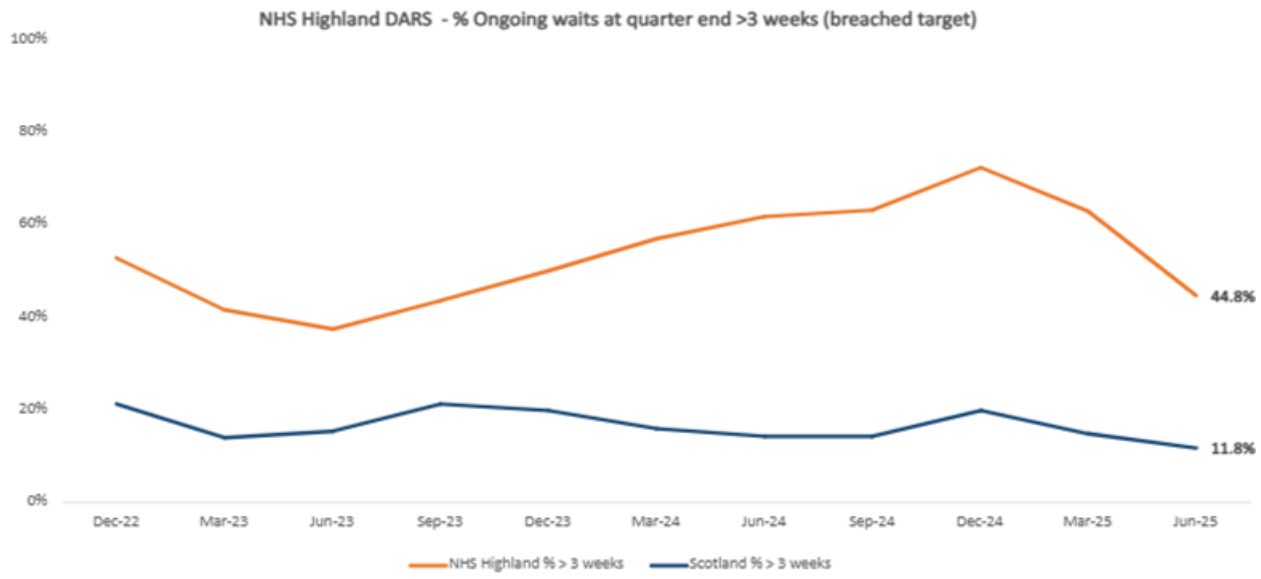
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	83.7%
National Benchmarking	94.3%
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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Exec Lead
Louise Bussell

Psychological Therapies Waiting Times

Key Performance Indicators

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)	
Increase number of completed PT waits (pan-Highland)	

Reasons for Current Performance

Highland
Psychology Services continues to make positive improvements in patient referral to treatment times. For the period April 2025 – July 2025, 87.6% of patients referred to the service received treatment within the national performance timescale of 18 weeks, compared to the national average of 79.5% for the same period.

Argyll & Bute
Argyll and Bute Adult Mental Health Psychological Therapies service continues to make improvements in referral to treatment times. In September 2025, average waiting time for CBT treatment remained below 18 weeks (mean = 17 weeks), although higher for Psychology treatment (mean = 20 weeks), with the longest wait across the service at 32 weeks. The service continues to be impacted by staffing and resource issues.

Plans, Mitigations and Actions

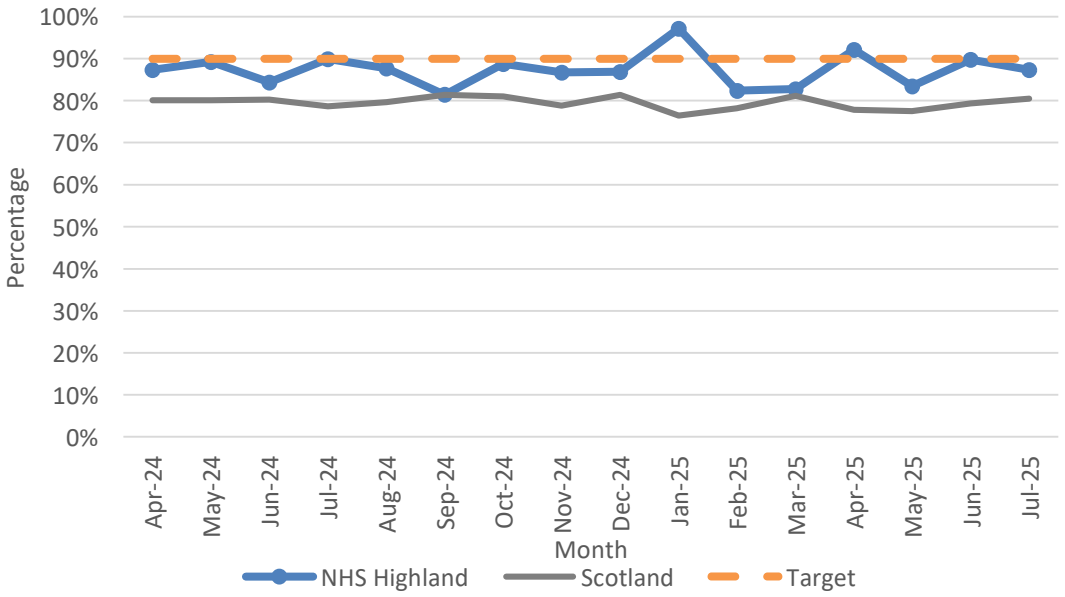
Highland
Several projects have now stalled due to our competing eHealth department priorities. This has prevented DCAQ and forecasting projects continuing, work on EPR for psychology, and has negatively impacted on CAPTND and aggregate reporting (e.g. sub-specialties and questionnaire).

Argyll & Bute
Current priorities include improving the service resource and resilience through recruitment to vacant permanent posts. The lack of a consistent EPR system across Argyll and Bute impacts information sharing between services. Eclipse EPR currently in development across Argyll and Bute, which will include Psychological Therapies.

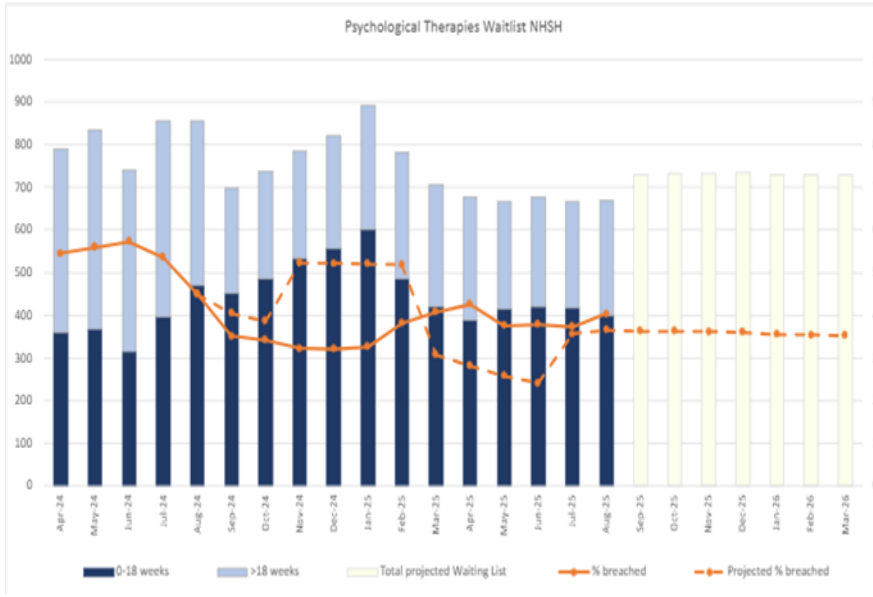
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	87.4%
National Benchmarking	80.5%
National Target	90%
National Target Achievement	Consistent improvements in targets and downward trajectory
Position	3rd out of 14 Boards

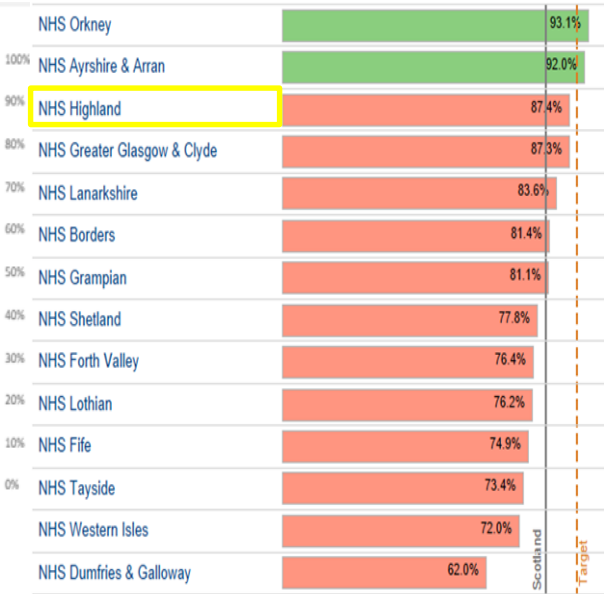
Patient seen < 18 weeks



Waiting List Size



Benchmarking with Other Boards



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Exec Lead
Katherine Sutton
Chief Officer, Acute

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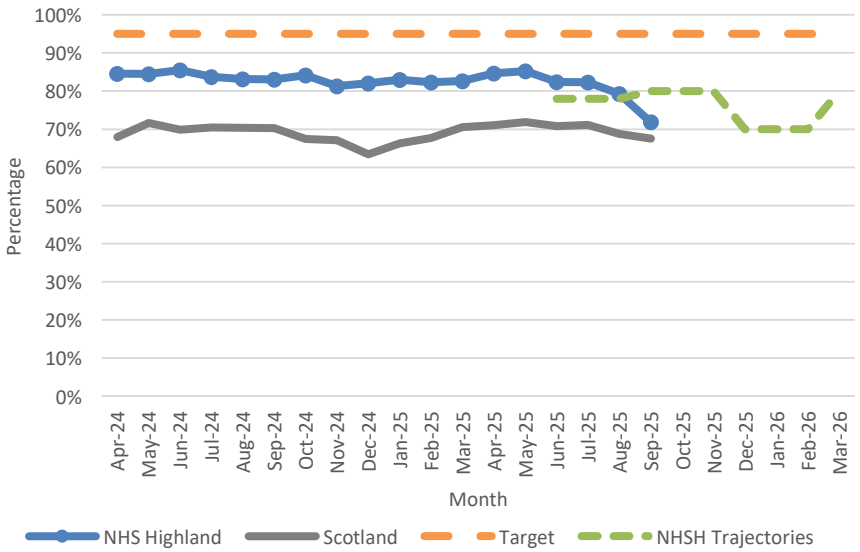
Emergency Department Access

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Achieve at least 95% of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2026.		**Raigmore Hospital –** is on track to launch extended SDEC service during November 2025. **Caithness General Hospital (CGH)** continues to experience high ED attendance with patients requiring admission staying longer in ED beyond Breach targets. Acutely sick patients requiring longer LoS, reduced numbers of non-complex (from a discharge perspective) patients being discharged and relatively high numbers of Delayed Transfers of Care (40% of beds). **Lorn & Islands Hospital (L&I)** – 12-hour breaches are currently extremely low. H@H expansion and implementation of pathways 7 days per week from end of November 2025 will help reduce A/E breaches and improve performance. Work taking place within community setting around frailty and prevention of admission. Appointment of 3 new Consultant Physicians at end of November will support front door decision making and implementation of SDEC/Ambulatory care pathways. **Belford Hospital (BH)** - the average time ED Performance is 84.4%. There was a spike in 12 hour waits in august due to bed occupancy impacted by high numbers of pts in delay and IPC ward closures requiring transfer out of the hospital.	**CGH** - Nurse staffing remains a concern across the site. **L&I -** H@H pathways 7 days per week. SNR Decision maker at front door with introduction of REP model. Regular bed flow meetings. **BH** -is undertaking several improvements actions to improve flow including capital works to develop a triage space in ED and ensure the minor injuries are streamed out of the Dept. OPEL scoring is now in place and action cards agreed. Recruitment to a fixed term frailty practitioner is underway.
Ensure that 99% of A&E patients are 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 to zero by March 2026, ensuring no patient experiences excessively prolonged waiting times.			

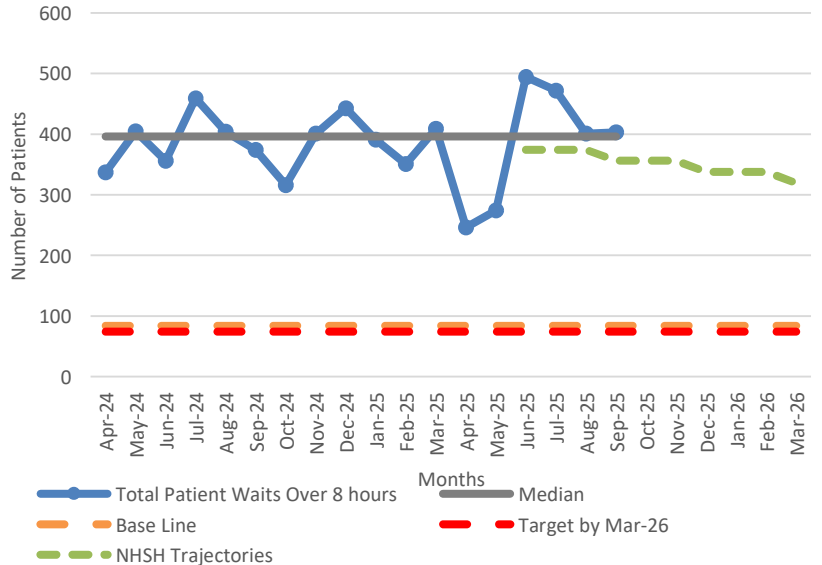
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	
Latest Performance	71.8%
National Benchmarking	67.6%
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	6th out of 14 Boards

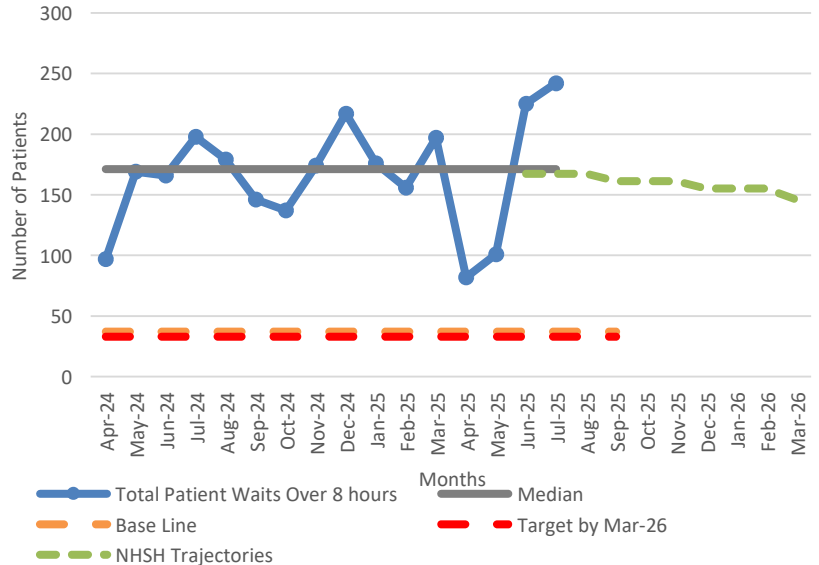
% of people seen in ED within < 4 hours per month



Total Patients waiting > 8 hours in ED per month



Total Patients waiting > 12 hours in ED per month



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Chief Officer, HHSCP

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Delayed Discharges

Key Performance Indicators

Reduce the total number of patients experiencing a standard delay in discharge from hospital across NHS Highland to agreed targets and trajectories.

Reasons for Current Performance

- All delays are reviewed daily to ensure that appropriate plans are in place via the DMTs exploring minimum levels of care package to facilitate discharge with support of families.
- Review of longest waits to see what alternative plans can be put in place continue to be carried out
- Ongoing work with D2A and AHP at the front door will support more timely discharge supporting criteria led discharge and functional assessment .
- Developing models of single-handed care to reduce the number of 2-1 C@H packages increasing the capacity available.

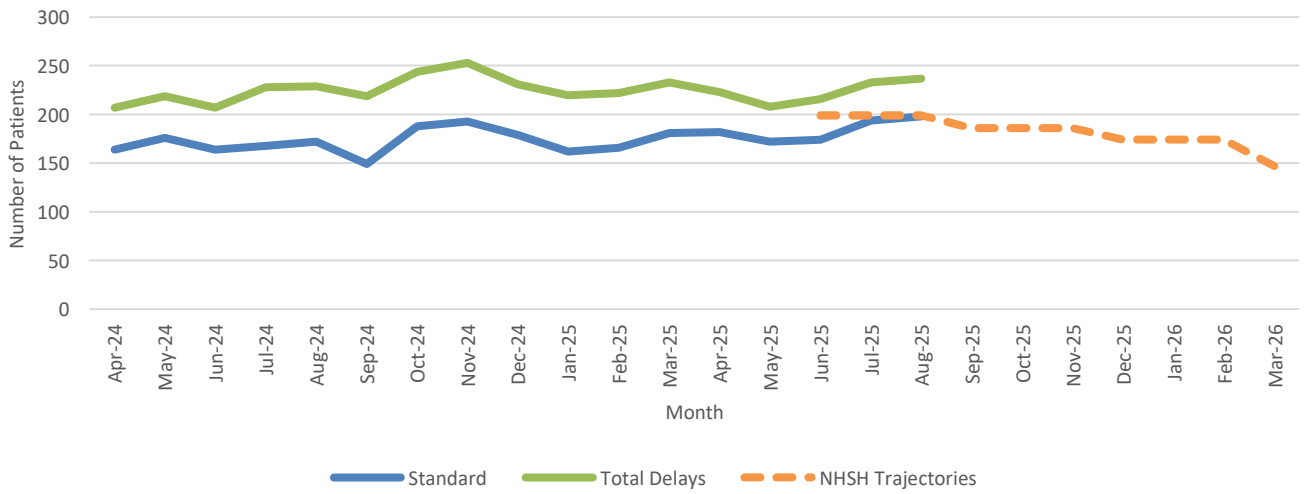
Plans, Mitigations and Actions

- In Highland HSCP Approx 50% Community hospital bed capacity has patients in delay this is impacting on step down from acute and step up from the community preventing admission into secondary care.

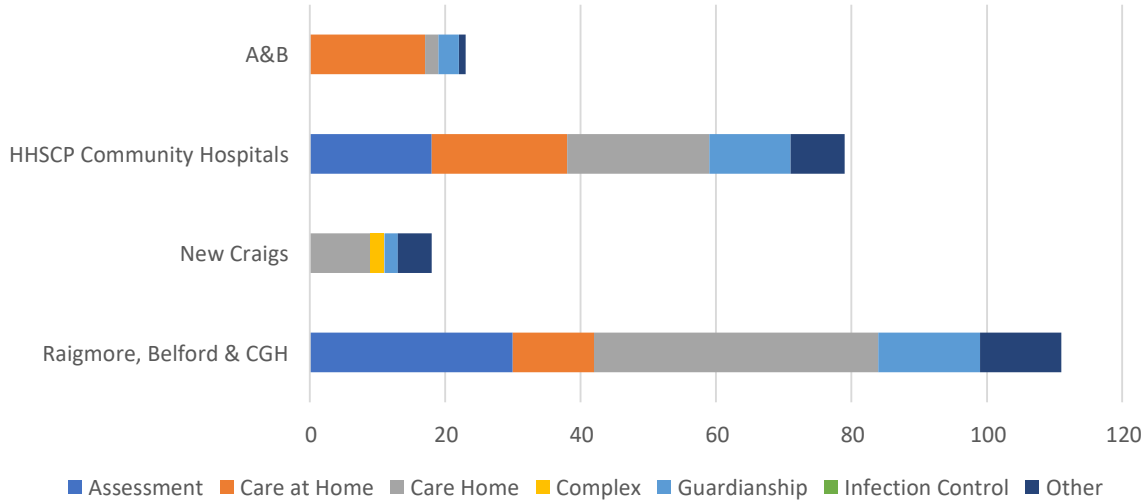
PERFORMANCE OVERVIEW
Strategic Objective: In Partnership
Outcome Area: Respond Well

Performance Rating	
Latest Performance	237 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 2

Key Performance Indicators	
Increase the percentage of new outpatient referrals seen within 12 weeks of referral equal to or above 95%.	
Reduce the number of new patients waiting over 52 weeks for a new outpatient appointment to 1393 by March 2026.	
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	
Total number of patients currently waiting for return outpatient appointments to be equal to or less than previous year's monthly average	

Reasons for Current Performance

Highland
The number of new outpatients seen since April 2025 is just short of our target to the end of September. This is mostly due to our externally funded additionality starting later than anticipated in some specialties. Despite this, we continue to exceed our plan in reducing the number of people waiting over 52 weeks for their appointments.
We have identified issues with the activity levels set for some specialties and are engaging nationally to reprofile our targets, this will result in an improvement. An example is Paediatrics where due to improvements in triaging referrals and additional capacity in the team, there is now a very short waiting list.

Argyll & Bute
The number of new outpatients between April and September is behind target due to a decrease in the availability of planned care funding for additional initiative clinics and in some specialties a drop in demand and/or returns being prioritised. That said the numbers are small and long waiting performance continues to improve. We will undertake a reprofiling exercise to ensure expected activity is in line with what can be delivered.

Plans, Mitigations and Actions

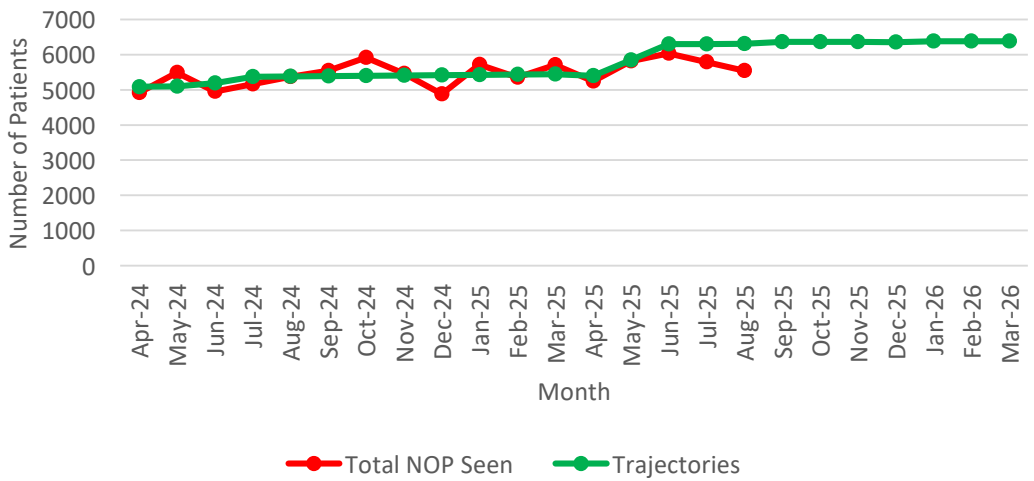
Highland are focused on a small number of specialties where there is risk around delivery of activity and/or achieving the target set to reduce long waits. This includes Ophthalmology, ENT and Gynaecology, services which have recovery plans to be delivered through October and November which will significantly improve activity and reduce waiting times.

Argyll & Bute have identified slippage within the planned care funding which will be allocated to allow additional initiative clinics targeted on pressure specialties such as Dermatology, Ophthalmology and Respiratory Medicine.

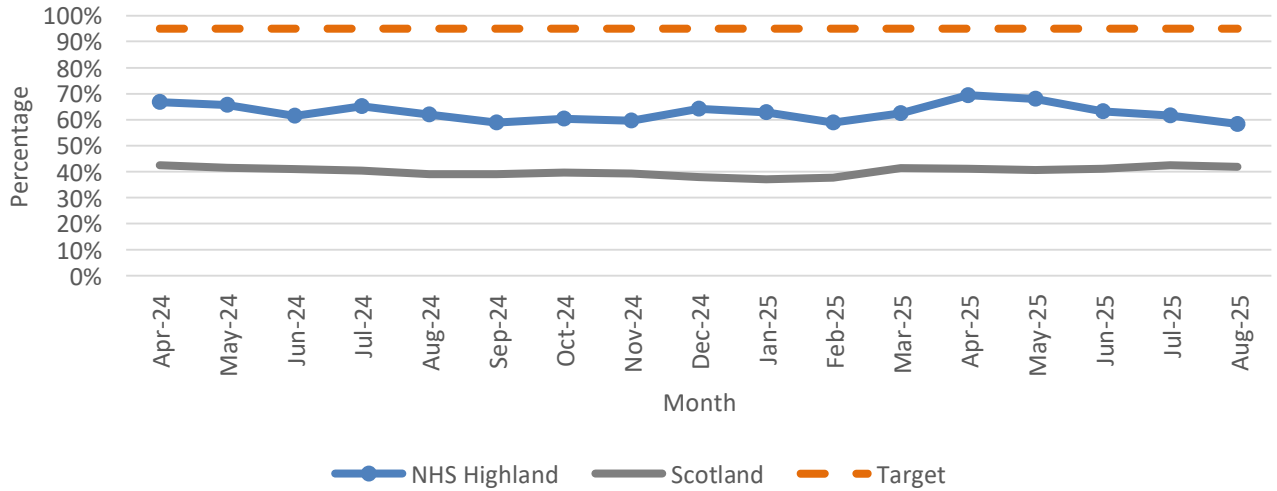
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating against Plan	
Latest Performance against Plan	-5.1% behind plan
National Benchmarking against 12 week performance	41.9%
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	3rd out of 15 Boards

New Outpatients Seen & Trajectories



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



Outpatients (Return Outpatients) - Slide 2 of 2

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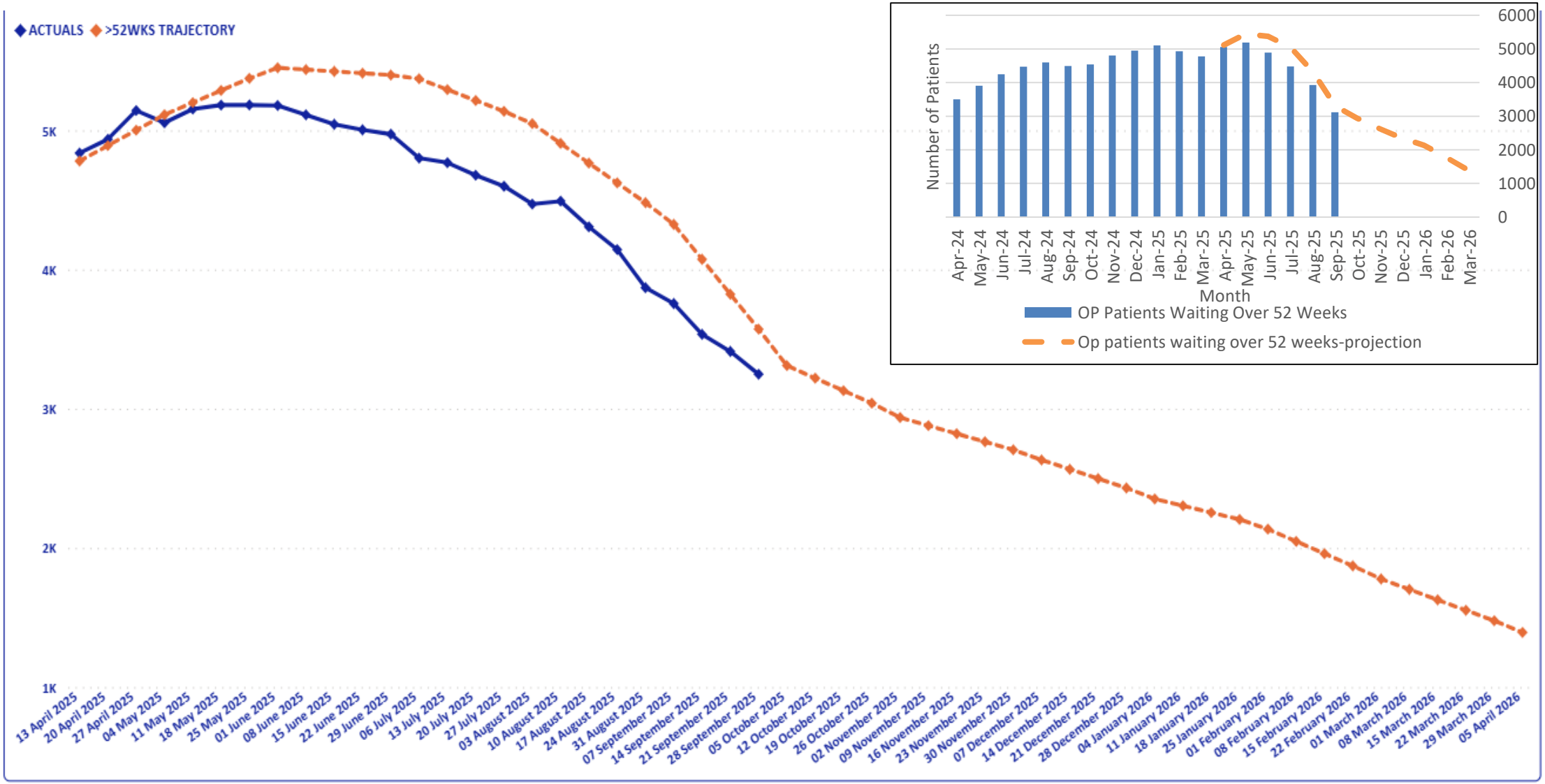
Long Waits >52 weeks Activity vs. Trajectory



Long Waits >52 weeks Total Waiting vs. Trajectory

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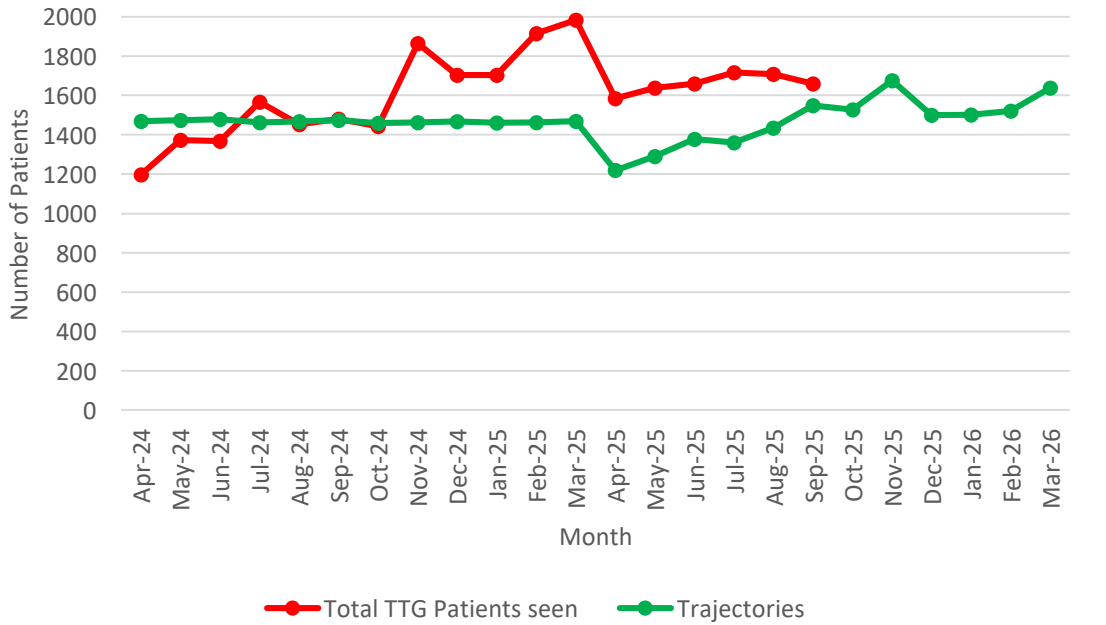
Treatment Time Guarantee: TTG < 12 week target

Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Percentage of TTG patients seen within 12 weeks of referral equal to or above 95% every month.		**Argyll & Bute** Consultant activity is not as high as 24/25 due to lack of planned care funding allocated to initiative clinics, however extra clinics will be scheduled between now and the year end which should improve the position. There is a targeted plan to ensure as close to a nil 52 week wait position at end March. Inpatient and daycase performance continues to be strong with no long waits reported. **North Highland** The number of new outpatients seen since the beginning of April is just over our target to the end of September. Activity has been particularly strong in Ophthalmology, General Surgery and ENT. We continue to exceed our plan in reducing the number of people waiting over 52 weeks for their appointments.	Activity continues to be monitored at inpatient/day case sites and meet frequently with services to review our long waiting patients.
Reduce the number of TTG patients waiting over 52 weeks to 200 by March 2026			
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			

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

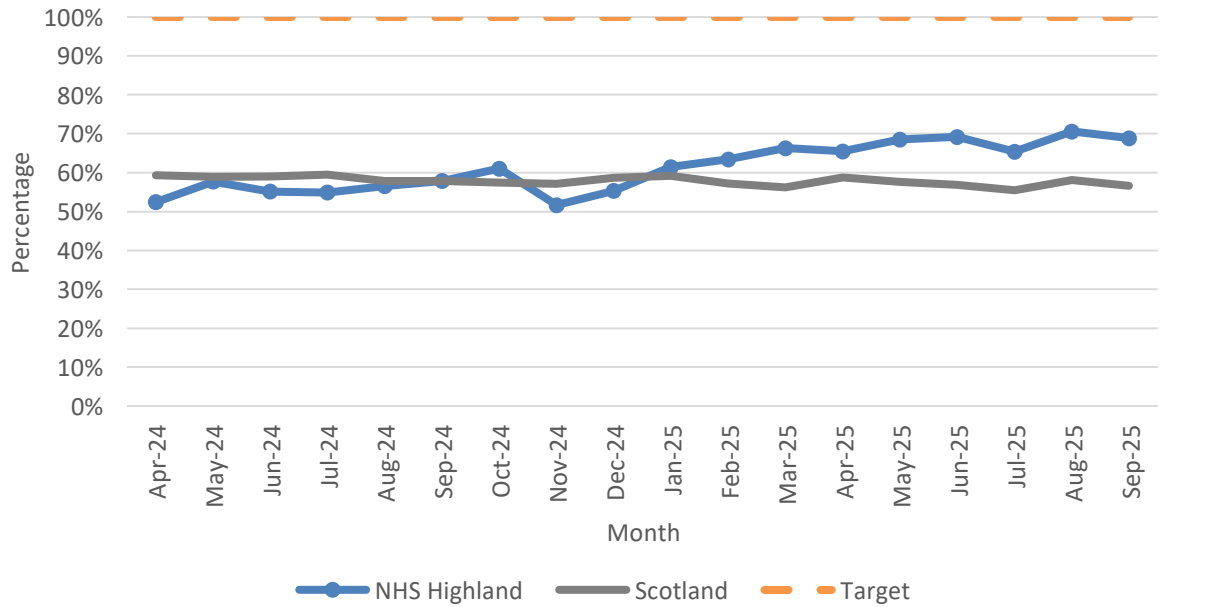
Performance Rating against Plan	
Latest Performance against Plan	2% ahead of plan
National Benchmarking against 12 week performance	68.9%
National Target against 12 week performance	100%
National Target Achievement against 12 week performance	Target Not Met; Above median for 1 month after 2 below
Benchmarking against 12 week performance	3rd of out 15 Boards

Patients Seen & Trajectories



TTG Seen <12 Weeks

Consultant Only



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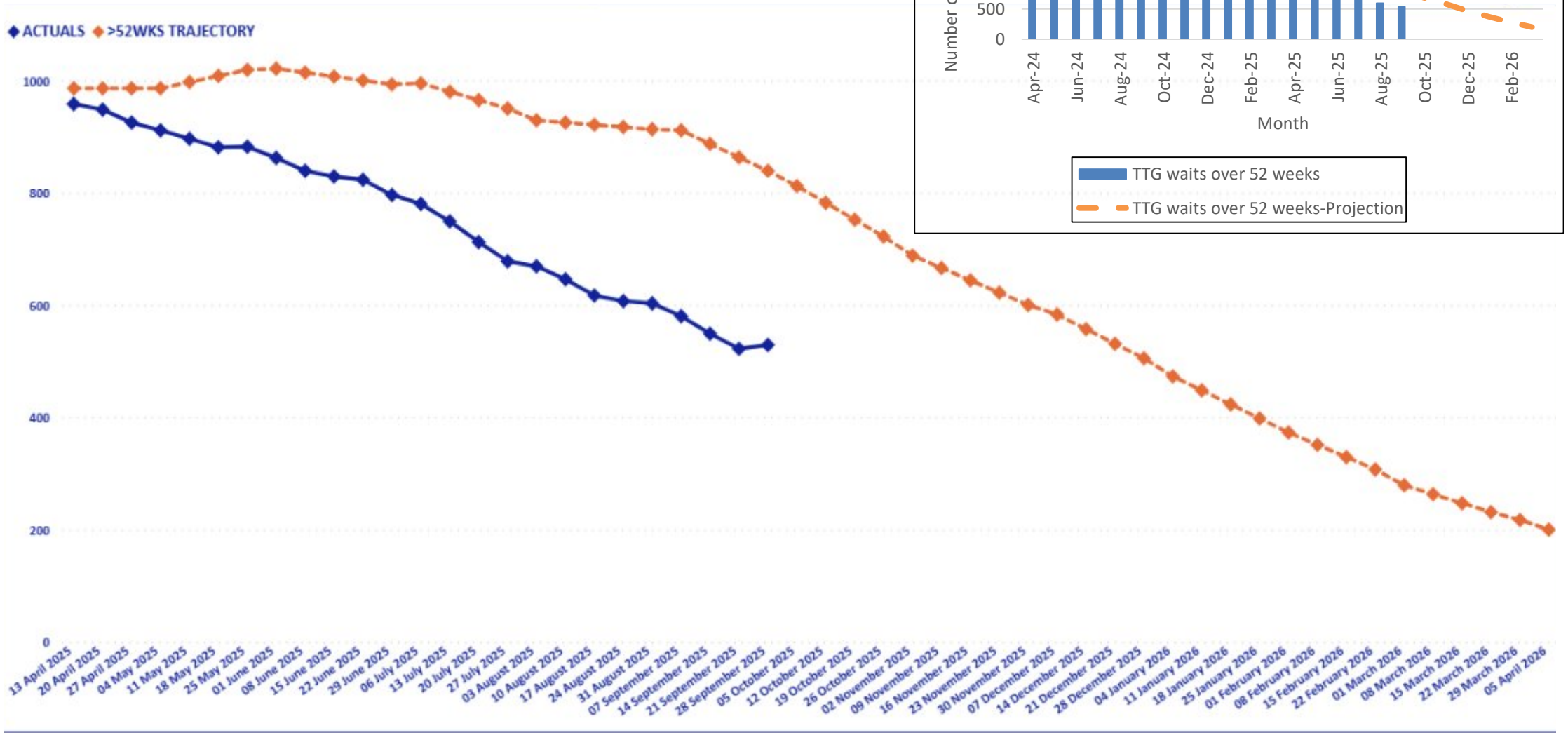
TTG (Long Waits) - Slide 2 of 2

Long Waits >52 weeks Activity vs. Trajectory



Long Waits >52 weeks Total Waiting vs. Trajectory

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Diagnostics – Radiology – Slide 1 of 2

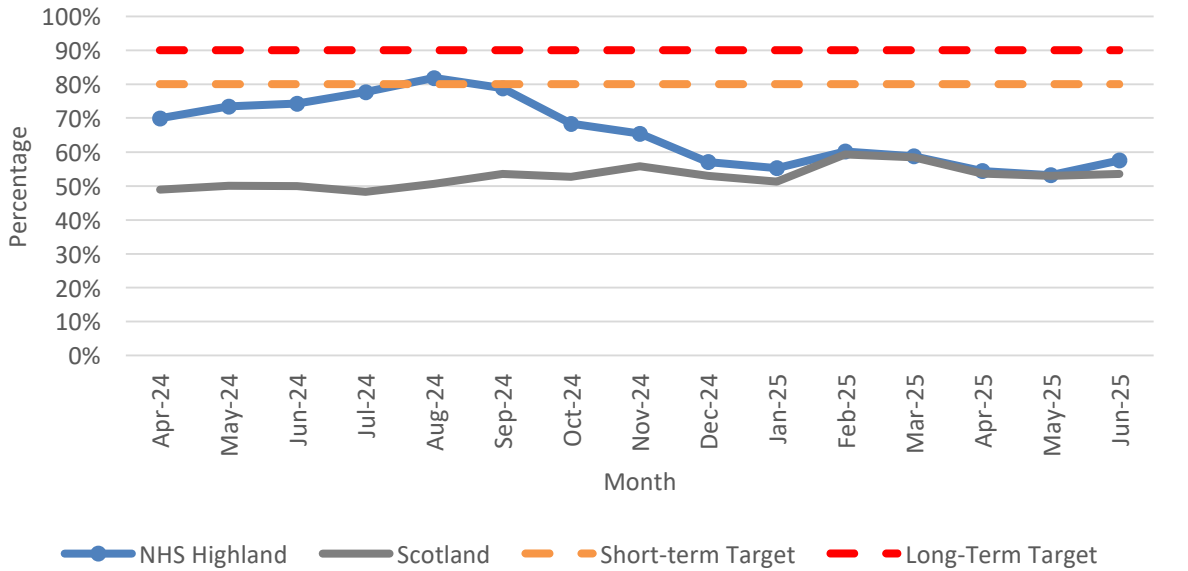
Key Performance Indicators		Reasons for Current Performance	Plans, Mitigations and Actions
Increase the number of patients receiving a key diagnostic test within 6 weeks from referral, in line with NHS Scotland guidance		**Highland** Increasing IP activity impacting upon OP capacity for CT and MRI. Increasing Planned Care and Cancer activity. **Lorn & Islands Hospital** A new radiographer team lead/professional lead has been appointed and will take up role in November. Axon providing outsourcing service, which is working well. Wait times satisfactory at present but pressure within General Ultrasonography from September onwards due to vacancy.	**Highland** Additionality plan commencing in October / November with 1300 extra patients planned to be seen. **Lorn & Islands Hospital** General Ultrasonography capacity due to recent retirement. Post out to advert and negotiating cover with locum to ensure waiting times maintained. Lack of Radiographer Team Leader full time due to vacancy with interim arrangements in place, but only on part time basis. Recruitment has successfully taken place and new post holder will be start in November. CTCA – pressure due to availability of clinician.
The number of patients who receive imaging (all) is equal to or exceeds the trajectory every month			
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			

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

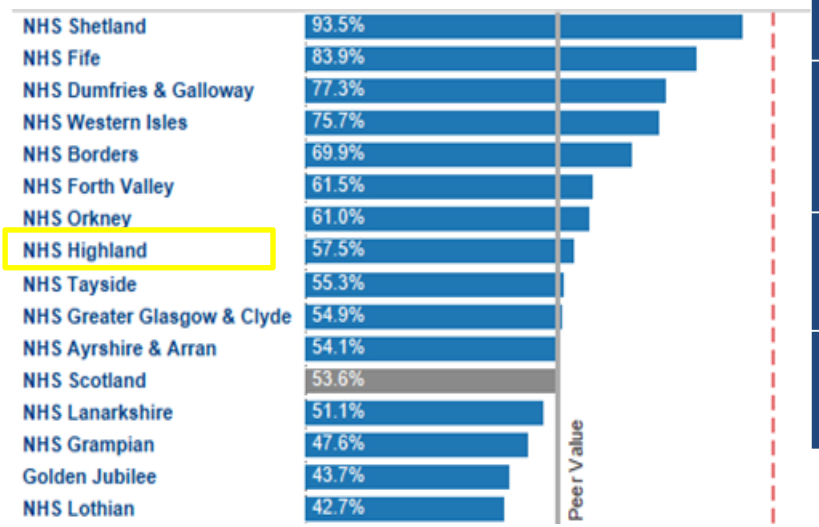
Performance Rating against Plan	
Latest Performance against 6 week target	57.5%
National Benchmark against 6 week target	53.6%
Local Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NHSH is below Scotland average
Benchmarking	8th out of 15 Boards

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	14,334 (50.00%)
Patients Seen – Sep 25	17813 (62.14%)
Overall	12.14% above target

Diagnostics – Radiology – Slide 2 of 2

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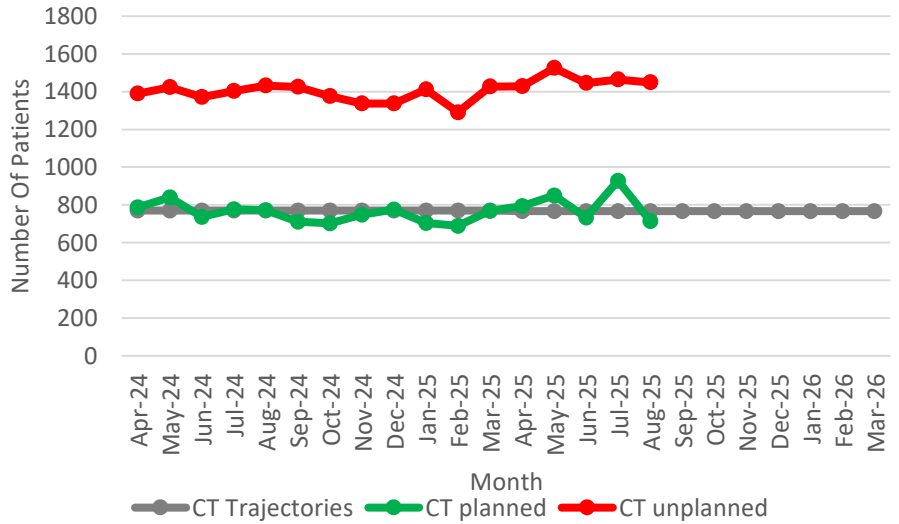
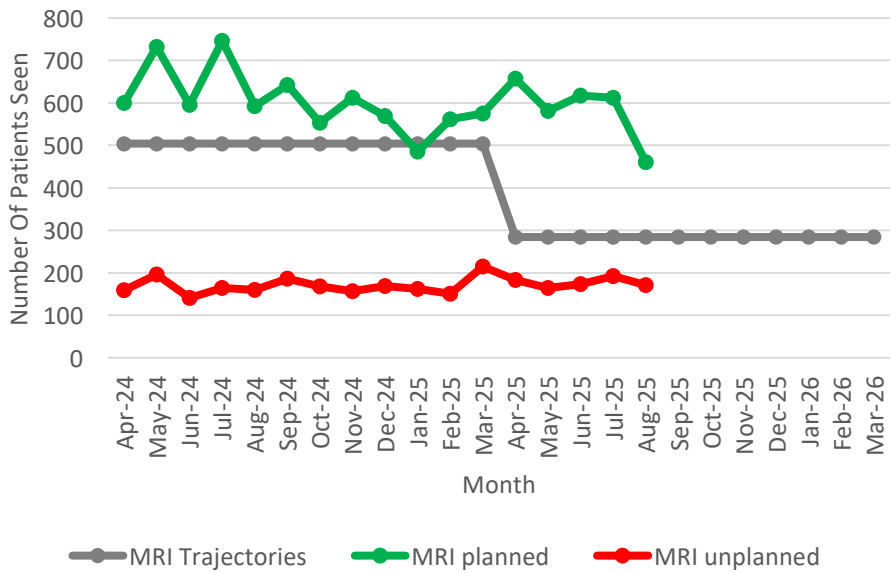
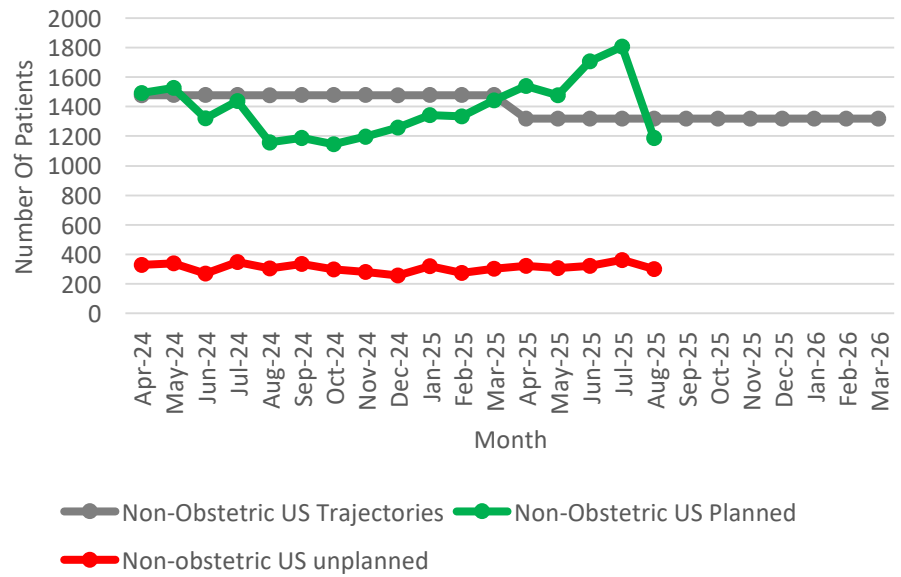
CT Patients Seen and Trajectories



MRI Patients Seen and Trajectories



Non-Obstetric Patients Seen and Trajectories



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Diagnostics – Endoscopy – Slide 1 of 2

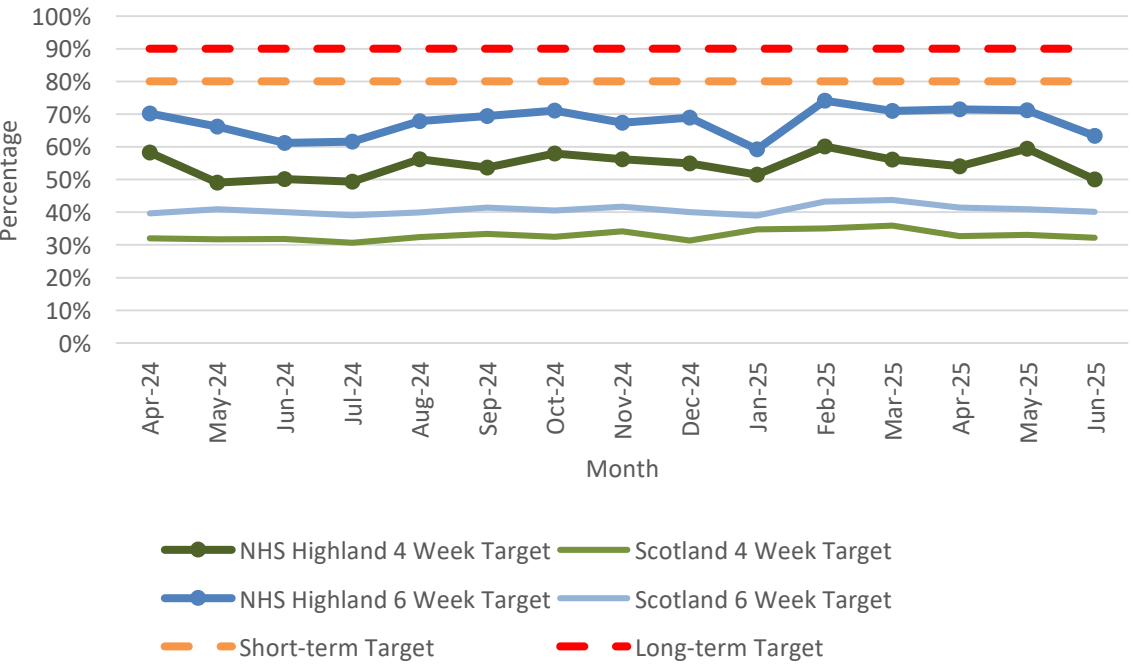
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
No patients waiting longer than 6 weeks for an endoscopy test (from referral to test) in line with Scottish Waiting Time Targets	GI endoscopy – Higher volume of all GI endoscopy due to Colorectal, Upper GI and Gastroenterology reducing their new outpatient waits.	GI endoscopy – Increased volume has been delivered by sacrificing return outpatient capacity. Paper submitted to request reallocation of funding from Colon Capsule Endoscopy to additional endoscopy sessions.
The number of patients seen for a new endoscopy appointment is equal to or exceeds the trajectory every month	Cystoscopy – Cystoscopy performance has varied due to staffing pressures – 2 consultant resignations.	Cystoscopy – Looking to complete High Intensity (HIT) sessions to recover position. All patients waiting over 12 weeks as of 1st October have had a letter asking them to contact Urology PIR line if they still wish to proceed. Will be removed from waiting list if no response within 4 weeks.
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

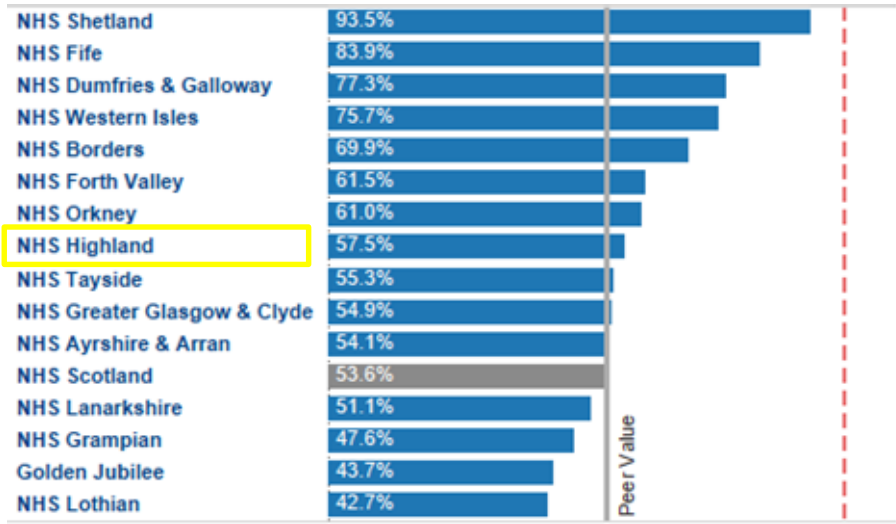
Performance Rating	
Latest Performance	63.4%
National Benchmark	40.1%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	While national target not met, performance in NHSH is ahead of Scotland average
Benchmarking	8th out of 15 Boards

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	2596 (50.15%)
Patients Seen – Sep 25	3,164 (61.13%)
Overall	10.97% above target

Diagnostics – Endoscopy – Slide 2 of 2

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Chief Officer, Acute

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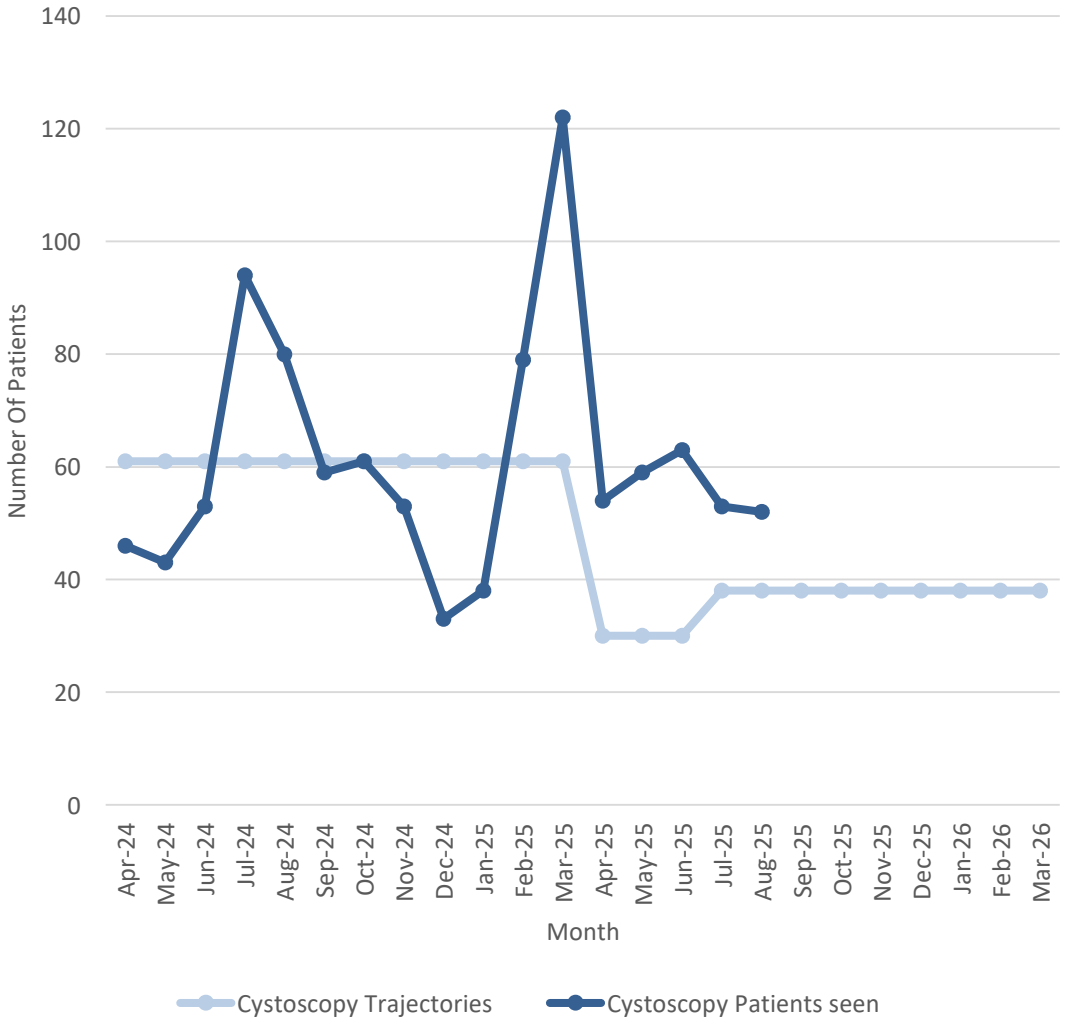
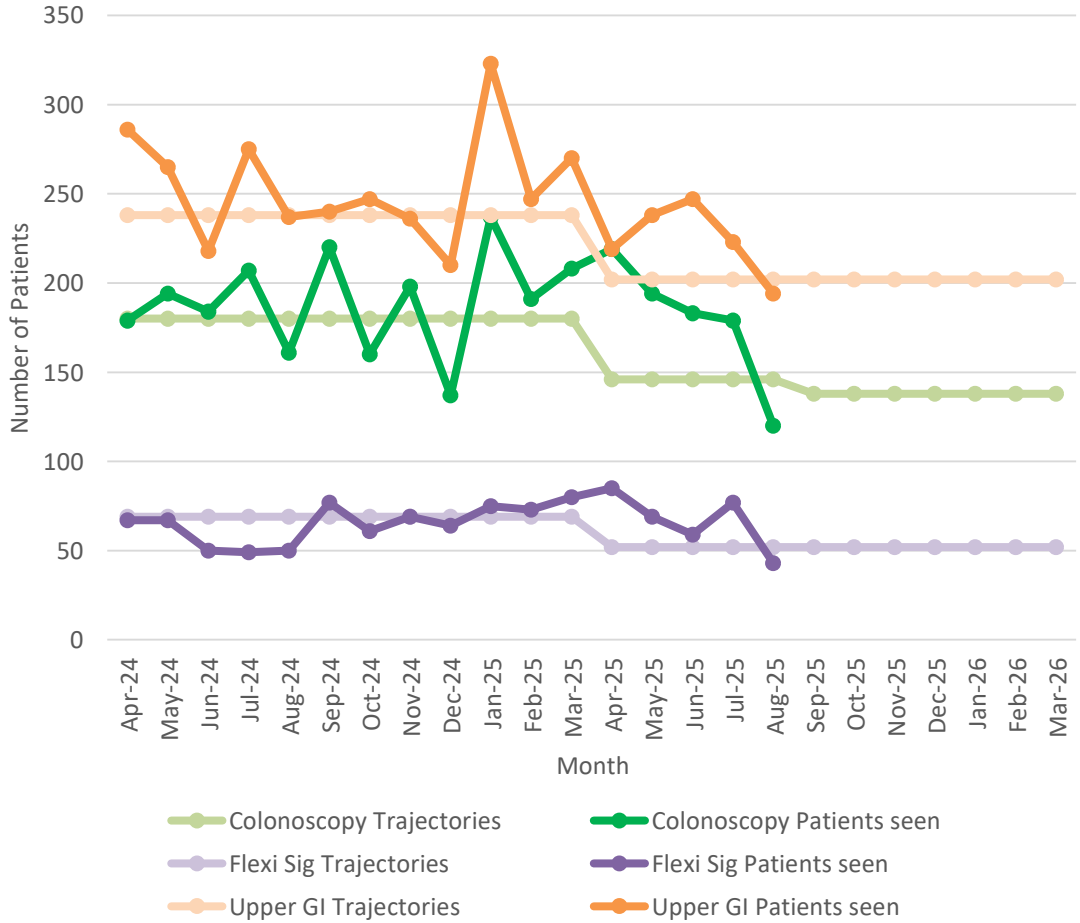
Patients Seen and Trajectories: *Cystoscopy*



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



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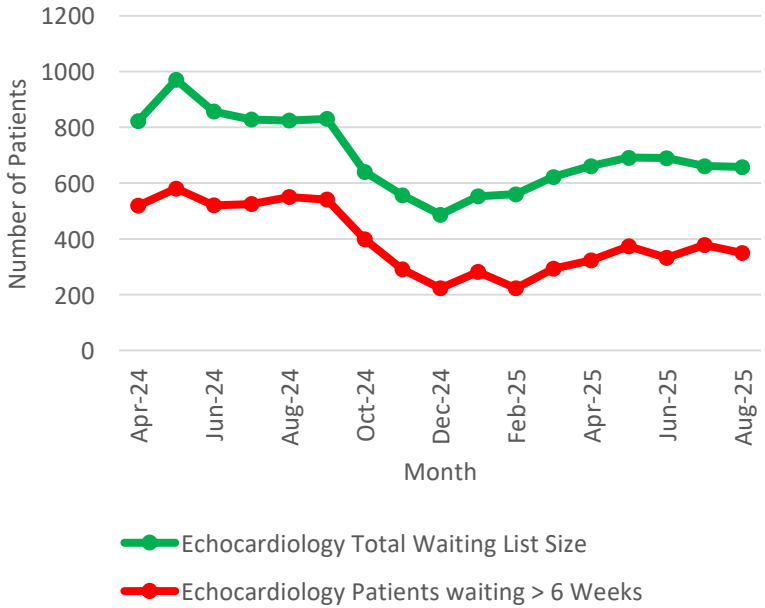
Diagnostics - Wait List Other

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		Clinical Physiology wait times overall have continued to trend downwards over the longer term. However, in recent months some staff turnover and closure of remaining locum arrangements due to financial pressure has challenged, particularly in Echo.	Progress recruitment episodes; and progress 4th Echo machine that has been funded by National Infrastructure Board capital.
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			

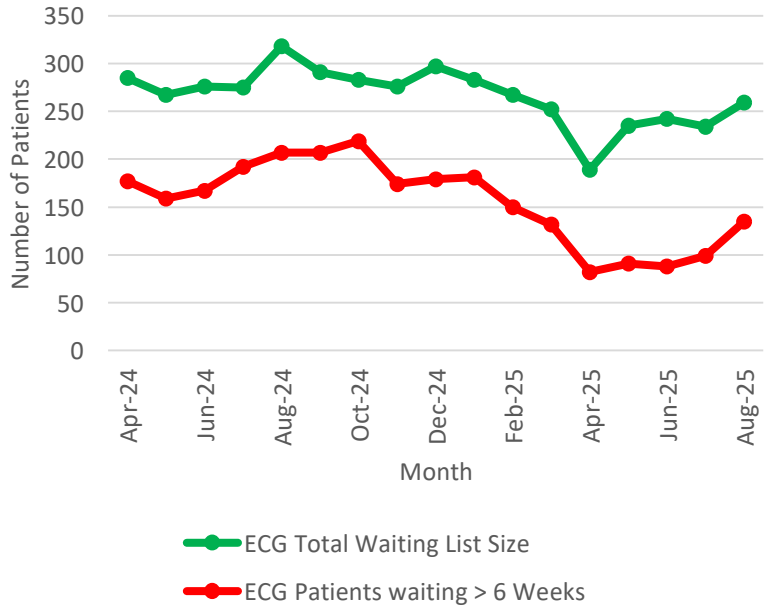
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

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

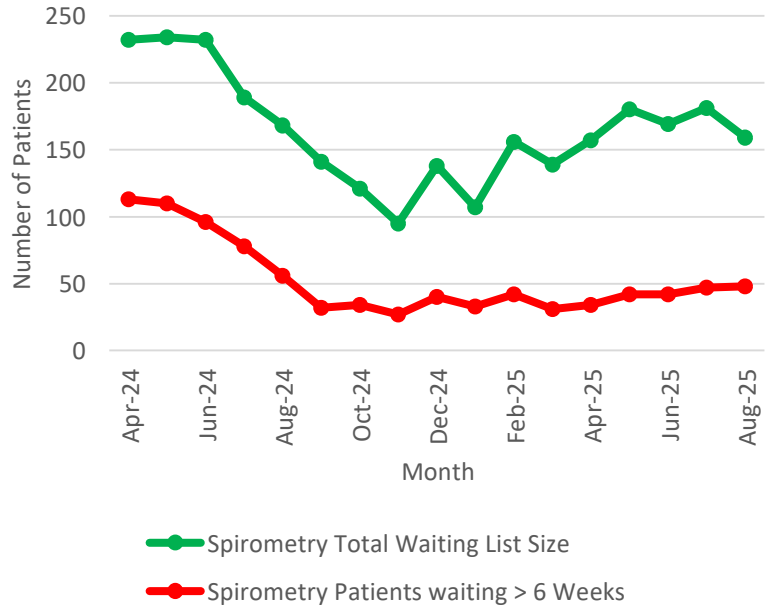
ECHO: Total Waiting List Size & Patients Waiting >6 Weeks



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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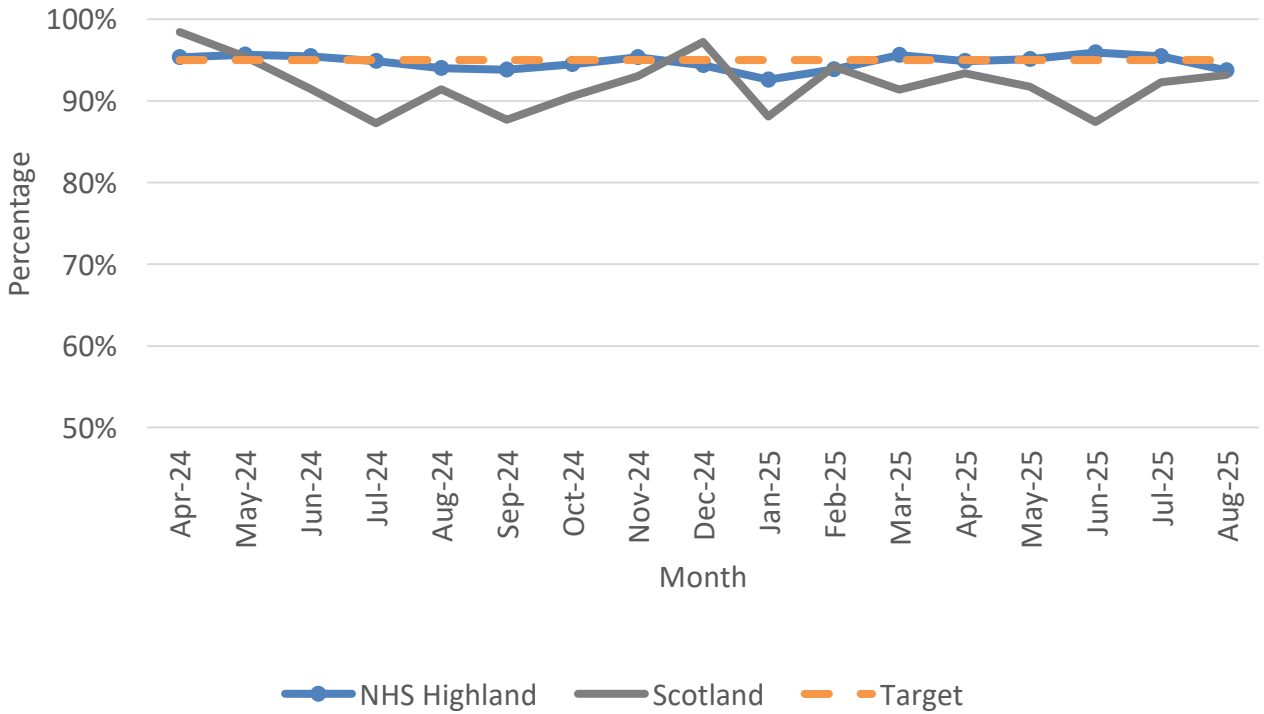
31 Day Cancer Waiting Times

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		Currently two out of six Consultant Urologist posts vacant and a Breast Surgeon has been on leave for a number of months. This has impacted performance in these pathways, although in a number of tumour groups, we are meeting the 95% target. For August 2025, NHS Highland was slightly below the national average in this KPI.	There is weekly service monitoring across all pathways to identify patients at risk of breach, and take action where possible. Challenges described with capacity due to vacancies and unexpected leave – recovery plans are instigated in affected pathways. There is a fortnightly performance monitoring with the Executive team and actions in progress to improve performance and meet this target consistently.

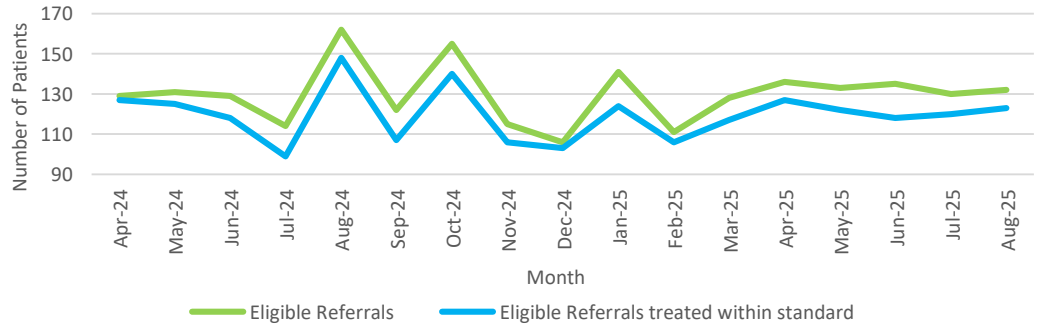
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	93.2%
National Benchmarking	93.7%
National Target Achievement	Last met in December 2024
Position	12th out of 15 Boards

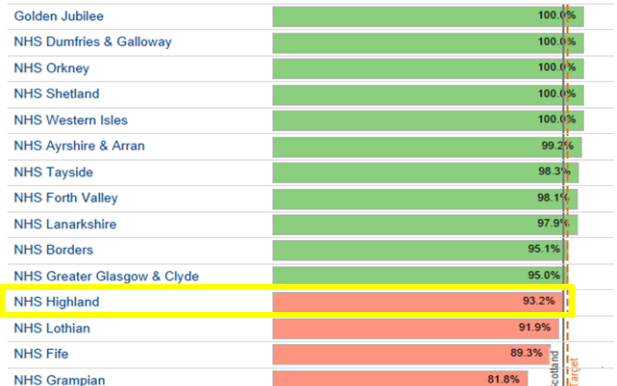
31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



31 Day Benchmarking with Other Boards



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OIP

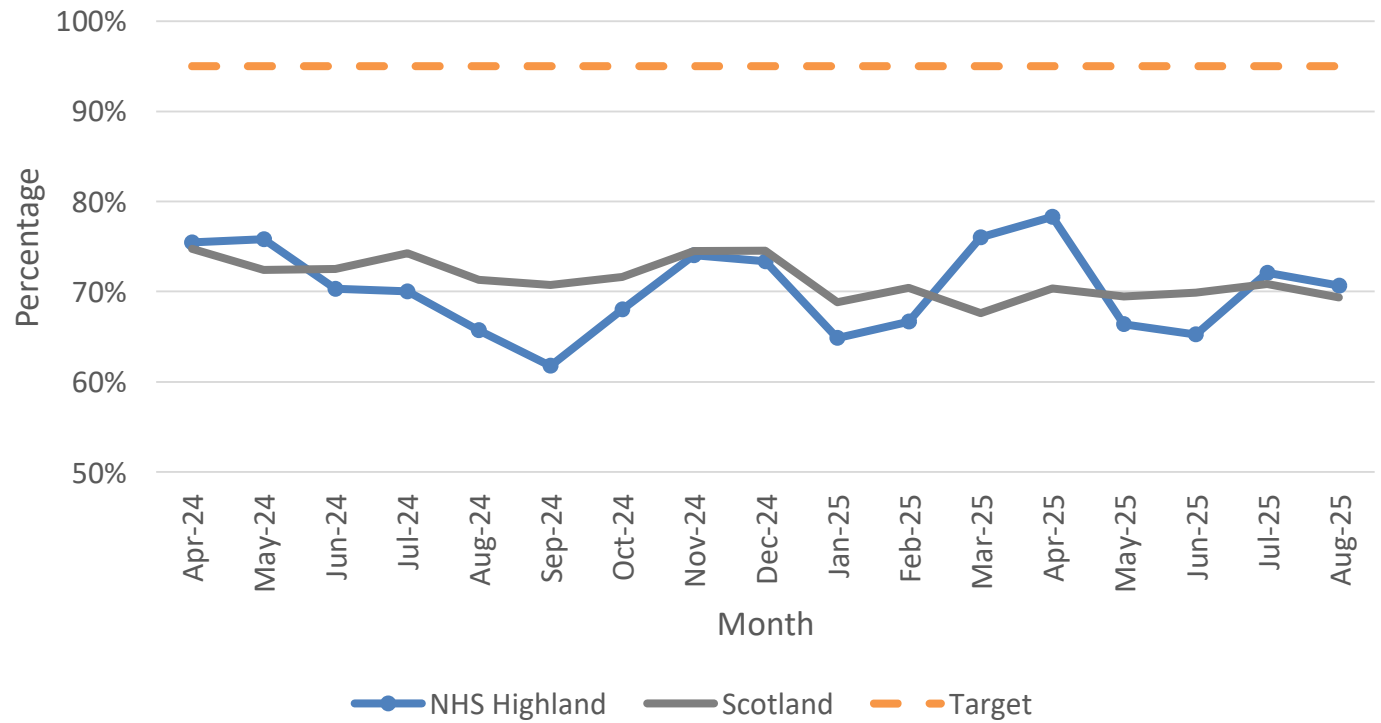
62 Day Cancer Waiting Times

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.	There are a number of reasons for the poor performance in the last quarter/month including: • Vacancies for the assessment and diagnosis of breast patients. • A delay to first assessment within colorectal pathway • Endoscopy and cystoscopy referrals and increased demand.	As described on previous slides, there is weekly service monitoring and fortnightly performance monitoring to improve performance. An improvement plan is in place with trajectories for improvement for the 62-day pathway to achieve 80% by March 2026, as part of the Operational Improvement Plan. A number of actions are in place including mutual aid from the Breast Service and Forth Valley and the recent appointment of a colorectal Nurse Specialist.

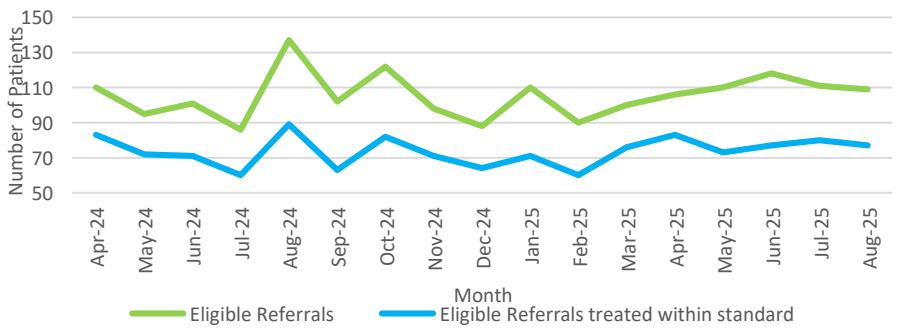
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	70.6%
National Benchmarking	69.3%
National Target	95%
National Target Achievement	Nationally target not achieved in some time
Position	8th out of 14 Boards

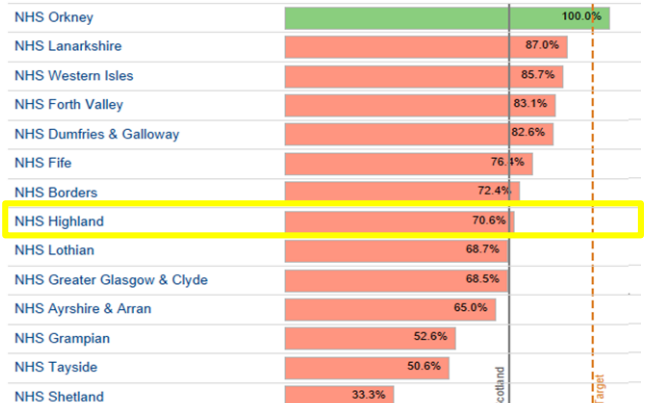
62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



62 Day Benchmarking with Other Boards



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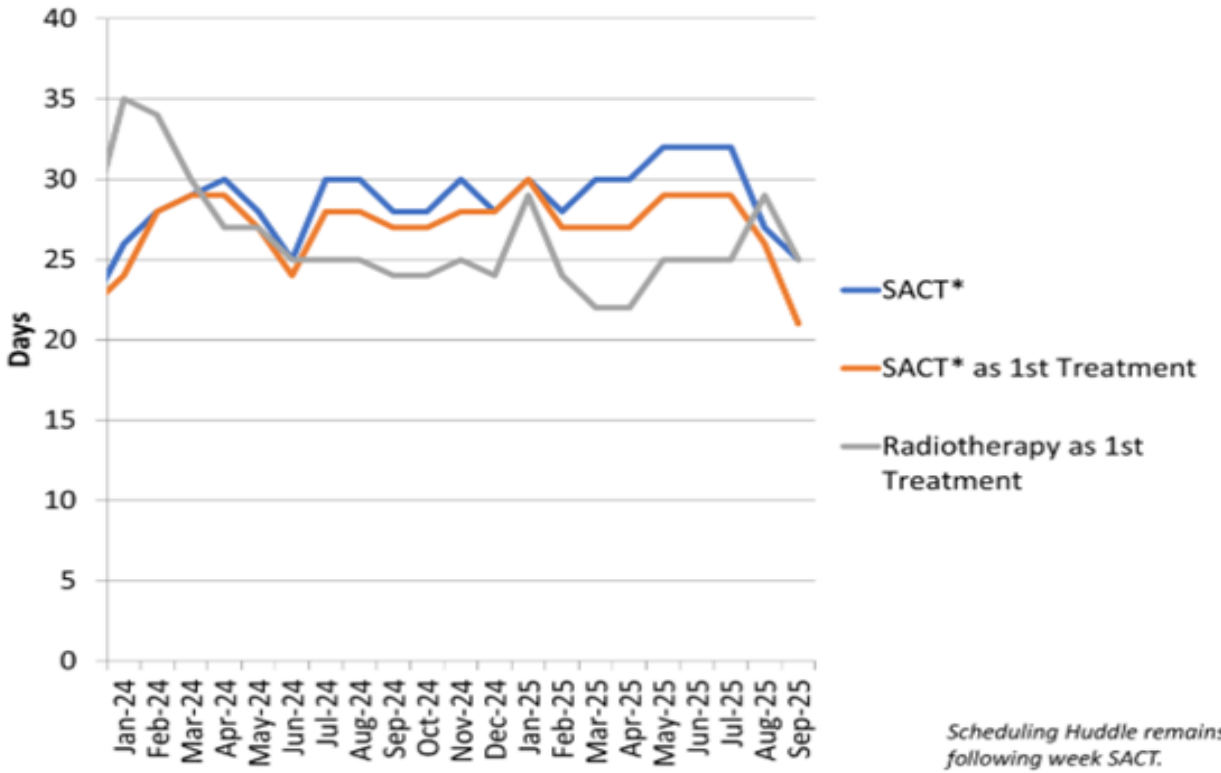
SACT Access and Benchmarking

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	The latest data for September 2025 shows a reduction in the average waiting times for start of treatment across NHS Highland. There is a continuing increase in referrals (both SACT and Radiotherapy) and vacancies (short and long term) within small teams of staff that impact upon overall performance.	There is a national and local review of the provision of SACT services underway to support timely and equitable access to SACT treatment.

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

Performance Rating	
Latest Performance	Average range = 21-25 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): average waiting times by month



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

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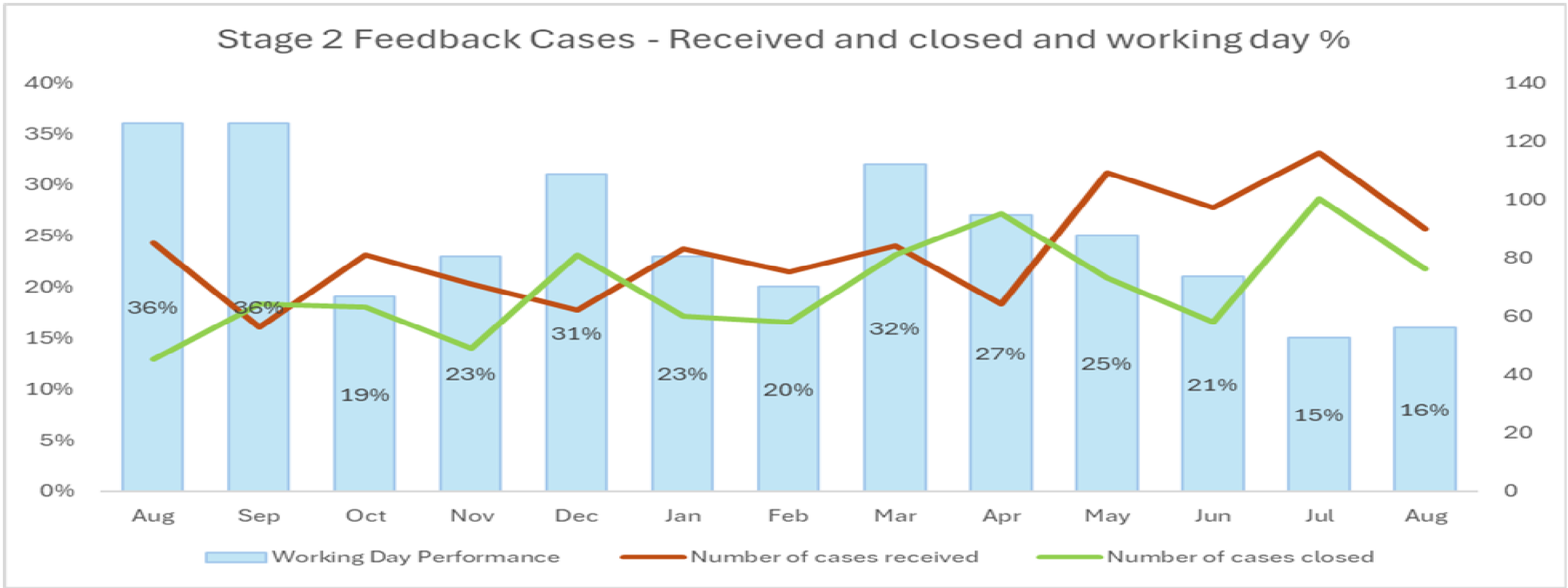
Stage 2 Complaint Activity (August 2024 – August 2025)

ADP Deliverables Progress as at End of Q1 2025/26		Insights to Current Performance	Plans and Mitigations
N/A		Continued poor performance against the 20 day working target with 36.5% increase in 3-month rolling average. Of note is that the past 3 months have resulted in more complaints being opened than closed. Over the past 13 months : 7 months more opened than closed. 2 months more closed than opennd. 4 months – equivalent amount opened and closed.	Reporting to EDG and escalation to Board Medical Director where required. Update at Acute SLT on performance and suggestions to improve. SOPS produced (to be shared for comment) to improve complainant experience and to allow refinement of the complaints process. Performance and quality indicators to be revised.

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

Performance Rating	
Latest Performance	19%
National Benchmarking	None
National Target	60%
National Target Achievement	
Position	



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SPSO Activity (September 2024 – September 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	SPSO activity has remains steady over the last few months. Recently there has been a slight increase in cases being received All cases closed were not taken forward as dealt with appropriately	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	

Number of SPSO Cases Received / Closed

SPSO cases received last 3 months:
10 received:

- 2 Acute
- 1 A&B
- 7 HHSCP

These relate to General Practice Services - General (salaried),
Paediatrics,
Surgical - Orthopaedics,
Mental Health Services - Adult Psychiatry,
Other - Adult Social Care - Care at Home,
Mental Health Services - Clinical Psychology

SPSO cases closed last 3 months:
4 SPSO enquiries closed

- 4x not taken forward

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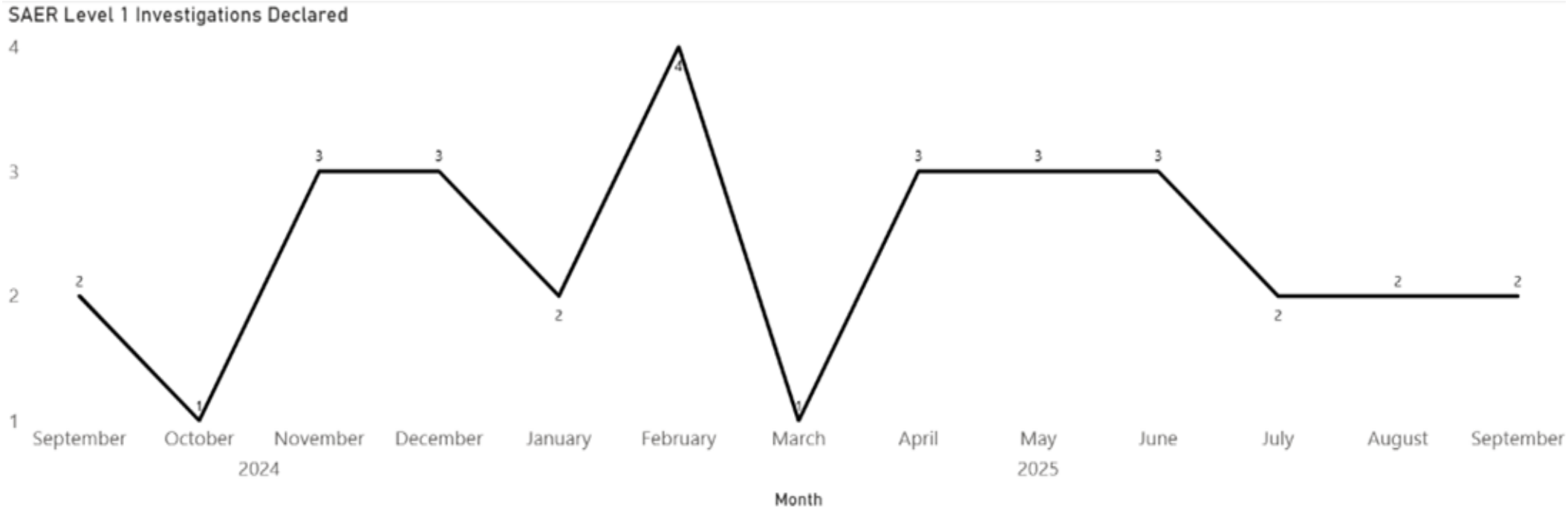
Level 1 SAERs Declared and Status Overview (September 2024 – September 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	11 SAERs are over the 26 week target, with 28 open. 77 SAER actions are overdue.	All 11 cases have been reviewed. 4 were completed and ready for approval. Are SAERs declared since 2020 have been review to confirm SAERs. BND and BMD are meeting with each Operational Area to discuss SAERs reviews and open actions. The adverse event policy and procedures have been updated to reflect the national framework. The policy is being updated to incorporate comments

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

28	12	31	0.19%
Open Level 1 (L1) Incidents	L1: Active more than 26 weeks	L1: SAER Declared Last 13 Months	Incident | SAER Conversion Last 13 Months



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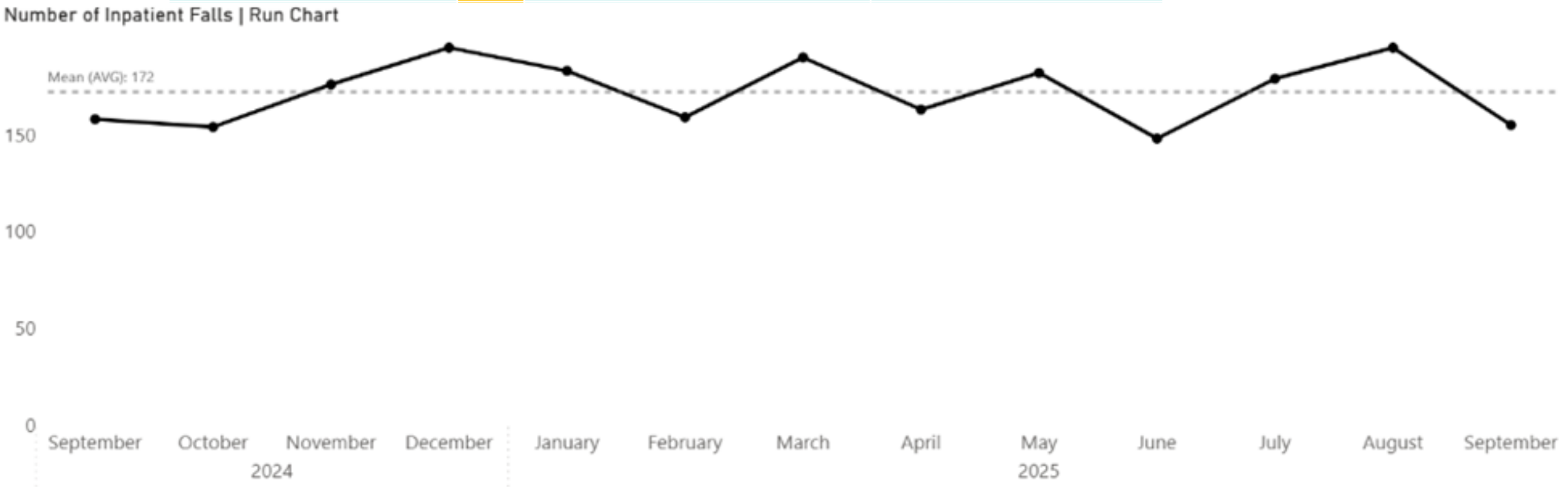
Hospital Inpatient Falls (September 2024 – September 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	No significant change in number of inpatient falls over the last 12 months. All areas in Acute operating with surge capacity beds in use. Patients are being placed in non - standard clinical areas within Raigmore using a risk assessment to support patient placement. Three areas with highest rates of falls since January 2025 are Ward 2C Raigmore, Rosebank ward Caithness and Sutor Ward in Invergordon	Work continues across the organisation to share learning – poster developed by A&B team Teams encouraging safe mobilisation for patients and families Exercise programme developed for patients in Belford and in Mid Argyll trail of regular exercise classes underway for inpatients Completion of DCP and non adherence to policy main reason for RIDDOR reporting

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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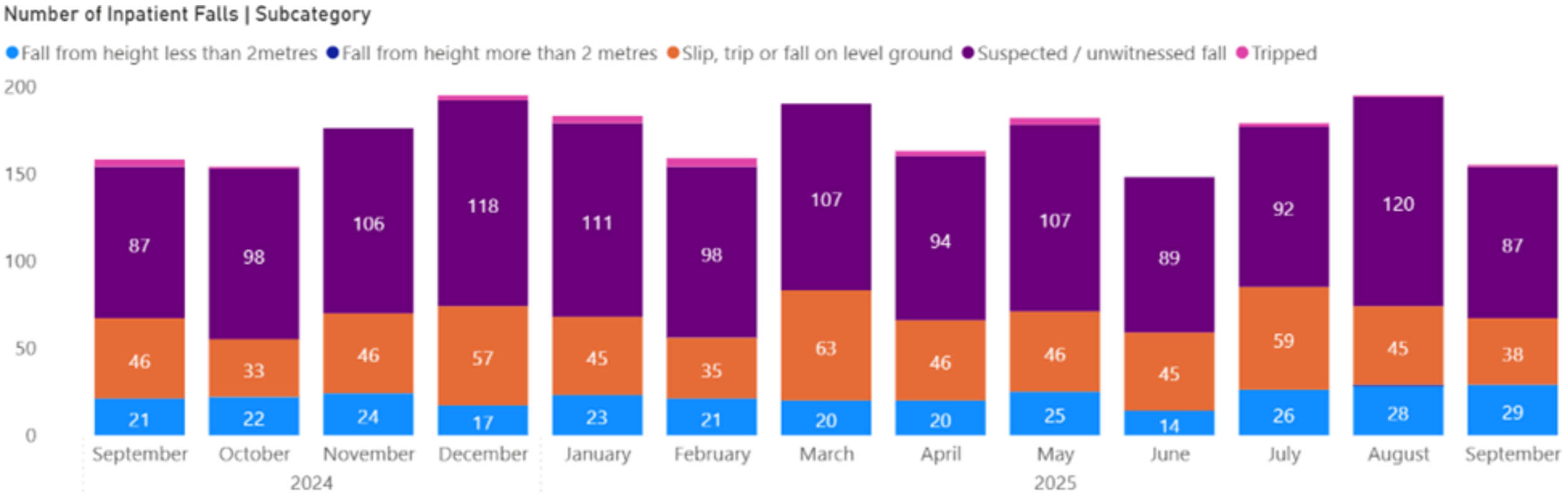
Hospital Inpatient Falls | Subcategory (September 2024 – September 2025)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
	Reduction in falls with harm over the last 8 months although total falls remain static	Continue to share learning through monthly falls steering group Falls audit tool determining areas of focus for individual teams

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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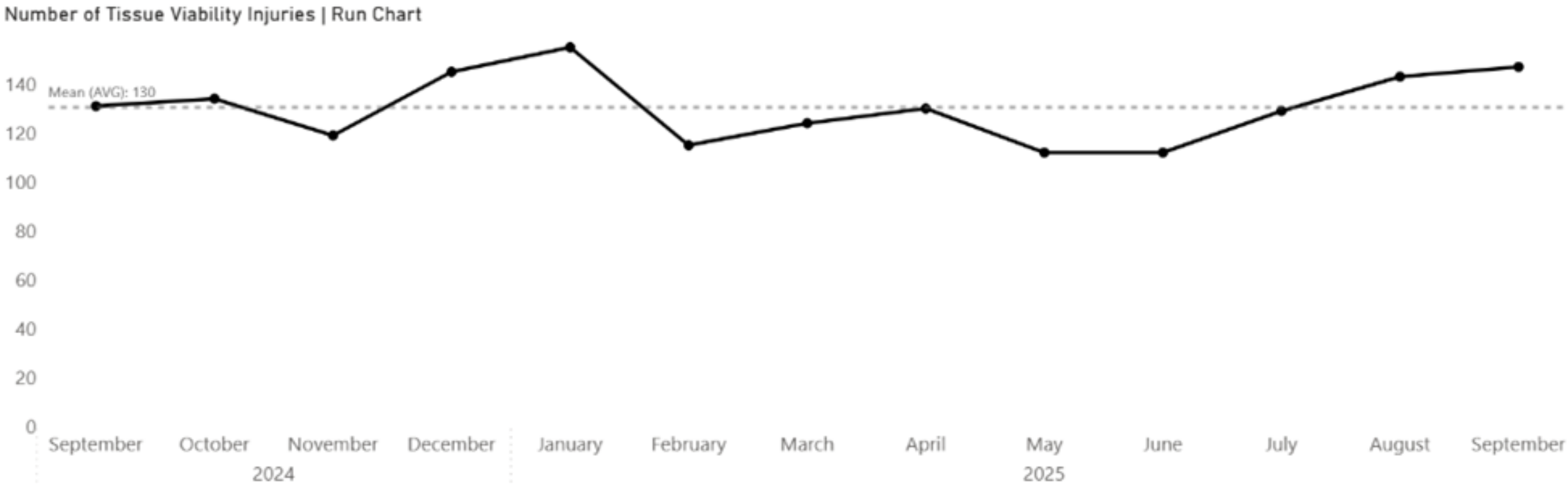
Tissue Viability Injuries (September 2024 – September 2025)

ADP Deliverables Progress as at End of Q1 2025/26		Insights to Current Performance	Plans and Mitigations
-MASD and PU Pathways complete via NATVNS- for publication via MedsIlls once minor changes complete due by November 2025 ending -Continue to veto for PU training to be mandatory		- IPC unpublishing TURAS modules for PUs. - PUs on feet adding to numbers via Datix for developed PUs and CPR feet training targeting key areas have started	- -Continue to implement support for high risk areas - CPR Feet - -CPR for Feet on Red Day Tool now PAG as passed TVLG, including RDT addition for CPR Feet - SLWG set up with NATVNS for pressure ulcer training materials as IPC will be unpublishing training slides on TURAS ? when
- SAS discussions ongoing re: frailty pathway and in discussions with Clarie Copeland and Kate Watson from NHS Glasgow for QI			

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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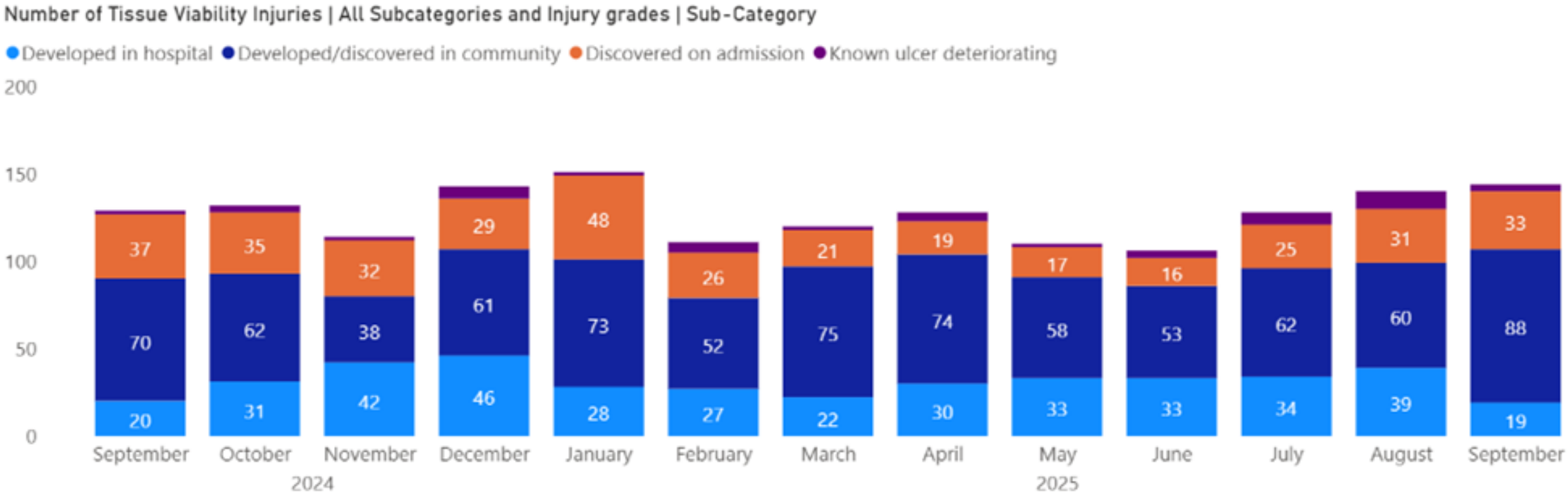
Tissue Viability Injuries by Subcategory (September 2024 – September 2025)

ADP Deliverables Progress as at End of Q1 2025/26		Insights to Current Performance	Plans and Mitigations
- 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		• - QI project started - CPR Feet forms part of lower limb training	- Wards 3A to start project with Podiatry and Laura Keel
- Lower Limb training x1 more for the year successfully 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 (September 2024 – September 2025)

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 Datixed, as well as Grade 2- as there is discussion that Grade 1 should not be reported- but it should as it is the start of skin damage	There is a head to toe inspection video that will be used via NATVNS – I have asked TURAS to share and be made accessible to/including non NHS Highland care homes- https://youtu.be/zUs93xdBKxU -Equipment guide being updated as a step up/step down guide for all clinicians across acute and community- for TVLG December 2025

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	17	1	14		**32**
Pressure Ulcer - combination lesions	5	8	2	0	**15**
Pressure Ulcer - deep tissue injury	22	93	11	6	**132**
Pressure Ulcer - ungradable	34	110	36	11	**191**
Pressure ulcer (grade not specified)	9	7	6	0	**22**
Pressure ulcer Grade 1	106	128	82	1	**317**
Pressure ulcer Grade 2	195	403	167	13	**778**
Pressure ulcer Grade 3	15	57	36	13	**121**
Pressure ulcer Grade 4	1	19	15	13	**48**
Ulcers	1	3	7	0	**11**
Total	**405**	**829**	**376**	**57**	**1667**

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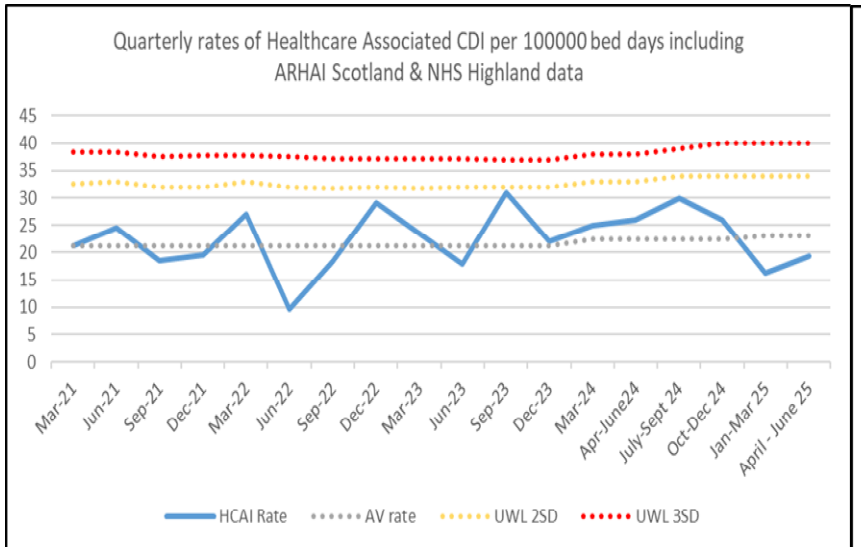
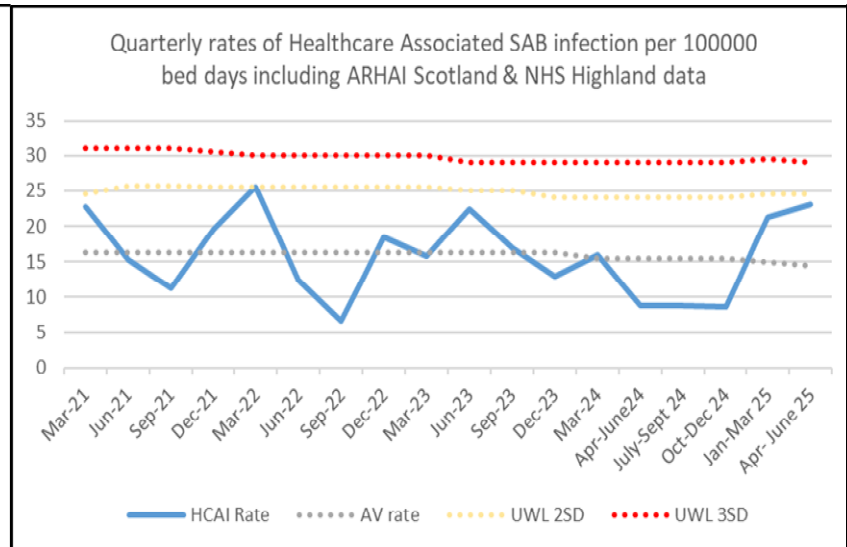
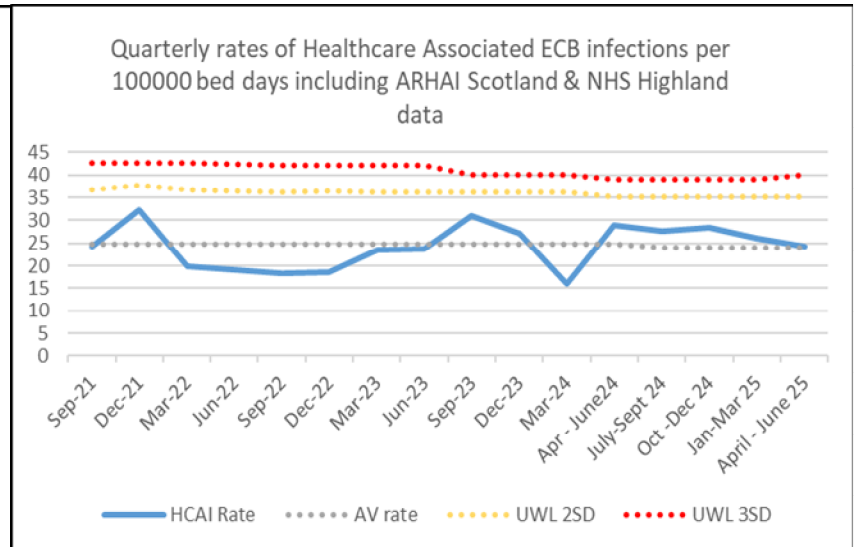
Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims

ADP Deliverables: Validated position for 2025/26 reduction aims		Insights to Current Performance	Plans and Mitigations
Clostridioides difficile (CDI) 2025/2026 reduction aim is 75 HCAI cases. As of 31/08/2025 25 HCAI cases reported. Currently on track to meet aim		The RAG rating is calculated on the predicted monthly numbers. A rise in SAB cases was seen in Jan-March 25, upon investigation no commonalities were identified. ARHAI Scotland have been approached regarding complexity of cases and have reported that NHSH is not an outlier in noting the complexity of recent cases. On the 7th of October 2025 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 (April - June (Q2) 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.	Continue to review individual cases for learning and any subsequent actions. Targeted work with antimicrobial prescribing continues, GP CDI pack updated. 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.
Staphylococcus aureus bacteria (SAB) 2025/26 reduction aim is 53 HCAI cases. As of 31/08/2025 24 HCAI cases reported. This is above predicted trajectory by 4 cases			
Escherichia Coli (ECB) 2025/2026 reduction aim is 75 HCAI cases. As of 31/08/2025 30 HCAI cases reported Currently on track to meet aim			







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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 6.3%. 25% 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 74.1%, 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.		Turnover decreased again this month to 6.93%	
Ensure the average Time to Fill rate for positions within NHS Highland remains below the 116 day national target.		Remains below national target of 116 days at 109.93 but is rising.	Work continues on 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 33% is significantly short of the 95% target. There is a slight decrease from 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

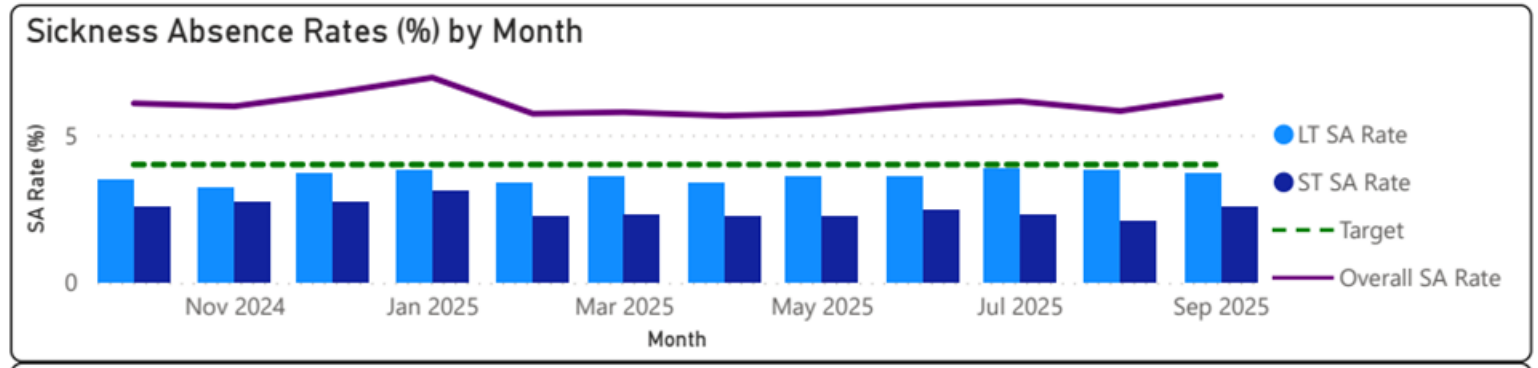
<5% off target

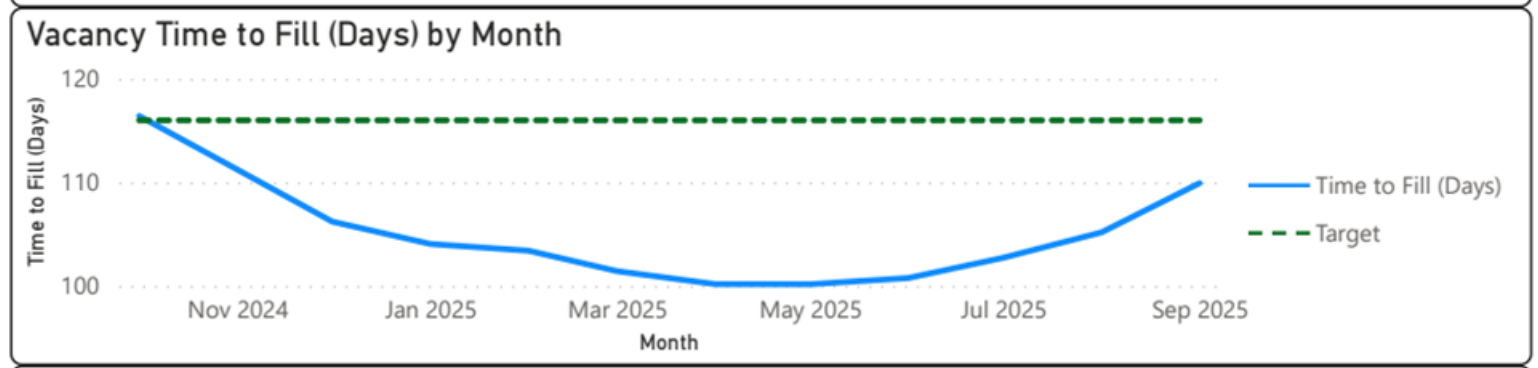
>5% off target

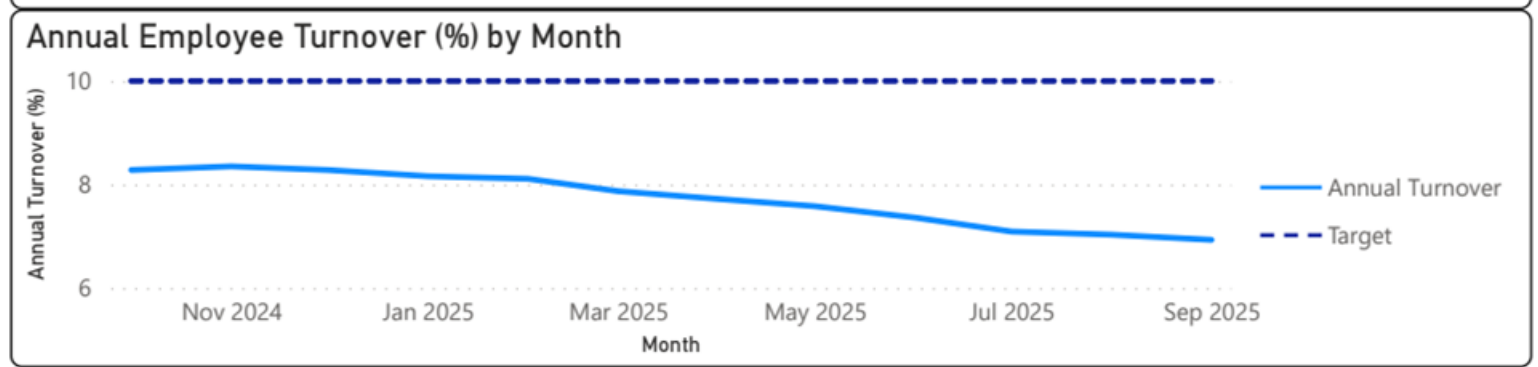
>10% off target

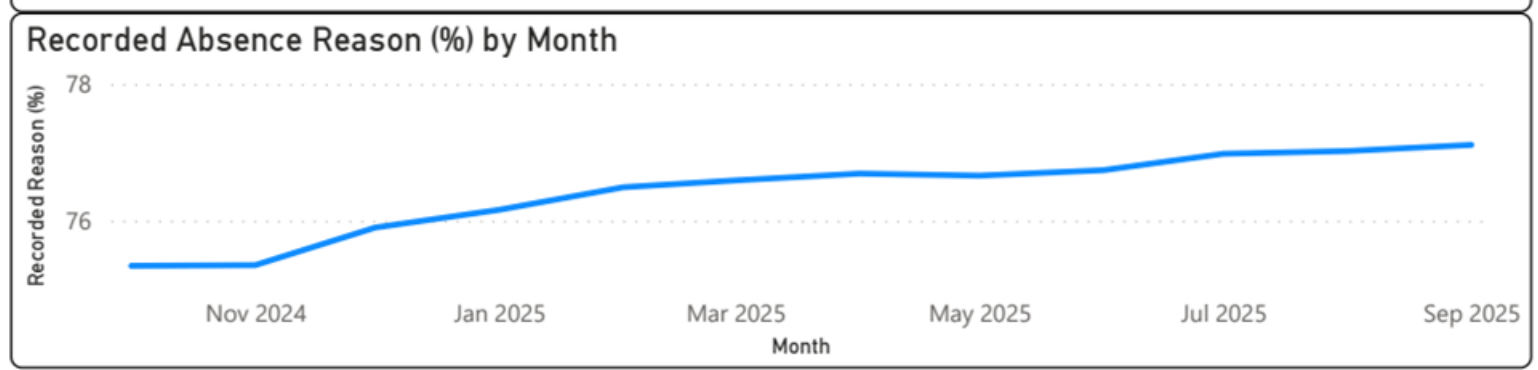
Organisational Metrics Sep 2025

Sickness Absence Rate (%)	6.31
Long Term SA Rate (%)	3.67
Short Term SA Rate (%)	2.57
Recorded Absence Reason (%)	77.11
Vacancy Time to Fill (Days)	109.93
Annual Employee Turnover (%)	6.93









Training Metrics Sep 2025

Bank eLearning Completion Rate (%)

49.1

Substantive eLearning Completion Rate (%)

79.0

Overall eLearning Completion Rate (%)

74.1

M&H Practical Training Completion Rate (%)

48.5

V&A Practical Training Completion Rate (%)

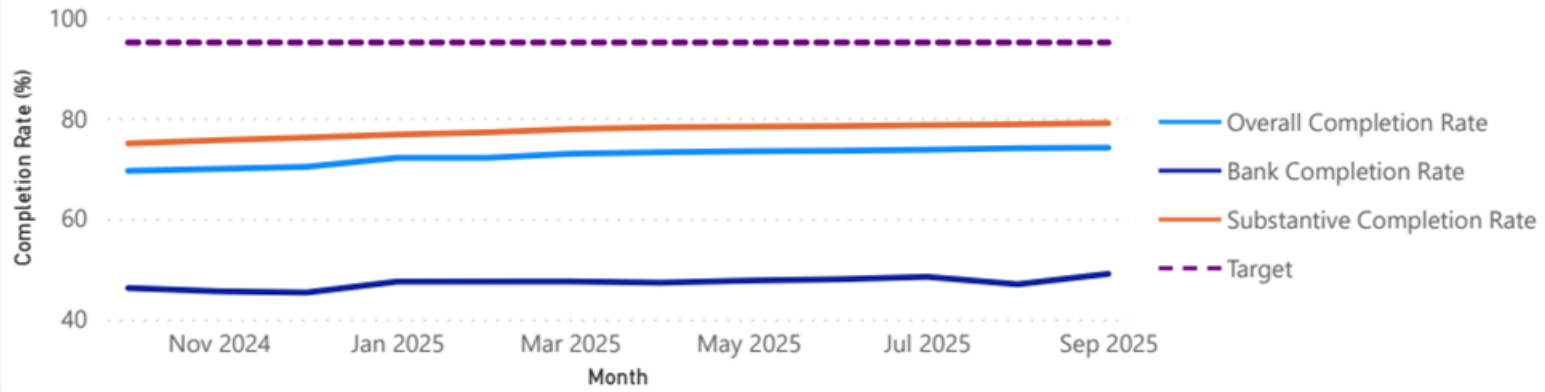
28.0

Appraisal Completion Rate (%)

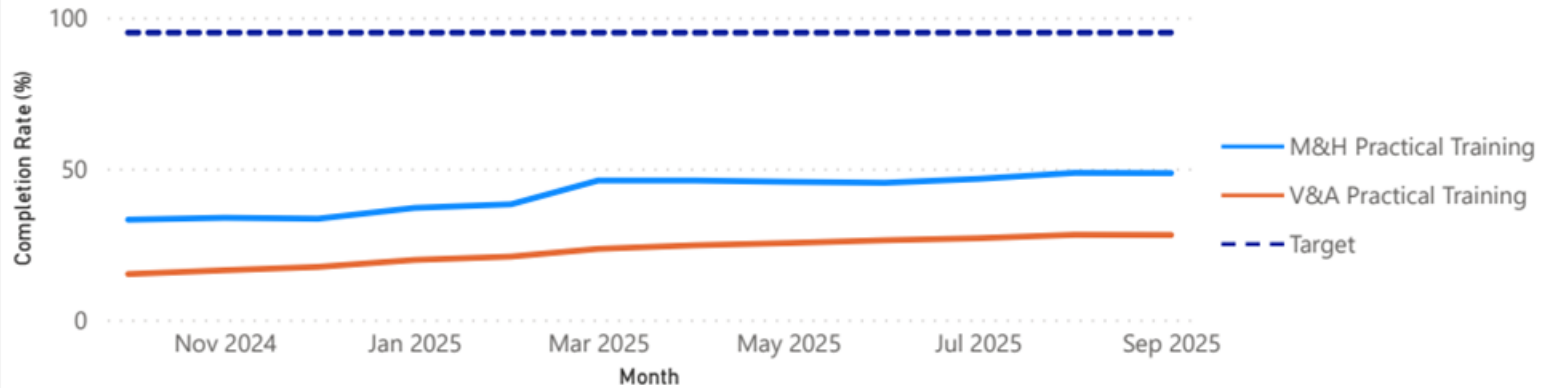
33.0

Note that from Sep 2024, new starts are no longer excluded from Appraisal figures.

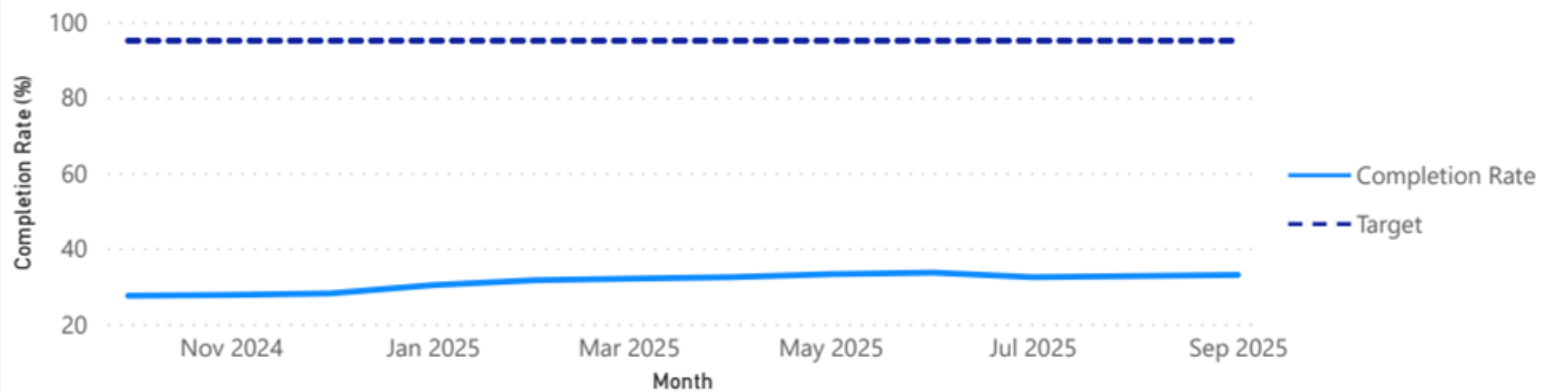
Core Mandatory eLearning Completion Rate (%) by Month



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	Progress towards drop off target - breastfeeding	Monthly	August 2025
6	CAMHS Waitlist NHSH	Monthly	August 2025
7	1st New Appointment Only	Monthly	August 2025
7	NDAS Total Awaiting 1st App (incl unvetted)	Monthly	August 2025
7	New + Unvetted Patients Awaiting First Appointment by Wait Band	Monthly	August 2025
8	Screening Programme Uptake KPIs in NHS Highland	Annual	August 2025
8	Inequality in Screening Comparison of NHS Highland and Scotland	Annual	August 2025
9	Children's Vaccination Uptake	Quarterly	August 2025
10	Smoking Cessation	Quarterly	August 2025
11	NHS Highland-Alcohol brief interventions 2025/26 Q1	Quarterly	August 2025
12	Drug and Alcohol Recovery Performance Against Standard for Completed Waits	Quarterly	August 2025
13	Psychological Therapy Waiting Times Patients seen <18 weeks.	Monthly	NEW
14	% of People Seen in ED Within <4 hours Per Month	Quarterly	August 2025
14	Total Patients Waiting >8 hours in ED per Month	Quarterly	August 2025
14	Total Patients waiting >12 hours in ED per Month	Monthly	August 2025
15	Number of People Delayed from Hospital Discharge at Monthly Cencus Point NHSH	Monthly	August 2025
15	Number of People Delayed from Discharge – Location and Code.	Monthly	August 2025
16	Outpatients (NOP) Seen & Trajectories	Monthly	August 2025
16	Outpatients seen <12 weeks Including Consultant and Nurse Lead Activity	Monthly	August 2025

Slide #	Report	Frequency of Update	Last Presented
17	OP Planned activity, long waits & Return OP Long waits >52 Weeks	Monthly	August 2025
17	Return Outpatients Wait List	Monthly	August 2025
18	TTG <12 Week Target Patients Seen & Trajectories	Monthly	August 2025
18	TTG Seen <12 Weeks (consultant Only).	Monthly	August 2025
19	TTG Long waits >52 Weeks.	Monthly	August 2025
20	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	August 2025
21	CT Patients Seen & Trajectories	Monthly	August 2025
21	MRI Patients Seen & Trajectories	Monthly	August 2025
21	Non Obstetric Patients Seen & Trajectories	Monthly	August 2025
22	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	August 2025
23	Patients Seen & Trajectories Cystoscopy	Monthly	August 2025
23	Patients Seen & Trajectories Colonoscopy, flexi sig & upper GI	Monthly	August 2025
24	ECHO: Total Waiting List Size & Patients waiting >6weeks	Monthly	August 2025
24	ECG Total Waiting List Size & Patients waiting >6weeks	Monthly	August 2025
24	Spirometry Total Waiting List Size & Patients waiting >6weeks	Monthly	August 2025
25	31 Day Cancer Waiting Times	Monthly	August 2025
25	Patients Seen on £! Day Pathway	Monthly	August 2025

Slide #	Report	Frequency of Update	Last Presented
26	62 Day Cancer Waiting Times	Monthly	August 2025
26	Patients Seen on 62 Day Pathway	Monthly	August 2025
27	SACT Average Waiting Times by Month	Monthly	August 2025
28	Stage 2 Complaint Activity	Monthly	August 2025
29	Number of SPSO Cases Received/ Closed	Monthly	August 2025
30	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	August 2025
31	Number of Hospital Inpatient Falls 2024/25	Monthly	August 2025
32	Number of Hospiital Inpatient Falls by Subcategory	Monthly	August 2025
33	Number of Tissue Viability Injuries | Run Chart	Monthly	August 2025
34	Number of Tissue Viability Injuries | All Subcategories and Injury Grades | Sub-Category	Monthly	August 2025
35	Number of Tissue Viability Injuries | Subcategory by Injury Grade	Monthly	August 2025
36	Infection Control, CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction Aims	Monthly	August 2025
37	Integrated Performance & Quality Report : Grow, Nurture & Plan Well	Monthly	August 2025
38	Sickness Absence Rates % By Month	Monthly	August 2025
38	Vacancy Time to Fill Days by Month	Monthly	August 2025

Slide #	Report	Frequency of Update	Last Presented
38	Annual Employee Turnover % by Month	Quarterly	August 2025
38	Recorded Absence Reason % by Month	Quarterly	August 2025
39	Training Metrics Sep 2025	Quarterly	August 2025
40	Organisational Metrics - Glossary	Bi-monthly	August 2025
41	Organisational Metrics - Glossary	Bi-monthly	August 2025
37	Workforce IPQR Narrative	Bi-monthly	August 2025