NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**29 September 2026**
Title:	**Integrated Performance and Quality Report**
Responsible Executive/Non-Executive:	**David Park, Deputy Chief Executive (FPRC); Gareth Adkins (SGC); Louise Bussell, Director of Nursing & Dr Boyd Peters, Medical Director (CGC)**
Report Author:	**Sammy Clark, Performance Manager**

Report Recommendation: The Board is asked:

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

1 Purpose

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

This is presented to the Board for:

- Assurance

This report relates to a:

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

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well	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

Indicators have been developed as part of the board's Annual Delivery and Operational Improvement planning activities.

2.4 Proposed level of Assurance

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

Substantial		Moderate	X
Limited		None	

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

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

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

3.3 Financial

Financial analysis is not included in this report.

3.4 Risk Assessment/Management

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

3.5 Data Protection

The report does not contain personally identifiable data.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

3.9 Route to the Meeting

Sections through the relevant Governance Committees;

- Staff Governance Committee – 1st September 2026
- Clinical Governance Committee – 3rd September 2026
- Finance Resource Performance Committee – 11th September 2026

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – September 2026 Board Meeting

NHS Highland Performance Report
Part of the NHS Highland IPQR
Meeting Date: 11 September 2026

Assuring NHS Highland Finance, Performance and Resources Committee on the delivery of the Board's 2 strategic objectives (Our Population and In Partnership) through strategic Key Performance Indicators in each Well Theme.

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NHS Highland Performance Report: September 2026

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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Performance

Executive Summary of Key Performance Indicators: Slide 1 of 3

Section 1 – Scheduled Care

Strategic Outcome	Key Performance Indicator	Current Performance (Date)	Previous Performance (Date)	Trend Indicator (Last 6 data points)	Local Target (Date)	National Target	Performance Rating (Latest Data)
Thrive Well	CAMHS <18-week referral-to-treatment	97.2% (Jun 26)	100% (Apr 26)	0 0 0 0 0 0	90%	90%	Target Met
Live Well	Psychological Therapies < 18-week referral to treatment	85.7% (Jun 26)	90.6% (Apr 26)	0 0 0 0 0 0	90%	90%	4.3% off target
Treat Well	New Outpatients (NOP) number of patients waiting >52 weeks	1534 (Jul 26)	1166 (Apr 26)	0 0 0 0 0 0	1763 by end Jul 26	1763 by end Jul 26	229 below forecast
Treat Well	TTG number of patients waiting >52 weeks	362 (Jul 26)	128 (Apr 26)	0 0 0 0 0 0	469 by end Jul 26	469 by end Jul 26	107 below forecast

Section 2 – Cancer & Diagnostics

Strategic Outcome	Key Performance Indicator	Current Performance (Date)	Previous Performance (Date)	Trend Indicator (Last 6 data points)	Local Target	National Target	Performance Rating (Latest Data)
Treat Well	Radiology <6-week waiting time	78.4% (Jun 26)	70.8% (Apr 26)	0 0 0 0 0 0	>80%	95%	1.6% off target
Treat Well	Endoscopy <6-week waiting time	77.8% (Jun 26)	89.0% (Apr 26)	0 0 0 0 0 0	>80%	95%	2.2% off target
Journey Well	31-Day Cancer Waiting Times: Diagnosis to 1st Treatment	88.6% (Jun 26)	86.7% (Apr 26)	0 0 0 0 0 0	95%	95%	6.4% off target
Journey Well	62-Day Cancer Target: USC Referral to 1st Treatment	67.6% (Jun 26)	61.9% (Apr 26)	0 0 0 0 0 0	>69.5% by 30 Jun 26	>69.5% by 30 Jun 26	1.9% off target
Journey Well	SACT and Radiotherapy as 1st Treatment: Average Waiting Time	20-24 Days (SACT & SACT 1st Treatment) 40 Days (Radiotherapy as 1st Treatment) (Jul 26)	Average 20-24 Days (May 26)	0 0 0 0 0 0	< 28 days	N/A	Target not met for Radiotherapy

Executive Summary of Performance Indicators: Slide 2 of 3

Section 3 – Unscheduled Care

Strategic Outcome	Key Performance Indicator	Current Performance (Date)	Previous Performance (Date)	Trend Indicator (Last 6 data points)	Local Target	National Target	Performance Rating (Latest Data)
Respond Well	Emergency Access (<4-hour % waits)	81.8% (Jul 26)	77.5% (Apr 25)	0 0 0 0 0 0	73.4% by July 26	>75.3% by Mar 27	0.4% off target
Respond Well	Emergency Access (>12-hour total waits)	255 (Jun 26)	337 (Apr 26)	0 0 0 0 0 0	<209 by Jun 26	0 by Mar 27	46 off target
Respond Well	SAS Turnaround Times (90TH Percentile)	01:13:54 (Jul 26)	01:11:46 (Jun 26)	0 0 0 0 0 0	01:31:01 by Jul 26	01:15:00 by Mar 27	Target Met
Respond Well	Delayed Discharges: All (monthly census point)	239 (Jun 26)	242 (Apr 26)	0 0 0 0 0 0	<221 by Jun 26	<186 by Mar 26	18 off target
Respond Well	Delayed Discharges: Standard Delays	204 (Jun 26)	190 (Mar 26)	0 0 0 0 0 0	Reduce	Reduce	Increased

Executive Summary of Performance Indicators: Slide 3 of 3

Section 4 – Population Health

Strategic Outcome	Key Performance Indicator	Current Performance (Date)	Previous Performance (Date)	Trend Indicator (Last 6 data points)	Local Target	National Target	Performance Rating (Latest Data)
Stay Well	Covid-19 Vaccination Uptake	56.6% (Spring 26)	62.3% (Winter 25 complete)	⓪⓪⓪⓪⓪⓪	60%	N/A	3.4% off target
Stay Well	Respiratory Syncytial Virus (RSV) Vaccination Uptake	62.6% (Maternity) 33.2% (Older Adults) (Aug 26)	60.6% (Maternity) 38.1% (Older Adults) (March 26)	⓪⓪⓪⓪⓪⓪	60%	N/A	Target Met
Stay Well	Childhood (6 in 1 at 12 months) Vaccination Uptake	91.9% (Q4 25/26)	91.6% (Q3 25/26)	⓪⓪⓪⓪⓪⓪	95%	95%	3.1% off target
Stay Well	Abdominal Aortic Aneurysm (AAA) Screening Uptake – reported annually	87.3% (25/26)	87.3% (23/24)	⓪⓪⓪⓪⓪⓪	85%	85%	Target Met
Stay Well	Bowel Screening Uptake – reported annually	68.8% (25/26)	70.4% (23/24)	⓪⓪⓪⓪⓪⓪	60%	60%	Target Met
Stay Well	Cervical Screening Coverage – reported annually	59.3% (25/26)	66.7% (23/24)	⓪⓪⓪⓪⓪⓪	80%	80%	20.7% off target
Stay Well	Smoking Cessation (Number of Quits per Quarter)	60 (Q3 25/26)	53 (Q2 25/26)	⓪⓪⓪⓪⓪⓪	84 per quarter	N/A	28.5% off target
Stay Well	Breastfeeding (Reduce the attrition rate of any breastfeeding at 6-8 weeks)	27.5% (25/26)	28.2% (24/25)	⓪⓪⓪⓪⓪⓪	25.1% by 2030/31	N/A	Target Met
Stay Well	Drug and Alcohol Recovery (DARS) (seen within 3 weeks of referral)	88.7% (Mar 26)	84.2% (Dec 25)	⓪⓪⓪⓪⓪⓪	90%	90%	1.3% off target
Stay Well	Alcohol Brief Interventions (ABIs) (Number per quarter)	1017 (Q4 25/26)	967 (Q2 25/26)	⓪⓪⓪⓪⓪⓪	N/A	3851 vs. target of 3688 by end of Q4	Target Met

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Executive Lead
Katherine Sutton,
Chief Officer,
Acute

Executive Lead
Evan Beswick,
Chief Officer,
A&B HSCP

CAMHS (Child and Adolescent Mental Health Service)

Strategic Objective: Our Population
Outcome Area: Thrive Well

Latest Performance	National Average	Board Position
97.2%	**92.4%**	**7th out of 14**

Key Performance Indicators

KPI 1: Consistent Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by March 2027 (Tier 3).

KPI 2: Reduction of people who are currently on the Tier 3 CAMHS waiting list by March 2027

Performance Analysis

Highland
For June 2026 under-18-week performance remained strong and over 52 week waits remained at 0%.

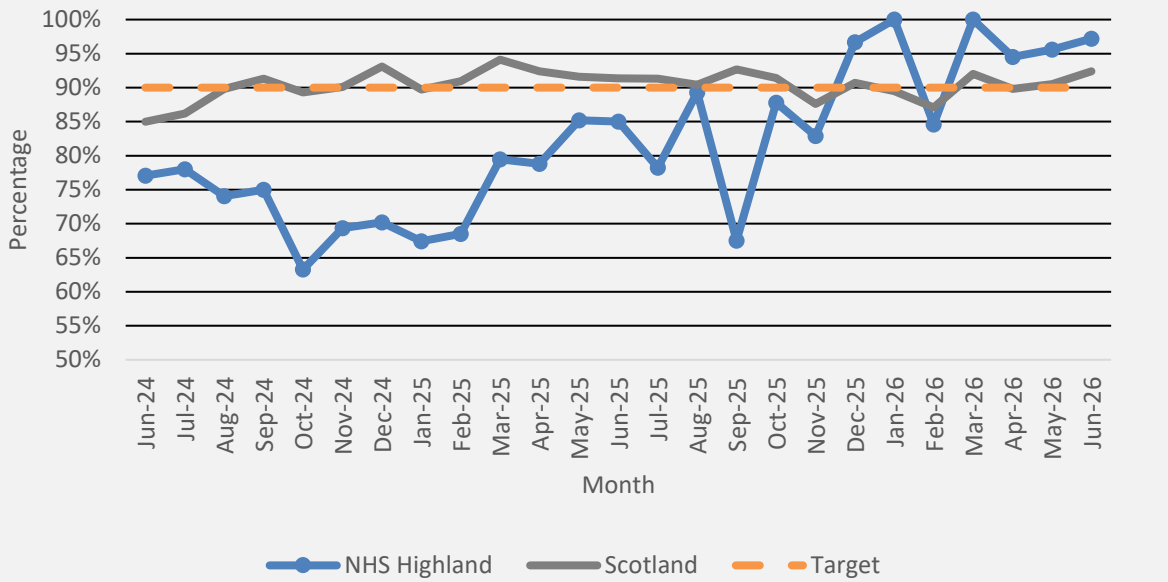
Argyll & Bute
Over this period there has been a sustained focus on RTT compliance with no breaches to wait time, though challenging due to workforce pressures.

Plans, Mitigations and Actions

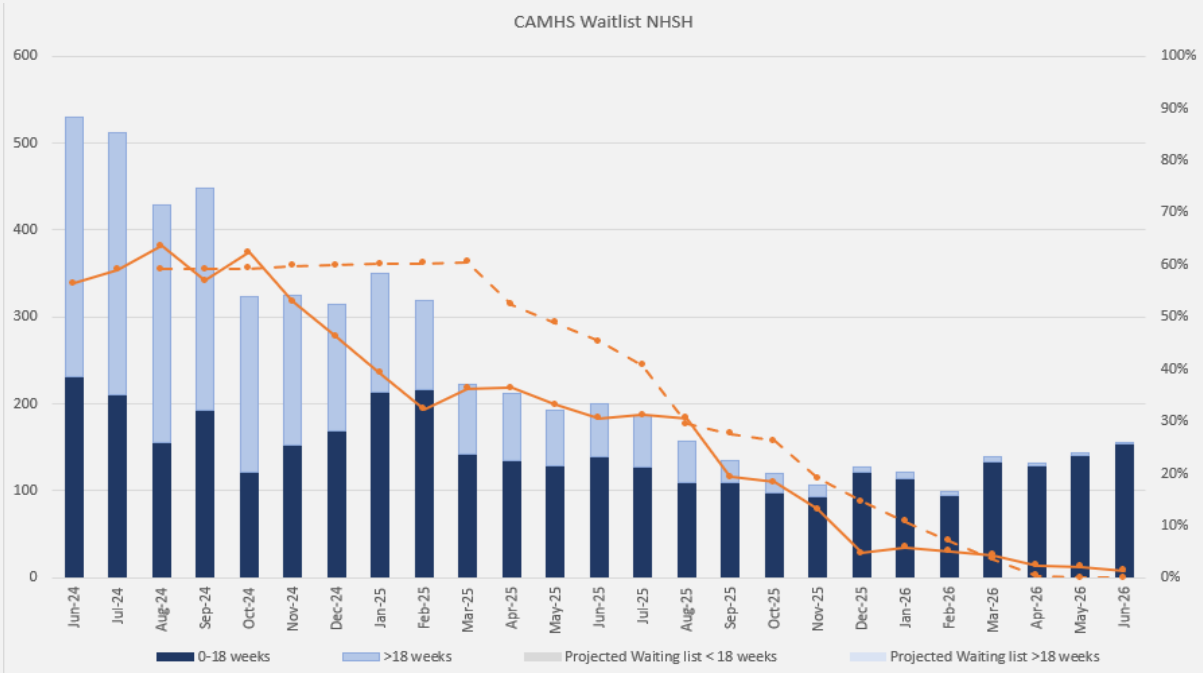
Highland
Significant demand and capacity pressures within unscheduled care and the CAMHS teams have necessitated an increased level of clinical activity by the Clinical Nurse Manager.

Argyll & Bute
Maximising staff availability across all localities has influenced performance, vacancy improvement, fixed term staff use and bank are continuous at this time.

KPI 1: CAMHS: Percentage of patients seen <18 weeks from referral



KPI 2: CAMHS: Tier 3 Waiting List (Breached and Unbreached)



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Executive Lead
Louise Bussell,
Nurse Director

Executive Lead
Evan Beswick,
Chief Officer,
A&B HSCP

Psychological Therapies Waiting Times

Strategic Objective: Our Population
Outcome Area: Live Well

Latest Performance	National Average	Board Position
85.7%	**82.3%**	**8th out of 14**

Key Performance Indicators

KPI 1: Ensure consistent achievement of the 90% 18-week access target for Psychological Therapies and eliminate >52-week waits

KPI 2: Increase the number of completed waits for Psychological Therapies services

Performance Analysis

Highland
Accepted referrals exceeded completed waits in the last reporting period. Access to treatment (RTT) has dropped to 86.4% although we remain above the national average.

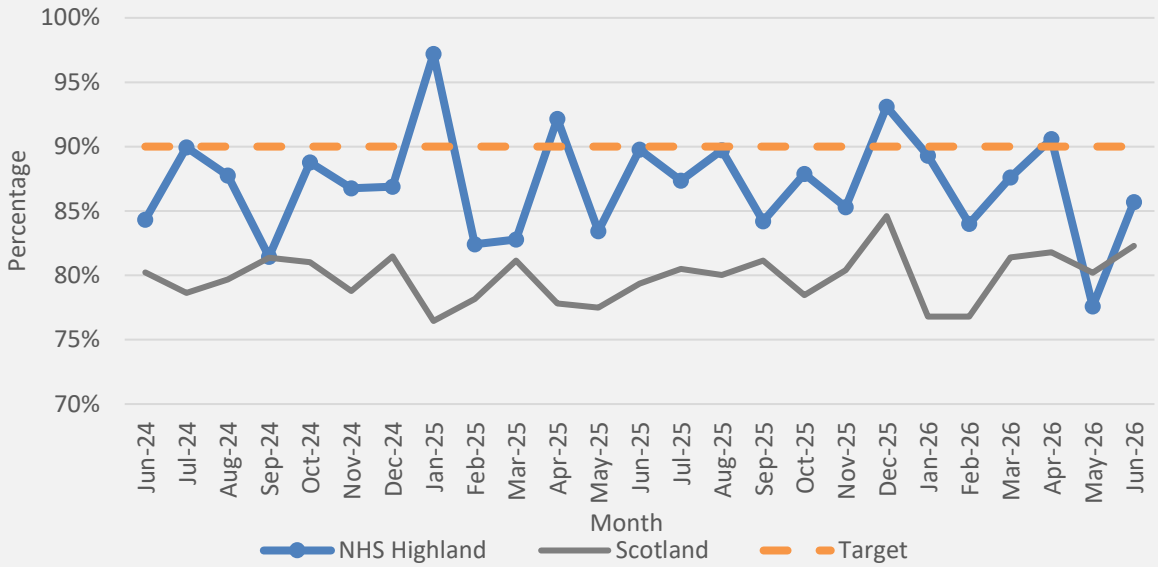
Argyll & Bute
Referrals remain consistently high. Clinical performance and output were significantly affected during the period due to high levels of sickness absence across both the Psychology and CBT teams.

Plans, Mitigations and Actions

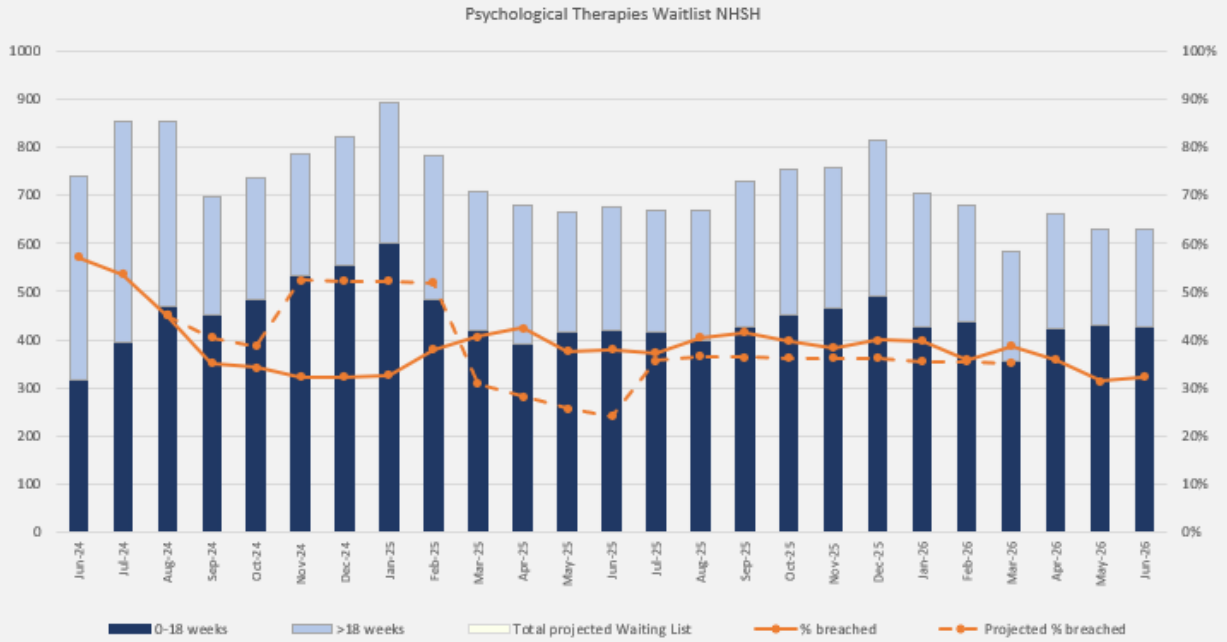
Highland
Ongoing programme to improve performance data collection, collation, and review. Monitoring staffing levels within Adult Mental Health Psychology which have breached critical floor.

Argyll & Bute
A range of measures were implemented to support service continuity and staff wellbeing. Significant managerial capacity was directed towards covering the responsibilities of vacant senior posts, ensuring essential leadership and operational functions continued despite the vacancies. While these mitigations helped maintain service delivery, they inevitably reduced capacity available for other activities and are likely to have limited overall clinical output.

KPI 1: PT: Patients seen <18 weeks



KPI 2: PT: Waiting List Size



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Executive Lead
Katherine Sutton,
Chief Officer,
Acute

New Outpatients (NOP)
(slide 1 of 2)

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
1534	N/A	N/A

Key Performance Indicators

KPI 1: Eliminate all >52 weeks waits for New Outpatient (NOP) across all specialties utilising sub-national planning, by March 2027	
KPI 2: The number of completed new outpatients appointments is equal to or exceeds the monthly target	

Performance Analysis

Highland
We remain on track with both activity and long waits. An anticipated increase in waits over 52 weeks has been seen in Q1 which will be resolved with additionality being undertaken from August.

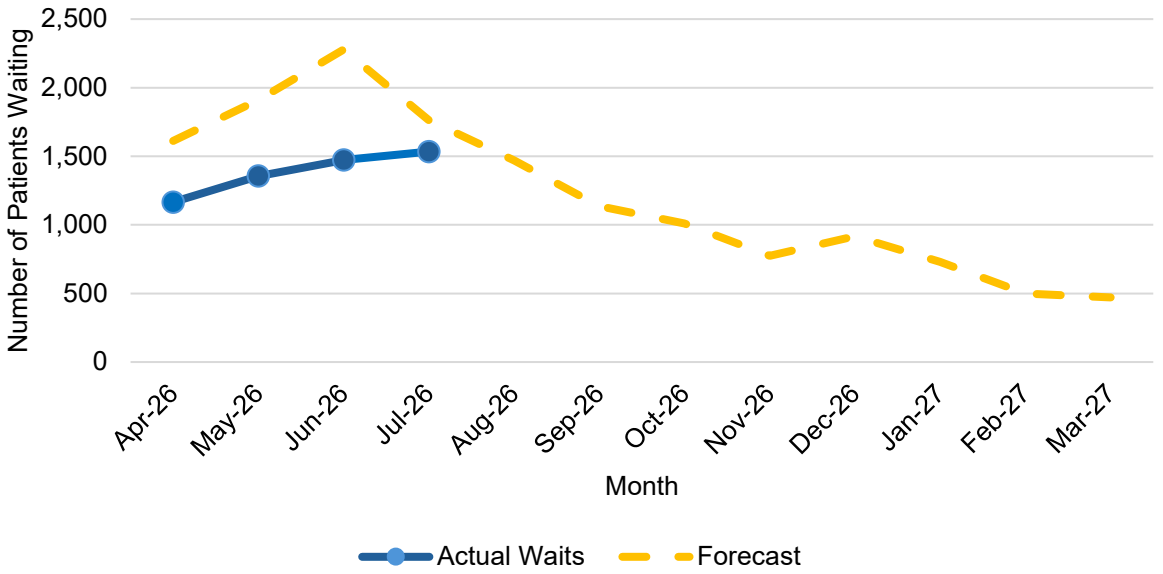
Argyll & Bute
At mid August, Argyll & Bute has 33 NOP waiting > 52 weeks. 70% of patients are awaiting a nurse led Urology appointment for which there is no local service. We will seek agency support. Orthodontic long waiting patients should clear once our newly appointed team lead takes up post in the coming month.

Plans, Mitigations and Actions

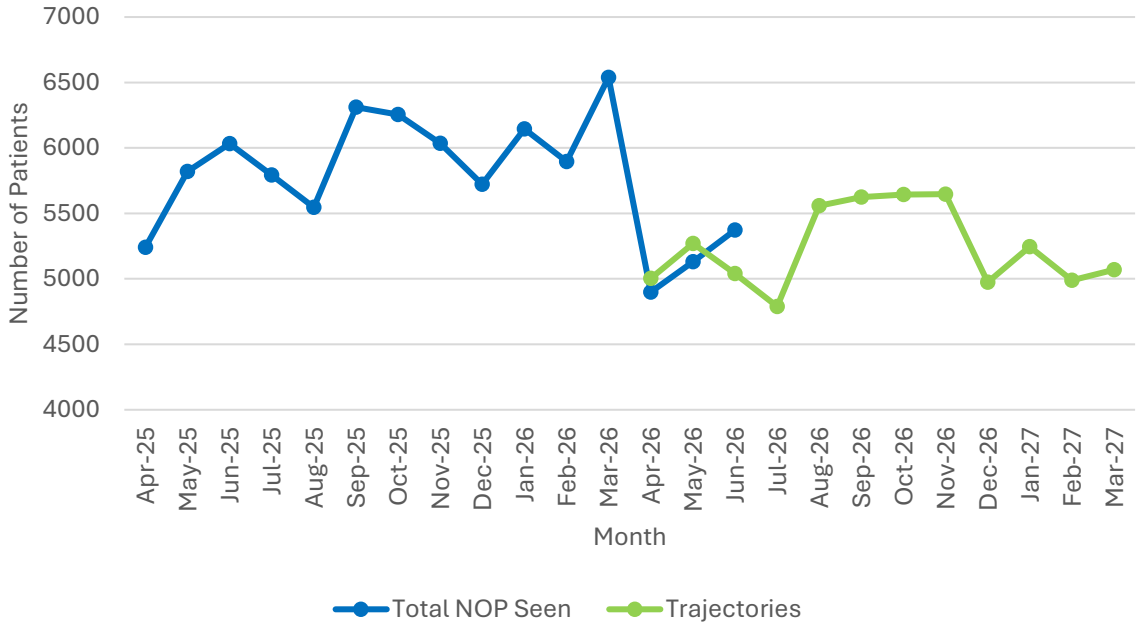
Highland
Additionality has commenced providing us with capacity. Focus on waiting list validation and booking in turn is on going.

Argyll & Bute
Work focusing on data quality including application of the local access policy will be undertaken.

KPI 1: NOP: Long Waits >52 Weeks



KPI 2: NOP: New Outpatients Seen & Trajectories



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Executive Lead
Katherine Sutton, Chief Officer, Acute

New Outpatients (NOP) (slide 2 of 2)

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
73.3%	**63.6%**	**7th out of 15**

Key Performance Indicators

KPI 3: Increase the % of patients seen less than 12 weeks to above the national target of 95%

Performance Analysis

Highland
The delay in the start of additionality in 26/27 has affected NHS Highland's performance, albeit it is still above the national average.

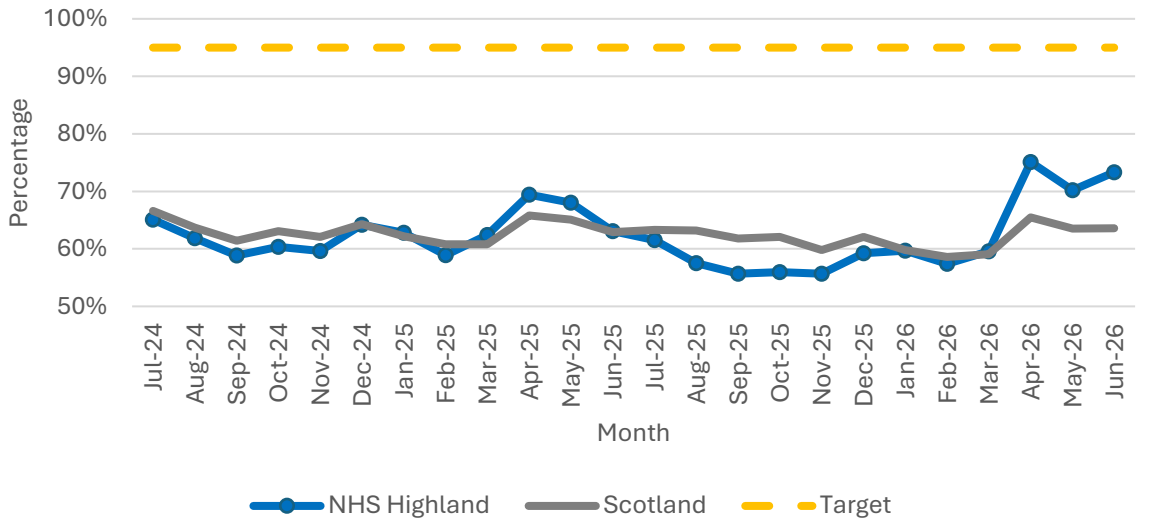
Argyll & Bute
Uncertainty around the availability of funding has meant no additional clinics have taken place as yet in Argyll & Bute.

Plans, Mitigations and Actions

Highland
Focus on booking in turn to reduce the longest waiting patients.

Argyll & Bute
Planned work to arrange additional clinics.

KPI 3: NOP: Outpatients Seen <12 Weeks (including Consultant & Nurse Lead Activity)



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Executive Lead
Katherine Sutton,
Chief Officer,
Acute

Return Outpatients

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
N/A	N/A	N/A

Key Performance Indicators

KPI 4: Total number of patients currently waiting for return outpatient appointments to be equal to or less than previous year's monthly average

KPI 5: Reduce the number of patients on the return outpatient waiting list who have not been seen within two years of their recall date

Performance Analysis

Highland
The focus continues to be new outpatients, however, we are continuing to increase the level of patient initiated returns (PIR) offered in NHSH with a 5% improvement expected this year.

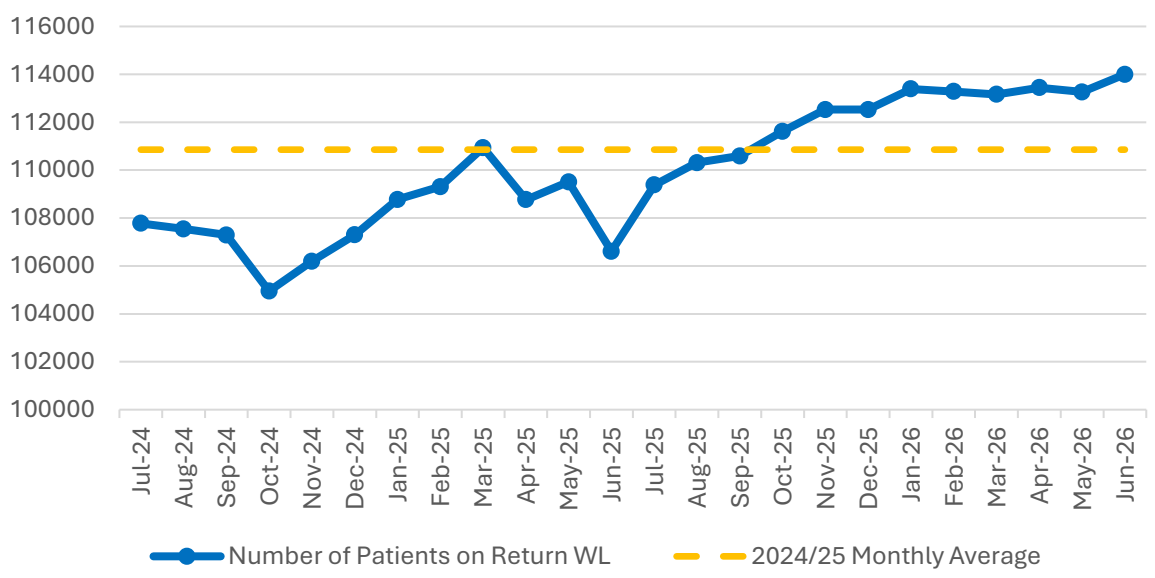
Argyll & Bute
Work to roll out Active Clinical Referral Triage / PIR being piloted.

Plans, Mitigations and Actions

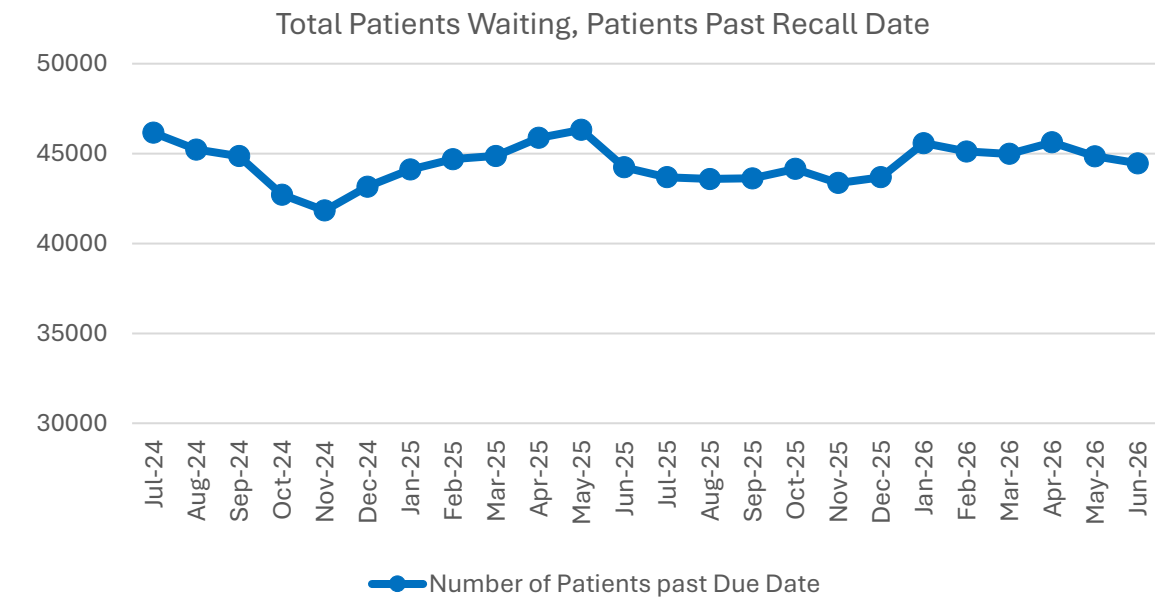
Highland
Continue to improve on PIR rates.

Argyll & Bute
Enhanced data quality.

KPI 4: NOP: Return Outpatients Wait List vs. 25/26 Average



KPI 5: Return Outpatients Wait List, Past Recall Date



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Executive Lead
Katherine Sutton,
Chief Officer,
Acute

Inpatient / Daycase (Treatment Time Guarantee - TTG) (slide 1 of 2)

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
321	N/A	N/A

Key Performance Indicators

KPI 1: Eliminate all >52 weeks waits Treatment Time Guarantee (TTG) across all specialties utilising sub-national planning, by March 2027

KPI 2: The number of completed TTG patient appointments is equal to or exceeds the monthly target

Performance Analysis

Highland
As with outpatients, we remain on track with both activity and long waits. An anticipated increase in waits over 52 weeks has been seen in Q1 which will be resolved with additionality being undertaken from August.

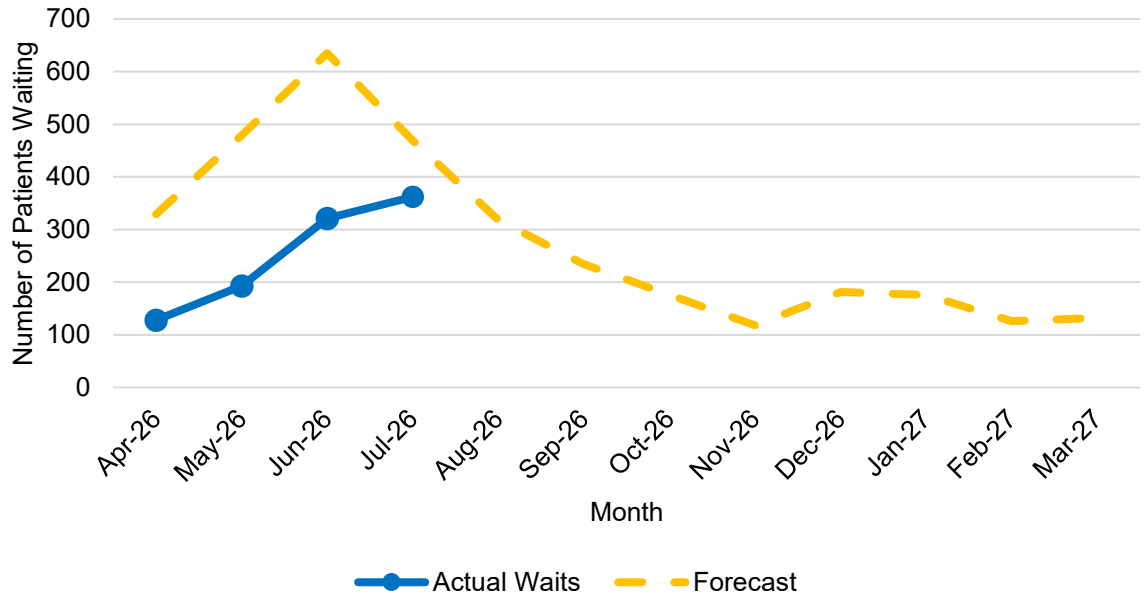
Argyll & Bute
Argyll & Bute has no long waiting TTG patients at present but forecast Oral Surgery breaches come Q4.

Plans, Mitigations and Actions

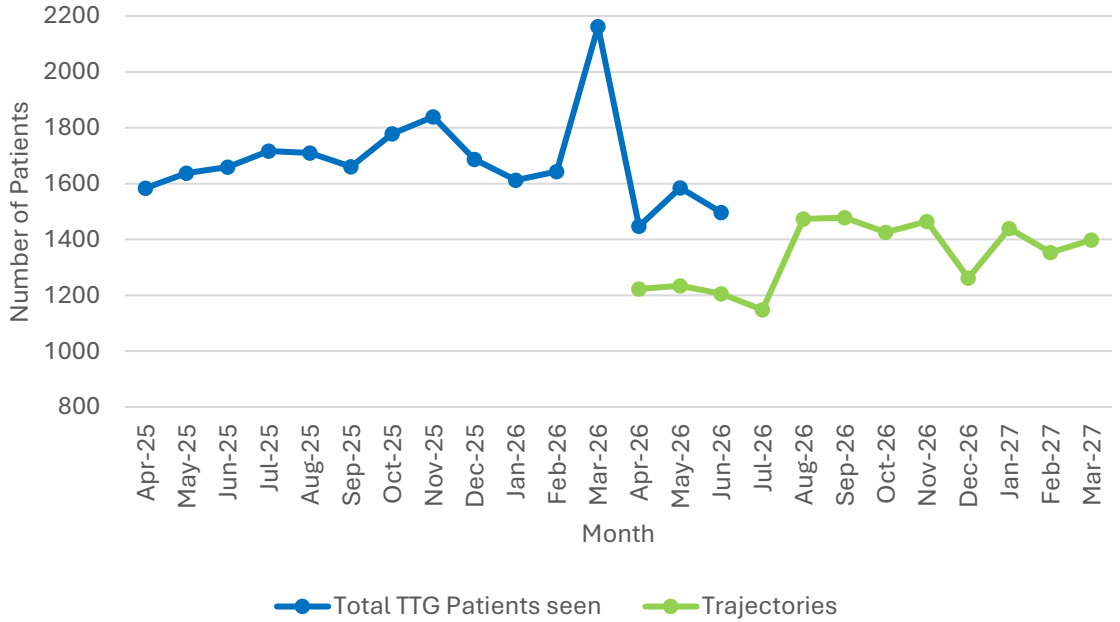
Highland
Additionality has commenced providing us with capacity. Focus on waiting list validation and booking in turn is on going.

Argyll & Bute
Local discussions around moving the oral service to sit in public dental service ongoing, agency additionality will be utilised in meantime.

KPI 1: TTG: Long Waits >52 Weeks



KPI 2: TTG: Patients Seen & Trajectories



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Executive Lead
Katherine Sutton,
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Inpatient / Daycase (Treatment Time Guarantee - TTG) (slide 2 of 2)

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
72.1%	**56.3%**	**4th out of 15**

Key Performance Indicators

KPI 3: Increase the % of patients seen less than 12 weeks to above the national target of 95%

Performance Analysis

Highland
The delay in the start of additionality in 26/27 has affected NHS Highland's performance, albeit it is well above the national average.

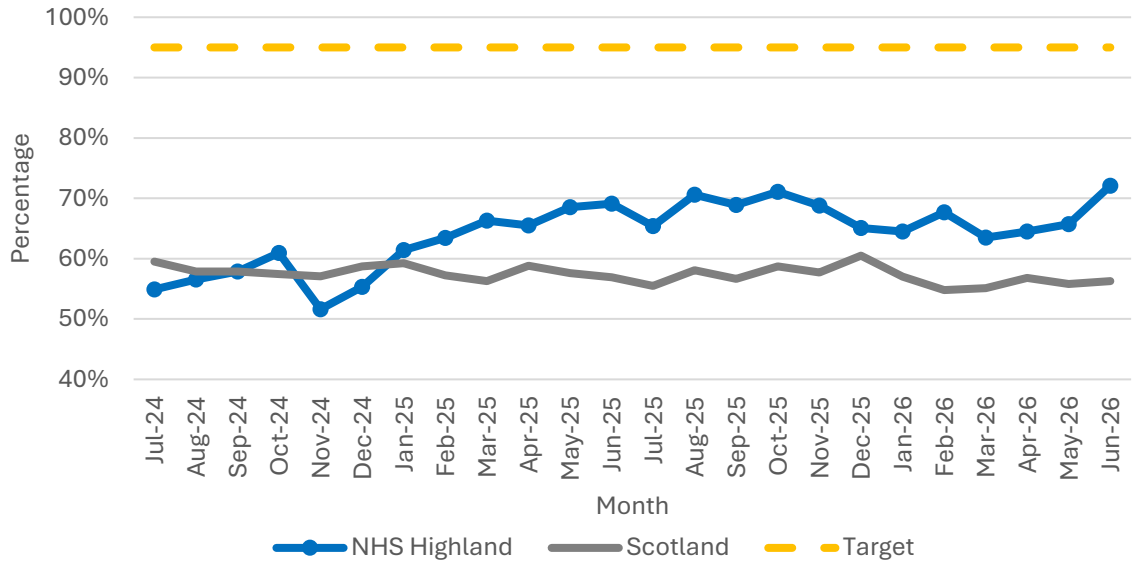
Argyll & Bute
Number of patients seen in Argyll & Bute continues to be on/above target.

Plans, Mitigations and Actions

Highland
Focus on booking in turn.

Argyll & Bute
Continue current process.

KPI 3: TTG Seen <12 Weeks



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Executive Lead
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Chief Officer,
Acute

Diagnostics - Radiology

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
78.4%	**78.6%**	**10th out of 15**

Key Performance Indicators

KPI 1: Increase the number of patients receiving a key diagnostic test within 6 weeks from referral

KPI 2: The number of patients who receive imaging (all) is equal to or exceeds the trajectory every month

Performance Analysis

Highland
Short notice restoration of mobile MRI van resulted in patients being booked out of turn. Loss of CT capacity due to scanner breakdown.

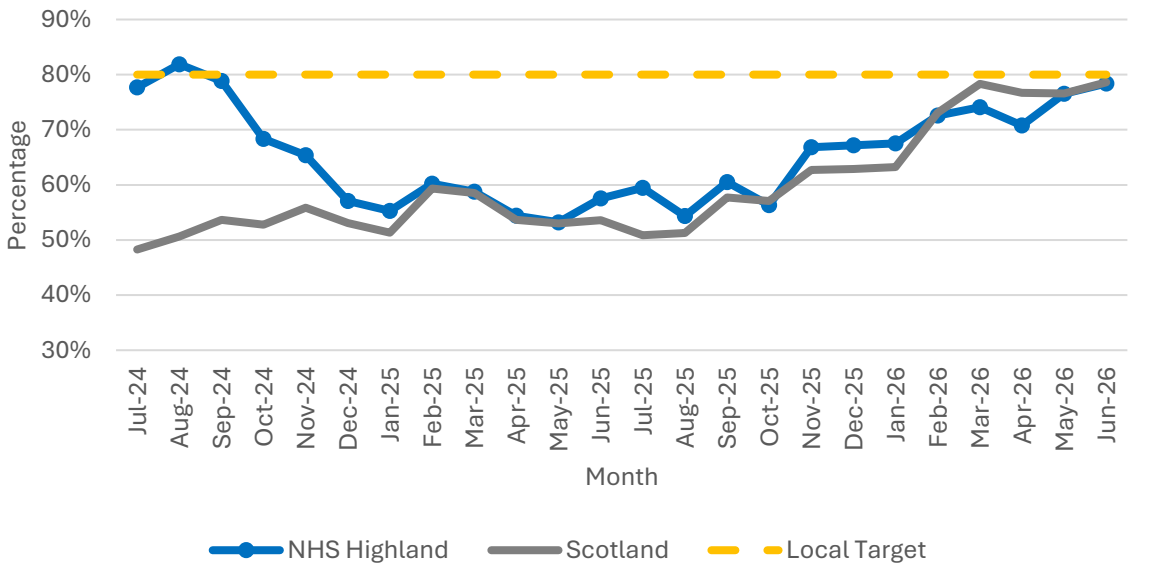
Argyll & Bute
Recent spike in US demand and reduced capacity has been impacted by vacancy and requirement for arrangement of locum cover.

Plans, Mitigations and Actions

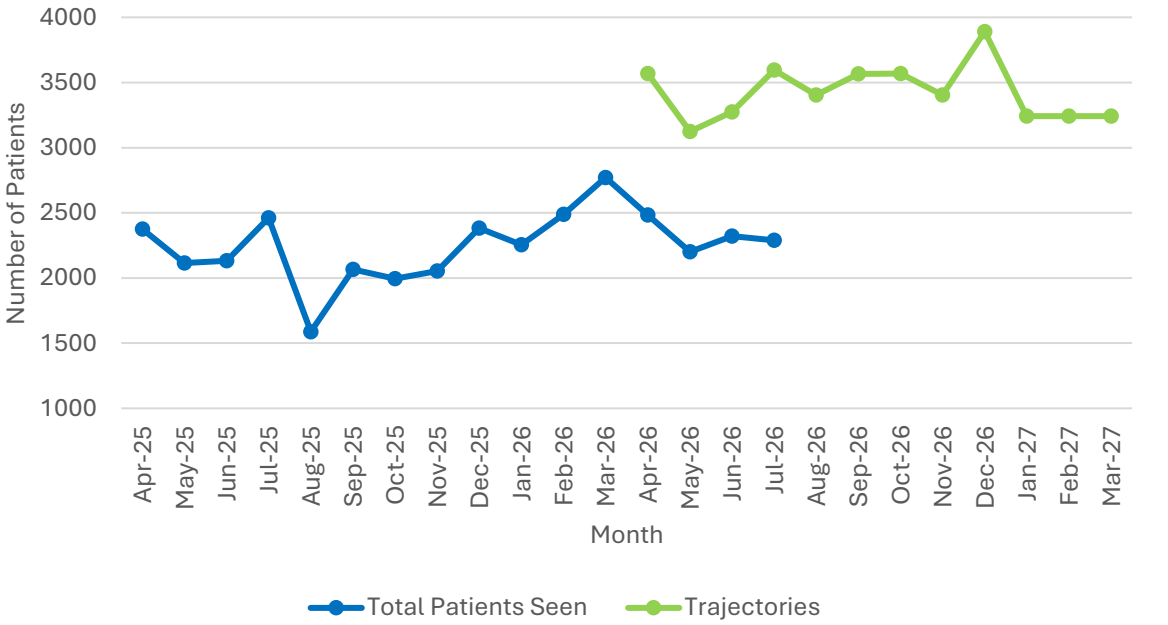
Highland
Longest waits now being addressed, lost capacity to be addressed by additional lists.

Argyll & Bute
Longest Waits – CT Cardiac we have generated extra capacity in September. US there is locum cover approval, and we have a tapestry of locums for 2 months to catch up with routine scans.

KPI 1: Radiology Imaging Tests: Maximum Wait Target 6 Weeks



KPI 2: Radiology Patients Seen & Trajectories



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Executive Lead
Katherine Sutton,
Chief Officer,
Acute

Diagnostics - Endoscopy

Strategic Objective: Our Population
Outcome Area: Treat Well

Latest Performance	National Average	Board Position
77.8%	**52.5%**	**6th out of 15**

Key Performance Indicators

KPI 1: Increase the percentage of people who receive their endoscopy within 6 weeks of referral	
KPI 2: The number of patients seen for a new endoscopy appointment is equal to or exceeds the trajectory every month	

Performance Analysis

Highland
Loss of capacity at Belford site and challenges with patients travelling to other sites in Highland.
Upcoming additional Nurse Endoscopist capacity at Raigmore will help position.
Urgent and Routine position – additionality being offered, only Raigmore site uptake thus far.

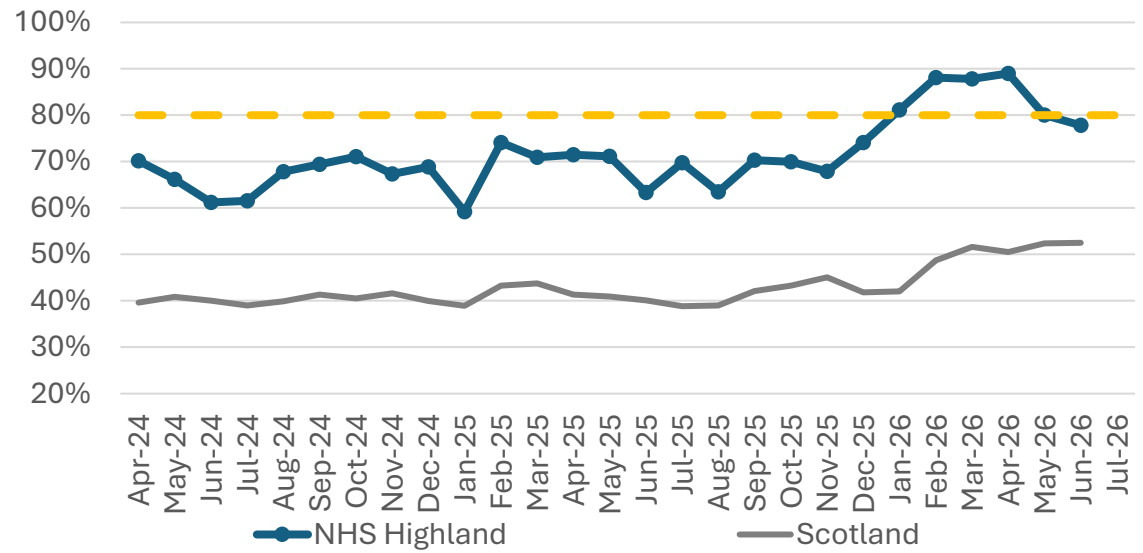
Argyll & Bute
Due to issue with washers, loss of capacity in July which has resulted in excessive waits.

Plans, Mitigations and Actions

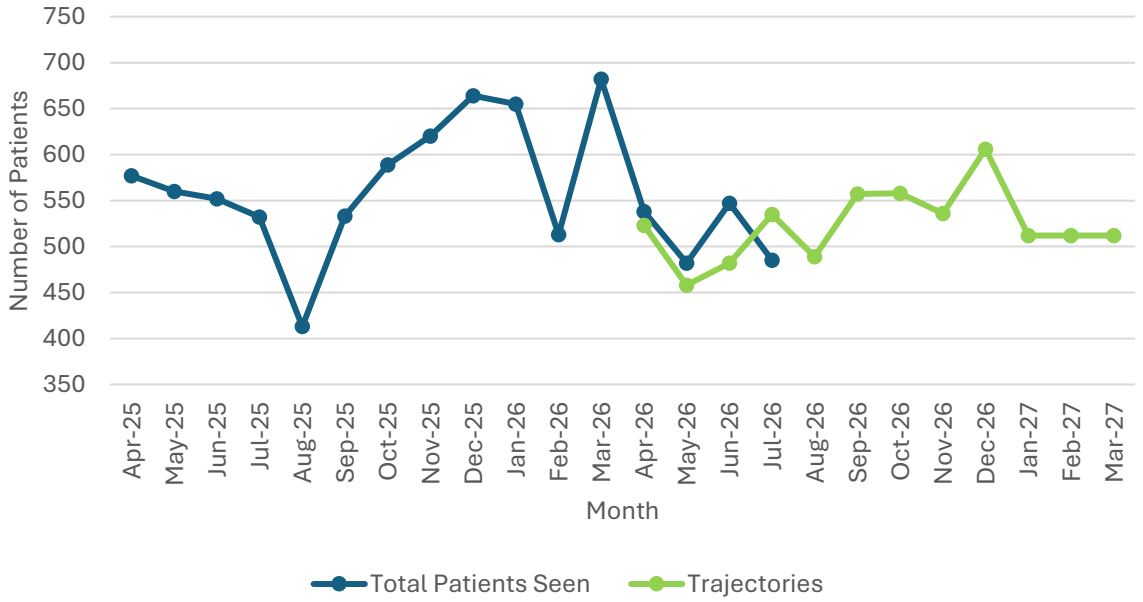
Highland
Vacancy paperwork completed for Raigmore Nurse Endoscopist through Planned Care additionality from Scottish Government. Belford – requirement for workforce and recovery plan being progressed.

Argyll & Bute
Requirement for workforce and recovery plan discussed.

KPI 1 & 2: Endoscopy Tests: Maximum Wait Target 6 Weeks



KPI 2: Endoscopy Patients Seen & Trajectories



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Acute

31 Day Cancer Waiting Times

Strategic Objective: Our Population
Outcome Area: Journey Well

Latest Performance	National Average	Board Position
88.6%	**94.4%**	**14th out of 15**

Key Performance Indicators

KPI 1: 95% of patients should begin treatment within 31 days of the decision to treat, regardless or the referral route

Performance Analysis

Highland
The gap in performance is almost entirely due to limitations in Breast Surgeon capacity and a reliance upon support from NHS Forth Valley for the provided "see and treat" service.

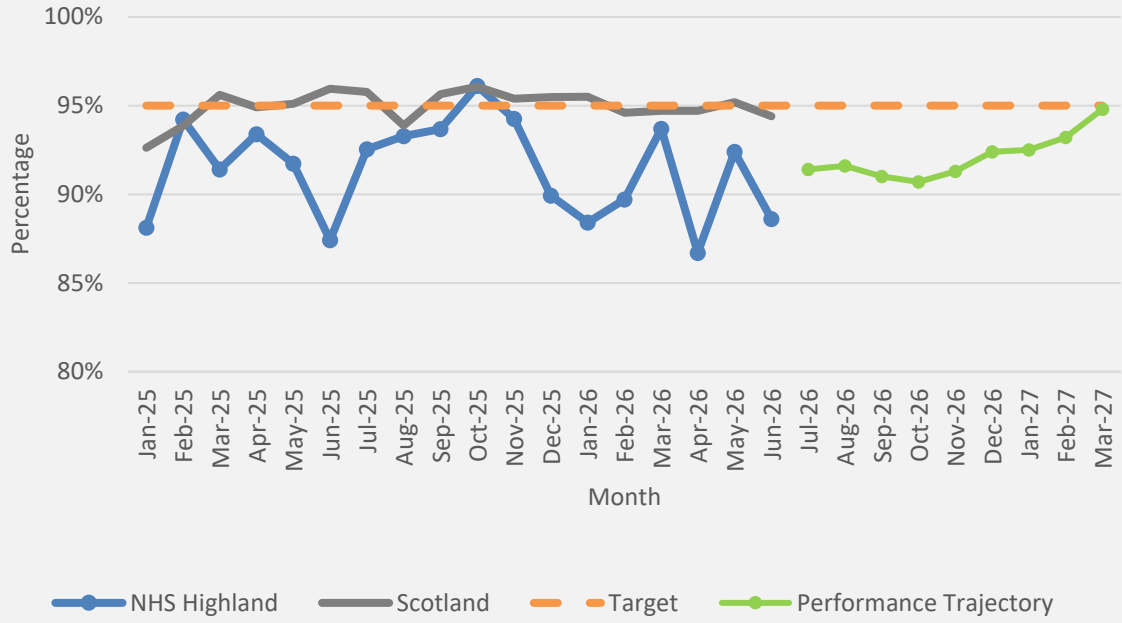
Argyll & Bute
There are no major issues within the A&B service.

Plans, Mitigations and Actions

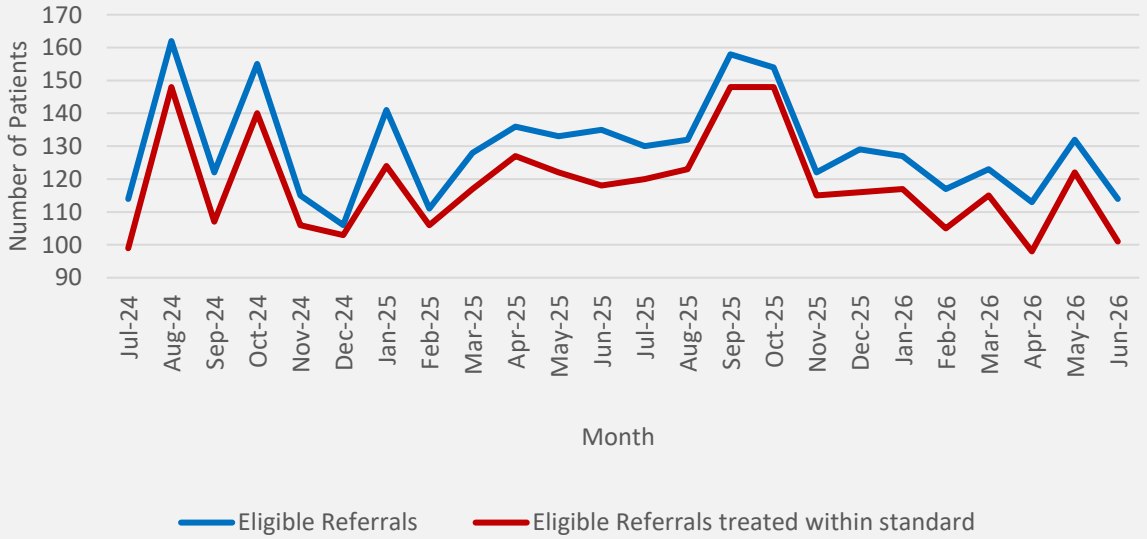
Highland
A replacement 2nd Breast Surgeon takes up post on 17 August and is expected to be able to work flexibly to undertake additional activity as required.

Argyll & Bute
None.

KPI 1: 31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



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62 Day Cancer Waiting Times

Strategic Objective: Our Population
Outcome Area: Journey Well

Latest Performance	National Average	Board Position
67.6%	**72.3%**	**9th out of 14**

Key Performance Indicators

KPI 1: Urgent Suspicion Cancer Referrals – Meet agreed improvement trajectory towards 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

Performance Analysis

Highland
A lack of radiology diagnostic capacity within the Breast Service and limited endoscopy capacity within the colorectal service are the main barriers to improved performance.

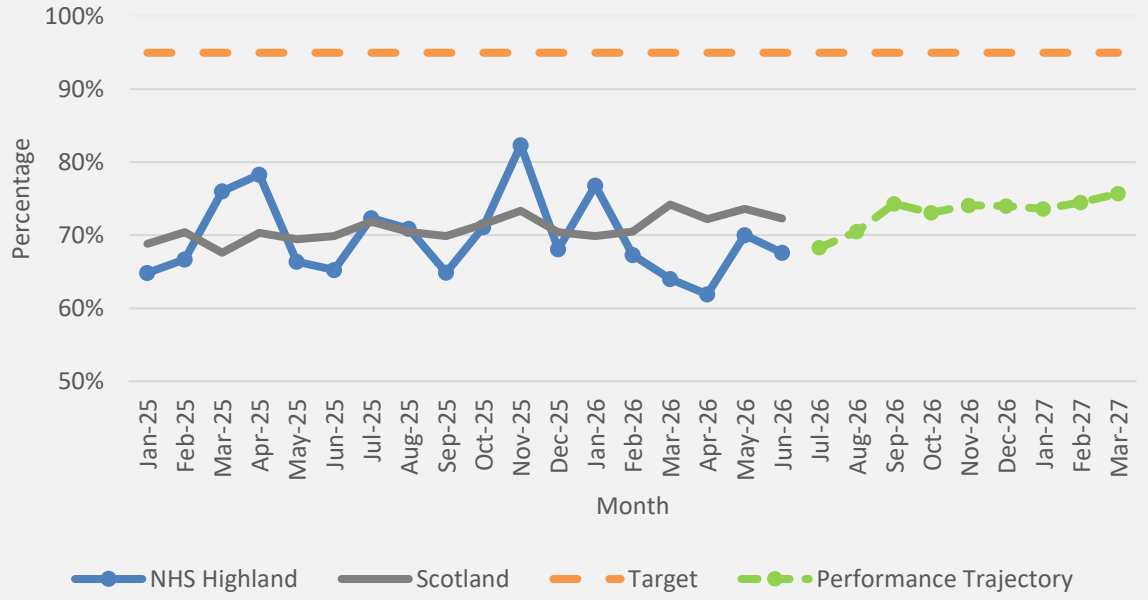
Argyll & Bute
N/A

Plans, Mitigations and Actions

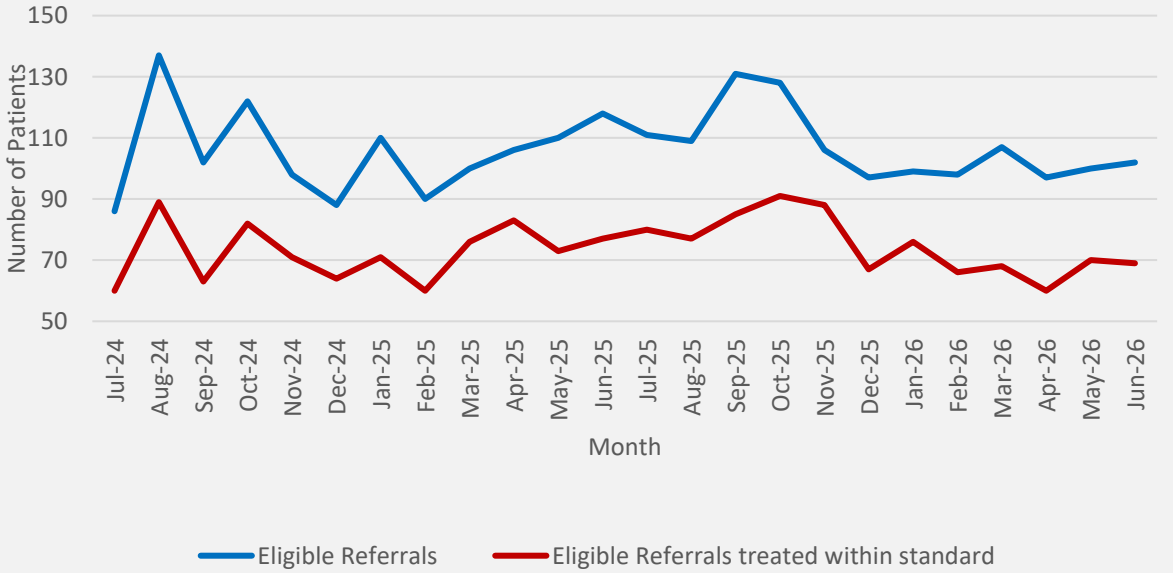
Highland
Immediate term – additional see and treat capacity from NHS Forth Valley Breast team.
Prioritisation of Urgent Suspected Cancer (USC) endoscopy activity.
Medium/Long Term - the appointment of a non consultant workforce to add to the diagnostic team.

Argyll & Bute
N/A

KPI 1: 62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



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Systemic Anti Cancer Therapy (SACT) & Radiotherapy Average WTS

Strategic Objective: Our Population
Outcome Area: Journey Well

Latest Performance	National Average	Board Position
SACT – 24 days **RT – 40 days**	**N/A**	**N/A**

Key Performance Indicators

KPI 1: The average waiting times for SACT as 1st Treatment, Radiotherapy as First Treatment and SACT patients overall (new and subsequent) will be no more than 28 days

Performance Analysis

Highland
Significant lack of radiotherapy capacity due to reduced capacity due to unexpected absence in oncology team.

Argyll & Bute
N/A

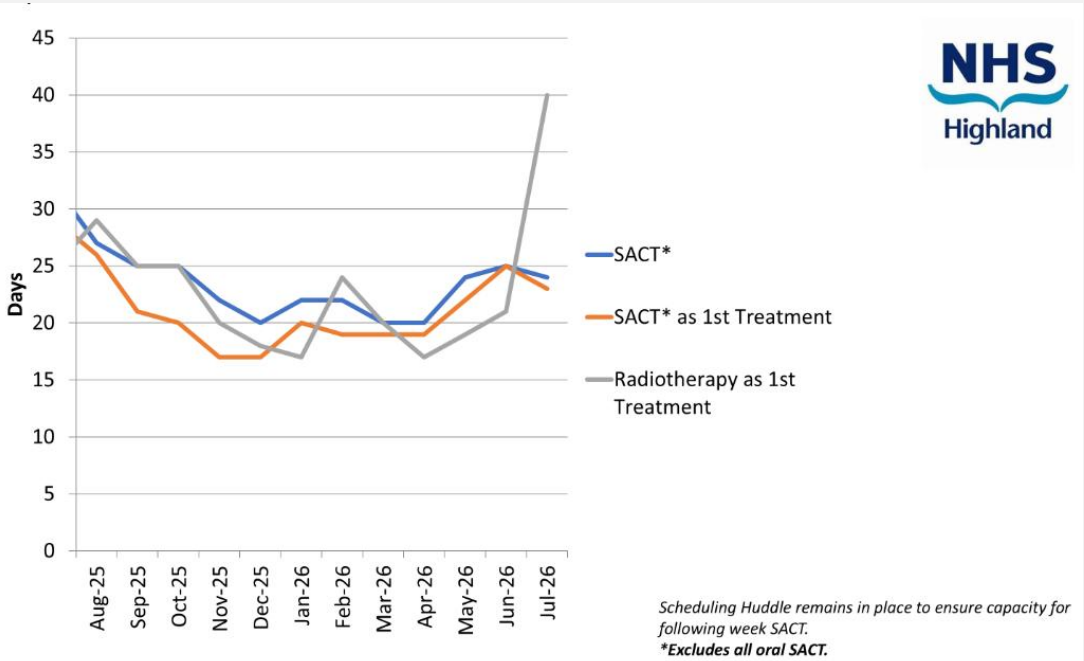
Plans, Mitigations and Actions

Highland
Implementation of mutual aid and other support under the auspices of the National Oncology Co-ordinating Group.

Argyll & Bute
N/A

KPI 1: Systemic Anti Cancer Therapy (SACT) and Radiotherapy Average Waiting Times by Month

ONCOLOGY



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Emergency Department Access

Strategic Objective: Our Population
Outcome Area: Respond Well

Latest Performance	National Average	Board Position
81.8%	**69.1%**	**6th of 14**

Key Performance Indicators

KPI 1: Achieve 75.3% of the ED target for the number of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2027

KPI 2: Reduce the number of patients waiting >12 hours in A&E by March 27 to zero

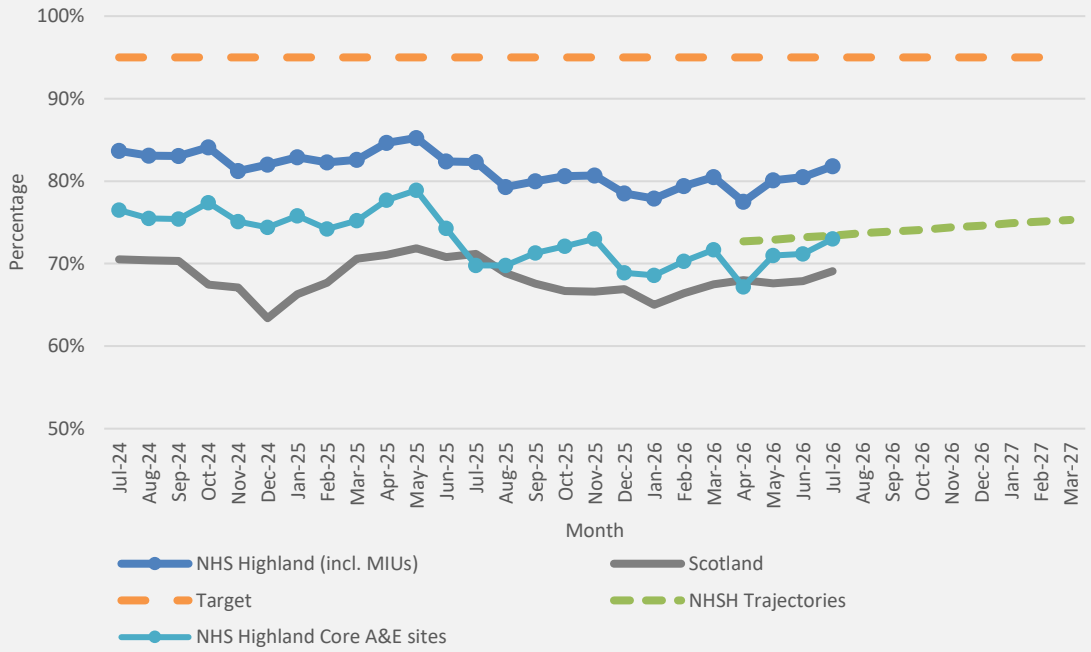
Performance Analysis

Raigmore - Performance remains under pressure, with the latest result at **60.7%** amid high attendance levels. Recent variation suggests demand may be contributing to the challenge, although performance has remained broadly stable overall.
Belford: Bed shortages and specialist input delays continue to compound breach issues; however, 4-hour performance has improved significantly since April, from just below 80% to just above 86% in July with 12 hour breaches at 0.5% in July.
Caithness: ED continues to be affected by inpatient capacity and patient flow pressures. Despite this, 4-hour performance improved from 72.2% to 77.6% between April and July 2026, while 12-hour breaches reduced from 106 to 81.
Lorn & Islands: Significant gaps within social work staffing, home care availability impacting on delayed discharges, which impacts on bed flow. Our performance is maintained over 90% but dipped recently.

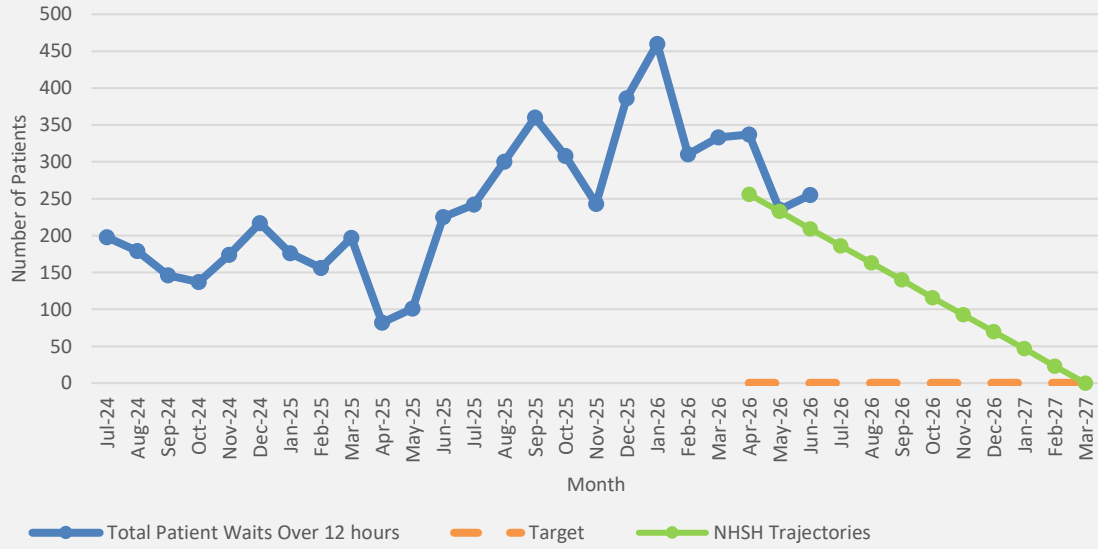
Plans, Mitigations and Actions

Highland - At Raigmore, improvement work continues to strengthen patient flow, support timely clinical decisions, improve ambulance TAT, reduce hospital LoS and reduce avoidable delays.
Belford: Current improvement work is focusing on flow and triage. Discussions have also begun on developing and opening an SDEC unit.
Caithness: Improvement work remains focused on discharge coordination, patient flow and Same Day Emergency Care pathways.
Lorn & Islands: Discussions on going to taking forward SDEC and how to embed Hospital at Home.

KPI 1: % of People seen in ED within <4 hours per month inc Minor Injury Units



KPI 2: Total Patients waiting >12 hours in ED per month



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SAS Turnaround Times

Strategic Objective: Our Population
Outcome Area: Respond Well

Latest Performance	National Average	Board Position
00:32:32	**00:49:20**	**4th of 11**

Key Performance Indicators

KPI 1: Reduce the ambulance turnaround time to target levels by March 2027

Performance Analysis

Highland: Average Turnaround Times reset in April 2026 to post winter levels however continues at 55mins, 4mins slower than 2024/25, indicating longer handover delays and reduced operational efficiency. Lost Operational Ambulances Hours remain elevated compared to the same period last year, showing a worsening operational position and more lost ambulance capacity. Further targeted action is needed to reduce ambulance patients waiting **over 1 hour.**

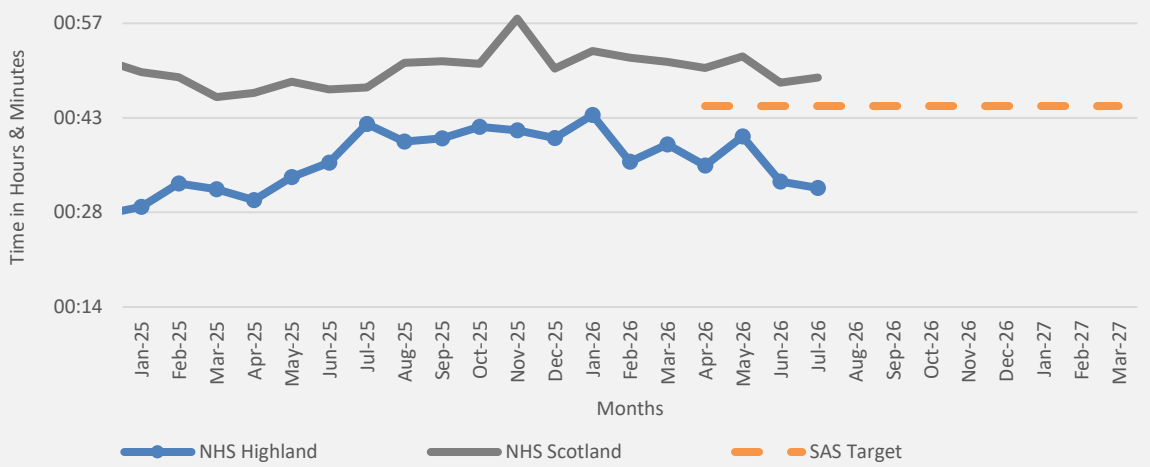
Argyll & Bute: Performance for A&B is similar to that of Highland.

Plans, Mitigations and Actions

Highland: SDEC Low Risk Chest Pain Pathway in development for patients attended to by SAS – 1st Oct 26. Working with FNC to develop alternative Pathway options to open up access route for SAS to refer into NHSH. Test of change extended to help schedule patients taken by ambulance to GA. Continue to work Raigmore Hospital to develop improvement trajectory for Ambulance Handover Times in line with NHS Scotland Chief Operating Officer Letter. Ongoing work with Hospital at Home Team to explore Paramedic role within the Service Delivery model to provide a sustainable and scalable workforce.

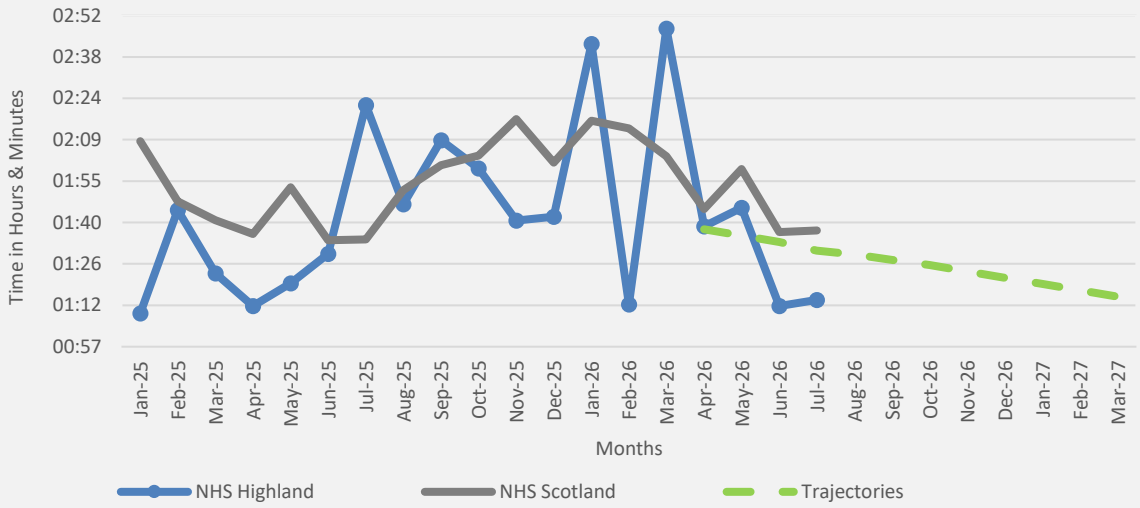
Argyll & Bute: Reduction in response times is needing to be investigated and actioned, but this comes down to the geographics. In September A&B will be trialling a transfer vehicle which will make the emergency vehicles more available for priority calls.

KPI 1: SAS Turnaround (Median)



* Median measure aligned with Chief Operating Officer of NHS Scotland

KPI 1: SAS Turnaround (90th Percentile)



* 90th Percentile measure agreed by Centre for Sustainable Delivery (CfSD)

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Executive Lead
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Delayed Discharges

Strategic Objective: Our Population
Outcome Area: Respond Well

Latest Performance	National Average	Board Position
239 (June 2026)	N/A	14th out of 14

Key Performance Indicators

KPI 1: Reduce the total number of patients experiencing delay in discharge from hospital across NHS Highland to agreed trajectories	18 off target

Performance Analysis

Highland
Overall delayed hospital discharges for North Highland remain over 200 with top three delay reasons being requirement for Care Home, Care at Home and Assessment.

Argyll & Bute
Argyll & Bute continues to focus on early prevention and "home first" practices, through dedicated MDTs and discharge to assess principles/pilots.

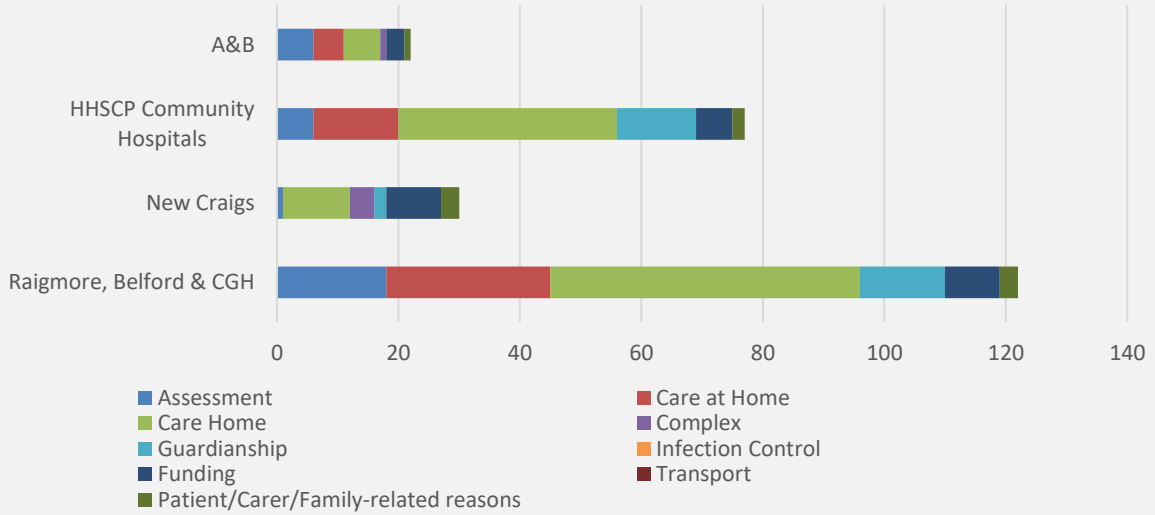
Plans, Mitigations and Actions

Highland
Focus on accelerated delivery of Home First / Discharge to Assess across North Highland from August to November, to target people in delay awaiting assessment. Development through organisational change processes of an Integrated Discharge Team in progress with key performance metrics based on Discharge Without Delay (DWD) programme monthly reporting, including reduction of people in delay.

Argyll & Bute
Care at Home remains the biggest challenge to progress in respect of delayed discharge progress. A revised dashboard with locality-based trajectories has been revised and will be used to focus on locality-based management of delays, which in turn supports whole HSCP improvement. Planned Date of Discharge (PDD) practice requires further work, and we continue to focus on this through DWD improvement.

KPI 1: 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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Executive Lead Evan Beswick, Chief Officer, A&B HSCP

Executive Lead Arlene Johnstone Chief Officer, HHSCP

Executive Lead Katherine Sutton, Chief Officer, Acute

Vaccinations

Strategic Objective: Our Population Outcome Area: Stay Well

Latest Performance	National Average	Board Position
Childhood (6 in 1 at 12 months)	93.2% (Q end Mar 26)	91.9% (Rank – 10/14)
COVID-19 (Spring 2026)	58.6% (End of season)	55.6% (Rank – 11/14)
RSV (Mat & older adult – Aug 2026)	62.6% (M) 33.2% (OA)	66.1% (6/14 M) 37.8% (6/14 OA)

Key Performance Indicators

Ensure that delivery of key programmes meets the required levels of uptake

Performance Analysis

- The maternal RSV programme is becoming more embedded with vaccination uptake increasing over time. The maternal RSV vaccination uptake in May 2026 was 74.4% for A&B and 64.1% for Highland. This compares against a Scottish average of 62.6%. Early evidence across Scotland has highlighted that infants under three months of age whose mothers were vaccinated had around 80% reduced risk of hospitalisation due to RSV infection compared to infants whose mothers were unvaccinated.
- The opportunity to co-administer RSV and Influenza as part of the spring programme across A&B HSCP has worked extremely well although final performance is awaited. An evaluation is planned with input sought from PHS to support consistency with other boards who progressed this approach.

Plans, Mitigations and Actions

- Childhood immunisations: Following the national incident affecting the new child health system, a targeted piece of catch-up work is in development to further drive uptake. In addition, a targeted piece of work has been instigated across A&B HSCP to increase primary immunisation uptake rates.
- Influenza: As part of a Scotland wide research project, there is a pilot project in development with PHS looking at ways to increase flu vaccination in at-risk cohorts such as those with chronic liver disease. However, there will be opportunities to drive uptake more broadly than flu vaccination.
- RSV: With regards the maternal programme, the performance and clinical impact has been shared with teams to further support midwives to promote this relatively new vaccination programme to pregnant women and to celebrate success across the maternal programmes.

Figure 1: Maternal RSV immunisation uptake by partnership and Scotland for 2026

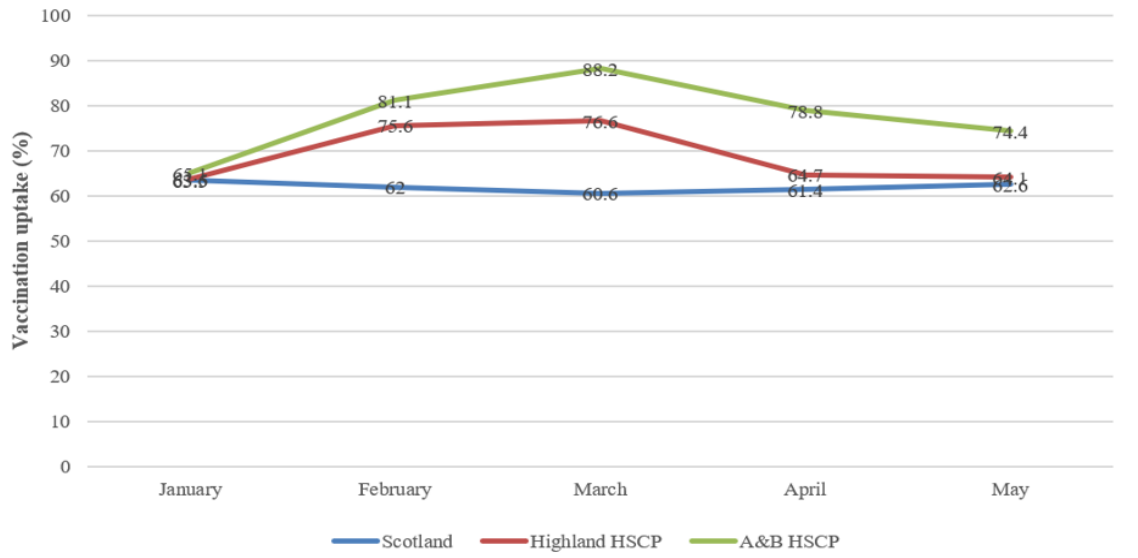
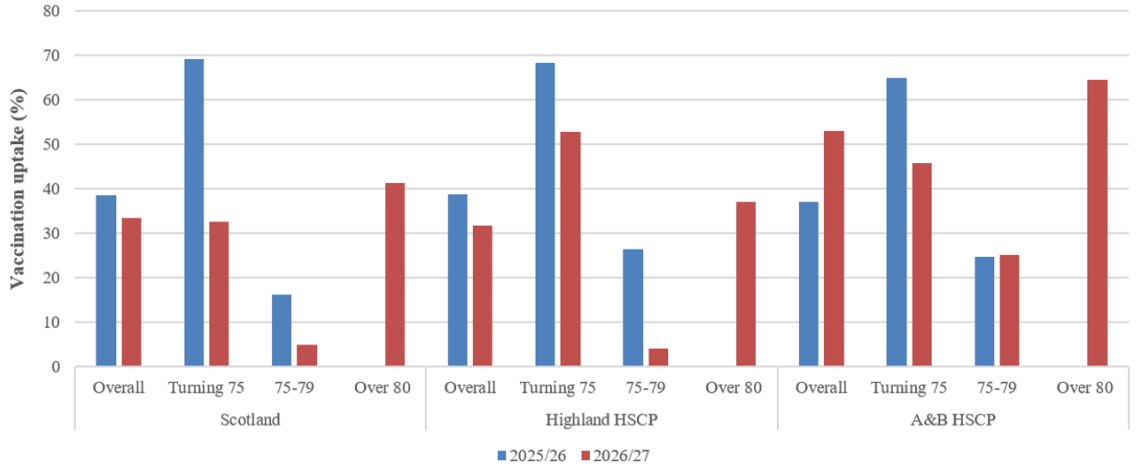


Figure 2: Older adult RSV uptake by cohort and partnership for 2025 and 2026



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Executive Lead
Jennifer Davies, Director of Public Health

Screening

Strategic Objective: Our Population
Outcome Area: Stay Well

Latest Performance	National Average	Board Position
AAA Uptake (87.3% vs 85% target) Bowel Uptake (68.8% vs 60% target) Cervical Coverage (59.3% vs 80% target)	AAA Uptake (84.8%) Bowel Uptake (65.2%) Cervical Coverage (55.3%)	Better than national average level

Key Performance Indicators

Increase uptake to close the gap with national targets and between SIMD groups

Performance Analysis

NHS Highland screening uptake remains broadly higher than the Scottish average across a number of established screening programmes, although variation persists between programmes and deprivation groups. Reducing inequalities in uptake remains a key priority, with the greatest challenges continuing to be seen in more deprived communities.

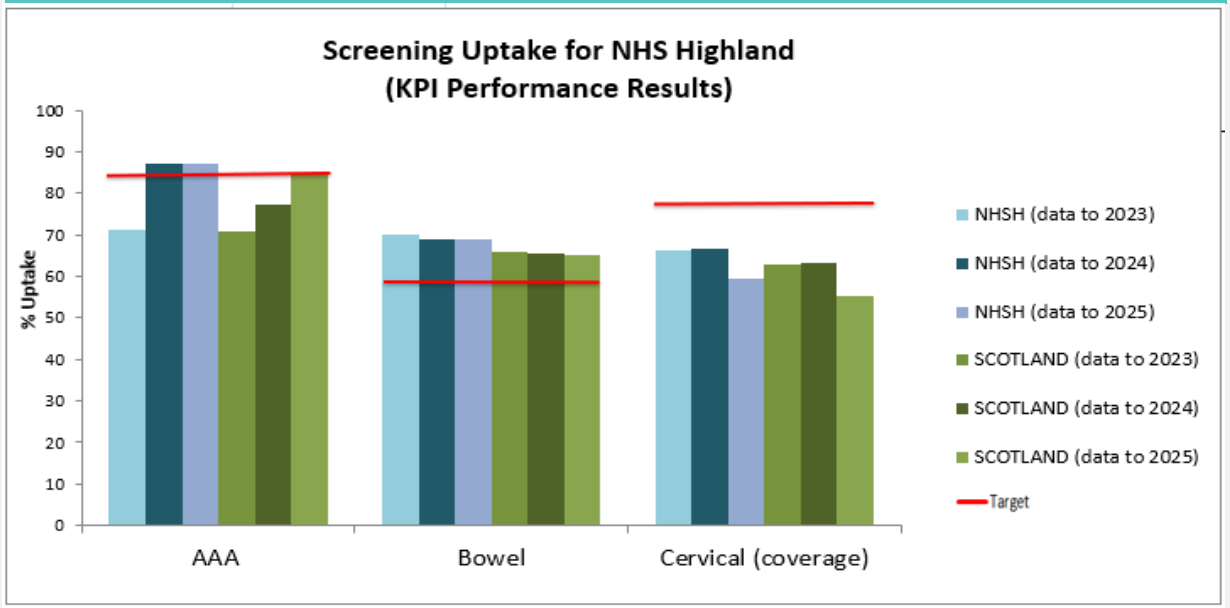
Performance monitoring continues to support local improvement. However, some national screening datasets remain subject to publication delays and data quality issues. Internal monitoring data is therefore used to identify areas requiring targeted intervention and support.

A national decreasing trend in cervical uptake is seen. The data is impacted by the transition to HPV testing when women transferred from a three to five-year recall. It is not possible to distinguish between these groups in the dataset. This will stabilise next year when all women will be on 5-year recall.

Plans, Mitigations and Actions

- Targeted improvement work will continue through the NHS Highland Screening Inequalities Plan, focusing on increasing uptake in lower-performing groups and reducing variation between SIMD populations. Community engagement and awareness activity will continue across priority areas.
- Performance monitoring through national publications and local management information, with actions refined as new data becomes available and any emerging risks identified.

KPI 1: Screening Uptake for NHS Highland (KPI Performance Results)



Inequality in Screening Most recent Performance Result for NHS Highland & Scotland for least and most deprived SIMD areas

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Jennifer Davies, Director of Public Health

Smoking Cessation

Strategic Objective: Our Population
Outcome Area: Stay Well

Latest Performance	National Average	Board Position
60 quits in Q3 of 2025/26	53.8% of annual target achieved by end of Q3	4th out of 14 62.8% of annual target achieved by end of Q3

Key Performance Indicators

Delivery on national targets for smoking cessation interventions for the 40% most deprived areas (as measured by 12 weeks quits) of 84 per quarter

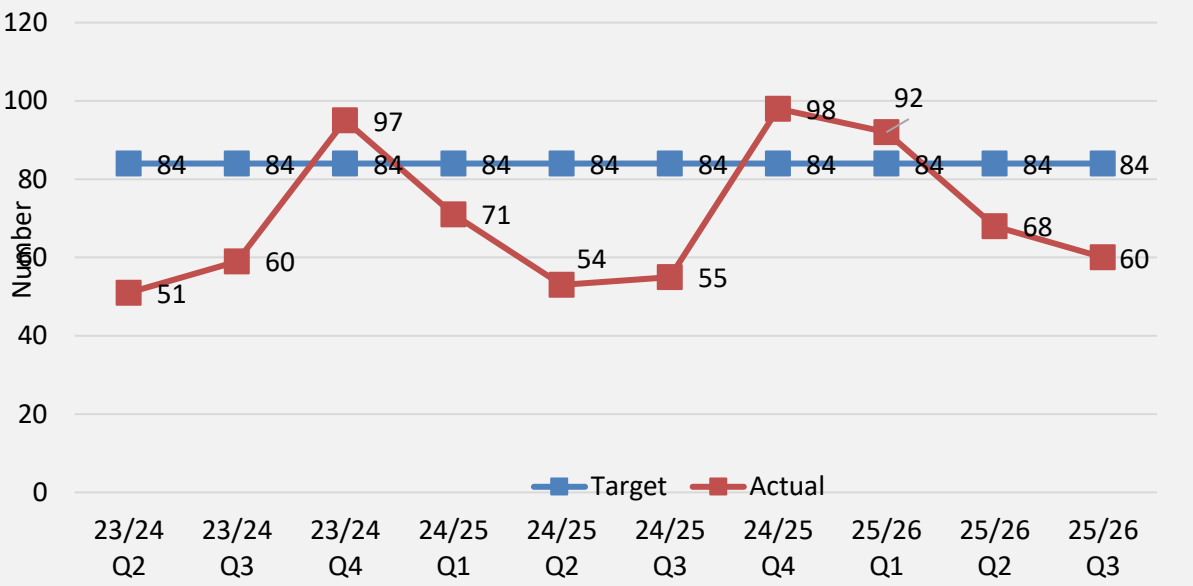
Performance Analysis

All quarters this year shows an improved position compared to the same time in previous 2 years. At the end of Q3 25/26, only 2 out of 14 NHS Boards were on target to meet their annual target. Highland is 4th out of the 14 boards, above the national average.

Plans, Mitigations and Actions

- By the end of 2026, a service evaluation report will be produced to assess the efficiency, effectiveness, and value for money of the NHS Highland Smoking Cessation Service, and its responsiveness to population need and health inequalities. It will identify opportunities for quality improvement. Consultation with staff via interviews has been completed.
- Ongoing missing follow up data is being reviewed however there is a delay in the data being updated due to capacity issues across the team.
- Annual Highland Smoking Cessation Service Development Day planned for 22 September 2026. The agenda includes presentations from smoking cessation midwives and community pharmacy representatives, workshops on progress against Highland Tobacco and Vaping Strategy actions, updates from the Raigmore pilot review, and smoke-free homes resources development.

KPI 1: 12 Week Quits by Quarter for NHS Highland



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Breastfeeding

Strategic Objective: Our Population
Outcome Area: Stay Well

Latest Performance	National Average	Board Position
KPI 1 – 27.5%	**25.6%**	**10 out of 14**

Key Performance Indicators

Reduce the attrition rate of any breastfeeding at 6-8 weeks by 25% by 2030/31

Performance Analysis

NHS Highland continues to monitor progress against the national breastfeeding improvement trajectory. Recent HEYS data shows improving any breastfeeding rates at 6–8 weeks, which is expected to contribute positively towards the national stretch aim. Ongoing analysis is informing targeted improvement activity to address variation and reduce inequalities in breastfeeding outcomes.

Plans, Mitigations and Actions

- Continue targeted improvement activity to improve breastfeeding outcomes and reduce inequalities, informed by HEYS data and local quality improvement work.
- Deliver priorities within the national Breastfeeding and Infant Feeding Strategic Framework.
- Progress UNICEF Baby Friendly Initiative activity and strengthen team capacity to support sustainable improvement
- Ongoing work towards filling vacant and maternity posts

KPI 1: Progress towards drop-off target – NHS Highland

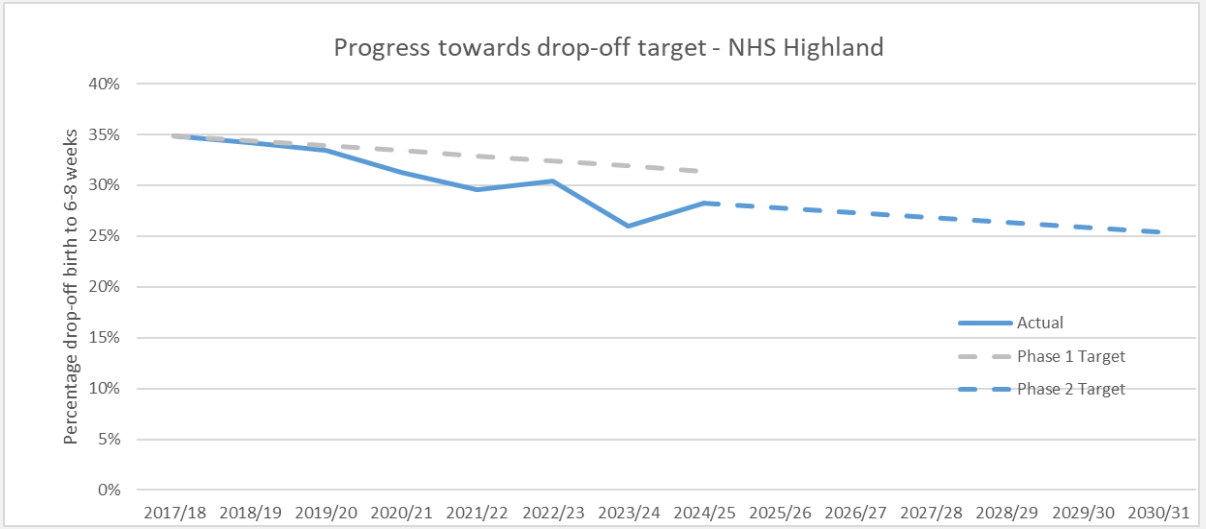


Figure 2: HEYS breastfeeding data for Highland

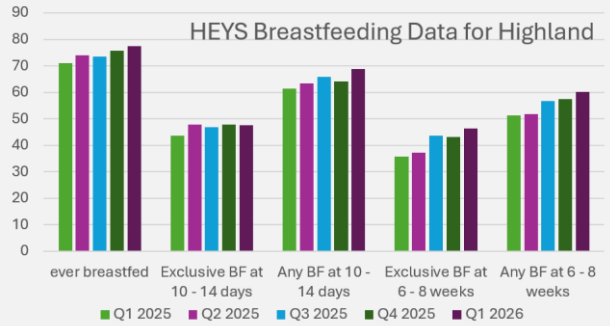
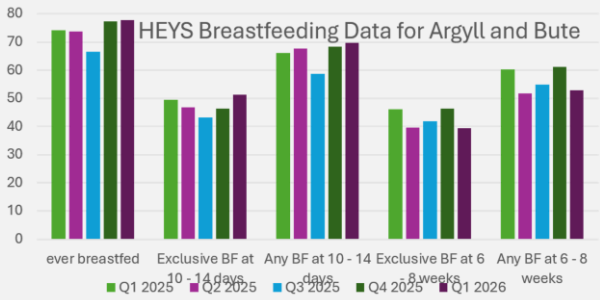


Figure 3: HEYS breastfeeding data for Argyll & Bute



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Drug & Alcohol Recovery (DARs)

Strategic Objective: Our Population
Outcome Area: Stay Well

Latest Performance	National Average	Board Position
88.7%	92.4%	N/A

Key Performance Indicators

Achieve 90% of clients referred to DARS commencing treatment within 3 weeks sustainably by March 2027

Performance Analysis

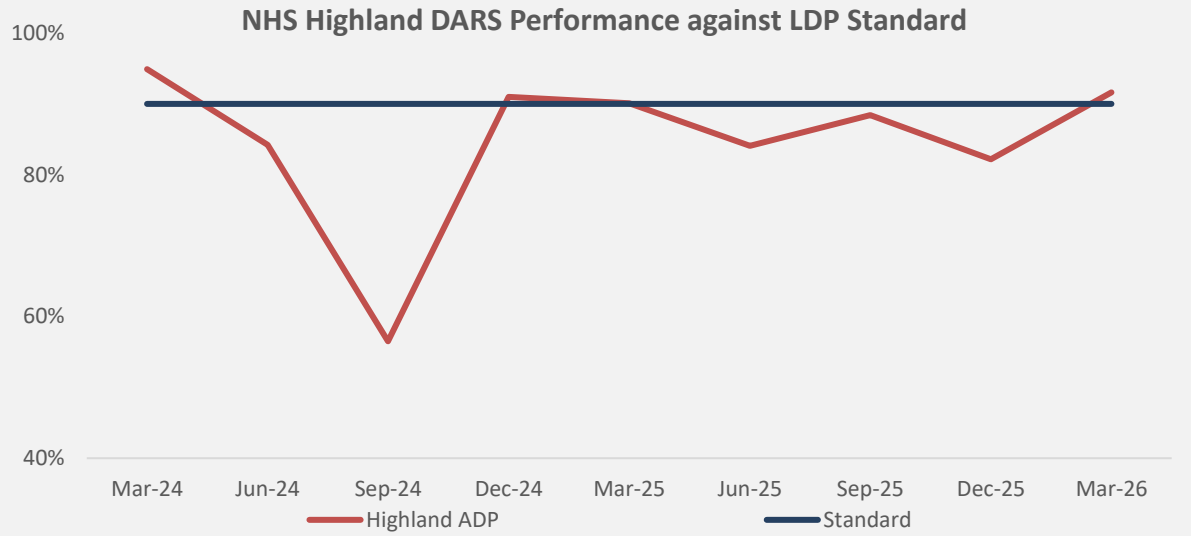
NHS Highland DARS performance against the LDP waiting time standard has been variable over the reporting period but remains broadly positive. Following a significant decline in September 2024, performance recovered rapidly and has subsequently remained close to the 90% target, with some periods of underachievement during 2025. The latest position shows performance above target at approximately 92%, demonstrating the service's ability to restore and maintain timely access. (North Highland

Plans, Mitigations and Actions

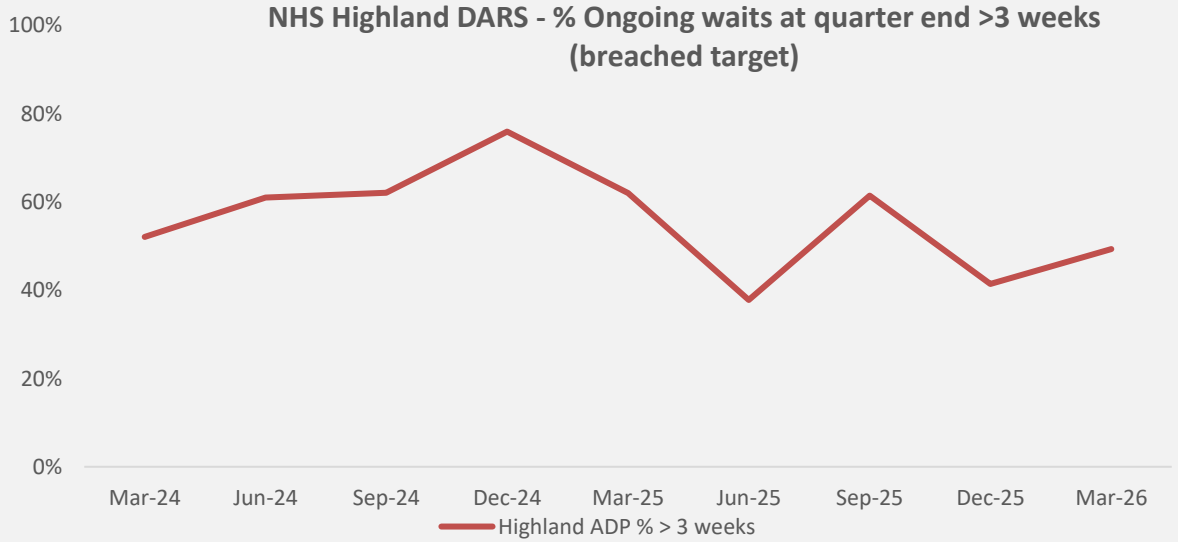
Continued monitoring to understand the factors contributing to variation will be completed monthly through the DARS management structure.

Standardisation work around reporting, operational process and joint working is contained within the internal delivery plan. Known risks include; staffing fragility, reduced working week, the vast geographical area and seasonal workers arriving in the area requiring care. Mitigations are part of the ongoing management monitoring arrangements. (North Highland)

KPI 1: NHS Highland DARs: Performance Against Standard for Completed Waits



KPI 1: NHS Highland DARs: % Ongoing Waits at Quarter End Waiting More than 3 weeks (Breached Targets)



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Executive Lead
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Alcohol Brief Interventions (ABIs)

Strategic Objective: Our Population
Outcome Area: Stay Well

Latest Performance	National Average	Board Position
3851 vs target of 3688 by end of Q4 2025/26	Not available. National data collection paused since 2024/25	Not available. National data collection paused since 2024/25

Key Performance Indicators

Deliver at least 100% of the planned Alcohol Brief Intervention (ABI) activity target by March 2027.

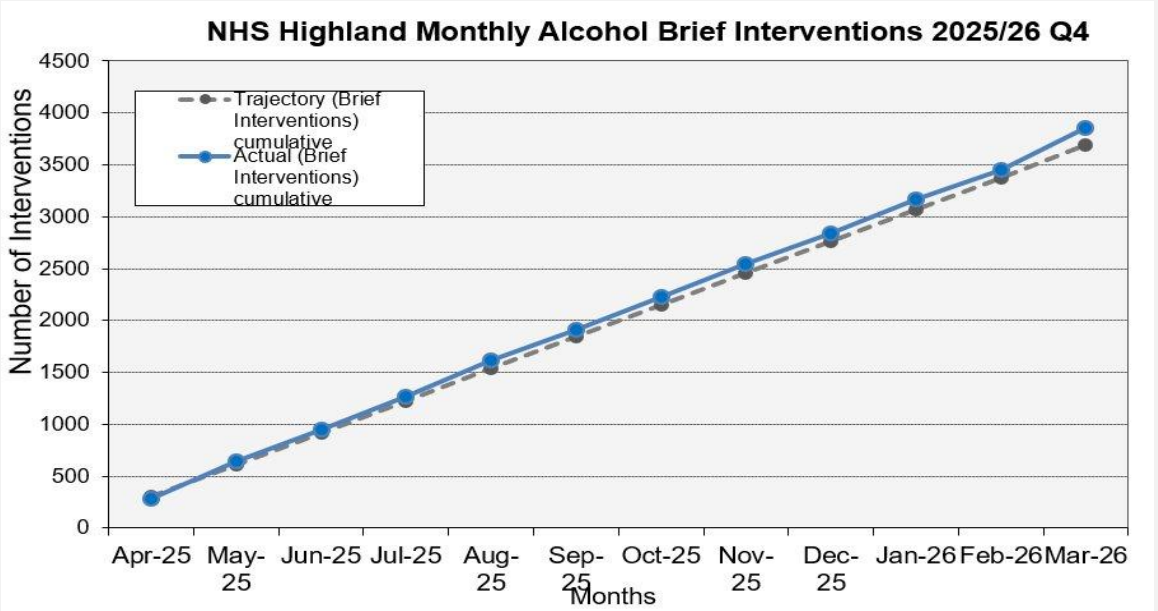
Performance Analysis

Target supported by ongoing training. In Q1 2026/27, 72 staff completed the ABI e-learning module with 19 still in progress.

Plans, Mitigations and Actions

- Focus will remain on sustaining performance above target whilst broadening delivery across a wider range of settings. Ongoing promotion of ABI training and workforce development will support delivery and help reduce reliance on a small number of service areas.
- National policy developments and recommendations from the Public Health Scotland review will continue to inform local planning, alongside wider work to reduce alcohol-related harm across NHS Highland.

KPI 1: NHS Highland Monthly Alcohol Brief Interventions 2025/26 Q4



Setting Contribution 2025/26

Setting Contribution in 2025/26 Full year

Primary Care	3535	91.8%
Antenatal	24	0.6%
Wider Settings	292	7.6%
TOTAL	**3851**	**100%**

Clinical Governance

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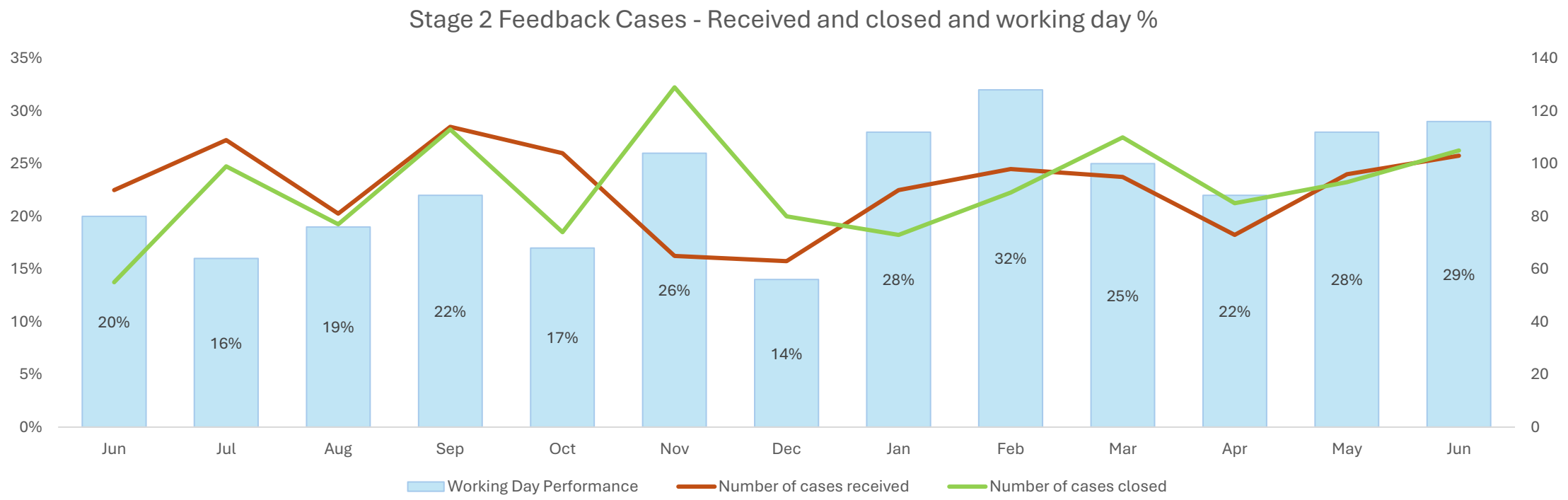
Exec Lead
Boyd Peters

Stage 2 Complaint Activity (June 2025 – June 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
N/A	Performance has improved over the past 2 months despite a significant increase in cases received. (36% increase from Apr to May/June average) Number of cases being closed on is now in line with those received on a monthly basis.	Reporting to EDG and escalation to Board Medical Director where required. Weekly and bi-weekly reports to Operational Units. this has been expanded within Acute Services over the past 6 months to include bespoke reports. Healthcare Guardian will be stretched to ensure that relevant 'live' reports are available to Services to aid with management of complaints and complaints performance

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

Performance Rating	
Latest Performance	22%
National Benchmarking	None
National Target	60%
National Target Achievement	
Position	



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SPSO Activity (June 2025 – June 2026)

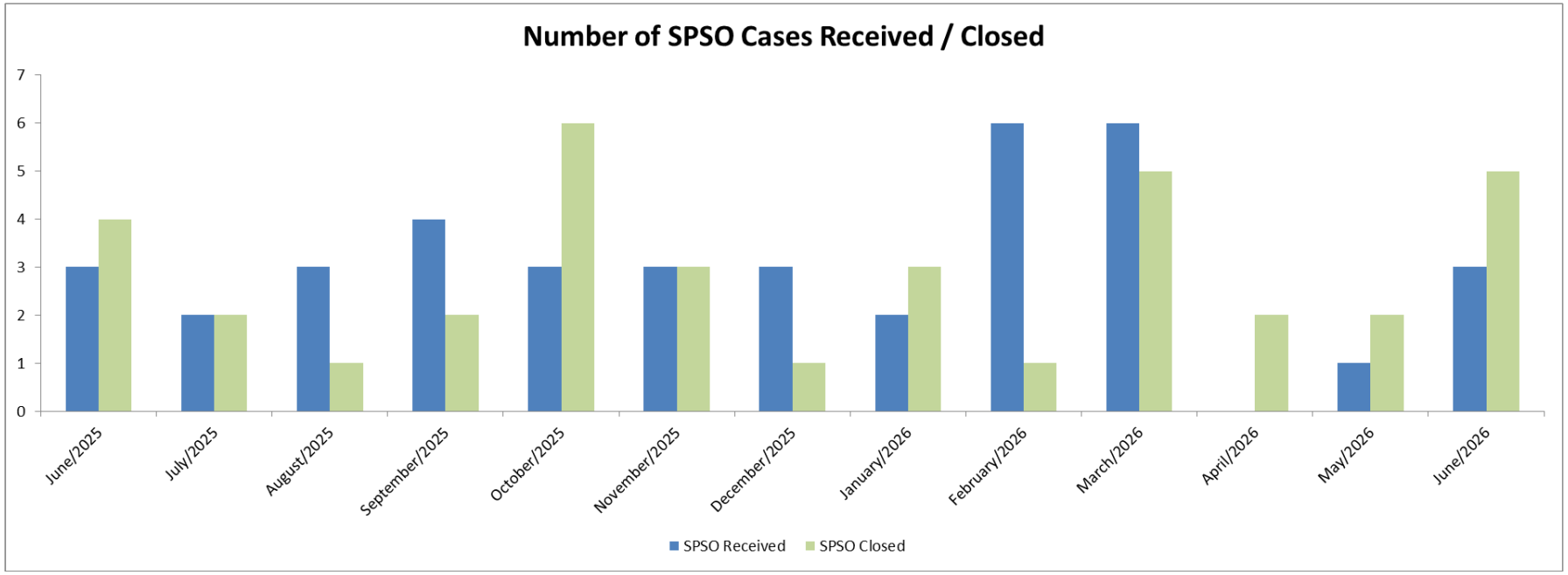
ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	There was one new case opened in May and three new cases opened in June. Of the cases closed in May – one was not taken forward, one report was laid before Scot Parliament (relating to CAMHS). Of the cases closed in June – three were not taken forward and two reports were laid before Scot Parliament. (One relating to MHLD Services and one to Campbelltown Hospital)	SPSO cases continue to be monitored via the Quality and Patient Safety structure.

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

SPSO cases received last 3 months:
4 received:
- 2 x Acute
- 1 x A&B
- 1 x HHSCP

These relate to Vascular, Cardiology, District Nursing, Dental.

SPSO cases closed last 3 months:
9 SPSO enquiries closed
- 6 x not taken forward



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

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	14 SAERs ae over the 26 week target. There are 27 open SAERs. 59 SAER actions are overdue which is an increase since the last reporting period. There are 70 open actions.	All operational areas have been actively reviewing their open SAERs to ensure that they are completed within the 26 week time frame. Training on the SAER process was held in April and May. There were 32 attendees. Further session are planned in June. Now have regular report to CCGQAG and actively discussing improvement plans.

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

Performance Rating	
Latest Performance	
National Benchmarking	
National Target	
National Target Achievement	
Position	

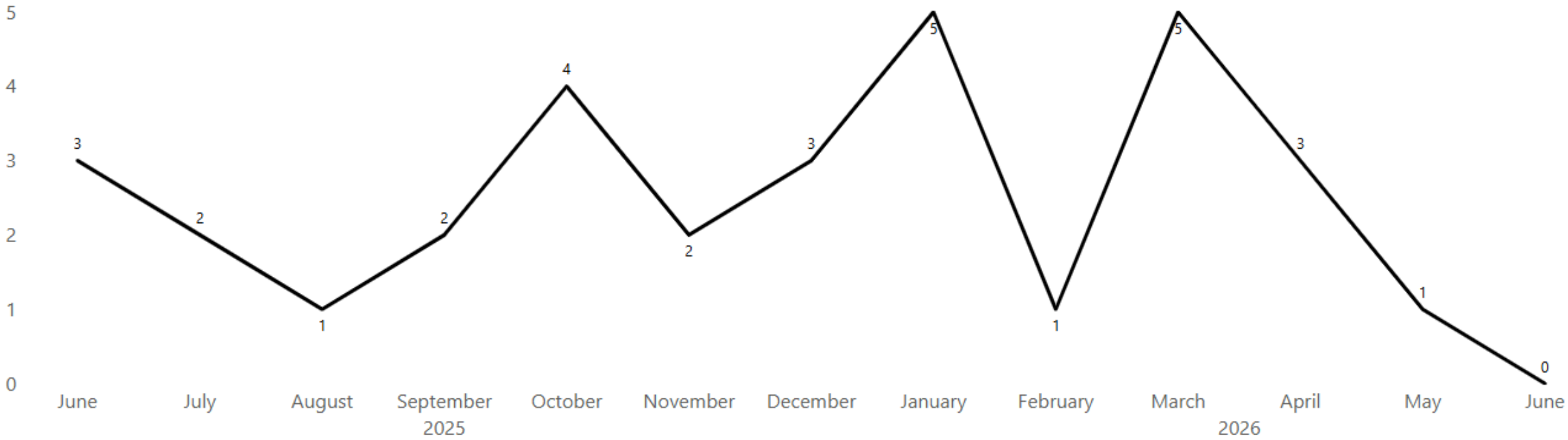
27
Open Level 1 (L1) Incidents

14
L1: Active more than 26 weeks

32
L1: SAER Declared Last 13 Months

0.20%
Incident | SAER Conversion Last 13 Months

SAER Level 1 Investigations Declared



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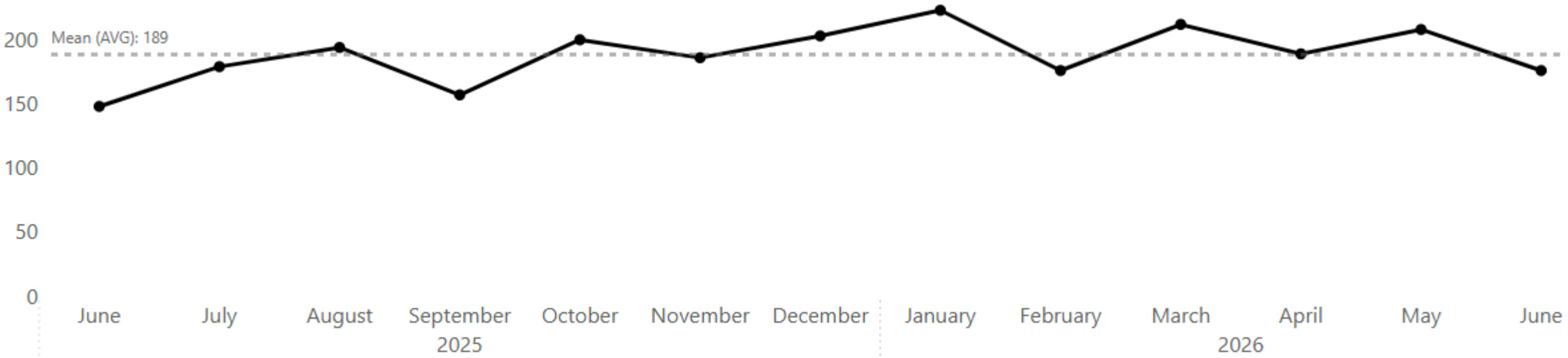
Hospital Inpatient Falls (June 2025 – June 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	There has been no significant variation in inpatient falls across NHSH. Acute has seen a reduction in falls with a downward trend in medicine despite the pressures. HHSCP has seen an increase in falls across Broadford Hospital and Ross Memorial but really good work with a significant reduction in mean across Migdale, Lawson Memorial and RNI. A&B – no significant change H&S safety annual RIDDOR review – significant percentage reduction in RIDDOR reportable falls in 25/26	Improvement work continues at a local level across all areas Focussed on unwitnessed falls across several wards

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	

Number of Inpatient Falls | Run Chart



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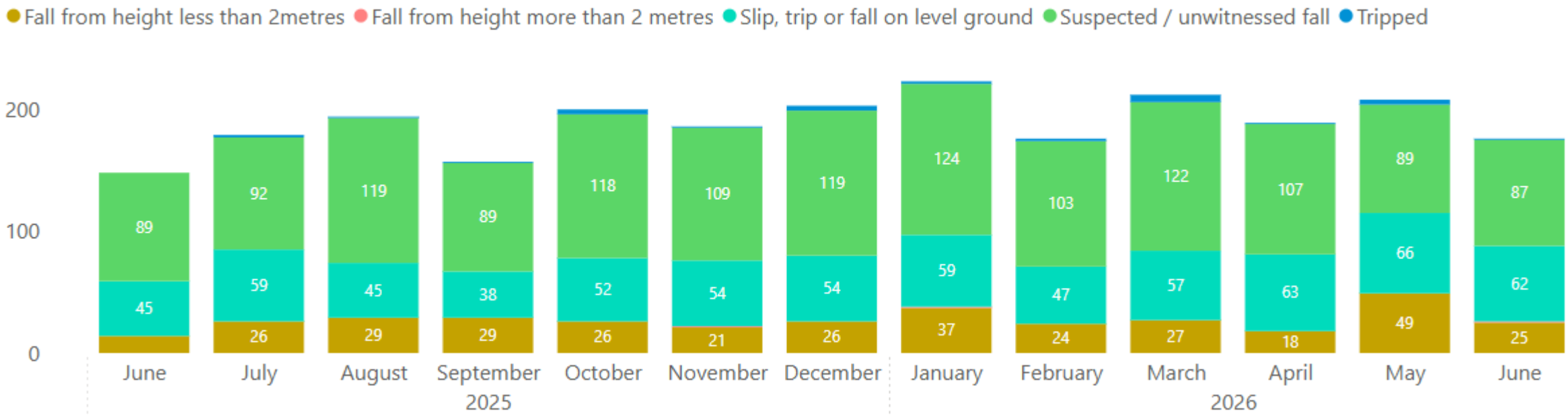
Hospital Inpatient Falls | Subcategory (June 2025 – June 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
		Majority of falls continue to be unwitnessed falls. The falls from a height has returned to the level that has been the position previously after a significant increase in May. This is being analysed for any learning and required actions.	Focussed work on unwitnessed falls looking at time of day and understanding place where falls are happening to drive improvement work

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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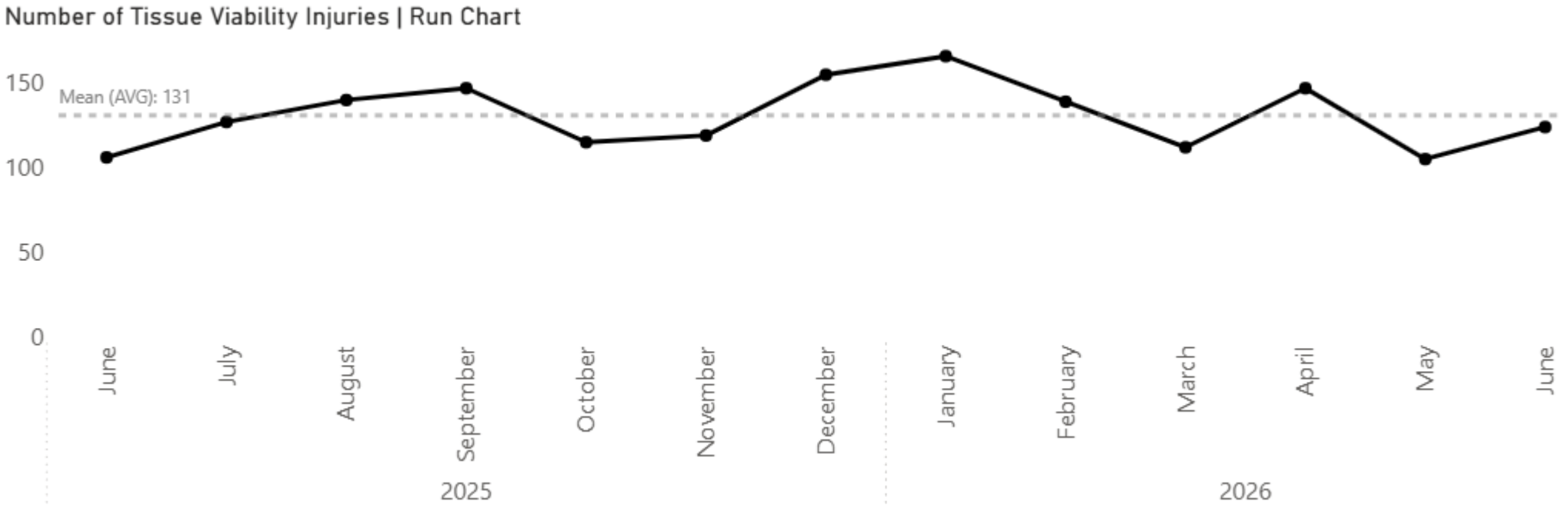
Tissue Viability Injuries (June 2025 – June 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
-MASD and PU Pathways completed via NATVNS- now on NES New Pressure Ulcer Grading Tool Training launched with dates via Teams.		- IPC unpublishing TURAS modules for Pressure Ulcers (PU). New Modules via NATVNS to be completed/pub;ished by November 2026 - CPR Feet training in community ongoing - Target work undergoing for C@H. - Increases in community likely due to increase in reporting for patients NOT on DN caseload - Acute Pathway for pressure ulcer related osteomyelitis for patients refusing hospital admission ongoing - Community Osteomyelitis Pathway for non sepsis related cases ongoing - Recent audit confirms socio-economic disparity in leg ulcer assessment and management with financial implications	- -Continue to implement support for high risk areas - -Develop training including for Feet - SLWG set up with NATVNS for pressure ulcer training materials as IPC will be publishing training slides on TURAS - PU Documents ongoing with NES support and NATVNS. - -There is still discrepancy on community figures due to the nature of the current system, which includes patients NOT known to DNS, but still captured under the headiing of 'developed in community'. Working with Datix Team to find a solution - New HIS SPSP due out soon - -Phase 2 of audit ongoing

Strategic Objective: Our Population
Outcome Area: Treat Well

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



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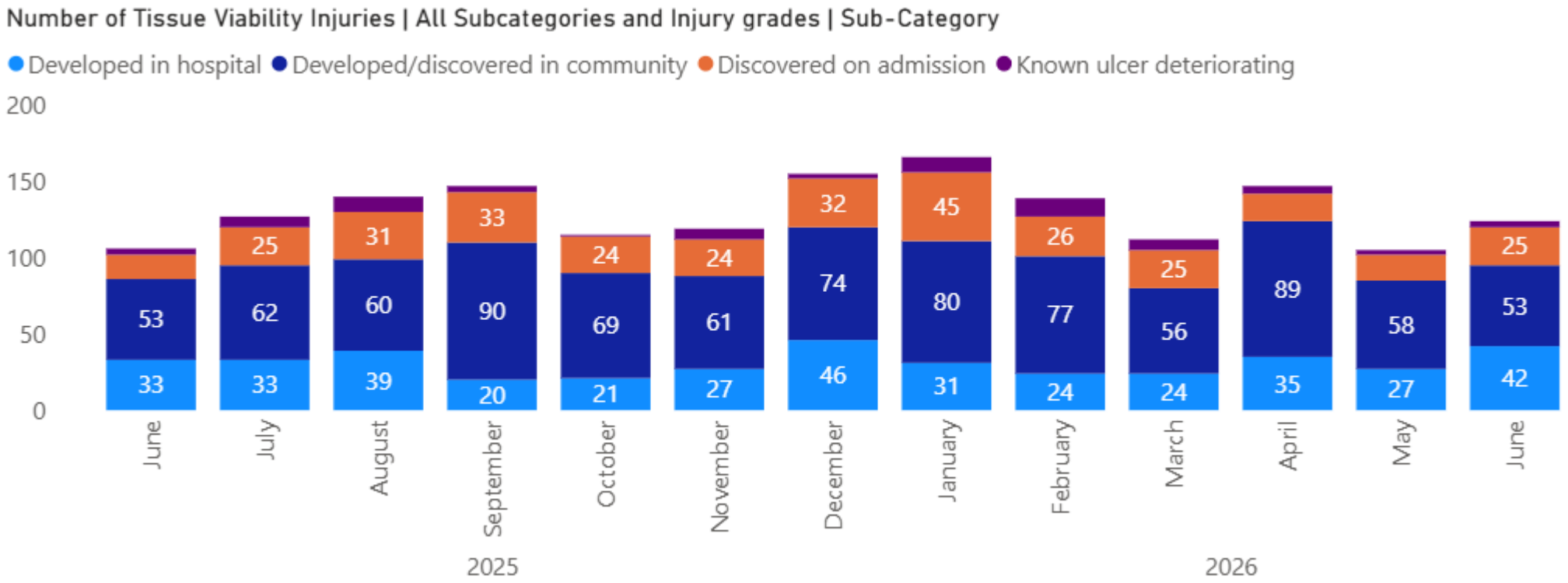
Tissue Viability Injuries | Subcategory (June 2025 – June 2026)

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
		• - QI project ongoing with acute high risk areas - CPR Feet forms part of lower limb training - At risk ward shows improvement with PUs, but now has increase in number of PUs to feet- ongoing support, and include roll out of CPR Feet - Infection and Biofilm Pathway QI ongoing	- Wards 3A to start project with Podiatry - -Leg Ulcer Audit 1st and 2nd stage completed - Lower Limb training x1 more for the year successfully ongoing - Infection and Biofilm Pathway QI ongoing - Rosebank QI ongoing and training to follow on new PU and IRD tool. Proactive seasonal intervention in place

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 (June 2025 – June 2026)

ADP Deliverables Progress as at End of Q1 2025/26	Insights to Current Performance	Plans and Mitigations
Need to focus on Grade 2 and Grade 1 prevention as these 2 categories still account for the highest incidents of developed PUs. HIS target of 20% achievable if reducing Grade 1 and Grade 2 numbers across Acute and HHSCP. Review of decision to not mandate or make PU training statutory to be had- one step closer for clinician specific PU training went to NMHAP (agreed) and now for PLT for agreement	• To discuss and target prevention strategies of Grade 1 incidents, to reduce deterioration and development to Grade 2 and above to achieve 20% figures. HIS (2026) work also targetting acute and community	• There is a head to toe inspection video that will be used via NATVNS- all staff to watch • Requested TURAS share and be made accessible to/including non NHS Highland care homes • Equipment guide being updated as a step up/step down guide for all clinicians across acute and community - ongoing • Work underway to address Grade 1 and Grade 2 wounds acute/community

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

Sub-category | Injury

Injury	Developed in hospital	Developed/discovered in community	Discovered on admission	Known ulcer deteriorating	**Total**
Pressure ulcer Grade 2	210	439	146	21	**816**
Pressure ulcer Grade 1	83	133	75	2	**293**
Pressure Ulcer - ungradable	35	112	47	13	**207**
Pressure Ulcer - deep tissue injury	34	105	15	13	**167**
Pressure ulcer Grade 3	15	58	13	13	**99**
Pressure ulcer Grade 4	1	16	10	11	**38**
Pressure ulcer (grade not specified)	10	7	17		**34**
Mucosal Pressure Damage	11	7	9		**27**
Pressure Ulcer - combination lesions	3	5	9	4	**21**
Total	**402**	**882**	**341**	**77**	**1702**

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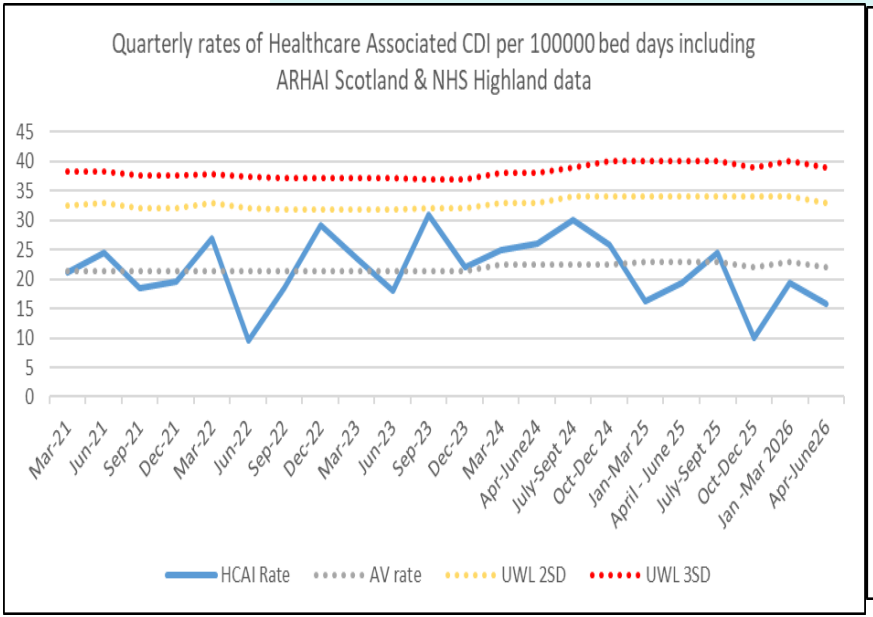
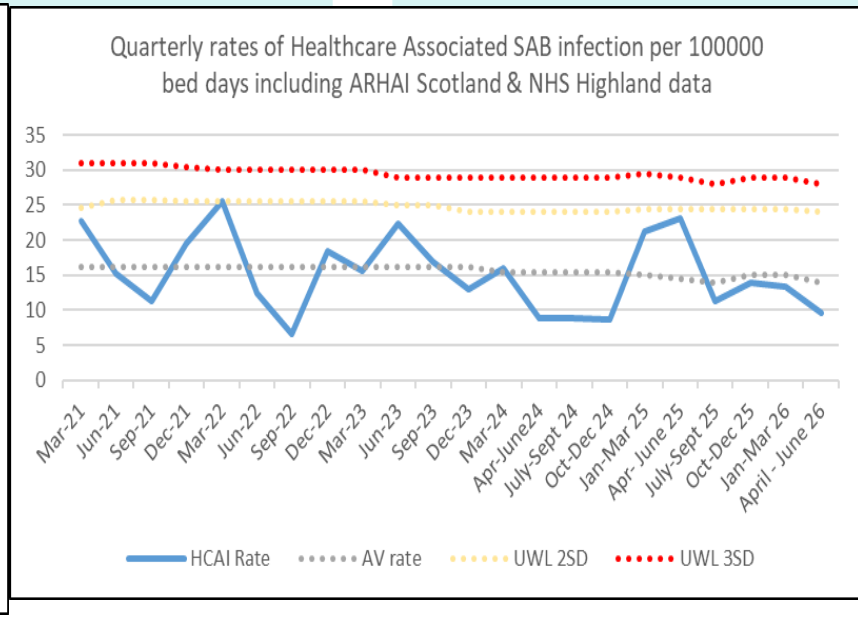
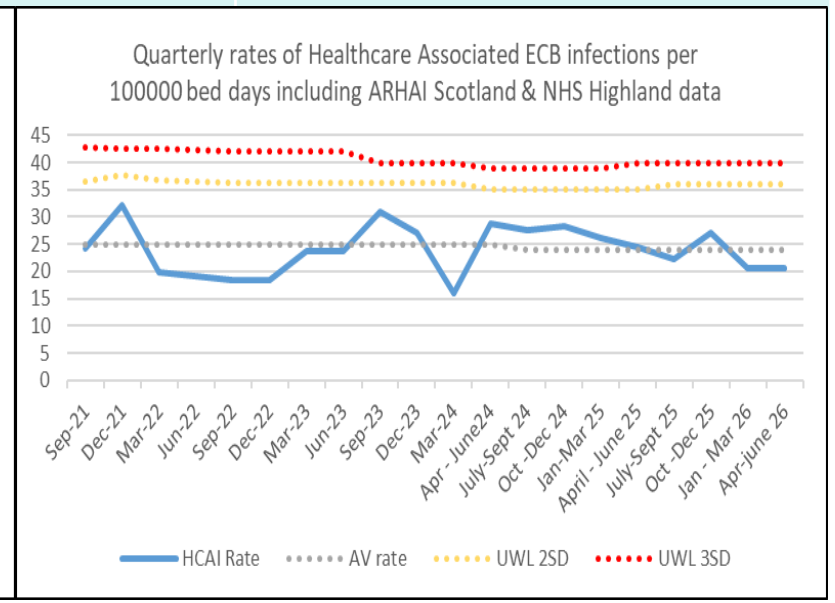
Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims
1st April 2026 to 8th August 2026

ADP Deliverables: Position for 2025/26 and 2026/27 reduction aims The RAG ratings are calculated on the predicted monthly numbers.		Insights to Current Performance	Plans and Mitigations
Clostridioides difficile (CDI) 2025/2026 and 2026/2027 reduction aim is 75 HCAI cases. Validated data for 2025/2026 is 59 HCAI cases. Reduction aim met (16 cases under aim) As of 08/08/2026 on track for 2026/2027 at 21 HCAI cases		National Services Scotland published the validated data on the reduction aims in July 2026 all were within predicted limits, with SAB and CDI being met and ECB being slightly above the reduction aim case number. NHS Boards notified via ARHAI that reduction aims for 2025/2026 will remain unchanged for 2026/2027.	Continue to review individual cases for learning and any subsequent actions. Targeted work with antimicrobial prescribing continues, The use of faecal microbiota transplant therapy continues to be progressed as a treatment for chronic CDI. Continue to ensure adherence to national guidance for the management of infections.
Staphylococcus aureus bacteria (SAB) 2025/26 and 2026/2027 reduction aim is 53 HCAI cases. Validated data for 2025/2026 is 54 HCAI cases,. Reduction aim over by 1 case, remains within predicted limits. As of 08/08/2026 on track for 2026/2027 at 14 HCAI cases			
Escherichia Coli (ECB) 2025/2026 and 2026/2027 reduction aim is 75 HCAI cases. Validated data for 2025/2026 is 81 HCAI cases reduction aim **NOT** met (6 cases over aim) however remains within predicted limits As of 08/08/2026 on track for 2026/2027 at 31 HCAI cases			







Staff Governance

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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 to 6.7%. 24.9% of Long-term absences are related to anxiety/stress/depression.	Attendance is not managed robustly/consistently and rates remain higher than 4%. Training on policy and process continues. Toolkit and checklist being developed.
Ensure 95% Core Mandatory eLearning compliance across NHS Highland staff (measured through the Core Mandatory eLearning Completion Rate).		Overall Mandatory eLearning compliance is 65.2%, 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 Mandatory eLearning dashboard.
Ensure the annual turnover rate of staff leaving NHS Highland remains below 10% of the total workforce.		Annual turnover increased slightly this month to 6.66%	
Ensure the average Time to Fill rate for positions within NHS Highland remains below the 116 day national target.		Above the national target of 116 days at 125.9 and rising.*	Work continues with training for recruiting managers and sustaining lower time to fill period
Ensure 60% of the NHS Highland workforce has a completed TURAS Appraisal within the financial year 2026/27.		Appraisal rate of 32.6% is higher this month but significantly short of the 60% target. There has been an increase of 2.6% since last report.	Noncompliance with staff governance standards. All areas asked to develop plans to ensure each employee receives a PDP annually.

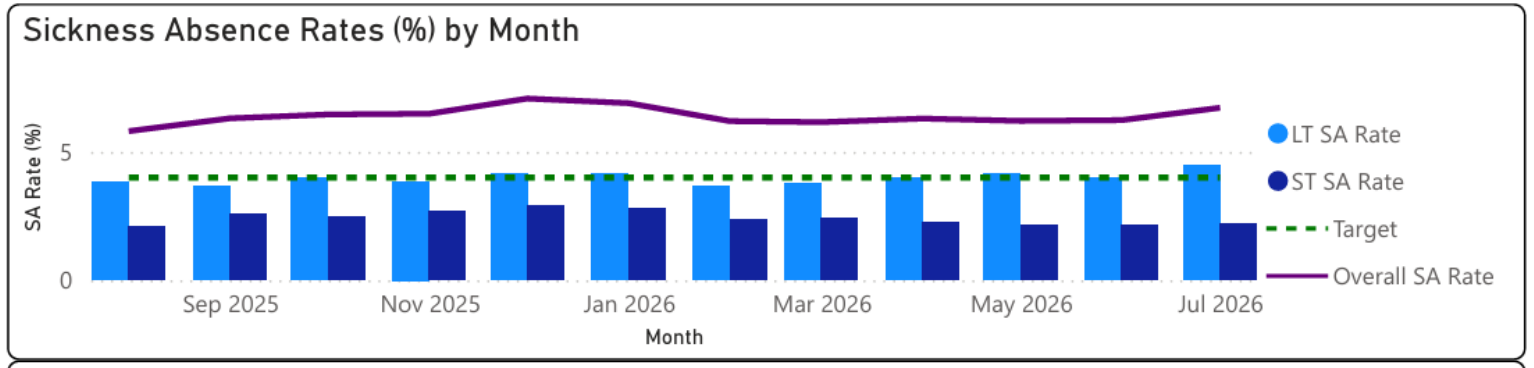
Guide to Performance Rating

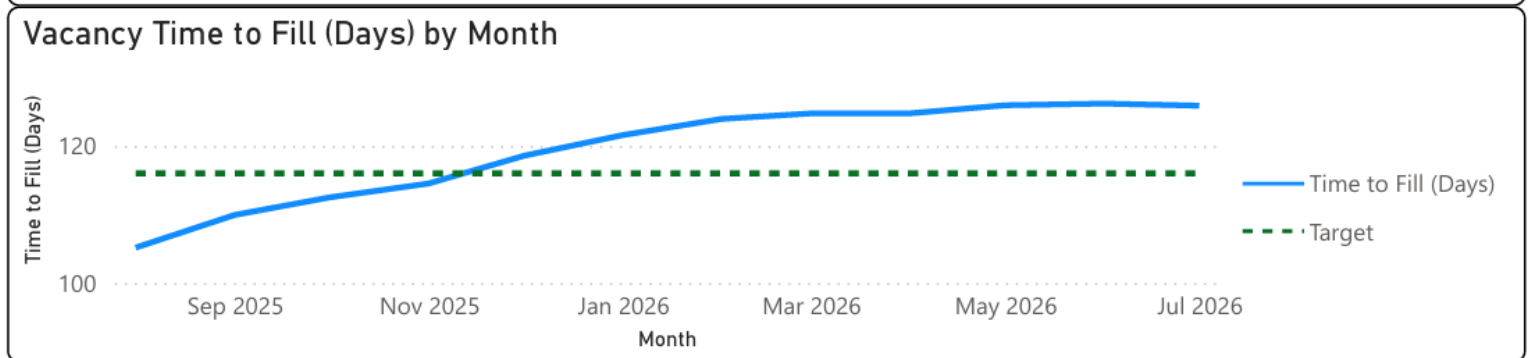
Meeting Target
<5% off target
>5% off target
>10% off target

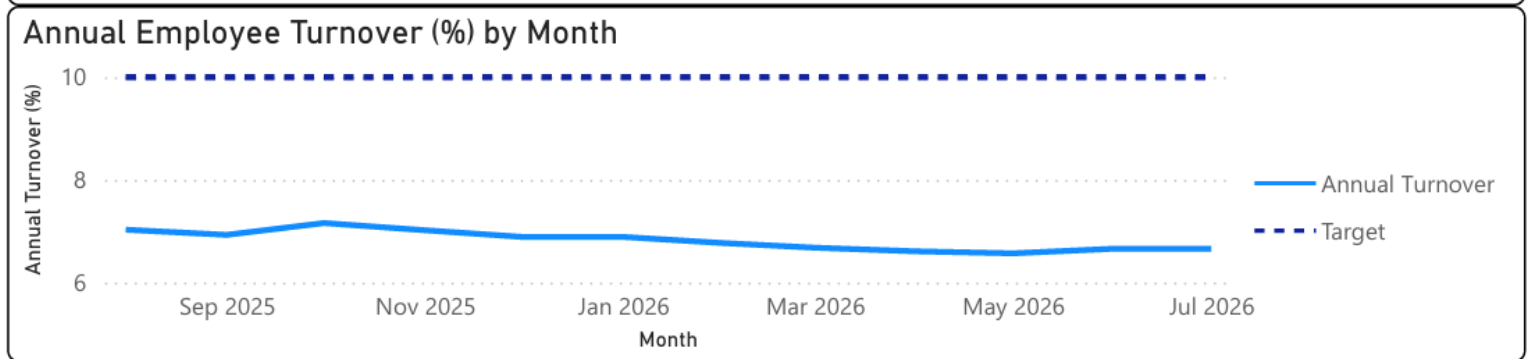
*There are a few bank vacancies negatively impacting Time to Fill figures due to being ‘always on’. Going forward these posts will be periodically closed and new entries raised thus reducing the impact on reported figures.

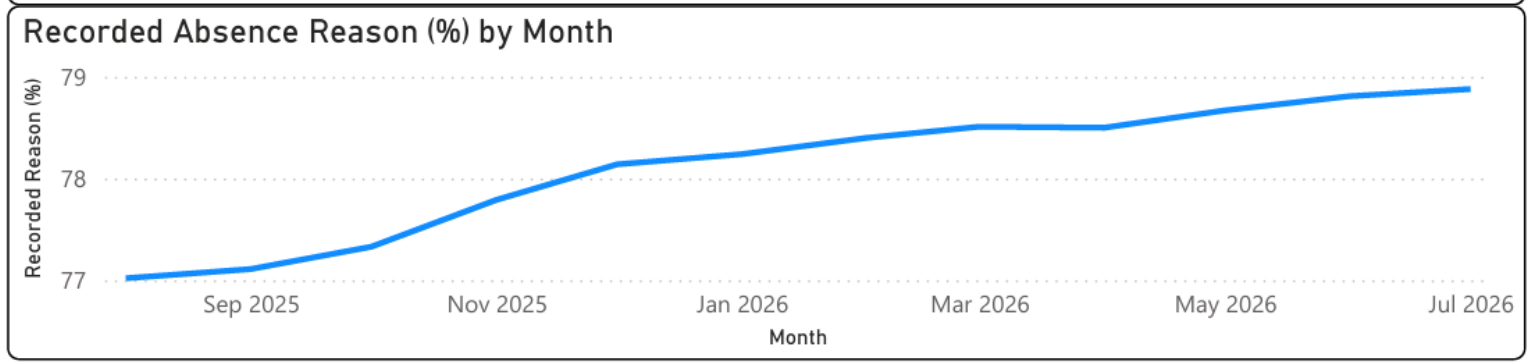
Organisational Metrics Jul 2026

Sickness Absence Rate (%)	6.72
Long Term SA Rate (%)	4.49
Short Term SA Rate (%)	2.22
Recorded Absence Reason (%)	78.88
Vacancy Time to Fill (Days)	125.89
Annual Employee Turnover (%)	6.66









Training Metrics Jul 2026

Bank eLearning Completion Rate (%)

40.8

Substantive eLearning Completion Rate (%)

70.2

Overall eLearning Completion Rate (%)

65.2

M&H Practical Training Completion Rate (%)

44.0

V&A Practical Training Completion Rate (%)

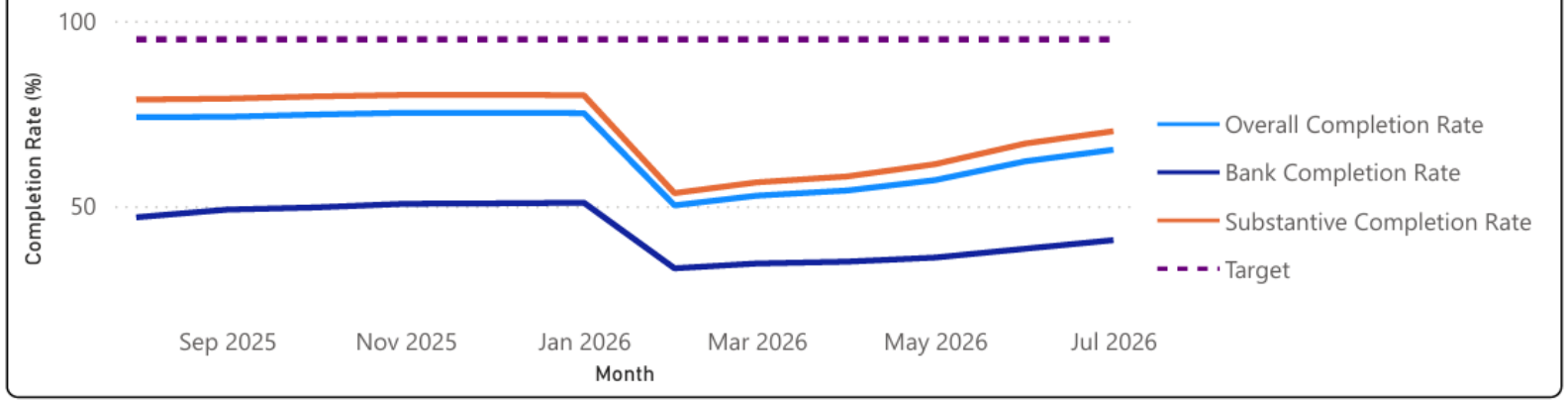
28.3

Appraisal Completion Rate (%)

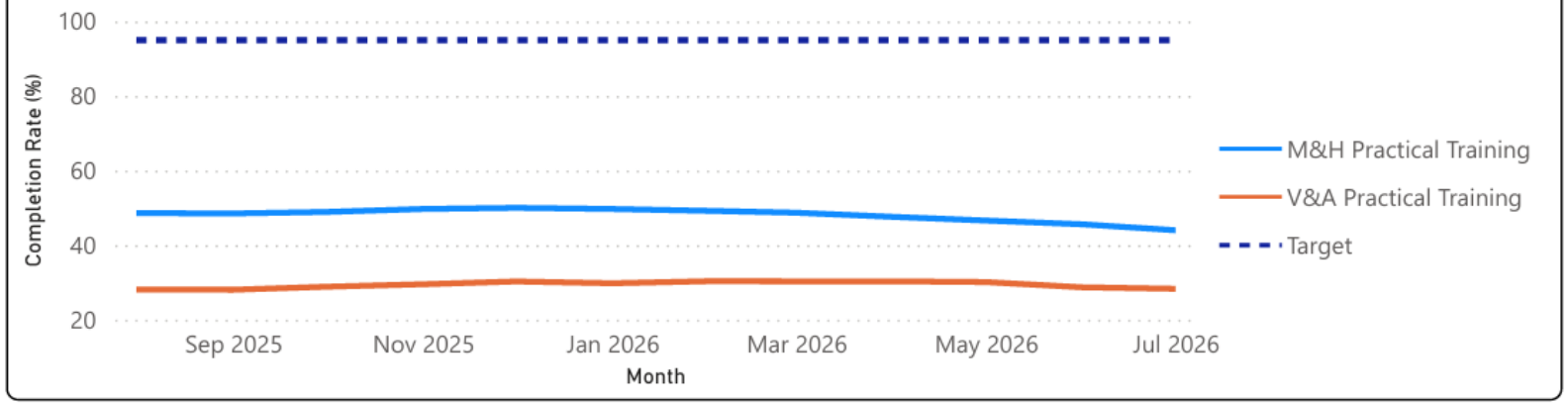
32.6

*** Note:** There has been a new mandatory course (Fraud Awareness) introduced, as well as changes to the renewal period of other courses which has led to the significant drop in compliance

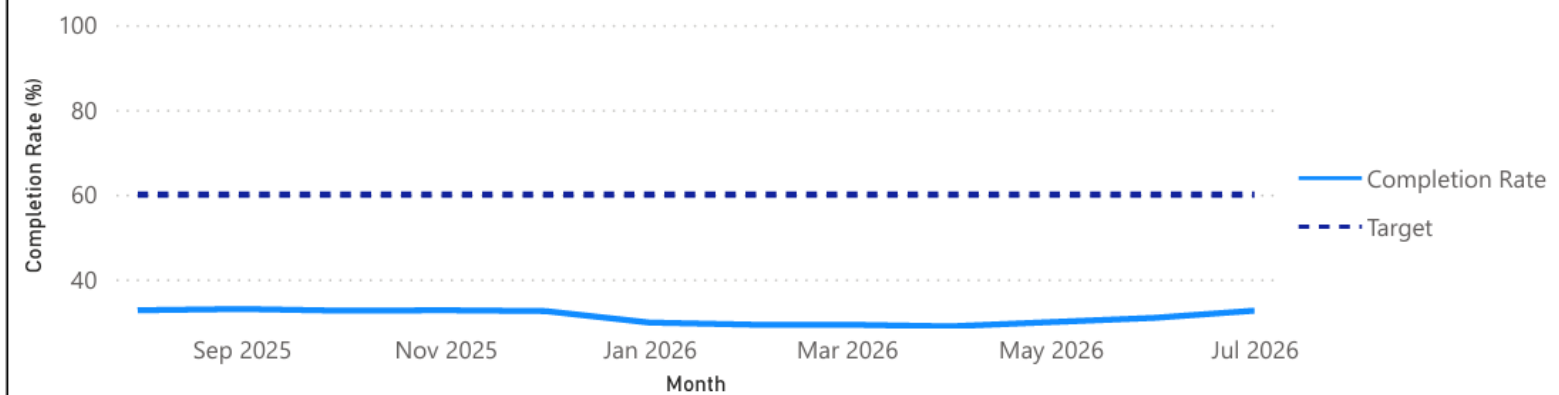
Core Mandatory eLearning Completion Rate (%) by Month



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 the 9 mandatory e-Learning courses within the required time period which varies by course. Courses included areChild protection and adult support and protection, Cyber security, Fire safety, Fraud Awareness, Manual handling, Prevention and management of violence and aggression, Safe information handling, Understanding equality, diversity and human rights, Why infection prevention control matters. Data is sourced from TURAS Learn.
- **Bank eLearning Completion Rate:** As above, for Bank only staff. Data is sourced from TURAS Learn.
- **Substantive eLearning Completion Rate:** As above, for staff who hold a substantive post. Data is sourced from TURAS Learn.
- **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 Learn.
- **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 Learn.
- **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 Appraisal.

Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented
7	CAMHS Waitlist NHSH	Monthly	July 2026
8	Psychological Therapy Waiting Times Patients seen <18 weeks.	Monthly	July 2026
9	Outpatients (NOP) Seen & Trajectories	Monthly	July 2026
10	Outpatients seen <12 weeks Including Consultant and Nurse Lead Activity	Monthly	July 2026
11	Return Outpatients Wait List	Monthly	July 2026
12	TTG <12 Week Target Patients Seen & Trajectories	Monthly	July 2026
12	TTG Seen <12 Weeks (Consultant Only)	Monthly	July 2026
13	TTG Long Waits >52 Weeks	Monthly	July 2026
14	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	July 2026
14	CT Patients Seen & Trajectories	Monthly	July 2026
15	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	July 2026
15	Endoscopy Patients Seen & Trajectories	Monthly	July 2026
16	31 Day Cancer Waiting Times	Monthly	July 2026
16	Patients Seen on 31 Day Pathway	Monthly	July 2065
17	62 Day Cancer Waiting Times	Monthly	July 2026
17	Patients Seen on 62 Day Pathway	Monthly	July 2026
18	System Anti Cancer Therapy (SACT)	Monthly	July 2026

Slide #	Report	Frequency of Update	Last Presented
19	% of People Seen in ED Within <4 hours Per Month	Monthly	July 2026
19	Total Patients waiting >12 hours in ED per Month	Monthly	July 2026
20	SAS Turnaround (Median)	Monthly	NEW slide
20	SAS Turnaround (90th Percentile)	Monthly	NEW slide
21	Number of People Delayed from Hospital Discharge at Monthly Census Point NHSH	Monthly	July 2026
21	Number of People Delayed from Discharge – Location and Code	Monthly	July 2026
22	Vaccinations – Maternal RSV Immunisation Uptake	Quarterly	July 2026
22	Vaccinations – Older adult RSV Uptake	Quarterly	July 2026
23	Screening (Cervical, AAA, Bowel)	Annual	July 2026
24	Smoking Cessation	Quarterly	May 2026
25	Breastfeeding	Annual	January 2026
26	Drug & Alcohol Recovery (DARS)	Quarterly	July 2026
27	Alcohol Brief Interventions (ABIs)	Monthly	July 2026
28	Stage 2 Complaint Activity	Monthly	July 2026
30	Number of SPSO Cases Received/ Closed	Monthly	July 2026
31	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	July 2026
32	Number of Hospital Inpatient Falls by Subcategory	Monthly	July 2026

Slide #	Report	Frequency of Update	Last Presented
33	Hospital Inpatient Falls Subcategory	Monthly	July 2026
34	Number of Tissue Viability Injuries | Run Chart	Monthly	July 2026
35	Number of Tissue Viability Injuries | All Subcategories and Injury Grades | Sub-Category	Monthly	July 2026
36	Number of Tissue Viability Injuries | Subcategory by Injury Grade	Monthly	July 2026
37	Infection Control, CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction Aims	Monthly	July 2026
39	Integrated Performance & Quality Report : Grow, Nurture & Plan Well	Monthly	July 2026
40	Sickness Absence Rates % By Month	Monthly	July 2026
41	Training Metrics % By Month	Monthly	July 2026
42	Organisational Metrics - Glossary	Bi-monthly	July 2026
43	Organisational Metrics - Glossary	Bi-monthly	July 2026
44	Appendix		
45	Appendix		
46	Appendix		