

NHS Highland



Meeting: NHS Highland Board

Meeting date: 26 May 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

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	<input type="checkbox"/>	Moderate	<input checked="" type="checkbox"/>
Limited	<input type="checkbox"/>	None	<input type="checkbox"/>

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 – 5th May 2026
- Clinical Governance Committee – 2nd April 2026
- Finance Resource Performance Committee – 8th May 2026

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – May 2026 Board Meeting

Integrated Performance and Quality Report **Board Meeting** **26th May 2026**

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



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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: Slide 1 of 2

Wells	Area	Current Performance (Date)	Previous Performance (Date)	Trend Indicator	Local Target	National Target	Performance Rating
Thrive Well	CAMHS <18-week referral-to-treatment	84.6% (Feb 26)	96.7% (Dec 25)	↑	90%	90%	>10% off target
Thrive Well	NDAS Waiting List Size	2197 (Feb 26)	2138 (Dec 25)	↑	Reduce	N/A	>10% off target
Stay Well	Smoking Cessation Quits	62 (Q3 25/26)	53 (Q2 25/26)	↑	84 per quarter	N/A	>10% off target
Stay Well	Breastfeeding	27.7% (25/26 so far)	27.7% (25/26 so far)	=	25.1% by 2030/31	N/A	<5% off target
Stay Well	Alcohol Brief Interventions (Number per Quarter)	923 (Q3 25/26)	967 (Q2 25/26)	↑	1841 (End of Q2)	2834 (End of Q3)	Meeting Target
Stay Well	Drug & Alcohol Waiting Times <3-weeks	84.2% (Dec 25)	87.4% (Q2 25/26)	↓	90%	90%	>5% off target
Live Well	Psychological Therapies < 18-week referral to treatment	83.3% (Jan 26)	93.1% (Dec 25)	↓	90%	90%	>5% off target
Respond Well	Emergency Access (4-hour waits)	72.7% (Feb 26)	78.5% (Dec 25)	↑	83% by 31/03/26	95%	>10% off target
Respond Well	Emergency Access (8-hour waits)	596 (Mar 26)	437 (Nov 25)	↑	Reduce	Reduce	>10% off target
Respond Well	Emergency Access (12-hour waits)	328 (Mar 26)	243 (Nov 25)	↓	Reduce	Reduce	>10% off target
Respond Well	Delayed Discharges: All	232 (Mar 26)	241 (Dec 25)	↓	Reduce	Reduce	>10% off target
Respond Well	Delayed Discharges: Standard Delays	190 (Mar 26)	198 (Dec 25)	↓	151 by 31/03/26	Reduce	>10% off target

Guide to Performance Rating

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

Note: the trend indicator arrow shows the general direction the indicator has moved in the last 3 months, and the colour represents the current trajectory of the indicator in relation to the target.

Executive Summary of Performance Indicators: Slide 2 of 2

Wells	Area	Current Performance (Date)	Previous Performance (Date)	Trend Indicator	Local Target	National Target	Performance Rating
Treat Well	New Outpatients (NOP) Cumulative Performance against Activity Plan	-3.6% (behind plan) (Feb 26)	-5.6% (behind plan) (Dec 25)	↓	N/A	Activity Plan (Core and Additional)	<5% off target
Treat Well	New Outpatients (NOP) number of patients waiting >52 weeks	1092 (Mar 26)	2013 (Dec 25)	↓	N/A	1133 by 31/03/26	Meeting Target
Treat Well	TTG Cumulative Performance against Activity Plan	0.0% (On Target) (Feb 26)	0.0% (4 behind plan) (Dec 25)	=	N/A	Activity Plan (Core and Additional)	Meeting Target
Treat Well	TTG number of patients waiting >52 weeks	105 (Mar 26)	354 (Dec 25)	↓	N/A	124 by 31/03/26	Meeting Target
Treat Well	Radiology: Cumulative Performance Against Activity Plan	26.4% (5517 ahead of plan) (Jan 26)	21.54% (6276 ahead of plan) (Dec 25)	↑	N/A	Activity Plan (Core and Additional)	Meeting Target
Treat Well	Radiology <6-week waiting time	72.6% (Feb 26)	66.8% (Nov 25)	↑	80% short term 90% long term	100%	>5% off target
Treat Well	Endoscopy: Cumulative Performance Against Activity Plan	28.2% (1028 ahead of plan) (Jan 26)	22.24% (1154 ahead of plan) (Dec 25)	↑	N/A	Activity Plan (Core and Additional)	Meeting Target
Treat Well	Endoscopy <6-week waiting time	88.1% (Feb 26)	67.9% (Nov 25)	↑	80% short term 90% long term	100%	Meeting Target
Journey Well	31-Day Cancer Target	89.7% (Feb26)	89.9% (Dec 25)	↓	95%	95%	>5% off target
Journey Well	62-Day Cancer Target	67.3% (Feb 26)	68.1% (Nov 25)	↓	95%	95%	>10% off target
Journey Well	SACT Access and Benchmarking (SACT as 1st Treatment) – Average Waiting Time	16-20 Days (Mar 26)	16-20 Days (Dec 25)	=	< 28 days	N/A	Meeting Target

Guide to Performance Rating

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

Note: the trend indicator arrow shows the general direction the indicator has moved in the last 3 months, and the colour represents the current trajectory of the indicator in relation to the target.



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**Executive Lead
Louise Bussell,
Nurse Director**

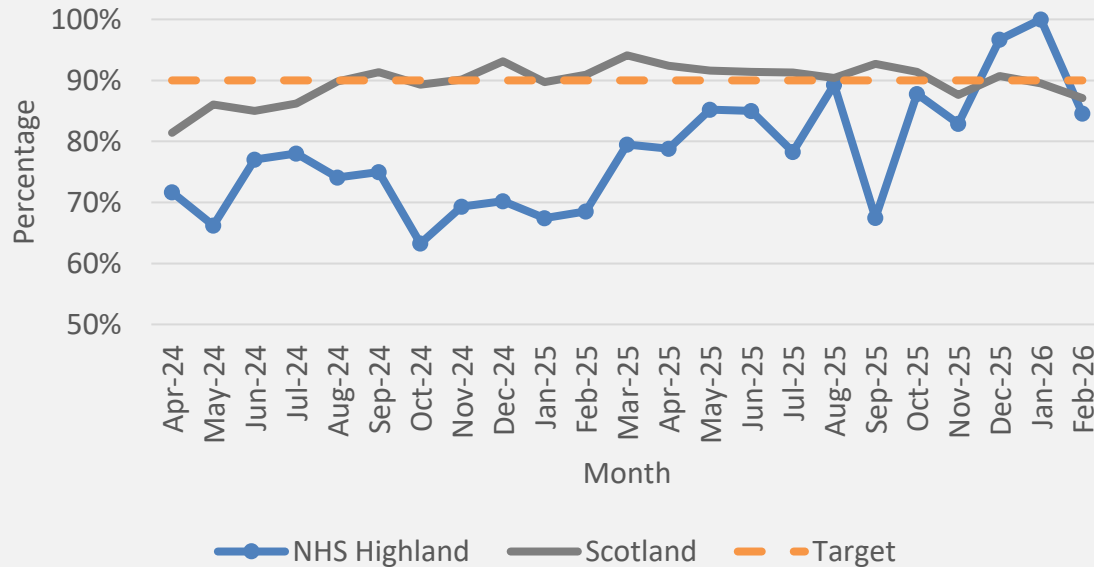
OIP

CAMHS (Child and Adolescent Mental Health Service)

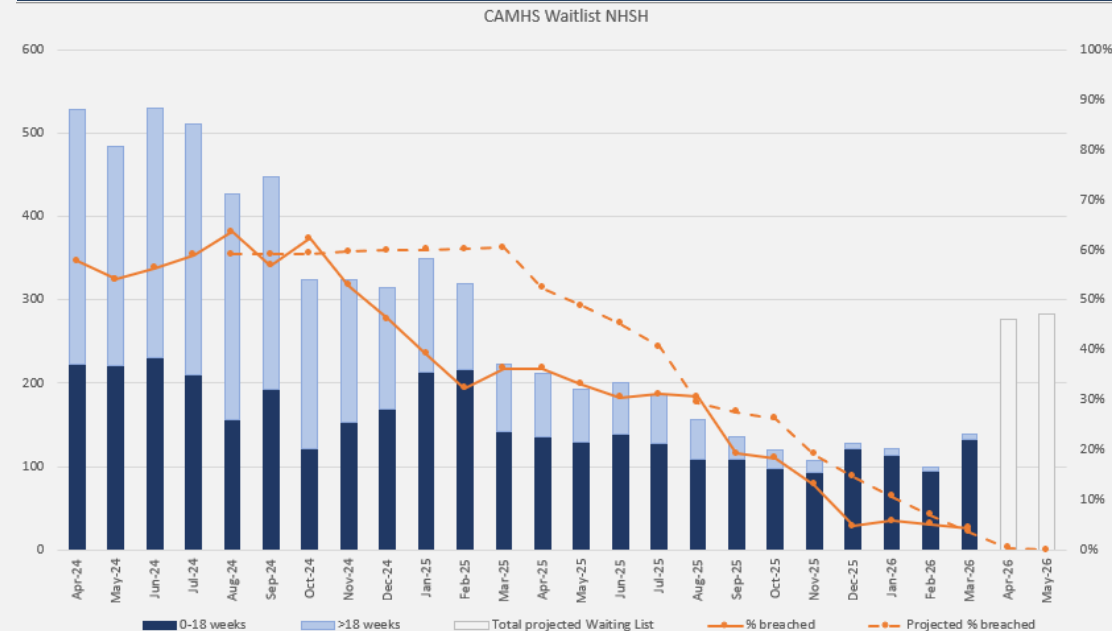
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by December 2025 (Tier 3).	Highland The service has achieved the waiting times target for December & January and eliminated all long waits > 35 weeks.	Highland <ul style="list-style-type: none"> Decision by The Highland Council (mid March) to decommission the Care Experience Young People (CEYP) service, which has been integrated within NHS Highland's CAMHS since 2019 - briefing paper escalated to Chief Officer and Nurse Director. Reduced Working Week has impacted with a reduction of 2.48wte across the service – impact assessment undertaken. As we move into the new fiscal year the allocation of mental health outcomes framework, money has now been confirmed on a substantive basis so that the service can effectively forward plan.
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	84.6%
National Average	89.5%
National Target	Full compliance to the National Service Specification by end of March 2026
National Target Achievement	n/a
Position	3 rd out of 14 Boards (note most boards achieved 100%)

CAMHS: Percentage of patients seen <18 weeks from referral



CAMHS Tier 3 Waiting List in Weeks





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Executive Lead
Katherine Sutton
Chief Officer,
Acute

Neurodevelopmental Assessment Service (NDAS)

Key Performance Indicators

Increasing percentage of NDAS patients seen within 18 weeks from referral, and towards meeting the national specification of greater than 95%.

Reduction in the total number of patients on the NDAS waiting list compared to the current baseline by March 2026.

Reasons for Current Performance

There is extremely limited clinical capacity within the service to complete any assessments.

Plans, Mitigations and Actions

Scottish Government initiated programmes of work:

- Essence D screening - Neuro profiling with support organisation Malvern
- Independent Sector – 49 Private Assessments autism agreed with private providers

The Highland Council £1.2 million funding via Transformation Fund and support to extend secondments into the NDAS service.

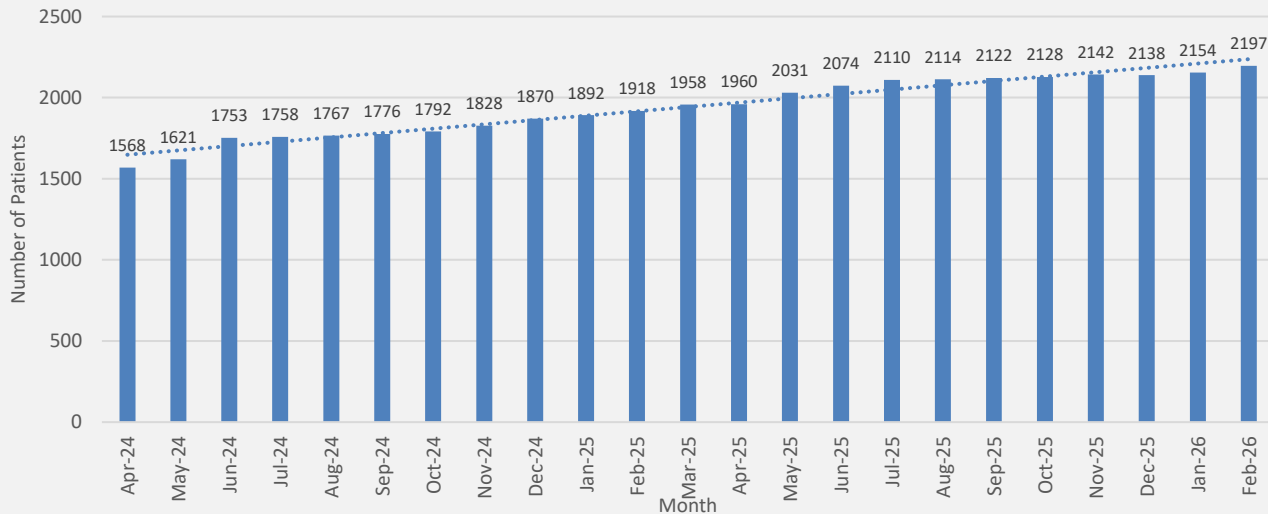
Recruitment for Consultant Psychologist is underway, but this represents a cost pressure to the service.

Phase one - New model test of change implemented to reviewing children on the waitlist (from a single primary school) by THC and NHS Health teams – this has concluded.

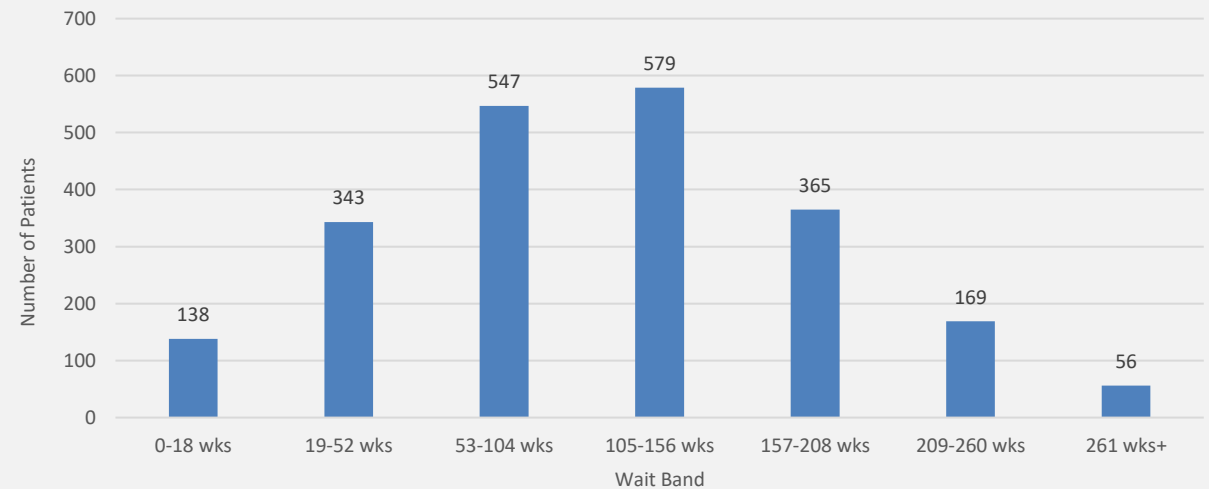
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	2197 on waiting list (Feb 2026)
National Average	n/a
National Target	Full compliance to the National NDAS Service Spec by end March 2026.
National Target Achievement	n/a
Position	n/a

NDAS Total Awaiting 1st Appointment (including unvetted)



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





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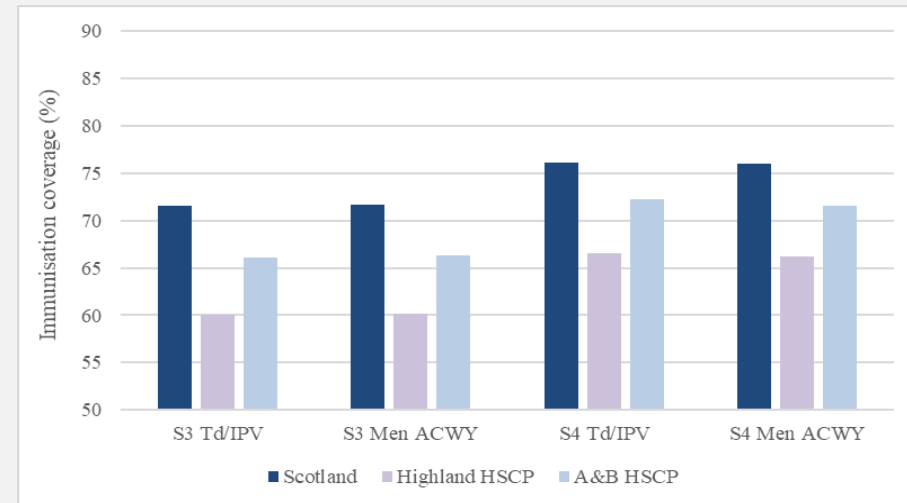
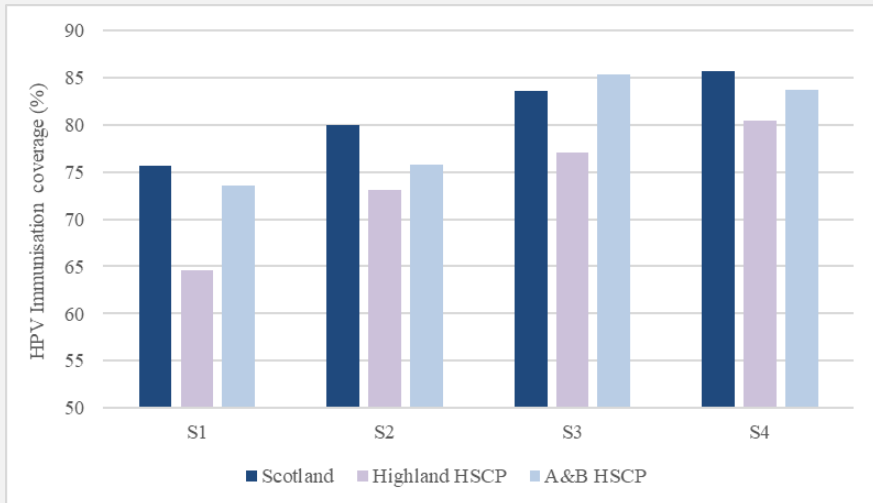
Exec Lead
Jennifer Davies,
Director of Public
Health

Vaccinations

Key Performance Indicators	Reasons for Current Performance (updated April 2026)	Plans, Mitigations and Actions
Key performance indicators are currently being developed to support the vaccination standards as part of a SVIP Task & Finish Group.	<p>Spring vaccination programme: The Spring vaccination programme is now underway with vaccination delivery beginning in care homes and domiciliary settings before progressing to delivery in community clinics. There is no uptake data available as of yet.</p> <p>School based programmes: Following the recent meningococcal outbreak affecting students in Kent, there has been an increase in requests for vaccination including school-based vaccines. The HPV and the teenage booster and MenACWY coverage rates by the end of the school year 2024/25 are shown in figures 1 & 2. Work is underway as part of the development of the collaborative model to implement approaches to better support uptake and address inequalities.</p> <p>Pre-school immunisation: Across Highland HSCP, there has been a further improvement in the uptake figures for the pre-school immunisations when measured at 12 months. The uptake figures for A&B HSCP have decreased and work is underway to investigate this.</p>	<p>Scottish Government is continuing to work with Highland HSCP in level 2 of its performance framework. A tripartite advisory group (SG, PHS, NHS) is meeting to offer external support to NHS Highland as part of the implementation of the hybrid model of delivery in Highland HSCP.</p> <p>Work is ongoing in Argyll & Bute to maintain uptake rates and to support wider improvement work.</p> <p>The cervical cancer elimination strategic action plan has been published and work underway to support implementation.</p>

PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Stay Well	
Performance Rating	
Latest position & performance	See charts
National Benchmarking	The overall performance for school-based vaccination uptake tends to be below the Scottish average.
National Target	There is not a national target for the school based vaccines.

Figure 1: HPV immunisation coverage rates by school year for girls by HSCP (2024/25) **Figure 2: Td/IPV and MenACWY immunisation coverage rates by school year for girls by HSCP (2024/25)**





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Exec Lead
Jennifer Davies,
Director of Public
Health

Smoking Cessation

Key Performance Indicators

Delivery on national targets for Smoking Cessation interventions (12 week quits) >84 per quarter

Reasons for Current Performance (updated April 2026)

- Poor follow up data within Community Pharmacy therefore many follow up outcomes have not been recorded. Capacity issues to complete these follow ups.
- High incidence of smoking in young pregnant women. Services have struggled to engage this group in supporting them to quit
- Limited support for patients within our acute setting.
- Peak in Q4 is seen across Scotland and is likely due to individuals making plans about changes they want to make in their lives for a new year.
- Q3 data will be published in June 2026.

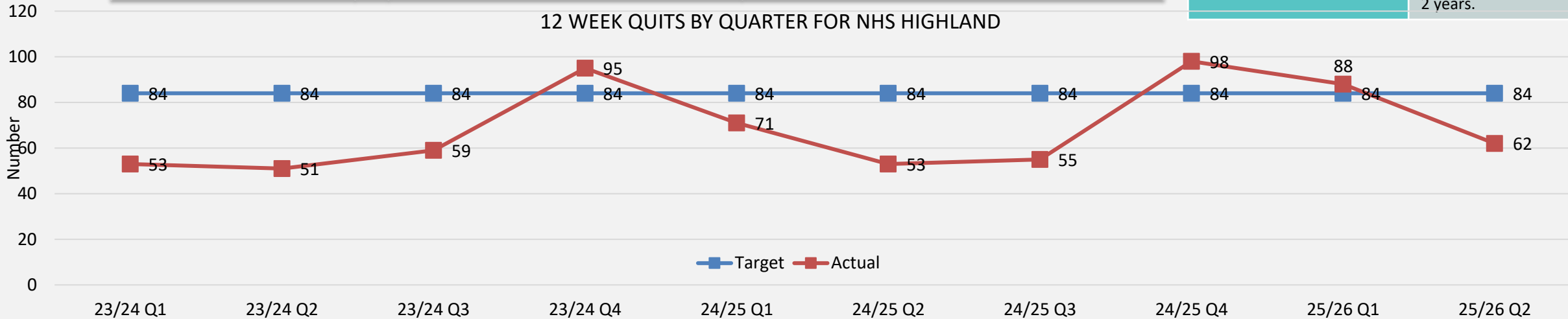
Plans, Mitigations and Actions

- A further set of missing data from pharmacy quit dates from 1st April 2025 – 30th September 2025 have been reviewed. Out of 62 quits missing 12 week follow up data, 26% (16) of individuals had maintained a successful quit, 18% (11) were undertaking another quit attempt and 10% (6) of clients re-engaged with the service. Missing data reviews are ongoing.
- Pilot to provide incentives for pregnant women commenced October 2025. Ongoing work to increase recruitment and expansion of eligibility criteria. Smoking Cessation Champions have been recruited in each community midwifery team and the Family Nurse Partnership team to aid communication and promote the pilot.
- After one year, a review of the Raigmore Inpatient Smoking Cessation pilot is currently being undertaken, including questionnaires for Ward Staff and data collection during April 2026. A final report due to be complete by June 2026.

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

Performance Rating	
Latest Performance	62 quits in Q2 of 25/26
National Benchmarking	
National Target	336 successful quits in 12 weeks in 40 most deprived SIMD areas
National Target Achievement	150 quits delivered by end of Q2. This is 45% of the annual target
Position	Q1 and Q2 shows an improved position compared to the same point in time in previous 2 years.

12 WEEK QUILTS BY QUARTER FOR NHS HIGHLAND





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Exec Lead
Jennifer Davies,
Director of Public
Health

Breastfeeding

Key Performance Indicators

Reduce the attrition of any breastfeeding at 6 –8 weeks by 10% by 2030/1

Reasons for Current Performance (Updated April 2026)

- National extension to breastfeeding stretch aim announced by Health Minister in November 2025. New trajectory to reduce attrition rates in any breastfeeding at 6 – 8 weeks by 10% by 2030/31. New target baselined using 2024/25 position. Trajectory detailed in Graph below. NHS Highland currently on track to deliver the new stretch aim.
- Health in Early Years Scotland (HEYS) dashboard replaced the COVID child data in January 2024. This dashboard enables the timeliest breastfeeding data available. It is published quarterly and graphs below detail quarterly data for both Highland and Argyll and Bute.
- Unicef BFI have agreed a proposal to now join maternity and health visiting services in North Highland for revalidation. This will take place on the 8th and 9th of July 2026.

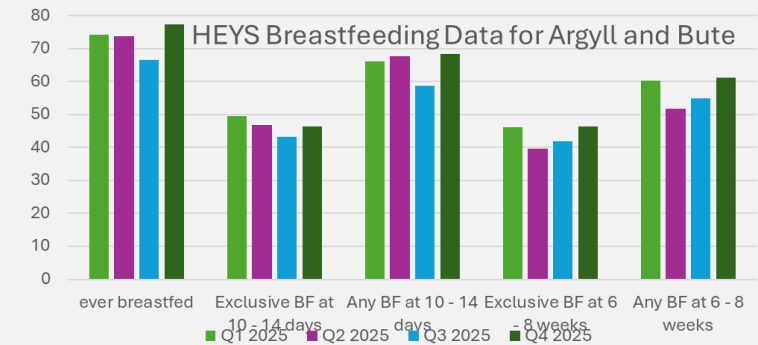
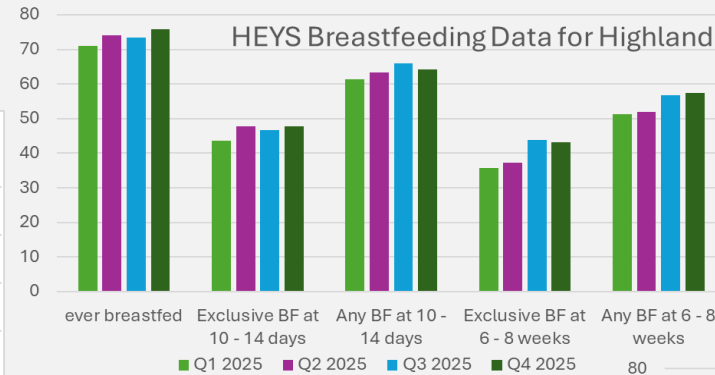
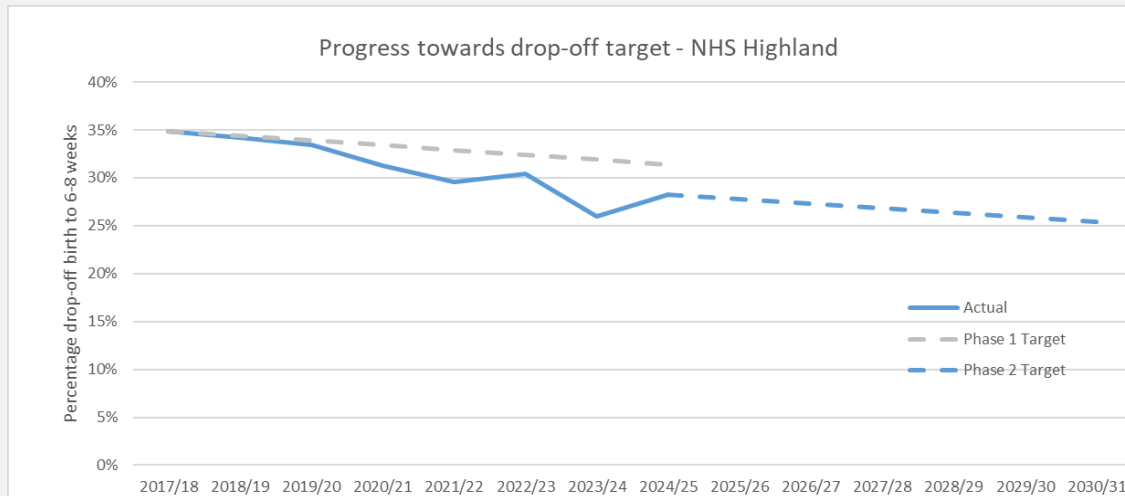
Plans, Mitigations & Actions

Work continues to drive improvements in all aspects of infant feeding workstreams and include infant feeding within the new NHS Highland 10-year Strategy

Publication of National Infant feeding strategy will support forward planning: [Breastfeeding and Infant Feeding Strategic Framework and Delivery Plan](#)

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

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



Alcohol Brief Interventions (ABIs)

Key Performance Indicators

Deliver at least 100% of the planned Alcohol Brief Intervention (ABI) activity target by March 2026

Insights to Current Performance (Updated April 2026)

Fig 1. Total no of ABIs delivered in Q3 is 923. This number is 2.5% 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 (92.7%) with the remainder being delivered in wider settings across NHS Highland.

Due to staff vacancies ABI training has been paused since February 2026.

Antenatal ABI's continue to be a priority. In Q3, 5 ABI's were delivered for in-pregnancy drinking and 4 ABI's for pre-pregnancy drinking.

Plans and Mitigations

Exploration of options to support delivery of ABI's, including training in Primary Care and wider settings is underway.

[PHS review report published Oct 2024](#) – suggesting a need for a refreshed approach. Recommendations include removing three focused priority areas for delivery of ABI's and developing an approach to embed opportunistic conversations about alcohol use into all health and social care settings.

ABI Training delivered to New Craigs staff in Q3

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

Performance Rating	2834 vs. target of 2764 by end of Q3
Latest Performance	923 Q3
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	2764 (End of Q3)
Position	n/a

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Exec Lead
Jennifer Davies,
Director of Public Health

Fig.1

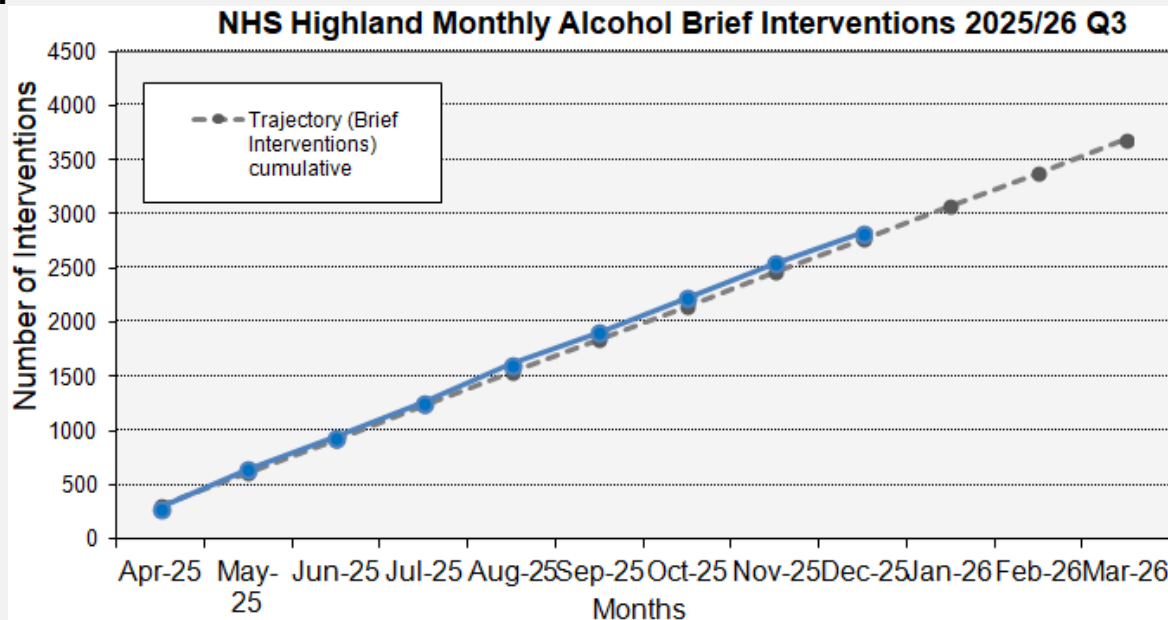
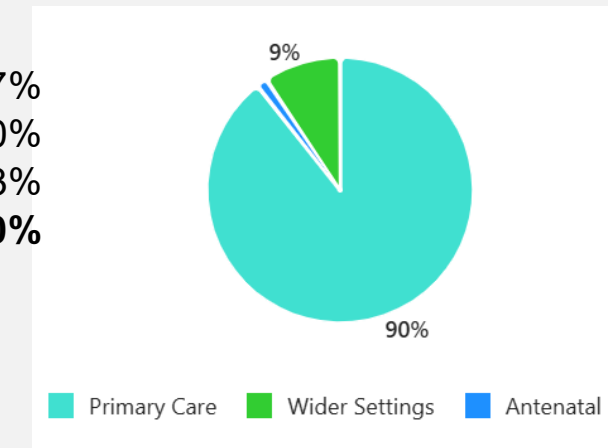


Fig.2 Setting Contribution 25/26 Q3

Primary Care	856	92.7%
Antenatal	9	1.0%
Wider Settings	58	6.3%
TOTAL	923	100%





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Exec Lead
Jennifer Davies,
Director of Public
Health

Screening

Key Performance Indicators

Encourage and promote screening programmes and increase uptake across available screening programmes above national targets.

Insights to Current Performance (Updated April 2026)

- 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, from Public Health Scotland, are typically published with a 1-year delay at the beginning of each financial year. In 2026 (for reporting time periods up to 2025), the results for three of the above four programmes have been released. The publication of Breast Screening Statistics is delayed and is expected once data verification is complete.
- Internal non-verified management data is also collected and used for management purposes, and internal management data suggests similar performance 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 average levels for these programmes too.

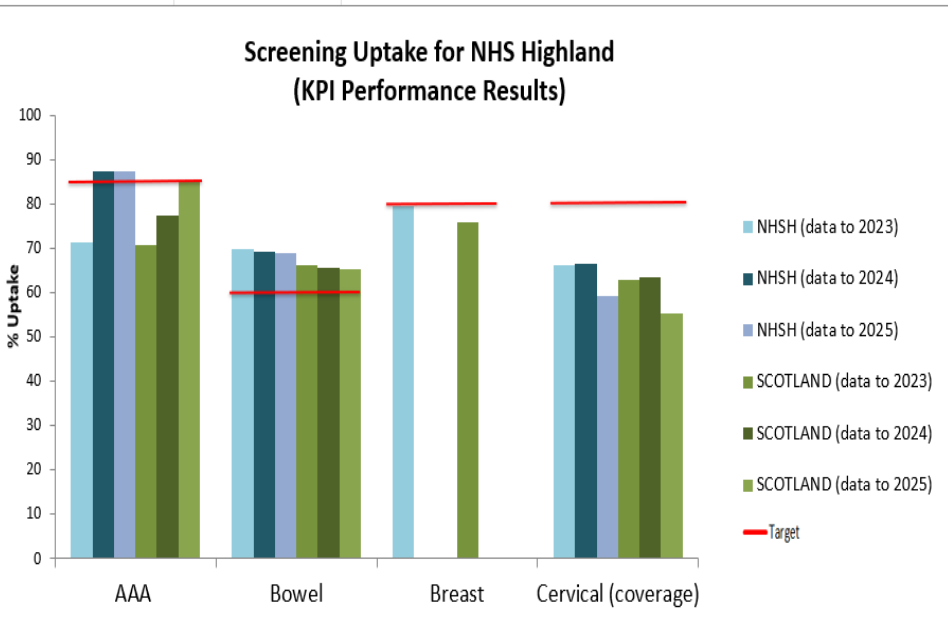
Plans and Mitigations

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	Increasing
Latest Performance	See chart
National Benchmark	See narrative
National Target	2 of 4 reported programmes has uptakes meeting target
National Target Achievement	See charts
Benchmark	See charts



NOTE:

For invitations in the report time period, lookback accounts for screening intervals

*Cervical screening applies a lookback of 3.5 years (for ages 26-49) and 5.5-year (for ages 50-64) to account for age-appropriate intervals. The % of eligible women screened within required timeframe is now referred to as "coverage".

Local community engagement work continues to promote screening in deprived areas. Equality Impact Assessments (for all programmes) are being revised at a national level.

Drug & Alcohol Recovery (DARS)



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Executive Lead
Arlene Johnstone
Chief Officer, HHSCP

Key Performance Indicators

Achieve 90% of clients referred to DARS receiving a completed intervention or treatment plan within 3 weeks by March 2026.

Reasons for Current Performance

- Variation over the reporting period reflects fluctuations in demand, and workforce capacity pressures, which have impacted the service's ability to consistently match NHS Scotland performance levels.
- Variability in performance reporting has highlighted the need for more consistent data entry, with work underway to ensure performance accurately reflects service activity.

Plans, Mitigations and Actions

- Ongoing improvement work to improve flow from referral to treatment planning has contributed to a reduction in waiting list size and more recent stabilisation in performance.
- Active waiting list management continues, with regular review of clients approaching or exceeding the 3-week threshold and prioritisation based on clinical risk.
- Actions are underway to strengthen data quality and assurance. A meeting has been requested with the DAISy team to ensure standardised data entry across all teams, supporting accurate performance reporting

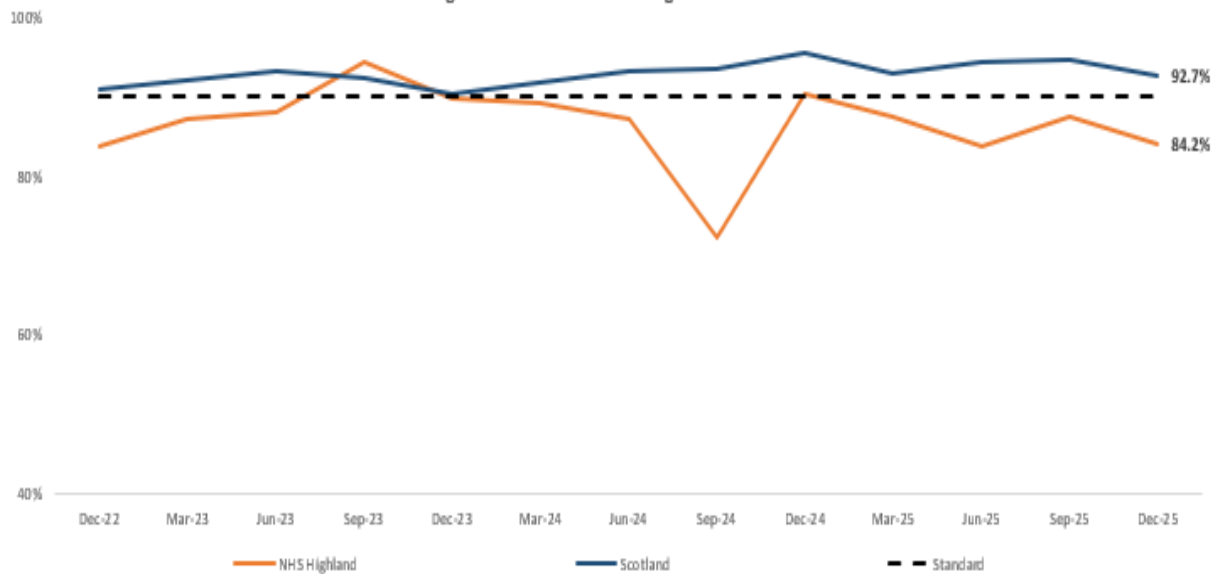
PERFORMANCE OVERVIEW

Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	
Latest Performance	92.7% (Dec 25)
National Benchmarking	84.2% (Dec 25)
National Target	90% DARS referrals seen within 3 weeks
National Target Achievement	n/a
Position	n/a

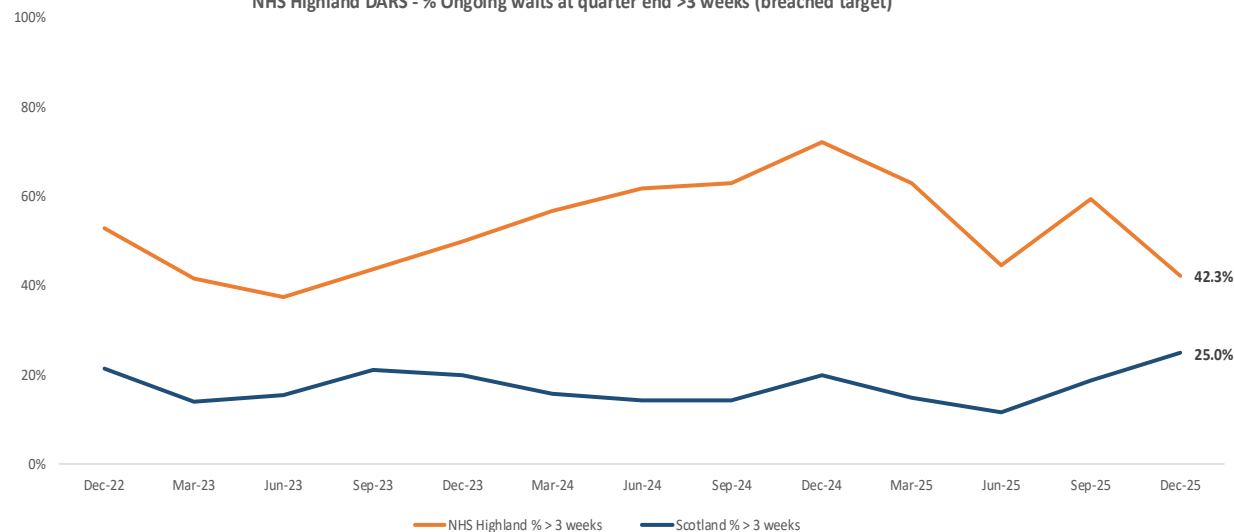
NHS Highland DARS: Performance Against Standard for Completed Waits

NHS Highland DARS Performance against LDP Standard



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

NHS Highland DARS - % Ongoing waits at quarter end >3 weeks (breached target)





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**Executive Lead
Louise Bussell,
Nurse Director**

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' RTT performance has dipped due to staffing vacancies and recruitment delays linked to funding uncertainty. Despite this, 86.7% of patients were treated within 18 weeks (Feb 2025–Jan 2026), outperforming the national average of 79.9%, and NHS Highland remains the second-highest performing mainland board despite a relatively small workforce.

Argyll & Bute

- 0.8 WTE psychologist absent ~10 weeks.
- 1.0 WTE CBT therapist absent 11+ weeks.
- New senior psychologist in induction, reducing clinical activity.
- Psychologists covering interim management duties, reducing clinical time.
- December–January reduced appointments, staffing, and overall activity.

Plans, Mitigations and Actions

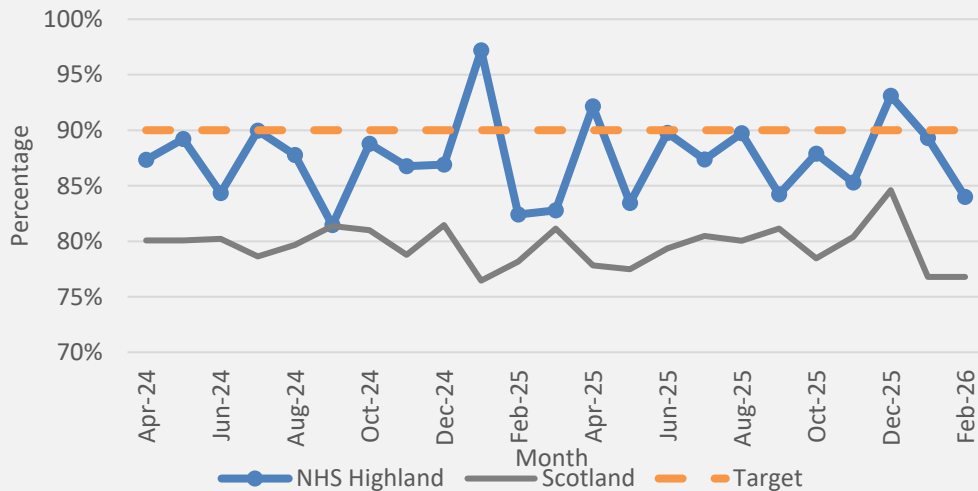
Highland Work with SG and PHS is ongoing to improve adult psychology data quality and forecasting through DCAQ modelling, supporting better planning and demand alignment. Further TrakCare PMS development is required to enable sub-specialty coding and a forecasting tool. In parallel, a psychology-specific staff bank is being developed to improve service resilience and address workforce pressures.

Argyll & Bute vWith some absences easing, key staff returning, and recruitment now moving forward, there is optimism that RTT performance can improve. The CBT resource in one locality is becoming more stable, psychologist in Cowal and Bute returned to work. Consultant recruitment underway, new senior psychologist is now fully operational.

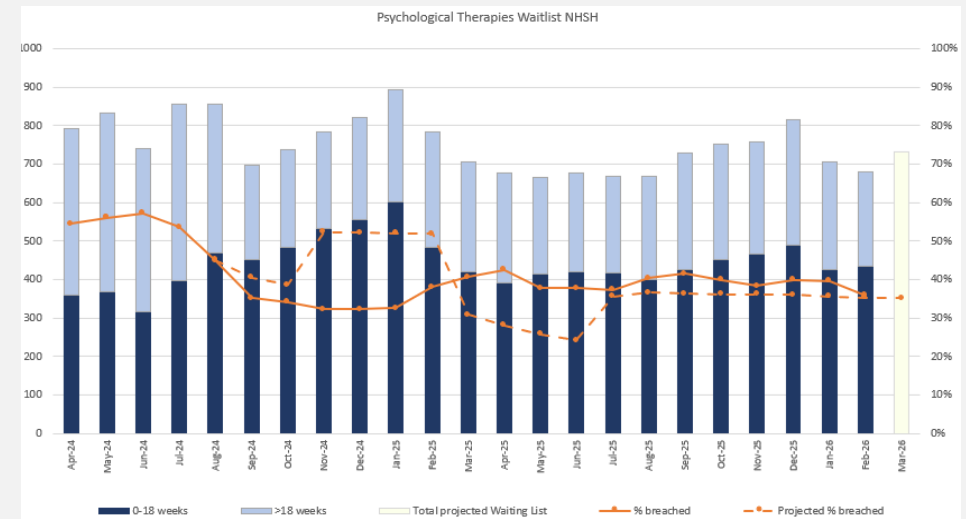
PERFORMANCE OVERVIEW Strategic Objective: Our Population Outcome Area: Treat Well

Performance Rating	
Latest Performance	84.0%
National Average	76.8%
National Target	90%
National Target Achievement	Consistent improvements in targets
Position	4th out of 14 Boards

Patient seen < 18 weeks



Waiting List Size





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**Executive Lead
Katherine Sutton
Chief Officer, Acute**

OIP

Emergency Department Access

Key Performance Indicators

Achieve a 5% improvement in the number of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2026.

Reduce the number of A&E patients admitted, transferred, or discharged within 8 hours of arrival by March 2026, reducing extended waits and improving care quality.

Reduce the number of patients waiting > 12 hours in A&E by March 2026, ensuring no patient experiences excessively prolonged waiting times.

Reasons for Current Performance

Raigmore Hospital: Standard DD numbers increased for 4th week in a row; however, AWI DD numbers have reduced over the last 4 weeks and are now at target.
ED Performance declined and below median of 69.5% for the first time in 8 weeks
Slight increase of 1 – 3-day LoS and 4–14-day LoS

Caithness Hospital (CGH): Reduced ED capacity and flow, increased 8/12/24-hour breaches

Belford Hospital (BH):

- System Pressures & flow delays due to bed shortages
- Delays in specialist input & patient transfers out
- Requirement to deviate from usual care pathways & extended observations due to capacity constraints

Plans, Mitigations and Actions

Raigmore: NHS Interface Meetings for System Pressures – reporting to EDG
Raigmore Capacity Stabilisation Program commenced on 25 Feb 2026, Use of non-standard bed spaces to eliminate 12-hour waits in ED
CGH: DMT meetings with community and discharge support nurse; escalation protocol reinforced for out-of-hours & staff awareness; OPEL score tests of change established for 13:15 and 14:45 daily; Day case area used as a discharge lounge; three daily OPEL huddles embedded

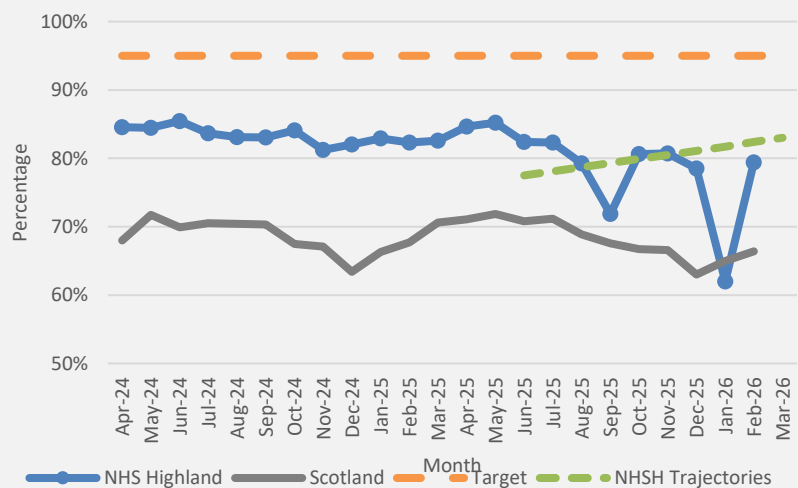
Belford Hospital (BH):

- Enhanced Operational Oversight at OPEL level 3
- Improved patient flow & discharge – use of trial discharge area
- Staffing adjustments – Recruitment of bank nurses and adjustment of twilight and night shifts

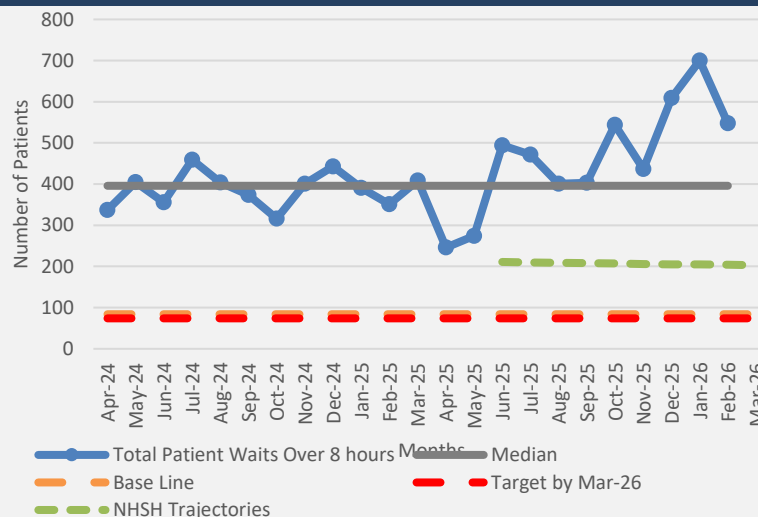
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	
Latest 4-hour Performance	79.4%
National 4-hour Average	66.4%
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	2nd out of 14 Boards

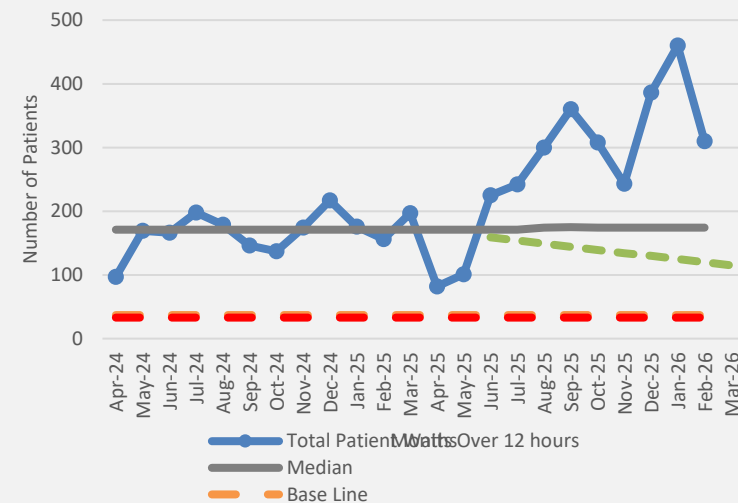
% of people seen in ED within < 4 hours per month



Total Patients waiting > 8 hours in ED per month



Total Patients waiting > 12 hours in ED per month





**Executive Lead
Arlene Johnstone
Chief Officer, HHSCP**

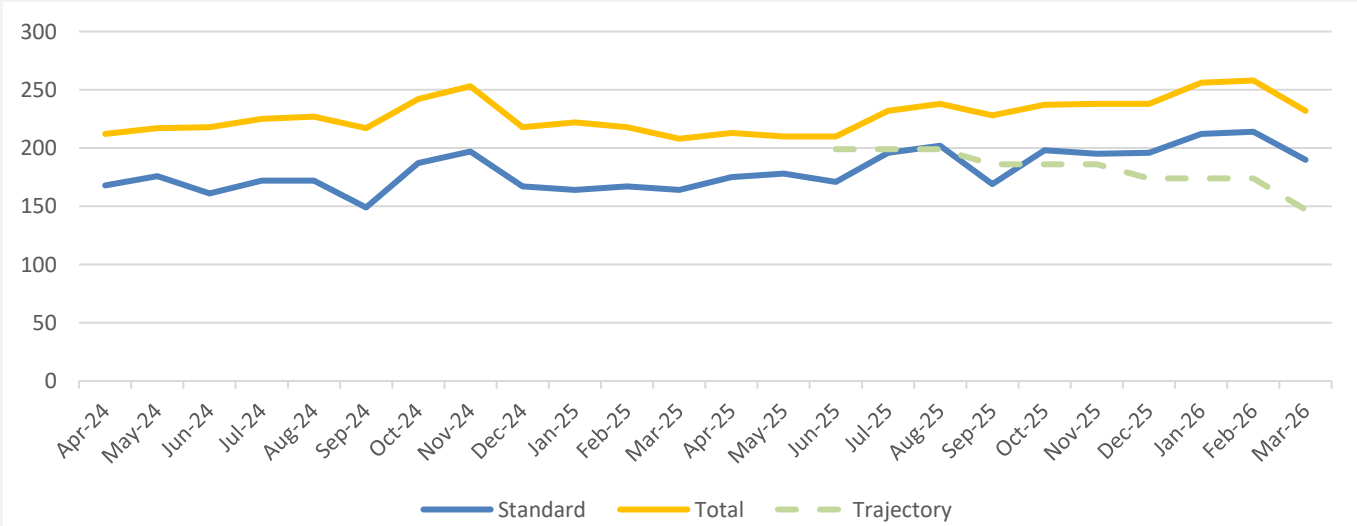


Delayed Discharges

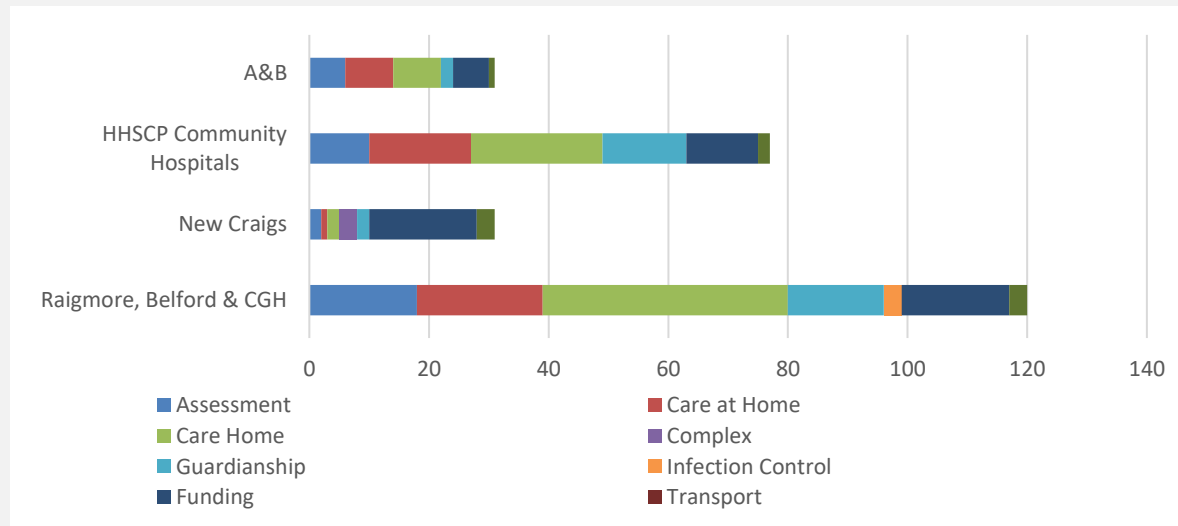
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
<p>Reduce the total number of patients experiencing a standard delay in discharge from hospital across NHS Highland to agreed targets and trajectories.</p> <p>Target = 151 standard delays and 37 AWI by 31/03/26</p>	<ul style="list-style-type: none"> There has been a slight improvement in delayed discharge position, however overall delays remain higher than improvement trajectory, due to pressures in the health and care system. 	<p>Highland HSCP: implementation of the DWD principles with focus on Integrated Discharge Team and D2A ensuring patients are on the appropriate pathway Daily escalation meetings within the community services to review DHDs and potential barriers Focused work with commissioned services to improve the access to LTC</p> <p>Argyll & Bute Argyll and Bute continue to note a downwards trajectory. Daily MDT flow meetings continue to take place. Dedicated Social Work resource has been operationalised across Clyde Sector Hospitals to target and prevent DDs in GGC sites. D2A Team (Whole System) is operational from 1 May 2026 and will target areas of highest system pressure. Care at Home budget and resources has been reviewed with a view to rebalancing available resources in line with demand.</p>

PERFORMANCE OVERVIEW Strategic Objective: In Partnership Outcome Area: Respond Well	
Performance Rating	
Latest Performance	232 at Census Point
National Benchmarking	Engagement through national CRAG group and CfSD
National Target	Trajectories developed
National Target Achievement	Not Met
Position	14 th 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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Executive Lead Katherine Sutton Chief Officer, Acute

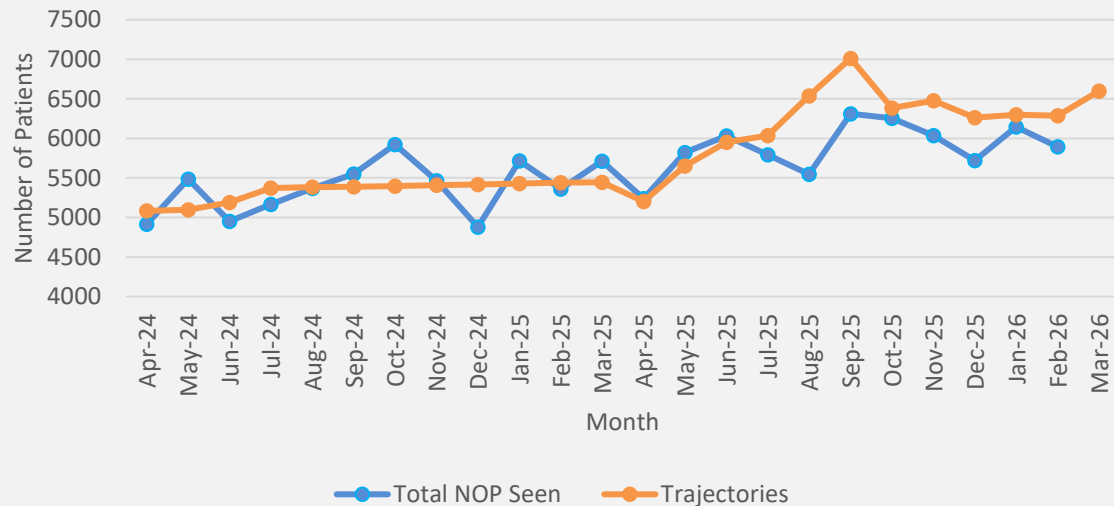
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Outpatients (New Outpatients – NOP – seen within 12 week target) – Slide 1 of 3

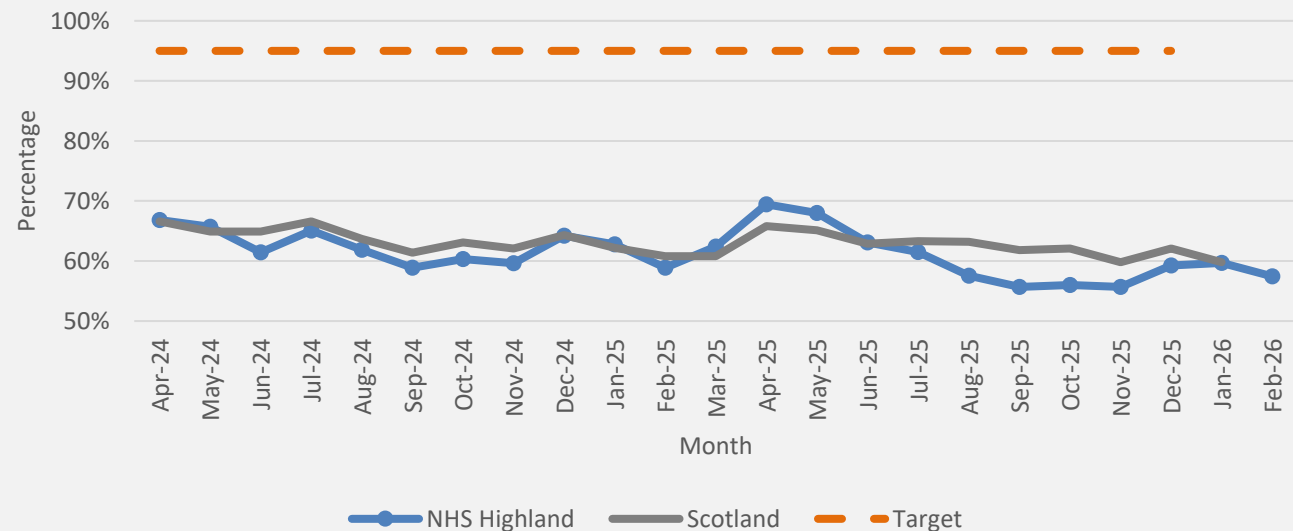
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the number of new patients waiting over 52 weeks for a new outpatient appointment to 1,133 by March 2026.	<p>Highland We have continued to focus on reducing the overall length of wait for new outpatient appointments. Core activity continues to be on target, however, there has been slippage with some of the additionally funded activity we have planned. Our target for the number of people waiting over 52 weeks was reviewed and adjusted to no more than 1,133 people to be waiting at the end of March 2026 – we are on target to achieve this.</p> <p>Argyll & Bute recorded 41 NOP waiting over 52 weeks at end March against our target of zero. This was mainly due to unavoidable patient cancellations on the 30th and 31st. We redirected some additional oral surgery activity to TTG to address the increasing backlog from the additional 150 NOP seen during February and March which allowed us to report just 3 oral NOP waiting over 52 weeks at year end. Work is ongoing to scope out a shared Urology nurse service with NHSH into 26/27.</p>	<p>Highland We are reviewing the impact the volume of activity we have undertaken has had on our return waiting lists and exploring options for improvement.</p> <p>Argyll & Bute We are considering the future of our locum led visiting oral surgery service as we no longer have any planned care funding available for agency additionality and this specialty will again become an area of huge pressure for us.</p>
The number of completed new outpatients appointments is equal to or exceeds the monthly target		
The number of completed new outpatients appointments is equal to or exceeds the cumulative target		
Increase the percentage of new outpatient referrals seen within 12 weeks of referral equal to or above 95%.		
Total number of patients currently waiting for return outpatient appointments to be equal to or less than previous year's monthly average		

PERFORMANCE OVERVIEW	
Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating against Plan	
Latest Performance against Plan	3.58% behind target
National Benchmarking against 12 week performance	57.4% (Scotland 43.3%)
National Target against 12 week performance	95%
National Target Achievement against 12 week performance	Target not met Below lower control limit
Position against 12 week performance	6 th out of 15 Boards

New Outpatients Seen & Trajectories



Outpatients Seen <12 Weeks Including Consultant and Nurse Lead Activity





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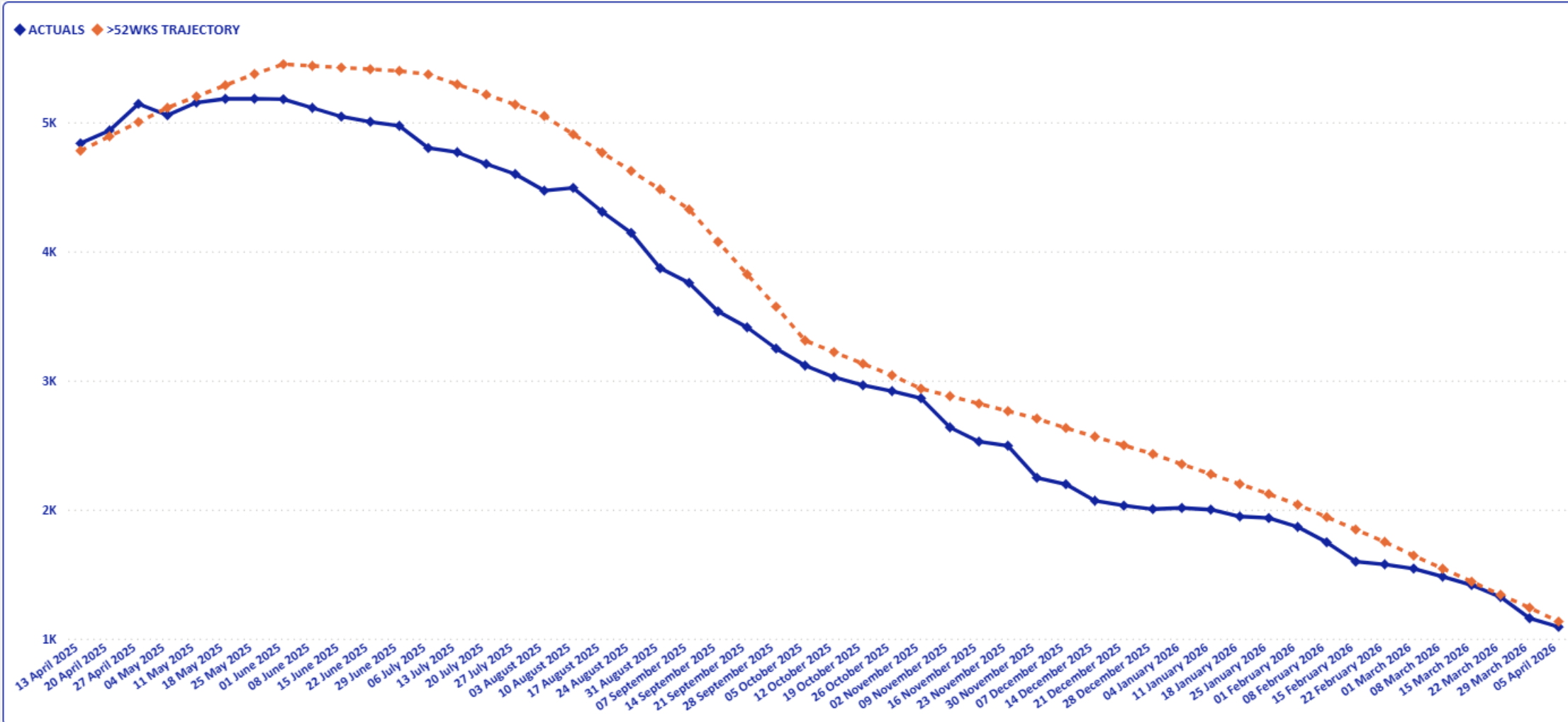
Executive Lead
Katherine Sutton
Chief Officer, Acute

OIP

Outpatients (Long Waits) - Slide 2 of 3

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

Long Waits >52 weeks





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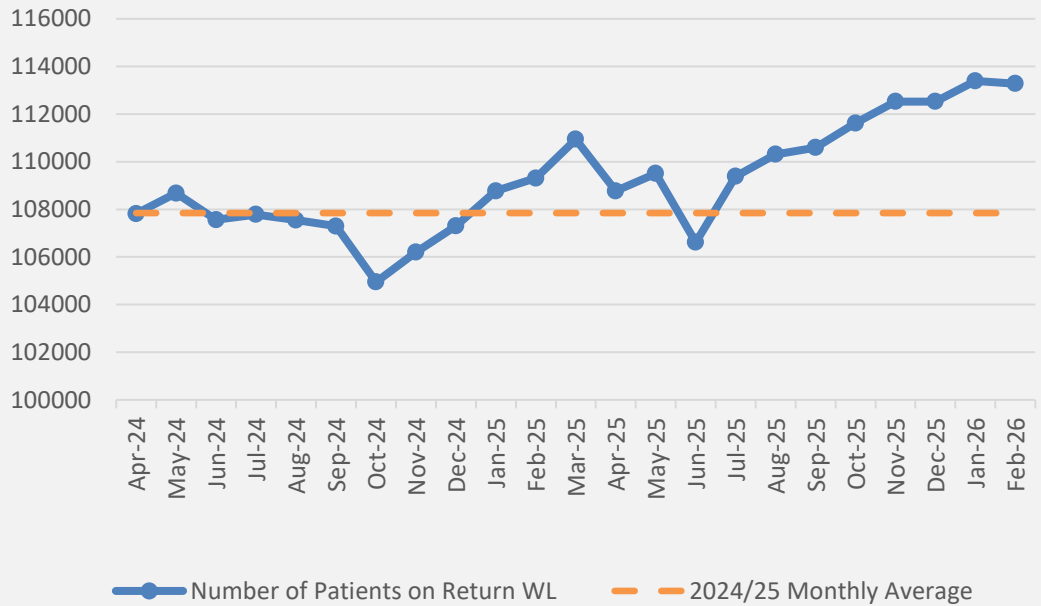
Executive Lead
Katherine Sutton
Chief Officer, Acute

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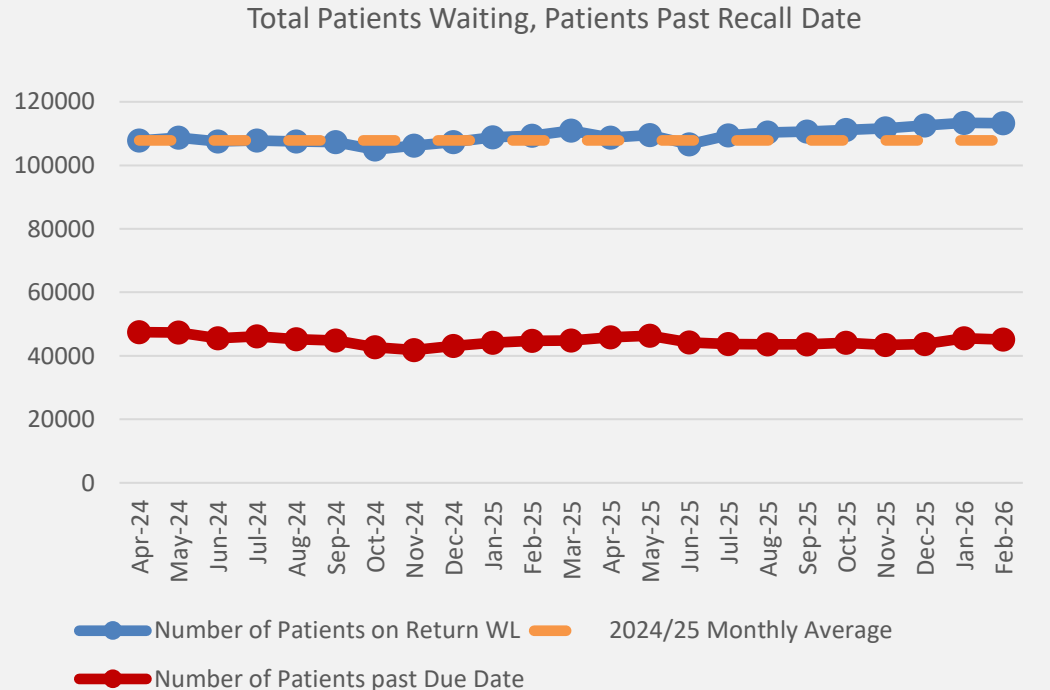
Outpatients (Return Outpatients) - Slide 3 of 3

NHS Highland continues to monitor the level of return outpatients on our waiting lists, and since summer 2025 we observe an increase on the average of this time last year. This may be a consequence of our focus on ensuring outpatient activity is focused on reducing the total number of new outpatients > 52 weeks. A focused programme of work is commencing to examine the reasons for the increasing return waiting lists and ensure the lists are cleansed and all relevant actions are applied to reducing return demand.

Return Outpatients Wait List vs. 24/25 Average



Return Outpatients Wait List





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Executive Lead
Katherine Sutton
Chief Officer, Acute

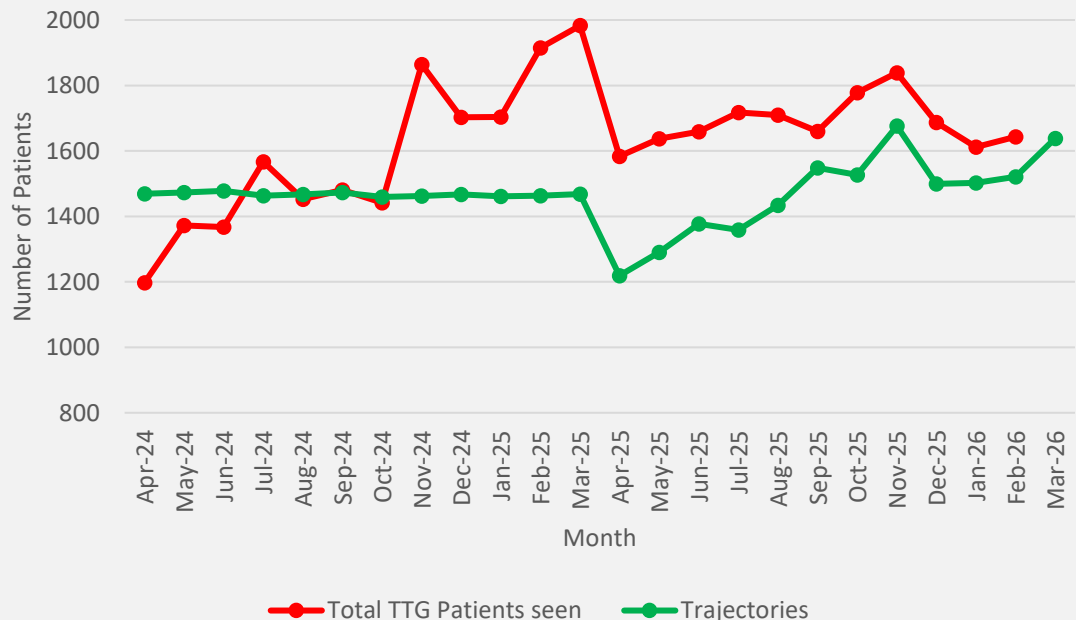
OIP

Treatment Time Guarantee (TTG) - Slide 1 of 2

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the number of TTG patients waiting over 52 weeks to 124 by March 2026	<p>Highland Activity targets for TTG are on track to be met. This has also resulted in a reduction of people waiting over 52 weeks in line with our trajectory.</p> <p>Argyll & Bute - Argyll & Bute reported zero 52 week TTG breaches at end March.</p>	<p>Highland There are a very small number of people who have had long waits and we are developing individual plans to ensure people are seen as required.</p> <p>Argyll & Bute - There is now a significant number of oral surgery cases on the TTG list and with only 7 theatre slots per month these will become an issue. Conversations about the service moving to the PDS are ongoing.</p>
The number of inpatient/day case procedures undertaken is equal to or exceeds the monthly target		
The number of inpatient/day case procedures undertaken is equal to or exceeds the cumulative target		
Percentage of TTG patients seen within 12 weeks of referral equal to or above 95% every month. within 12 weeks of referral equal to or above 95% every month.		

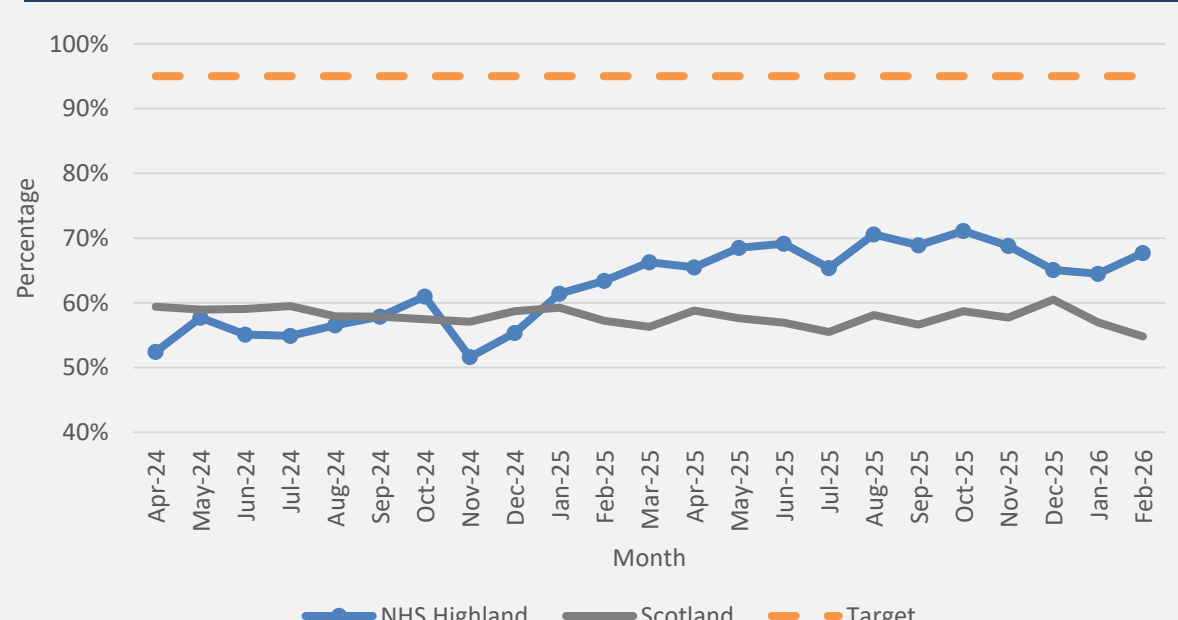
PERFORMANCE OVERVIEW	
Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating against Plan	
Latest Performance against Plan	On target
National Benchmarking against 12-week performance	67.7% (Scotland 54.8%)
National Target against 12-week performance	100%
National Target Achievement against 12-week performance	Target Not Met; But consistently above Scotland average
Benchmarking against 12-week performance	6 th of out 15 Boards

Patients Seen & Trajectories



TTG Seen <12 Weeks

Consultant Only





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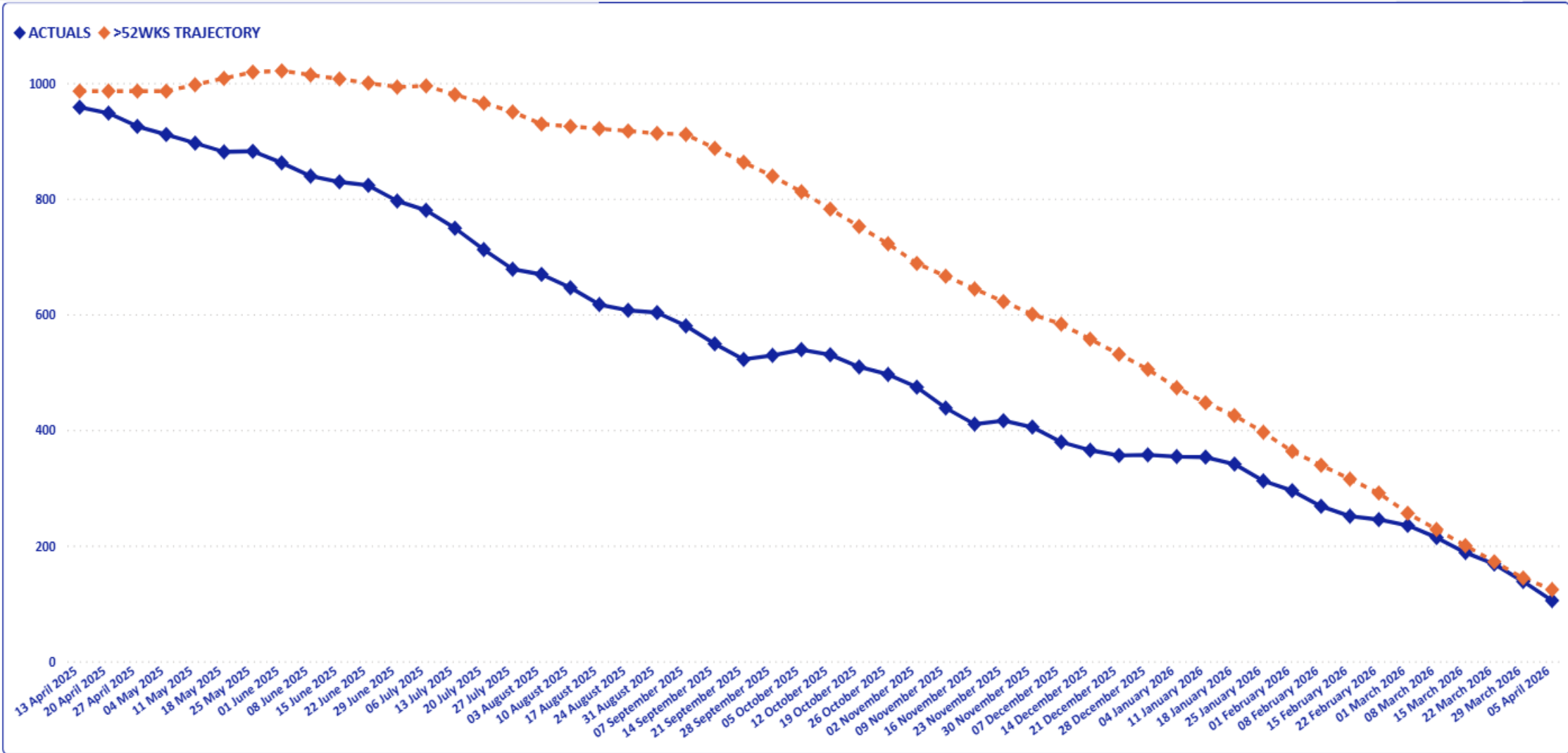
Exec Lead
Katherine Sutton
Chief Officer, Acute

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TTG (Long Waits) - Slide 2 of 2

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

Long Waits >52 Weeks





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Katherine Sutton
Chief Officer, Acute

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Diagnostics – Radiology – Slide 1 of 2

Key Performance Indicators

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

Increase the number of patients receiving a key diagnostic test within 6 weeks from referral, in line with NHS Scotland guidance

Reasons for Current Performance

Highland:

- Performance stable, additional CT activity beneficial. MRI inpatient activity high, outpatient activity keeping pace with demand. Ultrasound insourcing has ceased but activity exceeded new requests January to March.

Plans, Mitigations and Actions

Highland:

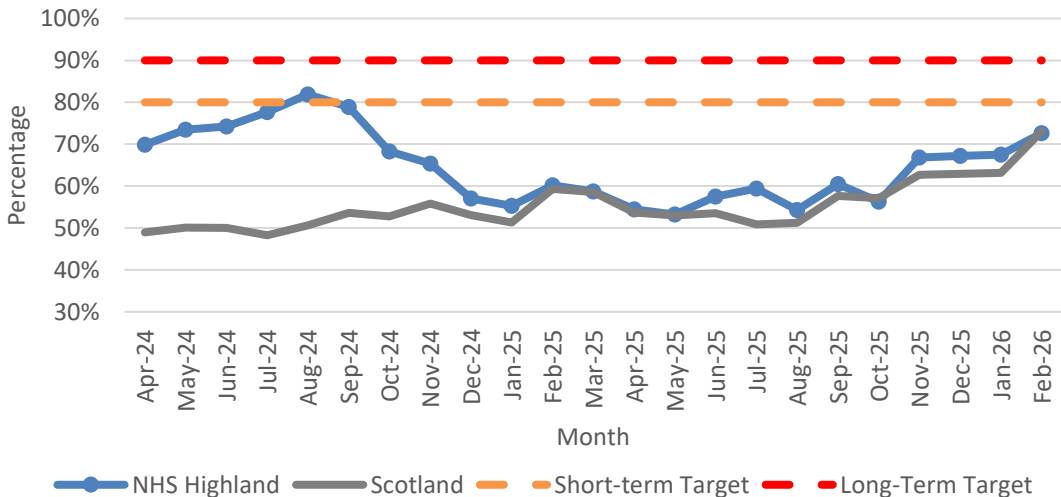
- Mobile van confirmed for Q1 26/27, patients booked in.
- New professional lead radiographer post appointed to (commencement date tbc), post holder will assist with performance planning.

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

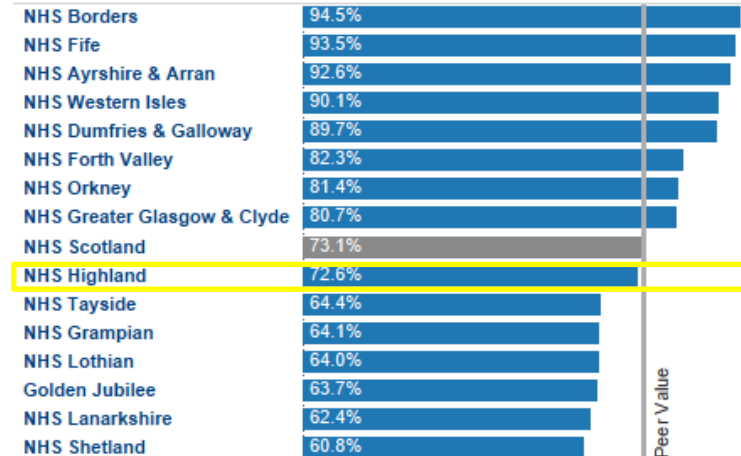
Performance Rating against Plan	
Latest Performance against 6-week target	72.6% (Feb 26)
National Benchmark against 6-week target	73.1%
Local Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NESH is above Scotland average
Benchmarking	9th out of 15 Boards

Imaging Tests: Maximum Wait Target 6 Weeks

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



Benchmarking with Other Boards



Planned Activity

Yearly Trajectory	28,668
YTD Performance Trajectory	26,279 (91.96%)
Patients Seen – Feb 26	33,845 (118.06%)
Overall	26.39% above target



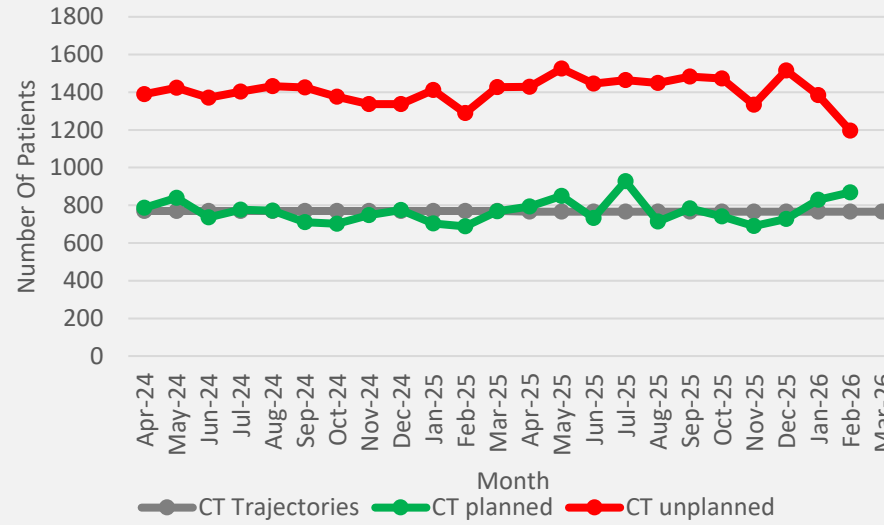
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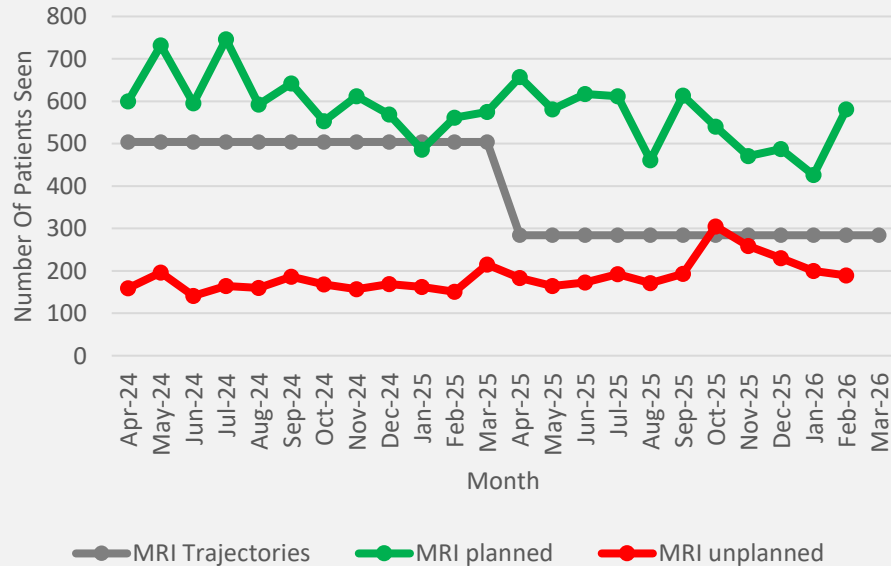
Exec Lead
Katherine Sutton
Chief Officer, Acute

OIP

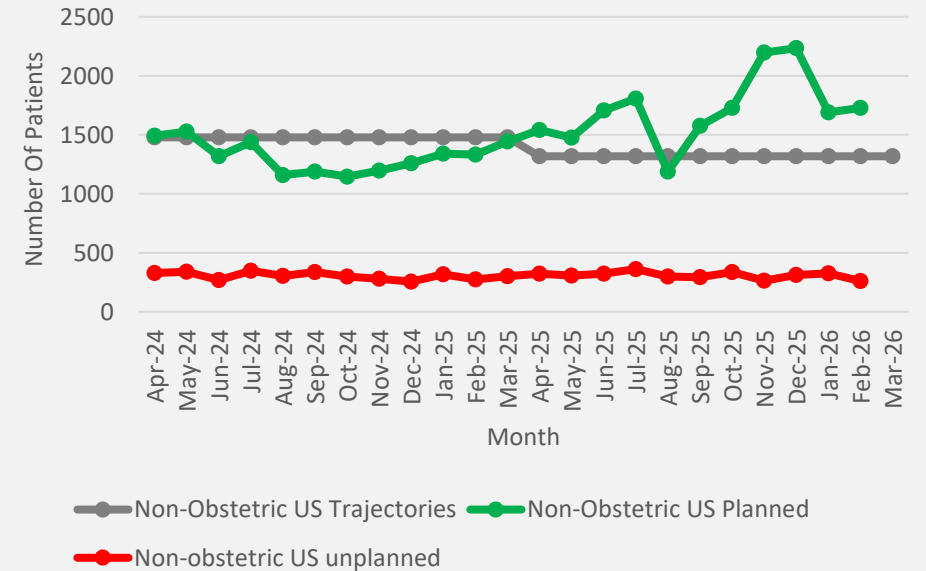
CT Patients Seen and Trajectories



MRI Patients Seen and Trajectories



Non-Obstetric Patients Seen and Trajectories





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Chief Officer, Acute

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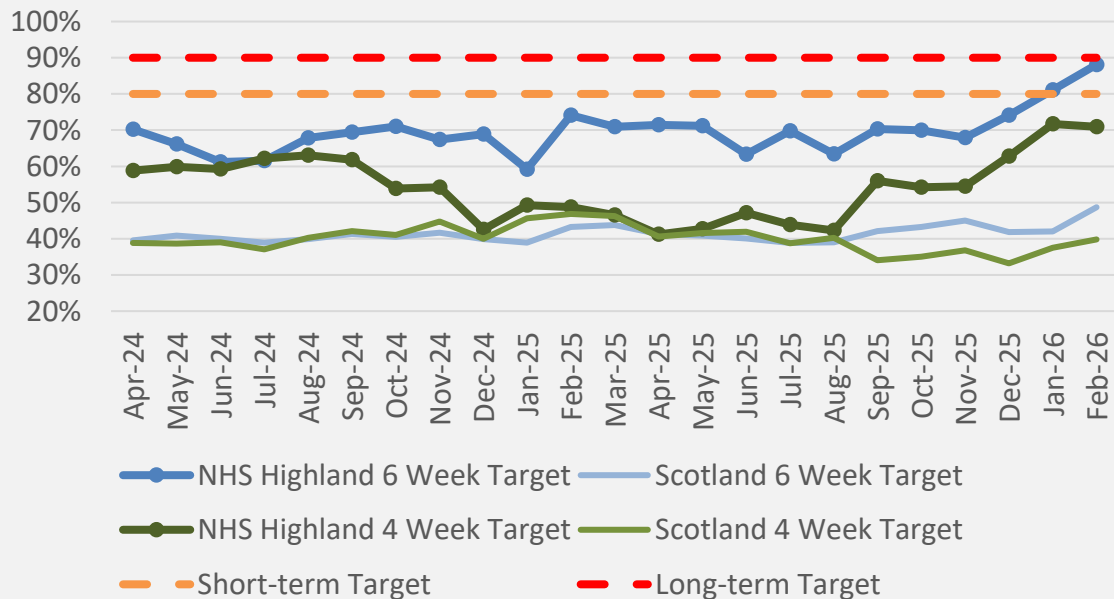
Diagnostics – Endoscopy – Slide 1 of 2

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	<p>GI endoscopy: Additional scope sessions provided with CCE funding after loss of reading service. Capacity has diminished at Belford and Caithness sites – paper to go to ASLT to propose recruitment of nurse endoscopist</p> <p>Cystoscopy: Reviewed nurse support model and DCAQ work completed</p>	<p>Overall: TrakCare PMS continues to measure waiting times on 28days rather than 42 days – this was first raised 2.5years ago</p> <ul style="list-style-type: none"> It is on digital plan It does have a work order raised through ehealth Single Point of Contact It has been raised with support services <p>Highland are the only board in Scotland failing to report on 42days; national team and JAG assessment both flagged this</p>
The number of patients seen for a new endoscopy appointment is equal to or exceeds the trajectory every month		
The number of patients seen for a new Colonoscopy, Cystoscopy, Flexi Sig and Upper GI is equal to or exceeds the number of planned appointments every month		

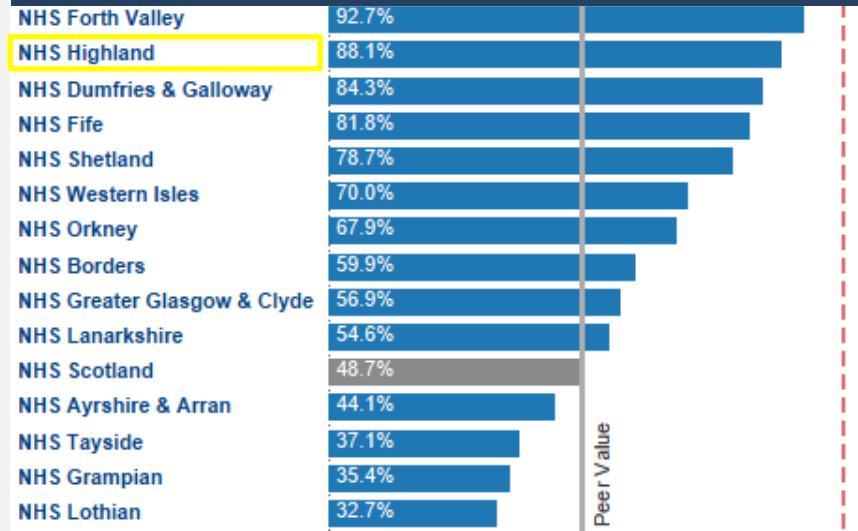
PERFORMANCE OVERVIEW	
Strategic Objective: Our Population Outcome Area: Treat Well	
Performance Rating	
Latest Performance	88.1% (Feb 26)
National Benchmark	48.7%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	
Benchmarking	2nd out of 15 Boards

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	4746 (91.69%)
Patients Seen – Feb 26	6,204 (119.86%)
Overall	28.17% above target



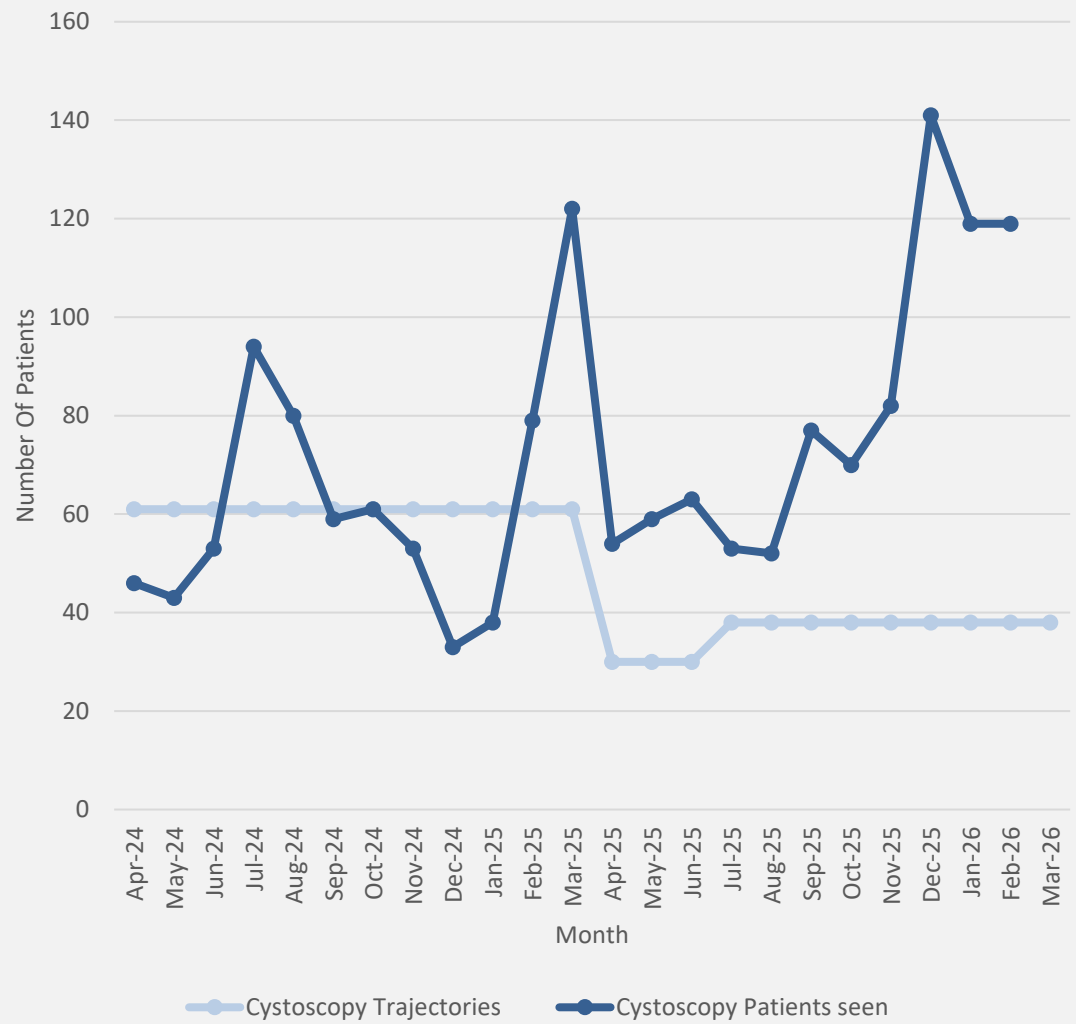
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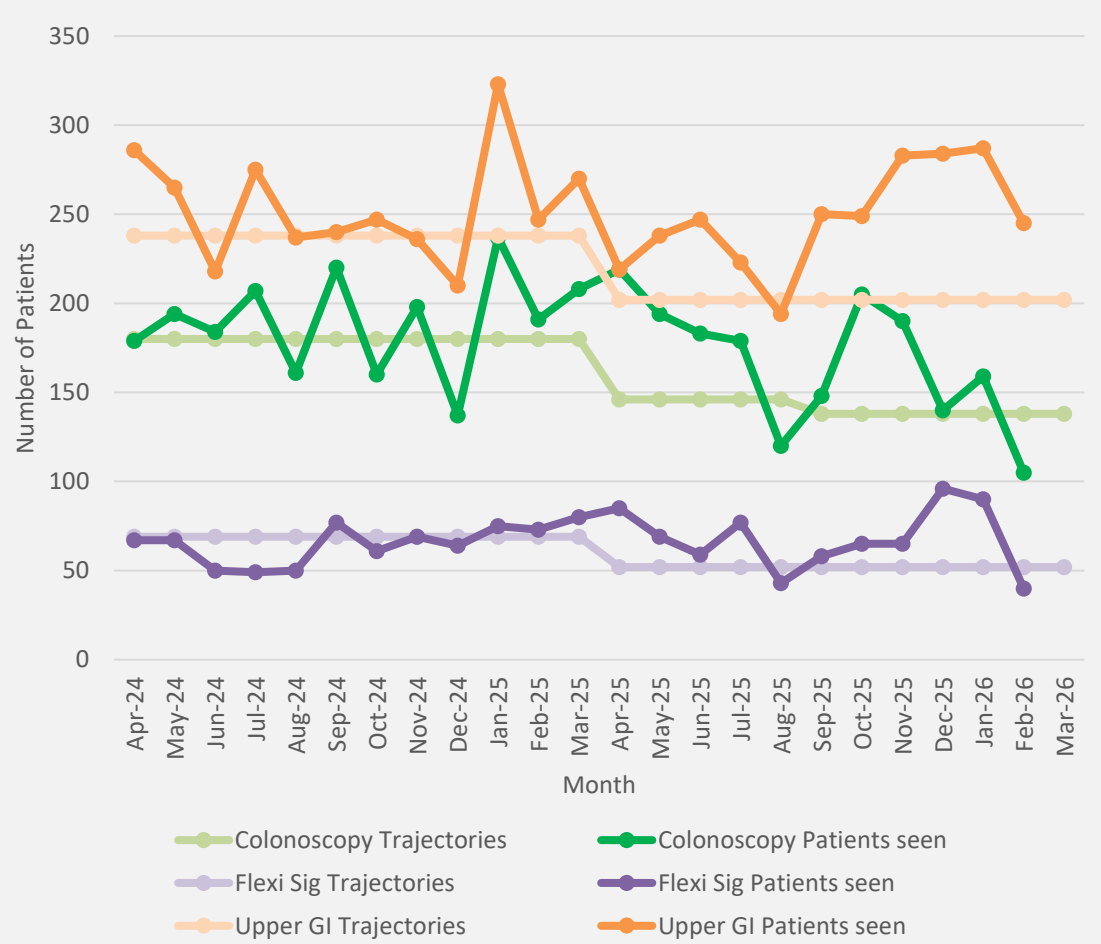
Exec Lead
Katherine Sutton
Chief Officer, Acute

OIP

Patients Seen and Trajectories:
Cystoscopy



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





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Executive Lead
Katherine Sutton
Chief Officer, Acute

OIP

31 Day Cancer Waiting Times

Key Performance Indicators

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

Reasons for Current Performance

- The majority of the patients that breach are on breast cancer pathways. The retirement of a Breast Surgeon and the inability to recruit a replacement now after three attempts is the main reason for the lack of capacity.

Plans, Mitigations and Actions

- The retired surgeon has come back to work on a regular basis as from March 2026.
- Continuing "See and Treat" capacity with NHS Forth Valley is also being considered in collaboration.

PERFORMANCE OVERVIEW

Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating

Latest Performance

National Benchmarking

National Target Achievement

Position

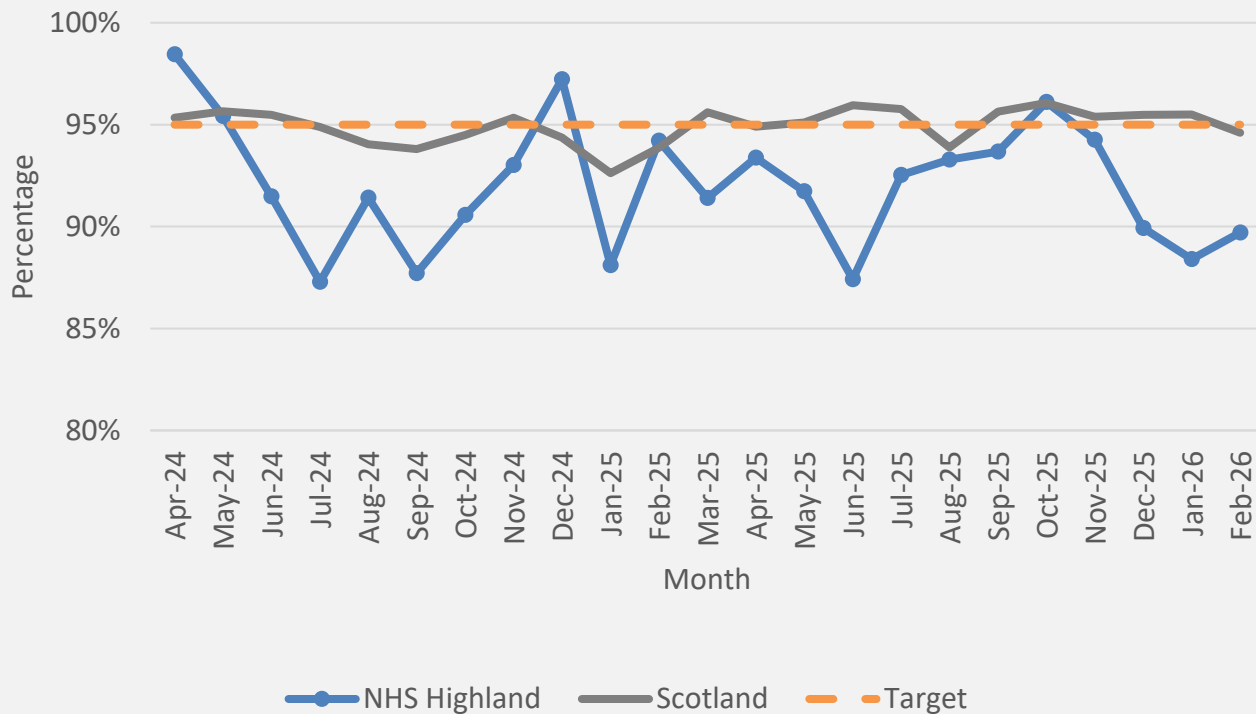
89.7%

94.6%

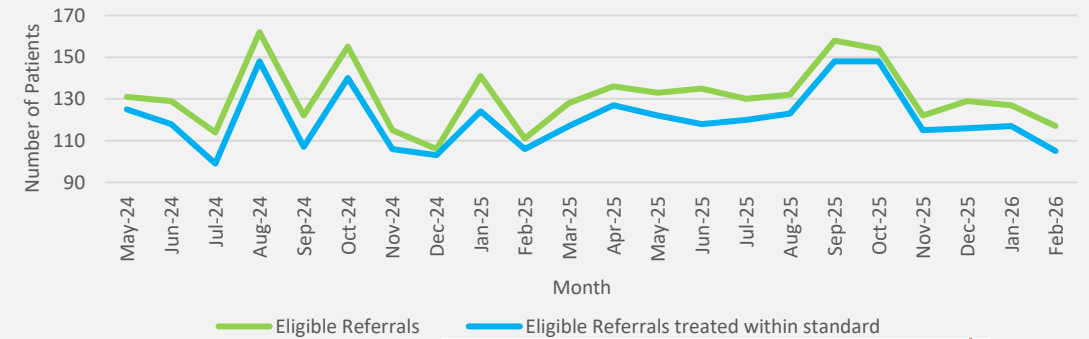
95%

14th out of 15 Boards

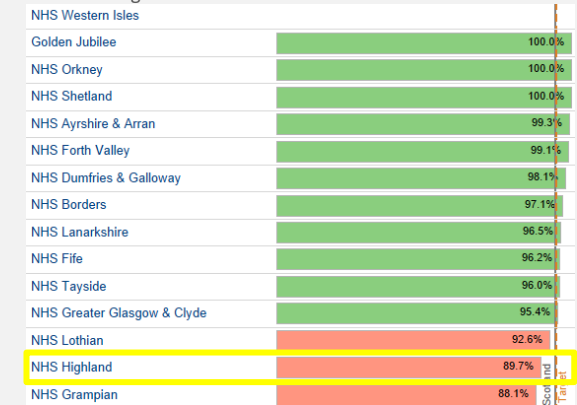
31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



31 Day Benchmarking with Other Boards





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Executive Lead Katherine Sutton Chief Officer, Acute

OIP

62 Day Cancer Waiting Times

Key Performance Indicators

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.

Reasons for Current Performance

- Prostate – a delay to MRI test and report due to a lack of staff and machine capacity.
- Colorectal – 4 week wait to Endoscopy
- Colorectal – waiting time to staging scan
- Breast – waiting time to assessment and diagnostic service

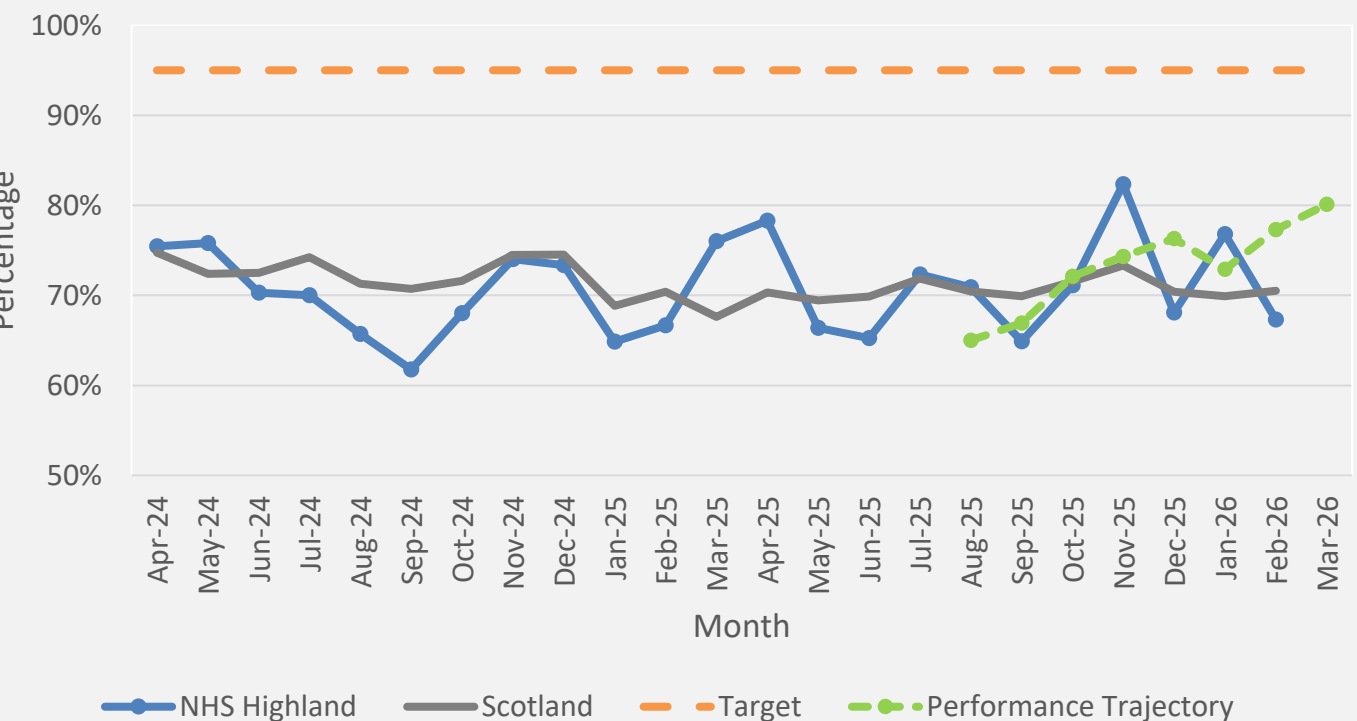
Plans, Mitigations and Actions

Prostate, until January 2026 was the best performing specialty in the country. Meetings have now been held with Radiology colleagues to restore waiting time to 2025 position.
Colorectal – appointment of Nurse Endoscopists in all RGH locations and ring fencing of staging scans
Breast – continued mutual aid from Forth Valley team

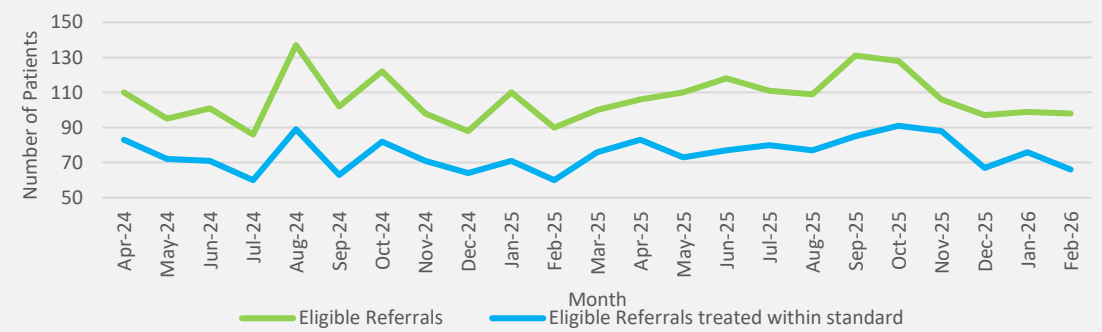
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	
Latest Performance	67.3%
National Benchmarking	70.5%
National Target	95%
National Target Achievement	Not Achieving
Position	8 th Out of 14 Boards

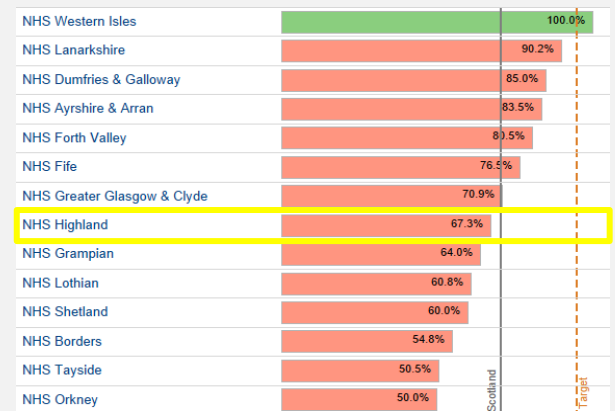
62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



62 Day Benchmarking with Other Boards





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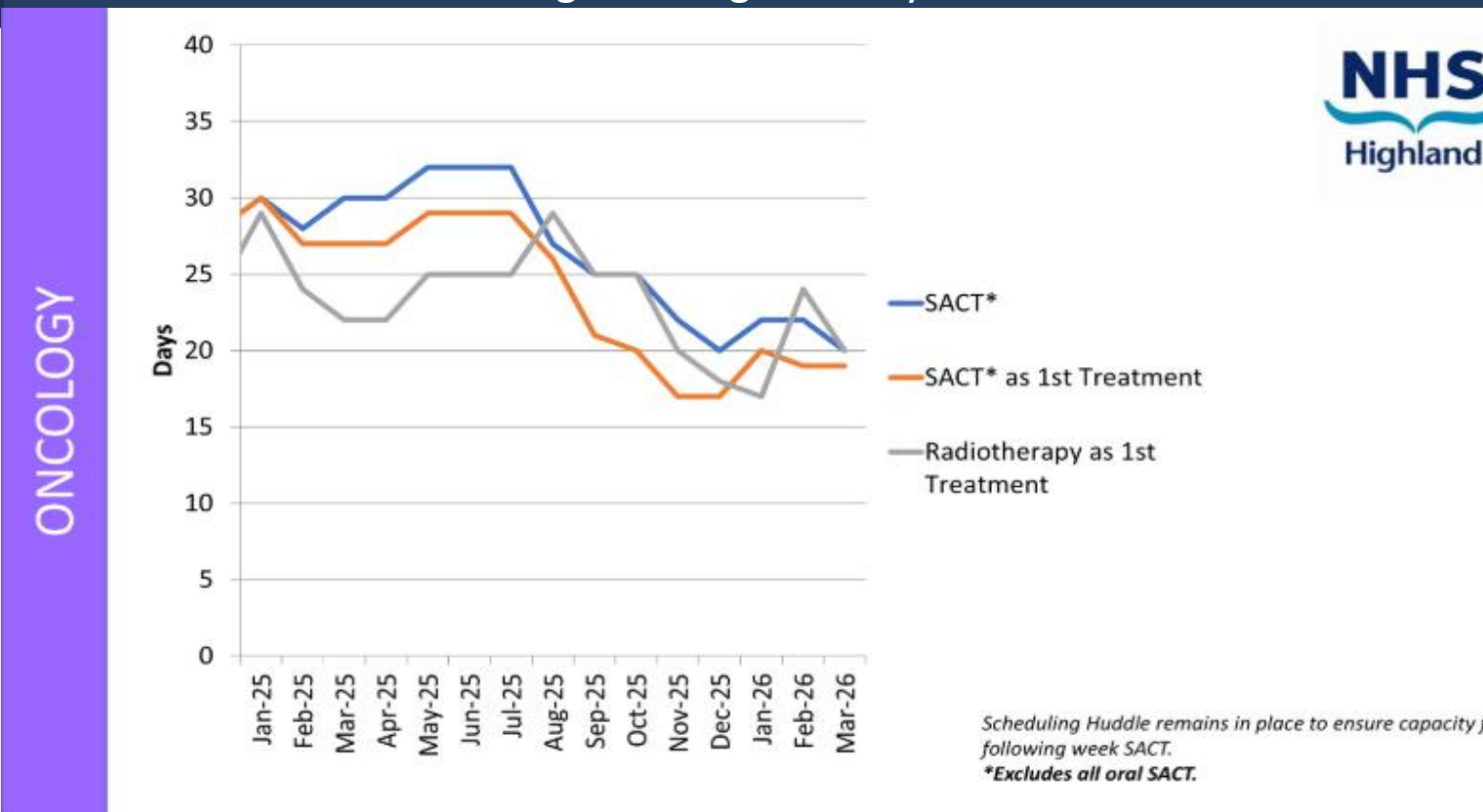
Executive Lead
Katherine Sutton
Chief Officer, Acute

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

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

PERFORMANCE OVERVIEW	
Strategic Objective: Our Population	
Outcome Area: Treat Well	
Performance Rating	
Latest Performance	Average range = 16-20 days to start treatment
National Benchmarking	n/a
National Target	n/a
National Target Achievement	n/a
Position	NHS Highland activity matches national trends

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





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**Exec Lead
Boyd Peters**

Stage 2 Complaint Activity (February 2025 – February 2026)

ADP Deliverables Progress as at End of Q2 2025/26

N/A

Insights to Current Performance

Improvement in performance over past 3 months. 30% of Stage 2 complaints responded to within expected timescale in February.

Response rate of Acute (38%) and A&B (40%) particularly good but concerns remain around performance of HHSCP.

Plans and Mitigations

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 2 months to include bespoke reports.

Meetings have been held with SLT. Investigations are the responsibility of the Operational Units. Chief Officers updated regularly to allow performance oversight within their units.

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

Performance Rating

Red

Latest Performance

30%

National Benchmarking

None

National Target

60%

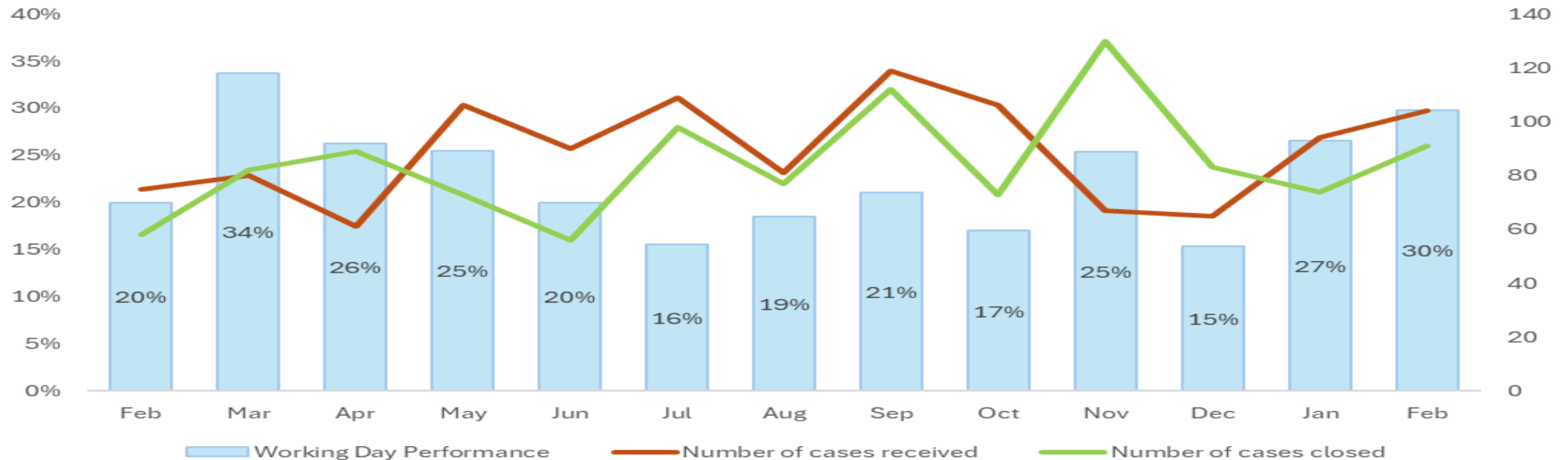
National Target Achievement

Grey

Position

Grey

Stage 2 Feedback Cases - Received and closed and working day %





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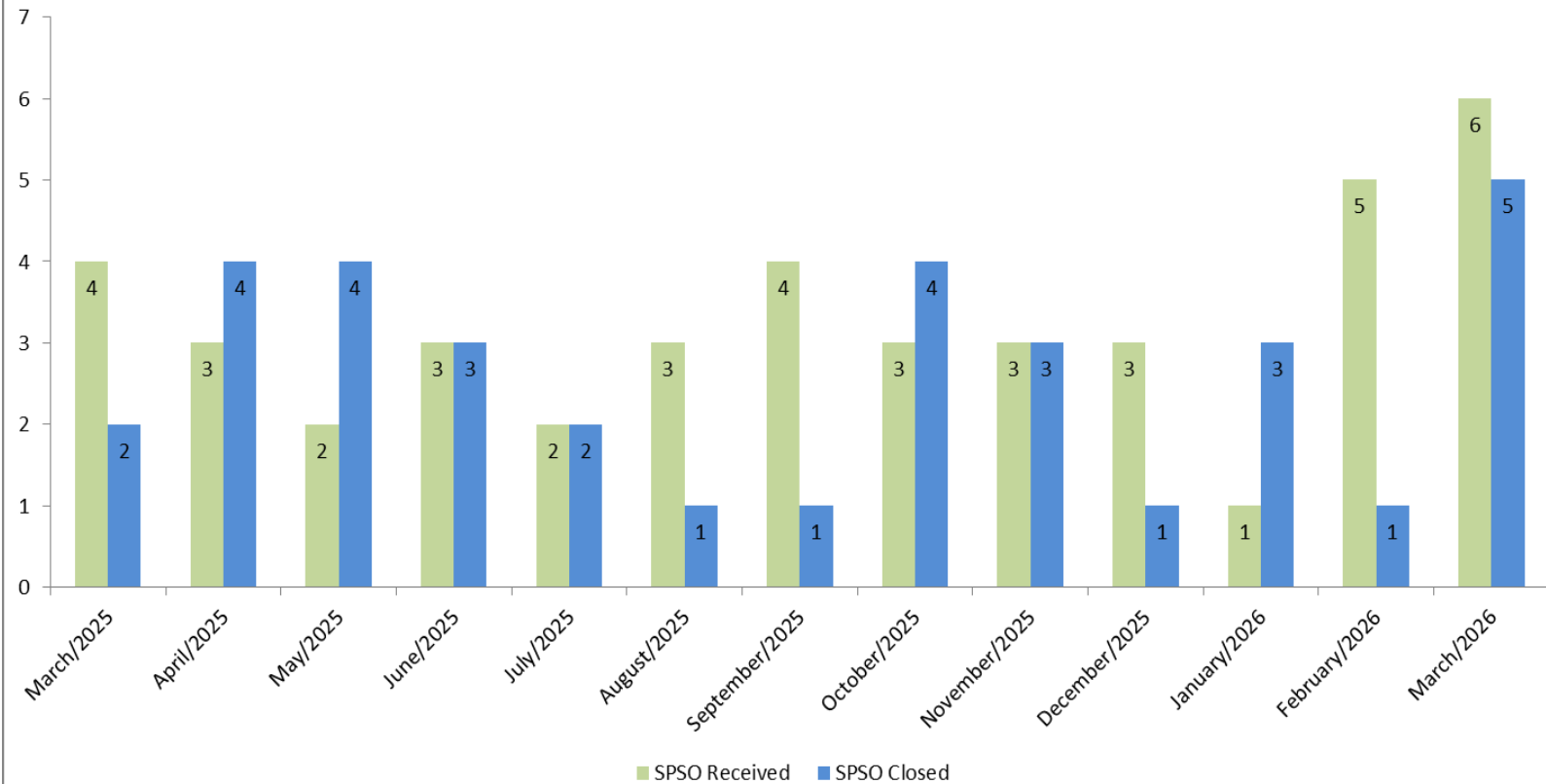
**Exec Lead
Boyd Peters**

SPSO Activity (March 2025 – March 2026)

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

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:

21 received:

- 2 x Acute
- 4 x A&B
- 15 x HHSCP

These relate to Mental Health Services - Adult Psychiatry, Mental Health Services - Clinical Psychology, Medical - Emergency Care, Allied Health Professionals - Physiotherapists, General Practice Services - General (salaried), Sexual Health Services - Genito Urinary Medicine, Mental Health Services - Community Mental Health, Radiology

SPSO cases closed last 3 months:

9 SPSO enquiries closed

- 9 x not taken forward



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Exec Lead
Boyd Peters

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

ADP Deliverables

Progress as at End of Q2 2025/26

Insights to Current Performance

Plans and Mitigations

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

Performance Rating

Latest Performance

National Benchmarking

National Target

National Target Achievement

Position

37

Open Level 1 (L1) Incidents

16

L1: Active more than 26 weeks

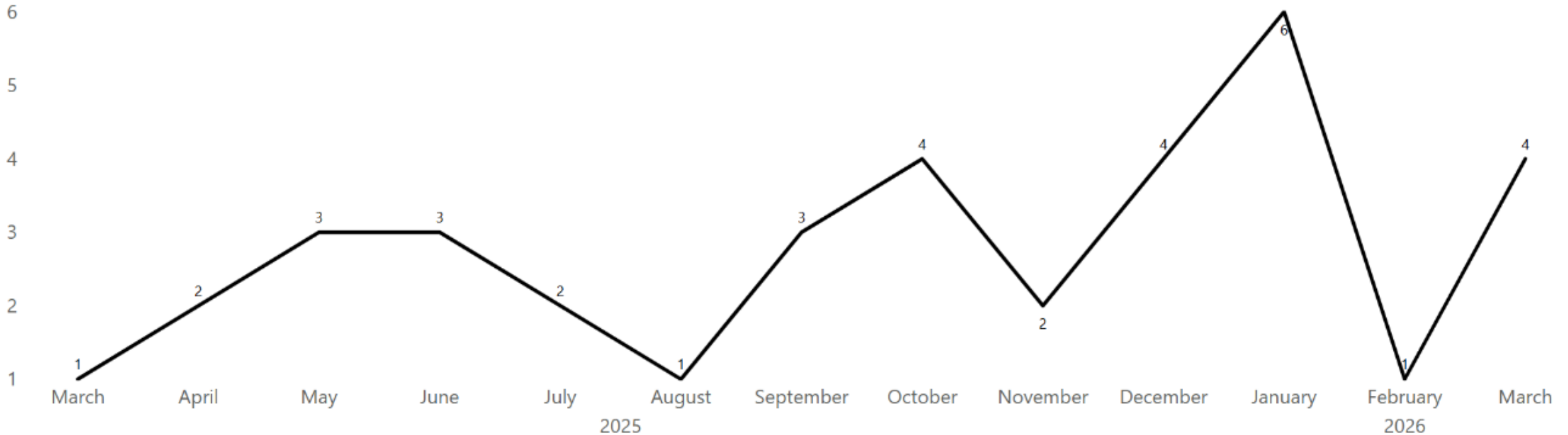
36

L1: SAER Declared Last 13 Months

0.19%

Incident | SAER Conversion Last 13 Months

SAER Level 1 Investigations Declared





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**Exec Lead
Louise Bussell**

Hospital Inpatient Falls (March 2025 – March 2026)

ADP Deliverables

Progress as at End of Q2 2025/26

Insights to Current Performance

There has been a slight decrease in inpatient falls rates since last reporting period. There has been no significant variation across either of the 3 areas, Acute, HHSCP and A&B
Falls with harm saw a sharp increase to 60 in March against a baseline of 40
Multiple bays in Raigmore hospital have had an additional patient in them over the winter months with a slight increase in falls between December and March
Several Community Hospitals have also had surge capacity open in recent months with a slight increase in falls October to March

Plans and Mitigations

Improvement work continues at a local level across all areas
Detailed review of areas operating surge capacity beds or risk assessed beds

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

Performance Rating

Latest Performance

National Benchmarking

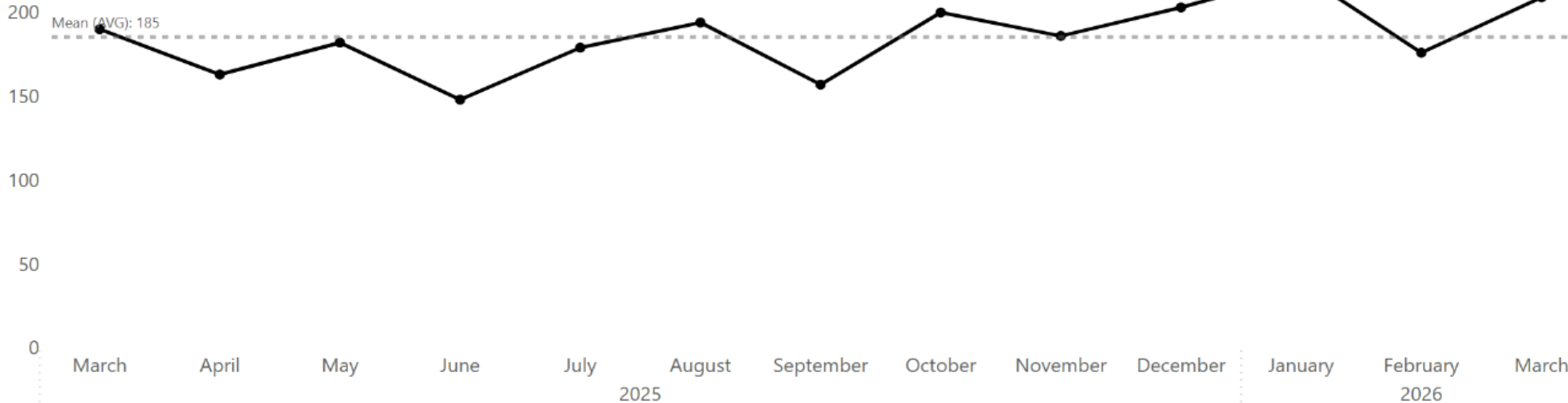
National Target

20% reduction (falls)
30% reduction (falls with harm)

National Target Achievement

Position

Number of Inpatient Falls | Run Chart





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Exec Lead
Louise Bussell

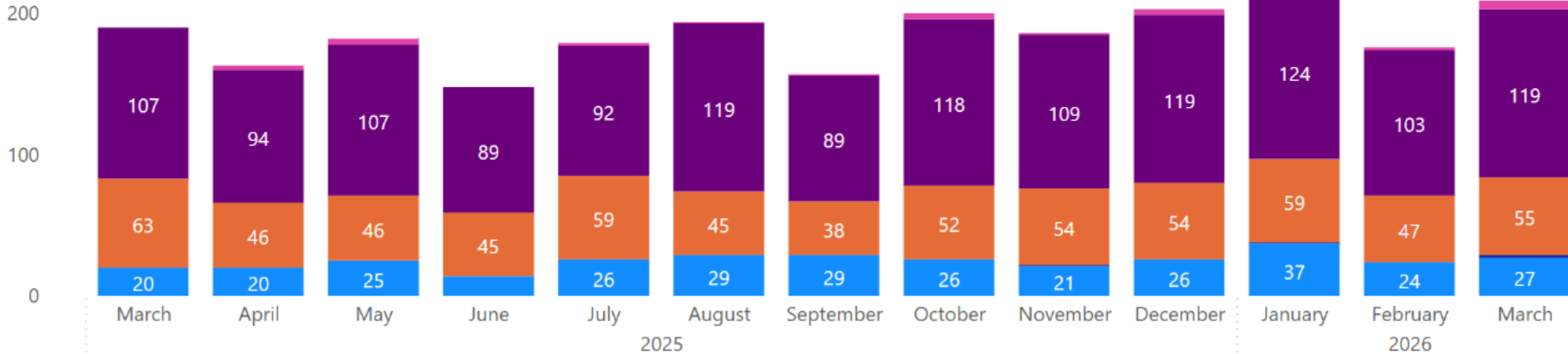
Hospital Inpatient Falls | Subcategory (March 2025 – March 2026)

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.	Review of data for time of day when falls are happening. In areas with highest number of falls do some detailed work to understand where falls are happening and target improvement work accordingly

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 | Subcategory

● Fall from height less than 2metres ● Fall from height more than 2 metres ● Slip, trip or fall on level ground ● Suspected / unwitnessed fall ● Tripped





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**Exec Lead
Louise Bussell**

Tissue Viability Injuries (March 2025 – March 2026)

ADP Deliverables

Progress as at End of Q2 2025/26

-MASD and PU Pathways complete via NATVNS-
New Pressure Ulcer Grading Tool
Training launched with dates via Teams.
Training and Audit to target wards on Datix so that figures are accurate across acute key wards

Insights to Current Performance

- IPC unpublishing TURAS modules for Pressure Ulcers (PU).
- PUs on feet adding to numbers - developed feet training
- SAS discussions ongoing re: frailty pathway and in discussions with Clarie Copeland and Kate Watson from NHS Glasgow for QI
- SAS/NHSH and NHSGCC to undertake above intervention with SAS awareness of PU development and escalation plan in ED
- NHS Grampian/SAS/NHSH PU launch
- MASD and PU Pathways complete via NATVNS-

Plans and Mitigations

- Continue to implement support for high risk areas
- Develop training including for Feet
- SLWG set up with NATVNS for pressure ulcer training materials as IPC will be publishing training slides on TURAS
- PU Documents ongoing with NES support and NATVNS. Current modules shortened to 2,4,5 and 6 until updated
- There is still discrepancy on community figures due to the nature of the current system, which includes patients NOT known to DNS, but still captured under the heading of 'developed in community'. Working with MB on this to drive change

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

Performance Rating



Latest Performance

National Benchmarking

HIS to confirm plans for future/ and how soon

National Target

20% reduction

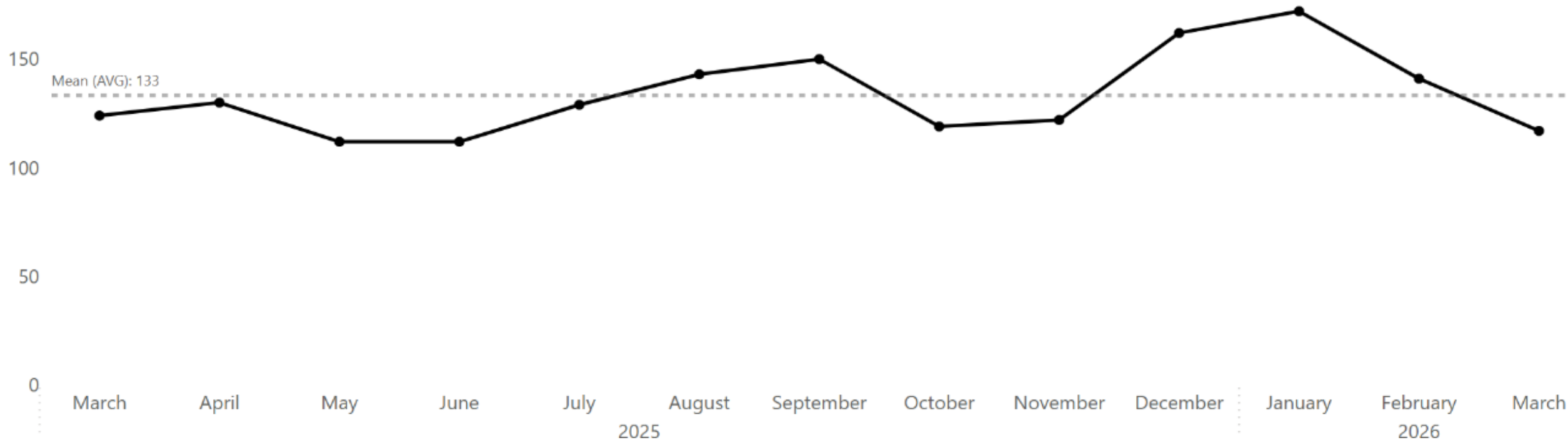
National Target Achievement

Not available currently

Position



Number of Tissue Viability Injuries | Run Chart





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**Exec Lead
Louise Bussell**

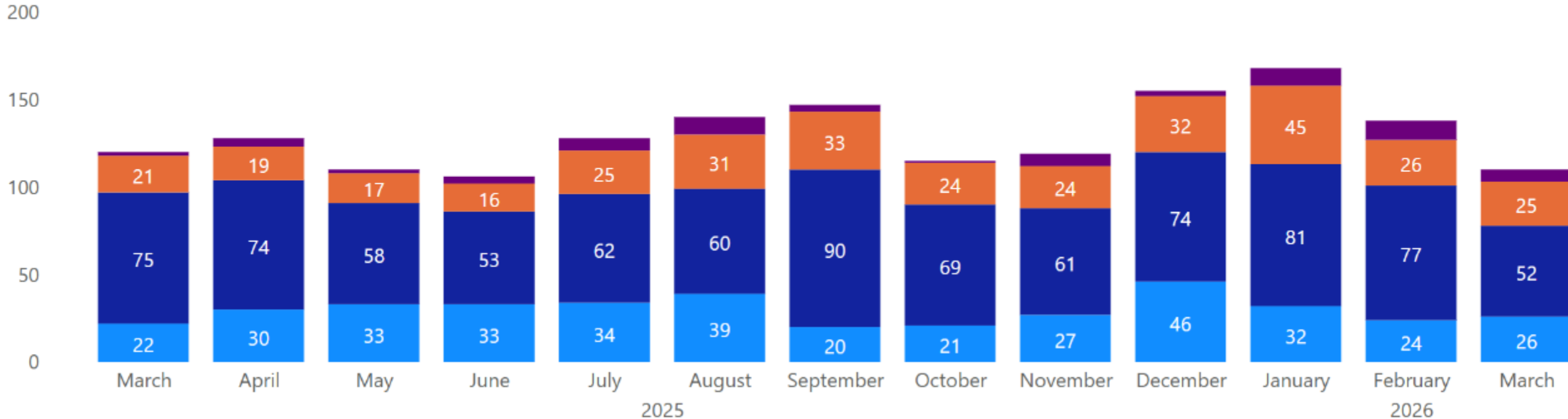
Tissue Viability Injuries | Subcategory (March 2025 – March 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	<ul style="list-style-type: none"> - QI project started - CPR Feet forms part of lower limb training - At risk ward shows improvement with PUs, but now has increase in number of PUs to feet- ongoing support, and include roll out of CPR Feet - Infection and Biofilm Pathway QI ongoing 	<ul style="list-style-type: none"> - Wards 3A to start project with Podiatry - -Leg Ulcer Audit 1st 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	

Number of Tissue Viability Injuries | All Subcategories and Injury grades | Sub-Category

● Developed in hospital
 ● Developed/discovered in community
 ● Discovered on admission
 ● Known ulcer deteriorating





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**Exec Lead
Louise Bussell**

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

ADP Deliverables Progress as at End of Q1 2025/26

Need to focus on Grade 2 and Grade 1 prevention as these 2 categories still account for the highest incidents of developed PUs.
Review of decision to not mandate or make PU training statutory to be had

Insights to Current Performance

- To discuss if Grade 1 can continue to be incident reported, as well as Grade 2

Plans and Mitigations

- There is a head to toe inspection video that will be used via NATVNS
- Requested TURAS share and be made accessible to/including non NHS Highland care homes
- Equipment guide being updated as a step up/step down guide for all clinicians across acute and community
- Work underway to address Grade 1 and Grade 2 wounds acute/community

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

Performance Rating

Latest Performance

National Benchmarking

HIS to confirm plans for future/ and how soon- ongoing

National Target

20% reduction

National Target Achievement

Position

Subcategory | Injury

Injury	Developed in hospital	Developed/discovered in community	Discovered on admission	Known ulcer deteriorating	Total
Mucosal Pressure Damage	10	4	12		26
Pressure Ulcer - combination lesions	3	7	8	4	22
Pressure Ulcer - deep tissue injury	29	93	15	14	151
Pressure Ulcer - ungradable	41	136	49	9	235
Pressure ulcer (grade not specified)	10	7	15	0	32
Pressure ulcer Grade 1	81	141	70	3	295
Pressure ulcer Grade 2	195	422	144	17	778
Pressure ulcer Grade 3	17	57	14	14	102
Pressure ulcer Grade 4	1	19	11	12	43
Ulcers	1	7	8	0	16
Total	388	893	346	73	1700



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Louise Bussell

Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims 1st April 2025 to 28th February 2026

ADP Deliverables: Validated position for 2025/26 reduction aims The RAG ratings are calculated on the predicted monthly numbers.

Insights to Current Performance

Plans and Mitigations

Clostridioides difficile (CDI)
2025/2026 reduction aim is 75 HCAI cases. As of 28/02/2026 56 HCAI cases reported.
Currently on track to meet aim (19 cases under aim)

Staphylococcus aureus bacteria (SAB)
2025/26 reduction aim is 53 HCAI cases. As of 28/02/2026 47 HCAI cases reported.
Currently below case aim (6 cases under aim) and on track to be within predicted limits

Escherichia Coli (ECB)
2025/2026 reduction aim is 75 HCAI cases. As of 28/02/2026 70 HCAI cases reported
Currently below case aim (5 cases under aim) and on track to be within predicted limits

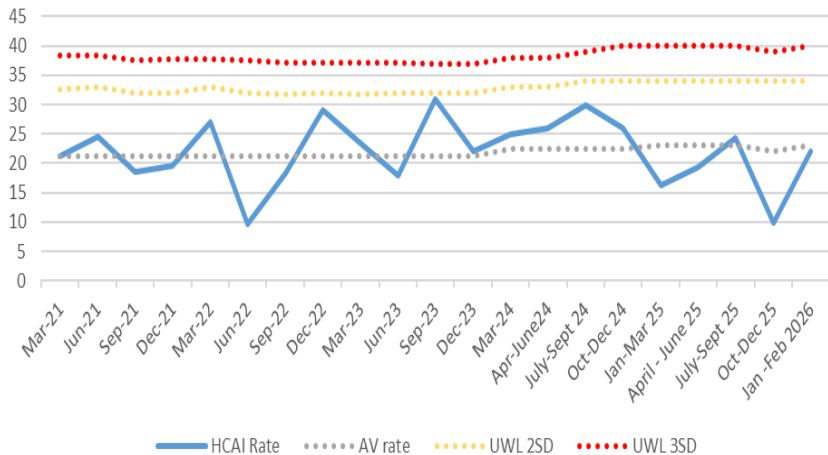
On the 7th of April 2026 National Services Scotland published the report for the Quarterly Epidemiological data on Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland (Oct -Dec 2025 (Q34 2025)). This data reports that NHS Highland is within normal variation for healthcare associated SAB, CDI and EColi when analysing trends over the past three years and is not above the 95% confidence interval upper limit in the funnel plot analysis. The next publication is expected July 2026 and will publish validated reduction aim performance.

Continue to review individual cases for learning and any subsequent actions.

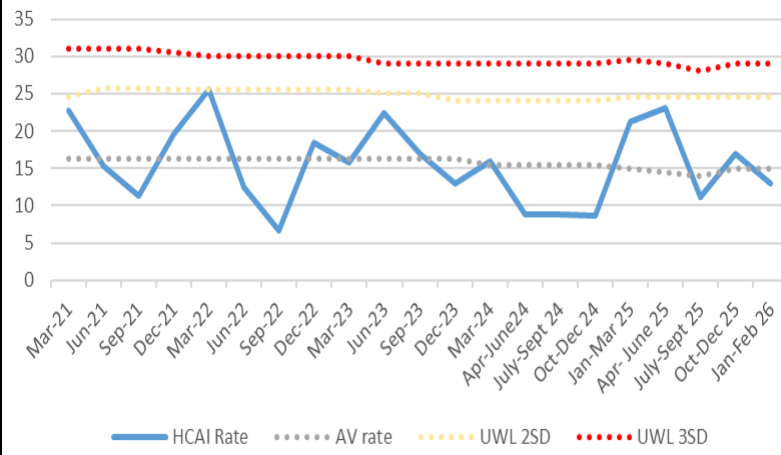
Targeted work with antimicrobial prescribing continues, The use of faecal microbiota transplant therapy continues to be progressed as a treatment for chronic CDI.

Continue to ensure adherence to national guidance for the management of infections.

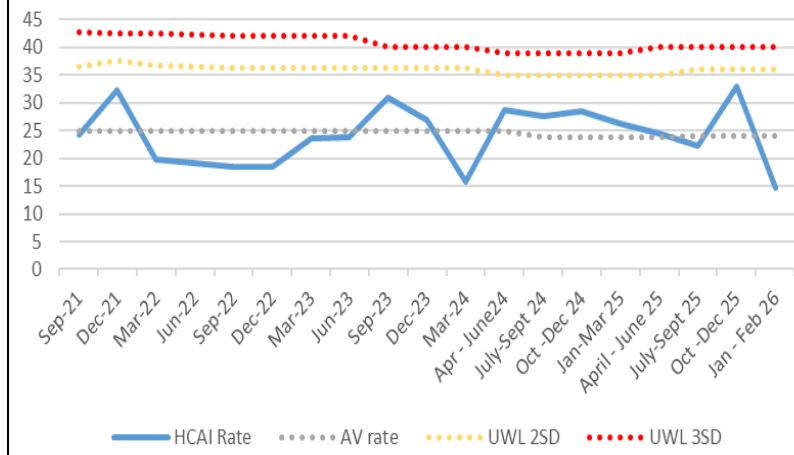
Quarterly rates of Healthcare Associated CDI per 100000 bed days including ARHAI Scotland & NHS Highland data



Quarterly rates of Healthcare Associated SAB infection per 100000 bed days including ARHAI Scotland & NHS Highland data



Quarterly rates of Healthcare Associated ECB infections per 100000 bed days including ARHAI Scotland & NHS Highland data





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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% but has decreased to 6.2%. 24.8% 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 52.8%, 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 decreased slightly this month to 6.78%	
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 124.8 and steadily rising.*	Work continues with training for recruiting managers and sustaining lower time to fill period
Ensure 95% of the NHS Highland workforce has a completed TURAS Appraisal within the financial year 2025/26.	Appraisal rate of 29.3% is significantly short of the 95% target. There has been a decrease of 0.5% 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 Mar 2026

Sickness Absence Rate (%)

6.16

Long Term SA Rate (%)

3.79

Short Term SA Rate (%)

2.40

Recorded Absence Reason (%)

78.51

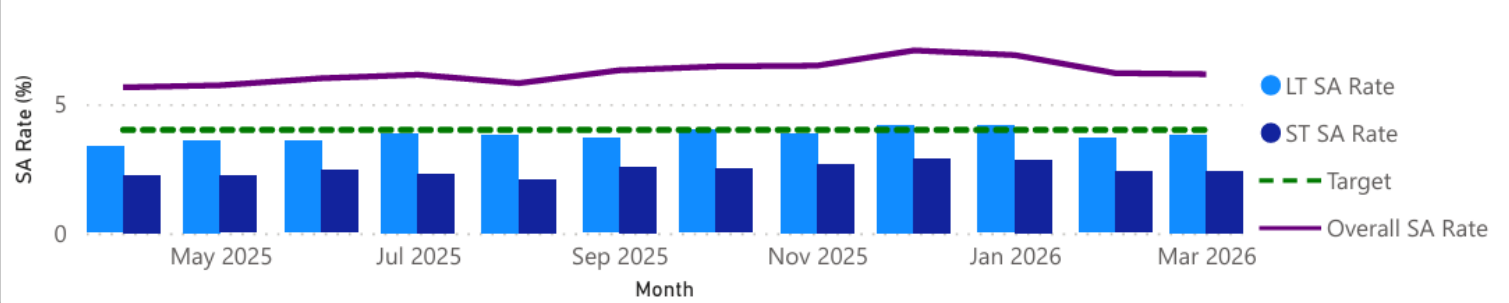
Vacancy Time to Fill (Days)

124.76

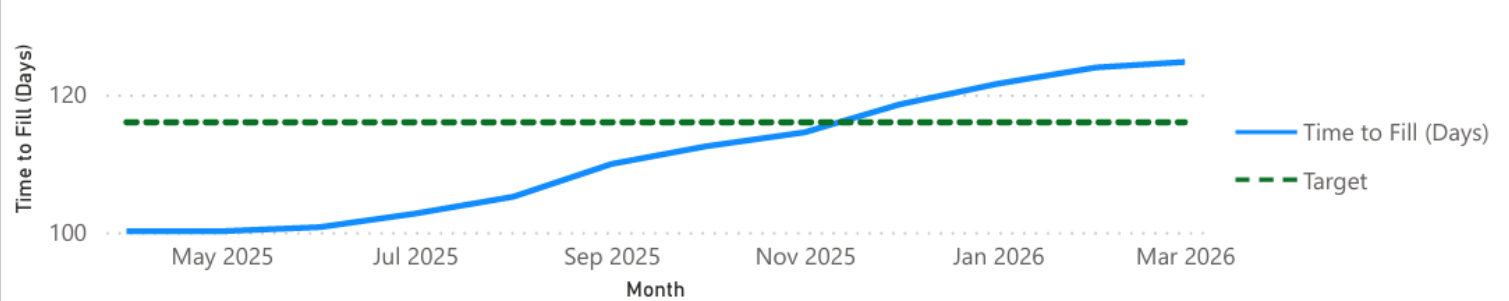
Annual Employee Turnover (%)

6.68

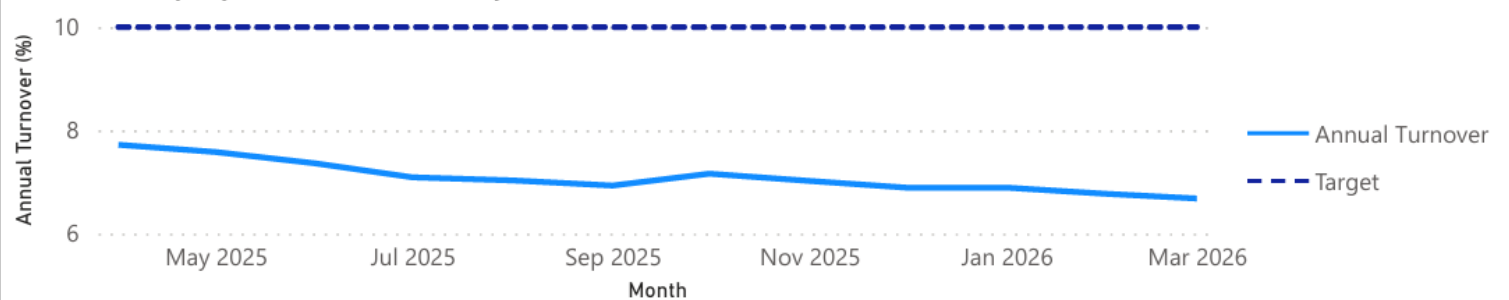
Sickness Absence Rates (%) by Month



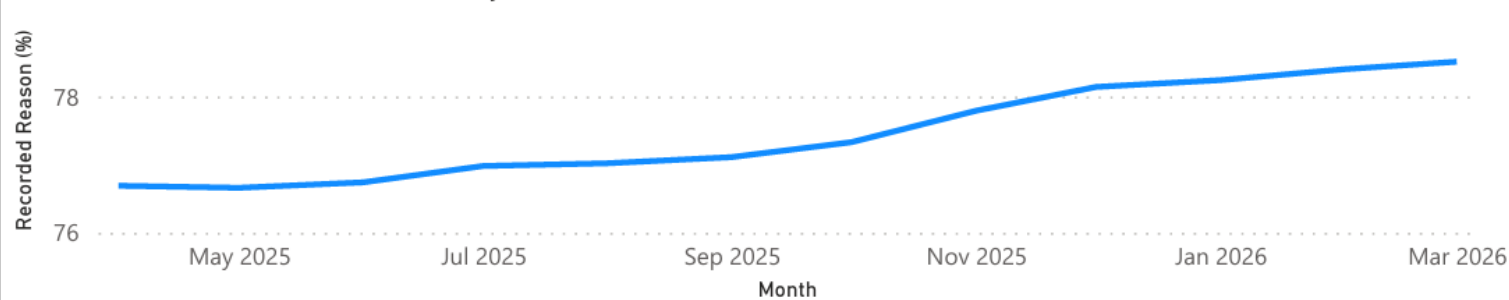
Vacancy Time to Fill (Days) by Month



Annual Employee Turnover (%) by Month



Recorded Absence Reason (%) by Month



Training Metrics Mar 2026

Bank eLearning Completion Rate (%)

34.5

Substantive eLearning Completion Rate (%)

56.4

Overall eLearning Completion Rate (%)

52.8

M&H Practical Training Completion Rate (%)

48.7

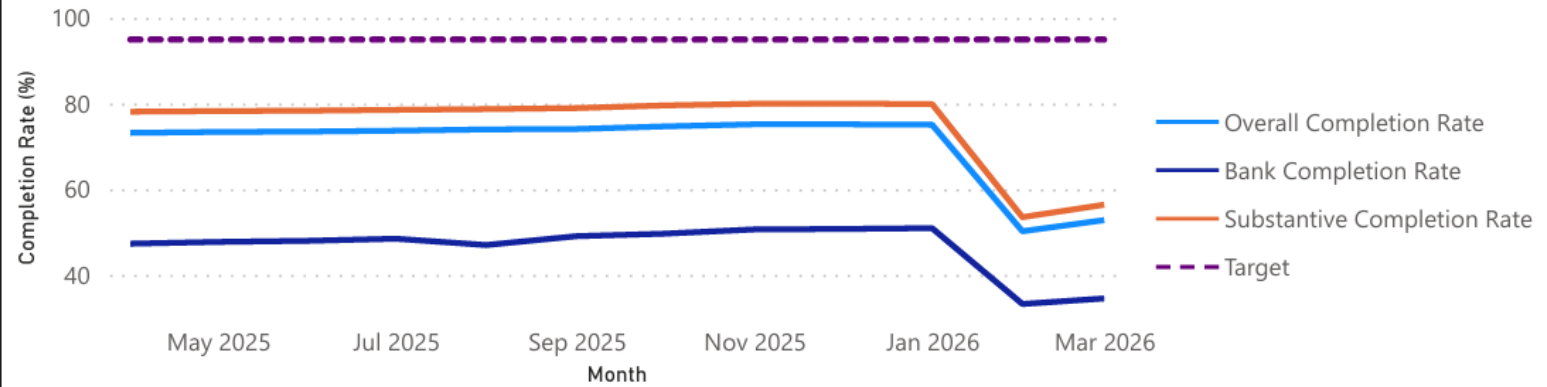
V&A Practical Training Completion Rate (%)

30.3

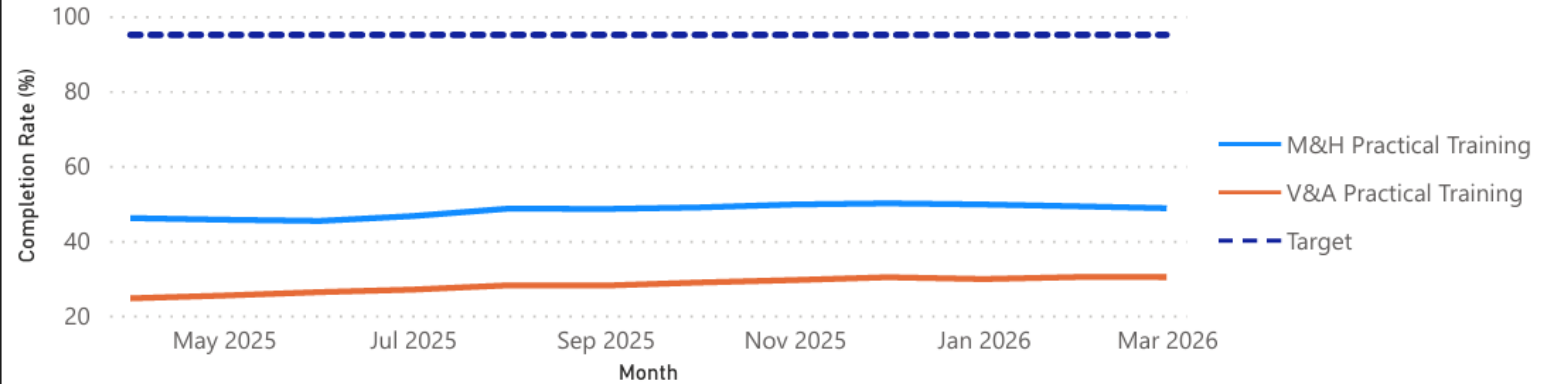
Appraisal Completion Rate (%)

29.3

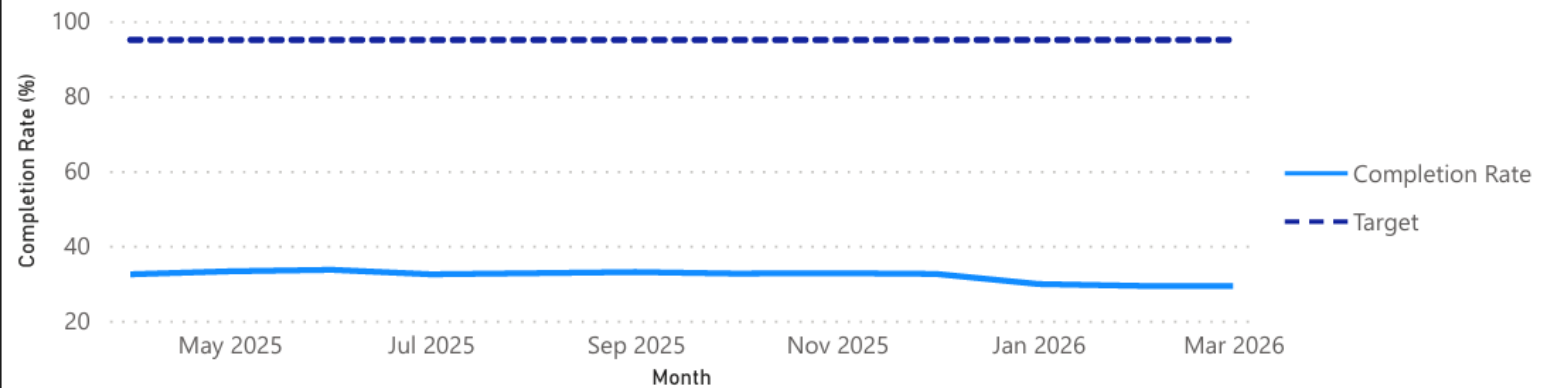
Core Mandatory eLearning Completion Rate (%) by Month



Practical Training Completion Rate (%) by Month



Appraisal Completion Rate (%) by Month



* **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

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.