Agenda Item 5

NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**28 July 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.

Planned Care Update

This IPQR includes planned care data that reflects performance against the agreed position of our Q1 trajectories as submitted to Scottish Government in April 2026.

Since then, there has been significant engagement with Scottish Government to agree our targets and trajectories for the coming year, including the scale of additionality for 2026/27 to eliminate all > 52 week waits across NHS Scotland by March 2027.

It is anticipated this will require cross-board collaboration to meet this requirement in some speciality areas for new outpatient and inpatient / daycase appointments.

Future IPQR updates will incorporate the agreed activity and long waits trajectories. Governance has been established within sub-national structures to oversee the reduction in the longest waiting patients.

Contributing to this is Chief Executive EDG oversight of planned care delivery through a weekly huddle focussed on planned care, diagnostics and cancer delivery, with sub-national meetings of Acute Chief Officers and Chief Executives from the 7 territorial boards.

NHS Highland's weekly data submission is consolidated with the position with the rest of Scotland West, and presented through reporting to Cabinet Secretary and First Minister on a routine basis.

Assurance reporting on progress against our planned care activity and long waiting position will be embedded within the IPQR from our next report for September's FRPC committee, including oversight of the high level of demand to deliver these levels of additionality within our planned care services.

2.3 Assessment

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

2.4 Proposed level of Assurance

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

Substantial		Moderate	X
Limited		None	

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

3 Impact Analysis

3.1 Quality/ Patient Care

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

3.2 Workforce

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

3.3 Financial

Financial analysis is not included in this report.

3.4 Risk Assessment/Management

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

3.5 Data Protection

The report does not contain personally identifiable data.

3.6 Equality and Diversity, including health inequalities

No equality or diversity issues identified.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

This is a publicly available document.

3.9 Route to the Meeting

Sections through the relevant Governance Committees;

- Staff Governance Committee – 7th July 2026
- Clinical Governance Committee – 2nd July 2026
- Finance Resource Performance Committee – 10th July 2026

4.1 List of appendices

The following appendices are included with this report:

- Integrated Performance and Quality Report – July 2026 Board Meeting

Integrated Performance and Quality Report

FRPC Meeting

10th July 2026

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

Our Population

Deliver the best possible health and care outcomes

Our People

Be a great place to work

In Partnership

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

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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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Performance

Executive Summary of Performance Indicators : Slide 1 of 2

Strategic Outcome	Key Performance Indicator (NHS Highland Board unless stated)	Current Performance (Date)	Previous Performance (Date)	Trend Indicator (Last 6 monthly data points)	Local Target	National Target	Performance Rating (to local target)
Mental Health							
Thrive Well	CAMHS <18-week referral-to-treatment	100% (Apr 26)	86.4% (Feb 26)	0 0 0 0 0 0	90%	90%	Target met
Thrive Well	NDAS (Neurodevelopmental Assessment Services)	2250 (Apr 26)	2197 (Feb 26)	0 0 0 0 0 0	N/A	N/A	Not Met
Live Well	Psychological Therapies < 18-week referral to treatment	90.6% (Apr 26)	83.3% (Jan 26)	0 0 0 0 0 0	90%	90%	Target met
Stay Well	DARS (Drug and Alcohol Recovery)	84.2% (Dec 25)	87.2% (Q2 25/26)	0 0 0 0 0 0	90%	90%	5.8% off national target
Planned Care							
Treat Well	New Outpatients (NOP) number of patients waiting >52 weeks	1166 (Apr 26)	1092 (Mar 26)	0 0 0 0 0 0	1292 by April 26	902 by 30 June 26	126 ahead of forecast
Treat Well	TTG number of patients waiting >52 weeks	128 (Apr 26)	105 (Mar 26)	0 0 0 0 0 0	137 by Apr 26	179 by 30 June 26	9 ahead of forecast
Diagnostics (updated data from PHS remains pending)							
Treat Well	Radiology <6-week waiting time	70.8% (Apr 26)	72.6% (Feb 26)	0 0 0 0 0 0	>80%	90%	9.2% off target
Treat Well	Endoscopy <6-week waiting time	89.0% (Apr 26)	88.1% (Feb 26)	0 0 0 0 0 0	>80%	90%	Target met
Cancer (data is based on patients referred to and treated through NHS Highland cancer services - predominantly those in Highland area)							
Journey Well	31-Day Cancer Waiting Times: Diagnosis to 1st Treatment	86.7% (Apr 26)	89.7% (Feb26)	0 0 0 0 0 0	95%	95%	8.3% off target
Journey Well	62-Day Cancer Target: USC Referral to 1st Treatment	61.9% (Apr 26)	67.3% (Feb 26)	0 0 0 0 0 0	>62.6% by 30 Apr 26	>69.5% by 30 Jun 26	1.7% off target
Journey Well	SACT as 1st Treatment: Average Waiting Time	Average 20-24 Days (May 26)	Average 20-24 Days (Apr 26)	0 0 0 0 0 0	< 28 days	N/A	Target Met
Unscheduled Care (further indicators will be added in for next round of reporting)							
Respond Well	Emergency Access (<4-hour % waits)	77.5% (Apr 25)	72.7% (Feb 26)	0 0 0 0 0 0	>73.2% by June 2026	>75.3% by March 2027	Target Met
Respond Well	Emergency Access (>12-hour total waits)	337 (Apr 26)	328 (Mar 26)	0 0 0 0 0 0	<290 by June 2026	0 by March 2027	13.9% off target
Respond Well	Delayed Discharges: All (monthly census point)	242 (Apr 26)	232 (Mar 26)	0 0 0 0 0 0	<221 by June 2026	<186 by March 2026	12.6% off target

Executive Summary of Performance Indicators : Slide 2 of 2

Strategic Outcome	Key Performance Indicator (NHS Highland Board unless stated)	Current Performance (Date)	Previous Performance (Date)	Trend Indicator (Last 6 quarterly data points)	Local Target	National Target	Performance Rating (to local target)
Population Health							
Stay Well	ABIs (Alcohol Brief Interventions)	1017 (Q4 25/26)	923 (Q3 25/26)	0 0 0 0 0 0	N/A	3851 vs. target of 3688 by end of Q4	Target Met
Stay Well	Covid-19 Vaccinations	62.3% (Winter 25 complete)	63.1% (Nov 25)	0 0 0 0 0 0	60%	N/A	Target Met
Stay Well	MMR Vaccinations	90.8% (Mar 26)	93.2% (Dec 25)	0 0 0 0 0 0	95%	95%	4.2% off target
Stay Well	Flu Vaccinations	55.5% (Mar 26)	55.6% (Nov 25)	0 0 0 0 0 0	60%	N/A	4.5% off target
Stay Well	AAA screening – reported annually	84.4% (25/26)	87.3% (23/24)	0 0 0 0 0 0	85%	85%	0.6% off target
Stay Well	Bowel Screening – reported annually	65.2% (25/26)	70.4% (23/24)	0 0 0 0 0 0	60%	60%	Target Met
Stay Well	Cervical Screening – reported annually	55.3% (25/26)	66.7% (23/24)	0 0 0 0 0 0	80%	80%	14.7% off target

Key to Performance Rating

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

Note: Performance ratings assessed vs. local targets

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Executive Lead
Louise Bussell,
Nurse Director

OIP

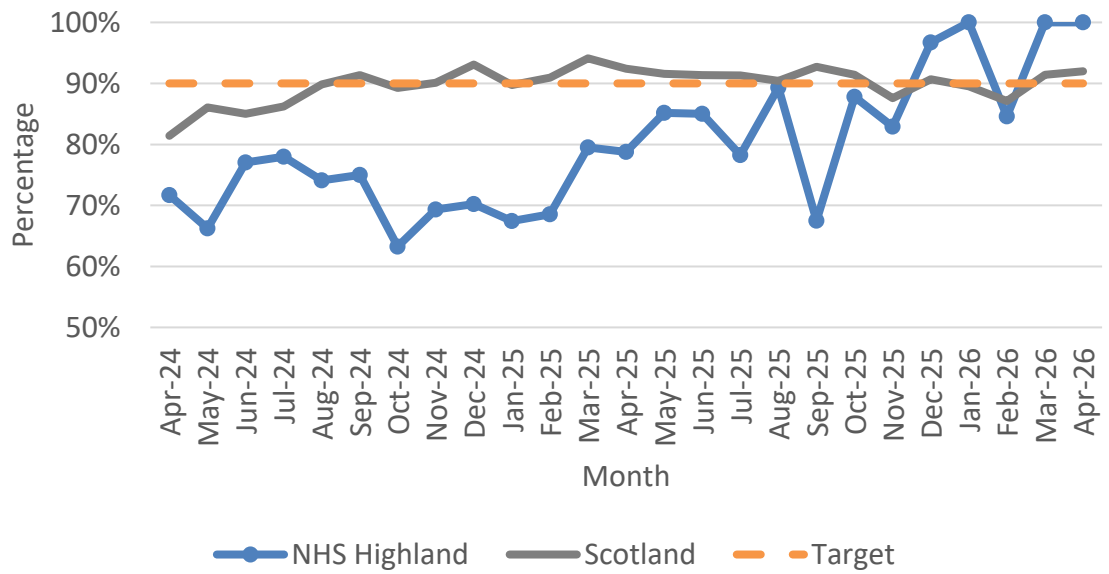
CAMHS (Child and Adolescent Mental Health Service)

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Achievement of CAMHS national standard of 90% of patients < 18 weeks from referral to treatment by December 2025 (Tier 3). Reduction of people who are currently on the Tier 3 CAMHS waiting list to <352 people by December 2025.	**Highland** The service has achieved RTT target for four of the last five months. • The reduction in the allocation of the now baselined Mental Health Outcome funding, the decommissioning of CEYP (Care Experienced Young Person), the absence of uplift to NES funding, and the loss of 2.48 WTE within RWW (North Highland) have placed the service in a challenging position with regard to both financial sustainability and workforce capacity.	**Highland** • Decommissioning timeline for THC commissioned CAMHS CEYP service agreed. New pilot of CAMHS clinical pathway has commenced. • Demand and capacity pressures within unscheduled care and iCAMHS teams have necessitated an increased level of clinical activity by the Clinical Nurse Manager. • S&T undertaking trajectory analyses to demonstrate the impact of extending the age range across all services in order to inform capacity and workforce modelling. • Engagement underway with SG colleagues with regard to de-escalation. Criteria recieved.

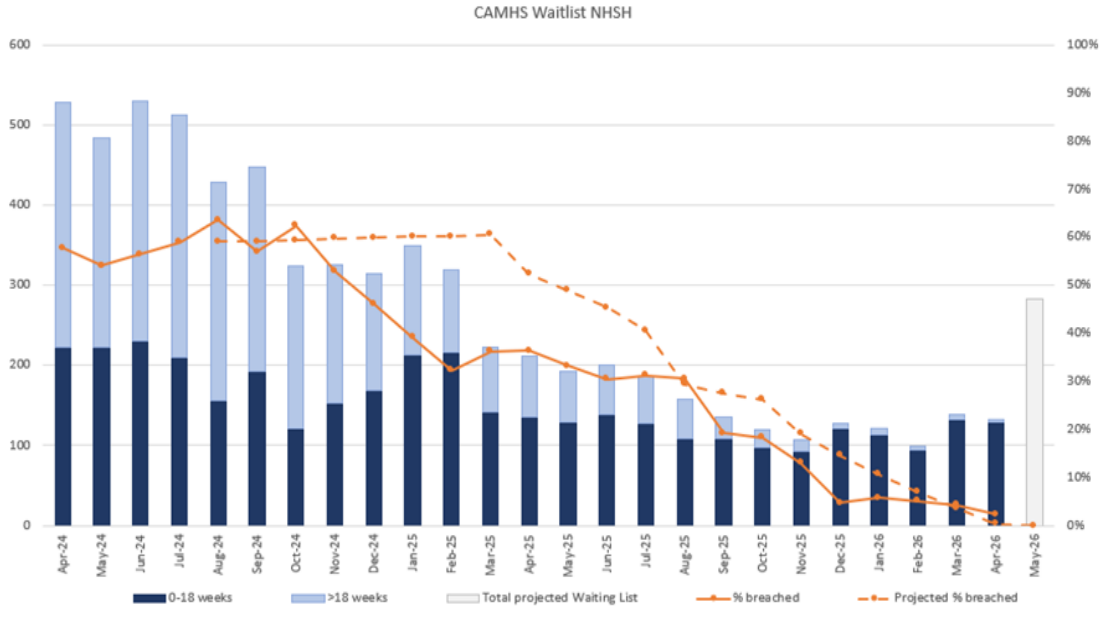
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	Local Target Met
Latest Performance	100%
National Average	92.0%
National Target	Full compliance to the National Service Specification by end of March 2026
National Target Achievement	Target Met
Position	3rd out of 14 Boards (note most boards achieved 100%)

CAMHS: Percentage of patients seen <18 weeks from referral



CAMHS Tier 3 Waiting List in Weeks



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Executive Lead
Katherine Sutton
Chief Officer, Acute

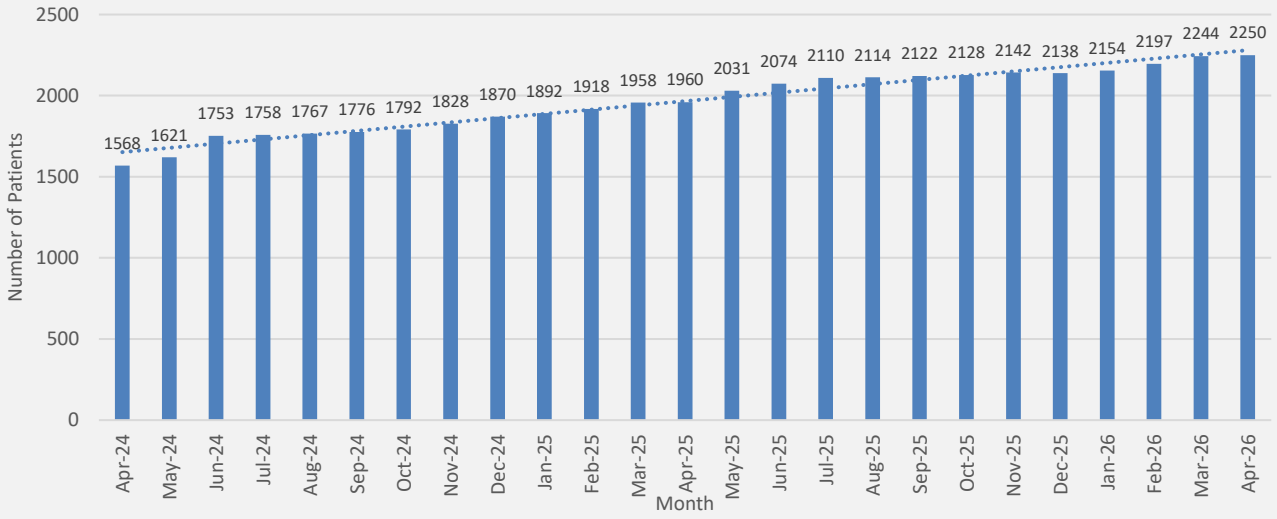
Neurodevelopmental Assessment Service (NDAS)

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Increasing percentage of NDAS patients seen within 18 weeks from referral, and towards meeting the national specification of greater than 95%.	There is extremely limited clinical capacity within the service to complete any assessments.	• Scottish Government–initiated programme of work with private provider Healios is being progressed for 49 autism assessments. • Delivery of a further 100 autism assessments is underway through the private provider Xyla, funded by the THC Transformation Fund. • A test-of-change model for a locality-based team is currently under development by THC. • ATR for NDAS Consultant Clinical Psychologist is underway.
Reduction in the total number of patients on the NDAS waiting list compared to the current baseline by March 2026.		

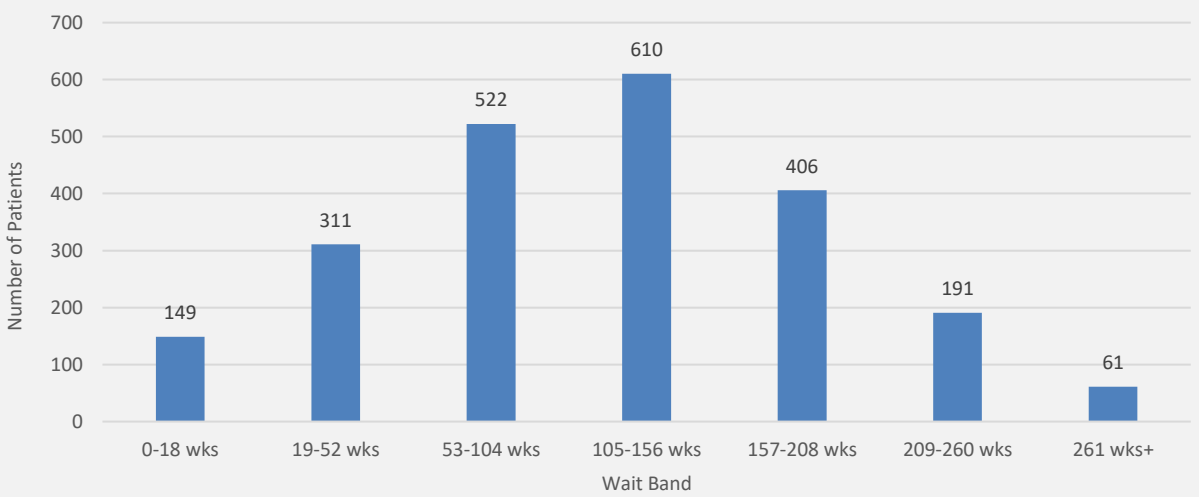
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Thrive Well

Performance Rating	
Latest Performance	2250 on waiting list (Apr 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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Executive Lead
Louise Bussell,
Nurse Director

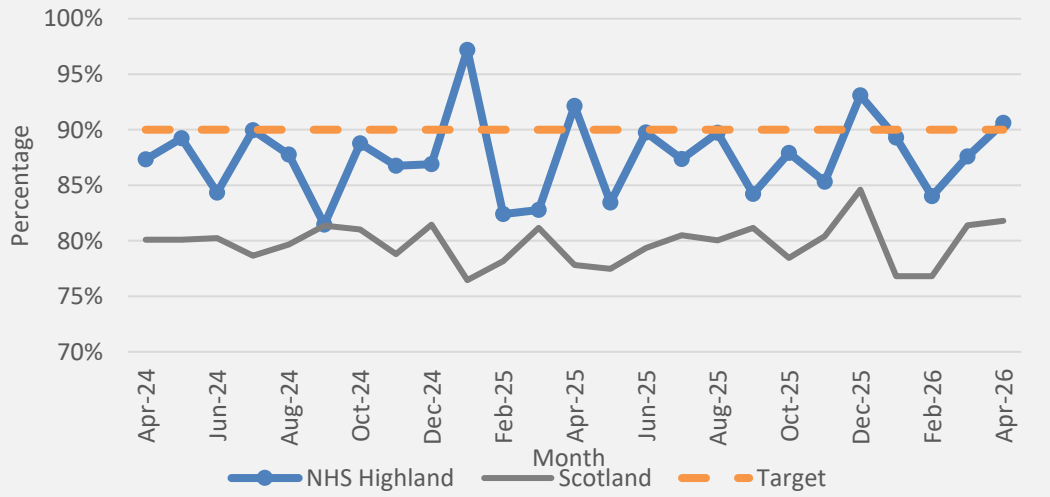
Psychological Therapies Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Ensure that at least 90% of patients referred to Psychological Therapy services are seen for their first appointment within 18 weeks of referral by March 2027. (pan-Highland)	**Highland** Performance in Highland reflects improving overall system position, with throughput exceeding demand and backlog reducing. However, RTT delivery remains inconsistent, with low activity weeks contributing to variable performance against the 18-week standard. **Argyll & Bute** Absences have resolved and baseline staffing restored; however, the service remains without a consultant psychologist in post, impacting senior clinical leadership, and RTT performance continues to lag against trajectory, with induction requirements and interim management cover further reducing clinical capacity.	**Highland** Actions are focused on stabilising weekly activity and reducing low-volume weeks to improve consistency of RTT delivery. This includes strengthening scheduling, monitoring weekly throughput, and supporting areas of operational pressure, while maintaining current activity levels to sustain backlog reduction. **Argyll & Bute** With absences easing somewhat and key staff returning, there is cautious optimism that RTT performance can improve. CBT provision in one locality is stabilising, and psychology capacity in Cowal and Bute has improved following a return to work. The service, however, continues to operate without a Consultant Psychologist. A new Senior Psychologist is now fully operational.
Increase number of completed PT waits (pan-Highland)		

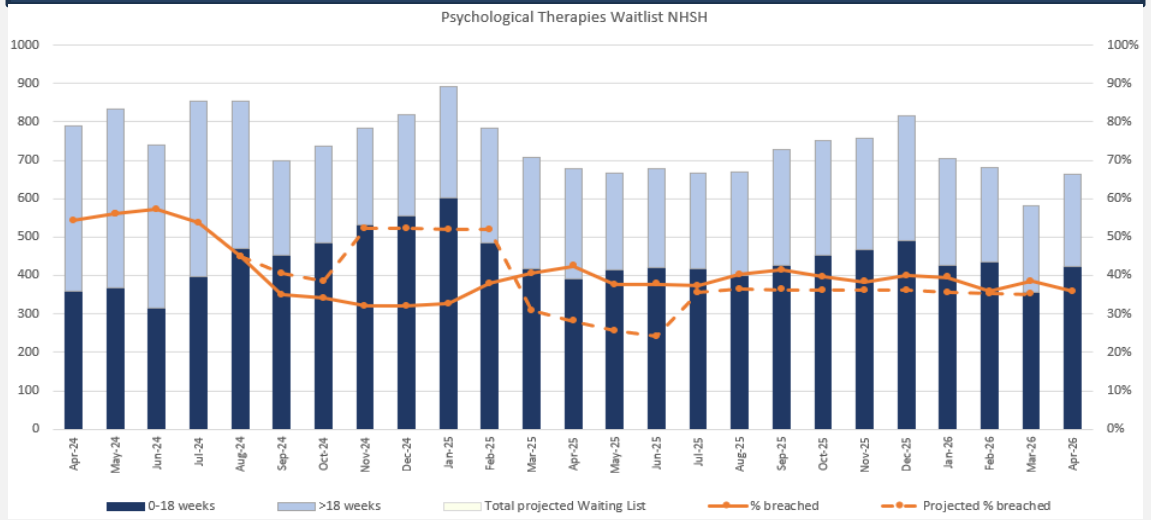
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	Local Target Met
Latest Performance	90.6%
National Average	81.4%
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
Arlene Johnstone
Chief Officer, HHSCP

Drug & Alcohol Recovery (DARS)

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.

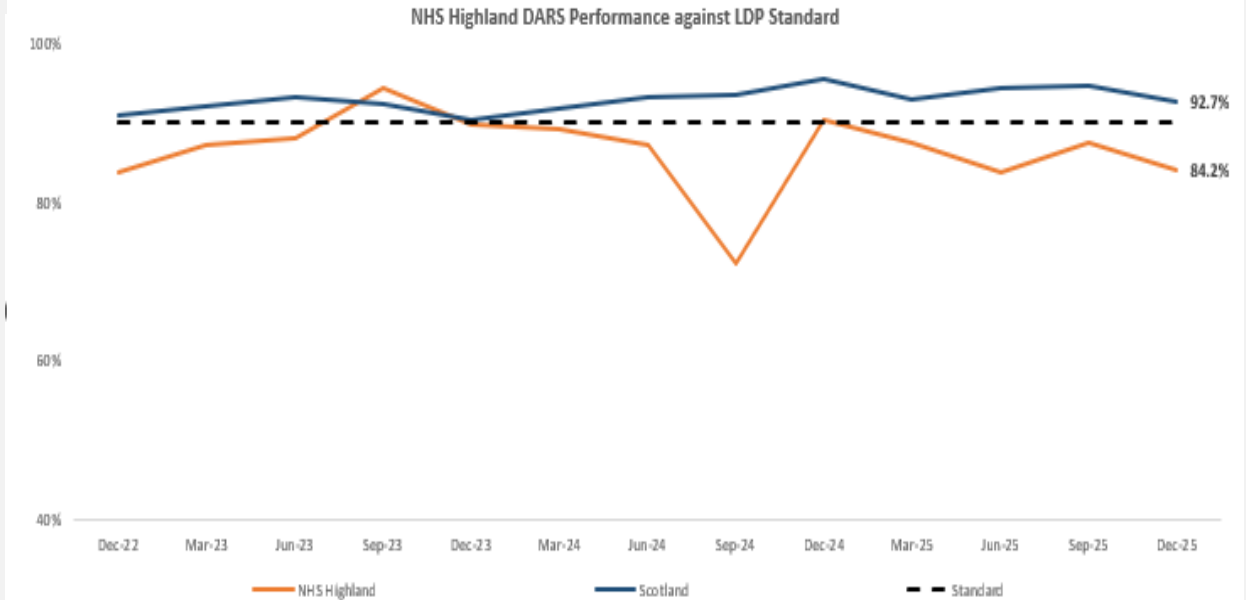
Plans, Mitigations and Actions

- 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

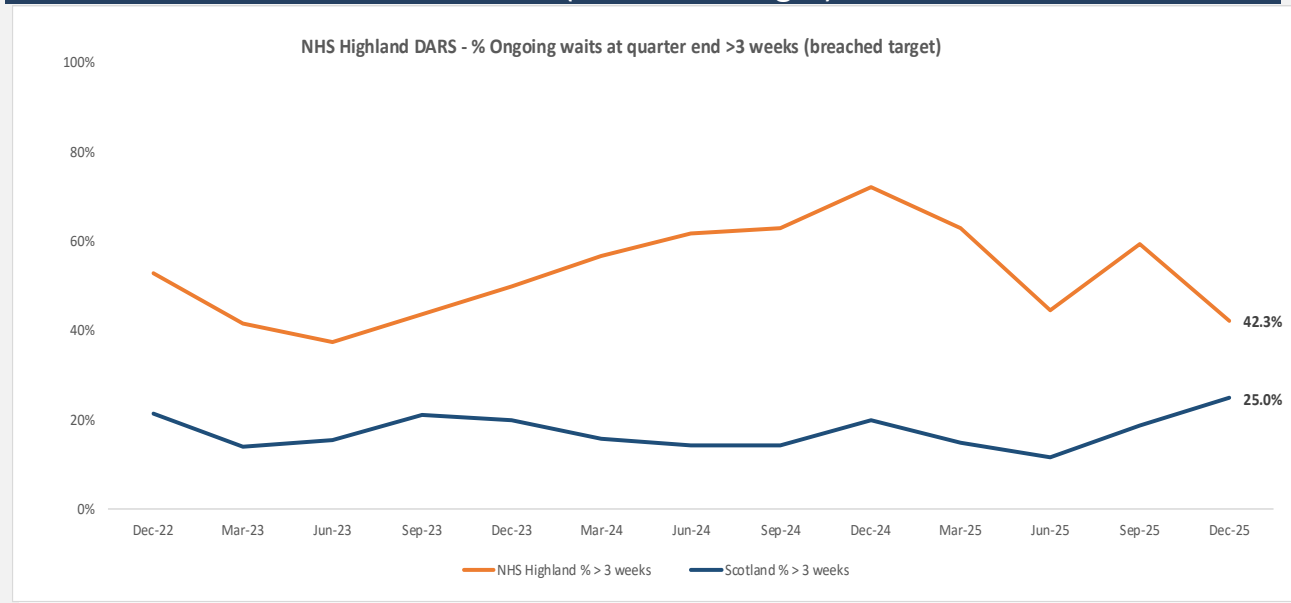
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Stay Well

Performance Rating	5.8% off national target
Latest Performance	84.2% (Dec 25)
National Benchmarking	92.7% (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: % Ongoing Waits at Quarter End Waiting More than 3 Weeks (Breached Target)



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Executive Lead
Katherine Sutton
Chief Officer, Acute

OIP

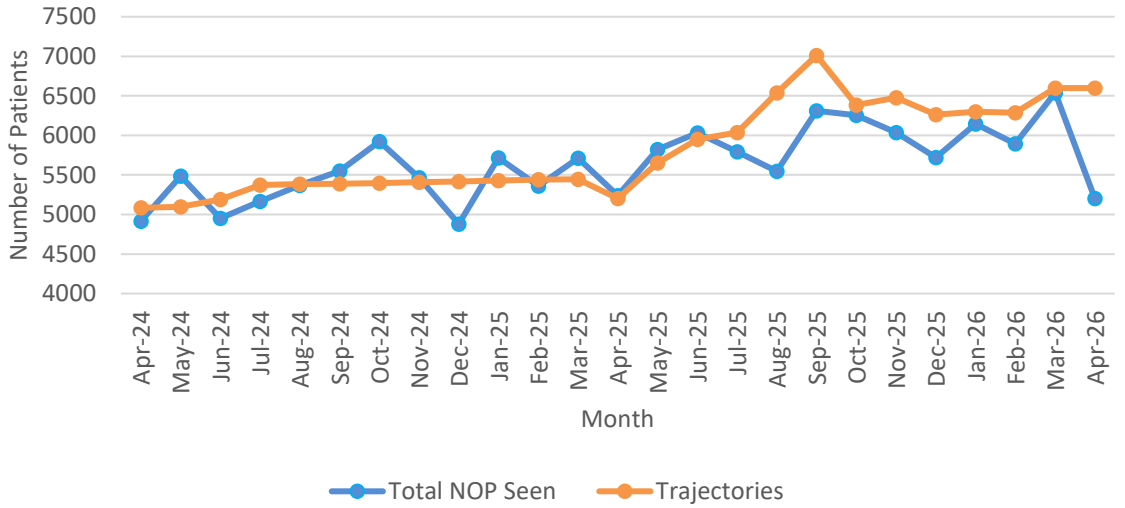
Outpatients (New Outpatients – NOP – seen within 12 week target) – Slide 1 of 3

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.	**Highland** The core activity plan for 25/26 was fully met. There was a shortfall in additionality, mostly due to independent sector capacity and challenges in organising further appointments within the short timescale with Q4 funding. Despite this, the long waiting target was met and exceeded with fewer people waiting over 52 weeks than we had planned.	**Highland** Engagement with CfSD is ongoing in relation to outpatients improvement. The Specialty Delivery Groups are supporting individual areas with improvement such as PIR which will support return waiting list improvement. We are also live with additional admin validation of waiting lists at 40 weeks which is in addition to validation already in place at 11 weeks wait.
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		

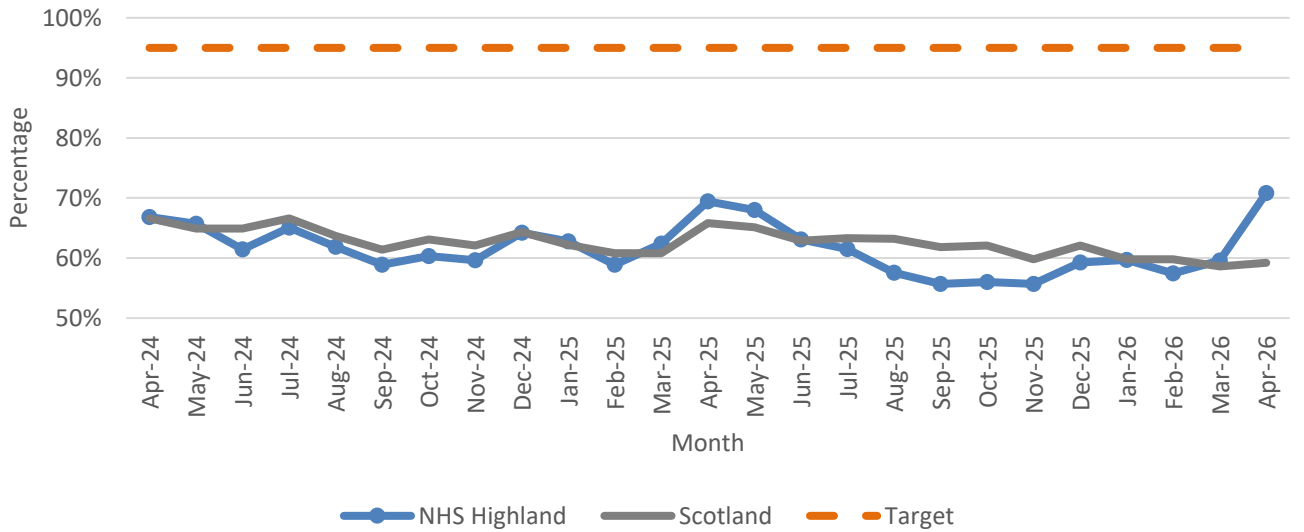
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating against Plan	126 ahead of forecast
Latest Performance against Plan	0.15% ahead of 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	6th out of 15 Boards

New Outpatients Seen & Trajectories



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



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Katherine Sutton
Chief Officer, Acute

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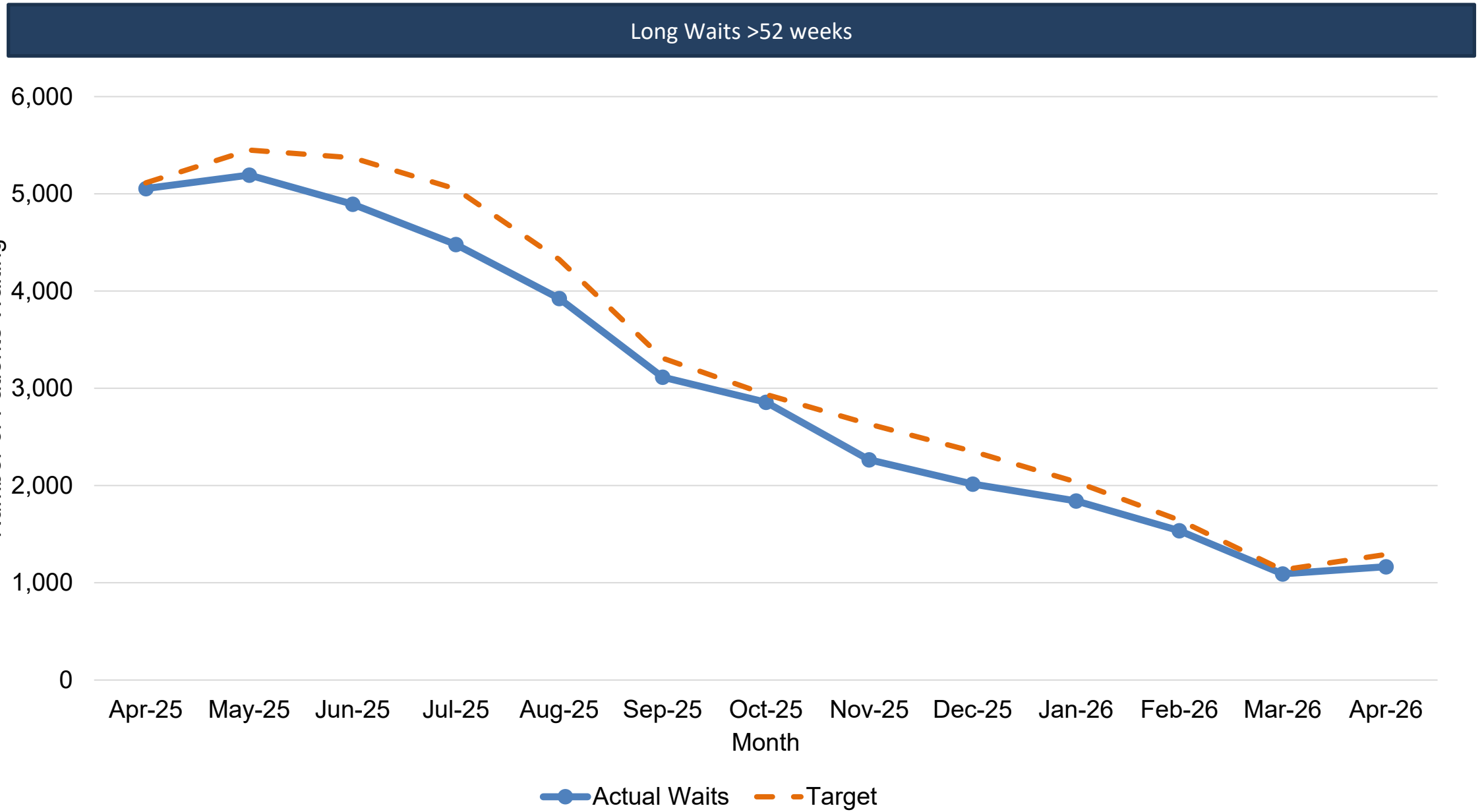
Outpatients (Long Waits) - Slide 2 of 3

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



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 programm 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.

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Executive Lead
Katherine Sutton
Chief Officer, Acute

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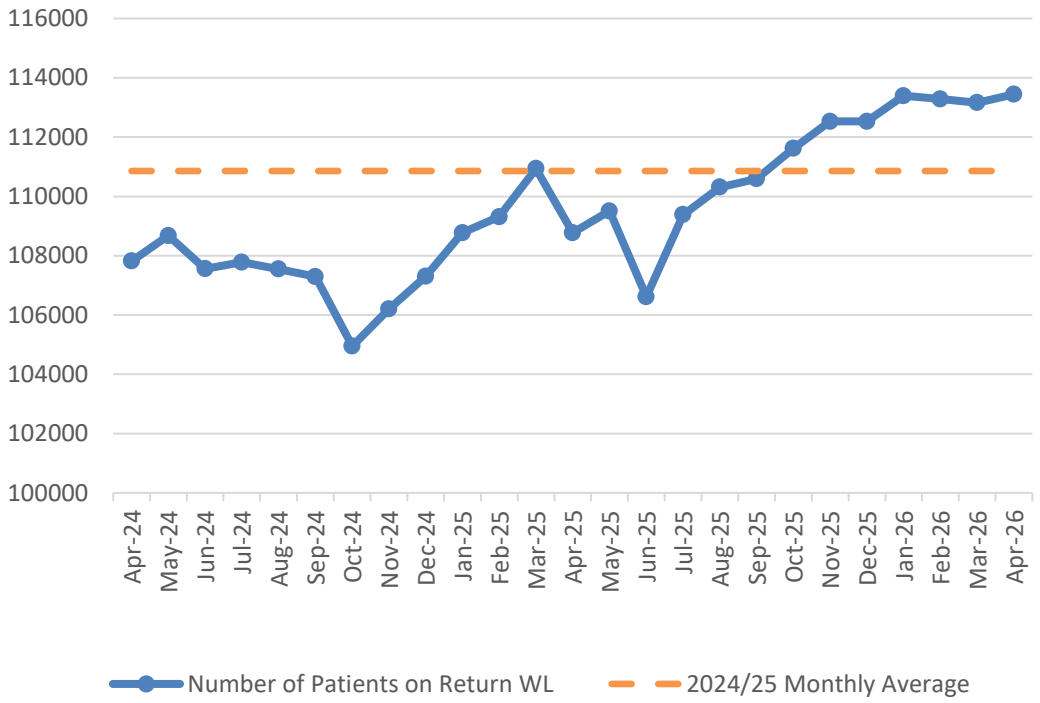
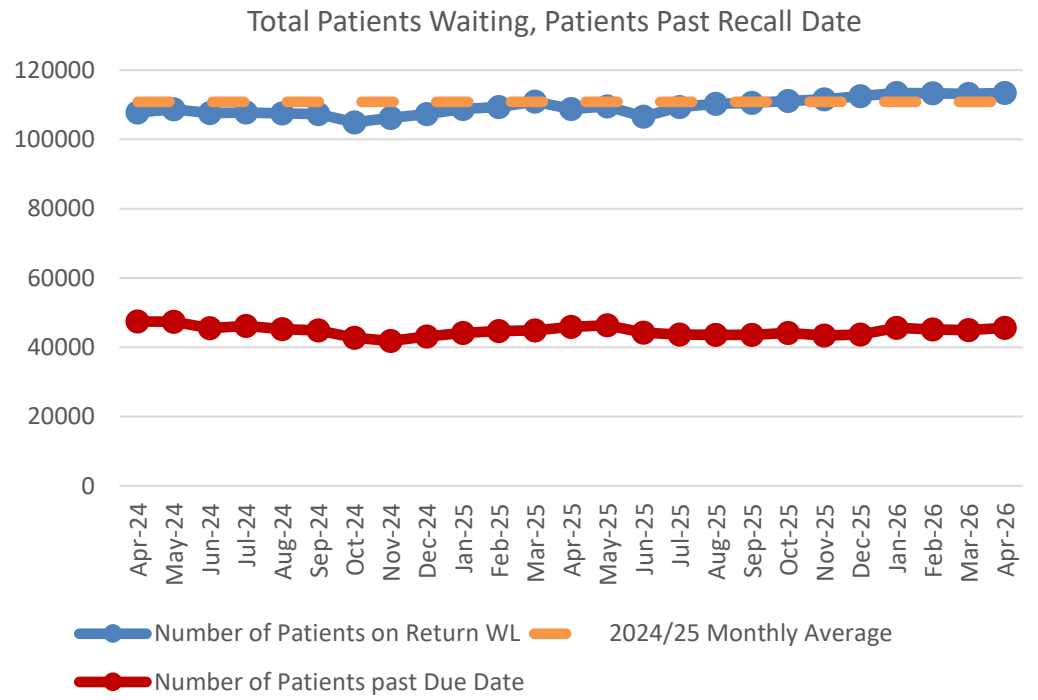
Return Outpatients Wait List vs. 25/26Average



Return Outpatients Wait List



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Executive Lead
Katherine Sutton
Chief Officer, Acute

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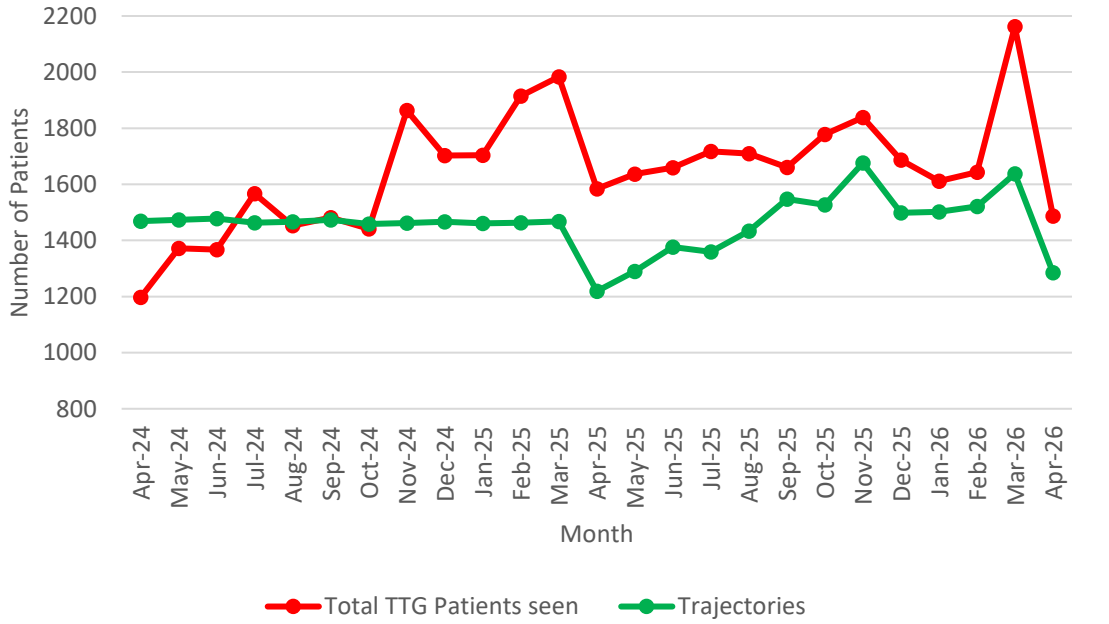
Treatment Time Guarantee (TTG) - Slide 1 of 2

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the number of TTG patients waiting over 52 weeks to 124 by March 2026	**Highland –** Activity and Long waiting targets for 25/26 were fully met across NHS Highland Activity was notably strong in Ophthalmology, General Surgery (Upper GI) and Trauma and Orthopaedics. This was due to the National Treatment Centre performing well and utilising some capacity which had initially been allocated to other Boards for Highland patients. Upper GI also performed well through utilising RGH sites and improved clinical validation	Without additional investment in 26/27 the number of people waiting over 52 weeks will increase. We are currently developing bids for in year investment from Scottish Government
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

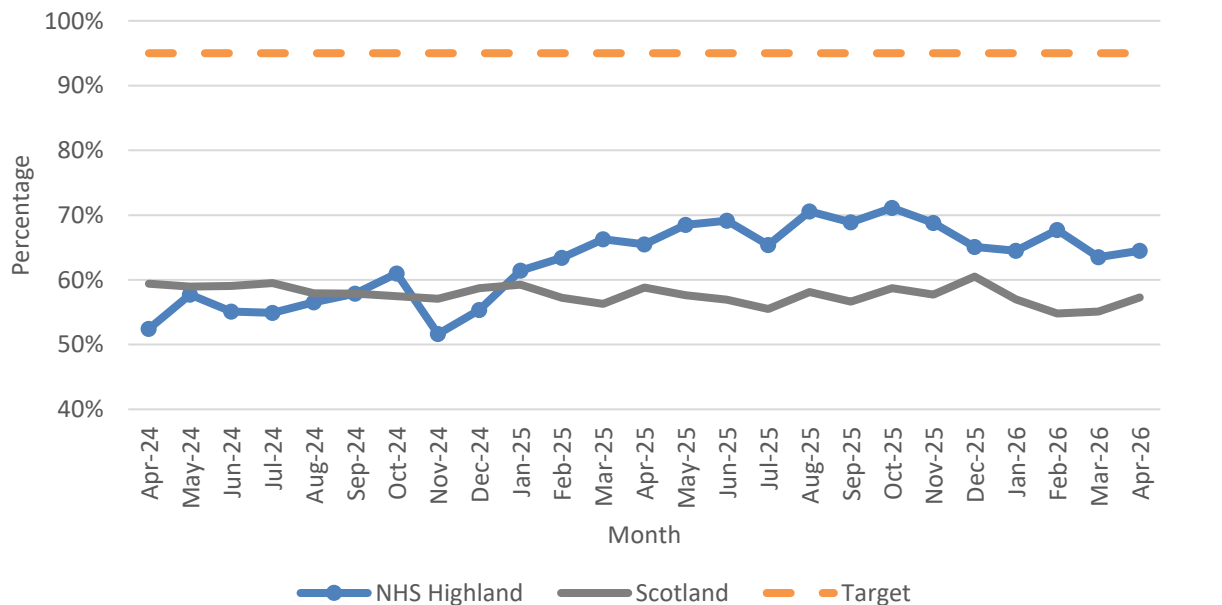
Performance Rating against Plan	9 ahead of forecast
Latest Performance against Plan	On target
National Benchmarking against 12-week performance	64.5% (Scotland 57.3%)
National Target against 12-week performance	100%
National Target Achievement against 12-week performance	Target Not Met; But consistently above Scotland average
Benchmarking against 12-week performance	4th 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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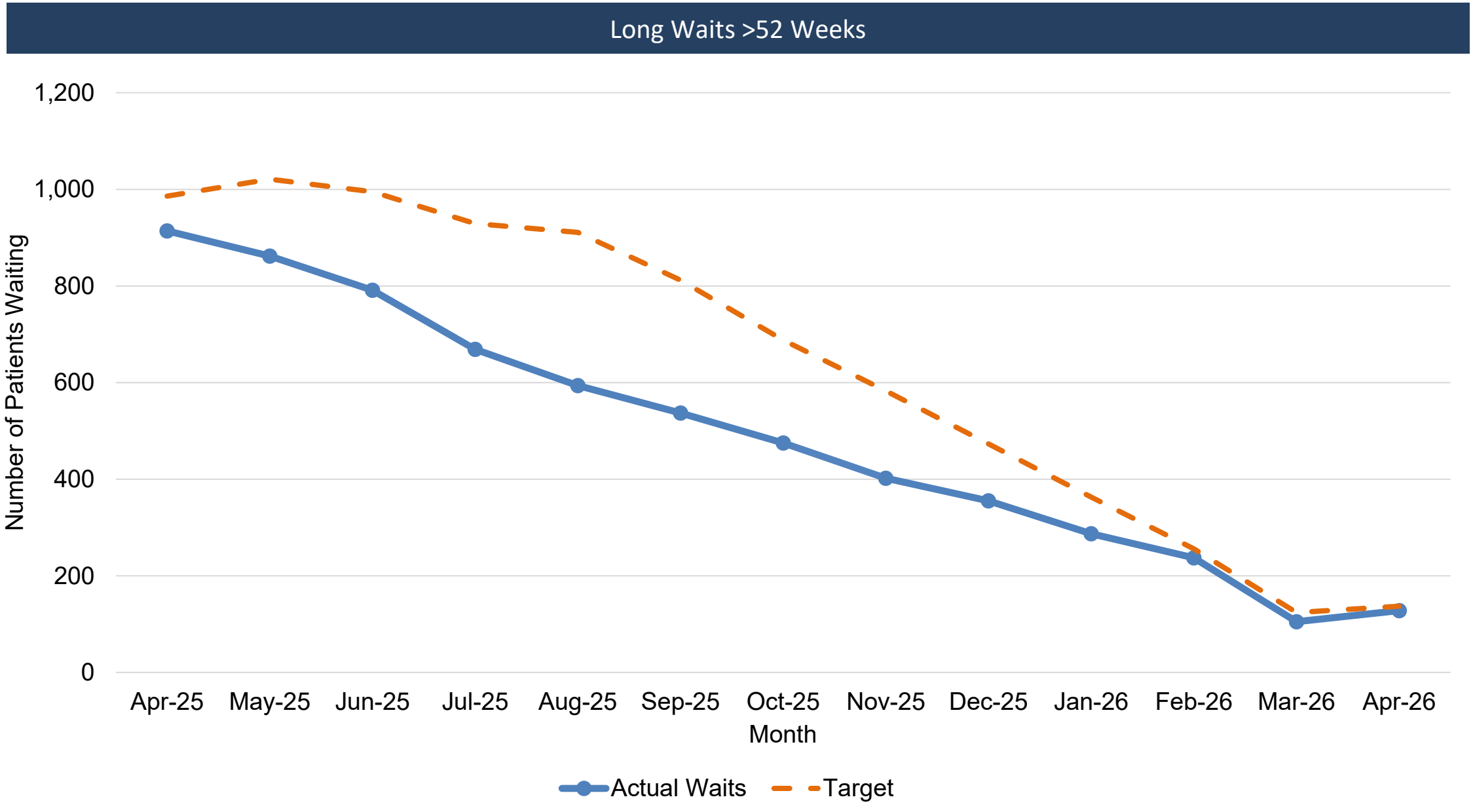
TTG (Long Waits) - Slide 2 of 2

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



Diagnostics – Radiology – Slide 1 of 2

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Katherine Sutton
Chief Officer, Acute

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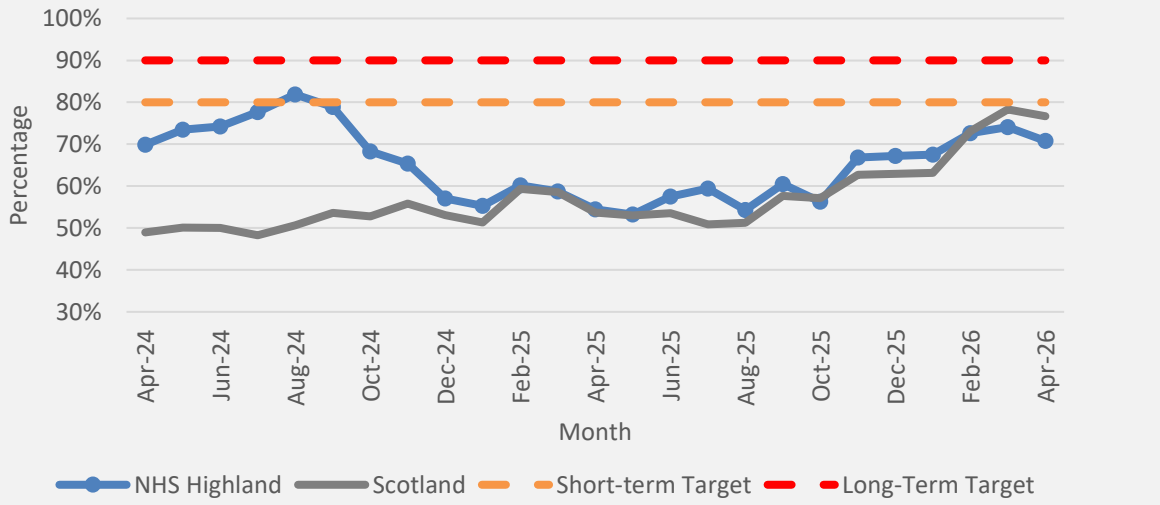
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
The number of patients who receive imaging (all) is equal to or exceeds the trajectory every month The number of patients who received a CT scan is equal to or exceeds the number of planned appointments every month 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	**Highland:** Ongoing high inpatient workload for Raigmore CT, MRI inpatient numbers stabilised but still high. Outpatient cancellations higher in April as a result. Ultrasound performance at Raigmore good overall, but some patient-specific delays plus new staff member only just reporting independently. Capacity at Belford impacted by vacancy. **Argyll and Bute:** Fortunate position of having good capacity – Q4 – 96.2% met the KPIs. As we hit summer months and loss of locum capacity we anticipate some loss of capacity and growth in waiting lists – particularly US.	**Highland:** MRI van in place for Q1, funding yet to be confirmed for Q2 onwards. Raigmore US capacity offered to CGH and Belford from May onwards. Meetings with SG reinstated post-election, monitoring and support in place. Professional lead commencing Aug26. **Argyll and Bute:** Position paper for NHS Highland for US services due to the fragility of staffing. CT we hope to maintain capacity with recruitment into bank positions

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

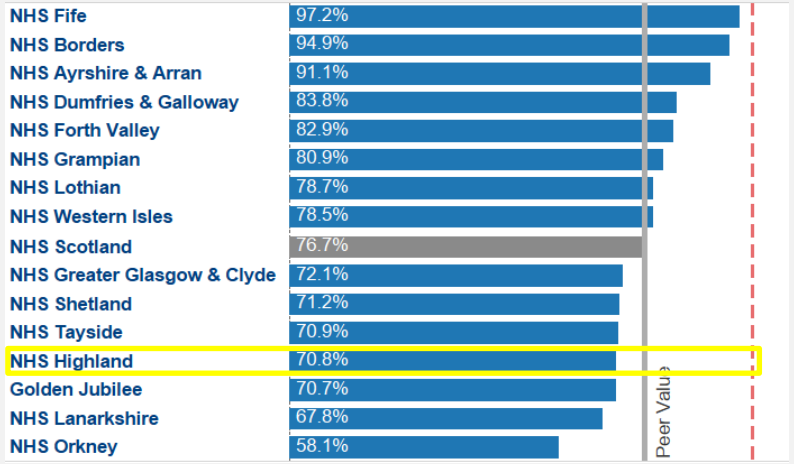
Performance Rating against Plan	9.2% off local target
Latest Performance against 6-week target	70.8% (Apr 26)
National Benchmark against 6-week target	76.7%
Local Target	80% (Short-term) 90% (Long-term)
National Target Achievement	National target not met, performance in NHSH is above Scotland average
Benchmarking	13th 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	37,671
YTD Performance Trajectory	3621 (91.96%)
Patients Seen – Apr 26	3144 (118.06%)
Overall	-1.27% behind target

Diagnostics – Radiology – Slide 2 of 2

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Chief Officer, Acute

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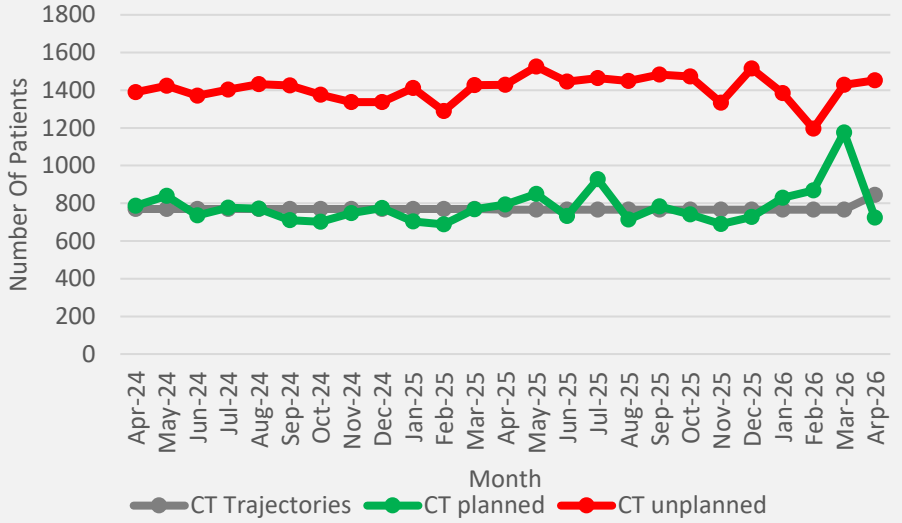
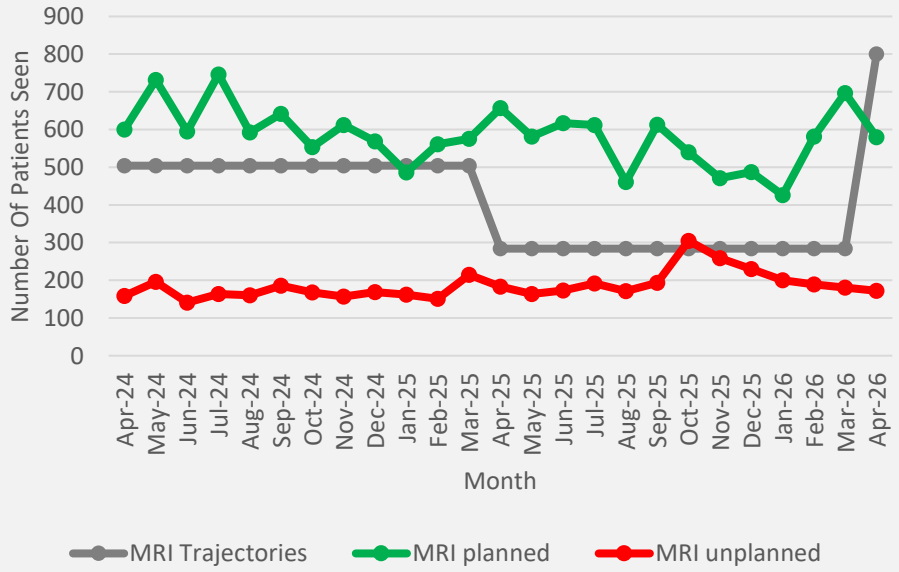
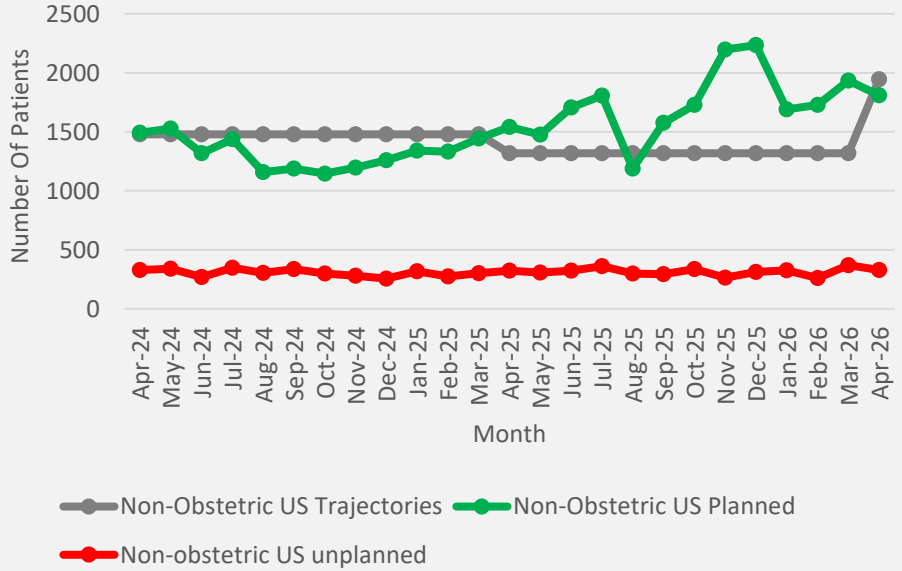
CT Patients Seen and Trajectories



MRI Patients Seen and Trajectories



Non-Obstetric Patients Seen and Trajectories



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Diagnostics – Endoscopy – Slide 1 of 2

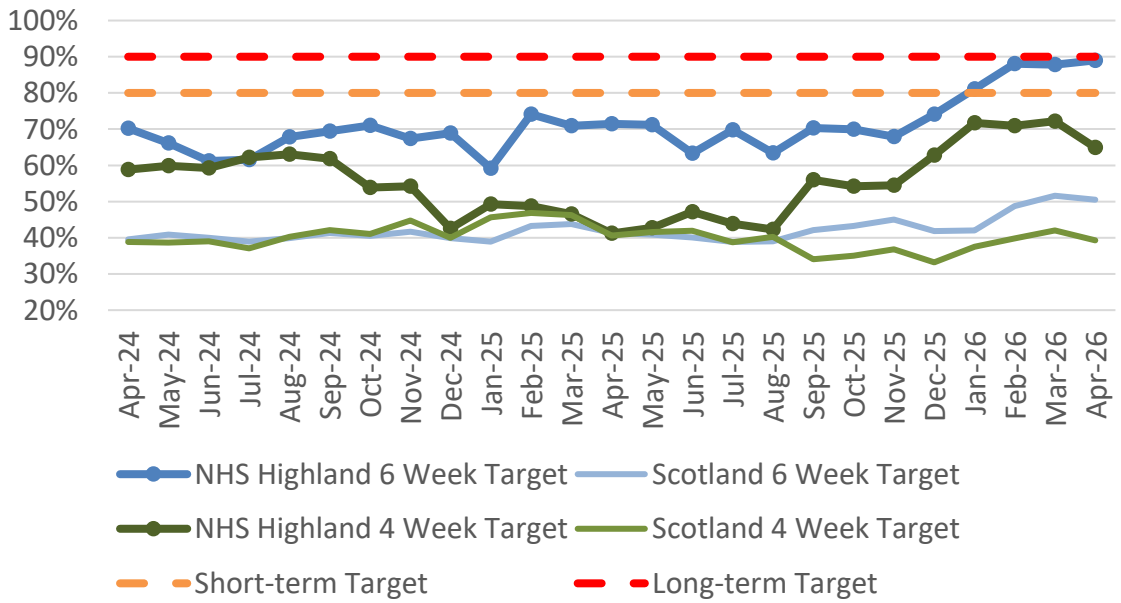
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
No patients waiting longer than 6 weeks for an endoscopy test (from referral to test) in line with Scottish Waiting Time Targets	**GI endoscopy:** Capacity has diminished at Belford and Caithness sites – SBAR has been prepared, Mike Hayward to review RGH funding ability No additionality allocated when Planned Care funding given to Gastro and General Surgery to deliver additional clinics in 2025/26 **Cystoscopy:** Reviewed nurse support model and DCAQ work completed	**Overall:** TrakCare PMS continues to measure waiting times on 28days rather than 42 days – this was first raised 2.5years ago • It is on digital plan • It does have a work order raised through ehealth SPoC • It has been raised with S&T Highland **are** the only board in Scotland failing to report on 42days; national team and JAG assessment both flagged this
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

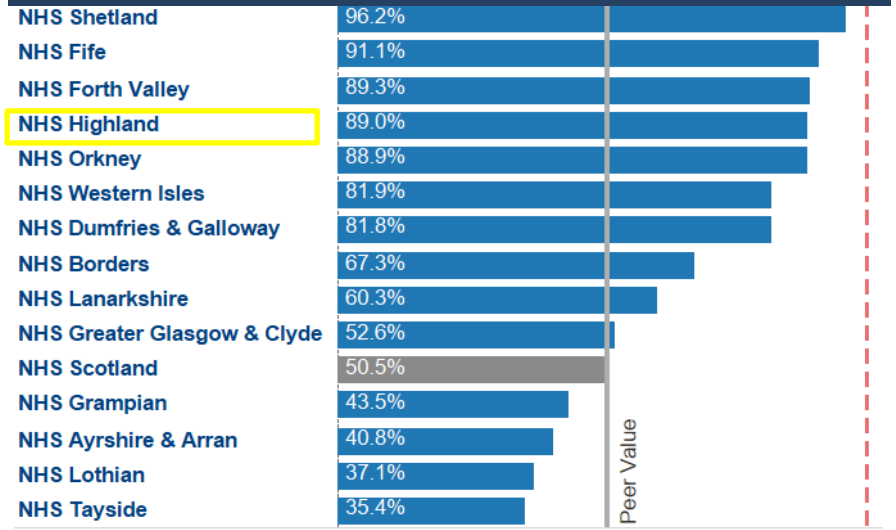
Performance Rating	1.0% off local target
Latest Performance	89.0% (Apr 26)
National Benchmark	50.5%
National Target	80% (Short-term) 90% (Long-term)
National Target Achievement	
Benchmarking	4th out of 15 Boards

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	6218
YTD Performance Trajectory	547 (8.80%)
Patients Seen – Apr 26	6,204 (119.86%)
Overall	-0.16% behind trajectory

Diagnostics – Endoscopy – Slide 2 of 2

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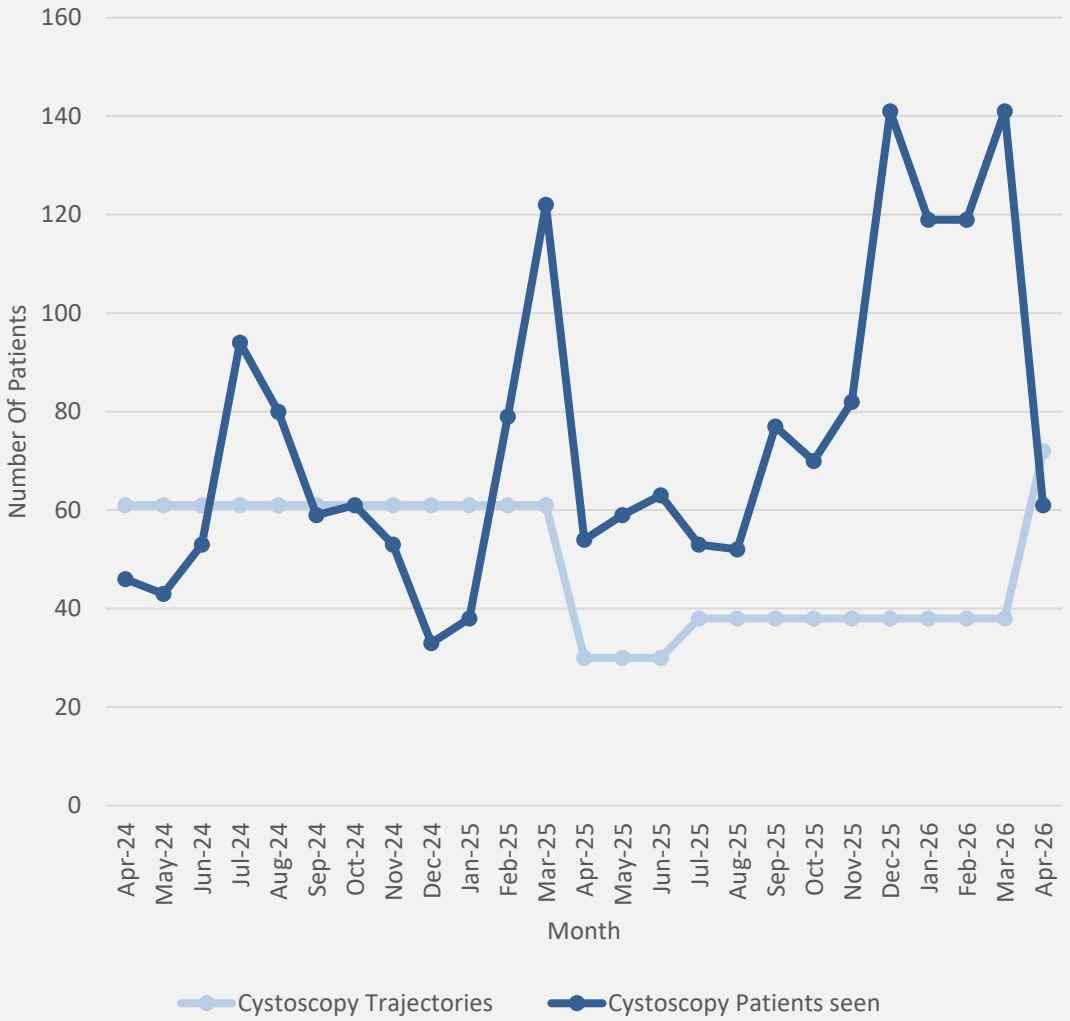
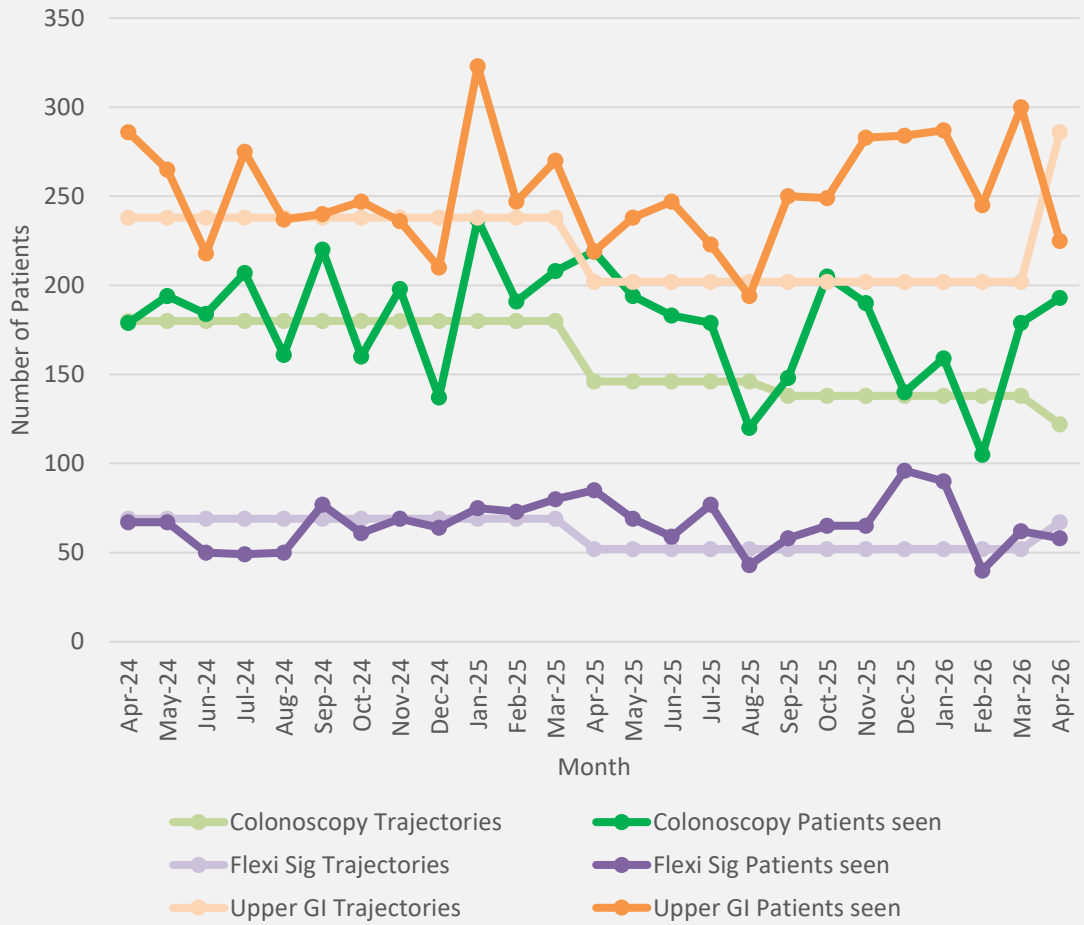
Patients Seen and Trajectories: *Cystoscopy*



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



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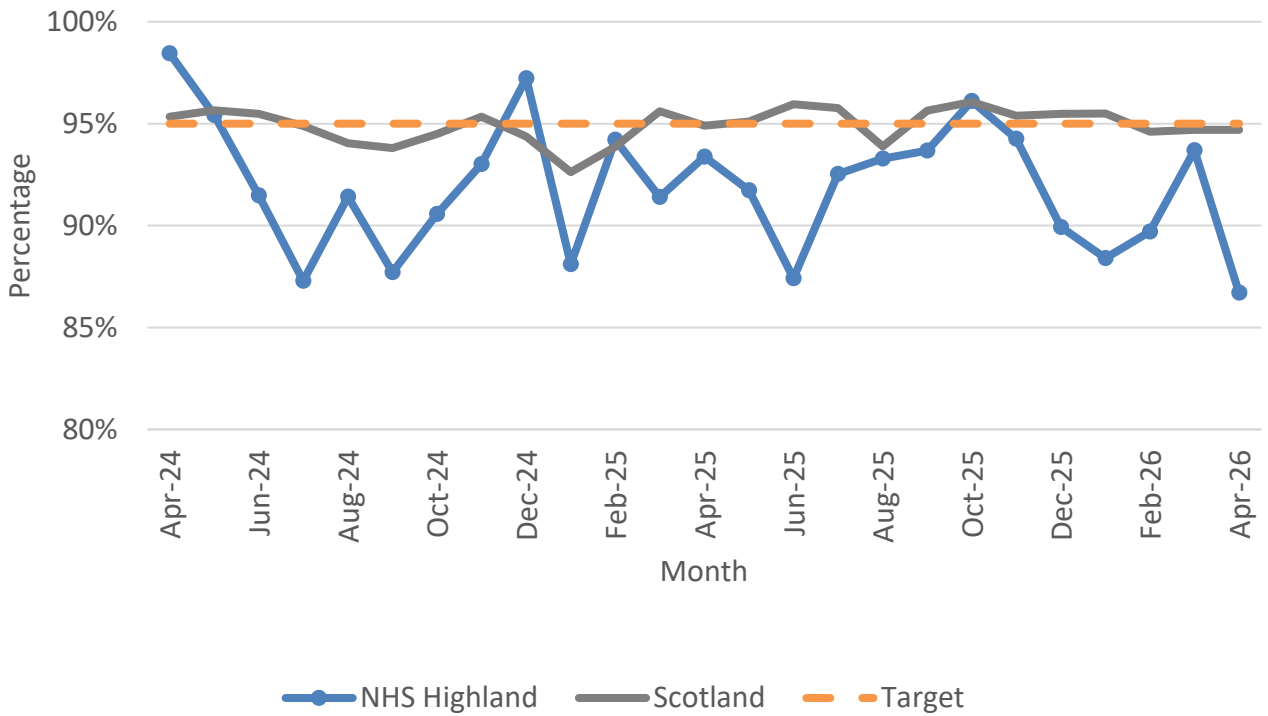
31 Day Cancer Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
95% of patients should begin treatment within 31 days of the decision to treat, regardless of the referral route	• Lack of Breast Surgery capacity is the reason for every breached patient apart from 1. • The Breast surgeons are focusing upon support patient waits at the beginning of the pathway for assessment and diagnostics	Increasing support for Forth Valley to provide See and Treat capacity

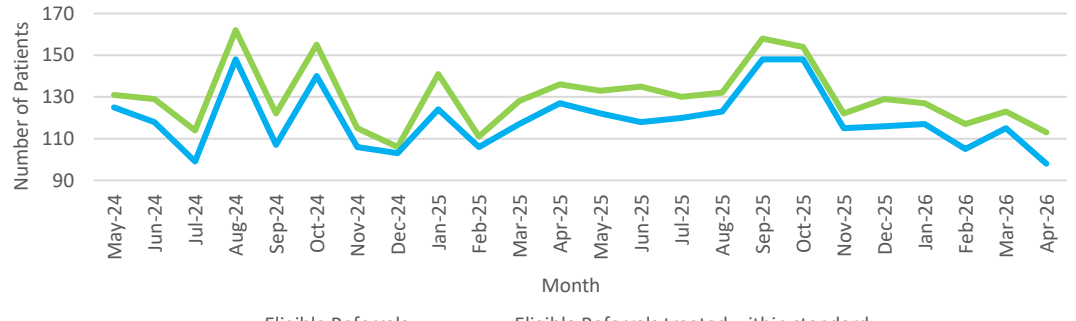
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	8.3% off local target
Latest Performance	86.7%
National Benchmarking	94.7%
National Target Achievement	95%
Position	15th out of 15 Boards

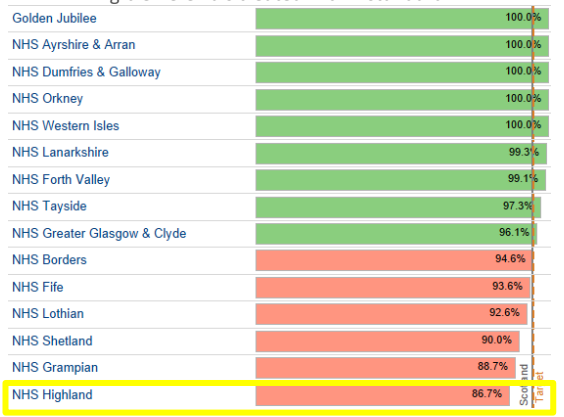
31 Day Cancer Waiting Times



Patients Seen on 31 Day Pathway



31 Day Benchmarking with Other Boards



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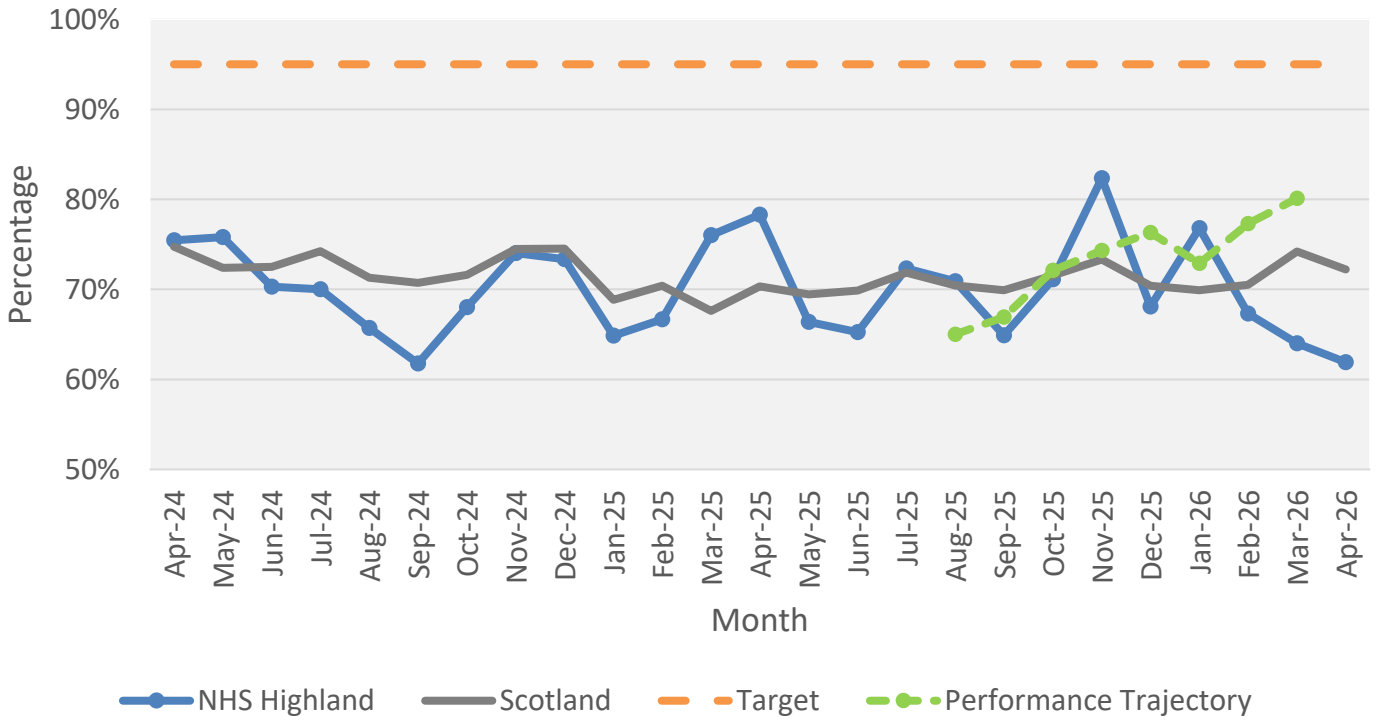
62 Day Cancer Waiting Times

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
95% of patients referred urgently with a suspicion of cancer (USC) - whether through a GP referral, national screening programme, should be their first cancer treatment within 62 days of receiving the referral.	• Colorectal – long wait for Endoscopy as 1st or 2nd assessment • Breast – lack of radiologist and radiographer capacity for assessment and diagnostics • Lack of MRI capacity in February lengthening wait for some Prostate patients	• Continued focus upon Patient Tracking List meetings for all patients in all tumour types. • Colorectal appointment to vacant posts at Nurse Endoscopist grade • Breast – continued support from Forth Valley and appointment to non Consultant grades (Specialty Dr appointed on 5 June) • Prostate – restoration for previous short waiting time

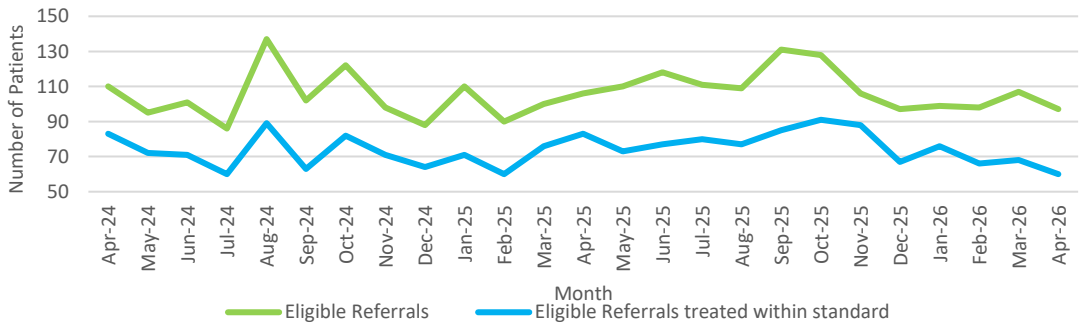
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Treat Well

Performance Rating	1.7% off local target
Latest Performance	61.9%
National Benchmarking	70.5%
National Target	95%
National Target Achievement	Not Achieving
Position	10th Out of 14 Boards

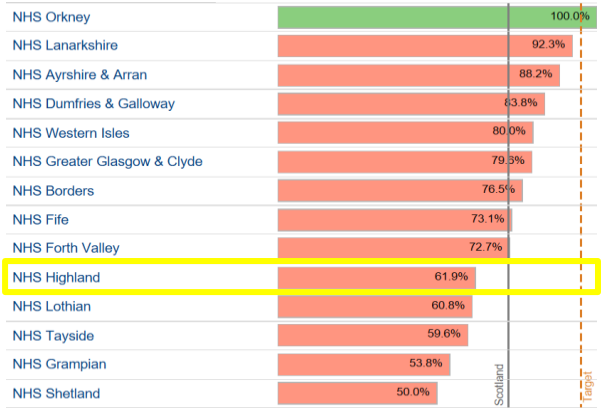
62 Day Cancer Waiting Times



Patients Seen on 62 Day Pathway



62 Day Benchmarking with Other Boards



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

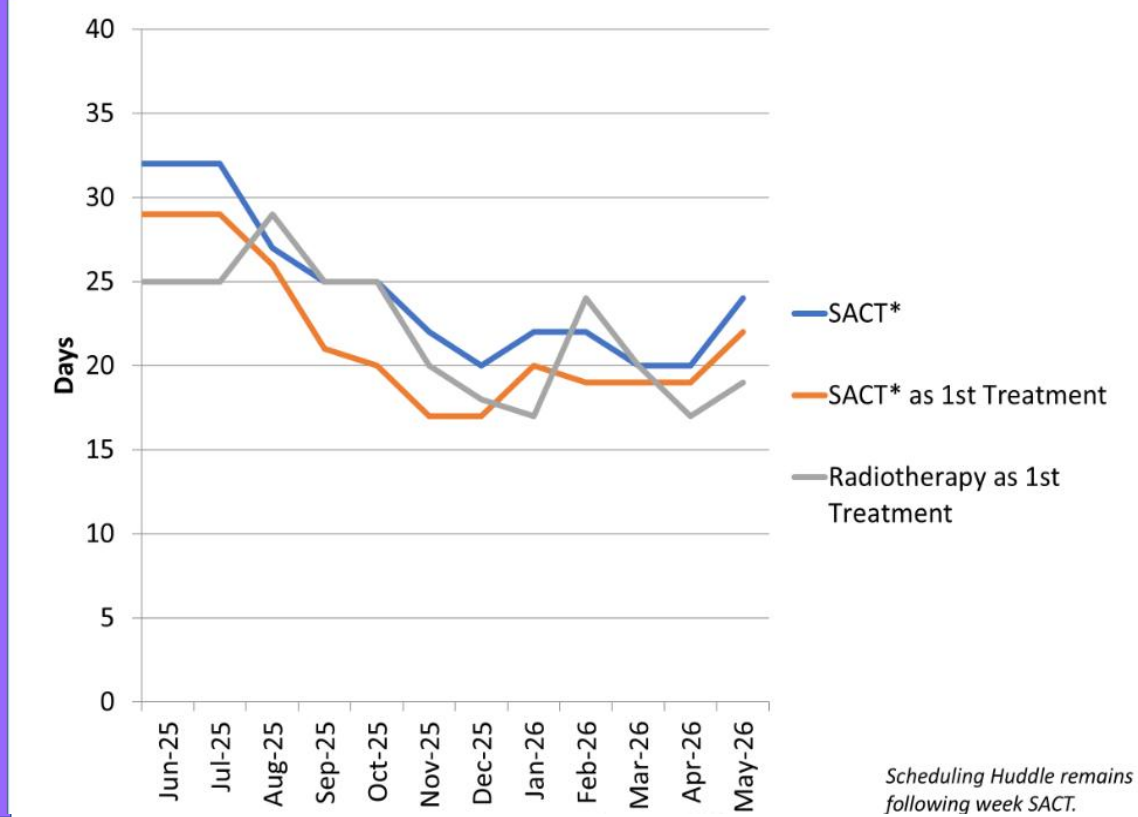
Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
The average waiting times for SACT as 1st Treatment, Radiotherapy as First Treatment and ASCT patients overall (new and subsequent) will be no more than 28 days	This is a local (Board) KPI which is likely to be adopted regionally in order to measure performance across the North. SACT capacity and demand is under pressure at each stage in the process (prescribing and administration in particular. The slight increase in the last month reflects a new increase in demand	• Appointment to vacant nursing posts and other clinical posts. • Ongoing review of SACT workforce staffing levels

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

Performance Rating	Local target met
Latest Performance	Average range = 20-24 days to start treatment
National Benchmarking	n/a
National Target	n/a
National Target Achievement	n/a
Position	NHS Highland activity matches national trends

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

ONCOLOGY



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

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Chief Officer, Acute

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Emergency Department Access

Key Performance Indicators

Achieve a 4% improvement in the number of patients attending A&E being seen, treated, admitted, or discharged within 4 hours by March 2027.	
Reduce the number of A&E patients admitted, transferred, or discharged within 8 hours of arrival by March 2027, reducing extended waits and improving care quality.	
Reduce the number of patients waiting > 12 hours in A&E by March 2027, ensuring no patient experiences excessively prolonged waiting times.	

Reasons for Current Performance

Raigmore: 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):
- Inpatient bed pressures remain the primary driver of ED performance, causing flow delays and deviation from standard care pathways
- Absence of SDEC facilities continues to require extended ED observations

Lorn & Islands (LIH):.
- Impact on performance if SNR decision maker absent
- Performance steady
- H@H supporting

Plans, Mitigations and Actions

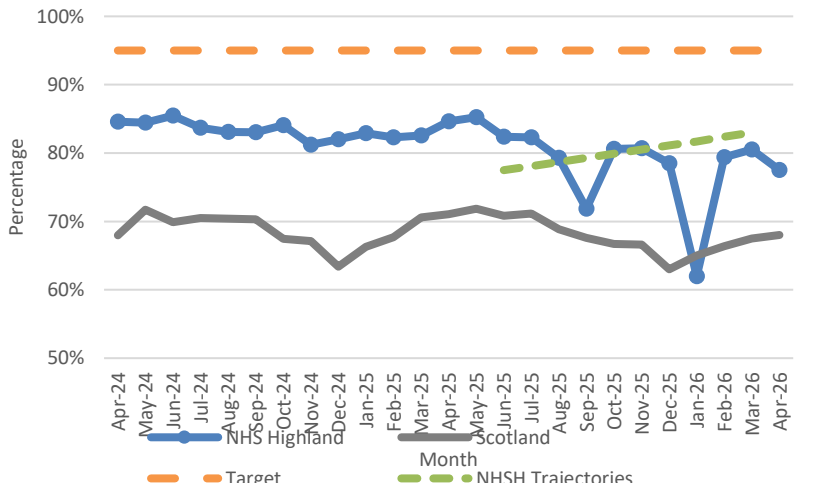
Raigmore: NHSH Interface Meetings for System Pressures – reporting to EDG
Raigmore Capacity Stabilisation Program commenced on 25 Feb 2026, Use of non-standard bed spaces to eliminate 12-hour waits in ED
CGH: DMT meetings with community and discharge support nurse; escalation protocol reinforced for 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
BH:
- New triage area in place and improvements to ED flow co-ordination; improved communication plan with Wards
- Focus on enhanced OPEL communication and stronger Primary Care links to support appropriate patient redirection

LIH:
- Staffing adjustment
- Enhanced oversight

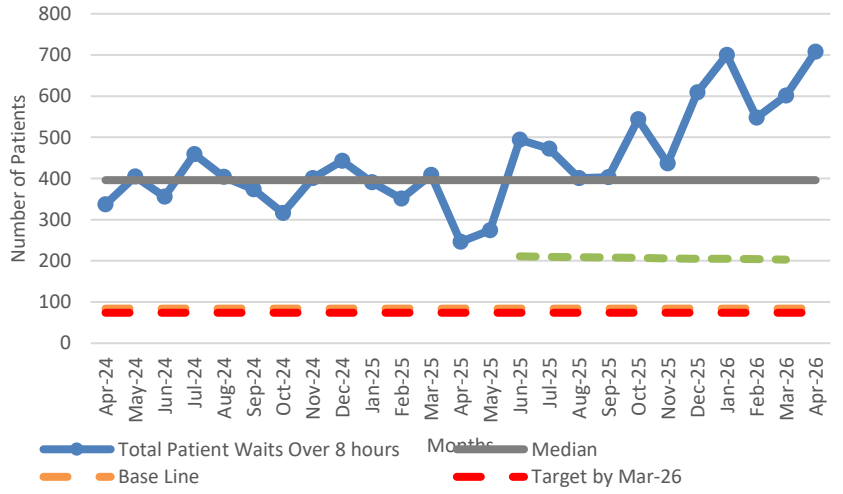
PERFORMANCE OVERVIEW
Strategic Objective: Our Population
Outcome Area: Respond Well

Performance Rating	Local target met
Latest 4-hour Performance	77.5% (Apr 26)
National 4-hour Average	68.0%
National Target	95%
National Target Achievement	NHS H as a whole remains above the Scotland average, but off target
Position	7th out of 14 Boards

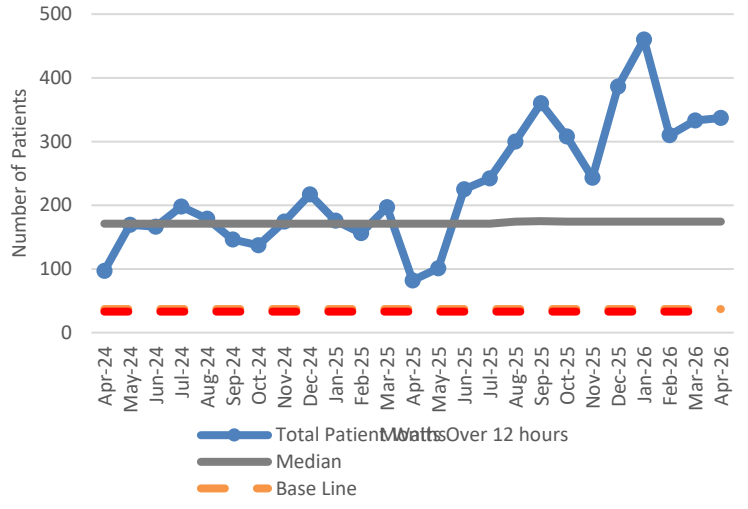
% of people seen in ED within < 4 hours per month



Total Patients waiting > 8 hours in ED per month



Total Patients waiting > 12 hours in ED per month



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Executive Lead
Arlene Johnstone
Chief Officer, HHSCP

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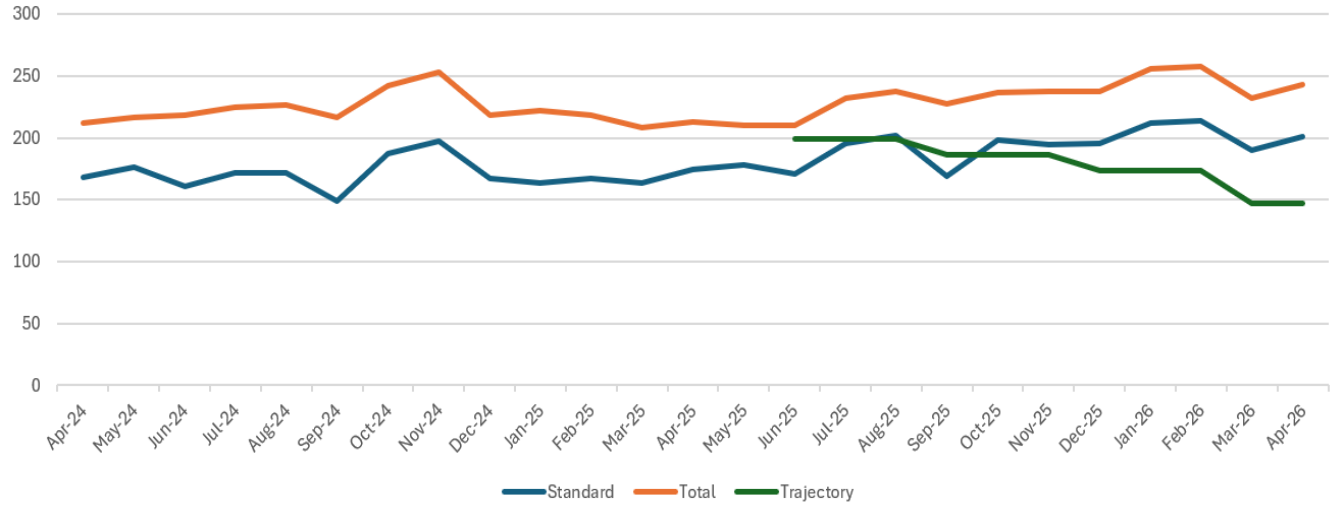
Delayed Discharges

Key Performance Indicators	Reasons for Current Performance	Plans, Mitigations and Actions
Reduce the total number of patients experiencing a standard delay in discharge from hospital across NHS Highland to agreed targets and trajectories.	Delays in hospital across the area have multifactorial causes related to availability of care, complexity related to Adults with Incapacity legislation and process and coordination issues. Current top three reasons for people being in delay are awaiting Care Home, Care at home and assessment	**Highland HSCP:** Implementation of National DWD Principles focusing on: • Implementation of pilot of Integrated Discharge Team (IDT) focusing on "Iner Moray Firth" Districts and identified wards in Raigmore due to commence. • Escalation; daily meeting with community services. Focus is to highlight/escalate issues impacting flow and to seek solutions. • Development of Power BI Dashboard for DHD to support trajectory monitoring **Argyll & Bute:** • Since March 2026, Ambulatory Care and D2A have launched in the Cowal locality and have noted positive results. Current reporting shows A&B DDs on trajectory • Relationship based MDT/Model continues to be developed across pressured areas. Daily focus meetings continue • Loss of major care at home provider (in excess of 800hrs) has had significant impact on social care provision. Mitigation in place.

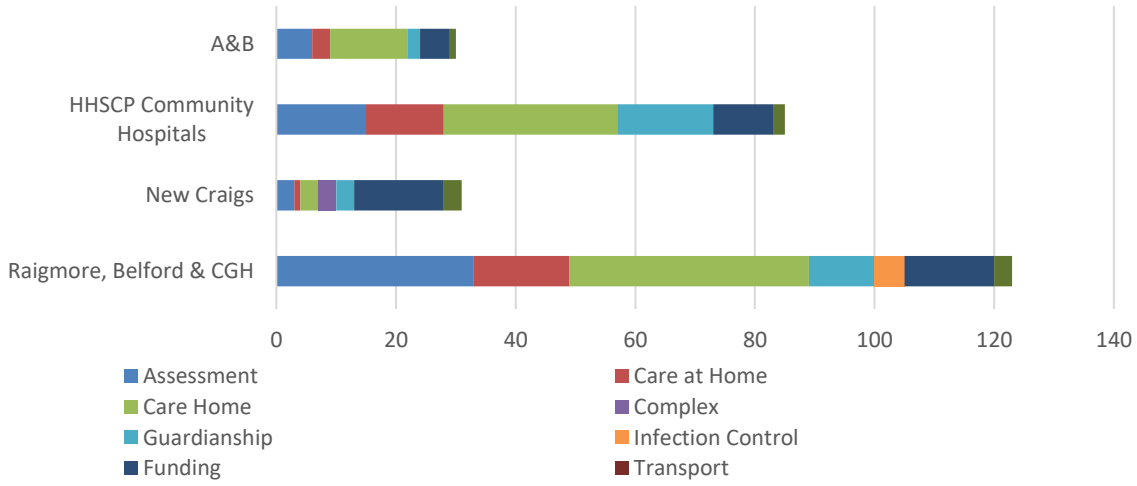
PERFORMANCE OVERVIEW
Strategic Objective: In Partnership
Outcome Area: Respond Well

Performance Rating	12.6% off local target
Latest Performance	243 at Census Point
National Benchmarking	Engagement through national CRAG group and CfSD
National Target	Trajectories developed
National Target Achievement	Not Met
Position	14th of 14 Boards

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



Number of people delayed from discharge – Location and Code



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Exec Lead Jennifer Davies, Director of Public Health

Alcohol Brief Interventions (ABIs)

Key Performance Indicators	Reasons for Current Performance (Updated June 2026)	Plans, Mitigations and Actions
Deliver at least 100% of the planned Alcohol Brief Intervention (ABI) activity target by March 2026	Fig 1.Total no of ABIs delivered in Q4 is 1017 . The end of year figure is 4.4% 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 (91.8%) with the remainder being delivered in wider settings across NHS Highland. There are online courses to support delivery of ABI's as well as e-learning opportunities for staff through the year but limited due to staff capacity. 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.	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. Awaiting national guidance on future delivery programme. Exploration of options to support delivery of ABI's, including training in Primary Care and wider settings is underway given limited capacity. One ABI online course delivered with 3 people attending in Q4. 90 completions of the e-learning module in Q4. ABI's is only one element of a broader programme of work to prevent harm from alcohol use.

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

Performance Rating	
Latest Performance	1017 in Q4
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	3851 vs. target of 3688 by end of Q4
Position	n/a

Fig.1

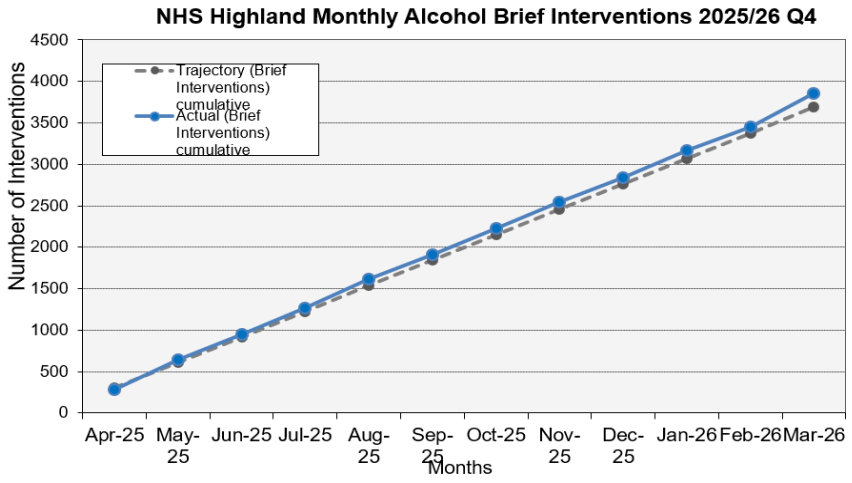

Fig.2 **Setting Contribution 25/26 Full year**

Setting Contribution in 2025/26 Full year

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

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Exec Lead
Jennifer Davies, Director of Public Health

Vaccinations

Key Performance Indicators	Reasons for Current Performance (updated June 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.	**Spring vaccination programme:** The Spring COVID-19 vaccination programme is well underway with current uptake rates for the programme in A&B HSCP exceeding the Scottish average (A&B = 50.2% and Scotland = 45.3%). The uptake in Highland HSCP is below the Scottish average at 40.8% although comparisons are difficult at this stage due to differences in operational delivery. **RSV older adult vaccination programme:** A co-administration approach has been taken to the RSV programme in A&B. The current uptake is 37.5% which already exceeds the end of season uptake for A&B HSCP for 2025/26. Board comparisons are difficult at this stage due to the differences in operational delivery. A briefing has been shared with healthcare professionals to raise awareness of the campaign and to support them to promote uptake. A poster has been developed and shared widely. **MMR vaccination:** The MMR uptake at 24 months and five years is shown in figure 1. The uptake for MMR 1 in A&B HSCP exceeds the 95% target at both time-periods. The figures for MMR 2 are lower across both partnerships and Scotland as a whole. A pilot is planned to support an MMR catch-up. The recent childhood schedule change (and the delivery of MMRV 2 at 18 months) has been undertaken with the aim of increasing MMR uptake rates.	Scottish Government is continuing to work with Highland HSCP in level 2 of its performance framework. A tripartite advisory group (SG, PHS, NHSH) is meeting to offer external support to NHS Highland as part of the implementation of the hybrid model of delivery in Highland HSCP. Work is ongoing in Argyll & Bute to maintain uptake rates and to support wider improvement work.

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

Performance Rating	
Latest position & performance	See charts
National Benchmarking	The performance varies by programme and by partnership although A&B tends to exceed the Scottish average.
National Target	There are not national targets for all of the programmes included. There is a 95% uptake target for childhood immunisations.

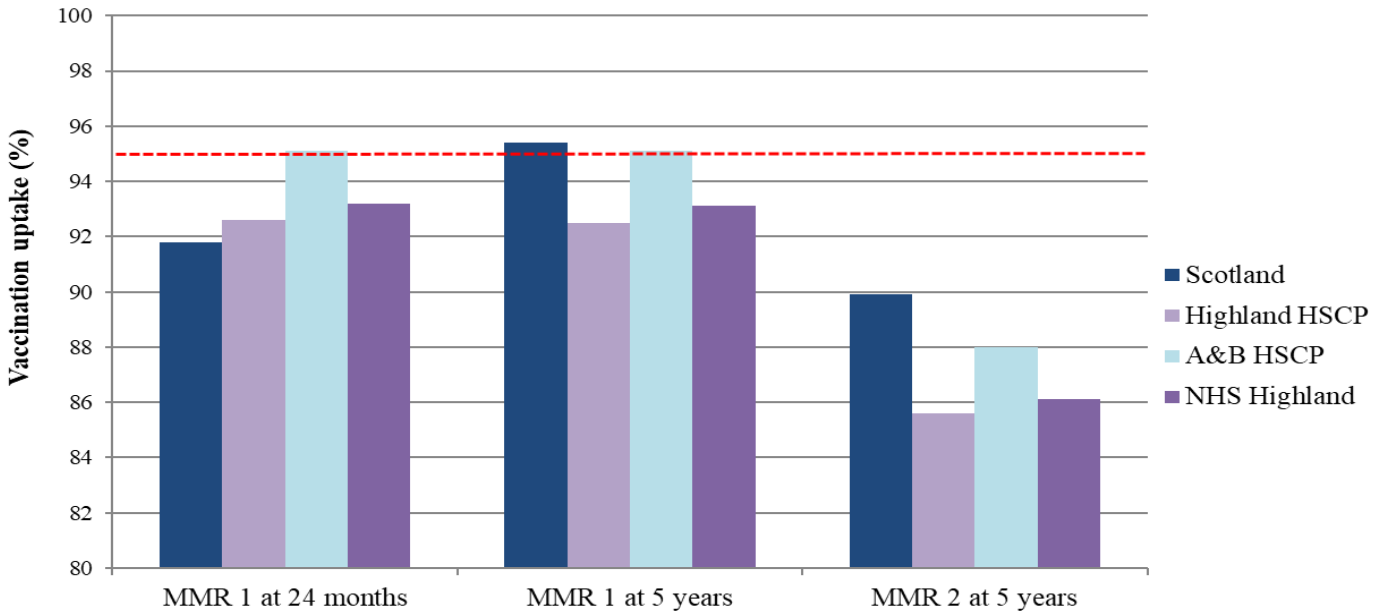

Figure 1: MMR uptake at both 24 months and five years of age by HSCP partnership, NHS Highland and Scotland (Q ending Dec. 2025)

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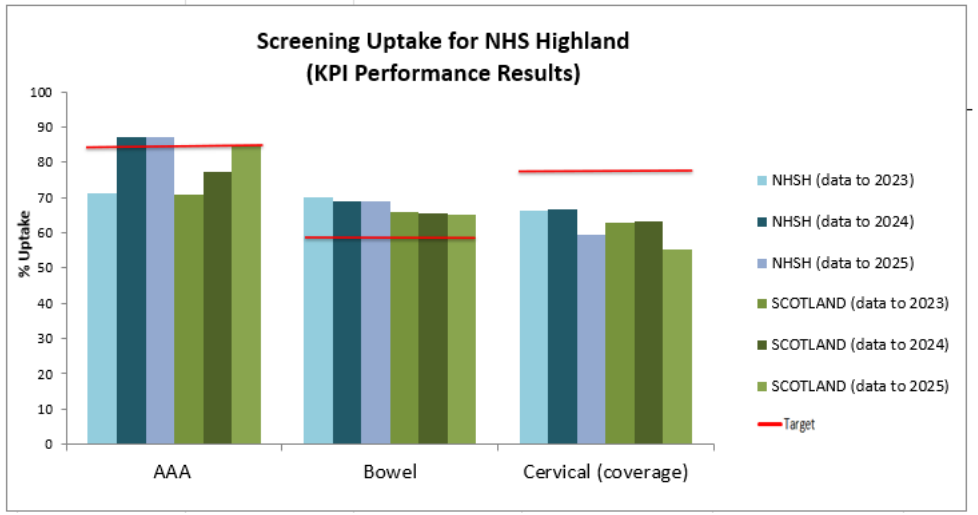
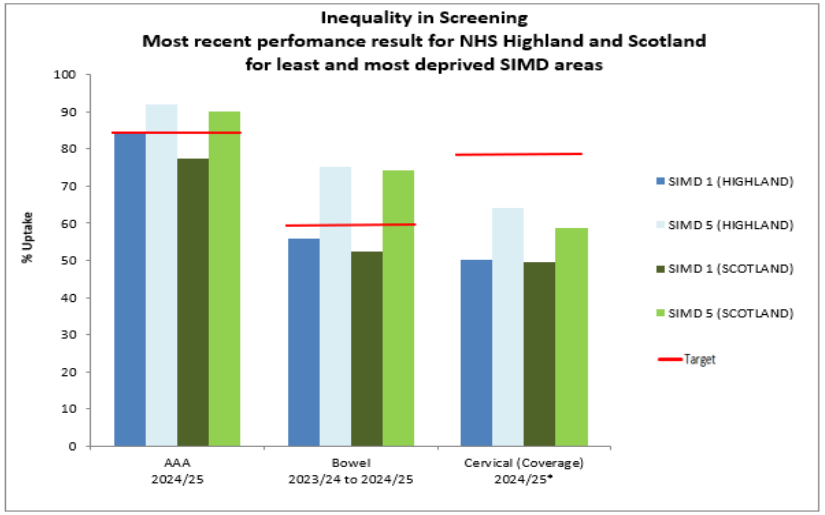
Exec Lead
Jennifer Davies, Director of Public Health

Screening (Cervical, AAA, Bowel and Cervical)

Key Performance Indicators	Reasons for Current Performance (Updated June 2026)	Plans, Mitigations and Actions
Encourage and promote screening programmes and increase uptake across available screening programmes above national targets.	• Screening performance is 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, 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 the most recent reporting time periods up to 31st March 2025), results for the above three screening programmes have been released. • Data errors were identified in current and historical datasets for Breast Screening. This has delayed the publication of Breast Screening Programme reports. In keeping with the caveats/recommendations for using historical breast data during this period, references to breast screening statistics have been removed. These will be represented once Public Health Scotland revise and publish their revised statistics. • Internal non-verified management data is also collected and used for service management purposes. Internal management data suggests similar performance findings for more recent time periods. • Performance data for the Diabetic Eye Screening (DES) programme 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.	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	Various
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.

Quality

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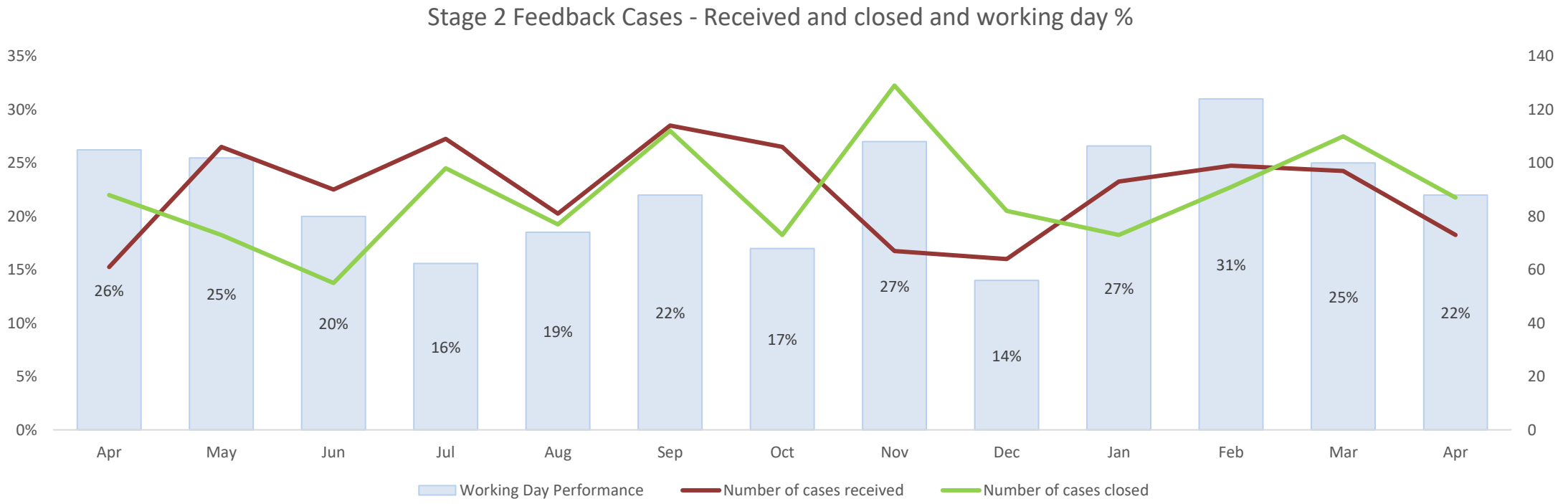
Stage 2 Complaint Activity (April 2025 – April 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
N/A	Performance has dipped again following encouraging improvements in the last reporting period. Performance of Acute fell below 20% for the first time since October 2025. Performance of HHSCP increased to 30% and 28% in March and April, respectively. Overdue complaints have fallen to their lowest level in the past 13 months - falling from a high of 211 in November 2025 to 110 in April 2026.	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. Further discussion with SLT required to expedite the acceptance of QA, initial contact with complainants and on-going liaison with complainants during the process

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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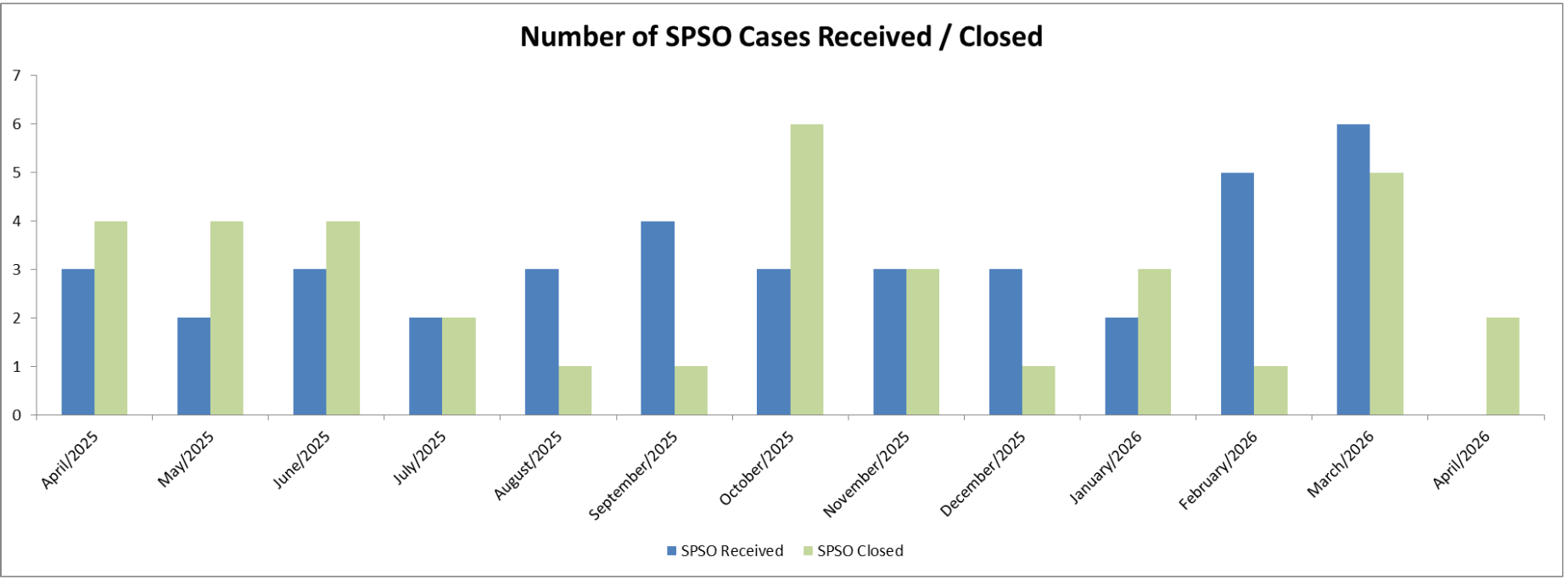
SPSO Activity (April 2025 – April 2026)

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	There were no new SPSO cases open in April. All cases closed have not been taken forward.	SPSO cases continue to be monitored via the Quality and Patient Safety structure.

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



SPSO cases received last 3 months:

11 received:

- 1 x Acute
- 2 x A&B
- 8 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:

8 SPSO enquiries closed

- 8 x not taken forward

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

ADP Deliverables Progress as at End of Q2 2025/26	Insights to Current Performance	Plans and Mitigations
	13 SAERs ae over the 26 week target. There are 34 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.

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

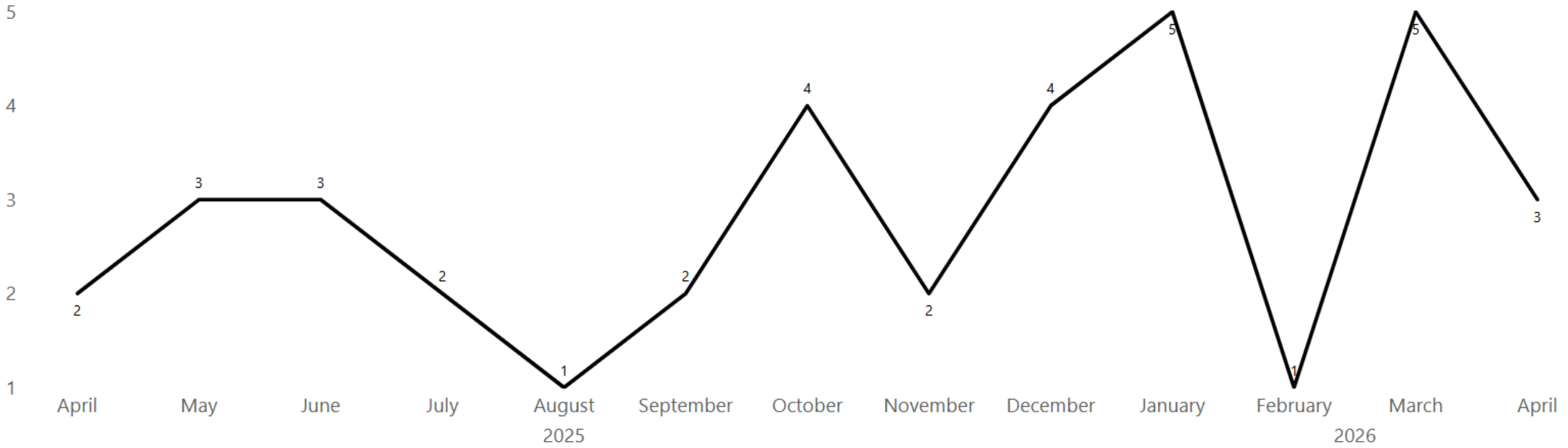
34
Open Level 1 (L1) Incidents

16
L1: Active more than 26 weeks

36
L1: SAER Declared Last 13 Months

0.21%
Incident | SAER Conversion Last 13 Months

SAER Level 1 Investigations Declared



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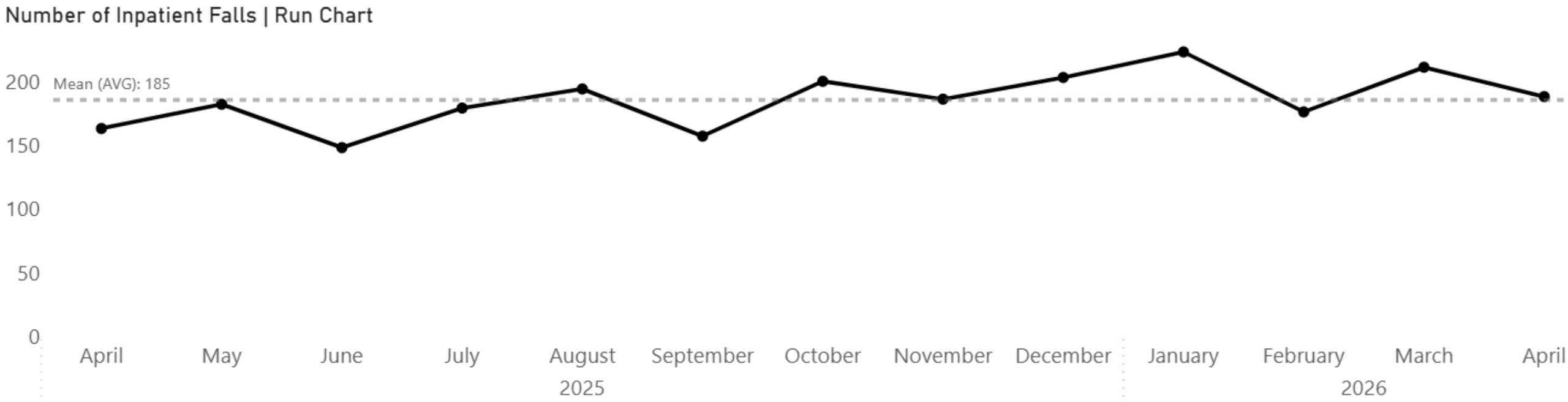
Hospital Inpatient Falls (April 2025 – April 2026)

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.	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	



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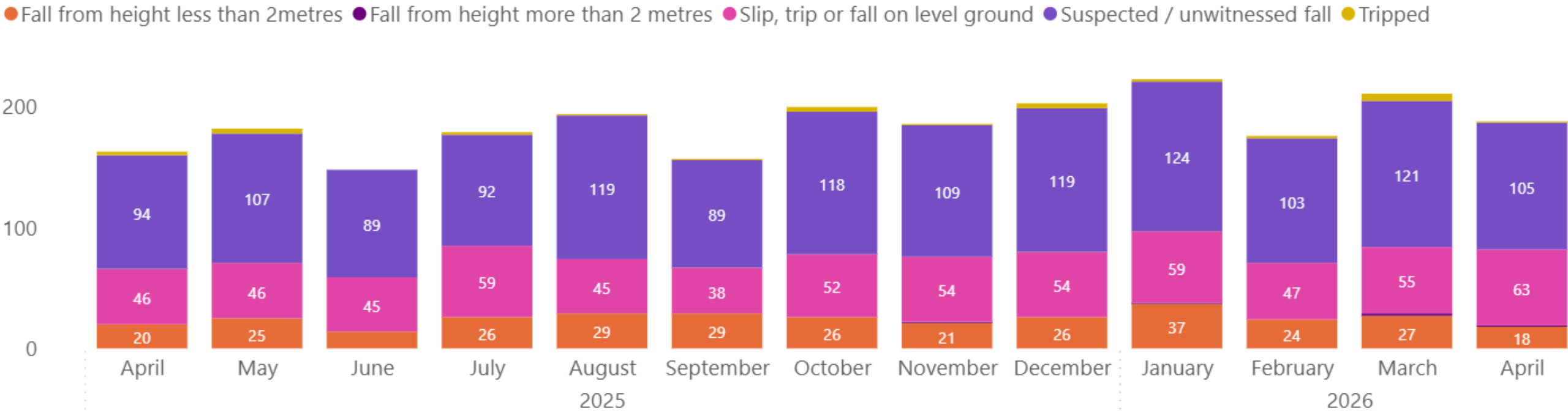
Hospital Inpatient Falls | Subcategory (April 2025 – April 2026)

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	



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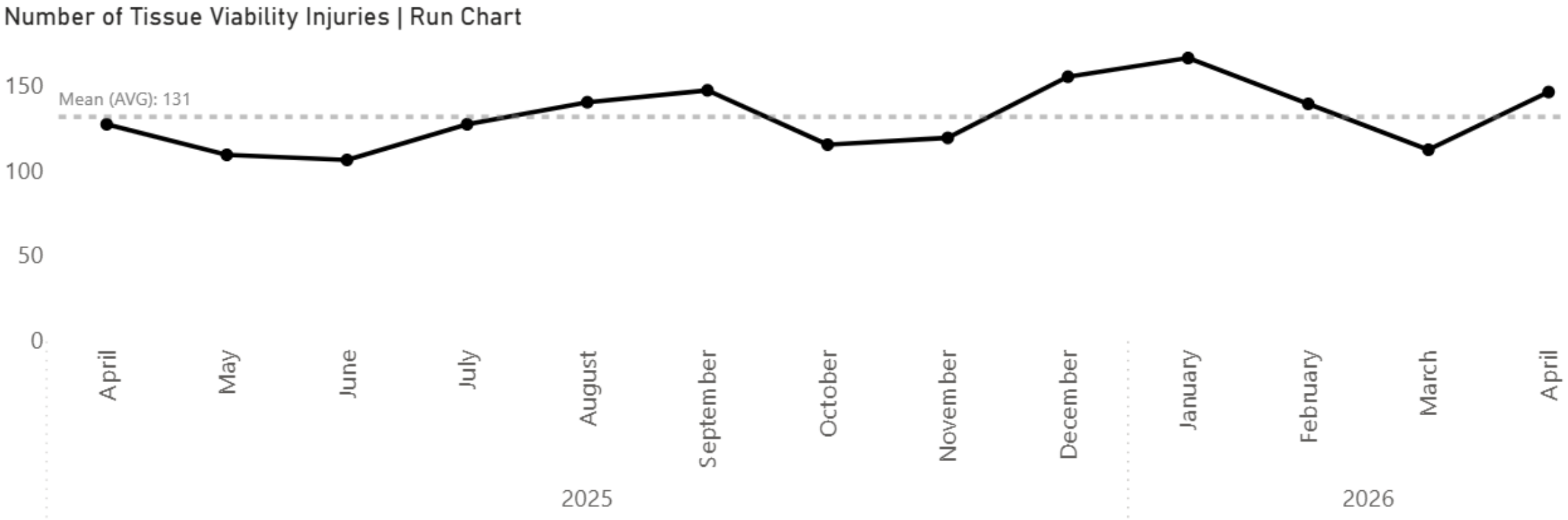
Tissue Viability Injuries (April 2025 – April 2026)

Strategic Objective: Our Population
Outcome Area: Treat Well

ADP Deliverables Progress as at End of Q2 2025/26		Insights to Current Performance	Plans and Mitigations
-MASD and PU Pathways complete via NATVNS- New Pressure Ulcer Grading Tool Training launched with dates via Teams. Training and Audit to target wards on Datix so that figures are accurate across acute key wards		- IPC unpublishing TURAS modules for Pressure Ulcers (PU). - PUs on feet adding to numbers - developed feet training - SAS training ongoing with PU prevention theme - 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 - Talamade and CGH to collaborate on PU reduction - Increases in community likely due to increase in reporting for patients NOT on DN caseload	- -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

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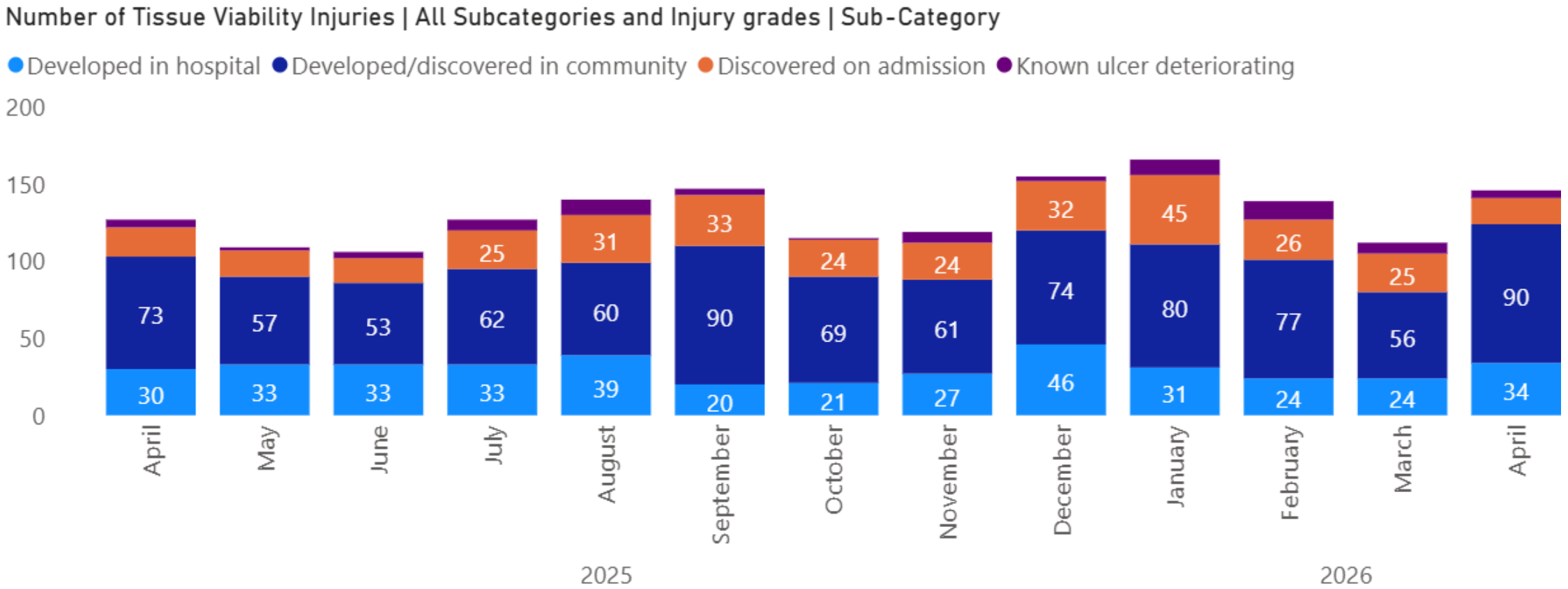
Tissue Viability Injuries | Subcategory (April 2025 – April 2026)

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 (April 2025 – April 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. Review of decision to not mandate or make PU training statutory to be had		• To discuss and target prevention strategies of Grade 1 incidents, to reduce deterioration and development to Grade 2 and above	• 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 - 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	199	431	144	19	**793**
Pressure ulcer Grade 1	83	134	69	3	**289**
Pressure Ulcer - ungradable	39	134	51	11	**235**
Pressure Ulcer - deep tissue injury	31	109	15	14	**169**
Pressure ulcer Grade 3	17	63	13	13	**106**
Pressure ulcer Grade 4	1	16	9	13	**39**
Pressure ulcer (grade not specified)	12	6	15		**33**
Mucosal Pressure Damage	10	4	10		**24**
Pressure Ulcer - combination lesions	3	5	8	4	**20**
Total	**395**	**902**	**334**	**77**	**1708**

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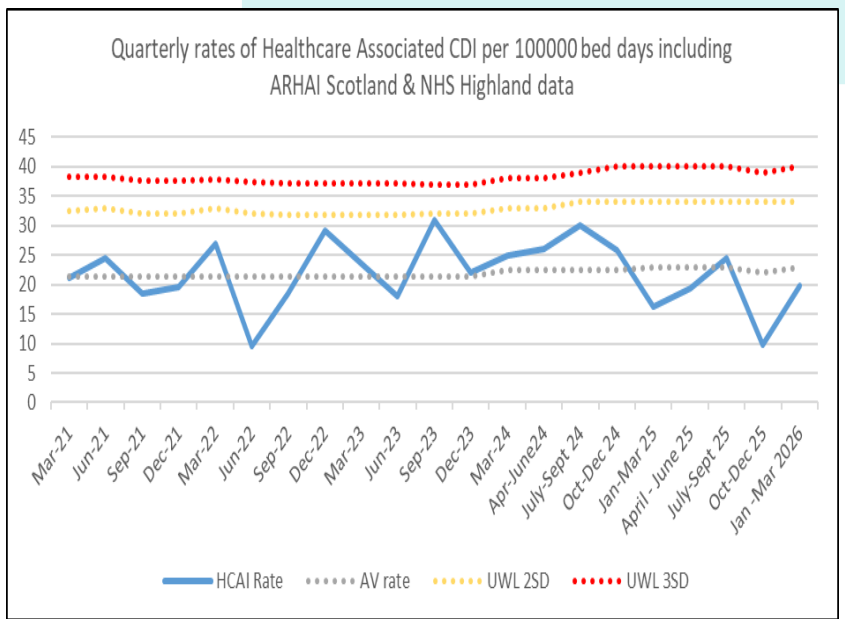
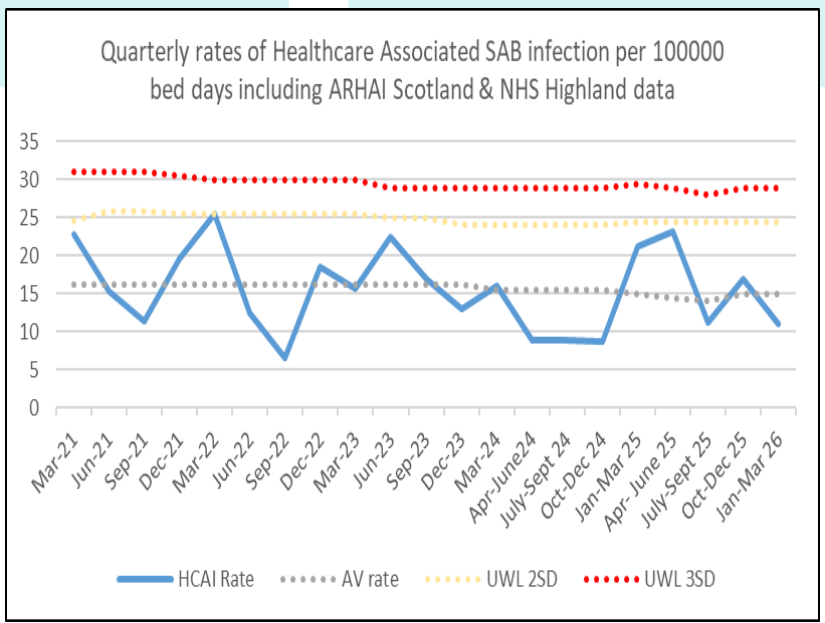
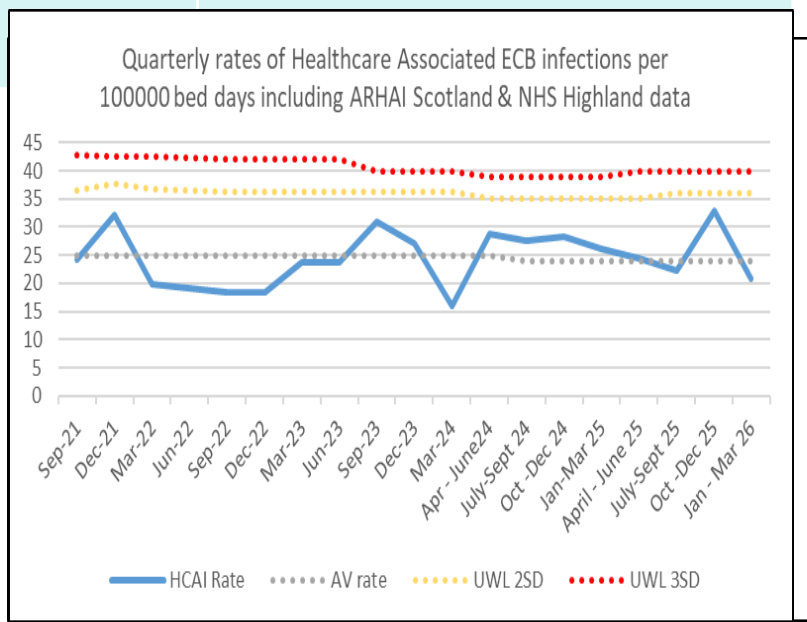
Infection Control - CDI, SAB and ECB Healthcare Associated Infection (HCAI) Reduction aims 1st April 2025 to 31st March 2026 and 1st April 2026 to 24th May 2026

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 reduction aim is 75 HCAI cases. As of 31/03/2026 58 HCAI cases reported. Await confirmation in July by ARHAI that reduction aim met (17 cases under aim) As of 24/05/2026 on track at 11 HCAI cases	National Services Scotland will publish the validated data on the reduction aims in July 2026 all are expected to be within predicted limits with SAB and CDI being met and ECB being slightly above the reduction aim case number. No reduction aims have been received by NHS Boards for 2026/2027 therefore the Infection Prevention and Control Committee have agreed to continue to work towards and maintaining the position on the current reduction aim case numbers.	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 reduction aim is 53 HCAI cases. As of 31/03/2026 50 HCAI cases reported. Await confirmation in July by ARHAI that reduction aim met (3 cases under aim). As of 24/05/2026 on track at 3 HCAI cases		
Escherichia Coli (ECB) 2025/2026 reduction aim is 75 HCAI cases. As of 31/03/2026 80 HCAI cases reported. Await confirmation in July by ARHAI that reduction aim **NOT** met (5 cases over aim) however will remain within predicted limits As of 24/05/2026 on track at 9 HCAI cases		







Workforce

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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%. 24.2% 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 57.0%, 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 6.57%	
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 29.9% is significantly short of the 60% target. There has been a increase of 0.6% since last report.	Noncompliance with staff governance standards. All areas asked to develop plans to ensure each employee receives a PDP annually.

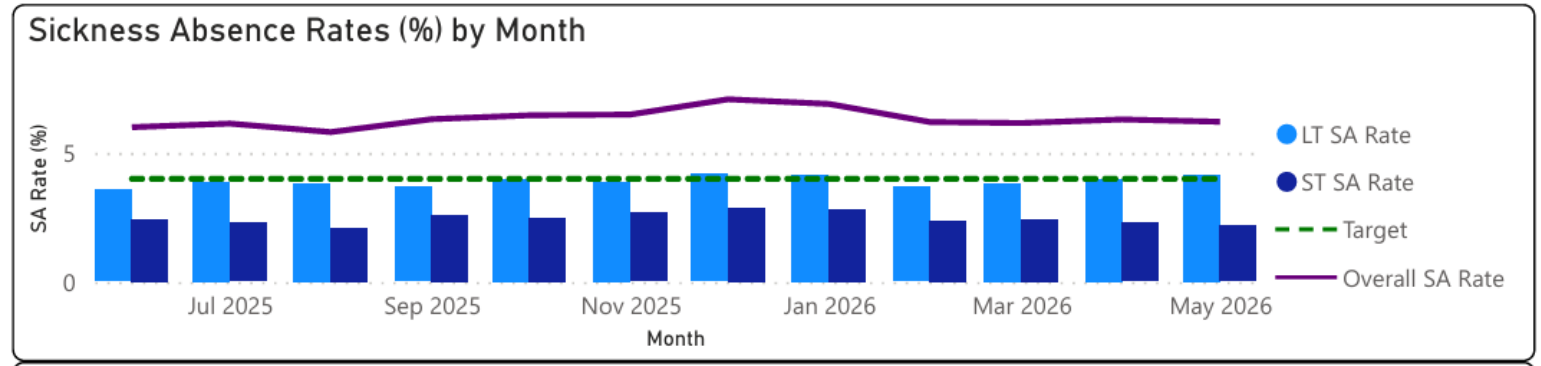
Guide to Performance Rating

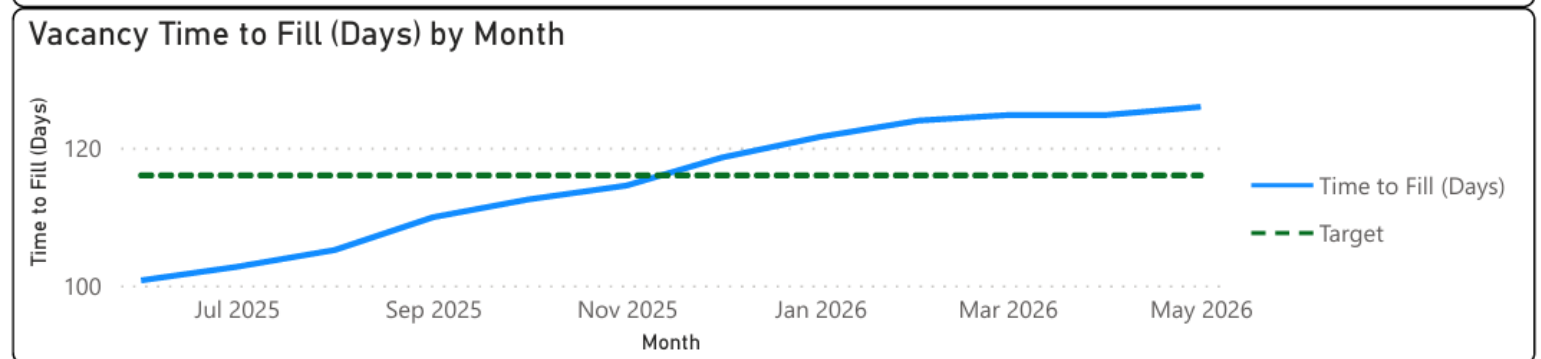
Meeting Target
<5% off target
>5% off target
>10% off target

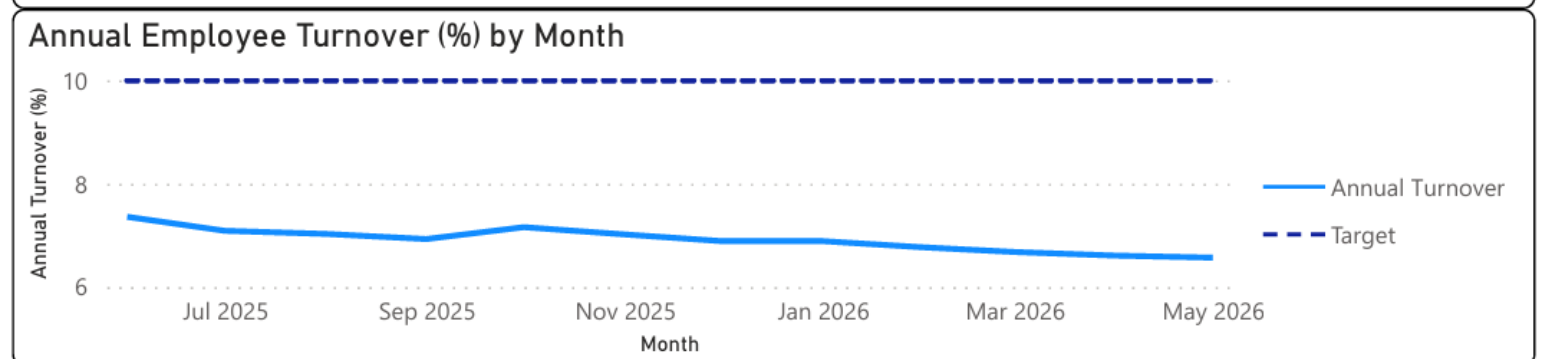
*There are a few bank vacancies negatively impacting Time to Fill figures due to being ‘always on’. Going forward these posts will be periodically closed and new entries raised thus reducing the impact on reported figures.

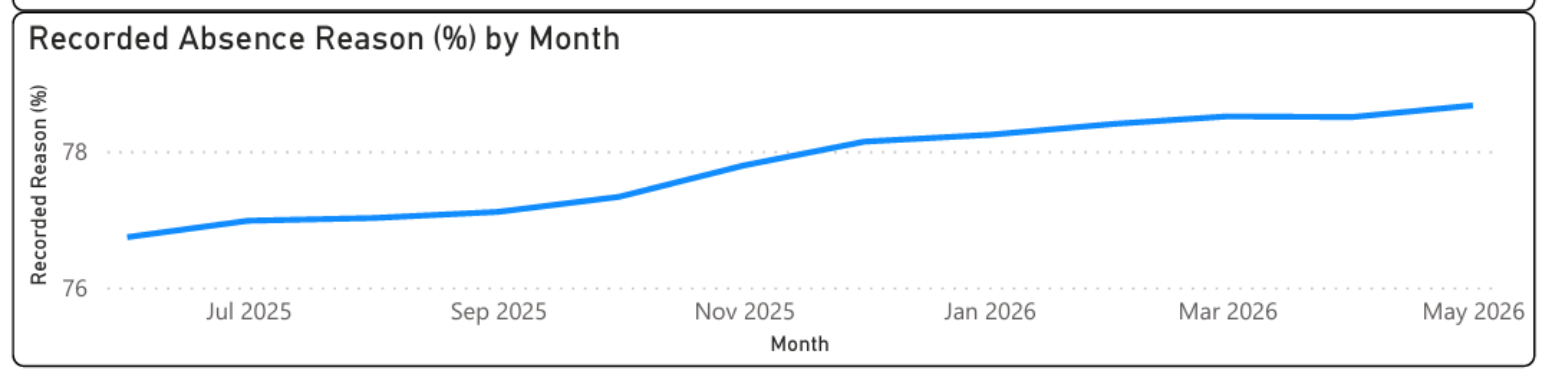
Organisational Metrics May 2026

Sickness Absence Rate (%)	6.21
Long Term SA Rate (%)	4.15
Short Term SA Rate (%)	2.16
Recorded Absence Reason (%)	78.67
Vacancy Time to Fill (Days)	125.95
Annual Employee Turnover (%)	6.57









Training Metrics May 2026

Bank eLearning Completion Rate (%)

36.1

Substantive eLearning Completion Rate (%)

61.3

Overall eLearning Completion Rate (%)

57.0

M&H Practical Training Completion Rate (%)

46.6

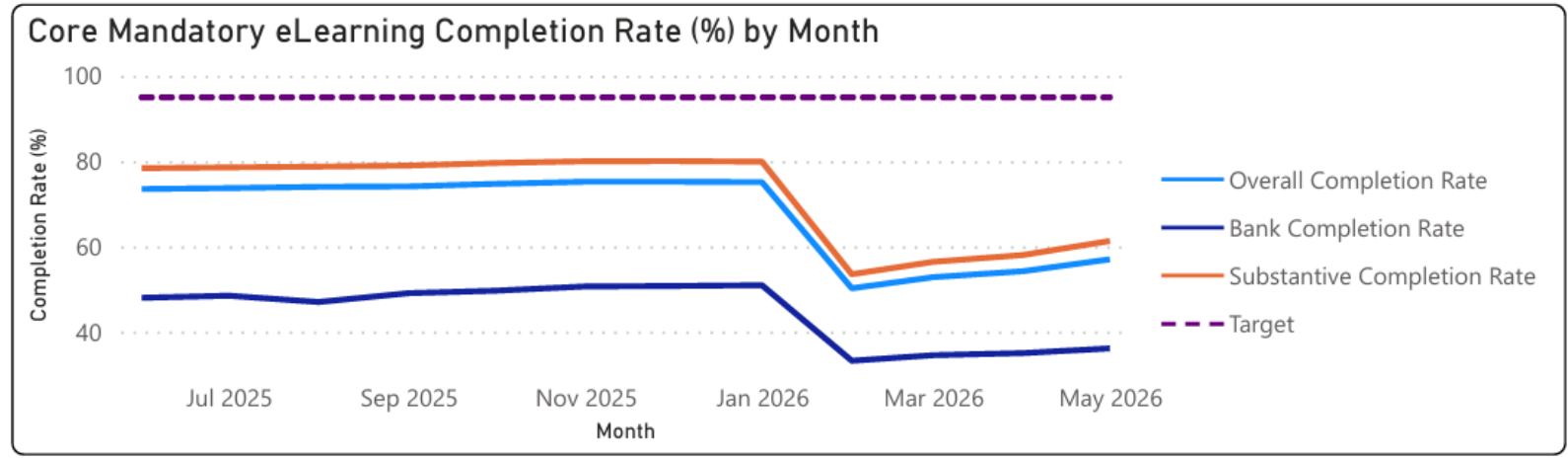
V&A Practical Training Completion Rate (%)

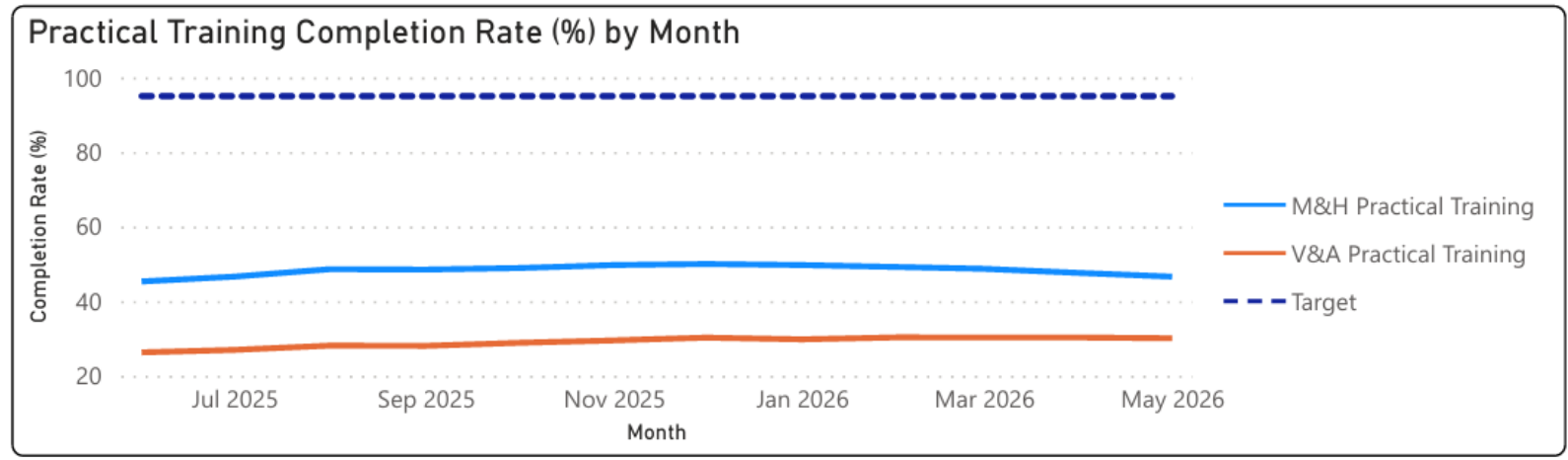
30.1

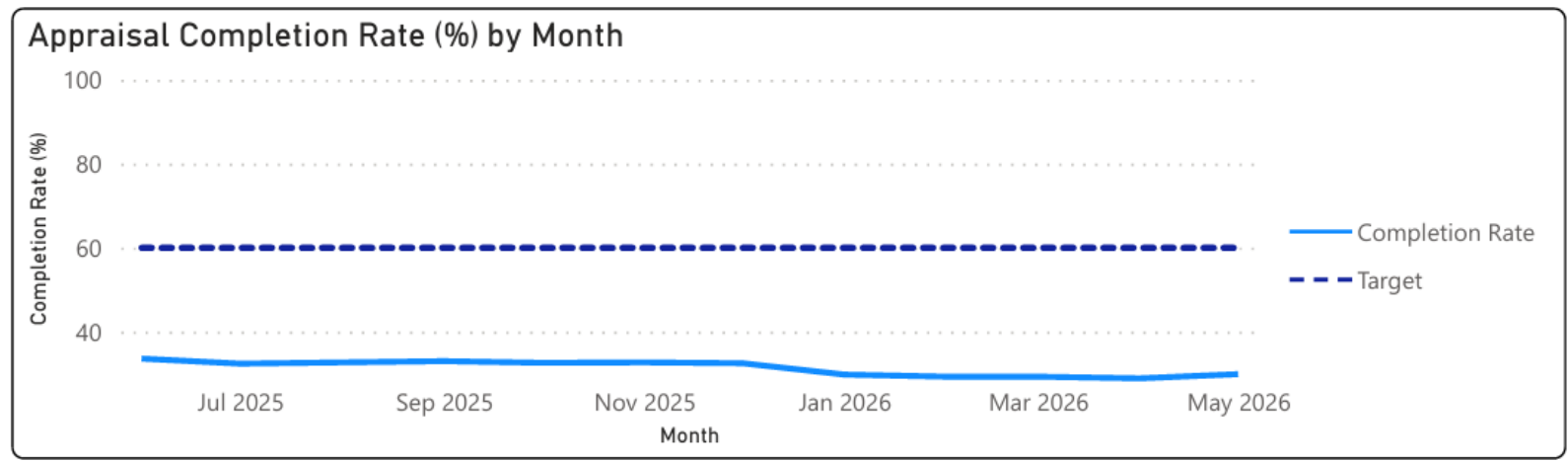
Appraisal Completion Rate (%)

29.9

*** 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.

Appendix: IPQR Contents

Slide #	Report	Frequency of Update	Last Presented
5	CAMHS Waitlist NHSH	Monthly	May 2026
6	NDAS Total Awaiting 1st App (incl unvetted)	Monthly	May 2026
6	NDAS New + Unvetted Patients Awaiting First Appointment by Wait Band	Monthly	May 2026
7	Psychological Therapy Waiting Times Patients seen <18 weeks.	Monthly	May 2026
8	Drug & Alcohol Recovery (DARS)	Quarterly	May 2026
9	Outpatients (NOP) Seen & Trajectories	Monthly	May 2026
10	Outpatients seen <12 weeks Including Consultant and Nurse Lead Activity	Monthly	May 2026
11	Return Outpatients Wait List	Monthly	May 2026
12	TTG <12 Week Target Patients Seen & Trajectories	Monthly	May 2026
12	TTG Seen <12 Weeks (Consultant Only)	Monthly	May 2026
13	TTG Long Waits >52 Weeks	Monthly	May 2026
14	Imaging Tests: Maximum Wait Target 6 weeks	Monthly	May 2026
15	CT Patients Seen & Trajectories	Monthly	May 2026
15	MRI Patients Seen & Trajectories	Monthly	May 2026
15	Non Obstetric Patients Seen & Trajectories	Monthly	May 2026
16	Endoscopy Tests: Maximum Wait Target 6 Weeks	Monthly	May 2026
17	Patients Seen & Trajectories Cystoscopy	Monthly	May 2026
17	Patients Seen & Trajectories Colonoscopy, flexi sig & upper GI	Monthly	May 2026

Slide #	Report	Frequency of Update	Last Presented
18	31 Day Cancer Waiting Times	Monthly	May 2026
18	Patients Seen on 62 Day Pathway	Monthly	May 2065
19	62 Day Cancer Waiting Times	Monthly	May 2026
18	Patients Seen on 62 Day Pathway	Monthly	May 2026
20	System Anti Cancer Therapy (SACT)	Monthly	May 2026
21	% of People Seen in ED Within <4 hours Per Month	Monthly	May 2026
21	Total Patients Waiting >8 hours in ED per Month	Monthly	May 2026
21	Total Patients waiting >12 hours in ED per Month	Monthly	May 2026
22	Number of People Delayed from Hospital Discharge at Monthly Census Point NHSH	Monthly	May 2026
22	Number of People Delayed from Discharge – Location and Code	Monthly	May 2026
23	Alcohol Brief Interventions (ABIs)	Monthly	May 2026
24	Vaccinations - MMR Uptake	Quarterly	May 2026
25	Screening (Cervical, AAA, Bowel)	Annual	May 2026
26	Stage 2 Complaint Activity	Monthly	May 2026
27	Number of SPSO Cases Received/ Closed	Monthly	May 2026
28	SAER & Level 1 Volumes: Declared Last 13 Months	Monthly	May 2026
29	Number of Hospital Inpatient Falls by Subcategory	Monthly	May 2026

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