Plan for the Future
Healthier Together
2022 - 2032

NHS Grampian

How are we doing?

Q2 2025/26 Board Performance Report

December 2025

Contents

Introduction

NHS Grampian's *Plan for the Future* sets out the strategic direction for 2022–2032 and provides the foundation upon which key enabling plans and activities are aligned. It defines the long-term outcomes we aim to achieve for the population we serve.

To support delivery, NHS Grampian has embedded an Integrated Performance Assurance and Reporting Framework (IPARF), which ensures that performance is assessed, monitored, and reported in a consistent, transparent, and outcomes-focused manner. This framework enables the Board and its Assurance Committees to maintain oversight of progress, understand variation, and evaluate the impact of interventions across strategic, operational, and financial domains.

This Board Performance Report is a key component of that framework. It provides a high-level, balanced summary of the organisation's progress against its strategic aims and delivery commitments. For the 2025/26 reporting year, performance is structured around three Change Programmes that act as vehicles for delivering in-year outcomes aligned to our longer-term strategic intent. These are:

- Value and Sustainability
- Unscheduled Care
- Planned Care

Each programme has a distinct focus, underpinned by clearly defined in-year outcomes, performance indicators, and deliverables. However, they are not standalone efforts. The three programmes form a coordinated and interdependent portfolio of change, connected by a shared emphasis on delivering the right care in the right place, reducing unwarranted variation, empowering our workforce, and measuring what matters through outcomes-based indicators. Progress in one programme supports and strengthens delivery across the others, enabling a more integrated, sustainable, and person-centred system.

In addition, the report reflects NHS Grampian's contribution to the Scottish Government's Operational Improvement Plan (OIP), which sets out national priorities for improving access, efficiency, and flow across the health and care system. These priorities are embedded within the relevant programmes to ensure alignment between national expectations and local delivery, and to support transparent reporting on progress.

Together, these elements provide the Board with a clear line of sight from strategic vision to operational delivery, enabling assurance that NHS Grampian is progressing towards its intended outcomes in a sustainable and measurable way.

Executive Summary

As Chief Executive of NHS Grampian, my focus remains delivering on our plans in our three priority areas and doing what we said we would do: Value and Sustainability, Unscheduled Care and Planned Care. This Quarter 2 How Are We Doing report provides an overview of our progress in these and wider areas of performance during Quarter 2 of 2025/26.

I am pleased to report an improved Quarter 2 position against our Value and Sustainability Programme, with savings exceeding the Quarter 2 target, reducing the in-year financial gap to just under £1m. We can also evidence improvements in Planned Care, with further reductions to our longest wait patients, though we have further work to do to get closer to delivering against the First Minister's commitment to having zero 52-week waits by the end of March 2026.

Challenges remain in the areas of emergency access (the 4-hour standard), ambulance handover times, diagnostic capacity and timely cancer treatment in some specialties.

We now have three Programme Boards in place in each of our priority areas, to ensure strengthened governance and oversight, which is a welcome step forward. These Boards are also overseeing the spend of the national funding we have secured to deliver improvements to unscheduled care and planned care.

Our commitment to patient-centred care and further improving patient experience remains unwavering. This quarter, we have strengthened our approach to patient experience reporting by bringing together complaints, patient feedback and operational performance, in turn providing a more rounded view of care quality and system pressures.

There has been an improvement in the percentage of complaints closed within the Model Complaints Handling Procedure Target of 20 days, increasing from 35% in April-September 2024, to 47% for the same period this year. Work is ongoing to ensure consistently timely responses to patients and families and to evidence our learning from complaints.

Laura Skaife-Knight, Chief Executive NHS Grampian

Voice of our Citizens

Complaints received Quarters 1 and 2 2025/26

In the first half of 2025/26, NHS Grampian received 843 complaints; the Integrated Specialist Care Portfolio accounted for 30% of these, Medicine & Unscheduled Care Portfolio accounted for 18%. These link to Planned Care and Unscheduled Care Programmes respectively.

- Complaints received increased by 7% compared to the second half of 2024/25 and by 5% from the same period in 2024/25.

We received an average of 32 complaints per week

complaints received equate to 0.1% of activity*

The number of complaints open at month end has been trending down over the six months to September 2025. Whilst the number of complaints received increased by 7% compared to the previous period, the average number of complaints closed each month increased by 22%, resulting in a greater number of complaints being closed than received.

Other feedback routes are available, including Care Opinion, compliments, and patient surveys. An overview of Care Opinion will be included in the next 'How are we Doing' report.

As part of Putting People First, we are now testing of Real Time Feedback loops in one clinical area in ARI. This is going well with positive feedback from patients and staff involved.

- Real Time Feedback Loops provide rapid feedback to allow responsive service improvement. They also create system learning loops so we can use 'ground up' feedback to inform how we do things at all levels of the organisation.
- NHS Grampian Charity has provided funding for post to deliver Real Time Feedback Loops in up to 20 areas in the next two years and recruitment is now underway.

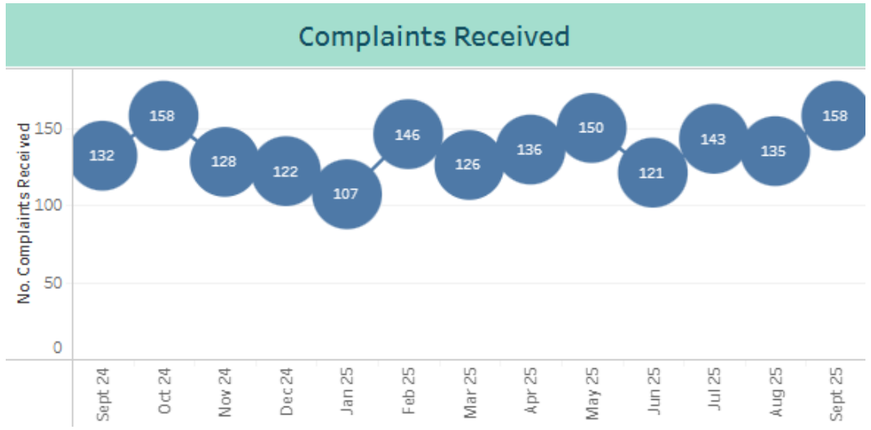
Timescales – move down

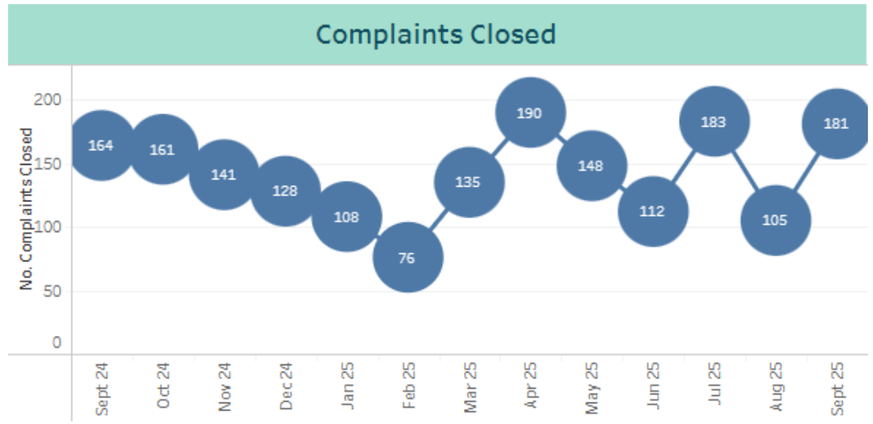
47% of complaints were closed within 20 day target

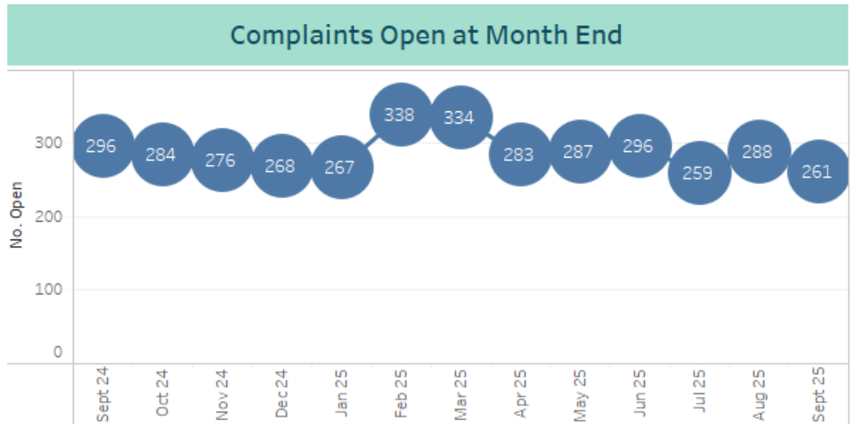
Performance in meeting timescales continues to improve, with 47% closed within the Model Complaints Handling Procedure target of 20 days; this compares to 43% for the previous six months, and 35% for the same period last year.

Integrated Specialist Care Portfolio closed 48% of complaints within 20 day target and Medicine & Unscheduled care Portfolio closed 42% within 20 day target.

The SPSO closed 7 Complaints for Integrated Specialist Care Portfolio and 4 for Medicine & Unscheduled Care Portfolio. Of the 25 SPSO complaints closed the SPSO decided not to investigate 21 cases as they felt either the care and treatment was acceptable or that NHS Grampian had responded appropriately and had identified learning and improvement to an acceptable standard.







* Inpatient, Outpatient, Emergency Department activity for the period 01/04/25-30/09/25

Voice of our Citizens

Themes

Staffing and Treatment remain the primary themes of complaints, being mentioned in 41% and 26% of complaints respectively (34% each in the previous six month period).

Staffing and Clinical Treatment are the most common complaint themes

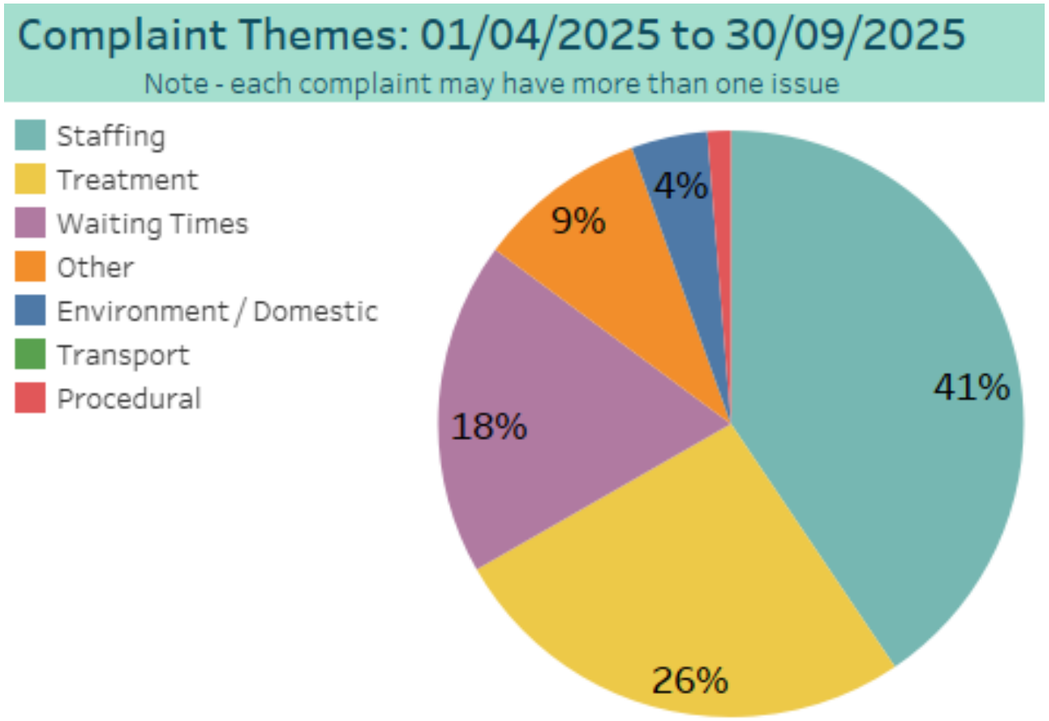
Breaking this down, the main sub-themes for complaints regarding staffing were oral communication (33%), staff attitude and behaviour (27%), written communication (18%), and staff competence (17%); for Treatment, 99% of complaints came under the sub-theme of clinical treatment.

Of the 843 complaints received 245 related to waiting times

- 164 waiting for a date for appointment
- 56 waiting for a date admission/attendance
- 25 waiting test results

Of the 245 related to waiting times:

- 56% were within Integrated Specialist Care Portfolio
- 15% were within the Medicine and Unscheduled Care Portfolio



Waiting-related complaint	Urgent referral following CT scan the week before. Scan and notes have not been seen by specialist	Patient attends for treatment on ulcer every two weeks but machine has broken. Patient wants to know when treatment will resume	Patient concerned they would be taken off the waiting list as they had rescheduled two appointments and required to reschedule a third
Actions taken to resolve	Early telephone call made by service to reassure that specialist was on holiday and would review on their return. Prompt action on return	Machinery has been repaired and nurse-led clinics are reinstated	Service contacted patient by telephone and provided reassurance that they will not be removed from waiting list

Our Performance towards our Outcomes by 31st March 2026

Value and Sustainability

Improving our financial position by £61.8m

How Are We Doing?

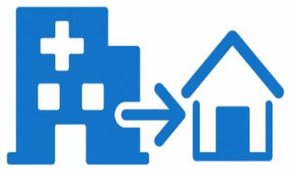
Cash-releasing savings to date

Recurring savings forecast

KEY:

Meeting/Exceeding target | Slightly below target | Well below target

Unscheduled Care



Faster and Safer Discharges

Shorter hospital stays and reduced ED waits

How Are We Doing?

Improve the percentage of ED patients seen and cared for within 4 hours

Reduce ambulance turnaround times

Reduce delayed discharges (all other hospitals)

No more than 15 Delayed Discharges (ARI & Dr. Gray's)

Planned Care

Reduce waits and faster cancer pathways

How Are We Doing?

Cancer Treatment within 31 days

Cancer Treatment within 62 days

Reduce 52-week outpatient waits

Reduce 52-week treatment waits

These are a selection of our key performance indicators at a glance. Full coverage is available from Page 8

What is our Performance Story so far?

This Section provides a high level narrative on how we are progressing towards our in-year outcomes, it highlights what Quarter 2 performance is telling us about our ability to deliver these by March 2026.

Three Change Programmes

Value and Sustainability:

Outcome: The in-year financial gap is reduced by £61.8m, to a deficit of no more than £45 million, through delivery of sustainable, cash-releasing recurring efficiency savings across the organisation by 31st March 2026.

What this means in Q2: Q2 delivery showed recovery to exceed target (£22.15m vs £21.6m), with total savings identified are £60.95m, closing gap to target to <£1m. While delivery risks remain, efforts to develop new schemes have recovered the position for Q2; sustained focus will still be required if the full outcome is to be realised by 31 March 2026. The appointment of an interim Director of Improvement, along with committed focus, is helping drive the programme forward as expected. Recurrent savings currently represent over 3% of our baseline budget, in line with Level 4 escalation requirements.

Unscheduled Care:

Outcome: Earlier specialist input, faster and safer discharges, greater use of urgent care alternatives to admission, and shorter hospital stays with reduced waits. *Detailed outcomes are set out in Tier 2.*

What this means in Q2: Q2 performance fell across USC, only ambulance turnaround times remaining on target. Hospital at Home and Delayed Discharges from acute hospitals showed the most significant drops, although other hospital discharges maintained some positive momentum. Q2 shows a general downturn in performance via our KPIs towards our outcomes, and sustained focus across USC will be required if our outcomes are to be realised by March 2026 while changes embed. While Deliverables have shown an increased completion prognosis by year end, which should positively impact these areas, other downstream activity is a supporting factor.

Planned Care:

Outcome: Outcome: Reduced long waits for new outpatients and treatment, improved access to cancer pathways, and shorter waits for diagnostics. *Detailed outcomes are set out in Tier 2.*

What this means in Q2: Q2 shows mixed progress. Q2 shows mixed progress. TTG waits continuing to make progress on target, while outpatient waits, and cancer 31 and 62 day standards have slipped below target, showing a deterioration in patient access. In diagnostics, both Endoscopy and Radiology failed to meet their Q2 targets, although improvements in MRI capacity should soon start to become visible. Quarter 2 therefore shows that while some Milestones and Outputs are being completed as planned, these may not as yet be producing sufficient tangible benefits to date, and require monitored if this Outcome is to be achieved.

Tier 1 on page 8 builds on this outcomes story by showing our Quarter 2 performance in two complementary ways: through the Change Programmes, where Outputs, Deliverables, KPIs and Outcomes are linked in the Performance Model. The detailed actions and mitigations supporting delivery, and the steps taken to address risks, are set out in Tier 2.

REPORT KEY

(A) RAG Ratings for Change Programmes:

The ratings of the Key Performance Indicators within each category highlighted in the Change Programmes are based on the criteria below, unless otherwise stated:

Assessment Rating	Criteria
Red	Current performance is outwith the target by more than 5%
Amber	Current performance is within 5% of the target
Green	Current performance is meeting/exceeding the target

(B) Each KPI also has a marker to indicate the direction of performance from the previous quarter, in relation to current target:

Marker	Description
	Performance has improved from previous quarter and moving closer/exceeding target
	Performance has improved from previous quarter but deviating from target
	Performance has declined from previous quarter and deviating from target.
	Performance has remain unchanged between previous and current quarter.

Trend graphs to show trend lines will be provided to support circle markers

(C) Performance status reporting of 2025/26 Deliverables:

Achievement of Milestones		Prognosis of delivering 2025/26 Deliverables by 31st March 2026
Yes	**No**	■ Completed ■ Will be Complete ■ Not on target - Anticipated Minor Delay ■ Not on target - Anticipated Significant Delay

Click to access:

- Three Change Programmes
  - Value & Sustainability
  - Unscheduled Care
  - Planned Care

Tier 1: Three Change Programmes

The **Three Change Programmes** (Value and Sustainability, Unscheduled Care, and Planned Care) act as the primary vehicles for delivering the priorities aligned to NHS Grampian's Plan for the Future. This represents an improvement in our assurance process, with measurement fully aligned to in-year Outcomes. Progress is tracked through well-defined and targeted KPIs, supported by deliverables, quarterly milestones, and outputs that collectively drive the achievement of these outcomes

Strategic Objective

In-year Outcomes 2025/26

11 Outcomes across Three Change Programmes

Value & Sustainability
Unscheduled Care
Planned Care

Are we seeing measurable change?

20 outcomes-focused KPIs to measure achievement of Outcomes

Overall KPI Performance Q1

Overall KPI Performance Q2

Our KPIs are distributed across our Three Change Programmes*

Value & Sustainability	Unscheduled Care	Planned Care	Total KPIs (20)
0 (↓2)	**5** (↑5)	**2** (↑2)	7 (35%)
1(↑1)	**4** (-)	**3** (↑1)	8 (40%)
3(↑1)	**1** (↓5)	**1** (↓3)	5 (25%)

***figure in brackets represents change from Q1 to Q2**

Direction of Performance:

5 KPIs have shown improved performance, 5 improved performance but deviated from target, and **10 declined** compared to Q1.

Did it result in meaningful progress against the in-year outcome?

Deliverables to enable the improvement of our KPIs

Prognosis of delivering 2025/26 Deliverables by March 31st 2026

16 Deliverables*	V&S	USC	Planned Care	Total
Anticipated Significant Delay	**0** (-)	**0** (-)	**1** (↓1)	**1**
Anticipated Minor Delay	**0** (-)	**2** (↓3)	**3** (↑3)	**5**
Will be Complete	**1** (-)	**7** (↑3)	**2** (↓2)	**10**

***figure in brackets represents change from Q1 to Q2**

16 Quarterly Milestones – Waypoints towards our Deliverables

	V&S	USC	Planned Care	Total
Achieved	1	3	3	7
Not Achieved	0	6	3	9

Will the output deliver the intended improvement?

Key Outputs driving our Outcomes

51 Key Outputs	V&S	USC	Planned Care	Total
Complete	0 (-)	3(↑2)	4 (↑4)	7 (↑6)
Not Complete	3 (-)	25 (↓1)	16 (↓4)	44 (↓5)

***figure in brackets represents change from Q1 to Q2**

Objective: Balance system capacity to meet health care and population needs whilst delivering financial targets for 2025/26 in line with our finding balance principles

Value and Sustainability

The Value and Sustainability programme focuses on achieving financial balance, through identifying and implementing efficiency improvements and cost savings measures. In 2025/26 the programme will enable the delivery of £61.8 million of savings, supporting the Board's requirement to deliver within a maximum deficit of £45 million. Key elements of the programme include increased efficiency and productivity of services, removing unnecessary waste from processes and supporting departments in identifying areas of improvements. The programme supports the management of the following strategic risk: *Inability to achieve the aspirations set out in Plan for the Future due to financial resource constraints and inefficiencies.*

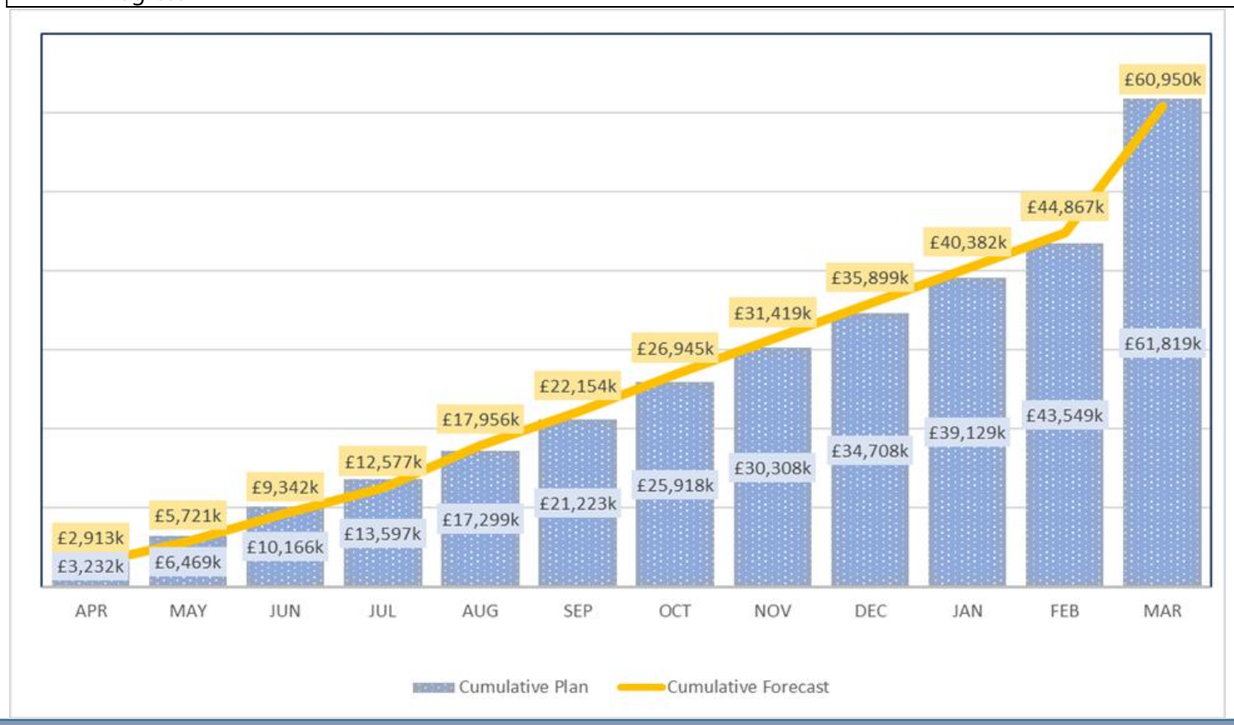
Our Outcomes: What change or improvement do we expect to see by 31st March 2026?

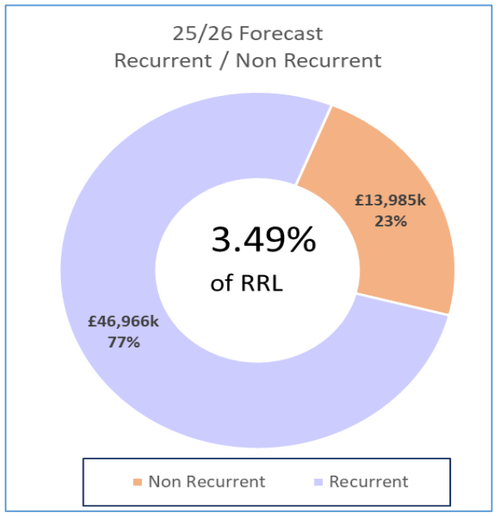
By 31st March 2026 we will have made the following difference....
Outcome: The in-year financial gap is reduced by £61.8m, to a deficit of no more than £45 million, through the delivery of sustainable, cash-releasing recurring efficiency savings across the organisation by 31st March 2026.

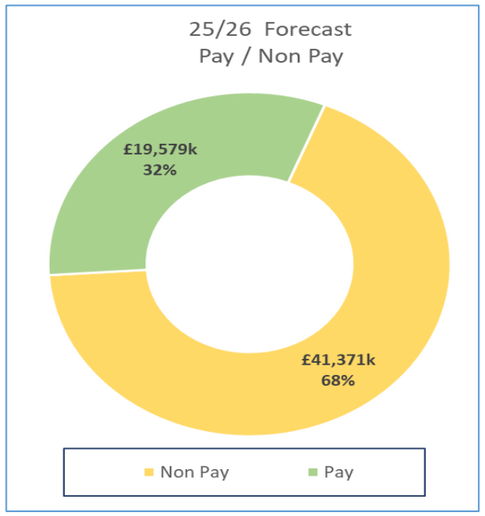
Key Performance Indicator	**Baseline** (As per financial plan)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Why are we in this position?**
		Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	
Total value of cash-releasing savings delivered year to date	£61.8m	£9.3m	£10.1m	**£22.15m**	**£21.6m**		£34.7m		£61.8m	Evidence based delivery of savings totalling £22.15m at September with savings plan reflecting assumed delivery timescales. Spotlight on Pg. 11
Total value of cash-releasing savings forecast for 2025/26	£61.8m	£54.5m	£61.8m	**£60.95m**	**£61.8m**		£61.8m		£61.8m	Forecasts trajectories deliver savings of £60.95m, albeit some risk is noted. Focus continues on underperforming schemes and new opportunities to close gap.
% of recurring savings forecast for 2025/26	3%	3.2%	3%	**3.49%**	**3%**		3%		3%	Current forecast exceeds Scottish Government requirement of 3% Revenue Resource Limit (RRL) recurrent savings.
Forecast outturn (deficit) for 2025/26	£45m	£45m	£45m	**£45m**	**£45m**		£45m		£45m	On plan, albeit risk from emergent cost pressures and savings slippage will be managed closely.

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Embed within NHS Grampian a sustainable programme framework that supports year on year cost reduction to enable de-escalation and a return to financial balance			Governance framework implemented from portfolio to Board level by Q3. *In progress and will be completed in Q3.*	Viable opportunities within the external diagnostic review and national benchmarking sources identified and implementation plans developed and approved by Board by March 2026 - *In progress.*	Schemes approved by Leadership teams are locally owned and driven by teams at service levels by February 2026 - *In progress*

2025/26 Overall Deliverable Update – what is the justification for this status?	Q2 Milestone: Service design to be complete. Ensure clinical, operational and project management is in place and an agreed governance structure regarding monitoring, reporting, risk management and escalation is established. Recruitment activity initiated.	Q2 Milestone Achieved?
Q2 KPI Performance has improved compared to the previous quarter as a result of the actions and additional interventions set out below: • £5.6m of new schemes identified along with improvement forecast savings delivery on existing schemes which remains insufficient to close the gap to the £61.8m target. • Continue to meet with challenged workstreams where reporting under performance against target (17 schemes to a value of £3.4m). • Risk remains over recently approved (Q2) high-risk schemes. Savings for these schemes are not fully reflected in the operational forecast, which is expected to improve as savings are delivered. • Finance Recovery Board continue to meet monthly with deep dives to focus on key areas of spend. • Streamlined vacancy and scrutiny panel in place with daily non-clinical non-pay review supported by weekly non-pay panels. • Opportunities within External Diagnostic Review being progressed to support improvement of in year forecast. • Agreement to establish fortnightly V&S programme Board chaired by Director of Finance from Q3. • Identify and approve further savings beyond the £61.8 million target to support return to financial balance – In Progress. • Identify opportunities to bridge the forecast £7m gap to £61.8m target with some mitigation allowance. - In Progress	• Establish Value & Sustainability Delivery Group detailing roles, responsibilities and clarifying accountability across savings programme. – Achieved • Established Non-Executive Director chaired Financial Recovery Board which meets monthly- Achieved • Develop savings tracker to enable monitoring of schemes – Achieved. • Review and implement changes to enhance grip and control measures across pay and non-pay. – Achieved. • Develop programme architecture for the 26/27 three-year value and sustainability programme including enhanced Quality Impact Assessment (QIA) approach. – Achieved. • Validation of all savings achieved to date and improved methodology for forecasting savings – Achieved.	Yes







Tier 3: Our Performance Spotlights - Value and Sustainability

Outcome: The in-year financial gap is reduced by £61.8m, to a deficit of no more than £45 million, through the delivery of sustainable, cash-releasing recurring efficiency savings across the organisation by 31st March 2026.

1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***

  Three of the four KPIs are now reporting on target at quarter 2. There remains a £0.9 million gap to the £61.8m savings target with efforts continuing to identify new savings opportunities and increase savings delivery for existing schemes.

- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***

  A strengthened governance framework is in place for the Value and Sustainability programme which will support delivery of the financial savings required to enable the Board to achieve a maximum deficit of no more than £45 million. Finance Recovery Board, V&S Delivery Group and reporting to the Assurance Board all implemented in Q2.

- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***
  The Finding Balance process is supported through an improved Quality Impact Assessment (QIA) which places workforce, patient, finance and prevention and staff impact at the centre for assessing the impact of change along with the statutory Integrated Impact Assessment (IIA) focusing on the impact of groups with protected characteristics.

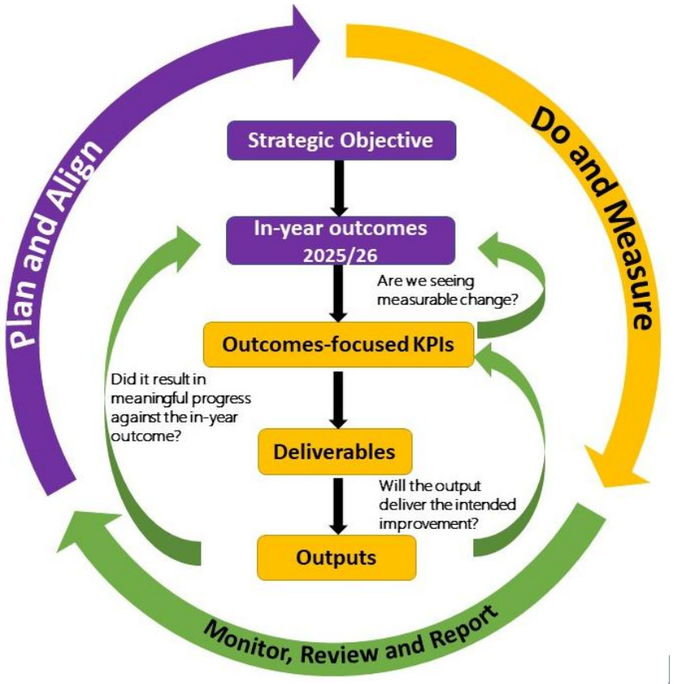
- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***

  The detailed monitoring in place enables rapid support to be put in place for all underperforming value and sustainability programmes. New savings schemes continue to be developed.

  With regard the overall operational position, areas reporting a deteriorating financial position are required to undertake a deep dive and report back to the Chief Executive Team on actions that are being taken to improve financial performance.

Commentary from
Alex Stephen

Director of Finance



2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***
  There is risk that financial decision making in HSCP's impact NHSG budget with the Integration Joint Board (IJB) risk sharing arrangements – to mitigate this DFO meets monthly with CFOs to ensure impacts are fully noted. There is a risk the organisation may not reduce agency or locum expenditure due to operational challenges – to mitigate this controls are in place for utilisation of locums and agency use, with clear exit strategies if utilised.

- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)?***
  There have been no identifiable unintended consequences or impacts towards the wider system such as Planned Care, USC and the deliverables within the Operational Improvement Plan. Consequences will be considered as required via the QIA and IIA process. All savings included in the 2025/26 value and sustainability programme have been assessed against the IIA process.

- ***How will the performance of this Programme reduce our strategic risks?***

  This Programme responds to the strategic risk: Inability to achieve the aspirations set out in Plan for the Future due to financial resource constraints and inefficiencies. The Value & Sustainability Plan will look to maximise operational and workforce efficiencies by reducing unwarranted variance across our clinical services to ensure we move towards evidencing strong value for money for the services we provide; and reducing our pay costs; where it is safe to do so, particularly around high-cost medical agency staff. We will continue to reduce our deficit position towards achieving financial balance over the medium to long-term so that our services, our people and our finances are focused on delivering our future ambitions

Objective: Optimise system capacity and efficiency to enable wellness and respond to illness resulting in reduced clinical risk

Unscheduled Care

The Unscheduled Care Programme Board exists to maximise the impact and alignment of improvement efforts across NHS Grampian, with the aim of improving performance across unscheduled care pathways, reducing risk, and enhancing patient experience. This is achieved by identifying and prioritising the most impactful change measures that align with the Board's strategic vision. These measures are then delivered through dedicated Delivery Groups, which are responsible for driving implementation, achieving the intended outcomes, and embedding successful initiatives into business-as-usual. Current priorities include strengthening admission avoidance, reducing length of stay in acute settings, and shifting care capacity towards community-based services to ease pressure on acute hospital occupancy. These focus areas directly address Strategic Risk 3639 – significant delays in delivering unscheduled care – which is largely driven by overcrowding in inpatient areas and changes in the nature of patient presentations.

Our Outcomes: What change or improvement do we expect to see by 31st March 2026?

By 31st March 2026 we will have made the following difference....
Outcome 1: A greater number of people with frailty and complex medical patients get specialist input during initial assessment. Fewer are admitted to hospital unnecessarily, and a greater proportion of those admitted are treated in specialist areas.
Outcome 2: Faster, safer discharges from hospital are achieved through a streamlined discharge process, better coordination between hospital and community teams and an improved balance in the volume of care capacity
Outcome 3: Increased proportion of people access urgent care through the right setting first time (e.g. NHS 24, Flow Navigation Centre, Ambulatory Care), reducing demand on emergency departments.
Outcome 4: Implementation of an enhanced Unscheduled Care model which results in shorter stays in hospital and reduced wait times in emergency assessment areas.

Our Unscheduled Care Programme supports these OIP Critical and Focus Areas		
Critical Area	**Focus Area**	
Shifting the Balance of Care	Frailty at the front door of ED	
	Reducing the Pressure in our Hospitals	Improve flow throughout the system
	Hospital at Home	

Outcome 1: A greater number of people with frailty and complex medical patients get specialist input during initial assessment. Fewer are admitted to hospital unnecessarily, and a greater proportion of those admitted are treated in specialist areas.

Key Performance Indicator	**Baseline** (Mar2025)	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**		**Trend over latest 12 months with 2025/26 target**	**Why are we in this position?**
		Actual	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**		
Reduce the number of (unscheduled) General Medicine and Frailty admissions to ARI each quarter (compared to equivalent 2024/25 quarter)	3206	3313	<3457	**3334**	**<3217**	1116 (Oct 25)	<3265		<3206		Where seasonal demand may have decreased during summer months we are no longer seeing this variation. The whole system mitigations we aim to put in place have not been fully integrated at this stage but is envisaged that these will start to show increased gains in Q3 and Q4.
Reduce average acute hospital weekday occupancy (ARI and DG) to 98% by March 2026*	112%	111%	111%	**108.2%**	**106%**	109.8% (Oct 25)	106%*		98%*		Where efficiencies in some parts of the system have improved occupancy, there still remains significant pressure in general medicine and frailty pathways, which has contributed to sustained high occupancy levels.

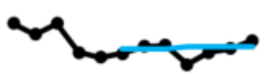
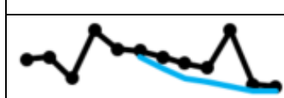
*KPI targets revised Nov 2025 – pending final approval

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Implement a 7-day frailty triage and assessment model at the front door, supported by a multidisciplinary team (MDT), to assess all patients aged 75+ within 2 hours of arrival			7-day frailty triage model operational at front door – *anticipated to be complete by January 2026*	MDT frailty assessment directing patients into alternative pathways and supporting some patients to return home. Full implementation *anticipated to be complete by January 2026*	Streaming of patients in to frailty pathways showing benefits in terms of reduced length of stay. *Anticipate to be complete by March 2026*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Deliver tests of change to support the implementation of a 7 day frailty triage and assessment model**		**Q2 Milestone Achieved?**
Confirmation of funding and recruitment delays have limited progress toward full implementation. However, all parts of the programme are underway, to fully realise the potential of this deliverable we need other downstream activity i.e. (community care capacity to enable us to discharge patients) to be delivered at the same time. Overall this deliverable remains on schedule to be complete by 31st March 2026. Frailty at the front door model in place showing more appropriate streaming of complex multi-comorbid patients in to frailty pathways, including non-admission. Due to imminent seasonal pressures, increased trauma and capacity demand, we will experience a slow progression of this development than anticipated in Quarter 3, performance will be continuously monitored as part of the USC improvement with the additional mitigations as planned.			Service and workforce design has been completed. Project governance is in place via the Unscheduled Care Programme Board (USCPB) Downstream Delivery Group. For Q2, recruitment activity has taken place, preliminary test of change has also taken place such as "delivering a frailty team at the front door with senior decision maker input". This has led to redirection of appropriate patients to pathways other than admission, reducing admissions and decreasing lengths of stay. Progressive delivery of this will enable improvement and key outputs to be delivered by March 2026.		No

Deliverable:	Expected Status at 31st March 2026	ANTICIPATED MINOR DELAY	Key Outputs:			
Rebalance of Acute specialty bed footprint to maximise efficiency and protect core planned care capacity			Initial commissioning work underway. – *Scheduled for completion in Q3*	Acute frailty footprint increased – *scheduled for completion in Q4*	Changes to bed base footprint will be delivered - *scheduled for completion in Q3*	Surge capacity in planned care will be minimised – *scheduled for completion in Q4*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Project scope agreed and aligned with CfSD and national work relating to General Medicine provision in Acute settings. Project leadership agreed.**			**Q2 Milestone Achieved?**
Expansion of the frailty footprint and reconfiguration of general medicine provision is reliant on capacity creation, throughout the rest of the system. Whilst it is possible to model some of the outcomes there is a need to see how the actual gains from all of the work in the unscheduled care plan are delivered. At this stage we are developing the commission document to begin this work together with an understanding of the data required to choose the appropriate pathway.			Slight delay against intended timeline due to the complexities of service redesign in Q2. For Q3 commission for the project currently being written and project leadership being identified – expect both to be complete by end November 2025. Changes to rebalancing of the bed footprint will provide the benefits in terms of capacity and discharge enhancements so that overall hospital occupancy percentage is reduced and support delivery of the key outputs. Programme leadership established and connection to national expertise via Centre for Sustainable Delivery (CfSD) in place.			No

Outcome 2: Faster, safer discharges from hospital are achieved through a streamlined discharge process, better coordination between hospital and community teams and an improved balance in the volume of care capacity

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
Increase the % of patients supported by Hospital at Home services who are discharged from hospital and not readmitted within 28 days	80.0%	78.9%	81%	**72.2%**	**82%**	66.7% (Oct 25)	82%*		83%*		Limited implementation of Hospital at Home and due to reconfiguration of resources to deliver more acute discharge without delay principles. With additional workforce expansion of this service should be realised in the coming months. Spotlight on page 19
Maintain the number of patients supported by Hospital at Home services by direct admission from the Community	332	322	322	**305**	**325**	114 (Oct 25)	325*		330*		Changes to pathways being considered but reliant on expansion of Hospital at Home service as a whole. Will increase in line with overall expansion.
No more than 30 Delayed Dishcarges in Acute Hospitals (ARI and Dr Gray's) by March 2026	38	29	36	**48**	**35**	40 (Oct 25)	35*		30*		Pressures on stepdown pathways remain high with limited care home placement available and high length of stay in community hospitals. Plans to improve are still to reach full potential
Reduce the number of Delayed Discharges in all other Hospitals by March 2026*	145	138	131	**128**	**125**	127 (Oct 25)	125*		130*		Work underway but reliant on downstream capability with additional workforce expansion. This should be realised in the coming months.

*KPI targets revised Nov 2025 – pending final approval

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Implement a standardised discharge protocol across all inpatient sites that ensures clear, timely referrals to Hospital at Home and Community Response teams for eligible patients, and follow up within 24 hours of discharge			Standardised discharge protocol implemented across all inpatient sites – *will be complete by March 2026*	Streamlined referral process in place to downstream services – *will be complete by March 2026*	Integrated Discharge Hub established – *will be complete by March 2026*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Map local processes against learning from Tayside and Highland and agree tests of change**		**Q2 Milestone Achieved?**
Number of projects being driven under the Downstream Delivery Group will support this deliverable, each have KPIs. As at Q2 in testing phase of the protocols and processes supporting Planned Date of Discharge and streamlining referral processes. Successful processes will be spread from test wards. Work is progressing on establishing the design, service model and function of the Integrated flow hub. Recruitment delays have limited the ability to realise the full potential of this TOC to date however recent recruitment will enable delivery. This deliverable remains on target for 31st March 2026. All parts of the programme are underway, to fully realise the potential of this deliverable we need other downstream activity i.e. (community care capacity to enable us to discharge patients) to be delivered at the same time. This is coordinated through the Delivery Groups and USC Improvement Programme Board.			For Q2 leading into Q3, tests of change currently in progress to increase compliance with Planned Date of Discharge. Currently testing in 2 clinical areas in ARI and DGH. Recruitment is progressing to support additional spread across adult inpatient teams. The second test of change is the re-launch of the Discharge Tab on Trak and roll out of Discharge Planning Education Pack. This is also being tested in 3 clinical areas currently. Initial outcome of 2 week TOC is awaited imminently and will inform spread. Mapping of social work referral criteria complete and activity underway to agree a single referral process. For Q3, we aim to upscale to further clinical areas with the KPI sought, a reduction in the number of delays across Acute Hospitals. Tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.		No

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Deliverable:	**Expected Status at 31st March 2026**	**ANTICIPATED MINOR DELAY**	**Key Outputs:**		
Reduction in Community Hospital Length Of Stay (LOS) to promote outflow from acute and increase capacity for direct community admissions			Revised discharge processes implemented in community hospitals– *will be complete by March 2026*	Admission criteria and pathways established for direct community access– *will be complete by March 2026*	Monitoring framework in place to track LOS and outflow impact– *will be complete by March 2026*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Agree targeted interventions to reduce average length of stay across community hospitals including strengthened admission criteria and pathways.**		**Q2 Milestone Achieved?**
For Q2 reporting, we anticipate a minor delay due to the need to create capacity by addressing delays within community hospitals and ensuring all key outputs are in place to reduce length of stay. For Q3, we will need to tackle these delays to create additional capacity, alongside implementing Discharge to Assess. These interim actions will progressively enable us to achieve the key outputs scheduled for completion by March 2026. Taking these steps in Q3 will support and contribute to improved KPI performance; otherwise, we risk continued decline in performance. Now that funding has been confirmed – activity will move at pace to achieve this deliverable by March 2026. Any impact on the KPI will rely on other downstream activity i.e. Discharge to Assess, moving delays from community hospitals" being delivered at the same pace.			Strategic review of Community Hospital in Aberdeenshire is progressing and is at the communication and engagement stage. LoS in community hospitals is impacted on by clinical focus, discharge planning processes and community capacity. Agreeing targeted interventions through the funded projects can now commence due to confirmation of Scottish Government Funding, we will aim to realise the benefits within Quarter 3. Tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.		No

Deliverable:	**Expected Status at 31st March 2026**	**WILL BE COMPLETE**	**Key Outputs:**		
Discharge To Assess (D2A) models implemented in all HSCPs			D2A criteria agreed – *scheduled to be completed by December 2025*	Process for identifying patient cohorts via the Integrated Discharge Hub established – *scheduled for completion in Q3*	Achieve a stabilised workforce across all HSCPs to enable implementation of D2A – *scheduled for completion by Q4*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Roles advertised and Bank/Agency staff secured (or contracts let) to allow initial stand up of capabilities and/or Tests of Change. Interface points with Integrated Discharge Hub identified and processes agreed**		**Q2 Milestone Achieved?**
For Q2, recruitment and training of staff has taken place in preparation for the rollout of the D2A models in Quarter 3 (for the City). Aberdeenshire and Moray are still in the process of recruitment. Now that funding has been confirmed, activity will move at pace to achieve this deliverable by March 2026, which will support the completion of one of the key outputs and contribute to the performance of the delayed discharges KPIs.			British Red Cross appointed as provider for City and will be based at ARI and recruitment and development of pathways is underway. Moray START will expand in Q3 following the confirmation received of SG Funding. Workforce requirements for D2A in Aberdeenshire will be agreed, with recruitment anticipated in Quarter 3. Tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.		No

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Outcome 3: Increased proportion of people access urgent care through the right setting first time (e.g. NHS 24, Flow Navigation Centre, Ambulatory Care), reducing demand on emergency departments.

Key Performance Indicator	Baseline (Mar2025)	Quarter 1 Actual	Quarter 1 Target	Quarter 2 Actual	Quarter 2 Target	Quarter 3 Actual	Quarter 3 Target	Quarter 4 Actual	Quarter 4 Target	Trend over latest 12 months with 2025/26 target	Why are we in this position?
Increase the % of urgent care contacts routed away from ED through the Flow Navigation Centre (FNC) in order to reduce occupancy pressure in inpatient areas	54.8%	55.2%	55%	**54.4%**	**55%**	59.9% (Oct 25)	55%*		60%*		Full 24 hour coverage of the FNC has been problematic. However, recent memorandum of understanding with G-MED service will provide 24/7 coverage with no degradation of G-MED service.
Increase the % of urgent care contacts treated via ambulatory care capabilities in order to reduce occupancy pressure in assessment and inpatient areas	7.8%	7.5%	7.6%	**6.9%**	**7.5%**	7.6% (Oct 25)	7.5%*		10%*		Ambulatory care / same day emergency care services have had limited hours of operation. Recent expansion of these services in to the evenings and over the weekend period will provide alternative pathways to admission. Spotlight on page 20

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Expand the Flow Navigation Centre model and enhance interface with NHS 24 and primary care by March 2026, ensuring all urgent care referrals are consistently triaged to the most appropriate service			Expanded Flow Navigation Centre model operational – *scheduled for completion within Q3*	Integrated digital and clinical interface with NHS 24 and primary care – *scheduled for completion within Q3*	Standardised triage protocols in place for urgent care referrals – *scheduled for completion within Q3*

2025/26 Overall Deliverable Update – what is the justification for this status?	Q2 Milestone: Map local processes against learning from Tayside and Highland and agree tests of change	Q2 Milestone Achieved?
The anticipated minor delay is due to the stabilisation of the FNC workforce and this meant that identifying appropriate team of senior decision makers that could deliver the service. We anticipate some recovery with additional capacity identified from the GMED service without degradation of that service in Q3. Due to the delays, meeting key output for the expansion of the FNC model by Q3 may not be possible, which means two other key outputs may be impacted as a result. We look to recover this position by expanding the senior decision maker cohort in Q3 and Q4, and prioritising pathway standardisation and additional pathway development. This also includes additional integration with partner organisation e.g. NHS24. This has increased reliability in redirection and non-admission pathways and support offered to services contacting the FNC. Expansion and enhancement of the service has not been prioritised whilst this period of stabilisation has taken place. There are complexities in recruitment and also in establishing new pathways, but the service is on a better foundation to allow this to happen. We are confident that the actions in place will enable the KPI Performance to be delivered consistently over Q3 and Q4.	Stabilisation of FNC provision is well underway with extra support from GMED, without any degradation of the GMED service. The project team are on course with plans for expansion both In terms of senor staffing and pathways that will be added to the service, examples would include – enhancement of NHS 24 pathways, paediatric pathways, GI pathways and care home pathways. KPIs for this project will include increased diversions from admission and patients flowing to appropriate pathways more directly. Tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.	Yes

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Surgical Ambulatory Care (SAC) clinic and Rapid Acute Ambulatory Clinic (RAAC) operating hours extended			Weekend opening of SAC achieved– *scheduled for completion within Q3*	Expansion of RAAC opening hours into the evening at ARI – *scheduled for completion within Q3*	RAAC chest pain pathway established - *scheduled for completion within Q3*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Service design to be complete. Ensure clinical, operational and project management is in place and an agreed governance structure regarding monitoring, reporting, risk management and escalation is established. Recruitment activity initiated.**		**Q2 Milestone Achieved?**
Reconfiguration of staffing models that integrate SAC and RAAC into in-patient services rely on the availability of senior decision makers to provide this extended service. This reconfiguration has been delayed whilst recruitment has been undertaken and funding models confirmed. With this in place it is envisaged that a more sustainable model of service delivery will lead to delivery of this ambulatory pathway on an ongoing basis. We are confident that the actions in place will enable the KPI Performance to be delivered consistently over Q3 and Q4.			Extended opening hours in RAAC well underway with fixed term recruitment in place to support with a go live date of the beginning of November. Chest pain pathways are still under discussion between front door and cardiology teams. A new point of care test should streamline this process with potential for redirection to a community setting. Expansion of SAC are ongoing which will enable the completion of the key output as planned. KPIs for this project are around speed of assessment and reduced Length of Stay. Tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.		No

Outcome 4: Implementation of an enhanced Unscheduled Care model which results in shorter stays in hospital and reduced wait times in emergency assessment areas.

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
Increase the % of ED patients seen, treated, admitted or discharged within 4 hours	50.8%	50.7%	51%	**47.7%**	**53%**	45.8% (Oct 25)	55%*		57%*		ED performance against this target is reliant on capacity within the department. This in turn has co-dependencies with capacity of downstream areas. Increased overall hospital occupancy ultimately reduces the ability to meet this target. Spotlight on page 21
Reduce NHSG median SAS turnaround times to 55 minutes by March 2026*	63	49	65	**55**	**65**	62 (Oct 25)	65*		55*		Turnaround time is reliant on the ability of the ED to assess patients within the department. The implementation of additional cohorting spaces has provided capacity to achieve this without delivering against overall performance.

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Fully implement Unscheduled Care improvement measures in Acute settings by March 2026, including Same Day Emergency Care (SDEC), Acute AHP 7 day service, flow enabler enhancements			DGH Discharge Lounge hours extended ✓	Domestics and Pharmacy capacity increased ✓	7 Day AHP service introduced ✓
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: USC Improvement Implementation Directive issued. Data collection and exploitation plan published. Balance of effort between Delivery Groups agreed and short term limited project leads and reporting mechanisms agreed. Steering Group established**		**Q2 Milestone Achieved?**
Whilst key outputs have been delivered, we acknowledged that this has not produced an improvement towards KPI performance in Q2 for "Increase the % of ED patients seen, treated, admitted or discharged within 4 hours". Whilst these key outputs created efficiencies in the system, they have limited reach in terms of capacity creation. We will look to redefine the key outputs to measure against performance in Q3 and Q4. Flow enabler enhancements have already been put in place but additional capacity for AHP and SDEC services has been limited to provision from the current workforce. With expansion of the workforce which has taken time due to funding and recruitment confirmation the full realisation of these improvement has not been seen yet.			Expansion of the flow enable workforce has already occurred with a much larger pool to draw from. This has allowed delivery of additional portering staff, domestic staff and flow support. Recruitment is now underway for AHP and SDEC services, which should allow this stable workforce to build on existing pathways and establish new pathways going forward. Tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.		Yes

Deliverable:	Expected Status at 31st March 2026	WILL BE COMPLETE	Key Outputs:		
Fully implement Unscheduled Care improvement measures in HSCPs by March 2026, including H@H expansion, and the rapid movement of delayed patients to care home settings – Expected Status at 31st March 2026			Hospital@Home expansion of early discharge from ARI including ED and AMIA project (Westhill & Portlethen) achieved – *expected completion by 31st January 2026*	Hospital@Home expansion of admission avoidance from ARI including ED and AMIA project (Westhill & Portlethen) achieved – *expected completion by 31st March 2026*	Expand pathways across General Medicine and Frailty achieved – *expected completion by 31st March 2026*
2025/26 Overall Deliverable Update – what is the justification for this status?			**Q2 Milestone: Review current activity and ensure support and resource is targeted to ensure required impact is being achieved**		**Q2 Milestone Achieved?**
For Q2, in the process of advertising posts to support the delivery of the key outputs which will enable the improvement of the KPI: "Increase the % of ED patients seen, treated, admitted or discharged within 4 hours". Current capacity is fluctuating due to sickness absence which has contributed to the decline in KPI performance for Q2. For Q3, we will look to assess demand with various interventions such as exploring nurse-bank availability which will help us progress towards achieving the outputs. In Q2, we have reviewed key outputs and the new Key outputs for reporting will support improvement of 4 hour ED wait KPI if in place timeously.			Number of projects being driven under the Downstream Delivery Group will support this deliverable, each have KPIs, funding and require recruitment. Where possible interim staffing (bank, additional hours will be used). Project Teams received funding confirmation end of August and recruitment commenced. For the Hospital@Home expansion project, data collection and working group established. Programme Structure in place in Q3 and tiered reporting approach to be in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.		Yes

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria

Tier 3: Our Performance Spotlights – Unscheduled Care

Outcome 2: Faster, safer discharges from hospital are achieved through a streamlined discharge process, better coordination between hospital and community teams and an improved balance in the volume of care capacity

1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***

While we have not yet observed measurable improvements across all KPIs since the last reporting period, this is not unexpected. Enhancements to discharge processes will take time to have an impact. Currently staff are testing new processes and the data collection around this. Following learning the improved processes will be rolled out with full implementation by end of March 2026. The Unscheduled Care Improvement Plan and the national funding will enable key enhancements in services in the HSCPs and acute hospitals. While some of the projects were able to commence in Q2 others are dependent on recruitment and the development and spread of new ways of working. This has meant that the first areas of change, predominately at the front door, have not led to increase flow across our whole system. However, work is underway to address this, with progress being made on all the projects and we anticipate seeing more tangible improvements over the next few months. A tiered reporting approach will be put in place in Q3 which ties project KPIs to HAWD KPIs allowing performance monitoring by the Unscheduled Care Improvement Programme Board.

- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***

Although measurable change is not yet evident, we are confident that the current suite of outputs and deliverables—such as streamlined discharge protocols, improved coordination mechanisms, and targeted capacity planning—are aligned with best practice and evidence-based approaches. These interventions are undergoing testing prior to full implementation. As operational and cultural shifts take effect, we expect to see a progressive and sustained impact. This will be monitored through project KPIs linked to HAWD KPIs and national reporting. Clinical and operational teams remain engaged in this work, though capacity pressures can occasionally limit full participation.

- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***

In our work to achieve faster, safer discharges, we have intentionally embedded the principles of reducing health inequalities and putting people first at every stage of the improvement journey. We recognise that discharge is not a one-size-fits-all process and that individuals' needs, circumstances, and vulnerabilities must be central to how we design and deliver care transitions.

- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***

All activity is aligned to a Delivery Group which monitors performance against the KPIs and each project group is asked to identify any barriers to improvement. To support this, we are developing data dashboards tailored to each project group, enabling monitoring and rapid issue resolution. As this is a whole system approach the project and delivery groups support co-designing solutions or learning good practice from other areas both locally and nationally.

Commentary from
Geraldine Fraser

Chief Officer – Acute Services

2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***

The main risks are around recruitment of additional staff to support delivering alternative models of care and also the capacity of existing operational and clinical staff to engage and deliver on the improvements during extreme pressure on the system. There are many areas of project activity aligned to the USC Improvement Plan that have attracted funding and recruitment is underway and progress with this will be monitored by the Downstream Delivery group and escalations reported to the USC Programme Board via the USC Steering Group. There is a dedicated USC Improvement Programme team supporting the delivery of the programme who will support operational and clinical colleagues. This programme team is also supported by dedicated Senior Responsible Officer capacity.

- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., other Change Programmes Outcomes in Unscheduled Care, Value and Sustainability, workforce, infrastructure)?***

At this stage, there is no evidence of unintended consequences or negative impacts on other KPIs or related programmes (e.g., Value and Sustainability, workforce, infrastructure). Ongoing monitoring through the Delivery and Steering Groups, alongside alignment with other improvement programmes, will ensure any emerging issues are identified and addressed promptly.

- ***How will the performance of this Programme reduce our strategic risks?***

These focus areas directly address Strategic Risk 3639 – Significant Delays in Unscheduled Care, driven by inpatient overcrowding. As the programme progresses, it is expected to reduce hospital occupancy by avoiding unnecessary admissions and minimising delays in discharge and transfers of care.

Tier 3: Our Performance Spotlights – Unscheduled Care

Outcome 3: Increased proportion of people access urgent care through the right setting first time (e.g. NHS 24, Flow Navigation Centre, Ambulatory Care), reducing demand on emergency departments.

1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***

Progress in improving access to urgent care remains in the early stages, and as yet we have not observed measurable change since the last quarter. KPIs and trajectories for all the Unscheduled Care Improvement Plan project are being set which tie into the HAWD KPIs. A key focus of activity is the strengthening the existing Flow Navigation Centre (FNC), which is central to improving access to alternative urgent care pathways. This work requires recruitment to multiple roles and the delivery of associated training. Once this is in place, the FNC will increase both access to and awareness of alternative pathways with the full impact planned for Q4. It is important to acknowledge that a significant proportion of Emergency Department (ED) attendances remain clinically appropriate, which may limit the extent to which overall reductions in ED activity can be achieved.

- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***

While measureable change has not yet been realised due to recruitment and pathways requiring development, we are confident that the interventions such as enhanced triage via NHS24, Flow Navigation Centre and expanded Ambulatory Care are aligned with the evidence base for improving access to urgent care. These interventions are still embedding and we expect to see progressive impact as operational and cultural change become embedded working up to full implementation in Q4. Clinical and operational teams are actively engaged in this work, although capacity constraints due to system pressures can occasionally affect participation.

- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***

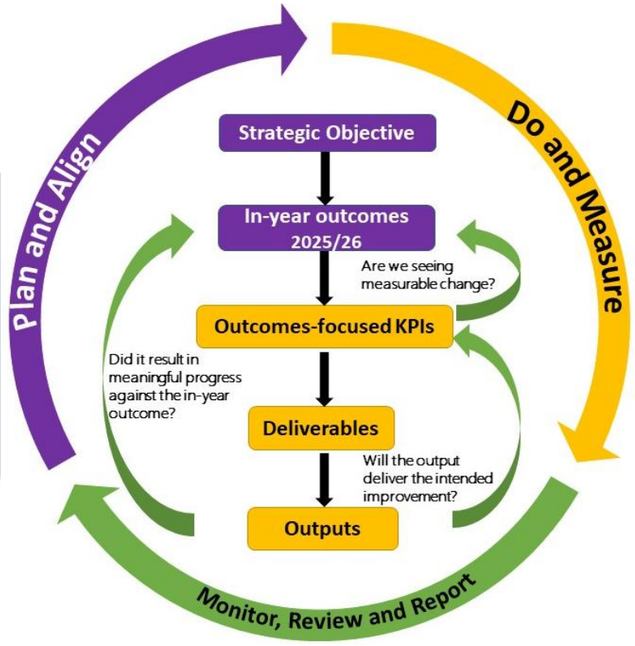
In our work to increase the proportion of people accessing urgent care through the right setting, we have intentionally embedded the principles of reducing health inequalities by offering multiple access points; the system aims to be inclusive and responsive to diverse needs, especially for those who face barriers to traditional care. In terms of putting people first, the planned model prioritises timely, person centred care, reducing unnecessary waits and improving experience by matching patients to the right service from the outset.

- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***

All activity is aligned to a Delivery Group which monitors performance against the KPIs and each project group is asked to identify any barriers to improvement. We are developing data dashboards for each project group that they will use to monitor their own progress and troubleshoot issues quickly. As this is a whole system approach the project and delivery groups support co-designing solutions or learning good practice from other areas both locally and nationally.

Commentary from
Geraldine Fraser

Chief Officer – Acute Services



2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***

The main risks are around recruitment of additional staff to support delivering alternative models of care and also the capacity of existing operational and clinical staff to engage and deliver on the improvements during extreme pressure on the system. There are many areas of project activity aligned to the USC Improvement Plan that have attracted funding and recruitment is underway and progress with this will be monitored by the Upstream Delivery group and escalations reported to the USC Programme Board via the USC Steering Group. There is a dedicated USC Improvement Programme team supporting the delivery of the programme who will support operational and clinical colleagues. This programme team is also supported by dedicated Senior Responsible Officer capacity.

- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., other Change Programmes Outcomes in Unscheduled Care, Value and Sustainability, workforce, infrastructure)?***

At this time, there is no evidence of unintended consequences or negative impacts on other KPIs or related programmes (e.g., workforce, infrastructure, or other unscheduled care outcomes). Ongoing monitoring through the Delivery and Steering Groups, with alignment to other improvement programmes, will ensure any emerging issues are identified and addressed proactively.

How will the performance of this Programme reduce our strategic risks?

These focus areas directly address Strategic Risk 3639 – Significant Delays in Unscheduled Care, driven by inpatient overcrowding. As the programme progresses, it is expected to reduce hospital occupancy by avoiding unnecessary admissions and minimising delays in discharge and transfers of care.

Tier 3: Our Performance Spotlights – Unscheduled Care

Outcome 4: Implementation of an enhanced Unscheduled Care model which results in shorter stays in hospital and reduced wait times in emergency assessment areas.

1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***

We have not seen measurable change across all of the KPIs since last quarter, although the implementation of the enhanced Unscheduled Care model is progressing. Improvement activity to support implementation will take time; which is consistent with the expected trajectory of a complex system transformation. Staff are currently testing new processes and the data collection around this. Community capacity has not yet increased in line with discharge demand. However, progress is being made in workforce recruitment, resource allocation, and the availability of care packages. In parallel, the Flow Navigation Centre is being strengthened to improve access to alternative care pathways. With Scottish Government funding now approved, we are progressing with a number of projects reducing hospital stays and assessment times including expansion of Rapid Assessment in medicine and surgical, frailty and AHPs at our front doors, use of discharge lounge, integrated flow hub and community discharge to assess. Each of these projects has KPIs and trajectories which contribute to increased flow.

- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***

While the KPIs have not yet shown measurable change, we remain confident that the enhanced unscheduled care model is the right approach. The deliverables, such as improved triage pathways, rapid assessment protocols and strengthened links with community services, are grounded in evidence-based practice to reduce delays and improve patient flow. These changes are embedding and we expect to see progressive impact as operational and cultural changes take hold. Clinical and operational teams are fully engaged, though system pressures can occasionally limit capacity for participation.

- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***

In our work to implement an enhanced Unscheduled Care Model, we have intentionally embedded the principles of reducing health inequalities by providing faster access to assessment and treatment which reduces risk of poorer outcomes for vulnerable groups and improved co-ordination helps ensure patients are not disadvantaged by where they live or their ability to advocate for themselves. In terms of putting people first, person centred triage ensures patients are seen by the right clinician at the right time and shorter stays reduce the risk of HAI complications and support recovering in homely settings.

- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***

All activity is aligned to a Delivery Group which monitors performance against the KPIs and each project group is asked to identify any barriers to improvement. We are developing data dashboards for each project group that they will use to monitor their own progress and troubleshoot issues quickly. As this is a whole system approach the project and delivery groups support co-designing solutions or learning good practice from other areas both locally and nationally.

Commentary from
Geraldine Fraser

Chief Officer – Acute Services

2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***

The main risks are around recruitment of additional staff to support delivering alternative models of care and also the capacity of existing operational and clinical staff to engage due to ongoing system pressures. There are many areas of project activity aligned to the USC Improvement Plan that have attracted funding and recruitment is underway and progress with this will be monitored by the Upstream Delivery group and escalations reported to the USC Programme Board via the USC Steering Group. There is a dedicated USC Improvement Programme team supporting the delivery of the programme who will support operational and clinical colleagues. This programme team is also supported by dedicated Senior Responsible Officer capacity.

- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., other Change Programmes Outcomes in Unscheduled Care, Value and Sustainability, workforce, infrastructure)?***

We are unaware of any unintended consequences or impact on other KPIs at this time. This will continue to be monitored via the Delivery and Steering Groups and linking in with other improvement programme.

- ***How will the performance of this Programme reduce our strategic risks?***

These focus areas directly address Strategic Risk 3639 – Significant Delays in Unscheduled Care, driven by inpatient overcrowding. As the programme progresses, it is expected to reduce hospital occupancy by avoiding unnecessary admissions and minimising delays in discharge and transfers of care.

Planned Care

Reducing the waits for elective treatment and diagnostics within NHS Grampian. Within the year the focus is on the ministerial commitments and the number of people waiting at the end of the financial year. Longer term the focus is on redesign and transformation to achieve waiting times sustainably within core capacity, within year achieve and where we can better the agreed trajectories shared and agreed with Scottish Government. This programme relates to the inability to meet population demand for Planned Care. Reducing the waits to an acceptable level on a sustainable basis will reduce this risk directly. This Programme addresses the strategic risk: "Inability to meet population demand for Planned Care" relates to the current risk of avoidable patient harm (physically, emotionally, financially and in terms of quality of life) given the current waits and the current absence of a plan to sustainably deliver acceptable planned care performance within core services

Our Outcomes: What change or improvement do we expect to see by 31st March 2026?

By 31st March 2026 we will have made the following difference....
Outcome 1: We want to reduce the number of patients waiting over 52 weeks for their first New Outpatient appointment.
Outcome 2: We want to reduce the number of patients waiting over 52 weeks for their Treatment Time Guarantee procedure.
Outcome 3: People diagnosed with cancer begin their first treatment within 31 days of the decision to treat, with improved coordination and increased capacity helping services meet national standards.
Outcome 4: People referred with an urgent suspicion of cancer are diagnosed and begin treatment within 62 days, through faster access to diagnostics and more responsive, optimised pathways.
Outcome 5: Reduce waits so that 95% of New Endoscopy patients receive their Endoscopy within 6 weeks of referral by the end of March 2026.
Outcome 6: Reduce waits so that 95% of Radiology patients receive their scan and report within 6 weeks of referral by the end of March 2026.

Our Unscheduled Care Programme supports these OIP Critical and Focus Areas		
Critical Area	**Focus Area**	
Improving access to treatment	Increasing Capacity	Reduce the number of patients waiting over 52 weeks for their first New Outpatient appointment
		Reduce the number of patients waiting over 52 weeks for their Treatment Time Guarantee procedure
		People diagnosed with cancer begin their first treatment within 31 days of the decision to treat
		People referred with an urgent suspicion of cancer are diagnosed and begin treatment within 62 days
	Diagnostics – Reducing the backlog	Reduce waits so that 95% of New Endoscopy patients receive their Endoscopy within 6 weeks of referral
		Reduce waits so that 95% of Radiology patients receive their scan and report within 6 weeks of referral

Outcome 1: We want to reduce the number of patients waiting over 52 weeks for their first New Outpatient appointment.

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
≤4,489 New Outpatients waiting over 52 weeks by the end of March 2026*	8654	9800	≤9884	**10800**	≤10,657	10522 (Provisional Oct 2025)	≤9,516*		≤4,489*		The number of waits over 52 weeks continues to trend up; the rate of increase slowed in August and September. *Revised trajectory submitted to Scottish Government 01/12/25 with Q3 target to be reviewed

Deliverable:	**Expected Status at 31st March 2026**	**WILL BE COMPLETE**

Deliver all projects included in the planned care plan to time, budget and outcome. Seek to reduce the recurring capacity gap going forward and redesign outpatient services to deliver sufficient capacity within core capacity

2025/26 Overall Deliverable Update – what is the justification for this status?

Core funding of £10.6m and additional funding of £0.9m specific to addressing Dermatology wait lists, coupled with enhanced scrutiny and governance via the monthly Planned Care Programme Board has led to an improved position being submitted at the end of Q2. There has been a conscious decision to do this at a speciality level which should be born in mind for future interpretation of any variances.
Dialogue remains ongoing with other Health Boards around additional Mutual Aid to improve the number of patients seen by end of March 2026 for both new outpatients and Treatment Time Guarantee (TTG). The impact of this will likely be minimal (less than 300 for NOP and 100 for TTG) and should be finalised in Quarter 3. During Quarter 3, in particular the mobilisation of the Dermatology independent sector contract will have a significant impact on achieving the trajectory which sits under Key output: "All planned care projects delivered to time, budget and scope"

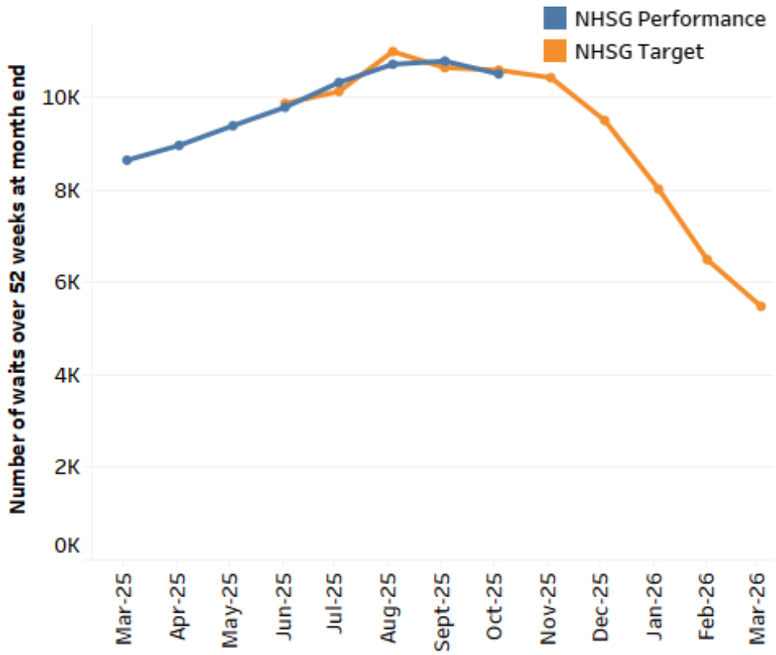
Key Outputs:

All planned care projects delivered to time, budget and scope – *On track at present. Revised trajectories will be set in December 2025 that NHS Grampian will be held to account for by Scottish Government.*	Outpatient capacity delivered increasingly within core service levels – *On track. We continue to deliver against our core plan of 5,489 NOP by the end of March 2026*	Redesigned pathways implemented to improve flow and reduce backlog growth – *ongoing until Q4 with focus around utilising day surgery unit, endoscopy rooms and location changes for service provision.*	Development of a formal plan for core balance across key specialties – *On track against current planned trajectories.*

Q2 Milestone: On trajectory; Key variance specialities redesign work commenced	**Q1 Milestone Achieved?**
Service and workforce design has been completed. Project governance is in place via the Unscheduled Care Programme Board (USCPB) Downstream Delivery Group. Recruitment activity prepared.	Yes

Performance against the outpatient 52 week target*:

Reduce the number of waits over 52 weeks for a new outpatient appointment



The national target is to have no waits over 52 weeks for a new outpatient appointment by 31/03/2026.

Our performance trajectory (shown in orange) is such that we projected the number of waits over 52 weeks would increase to August, before decreasing to 31/03/26 (but will not reach zero by then). Positive performance is where number of waits is below trajectory.

The number of waits over 52 weeks has been trending up over the last four years.

At the end of October 2025, the number of waits over 52 weeks had decreased, to just below trajectory.**

* Revised Q4 target submitted to Scottish Government 01/12/25 with Q3 and Q4 monthly target to be reviewed
**Note that data for Q3 2025 is provisional local data which may be subject to change prior to final publication and in subsequent reports.

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria

Outcome 2: We want to reduce the number of patients waiting over 52 weeks for their Treatment Time Guarantee (TTG) procedure.

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
≤4,622 TTG patients waiting over 52 weeks by the end of March 2026*	5330	4879	≤5323	**4505**	**≤4559**	4492 (Provisional Oct 2025)	≤4082*		≤4,622*		The number of waits over 52 weeks continues to trend down. *Revised trajectory submitted to Scottish Government 01/12/25 with Q3 target to be reviewed

Deliverable: | **Expected Status at 31st March 2026** | **WILL BE COMPLETE**

Reinstate the Short Stay Theatre Complex at ARI, stream and merge all NHS Grampian assets, work regionally to reduce waits

2025/26 Overall Deliverable Update – what is the justification for this status?

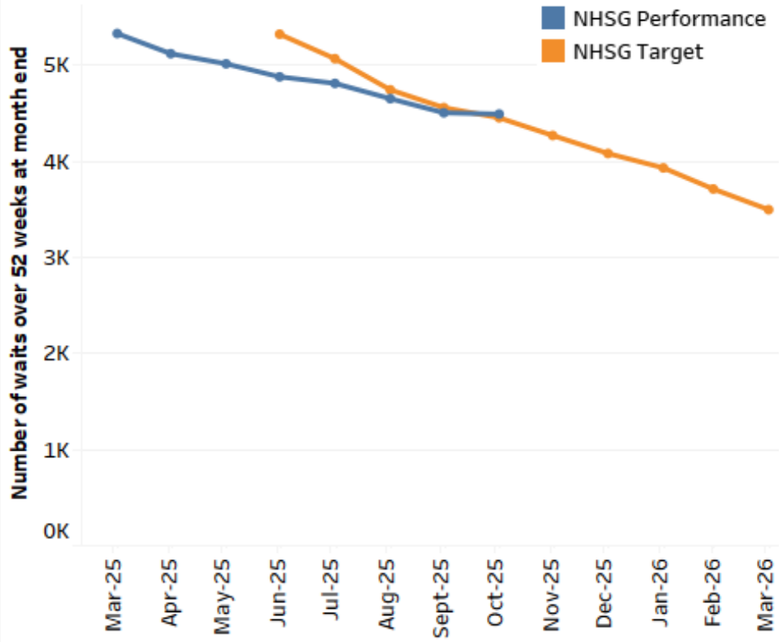
Revised submission reflects Patient Treatment List (PTL) focus and ensuring the maximum amount of available capacity is being dedicated to this target cohort. Re-opening of Short Stay Theatre 1 for November is progressing with no identified risks so far identified, and we expect will deliver an improved TTG position by treating an additional 265 patients before the end of March 2026. There remains an ask for mutual aid and proposals to improve this position further out for active consideration.
The other key outputs are around service redesign to deliver capacity-demand balance within core services. This is ongoing and will be sense checked at the end of Q4

Key Outputs:

Short Stay Theatre Complex at ARI fully operational and staffed - *expected Q3*	Elective assets across optimised through merged scheduling – *ongoing until Q4*	Regional mutual aid delivered to reduce longest waits – *expected Q3*	Operationalising regional mutual aid delivered – *expected Q3*

Q2 Milestone: Regional mutual aid; Grampian assets formally merged	**Q2 Milestone Achieved?**
Small variation from the planned position but not considered significant at this scale. Short stay theatre complex is not yet open, but planned opening date is considered robust for ~November during Q3; slippage should be manageable within the overall programme. Similar to OP a revised (improved) end of Q4 trajectory has been submitted and will be reported on for subsequent HAWD reports	**Yes**

Performance against the TTG 52 week target*:
Reduce the number of waits over 52 weeks to be admitted for treatment



The national target is to have no waits over 52 weeks for TTG admission for treatment by 31/03/2026.

Our performance trajectory (shown in orange) will reduce the number of TTG inpatient waits over 52 weeks by 31/03/2026, but will not reach zero by then. Positive performance is where number of waits is below trajectory.

The number of waits waiting over 52 weeks has been trending down since the start of 2024.

At the end of October 2025, the number of waits over 52 weeks had increased, to just above trajectory.**

* Revised Q4 target submitted to Scottish Government 01/12/25 with Q3 and Q4 monthly target to be reviewed
**Note that data for Q3 2025 is provisional local data which may be subject to change prior to final publication and in subsequent reports.

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**

Outcome 3: People diagnosed with cancer begin their first treatment within 31 days of the decision to treat, with improved coordination and increased capacity helping services meet national standards.

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
95% of patients will be compliant with the 31 day standard as of end of March 2026	90%	91.6%	92%	**91.7%**	**93%**	91.5% (Provisional Oct 2025)	94%		95%		31-day performance has fallen just short of target trajectory outlined in Planned Care and Cancer plan. This is in part due to delay in mobilisation of additional capacity through funded improvement projects

Deliverable:	**Expected Status at 31st March 2026**	**ANTICIPATED MINOR DELAY**

Deliver all projects included in the planned care plan, to time, budget and outcome. Continue to work to sustainably deliver the standard within core capacity

2025/26 Overall Deliverable Update – what is the justification for this status?

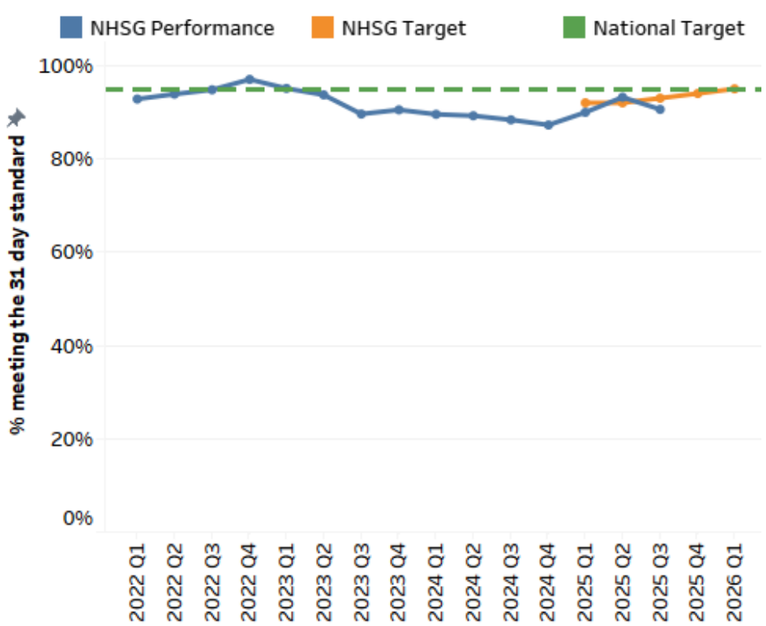
Delay to change in utilisation of short stay theatres to increase capacity. Re-opening of Short Stay Theatre 1 for November is progressing with no identified risks so far identified, Around 40% of 31-day patients have surgery as first treatment. Cancer waiting times Breach analysis shows theatre capacity is primary breach reason if failing to meet 31-day target. Increased capacity will result in faster access to surgical treatment.
Demand for robotic prostatectomy has increased by 30% due to regional support being provided for NHS Tayside patients at ARI for the Prostate cancer pathway
Backlog generated in Breast surgery pathway, work ongoing to recover position will result in a declining performance during the period of recovery to treat breached patients. 17 Breast pathway patients breached target in this quarter. At end of quarter 10 Breast pathway patients already breached and not yet treated. Delay between July – October 2025.
Average time from decision to treat to treatment has remained consistent.
Projects that have been delivered are to date having the impacts anticipated on trajectories. Efforts ongoing to improve to March Key Output trajectory.

Key Outputs:

Cancer improvement projects delivered to time, budget and scope - *ongoing until Q4*	Capacity secured to deliver standard within core capacity– *Not complete – ongoing until Q4*	Treatment coordination processes strengthened to reduce delays from decision to treat to first intervention ✓

Q2 Milestone: Mobilise improvement projects	**Q2 Milestone Achieved?**
Some improvement projects have commenced with others having minor delay due to time to mobilise additionality through recruitment and training of staff. Projects which are delayed are chased via the weekly meeting and the planned care programme board intended to start in Q3.	**No**

Performance against the 31-day cancer standard:
Proportion of patients waiting no more than 31 days from decision to treat to first cancer treatment



National target: 95%

NHSG Target: 95% by 31/03/2026

Our performance trajectory (shown in orange) is for 95% of patients to meet the 31 day standard by 31/03/2026. Positive performance is where the trajectory is met or exceeded.

Following a decline in quarterly performance through 2023 and 2024, there was an improvement for the first two quarters of 2025, before a decrease for the quarter to September.

For the quarter to September 2025*, provisional performance of 90.6% is below the NHSG quarterly target of 93%, and the national target of 95%

*Note that data for Q3 2025 is provisional local data which may be subject to change prior to final publication and in subsequent reports

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**

Outcome 4: People referred with an urgent suspicion of cancer are diagnosed and begin treatment within 62 days, through faster access to diagnostics and more responsive, optimised pathways.

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
85% of patients will be compliant with the 62 day standard as of end of March 20256	52.5%	61.2%	58%	61.1%	67%	62% (Provisional Oct 2025)	76%		85%		62-day performance has fallen short of target trajectory outlined in Planned Care and Cancer plan. This is in part due to delay in mobilisation of additional capacity through funded improvement projects Spotlight on page 29

Deliverable:

Deliver all projects included in the planned care plan, to time, budget and outcome, continue to work to sustainably deliver the standard within core capacity

2025/26 Overall Deliverable Update – what is the justification for this status?

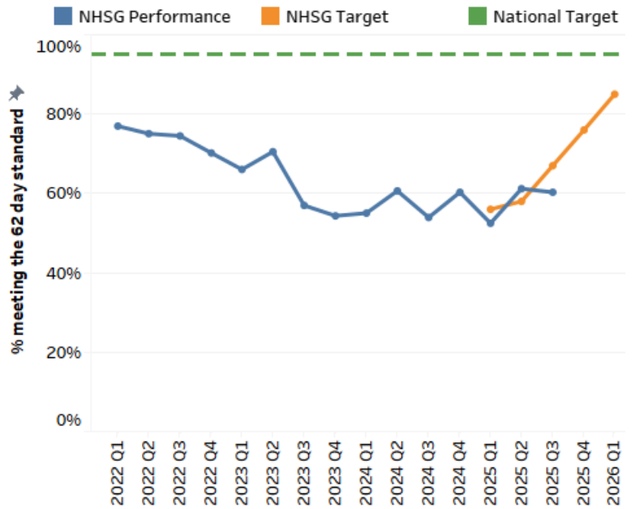
Time to mobilise additionality through recruitment and training of staff funded by improvement projects
Delay in mobilising MRI van and endoscopy additionality due to infrastructure issues.
Demand for robotic prostatectomy has increased by 30% due to regional support being provided for NHS Tayside patients at ARI for the Prostate cancer pathway. Prostate Cancer DCAQ planning tool in development to help assess impact volume.
Median time from referral to treatment has successfully reduced.
Projects that are on track are delivering the expected improvements; total cancer performance is calculated across 15 tumour group pathways. Improved or maintained performance in some pathways supports the overall KPI, with Lung, Melanoma, Ovarian and Upper GI all demonstrating improved performance.
The completed output will support the KPI to be maintained at current position, with remaining Outputs multi-factorial across the delivery of planned care and being progressed through planned care board.

Key Outputs:

Cancer improvement projects delivered to time, budget and scope– *ongoing until Q4*	Capacity secured to deliver standard within core capacity *– ongoing until Q4*	Treatment coordination processes strengthened to reduce delays from decision to treat to first intervention ✓

Expected Status at 31st March 2026 **ANTICIPATED MINOR DELAY**

Performance against the 62-day cancer standard:
Proportion of patients receiving first treatment within 62 days of urgent suspicion of cancer referral



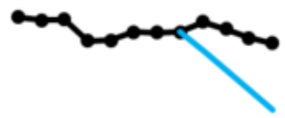
National target: 95%
NHSG Target: 85% by 31/03/2026
Our performance trajectory (shown in orange) is for 85% of patients to meet the 62 day standard by 31/03/2026. Positive performance is where the trajectory is met or exceeded. Following a decline through 2023 quarterly performance fluctuated through 2024 and into 2025.
For the quarter to September 2025*, provisional performance of 60.3% is below the NHSG quarterly target of 67%, and the national target of 95%

Q2 Milestone: Mobilise improvement projects	**Q2 Milestone Achieved?**
Some improvement projects have commenced with others having minor delay due to time to mobilise additionality through recruitment and training of staff. Projects which are behind schedule are monitored via the weekly performance meetings and the Planned Care Programme Board anticipated to start in Q3. We estimate the value of this delay to be c£0.7m forecast against our total £11.5m planned care monies (£10.6m +£0.9m). Delays relate to: Breast Pathway: Reduce waits for first Appointment • Delay to recruitment of nurses for nurse-led clinics, in post as of Sept 25. Wait to first OPA successfully reduced from 4 weeks to 2 weeks as of Oct 25 • Unable to recruit to speciality Dr post as no suitable candidates, locum commenced Nov 25 Head & Neck and Lymphoma Pathway: Commence one-stop Neck Lump Clinic • Work to finalise complex moves of multi-disciplinary team job plans delayed project start. One-stop clinic commenced 4th Sept with successful reduction in time to diagnosis, expected to see impact to performance as of Q3 / Q4 All cancer pathways: Pathology Turnaround times • Purchase of pathology equipment has mitigated risk of old equipment failure and enabled pathology turnaround times to be maintained resulting in timely MDT discussion • Further improvement to genomics molecular testing turnaround times has been reliant on recruitment of staff who started Sept 25. A 3 month training period is required and improvement is now expected to be realised from Q4. This is expected to be seen in improvement in Breast and Lung pathway performance	**No**

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**

*Note that data for Q3 2025 is provisional local data which may be subject to change prior to final publication and in subsequent reports

Outcome 5: Reduce waits so that 95% of New Endoscopy patients receive their Endoscopy within 6 weeks of referral by the end of March 2026

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
No Endoscopy patients (4 key diagnostic tests) waiting over 6 weeks by the end of March 2026	2516	**2645**	**2644**	**2552**	**1763**	2465 (Provisional Oct 2025)	822		0		The number of waits over 6 weeks at month end followed an upward trend for the six month to July, before decreasing over the last two months Spotlight on page 30

Deliverable:	**Expected Status at 31st March 2026**	**ANTICIPATED SIGNIFICANT DELAY**

Open a fourth endoscopy room at ARI, merge into a single Endoscopy Service for Grampian, restart the EndoSign service

2025/26 Overall Deliverable Update – what is the justification for this status?

The Endosign service will start in November but this is a slippage from plan.
Delay in delivering the fourth endoscopy room output is the key cause of the variation from plan. Work remains ongoing with the Endoscopy Service and Support Services to identify if weekend working can partial mitigate this, which will be known by November. These actions remain substantial and crucial to improve our position in Q2 but the lag in implementing the actions means that the end of Q3 target will not be achieved and subsequently impacting the achievement of the Q4 target. We intend to re-profile our Q4 position when the start date is fully confirmed, which we anticipate to be to Scottish Government by 01 December.

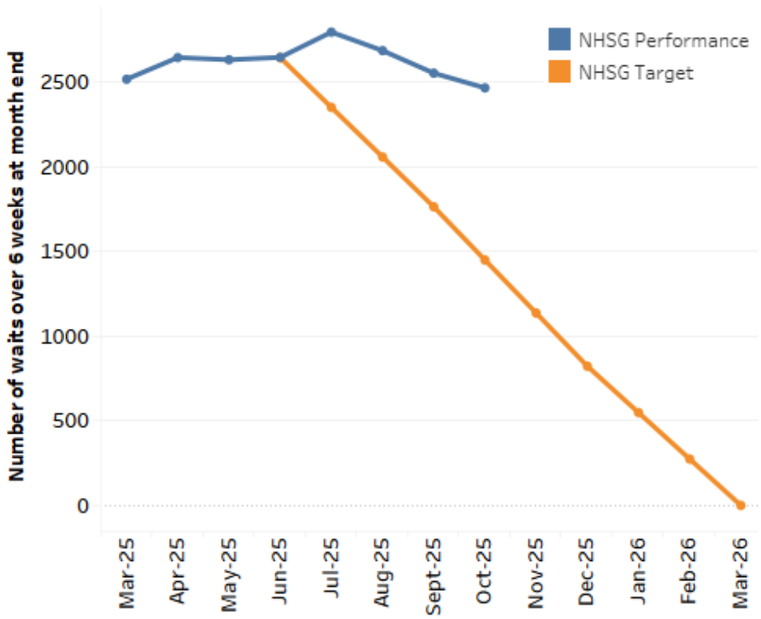
Key Outputs:

ARI fourth endoscopy room opened and staffed – *now planned for Q3*	Single Endoscopy service model in place with unified staffing and scheduling – *Now planned for Q3*	EndoSign service reinstated to support triage and reduce unnecessary procedures - *Now planned for Q3*

Q2 Milestone: Restart Endosign Service	**Q2 Milestone Achieved?**
The Endosign service did not restart in September but is considered robust for a starting point early in Q3. The fourth room continues to be looked at as part of the Short Stay complex reopening which we will aim to reach a decision in October to then commence from November, if plausible. This will be dependent upon a number of additional moves of clinical services as issues were identified with the initial plan. This remains an area of priority focus but also a key risk.	**No**

Performance against the endoscopy tests 6 week target:

No waits longer than 6 weeks for one of the 4 key endoscopy diagnostic tests



The target is to have no waits over 6 weeks for one of the 4 key endoscopy tests by 31/03/2026.

Tests include colonoscopy, cystoscopy, and endoscopy; there is variation in the volume of waits across the 4 tests. Positive performance is where number of waits is below trajectory.

The number of waits over 6 weeks at month end had been trending down through the second half of 2024 and into 2025, before increasing to July; there has since been a decrease.

At the end of October 2025*, the number of waits over 6 weeks was above trajectory

*Note that data for Q3 2025 is provisional local data which may be subject to change prior to final publication and in subsequent reports

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria

Outcome 6: Reduce waits so that 95% of Radiology patients receive their scan and report within 6 weeks of referral by the end of March 2026

Key Performance Indicator	Baseline (Mar2025)	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Trend over latest 12 months with 2025/26 target	Why are we in this position?
		Actual	Target	Actual	Target	Actual	Target	Actual	Target		
No Radiology patients (4 key diagnostic tests) waiting over 6 weeks by the end of March 2026	3629	5145	6000	**6567**	**6442**	6175 (Provisional Oct 2025)	3000		0		The number of waits over 6 weeks at month end had been trending down through 2024, but has increased through 2025 Spotlight on page 31

Deliverable:	**Expected Status at 31st March 2026**	**ANTICIPATED MINOR DELAY**

Deploy the second mobile MRI, implement funded improvements in capacity, in particular 7 day working as core capacity

2025/26 Overall Deliverable Update – what is the justification for this status?

Due to the achievement of the two outputs in Q2, there has been excellent work to recover the MRI position and a robust plan in place to do this, with the second MRI machine now in place contributing to this along with additional capacity in NHS Highland and planned for Dr Gray's. Together this should recover the MRI six week trajectory by March 2026. As a result of this, we have seen an improvement in the KPI performance however due to an emergent risk with the Ultrasound Service and difficulty in filling gaps, Q2 performance has declined. We are actively pursuing what potential additional solutions may be possible to address this both internally and on and NoS and National basis. This will then inform what impact this may have on our overall trajectory to the end of March 2026.

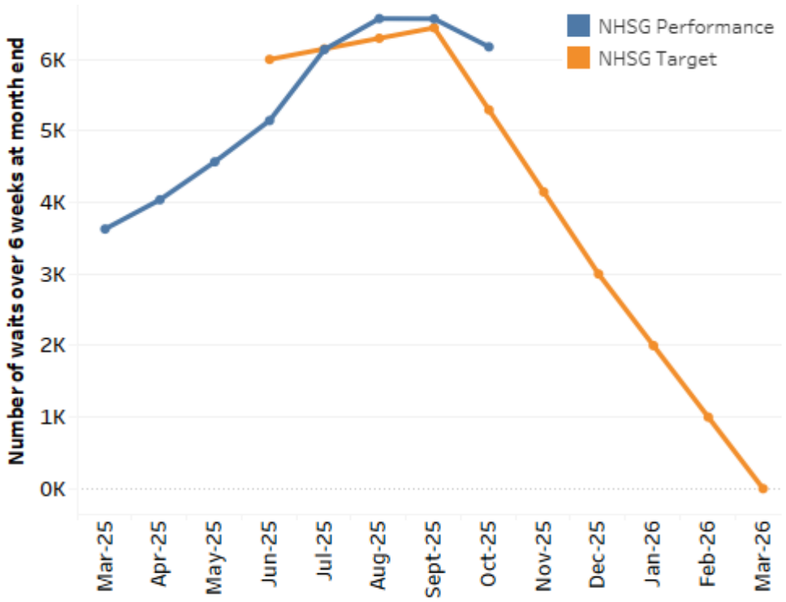
Key Outputs:

Second mobile MRI deployed and operational to increase scanning ✓	7 day radiology service implemented as core capacity model ✓	Funded capacity improvements in place – *ongoing until Q4*

Q2 Milestone: 7 day service plans progressing	**Q2 Milestone Achieved?**
Although there is a small variation in the position the second mobile MRI machine is now in place and operating and there is an agreed mitigation plan via Highland and Dr Gray's to recover the position.	**Yes**

Performance against the radiology tests 6 week target:

No waits longer than 6 weeks for one of the 4 key radiology diagnostic tests



The target is to have no waits over 6 weeks for one of the 4 key radiology tests by 31/03/2026.

Tests include CT, MRI, and ultrasound; there is variation in the volume of waits across the 4 tests. Positive performance is where number of waits is below trajectory.

The number of waits over 6 weeks at month end had decreased through 2024; there has been an upward trend through 2025 to August, before a decrease to October 2025.

At the end of October 2025*, the number of waits over 6 weeks was above trajectory

*Note that data for Q3 2025 is provisional local data which may be subject to change prior to final publication and in subsequent reports

Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria

Tier 3: Our Performance Spotlights – Planned Care

Outcome 4: People referred with an urgent suspicion of cancer are diagnosed and begin treatment within 62 days, through faster access to diagnostics and more responsive, optimised pathways.

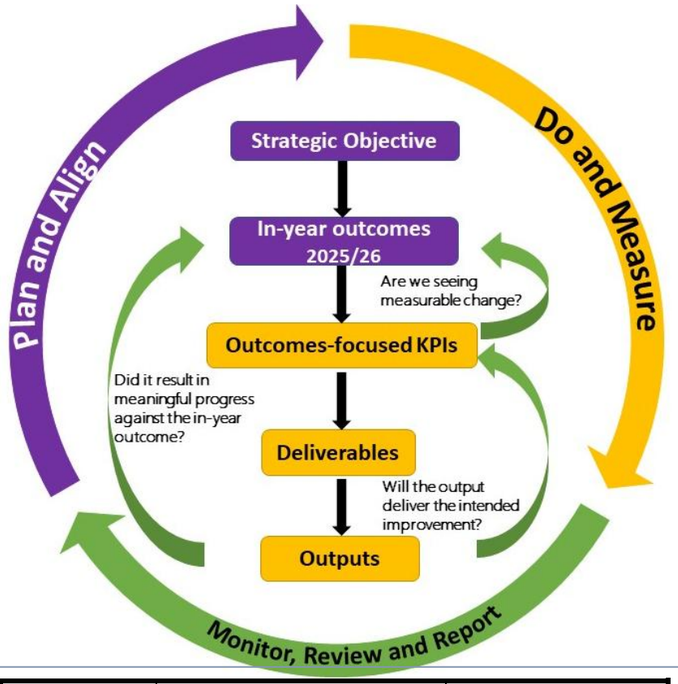
1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***
  Performance against the standard increased the first month of this quarter, this has subsequently fallen in the last two months with provisional quarterly performance figure being below the anticipated trajectory. Despite drop in performance, the median time from urgent suspicion of cancer referral to treatment has remained the same.
  Progress in measurable change will be aligned to faster access to diagnostics with urology and endoscopy being key areas of challenge.
  The key change will be the commencement of the fourth Endoscopy Room in ARI. Unfortunately the initial plan to locate this directly within the short stay unit has hit unexpected issues so the current plan requires a larger movement of clinical services to achieve the outcome. The fourth Endoscopy Room will commence the week of 10 November providing two-full day lists per week increasing each week thereafter until we achieve five days per week.
  As of Q3 new clinical practice in the prostate pathway with direct to MRI and same-day biopsy in some cases will see a reduction in diagnostic turnaround times of around 6 weeks. Urgent Suspected Cancer referrals to the prostate pathway continue to increase with 40% increase in referrals received over Q2 2025 when compared to Q2 2024, this continues to put pressure on the urology team and diagnostic services to meet demand within expected turnaround times. Plans to mitigate included opening of the SURE (Swift Urological Response and Evaluation.) unit at ARI in summer 2025, this has been delayed pending review of suitable location and infrastructure.
- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***
  There has been delay to some additionality being mobilised due to recruitment and training of staff funded by improvement projects. There was a delay in mobilising the MRI van additionality, this is now improving. Endoscopy do not believe the original position is deliverable given the slippage in commissioning the fourth Endoscopy Room. As per Outcome 5 - As previous update, we do not believe the original position is deliverable given the slippage in commissioning the fourth Endoscopy Room which will be partially utilised from 10 November. We will re-profile the delivery position once the fourth room has a confirmed start date. In the interim we are focussed on identifying if weekend or other additional activity can partially mitigate this delay.
  As per Outcome 6 - MRI was previously the most significant risk within Radiology, though this has now been successful mitigated with a revised trajectory through the rest of the financial risk. Wait for MRI was a contributing factor to delays on the Cervical, Colorectal and Prostate pathways. Breach analysis data will continue to be monitored to ensure primary pathway breach reason due to wait for MRI decreases.

Commentary from
Paul Bachoo

Acute Medical Director



Cancer Pathway	**Are we seeing measurable change (since the last quarter) Q1 to Q2**	**If Not, why not**	***Cancer Pathway***	**Are we seeing measurable change (since the last quarter) Q1 to Q2**	**If Not, why not**
Breast	No – Declined	Delay in recruitment to clinic staffing Theatre Capacity	HPB	Yes - improved	
Breast Screening	No – Declined		Lung	Yes - improved	
Cervical	Yes - improved		Lymphoma	No - Declined	Delay in commencing one stop neck lump clinic – started 04/09/25
Cervical Screening	Yes - improved		OG	Yes - improved	
Colorectal	No – Declined	Endoscopy Capacity Theatre Capacity	Ovarian	Yes - improved	
Colorectal Screening	No – Declined		Plastic Surgery	Minor decline	Low volume pathway – performance can be variable
Dermatology	Yes - improved		Urology - Other	Yes – continue to meet performance	
Head & Neck	Yes - improved		Urology - Bladder	Performance maintained	Theatre Capacity
Head & Neck (OMFS)	Yes - improved		Urology – Prostate	Performance maintained	Diagnostic Capacity Theatre Capacity

1) Are we progressing towards our outcomes? (cont.)

- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***
  We are committed to increasing the proportion of people diagnosed and starting cancer treatment within 62 days of referral. Our approach is grounded in the principles of enabling balance by prioritising prevention and early diagnosis to improve clinical outcomes and overall performance. Optimising pathways, particularly through one-stop clinic models, supports efficiency and productivity by enabling faster diagnosis and reducing the need for multiple appointments. Putting people first means reducing lengthy waits for cancer diagnosis and treatment, which will significantly enhance patient experience and positively impact outcomes, including supporting more people to live well beyond a cancer diagnosis.

- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***

  Continued progress with national Framework for Effective Cancer Management (FECM) including dynamic tracking and escalation. The FECM is a guidance tool for Cancer Teams across NHS Scotland to improve and sustain performance of the National Cancer Standards. The new version of the Framework now incorporates 10 elements to consider when planning and delivering cancer services. Implementation of this framework will be monitored be a self-assessment tool due to be launched by the Centre for Sustainable Delivery (CfSD) in Q3.

  This tool has been developed to help you assess the Board's current progress in implementing the FECM and is designed to support understanding of local challenges and enablers, promote a shared language across Boards and pathways, and provide a consistent structure for comparison, learning, and collaboration. The outputs will help identify areas of good practice and common challenges, enabling national teams to target support and improvement actions where they are most needed. This is an evolving and interactive tool that will continue to be refined and enhanced over time, informed by user feedback and real-world experience. The first submission is due to be returned to CfSD by 19th December 2025.

2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***
  The key risks affecting performance are theatre capacity and endoscopy capacity. These risks interlinked within the Planned Care risk and captured within the Strategic Risk Register. Status of this risk has been mitigated sufficiently to be reduced from Very High risk to High due to ongoing work to improve waiting times following the award of additional funding for improvement projects. Breach analysis when cancer waiting times breach occurs, captures data on patient harm which is managed through adverse event processes within Datix.

- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., other Change Programmes Outcomes in Unscheduled Care, Value and Sustainability, workforce, infrastructure)?***

  Unintended consequences as a result of delays in cancer waiting times could include disease progression requiring more invasive diagnostics or treatments or increase in presentations to Unscheduled Care:

  - Patients with delayed cancer care may present as an emergency admissions with complications (e.g. bowel obstruction)
  - Potential increase in self-referrals to A&E as a result of delayed diagnostic or treatment pathways
  - Delay in diagnosis could lead to advanced stage cancers which require more resource intensive treatments, palliative care or urgent surgery leading to longer hospital stays
  - Delays in cancer pathways create competition for clinical support services (e.g. Radiology and pathology impacting other non-cancer specialties
  - Prioritisation of urgent cancer cases may worsen waiting times for planned care. This creates a cycle of delays across specialties, amplifying public dissatisfaction and health inequalities.

- ***How will the performance of this Programme reduce our strategic risks?***

  This Programme will reduce the strategic risk "Inability to meet population demand for Planned Care" by creating capacity to see additional patients. This is a key OIP deliverable and closely related to the ability to deliver high quality and timely care to the population of Grampian. The delivery of cancer waiting times performance is reliant on the delivery of planned care in pathways relating to cancer diagnosis and treatment.

Tier 3: Our Performance Spotlights – Planned Care

Outcome 5: Reduce waits so that 95% of New Endoscopy patients receive their Endoscopy within 6 weeks of referral by the end of March 2026

1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***
  We are not yet seeing measurable change. The key change will be the commencement of the fourth Endoscopy Room in ARI. Unfortunately the initial plan to locate this directly within the short stay unit has hit unexpected issues so the current plan requires a larger movement of clinical services to achieve the outcome. The fourth Endoscopy Room will commence the week of 10 November providing two-full day lists per week increasing each week thereafter until we achieve five days per week.

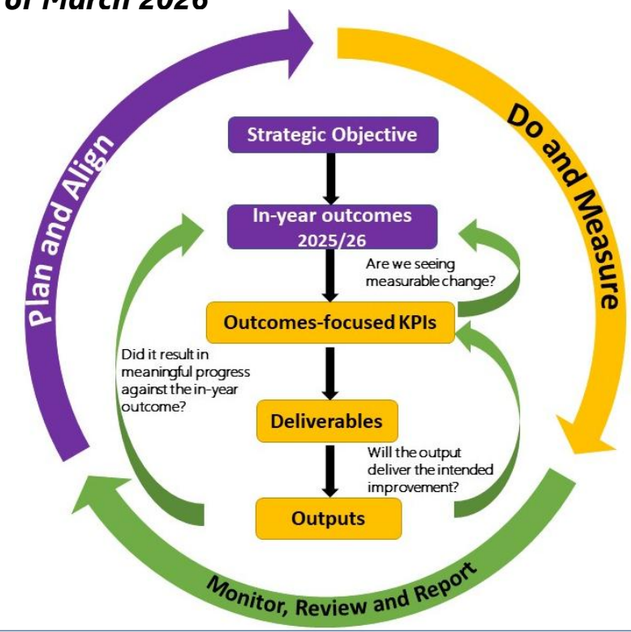
- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***
  As per the previous update we do not believe the original position is deliverable given the slippage in commissioning the fourth Endoscopy Room which will be partially utilised from 10 November. We will re-profile the delivery position once the fourth room has a confirmed start date. In the interim we are focussed on identifying if weekend or other additional activity can partially mitigate this delay.

- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***
  The principle of Realistic Medicine has supported progress towards this Outcome by ensuring care is person-centred and tailored to individual needs, which aligns with Putting People First. By focusing on reducing unnecessary variation in clinical practice, we have promoted equity in access and outcomes, contributing to the goal of reducing health inequalities. This approach also prioritises interventions that deliver clear patient benefit, while minimising unintended consequences and reducing waste within the system. Through shared decision-making and personalised care planning, patients are empowered to make informed choices, reinforcing the commitment to realistic, sustainable healthcare.

- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***
  We are addressing performance by applying scrutiny through real-time data monitoring, including breach analysis, patient tracking, and weekly sector-level reviews. All information is consolidated and mapped against the pathway in real time to identify issues promptly. If something hasn't worked, we will conduct a deeper dive to confirm delivery of agreed actions. Where actions have not been implemented, we will apply performance management measures and assess whether competing priorities are impacting progress. Alternative actions will then be considered to ensure performance is brought back on track.

Commentary from
Paul Bachoo

Acute Medical Director



2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***
  - The fragility of the Endoscopy Decontamination Service at ARI remains a risk with a percentage of washers currently out of action and a risk should further failure occur. We continue to liaise with estates colleagues around this risk which is expected to resolve by the New Year.
  - We continue to work to mitigate the impact via weekend working but this requires additional voluntary overtime by, in particular, support staff in the decontamination service.

- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., other Change Programmes Outcomes in Unscheduled Care, Value and Sustainability, workforce, infrastructure)?***
  We are not aware of any unintended consequences or impacts on other KPIs or programmes at this stage. However, we recognise the inherent challenge within a mixed service delivery model that combines urgent, planned, and emergency care for cancer and non-cancer patients on a single site. When resources are capped at maximum levels, allocation becomes complex.
  This risk is linked to delays in progressing the NTC-Grampian development and the proposed Endoscopy Suites, which has required identifying alternative physical space. Additionally, continued reliance on private sector contracts may increase the risk of transitioning to a substantive workforce model.
- ***How will the performance of this Programme reduce our strategic risks?***

  This Programme will reduce the strategic risk "Inability to meet population demand for Planned Care" by creating capacity to see additional patients.

Tier 3: Our Performance Spotlights – Planned Care

Outcome 6: Reduce waits so that 95% of Radiology patients receive their scan and report within 6 weeks of referral by the end of March 2026

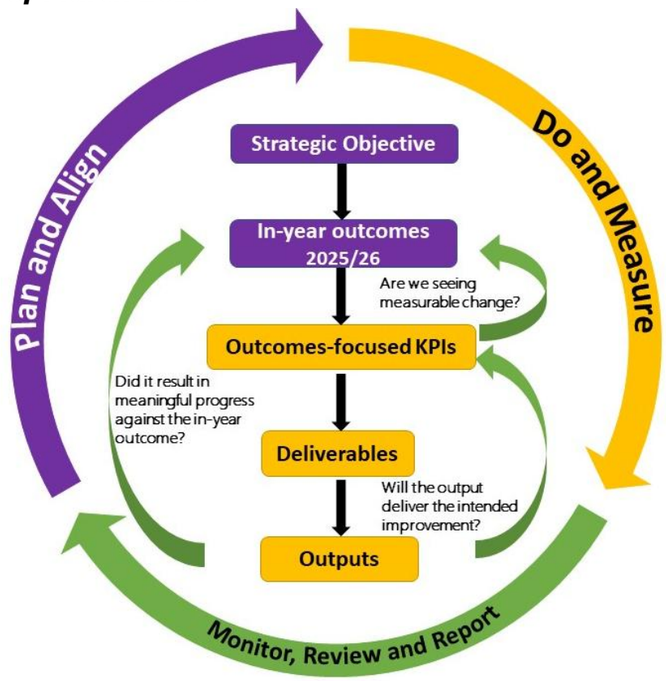
1) Are we progressing towards our outcomes?

Assures the Board that measurable improvement is evidenced through KPIs, that deliverables and outputs are influencing those KPIs, and that these combined efforts are driving progress towards the in-year outcome.

- ***Are we seeing measurable change (since the last quarter) in the outcome via its KPIs? If not, why not.***
  There has been progress since last quarter with the second MRI scanner now in place and operational. Additional mitigation capacity has also been secured at Raigmore and is planned to be put in place in Dr Gray's. Together this is expected to allow a return to our original trajectory for MRIs.
  The Ultrasound position remains challenging with vacant posts, and a shortage of Ultrasonographers nationally. Attempts remain under way to mitigate this via either agency or independent sector contracts.
- ***Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?***
  MRI was previously the most significant risk within Radiology, though this has now been successful mitigated with a revised trajectory through the rest of the financial risk.
  The key risk now is Ultrasound with an inability to recruit locum staffing. Mitigation is being explored via private sector options currently. The current backlog is 4000 ultrasounds, we will undertake a procurement exercise in Q3 to secure independent sector capacity to address this backlog. There is a £130k funding already set aside to facilitate this outcome.
- ***How have principles supported the work towards this Outcome? (i.e. Reducing health equalities, Putting People First)***
  The principle of Realistic Medicine has supported progress towards this Outcome by ensuring care is person-centred and tailored to individual needs, which aligns with Putting People First. By focusing on reducing unnecessary variation in clinical practice, we have promoted equity in access and outcomes, contributing to the goal of reducing health inequalities. This approach also prioritises interventions that deliver clear patient benefit, while minimising unintended consequences and reducing waste within the system. Through shared decision-making and personalised care planning, patients are empowered to make informed choices, reinforcing the commitment to realistic, sustainable healthcare.
- ***How are we addressing performance and getting it back on track? If something hasn't worked, what alternative course of action will be taken?***
  To get performance back on track, we have secured a location for the MRI service, including necessary infrastructure upgrades, and strengthened regional collaboration with NHS Highland to mitigate lost capacity. Additional infrastructure work and engagement with SG colleagues are underway to optimise capacity at DGH. Options continue to be explored to achieve similar outcomes for Ultrasound, which will further support additional capacity. The deployment of a mobile MRI unit, alongside support from NHS Highland, will enable delivery of the original six-week MRI performance trajectory. The mobile MRI service at DGH is scheduled to commence at the beginning of December.

Commentary from
Paul Bachoo

Acute Medical Director



2) Our key risks and mitigations:

Assures the Board that the system understands the barriers and systemic factors.
Assures the Board that credible actions and mitigations are in place to address those barriers.

- ***What are the key risks and challenges affecting performance? What actions and mitigations are in place to improve performance and reduce harm?***
  The key risk around Ultrasound is the national shortage of locum Ultrasonogaphers.
  We are working to maximise the use of Golden Jubilee National Hospital (GJNH) capacity, local Waiting List Initiative, overtime capacity and exploring off framework options.
- ***Are there any unintended consequences or impacts on other KPIs or areas (e.g., other Change Programmes Outcomes in Unscheduled Care, Value and Sustainability, workforce, infrastructure)?***
  We are not aware of any unintended consequences or impacts on other KPIs or programmes at this stage. However, we recognise the inherent challenge within a mixed service delivery model that combines urgent, planned, and emergency care for cancer and non-cancer patients on a single site. When resources are capped at maximum levels, allocation becomes complex. Achieving the 6 week standard is an underpinning necessity for achieving cancer target in particular as this is a part of many tumour group pathways.
- ***How will the performance of this Programme reduce our strategic risks?***
  This Programme will reduce the strategic risk of "Inability to meet population demand for Planned Care" by creating additional capacity to see more patients. By enabling timely access to radiology diagnostics, the Programme ensures patients receive investigations within an acceptable timeframe, directly mitigating the planned care risk and supporting improved flow across the pathway.

National Waiting Times Standards

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Jun 2025**: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
95% of unplanned A&E attendances to wait no longer than 4 hours from arrival to admission, discharge or transfer *(% admitted, discharged or transferred within 4 hours of arrival at an Emergency Department or Minor Injury Unit)*	95%	67.6%	64.3%	66.2%	65.7%	**63.2%**	8th Scotland: 69.3%	Overall A&E performance increased for the quarter ending March 2025, before decreasing over the subsequent two quarters. Performance remains lower than at the same time the previous year. Based on national data to the end of September, Grampian's performance remained 8th of the mainland Boards for the second consecutive quarter (having previously been 6th or 7th); we remain below the overall Scotland level. *The sustained high level of presentations to Emergency Departments over the period in question, as well as the consistent level of delayed discharges in the Acute settings which retains overall occupancy above 100%, has hampered the inability to significantly reduce the number of patients who wait for more than 4 hours at our Emergency Departments. Relieving exit block in our assessment areas through increased flow through the hospitals is key to positively impact this measure.*
All patients requiring one of the 8 key diagnostic tests will wait no longer than 6 weeks *(% of waits of 6 weeks or less at quarter end)*	100%	48.3%	50.1%	51.9%	47.6%	**41.7%**	11th Scotland: 54.4%	Performance improved each quarter through 2024 and into 2025, before a decrease for the latest two quarters to September 2025. Performance improved each quarter through 2024 and into 2025, before a decrease for the latest two quarters to September 2025. Based on national data to the end of September, we moved from 10th to 11th of the mainland Boards; we have been below the overall Scotland level for the last year. *The declining performance is due to the delayed commissioning of the fourth Endoscopy Room at ARI and the delayed ability to commence the deployment of the second MRI van due to facilities issues. The MRI issue is now resolved with a recovery plan in place through to Q4. The Endoscopy room continues to slip and is now planned for a partial opening at the end of November. A new risk has emerged in terms of Ultrasound and inability to secure locum staff. Mitigation planning is ongoing*

* Provisional local data

** National benchmarking data is for the quarter to June 2025; national data to September 2025 is not available at time of report preparation

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Jun 2025**: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
95% of New Outpatients should be seen within 12 weeks of referral *(% of waits where patient was seen at a new appointment within 12 weeks of referral)*	95%	64.0%	62.0%	58.8%	65.1%	**66.8%**	3rd Scotland: 62.7%	Performance increased for the second consecutive quarter, to September 2025. Based on national data to the end of September, we moved from 6th to 3rd of the mainland Boards, and remain above the overall Scotland level. *Our elective care plan does not directly address this metric with the focus on meeting no patients waiting more than 52 weeks by the end of this year. We have now hit our planned trajectory mark for this but are aware of upcoming delivery risks that will require to be mitigated*
All TTG patients should be seen within 12 weeks of decision to treat *(% of waits where patient was admitted for treatment within 12 weeks of decision to treat)*	100%	46.1%	48.1%	44.4%	47.9%	**50.3%**	7th Scotland: 56.7%	Performance improved for the second consecutive quarter, to September 2025. Based on national data to the end of September, we remain 7th of the mainland Boards; we remain consistently below the overall Scotland level. *Our elective care plan does not directly address this metric and is focussed on achieving no patients waiting more than 52 weeks. We are on track against our current performance trajectory. There is a key deliverable risk in terms of the CDU issue that is currently unquantified.*
95% of patients should wait no more than 31 days from decision to treat to first cancer treatment *(% of waits where patient was treated within 31 days of decision to treat)*	95%	88.4%	87.3%	90.0%	93.2%	**90.6%**	10th Scotland: 95.3% *(Quarter end June: benchmarking for Q end Sept will be not be available until 23/12)*	Following two consecutive quarterly improvements to June 2025, performance decreased for the quarter ending September. Based on national data to the end of June, we moved from 11th to 10th of the mainland Boards, and have been below the overall Scotland level since quarter ending June 2023. *The 31-day performance has fallen just short of the target trajectory as outlined in the planned care and cancer plan. This is not where we want to be which unfortunately is in part due to mobilisation of additional capacity through funded improvement projects.*

* Provisional local data

** National benchmarking data is for the quarter to June 2025; national data to September 2025 is not available at time of report preparation

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Jun 2025**: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
95% of patients receive first treatment within 62 days of urgent suspicion of cancer referral *(% of waits where patient was treated within 62 days of urgent suspected cancer referral)*	95%	53.9%	60.3%	52.5%	61.2%	**60.3%**	9th Scotland 69.9% *(benchmarking for Q end Sept will not be available until 23/12)*	Following an improvement to June 2025, performance decreased to September 2025. Based on national data to the end of June, we moved from 10th to 9th of the mainland Boards, having been 11th for the previous two quarters. We remain consistently below the overall Scotland level. *The 62-day performance has fallen just short of the target trajectory as outlined in the planned care and cancer plan. This is not where we want to be which unfortunately is in part due to mobilisation of additional capacity through funded improvement projects. Dynamic tracking and escalation of cancer patients continue to achieve the set-out trajectories.*
90% of children and young people should start treatment within 18 weeks of referral to CAMHS *(% of waits where patient started treatment within 18 weeks of referral)*	90%	97.9%	97.8%	97.7%	98.3%	**97.8%**	7th (meeting target) Scotland: 93.6% *(benchmarking for Q end Sept will be not be available until 02/12)*	Performance decreased for the quarter to September 2025, having improved the previous quarter. CAMHS have consistently met the target over the last two years. *The service continues to operate with reduced capacity due to various financial/funding challenges impacting recruitment of staff. NHS Grampian CAMHS is the lowest staffed Board in Scotland (16.2wte per 100,000 population). The CAMHS service continues to meet 18 week RTT performance targets and focussed work is progressing around Partnership (2nd appointment waits). We are engaged with SG and health intelligence to continue our DCAQ data analysis and trajectory planning. With the EMHOF funding allocation received we hope to be able to maintain performance with associated greater security of clinical resource.*

* Provisional local data

** National benchmarking data is for the quarter to June 2025; national data to September 2025 is not available at time of report preparation

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Sep 2024**	**Quarter end Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Jun 2025**: ranked 1st = best performing)	**Commentary** *Comment from service on NHSG's position*
90% of people should start their treatment within 18 weeks of referral to psychological therapies *(% of waits where patient started treatment within 18 weeks of referral)*	90%	80.4%	80.4%	77.8%	79.2%	**80.5%**	5th Scotland: 78.3% *(benchmarking for Q end Sept will be available on 02/12)*	Performance increased for the second consecutive quarter, to September 2025. Based on national data to the end of June, we have moved from 6th to 5th position of the mainland Boards, and have returned to above the overall Scotland level. *Performance has been maintained this quarter. We are engaged with SG and health intelligence to continue our DCAQ data analysis and trajectory planning. With the EMHOF funding allocation received recently we should be able to maintain performance with associated greater security of clinical resource*
90% of patients will commence IVF treatment within 52 weeks *(% of waits for patients screened at an IVF centre within 52 weeks of a referral from secondary care to one of the four specialist tertiary care centres)*	90%	97.8%	97.7%	98.3%	100%	**100%**	Scotland: 100.0% *(benchmarking for Q end Sept will be available on 25/11)*	We continue to consistently achieve the target *We at Aberdeen Fertility centre have been working on improving our KPI's such as waiting times and clinical activity to benefit patient experience and identify a clearer and defined pathway. We continue to offer appointments at a fraction of the national average. We are experiencing a large influx of non-UK nationals and patients on visa statuses which can delay the referral to treatment timeline however we have been working closely with the Overseas team to combat this efficiently without reaching over 52 weeks wait.*

From PHS national waiting times publications

* Provisional local data

** National benchmarking data is for the quarter to June 2025; national data to September 2025 is not available at time of report preparation

Appendix 1 - Our Approach to Delivering 2025/26 Priorities

What do we need to deliver by 31st March 2026?

NHS Grampian
Annual Delivery Plan (ADP) Objectives

- Balance the system capacity to meet healthcare and population needs whilst delivering financial targets for 2025/26 in line with our finding balance principles
- Optimising system capacity and efficiency to enable wellness and respond to illness resulting in reduced clinical risk

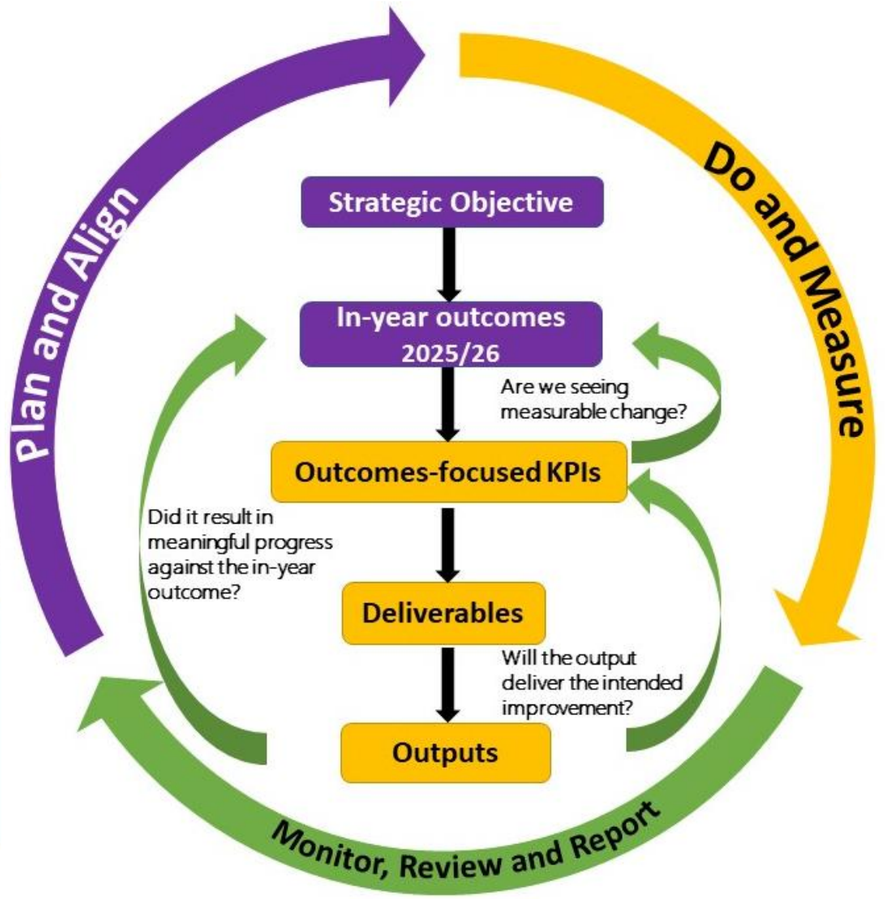
Three Change Programmes		
1 Outcome	4 Outcomes	6 Outcomes
4 KPIs	10 KPIs	6 KPIs
1 Deliverable	9 Deliverables	6 Deliverables
3 Outputs	27 Outputs	20 Outputs
Value & Sustainability	Unscheduled Care	Planned Care

Scottish Government
Operational Improvement Plan (OIP)

The plan brings focus to four critical areas that the Government is committed to delivering, to help protect the quality and safety of care, supported by the increased investment for health and social care in the 2025-26 Scottish Budget: improving access to treatment.

Four Critical Areas			
2 Focus Areas	8 Focus Areas	4 Focus Areas	6 Focus Areas
Prevention	Shifting the balance of care	Improving access to treatment	Improve access via Digital and Innovation

NOTE: Detailed OIP update is included in a separate dedicated report



NHS Grampian
Enhanced Performance Model
(2025/26)

Appendix 2 - Reading Guide

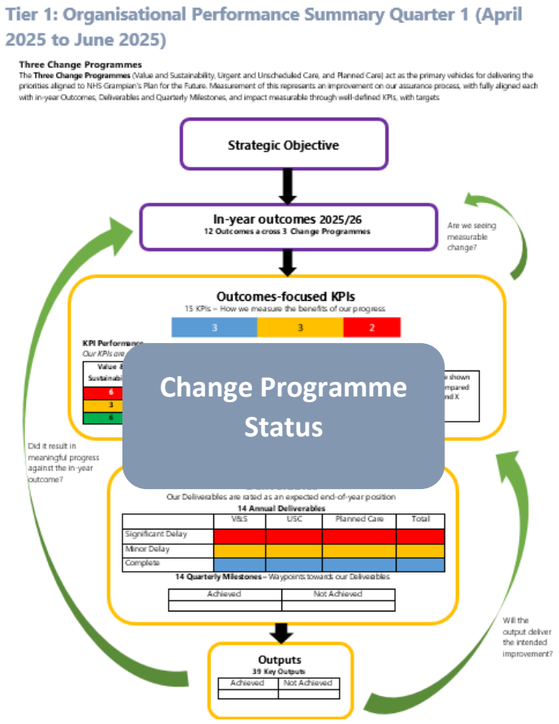
The format of this report supports a tiered approach on how we review performance information. The purpose of the reading guide is to help you navigate the sections in this report. These are intended to flow, enabling you the flexibility to view high level or drill down data.

(Tier 1)
Our Organisational Performance Summary
(High level overview of "How we are doing" as an NHS Board across our strategic intent)

(Tier 2)
Our Deliverables, KPIs status
(Summary of Key Performance Indicators and Deliverables across our Change Programmes and Operational Improvement Plan)

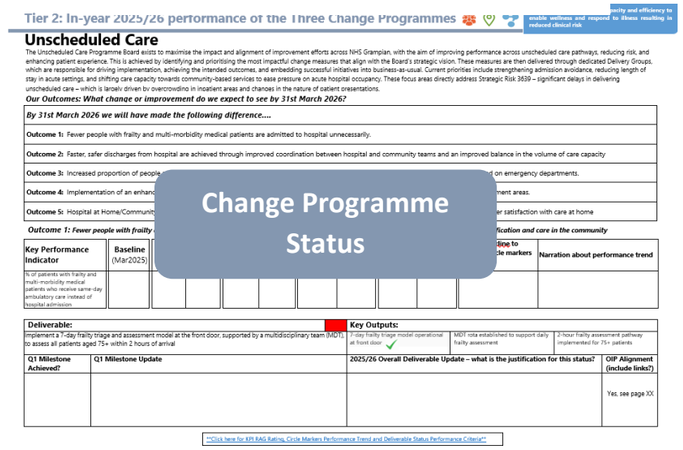
(Tier 3)
Performance Spotlights
(Detailed focus on adverse performance with detailed commentaries on our in-year Outcomes)

Our Board Performance Summary across our Change Programmes:

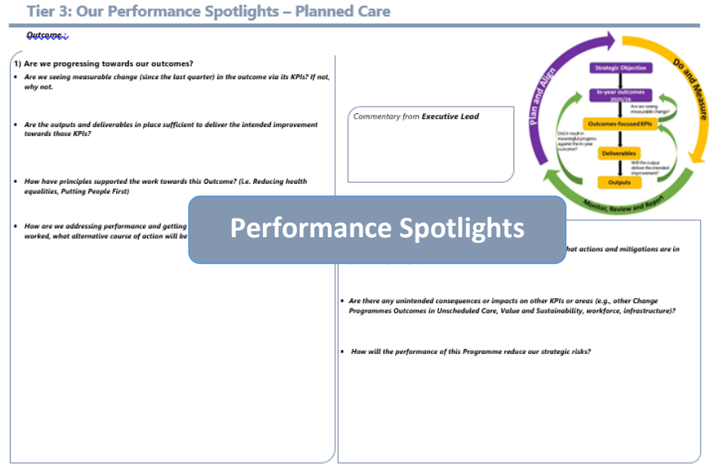


A high level overview of our performance as a Board across Value & Sustainability, Unscheduled Care, and Planned Care

In this section, Performance focuses on the outcomes for featured Change Programmes.



Within each Change Programme, aligned to its own Objective, you will be presented with in-year Outcomes, with targeted KPIs and Deliverables to demonstrate performance, supported by the completion of key Outputs.



In this section, our Performance Spotlights will provide more drilled down data and narratives, highlighting areas of adverse performance against our in-year Outcomes from the Three Change Programmes.

The detailed commentaries from Executive Leads cover:

- Our Key Risks, Challenges and Impacts
- Our Mitigations and Recovery Actions

Key spotlight components will focus on Outcomes that have one or more KPI or Deliverable with a RED status RAG rating, and aim to provide both an explanation of the performance and outline actions towards future improvement.

Appendix 2 - Definitions

The following definitions will support you in your understanding of the various key words found throughout the report.

- **3 Change Programmes**
  These act as the primary vehicles for delivering the priorities aligned to NHS Grampian's Plan for the Future. Certain aspects of the Programmes such as Planned Care, Unscheduled Care should also drive improvement across focus areas in the Operational Improvement Plan.
- **Operational Improvement Plan (OIP)**
  The Operational Improvement Plan sets out how the Scottish Government plans to improve access to treatment, reduce waiting times and shift the balance of care from hospitals to primary care**.**
- **Key Performance Indicator (KPI)**
  A KPI is a carefully selected metric, directly linked to our Outcomes and indicative of overall performance. KPIs are chosen to provide actionable insights into the progress and success of specific goals and objectives, and help assess performance and drive decision-making.
- **Deliverables**
  A key deliverable is a task or project activities taking place, which will help us achieve our Outcomes. Typically outlined at the outset, key deliverables are quantifiable and linked to quarterly milestones for monitoring progress. Milestones serve as markers in time to track and measure progress
- **Outcomes**
  Outcomes are the specific, immediate or intermediate, tangible and measurable results or changes resulting directly from a programme/project's activities or interventions. They reflect changes in behaviour, knowledge, skills, attitudes, or conditions and are used to assess progress towards long-term goals and impact.
- **Baseline**
  This indicates the level of performance against each indicator at the end of 2025/26, serving as a reference point against which progress or change can be evaluated.
- **Targets**
  These indicate the performance we are seeking to achieve for the KPIs each quarter as we progress towards the overall Outcomes by March 2026. Each KPI will have quarterly targets, some of which will be level throughout the year and some will be cumulative.
- **Spark Graphs**

Each KPI has a spark graph which show the performance trend over the course of 12 months, where data is available (black line), together with the 2025/26 target (blue line)