

How are we doing?

Q1 2025/26 Board Performance Report

October 2025



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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:

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- 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.

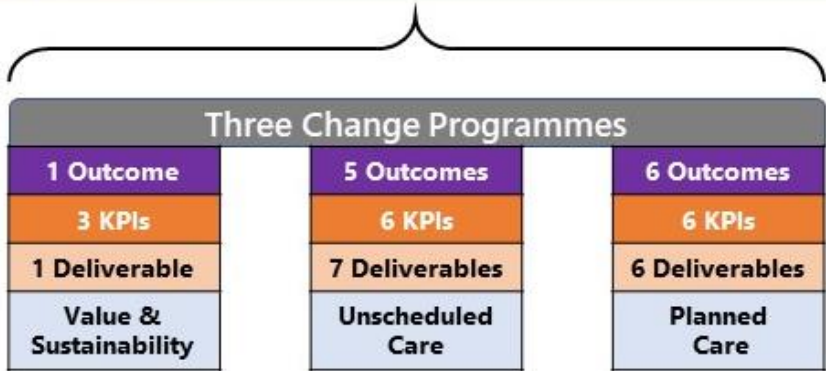
In addition, the report reflects NHS Grampian's contribution to the Scottish Government's Operational Improvement Plan (OIP), which sets out national priorities for improving access, efficiency, and flow across the health and care system. These priorities are embedded within the relevant programmes to 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.

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

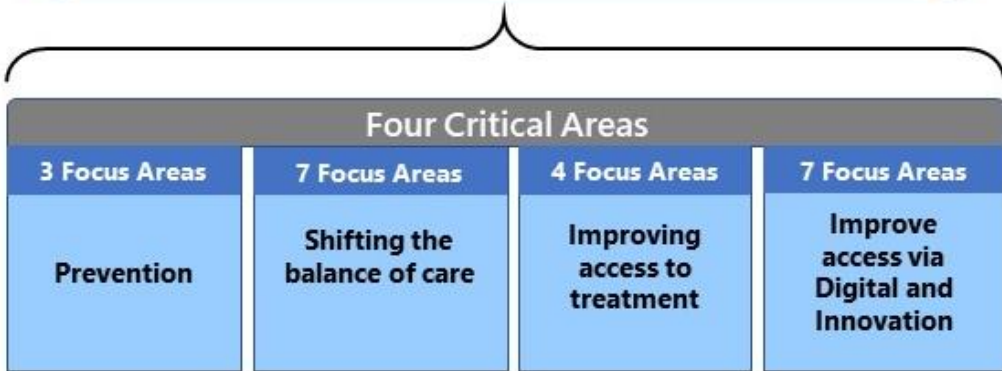
NHS Grampian Annual Delivery Plan (ADP) Objectives

- ❖ 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



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.



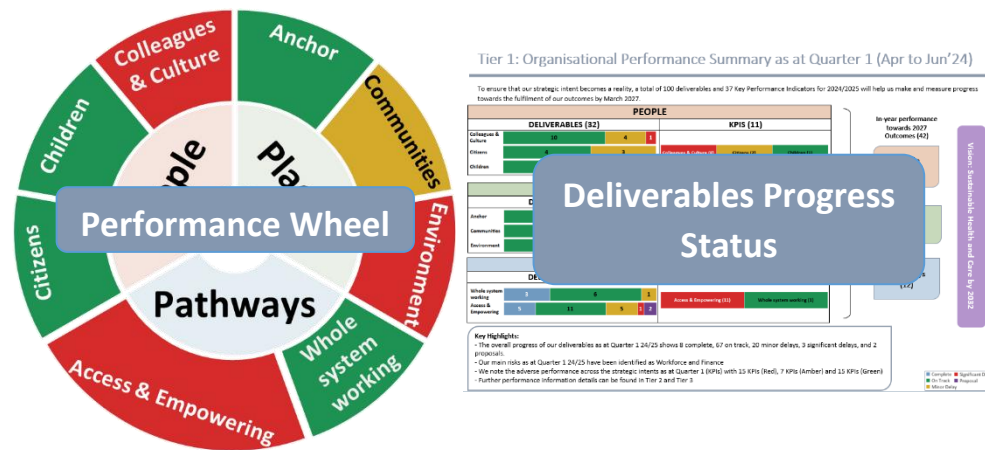
NHS Grampian
Enhanced Performance Model
(2025/26)

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.

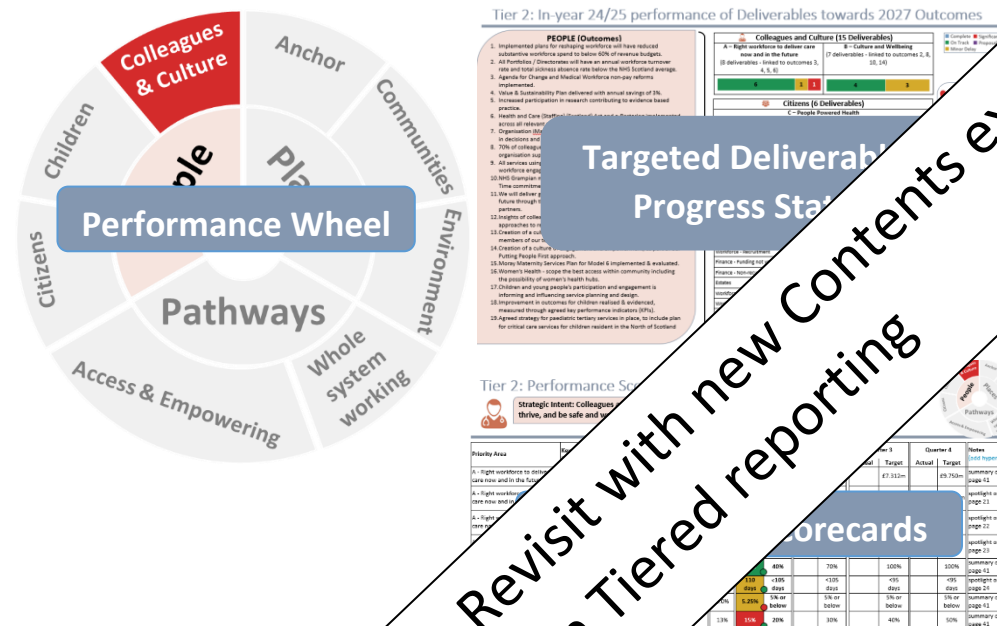
(Tier 1)

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



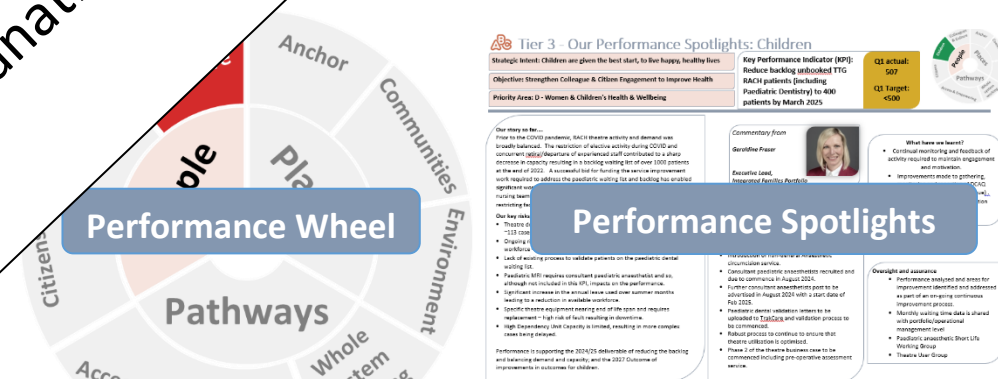
(Tier 2)

Our Performance Scorecards and Deliverables
(Summary of Key Performance Indicators and Deliverables across categories in strategic intent)



(Tier 3)

Performance Spotlights
(Detailed focus on adverse or favourable performance with detailed commentaries)



This section covers two key areas of focus:

1) Our Board Performance Summary across our strategic intent:

The Performance Wheel and Deliverables above indicate a high level overview of our performance as a Board across each of our strategic intent set out in People, Places and Pathways. The Red, Amber, Green (RAG) rating assessment criteria for the Key Performance Indicators (KPIs) and progress status of our Deliverables can be found on the next page.

2) Our Board Performance Summary across key critical areas of our organisation:

A high level overview to provide a wider landscape not specifically covered via People, Places and Pathways but critically important for the organisation will be included here.

In this section, the Performance Wheel will feature throughout and apply a focus on the strategic intent illustrated by its RAG rating and target. The Performance Scorecards and targeted Deliverables are aligned to the strategic intent, objectives and areas set out in the Delivery Plan.

We will expand its overall RAG rating e.g. Access into the Performance Scorecards showing performance against those Key Performance Indicators considered to be most important and as agreed by the Board and status reporting of the Deliverables as per the Annual Delivery Plan.

Definitions of the key headings on the Performance Scorecards and Deliverables can be found in the next page.

In this section, our Performance Spotlights will provide more drilled down data highlighting areas of favourable and adverse performance from the Performance Scorecards and Deliverables.

The detailed commentaries from Executive Leads cover:

- Our Story so far
- Our Key Risks, Challenges and Impacts
- Our Mitigations and Recovery Actions
- What have we learnt?
- Our Oversight and Assurance

Key spotlight components will be subject to change depending on the areas of focus for the period of reporting.

KEY

(A) RAG Ratings for the Performance Scorecards:

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

| Assessment Rating | Criteria |
|-------------------|--|
| Red | Current performance is outwith the standard/target by more than 5% |
| Amber | Current performance is within 5% of the standard/target |
| Green | Current performance is meeting/exceeding the standard/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 |
|--------|---|
| ● | Improvement in performance from previous quarter |
| ● | Decline in performance from previous quarter |
| ● | There has been no change 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 31 st March 2026 | |
|---------------------------|----|---|---|
| Yes | No | <div>Complete</div> <div>Minor Delay</div> | <div>Significant Delay</div> <div>Postponed</div> |

Click to return to:

- [Value & Sustainability](#)
- [Unscheduled Care](#)
- [Planned Care](#)

DEFINITIONS

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

✚ Strategic Intent

This means People, Places and Pathways as set out in the Plan for the Future.

✚ Priority Areas

These are the priorities that set out in our delivery plan that helps to align our performance, activities to meet our objectives and strategic intent.

✚ Key Performance Indicator (KPI)

A KPI is a carefully selected metric, directly linked to our strategic objectives 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 an outcome of a task or project activities taking place. 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 2024/25, 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 objective by March 2026. Each KPI will have quarterly targets, some which will be level throughout the year and some will be cumulative.

✚ 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.

✚ Trend Graphs



Each KPI has a trend graph which shows performance trends over the course of 12 months, where data is available

PLACEHOLDER – Executive Summary to be retained

Voice of our Citizens

Complaints received Quarters 3 and 4 2024/25

In the second half of 2024/25, NHS Grampian received 793 complaints; the Integrated Specialist Care Portfolio accounted for 27% of these, we continue to receive a high proportion of complaints in relation to waiting times.

- Complaints received decreased by 2% compared to the first half of 2024/25 and increased by 8% from the same period in 2023/24.

complaints received equate to 0.1% of activity*

- Of the 793 complaints received Advocacy services were used by complainants in only 8 complaints. MSP/MP supported 53 complainants, on several occasions more than 1 MP/MSP was involved in the same complaint. Complaints raised by MP/MSP follow the same process as all other complaints. The Scottish Government followed up on 3 complaints they set a deadline for response, the feedback service collates the response which is sent directly to the Chief Executive support team.

- The number of complaints open at month end had been trending up in the year to August 2024, before decreasing to January 2025. An increase in the number of complaints received in February, together with a decrease in complaint closures in that month has resulted in an increase in the number of complaints open at month end.

Complaints continue to be received via feedback cards as well as Care Opinion, and work is ongoing to encourage use of Care Opinion to record feedback in real time.

* Inpatient, Outpatient, Emergency Department for the period 01/10/24-31/03/25

Timescales

Performance in meeting timescales has improved compared with the same period in the previous year.

24% of complaints were closed by early resolution

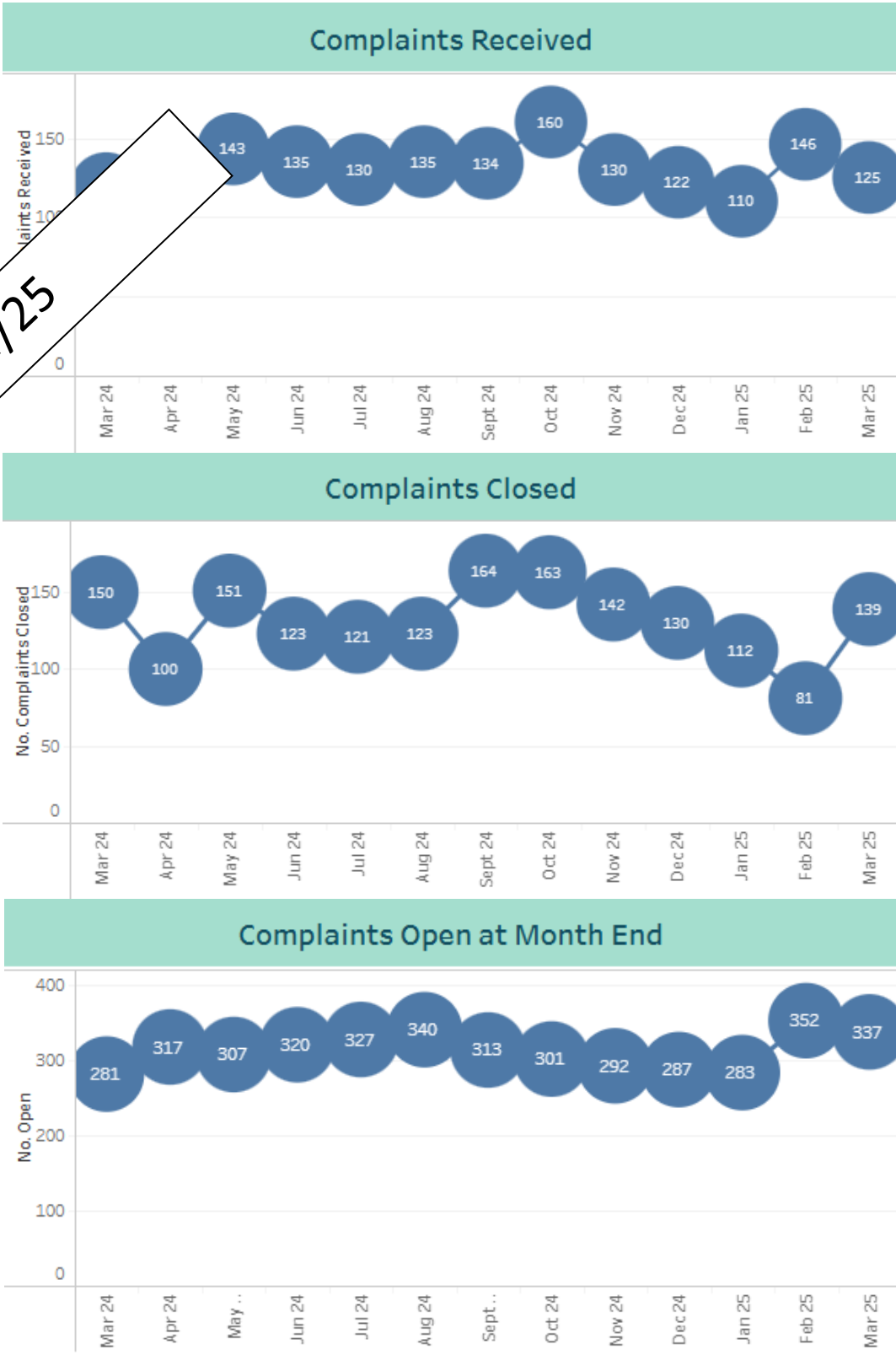
- 24% of complaints were resolved via early resolution (compared to 16% in the previous six months), with an average response time of 7.1 working days.
- 43% were closed within the Model Complaints Handling Procedure target of 20 days, an improvement from 35% for the same period the previous year.

It is best practice to make contact by telephone with a complainant at the earliest opportunity. We have up to 5 working days, or up to 10 if an extension is requested to resolve a complaint under early resolution. This is the best outcome for the complainant as they feel listened to and can expand on the points raised if necessary. It is also of benefit to staff as it allows them to focus on patient care delivery. Sometimes it is possible to agree with the complainant at the initial call what it is that they want us to do and resolve the complaint at that point. Regardless the early contact helps the staff member investigating the complaint to fully understand the most important issues and agree what will be investigated.

We received an average of 31 complaints per week

PLACEHOLDER - Example from Q4 2024/25

Average time to respond by early resolution was 7.1 working days



Themes

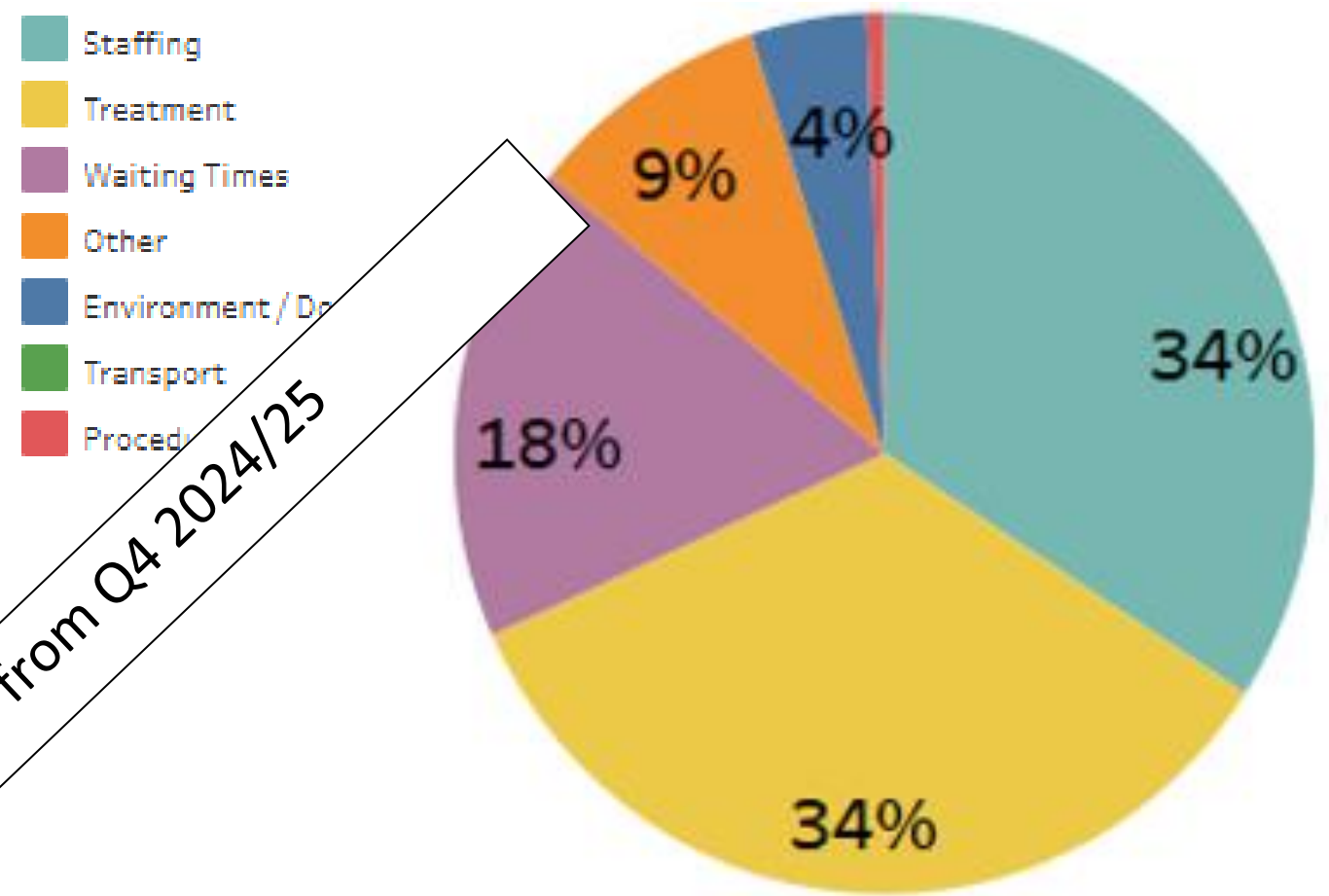
For the latest six months, staffing and treatment have been the primary themes of complaints, with 34% of complaints attributable to each. Previously staffing was the most common theme, accounting for 41% of complaints.

Breaking this down, the main sub-themes for complaints regarding staffing were oral communication (40%) and staff attitude and behaviour (29%); for treatment, all complaints came under the sub-theme of clinical treatment (100%).

We held a 2-hour critical thinking session in November focusing on communication, which provided the opportunity for Quality Improvement trained colleagues across our system to facilitate and challenge us to explore fresh approaches and bold ideas to this persistent issue. Approximately 50 colleagues of varying roles across NHS Grampian were in attendance. We had ambitious aims for our session to build a movement of colleagues across our system on one shared purpose and project, provide colleagues with a chance to share their ideas, hear lived experience and gather ideas and agreed an overall project aim. 83% of colleagues said they had opportunity to share your ideas and listened to, 67% expanded their network as result of this session, and 83% found the session helpful. Key themes from our good examples included kindness, living to our NHS Grampian values, being honest and approachable, clarity with action focus, and acknowledging learning in encouraging listening and checking more on understanding.

 **Staffing and Clinical Treatment are the most common complaint themes** 

Complaint Themes: 01/10/2024 to 31/03/2025
Note - each complaint may have more than one issue



PLACEHOLDER - Example from Q4 2024/25

Communication - related complaint

Lack of suitable specialist equipment for patient to manage personal hygiene

Actions taken to improve communication

Equipment located and agreement that it will be available for loan on future in patient stays.

Patient complained of lengthy delays in receiving a course of daily chemotherapy

It was identified that there were simple administrative errors. The Aseptic team has implemented a revised electronic worklist system, and also introduced a label which is applied to prescriptions to highlight they are multiday.

Patient advised where to wait for their outpatient appointment, was not called in for appointment. Waited for an hour and then let reception know they were leaving. Received a letter saying removed from list

Service called patient and apologised. A new appointment was made during the call. The patient should have been asked to wait in a smaller dedicated area, not the main waiting room. Complaint shared with the team who now have a board to check to ensure patients are in the correct area.

Top level review of the three Change Programmes, OIP. Overall Deliverable and KPI Performance RAG status. Key Highlights. Detailed presentation and content to be developed

Key highlights:



Value & Sustainability Introduction of this Programme. What is this Programme about, what are we trying to do? How is this Programme addressing our Strategic Risks?


The V&S programme focuses on achieving financial balance, through identifying and implementing efficiency improvements and cost savings measures. This is achieved by becoming more efficient and increase productivity, removing unnecessary bureaucracy and waste from processes, and supporting departments in identifying areas of improvements is a key elements of the programme. The programme supports the mitigation on the following strategic risks: inability to achieve the aspirations set out in Plan for the Future due to financial resource constraints and inefficiencies. Insufficient change and innovation to create a system which can meet demand and deliver on our strategic intent.

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 £30.9m through delivery of sustainable, cash-releasing, and efficiency savings across the organisation by 31st March 2026 |

| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| Total value of cash-releasing savings delivered (YTD and FYE) | | | | | | | | | | | |
| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| % of planned recurring savings achieved by 31 March 2026 | | | | | | | | | | | |
| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| Variance between forecast and actual savings (FYE) | | | | | | | | | | | |

[**Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**](#)

| Deliverable: | | | Key Outputs: | | |
|---|---------------------|--|---|---|---|
| Implement and maintain a Value & Sustainability (V&S) programme with clear governance, oversight, and accountability to deliver sustainable financial savings | | | V&S schemes are tracked using an agreed framework  | Programme updates go to Financial Recovery Board and Assurance Committees | KPI reporting is embedded in V&S tracking for outcome assurance |
| Q1 Milestone Achieved? | Q1 Milestone Update | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | OIP Alignment (include links?) |
| Yes | | | | | |

Tier 3: Our Performance Spotlights - Value & Sustainability

Outcome: Insert text here

Commentary from

Executive Lead

Our key risks, challenges and impacts...

- a) What are the key risks and challenges affecting performance?
- b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)?
- c) How have enablers supported the work towards this Outcome? (Workforce, Digital, Infrastructure, Innovation)
- d) How have principles supported the work towards this Outcome? (i.e. Reducing health inequalities, Putting People First)
- e) How will the performance of this Programme reduce our intolerable strategic risks?

Our mitigation and recovery actions

- a) What actions and mitigations are in place to improve performance and reduce harm?
- b) How will we measure the expected impact, and what could prevent success?
- c) If something hasn't worked, what alternative course of action will be taken?
- d) How are we addressing performance and getting it back on track?



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: Fewer people with frailty and multi-morbidity medical patients are admitted to hospital unnecessarily. |
| Outcome 2: Faster, safer discharges from hospital are achieved through improved 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), 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. |
| Outcome 5: Hospital at Home/Community hospital capacity and Community Response services increase flow across the system and increase patient and carer satisfaction with care at home |

Outcome 1: Fewer people with frailty and multi-morbidity medical patients are admitted to hospital unnecessarily through improved early identification and care in the community

| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
|--|--------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| % of patients with frailty and multi-morbidity medical patients who receive same-day ambulatory care instead of hospital admission | | | | | | | | | | | |

| Deliverable: | | | 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  | | MDT rota established to support daily frailty assessment | 2-hour frailty assessment pathway implemented for 75+ patients |
| Q1 Milestone Achieved? | Q1 Milestone Update | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | Yes, see page XX |

[**Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**](#)

| | | | | | | | |
|---|----------------------------|--|--|---|--|---|---------------------------------------|
| Deliverable: | | | | Key Outputs: | | | |
| Implement an urgent care hub to stream medical patients to the most appropriate treatment pathways and an integrated discharge hub to minimise length of stay in an acute setting | | | | Urgent care hub operational with streaming pathways and referral criteria  | Integrated discharge hub established with MDT and 7-day staffing | SOPs in place to support triage and discharge processes | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Yes, see page XX |

Outcome 2: Faster, safer discharges from hospital are achieved through improved 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 | | Insert sparkline to support circle markers | Narration about performance trend |
|--|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| % of patients supported by Hospital at Home or Community Response services who are discharged from hospital and not readmitted within 7 days | | | | | | | | | | | |

| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
|--|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| Achieve a 15% reduction in the volume of Delayed Discharges by March 2026 (compared to the 2024/25 baseline) | | | | | | | | | | | |

| | | | | | | | |
|--|----------------------------|--|--|--|--|--|---------------------------------------|
| Deliverable: | | | | 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 | Referral process in place to Hospital at Home and Community Response | 24-hour follow-up process established post-discharge | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Y, see page XX |

[**Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**](#)

| | | | | | | | |
|--|----------------------------|--|--|--|---|---|---------------------------------------|
| Deliverable: | | | | 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 | Admission criteria and pathways established for direct community access | Monitoring framework in place to track LOS and outflow impact | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Y, see page XX |

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

| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| % of urgent care contacts routed away from ED through NHS 24, Flow Navigation Centres or other alternative care pathways in order to reduce occupancy pressure in inpatient areas | | | | | | | | | | | |

| | | | | | | | |
|---|----------------------------|--|--|--|--|--|---------------------------------------|
| Deliverable: | | | | 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 | Integrated digital and clinical interface with NHS 24 and primary care | Standardised triage protocols in place for urgent care referrals | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Y, see page XX |

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 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| % of ED patients seen, treated, admitted or discharged within 4 hours | | | | | | | | | | | |

[**Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**](#)

| | | | | | | | |
|--|----------------------------|--|--|--|---|---|---------------------------------------|
| Deliverable: | | | | Key Outputs: | | | |
| Fully implement Unscheduled Care improvement measures in relevant parts of the system by March 2026, including Same Day Emergency Care (SDEC) /Frailty @ the Front Door, Urgent Care Hub, Integrated Discharge Lounge, Discharge to Assess | | | | SDEC and Frailty @ the Front Door models operational across relevant sites | Urgent Care Hub and Integrated Discharge Lounge fully implemented | Discharge to Assess pathways embedded with supporting protocols | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Y, see page XX |

Outcome 5: Hospital at Home/Community hospital capacity and Community Response services increase flow across the system and increase patient and carer satisfaction with care at home.

| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| Average length of stay in acute and community hospitals reduces to ≤ 10 days | | | | | | | | | | | |
| The KPI: “% of patients accepted into Hospital at Home service who rate their experience as ‘good’ or ‘excellent’ in post-discharge surveys” will be activated following full implementation of feedback system by March 2026 | | | | | | | | | | | |

| | | | | | | | |
|--|----------------------------|--|--|--|--|--|---------------------------------------|
| Deliverable: | | | | Key Outputs: | | | |
| Introduced a standardised post discharge feedback system for Hospital at Home and Community Response services, capturing real time patient and carer experience by March 2026. | | | | Standardised feedback system implemented across both services | Real-time data capture process in place for patient and carer experience | Feedback reporting mechanism established for service improvement | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Y, see page XX |

[**Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**](#)

Tier 3: Our Performance Spotlights – Unscheduled Care

Outcome: Insert text here

Commentary from

Executive Lead

Our key risks, challenges and impacts...

a) What are the key risks and challenges affecting performance?

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)?

c) How have enablers supported the work towards this Outcome? (Workforce, Digital, Infrastructure, Innovation)

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

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

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

b) How will we measure the expected impact, and what could prevent success?

c) If something hasn't worked, what alternative course of action will be taken?

d) How are we addressing performance and getting it back on track?



Planned Care

Reducing the waits for elective treatment and diagnostics within NHS Grampian. Within 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 reduces this risk directly.

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. |

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 | | Insert sparkline to support circle markers | Narration about performance trend |
|--|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| <12,181 New Outpatients waiting over 52 weeks by the end of March 2026 | | | | | | | | | | | |

| | | | | | | | |
|--|---------------------|--|--|---|---|---|--------------------------------|
| Deliverable: | | | | Key Outputs: | | | |
| 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 | | | | All planned care projects delivered to time, budget and scope | Outpatient capacity delivered increasingly within core service levels | Redesigned pathways implemented to improve flow and reduce backlog growth | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | OIP Alignment (include links?) |
| | | | | | | | Y, see page XX |

[**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 procedure.

| Key Performance Indicator | Baseline (Mar2025) | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Insert sparkline to support circle markers | Narration about performance trend |
|--|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| <3,703 TTG patients waiting over 52 weeks by the end of March 2026 | | | | | | | | | | | |

| Deliverable: | | | | | | Key Outputs: | | | | |
|--|---------------------|--|--|--|---|--------------|--|--|---|--|
| Reinstate the Short Stay Theatre Complex at ARI, stream and merge all NHS Grampian assets, work regionally to reduce waits | | | | | Short Stay Theatre Complex at ARI fully operational and staffed | | Elective assets across optimised through merged scheduling | | Regional mutual aid delivered to reduce longest waits | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | | OIP Alignment (include links?) | |
| | | | | | | | | | Y, see page XX | |

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 | | Insert sparkline to support circle markers | Narration about performance trend |
|--|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | 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 | | | | | | | | | | | |

| Deliverable: | | | | | | Key Outputs: | | | | |
|--|---------------------|--|--|--|---|--------------|---|--|---|--------------------------------|
| 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 | | | | | Cancer improvement projects delivered to time, budget and scope | | Capacity secured to deliver standard within core capacity | | Treatment coordination processes strengthened to reduce delays from decision to treat to first intervention | |
| Q1 Milestone Achieved? | Q1 Milestone Update | | | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | | | | OIP Alignment (include links?) |
| | | | | | | | | | | Y, see page XX |

[**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 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | 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 | | | | | | | | | | | |

| Deliverable: | | | Key Outputs: | | |
|--|---------------------|--|---|---|---|
| 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 | | | Cancer improvement projects delivered to time, budget and scope | Capacity secured to deliver standard within core capacity | Treatment coordination processes strengthened to reduce delays from decision to treat to first intervention |
| Q1 Milestone Achieved? | Q1 Milestone Update | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | OIP Alignment (include links?) |
| | | | | | Y, see page XX |

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 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| 95% compliance with 6 weeks within the 8 key diagnostic tests dataset | | | | | | | | | | | |

| Deliverable: | | | Key Outputs: | | |
|---|---------------------|--|---|--|---|
| Open a fourth endoscopy room at ARI, merge into a single Endoscopy Service for Grampian, restart the EndoSign service | | | ARI fourth endoscopy room opened and staffed | Single Endoscopy service model in place with unified staffing and scheduling | EndoSign service reinstated to support triage and reduce unnecessary procedures |
| Q1 Milestone Achieved? | Q1 Milestone Update | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | OIP Alignment (include links?) |
| | | | | | Y, see page XX |

[**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 | | Insert sparkline to support circle markers | Narration about performance trend |
|---|-----------------------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|--|-----------------------------------|
| | | Actual | Target | Actual | Target | Actual | Target | Actual | Target | | |
| 95% compliance with 6 weeks within the 8 key diagnostic tests dataset | | | | | | | | | | | |

| Deliverable: | | | Key Outputs: | | |
|---|---------------------|--|---|--|---------------------------------------|
| Deploy the second mobile MRI, implement funded improvements in capacity, in particular 7 day working as core capacity | | | Second mobile MRI deployed and operational to increase scanning | 7 day radiology service implemented as core capacity model | Funded capacity improvements in place |
| Q1 Milestone Achieved? | Q1 Milestone Update | | 2025/26 Overall Deliverable Update – what is the justification for this status? | | OIP Alignment (include links?) |
| | | | | | Y, see page XX |

[**Click here for KPI RAG Rating, Circle Markers Performance Trend and Deliverable Status Performance Criteria**](#)

Tier 3: Our Performance Spotlights – Planned Care

Outcome: Insert text here

Commentary from

Executive Lead

Our key risks, challenges and impacts...

a) What are the key risks and challenges affecting performance?

b) Are there any unintended consequences or impacts on other KPIs or areas (e.g., workforce, infrastructure)?

c) How have enablers supported the work towards this Outcome? (Workforce, Digital, Infrastructure, Innovation)

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

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

Our mitigation and recovery actions

a) What actions and mitigations are in place to improve performance and reduce harm?

b) How will we measure the expected impact, and what could prevent success?

c) If something hasn't worked, what alternative course of action will be taken?

d) How are we addressing performance and getting it back on track?

Operational Improvement Plan-2025/26

The NHS Scotland Operational Improvement Plan is intended as a short term, realistic support to local health boards existing planning, and is the first part of a longer term commitment of reform and renewal to ensure long-term sustainability, reduce health inequalities, further harness the benefits of digital technology, and improve population health outcomes in Scotland, while focussing on the following 4 critical areas:

| | |
|---|--|
| Improving access to treatment | Improving access to health and social care services through digital and technological innovation |
| Shifting the balance of care | Prevention – ensuring we work with people to prevent illness and more proactively meet their needs |

For OIP topics that are data-driven and lend themselves to quantitative reporting

| What is it? | What are we trying to achieve by 31 st March'26 | Are we on target? | If not, what actions have been taken to recover from this position? | Exec Lead | Notes (insert hyperlinks to national frameworks) |
|-------------------------------|---|-------------------|---|--|--|
| <i>This is about 52 weeks</i> | <i>Insert KPI here No more than 12181 patients waiting more than 52 weeks</i> | <i>No</i> | <i>Insert justification here</i> | <i>Paul Bachoo, Acute Medical Director</i> | |

| What is it? | What are we trying to achieve by 31 st March'26 | Are we on target? | If yes, what actions can be taken to sustain this position? | Exec Lead | Notes (insert hyperlinks to national frameworks) |
|-------------------------------|---|-------------------|---|--|--|
| <i>This is about 52 weeks</i> | <i>Insert KPI here No more than 12181 patients waiting more than 52 weeks</i> | <i>Yes</i> | | <i>Paul Bachoo, Acute Medical Director</i> | |

For OIP topics that are project-based and not suited to quantitative reporting

| What is it? | What are we trying to achieve by 31 st March'26 | Are we on target? | If Complete/On Track, what actions can be taken to sustain this position? If Minor Delay/Significant Delay, what actions have been taken to recover from this position? | Exec Lead | Notes (insert hyperlinks to national frameworks) |
|--|--|---|--|-----------|--|
| <i>Access to GPs & other Primary & Community Care Clinicians</i> | <i>Contribute to development of a new national quality framework and work to increase capacity and support recruitment and retention of GP workforce</i> | <i>Complete Minor Delay Significant Delay</i> | | | |

National Waiting Times Standards

| National Waiting Times Target/Access Standard <i>(measurement definition, based on quarterly period unless otherwise stated)</i> | Target | Quarter end Dec 2023 | Quarter end Mar 2024 | Quarter end Jun 2024 | Quarter end Sep 2024 | Quarter end Dec 2024 | Benchmarking (of 11 mainland Boards quarter end Dec 2024: ranked 1 st = best performing) | Commentary <i>Comment from service on NHSG's position</i> |
|---|--------|----------------------|----------------------|----------------------|----------------------|----------------------|--|--|
| 95% of unplanned A&E attendances to wait no longer than 4 hours from arrival to admission, discharge or transfer <i>(% admitted, discharged or transferred within 4 hours of arrival at an Emergency Department or Minor Injury Unit)</i> | 95% | 66.5% | 66.7% | 67.9% | 67.6% | 64.3% | 7th Scotland: 67.1% | <p>Overall A&E performance increased over the first two quarters of 2024, before decreasing through the second two quarters to September 2024. The level remains lower than at the same time previous year. We remain 7th of the mainland Boards for the second consecutive quarter (with Ayrshire & Arran improving); we remain below the overall Scotland level.</p> <p><i>This performance recovery is surprising, given the increased proportion of DD/DTOC in Acute wards. Close scrutiny remains from SG in terms of our ability to reduce ambulance stacking. Bed waits in ED/AMIA continue to outnumber ambulance waits on a daily basis. The key constraint remains admitting capacity over ED/AMIA performance at this time. – Q4 Update Pending</i></p> |
| All patients requiring one of the 8 key diagnostic tests will wait no longer than 6 weeks <i>(% of waits of 6 weeks or less at quarter end)</i> | 100% | 33.8% | 39.4% | 42.2% | | | 8th Scotland: 53.1% | <p>Performance has improved each quarter through 2024. We remain 8th of the mainland Boards for the second consecutive quarter; we have been below the overall Scotland level for the last year.</p> <p><i>Our elective care plan does not target this metric directly. However the Radiology service is showing sustained improvement and this is likely to persist to the end of the financial year given the financial funding associated with it. The rate of improvement in Endoscopy is likely to deteriorate as significant capacity ceased at the end of Dec 2024.</i></p> |
| 95% of New Outpatients should be seen within 12 weeks of referral <i>(% of waits where patient was seen at a new appointment within 12 weeks of referral)</i> | 95% | | 61.8% | 65.9% | 64.0% | 62.0% | 7th Scotland: 63.2% | <p>Performance decreased for the second consecutive quarter, to December 2024, following an increase the previous quarter. This pattern was also observed at Greater Glasgow & Clyde, Highland, and Lanarkshire, as well as Scotland overall. We remain 7th of the mainland Boards, but have dropped below the overall Scotland level for the first time since quarter ending June 2021.</p> <p><i>Our elective care plan does not directly address this metric. Our longest waits to continue to be above trajectory though the lower waiting trajectories are over performing demonstrating a split between specialities. There has been a positive downward trend in the longer waits throughout January</i></p> |

| National Waiting Times Target/Access Standard <i>(measurement definition, based on quarterly period unless otherwise stated)</i> | Target | Quarter end Dec 2023 | Quarter end Mar 2024 | Quarter end Jun 2024 | Quarter end Sep 2024 | Quarter end Dec 2024 | Benchmarking (of 11 mainland Boards quarter end Dec 2024: ranked 1 st = best performing) | Commentary <i>Comment from service on NHSG’s position</i> |
|--|--------|----------------------|----------------------|----------------------|----------------------|----------------------|--|--|
| All TTG patients should be seen within 12 weeks of decision to treat <i>(% of waits where patient was admitted for treatment within 12 weeks of decision to treat)</i> | 100% | 47.3% | 43.9% | 46.2% | 46.1% | 48.1% | 11th Scotland: 97.0% | <p>There was an improvement in performance for the quarter to September 2024, following a fractional decrease the previous quarter. We have moved from 9th to 8th position of the Mainland Boards (with a decreases at Dumfries & Galloway); we remain consistently below the overall Scotland level.</p> <p><i>Our elective care plan does not directly address this metric. Our longest waits have broadly stabilised although above trajectory. The situation is not likely to improve until short stay surgical capacity is brought online which will not now be this financial year. The reduction in surgery and actual and potential changes of case mix in DGH is not yet stable enough to predict the overall impact this will have</i></p> |
| 95% of patients should wait no more than 31 days from decision to treat to first cancer treatment <i>(% of waits where patient was treated within 31 days of decision to treat)</i> | 95% | 90.5% | 89.5% | 89.2% | 89.2% | 87.3% | 11th Scotland: 94.8% | <p>Performance decreased for each quarter through 2024. We remain with the lowest performance of the mainland Boards, and have been below the overall Scotland level since quarter ending June 2023.</p> <p><i>We are not where we had have hoped to be, Capacity issues as well as infrastructure issues has slowed progress. Despite poor performance, levels of activity in the number of cancer treatments delivered have remained high.</i></p> |
| 95% of patients receive first treatment within 62 days of urgent suspicion of cancer referral <i>(% of waits where patient was treated within 62 days of urgent suspected cancer referral)</i> | 95% | 90.4% | 55.0% | 60.6% | 53.9% | 60.3% | 11th Scotland 73.5% | <p>Following a decrease to September 2024, performance improved to December 2024. We remain with the lowest performance of the mainland Boards, and consistently below the overall Scotland level.</p> <p><i>This is not where we would want to be, but the Q end June 2024 did meet the projected target for the period. Capacity issues, particularly in diagnostics, as well as infrastructure issues has slowed progress. Despite poor performance, levels of activity have remained high. The demand in referrals to cancer pathways have also remained high and outweigh available capacity which generates a backlog and thus any efforts to reduce the backlog results in a reduction in the performance and does not translate the work of the system to maintain or recover.</i></p> |

| National Waiting Times Target/Access Standard <i>(measurement definition, based on quarterly period unless otherwise stated)</i> | Target | Quarter end Dec 2023 | Quarter end Mar 2024 | Quarter end Jun 2024 | Quarter end Sep 2024 | Quarter end Dec 2024 | Benchmarking (of 11 mainland Boards quarter end Dec 2024: ranked 1 st = best performing) | Commentary <i>Comment from service on NHSG's position</i> |
|--|--------|----------------------|----------------------|----------------------|----------------------|----------------------|--|---|
| 90% of children and young people should start treatment within 18 weeks of referral to CAMHS <i>(% of waits where patient started treatment within 18 weeks of referral)</i> | 90% | 96.7% | 97.4% | 96.5% | 97.9% | 97.8% | 3rd Scotland: 97.8% | Performance decreased fractionally for the quarter to December 2024. We have moved from 5th to 3rd position of the mainland Boards (with decreases at Forth Valley and Highland remain above the overall Scotland level, and have improved on achieving the national target for the last year. <i>The services continue to operate with reduced capacity due to various financial/funding challenges impacting recruitment and retention of staff over the previous 2 quarters. Nonetheless, our performance to waiting times standards has remained relatively stable which we aim to maintain over the coming quarter.</i> |
| 90% of people should start their treatment within 18 weeks of referral to psychological therapies <i>(% of waits where patient started treatment within 18 weeks of referral)</i> | 90% | 76.4% | 75.4% | 81.7% | 80.4% | 79.1% | 6th Scotland: 80.5% | Performance decreased for the quarter to September 2024, following an increase the previous quarter. We have moved from 5th to 6th position of the mainland Boards (with improvement at Fife), and we have dropped just below the overall Scotland level. <i>The services continue to operate with reduced capacity due to various financial/funding challenges impacting recruitment and retention of staff over the previous 2 quarters. Nonetheless, our performance to waiting times standards has remained relatively stable which we aim to maintain over the coming quarter.</i> |
| 90% of patients will commence IVF treatment within 52 weeks <i>(% 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)</i> | 90% | 100% | 100% | 100% | 100% | 100% | Scotland: 100.0% | We continue to consistently achieve the target <i>We are continuing to perform comfortably at our targeted goal. Many of our patients are being brought through the pathway from referral to commencing of treatment on a much smaller timeline. We are managing outliers with delayed treatment for various reasons appropriately.</i> |

From national waiting times publications