Board Meeting
19.02.26
Open Session
Item 8.1

Plan for the Future
Healthier Together
2022 - 2032

NHS Grampian

How are we doing?

Q3 2025/26 Board Performance Report

February 2026

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

Having three clear organisational priorities for the year continues to serve us well when it comes to the grip and control in each of these areas, supported by strengthened governance arrangements to ensure delivery of our plans for Value and Sustainability, Unscheduled Care and Planned Care. This Quarter 3 How Are We Doing report provides an overview of our progress in these and wider areas of performance during Quarter 3 of 2025/26.

Notwithstanding the sustained pressure on our services and the impact of the Central Decontamination Unit shutdown from October 2025, I am pleased to report that we can evidence progress in each of our priority areas and demonstrably so for Value and Sustainability specifically. Planned Care is a mixed picture when it comes to performance, however, on the whole we can evidence much progress when it comes to reducing our longest wait patients and delivery against our 52-week trajectories, whilst not without its challenges. We now need to replicate this progress in Unscheduled Care via sustained focus on delivery now we have the leadership, whole system plan, agreed priority workstreams and financial support in place to do so.

We remain on track to deliver our financial and savings plan for 2025/26 as a result of the consistent application of strengthened financial discipline in the organisation and an organisation-wide focus from our staff. In November 2025, we arranged a system-wide integrated financial planning session, including with Local Authority and Integration Joint Board partners, to ensure a joined-up approach to planning. A second meeting is scheduled for mid-February 2026 as all organisations finalise their financial plans for the year ahead so there is a system-wide view and understanding of plans for 2026/27 and choices each organisation will be making to deliver savings. This should ensure that there is less risk of any unintended consequences of a decision made in one part of the system, on another.

Planned Care showed some decline in performance in Quarter 3 versus Quarter 2 (including performance against the 52-week Treatment Time Guarantee standard and continued challenges with 62-day cancer performance and some diagnostic standards) including due to the impact of the Central Decontamination Unit shutdown, however mutual aid and support from other Health Boards, independent sector capacity and a series of internal improvements, including the new mobile MRI scanner at Dr Gray's Hospital is supporting our recovery. I welcome the inclusion of 62-day cancer performance by tumour site in this report to allow closer scrutiny of our most challenged specialties.

Our biggest challenge remains Unscheduled Care and seeing the plan begin to impact our performance which is currently at unacceptable levels for the emergency access standard and ambulance handover times, with too many of our patients experiencing long waits for care and treatment, - which we are determined to address through our Scottish Government-funded whole system improvement programme. Quarter 3 signalled some green shoots with five KPIs being met and a much-strengthened focus on early-in-the day movement and flow and pre-noon discharges (which is within our gift and control) and where there are clear opportunities for improvement, with just 10-12% of our discharges currently before noon and with over 30% really needed and what we are aiming for through our focussed improvement work.

Laura Skaife-Knight, Chief Executive NHS Grampian

Voice of our Citizens

Care Opinion stories July-December 2025

402 stories in Jul-Dec 2025

88% of stories have a response

3 stories have a change planned

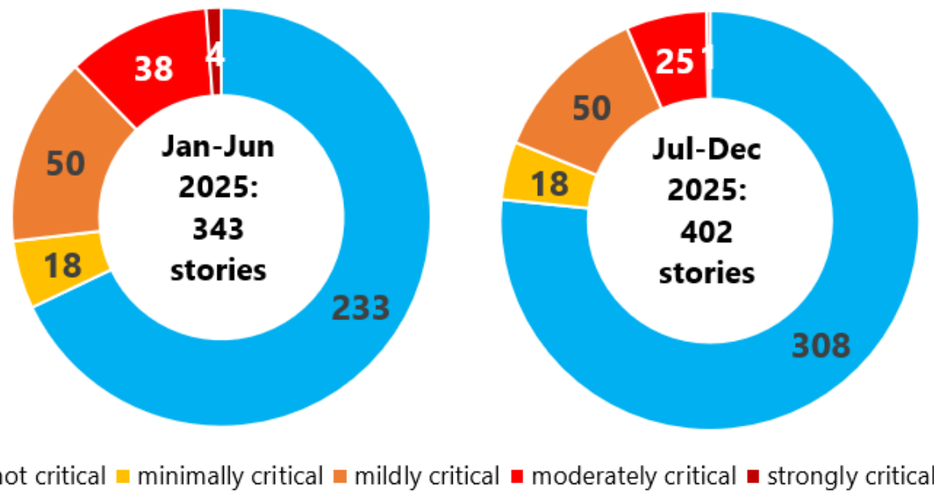
no stories had a change made

The 402 stories published to Care Opinion in the period July-December 2025 represent a 17% increase from the previous six-month period, and over a third more than published in the same period the previous year.

- The proportion of 'not critical' (or 'positive') stories increased from 68% in the first half of 2025, to 77% in the second half of the year
- The proportion of 'minimally', 'mildly', 'moderately', and 'strongly critical' stories have decreased.
  - One story was rated as 'strongly critical', a decrease from four in the previous six months. For this story, the service area responded on the day the story was published, requesting the story author contact them to discuss in more detail.
- Overall initial responsiveness has decreased for the third consecutive period, to 88%

Stories received equate to 0.05% of activity*

How moderators have rated the criticality of stories



Criticality scores in relation to the most negatives statements within the story are assigned by moderators to support the alerting service in identifying issues which might need urgent response, action or escalation

Contributing to change

Sharing their experiences through Care Opinion stories allows citizens to acknowledge good practice as well as contributing to change.

- For the July-December 2025 period, three of these stories' responses show a change has been planned or made (see next page for further detail), two more than the previous six-month period.

Governance

Care Opinion (along with feedback and complaints) data is regularly provided to the Clinical Risk Management meeting and the Clinical Governance Committee.

It is important to note that Care Opinion stories are representative of a small sample of our population who choose to provide feedback through this method.

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

Key risk: are we missing an opportunity to build trust in our services

- Where areas for improvement are identified, completing the feedback loop with the story's author can help build trust and inspire confidence in our services.
- It also enables sharing of improvements with other service areas.

There are occasions where changes made are communicated directly with the story author and not recorded on Care Opinion. Responders receive an email reminder to complete the online feedback loop by sharing actions taken on the Care Opinion platform.

The majority of stories we receive are completely positive (not critical), these stories are shared with the relevant teams and no change is required within the service.

Ongoing actions to improve recording on Care Opinion:

- During Care Opinion training, the value of recording changes is being highlighted, together with the importance of ensuring responses to stories are person-centred.
- Service-specific links are being provided to all services for them to share, making it easier for citizens to provide feedback
- Work is ongoing to establish citizens' and colleagues' level of awareness of Care Opinion, with an increase in the number of stories in the latest quarter.
- Raising awareness through the Quality Improvement and Assurance Team newsletter, shared with all colleagues through the Daily Brief.

* Inpatient, Outpatient, Emergency Department activity for the period 01/07/25-31/12/25

Voice of our Citizens

Citizens stories via Care Opinion July-December 2025

Changes planned

[Fantastic care during my stay]

I have spent a few weeks in hospital this summer. I'm not one to write things like this but couldn't let the opportunity pass to share my appreciation for every single member of staff on ward 206. The nurses showed such care, compassion and kindness with every single interaction. The ward is big and busy with lots of unwell patients but I was made to feel like the only patient in the world and the staff took the time to chat and spent a lot of time with me the night after my surgery. The nurses also took time to discuss how I was feeling emotionally after a few tough weeks and a big surgery. They took time to suggest practical strategies which were helpful, this made a huge difference to my recovery...

www.careopinion.org.uk

CHANGE PLANNED

Response from Senior Charge Nurse, Surgical Division (September 2025):

Thank you so much for taking the time to share your experience with us. We are delighted to hear about the excellent care and compassion you received from the whole team on Ward 206. It means a great dealt to the team to know that their efforts to listen, provide emotional support, and go the extra mile made such a positive difference to your recovery. Your kind words will be shared with the team and I know they will take great encouragement from them.

We are also grateful for your constructive feedback regarding the temperature on the ward. We fully understand how important a comfortable environment is to recovery. I am pleased to say that there are some significant improvements taking place soon to help future patients feel more comfortable.

On behalf of the team thank you again for your thoughtful feedback. We all wish you the very best in your continued recovery.

[Ectopic pregnancy - It really felt like I wasn't believed]

I had an ectopic pregnancy when I was approx. 7 weeks pregnant. I experienced worsening pain and bleeding throughout the day resulting in me calling the maternity hospital (Rubislaw ward) on 5 separate occasions. On each phone call; I was felt to be a nuisance and not reassured. As the pain worsened, I was describing sharp pain in one side and pain radiating down my leg. I was advised to either wait 2 days for a scan appointment, or eventually on the fifth call, if I wasn't managing the pain, to make my way to hospital. On attendance at hospital, a doctor advised the pain was symptomatic of an ectopic pregnancy, yet I wasn't provided an ultrasound until 10h after my admission...

www.careopinion.org.uk

CHANGE PLANNED

Response from Midwifery Manager, Aberdeen Maternity Hospital (September 2025):

Thank you for sharing your feedback in relation to your care, I am so sorry for your loss and apologise for the experience you have had. At all points of contact, whether that is over the phone or face to face, you should have been listened to, taken seriously and felt reassured. I apologise this was not the case.

All diagnosed ectopic pregnancies should be recorded on our adverse event system and care reviewed through our risk management process for any feedback and learning to be shared with our staff. I will also share your experience with the Rubislaw team.

I appreciate that this is an anonymous forum, but if you do wish to make contact with me to discuss your experience further please email *(email provided)* and ask for your email to be directed to *(name provided)*. Thank you for sharing your experience with us and I apologise again for the care you received.

[One thing that needs improved]

Had a recent stay in the medical ward at RACH with my 4 month old son. All the staff were lovely. However, with the ward being very busy I felt that they didn't have much time to really get to know us and just chat.

One thing that needs improved on is how long it takes to warm a bottle of formula. We were often waiting 30-40 minutes for a bottle of milk for my son, by this point he was obviously hysterical. They stated the warmers take ages and there's only 2 of them. Just a little something that I think if improved could make a huge difference in an already stressful time.

www.careopinion.org.uk

CHANGE PLANNED

Response from Clinical Nurse Manager, Children's Division (October 2025):

Thank you for taking the time to leave feedback following you son's stay in the medical ward. I can only apologise for the length of time to wait for a feed for your son.

The warmers used in hospital differ from those that are generally in use in most homes. They are waterless and do take a bit longer than a normal feed warmer although I would not have expected 30-40 mins. A large volume from fridge temperature could take 18 mins. We are required to have waterless warmers for infection control purposes. Bacteria and moulds love to grow in warm damp environments, such as feed warmers that use water, and waterless practice minimises this risk. I will however speak to the staff to see if we can purchase more to avoid a queue of feeds waiting to be heated.

Thank you for leaving us feedback as we continually strive to improve and your feedback helps us to do this.

Voice of our Citizens

Themes from Care Opinion Feedback July-December 2025

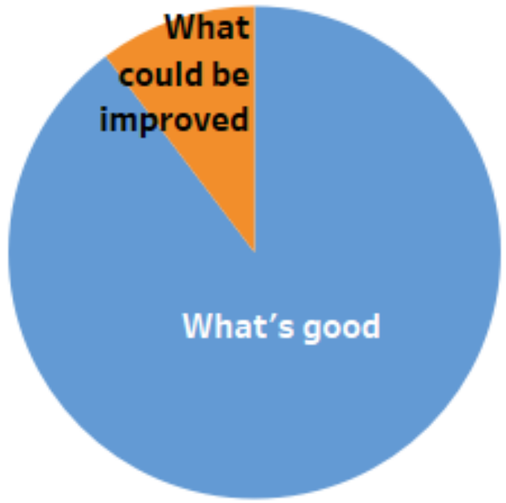
The Care Opinion platform lets our citizens attach brief tags to their stories, providing a summary of what was good and what could be improved about their experience.

What's good?

Feedback is predominantly positive, with "nurse" the most frequently used positive tag, alongside "caring", "care", and "helpful"

Tag categorisation Jul 2025 - Dec 2025

based on 402 stories submitted



What could be improved?

There are some areas where our citizens' stories suggest improvement can be made. "Communication" remains the most frequently tagged area for improvement, followed by "staff", and "waiting times"

These word clouds provide a visual representation of the tags from citizens' stories: the larger and darker the word, the more frequently it was used as a tag. Tags are added by story authors to help summarise what was important to them at the time of writing. The content of stories may highlight themes which have not been tagged. To maintain the authenticity of the story, tags are not altered.

There were 36 stories in the period July to December 2025 where "communication" has been tagged as an area for improvement; the themes include: bedside manner and staff attitude, missed opportunities to communicate, poor explanations

It is recognised the local Clinical Governance Meetings regularly review complaints as one of the meeting agenda items, and encouragement is provided for staff within Portfolios to undertake the training modules available, with the theme of communication remaining an area of focus.

Our Performance towards our Outcomes by 31st March 2026

Value and Sustainability

Improving our financial position by £61.8m

How Are We Doing?

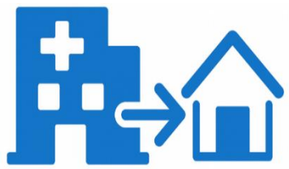
Cash-releasing savings to date

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 9

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 3 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 Q3: Q3 delivery continues to exceed target (£38.06m vs £37.01m), with total savings identified are £61.9m, now exceeding the end of year target. Recurrent savings currently represent over 3% of our baseline budget for the 3rd consecutive quarter, in line with Level 4 escalation requirements. Prognosis for achieving the in-year Outcome is positive, while delivery risks remain. Continued focus will still be required if the full outcome is to be realised by 31 March 2026.

Unscheduled Care:

Outcome: Earlier specialist input, improved flow and earlier 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 Q3: Q3 performance showed some recovery across USC, with 5 KPIs now meeting targets. Optimising flow and improving appropriate access showed the most significant gains, whilst hospital discharges maintained some positive momentum. While Q3 performance shows improvement, some areas still lag behind the improvement trajectories targeted via our KPIs towards our outcomes, specifically reducing hospital occupancy and achieving the 4 hour standard. Sustained focus across USC will be required to continue making improvements while changes embed and new services are brought online.

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 Q3: Q3 shows a general decline in performance compared to Q2. Outpatient waits recovered to be on target, and 31 day cancer standard moving within a percentage point of trajectory, treatment time guarantee waits slipped below target, showing a deterioration in patient access. In diagnostics, both Endoscopy and Radiology both failed to meet their Q3 targets, although delayed improvements in MRI capacity should start to have more impact in Q4. Quarter 3 therefore shows that while some Outputs continue to be completed as planned, these may not as yet be producing sufficient tangible impacts, and require monitored with increasing focus if this Outcome is to be achieved, particularly around the Significantly Delayed Deliverable associated with 62-day Cancer Treatment times.

Reporting 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:

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

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.

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

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

Organisational Performance Summary Quarter 3 (Oct 2025 to Dec 2025)

Tier 1 provides a high-level summary of organisational performance across the three Change Programmes – Value and Sustainability, Planned Care and Unscheduled Care, which are the primary mechanisms for delivering NHS Grampian's priorities aligned to the Plan for the Future. This view brings together the scale of outcome commitments due by 31st March 2026 and the key performance signals that show how we are progressing towards those outcomes. Progress towards outcomes is shown through movement in performance, with the delivery outlook for planned work and completed actions indicating what is being put in place to support that progress. Performance information at Tier 1 is presented in aggregate to highlight patterns, signals and areas for further assurance.

The relationship between actions, KPIs and Outcomes is explored in detail at Tier 2, with Tier 3 Spotlights providing deeper scrutiny where required.

Our 3 Priority Programmes	Number of Outcomes to be delivered by 31st March 2026	Performance Movement (KPIs)	Delivery Outlook (Deliverables) *Delivery Outlook (Deliverables) reflects whether planned work is expected to be delivered on time, informed by completed actions (Outputs) to improve performance*	Actions completed (Outputs)	Outcomes under Spotlights (Tier 3)
Value and Sustainability	1	(4)	(1)	(1) (2)	0
Planned Care	6	(2) (4)	(5) (1)	(10) (10)	3
Unscheduled Care	4	(5) (5)	(7) (2)	(8) (20)	4

Key:

Marker	Description	Prognosis of delivering 2025/26 Deliverables by 31st March 2026
🟢	Performance has improved from previous quarter and moving closer/exceeding target	Completed
🟡	Performance has improved from previous quarter but deviating from target	Will be Complete
🔴	Performance has declined from previous quarter and deviating from target.	Not on target – Anticipating Minor Delay
⚪	Performance has remain unchanged between previous and current quarter.	Not on target – Anticipating Significant Delay

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**	**£38.06m**	**£37.01m**		£61.8m	Evidence based delivery of savings totalling £38.01m as at December with positive variation of £1.0m. Savings plan reflecting assumed delivery timescales with sixth consecutive month of delivering above savings target.
Total value of cash-releasing savings forecast for 2025/26	£61.8m	£54.5m	£61.8m	**£60.95m**	**£61.8m**	**£61.9m**	**£61.8m**		£61.8m	Forecast trajectories deliver savings of £61.9m against year-end target of £61.8m. Positive variation of £0.1m due to continued monthly monitoring and increased confidence in delivery of high risk schemes.
% of recurring savings forecast for 2025/26	3%	3.2%	3%	**3.49%**	**3%**	**3.51%**	**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**		£45m	Both the savings forecast and overall financial forecast continue to be reviewed in detail on a monthly basis which has led to an improved forecast deficit financial outturn in line with the original Board and Scottish Government approved plan.

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

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
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		

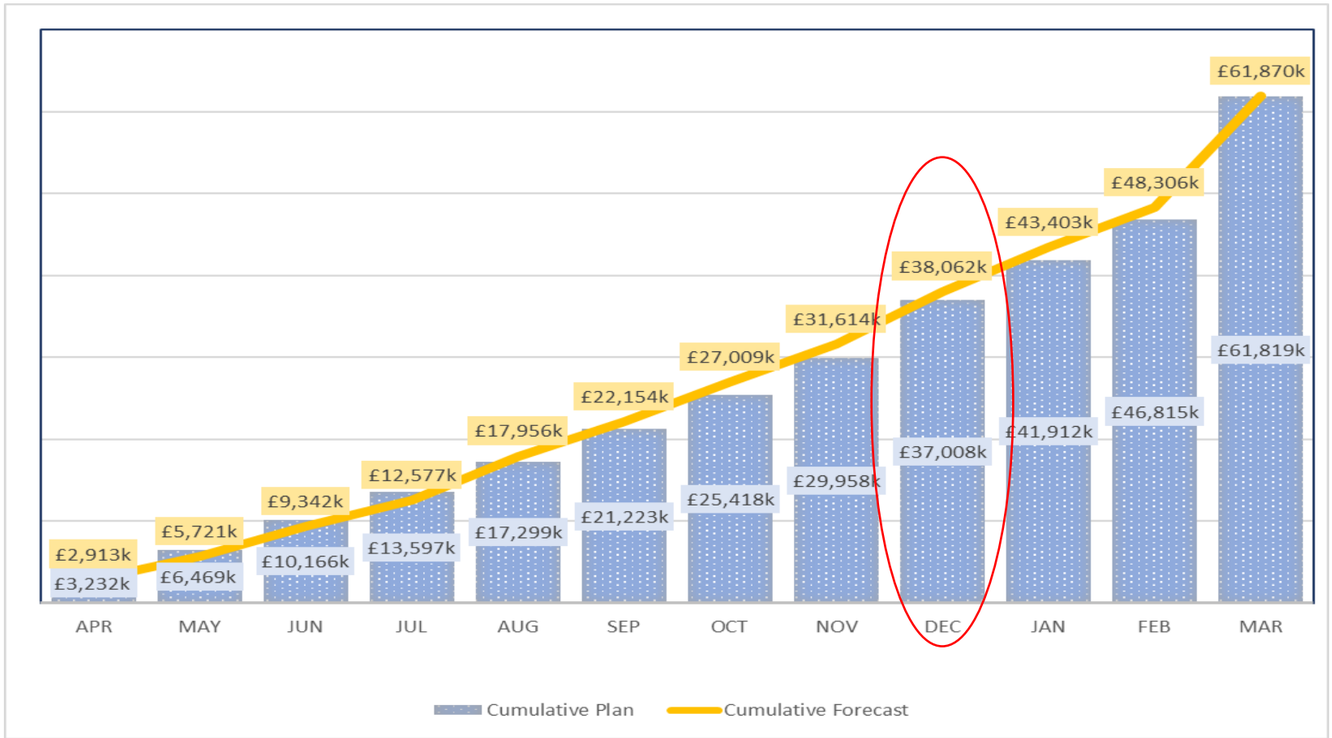
Key Outputs to deliver intended KPI Performance:

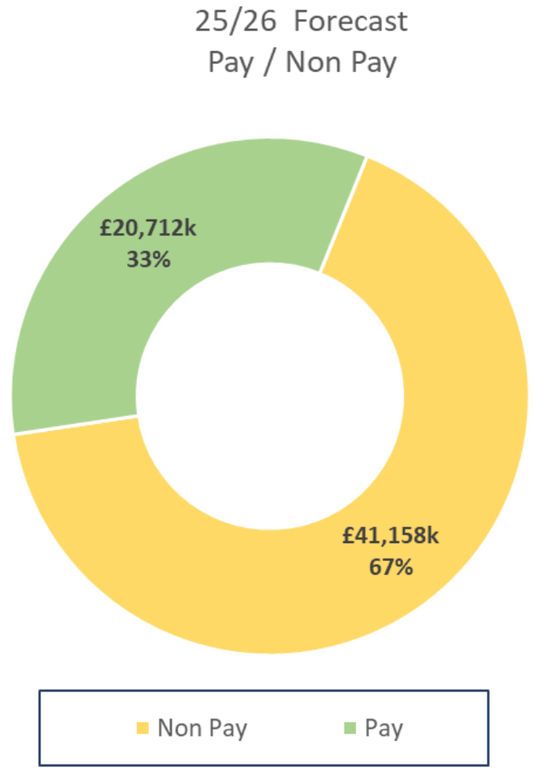
1. Governance framework implemented from portfolio to Board level by Q3 *Complete – Q3* ✓	**2.** Viable opportunities within the external diagnostic review and national benchmarking sources identified and implementation plans developed and approved by Board by March 2026	**3.** Schemes approved by Leadership teams are locally owned and driven by teams at service levels by February 2026

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	Weekly and fortnightly meetings established for all workstreams for the 2026/27 programme. Launched the 20-week development phase commenced in October 2026. Continuation of the monthly V&S Delivery Group, the fortnightly V&S Exec-attended Programme Board; and the Non-Exec Director Chaired monthly Finance Recovery Board (FRB). Deep dives into nursing workforce, medical workforce & IJB savings presented to FRB to increase scrutiny. Dissemination of standardised CIP templates and Quality Impact Assessment (QIA) templates. Chairs Assurance Reports to Chief Executive Team and PAFIC. Updates to PAFIC and Board.	Completed as planned	- Delivery of savings achieved in line with plan at M07, 08 & 09. - Indicative savings identified across all workstreams to a value of £33.5m in-year savings for 2026/27 programme. - Continued engagement with teams across NHS Grampian maintaining Value & Sustainability programme as key priority programme against other competing operational pressures.	- No material risk to 2025/26 programme. - Inability to identify savings to bridge savings gap to £40m for the 2026/27 programme risking confidence by Scottish Government we will meet requirements for de-escalation from Level 4 status. Continued meeting framework and Board scrutiny to address any slippage and risk-assess 'difficult decisions' to close the gap to £40m.	1. Continue monitoring delivery of 2025/26 programme – in line with month-end finance reporting. 2. Draft CIP templates for schemes for approval to form part of 2026/27 programme – on-going. 3. Commence QIA panels - 27 January, 27 February and 27 March. 4. Final summary V&S plan submitted to PAFIC and Board March 2026.
2	- Chief Executive Team have systematically reviewed all 96 recommendations and assigned Executive Director owners. - Opportunities shared with workstream teams to assess viability. - Presentation to Board Seminar for information sharing and agreement on governance framework for monitoring. - Board approval to remove nine recommendations from Improvement Plan. - Indicative savings ascribed to opportunities to determine prioritisation to progress.	October 2025 November 2025 November 2025 December 2025 December 2025	- Provides granularity on ownership across all 87 approved recommendations. - Puts in place a framework for effective monitoring during Quarter 4 2025/26 and through 2026/27. - Contributes to evidenced-based risk-assessed written plans in line with the 20-week development phase timetable for the 2026/27 savings plan.	- Scale of change across 87 approved recommendations requires more resource and time than originally expected leading to delays in closing off recommendations. Regular reporting to CET will highlight escalations early and ensure Executive ownership.	1. Updates through programme governance structure. 2. Savings plans to be presented to QIA panel. 3. Approved savings included in final summary plan to PAFIC and Board from March 2026.
3	- Workstreams meet regularly to review opportunities to analyse, assess and validate final savings opportunities. - Monthly Delivery Group reviews and discusses opportunities to ensure local impact and interdependencies understood. - Schemes shared through local teams for input and challenge. Meetings held where variance to plan to determine mitigating actions to recover plans, where reasonable to do so.	February 2026	- Provides a framework for local teams to engage that meets the necessary criteria for ensuring schemes are locally owned and led. - Workstream teams responsible for putting forward schemes that have staff buy-in and confidence that savings and other benefits will materialise.	NHS Grampian are required to implement 'difficult decisions' to meet the minimum £40m savings target that impact on clinical services or staff; that staff are unwilling to support. This will be mitigated by the QIA panel that has the function to safeguard patient safety, clinical outcomes and staff health and well-being.	1. Continued engagement through workstream meetings and Delivery Group. 2. Savings to be approved at local service level. 3. QIA panels to ensure patients and staff fully considered. 4. Plan to PAFIC and Board in March 2026

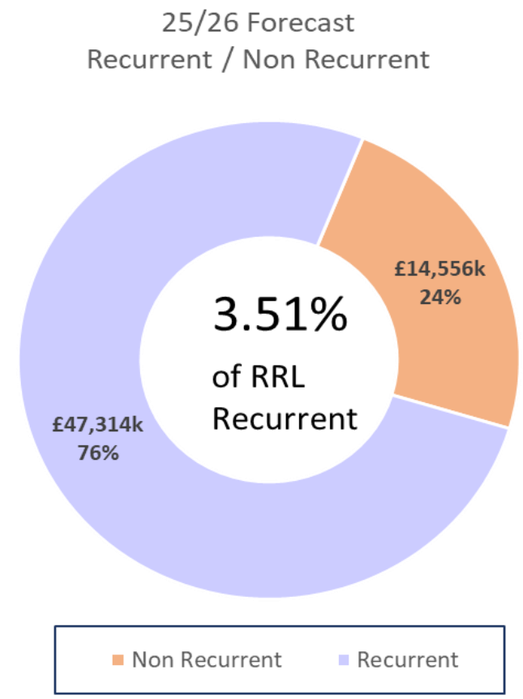
2025/26 Value & Sustainability Programme Update





2026/27 Value & Sustainability Programme Update

Workstream	Executive Lead	IY Indic Savings (£'000)	Delivery Rating - High (£'000)	Delivery Rating - Medium (£'000)	Delivery Rating - Low (£'000)
Integrated Joint Boards	IJB Chief Officers	6000	6000	0	0
Operational Improvement	Alex Stephen	4000	3000	1000	0
Corporate - Finance	Alex Stephen	3500	3500	0	0
Corporate - Other	Executive Directors	1057	47	10	1000
Pharmacy	Hugh Bishop	4600	3300	0	1300
Estates & Facilities	Alan Wilson	2430	160	170	2100
Nursing & Midwifery	June Brown	2900	1700	1200	0
Medical Workforce	Paul Bachoo	3100	0	1600	1500
Procurement	Alex Stephen	2800	2300	500	0
Mental Health & Learning Disability	Fiona Mitchelhil	1390	327	1063	0
Acute Sector	Geraldine Fraser	1129	74	0	1055
Digital Directorate	Stuart Humphreys	330	65	265	0
Infrastructure & Sustainability	Alan Wilson	250	180	70	0
Public Health	Shantini Paranjothy	23	23	0	0
Total		**33,509**	**20,676**	**5,878**	**6,955**
	Delivery Rating %		**90**	**60**	**25**
	Risk Adjusted £'000	**23,874**	**18,608**	**3,527**	**1,739**



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	**3367**	**<3265**		<3206		Figures are balancing out between reduction in Gen Med and increase in Frailty admissions due to use of correct pathways Spotlight on Pg. 21
Reduce average acute hospital weekday occupancy (ARI and Dr Gray's) to 98% by March 2026*	112%	111%	111%	108.2%	106%	**108.3%**	**106%***		98%*		Improvement requires actions (programme and operational improvements) across the USC system working simultaneously and compensating for winter pressures (e.g. flu). These have not had sufficient effect.

*KPI targets revised Nov 2025

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

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE

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

Key Outputs to deliver intended KPI Performance:

1. 7-day frailty triage model operational at front door – *anticipated to be complete by January 2026*
2. MDT frailty assessment directing patients into alternative pathways and supporting some patients to return home. Full implementation *anticipated to be complete by January 2026*
3. Streaming of patients in to frailty pathways showing benefits in terms of reduced length of stay. *Anticipate to be complete by March 2026*

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	USC03: Completion of test of change for consultant geriatrician assessment in the ARI Emergency Department (ED). Consultant geriatrician attending the Emergency Department routinely KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	December 2025	This action has led to an improvement: 30% of patients reviewed by the geriatrician as part of the test of change being discharged directly. Of those admitted there has been an increase in admissions to ward 102 (Geriatric Assessment) and this is alongside a reduction in frail patients being admitted into general medicine wards, resulting in better care for frail patients and predicted shorter lengths of stay.	Locum consultant geriatrician in place. Risk - Recruitment for substantive consultant was not successful. Mitigation - Clinical Fellow / Nurse out to recruitment. Advanced Nurse Practitioner temporary. Interdependencies with other workstreams.	Progress recruitment (substantive geriatrician/ clinical fellow / nurse, discharge co-ordinators) progressing in January. Investigate the potential of geriatricians getting involved earlier in the patient's initial assessment in ED. Continue to increase completion of Clinical Frailty Scores
2	USC04: Dr Gray's Hospital Front Door Allied Health Professional Assessment. Assessments commenced with one Physiotherapist in post at end of quarter and seeing patients. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	January 2026	This action will improve/sustain by: 1 Physiotherapist in post at end of Q3; no significant impact will be possible until further recruitment completed and Multi-Disciplinary Team (MDT) operating fully in Q4. Other posts in the process of being recruited.	Risk – inability to recruit second Physiotherapist, 1x Occupational Therapist, 1x Advanced Nurse Practitioner Mitigation – interviews mid to end of December 2025.	Recruitment of team to operate Allied Health Professional Assessment at the front door complete (expected January 2026) and service fully operational.

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	ANTICIPATED SIGNIFICANT DELAY

Rebalance of Acute specialty bed footprint to maximise efficiency and protect core planned care capacity

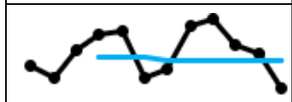
Key Outputs to deliver intended KPI Performance: **(Due dates for Outputs are deferred due to complexity of engagement and will require whole system alignment and sequencing of events)**

1. Initial commissioning work underway. – *Scheduled for completion in Q3 – scheduled for January 2026*
2. Acute frailty footprint increased – *scheduled for completion in Q4* Not complete – expected completion Jul 26
3. Changes to bed base footprint will be delivered - *scheduled for completion in Q3* Not Complete - expected completion Jul 26
4. Surge capacity in planned care will be minimised – *scheduled for completion in Q4* Not complete - expected completion Jul 26

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	Bed Base reallocation work initiated – Frailty and GenMed agreed as the priority in December 2025. Data reviewed, initial development of potential options for discussion with key stakeholders.	January 2026	This work provides the foundation for onward contribution towards KPI performance.	Risks: Not anticipating any risks.	Deliver the initial workshop, and this will facilitate the next stages of improvement, January 2026.
2	Planning of the Initial Frailty expansion workshop	December 2025	This work provides the foundation for onward contribution towards KPI performance.	Risks: lack of attendees, not engagement, not progress as planned Mitigation: ensuring people's understanding and purpose of the work involved.	Deliver Ward footprint options being generated from workshop feedback in January 2026 to support delivery of output 2. Deliver the initial workshop, and this will facilitate the next stages of improvement as per Output 1, January 2026.

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%	**75%**	**82%***		83%*		Expansion of Hospital@Home team to Aberdeenshire did not take place until January 2026. Spotlight on Pg. 22
Maintain the number of patients supported by Hospital at Home services by direct admission from the Community	332	322	322	305	325	**346**	**325***		330*		Effective operation of existing Hospital@Home service responding to system pressures.
No more than 30 Delayed Dishcarges in Acute Hospitals (ARI and Dr Gray's) by March 2026	38	29	36	48	35	**26**	**35***		30*		Interventions including delayed discharges supported with targeted funding (firebreak) at the end of December, operational focus on PDDs, USC improvement projects.
Reduce the number of Delayed Discharges in all other Hospitals by March 2026*	145	138	131	128	125	**129**	**125***		130*		Interventions including delayed discharges supported with targeted funding (firebreak) at the end of December, operational focus on PDDs, USC improvement projects.

*KPI targets revised Nov 2025

Deliverable to enable Q4 KPI Target:	**Expected Status at 31st March 2026**	**WILL BE COMPLETE**
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		

Key Outputs to deliver intended KPI Performance:

1. Standardised discharge protocol implemented across all inpatient sites – *will be complete by March 2026*	**2.** Streamlined referral process in place to downstream services – *will be complete by March 2026*	**3.** Integrated Discharge Hub established – *will be complete by March 2026*

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	USC11 and 12: Integrated Flow Hub and Planned Date of Discharge (PDD): Developed model for Integrated Flow Hub with discharge roles and processes scoped. Recruitment commenced. Tests of change on Planned Date of Discharge Planning and Discharge Planning Education Pack) commenced in Q3. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	March 2026	This action has improved/sustained by: Working with recruitment to appoint three Flow Coordinators, 2.54 Healthcare Support Workers, 2 Hospital Ambulance Liaison Officer (SAS), 1.02 Admin. Early feedback from the three tests of change (two on Planned Date of Discharge Planning, one Discharge Planning Education Pack) is positive with staff engagement and adherence.	Risk- Putting in place an effective workforce model. Mitigation – Workforce model was reviewed and changed. Risk: Effective, comprehensive roll out of PDDs. Mitigation: Operational support for PDDs, modifying test of changes to make less resource intensive.	Recruitment activity will be completed by end January 2026. Recruitment to all posts to Integrated Flow Hub for full implementation for March 2026. Build on PDD tests of change underway and build on roadmap to full implementation for March 2026.

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

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
Reduction in Community Hospital Length Of Stay (LOS) to promote outflow from acute and increase capacity for direct community admissions		

Key Outputs to deliver intended KPI Performance:

1. Revised discharge processes implemented in community hospitals – *will be complete by March 2026*	**2.** Admission criteria and pathways established for direct community access – *will be complete by March 2026*	**3.** Monitoring framework in place to track LOS and outflow impact – *will be complete by March 2026*

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	USC13: Aberdeenshire Enhanced Stepdown Pathways to Community Hospitals: Recruitment of two band 6 nurses has taken place for the Hub which is now fully staffed. Consultation has taken place on community hospital guidelines and standard operating procedure for discharge. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	March 2026	This action has improved/sustained by: This additional provision is supporting patients to be transferred from secondary care in a timelier manner. An MDT self-assessment tool is being trialled in one setting. Aberdeenshire Community Hospital Intra-System Transfer Guidance is being reviewed.	Risk – inability to recruit rest of team, Mitigation – continuing to work on recruitment to promote opportunities. Working alongside Geriatrician colleagues to consider recruitment to alternative roles.	Finalise documentation. Follow up workshop planned in January 2026 on delayed discharge processes across community hospitals. Completion of Discharge Without Delay benchmarking tool and Aberdeenshire specific Day of Care Audit by March 2026.
2	USC16: Aberdeenshire Firebreak (supporting care home placements for delayed discharges, freeing up hospital beds): Planning undertaken for main firebreak in early 2026. Smaller firebreak (firebreak 2) funded from USC Funding slippage enabled 17 individuals to be discharged to care homes over the festive period. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	March 2026 December 2025	This action has improved/sustained by: The impact of firebreak 2 is being tracked and its implementation supported improvement in Q3. Patients were moved from high impact areas in ARI as beds were realised in the Community Hospitals, following moving individuals to care homes.	Risk – Continuation of funding for individuals moved in firebreak 2. Mitigation – system financial planning. Risk – impact of firebreaks short lived with delayed discharges building up. Mitigation – USC projects developing community capacity.	Implementation of main firebreak in early 2026 linked to wider system flow USC workstreams to have an impact on KPIs by end of March 2026.

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
Discharge To Assess (D2A) models implemented in all HSCPs		

Key Outputs to deliver intended KPI Performance: (In Q3, all outputs have now been tied to the three HSCPs D2A projects)

D2A in Aberdeen City agreed – *scheduled to be completed by December 2025* Complete in Q3 ✓	**2.** D2A in Moray Assessment Pathway – *scheduled for completion March 2026*	**3.** D2A in Aberdeenshire – scheduled for completion March 2026

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	D2A criteria completed and this is implemented in Aberdeen City Screening all discharge hub patients for D2A suitability has taken place to enable patients to be discharged from hospital earlier. As a follow up, prepared for next phase expansion (target: end of February/March, doubling capacity). Separate Aberdeen City HSCP initiative with KPIs monitored through HSCP.	December 2025 March 2026	This action has improved/sustained by: Screening all discharge hub patients for D2A suitability has enabled individuals to be discharged earlier in their care journey. We will anticipate the doubling of capacity by the end of February/ March 2026.	Risk - inability to expand capacity. Mitigation – HSCP resource and capacity available.	Expansion of capacity for March 2026.
2	USC14&17: Moray Home Assessment Pathway. Pharmacist now in post; agency being used for Social Worker cover. All other posts are out to advert. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	March 2026	This action has improved/sustained by: Model in development, impact limited by current capacity.	Risk - delays in recruitment/ inability to recruit. Mitigation - majority of posts are now out to advert and early indications show a high degree of interest across	Recruitment of posts to enable extended / enhanced service in place for March 2026.
3	USC15: Establish Aberdeenshire Discharge 2 Assess Two of the three band 6 occupational therapists started in Q3. Workshops were held on D2A processes, pathways, criteria and documentation. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	March 2026	This action has improved/sustained by: Model limited as not fully recruited to. Have 2.5 preferred candidates for the three enablement support co-ordinators. Will now be looking to recruit the 14 carers on fixed term posts.	Risk – not recruited. Mitigation - prioritisation of resource within core services / teams where possible and required and continued work on recruitment.	Continued recruitment for roles required. Finalise standard operating procedure and pathway flowchart for D2A service. Seek feedback from GP Sub-Group on "medically stable" terminology. Agree roles of staff supporting the service and D2A patient criteria.

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

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		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 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%**	**62.6%**	**55%***		60%*		FNC coverage increased and staffing levels reinforced over the weekend period. Spotlight on page 23
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%**	**8.0%**	**7.5%***		10%*		RAAC additional hours activated and new pathways from ED added.

*KPI targets revised Nov 2025

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
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		

Key Outputs to deliver intended KPI Performance:

1. Expanded Flow Navigation Centre model operational – *scheduled for completion within Q3*
   Completed in Q3 ✓
2. Integrated digital and clinical interface with NHS 24 and primary care – *scheduled for completion within Q3*
   Completed in Q3 ✓
3. Standardised triage protocols in place for urgent care referrals – Complete – (November 2025) ✓

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	KPIs set and performance reporting to Upstream Delivery Group and USC Programme Board. Expanded the coverage of the FNC rota now above 95% across the week and double staffed with clinicians over the weekend period.	November 2025	This action has improved/sustained by: Greater proportion of diverts achieved as a result of increased opening hours. Speed of call back at weekends increased which has reduced ambulance presentations. See KPI above.	N/A as actions completed	N/A as actions completed
2	Ensure appropriate capacity and resilience to support additional pathways to manage demand from NHS24 4 hour calls.	November 2025	This action has improved/sustained by: Reduction in proportion of callers attending ED as a result of further clinical advice. See KPI above.	N/A as actions completed	Further expansion of the NHS24 1 hour calls to be taken on by FNC when recruitment activity concludes by March 2026, which will continue to improve KPI Performance and increase opportunities to redirect the patients to the right place.
3	Standardised triage protocols in place for urgent care referrals now complete FNC Triage Matrix now established and undergoing operational validation.	November 2025 1st February 2026	This action has improved/sustained by: Consistency in signposting to alternative pathways achieved which has increased take up and confidence in operators.	N/A as actions completed	Ensure Dr Gray's processes are validated – February 2026 to improve consistency where possible.

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

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
Surgical Ambulatory Care (SAC) clinic and Rapid Acute Ambulatory Clinic (RAAC) operating hours extended		

Key Outputs to deliver intended KPI Performance:

1. Weekend opening of SAC achieved – *scheduled for completion March 2026*	**2.** Expansion of RAAC opening hours into the evening at ARI – *scheduled for completion within Q3* Completed in Q3 (November 2025) ✓	**3.** RAAC chest pain pathway established - *scheduled for completion within Q3* Completed in Q3 (November 2025) ✓

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	USC06(a): Expansion of Surgical Ambulatory Care (SAC) KPIs set and performance reporting to Upstream Delivery Group and USC Programme Board. Recruitment process in train to support the expansion of Surgical Ambulatory Care (SAC). Workforce appointed 18 Dec 25	24 January 2026 December 2025	No impact for Q3 but we are anticipating improvement towards KPI performance in Quarter 4.	Risks: Inability to find suitable candidates, finite resource for skilled roles. Mitigation: bank covering additional hours from existing resource.	Complete the recruitment. Expand week day operating hours Introduce weekend opening.
2	USC6(a): Expansion of Rapid Assessment and Care (RAAC) Local recruitment and rota adjustments completed KPIs set and performance reporting to Upstream Delivery Group and USC Programme Board.	November 2025	This action has improved/sustained KPI performance of ambulatory care by: Extended hours opening into the evening. This has seen 6 additional patients being seen per session which has been an improvement which is within anticipated range of activity.	Risk: Staffing model remains Locum/Bank due to the time bound nature of the initiative. Short notice cessation of service remains a risk. Mitigation: to seek recurring funding to make the posts attractive to recruit to.	Make the case for longer term funding which will enable substantive recruitment and further expansion of pathways from ED/AMIA/H@H.
3	Revised RAAC Chest pain pathway to maximise opportunities to see patients in an ambulatory setting.	November 2025	This action has improved/sustained by: Pathway now pulls suitable patients from ED into RAAC as well as from AMIA. See KPI Performance.	N/A as actions now completed	N/A as actions now completed

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 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 ED patients seen, treated, admitted or discharged within 4 hours	50.8%	50.7%	51%	47.7%	53%	**45.6%**	**53%**		57%*		Hospital occupancy has increased over the autumn period, and backlog of bed requests at the rear of ED remain significant – this constrains the number of concurrent assessments abler to be undertaken in the ED. Spotlight on page 24
Reduce NHSG median SAS turnaround times to 55 minutes by March 2026*	63	49	65	55	65	**62**	**65**		55*		Slight increase in Turnaround Time attributable to seasonal variation.

*KPI targets revised Nov 2025

Deliverable to enable Q4 KPI Target:	**Expected Status at 31st March 2026**	**WILL BE COMPLETE**
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		

Key Outputs to deliver intended KPI Performance:

1. DGH Discharge Lounge hours extended Complete in Q2) ✓	**2.** Domestics and Pharmacy capacity increased Completed in Q2 ✓	**3.** Implement 7 Day AHP service - scheduled in completion (Jan 2026)

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	Completed in Q2.		The KPIs for this deliverable are influenced by a variety of factors and are ultimately indicators of whole system performance. It is challenging to draw a direct correlation between this particular output and the overall performance of the whole system.	N/A as actions completed	N/A
2	Completed in Q2.		The KPIs for this deliverable are influenced by a variety of factors and are ultimately indicators of whole system performance. It is challenging to draw a direct correlation between this particular output and the overall performance of the whole system.	N/A as actions completed	N/A
3	USC08: Increase AHP Provision (7 day service) Recruitment not completed – interview process concluded and appointments made. Notice periods being served.	27 January 2026	No impact at this stage due to initial recruitment activity taking place.	N/A	Agreed posts should be in place and working by end of Jan 26.

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

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	ANTICIPATED SIGNIFICANT DELAY
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		

Key Outputs to deliver intended KPI Performance:

1. Hospital@Home expansion of early discharge and admission avoidance from ARI including ED and AMIA project (Westhill & Portlethen) achieved – Scheduled for completion by 31st January 2026	**2.** 2. Aberdeen City Increased Community Capacity – scheduled for completion by 31st January 2026	**3.** Expand pathways across General Medicine (1 July 2026) and Frailty (January 2026) achieved

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	USC18: Hospital@Home Expansion Planning completed to enable test of change to expand Hospital@Home. Negotiated out-of-hours nursing cover and GMED agreement. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	January 2026	This action has improved/sustained by: Has not impacted on Q3 as the test of change to expand Hospital@Home to Portlethen and Westhill will commence on 8 January 2026. The KPIs for this deliverable are influenced by a variety of factors and are ultimately indicators of whole system performance. It is challenging to draw a direct correlation between this particular output and the overall performance of the whole system.	Risk - failure to recruit to substantive posts. Mitigation - advertising posts together to improve visibility.	Review the outcome of test of change – End Feb 2026
2	USC19: Aberdeen City Increased Community Capacity Planning and negotiations taken place with external providers for additional care at home capacity. KPIs set. Fortnightly assurance report to Programme Board. Project monthly progress reports.	January 2026	This action has improved/sustained by: Increased capacity is dependent on external providers and continued discussions are taking place for additional care at home capacity. The KPIs for this deliverable are influenced by a variety of factors and are ultimately indicators of whole system performance. It is challenging to draw a direct correlation between this particular output and the overall performance of the whole system.	Risk – lack of provider interest in delivering. Mitigation – continued engagement with providers. Risk – lack of improvement in patient flow. Mitigation - explore moving long-stay patients to vacant care home beds.	Monitor interim bed turnover and evidence benefits for recurring funding during Q4 to inform commissioning.
3	Progress to pathway expansion to Frailty	January 2026	No impact on Q3 so far as actions not due to be completed till January 2026.	Risk - failure to recruit to substantive posts. Mitigation: advertising posts together to improve visibility.	Successful recruitment and out of hours cover to support full implementation for March 2026 for Frailty Commence planning for expansion to General Medicine in Quarter 4.

Tier 3: Our Performance Spotlights – Unscheduled Care

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

- There has been no improvement in the indicators of a reduction of the number of unscheduled care General Medicine and Frailty admissions to ARI. A frailty at the front door service was in place in Q3 provided through additional work from existing consultant Geriatricians, meaning cover is not consistent. An advertisement for a Geriatrician which was not successful. This role is now been modified for a Clinical Fellow/Specialist Nurse.
- Measurement taking place shows that a Geriatrician is able to discharge around 30% of individuals attending the Emergency Department back to the community but this needs to be done early in the assessment process. Feedback has also been that more frail individuals are being admitted to frailty wards rather than general medicine. This enables access to expert care but with our aging population is putting a strain on the frailty service.
- In Q4 recruitment will progress with a Clinical Fellow/Specialist Nurse and the aim will be to undertake a frailty assessment as soon as possible in the Emergency Department.
- The Dr Gray's Hospital Front Door Allied Health Professional Assessment service has been partially in place in Q3 with one Physiotherapist in post. The rest of the posts (second Physiotherapist, an Occupational Therapist and Advance Nurse Practitioner) are expected to be in post in January 2026.

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

- KPIs have been agreed for both Front Door Assessment projects and these, which along with a monthly progress report is considered by the USC Programme Board.
- Health Intelligence has developed a Logic Model identifying the impact projects will need to make to reduce hospital occupancy and enable flow to meet the Board overall Annual Delivery Plan KPIs and provide improved quality of care (reduce ambulance waiting times). This shows that operational improvements are also required. The new Site Director and USC Deputy Medical Director will support this.

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

- In January an assurance review is taking place of each USC Project to ensure progress. This will inform a USC Programme Board decision about whether projects should continue, be modified / have support or stood down. Scoping has been undertaken to rebalance the acute specialty bed footprint and a workshop will take place on 21 January 2026.

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

- The principles are unchanged. Joint work has commenced to more closely align with Putting People First by looking to bring staff and people's experience of services into project delivery.

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 KPI of reducing average acute hospital weekly occupancy (ARI and DG) to 98% by March 2026 has been considered in detail through the Logic Modelling, which has shown it will require all the planned improvements in the front door (Emergency Department, Flow Navigation Centre, medical and surgical assessment centres) and downstream flow (prevention of admission and reduction in delayed discharges) as well as tightening operational flow. The model raises concerns about the ability to meet a 98% occupancy level.
- By reviewing the progress of the USC projects in line with the Logic Model's predictions, the aim is to focus on both the USC Improvement Programme and operational improvements to best effect.
- We are also sharing our learning with the Centre of Sustainability Delivery and the Sub Group of the Assurance Board as some of the challenges we are encountering around higher number of frail individuals and higher acuity along with lack of social care capacity are national issues.

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

- Frailty at the Front Door in ARI has put pressure on our Geriatricians in relation to covering this service and the indications are that more frail patients are being admitted to Frailty wards rather than General Medicine.

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

- The USC Improvement Plan and Programme and operational improvements underway are mitigations for the Strategic Risk 3639 Significant delays in the delivery of Unscheduled Care, this risk is in the process of being reviewed considering these mitigations.

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.

- Of the four related KPIs, two are showing as green, maintaining the number of patients supported by Hospital@Home through direct admission from the community and the number of delayed discharges in acute hospitals (26). The first measure reflects the proactive activity by Aberdeen City HSCP and the level of delay discharges reflects the active management as well as a firebreak (17 individuals moved by Aberdeenshire HSCP into care homes) which was funded by the underspend in the USC Scottish Government funding. Planning for the expansion of Hospital@Home into Portlethen and Westhill was undertaken in Q3 but commenced on 8 January 2026. This is likely to have affected the KPI on the % of patient supported by Hospital@Home on discharge from hospital and not readmitted within 28 days. The indicator on reduced delayed discharges in community hospitals was not achieved, recognising that the focus has been on releasing acute hospital capacity.
- A number of USC improvement projects relate to this outcome including putting in place the Integrated Flow Hub, improvement work on discharge processes (Planned Date of Discharge), Aberdeenshire Enhanced Stepdown Pathways to Community Hospitals, the main Aberdeenshire firebreak, Discharge to Assess projects in Aberdeen and Aberdeenshire and enhanced Moray Home Assessment Pathway. Recruitment has been underway for these projects with the aim to implement them fully in Q4.

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

- Project KPIs have been agreed for these projects, along with a monthly progress report which is considered by the Downstream Delivery Group and the USC Programme Board.
- Improvement on the KPIs requires programme and operational improvements working simultaneously and compensating for winter pressures (e.g. flu). These have not had sufficient effect. A logic model was developed in Q3 to identify the most impactful interventions.

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

- In January an assurance review is taking place of each USC Project to ensure progress. This will inform a USC Programme Board decision about whether projects should continue, be modified / have support or stood down. A number of quick interventions have been agreed with the Scottish Government and are planned in Q4 utilising the USC funding underspend.

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

- The principles are unchanged. Joint work has commenced to more closely align with Putting People First by looking to bring staff and people's experience of services into project delivery.

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?

- A number of risks and pressures are impacting on delivery of the projects and improvement including the increase frailty and acuity of individuals presenting, recruitment timelines for the projects/ capacity and the roll out of new working practices.
- Additional leadership and support is in place in Q4 with the new Site Director and Deputy Medical Director for USC and a GP Lead will also be recruited.
- USC is one of NHS Grampian's three priorities, however staff leading the improvements have had to focus on normal winter pressures such as flu and latterly bad weather.

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

- During the festive period Aberdeenshire HSCP had to support a significant number of clients care when a provider handed back its contract, this diverted activity from the improvement projects. Careful workforce planning has been required operationally to support the new projects while not undermining current services.

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

- The USC Improvement Plan and Programme and operational improvements underway are mitigations for the Strategic Risk 3639 Significant delays in the delivery of Unscheduled Care, this risk is in the process of being reviewed considering these mitigations.

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.

- There has been a positive move in each of the related KPIs for this outcome. The increased shift coverage and additional clinical decision making capacity at weekends have combined to see Flow Navigation Centre redirections increase from 54.4% to 62.6%. This exceeds the Q4 target.
- Extended opening hours of the Rapid Acute Assessment Clinic (RAAC) has increased daily throughput of ambulatory patients by 20% meaning that Q3 represents the highest proportion of urgent care contacts treated in an ambulatory manner so far.
- The linked element of this initiative was the mirrored expansion of the Surgical Ambulatory Clinic (SAC), which is yet to come on line. Recruitment activity for SAC expansion has just concluded and it is anticipated that extended hours, including weekend coverage, will begin from the end of January.

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

- The outputs and deliverables are delivering the intended improvements. FNC has already achieved the Q4 target. The upwards trajectory of ambulatory care treatment proportion is encouraging and the additional SAC extended hours and weekend opening will, we anticipate, provide sufficient further ambulatory capacity to meet, if not exceed, the Q4 target.

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

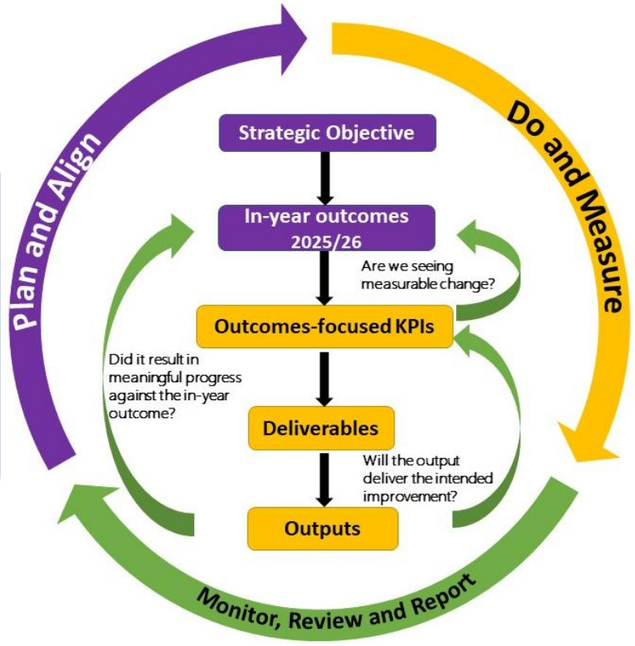
- Not Applicable

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

- Principles associated with these measures have not altered over the last quarter. The key principle of 'right care, right place, right time, first time' continues to drive both the development of the FNC as an 'air traffic control' function, as well as the criteria attached to the pathways into RAAC. The chest pain pathway is a prime example of this in action. RAAC has established a mechanism to pull patients from the ED waiting room/ambulance stack with low risk chest pain into the ambulatory setting to reduce waiting times, not just for this cohort of patients, but also through their removal from queues into ED, other patients who do require that level of care.

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?

- There are limited risks associated with delivery of the measures within this Financial Year (FY). Key risk area is staffing. For FNC expansion it is the ability of Grampian Medical Emergency Department (GMED) to provide staff at the required volume and time. We assess this risk to be low, given performance to date. Staffing risk in this FY relating to RAAC lies in the current staffing model which relies on Locum senior decision makers which can prove unreliable. The key risks to the ambulatory care initiative overall are sustainability and inability to maximise impact/opportunity – RAAC pathway development is already constrained by the absence of substantive staffing, and both RAAC and SAC funding is only for 9 months. Long-term funding for these initiatives will, on the basis of performance/impact to date, significantly reduce pressure on ED and AMIA, as well as reduce inpatient bed days for planned care.

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

- Extended SAC operating hours will not only reduce pressure on ED/AMIA, but also reduce bed day usage within Planned Care bed footprint, enabling greater throughput.

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

- Risk 3639 – delays in delivery of unscheduled care. These measures directly accelerate time to treatment through effective pathway navigation and ambulatory care options, which also releases capacity within impatient care settings for other patient cohorts.

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.

- There is little measurable change in ambulance turnaround times over the quarter, with a slight increase attributable to seasonal variation. A deterioration in 4 hour access performance has been recorded over this quarter, noting that they key drivers for timely flow - hospital occupancy levels, the volume of delayed patients, and length of stay metrics - have not materially altered. Alongside the extension of DGH Discharge Lounge hours and 7 day AHP working, the policy of capping ambulance waits and reducing the maximum permitted wait time, as well as the '10 discharges and 10 moves from front doors before 10am' will promote more timely flow into the hospital from January, though this is likely to reduce 90th percentile wait metrics first. Implementation of the Aberdeenshire 'firebreak' is likely to have the greatest short term impact on bed turnover rate in Acute settings.

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

- The outputs listed against this outcome are yet to be implemented in full due to the lag time in recruitment. It is likely that increased flow enablers within the Acute setting (achieving greater efficiency in reducing the time beds are empty between occupants) will provide increased flow at times of greatest pressure and against the longest waits which will reduce median turnaround times and 4 hour access performance to some degree. However, 4 hour access performance is rightly described as a 'system-wide' measure as it relies on downstream flow to be sustained in driving it down. Essentially, all 19 initiatives in the whole system improvement plan will contribute. There is a linear relationship between ambulance turnaround times and 4 hour access performance.

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

- Extended pharmacy hours were implemented rapidly from the outset of the whole system improvement plan and have not yielded the additional volume of daily discharges anticipated. The intent is that the extra capacity will be rapidly refocused towards preparation of discharge medication the day before discharge to maximise access of these patients to transport resource.

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

- No change to the principles on which the outputs have been based – the Discharge without Delay (DWD) principles and early planning for discharge remain the primary source material for all related outputs.

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 primary risk to delivery of improvement, as monitored by the KPIs, remains a lack of reduction in occupancy levels across the Acute settings.
- The logic model identifies the measures in the plan which have the greatest impact on Acute occupancy – guaranteeing delivery of these initiatives, or accelerating where able, will provide the greatest mitigation.

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

- The lack of positive impact around this outcome in Q3 has the potential to adversely affect the Planned Care Programme in that the volume of boarding further constrains the amount of planned care procedures able to be undertaken. This is monitored daily and a multi-disciplinary team have successfully reduced the number of boarded patients by half over the course of 2 weeks in January, which has included additional care management/social work reviews and planning for management and rapid discharge of boarded patients as a priority.

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

- Risk 3639 – delays in the delivery of unscheduled care – performance against this outcome directly impacts the rate at which patients gain access to emergency unscheduled 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 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?
≤5,839 New Outpatients waiting over 52 weeks by the end of March 2026*	8654	9800	≤9884	10800	≤10,657	**8752**	**≤9,516***		≤5,839*		*Revised trajectory has been agreed with Scottish Government, effective from January 2026 Graph on Pg. 35

*KPI targets revised Nov 2025

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
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		

Key Outputs to deliver intended KPI Performance:

1. All planned care projects delivered to time, budget and scope – *ongoing until Q4*	**2.** Outpatient capacity delivered increasingly within core service levels – *ongoing until Quarter 4*	**3.** Redesigned pathways implemented to improve flow and reduce backlog growth – *ongoing until Q4*	**4.** Development of a formal plan for core balance across key specialties – *ongoing until Q4*

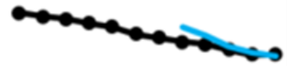
Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	- Enhanced governance structure continues with weekly operational meetings and monthly Planned Care Programme Board performance reporting against all six outcomes and trajectories. - Monthly financial monitoring of NHS Grampian expenditure against Scottish Government funding. - 100% compliance in responding to all Scottish Government submission requests. - Worked with Scottish Government, other Health Boards and private providers to address forecast underperformance against plan in Dermatology due to Independent Sector due to a lack of Dermatology consultants. No improvement expected now through 2025/27. - Progressed discussions with Independent Sector contract for Gastroenterology to improve 52-week patient backlog. Expect to finalise contract in Quarter 4, 2025/26 - Developed and submitted narrative on 15 December setting out reasons for revising forecast New Outpatient trajectory for Scottish Government. Final revision due 16 January 2026.	Completed and on-going Completed and on-going Completed December 2025 Quarter 4, 2025/26 Completed and then 16 January 2026	Continuous weekly meetings between Operational leads, Finance and Performance Team providing immediate identification of adverse variances to performance and discussion on mitigations. Monthly oversight from Planned Care Programme Board provides additional oversight and assurance and route to escalation to the Chief Executive Team via the Chairs Assurance Report. Informed work with the National Elective Coordination Unit (NECU) to review any deviations to performance. Discussions with and written submissions to Scottish Government ensure NHS Grampian can optimise any additional funding opportunities, demonstrate operational grip on this programme and receive support to explore nationally supported solutions (i.e. Mutual Aid from other Health Boards).	Dermatology Independent Sector Contract: Due to provider struggling to recruit sufficient Dermatologists at price point tendered due to national demand for Dermatologists driving up market rates. All possible mitigations have been explored up to and including legal guidance around the maximum legally defensible contract, There is a risk that adverse weather or other factors (Central Decontamination Unit - CDU) reduce likelihood to meet forecast trajectory. This is sufficiently mitigated through stringent monitoring and reporting, current delivery history, and defined timetable to install new machines in the CDU at ARI across January and February 2026.	1. Continue to monitor activity and financial performance against all 52-week new outpatient appointments. 2. Submit revised 52-week new out-patient trajectory to Scottish Government by 16 January 2026 reflecting reduced activity levels for Dermatology. 3. Engage with Scottish Government around planning and priorities for financial year 2026/27 to ensure NHS Grampian maintains momentum to improve patient care and experience.

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

2	The Healthcare Improvement Scotland (HIS) sprint work in Dermatology and Urology services completed in Q3. These have both identified opportunities for improvement in both services. This is the completion of the exploration and solution identification stage. All services have reviewed their use of Patient Initiated Return (PIR) with an aim of reducing the number of return patients seen and redirecting this capacity to the new patient cohort.	Implement during Q4	This has identified the improvement required for a subset of both services, This impact of this for Dermatology will start to be seen in Q4. For Urology implementation is likely to be required through Q4 before an impact is seen on the KPI There has been a gradual increase in PIR across all specialities, though this has not a significant impact on the KPI. We have not achieved a step change in PIR usage, so this maintained the KPI rather than improved it	To deliver this output we still need resilient services in demand-capacity balance. For many services this still requires substantial service redesign. The key risk to enabling this is securing appropriate clinical, managerial and change management time to robustly service plan and then implement these changes. This will be a focus of attention in 2026/27	During Q4 we will continue to design and implement the HIS outputs for Urology and Dermatology. We will continue to explore all options to increase PIR rates and secure a solid basis during 2026/27 to robustly service plan
3	There is a cross over between this Output and Output 2. The collection of non-recurring measures (mutual aid, independent sector contracts and additionality) are all reducing the longest patient's backlogs. The recurring capacity additions has increased core capacity	31st March 2026	The recurring and non-recurring capacity all contributes to reducing the backlog. The longest waiting backlogs (52, 78 and 104 weeks) are al reducing. The total backlog (12+ weeks) continues to increase. These actions are therefore successfully address the largest backlogs but have not been successful in reducing the total backlog	The key risks are primarily the same as output 2 in terms of the recurring capacity gap. The backlog recovery risks are encapsulated in output 1	Continued efforts. Will be carried forward into 2026 primarily via Output 2
4	The HIS Sprint work has assisted the first phase of this action for the key specialities of Urology and Dermatology.	31st March 2026	This work has not had an impact during Q3 but will start to impact for the relevant subspecialty in Dermatology during Q4. This will not feed into this year's trajectory but will assist on a recurring basis	There is minimal risk to the delivery of these aspects during Q4, though the key risk is in completing this action during 2026/27 due to available capacity to take forward	Continued efforts. Will be carried forward into 2026 primarily via Output 2

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		
≤3,933 TTG patients waiting over 52 weeks by the end of March 2026*	5330	4879	≤5323	4505	≤4559	**4388**	**≤4082***		≤3,933*		Graph on Pg. 35 Spotlight Pg. 36

*KPI targets revised Nov 2025

Deliverable to enable Q4 KPI Target:	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		

Key Outputs to deliver intended KPI Performance:

1. Short Stay Theatre Complex at ARI fully operational and staffed - *expected Q3* Complete in Q3 ✓	**2.** Elective assets across optimised through merged scheduling – *ongoing until Q4* Complete in Q3 ✓	**3.** Regional mutual aid delivered to reduce longest waits – expected Q3 Complete in Q3 ✓	**4.** Operationalising regional mutual aid delivered – *expected Q3* Complete in Q3 ✓

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	The additional short stat theatre was made available for during December 2025. Unfortunately due to reduced capacity due to the Central Decontamination Unit (CDU) issues only partial use of these theatre was made in December.	December 2025	The partial opening in December had a limited impact, but did add total capacity to our system. The impact will be more noticeable during Q4 when full use is expected.	The key risks to the use of this delivered outcome during Q4 is surges in unscheduled care patients requiring the use of the elective bed base to accommodate these patients If this occurs above the assumed level then elective patients will be cancelled and our total theatre activity will reduce.	Tight operational management of all theatres capacity inclusive of the short stay unit will remain in place both in terms of maximising daily throughput and ensuing the maximum number of Patient Tracking List (PTL) patients are booked. The end of March KPI trajectory assumes full utilisation of the Short Stay Theatre.
2	On a board level the Acute Integration project has merged the Orthopaedics waiting list. Gynaecology and General Surgery, outwith the acute integration process, has made significant improvements in removing variation in waiting times performance between the Aberdeen and Elgin based services by merging the waiting list and booking patients in turn irrespective of their postcode and irrespective of their local hospital.	March 2026	This contributed the KPI performance by reducing variation in waiting times across NHS Grampian and therefore treating the longest waiting patients within these specialities, whilst other patients will now experience a longer, albeit consistent, wait.	Minimal risk, though for those services outwith the acute integration work, continued operational management is required.	The operational management and monitoring will continue through Q4 to ensure that this process does not slip back.
3	- NHS Grampian concluded formal discussions with seven Health Board on the provision of Treatment Time Guarantee (TTG). - Initial offer of 560 patients to be seen and treated in 2025/26 was reduced to 0 patients mainly due to changing circumstances in other Health Board positions or patients not meeting clinical criteria for treatment. - Scottish Government written to on 15th December to inform no agreements reached for TTG support. Lessons learned document created and shared with Board Chief Executives to inform future discussions. - Developed and submitted narrative on 15 December setting out reasons for revising forecast New Outpatient trajectory for Scottish Government. Final revision due 16 January 2026.	December 2025 December 2025 December 2025 November 2025 Completed and then 16 January 2026	Confirmed that the TTG contribution from Mutual Aid will be 0 patients in 2025/26. This is consistent with earlier TTG 52-week wait list trajectories submitted to Scottish Government and therefore there is no deterioration in the in-year position, as any agreements to treat patients would have improved the trajectory. As a result, we do not foresee any further Mutual Aid conversations to take place this financial year.	There are no risks associated with this outcome as the concluded position is in line with original activity planning assumptions. As such, there are no mitigations to apply.	There are no actions to implement in Quarter 4 as the position shared through our internal governance structures and with Scottish Government through Quarter 3 2025/26 render this outcome closed.
4	As per narrative supplied in outcome 3 above, the TTG mutual aid offering of zero patients being treated by other Health Boards confirms this outcome will not be implemented this financial year and therefore can be closed.	December 2025	Confirmed that the TTG contribution from Mutual Aid will be 0 patients in 2025/26. This is consistent with earlier TTG 52-week wait list trajectories submitted to Scottish Government and therefore there is no deterioration in the in-year position, as any agreements to treat patients would have improved the trajectory.	There are no risks associated with this outcome as the concluded position is in line with original activity planning assumptions. As such, there are no mitigations to apply	There are no actions to implement in Quarter 4 as the position shared through our internal governance structures and with Scottish Government through Quarter 3 2025/26 render this outcome closed.

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%	**93.43% (prov.)***	**94%**		95%		31-day performance has improved as a result of mobilisation of additional capacity through funded improvement projects.

*Q3 cancer figures are currently provisional; finalised figures will be available 20/02/2026

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
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		

Key Outputs to deliver intended KPI Performance:

1. Cancer improvement projects delivered to time, budget and scope - ongoing until Q4	**2.** Capacity secured to deliver standard within core capacity – ongoing until Q4	**3.** Treatment coordination processes strengthened to reduce delays from decision to treat to first intervention Completed in Q2 ✓

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	Enhanced governance structure continues with weekly operational meetings and monthly Planned Care Programme Board performance reporting against all six outcomes and trajectories. Recruitment to locum medical staff in Breast service has provided support in additionality to reduce waiting times in the urgent suspicion of cancer (USC) pathway for first appointment and treatment. Recruitment of staff to support additionality in treatments undertaken on radiotherapy machine that was extended for use in Q1	Completed and on-going Complete – Dec 2025 Complete – Jan 2026	Continuous weekly meetings between Operational leads, Finance and Performance Team providing immediate identification of adverse variances to performance and discussion on mitigations. In Q3, approximately 800 patients were treated on the 31-day cancer pathway across all specialties, consistent with Q2 activity. Notably, the Breast pathway saw an improvement in performance, increasing from 87% in Q2 to 93% in Q3. This uplift contributed around a 2% improvement to the overall combined KPI performance In Q3, the average time to radiotherapy treatment was 21 days, an improvement from 23 days in Q2. This has helped maintain strong performance where radiotherapy is the first treatment on 31-day pathways. Urology (Prostate) remains the main source of breaches, although the average wait has improved from 38 days in Q2 to 33 days in Q3	**Risk:** Central Decontamination Unit (CDU) closure and consequent availability of sterile equipment impacts scheduling, diagnostic and treatment backlog, and flow and bed capacity, risking meeting required capacity. **Mitigation:** planning and scheduling of replacement CDU machines in place, and underway **Risk:** Rescheduling of cancer treatments due to winter travel pressures has created a knock-on impact on available scheduling and treatment capacity **Mitigation:** All affected patients will continue to be closely tracked and monitored to ensure timely rebooking **Risk**: Backlog recovery activity is increasing the number of breached patients now being treated, which is having a negative impact on performance **Mitigation:** We will prioritise clinically urgent cases, continue proactive tracking of breached patients, and use capacity planning to minimise further delays while ensuring that performance impacts are understood, monitored, and clearly reported	**In Q4 we will:** A) Resume CDU to 100% capacity by January 2026 B) Commence Breast cancer treatments in Stracathro Hospital by February 2026 C) Continue daily monitoring and escalation of all potential breach patients to ensure delays are identified and acted on early as per actions in the national Framework for Effective Cancer Management. **These actions will help towards achieving our KPI target by:** A) Restoring surgical activity to full capacity increases the number of patients who can begin treatment promptly, reducing bottlenecks in high-volume tumour pathways (Breast, Colorectal, Urology) that are currently delaying performance recovery B) Sending straightforward breast surgery to another site frees local theatres and specialist teams to focus on complex cancer cases, helping more high-risk patients start treatment within target times C) This focused, early oversight directly reduces avoidable breaches and strengthens performance against cancer waiting time standards

2	Delivery of Extended Long Day Operating for Cancer – Urology, Plastic/Breast, Head & Neck and General Surgery	Complete – June 2025	In Q3, the average time to surgical treatment was 12 days, an improvement from 14 days in Q2. This has helped maintain strong performance where surgery is the first treatment on 31-day pathways. Urology (Bladder) remains the main source of breaches, with average wait of 43 days.	As above	As above
3	Completed in Q2	Complete	This output has supported the KPI by an overall sustained position in the average number of days from decision to treat to treatment of 9 days. Further improvements in Q4 are limited due to the negative impact of backlog recovery on performance.	Output has been delivered	No further actions in Q4

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%	65.46% (prov.)*	76%		85%		62-day performance has improved as a result of mobilisation of additional capacity through funded improvement projects, however has not met the planned trajectory for this quarter due to delay in mobilisation. Spotlight on pg. 37

*Q3 cancer figures are currently provisional; finalised figures will be available 20/02/2026

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	ANTICIPATED SIGNIFICANT 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		

Key Outputs to deliver intended KPI Performance:

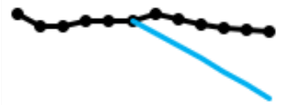
1.	2.	3.
Cancer improvement projects delivered to time, budget and scope– ongoing until Q4 Ongoing to March 2026	Capacity secured to deliver standard within core capacity – ongoing until Q4 Ongoing to March 2026	Treatment coordination processes strengthened to reduce delays from decision to treat to first intervention Completed in Q2 ✓

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	See outcome 5 – Endoscopy Capacity Commencement of one-stop Head & Neck pathway Maintain Optimal Lung Cancer Pathway through use of Chest X-Ray A.I. to triage high risk patients	Complete Dec 2024 / Jan 2026 Complete Sept 2025 Complete Dec 2025	In Q3, approximately 500 patients were treated on the 62-day cancer pathway across all specialties, a slight increase from Q2 activity of 460 patients. Notably, the Colorectal pathway saw an improvement in performance, increasing from 37% in Q2 to 44% in Q3 due to reduction in waiting times to colonoscopy. This uplift contributed to a marginal improvement to the overall combined KPI performance. Improvement projects underway in Head & Neck have not realised impacts on this KPI in Q3, expected impact of increased performance is expected to be seen by end Jan 2026. Performance in the lung cancer pathway has steadily improved, rising from 83% in Q1 to 94% in Q2 and reaching 97% in Q3. Q3 performance exceeds the national 95% target. However, as the Lung pathway is a low-volume pathway, these gains are not always reflected in the overall 62-day performance	**Risk:** Central Decontamination Unit (CDU) closure and consequent availability of sterile equipment impacts scheduling, diagnostic and treatment backlog, and flow and bed capacity, risking meeting required capacity. **Mitigation:** planning and scheduling of replacement CDU machines in place, and underway **Risk:** Rescheduling of diagnostic tests and cancer treatments due to winter travel pressures has created a knock-on impact on available scheduling and treatment capacity **Mitigation:** All affected patients will continue to be closely tracked and monitored to ensure timely rebooking **Risk**: Backlog recovery activity is increasing the number of breached patients now being treated, which is having a negative impact on performance **Mitigation:** We will prioritise clinically urgent cases, continue proactive tracking of breached patients, and use capacity planning to minimise further delays while ensuring that performance impacts are understood, monitored, and clearly reported	**In Q4 we will:** A) Resume CDU to 100% capacity by January 2026 B) Commence additionality in molecular testing by January 2026 C) Continue daily monitoring and escalation of all potential breach patients to ensure delays are identified and acted on early as per actions in the national Framework for Effective Cancer Management. **These actions will help towards achieving our KPI target by:** A) Restoring surgical activity to full capacity increases the number of patients who can begin treatment promptly, reducing bottlenecks in high-volume tumour pathways (Breast, Colorectal, Urology) that are currently delaying performance recovery B) Rapid molecular genetics testing speeds up diagnosis, enabling earlier treatment decisions and reducing delays that lead to 31- and 62-day breaches C) This focused, early oversight directly reduces avoidable breaches and strengthens performance against cancer waiting time standards

2	Recruitment of 2.4 WTE (Whole Time Equivalent) additional nursing and 1 WTE locum medical staff to Breast service Purchase of microtome equipment for use in preparing pathology specimens	Complete – Dec 2025 Complete – Jun 2025	Additional staffing has reduced the first USC appointment wait in the Breast pathway from 4 weeks to 2 weeks. This has improved performance from 78% in Q2 to 87% in Q3, contributing to a small uplift in the overall combined KP The average pathology reporting time has been maintained at 16 days. Given the strong interdependence of diagnostic steps across the cancer pathway, sustaining this turnaround has helped stabilise overall performance, supporting the KPI to remain relatively consistent from Q2 to Q3.	**As Above** **Risk**: Increasing volumes of urgent suspicion of cancer referrals are placing additional pressure on diagnostic and treatment capacity, increasing the risk of delays and breaches **Mitigation:** The rollout of the new referral guidelines from February 2026 will support more appropriate referral triage and help manage demand, reducing pressure on the system and supporting pathway performance. **Risk:** The high interdependence between cancer pathways and diagnostics increases the risk of delays, as pressure on endoscopy and radiology capacity can slow key steps and negatively impact overall performance. **Mitigation:** Actions underway in Outcome 5 to expand endoscopy capacity and in Outcome 6 to increase radiology capacity will help relieve these diagnostic bottlenecks, reducing delays and supporting improved pathway performance.	As above See also Actions in: Outcome 5 – Endoscopy Capacity Outcome 6 – Radiology Capacity
3	Completed in Q2	Complete	This output has supported the KPI by an overall sustained position in the average number of days from referral to treatment of 73 days. Further improvements in Q4 are limited due to the negative impact of backlog recovery on performance.	Output has been delivered	No further actions in Q4

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		
≤1,685 Endoscopy patients (4 key diagnostic tests) waiting over 6 weeks by the end of March 2026	2516	2645	2644	2552	1763	2379	822		≤1,685		Graph on Pg. 35 Spotlight on Pg. 39

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE

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

Key Outputs to deliver intended KPI Performance:

1. ARI fourth endoscopy room opened and staffed
   To be completed by end Jan 2026
2. Single Endoscopy service model in place with unified staffing and scheduling
   Completed in Q3 ✓
3. EndoSign service reinstated to support triage and reduce unnecessary procedures
   Completed in Q3 ✓

Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	The fourth room became operational in Q3, though unfortunately not five days a week. During Q3 it has been opened for two days a week with the plan to continue to add additional days	Jan 2026 (Mondays additional day)	The partial opening has had a positive impact on our trajectory mainly during December. The additional capacity has delivered the expected degree of improvement.	We have a firm plan to increase to an additional day in Jan 2026, but further agreement and plans are required to get to the full five day capacity. This will require standing down elective surgical capacity so is a trade-off between this KPI and the Treatment Time Guarantee (TTG) KPI. We believe Endoscopy is the priority, but detailed planning and the loss of capacity on the impact services is taking longer than expected.	The key outcome during Q4 will be opening the additional day and ideally at a minimum confirming the plan and start date for the remaining days of the week
2	The Acute Integration Project has delivered a unified Endoscopy Service for Grampian. There is now a single waiting list in place across Grampian under a single management structure.	Dec 2025	The single service allows greater service resilience and equalises waiting times experience and therefore reduces the longest waiting times. This is assumed in the KPI trajectory so this action has supported the delivery of the KPI	N/A as Output completed	N/A as Output completed
3	The Endosign Service has been restarted. This involves updated Information Governance and Information Security protocols to accommodate the new product and license along with staff retraining on the new product	Dec 2025	The service commencement has started to address surveillance patients. This has an indirect impact on the new patients as it reduces the total demand on Endoscopy and therefore frees capacity for other patients. As a less invasive test it has also improved the patient experience for these patients	Considered a standard part of the service, so now standard operational risks	The key actions during Q4 will be set out a clear plan to expand the cohort of patients who are able to access this service along with a timeline for implementation

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 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?
≤2,151 Radiology patients (4 key diagnostic tests) waiting over 6 weeks by the end of March 2026	3629	5145	6000	**6567**	**6442**	**5695**	**3932**		≤2,151		Graph on Pg. 35 Spotlight on Pg. 40

Deliverable to enable Q4 KPI Target:	Expected Status at 31st March 2026	WILL BE COMPLETE
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		

Key Outputs to deliver intended KPI Performance:

1. Second mobile MRI deployed and operational to increase scanning Completed in Q2 ✓	**2.** 7 day radiology service implemented as core capacity model Completed in Q2 ✓	**3.** Funded capacity improvements in place – ongoing until Q4

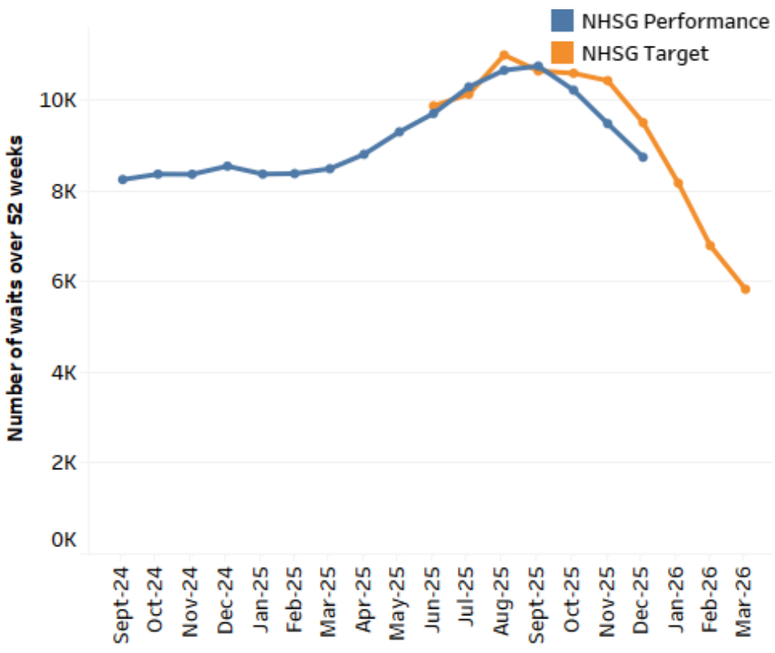
Q3 Output Update

Output	What actions have you taken in Q3?	When will this be complete?	How did this sustain or improve KPI performance in Q3?	Risks to Delivery and Mitigations	Q4 - what final actions will be in place to achieve KPI target, by when in Q4?
1	The second MRI mobile scanner was made fully operational during Q3 as well as additional capacity at DGH via a visiting mobile to mitigate for the delay in getting this scanner in place	Completed Q3	This has provided additional capacity that has had a significant impact on the MRI trajectory. This positive impact is unfortunately hidden by the deteriorating of the Ultrasound position in the combined imaging KPI	Normal operational risks	The van will remain in situ until the end of Q4 and will continue to deliver activity
2	There has been successful recruitment, training and appropriate redesign to allow the 7 day service to be implemented	Complete	This has increased the core capacity on a recurring basis and has therefore improved (as per the improvement trajectory) the KPI	Normal operational risks	This is recurring additional core capacity
3	All projects are progressing. To address drop in Ultrasound capacity due to the inability to replace the locum and in-reach independent sector contract has been specified and is out for mini-competition with an aim to commence in Q4	End of Q4	The combined projects deliver the KPI for modality of MRI, Computed Radiography (CR), Barium and Ultrasound. All have contributed to the KPI with the divergence currently related to the Ultrasound agency staffing issue	The key risk is not being able to mobilise the Incentive Scheme (IS) contract in time during Q4 to regain the trajectory. Awarding the contract requires the support of InfoGov and procurement along with the service and then there may be unexpected operational issues. Mobilising this contract is however a priority	Award and mobilise the Ultrasound IS contract

Planned Care Performance Charts

Outcome 1: 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.

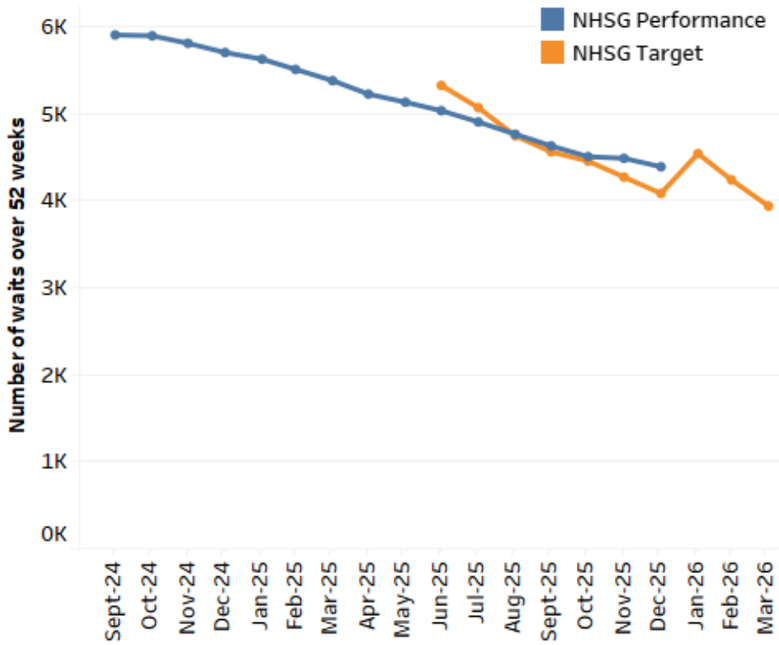
Our performance trajectory (shown in orange) is such that we projected the number of waits over 52 weeks would increase to August, before decreasing to 31/03/26, but will not reach zero by then (trajectory revised January 2026, in agreement with SG). Positive performance is where number of waits is below trajectory.

The number of waits over 52 weeks had been trending up over the previous four years, before decreasing through the last quarter.

At the end of December 2025*, the number of waits over 52 weeks had decreased, remaining below trajectory.

Outcome 2: 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.

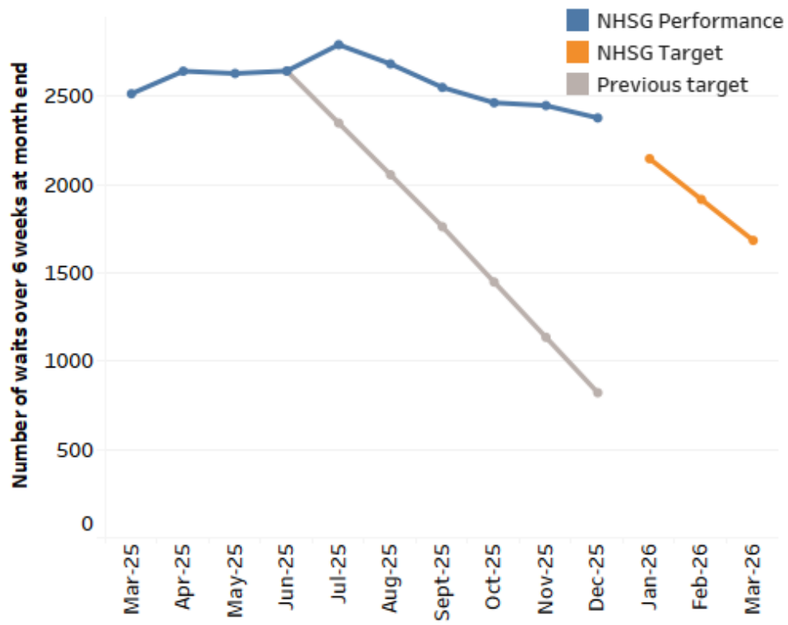
Our performance trajectory (shown in orange) will reduce the number of TTG inpatient waits over 52 weeks by 31/03/2026, but will not reach zero by then (trajectory revised January 2026, in agreement with SG). Positive performance is where number of waits is below trajectory.

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

At the end of December 2025*, the number of waits over 52 weeks had decreased, remaining above trajectory.

Outcome 5: Performance against the endoscopy tests 6 week target:

Reduce the number of waits over 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.

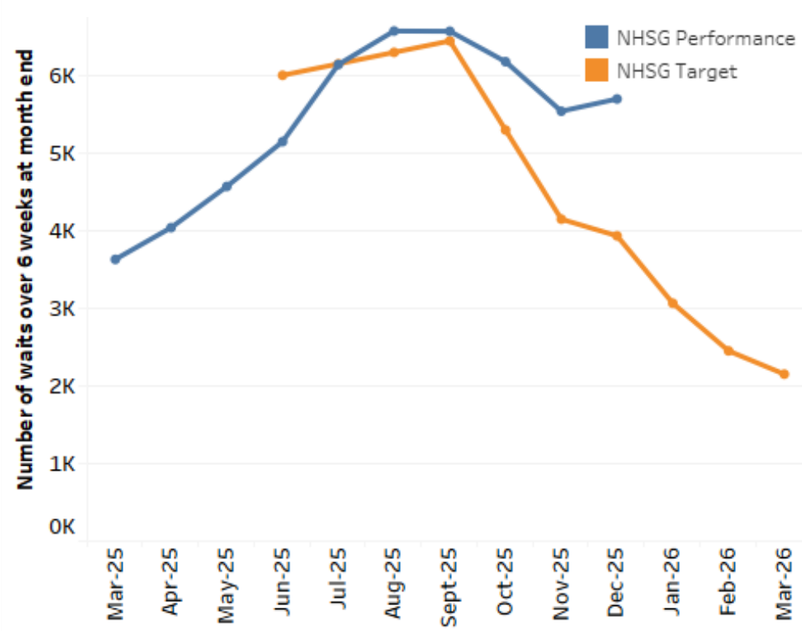
Our performance trajectory (shown in orange) was revised in January 2026, in agreement with SG. It shows a decrease in waits over 6 weeks to 31/03/2026, but will not reach zero by then. Positive performance is where number of waits is below trajectory.

The number of waits over 6 weeks at month end has decreased since July 2025.

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

Outcome 6: Performance against the radiology tests 6 week target:

Reduce the number of waits over 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.

Our performance trajectory (shown in orange) is such that we projected the number of waits over 6 weeks would increase to September, before decreasing to 31/03/2026, but will not reach zero by then (trajectory revised January 2026, in agreement with SG). Positive performance is where number of waits is below trajectory.

There was an upward trend in the number of waits over 6 weeks at month end through 2025 to August, before a decrease to November 2025 followed by an increase in December.

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

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

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

Tier 3: Our Performance Spotlights – Planned Care

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

2) 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 on a positive trajectory but have diverged from our original plan to the impact of the Central Decontamination Unit (CDU) closure. In agreement with the assurance board we have agreed to re-submit an amended end of year trajectory taking this into account by the end of January 2026. At the end of Q3 we also received additional funding to support private sector activity during Q4 which will partly, but not completely, mitigate the lost capacity due to CDU. The CDU closure due to concerns around potential contamination has necessitate a reduction in surgical activity although this reduction has been heavily reduced due to significant work and mutual aid.

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

- The outputs are appropriate with majority of the activity coming from Grampian projects or additional capacity provided via national cold elective sites (Golden Jubilee National Hospital and National Treatment Centre-Highland). The contribution so far from regional or national mutual aid has been minimal for TTG. We are confident we would have been on our original trajectory should the CDU issue not have materialised.

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

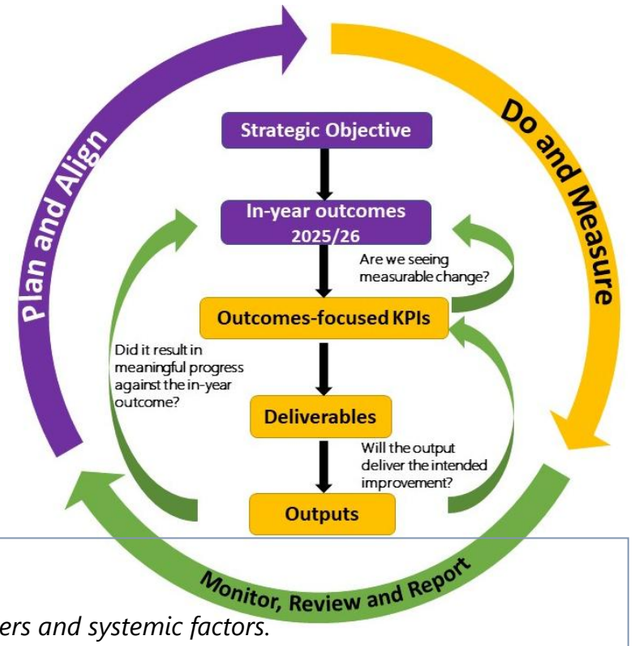
- We have explored all options to mitigate the CDU issue and have worked hard to maintain as much capacity as possible during the CDU disruption. Significantly this includes additional private sector capacity during Q4 an ambition to ramp up Waiting List Initiative which is being supported by additional financial risk and a wide search for mutual aid across NHS Scotland.

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

- We continue to deploy administrative and clinical validation to ensure that all patients on the waiting list are ready and require their surgery. The waiting well team continues to support patients whilst they are waiting.

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 risks into quarter 4 are supplier under-delivery for the private sector activity and/or delays in agreeing contractual details limiting the available capacity. This is being prioritised currently by Procurement and Information Governance Colleagues
- There remains a risk of infrastructure failure reducing our capacity
- Winter pressures both in terms of travel and staffing disruption and in terms of an ability to protect planned care capacity from unscheduled care demands remains a key risk. This is managed via the unscheduled care programme board

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)?

- There are key links between the success of the unscheduled care programme and the elective care programme and delays in one impact negatively on the other. There remains risks associated with some of the value and sustainable projects but they are not considered in year delivery risks through Q4 in either direction.

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

- Strategic Risk 3065: The strategic risk is an inability to produce elective care to the population in an acceptable timeframe. Reducing the number of patients waiting over a year for their surgery directly reduces this risk

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) Q2 to Q3**	**If Not, why not**	***Cancer Pathway***	**Are we seeing measurable change (since the last quarter) Q2 to Q3**	**If Not, why not**
Breast	*Yes - improved*		HPB	*No - Declined*	*Complex pathway*
Breast Screening	*Yes - improved*		Lung	*Yes - improved*	
Cervical	*Yes – maintained*		Lymphoma	*Yes - improved*	
Cervical Screening	*Yes – maintained*		OG	*Yes - improved*	
Colorectal	*Yes – maintained*		Ovarian	*No - Declined*	*Theatre capacity*
Colorectal Screening	*Yes - improved*		Plastic Surgery	*Yes - improved*	
Dermatology	*Yes – maintained*		Urology - Other	*Yes - improved*	
Head & Neck	*No - Declined*	*Complex pathway*	Urology - Bladder	*Yes - improved*	
Head & Neck (OMFS)	*Yes – maintained*		Urology – Prostate	*No - Declined*	*Urology Diagnostics / 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 is a key Operational Improvement Plan (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)

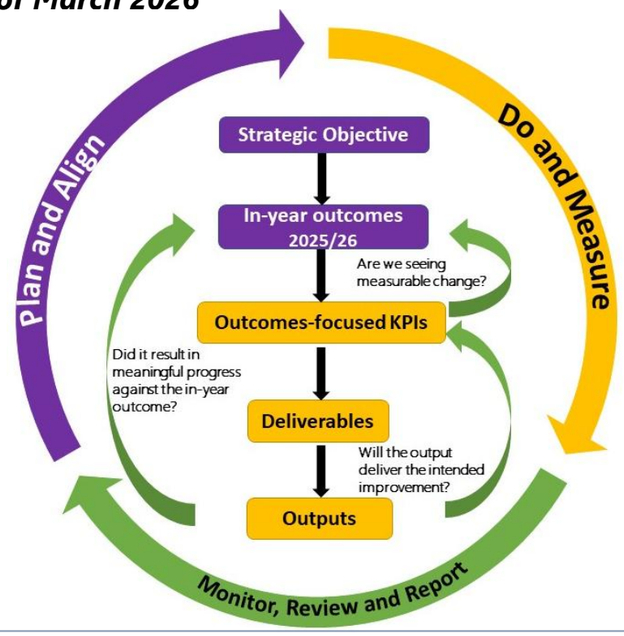
- The principle of Realistic Medicine has supported progress towards this Outcome by ensuring care is person-centred and tailored to individual needs, which aligns with Putting People First. By focusing on reducing unnecessary variation in clinical practice, we have promoted equity in access and outcomes, 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 National Treatment Centre-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

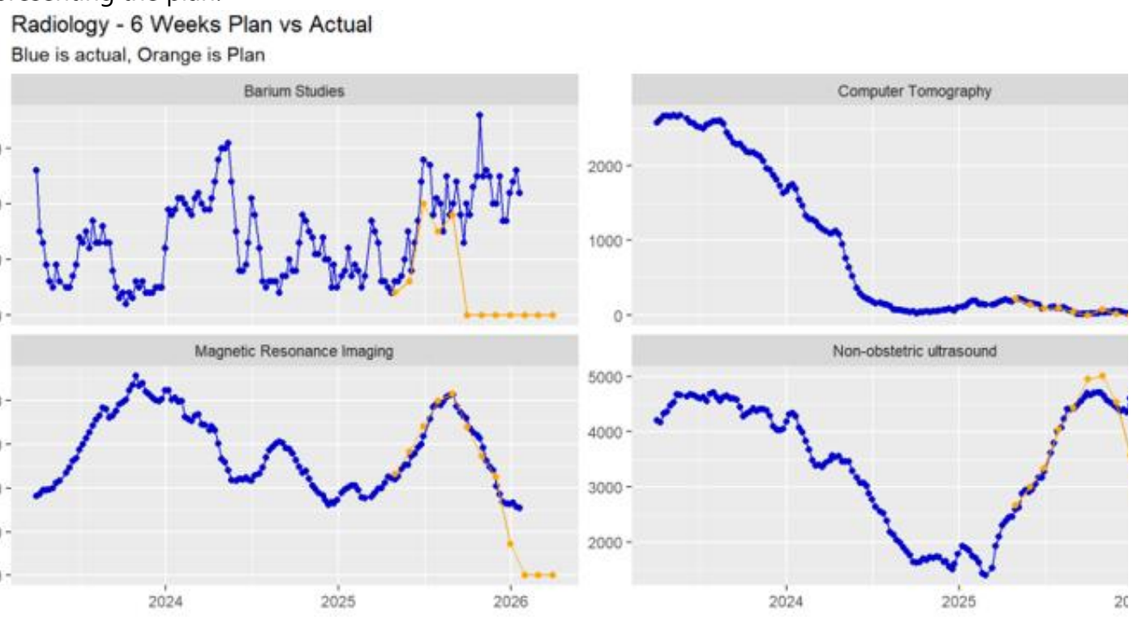
Outcome 6: Reduce waits so that 95% of Radiology patients receive their scan and report within 6 weeks of referral by the end of March 2026

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.

- During Q3 significant improvements in MRI waits have been achieved as planned with CT and Barium remaining on the planned glide path. There has however been negative variation in Ultrasound due to continuing challenges in securing a replacement locum. This movement is summarised by modality in the graphs below with blue representing the actual position over time and the amber representing the plan.

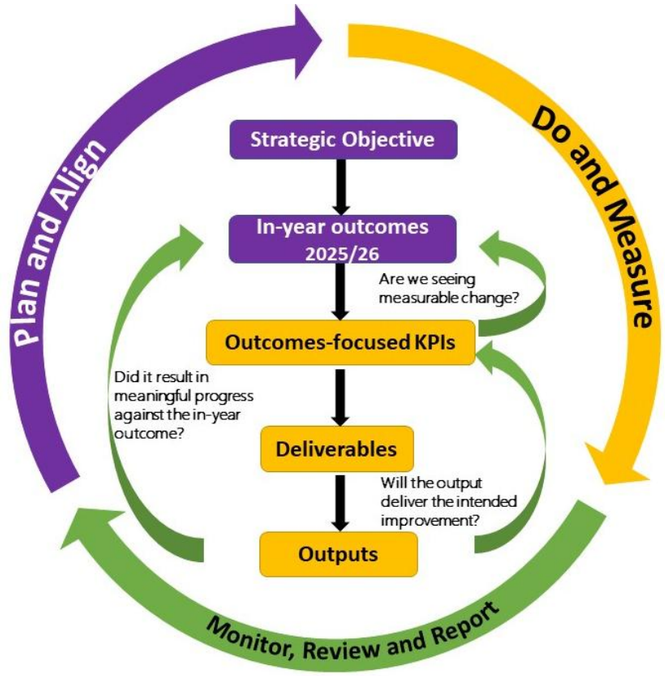


Are the outputs and deliverables in place sufficient to deliver the intended improvement towards those KPIs?

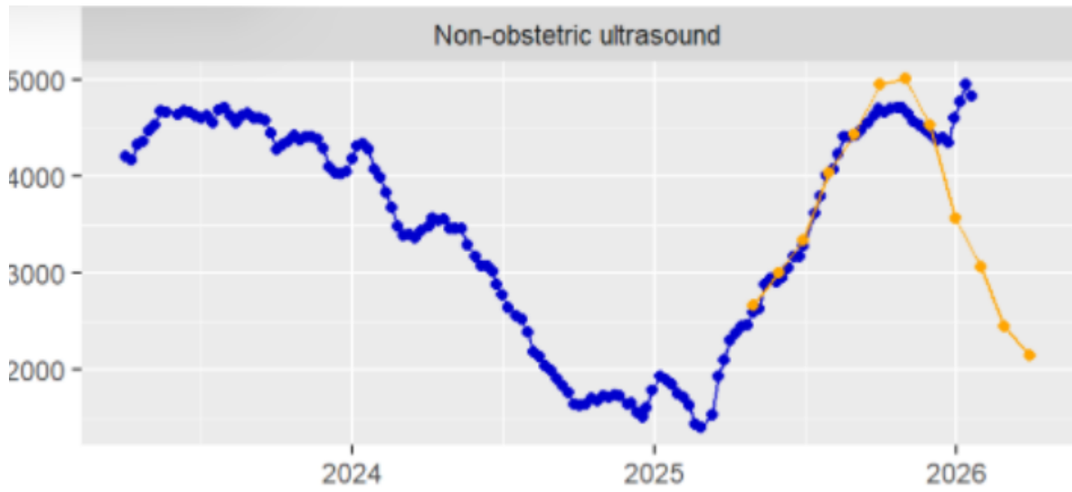
- The main Q4 action relates to mobilising the Ultrasound Independent Sector contract which is intended to mitigate for the locum capacity loss. This is intended to be mobilised by the end of Jan 2026. The MRI capacity should achieve the trajectory. The expectation that this will recover the original plan though there relies on the Ultrasound contract being mobilised quickly and leaves little flexibility for any unforeseen challenges.

Commentary from
Paul Bachoo

Acute Medical Director



As per the planned trajectory line (amber):



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 loss of the locum and the inability to secure an alternative has been addressed via the procurement exercise for the independent sector contract. This contract is expected to be procured and operational by the end of January 2026.

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

- The principle of Realistic Medicine has continued to support 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.

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 are delay on commencement or supplier failure around the Ultrasound contract; infrastructure failure and the continued reliance on Independent Sector contracts for substantial proportions of our capacity. These will be mitigated via prioritisation and escalation to relevant teams for senior support for timely action if required

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)?

- There are links to unscheduled care performance and the infrastructure risks. Infrastructure failure will lead to service interruption and capacity reduction. Unscheduled care performance and demands will divert radiological capacity away from elective work towards urgent inpatient requirements and divert resources away from this objective

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

- Strategic Risk 3065: The strategic risk of an inability to delivery planned care to the population of NHS Grampian is inclusive of the requirement to provide timely diagnostic imaging for appropriate patients. Reducing the time to this for Radiological examinations directly contributes towards this

National Waiting Times Standards

National Waiting Times Target/Access Standard *(measurement definition, based on quarterly period unless otherwise stated)*	**Target**	**Quarter end Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025**	**Quarter end Dec 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Sep 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%	64.3%	66.2%	65.7%	63.2%	**60.8%**	9th Scotland: 66.8% *(Quarter end Dec)*	Overall A&E performance increased for the quarter ending March 2025, before decreasing over the subsequent three quarters to December. Performance remains lower than at the same time the previous year. Based on national data to the end of December, Grampian's performance was 9th of the mainland Boards (having been 8th for the previous two quarters); we remain below the overall Scotland level. *The consistent level of delayed patients in the Acute settings, as well as a marginal increase in average Acute Length of Stay, retains overall midnight occupancy above 100% and continues to constrain 4 hour access performance. Relieving exit block in our assessment areas through faster hospital flow remains 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%	50.1%	51.9%	47.6%	41.7%	**40.3%**	11th Scotland: 54.4% *(Quarter end Sept: benchmarking for Q end Dec will not be available until 24/02)*	Performance decreased for the latest three quarters to December 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 primarily related to a rise in the backlog of Ultrasound after unsuccessful attempts to secure a locum. This is now being addressed via an Independent Sector contract which is due to commence in Q4. The fourth endoscopy room remains partially open with an additional day at a minimum intended to be introduced in Q4*

* Provisional local data shown where December 2025 national benchmarking data is not yet available

** National benchmarking data is for the quarter to September 2025 unless otherwise indicated; for some targets, national data to December 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 Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025**	**Quarter end Dec 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Sep 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%	62.0%	58.8%	65.1%	66.8%	**61.0%**	6th Scotland: 60.6% *(Quarter end Dec)*	Performance decreased for the quarter to December 2025. Based on national data to the end of December, we moved from 3rd to 6th 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 formalised an adjustment to our 52 week trajectories to reflect challenges with the Dermatology Independent Sector contract*
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%	48.1%	44.4%	47.9%	50.3%	**57.9%**	5th Scotland: 57.9% *(Quarter end Dec)*	Performance improved for the third consecutive quarter, to December 2025. Based on national data to the end of December, we are 5th of the mainland Boards (previously 7th); with the same level of performance as Scotland overall. *Our elective care plan does not directly address this metric and is focussed on achieving no patients waiting more than 52 weeks. We have formalised an adjustment to our trajectory to reflect the lost Central Decontamination Unit activity which is partly mitigated by additional Independent Sector capacity due in Q4*
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%	87.3%	90.0%	91.6%	90.1%	**93.4%**	11th Scotland: 95.1% *(Quarter end Sept: benchmarking for Q end Dec will be not be available until 31/03)*	Following a decrease to September 2025, provisional data shows an improvement to December 2025. Based on national data to the end of September, we returned to 11th of the mainland Boards. We 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 delay in mobilisation of additional capacity through funded improvement projects.

* Provisional local data shown where December 2025 national benchmarking data is not yet available

** National benchmarking data is for the quarter to September 2025 unless otherwise indicated; for some targets, national data to December 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 Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025**	**Quarter end Dec 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Sep 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%	60.3%	52.5%	61.2%	60.8%	**64.6%**	11th Scotland 70.7% *(Quarter end Sept: benchmarking for Q end Dec will not be available until 31/03)*	Following a decrease to September 2025, provisional data shows an improvement to December 2025. Based on national data to the end of September, we moved from 9th to 11th of the mainland Boards. We remain consistently below the overall Scotland level. *The median time from urgent suspicion of cancer referral to treatment and number of patients treated on the 62-day pathway has remained consistent over the last three quarters. Performance against the standard has marginally improved but remains below the anticipated trajectory. This is not where we want to be which unfortunately is in part due to delay in 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%	97.8%	97.7%	98.3%	97.8%	**97.4%**	4th (meeting target) Scotland: 91.5% *(Quarter end Sept: benchmarking for Q end Dec will not be available until 03/03)*	Performance decreased fractionally for the second quarter to December 2025 (provisional data). CAMHS have consistently met the target over the last two years. Based on national data to the end of September, we moved from 7th to 4th of the mainland Boards. *Enhanced Mental Health Outcomes Framework (EMHOF) funding allocation has now been baselined which has allowed recruitment to progress. 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. The CAMHS Workforce Plan and Service Plan have identified structured improvements over the next quarter.*

* Provisional local data shown where December 2025 national benchmarking data is not yet available

** National benchmarking data is for the quarter to September 2025 unless otherwise indicated; for some targets, national data to December 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 Dec 2024**	**Quarter end Mar 2025**	**Quarter end Jun 2025**	**Quarter end Sep 2025**	**Quarter end Dec 2025***	**Benchmarking**** (of 11 mainland Boards quarter end **Sep 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%	77.8%	79.2%	80.5%	**80.2%**	5th Scotland: 80.7% *(Quarter end Sept: benchmarking for Q end Dec will not be available until 03/03)*	Performance decreased fractionally to December 2025 (provisional figure). Based on national data to the end of September, we remain 5th of the mainland Boards. *Performance has been maintained this quarter. We are engaged with SG and Health Intelligence to continue our DCAQ data analysis and trajectory planning. With this work we are confident that we are working to capacity. EMHOF funding allocation has now been baselined which has allowed some further recruitment to be realised. We have also developed a further improvement plan for 2026 with a focus on further efficiencies which we expect will allow performance to be maintained over the next quarter.*
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%	100%	100%	100%	100%	**100%**	Scotland: 100.0% *(Quarter end Sept: benchmarking for Q end Dec will not be available until 24/02)*	We continue to consistently achieve the target *We continue to achieve our goal of all patients being referred and seen within the 52-week window. The average wait time to treatment for all patients that meet treatment criteria as of December 2025 is 10-12 weeks. This figure can fluctuate depending on demand and complexity of each patient case however we remain resolved to prioritise patient wait time and are always exploring avenues to reduce this further.* *For the patients that are referred to service however require additional testing, procedures or treatment prior to IVF treatment, they are reviewed on a regular basis to mitigate an extended waiting time prior to treatment.* *As we move into 2026 we aim to improve our vetting procedure and increase clinical capacity through recruitment and additional training.*

From PHS national waiting times publications

* Provisional local data shown where December 2025 national benchmarking data is not yet available

** National benchmarking data is for the quarter to September 2025 unless otherwise indicated; for some targets, national data to December 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

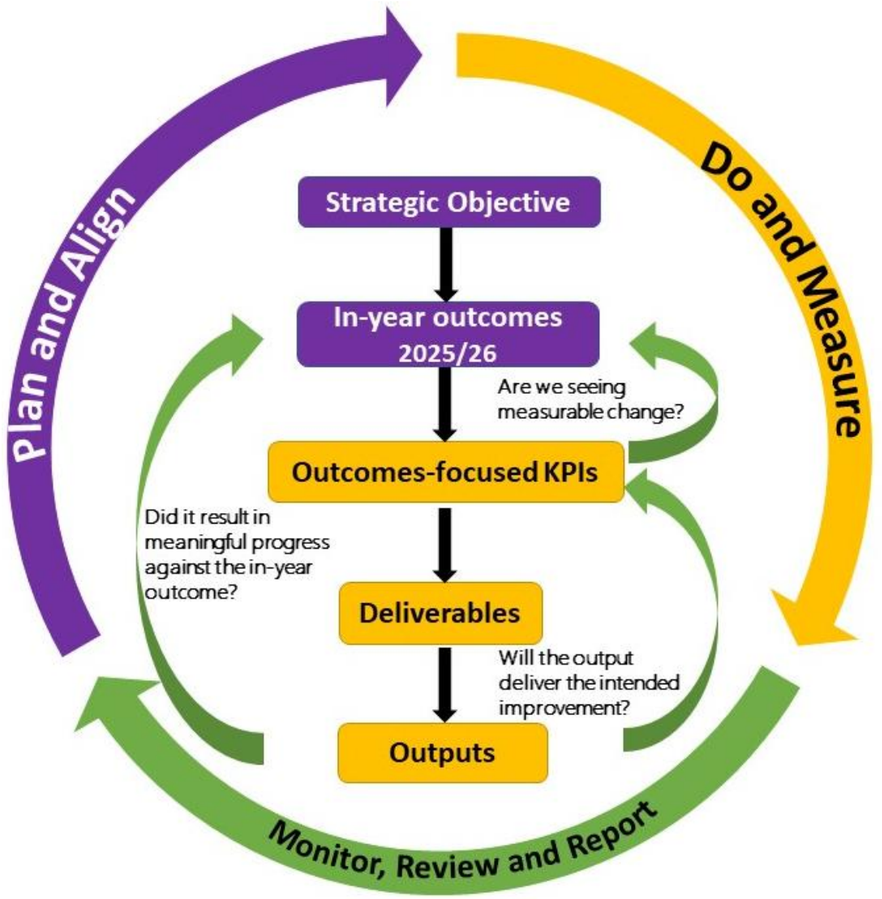
Three Change Programmes		
1 Outcome	4 Outcomes	6 Outcomes
4 KPIs	10 KPIs	6 KPIs
1 Deliverable	9 Deliverables	6 Deliverables
3 Outputs	27 Outputs	20 Outputs
Value & Sustainability	Unscheduled Care	Planned Care

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

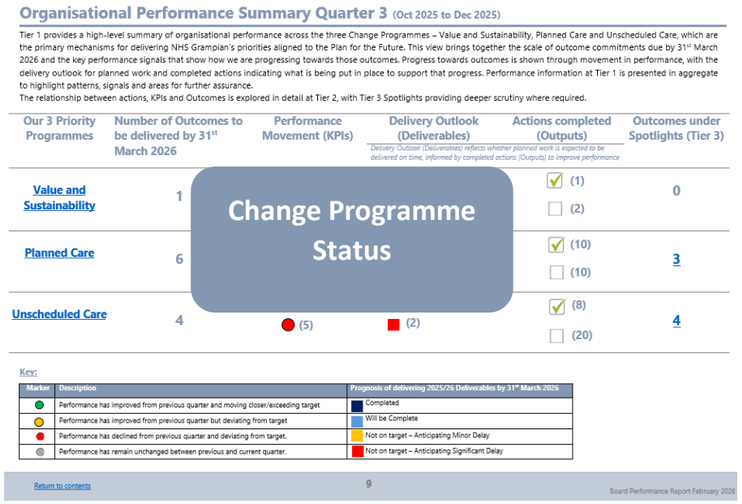
The format of this report supports a tiered approach on how we review performance information. The purpose of the reading guide is to help you navigate the sections in this report. These are intended to flow, enabling you the flexibility to view high level or drill down data.

(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)

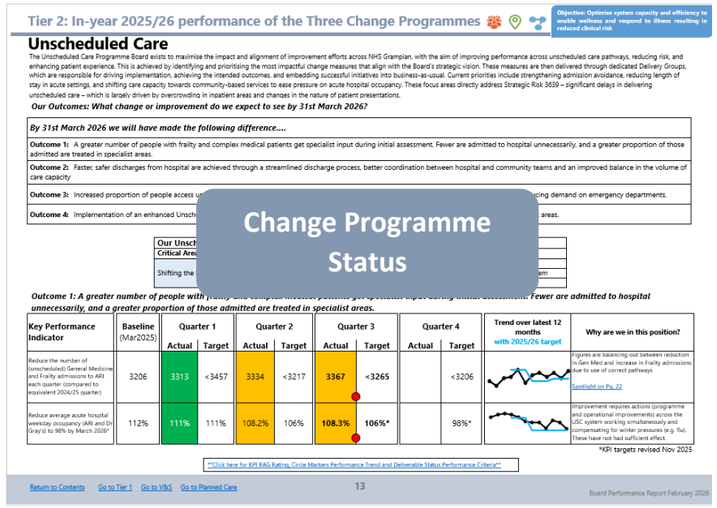
(Tier 3)
Performance Spotlights
(Detailed focus on adverse performance with detailed commentaries on our in-year Outcomes)

Our Board Performance Summary across our Change Programmes:

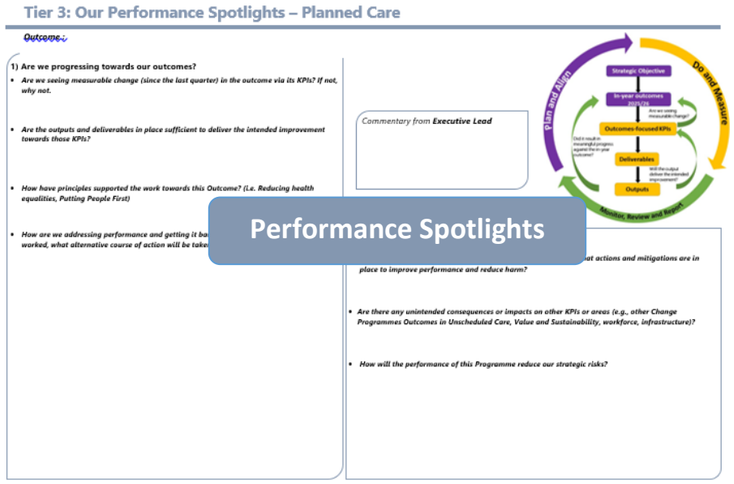


A high level overview of our performance as a Board across Value & Sustainability, Unscheduled Care, and Planned Care

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)