NHS Orkney Board
26 June 2025

Purpose of Orkney NHS Board

The overall purpose of Orkney NHS Board is to ensure the efficient, effective and accountable governance of the NHS Orkney system, and to provide strategic leadership and direction for the system as a whole.

Our **Values**, aligned to those of NHS Scotland, are:

- Open and honest
- Respect
- Kindness

Our **Strategic Objectives** are:

Place Be a key partner in leading the delivery of place-based care which improves health outcomes and reduces health inequalities for our community

Patient safety, quality and experience Consistently deliver safe and high-quality care to our community

People Ensure NHS Orkney is a great place to work

Performance Within our budget, ensure our patients receive timely and equitable access to care and services and use our resources effectively

Potential Ensure innovation, transformation, education and learning are at the forefront of our continuous improvement

---

Quorum:

Five members of whom two are Non-Executive Members (one must be chair or vice-chair) and one Executive Member

Public Board 24 April 2025 Minutes

Attendance

Present: Melanie Barnes (Interim Director of Finance), Kirsty Cole (Chair, Area Clinical Forum), Debs Crohn (Head of Improvement), John Daniels (Head of Primary Care), Rona Gold (Non-Executive Director), Issy Grieve (Non-Executive Director), Joanna Kenny (Non-Executive Director), Dr Anna Lamont (Medical Director), Shona Lawrence (Corporate Communications Officer), Meghan McEwen (Board Chair), Ryan McLaughlin (Non-Executive Director/Employee Director), Steven Phillips (Head of People and Culture), Laura Skaife-Knight (Chief Executive Officer), Jean Stevenson (Non-Executive Director), Jason Taylor (Non-Executive Director), Sam Thomas (Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Phil Tydeman (Director of Improvement)

Guests: Lynn Adam (Clinical Lead for Workforce), Lorraine Davidson (Diabetes Specialist Nurse), Margaret Henning.

1. **Cover page**

2. **Patient Story (Presenter: Director of Nursing. Midwifery, Allied Health Professionals and Chief Officer Acute Services (DoNMAHP)**

   The Board welcomed a patient story from the Diabetes Community Team. The Director of Nursing. Midwifery, Allied Health Professionals and Chief Officer Acute Services (DoNMAHP) introduced Lorraine Davidson (Diabetes Specialist Nurse) and Margaret (Maggie) Henning to the meeting.

   A video from Caroline Page (Diabetes Specialist Nurse) was presented celebrating the success of the Diabetes service in Orkney and our passion to deliver patient centred care whilst innovative developments place us in a good position nationally.

   In January, this year with the support of our Diabetic Service Maggie moved on to the hybrid closed-loop system. which takes readings from a continuous glucose monitor and uses an algorithm to notify the patients insulin pump how much insulin to deliver over a 24-hour period.

   ### Decision/conclusion

   Members welcomed the presentation and thanked Maggie, Lorraine, and Caroline for their presentation.

3. **Welcome and Apologies (Presenter: Chair)**

   Apologies were received from David Campbell (Non-Executive Director) Jarrod O Brien (Director of People and Culture), Stephen Brown (Chief Officer Integration Joint Board) and Dr Louise Wilson (Director of Public Health).

   The Chair welcomed and thanked Steven Phillips (Head of People and Culture), John Daniels (Head of Primary Care) and Hannah Casey (Public Health Improvement Manager) deputies for

the Director of People and Culture, Chief Officer Integration Joint Board and Director of Public Health.

The Chair acknowledged and thanked Phil Tydeman (Director of Improvement) and Alan Cooper (Interim Head of Strategy) for the significant work and contribution to the Boards improvement journey over the past 12 months recognising they will leave the Board in May 2025.

The meeting was quorate in accordance with the Board's Code of Corporate Governance.

4. **Declarations of Interest (Presenter: Chair)**

There were no declarations of interest raised.

5. **Minutes of Previous Meeting 27 February 2025 OHB2426 - 01 (Presenter: Chair)**

The minutes of the meeting held on 27 February 2025 were accepted and approved as an accurate record of the meeting.

6. **Matters Arising (Presenter: Chair)**

No matters arising were raised.

7. **Action Log OHB2426 (Presenter: Chair)**

The action log was reviewed, and corrective action agreed on outstanding issues (see action log for details).

8. **Board Chair and Chief Executive Report to the Board April 2025 OHB2426 - 02 (Presenters: Chair, Chief Executive)**

The Chair and Chief Executive presented their report to the Board providing an update on key events and activities from February and March 2025, these are as follows.

- **Financial Performance** - NHS Orkney is one of few boards in Scotland to deliver and achieve their financial plan for 2024/25. Chief Executive thanked all colleagues across the Organisation, we now go into a new financial year with hope.
- **Team Orkney awards** – The Chief Executive thanked The Orcadian for supporting the Patients Choice Award and Cameron Stout (BBC Radio Orkney) for hosting the event acknowledging it was a truly memorable evening for all of those who attended.
- **National recognition** - We have 2 finalists in the Royal College Nursing (RCN) 2025 awards and a finalist and winner in Scottish Governments Chief Scientist Awards.
- **NHS Reform and Renewal** - Meeting has taken place with Cabinet Secretary and Director General regarding the following priorities: further improvements on planned care, reducing delayed transfers of care, system leadership and cross-boundary collaboration.
- **Year 2 Corporate Strategy 2025/26** was launched on the 1 April 2025 following extensive engagement with our patients, community, and staff.

Employee Director added his thanks to the organising Committee and to Unison for supporting the Respect Award.

Decision/conclusion

Members received the update.

9. **Renewal & Reform Paper to NHS Boards - Health Board Collaboration and Leadership OHB2426 - 03 (Presenter: Chief Executive**)

The Chief Executive presented the Renewal & Reform Paper to NHS Boards - Health Board Collaboration and Leadership and the commitment set out by the First Minister to progress the renewal and reform of the NHS in Scotland. The Chief Executive described the associated requirement for the Board to seek assurance on delivery of these commitments and the evolution of the new governance arrangements (NHS Scotland Executive) which are intended to enable and foster stronger collective accountability whilst underpinning the strength of local accountability mechanisms. This is being taken forward through our Corporate Strategy, Annual Delivery Plan (ADP), 3-Year-Financial Plan and monitored through the bi-monthly Integrated Performance Report (IPR).

Chief Executive advised that there will be a real shift in patients moving between boards recognising that patients must have a choice of where they receive care.

I Grieve asked if remote and rural communities had been considered in the paper. The chair confirmed that concerns regarding remote and rural inclusion in the paper. Executive Directors and Chief Executives have been asked to contribute to the plans, which is a real change seen over the past 6 months.

R Gold asked for clarity on whether this will result in additional governance and scrutiny from Scottish Government and asked for a summary to be shared with Board members of the 3 products outlined in the paper. The Chief Executive confirmed that the products mentioned in the paper have been included in the Corporate Strategy to ensure all local and national priorities are monitored and reviewed in one place.

R McLaughlin asked if there was equity of voice of smaller Boards in this new structure. Chief Executive was clear that all 22 Board Chief Executives are equal partners, and NHS Orkney is not viewed any differently from any other Health Boards.

Decision/Conclusion

The Board acknowledged, endorsed, and supported.

- their role for the population its serves as well as its contribution to population planning that will cross traditional Board boundaries and approves local implementation of this approach, consistent with DL (2024)31 and 12 (J) of the 1978 NHS Scotland Act
- the anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months as there is requirement to deliver the principles set out by the First Minister in his speech on 27 January, to deliver efficiencies and savings and to put into action the commitments set out in the three reform directions.

10.   CHAIRS ASSURANCE REPORTS

10.1.   Joint Clinical and Care Governance Committee Chairs Assurance Report - 2 April 2025 OHB2426 - 04 (Presenter: Rona Gold - Chair of Joint Clinical and Care Governance Committee)

The Chair of the Joint Clinical and Care Governance Committee presented the report highlighting the following items which had been discussed at Committee on the 2 April 2025:

- Excellent staff story on the Green Maternity project which set a real focus on the purpose of the meeting.
- The meeting was extended due to the extensive agenda with lots of positive assurance given to the Board.
- Comprehensive update from Dentistry, a further update on the action plan will be brought to Committee later in the year.
- Matters of concern have leads assigned to address the actions.

The Board Chair thanked the Committee, acknowledging the maturity of the Committee on its improvement journey.

The Employee Director asked for assurance that staff have received communication on the actions in relation to the Mental Health Peer Review. The Head of Primary Care advised that there are good relationships between managers and teams and would confirm that this action plan was well-communicated.

Chief Executive provided assurance in relation to the Robertsons contract, additional leadership is now in place via the Interim Director of Finance, further update will be provided at the next Finance and Performance Committee in May 2025.

Decision / Conclusion

The Board noted and accepted the update provided.

10.2.   Finance and Performance Committee 27 March 2025 OHB2426 - 05 (Presenter: Meghan McEwen - Vice Chair Finance & Performance Committee)

The Chair presented the Finance and Performance Committee Chairs Assurance Report from the meeting on the 27 March 2025.

The Chief Executive asked if wording on limited assurance on the Island Games draft plan should be amended as it does not reflect conversations at the Committee or provide assurance to our community.

The Chief Executive asked for clarity on the Band 6 post referenced in the report. DoNMAHP advised that the post is in relation to a new post within the Laboratory Service. As this is a new post, it will be brought through the internal business case process.

R Gold welcomed the contract register being presented to the Finance and Performance Committee and asked for clarity on what the Clinical Services Review (CSR) is and will deliver as it was unclear in the report.

R Gold asked that Chairs Assurance Reports are made clearer for members who were not present at meetings.

Decision / Conclusion

The Board noted the update provided subject to the amendments discussed and agreed above.

10.3.   **Audit and Risk Committee 4 March 2025 OHB2426 - 06 (Presenter: Jason Taylor, Chair of Audit and Risk Committee)**

The Chair of the Audit and Risk Committee presented the report highlighting the following items which had been discussed at their meeting on 4 March 2024:

- **Internal Audit Plan 2025/26** - significant reduction in the number of internal audits in 2025/26. The Audit and Risk Committee Chair thanked the Senior Leadership Team for their support. Board Chair thanked the Audit and Risk Committee for the maturity displayed in the Chairs Assurance Report.
- The Committee Chair thanked the Director of Improvement for their support.
- Board Risk Management Workshop scheduled for the 29 May 2025.

I Grieve asked for assurance that the internal audit recommendations have been delivered by the 31 March 2025. Director of Improvement advised that delayed actions are in relation to digital, one of the lessons learned is to be realistic with timescales so assurance can be taken.

Decision / Conclusion

The Board noted the update provided.

10.4.   **Senior Leadership Team - March and April 2025 OHB2426 - 07 and OHB2426 - 08 (Presenter: Chief Executive - Chair of Senior Leadership Team**)

The Chair of the Senior Leadership Team (SLT) presented the report highlighting the following items which had been discussed at their meetings on 6 March 2025, 21 March 2025, and 1 April 2025.

6 March 2025

- **Corporate Risk Register** - digital maturity risk score has now reduced due to the work undertaken by the Digital Information Operations Group.

21 March 2025

- **Wider staff communications regarding workforce workstream** - Deep dive taking place with SLT and Area Partnership Forum in May 2025

- **Medical Device policy** - draft Medical Device Policy has been sent to Scottish Government, this will be presented to the SLT and Board in June 2025.
- **HR Records Management** - is now being picked up as part of Business as Usual. Board Chair asked for assurance on policies being updated to ensure policies are fit for the future. Chief Executive advised that further work is required, a Board Seminar will be arranged to fully update the Board on work underway.

1 April 2025

- **Financial sustainability** - the risk rating has been upgraded due to no brokerage being available to Boards in 2025/26.
- **Integrated Performance Report (IPR)** - there has been a deterioration in our planned care performance, a deep dive session to take place with the Board 24 April 2025.

R Gold thanked the SLT for the work being undertaken on the review of metrics in the IPR. Interim Head of Strategy is leading this piece of work to look at our current key performance indicators to ascertain what local indicators are not included, which will add value to the Board and our Community.

The Chief Executive advised that a full review of the IPR will be undertaken with the Board taking into consideration best practice ahead of IPR 2026/27.

Decision / Conclusion

The Board noted the update provided.

10.5. **Area Clinical Forum - OHB2426 - 09 (Presenter: Kirsty Cole, Chair of the Area Clinical Forum)**

The Chair of the Area Clinical Forum presented the report highlighting the following items which had been discussed at their meeting on XX 2025:

Matters of concern

- **Accommodation concerns highlighted for students** - work is underway to look at housing and clinical accommodation. This is being led by the Boards Head of Estates.
- **Delays at Vacancy Control Panel** are causing concerns this was raised by clinical advisory committee.

  Positive assurance
- Tongue Tie Policy approved for onward clinical consultation and approval.
- Allied Health Professionals are now being included in the discharge planning process - this was welcomed by the Board.

- Board Chair confirmed that Board agendas are now being shared with the Area Clinical Forum to ensure clinicians are sighted on and able to contribute to Board Agendas

Decision / Conclusion

The Board noted the update provided.

10.6. Staff Governance Committee (Presenter: Joanna Kenny - Chair of Staff Governance Committee)

No meetings have taken place since the last Board Meeting.

The Chair of Staff Governance Committee advised that there are still concerns in relation to mandatory training, appraisals, staff sickness and limited assurance on the Health and Social Care Staffing Act.

11. Corporate Risk Register OHB2426 - 10 (Presenter: Medical Director)

The Medical Director presented the report which provided an update on active risks, changes to risk ratings, any newly added risks and any risks that had been closed or made inactive within the last reporting period.

Members were advised that the top three highest scored risks for the organisation were lack of senior leadership capacity and capability, lack of organisational digital maturity and corporate financial sustainability.

The chair welcomed sight of the Corporate Risk Register and the opportunity the Board Development Session in May 2025 will bring.

Decision / Conclusion

The Board noted the update provided and the current mitigation of risks highlighted.

12. STRATEGIC OBJECTIVE - PLACE

12.1. Community Planning Partnership Update OHB2426 - 11 (Presenter: Public Health Manager)

The Public Health Manager provided an update from the Community Planning Partnership (CPP) meeting held on the 24 April 2025 on behalf of the Chief Officer Integration Joint Board (IJB).

The CPP meeting was held at The Balfour and members had a tour of the hospital and learnt more about our approach to Net Zero. The Community Wealth Plan was approved, and discussions took place regarding the gender pay gap.

I Grieve advised that the CPP recognise that impact assessments are being undertaken in isolation, partnership committed to ensuring that they are undertaken in partnership going forward.

The Board Chair recognised the Community Planning Partnerships improvement journey.

Decision/Conclusion

Members received and noted the update.

12.2. Integration Joint Board (IJB) update OHB2426 - 12 (Presenter: Head of Primary Care)

The Head of Primary Care provided an update from the Integration Joint Board held in February.

- 2 new carer representatives were welcomed to the board.
- Assurance given following the joint inspection of adult services.

J Kenny asked if a direction has been issued to the Board for the Daisy Villa, once minutes from the IJB are available, a direction will be sent to the Chief Executive, Interim Director of Finance and Head of Corporate Governance.

Decision/conclusion

Members received and noted the update.

13. STRATEGIC OBJECTIVE - PEOPLE

13.1. External Review - culture governance and senior leadership - April 2025 progress update OHB2426 - 13 (Presenter: Chief Executive)

The Chief Executive presented the report summarising the external review that was commissioned by her in mid-2024 into Cultural Development, Governance and Senior Leadership at NHS Orkney to help to identify good practice and recommendations for areas of focus to support our continuous improvement.
The paper highlights several actions that have been delivered since the last meeting.

- All Executive Directors have completed a 360 appraisal.
- Behavioral values and standards workshops have taken place with the Board and SLT
- Leadership Development Programme socialised at Extended Senior Leadership Team (ESLT)
- Portfolio changes have now taken place - Deputy CEO joins the Board 12 May 2025

The board Chair noted that the external review of culture governance and senior leadership improvement plan being brought to Board demonstrates our commitment to openness and honesty.

Decision / Conclusion

Members accepted the report and approved the Action Plan which would feature at each Board meeting.

13.2. Your Employee Journey Staff Experience Programme OHB2426 - 14 (Presenters: Head of People and Culture)

The Head of People and Culture presented the Your Employee Journey Staff Experience Programme Report

Extensive engagement has been undertaken with staff to co-produce the programme to deliver our commitment as set out in Corporate Strategy.

39 improvements have been identified to improve employee journey and specifically designed to include as many people as possible. SLT have agreed on 5 areas of focus in particular values and behaviours.

Organisational development programme has been approved by SLT and Staff Governance Committee.

Chair asked for reflections from the SLT workshop on values and behaviours. The Head of People and Culture advised that there are some common themes and a fantastic opportunity for the SLT to learn more about their peers and to deliver the values session in their teams.

J Kenny acknowledged the tremendous amount of work that has gone into the Your Employee Journey Staff Experience Programme recognising this is a big part of the Staff Governance Committees improvement journey.

The Employee Director asked for clarity about who is leading this piece of work. Head of People and Culture advised highlight reports will be provided to the Senior Leadership Team with assurance provided to the Staff Governance Committee which has representation from across the Organisation. This work will be led by the People and Culture team.

Board Chair asked what clinical buy in there is for the programme. The Head of People and Culture advised that face-to-face sessions have taken place across teams including clinical teams.

The Chief Executive thanked the People and Culture team, recognising this is a single blueprint for our people strategic objective and asked that we map out what will be delivered and when. The Chief Executive raised concerns regarding charitable funding for staff well being, there needs to be a sustainable solution in place recognising the importance of staff well-being as referenced in our iMatter results.

The Chief Executive asked that we challenge ourselves to have a patient experience framework at the next Board meeting following the same blueprint led by our Director of People and Culture.

Decision/conclusion

The Board received and approved the Your Employee Journey Staff Experience Programme

13.3. **NHS Orkney Annual (Health and Care Staffing Act) Report 2024/25 OHB2426 -27 (Guests: Lynn Adam - Clinical Lead for Workforce)**

The Clinical Lead for Workforce presented the NHS Orkney Annual (Health and Care Staffing Act) Report 2024/25 for approval before submission to Scottish Government thanking those involved in providing updates.

The DoNMAHP advised that our primary focus in Year 1 on embedding the Health and Care Staffing Act has been to increase understanding across the whole system. There is recognition of compliance in some areas but not all duties, this has resulted in the Board being in a position of limited assurance with compliance. The DoNMAHP advised that there is a need to produce a summary document for our patients and communities which sets out what this means for NHS Orkney.

The Chair asked what actions will be put in place to address areas which are non-compliant, where the work is being undertaken and what the red, amber, green status in the self-assessment means. The Clinical Lead for Workforce advised that grading for each duty is an amalgamation of self-assessment scores from staff. DoNMAHP advised that the Workforce Operational Group will provide oversight of the improvement trajectories led by the Director of People and Culture. Inconsistencies are due to systems and processes not being in place. The Board noted that there are currently no meetings in the diary for the Workforce Operational Group. The chair requested confirmation of dates for the next 12 months from the Director of People and Culture.

The Employee Director advised that implementation of the Act is on our Corporate Risk Register, clarity is still required on what resources are required to bring the Board compliant with the Act.

DoNMAPH advised that work has been undertaken to identify what resources are required, challenges remain in terms of competing clinical priorities, double entry of data and additional information being provided by Scottish Government.

R Gold thanked the report author for the cover paper and comprehensive self-assessment and the information provided.

J Kenny advised that Scottish Government are aware of our current position but felt that insufficient mitigations continue to be presented via quarterly reports to Staff Governance Committee. J Kenny asked the Board to consider the actions, recognising the inaccuracies noted in the submission, for example all leavers have an exit interview. Staff Governance Committee have continued to provide limited assurance on the Health and Social Care Act.

The Medical Director commended the report to the Board, celebrating that data is now available and recognising the amount of work undertaken to complete and produce the report.

The Employee Director recommended that the report be approved, with the focus being on the improvement plan going forward.

The Chief Executive asked that a recovery plan be put in place by the Executive Team and brought back to the Board in June 2025.

Decision/conclusion

Whilst limited assurance can be provided to Scottish Government, members received and approved the NHS Orkney Annual (Health and Care Staffing Act) Report 2024/25 subject to the Chair of Staff Governance Committee, Employee Director, Clinical Lead Workforce and DoNMAHP providing assurance to the Chief Executive the issues raised above are addressed prior to submission to Scottish Government.

13.4. Succession Planning Committee Terms of Reference Cover Paper OHB2426 - 15 (Presenter: Chair)

The Board Chair presented the Succession Planning Committee Terms of Reference for consideration recognising that several Board Members' terms of office are ending.

I Grieve has been asked to Chair the Succession Planning Committee.

Decision/conclusion

Members welcomed the report and approved the Terms of Reference and membership of the Succession Planning Committee

13.5. Board Walkaround Feedback OHB2426 - 16 (Presenter: Chief Executive)

The Chief Executive presented the feedback from Board Walkarounds which took place in February and March 2025.

Decision/conclusion

Members received the update

14. STRATEGIC OBJECTIVE - PATIENT SAFETY, QUALITY AND EXPERIENCE

14.1. Healthcare Associated Infection Reporting Template (HIART) Report OHB2426 - 17 (Presenter: Director of Nursing, Midwifery, AHP and Chief Officer Acute)

The DoNMAHP presented the report providing assurance on infection prevention and control standards for all key performance targets as set out by the Scottish Government and locally led initiatives, highlighting the following:

- Updated Direction Letter shared with the Board
- Increased our compliance with Methicillin-resistant Staphylococcus aureus (MRSA) reporting
- 6 walk arounds have taken place since the last meeting

Board Chair noted consistent excellence and performance in our domestics and estates team.

Decision / Conclusion

The Board noted the update provided received assurance.

14.2. Code of Corporate Governance 2025/26 OHB2426 - 18 (Presenter: Chief Executive)

The Chief Executive presented the refreshed Code of Corporate Governance 2025/26 which has been aligned to our Corporate Strategy.

The board welcomed track changes in papers.

Decision/Conclusion

Members approved the updated Code of Corporate Governance 2025/26.

14.3. Whistleblowing Standards Annual Report 2024/25 OHB2426 - 19 (Presenter: Chief Executive)

The Chief Executive presented the Whistleblowing Standards Annual Report 2024/25. Annual report 2025/26 outlines the approach to whistle blowing and transition of Whistle blowing Executive Lead transferring to the Medical Director from Chief Executive.
1 whistle blowing case this financial year - this has been dealt with and is closed.

This has been another year of improvements but recognise more to do.

Decision/Conclusion

Members received and approved the Whistleblowing Standards Annual Report 2024/25.

14.4. Whistleblowing Champions Assurance Report OHB2426 - 20 (Presenter: Whistleblowing Champion - Jason Taylor)

The Whistleblowing Champion presented the Whistleblowing Champions Assurance Report 2024/25 outlining how lessons learned are being implemented. A workshop has taken place to look at whistle blowing processes recognising the impact this has on the individual raising concern.

The Board Chair thanked the Whistleblowing Leads and those colleagues who have raised concerns.

Decision/Conclusion

Members received and approved the Whistleblowing Champions Assurance Report 2024/25.

15. STRATEGIC OBJECTIVE - PERFORMANCE

15.1. Corporate Strategy 2024/25 Quarter 4 Update OHB2426 - 21 (Presenter: Chief Executive)

The Chief Executive presented the Corporate Strategy 2024/25 Quarter 4 update.

Decision/conclusion

Members received and approved the Corporate Strategy Quarter 4 update.

15.2. Board Assurance Framework Quarter 4 Update OHB2426 - 22 (Presenter: Chief Executive)

The Chief Executive presented the Board Assurance Framework Performance Scorecard (BAFPS) Quarter 4 2024/25 update for discussion and approval.

Decision/conclusion

Members welcomed and approved the Board Assurance Framework Performance Scorecard (BAFPS) Quarter 4 2024/25 update.

15.3. Corporate Strategy Year 2 High Level Priorities and Key Performance Indicators OHB2426 - 23 (Presenter: Chief Executive)

The Chief Executive presented the Corporate Strategy Year 2 High Level Priorities and Key Performance Indicators set out in Appendix 4. Senior Leadership Team have approved the Corporate Strategy, this year Corporate Strategy reflects how we have listened to our patients, community, and staff.

Detailed in the report is how priorities will be overseen by each of our Governance Committees.

I Grieve attended the Extended Senor Leadership Team (ESLT) where the Corporate Strategy was presented, this was well received with a high level of engagement.

Decision/conclusion

- Members received and approved the Year 2 Corporate Strategy High Level Priorities and Key Performance Indicators/metrics for delivery in 2025/26, noting the engagement activity and feedback received from our patients, community, partners, and staff that has informed the development of the Year 2 Corporate Strategy

15.4. Integrated Performance Report April 2025 OHB2426 - 24 (Presenter: Chief Executive)

The Chief Executive presented the Integrated Performance Report (IPR) by exception in chapters which summarised NHS Orkney's performance based on national and local reporting requirements as well as those indicators which matter patients, staff, and local community.

The reporting schedule was presented to members to ensure all Governance Committees receive IPR chapters ahead of coming to the Board.

Patient safety, Quality and Experience

- The Board Chair asked for clarity on inpatient falls and what evaluation is in place for improvement work. DoNMAHP advised that our excellence in care leads supports staff on the wards, all falls have a 5-minute analysis undertaken

by staff. Board Chair asked that Red, Amber, Green status be reviewed. DoNMAHP will consider how the Excellence in Care dashboard can be incorporated into IPR.

Operational Standards

- J Stevenson asked for assurance on the recovery plan for endoscopy services. The Medical Director advised that recruitment has now commenced.
- **Post-natal midwife standard** - Board Chair asked for clarity on why the standard is 0%. The DoNMAHP advised that a change to service delivery means that patients will have the same midwife throughout their pregnancy. Board Chair asked that oversight of this standard is discussed at the Joint Clinical Care Governance Committee.

Community

- **Podiatry** - Board Chair asked for assurance on the additional resources identified for the podiatry service and what risks are presented to patients of long waits. DoNMAHP advised that a substantive podiatrist has commenced, a piece of work is underway led by the Associate Director of Allied Health Professions.
- **Mainland Community Nursing** - K Cole asked for clarity on capacity issues within the mainland community nursing team. The Head of Primary Care advised that one of the challenges is the lack of an electronic health record. Work is underway to optimise activity within the team. The service has now been transferred into the Primary Care Directorate.

Population Health

- Chair asked for assurance on the reduction of blood spot testing and what learning could be shared. DoNMAHP advised that the maternity team are taking a person centred approach, this will be included in the next IPR.

Workforce

- J Taylor asked if the number of vacant/absent hours could be included in the IPR. To be reviewed by the Director of People and Culture.

Decision / Conclusion

Members noted where Key Performance Indicators were off track and the improvement actions in place to bring deliverables back on track and the IPR reporting Schedule for 2025/26.

15.5. Month 11 Finance Report OHB2426 - 25 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Month 11 Finance Report. The reported financial position at the end of Month 11 was an improved position from Month 10 due to additional funding received from Scottish Government for Distant Islands Allowance and Agenda for Change.

Year-end out turn (Month 12) is anticipated to be an improved position based on our planned trajectory. The Chair acknowledged that this is the first time the financial and efficiency plan has aligned and welcomed improved financial reporting, recognising we are on a continuous improvement journey.

Chair encouraged members to meet with the Interim Director of Finance if they have any questions in relation to Boards finances and financial reporting reports.

The chair asked that the Agenda for Change work be overseen by the Workforce Operational Group.

I Grieve thanked the Interim Director of Finance for the quality of data presented, recognising that whilst we are in an improved position in Year 1 - it will be challenging to sustain this in Year 2.

The Interim Director advised that there is a risk in Year 2, however our Improving Together Programme Board continues to ensure we are sighted on and coordinating delivery of the programme.

Chair asked that the Integration Joint Board be referred to as the Health and Social Care Partnership so clarity in financial reporting between the IJB and HSCP can be provided on the Board's responsibilities for best value and financial improvement.

Decision / Conclusion

Members took assurance from the report.

15.6. First draft Improving Together Programme Plan 2025/26 OHB2426 -26 (Presenter: Director of Improvement)

The Director of Improvement presented the first draft Improving Together Programme Plan 2025/26.

There was a strong level of confidence in the schemes presented to the Board, all plans will be further developed and brought back to the Board in June 2025.

Chief Executive thanked, Executives and the SLT for their work undertaken, recognising that investing in leadership development and quality improvement training is critical in delivering our improvement programme and that we start Quarter 1 of 2025/26 in a strong position.

K Cole asked that we refer to The Balfour as a Health and Care facility, recognising it is much more than a hospital and asked for clarity on the number of individuals living on ferry linked isles. The Medical Director to confirm the percentage of individuals living on ferry linked isles ahead of the final plan coming to Board in June 2025.

The Chair asked that scrutiny, grip and control continue moving forward.

Decision/conclusion

Members received and noted the first draft of the Improving Together Programme 2025/26

16.   STRATEGIC OBJECTIVE – POTENTIAL

No papers for discussion

17.   ANY OTHER COMPETENT BUSINESS

18.   MINUTES FROM GOVERNANCE COMMITTEE MEETINGS

18.1.   Staff Governance Committee (Presenter: Chair)

Members noted the minutes.

18.2.   Joint Clinical Care Governance Committee

Members noted the minutes.

18.3.   Audit and Risk Committee (Presenter: Chair)

Members noted the minutes.

18.4.   Area Clinical Forum (Presenter: Chair)

Members noted the minutes.

18.5.   Finance and Performance (Presenter: Chair)

Members noted the minutes.

19.   ITEMS FOR INFORMATION (Presenter: Chair)

19.1.   Board Meeting Schedule 2025/26

Members noted the meeting schedule 2025/26.

19.2.   Evaluation of the meeting

- The board recognised the value of having the patient story at the start of the meeting.
- Meeting felt rushed at times - consideration to be given to the best way for patient stories to be brought to the Board.
- Information about the patient story being presented would have been useful ahead of the meeting.
- The chair acknowledged the agenda was challenging and there is a need to say no to items coming to Board.
- Positive meeting, quality papers presented.

The Chair closed the meeting at 12.33.

NHS Orkney Board Action Log 2025/26

Purpose: The purpose of the action log is to capture short term actions to enable Board members to assure themselves that decisions have been implemented appropriately.

Ref No	Strategic Priority	Meeting Date	Action	Due Date	Action Owner	Update	Status
OHB2526-01	People	24 April 2025	**Health and Social Care Staffing Act 2024/25** Director of People and Culture (Lead Exec), Chair of Staff Governance Committee, Medical Director, Employee Director, Clinical Lead Workforce and DoNMAHP to meet to review submission with assurance provided to Chief Executive prior to submission to SG	26/06/2025	Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services Medical Director Director of People	**24/04/2025 - meeting took place Monday 28 April 2025 - submitted to Scottish Government 30 April 2025 and uploaded to NHSO website. Action complete.**	Closed
OHB2526-02	Performance	24 April 2025	**Finance and Performance Committee Chairs Assurance Report** Board Chair, Chair of Finance and Performance Committee and Interim Director of Finance to meet, to review CAR from March 2025. CAR to be included in the papers for the next Board Meeting	26/06/2025	Interim Director of Finance	**18/06/2025- Board Chair, Chair of Finance and Performance Committee and Interim Director of Finance have reviewed and updated the CAR from March 2025.Updated CAR included in the papers for the 26 June 2025 Board Meeting. Action complete**	Closed
OHB2526-03	Patient Safety, Quality and experience	24 April 2025	**Code of Corporate Governance** Head of Improvement to add Code of Corporate Governance 2025/26 to resources on Onboard	24/04/2025	Head of Improvement	**24/04/2025 - Approved Code of Corporate Governance uploaded and available on Onboard. Action complete**	Closed
OHB2526-04	Performance	24 April 2025	**Integrated Performance Report** Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services to provide an update at Joint Clinical Care Governance Committee on post natal midwife standard.	26/06/2025 28/08/2025	Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services	**24/04/2025 - next meeting of the JCCGC 3 July 2025. Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services is aware of the action and will bring an update to the August Board Meeting.**	In Progress
OHB2526-06	Performance	24 April 2025	**Integrated Performance Report** Associate Director Allied Health Professionals (AHP's) to bring an update to Board in June 2025 on podiatry improvement plan	26/06/2025	Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services	**24/04/2025 - update included with Board Papers for awareness.**	Closed
OHB2526-07	Performance	24 April 2025	**Integrated Performance Report** Head of Primary Care to bring an update on Mainland Community Nursing to clinical advisory groups	26/06/2025 28/08/2025	Head of Primary Care	**24/04/2025** - Item deferred to August Board Meeting due to Annual Accounts being presented at June meeting.	In Progress

NHS Orkney Board Action Log 2025/26

Purpose: The purpose of the action log is to capture short term actions to enable Board members to assure themselves that decisions have beenimplemented appropriately.

Ref No	Strategic Priority	Meeting Date	Action	Due Date	Action Owner	Update	Status
OHB2526-08	Performance	24 April 2025	**Integrated Performance Report** Director of People and Culture to confirm if the number of vacant/absent hours could be included in the IPR.	26/06/2025	Director of People and Culture	**24/04/2025 - commenced discussions with Director of Performance and Transformation about IPR workforce metrics overall to ensure more actionable insight. Workforce dashboards designed by Viridian and ready for user testing week by the end of June, which will include Health Intelligence as a link with the IPR."**	In Progress
OHB2526-09	Performance	24 April 2025	**First draft Improving Together Programme Plan 2025/26** Medical Director to confirm the percentage of individuals living on ferry linked isles ahead of the final plan coming to Board in June 2025	26/06/2025	Medical Director	**24/04/2025 - update included with Board Papers for awareness.**	Closed
OHB2526-10	Patient Safety, Quality and experience	24 April 2025	**JCCGC Chairs Assurance Report** Chief Executive to share an update on the Robertsons escalation item in relation to concerns raised re water reporting inaccuracies	26/06/2025	Chief Executive	**25/04/2025** - update sent to Board members.	Closed
OHB2526-11	Performance	24 April 2025	**Collaboration and System Leadership** Chief Executive to write to Caroline Lamb to confirm Board Discussion in relation to Collaboration and System Leadership has taken place	26/06/2025	Chief Executive	**25/04/2025** - Letter sent to Caroline Lamb 25/04/2025	Closed

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Board Chair and Chief Executive Report**
Responsible Executive/Non-Executive:	**Meghan McEwen, Board Chair and Laura Skaife-Knight, Chief Executive**
Report Author:	**Meghan McEwen, Board Chair, and Laura Skaife-Knight, Chief Executive**

1   Purpose

This is presented to the Board for:

- Awareness

2   Report summary

2.1   Situation

This report has been provided to update the Board on key external/internal events and activities from April-June 2025, including:

- A summary of our overall operational performance
- Planned care update: the work underway at NHS Orkney to reduce our longest waits and have zero 52-week waits by the end of March 2026
- iMatter (staff survey) results show improvements for fourth successive year
- New Leadership Development Programme and Education and Improvement Centre developments approved and launching soon
- National recognition for long-serving NHS Orkney nurse
- MRI scanner arrives in Orkney
- People and recruitment updates
- Board Chair and Chief Executives' diaries – including meetings with external stakeholders and partners
- Looking ahead to Quarter 2 (July-September) 2025/26

2.2   Background

2.2.1   A summary of our overall operational performance

- Monthly sickness absence rates at the end of March 2025 were 6.13% compared to 6.52% at end of November 2024. The percentage of long-term sickness is higher than

short-term absence, and remains cause for concern, with the focus supporting colleagues back to work from long-term illness.

- Appraisal rates have increased slightly to 38.33%, which is an improvement compared to 36.49% at end of December 2024. Improving performance remains a key agenda item at our quarterly Performance Review meetings and Senior Leadership Team meetings.
- Some improved performance has been seen in training compliance including a 2-4% increase across most Health and Safety courses since we strengthened our interventions and took a more targeted approach, however, this remains a risk on the Corporate Risk Register.
- We launched our new Employee Journey (staff experience programme) in May 2025, which is our overarching experience programme, encompassing how we will respond to our workforce issues.

Operational Standards

Four-hour emergency access standard

- Four-hour emergency access standard performance at the end of April 2025 was 94.51% compared to 92.6% at end of November 2024, against the national 95% standard. NHS Orkney remains a consistently top three performing Health Board in Scotland for this national standard.

18-week Referral to Treatment Standard

- Data submissions and reporting for this standard have been paused and this was communicated to Health Boards on 11 March 2025.

31-and 62-day cancer standard

- Performance remains consistently better than the 31-day cancer standard target (100% for NHS Orkney versus the 95% national standard). For the period ending December 2025 both 31-day and 62-day standards compliance was 100%.

Waiting lists and backlogs

- New outpatient waiting list has seen a deterioration in compliance of 1.37% between April 2025 and May 2025. A total of 932 (42.5%) patients have waited more than 12-weeks against a total list size of 1,621. Additional new outpatient appointments have been scheduled to address the longest waits for Ophthalmology and Ear, Nose and Throat.
- Against the national 12-week target of 100 per cent of patients not waiting longer than 12 weeks from agreeing treatment with the hospital to treatment for inpatient or day case treatment, compliance is 58.22% this is an increase of 1.17% between April 2025 and May 2025.

Operational (Community) standards

- Capacity issues across both public and private dentistry continue to be challenging but recent recruitment in public dentistry has been successful and will alleviate some pressure as successful candidates are on-boarded.

- Performance continues to be strong in both Psychological Therapies and Children and young People's Mental Health Services (CAHMS). CAMHS are participating in a short-term regional pilot for Intensive Home Treatment. Both services are looking at the in-house capacity to strengthen the neuro-developmental assessment pathways in adults and children.

Population Health

- The Winter COVID-19 vaccination offer ended on 31 January 2025, with Orkney being the top performing Board in Scotland with an 58.7% overall uptake. The Winter Flu vaccination offer ended on 31 March 2025, with Orkney also being the top performing Board in Scotland at 64.2% overall uptake. The Spring 2025 COVID vaccination is underway, with an uptake of 55.8% and Orkney again being the top performing Board. Orkney RSV Immunisation uptake rate is 73.4% (above the 67.4% Scotland average).

2.2.2 Planned care update: the work underway at NHS Orkney to reduce our longest waits and have zero 52-week waits by the end of March 2026

We know many of our patients continue to experience unacceptably long waits for planned appointments and surgery. Reducing waiting times and our longest waits for our patients remains a top priority for NHS Orkney in response to patient and community feedback.

Since our last Board meeting, we have received £165,000 from Scottish Government to address some of our longest waits – particularly in Ear, Nose and Throat and Ophthalmology – with a strong focus on aiming to have zero 52-week waits by the end of March 2026 consistent with the national number one priority for all Health Boards. We are awaiting updates on funding requested for Endoscopy and we have been awarded circa £8,000 to reduce long waits in Orthopaedics. The additional funding received to date means we will be able to treat our longest wait patients in 2025/26 which is great news for our patients and community and means we are on track to eliminate 52-week waits in acute specialties by the end of March 2025, consistent with the First Minister's expectations for all Health Boards. We have strengthened our internal governance and oversight of our longest waits to ensure we have the appropriate grip and control in place and continue to deliver against the trajectories we have set for the year.

Please see the paper on this later on the agenda for further information.

2.2.3 National iMatter (staff survey) results show improvements for fourth successive year

In June 2025, we received our latest annual staff survey results - called iMatter - which show that people's experience of working at NHS Orkney continues to improve year-on-year.

The latest results show further progress in most areas, suggesting that we are doing the right things to make NHS Orkney a great place to work.

There are 30 questions in the iMatter survey and NHS Orkney improved in 20 of them. The scores were the same as last year for the remaining nine questions and only one decreased

by just one point. There is a lot to celebrate about these results, especially given the busy year we have had.

69% of staff responded to the survey this year and had their say which is the same response rate as last year.

Our Employee Engagement Index score (scale of 0-100) has improved for the fourth consecutive year and is 76 (75 last year) and the overall experience of working here score (scale of 0-10) is 6.7 (up from 6.5 last year).

Please see the paper on this later on the agenda for further information.

2.2.4 New Leadership Development Programme and Education and Improvement Centre developments approved and launching soon

Our Senior Leadership Team has approved two important developments that are set out as priorities in our Year 2 2025/26 Corporate Strategy which means we have moved into developing the detail for implementing our new Leadership Development Programme and Education and Improvement Centre, which evidences our commitment to investing in our staff, and responds to feedback we have received, including the mitigating actions in our Corporate Risk Register when it comes to leadership capacity and capability. I look forward to keeping our Staff Governance Committee and the full Board updated on these key pieces of work in the months to come with Autumn 2025 the intended completion and launch date for both.

2.2.5 National recognition for long-serving NHS Orkney nurse

We extend our extra special congratulations to Moira Sinclair – one of our longest-serving and respected colleagues – who was recognised in the King's Birthday Honours on 14 June 2025 and awarded a British Empire Medal for her commitment to patient care in a career spanning over four decades.

There are few more deserving than Moira, who is an incredible person, leader and nurse, now working as a Clinical Nurse Manager for Acute Services and previously Senior Charge Nurse for our Emergency Department.

Week commencing 23 June 2025 Moira is retiring and as such there is no more fitting end for such a successful and impactful career. Thank you to Moira for all she has done for our patients and community and the positive difference she has made to so many over the last 40 plus years.

2.2.6 MRI scanner arrives in Orkney

At the end of May 2025, our new MRI scanner arrived in Orkney, following a successful bid and lots of hard work from our staff to bid to trial a full-time scanner at The Balfour until the end of March 2026. Over the next year, there will be an ongoing evaluation of this service model.

This incredible opportunity will tap into our local skills and expertise, marking a significant milestone that will enhance our healthcare services here in Orkney. If all goes well and patients find it beneficial, we are hopeful this will become a permanent resource for the future.

The team responsible for the MRI scanner will be reviewing the service and producing a report for the NHS Orkney Health Board and Scottish Government later this year to evaluate the success of the provision of scanning at The Balfour and will therefore be seeking feedback from patients about the service and the difference it has made to patients and the community.

2.2.7 People and recruitment updates

In May 2025, we were delighted to welcome Tammy Sharp to NHS Orkney as our new Director of Performance and Transformation (and Deputy CEO). This role is an 18-month fixed term post, fully funded by Scottish Government, and forms part of a reduced package of national financial support that is a requirement for NHS Orkney while we are at level 3 escalation of the NHS Scotland Support and Intervention Framework (related to our financial performance).

Tammy is leading on the delivery of our efficiency (Improving Together) programme, wider integrated improvement work, planning and performance at Board-level and internal audit and will formally deputise for our Chief Executive in this next period.

In May 2025, we also announced that Jay O'Brien, our Director of People and Culture, is sadly leaving NHS Orkney this September for personal and family reasons so he can return to Australia.

Jay has made a significant difference during the 14-months he has been in post, not least because of the way he leads – and has played a really important part in our improvement journey over the last year, including taking forward our staff experience and culture programmes so we can further improve people's experience of working here and in turn patient experience.

Substantive recruitment is currently underway to appoint Jay's successor and a permanent Director of Finance with interviews to take place by mid-July 2025.

2.2.8 CEO and Chair diaries – including meetings with external stakeholders and partners

Board Chair

Meghan has chaired the first two Financial Escalation Board meetings, and the agendas continue to evolve and the engagement with colleagues, and membership including Scottish Government colleagues has been encouraging. Meghan has undertaken all Non-Executive appraisals, which offer an opportunity to reflect on the value and contribution of Non-Executive colleagues through the lens of the Blueprint for Good Governance.

Meghan chaired the North Cancer Alliance Prehabilitation Steering Group, and also an Operational Delivery Group meeting of the Transforming Cancer Care Steering Groups. The prehabilitation project is due to conclude in September of this year, and wrapping up and celebrating the success of the project is a focus for the group.

Meghan has attended both the Board Chairs and Territorial Board Chairs meetings. There was a special meeting convened in May 2025 to discuss how to best address long waits for planned

care across Scotland, and this meeting was led by the newly appointed Chief Operating Officer, Christine McLaughlin.

Meghan attended a meeting of the Improving Population Health portfolio group of Chairs and officials where we discussed how to ensure NHS Scotland Boards can act as population health organisations.

Meghan chaired a meeting of the North of Scotland Chairs and Chief Executives, where the planned care focus was discussed, specifically through the unique lens of the North of Scotland. We also discussed how to organise ourselves to meet the evolving policy landscape including the 10-year Population Health Framework, Operational Improvement Plan and Service Renewal Framework.

Chief Executive

I attended an in-person meeting with the First Minister, John Swinney, the Cabinet Secretary for Health and Social Care and the Director General for Health and Social Care in Scotland and Chief Operating Officer for NHS Scotland, with all other Board Chief Executives, where we focused exclusively on the enhanced work that needs to take place in all Health Boards and across the NHS in Scotland to reduce long waits and ensure there is a clear path to zero for 52-weeks across Scotland by the end of March 2026 (as above).

He also updated Chief Executives on the three key publications in development which set the policy and priorities for the NHS in Scotland in the short and longer-term, notably:

1. Operational Improvement Plan – published end of March 2025
2. Population Health Framework – to be published mid-June 2025
3. Service Renewal Framework – to be published mid-June 2025

I attended the latest NHS Scotland Executive Group meeting in June 2025, where the focus was on planned care and work underway to reduce system pressures and develop sustainable services with a particular focus on: vascular, diagnostics and neonatal services, and the Board Chief Executive's meetings, where there was a wider focus on areas such as financial performance, primary care and business service developments currently underway. Since the last Board meeting, I attended a Board Chief Executive Development Day where we discussed how we will work differently together to ensure collective leadership across our 22 Health Boards and began to develop a workplan for the year ahead so that we maximise our contribution to delivering national policy and priorities.

I joined our Chair to represent NHS Orkney at the June 2025 North of Scotland Chairs and Chief Executive meetings where items for discussion included planned care, reimagining the North of Scotland and how we work differently moving forward to respond to national policy and developments and planning for a North of Scotland workshop in the months to come.

I also attended the June 2025 North of Scotland Chief Executive meeting, where items for discussions also included planned care and a discussion about NHS Grampian's recent escalation to Level 3 of the Escalation and Intervention Framework so that the implications are better understood across the North of Scotland Health Boards and strengthened collaboration can happen where relevant, to support neighbouring Boards.

I joined other Board Chief Executives in the North of Scotland in May 2025 for a performance meeting with the Cabinet Secretary where Chief Executives updated Mr Gray on performance in relation to planned care, unscheduled care and Delayed Transfers of Care.

I joined Meghan, the Leader and Chief Executive at Orkney Islands Council and COSLA and Scottish Government colleagues, to discuss how we take forward the discussions about how our organisations could better work together to improve services, outcomes and efficiency and to reduce bureaucracy and duplication in doing so. These discussions are part of the public sector reform agenda which Orkney is both responding to and proactively embracing.

We have held a number of additional Extended Senior Leadership meetings since our last Board meeting with our wider senior leadership community to focus on developments such as our Improving Together workforce workstream, developing our new behavioural standards, our Education and Improvement Centre, our new Leadership Development Programme and our new Staff Experience Programme – to engage and seek buy-in for these vital developments, which feature in our 2025/26 Corporate Strategy.

Meghan and I were thoroughly enjoyed spending part of an afternoon listening to and hearing from our Children's Services colleagues at a whole team meeting where we heard about what the team are proud of the many success stories and also what gets in the way of progress presently. We look to returning to meeting the team again at an upcoming whole team meeting in July 2025 to continue this conversation with this dedicated and committed team.

I enjoyed joining our Board Chair and Director of Nursing, Midwifery, AHPs and Chief Officer of Acute to thank and wish a happy retirement to long-serving nurse May Leisk who has left NHS Orkney after 42-years of service to the NHS and our organisation.

I spent a morning shadowing and observing colleagues from Scottish Ambulance Service who are based and co-located in The Balfour with our A&E Team and listening and gaining an insight to the great work this team do and hearing some of their challenges, frustrations and what would improve colleagues experience at work.

I joined our Board Chair to visit our laboratory to congratulate Laura Van Schayk for winning the Rising Star Award at this year's Scottish Government's Chief Scientific Officer's Awards.

I was pleased to visit the brilliant new Charity Shop in Kirkwall with our Head of Facilities, to show our support for the Peedie Retreat Charity and associated fundraising which is raising money for a bespoke and accessible house at Inganess Beach to support those affected by Multiple Sclerosis and cancer through a short break away with friends and family.

I met with Professor Sam Phillip, NHS Grampian as a Consultant Physician in the Department of Diabetes and Endocrinology, during his latest visit to Orkney, where I heard his views about the outstanding work taking place by the team in Orkney to deliver excellent care to diabetes patients. This work and innovation practice should be applauded.

I Chaired the May 2025 Performance Review Meetings which focused on staff experience, mandatory training, appraisals and sickness absence, and continue to Chair our monthly Improvement Board, where progress against our Improving Together Programme is monitored. I

also attended our first two Escalation Boards, a new meeting in place to ensure appropriate oversight of our financial performance given we remain in Escalation Status Level 3, which is supported and attended by Scottish Government, and joined our Interim Director of Finance for our Quarter 4 performance review meeting with Scottish Government where we updated on our 2024/25 results and our plans to achieve our financial plan in 2025/26 consistent with the plan we submitted in recent months.

2.2.9 Looking ahead to Quarter 2 (July-September) 2025/26

As we look to the next Quarter of the year, our priorities are:

- Clinical Service Review - agreeing the next steps for taking forward this critical work
- Continued operational and financial grip
- A strengthened focus on planned care and reducing our longest wait patients, and ensuring we remain on track to achieve zero 52-week waits by the end of March 2026
- Ensuring we are clear how Orkney will respond to the Population Health Framework and Service Renewal Framework which set out the 10-year plan for the NHS in Scotland in these vital areas – so we understand what this means for our community
- As we deliver and implement our new Staff Experience Programme, we look forward to celebrating our long-serving staff at this year's Long Service Awards event in July 2025
- Recruiting to our two substantive Executive Director posts to ensure we stabilise leadership, which must remain a focus

Finance and Performance Committee

Title of Report:	Chair's Assurance report from **Finance and Performance Committee**	Date of Meeting: 27 March 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Davie Campbell, Chair Finance and Performance Committee	
Presented By:	Davie Campbell, Chair Finance and Performance Committee	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee on the **27 March 2025.**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Committee expressed their disappointment that the Business Continuity Plan update was not received, raising concerns regarding capacity within the Boards Resilience team. Update to be brought to Senior Leadership Team 22 April 2025 and Finance and Performance Committee 22 May 2025. Chief Executive to review Executive Leadership of the resilience team. 2. Committee were not assured by the operational data presented in the Integrated Performance Plan, raising concerns regarding the lack of data on ophthalmology performance and a disconnect between narrative and performance data. 3. The Island Games 2025 plan is now 80% complete, Committee were not in a position to recommend approval of the plan due to several outstanding actions. Assurance was taken by Committee 4. Committee raised concerns regarding the increase in costs at Month 11 due to unknown quantified prescribing costs, however noted that the efficiency programme remains on track to deliver the predicted £4 million savings by the end of the financial year. 5. Committee discussed and recommended that the funding proposal from Scottish Government be approved by the Board noting the risks associated with accepting the conditions outlined in the proposal. 6. Concerns were raised by Committee in relation to the Agenda for Change implications. As a substantial amount of our efficiency programme for 2025/26 (around 28%) is related to workforce, deep dives into the Improving Together Workstream and Agenda for Change will be brought to Committee 22 May 2025.	1. Contracts register is now in place and will be presented at all Finance and Performance Committee. 2. Director of Nursing, Midwifery, Allied Health Professional and Chief Officer Acute Services to develop a Business Case for an additional Band 6 post and the risk to patient care if additional resources are not brought in to support delivery of this clinical service.

Positive Assurances to Provide	Decisions Made
1. Committee thanked the Interim Director of Finance for the update from the National Directors of Finance Meeting, Board Chair suggested that this approach should be used as an exemplar for all national meeting updates at Board Committees. 2. Improving Together Programme Update - the Board is in a much better position than this time last year. The Improving Together Plan for 2025/26 will be brought to Board 24 April 2025, to ensure alignment with the Clinical Services Review 3. First Cytosponge clinic has now taken place – 8 patients who were eligible for this type of diagnostic examination have been seen at the first clinic in Orkney removing the need for patients to travel south. 4. Committee noted the NHS Orkney Procurement Annual report 2023/24 5. Committee acknowledged improvements within the finance team and welcomed the internal controls put in place to address the issues raised in internal and external reviews.	1. Committee Annual Report 2024/25 approved for onward submission to the Audit and Risk Committee. 2. Refresh of Standing Financial Instructions and Scheme of Delegation (Phase 1) approved.

Comments on Effectiveness of the Meeting

- Consideration should be given to the level of assurance given at the meeting.

NHS Orkney

Finance and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Finance and Performance Committee	Date of Meeting: 22 May 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	David Campbell, Chair, Non-Executive Director	
Presented By:	David Campbell, Chair, Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Performance Committee at its meeting on 22 May 2025		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Performance of Delayed Transfers of Care remains an issue - joint paper to be presented to Integration Joint Board July 2025. Workshop place to look at Hamnavoe house and future demographic needs of our population – update to be brought to Committee in July 2025. 2. There is a risk that the lack of capacity and capability to undertake change management may restrict our ability to implement service re-design and achieve the transformational change required to meet financial balance by 2028/29. 3. There is a risk of not delivering the savings attached to the Workforce Workstream of the Improving Together (efficiency) programme - the risk has increased as a result of accepting Scottish Government transitional funding.	1. Board Chair, CEO and Interim Director of Finance to raise concerns with SG regarding feedback on the ADP not being received until the end of Quarter 1. 2. Integrated Performance Report to be amended to include Key Performance Indicators (KPI's) for Business Continuity, Roberson's Contract and Sustainability - Amber status to be included going forward to indicate metrics which are off target. 3. Finance and Performance Chapter of the IPR to include Serious Adverse Event Reviews and Complaints going forward. 4. Process for approval of Business Cases to be brought to Committee in July 2025.
Positive Assurances to Provide	**Decisions Made**
1. Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register 2. Financial performance is rated green at 2024/25-year end, and noted the excellent progress made this financial year. 3. External auditors are halfway through the Annual Accounts and External Audit 2024/25 audit - no significant issues have been raised to date. 4. Performance management, governance and additional leadership now in place for Robertsons contract (The Balfour) 5. Contract Register/Service Level Agreement (SLA) Update provided assurance that lessons learned have been learned from previous contracts.	1. Final NHS Orkney Preparedness Plan – Island Games 2025 approved for onward submission to the Board in June 2025. 2. Improving Together (efficiency) Programme Plan 2025/26 approved. 3. NHS Orkney Procurement strategy 2025-2030

6. Finance Improvement Implementation plan (Response to Viridian Report) progress continues assurance provided. 7. Quarter 4 financial review meeting with Scottish Government. 8. A positive Quarter 4 Finance review meeting with Scottish Government - Board are in a good trajectory back to financial balance by 2028/29. 9. Cross Committee working conversations took place in relation to Agenda for Change Reform and Improving Together (efficiency) programme Workforce Workstream 10. Assurance taken on the Vacancy Control Panel Annual Report 2024/25. 11. Members welcomed and noted the Digital Delivery Plan 2025/26.	
Comments on Effectiveness of the Meeting	
• Committee is demonstrating its commitment to Openness.	

Audit and Risk Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from Audit and Risk Committee	Date of Meeting: 6 May 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Jason Taylor, Chair/Non-Executive Director	
Presented By:	Jason Taylor, Chair/Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Audit and Risk Committee **6 May 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concern or key risks to escalate.	1. Board Development Risk Management workshop scheduled for the 29 May 2025. 2. Head of Finance is leading a piece of work to enhance our fraud prevention strategy.

Positive Assurances to Provide	Decisions Made

1. Improvements are being seen across the Organisation in relation to completing risk jotters. Triangulation of risks between the Senior Leadership Team, Risk Management Group and Audit and Risk Committee.
2. A test of change in Children's services on managing operational risk is now complete - the service is now managing its operational risks effectively.
3. Assurance provided on Committee Performance via individual Committee Annual Reports 2024/25 – these will come forward to Board in June 2025 for approval, as part of the Boards Annual Report to Scottish Government.
4. Members took assurance on the Quarter 4 Board Assurance Framework 2024/25 performance.
5. Internal Audit Recommendations - Assurance on progress:
 	
   - 2023/24 Internal Audit Recommendations - 14 management actions evidenced as closed, 3 have revised completion dates
   - 2024/25 Internal Audit Recommendations - 21 management actions evidenced as closed, 7 have revised completion dates
 	
6. The draft Internal Audit Report 2024/25 confirmed an Internal Audit Opinion of reasonable assurance. Final Plan to be presented to Board in June 2025 as part of our Annual Report 2024/25.
7. Members received reassurance on progress with the annual accounts
	1. Minutes and Chair's Assurance Report from the meeting held on 4 March 2025 approved.
	2 Audit and Risk Committee Annual Report 2024/25 approved.
	3. Statutory and Mandatory Training Requirements for Non-Executives approved with the addition of Violence and aggression training.
	4. Board Assurance Framework Performance Scorecard for 2025/26 approved – this will form part of the Board Development Session on Risk Management on the 29 May 2025.

8. External Audit recommendations on track for completion, subject to review in our year end external audit assurance report.	

Feedback about meeting:
- Meeting was split to reduce the number of papers coming to the Annual Accounts meeting in 29th May 2025, this was welcomed.
- The Chair welcomed the Fraud Services Quarterly Report and how information was summarised in the refreshed cover paper.

Audit and Risk Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from Audit and Risk Committee	Date of Meeting: 27 May 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Jason Taylor, Chair/Non-Executive Director	
Presented By:	Jason Taylor, Chair/Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Audit and Risk Committee **27 May 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concern or key risks to escalate.	1. Second draft of Annual Report and Accounts 2025/26 to be shared with Committee members before submission to Scottish Government Friday 30 May 2025 for transparency.
Positive Assurances to Provide	**Decisions Made**
1. Scrutiny of the draft Orkney Health Board Endowment Fund Annual Accounts 2024/25 2. Assurance taken from the Orkney Health Board Endowment Fund Governance Statement 2024/25 which will be presented to Endowment Fund Trustees 5 June 2025 3. Assurance taken from Directors Subsidiary Assurance Statement 2024/25 that NHSO has satisfactory internal controls in place. 4. Scrutiny of draft NHS Orkney Annual Report and Accounts for year ended 31 March 2025 – amendments proposed. 5. Assurance taken 2 NHS Scotland Service Audits	1. Minutes and Chair's Assurance Report from the meeting held on 6 May 2025 approved, subject to minor amendment. 2. Draft Audit and Risk Committee assurance statement 2024/25 approved.
Feedback about meeting: - Decision to retain two May meetings, with early May meeting foucusing on internal audit and risk, and late May meeting on draft annual accounts was welcomed as this had ensured that the volume of papers and reading at both meetings was manageable and enabled proper scrutiny.	

Senior Leadership Team (SLT) People and Potential

Title of Report:	Chair's Assurance report from the Senior Leadership Team	Date of Meeting: 22 April 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Senior Leadership Team	
Presented By:	Laura Skaife-Knight, Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **22 April 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Limited assurance on performance on compliance with the Health and Care Staffing Act as detailed in the Annual Report for 2024/25.	1. Deep dive scheduled for the 1 May 2025 SLT to discuss the Improving Together efficiency schemes programme for 2025/26 with a focus on the Workforce Workstream given the significant amount of savings attached to this workstream (circa 30%/£1m). 2. Business Continuity Planning update to be brought back to SLT on 3 June 2025 which includes a plan for the training needs analysis that will be undertaken. 3. Further work is needed on the changes to PVG checks for staff – to return to SLT in July 2025. 4. Further work to be undertaken on the Distant Islands Allowance (DIA), to return to SLT in June 2025. 5. Position statement provided to Scottish Government on the Board's Medical Devices Policy- to come to SLT on 3 June 2025 and Board 26 June 2025 for final approval.
Positive Assurances to Provide	**Decisions Made**
1. Open and honest discussions took place at the Extended Senior Leadership Team on 15 April 2025 particularly in relation to the developing Integrated Education Strategy and Leadership Development Programme. 2. People and Culture team continue to support Line Managers to reduce sickness absence rates and increase statutory/mandatory training compliance through targeted intervention, with positive early results via this different approach.	1. NHS Orkney Annual (Health and Care Staffing Act) Report 2024/25 was approved for onward submission to the Board on 24 April 2025. 2. The Quarter 4 Board Assurance Framework Performance Scorecard was approved for onward submission to Board in April 2025. 3. The Communication and Engagement approach to the Digital Services review approved.

3. iMatter planning for 2025 has begun and communications will be issued to staff summarising how we have listened to and responded to staff feedback through the year.	

Feedback about meeting:

- Positive to have early sight of deliverables in the Corporate Strategy at Senior Leadership Team and Extended Senior Leadership Team including our behavioural standards work, leadership development programme, education and improvement hub proposal and the Digital Services review.
- Excellent engagement in the values and behaviours workshop led by the People and Culture team – feedback will form part of our behavioural standards framework and come back to SLT later this year.

Senior Leadership Team (SLT) Place, Patient Safety Quality, Experience and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Senior Leadership Team	Date of Meeting: 1 May 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Senior Leadership Team	
Presented By:	Laura Skaife-Knight, Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **1 May 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Corporate Risk Register: Risk 1211 (Waiting Times Data) target score has now been met and downgraded due to mitigating actions now being completed. Risk to be closed at the next Risk Management Group.	1. Equality Impact Assessment to be completed, monitoring to be clear and internal and external communications issued for the refreshed Waiting Times Access Policy to patients and our staff.

Positive Assurances to Provide	Decisions Made
1. The first draft of the NHS Orkney Annual Report 2024/25 was received and will be brought back to the Senior Leadership Team (SLT) for approval before submission to the Board in June 2025. 2. A deep dive on the workforce workstream of the Improving Together (efficiency) Programme was held. SLT approved the proposed approach to the workforce workstream and the plan to deliver pay savings of up to £1.25m in 2025/26. 3. A deep dive on the draft Finance and Efficiency (Improving Together) Programme Plan 2025/26 was received, scrutinised and approved – to return to SLT in June 2025 for approval ahead of submission to Board (also in June 2025). 4. NHS Scotland Operational Improvement Plan (OIP) was discussed with a focus on how NHS Orkney is responding to this Plan – there is clear alignment with our Corporate Strategy, Annual Delivery Plan (ADP) and 3-Year-Financial Plan. Paper to be submitted to Finance and Performance Committee in May 2025 and come onward to the public Board in June 2025.	2. Refreshed Waiting Times Access Policy approved subject to an Equality Impact Assessment being completed, monitoring being clear and internal and external communications being issued to patients and staff. 3. Proposed Communication and Engagement approach to undertaking the Operational Governance Review was approved. 4. NHS Orkney Procurement Strategy 2025-2030 recommended to Finance and Performance Committee for approval (at its May 2025 meeting). 5. Equality and Diversity Annual Reports (Gender Pay and Monitoring Report) 2024/25 received. Both reports were recommended for approval to the Staff Governance Committee where they will go on 15 May 2025.

Feedback about meeting:
- Good attendance and challenging discussions
- SLT is getting stronger as a senior leadership community
- Deep dives at the start of the meeting followed by the business were welcomed
- 3 members of staff attended to observer the meeting - feedback informative and fun
- Meeting concluded 5 minutes early and ran to time

Senior Leadership Team (SLT) People and Potential

Title of Report:	Chair's Assurance report from the Senior Leadership Team	Date of Meeting: 20 May 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Senior Leadership Team People and Potential	
Presented By:	Laura Skaife-Knight, Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **20 May 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No items of concern or key risks to be escalated.	1. Full Business Case to return to SLT which sets out the Leadership Development Programme prior to moving to procurement. The business case will include the expected measurable impact and outcomes. 2. Full Business Case for the Education and Improvement Hub to return presented to SLT – with an aspiration for the Hub to be open by Autumn 2025. 3. Area Partnership Forum discussion to take place in June 2025 on managing sickness with an update to be brought to SLT in July 2025. 4. Future iterations of the Integrated Performance Report/Workforce Report to include fuller details on sickness absence, including the evidence of active management of sickness. 5. Use of Microsoft 365 Copilot update to be presented to SLT 24 June 2025 which outlines the approach to training, proposed teams to receive advanced licenses and roll-out timelines.
Positive Assurances to Provide	**Decisions Made**
1. Workforce Report was presented to the SLT for the first time. 2. A smaller agenda enables greater discussions and time to reflect.	1. 3-strand mandatory Leadership Development Programme approved 2. Lower CSB be re-modelled to accommodate the Board's Education and Improvement Hub. 3. Updated Health and Safety Policy approved. 4. Approach to the introduction of Microsoft 365 Copilot to the organisation approved.
Feedback about meeting: - Check and challenge shows growing maturity of the Senior Leadership Team	

Senior Leadership Team (SLT) Place, Patient Safety Quality, Experience and Performance Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Senior Leadership Team	Date of Meeting: 3 June 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Senior Leadership Team	
Presented By:	Tammy Sharp, Director of Performance, Transformation and Deputy CEO	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **3 June 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. The First Minister has been clear all health must reach a position of zero, 52 week waits by the financial end of the year. Scottish Government have asked all Boards to put in place increased controls and scrutiny to ensure we meet those trajectories. A monthly performance report will be brought to SLT to ensure trajectories are monitored, so improvement plans can be put in place should they be required.	1. The 3 risk jotters presented regarding derogation from the National Infection Prevention Manual to be reviewed by the Risk Management Group to ensure they meet the criteria for inclusion on the Corporate Risk Register, with an update brought to the next SLT. 2. Work to be undertaken with our public health team to raise awareness for patients and staff on using sustainable travel to alleviate some of the challenges of car parking at The Balfour. 3. Workforce performance dashboards are in development - a design workshop will be delivered in the next 2 weeks to ensure the dashboards meet the needs of the Business going forward. 4. A detailed options appraisal be brought to SLT in 3 months setting out the medium- and long-term options for patients and staff at The Balfour.
Positive Assurances to Provide	**Decisions Made**
1. The risk in relation to Waiting Times data has been downgraded and will be closed at the next risk management group. 2. Communications to be issued this week to patients and staff to raise awareness of the refreshed Waiting Times Access Policy now the Boards Website has been moved to a new platform. 3. Improving Together Programme Bright Ideas Scheme will be relaunched by the end of June 2025 and will now invite people to share their issues as well as bright ideas. 4. The iMatter survey closed at 5,00pm 2 June 2025 - our completion rate is 69%, which is the same as last year. 5. Assurance provided that the Draft NHS Orkney Annual Report and Accounts 2024/25 is progressing as planned for approval by the	1. The Safety, Quality and Experience Quarter 4 Report approved for onward assurance to the Joint Clinical Care Governance Committee 3 July 2025. 2. SLT recommended approval by the Board of the NHS Orkney Medical Device Policy. 3. Short-term use of the Old Balfour Site for staff parking approved whilst an options appraisal for a longer-term solution is completed. 4. Integrated Performance Report (IPR) approved for onward submission to the Board in June 2025.

Audit and Risk Committee and Board 26 June 2025 with onward submission to Scottish Government 30 June 2025. 6. SLT discussed the addendum to 3-Year Financial Plan. 7. SLT noted the Scottish Government Quarter 4 Review Meeting update. 8. Programme for Government paper discussed, SLT noted the implications for NHS Orkney, report to be shared with Finance and Performance Committee and the Board in June 2025 for awareness.	
Feedback about meeting: - The meeting closed 30 minutes earlier than planned	

Chair's Assurance Report Area Clinical Forum

Title of Report:	Chair's Assurance report Area Clinical Forum	Date of Meeting: 2 June 2025
Prepared By:	Dr. Kirsty Cole – Chair Area Clinical Forum	
Approved By:	Dr. Kirsty Cole - Chair Area Clinical Forum	
Presented By:	Dr. Kirsty Cole - Chair Area Clinical Forum	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Clinical Forum at its meeting on 2 June 2025		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. An upcoming gap in lymphoedema care service provision was highlighted. Awaiting an update from Head of Primary Care Services. 2. Waiting times to see Psychiatry for consideration of medication following diagnosis of ADHD highlighted as an area causing distress to patients. 3. Ongoing absence of primary care physiotherapy and primary care mental health services highlighted as a significant source of additional pressure on all GP practices.	1. Joint session with Area Partnership forum planned on Organisational Values and Behaviours – provisionally planned for start of July.

Positive Assurances to Provide	Decisions Made
1. Informative update on the Integrated Education Strategy received with offers of support from ACF members to support further development in this area. 2. Review of previous month's development session on frailty highlighted this was very well received by members. Enthusiasm for further work in this area with a request for the Chair to arrange a follow up session with the frailty lead.	1 Draft Public Protection Policy and draft Safeguarding Children Supervision Policy both recommended for approval pending receipt of additional information on information sharing arrangements.

Comments on Effectiveness of the Meeting
Good level of scrutiny offered on the draft policies that were presented to the committee. Ongoing good attendance from regularly present members, but absence from Dental and Hospital colleagues notable.

Staff Governance Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report to the Board	Date of Meeting 15 May 2025
Prepared By:	Debbie Crohn, Head of Improvement	
Approved By:	Joanna Kenny, Chair, Staff Governance Committee	
Presented By:	Joanna Kenny, Chair, Staff Governance Committee	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Staff Governance Committee at its meeting on **15 May 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Limited assurance on the Health and Social Care Staffing Act Annual Report 2024/25 – an improvement plan is in place; this will be overseen by the Operational Workforce Group noting there is a significant amount of work required to deliver the plan.	• Operational Workforce Group to review mitigating actions on the Corporate Risk Register at its meeting 27 May 2025 • Single Workforce Chapter to be developed for the Integrated Performance Report (IPR) including long term and short-term sickness absence rates, agency, bank, and excess hours. • Agenda for Change Reform Implementation plan to be brought back to Committee in August 2025 setting out the roadmap and timelines in relation to Reducing Working Week by 1 April 2025. • Meeting to be arranged for the Board to discuss implications of the Agenda for Change Reform Implementation plan. • Nursing and Midwifery Taskforce Report: Delivering Together for a Stronger Nursing and Midwifery Workforce Publication (February 2025). Recommendations will be taken to NAMAC and brought back to Committee in Quarter 4 2025/26. • Job planning progress update deferred to the next meeting in August 2025. It was requested that the report be updated for the next meeting to include detail around engagement and outcomes as well as the process elements.
Positive Assurances to Provide	**Decisions Made**
• Committee welcomed a presentation from Lou Willis Service Manager – Children's Health Services who provided an overview what it meant be awarded the Team Orkney Leader of the Year Award and the importance of compassionate and quiet leadership. • TURAS models have now been introduced for inducting staff on the use of electric vehicles, pre-inspection checks and legal requirements. • Increase in the completion of statutory/mandatory training and appraisals recognising the step change reported at the May 2025 Performance Review Meetings.	• Staff Governance Committee Annual Report 2024/25 approved. • Recommendation that the Board approve the Equality and Diversity Annual Report 2024/25. • Manual Handling policy and procedure approved

- Your Employee Journey programme launched to the Extended Senior Leadership Team 12 May 2025 and to the wider Organisation 13 May 2025.   - Values and Behaviours workshop held with ESLT on 12 May 2025, feedback will be categorised with a follow up session being delivered by the People and Culture team.   - Automated process and face to face sessions are taking place for staff to upload documentation to support completion of PVG checks.   - Equality and Diversity data was included in the bi-annual workforce report, noting the quality of the report which has evolved over time.   - Clinical restorative supervision policy will be rolled out later this year, this will support staff health and well-being.   - Area Partnership Forum (APF) Annual Report 2024/25 received.   - Equal pay statement agreed in Area Partnership Forum.

Comments on Effectiveness of the Meeting

- Committee welcomed the staff story at the start of the meeting.
- Some real breadth and depth of information is now being presented.
- The meeting was well attended with a good level of check and challenge from members

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Corporate Risk and Assurance Report**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Kat Jenkin, Head of Patient Safety, Quality and Risk; Diane Smith, Clinical Governance and Risk Facilitator**

1   Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Annual Operation Plan
- Local policy

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective

2   Report summary

2.1   Situation

The Corporate Risk Register Report is presented to the Board to support clarity, oversight, and enhance scrutiny for the organisation.

The risk actions are continually added to and to ensure the actions remain relevant, any actions more than six months old will be removed from the current register to aid clarity.

2.2   Background

This report provides an at a glance view of what has changed over two months, and how the risks are shared across committees.

2.3 Assessment

The Corporate Risk Register with overview is attached as appendix one. The first sheet summarises changes over two months, with an extract summary as below.

Corporate Risks - Split by Score

Total Number of Risks Split by Review

NHS Orkney
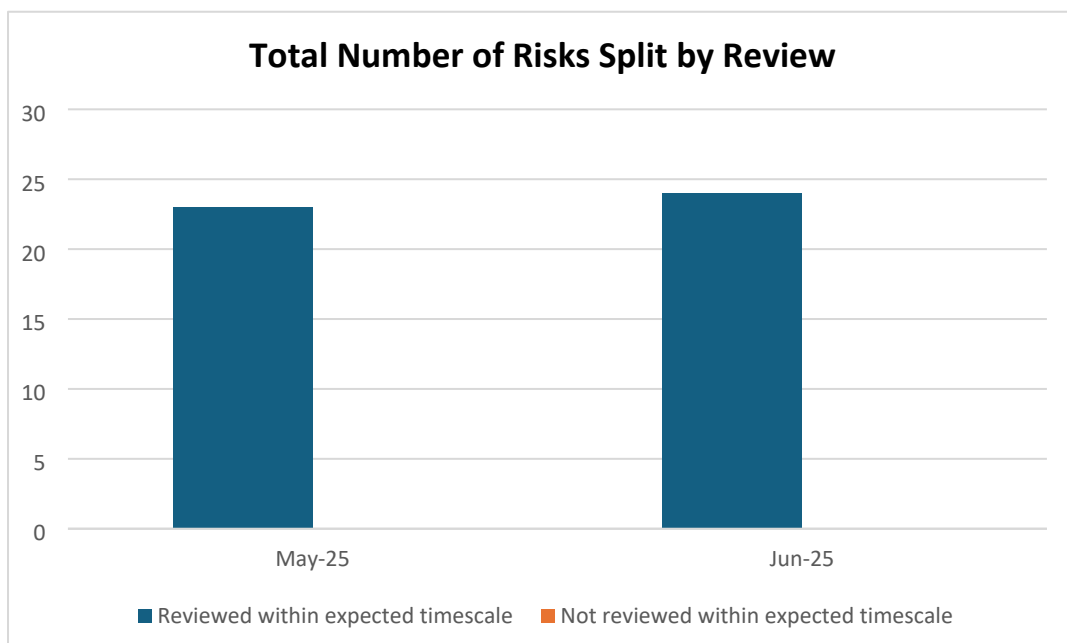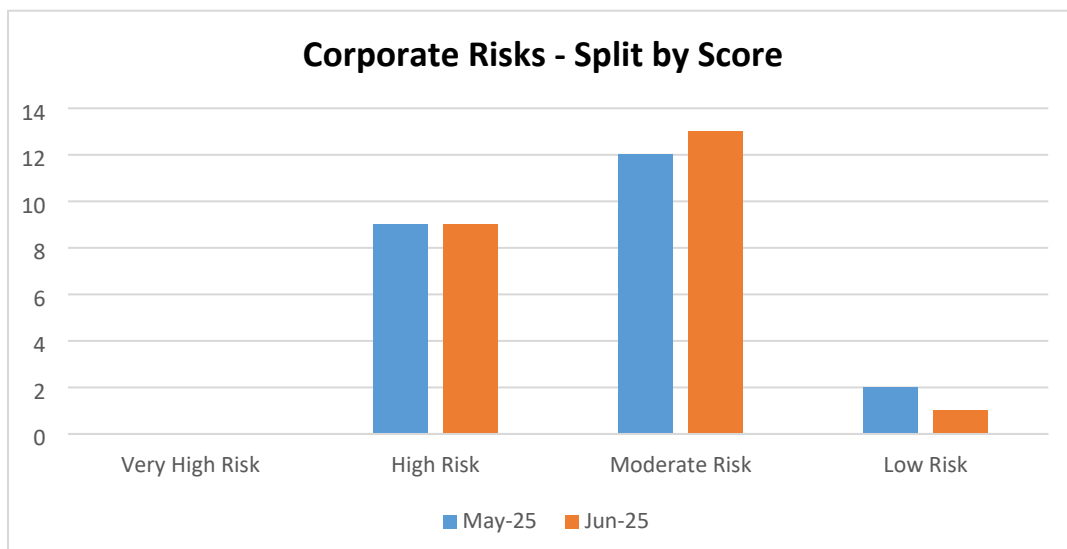
Risks Split by Oversight Committee

Legend: JCCGC, Staff Gov. Com., F&P, ARC
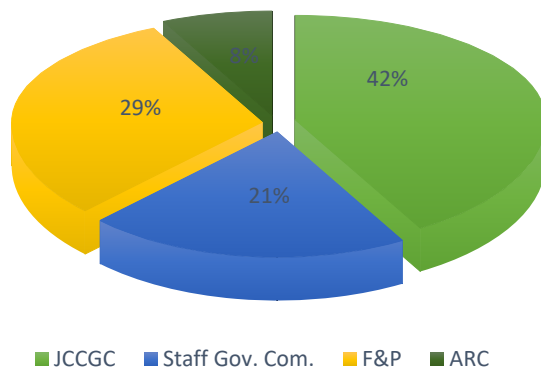
The following table would normally hold the top three risks for the organisation, but currently there are nine risks that are all scoring 12 which is the third highest risk score. Therefore, the third risk has been selected by looking at the clinical impact to patients.

Top Three Corporate Risks

ID	Risk Title	Current Impact	Current likelihood	Current Risk Level	Target Risk Level	Mitigating Actions	Actions
C-2024-01	Lack of senior leadership capacity and capability	4	4	16	4	8a – d leadership development programme and PDPs for all senior leaders SLT formal development programme 8c and d personal objectives set and agreed by Renumeration committee Interim Director of Finance commenced in post in September 2024 for 6 months Interviews for substantive Director of Finance are at the end of October Interim Head of Strategy in post on secondment for 6-month period	**Update 13/05/2025 -** A paper is going to SLT in May for leadership, management and quality improvement training, impeding approval a leadership programme will be procured. In May a substantive Director of Finance and a replacement for the Director of People and Culture. The Director of Performance and Transformation and Deputy Chief Executive commenced on 12/05/2025. **Update 3 Feb 2025** – Interim Director of Finance has been appointed from SAS on a 6-month secondment. Successfully appointed the Director of Performance and Transformation (Deputy Chief Executive) start date to be confirmed. **Update 8 Dec 2024** – Interim Director of Finance secured from February 2025 and interviews for an 18-month fixed term Director of Performance and Transformation (Deputy Chief Executive) 13 December Some phased returns for senior colleagues have commenced to ensure a supported return, and cover for colleagues on sickness absence in place (including support from Scottish Government and other Health Boards as development opportunities (finance, strategy, performance and planning) Quarter 4 2024/25 – Next phase of executive development programme to be planned and a Heads of Service development prorgamme will be a priority for the Director of People and Culture to lead delivery and to ensure senior colleagues feel supported Extended Senior Leadership and Senior Leadership Team membership updated to be as inclusive as possible across our most senior leadership community – so that colleagues feel involved and engaged and all voices are heard

| 510 | Corporate Financial Sustainability | 5 | 3 | 15 | 10 | 3.2m of efficiency programmes currently in implementation, 2.5m recurrent (above 3% target)

in excess of 1m in cost reduction schemes

Strengthened governance arrangements - scheme of delegation, performance review meetings, streamlines investment approval process

Additional grip and control measures - vacancy control panel, discretionary spend, budget trackers, workforce establishments

Plan currently on track to be delivered, expectation is brokerage support to this value will be received.

Financial Escalation Board to be stood up. | **Update 14/05/2025** - Unaudited outcome for 2024/25 is a deficit of 3.874M, significant improvement from forecast plan of 5.778m. The 2025/25 financial plan has been approved by Scottish Government this outlines a forecast deficit of 3.1m 2025/26 reducing to 1.7m 2027/28. In addition Scottish Government have confirmed that NHS O will receive non-repayable, non-recurring funding over the next 4 years to support the return to financial balance by 2028/29 this means that the risk of a section 22 qualification is significantly reduced as this funding should result in a break even position in 2025/26. Risk can therefore be reduced to 15.
Update 13/04/2025 - Final out-turn for 2024/25 is being finalised but is on-track to deliver our revised target of £4.2m. 2025/26 Financial Plan has been submitted to SG with forecast £3m. Conversations are ongoing regarding the plan and we will have a final position from SG at the end of April. Financial Escalation Board first meeting at the end of April to commence scrutiny of the Board's finances. No change to SG position of no brokerage therefore 2025/26 still likely to result in a Section 22 Qualification. No change to the risk level at this stage – continues to be a very high risk
Update 12/03/2025 - 2024/25 will deliver a lower deficit than forecast. Primarily due to additional funding received and not due to lowering of costs however, 2025/26 is forecasting another £3million deficit and Scottish Government have confirmed that no brokerage is available from April and therefore we won't meet our statutory requirements to break even. External audit will therefore likely qualify our 2025/26 annual accounts and we will have to appear at Scottish Government Public Audit and Post - Legislative Scrutiny Committee. From April 2025 Financial Escalation Board will be stood up to provide Executive and Non-Executive oversight and responsibility to deliver the financial position that is aligned to Scottish Governments agreed plan. Risk Score increased to 20 - likelihood increased from 3 to 4.
Update 09/12/2024 - Risk description revised to more accurately reflect the risk. |

						Ophthalmology - Establish outstanding Highland SLA provision and ensure backlog is recovered. •Establish use of NTC (Highland and Golden Jubilee) for cataract operations. •Establishment consultant vacancies mapping for all services •Recruitment to establishment Consultant vacancies •Business cases for additional clinical resource for fragile services - recurring & non-recurring - complete for paediatrics (community and mental health)	**Update 11/04/2025** 6.4 Consultant vacancies currently being advertised and the CSR currently underway mapping the current provision and recommending the model for sustainable services. **Update 03/01/2025** - The planned care programme board continues to provide oversight, however definitive improvement and stabilisation plans for services are outstanding. An ophthalmology peer review on 8th Jan aims to establish a sustainable operating model. Under the requirements for financial balance, some services in the short to medium term will need to revert to NHS Grampian.
1228	Fragile Clinical Services	3	4	12	6		

There was one risk added to the Corporate Risk Register in May 2025 – C-2025-01 - Temporary of Clinical Decontamination Unit (CDU) - installation of a new air handling unit, cooling coil.

There was one risk added to the Corporate Risk Register in June 2025 – C-2025-02 – Management of Staff Attendance.

No risks were closed in May 2025 and June 2025.

Risk 510 (Corporate financial sustainability) has reduced the risk scoring from 20 to 15, moving it from very high risk to high risk.

Risk 1225 (Insufficient capacity in the social care system) has reduced the risk scoring from 12 to 8, moving it from high risk to medium risk.

It is asked that the Board review and discuss the Corporate Risk Register.

2.3.1 Equality and Diversity, including health inequalities

There are no identified impacts identified through this report.

2.3.2 Climate Change Sustainability

There are no identified impacts identified through this report.

2.3.3 Route to the Meeting

This paper is prepared for this meeting only.

2.4 Recommendation

The Board are asked to review and scrutinise the Corporate Risk Register. To note that Board members are asked to critically consider the register, and raise any recommended changes or clarifications beyond those noted in the cover report:

- **Discussion** – Review and discuss the Corporate Risk Register.

3 List of appendices

The following appendix is included with this report:

- **Appendix 1**: Corporate Risk Register

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 26 June 2025
Title: Responsible Executive/Non-Executive:	Integrated Performance Report (IPR) June 2025 – Tammy Sharp, Director of Performance and Transformation (and Deputy CEO)
Report Author:	Carrie Somerville – Head of Planning, Performance and Information

1   Purpose

This report is presented to the Board for **Assurance:**

Members are asked to:

   i.   **Receive** the Integrated Performance Report (IPR) June update.
  ii.   **Note** where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Annual Delivery Plan 2024/25
- Emerging issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Sustainability

2   Report summary

2.1 Situation

The Integrated Performance Report (IPR) (Exception Only) (Appendix 1) summarises NHS Orkney's performance based on national and local reporting requirements as well as those indicators which matter to our patients and community. The IPR aligns to our Corporate Strategy 2024-28, Realistic Medicine Plan, Annual Delivery Plan 2024/25, Financial Recovery Plan and our Improving Together (efficiency) Programme.

Appendix 1 contains a summary against each of NHS Orkney's Key Performance Indicators (KPIs) highlighting what is going well, successes, causes for concern, challenges and planned improvements/actions being taken to bring performance back on track.

2.2 Background

The IPR is the mechanism by which Executive Leads provide assurance to Board Committees and the Board on how we are performing on national reportable metrics required by Scottish Government (SG).

2.3 Assessment

The period covered by the performance data is generally up to the end of April 2025.

Key points for consideration

- Monthly sickness absence rate at the end of February 2025 was 6.13% compared to 6.05% at end of December 2024.
- Appraisal rates increased at the end of February 2025 up from 36.49% to 38.33% against a target of 85%.
- Four-hour emergency access standard performance at the end of April 2025 was 94.51% compared to 91.99% at end of February 2025, against the national 95% standard. NHS Orkney remains a top three performing Health Board in Scotland for this national standard.
- Inpatient total wait list at end of April 2025 was 262 compared to 300 at February 2025. Against the national 12-week Treatment Time Guidance (TTG) target, patients waiting in excess of this standard at the end of April was 134 compared to 136 at end of February 2025.

The Director of Performance and Transformation (and Deputy CEO) will lead a review to determine the next steps for enhancing the Integrated Performance Report. The review will focus on evaluating the relevance of current content and developing clear, time-bound action plans for improvement.

2.3.1 Patient Safety and Quality

Performance data relating to Patient Safety, Quality and Experience are reported through the Joint Clinical Care and Governance Committee. Whilst the process for the collection of the patient safety, quality and experience metrics is established and provided consistently, work to expand this dataset to provide the necessary assurance to the Board as some KPI's do not have targets set against them either locally or nationally.

2.3.2 Workforce

The Workforce improvement workstream within the Improving Together Programme is well developed with 8 areas of focus. These include sickness management, mandatory training and appraisals. Corporate Leads have been identified for each area to drive delivery.

2.3.3 Financial

The Board remains at level 3 of the Scottish Government's NHS Finance and Escalation Framework. Workforce transformation accounts for around one third of projected savings for this Financial Year.

2.3.4 Risk Assessment/Management

The following risks are captured in the Corporate Risk Register which may impact on the Board's ability to timeously deliver patient care, impacting on the patient experience:

- Risk 510 - Corporate Finance Risk
- Risk 1225 - System Capacity

- Risk 1228 - Fragile Services

2.3.5 Equality and Diversity, including health inequalities.

Reducing health inequalities is a key priority as part of the Place strategic objective. Equality, diversity and inclusion are also central to the delivery of our People priorities and our Corporate Strategy takes into consideration local, regional, and national policy. The Equality and Diversity Monitoring Report for 2024/25 was approved by the Senior Leadership Team on 1 May 2025.

2.3.6 Communication, involvement, engagement, and consultation

Discussions have taken place with Section leads, Executive leads and Health Intelligence Team, in the development of this paper.

2.3.7 Route to the Meeting

- Full report discussed and agreed at the Senior Leadership Team meeting on 3 June 2025
- Finance, Operational Standards and Community Chapters were discussed at the Finance and Performance Committee meeting on 22 May 2025.
- Workforce Chapter was discussed at the meeting of the Staff Governance Committee on 15 May 2025.
- Patient Safety, Quality and Experience and Population Health Chapters come straight to the meeting as there is no Joint Clinical Care Governance Committee meeting in May 2025.

3. Recommendation(s)

Assurance - The Board is asked to:

i. **Receive** the Integrated Performance Report (IPR) June update.
ii. **Note** where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

4. List of appendices

The following appendix is included with this report:

- **Appendix 1**, Integrated Performance Report (Exception Only) - June 2025

NHS
Orkney

Integrated Performance Report

June 2025

Chief Executive: **Laura Skaife-Knight**

Operational Standards (Acute and Community)
Patient Safety, Quality and Experience
Population Health | Workforce
Community | Finance

HEALTH Intelligence

ORK.healthintelligence@nhs.scot

Introduction

The Integrated Performance Report (IPR) has been created to monitor overall performance at NHS Orkney across all domains. These are currently Operational Standards (Acute and Community), Population Health, Workforce, Patient Safety, Quality, and Experience, and Finance.

The IPR aims to measure key performance indicators (KPI) from each of these areas, and will identify if they are meeting their respective targets. Each KPI will be assigned a red or green classification dependent on whether they are meeting their target or not. An example of how this will be displayed throughout this report is shown below on the left.

Further to this, each metric will also be measured on its own performance, showing if the position has improved, deteriorated, or stayed the same when compared to the previous reporting period. An example of the icons used to demonstrate the change in month-by-month performance is shown below on the right.

Reporting is by exception. Where areas are Red, a page summarising recovery and improvement actions to recover performance is included.

RAG Status Values	
RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

Icon	What it shows.
⬆	Performance has improved.
⬇	Performance has deteriorated.
⬌	Performance has remained the same.
✕	Insufficient data available to allow comparison.

NHS
Orkney

NHS Orkney Performance Scorecard

Key Performance Indicators Implemented

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG	Position Change
1	Patient Safety, Quality, and Experience	Excellence in Care	Number of inpatient acquired pressure ulcers this month	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	0	0	Green	↔
2	Patient Safety, Quality, and Experience	Excellence in Care	Multi-Drug Resistant Organism (MDRO) screening compliance - hospital and community acquired CPE	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	90%	100%	Green	X
3	Patient Safety, Quality, and Experience	Excellence in Care	Multi-Drug Resistant Organism (MDRO) screening compliance - hospital and community acquired MRSA	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	90%	93.3%	Green	X
4	Patient Safety, Quality, and Experience	Excellence in Care	Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level)	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	0	5	Red	↓
6	Patient Safety, Quality, and Experience	Complaints	Change in number of complaints received this reporting period	Medical Director	0	7	Red	↓
7	Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 1 5 Working Day Response Compliance	Medical Director	100%	60.00%	Red	↓
8	Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 2 20 Working Day Response Compliance	Medical Director	100%	33.33%	Red	↑
9	Patient Safety, Quality, and Experience	Complaints	Complaints upheld and partially upheld by SPSO	Medical Director	0	0	Green	↔
10	Patient Safety, Quality, and Experience	Incident Reporting	Incident Reporting and 7 Working Day Review Compliance	Medical Director	100%	100%	Green	↔
11	Patient Safety, Quality, and Experience	Significant Adverse Event Reviews	Significant Adverse Event Review Compliance (closed within target date)	Medical Director	100%	50.00%	Red	↑
13	Patient Safety, Quality, and Experience	Women and Children	Maternal Early Warning Score Observations	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	↔
14	Patient Safety, Quality, and Experience	Women and Children	Maternal Early Warning Score Escalation	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	↔
15	Patient Safety, Quality, and Experience	Women and Children	Paediatric Early Warning Score (PEWs) - % Compliance with PEWS Bundle	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	82.35%	Red	↑
16	Patient Safety, Quality, and Experience	Women and Children	Paediatric Early Warning Score (PEWs) - % 'at-risk' observations identified and acted upon	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	↑
17	Operational Standards	Planned Care	100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (TTG)	Medical Director	100%	58.22%	Red	↓
18	Operational Standards	Planned Care	10% reduction in waiting times for Treatment Time Guarantee patients	Medical Director	-10%	-4.13%	Red	↓
21	Operational Standards	Planned Care	90% of planned/elective patients to commence treatment within 18 weeks of referral	Medical Director	90%	79.8%	Red	↓
22	Operational Standards	Planned Care	100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	Medical Director	100%	44.74%	Red	↑
23	Operational Standards	Planned Care	100% of patients waiting for key imaging diagnostic tests and investigations should wait no longer than six weeks (42 days).	Medical Director	100%	97.02%	Red	↑
24	Operational Standards	Planned Care	100% of patients waiting for key cardiology diagnostic tests and investigations should wait no longer than six weeks (42 days).	Medical Director	100%	66.67%	Red	↑
25	Operational Standards	Cancer	90% of those referred urgently with a suspicion of cancer are to begin treatment within 62 days of receipt of referral	Medical Director	90%	100%	Green	↔
26	Operational Standards	Cancer	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	Medical Director	95%	100%	Green	↔
29	Operational Standards	Unscheduled Care	95% of patients wait less than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	94.51%	Red	↑
30	Operational Standards	Unscheduled Care	Patients wait less than 12 hours to admission, discharge, or transfer from A&E	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	↔
31	Operational Standards	Unscheduled Care	Scottish Ambulance Service Turnaround Times - 90th percentile within 60 minutes	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	60:00	23:26	Green	↑
32	Operational Standards	Delayed Transfer of Care	Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	55.00%	Red	↑
33	Operational Standards	Delayed Transfer of Care	Number of people experiencing a delay of any length or reason in discharge from hospital at the monthly census point	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	4	11	Red	↓
34	Operational Standards	Delayed Transfer of Care	Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	56	325	Red	↓
35	Operational Standards	Women and Children	90% of eligible patients to commence IVF treatment within 12 months of referral	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	90%	N/A	Green	↔
36	Operational Standards	Women and Children	100% of women booking in a Board allocated to a primary midwife	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	↔
37	Operational Standards	Women and Children	50% of women receive care during the intrapartum period from the primary, buddy or member of the team who she has met.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	50%	71.40%	Green	↔
38	Operational Standards	Women and Children	75% of scheduled antenatal care delivered by the primary and no more than one other midwife.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	75%	50%	Red	↓
39	Operational Standards	Women and Children	75% of scheduled community based postnatal care delivered by the primary and no more than one other midwife.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	75%	33.30%	Red	↑
41	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	56.07%	Red	↓
42	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led podiatry musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	9.09%	Red	↑
43	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led physiotherapy musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	65.12%	Red	↓
44	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led orthotics musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	30.00%	Red	↑
46	Community	Child and Adolescent Mental Health Service (CAMHS)	90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Compliance rate 98.5%	Chief Officer (Integration Joint Board)	90%	100%	Green	↔
47	Community	Psychological Therapies	18 Week Referral to Treatment	Chief Officer (Integration Joint Board)	90%	100%	Green	↑
48	Population Health	Promoting health and wellbeing outcomes	Increase smoking cessation services across Scotland and successful quits year on year, including during pregnancy.	Director of Public Health	18.5	25	Green	↑
49	Population Health	Promoting health and wellbeing outcomes	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards)	Director of Public Health	25.83	20	Red	↑
50	Population Health	Prevention of Disease	Immunisation uptake rate 6-in-1 primary Course by 12 months	Director of Public Health	95%	96.90%	Green	↓
51	Population Health	Prevention of Disease	Immunisation uptake rate MMR2 by 6 years of age	Director of Public Health	95%	91.80%	Red	↓
52	Population Health	Promoting health and wellbeing outcomes	Diabetic Retinopathy Screening - 100% of the population eligible sent at least one invitation for retinal screening (with or without a pre-booked appointment) within the Reporting Period.	Director of Public Health	40%	43.5%	Green	X
53	Population Health	Promoting health and wellbeing outcomes	Breast Screening - 80% Uptake Over Rolling 3-Year Period	Director of Public Health	80%	83.70%	Green	X
55	Population Health	Promoting health and wellbeing outcomes	Bowel Screening - 60% of eligible persons successfully completing a screening test (i.e. an outright positive or negative test result).	Director of Public Health	60%	69.90%	Green	X
56	Population Health	Promoting health and wellbeing outcomes	AAA Screening - 75% of eligible population are tested before reaching the age of 66 and 3 months	Director of Public Health	75%	91.1%	Green	X
57	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	Director of Public Health	100%	88.60%	Red	↓
58	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	Director of Public Health	100%	87.5%	Red	↓
59	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	Director of Public Health	100%	87.5%	Red	↓
60	Population Health	Promoting health and wellbeing outcomes	Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	Director of Public Health	100%	100%	Green	↔
61	Population Health	Promoting health and wellbeing outcomes	Universal Newborn Hearing Screening - The proportion of babies eligible for UNHS for whom the screening process is complete by 4 weeks corrected age is ≥ 98%	Director of Public Health	98%	100%	Green	X
63	Workforce	Sickness Absence	Sickness rates consistently below the national average of <6%	Director of People and Culture	5.80%	6.13%	Red	↑
64	Workforce	Sickness Absence	Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	Director of People and Culture	6.47%	6.31%	Green	↑
65	Workforce	Appraisals	Appraisal compliance rate over the previous 12 months	Director of People and Culture	85%	38.33%	Red	↑
66	Workforce	Hours Utilised	Agency	Director of People and Culture	x̄	1550	Green	↑
67	Workforce	Hours Utilised	Bank	Director of People and Culture	x̄	4612.93	Red	↑
68	Workforce	Hours Utilised	Overtime	Director of People and Culture	x̄	480.5	Green	↑
69	Workforce	Hours Utilised	Excess	Director of People and Culture	x̄	1073.14	Red	↓
70	Finance	Finance	Financial performance against plan - YTD.	Director of Finance	£5,778,000.00	£3,874,000.00	Green	↑
71	Finance	Finance	Financial performance against plan - Forecast.	Director of Finance	£5,778,000.00	£3,874,000.00	Green	↑
72	Finance	Finance	Efficiency performance against plan - YTD.	Director of Finance	£4,000,000	£4,069,000.00	Green	X
73	Finance	Finance	Efficiency performance against plan - Forecast.	Director of Finance	£4,000,000	£4,069,000.00	Green	↓
75	Finance	Finance	Capital performance against plan - YTD.	Director of Finance	£4,336,000.00	£4,308,000.00	Green	↓
76	Finance	Finance	Capital performance against plan - Forecast.	Director of Finance	£4,336,000.00	£4,308,000.00	Green	↓

Key Performance Indicators In-Progress

A number of Key Performance Indicators (KPIs) have been included in this section but are not yet fully represented in this report. The reasons behind current non-inclusion vary and can be due to current data and/or definition availability, NHS Orkney awaiting national targets to be set, or work still being required to ensure that any data being shared is compliant with the Code of Practice for Statistics. A QR code linking to the UK Statistics Authority has been added below.

Whilst they have not been featured in this edition of the Integrated Performance Report (IPR), NHS Orkney will continue to develop these KPIs and endeavour to deliver these in the next edition of the IPR scheduled for release in August 2025.

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG	Position Change
27	Operational Standards	Inpatients	Ensure that acute receiving occupancy is 95% or less.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%			X
28	Operational Standards	Inpatients	Pre-noon discharges	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute				X
40	Community	Drug and Alcohol Treatment	90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	Chief Officer (Integration Joint Board)	90%			X
45	Community	Dementia Post-Diagnostic Support	People newly diagnosed with dementia will have a minimum of one years post-diagnostic support	Chief Officer (Integration Joint Board)	100%			X
54	Population Health	Promoting health and wellbeing outcomes	Cervical Screening - 80% of eligible women (aged 25 to 64) who were recorded as screened adequately	Director of Public Health	80%			X
74	Finance	Finance	Efficiency programme recurrent savings against plan.	Director of Finance		£2,883,000.00		X

NHS Orkney

Patient Safety, Quality, and Experience

Section Lead(s):
Medical Director
Executive Director of Nursing, Midwifery, Allied Health Professionals & Chief Officer Acute

What's Going Well?

The target for the number of complaints is set at zero to ensure this is consistently reported on, however the number of complaints received monthly has remained stable from at least June 2024, with a small reduction in stage one complaints as clinical staff are addressing concerns at the time and managing these at ward level.

The numbers of pressure ulcers remain in the green.

One of the outstanding overdue Significant Adverse Event Reviews (SAERs) has now been completed.
Work is ongoing to improve level two reviews including work with other Island Boards to share ideas and learning.

RAG Status Values

RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

Areas of Concern

The small numbers that can be reported on monthly continue to limit the utility of reporting Key Performance Indicators (KPIs) to identify trends. However the 20 day stage two response rate should be more consistent and is an area of improvement focus for complaints.
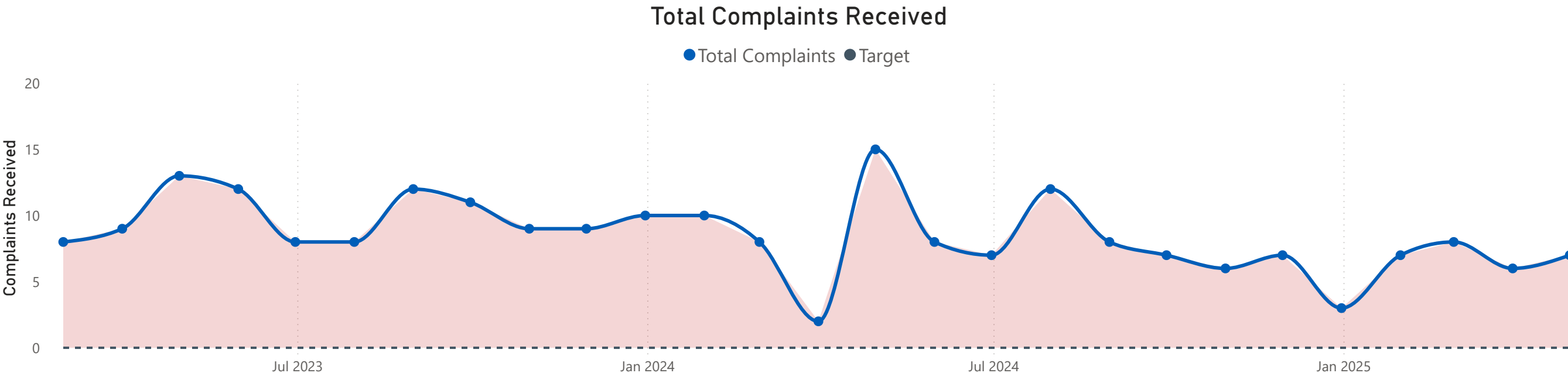
Patient Safety, Quality, and Experience
Complaints Received

Total Complaints Received

● Total Complaints ● Target

KPI	Target	Actual	RAG Value
Change in number of complaints received this reporting period	0	7	Red

Actions to Improve/Recover Performance

The number of Stage 2 complaints is comparable to the numbers at this time last year, and there has been a significant drop from 19 to six for Stage 1s. This is mainly due to staff undertaking to resolve some issues as a concern which has had a beneficial impact on the recorded number of Stage 1 complaints.

Improvement Target Date
31/05/2025

Patient Safety, Quality, and Experience
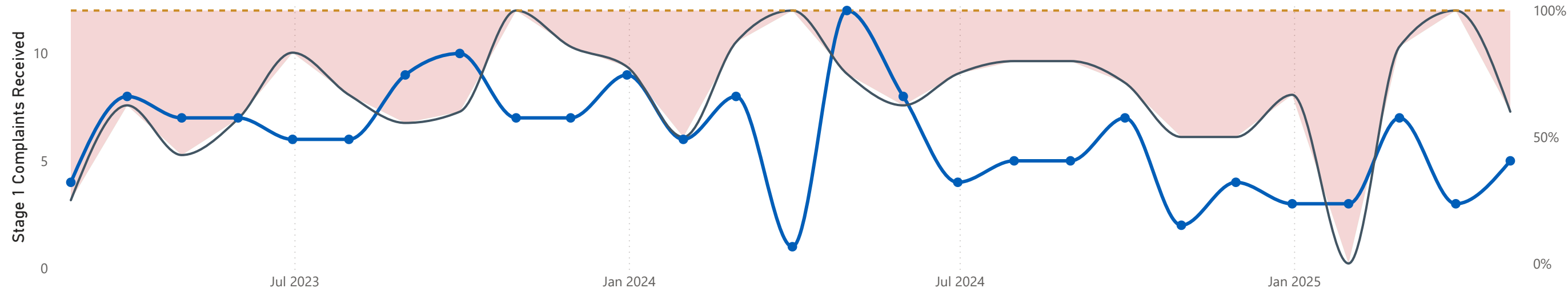## Stage 1 Complaints

Data Source

Patient Experience Officer

Latest Data

30/04/2025

Stage 1 Complaints – 5 Working Day Response Compliance

● Stage 1 Complaints Received ● 5-Day Response Compliance % ● Target

KPI	Target	Actual	RAG Value
Complaints Received - Stage 1 5 Working Day Response Compliance	**100%**	**60.00%**	**Red**

Actions to Improve/Recover Performance

Due to the small number of complaints received one complaint has a significant effect on the percentage of compliance. The Safety, Quality and Risk Team continues to support reviewers to complete responses within a timely manner.

Improvement Target Date

30/06/2025

Stage 2 Complaints – 20 Working Day Response Compliance

● Stage 2 Complaints Received ● 20-Day Response Compliance % ● Target
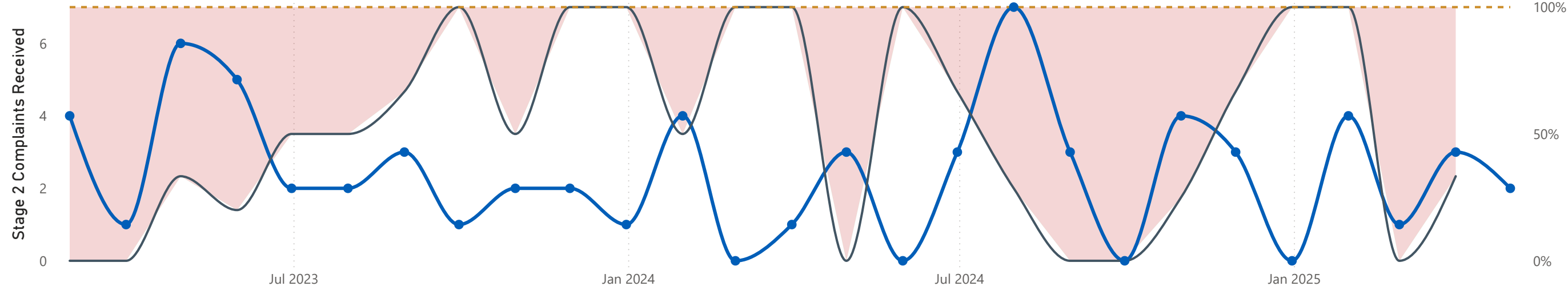
KPI	Target	Actual	RAG Value
Complaints Received - Stage 2 20 Working Day Response Compliance	**100%**	**33.33%**	**Red**

Actions to Improve/Recover Performance

In the first quarter of this year, four Stage 2 complaints have been received. Two complaints have not been responded to within timescales. These are both under investigation but are complicated by their complex nature. Two complaints remain open at the time of reporting and are currently within timescales.

Improvement Target Date

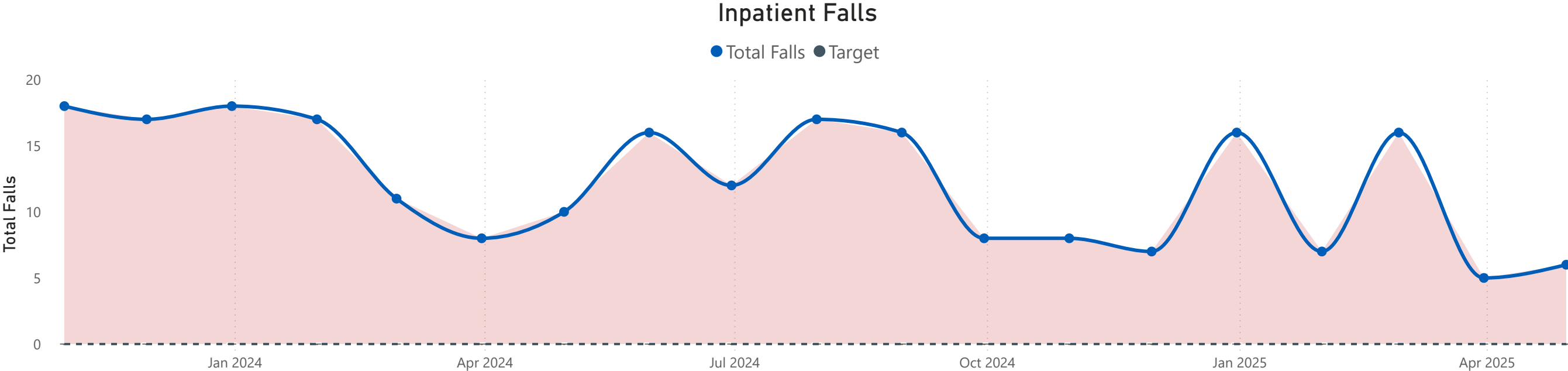31/03/2025

Patient Safety, Quality, and Experience
Inpatient Falls

Inpatient Falls

- Total Falls
- Target

KPI	Target	Actual	RAG Value
Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level)	0	5	Red

Actions to Improve/Recover Performance

Whilst there was an increase in falls seen during February, in part due to a higher patient cohort who were at risk of falls, improvements have been seen in March with a decrease in falls on both Inpatient 1 and Inpatient 2. Improvement work around falls through the Excellence in Care programme continues. Falls data from April shows a sustained improvement.

Improvement Target Date
30/06/2025

Significant Adverse Events – Review Compliance

Legend: ● SAER's Commissioned ● % SAER Compliance ● Target
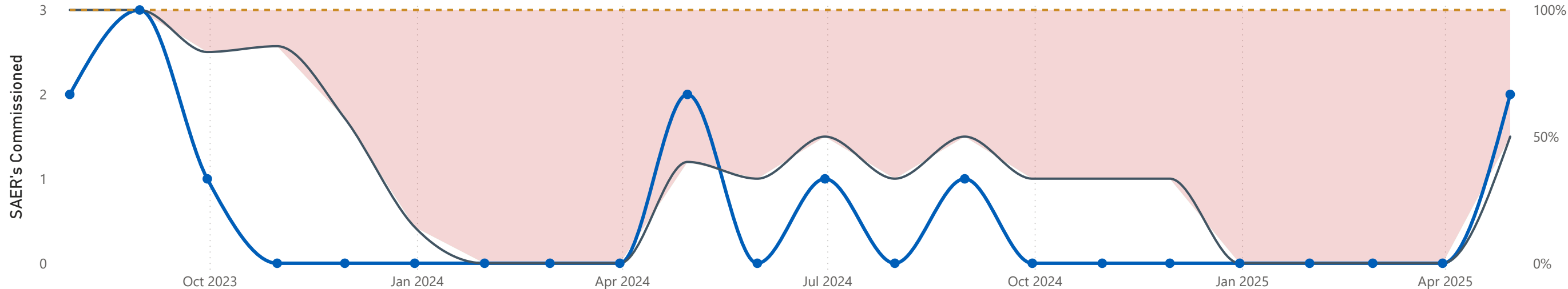
KPI	Target	Actual	RAG Value
Significant Adverse Event Review Compliance (closed within target date)	**100%**	**50.00%**	**Red**

Actions to Improve/Recover Performance

One of the outstanding SAERs has been closed and is now going through the shared learning part of the process. The remaining two from last year are reviewed with the reviewers regularly and causes for the delays reduced where possible. There are two SAERs from this year and they are both currently within the expected timeframe.

Improvement Target Date

30/06/2025

Patient Safety, Quality, and Experience
Paediatric Early Warning Score (PEWS) Bundle Compliance

Data Source

Clinical Records

Latest Data

30/04/2025

Paediatric Early Warning Score Compliance (Age, Observation, Scoring)

● Cases Reviewed ● Total Compliant % ● % Target
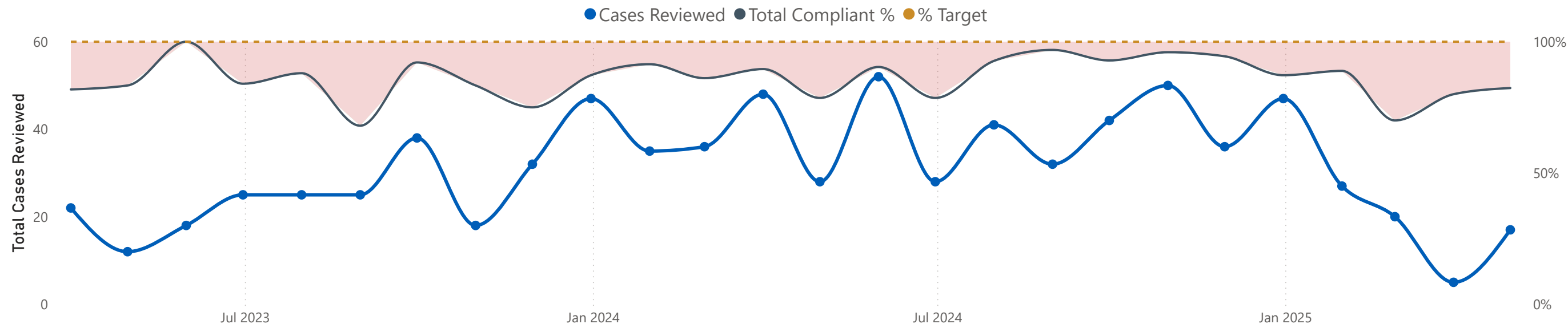
KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % Compliance with PEWS Bundle	100%	82.35%	Red

Actions to Improve/Recover Performance

There is now a national target for PEWS and this has been added to the IPR. Work continues around the compliance, but due to the small numbers involved when incomplete chart can reduce the percentage of compliance significantly.

Improvement Target Date

30/04/2025

Operational Standards Acute

Section Lead(s):
Medical Director
Executive Director of Nursing, Midwifery, Allied Health Professionals & Chief Officer Acute

What's Going Well?

NHS Orkney Clinical Services Review continues, engaging with key stakeholders and partner Health Boards. It is anticipated that a proposal will be ready for consideration by July 2025. A Target Operating Model Workshop for Ophthalmology took place, which allowed engagement with clinical and non-clinical colleagues to develop what a future model could be.

Additional funding to address new outpatient waiting lists, has been approved for Ophthalmology and Ear, Nose and Throat new outpatient capacity. Additional capacity has been scheduled for Ophthalmology and discussions are ongoing to schedule Ear, Nose and Throat we aim to have these confirmed by end of June, and we are likely to have capacity over 5 days with 2 consultants twice throughout the year to address the longest waits.

RAG Status Values

RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

Areas of Concern

Availability of visiting specialists continue to impact service performance. New Outpatient waiting times have seen some improvement through non-recurring funding to address the longest waits, this will have an impact on the numbers waiting for Inpatient activity in the coming weeks and months as patients are referred for treatment.

Operational Standards
Accident & Emergency 4-Hour Compliance

Data Source

PHS A&E Publication, TrakCare

Latest Data

30/04/2025

Accident & Emergency 4-Hour Standard Compliance

● % Seen in 4Hrs   ● Target
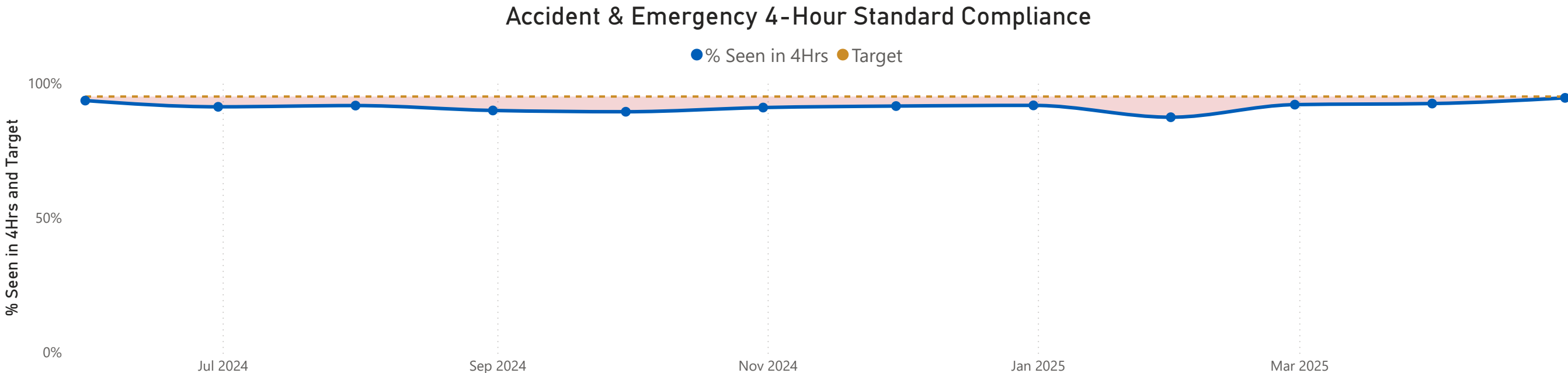
KPI	Target	Actual	RAG Value
95% of patients wait no longer than four hours from arrival to admission, discharge, or transfer for A&E treatment. Boards work towards 98%.	95%	94.51%	Red

Actions to Improve/Recover Performance

Executive lead awareness of whole system pressures impacting on Emergency Department performance in conjunction with increased presentations at the department. For the weeks ending 27th April, 4th May, 11th May, performance has consistently been above 96%.

Improvement Target Date

31/05/2025

Operational Standards
New Outpatients (NOP) 12 Week Compliance

Data Source
OP Recovery Weekly Return

Latest Data
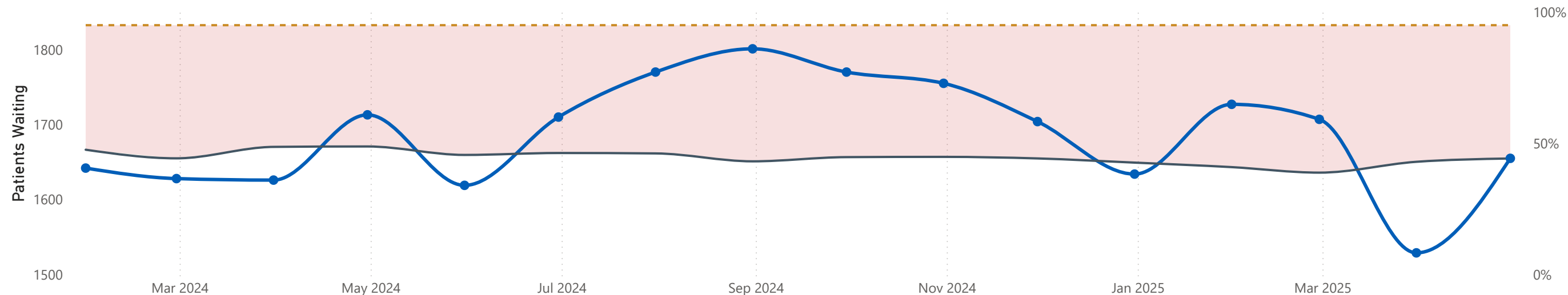27/04/2025

New Outpatients – 12 Week Compliance

● Patients Waiting ● 12Wk Compliance % ● Target

KPI	Target	Actual	RAG Value
95 per cent of patients wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100%	**95%**	**44.23%**	**Red**

Actions to Improve/Recover Performance

Compliance remains significantly below the 95% target; the position has increased slightly since the last reporting period currently at 44.23% previously 38.84%. The trend shows seasonal variation, with a worsening position in late 2024 and a slight improvement in early 2025. Additional capacity to address the longest waits during April have impacted on overall performance. Limitations in visiting consultant clinics contribute to performance throughout the previous 12 months. Short-term external contracts are being pursued to mitigate the backlog with additional funding and clinical sessions in year agreed.

Improvement Target Date

30/09/2025

Operational Standards
New Outpatients (NOP) Local Improvement Target

New Outpatients – Local 10% Waiting Times Reduction Compliance

● List Size +/- ● % Variation ● Reduction % Target

KPI	Target	Actual	RAG Value
10% reduction in waiting times for New Outpatients	-10%	24.90%	Red
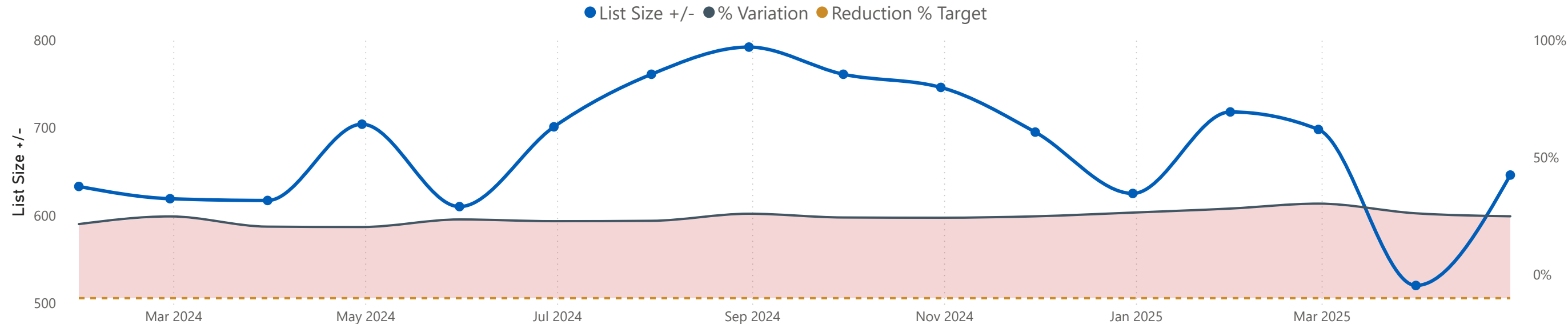
Actions to Improve/Recover Performance

The target was a 10% reduction in waiting times; however, the actual change reported for the last period was +30.29% compared to +24.9%, continuing to indicate an increase rather than a decrease. The backlog has continued to grow due to persistent consultant workforce gaps, further recruitment advertising went live at the end of March 2025. The Planned Care Board has requested improvement plans from service areas.

Improvement Target Date

30/09/2025

Treatment Time Guarantee – 12 Week Compliance

● Patients Waiting ● Target ● 12Wk Compliance %
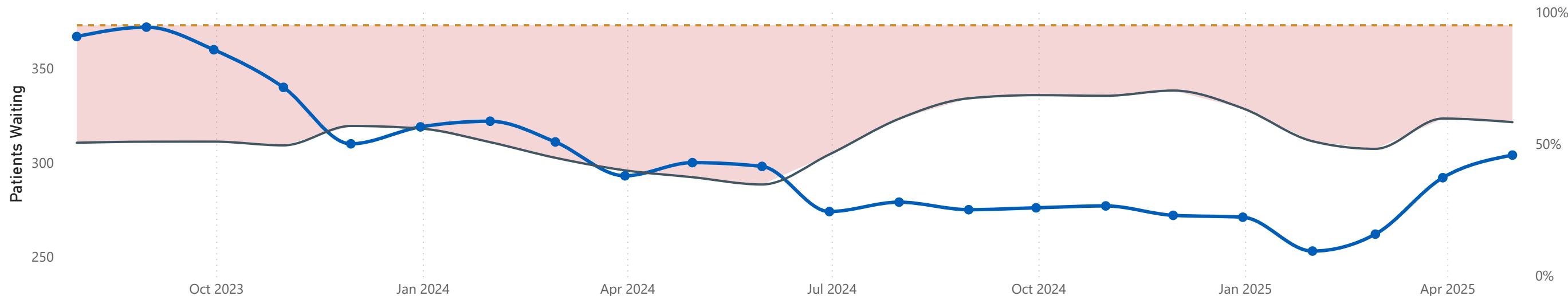
KPI	Target	Actual	RAG Value
100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (TTG)	**100%**	**58.22%**	**Red**

Actions to Improve/Recover Performance

Compliance stands at 58.22% compared to 48.09% for the last reporting period, still well below the 100% target. While there was an initial improvement in mid-2024, progress has stalled due to limited access to NHS Grampian visiting specialists and a small on-site consultant team. When fewer patients are seen in outpatients, TTG figures for number of patient waiting appear better due to fewer inpatient referrals.

Improvement Target Date

30/09/2025

Treatment Time Guarantee – Local 10% Waiting Times Reduction Compliance
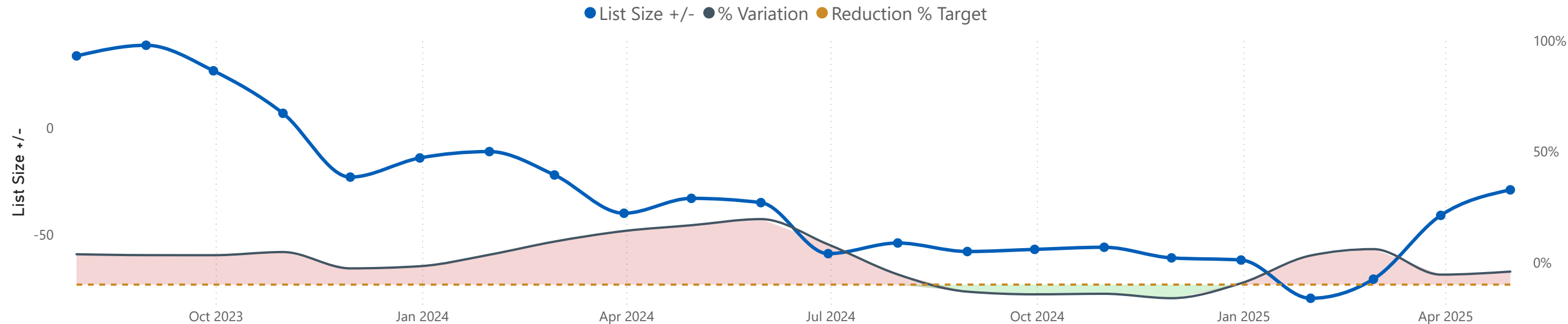
● List Size +/- ● % Variation ● Reduction % Target

KPI	Target	Actual	RAG Value
10% reduction in waiting times for Treatment Time Guarantee patients	-10%	-4.13%	Red

Actions to Improve/Recover Performance

A 10% reduction was the goal, actual performance shows a -4.13% reduction compared to 6% increase at the last reporting period. External recruitment and commissioned service reviews are ongoing to stabilise treatment pathways. Funding has been approved to address long waits for new outpatient activity which will impact the demand for inpatient capacity in the coming months.

Improvement Target Date

30/09/2025

Diagnostic Endoscopy – 6 Week Compliance
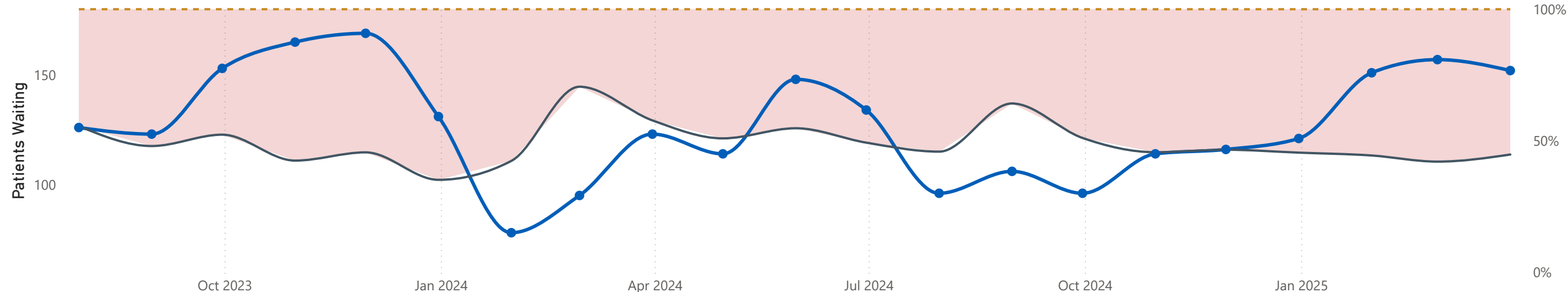
● Patients Waiting ● % Compliance ● Target

KPI	Target	Actual	RAG Value
100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	44.74%	Red

Actions to Improve/Recover Performance

Compliance is at 44.74% compared to 44.37% for the last reporting period, well below the 100% target. The trend has been highly variable, reflecting reliance on visiting locums and inconsistent service provision. Capacity has been scheduled up until September 2025, with further planning underway to ensure capacity is available beyond this time.

Improvement Target Date

30/09/2025

Operational Standards
Diagnostic Imaging 6 Week Compliance

Diagnostic Imaging – 6 Week Compliance

● Patients Waiting ● % Compliance ● Target

KPI	Target	Actual	RAG Value
100% of patients waiting for key imaging diagnostic tests and investigations should wait no longer than six weeks (42 days).	**100%**	**97.02%**	**Red**

Actions to Improve/Recover Performance

Compliance is 97.02% compared to 85.92% for the last reporting period, below the 100% target but relatively stable. Local diagnostics remain strong, but dependency on NHS Grampian for specialist imaging results in wait time fluctuations. We await delivery of the MRI scanner and consideration will be given to what can be delivered in Orkney to allow patients to be seen closer to home wherever possible.

Improvement Target Date

30/09/2025

Operational Standards
Diagnostic Cardiology 6 Week Compliance

Data Source

DMMI Monthly Return

Latest Data

31/03/2025

Diagnostic Cardiology – 6 Week Compliance
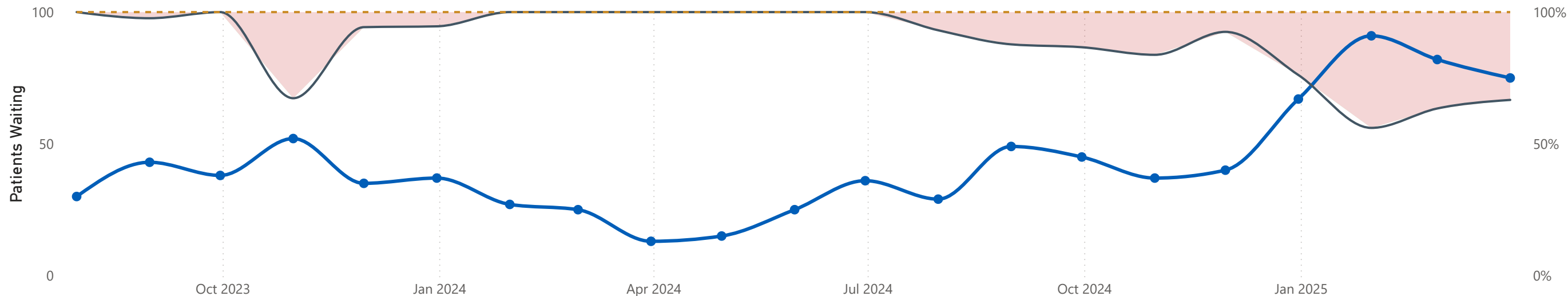
● Patients Waiting ● % Compliance ● Target

KPI	Target	Actual	RAG Value
100% of patients waiting for key cardiology diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	66.67%	Red

Actions to Improve/Recover Performance

Compliance is 66.67% compared to 56.04% for the last reporting period, reflecting challenges in service access. This service is currently only available externally, leading to delays. Local cardiology ultrasound models have been approved, but recruitment has been unsuccessful so far.

Improvement Target Date

30/09/2025

Operational Standards
Delayed Transfers of Care Discharge Compliance

Delayed Transfers of Care - Discharge Within 14 Days Compliance (excl. Code 9)
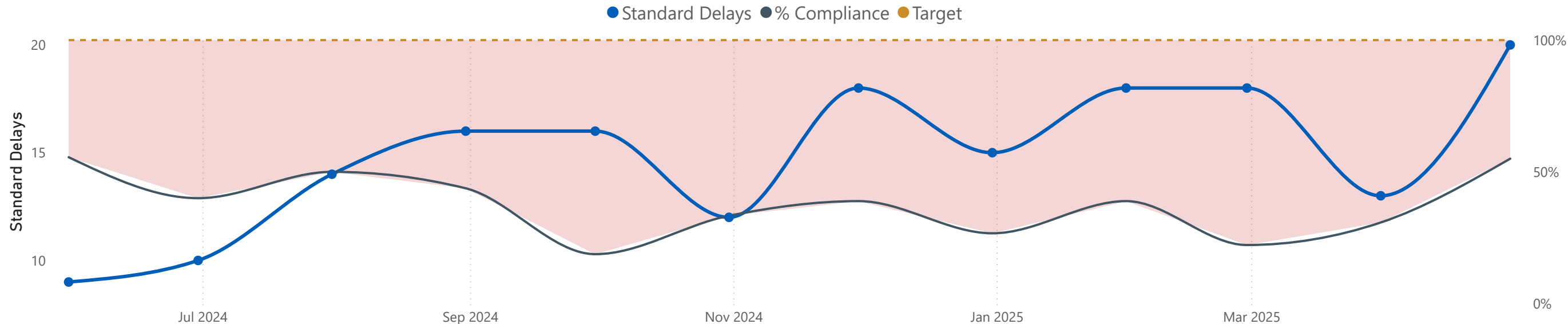
● Standard Delays ● % Compliance ● Target

KPI	Target	Actual	RAG Value
Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	100%	55.00%	Red

Actions to Improve/Recover Performance

Twice weekly RMM (Resource Management Meeting) continues with whole system approach to facilitate discharge. Recruitment to social care vacant posts remains challenging despite a recent campaign. Focus on planned date of discharge and discharge planning on admission through the discharge planning group will help support early conversations around discharge to home/own residence in the first instance.

Improvement Target Date

31/05/2025

Data Source	**Latest Month**
Delayed Discharges Monthly Return	30/04/2025

Delayed Transfers of Care - Delays at Census Date
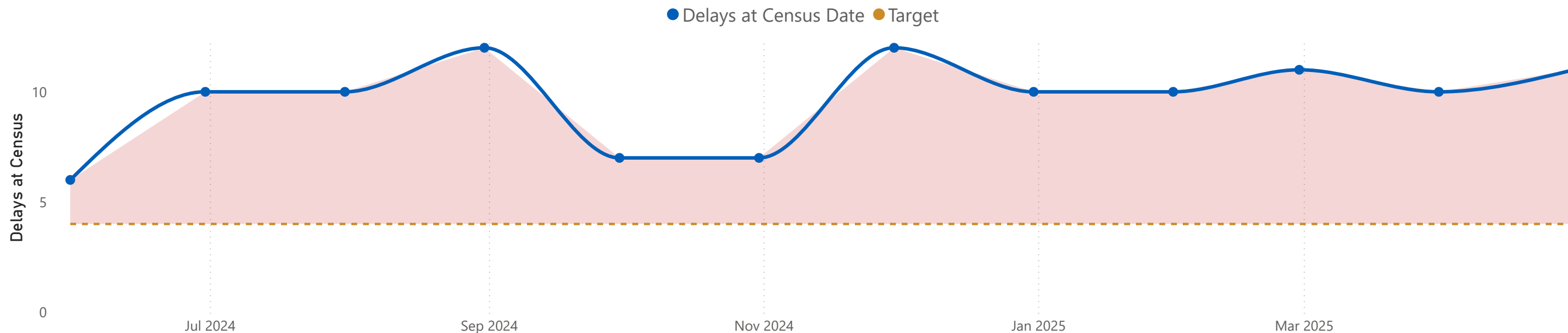
● Delays at Census Date ● Target

KPI	Target	Actual	RAG Value
Number of people experiencing a delay of any length or reason in discharge from hospital at the monthly census point	4	11	**Red**

Actions to Improve/Recover Performance

Twice weekly RMM (Resource Management Meeting) continues with whole system approach to facilitate discharge. Recruitment to social care vacant posts remains challenging despite a recent campaign. Focus on planned date of discharge and discharge planning on admission through the discharge planning group will help support early conversations around discharge to home/own residence in the first instance. Current performance update as at 12/05/2025 is 10 delayed transfers of care. Of these 10, 5 are awaiting residential home placement.

Improvement Target Date
31/05/2025

Operational Standards
Delayed Transfers of Care Bed Days Occupied

Delayed Transfers of Care - Bed Days Occupied

● Number of Delays ● Bed Days Occupied ● Target

KPI	Target	Actual	RAG Value
Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	56	325	Red

Actions to Improve/Recover Performance

Twice weekly RMM (Resource Management Meeting) continues with whole system approach to facilitate discharge. Recruitment to social care vacant posts remains challenging despite a recent campaign. Focus on planned date of discharge and discharge planning on admission through the discharge planning group will help support early conversations around discharge to home/own residence in the first instance. Current performance update as at 12/05/2025 is 10 delayed transfers of care. Of these 10, 5 are awaiting residential home placement.

Improvement Target Date

31/05/2025

Antenatal Care Appointment Delivery – Primary/Buddy Midwife %

● % of appts completed by PMW or BMW ● Target
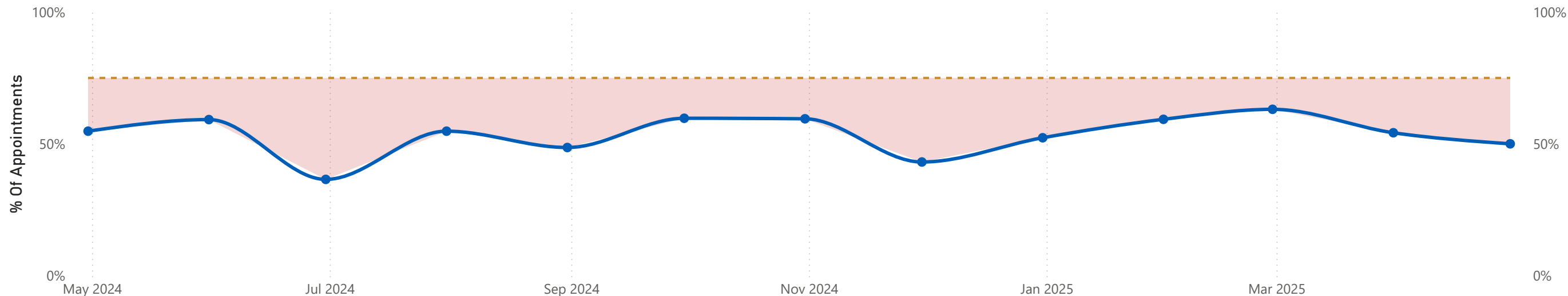
KPI	Target	Actual	RAG Value
75% of scheduled antenatal care delivered by the primary and no more than one other midwife.	**75%**	**50%**	**Red**

Actions to Improve/Recover Performance

Recent updates were made to the main system used in recording maternity data to better document the data points around the team/buddy way of working. This means that some women are yet to reach the stages of intrapartum or postnatal care since these updates, and may not yet be represented accurately in terms of compliance with these metrics. We expect this to improve over the course of 2025.

Improvement Target Date

31/12/2025

Operational Standards
Postnatal Midwifery Care Delivery By Primary/Buddy Midwife

Data Source

Badgernet

Latest Data

30/04/2025

Intrapartum Midwifery from Primary/Buddy/Team Midwife

● Total % of Care Delivered ● Target
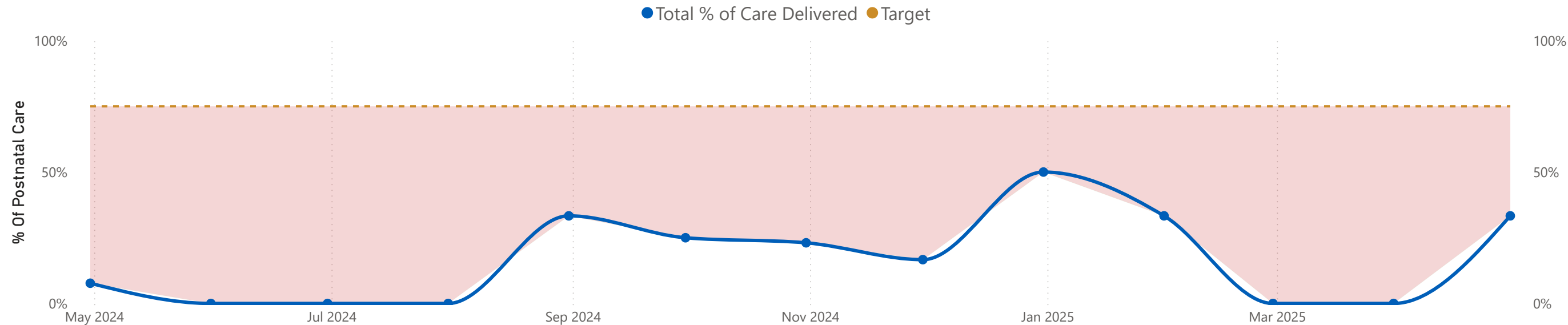
KPI	Target	Actual	RAG Value
75% of scheduled community based postnatal care delivered by the primary and no more than one other midwife.	**75%**	**33.30%**	**Red**

Actions to Improve/Recover Performance

Recent updates were made to the main system used in recording maternity data to better document the data points around the team/buddy way of working. This means that some women are yet to reach the stages of intrapartum or postnatal care since these updates, and may not yet be represented accurately in terms of compliance with these metrics. We expect this to improve over the course of 2025.

Improvement Target Date

31/12/2025

Community

Section Lead(s):
Chief Officer (Integration Joint Board)

What's Going Well?

Performance continues to be strong in both Psychological Therapies and CAMHS. CAMHS are now participating in a short term regional pilot for Intensive Home Treatment and both services are looking at the in-house capacity to strengthen the neuro-developmental assessment pathways in adults and children.

Improved engagement with independent contractors, both in terms of GPs, Dental and Optometry, enabling a more collaborative approach to improve service delivery and mitigate challenges being faced.

RAG Status Values

RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

Areas of Concern

Significant vacancies/capacity issues within some services continue to prove challenging. The vacant First Contact Practitioner Physiotherapy posts are an example of the impact of these vacancies.

AHP MSK All Specialties – 4 Week Compliance

● Patients Seen ● 4Wk Compliance % ● Target
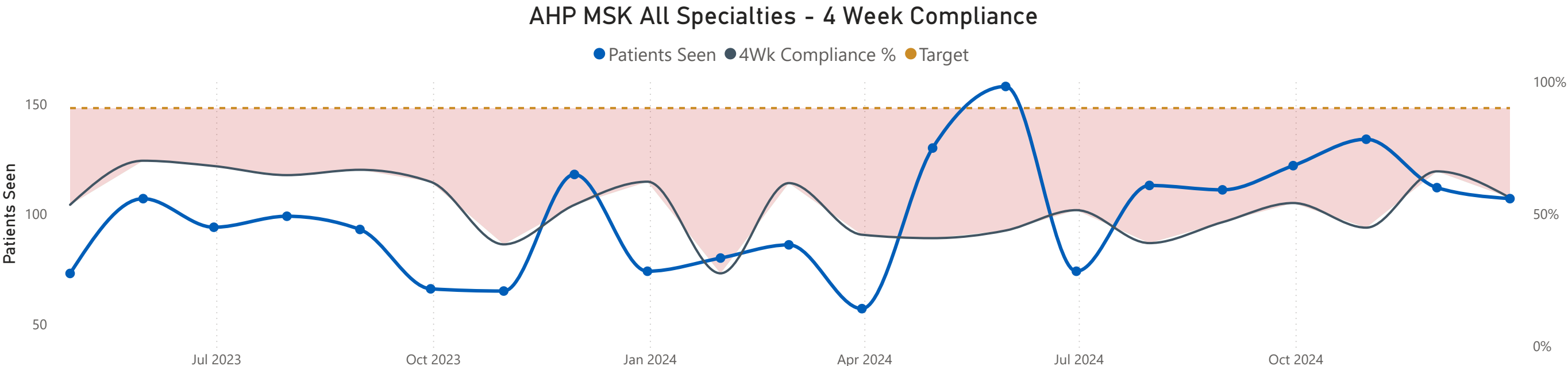
KPI	Target	Actual	RAG Value
At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led musculoskeletal services.	**90%**	**56.07%**	**Red**

Actions to Improve/Recover Performance
This target is an amalgam of the following three indicators and the actions are detailed by specialty in the following sections.

Improvement Target Date

30/09/2025

Community
Allied Health Professions (AHPs) MSK 4 Week Compliance - Orthotics

Data Source

MSK Quarterly Publication/TrakCare

Latest Data

31/12/2024

AHP MSK Orthotics - 4 Week Compliance
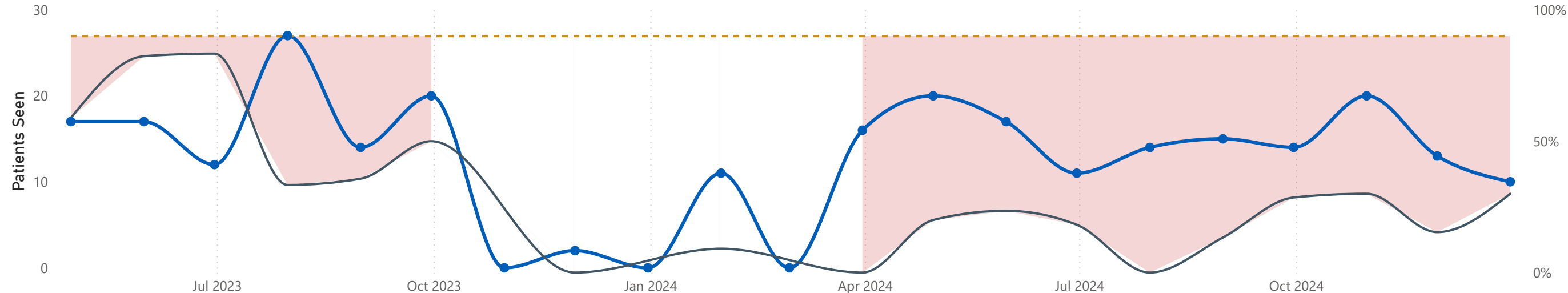
● Patients Seen ● 4Wk Compliance % ● Target

KPI	Target	Actual	RAG Value
At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led orthotics musculoskeletal services.	**90%**	**30.00%**	**Red**

Actions to Improve/Recover Performance

The number of new referrals per month is steady with most coming from podiatry and physiotherapy services therefore when podiatrists/physiotherapists are on annual leave new referral rates reduce. Over the last few months where the podiatrists have been able to target MSK, an increase in orthotic referrals can be seen. The orthotic service is a visiting service which operates once a month. This makes meeting the four week target unachievable without review of the Service Level Agreement and investment. However, improvements have been seen overall with the longest waits down from 12 months to eight months. Further improvement in service delivery may be achieved by reducing Did Not Attend (DNA)'s which is on average 12%. This represents a significant impact on clinical service delivery and opportunities to address this will be directed through the Outpatients Improvement Group.

Improvement Target Date

30/09/2025

Community
Allied Health Professions (AHPs) MSK 4 Week Compliance - Physiotherapy

Data Source

MSK Quarterly Publication/TrakCare

Latest Data

31/12/2024

AHP MSK Physiotherapy - 4 Week Compliance

● Patients Seen ● 4Wk Compliance % ● Target

KPI	Target	Actual	RAG Value
At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led physiotherapy musculoskeletal services.	**90%**	**65.12%**	**Red**

Actions to Improve/Recover Performance

There has been a slight increase in resource to support MSK in this last quarter (0.3 WTE physiotherapy hours). This is reflected in the statistics showing a reduction in the average waiting times for patients despite an increasing waiting list. The very long waits are gradually reducing. The service has been impacted by 50 % staffing gaps (2 WTE posts) over 17 months in First Contact Practitioner (FCP) roles. The data shows that there has been a direct correlation with the vacancies and the increased numbers of patients waiting. Recruitment to try to fill these FCP vacancies is underway with interviews scheduled in the coming weeks. Roll out of PHIO (a digital health tool consisting of triage and a patient self-management app) is progressing well. Week commencing 10 March, 50 patients will be triaged and, if appropriate, referred direct to service or will self manage. This first tranche will enable the service to refine and test readiness to manage this new model of care. Thereafter 250 patients will be invited to participate. Reconfiguration of clinical space in outpatients has been completed creating three treatment cubicles which will address some of the challenges in offering treatment due to competing demands on clinical space. The combination of successful recruitment and PHIO will dramatically improve access to service and patient care.

Improvement Target Date

30/09/2025

Community
Allied Health Professions (AHPs) MSK 4 Week Compliance - Podiatry

Data Source

MSK Quarterly Publication/TrakCare

Latest Data

31/12/2024

AHP MSK Podiatry – 4 Week Compliance
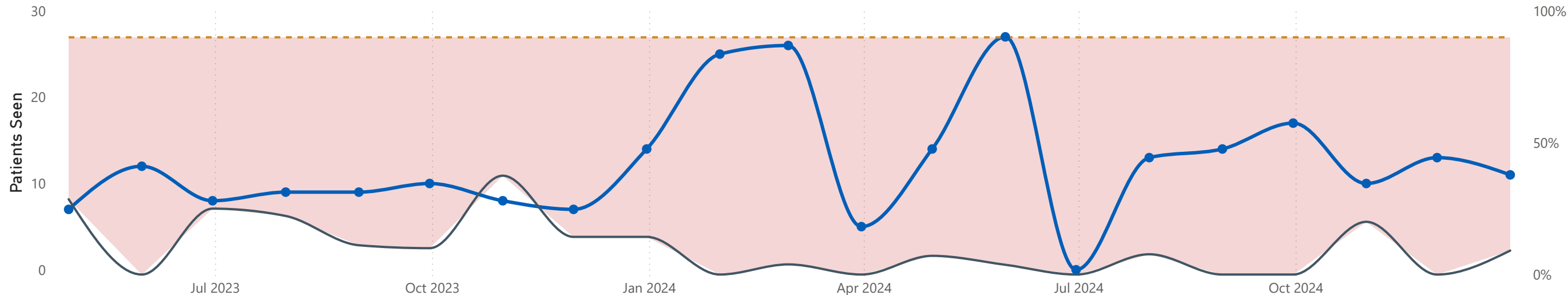
● Patients Seen ● 4Wk Compliance % ● Target

KPI	Target	Actual	RAG Value
At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led podiatry musculoskeletal services.	90%	9.09%	Red

Actions to Improve/Recover Performance

The clinical demand of urgent and high risk patients impacts on achievement of this target. However, some additional capacity created by 0.4 WTE podiatrist is supporting the team to address MSK referrals in a more timely manner.

Improvement Target Date

30/09/2025

Population Health

Section Lead(s):
Director of Public Health

What's Going Well?

Winter Covid-19 vaccination offer ended 31 January, with Orkney being the top performing Board with 58.7% overall uptake. Winter Flu vaccination offer ended 31 March, with Orkney also being the top performing Board at 64.2% overall uptake. Spring Covid vaccination is underway, with an uptake of 55.8% and Orkney again being the top performing Board. Orkney RSV Immunisation uptake rate is 73.4% (above 67.4% Scotland average).

Diabetic eye screening recovery is almost complete following a recent pause in the service, with the highest attendance rate in all Scottish Boards. New Bowel and AAA Screening data shows that uptake remain above target. Bloodspot screening compliance has now recovered, met the 100% target in March and April 2025. Newborn Hearing Screening also met the 100% target in 2023-24 and April-Jun 2024.

The Immunisation 6-in-1 uptake rate compliance has now recovered, with 96.9% uptake rate for Oct-Dec 2024.

RAG Status Values

RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

Areas of Concern

The latest diabetic eye screening data (1 Apr 2024 to 30 March 2025) at 89.9% has not met the 100% uptake (invitations sent) target, with a potential for inaccuracies in this figure. It is expected that the uptake will improve in the next release, expected in October 2025. The attendance to the service (annual 80.8% and biennial 88.8%, target 80%) remains the highest of all Scottish Boards. Pregnancy Screening has not met the 100% uptake rates target (at 88.6% for trisomy screening, 87.5% for haemoglobinopathies screening and 87.5% for infectious diseases screening) in April 2025. The reason for this was to adapt to the circumstances of eligible women during these months. The position is expected to recover by the end of May 2025.

The Immunisation MMR2 uptake rate is now below 95% target, with 93.3% uptake rate for Oct-Dec 2024. This figure shows high variability due to small numbers. It is expected to recover for Jan-Mar 2025.

Population Health
Immunisation Uptake Rate MMR by 6 Years of Age

Immunisation Uptake – MMR by 6 Years of Age Compliance

● NHS Orkney % Compliance   ● Target
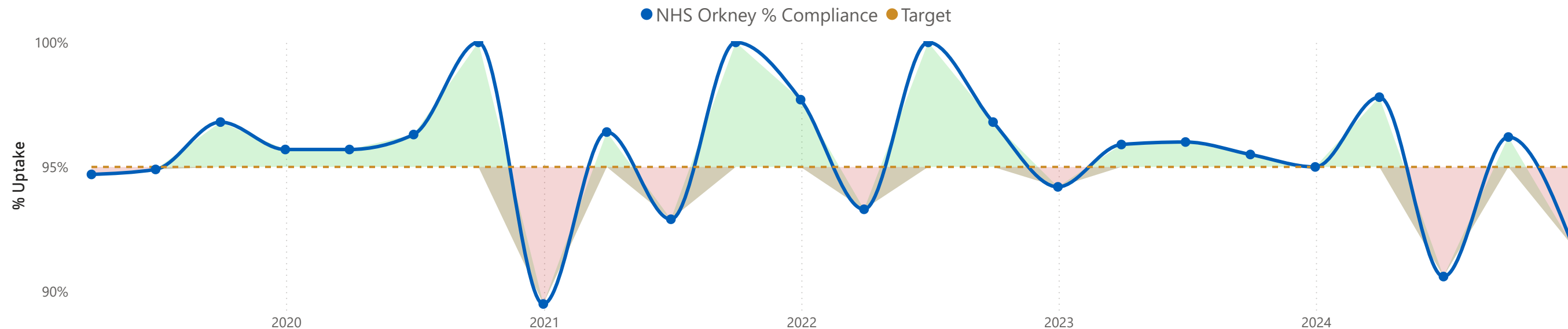
KPI	Target	Actual	RAG Value
Immunisation uptake rate MMR2 by 6 years of age	**95%**	**91.80%**	**Red**

Actions to Improve/Recover Performance

The Immunisation MMR2 uptake rate is now below 95% target, with 91.8% uptake rate for Oct-Dec 2024. This figure shows high variability due to small numbers. It is expected to recover for Jan-Mar 2025.

Improvement Target Date

31/03/2025

Population Health
Smoking Cessation 12-Week Quits

Smoking Cessation - 12-Week Quits vs. Local Delivery Plan (LDP)

● SIMD 12 Week Quits Total ● LDP Target
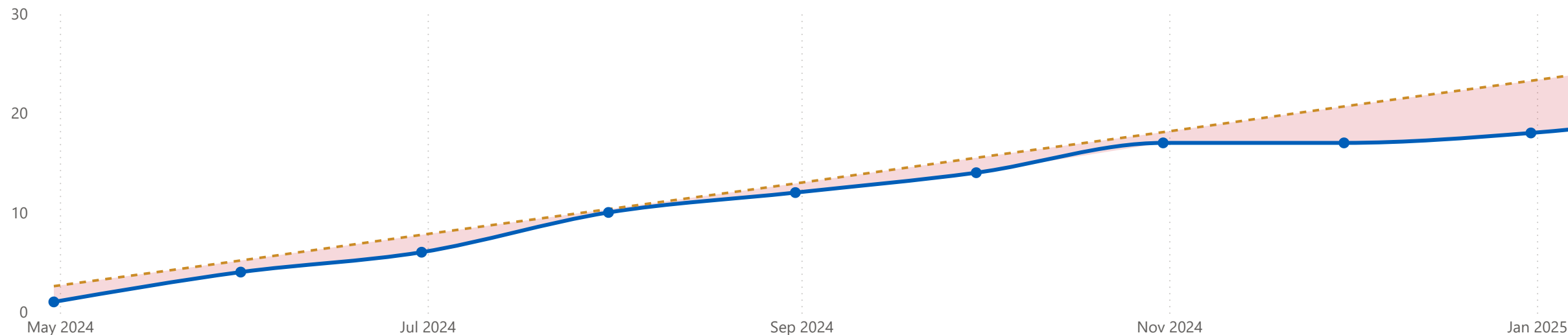
KPI	Target	Actual	RAG Value
NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards)	**25.83**	**20**	**Red**

Actions to Improve/Recover Performance

In 2023/24, only two health boards achieved their Stop Smoking Services Local Delivery Plan (LDP) target. Orkney achieved 64.5% of it's target, an increase from the previous year's achievement of 61.3%. The Public Health Team have developed a multi-agency Group to steer action relating to tobacco in Orkney which developed a tiered approach to smoking cessation services based on client need. The Quit Your Way Orkney team have continued to run a specialist stop smoking service with a localised training programme for advisors to support sustainability of the service. Very Brief Interventions training has been roles out to staff groups across Orkney to support referrals into stop smoking services. We are striving to continue improve performance against this target, as noted by our increasing improvement over the last few years.

Improvement Target Date

31/03/2026

Population Health
Pregnancy Screening - Haemoglobinopathies

Pregnancy Screening - Haemoglobinopathies Screening Offered

● Haemoglobinopathies % Compliance ● Haemoglobinopathies % Target
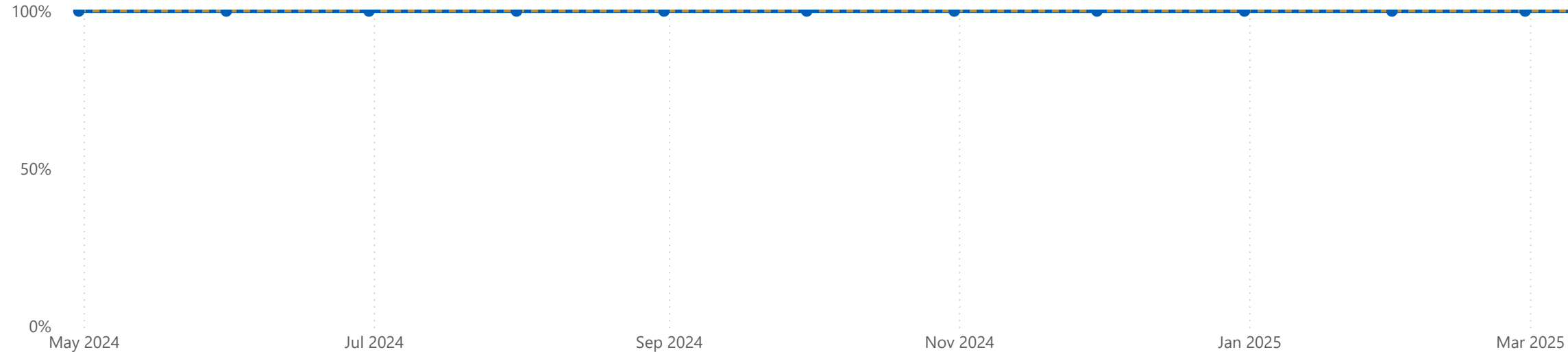
KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	**100%**	**87.5%**	**Red**

Actions to Improve/Recover Performance

Pregnancy Screening has not met the 100% uptake rates target with 87.5% for haemoglobinopathies screening in April 2025. The reason for this was to adapt to the circumstances of eligible women during these months. The position is expected to recover by the end of May 2025.

Improvement Target Date

31/05/2025

Population Health
Pregnancy Screening - Infectious Diseases

Data Source

Maternity Team

Latest Data

30/04/2025

Pregnancy Screening - Infectious Diseases Screening Offered

● Infectious Diseases % Compliance   ● Infectious Diseases % Target
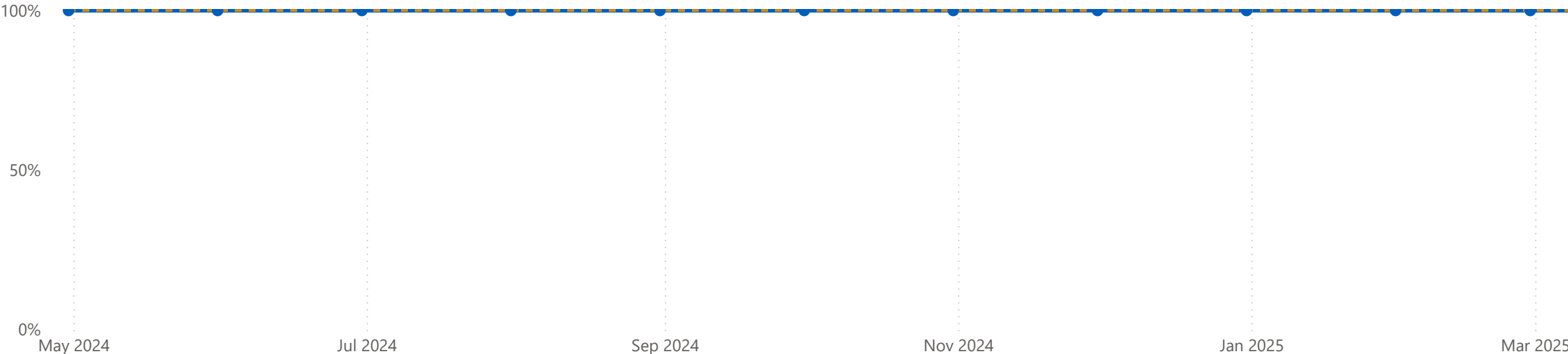
KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	**100%**	**87.5%**	**Red**

Actions to Improve/Recover Performance

Pregnancy Screening has not met the 100% uptake rates target with 87.5% for infectious diseases screening in April 2025. The reason for this was to adapt to the circumstances of eligible women during these months. The position is expected to recover by the end of May 2025.

Improvement Target Date

31/05/2025

Population Health
Pregnancy Screening - Trisomy

Pregnancy Screening - Trisomy Screening Offered Within 20+0 Weeks
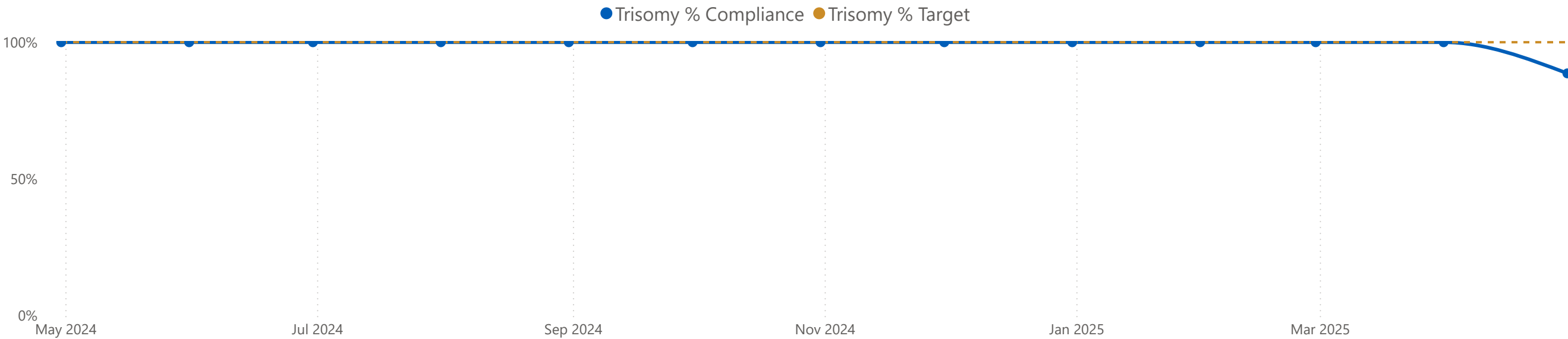
● Trisomy % Compliance　● Trisomy % Target

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	100%	88.60%	Red

Actions to Improve/Recover Performance
Pregnancy Screening has not met the 100% uptake rates target with 88.6% for trisomy screening in April 2025. The reason for this was to adapt to the circumstances of eligible women during these months. The position is expected to recover by the end of May 2025.

Improvement Target Date

31/05/2025

Workforce

Section Lead(s):
Director of People and Culture

What's Going Well?

The Workforce improvement workstream within the Improving Together Programme is well developed with 8 areas of focus, including sickness management, mandatory training and appraisals. Corporate leads are identified for each area to drive delivery and fortnightly meetings take place to maintain momentum. Progress is starting to be seen in training compliance for example, 2-4% increases have been seen across most Health and Safety courses. Appraisal rates have also increased to 38.33%.

RAG Status Values

RED	Key performance indicator not achieved.
GREEN	Key performance indicator achieved.

RAG status values are assigned to each metric based on their compliance with national and/or locally set targets. Metrics assigned a red status will be accompanied with improvement actions, and a timeline for recovery of the position.

Metrics with a target of 'x̄' are given a RAG value based on their performance against their own average.

Areas of Concern

Although the sickness absence rate has decreased slightly year-to-date, it is below the current national average of 6.47% (NHSO currently at 6.13%)

Compliance with statutory and mandatory training continues to be variable and this remains a risk on the Corporate Risk Register. Monthly reports are sent to Executive Directors on training compliance in their areas and a list of all non-compliant people will be pulled from Turas so that those people can be contacted directly.

Workforce
NHS Orkney Monthly Sickness Absence

Sickness Absence – NHS Orkney vs. National Average

● NHS Orkney Monthly Total ● NHS Scotland Monthly Average ● Local Target %

KPI	Target	Actual	RAG Value
Sickness rates consistently below the national average of <6%	**5.80%**	**6.13%**	**Red**
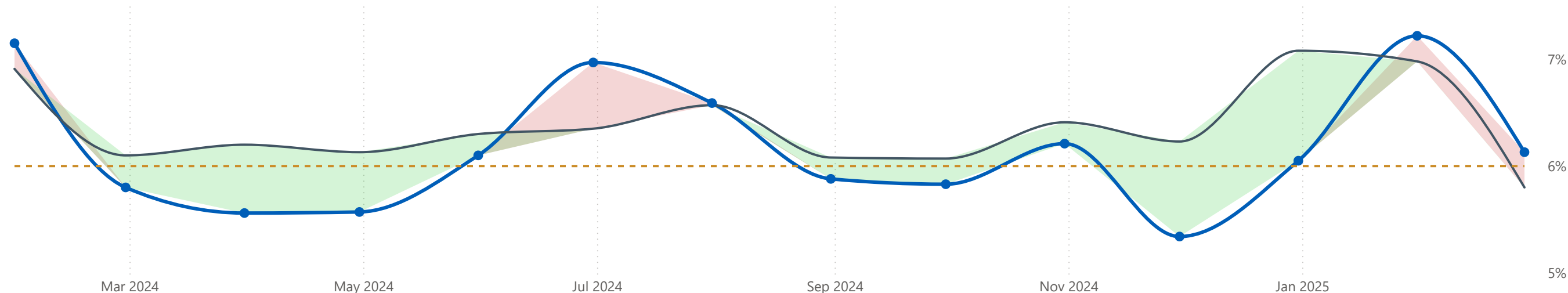
Actions to Improve/Recover Performance

Sickness absence forms part of the Workforce improvement workstream. The 6 areas with highest sickness absence rates have been identified and % improvement targets have been mapped out for 2024/25. The People and Culture Team is working directly with these areas to support sickness management in line with Once for Scotland Workforce Policy and to better support people back to work.

Improvement Target Date

31/03/2026

Workforce
NHS Orkney Appraisal Rates

Completed Appraisal Rates

● Completed Appraisals ● % Completed ● % Target

KPI	Target	Actual	RAG Value
Appraisal compliance rate over the previous 12 months	**85%**	**38.33%**	**Red**
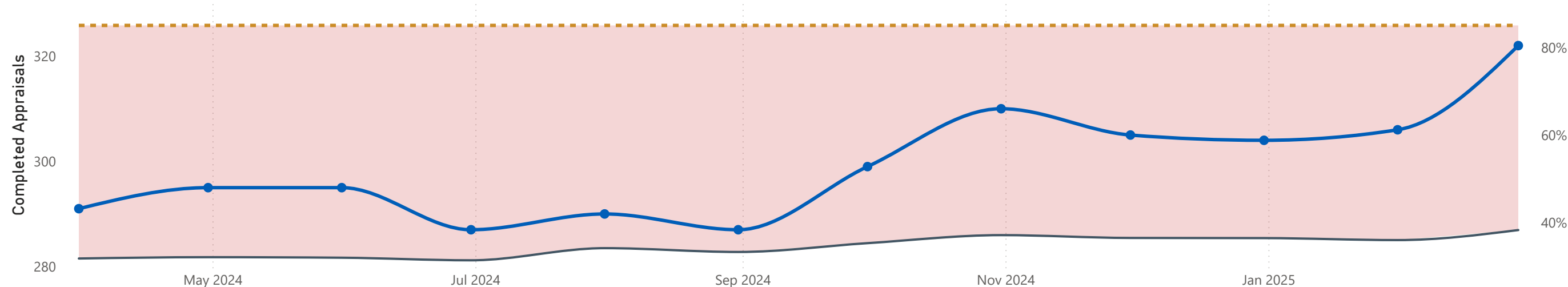
Actions to Improve/Recover Performance

Appraisal rates have increased slightly to 38.33%. The People and Culture team continues to provide training and individual support to managers and teams. Notifications have been sent to those people whose appraisals were only partially complete outlining the actions needed to complete them. Lists of colleagues who have not yet had an appraisal are regularly shared with managers, and where structures need amending in the system, the People and Culture Team are working with those teams. Additional system functionality is available to allow paper uploads and this has been communicated to managers. Currently bank staff are included in the figures for appraisals although the intention is to remove them from the denominator once plans are in place for more coordinated management of bank workers.

Improvement Target Date

30/06/2025

Workforce
Bank Hours Utilised

Hours Utilised - Bank Hours

● Bank Hours   ● Bank Hours 12-Month Average
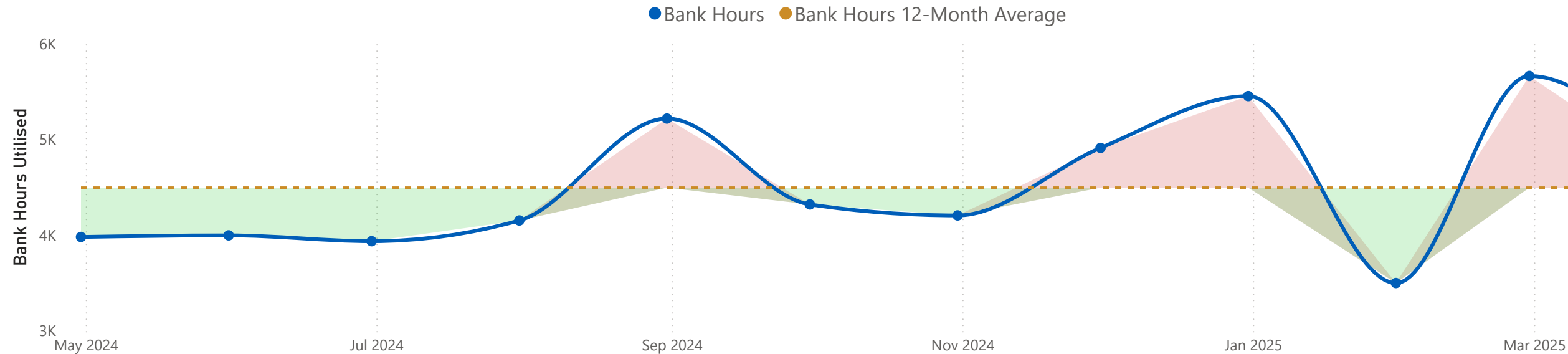
KPI	Target	Actual	RAG Value
Bank	x̄	**4612.93**	**Red**

Actions to Improve/Recover Performance

We do not have an organisational target for bank usage but have undertaken analysis to look at bank, overtime and excess hours in relation to total hours of absence. The use of additional hours should not exceed hours vacant or lost to absence.

Improvement Target Date

30/06/2025

Workforce
Excess Hours Utilised

Hours Utilised - Excess Hours

● Excess Hours ● Excess Hours 12-Month Average

KPI	Target	Actual	RAG Value
Excess	x̄	1073.14	Red
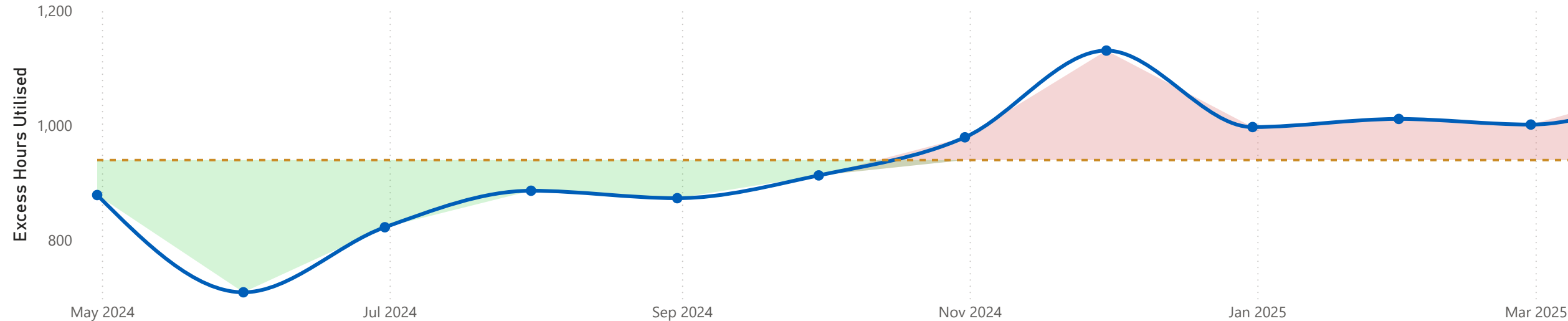
Actions to Improve/Recover Performance

Requests for excess hours in both clinical and non-clinical areas are approved by the relevant Executive Director in accordance with the terms of reference of the Vacancy Control Panel. These approvals are recorded by the implementation hub and reported weekly to the Vacancy Control Panel for oversight. A detailed piece of work will commence in May 2025 to look at the use of bank, agency, overtime, excess hours in relation to staffing establishments, vacancy rates and sickness absence team by team.

Improvement Target Date

30/06/2025

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**IJB Strategic Plan 2025 – 2028 – What This Means for NHS Orkney**
Responsible Executive/Non-Executive:	**Stephen Brown, Chief Officer Integration Joint Board.**
Report Author:	**Stephen Brown, Chief Officer Integration Joint Board.**

1   Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2   Report summary

2.1   Situation

NHS Orkney, as well as Orkney Islands Council, have delegated a range of health and social care services to the Orkney Integration Joint Board as detailed in the Integration Scheme.

2.2   Background

The Orkney Integration Joint Board is required to have a Strategic Plan covering a period of three years. The Strategic Plan 2025 – 2028 was approved by the Integration Joint Board on 30 April 2025 following some amendments being incorporate.

The Strategic Plan establishes the Orkney IJB's focus and the direction for the next three years, based on clear principles and priorities. The national integration principles have also been considered when designing this plan.

The new Plan is designed to be read and understood by the whole community.

The Strategic Plan Delivery Plan 2025/26 details the actions which will be undertaken in the first year of the Strategic Plan.

2.3   Assessment

Following a series of stakeholder engagement, it was agreed that the previous six Strategic Priorities were still relevant and with one slight amendment to the name of the 'Supporting Older People to Remain in Their Own Homes' to 'Supporting People to Age Well'.The six Strategic Priorities are:

- Tackling Inequalities and Disadvantages.
- Early Intervention and Prevention.
- Supporting Unpaid Carers.
- Supporting People to Age Well.
- Community Led Support.
- Mental Health and Wellbeing.

Tackling Inequality and Disadvantage

Inequalities and disadvantage are known to affect how people access services and maintain good health. By progressing actions aimed to improve this Priority it is hoped that this will assist in protecting vulnerable groups by keeping them safe from harm, improve access to services/treatments, removing barriers that prevent individuals using services, work with other organisations to help those facing financial hardship and build strong communities.

The strategic intention of this Priority is "The provision of multi-professional, 21st century health and social care, which is tailored to the needs of our population".

This Priority also contributes to the National Health and Wellbeing Outcomes 5.

Early Intervention and Prevention

Progressing actions in early intervention and prevention prevents individuals requiring more intense intervention when they are in crisis. It is known that early intervention and prevention provides better outcomes for individuals and is less resource intensive, both cost and staffing, that those presenting in crisis.

The strategic intention of this Priority is "Prevention and Early Intervention, across the lifespan, is vital to all our priorities. We want to empower people to be more aware of, and

responsible for, their health and wellbeing, whatever their age or background. We are committed to improving the overall health and wellbeing of children, young people, and adults, in Orkney. Communities and the local environment play an important role in promoting good health and providing opportunities to be active, to be involved, and to connect with others".

This Priority also contributes to the National Health and Wellbeing Outcomes 1 and 4.

Supporting Unpaid Carers

It is known that statutory services would not be able to provide the services to individuals in the communities without the support of those who care for a loved one, friend or neighbour. By progressing actions in this Priority, it is hoped that unpaid carers feel supported to continue in their valuable roles.

The strategic intention of this Priority is "The Carers' Strategy Group, a group with membership from across the statutory and third sectors, as well as unpaid carer representation, is charged with delivery of the Carers' Strategy.

The group is currently developing the new Carers' Strategy, a document that will provide detail on how we will improve the lives of unpaid carers in Orkney. This strategy is being developed in collaboration with unpaid carers themselves: each of the actions included in the strategy, and in this plan, will be both articulated and validated by unpaid carers, themselves".

This Priority also contributes to the National Health and Wellbeing Outcomes 1, 2, 4 and 6.

Supporting People to Age Well

Supporting people to age well actions will help improve service delivery for individuals who do not wish to move to a care facility. The actions detailed within the Strategic Plan Delivery Plan are aimed to keep individuals as safe as possible in their own homes as well as to agree the use of the fourth wing of Hamnavoe House to best meet the needs of the community.

The strategic intention of this Priority is "If we are to be more successful in meeting peoples' preferences, we need to ensure we have an adequate workforce, appropriately remunerated and fully trained in the delivery of complex care. We need to ensure all possible use of technology is maximised and we need to ensure all community-based teams are working collaboratively together for the benefit of the people in our care.

We will work together with our partners across the health, care, and third sector to help people access activities and services to meet the needs of vulnerable older people.

We will ensure that people living with frailty are able to access well planned and well-coordinated services which are tailored to their individual needs and support their health, wellbeing, and independence at every stage of their condition".

This Priority also contributes to the National Health and Wellbeing Outcomes 1, 2 and 9.

Community Led Support

The progress of Community Led Support will improve partnership working with statutory organisations, third sector organisations and communities to best utilise the knowledge, skills and resources available to best meet the needs of communities. Sometimes the best outcomes for individuals do not come from statutory services but comes from those in the community such as participation in running groups, knit and natters.

The strategic intention of this Priority is: "Working with communities and partners to collaboratively design services with a focus on prevention, early intervention and on enabling people to be as independent as possible. This will strengthen integrated health and social care provision, improve mental health and wellbeing support, bolster partnership working and drive further development of Community Led Support / care in a co-designed approach".

This Priority also contributes to the National Health and Wellbeing Outcomes 7, 8 and 9.

Mental Health and Wellbeing

The actions detailed within the Strategic Plan Delivery Plan will help to improve mental health and wellbeing service delivery across Orkney, both for statutory and third sector organisations. Actions such as establishing the All Age Nurse Led Psychiatric Liaison Team will mitigate some of the impact to service delivery when the emergency Mental Health Transfer Bed is in use and bolster the staffing resource to the Mental Health Service.

The strategic intention of this Priority is "described within the current Mental Health Strategy as "Helping people in Orkney to ensure that preventive measures are deployed at the earliest opportunity and that those with enduring mental health conditions live longer, healthier and more independent lives within their own communities. Getting it right for everyone applies equally to those with mental health conditions as it does those with physical health conditions." In addition, our intention is to bolster the current service and create a sustainable service, recognising the changes in need and demand from our local population".

This Priority also contributes to the National Health and Wellbeing Outcomes 1, 3, 5, 7 and 9.

Specific Implications of the Plan for NHS Orkney

There are no significant implications for NHS Orkney relating to the Plan. Many NHS-employed staff, working as part of the Health and Social Care Partnership under the delegated services arrangements, are already delivering many aspects of support that contribute to the priority areas.

The Priority relating to Prevention and Early Intervention, however, cannot be delivered without the ongoing support of the Public Health Service. It will be vital over the lifespan of

the Plan that this service continues to contribute to the agenda and takes an active lead in health promotion.

Given the First Minister's most recent announcement on the subject, it is evident that moving upstream in supporting people will be a national, as well as local, priority.

Nationally, the share of spend on hospital-based services has increased over the last three years from £12 billion to £14.5 billion whilst health spend on community and primary care services has remained static at £6 billion. This investment profile needs to shift over time if the aspiration to intervene and support people before they need crisis and acute care, is to be truly delivered.

2.3.1 Quality/ Patient Care
Progress on the actions contained within the Strategic Plan Delivery Plan will improve service delivery and quality of care.

2.3.2 Workforce
There are no workforce implications directly arising as a result of this report.

2.3.3 Financial
There are no financial implications directly arising as a result of this report.

2.3.4 Risk Assessment/Management
The progress of the actions detailed in the Strategic Plan Delivery Plan will help to mitigate risk of service delivery.

2.3.5 Equality and Diversity, including health inequalities
The Integration Joint Board undertook an Equality Impact Assessment and an Island Communities Impact Assessment.

2.3.6 Climate Change Sustainability
There are no climate change sustainability implications directly arising as a result of this report.

2.3.7 Other impacts
There are no other implications directly arising as a result of this report.

2.3.7 Communication, involvement, engagement and consultation
Not Applicable.

2.3.9 Route to the Meeting
Not Applicable.

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1:** Strategic Plan 2025 – 2028
- **Appendix 2:** Strategic Plan Delivery Plan 2025/26

STRATEGIC PLAN 2025 – 2028

ORKNEY HEALTH AND SOCIAL CARE PARTNERSHIP

Getting it Right for Orkney

Contents

1. Introduction

Chair of the Integration Joint Board

I am delighted to present our fourth Strategic Plan. Working in partnership with NHS Orkney, Orkney Islands Council, and a range of other partners across the statutory and third sector, the Integration Joint Board oversees the commissioning and development of community health and care services across our islands.

The quality of our island life can be significantly enhanced by the health and social care provision and the fact that many of us are living longer means that we require to retain a focus on how we support older people and also those who care for them. In addition, for parents and carers of people with physical and learning disabilities, mental health or addiction issues, it is vital that we find effective and creative ways of caring for the carers as well as those who require care.

With the ongoing cost of living crisis, reducing public sector investment and increased demand on mental health services it will be crucial that we continue to focus on our priorities in the coming year and build upon the progress made from the Strategic Plan 2022 – 2025.

Along with our communities, we hope to continue to develop and evolve a health and social care system that we can be proud of.

Rachael King – Chair of the Integration Joint Board.

Chief Officer

The priority areas in this Plan have been identified following extensive analysis of the health and care profile of our islands and in engagement with communities through various ways.

Our biggest challenge (albeit not unique to Orkney) remains our workforce gaps. There are nationwide issues in recruiting to the social care workforce and we also have a number of vacancies across our health services too, most notably within our Allied Health professions. It is testament to our existing staff teams across Orkney that we have managed to not only keep services operating but, in many instances, still managed to make improvements. There is, of course, still much to do and the financial challenges faced by all public sector bodies in the years ahead will be a real test of how we work with our communities and those who need our support.

As we continue to design and deliver services to meet the needs of our entire population, these priorities will help inform not only what we do but how we do it.

Stephen Brown – Chief Officer, Integration Joint Board.

2. What Is Health and Social Care Integration?

Health and Social Care integration is when health boards and councils work together to jointly plan services.

Integration is about making sure that every person who uses health and social care services gets the right care and support, at the right time, and in the right place, for them.

The government passed a law in 2014 called the Public Bodies (Joint Working) (Scotland) Act 2014. This law required most adult community health and social care services to be integrated or brought together, with the ability to add further services.

In Orkney there was a decision to include not only services for adults, but also many of the services that used to be delivered separately by NHS Orkney and Orkney Islands Council (OIC).

These services are delivered jointly by the Orkney Health and Social Care Partnership (HSCP). The services delegated to the partnership include adult health and care services, primary care (GP surgeries and dental services, for example), children's health and social care services, and justice services. You can find the full list of services, **here**.

3. Orkney Integration Joint Board and Orkney Health and Social Care Partnership

In April 2016, the Orkney Integration Joint Board (IJB) was formed. This is a legal body, separate from both NHS Orkney and OIC with responsibility for planning, resourcing, and overseeing, integrated health and social care services.

The Orkney IJB is made up of members from NHS Orkney, OIC, and the third sector, as well as staff, unpaid carers, housing and service user representatives.

The Orkney IJB meets regularly to discuss, plan, and monitor how integrated health and social care services are delivered in Orkney. You can find a full list of Orkney IJB members **here**.

The Orkney IJB makes decisions about integrated services at each meeting. The Orkney Health and Social Care Partnership are then directed to deliver services based on those decisions.

Our Workforce

Orkney HSCP has over 1,000 staff working for NHS Orkney and OIC, including our colleagues in the independent and third sectors.

This includes staff who provide frontline care services, business support staff, and senior and operational managers. For example, NHS Orkney and OIC deliver services such as Care at Home, residential care in our care homes, GP surgeries, dentists, and opticians, whilst Crossroads Care

Over 1,000 staff, from NHS Orkney, OIC, independent organisations, and the third sector, deliver health and social care services in Orkney

Orkney provide unpaid carer support services, Age Scotland Orkney deliver services for older people, and Orkney Blide Trust support people with mental health problems.

As a HSCP, recruiting to some key jobs and professions has been a big challenge over the past few years. Although this is a problem across the country, Orkney has seen a larger reduction in the proportion of working-aged people who are available to take up roles and careers in health and social care.

Some of the most difficult areas to recruit to have included social care, social work, speech and language, physiotherapy, dentistry, and community nursing. Our people our greatest asset and the high number of vacancies in some of our teams has an impact on our ability to deliver timely, high-quality services.

We are especially focussing our efforts on attracting younger people into these professions, as well as train and support our people to use technology and innovation to constantly improve the care we give to people in Orkney.

We have introduced some key initiatives over the last few years to fill posts, including international recruitment, Grow Our Own (a scheme to train staff to take on new roles) and the introduction of recruitment incentives such as Golden Hellos and Refer a Friend. Whilst the results of these initiatives have been mixed, we will continue to focus on creative and innovative ways to recruit staff, throughout the lifetime of this plan.

Award Winners!

The hard work and dedication of our staff is consistently acknowledged by the community. For example, two of the three Awards in the inaugural Orkney Islands Council VIP Awards went to health and social care staff, with multiple nominations in each category. In NHS Orkney's Team Orkney Awards four of the Awards went to health and social care staff within Orkney HSCP.

The Partnership puts people at the heart of everything we do. Through the hard work, dedication, and commitment of NHS Orkney, OIC, independent, and third sector employees, we work together to focus on the health and wellbeing of the people who live in our communities.

As with all health and social care services, locally and nationally, it is challenging to make sure we have the right staff with the right skills, in the right place, at the right time.

4. What is a Strategic Plan?

The Scottish Government requires each IJB to create a Strategic Plan for the services it provides. This Plan is a roadmap for delivering health and social care services in the community. Here's what the Plan must do:

- **Deliver on national outcomes:** Show how the nine National Health and Wellbeing Outcomes will be met locally. [You can find these outcomes here](#).

- **Set priorities:** Clearly outline the Orkney IJB's main goals and how these will be achieved.

- **Identify local areas:** Highlight the specific "localities" within Orkney that the plan will focus on.

- **Work with others:** Develop the Plan with all our partners, including patients, service users, staff, third sector organisations, and IJB members.

- **Guide implementation:** Be the foundation for the Strategic Plan Delivery Plan, which will detail how, when, and by whom, the goals will be achieved.

- **Monitor progress:** Be regularly reviewed, with updates provided in the Orkney IJB's Annual Performance Report, to show how well we are doing.

- **Stay current:** Be updated every three years. You can view Orkney's previous plans in the "Related Downloads" section [here](#). Our most recent Strategic Plan covered 2022 – 2025.

Performance Review

Every year, the Orkney IJB will report on progress with this Strategic Plan, through our Annual Performance Report. More regular quarterly performance reports will also be provided to the Orkney IJB's Performance and Audit Committee and, afterwards, to the Health Board and Council. You can read our recent Annual Performance Reports [here](#).

5. How We Can Work Together

What WE will do to make a difference

- We will work with communities to make sure their voice is heard.

- We will focus on prevention and enablement – this means we will help people to help themselves.

- Money for public services is tight, so we will be realistic about what we can do, whilst providing safe and effective services.

- We will be more creative and courageous in how we design and deliver our services.

- As technology, especially digital technology, becomes the norm, we will use this more widely in our daily work.

- We will deliver on our Plans. You can read our Strategies and Plans here.

What YOU can do to make a difference

- Take control of your own health and wellbeing.

- Whatever your stage in life, stay active.

- Make sure you know how to best address your health concerns.

- Keep an eye on the wellbeing of others in your community.

- Be active and involved in your local community.

- Join-in the conversations to help shape health and social care services for the future. Please see the final section of our Plan, "Get Involved".

Get Involved

We would really welcome your feedback. Here's how you can have your say:

- Just drop us an email with your comments and we'll get back to you: OHACFeedback@orkney.gov.uk.

- We also have a dedicated area within Engage Orkney where you can contribute your views: www.engageorkney.com/.

- You can call us for a chat, and we'll direct you to the right person! 01856 873535 extension 2601.

- You can still write to us! Our address is: Orkney Health and Social Care Partnership, School Place, Kirkwall, Orkney, KW15 1NY.

- We are always looking for input from folk and have spaces on some of our strategic groups. Please call us on the number above, for a chat.

6. Localities

As we mentioned earlier, the Public Bodies (Joint Working) (Scotland) Act 2014 requires the Orkney IJB to identify specific localities for the planning and delivery of services at a local level.

Identifying localities helps services to work together across primary and secondary health care, social care, third and independent sector services. There is a strong focus on community involvement and engagement, which is at the heart of one of our Priorities, Community Led Support.

We have identified two localities in Orkney, one across the Mainland and linked south isles, and one across the ferry-linked isles. These two localities are large enough to allow us to plan and develop services, but small enough to allow local involvement and recognise that every parish and every island is different.

There are two Localities in Orkney.

Most Community Council areas have committed to produce a local place plan. We have been working with these communities to make sure health and social care issues are included and addressed in their place plans.

We will also work with those communities who have decided not to produce their own local plan, to ensure we tackle their health and social care needs, too.

7. Our Priorities

Listening to and engaging with our communities is very important to us, and we have continued to do so for the last three years, the lifetime of our previous Strategic Plan.

We have hosted a number of events to hear from unpaid carers, third sector and community groups, staff teams working within health and social care, Community Councils, elected members, and many others. Overwhelmingly, people have told us that the six Strategic Priorities from our previous plan are still relevant and cover the most pressing issues facing health and social care services in Orkney.

We have compared these responses with our most recent Joint Strategic Needs Assessment (JSNA) and subsequent JSNAs undertaken in relation to Alcohol and Drugs and Community Justice purposes. These are assessments we do regularly, identifying where there is the most need for health and social care services.

This has allowed us to identify themes that have been consistently highlighted by you, the government, and our staff.

Consultations and plans that we have taken consideration of include:

The Orkney Mental Health Strategy 2020 – 2025.
Dementia Strategy 2020 – 2025.
The Child Poverty Strategy 2022 – 2026.
NHS Orkney Clinical Strategy 2022 – 2027.
Orkney Unpaid Carers Strategy 2023 – 2026.
The Orkney Islands Council Plan 2023 – 2028.
NHS Orkney Corporate Strategy 2025/26.
Orkney Partnership Local Outcomes Improvement Plan 2025 – 2030.
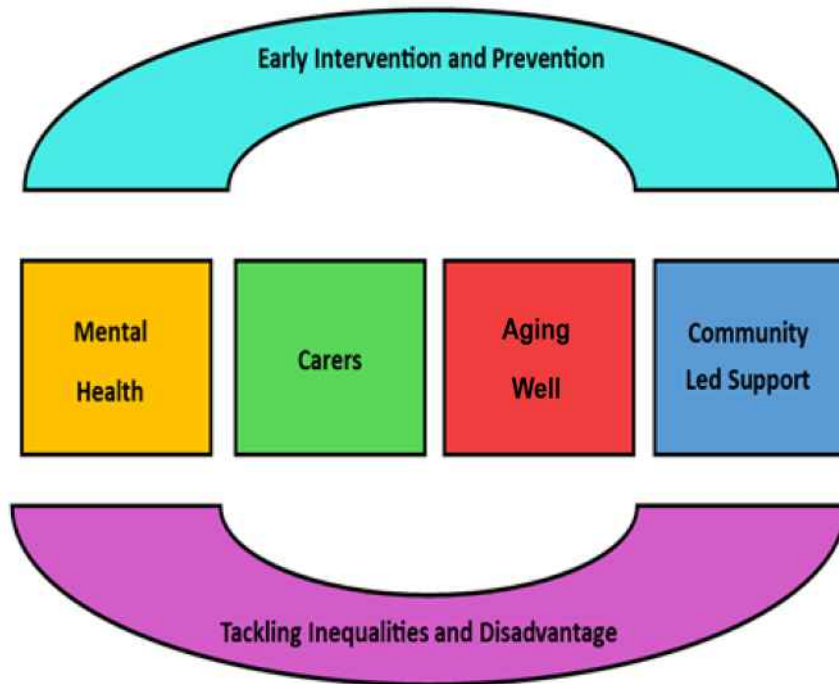
Our Priorities

- Unpaid Carers.
- Supporting People to Age Well.
- Community Led Support.
- Mental Health and Wellbeing.

Two overarching Priorities encompass our approach:

- Early Intervention and Prevention.
- Tackling Inequalities and Disadvantage.

However, all our Strategic Priorities are directly linked, with the work we do to address one priority having a direct impact on the others. For example, a lot of our work to support unpaid carers, and the help available to them, is because of work done to develop Community Led Support. Helping people to maintain good mental health will help them to look after their physical health, too, meaning they are less likely to need support services, especially residential support services, when they get older.

National Health and Wellbeing Outcomes

Scottish Government's plan to improve health and wellbeing across Scotland is summarised in the nine National Health and Wellbeing Outcomes. You can read more about these outcomes **here**. You will find a summary of the Outcomes addressed by each of the Strategic Priorities, below.

Our Priorities into Action

The following sections of the Plan detail what we have been doing in relation to our Strategic Priority areas and provides an update on what we plan to do moving forward. We have developed an accompanying Delivery Plan which provides specific detail of what we will do on each of our Priorities, throughout 2025/26. Our progress will be reported via our Performance and Audit Committee and we will review and update our Delivery Plan annually.

Tackling Inequalities and Disadvantage

This Strategic Priority Contributes to the following National Health and Wellbeing Outcomes:

Outcome 5: Health and social care services contribute to reducing health inequalities.

Inequalities and disadvantage are known to affect how people access services and maintain good health. For example, people in rural communities and, especially, those in the ferry-linked isles, often have to take multiple bus, ferry, and plane trips just to get to a hospital appointment.

We recognise, too, that people living in poverty are more likely to have a poor diet, may struggle to heat their homes, and are less likely to participate in their communities, often resulting in poor mental and physical health.

We have supported the Isles Wellbeing Project to tackle the barriers people in isles face in accessing health and social care services.

We are working with our partners in the Orkney Partnership to directly tackle disadvantage and have made inequalities a priority in the new Local Outcomes Improvement Plan. You can read more about The Orkney Partnership here.

We have also supported the Isles Wellbeing Project to tackle the barriers that living in the ferry-linked isles can present when trying to get access to health and social care services. We will continue to support this project, alongside others, by making sure we are:

- **Protecting vulnerable groups:** Keeping children, young people, and vulnerable adults safe from harm.
- **Improving access:** Ensuring everyone can reach the services or treatments they need.
- **Removing barriers:** Identifying and breaking-down obstacles that stop people from using services.
- **Supporting financial wellbeing:** Partnering with others to help people facing financial hardship.
- **Building a strong community:** Working with partners to make Orkney a safe, welcoming, and supportive place for all.

Our goal is to create a fairer Orkney where everyone can live well.

Early Intervention and Prevention

This Strategic Priority Contributes to the following National Health and Wellbeing Outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Prevention and Early Intervention, throughout people's lives, is vital to all our priorities. We want to give people the power to be aware of, and responsible for, their health and wellbeing, whatever their age or background.

We are committed to improving the health and wellbeing of children, young people, and adults, in Orkney. Communities and the local environment play an important part in promoting good health and providing opportunities to be active, to be involved, and to connect with others.

What are we doing now?

There are clearly defined rules and regulations that set out how health and social care services must work. Most of the services we deliver are statutory services, which means we are required to deliver these services, by law. Some examples of statutory services include protecting vulnerable children, young people, and adults, or delivering primary care and community services, such as GP and Care at Home services.

We want to avoid, where possible, people waiting until they have a crisis in their life before they look for support.

We will continue to deliver high quality core services but will also be exploring how we can change the emphasis of our services to preventing crises from happening.

Something else we are doing is participating in an initiative called 'Getting It Right For Everyone'. This is a nationwide programme that provides a more personalised way for people to get the help and support they need. In Orkney, we have focussed our work on helping people to "age well", delaying, or even removing altogether, the need for Care at Home or residential care.

What do we plan to do?

We will continue to redesign how we deliver services so that people get the right advice and support, meaning they need crisis services much less often: we want to avoid, where possible, people waiting until they have a crisis in their life before they look for

support. For example, we will be working with families to ensure we can identify health conditions early in children under five, reducing the likelihood of life-long poor health.

Our strengthened focus on prevention and early intervention will promote good, positive, physical, mental health and wellbeing, for all people, whatever their age.

We know how damaging inactivity can be to health. In fact, The World Health Organisation estimates that nearly 1.8 billion adults across the world are at risk of disease from not doing enough physical activity.

OIC's Leisure and Cultural Services recognise their role in helping people to be more physically active and has developed their Physical Activity and Wellbeing Strategy. This sets-out how they will work with services across OIC, other statutory organisations, and the third and private sectors, make the most of resources and get people in Orkney active and healthy.

How will we know we have made a difference?

Prevention and early intervention can take place at different stages of the progression of a person's condition, including before it has developed, when it is in its early stages, or when it is more established. At every stage this can improve a person's condition by slowing down, or stopping, further development or complications.

We will continue to strengthen our approach to prevention and early intervention by further developing multi-professional teams in primary care. This means that physiotherapists, mental health nurses, pharmacists, community link workers, and other specialist nurses and practitioners, will work alongside GPs and practice nurses. This will see patients able to receive support from the most appropriate professional, at the earliest opportunity, and help support adults and young people to adopt healthy lifestyles, reducing their risk of developing a wide range of health problems.

Unpaid Carers

This Strategic Priority Contributes to the following National Health and Wellbeing Outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Some facts and figures

The Carers Trust estimate there are 800,000 unpaid carers in Scotland, which is nearly 15% of the total population of the country. This includes at least 30,000 young carers under the age of 18.

Did you know, the Carers Trust estimate that 15% of people in Scotland are unpaid carers?

Estimates vary substantially around the value of unpaid care. Scottish Government, for example, suggest £12.8 billion, whilst Oxfam Scotland analysis, in 2020, estimated this figure to be nearer £36 billion. Whichever is more accurate, these are astonishing figures, especially as spending on social care in Scotland was £5.75 billion in 2022/23. This means unpaid care is worth between two and six times the total national spend on social care services.

Unpaid care in Scotland is thought to be worth as much as £36 billion.

Scottish Government recognised this when they introduced the Carers Act. This Act, introduced in 2018, means unpaid carers can get help from their local authority.

So much for figures, but what does this mean for Orkney? Well, there are just over 22,000 people in the county, which means there are around 3,500 unpaid carers in Orkney, including more than 100 young carers. Even if we take the lowest estimate for Scotland, this means unpaid care here in Orkney is worth around £51 million.

These are, of course, enormous sums of money and are difficult to comprehend. Perhaps it is easier just to say that, without the care delivered every hour of every day, up-and-down the land, social care services would be unable to cope.

Who are unpaid carers?

An unpaid carer is anyone looking after a loved one who needs help with their care. This could be a family member, a friend, or a neighbour. They might have an illness, a disability, a physical or mental health problem, or an addiction.

Anyone who provides care for a loved one is an unpaid carer.

And unpaid carers can be any age, too. For example, many young people look after parents and other family members.

You do not have to be related to, or live with, the person, to be a carer, and you do not need to be registered as a carer.

How have we been helping unpaid carers?

Some of the things we have been working on to support unpaid carers during the last three years include:

- Holding the first Unpaid Carers Conference, where we were able to highlight the support available for unpaid carers.

We held the first Unpaid Carers Conference, in 2023.

- Publishing our new Unpaid Carer Strategy.

- Developing our new Adult Carer Support Plan for adult carers, and a Young Carer Statement for young carers.

- Improving ways to identify carers.

- Appointing our new Carer Lead Officer, and Carer Support Worker, who will spend all of their time working to improve services for unpaid carers.

But it's clear we must do a lot more. A survey carried out every two years has consistently showed Orkney to be the second-best place in the country for getting the right support to be an unpaid carer. However, the actual number of people who said they felt supported was only 43% in 2022, and fell to 34%, last year.

As we have seen, we think there are around 3,500 unpaid carers in Orkney, but only 400 or so are asking for support from services, meaning it is likely around 3,000 are not asking for any support. No wonder only 34% of carers feel supported!

This means, of course, that we must work much harder to identify these folk and help them to get the support they need and are entitled to.

> We must make sure unpaid carers get a break from caring.

Our biggest challenge, though, is to make sure that our unpaid carers can get a break from caring, which is called respite. It's been difficult for us to provide planned respite, so we are now working on new ways of helping unpaid carers to get the break they need.

What are our plans to continue supporting unpaid carers?

Along with our partners in the third sector, we will:

- Invest even more time and money in services that allow unpaid carers to take a break.

- Continue to work hard publicising the support available to our unpaid carers.

- Train our staff to identify unpaid carers and help them to access support.

> We will hold our second Unpaid Carers Conference, in 2025.

- Make sure we offer an assessment (called an Adult Carer Support Plan or Young Carer Statement) to everyone who wants one.

- Hold another Unpaid Carers Conference.

- Write a Strategy specifically for our young carers.

How will we know we are making a difference to unpaid carers?

If we manage to make more people aware of the support available to unpaid carers, we can expect to offer more Adult Carer Support Plans and Young Carer Statements. We will also record how many staff are being trained to identify unpaid carers.

The ultimate test is to ask carers whether they feel they are supported. The more people who say they do, the better and more effective our support will be.

> We will ask carers if they feel supported.

Where can I find out more about Unpaid carers?

We have published a strategy explaining how we will help Unpaid carers. You can find it **here**.

Additional information for unpaid carers can be found on the Carers Trust website **here**

The carer support service in Orkney is delivered by our partners at Crossroads Care Orkney. You can find their website **here**. They offer a number of services for unpaid carers, including information, advice, emotional support, advocacy, and training, as well as respite care.

Supporting People to Age Well

This Strategic Priority Contributes to the following National Health and Wellbeing Outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

What have we done?

More older people with complex needs are now able to stay at home, than ever before, as our carers are trained to look after people with greater needs. In addition, we support over 800 people who have a community care alarm and other associated alarms to enable them to be safe in the community. Our oldest care home, St Rognvald House, is being replaced during 2025 with Kirkjuvagr House, which offers modern facilities fit for the future. Once that move is complete all of the Council's care homes will be less than 25 years old and all have land surrounding them to enable future extra care housing to be built.

We continue to work with colleagues across statutory and third sector organisations to consider the cost of living crisis and, specifically, what we can do to make things easier for older people.

We have worked with Housing colleagues in respect of the Orkney Housing Market Partnership which seeks to identify where all housing gaps are across the county and plan to resolve

What we plan to do?

We will make sure our Telecare service is ready to cope with the forthcoming telecommunications switch, from analogue to digital, ensuring no one who has Telecare is left without the ability to summon help. Following the move from St Rognvald House we will ensure that day care services, previously provided from Gilbertson Day Centre, are replaced by a service based in one location, wherever possible.

We will make sure people who have challenging behaviours, are able to stay in our care homes, here in Orkney, where they belong.

Adult Social Work will ensure that no older person we are told about is harmed, be it financial, physical, or mental harm. We will also try to make sure people do not harm themselves accidentally, such as by hoarding items in their home and increasing the risk of a fire or a fall.

With the opening of Kirkjuvagr House, we will take the opportunity to consider whether some older people's care home places should be classed as nursing care. Orkney is unusual in that we have no access to nursing care home beds in the county. Our Community Nursing teams support those living in the community, and in residential care but, given that our elderly population is rising, nursing home beds would help to make sure people stay here, even if they are very dependent on support.

We will also consider how best to use the empty wing at Hamnavoe House; this will mean we will have to think about how we staff and fund the wing.

Our multi-disciplinary Intermediate Community and Home First teams also provide huge support to people in the community, meaning they can remain as independent as possible, for as long as possible.

How will we know we have made a difference?

We can monitor our progress via numbers, produced nationally, called Integration Indicators. We will also ask for feedback directly from the people we work with and will check our progress by measuring a variety of numbers. These will include the number of people being supported via Care at Home, the size of our waiting lists for social work assessments, and the number of people in hospital awaiting discharge who are delayed.

Community Led Support

This Strategic Priority Contributes to the following National Health and Wellbeing Outcomes:

Outcome 7: People who use health and social care services are safe from harm. They do and are supported to continuously improve the information, support, care, and treatment they provide.

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care, and treatment they provide.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

What is Community Led Support

Community Led Support (CLS) means involving people in shaping and running services that meet their needs, with a focus on local solutions. It's about working together as a community to make things better for everyone. People who use the services, along with local groups and organisations, have a say in how things are done, ensuring support is friendly, flexible, and works well for the community.

What have we done?

Since summer 2019, we've been talking to our communities to understand what's important to them, what helps, and what they need. From these conversations, we created *Blether* spaces in Kirkwall, Sanday, and St Margaret's Hope. These were places where people could drop in to find support if they were struggling or worried about someone they care about.

We also ran workshops called *Good Conversations* to help people learn how to talk in a way that focuses on what really matters to others.

Unfortunately, just as the *Blethers* were starting to grow, the pandemic hit. Resources had to shift quickly to help those most in need. The *Covid Community Support Hub* at the Pickaquoy Centre became a kind of virtual *Blether*, where people could call in for support instead of meeting in person.

During the first lockdown, over 800 people in Orkney were shielding because of health conditions. Staff from OIC, Social Work teams, and health professionals worked together to check in with them weekly, offering help and reassurance. Local communities also stepped up with their own support efforts, which were hugely successful.

We've learned a lot from these experiences and are now working on a plan to continue this collaborative, community-focused approach.

Examples of CLS in Orkney

Here are some examples of CLS in Orkney:

Blether Spaces: These were drop-in spaces set up in Kirkwall, Sanday, and St Margaret's Hope. They offered a welcoming environment where people could find out about local support services, talk about their concerns, and connect with others in the community.

Covid Community Support Hub: During the pandemic, this phone-based hub, hosted at the Pickaquoy Centre, provided help to people shielding or struggling. It was run by redeployed staff from OIC, alongside social workers and health professionals.

Parish and Island-Led Initiatives: Local parishes and islands organised their own support systems during the pandemic. For example, volunteers delivered groceries and prescriptions to those shielding, whilst informal networks checked in on neighbours, particularly the elderly and isolated.

Community Transport Services: Some islands operate volunteer-run transport services, helping residents attend appointments, go shopping, or visit family and friends.

Community Gardens and Food Initiatives: Groups like the Orkney Blide Trust have created spaces where people can grow food, meet others, and support mental health through gardening activities.

Youth and Family Activities: Local groups have organised activities like outdoor learning sessions, after-school clubs, and support for young carers to give children and families a chance to connect and thrive.

Community Link Practitioners: Based in GP surgeries across Orkney, Community Link Practitioners help people access support for their health and wellbeing needs. They connect individuals with local services, activities, and groups, such as exercise programs, social groups, or mental health support. This person-centred approach ensures people get the help they need in ways that work best for them.

Community Wellbeing Coordinators (Isles Wellbeing Project): Part of the Isles Wellbeing Project, these coordinators work across most of the ferry-linked isles to address specific challenges in rural areas. They help residents access support, create local wellbeing initiatives, and promote a sense of connection and resilience within island communities. Their work empowers people to identify and meet their own community's needs.

These examples highlight how Orkney uses a combination of local leadership, collaboration, and tailored solutions to build stronger, more supportive communities.

What are we doing to support CLS in Orkney?

To support CLS across Orkney, we will focus on the following key actions:

Actively Involve Communities:

- **Listen to local voices:** Regularly consult with communities to understand their needs, priorities, and challenges.
- **Support co-design:** Involve community members and organisations in designing services that work for them.
- **Celebrate local efforts:** Acknowledge and highlight successful community-led initiatives to encourage others.

Strengthen Collaboration:

- **Facilitate partnerships:** Create stronger links between voluntary groups, local organisations, and statutory services to share knowledge and resources.
- **Engage with Community Councils:** Work closely with Community Councils to ensure local leadership is supported.
- **Promote joint working:** Encourage collaboration between Community Link Practitioners, Community Wellbeing Coordinators, and other frontline workers.

Build Local Capacity:

- **Offer training and resources:** Provide communities with skills such as *Good Conversations* or organising local initiatives.

- **Simplify funding:** Make small grants and funding accessible for grassroots projects that align with CLS principles.
- **Empower volunteers:** Support volunteer networks by offering recognition, training, and practical help.

Ensure Equitable Access:

- **Support remote communities:** Address the unique challenges faced by Orkney's linked isles, such as transport, digital connectivity, and access to services.
- **Invest in local coordinators:** Expand roles like Community Link Practitioners and Community Wellbeing Coordinators to cover more areas.
- **Enhance digital support:** Improve online access to services and community networks for those in remote areas.

Provide Practical Support:

- **Create welcoming spaces:** Invest in physical locations, like Blether spaces, where people can connect and access help informally.
- **Help navigate services:** Ensure people can easily find and access the right support through well-structured hubs or clear information pathways.
- **Be flexible:** Allow services to adapt to local needs rather than using a one-size-fits-all approach.

Learn from Experience:

- **Evaluate regularly:** Collect feedback and data to understand what's working and what isn't.
- **Share success stories:** Highlight effective approaches from across Orkney to inspire and inform others.
- **Stay open to innovation:** Be willing to pilot new ideas and adapt based on community feedback.

By enabling communities to take the lead and providing the right support, we can help ensure CLS thrives across Orkney, building resilience, reducing isolation, and improving wellbeing for all.

Mental Health and Wellbeing

This Strategic Priority contributes to the following National Health and Wellbeing Outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.

> "The service provided has literally made the difference between allowing me to function or spiral downwards".

Outcome 5: Health and social care services contribute to reducing health inequalities.

Outcome 7: People who use health and social care services are safe from harm. They do, and are, supported to continuously improve the information, support, care, and treatment they provide.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

What is Mental Health, Mental Wellbeing and Mental Illness?

Mental health is a part of our overall health, alongside our physical health. It is what we experience every day and, like physical health, it ebbs and flows. Good mental health means we can realise our full potential and feel safe, secure, and can thrive daily.	Mental wellbeing is our positive view that we are coping well psychologically with the everyday stresses of life. It can work productively and fruitfully to allow us to feel happy and live our lives the way we choose.	Mental illness is a health condition that affects emotions, thinking and behaviour, which substantially interferes with, or limits, our lives. Mental illness is a term used to cover several conditions (e.g. depression, post-traumatic stress disorder, schizophrenia) with different symptoms and impacts for varying lengths of time.

Why is mental health and wellbeing important?

Mental illness is one of the major public health challenges in Scotland. Around one in three people are estimated to be affected by mental illness in any one year.

We think it's important that people who experience mental health problems receive the same level of social and clinical support as those with physical health problems, so we have committed to improve and develop mental health and wellbeing support across Orkney so that people can live longer, healthier, and more fulfilling lives.

What are we doing to support mental health and wellbeing in Orkney?

Orkney's Mental Health Strategy (2020 – 2025) sets out how we will improve and develop mental health and wellbeing support. It was partly influenced by the Scottish Government Mental Health Strategy 2017-2027, as well as what people who use and deliver services said. You can read the Government's Mental Health Strategy **here**.

We have also extended the pilot of something called the Distress Brief Intervention (DBI), in Orkney. This is an 'ask once, get help fast' approach, and offers connected, compassionate, support to people experiencing distress. This service is being delivered by Orkney Blide Trust and Penumbra, who are working in partnership with the Scottish Ambulance Service and Scottish Police.

Mental Health support for children and young people provided by the Child and Adolescent Mental Health Service (CAMHS) has greatly expanded. We have also extended support for people with Dementia and Learning Disability:

- A GP with Special Interest (Dementia).
- An Admiral Nurse, who is hosted by Age Scotland Orkney and part-funded by the IJB.
- Increased nursing support for learning disability.

We now have funding for an All Age Nurse Led Psychiatric Liaison Team. This will improve the experience of everybody using the emergency mental health transfer room and, importantly, reduce the impact of cancelled appointments on individuals who are in crisis.

We are also finalising the local Suicide Prevention Action Plan. This will set out how the Suicide Prevention Task Force will achieve the four outcomes detailed in the Creating Hope Together: Scotland's Suicide Prevention Strategy 2022-2032. You can read the Strategy **here**.

What future plans do we have to improve mental health and wellbeing?

Some of our plans to improve mental health and wellbeing services include:

- Improving how statutory and third sector organisations work together, to make sure the needs of people across the community are met.
- Working with third sector organisations to put a greater focus on prevention and early intervention, including increased support for our children and young people, adults, and those affected by substance misuse.
- Encouraging everyone in our community to work together to reduce the stigma sometimes associated with mental illness, as well as encouraging positive conversations about mental health and wellbeing.

- Increasing training of our staff across health and social care, including our third sector colleagues, so that they have the knowledge, skills and resources to provide the sort of support that people need.
- We are working with Orkney Housing Market Partnership to provide homes for people with enduring mental health conditions.
- Delivering a greater awareness of the support available for people in distress. We will do this by creating a webpage detailing support and contact details, as well as promoting the Growing Up In Orkney website for children and young people.

How will we know we are making a difference?

- Many people with significant mental health issues currently receive the support they need from outwith Orkney. However, investment in our services will see an increasing number of these people return home.
- Early intervention will see a reduction in the number of people who need to receive support outwith Orkney.
- As we see earlier access to services, we will be seeking to reduce the number of people who take their own lives.
- The number of people engaging with the new support services available, as well as the Growing Up In Orkney webpages, will increase. You can visit the Growing Up In Orkney website **here**.

8. Facts and Figures

The population of Orkney has increased from 19,220 in 2001 to 21,958 in 2022.

This is an increase of 14.25%. During the same period, the population of Scotland increased by 7.5%.

0 – 15

1982	2002	2022
4,453	3,818	3,510
23%	20%	16%

16 – 64

1982	2002	2022
11,417	12,248	12,976
60%	63%	59%

Over 65

1982	2002	2022
3,226	3,274	5,475
17%	17%	25%

25% of the population in Orkney are aged 65+, whilst across Scotland it is 20%.

Life expectancy in Orkney is 82.7 years for women and 78.7 years for men.

There are around 3,500 unpaid carers in Orkney.

There were 863 people with a Community Care Alarm and/or Telecare, as of the beginning of 2025.

There are 168 people receiving Care at Home services, as of early 2025.

9. How Housing Services Will Help

One of our priorities is to support people to stay at home. The Scottish Government, too, wants services to try and support people in their home and community, rather than in a hospital or care facility, so it is important that our colleagues from the OIC's Housing Service plan for how they will support health and social care services to do this.

This is called the **Housing Contribution Statement** and is a really important link between this plan and the OIC's Local Housing Strategy. It highlights, amongst other things, the need to help people who have physical and other support needs and identifies a number of areas for action. In fact, one of the Strategy's key objectives is to support people to stay at home, something that is called Independent Living.

People who need specialist housing or support to live independently can be found across Orkney's population. Some people need these services for a short time whilst, for others, specialist housing or support will be needed for the long-term.

Introduction to the Housing Contribution Statement

The Housing Contribution Statement (HCS) is a statutory requirement, as set out in the Government's Housing Advice Note, 'Statutory Guidance to Integration Authorities, Health Boards and Local Authorities on their responsibilities to involve housing services in the Integration of Health and Social Care, to support the achievement of the National Health and Wellbeing Outcomes'.

The HCS sets out the contribution of housing and related services in Orkney towards helping achieve priority outcomes for health and social care. It serves as a key link between the Strategic Plan and the Local Housing Strategy and supports improvements in aligned strategic planning and the shift to prevention.

As a local housing authority, the Council has a statutory duty and a strategic responsibility for promoting effective housing systems covering all tenures and meeting a range of needs and demands.

The Council's Strategic Housing Plan is articulated in the Local Housing Strategy (2024-2029) which is underpinned by the robust and credible evidence from the Housing Need and Demand Assessment (HNDA, 2023).

Health and Social Care Partnership

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care to ensure joined-up, seamless services. In 2015 the Orkney IJB was established as a separate legal entity.

The Head of Community Learning, Leisure and Housing is represented on the Strategic Planning Group to actively promote the housing sector's role in health and care integration.

Delegated Function

The Act sets out a range of health and social care functions, including functions under housing legislation which 'must' or 'may' be delegated to the IJB. These are contained in the Health and Social Care Integration Scheme which was approved by the Scottish Government and came into force from 6 February 2016.

The housing functions that are delegated to the IJB are:

- Housing Adaptations (General Fund and Housing Revenue Account) – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. The Housing Revenue Account is where any adaptations for tenants of Council houses are funded.

- The General Fund adaptations are carried out by Orkney Care and Repair and are for owner occupiers and tenants of private landlords. This constitutes the Disabled Grants and Small Repairs Grants in so far as an aid or adaptation applies only.

Other housing functions which have a close alignment with health and social care outcomes but are not part of any delegated functions are:

- Housing support services and homelessness.

- Other wider functions to address future housing supply, specialist housing provision and measures to address fuel poverty.

Local Housing Strategy

The Local Housing Strategy (2024-2029) sets out the vision for Housing in Orkney:

"Orkney has a wide range of good quality, sustainable homes that are affordable and meet the current and future needs of individuals, families and local communities across the Orkney Islands."

Orkney's three housing priorities over the next five years are:

- More Homes.
- Quality Warm Homes.
- Access and Choice of Housing for all.

All the priorities within the Local Housing Strategy are relevant to the Housing Contribution Statement, although of particular relevance is 'More Homes' and 'Access and Choice of Housing for all'.

Demographics

Household projections and existing unmet need (those in temporary accommodation and acute housing need as who are on waiting lists) are the basis of assessing housing requirements in Orkney (HNDA 2023). There has been almost double the rate of household growth in Orkney at 29.5% over the last 20 years compared to Scotland's 16%.

Looking forward at a range of different scenarios using National Record of Scotland's 2018 based household projections, it is predicted that household growth will continue to increase, although at a slower rate and most significantly in the next 15 years. Key points are:

- According to the 'principal' projection, there will be 8% household population growth overall.
- Household growth will be mainly driven by 1- and 2-person households – single person households will grow by 18% and two-person households by 9%, with the number of two parent households with children declining by 12%.
- Kirkwall and East Mainland are projected to see growth while the North Isles are projected to see a decline in population.
- The greatest expected proportionate growth is in the older households. There is also some growth projected in the 16-19 age group and 35-44 years age groups, but a drop in the proportion aged 20-34 years and 50-60 years. This means the right type of housing, increased level of adaptations, and care and support services will be required to support the aging households.
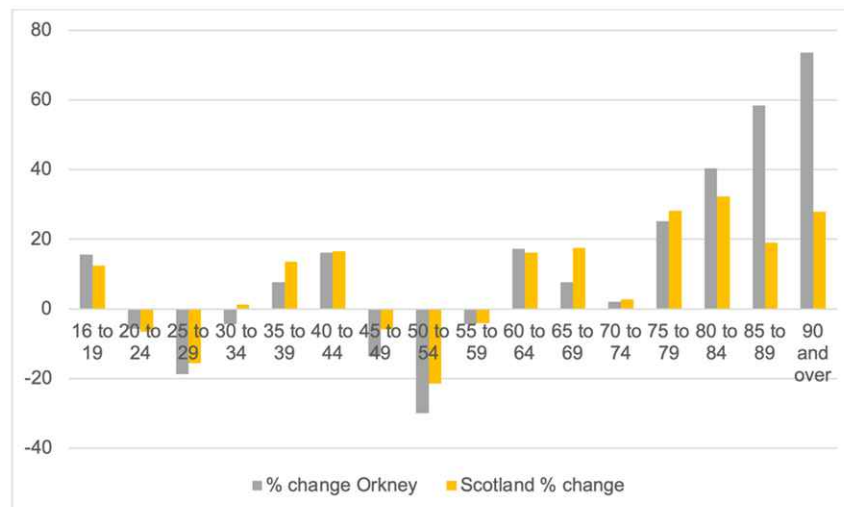
Source: 2018-based Household Projections (Council area profiles)

Ongoing pressure in the housing market is evidenced by increasing house prices, and rental prices, and lack of availability of private rented and social rented housing for residents and essential incoming workers. Most recent data from Registers of Scotland shows Orkney house price growth being double the Scottish average (2021/22 and 2022/23).

Key issues

The Housing Need and Demand Assessment and the Local Housing Strategy sets out the current provision and the requirements for new supply, and additional accessible, adapted and wheelchair housing.

- Around 300-600 households each year require adaptations to help people remain in their own homes – in practice Orkney Care and Repair typically provides 550 annually, with the most common major adaptations being level access showers, external ramping, stair lifts and grab rails. Recent resource levels (until 2023) have been in line with needs, but with the increasing ageing population, this will mean increasing need, and increasing resource requirements for adaptations. There is currently a significant backlog of level access shower installations, in part due to lack of capacity in the specialised workforce required for this type of adaptation.

- The small repairs service offered by Orkney Care and Repair provided 520 small repairs in 2023. Again, the need will increase with the aging population, projected at 630 small repairs by 2033. This means a need for increasing resources.

- There is very high demand and unmet need for care at home services, in part due to lack of workforce. At the same time, the level of care home provision is well below the Scottish average rate. This does not mean the solution is more care homes, but there must be adequate resources for the alternative including care at home, very sheltered and/or extra care housing as the need increases.

- The Council has recently completed a core and cluster development for people with learning disabilities and the Housing Market Partnership discussed using more core and cluster developments, including extra care housing for mixed client groups (e.g. older people, those with dementia, disabled people). This could be a more efficient and effective approach compared to home care in a rural setting, particularly in the context of travel distances and lack of care workforce.

- There is a gap in supported housing provision for those with enduring mental health needs who currently live on the Scottish mainland due to lack of appropriate provision in Orkney.

- There is limited ability of the public, voluntary and private sectors to be able to recruit and retain key- and essential workers (including interim and agency workers) with lack of availability of the right type, size and price of housing. This is evidence through the Council's Essential Workers Housing Strategy which shows migration being constrained due the to the lack of housing for incoming essential permanent workers.

Housing Contributions to Integration

The Local Housing Strategy sets out a comprehensive action plan to meet the needs of aging households, and others with specific housing, care and support requirements.

- The Council and its partners is planning for supply of 60 new affordable homes per annum (across all tenures) in Orkney for the next 10 years, some of which will have to be accessible and wheelchair properties. Some of the supply will also be suitable for Essential Workers (including Mid-Market rent).

- There is strong demand, and provision for/of bungalows among older residents, which will make adaptation for wheelchair use easier.

- There is scope to adapt some of the existing social ambulant disabled housing stock to wheelchair housing to meet this demand.

- New supply will be built which is suitable for older people, and those with a range of other needs – this will be achieved through a core and cluster approach with the 'core' being care homes so that neighbouring independent households can be supported from the 'core'.

- Ensuring sustainable resourcing for the Orkney Care and Repair service, recognising the vital role this plays in enabling timely discharge from hospital and supporting independent living.

- Enhancing the telecare service and introducing SMART homes.

- Putting in place supported housing/care provision for those with enduring mental health needs.

- Review incentives for older people to downsize to move to homes more suitable for their needs.

Challenges

Demographic – projected rapidly ageing population will present a universal challenge in terms of delivering services to meet projected increased demands.

Financial – continued financial pressure on public sector budgets will present a number of challenges going forward. Changes to welfare benefits will impact on the housing sector.

Knowledge – there is a real need to develop better, shared baseline information about the housing and support needs of people with long term, multiple health conditions and complex needs.

Support needs – demographic change suggests that there will be a small but significant number of people who will require intensive levels of support and care. This will bring challenges in small, mainly rural local authorities where availability of specialist services may not always be locality based. There is also likely to be an increase in the demand for lower level housing support to enable people to sustain their own tenures and allow them to continue to be supported at home as far as is practicable.

Housing Stock – Provision of sufficient affordable housing of the right size in the right area remains a challenge for Orkney. Given the relatively small size of its housing stock, statistical distortions can occur such as an imbalance in one size of properties, currently there is significant demand for one bedroom housing and this greatly outstrips supply. There are also limitations in respect of our ability to address this through new build, particularly in Kirkwall.

Monitoring and Review

This statement forms the link between the Local Housing Strategy and the Strategic Commissioning Plan. Actions will be reviewed jointly through monitoring arrangements for both strategies. The Housing Market Partnership meets quarterly and includes representatives from Orkney HSCP to monitor outcomes.

Local Housing Strategy Outcome:
People live independently and safely at home or in a homely setting in their own community.
Actions
Provide supported accommodation through a core and cluster approach in the campus of each of the three care homes (with the care homes acting as the core) for mixed client groups to maximise efficiency and outcomes for those requiring care and support.
Ensure the housing needs for older people are met on the isles through developments including co-housing.
Review joint adaptations protocol particularly around private housing adaptations to ensure there is equity of access across housing tenure for adaptations.
Ensure there is sufficient provision for wheelchair provision through the More Homes programme, or through conversion of existing amenity housing.
Explore options to supplement the Orkney Housing Association adaptations budget from Orkney Health and Care, recognising the importance of timely adaptations in reducing hospital admissions.
Work in partnership with NHS Orkney/Orkney Health and Care to support resourcing of Orkney Care and Repair to both aid hospital discharge and prevent hospital admission or demands on care services.
Ensure Orkney Care and Repair is sustainably resourced to meet the growing demand which supports independent living
Work in partnership with Orkney Health and Care to enhance the existing telecare provision including provision of SMART homes.
Explore developing local letting initiatives, especially on the outer isles to prioritise housing to health and care staff and other essential workers.
Work with the Development Trusts to advertise vacant social homes, where local letting initiatives exist to prioritise health and care staff, or other essential workers as relevant.
Review current approaches to downsizing to further incentivise smaller older households to move to homes suitable for the needs.
Ensure supported housing/care provision is supplied for people with enduring mental health conditions to enable people living on Scottish mainland to return to Orkney.
Review housing support in the round – enabling the third sector to provide lower level housing support and freeing up resources for more intense provision to be provided by the statutory sector.

10. Financial Implications

The Orkney HSCP's budget is funded through delegated money from NHS Orkney and OIC – the budget for 2025/26 is just over £74 million.

A Medium Term Financial Plan is being developed to highlight factors affecting the financial sustainability of the Orkney HSCP over the medium term. This Plan establishes the estimated level of resources required by the Orkney HSCP to operate its services, over the next three financial years, given the demand pressures and funding constraints that we are likely to experience.

Funding Source (Millions)

- £10.26
- £32.58
- £31.58
  - NHS Orkney
  - Orkney Islands Council
  - Set-Aside
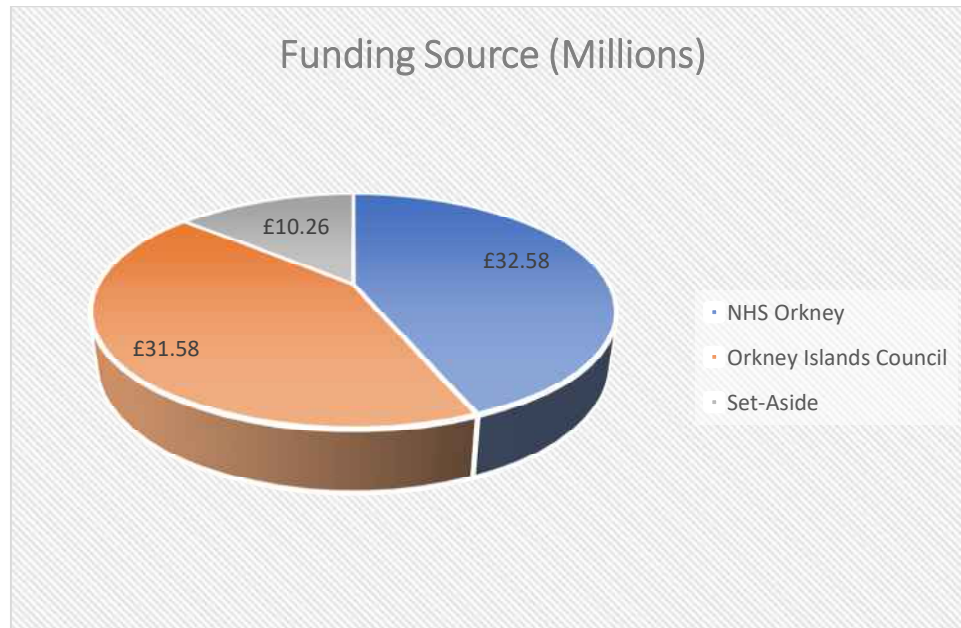
Local Context

Due to medical advances and improved quality of care, individuals who require, or are in receipt of, complex care have substantial and ongoing health and social care needs. These can be the result of chronic illness, disabilities, or following hospital treatment.

The demand for services continues to grow with funding uplifts struggling to keep pace.

Although this challenge is not unique to Orkney, our older population is increasing faster than the national average. In addition, significant numbers of our working age population are leaving the islands, leaving fewer people available to provide the care and support required. Alongside the challenges, the contribution that older people make to our society also needs to be recognised. For example, people over 65 years of age deliver more care than they receive – acting as unpaid carers, child minders and volunteers.

The IJB continues to commission services within the financial envelope available and the chart below illustrates the breakdown of where our money currently goes.

Where the money is spent (Millions)

- Allied Health Professions
- Care at Home
- Community Nursing
- Children and Families
- Disabilities
- Justice Services
- Mental Health
- Older People's Residential and Daycare
- Prescribing
- Primary Care
- Support Services and Overheads

£4.31 £3.27 £5.56 £2.10 £13.64 £7.06 £6.15 £7.46 £10.60 £0.24
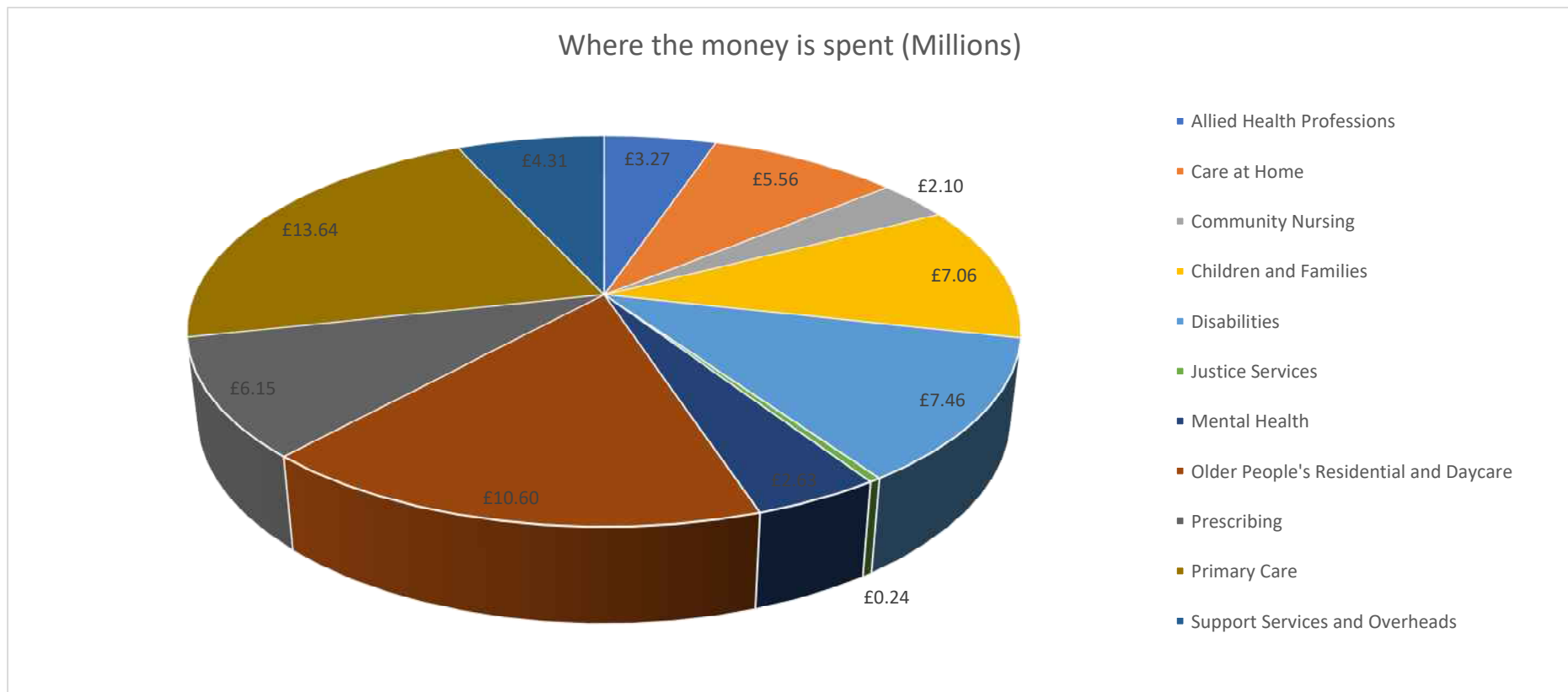
Budgetary Pressures

The single biggest pressure on our budgets continues to be through the engagement of agency staff to offset our workforce vacancy rate. Many of our services would not have been able to function over the last few years had it not been for the deployment of agency staff to cover critical roles. Whilst this is a situation that is not unique to Orkney, our agency costs are higher than other parts of the country given the need to pay for travel and accommodation costs.

The overall costs of agency staff have continued to grow over the last four years, as illustrated in the graph below.
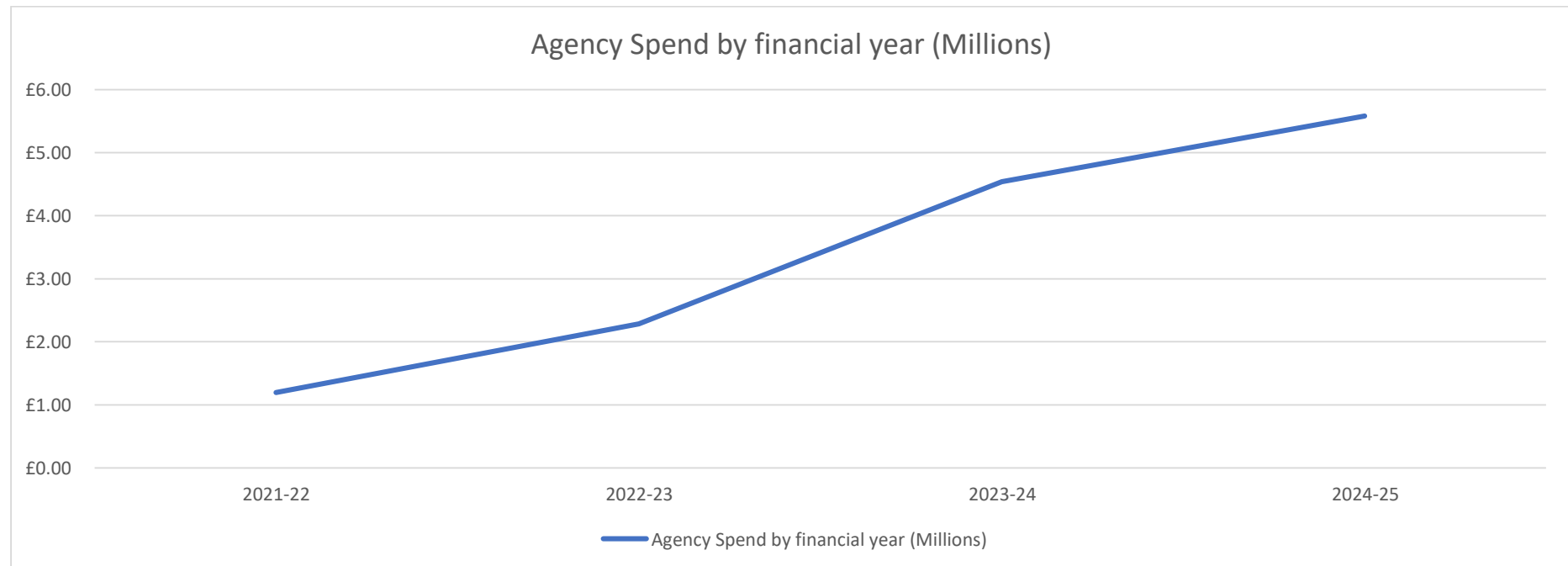
By the end of 2024/25 our total agency spend in social work and social care alone was £5.58 million with approximately £1 million of that figure accounting for accommodation and travel. Although the rise in costs slowed slightly in 2024/25, they have, nevertheless, continued to increase. We anticipate that some of our substantive recruitment will begin to impact favourably on the position through 2025/26 and further efforts will be made to build on the recruitment initiatives already in place.
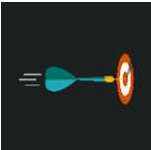
Additional Funding

The Scottish Government budget for 2025/26 shows a record investment of £21 billion in health and social care. However, budget figures show that most of the 'additional' funding is to support UK and Scottish Government policies in respect of Real Living Wage, and changes to Employers National Insurance contributions (eNIC). Therefore, the additional funding is effectively to meet existing costs.

The UK Government budget policies increase spending by almost £70 billion over the next five years. However, these policies have already been challenged in the March Spending Review. Whether these policies, and subsequent distribution via the Barnett formula to the Scottish Government, can be delivered is unknown as global economic uncertainty has increased sharply, growth has slowed in many of Britain's major trading partners, and borrowing costs have risen across most advanced economies.

While this additional funding is welcome, the Orkney Integration Scheme requires a recovery plan to be put in place to address the forecast overspend and return to a breakeven position. In addition, there is an expectation that savings targets to be met from existing resources will require substantial transformation in service delivery.

Key Areas Identified to Close the Financial Gap

	Transform and Redesign Services • Introduce a programme of transformation and service redesign, focussing on identifying opportunities to redesign services and use alternative care models that match the ambitions of the Orkney HSCP's Strategic Plan.
	Improve Efficiency • Introduce initiatives to deliver services more efficiently.
	Strategic Commissioning • Ensure services that we commission from external providers deliver the best quality support and focus on the needs of the local population, deliver good quality support, and are aligned to the Strategic Priorities of the Orkney IJB.

	Shift the Balance of Care • Address a shift in the balance of care away from hospital-based to community-based services.
	Prevention and Early Intervention • Promote good health and wellbeing, help people to manage their long-term conditions, and intervene earlier, reducing the need for people to receive care outwith their own home.

Annual Strategic Plan Delivery Plan 2025/26

How we will deliver our Strategic Priorities this year

Orkney Health and Social Care Partnership

Contents

Introduction

This Strategic Plan Delivery Plan provides details of how we intend to deliver the Partnership's six Strategic Priorities, over the coming year. We will review this plan at the end of the year and update our Milestones and Measures.
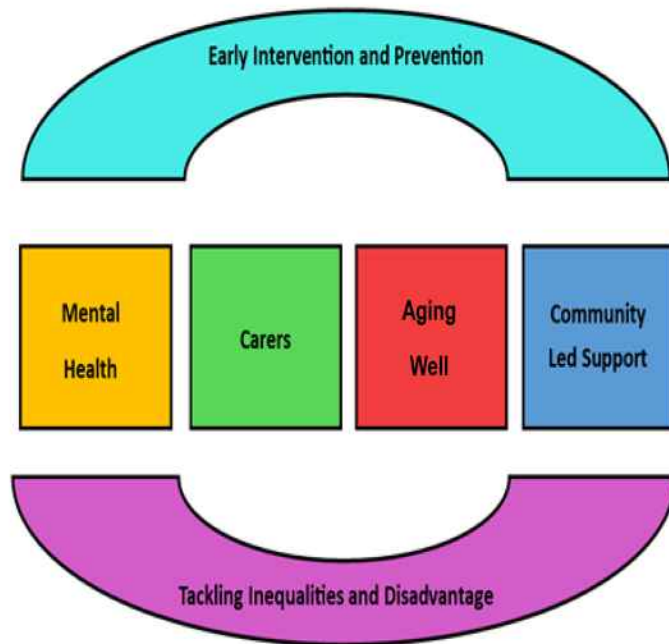
Our Strategic Priorities have been determined through consultation and engagement with service users and professionals.

It is clear people still feel the Strategic Priorities from our previous plan are still relevant, covering the most pressing issues facing health and social services in the County.

Professional acknowledgment that services must respond to changing public expectations, budgetary challenges, staffing shortages, and changing demographics, have resulted in new ideas and innovations in service delivery, such as the use of digital technology.

The priorities must be considered within the broader context and recognition that helping people to maintain their health and wellbeing, providing access to preventative services, and delivering for everyone, regardless of circumstance, will encompass every aspect of strategic planning and service delivery. We will use shared decision making to place our population at the centre of their care, always listening to what matters to you.

Orkney Health and Social Care Partnership's Strategic Plan, and this Delivery Plan, should be read within the context of public services' delivery, in Orkney. There are multiple strategic plans, issued by a number of responsible statutory and third sector agencies, all of which retain common themes. Despite attempting to tackle different challenges, all these plans seek to improve the overall health and wellbeing of the people of Orkney and, consequently, are inextricably linked.

Scottish Government, too, has a plan to improve health and wellbeing across Scotland. This plan is summarised in the nine National Health and Wellbeing Outcomes. (You can read more about these outcomes here.) You will find a summary of the Outcomes addressed by each of the Strategic Priorities, below.

Finally, it should be noted that no single Strategic Priority sits in isolation; each has a direct influence and effect on the others. This means co-production, across every aspect of service delivery in the health and social care sector (and in public services delivery, in general) is mandatory if we are to successfully deliver upon our stated Strategic Priorities and, most importantly, improve the health and wellbeing of people in Orkney.

Priority: Tackling Inequalities and Disadvantage

Outline

We are committed to:

- Working to keep children, young people, and vulnerable adults safe.
- Making sure that everybody can access the service or treatment that they might need, when they need it.
- Removing barriers to accessing services.
- Working with partners to address financial hardship.
- Ensuring Orkney is a safe and happy place to live, for everyone.

Strategic Intention

The provision of multi-professional, 21st century health and social care, which is tailored to the needs of our population.

This Strategic Priority Contributes to:

Outcome 5: Health and social care services contribute to reducing health inequalities.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
We will ensure that all school children across Orkney are able to access a breakfast.	All young people attending school will have access to a free breakfast.	Chief Officer Cost of Living Task Force.	End of March 2026.
We will provide annual health checks to those with Learning Disabilities.	We will increase the percentage of Learning Disabled people receiving	Service Manager – Mental Health Service.	End of March 2026.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
	annual health checks to 100%.		

Priority: Early Intervention and Prevention

Outline

Our strengthened focus on prevention and early intervention will promote good, positive, physical and mental health, and wellbeing, for all people, whatever their age.

Strategic Intention

Prevention and Early Intervention, across the lifespan, is vital to all our priorities. We want to empower people to be more aware of, and responsible for, their health and wellbeing, whatever their age or background. We are committed to improving the overall health and wellbeing of children, young people, and adults, in Orkney. Communities and the local environment play an important role in promoting good health and providing opportunities to be active, to be involved, and to connect with others.

This Strategic Priority Contributes to:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Implement a partner-approved systems-based approach to Physical Activity.	Deliver update to the IJB in February 2026 to update on progress and outcomes.	Service Manager (Leisure and Culture).	End of February 2026.
Launch a program to promote healthy lifestyles in schools, reaching 100% of students by June 2025.	Deliver workshops on nutrition, mental health, and physical activity in partnership with educators.	Head of Children, Families and Justice Services and Chief Social Work Officer. Service Manager (Children's Health Services). Service Manager (Leisure and Culture).	End of June 2025.
Establish a data-driven falls prevention program, for older people, by June 2025.	Analyse hospital and community data to identify risk patterns and implement tailored interventions.	Head of Community Health and Care.	End of September 2025.
Implement a single pathway for neurodevelopmental assessment for children and young people.	Children and families will experience more timely assessments, with longest waits reducing from 101 weeks to 12 weeks, in line with National Outpatient appointment targets.	Head of Children, Families and Justice Services and Chief Social Work Officer. Service Manager (Children's Health Services). Clinical Director, CAMHS.	End of March 2026.

Priority: Supporting Unpaid Carers

Outline

The Scottish Government has observed that the care system could not cope without the enormous contribution from unpaid carers. The Carers (Scotland) Act 2016 recognised this contribution, promising to 'promote, defend, and extend the rights' of adult and young carers across Scotland. The Act enhances and extends the rights of carers, with carers now entitled to their own support plan.

The role of unpaid carers is also recognised in the Scottish Government's nine National Health and Wellbeing Outcomes. This recognition is local, too, with support for unpaid carers being one of our strategic priorities.

Strategic Intention

The Carers' Strategy Group, a group with membership from across the statutory and third sectors, as well as unpaid carer representation, is charged with delivery of the Carers' Strategy.

The group will make sure that unpaid carers can access the help and support services they need to enable them to continue in their caring role for as long as they wish to.

This Strategic Priority Contributes to:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Hold a second Orkney Unpaid Carer Conference.	Hold the conference before the end of 2025.	Policy and Performance Manager.	End of December 2025.
Offer an assessment to all unpaid carers seeking support and measure that number.	Increase the number of carers offered an assessment from 33 in 2022, to 60 by the end of 2025.	Policy and Performance Manager.	End of December 2025.
Prepare and publish a dedicated Young Carer Strategy.	Young Carer Strategy will be approved and published.	Policy and Performance Manager.	End of March 2026.
Deliver an Unpaid Carer-Friendly policy for staff employed by OIC.	Prepare and publish an OIC Unpaid Carer-Friendly policy by the summer of 2025.	Policy and Performance Manager. Head of Human Resources, OIC.	End of September 2025.
Begin training frontline workers throughout statutory and third sector organisations, making them "carer-aware".	Undertake training of at least 100 frontline workers by the end of March 2026.	Policy and Performance Manager.	End of March 2026.
We will reach more people delivering care to family or friends, who have not sought carer services, and measure that number.	Increase the number of unpaid carers contacting Crossroads Care Orkney, for support, from 78, in 2022, to 150, by 2026.	Policy and Performance Manager	End of March 2026.

Priority: Supporting People to Age Well

Outline

Older people consistently tell us they would prefer to stay in their own homes, in their own communities, for as long as possible, rather than move into supported accommodation or residential care. Whilst we have invested significantly in improving sheltered and residential care for our most frail and vulnerable older people (such as the new care home in Stromness, and the planned new care facility in Kirkwall), we recognise people want to receive support, wherever possible, at home.

Strategic Intention

If we are to be more successful in meeting peoples' preferences, we need to ensure we have an adequate workforce, appropriately remunerated and fully trained in the delivery of complex care. We need to ensure all possible use of technology is maximised and we need to ensure all community-based teams are working collaboratively together for the benefit of the people in our care.

We will work together with our partners across the health, care, and third sector to help people access activities and services to meet the needs of vulnerable older people.

We will ensure that people living with frailty are able to access well planned and well-coordinated services which are tailored to their individual needs and support their health, wellbeing, and independence at every stage of their condition.

This Strategic Priority Contributes to:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, can live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Improve our preparedness for the analogue to digital switchover to ensure that our telecare services are fit for purpose.	We will increase the percentage of service users using digital from 26.5% to 60%.	Service Manager (Community Care). Head of Community Health and Care.	End of March 2026
We will use projected need data to determine and agree the most appropriate use of the currently unutilised wing of Hamnavoe House.	A plan for how the fourth wing in Hamnavoe House will be commissioned, will be available with costings.	Head of Community Health and Care.	End of March 2026.
Individuals who are referred for a social work assessment will receive this in a timely manner.	Reduce the outstanding social work assessments from 59 (as at 31/03/25) to 25.	Service Manager (Adult and Learning Disability Social Work). Head of Community Health and Care.	End of March 2026.
Further improve access to Care at Home provision.	Increase the number of service users in receipt of Care at Home by 5% from 171 (as at 31/03/25) to 180.	Service Manager (Community Care). Head of Community Health and Care.	End of March 2026
We will continue to improve the quality of adult care provision in Orkney.	All adult care provision Inspectorate Grades will be at Good or above.	Service Manager (Social Care). Service Manager (Community Care). Head of Community Health and Care.	End of March 2026.

Priority: Community Led Support

Outline

Community Led Support aims to provide the foundation for a more modern, effective way of delivering health and social care support that strengthens individuals, and community resilience and wellbeing. It is based on joined up working and collaborations across a range of organisations and partners, working collaboratively in the interests of the community, and moves away from professionally led processes and decisions, with the aim of focusing on good, effective conversations with people.

Strategic Intention

Working with communities and partners to collaboratively design services with a focus on prevention, early intervention and on enabling people to be as independent as possible. This will strengthen integrated health and social care provision, improve mental health and wellbeing support, bolster partnership working and drive further development of Community Led Support / care in a co-designed approach.

This Strategic Priority Contributes to:

Outcome 7: People who use health and social care services are safe from harm. They do and are supported to continuously improve the information, support, care, and treatment they provide.

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care, and treatment they provide.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Engage in the co-production of community action plans for Orkney's parishes by December 2025.	Action plans will be available and will include key health and social care data and plans.	Policy and Performance Manager.	December 2025.
We will convene and host quarterly evening meetings with Islands Community Councils and Mainland Community Councils to enhance responsiveness to their health and social care needs.	Schedule of meetings and minutes will be available.	Chief Officer.	End of March 2026.

Priority: Mental Health and Wellbeing

Outline

The Strategic Plan highlights that we think it is important that people who experience mental health problems receive the same level of social and clinical support as those with physical health problems, and that we have made a commitment to improve and develop mental health and wellbeing supports across Orkney, so that people can live longer, healthier, and more fulfilling lives.

Strategic Intention

Our strategic intention is described within the current Mental Health Strategy as "Helping people in Orkney to ensure that preventive measures are deployed at the earliest opportunity and that those with enduring mental health conditions live longer, healthier and more independent lives within their own communities. Getting it right for everyone applies equally to those with mental health conditions as it does those with physical health conditions**."** In addition our intention is to bolster the current service and create a sustainable service, recognising the changes in need and demand from our local population.

This Strategic Priority Contributes to:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 3; People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 5: Health and social care services contribute to reducing health inequalities.

Outcome 7: People who use health and social care services are safe from harm. They do, and are, supported to continuously improve the information, support, care, and treatment they provide.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Publish and implement a Suicide Prevention Plan, by April 2025.	Suicide Prevention Plan will be considered and approved by IJB and the Orkney Community Planning Partnership.	Chief Officer. Corporate Director, Education, Leisure and Housing.	End of July 2025.
Introduce an electronic patient record system for those with mental health issues.	Morse will be fully operational and performance data easier to produce.	Service Manager – Mental Health Services. Head of Health and Community Care.	End of December 2025.
Recruit to the All-Age Nurse Led Psychiatric Liaison Team.	The All-Age Nurse Led Psychiatric Liaison Team is established and operational.	Service Manager – Mental Health Services. Head of Health and Community Care.	End of March 2026
Raise greater awareness of mental health supports available.	We will promote the suicide prevention app 'SOS' and report throughout the year it's utilisation.	Lead Officer, Public Protection.	End of March 2026.
The School Health Team will work with families and schools to offer LIAM (Lets Introduce Anxiety Management Programme) to eligible children.	Eligible children will be offered a place on LIAM programme. Audit and Feedback will inform development of the service and future offer.	Service Manager (Children's Health Services). Head of Children, Families and Justice Services and Chief Social Work Officer.	End of March 2026.

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Establish Mental Health Practitioner roles to ensure that GPs can access appropriate supports for patients at an early stage.	Mental Health Practitioners will be in place and providing support to patients.	Head of Primary Care Services.	End of December 2025.
Expand the use of telehealth for remote consultations and therapy sessions.	To increase the number of sessions using Near Me from 80% to 90%.	Consultant Psychologist.	End of March 2026.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Integration Joint Board Key Items and Discussion.**
Responsible Executive/Non-Executive:	**Stephen Brown, Chief Officer – Integration Joint Board**
Report Author:	**Stephen Brown, Chief Officer – Integration Joint Board**

1   Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2   Report summary

2.1   Situation

NHS Orkney receives Directions from the Orkney Integration Joint Board in relation to a range of delegated services. There are three Non-Executive Directors of the NHS Orkney Board who are also voting members of the Integration Joint Board.

2.2   Background

Integration Joint Boards arose from the Public Bodies (Joint Working) (Scotland) Act 2014 which required integration of certain aspects of adult health and social services. As well as prescribed functions that had to be delegated additional functions could be included and these are captured in the Integration Scheme set out in Appendix 1.

The last meeting of the Orkney Integration Joint Board was on 30 April 2025.

2.3   Assessment

Key Points from the 30 April 2025 meeting include:

The Integration Joint Board approved Mr Ryan McLaughlin, NHS Staff Representative, Mr Danny Oliver, Council Staff Representative and Ms Frances Troup, Housing Representative on the Board. The Board also approved the Chair and Vice Chairs of the Joint Clinical and Care Governance Committee, and the Chairs of the Performance and Audit Committee and Strategic Planning Group.

The Board also noted the NHS voting and proxy members for the period to June 2025, and that Ms Joanna Kenny would take up the role of Chair of the Integration Joint Board in May 2025.

The Integration Joint Board took assurance from the Strategic Planning Group meeting from 14 March 2024, the Performance and Audit Committee meeting on 19 March 2025 and the Joint Clinical and Care Governance Committee on 2 April 2025.

The Annual Budget for 2025/26 was presented, highlighting a draft overspend position for 2024/25 estimated at £4.215 million, and approved. It was noted that a Financial Recovery Plan will be presented at the end of quarter 1, alongside the final position for 2024/25.

The Strategic Plan 2025 – 2028, pending some small amendments detailed discussed in the meeting was approved. The Plan focuses on six strategic priorities and aligns with national design principles and has been developed with input from a range of key stakeholders, ensuring alignment with local and national partners' strategies.

The Strategic Plan Delivery Plan 2025/26, the annual delivery plan which outlines the actions to be undertaken in the first year of the Strategic Plan, was approved pending some small amendments discussed in the meeting.

The Joint Clinical and Care Governance Committee Terms of Reference and Work Plan were presented for approval. Following a discussion, it was agreed that a small discussion on the Terms of Reference would be helpful and following that a briefing note with the revised Terms of Reference would be circulated.

The revised Communication and Engagement Strategy was approved, with plans to incorporate additional suggestions and develop an action plan for implementation.

Following discussion on the Risk Management Strategy, the Strategy was approved, and it was further agreed that a further discussion would be taken at the Performance and Audit Committee.

The Board considered the Equality Outcomes and Mainstreaming and approved the four current outcomes to continue for the next period.

The Suicide Prevention Action Plan was presented for Members awareness highlighting the actions which will be undertaken to progress the Scottish Government 10 year Strategy.

An update on the Kirkwall Care Facility was provide to Members for awareness.

2.3.1 Quality/ Patient Care
The Integration Joint Board aims to improve quality of care through joined up provision of services.

2.3.2 Workforce
There are no workforce implications directly arising as a result of this report.

2.3.3 Financial
There are no financial implications directly arising as a result of this report. There are close links between NHS Orkney's finance department and the Chief Officer and Chief Finance Officer.

2.3.4 Risk Assessment/Management
There are no risk implications directly arising as a result of this report.

2.3.5 Equality and Diversity, including health inequalities
There are no equality or diversity implications directly arising as a result of this report.

2.3.6 Climate Change Sustainability
There are no climate change implications directly arising as a result of this report.

2.3.7 Other impacts
There are no other implications directly arising as a result of this report.

2.3.7 Communication, involvement, engagement and consultation
The Integration Joint Board is a public meeting, where members of the public can attend in the viewing gallery at the Council Chamber or can listen to the audio casting of the meeting which is available for one year after the date of the meeting.

2.3.8 Route to the Meeting
This is a summary of the Integration Joint Board meeting key items and discussion.

2.4 Recommendation
- **Awareness** – For Members' information only.

3 List of appendices
- **Appendix 1**, Orkney Integration Scheme

Orkney Integration Scheme

Between

Orkney Islands Council

And

NHS Orkney

Date.	Issue.	Sections revised.	Status.	Distribution.
02.02.15.	V1.		Consultation.	Public Consultation.
16.03.15.	V2.		Final draft.	Integrated Programme Board.
24.03.15.	V3.		Consultation feedback.	Orkney Islands Council.
26.03.15.	V3.		Consultation feedback.	NHS Orkney.
31.03.15.	V4.		OIC/NHSO amendments.	OIC/NHSO.
15.05.15.	V5.		Amendments (GM) following feedback from Scot Gov.	OIC/NHSO.
23.07.15.	V6.		Amendments (CC) to update outstanding text and to redraft care and clinical governance section.	OIC/NHSO.
27.07.15.	V7.		Review of draft (GM, CG, CS and CC) presented to Integration Programme Board (23.7.15).	OIC/NHSO.
30.07.15.	V8.		Final updated draft (CC).	GM/JT/CG/CS/LW.
10.08.15.	V8(2).		Version with proposed amendment from AB at 9.3.	GM/AB/CC/CS (not yet agreed by NHS Orkney).
16.09.15.	V9.		Version with added finance (acute set aside) budget.	CC (to be agreed by OIC delegated to Convener and CEO and to be agreed by NHS Orkney).
29.09.15.	V10.		Version with amendments received from Govt colleagues.	CC (to be agreed by OIC delegated to Convener and CEO and to be agreed by NHS Orkney).
13.10.15.	V11.		Updated.	CC (to be agreed by OIC delegated to Convener

Date.	Issue.	Sections revised.	Status.	Distribution.
				and CEO and to be agreed by NHS Orkney).
19.10.15.	V12.		Updated.	CC and GM (agreed by both OIC and NHS Orkney).
12.01.18.	V13.	Annex 1 and Annex 2.	Updated.	CEO NHS Orkney and CEO OIC.
12.04.21.	V14.	5 year statutory review – general revision.	Updated.	All NHS Orkney / OIC leads.
27.04.21.	V15.	Track-changed version for informal consultation with the Scottish Government.	Updated.	Paul Richardson, Iain MacAllister, Glen Deakin. (Scottish Government).
17.08.21.	V16.	Changes following consultation with the Scottish Government.	Updated.	OIC/NHSO.

Contents

1. Introduction and Background

1.1. Foreword

1.1.1. The Public Bodies (Joint Working) (Scotland) Act 2014 requires health boards (constituted under section 2(1)(a) of the National Health Service (Scotland) Act 1978) and local authorities to integrate planning for, and delivery of certain adult health and social care services. These parties can also choose to integrate planning and delivery of other services including additional adult health and social care services beyond the minimum prescribed by Scottish Ministers and children's health and social care services.

1.1.2. The Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act") requires health boards and local authorities to prepare, agree and consult on an integration scheme setting out how this joint working is to be achieved. There is a choice of ways in which they may do this:

- The Health Board and local authority (both as defined in section 1.2 below) delegate the responsibility for planning, resourcing and operational oversight of integrated health and social care services to a third body called an integration authority or integration joint board under section 1(4) (a) of the Act. This integration model is commonly referred to as a body corporate arrangement.
- The Health Board or local authority takes the lead responsibility for planning, resourcing and delivery of integrated health and social care services (under section 1 (4) (b) (c) and (d) of the Act. This integration model is commonly referred to as a lead agency arrangement.

1.1.3. In Orkney, NHS Orkney and Orkney Islands Council have opted to delegate functions to an integration joint board. This board is a separate legal entity.

1.1.4. The original Scheme as defined in section 1.2 below was approved by the Scottish Ministers in February 2016 and the Board (which has a distinct legal personality) was established by an Integration Joint Board Order of the Scottish Ministers as defined in section 1.2.

1.1.5. As a separate legal entity, an integration joint board has full autonomy to act on its own behalf and can accordingly make decisions in regard to its responsibilities and functions as it sees fit. However, the legislation that underpins the board requires that its voting members are appointed by the Health Board and Local Authority and whilst serving on the integration joint board its members must carry out their functions under the Act on behalf of the integration joint board itself, and not as members of the Health Board or Local Authority. It is therefore important that because the same individuals sit on the Integration Joint Board and the Health Board or Local Authority, accurate recording keeping and minute taking are essential for transparency and accountability purposes.

1.1.6. The Integration Joint Board is responsible for the strategic planning and oversight of functions delegated to it and for ensuring the delivery of these functions through its chief officer and Local Operational Delivery Arrangements as set out within section 3 of this Scheme. However, the Act provides that the Health Board and the Local Authority, acting jointly, can require an Integration Joint Board to

replace their Strategic Plan (as defined in section 1.2) in certain circumstances on the basis that they are jointly accountable for the delivery of improvements in health and wellbeing, people's experience of services and achieving sustainable and affordable service for Orkney in the long term.

1.2. Definitions and Interpretation

1.2.1. In this Scheme, the following terms shall have the following meanings:

- "Board" means the Integration Joint Board as established by Order under section 9 of the Act.
- "Chair" means the Chair of the Integration Joint Board.
- "Chief Finance Officer" means the officer responsible for the administration of the Integration Joint Board's financial affairs appointed under section 95 of the Local Government (Scotland) Act 1973.
- "Chief Officer" means the Chief Officer of the Integration Joint Board whose role is defined in section 6 of this Integration Scheme.
- "Health Board" means the Orkney Health Board established under section 2(1) of the National Health Service (Scotland) Act 1978 and having its offices at The Balfour, Forelands Road, Kirkwall, Orkney, KW15 1NZ.
- "Integration Joint Board Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.
- "Integrated Services" means those services listed in both Annex 1 Part 2 and Annex 2 Part 2.
- "Local Authority" means Orkney Islands Council established under the Local Government (Scotland) Act 1994 and having its offices at School Place, Kirkwall, Orkney KW15 1NY.
- "Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act.
- "Parties" means Orkney Islands Council and Orkney Health Board (which may also be referred to as NHS Orkney).
- "Scheme" means this integration scheme.
- "Strategic Plan" means the plan which the Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults and children in accordance with section 29 of the Act.

1.3 Aims and Outcomes of the Integration Scheme

1.3.1. This Scheme is a legally binding contract between the Local Authority and the Health Board. This Scheme has established a body corporate arrangement as set out in section 1(4)(a) of the Act.

1.3.2. The purpose of the Board is to plan, resource and oversee the delivery of high quality health and social care services for and with the people of Orkney.

1.3.3. The main purpose of integration is to improve the health and wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This Scheme is intended to achieve the Outcomes, namely that:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

1.3.4. The national outcome for children is:

- We grow up loved, safe and respected so that we realise our full potential.

1.3.5. The national outcomes and standards for social work services in the criminal justice system are:

- Community safety and public protection.
- The reduction of re-offending.
- Social inclusion to support desistance from offending.

1.4. Our Vision and Values

1.4.1. Community Planning Vision and Values

1.4.1.1. The Local Authority, the Health Board and the Board are all members of the Partnership Board of Orkney's Community Planning Partnership and share the same values.

"To strengthen and support Orkney's communities by enabling those developments which will have a positive and substantiable socio-economic impact, and utilise locally-available resources, whilst striving to preserve and enhance the rich natural and cultural heritage assets upon which Orkney's economy and society depends".

1.4.1.2. The shared mission is: "Working together for a better Orkney" and the seven key values are:

- Resilience.

- Enterprise.
- Equality.
- Fairness.
- Innovation.
- Leadership.
- Sustainability.

The Orkney Partnership focuses its collective resources of the Partnership on a small number of strategic priorities at one time. At present, the strategic priorities are strong communities, living well and a vibrant economy.

The Board contributes to all of these priorities.

1.4.1.3. The Orkney Health and Care Partnership – the delivery arm of the Board, agreed its own mission statement in the first year of the formation of the Board. It is: "Working together to make a real difference".

1.4.2. Board Vision and Values

1.4.2.1. The Board approved its Strategic Plan 2019 – 2022 in 2019, which sets out the Board's visions as "Getting it right for Orkney" and the Board's values as 'person-centred, enabling, caring and empowering'.

2. Integration Scheme

2.1. The Parties

2.1.1.

In implementation of their obligations under the Act, the Parties hereby agree as follows:

2.1.1.1. In accordance with section 1(2) of the Act, the Parties have agreed that the integration model set out in section 1(4)(a) of the Act will be put in place for Orkney, namely the delegation of functions by the Parties to a body corporate that is to be established by order under section 9 of the Act 'an integration joint board'. This Scheme came into effect in April 2016, as set out in the Integration Joint Board Order which established the Board.

2.2. Local Governance Arrangements

2.2.1. In accordance with the Act, the Board has a legal personality distinct from the Parties, and the consequent authority to manage itself to:

- Prepare and implement a Strategic Plan in relation to the provision of health and social care services in accordance with the Act.
- Oversee the delivery of services delegated by the Parties in pursuance of the Strategic Plan.
- Allocate and manage the delegated budget in accordance with the Strategic Plan.

2.2.2. There is no role for either Party to independently sanction or veto decisions of the Board. However, the Act provides for the Health Board and the Local Authority, acting jointly, to require the Board to replace their Strategic Plan in certain circumstances given the Parties are jointly accountable for the delivery of improvements in health and wellbeing, people's experience of services and achieving sustainable and affordable services for Orkney in the long term.

2.3. Membership of the Board

2.3.1. Voting Members

- Three elected members of the Local Authority.
- Three non-executive directors of the Health Board, although article 3(5) of the Integration Joint Board Order permits otherwise if necessary.

2.3.2. Co-opted Non-voting Members

- The Chief Officer of the Board.
- The Chief Finance Officer of the Board.
- Senior clinicians including:
  o A registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978.
  o A registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract.
  o A registered medical practitioner employed by the Health Board and not providing primary medical services.
- The Local Authority's Chief Social Work Officer.
- A patient/service user representative.
- A carer's representative.
- A representative of the third sector.
- A staff representative from each of the Parties.

2.3.3. Chair and Vice-chair

2.3.3.1. An elected member of the Local Authority will be appointed to the role of Chair/Vice Chair by the Local Authority and be one of the elected members on the Board.

2.3.3.2. A non-executive member of the Health Board will be appointed to the role of the Chair/Vice Chair by the Health Board and be one of the non-executive Health Board members on the Board.

2.3.4. Period of Office

2.3.4.1. The Chair and Vice Chair rotate every two years in May, to enable the appointments of Chair and Vice Chair to rotate equally between the Local Authority and the Health Board. The Chair does not have a casting vote. All other appointments with the exception of the Chief Officer, Chief Finance Officer of the Board and the Chief Social Work Officer, who are members of the Board by virtue of the Regulations and the post they hold, will be for a period of two years.

2.3.4.2. In addition, individual Board appointments will be made as required when a position becomes vacant for any reason. Any member of the Board can be appointed for a further term.

2.3.4.3. The standing orders of the Board set out the dispute resolution mechanism to be used in the case of an equality of votes cast in relation to any decision put to a meeting of the Board.

2.4. Delegation of Functions

2.4.1. The functions that are delegated by the Health Board to the Board are set out in Part 1 of Annex 1. The services to which these functions relate, which are delegated by the Health Board and which are to be integrated are set out in Part 2 of Annex 1. The functions in Part 1 are being delegated only to the extent that they relate to services listed in Part 2 of Annex 1.

2.4.2. The functions that are delegated by the Local Authority to the Board are set out in Part 1 of Annex 2. The services to which these functions relate, which are delegated by the Local Authority and which are to be integrated are set out in Part 2 of Annex 2.

2.4.3. Both adult and children's services are included within this Scheme.

2.4.4. In exercising its functions, the Board must take into account the Parties' requirements to meet their respective statutory obligations. Apart from those functions delegated by virtue of this Scheme, the Parties retain their distinct statutory responsibilities and formal decision making roles.

3. Local Operational Delivery Arrangements

3.1. Responsibilities of the Board on behalf of the Parties

3.1.1. The Board has the responsibility for the planning of Integrated Services. This is achieved through the Strategic Plan.

3.1.2. The Board has responsibility for the operational oversight of Integrated Services.

3.1.3. In this regard the Health Board and the Local Authority will support the Board to fulfil its operational oversight role whilst remaining accountable for the operational delivery of health and care services which will be through the Chief Officer who in this regard is also responsible to the Board. The Chief Officer is line managed by the Chief Executives of both Parties.

3.1.4. The Board is responsible for the planning of those limited acute hospital services delegated to it. The Health Board is responsible for the operational delivery and management of all acute services. The Chief Officer and the senior manager responsible for the delivery and management of hospital services will ensure joint arrangements are in place to enable effective working relationships across the whole health and care system. The Health Board is responsible for providing information on a regular basis to the Board on the operational delivery of all acute services and associated spend.

3.1.5. The Chief Officer will continue to be a member of the senior management teams of both the Health Board and the Local Authority to ensure strategic links are maintained for the purposes of overall planning and policy development.

3.1.6. The Parties will continue to support the Board to work closely with Orkney's Community Planning Partnership Board to help contribute to the delivery of the wider community planning objectives notably addressing inequalities.

3.2 Corporate Support Services

3.2.1. The Parties will continue to provide appropriate corporate support to the Board as required and negotiated between the Board and the Parties. The detail of the agreement between the Parties and the Board in this regard will be set out in supplementary documentation to this Scheme. The agreement will include, but not be limited to the following service areas:

- Finance.
- HR/Personnel.
- IT.
- Administrative support.
- Performance reporting including risk management.
- Legal Services.
- Internal Audit.

3.2.2. Corporate Support Services arrangements will be reviewed annually as part of the budget setting and planning processes of the Parties and the Board. This will be achieved through discussion at the senior management teams of the Parties and through the regular accountability meetings with the Chief Executives and Chief Officer.

4. Strategic Plan

4.1. The Parties will continue to provide support for strategic planning through their respective strategic planning and Corporate Support Services systems. The Health Board will provide necessary activity and financial data for the planned use of services provided by other Health Boards for strategic planning purposes; and the Council will provide necessary activity and financial activity for the planned use by other Local Authorities for strategic planning purposes. This support to the Board will ensure compliance with its duty under s30(3) of the Act.

4.2. The Parties will inform the Board where they intend to make a change to service provision which may have an impact on the delivery of the Strategic Plan.

4.3. When preparing the Strategic Plan, the Board must ensure that it is consistent with the need to operate within the Board budget and determine and allocate a budget amount to each function that is to be carried out by one or both Parties.

4.4. Performance Targets, Improvement Measures and Reporting Arrangements

4.4.1. The Parties will identify a core set of indicators that relate to Integrated Services delegated to the Board as listed in Annexes 1 and 2 including the national indicators and targets that the Parties currently report against. A list of indicators and measures which relate to integration functions will be collated in an 'integration dashboard' known as the performance system.

4.4.2. The Parties will be responsible for sharing all performance information, targets and indicators with the Board. The improvement measures will be a combination of existing and new measures to allow assessment at a local level. The performance targets and improvement measures will be linked to the national and local Outcomes and will provide analysis to inform change and chart performance.

4.4.3. The dashboard/performance system once established will state where the responsibility for each measure lies. Where there is an ongoing requirement in respect of organisational accountability for a performance target for the Health Board or the Local Authority this will be taken into account by the Board when preparing the Strategic Plan.

4.4.4. The Parties are obliged to meet targets for functions which are not delegated to the Board but which are affected by the performance and funding of integration functions. The Parties also set a number of local targets which may similarly be affected. Therefore, when preparing performance management information, the Parties agree that the effect on both integration and non-integration functions must be considered and details provided to the Board for consideration when preparing the Strategic Plan. These targets are currently available and set out in the Local Authority's Council Plan monitoring report and the Health Board's Annual Operational Plan and in Performance Management Reports both to the Local Authority and to the Health Board.

4.4.5. Community Planning Outcome Targets are set out in the Local Outcomes Improvement Plan (LOIP).

5. Clinical and Care Governance

5.1. The detailed clinical and care governance arrangements have been approved taking account of the Scottish Government's Clinical and Care Governance Framework published in December 2014. These arrangements are set out below.

5.2. The Parties established a joint Clinical and Care Governance Committee ('CCGC') which replaced existing arrangements. The CCGC includes members of the Board and representatives of the relevant professional groups for all health and

social care professions. Details of the membership of the CCGC are set out in the terms of reference of the CCGC.

5.3. The CCGC will ensure that there is appropriate assurance for both the Board and the Health Board on the standards of health and care services provided.

5.4. The CCGC will fulfil the role with regard to the clinical governance arrangements of all the health services delivered or purchased by the Health Board as required by statute including health services delegated to the Board. The CCGC will also oversee the care governance arrangements for all social care services provided or purchased by the Local Authority delegated to the Board.

5.5. The CCGC will provide advice and information through direct reporting to the Parties and to the Board as necessary and required including input and advice from professional advisory groups, for example, Area Clinical Forum, Public Protection Committee and from professional lead officers working both in the Health Board and the Local Authority (social care services). The Chief Officers' Group (COG) will provide a report annually on the work of the Public Protection Committee and the implications for the local authority area to the CCGC.

5.6. Reports to the Parties and the Board will cover the quality of service delivery, continuous improvement, organisational and individual care risks, clinical and professional standards and the compliance with legislation and guidance.

5.7. The Board will be responsible for ensuring the Strategic Plan is consistent with good Clinical and Care Governance and is appropriately informed on the relevant clinical and care standards and will be guided on this by the CCGC.

5.8. The CCGC will provide advice as necessary to the Strategic Planning Group and localities.

5.9. The Parties, as the bodies employing the staff and being directed to provide the services, will be responsible for ensuring the clinical and care governance standards are delivered. This will apply to services provided directly by the Parties or purchased from other health boards, local authorities, and third and independent sector providers.

5.10. The Parties will be responsible through commissioning and procurement arrangements for the quality and safety of services procured from the third and independent sectors and ensure that the services are delivered in accordance with the Strategic Plan.

5.11. The Chief Officer manages the Integrated Services and is accountable for these through the Parties' Chief Executives. The Chief Officer is accountable for the care standards and safe delivery of these Integrated Services i.e. ensuring that they are person centred, effective and delivered to agreed clinical and care governance standards.

5.12. Working alongside the Chief Officer the Parties will ensure that staff working in integrated services have the necessary skills and knowledge to deliver the appropriate standards of care. Managers will manage teams of Health Board staff,

Local Authority staff or both and will promote best practice, cohesive working and provide guidance and development to their teams. This will include effective staff supervision and implementation of staff support policies.

5.13. The clinical and care governance arrangements require appropriate oversight of professional standards. A number of professional lead officer roles are in place across the Local Authority and the Health Board e.g. Medical Director, Director of Nursing, Midwifery and Allied Health Professions, Chief Social Work Officer (CSWO), Director of Public Health and Chief Pharmacist. The professional lead officers have statutory functions relating to professional regulatory bodies and a legal duty to their respective regulatory authorities to ensure that professional standards are maintained.

5.14. The professional lead officer can provide professional advice to, or raise issues directly with, the Board, in writing, or through the representatives on the Board. The Parties would expect the Board to respond in writing to issues raised in this way. In addition, the professional lead officers will be responsible for reporting directly to the Local Authority (CSWO) or the Health Board (Medical, Nurse, Dental, Pharmacy and Public Health Directors).

5.15. The Parties and the Board will continue to support the Chief Officer and the professional lead officers to liaise and communicate regularly to ensure that their respective roles in relation to professional standards are met.

5.16. The members of the Board will continue to actively promote through its planning and commissioning role an organisational culture that supports human rights and social justice; values partnership working through example; affirms the contribution of staff through the application of best practice, including learning and development; and is transparent and open to innovation, continuous learning and improvement.

6. Chief Officer

6.1. The Board shall appoint a Chief Officer in accordance with section 10 of the Act. The arrangements in relation to the Chief Officer agreed by the Parties are:

6.2. The Chief Officer reports directly to both the Chief Executive of the Local Authority and the Chief Executive of the Health Board and is a full member of the senior management teams of both the Local Authority and the Health Board.

6.3. The management structure for operational delivery of the Integrated Services managed by the Chief Officer is through a single hierarchical management structure illustrated in the detailed organisational structure diagram, which is included in supplementary documentation to the Scheme. The management structure and levels of authority including the management of services in localities are summarised in supplementary documentation to the Scheme.

6.4. The Chief Executives of the Local Authority and the Health Board, at the request of the Board and in conjunction with the Chief Officer where appropriate, are responsible for making cover arrangements through the appointment or nomination

of a suitable interim replacement or depute in the event that the Chief Officer is absent or otherwise unable to carry out their functions.

6.5. The Chief Officer and the senior manager for acute services both sit on the Health Board senior management team, and will continue with joint arrangements to ensure effective working relationships across the whole health and care system.

7. Workforce

7.1. The Parties will continue to ensure that there is an effective joint staff forum where staffing issues, professional issues and concerns relevant to joint working can be raised and discussed, where difficulties can be explored and resolved and where shared routes forward can be agreed. The structure and membership of groups are set out in supplementary documentation to the Scheme.

7.2. A workforce development strategy and action plan will continue to be maintained by the staff supporting the HR strategic management of the delivery of the Integrated Services that is under the direction of the Chief Officer including services delivered in localities.

7.3. A training plan agreed by the Parties and agreed with the Board will be maintained as part of the supplementary documentation to the Scheme. Training support functions will be provided by the Parties to the integrated services managed by the Chief Officer. The training plan will be refreshed annually.

8. Finance

8.1. General Principles – Financial Governance

8.1.1. The Board shall continue to determine its own internal financial governance arrangements in line with Scottish Government guidance. The Chief Finance Officer will continue to respond to the decisions of the Board and the principles of financial governance that have been set out in this Scheme.

8.1.2. The Board will continue to have no cash transactions and, until directed otherwise, will not directly engage or provide grants to third parties.

8.1.3. The Local Authority and the Health Board will ensure their payments to the Board are sufficient to fund the delegated functions. The Local Authority and the Health Board will continue to provide an integrated budget for the Board and the Chief Executives of the Health Board and the Local Authority through the Officer appointed pursuant to section 95 of the Local Government (Scotland) Act 1973 will continue to hold the Chief Finance Officer of the Board to account for the use of the financial resources allocated to the Board for the delegated functions that shall be managed by the Chief Officer. Both Partners agree to make a revenue contribution to the Board representing the level of resources available for the service areas delegated to the Partnership.

8.1.4. The Board will continue to monitor its financial position and make arrangements for the provision of regular, timely, reliable and relevant financial information on its financial position. The Board, the Local Authority and the Health Board will share financial information to ensure all Parties have a full understanding

of their current financial information and future financial challenges and funding streams.

8.1.5. The Board will maintain its own financial regulations. These will be reviewed periodically by the Chief Finance Officer and with a report on the review and proposed changes submitted to the Board.

8.2 Chief Finance Officer

8.2.1. The Board will continue to have regard to the current CIPFA guidance on the role of the Chief Finance Officer in local government and any Scottish Government or professional guidance on the operating parameters of the Chief Finance Officer and also on the appointment of a Chief Finance Officer.

8.3. Roles and Responsibilities – Finance

8.3.1. The Chief Finance Officer will continue to be responsible for preparing the Board accounts (including gaining the assurances required for the governance statement) and financial planning (including the financial section of the Strategic Plan) and will provide financial advice and support to the Chief Officer and the Board ensuring compliance with statutory reporting requirements as a body under the relevant legislation, including the Annual Financial Statement.

8.3.2. The officer appointed by the Local Authority pursuant to section 95 of the Local Government (Scotland) Act 1973 and the Health Board's Accountable Officer (Chief Executive) are responsible for the resources that are allocated by the Board to their respective organisations for operational delivery.

8.3.3. The Chief Finance Officer will continue to work with the officer appointed by the Local Authority pursuant to section 95 of the Local Government (Scotland) Act 1973 and the Health Board's Director of Finance to ensure both organisations work together to develop systems which allow the recording and reporting of the Board's financial transactions.

8.4. Resources Delegated to the Board

8.4.1. The Board's three year Strategic Plan will continue to incorporate a Medium Term Financial Plan for its resources. On an annual basis a financial statement will be prepared setting out the amount the Board intends to spend to implement its three year Strategic Plan. The Medium Term Financial Plan will be prepared for the Board following discussions with the Local Authority and the Health Board. The approved Plan will be supplied to the partner organisation in regard to plans on achieving efficiency savings and financial balance.

8.4.2. The Medium Term Financial Plan will be prepared to take account of the previous year payment as a baseline that will be adjusted to take account of:

- Activity changes arising from the impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes.
- Cost inflation on pay and other costs.
- Efficiency savings that can be applied to budgets.

- Performance on outcomes. The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Council and the Health Board.
- Legal requirements that result in additional and unavoidable expenditure commitments.
- Transfers to/from the set aside budget for hospital services.
- Budget savings required to ensure budgeted expenditure is in line with funding available including an assessment of the impact and risks associated with these savings.

8.4.3. The funding available to the Board will be dependent on the funding available to the Local Authority and the Health Board and the corporate priorities of both. Both Parties will provide indicative three year allocations to the Board subject to annual approval through the respective budget setting processes. These indicative allocations will take account of changes in NHS funding and changes in local authority funding.

8.4.4. The budgets for the integrated services will be pooled by the Board under the direction of the Chief Officer supported by the Chief Finance Officer. The pooled budget envelope for each theme in the Strategic Plan will be prioritised and detailed budget allocations will be made for the services to be delivered by the Parties under the direction of the Board in line with the agreed priorities set out in the Strategic Plan and any associated strategic planning document.

8.5. Financial Management of the Board

8.5.1. The Board is able to hold reserves. There is an expectation that they will achieve a break-even position each year unless there are clear plans to create/utilise reserves. The Board cannot budget for a position which would result in the reserves moving into a deficit.

8.5.2. The Local Authority will host the financial transactions specific to the Board.

8.5.3. The term payment is used to maintain consistency with legislation and does not represent physical cash transfer. As the Board does not operate a bank account, the net difference between payments into and out of the Board will result in a balancing cash payment between the Local Authority and the Health Board. Any cash transfer will take place between the Parties monthly in arrears based on the annual budgets set by the Parties and the directions from the Board. A final transfer will be made at the end of the financial year on closure of the annual accounts of the Board to reflect in-year budget adjustments agreed. An initial schedule of payments will be agreed within the first 40 working days of each new financial year and may be updated taking into account any additional payments in-year.

8.6. In Year Variations in the Spending of the Board

8.6.1. Any potential deviation from a break even position should be reported to the Board, the Local Authority and the Health Board at the earliest opportunity.

8.6.2. Where it is forecast that an overspend will arise then the Chief Officer and Chief Finance Officer of the Board will identify the cause of the forecast overspend

and in consultation with both Parties, prepare a recovery plan setting out how they propose to address the forecast overspend and return to a breakeven position. The Chief Officer and Chief Finance Officer of the Board will consult the officer appointed by the Local Authority pursuant to section 95 of the Local Government (Scotland) Act 1973and Director of Finance of the Health Board in preparing the recovery plan as part of a one system approach. The recovery plan shall be approved by the Board.

8.6.3. A recovery plan will aim to bring the forecast expenditure of the Board back in line with the budget within the current financial year. Where an in year recovery cannot be achieved then any recovery plan that extends into later years should ensure that over the period of the strategic plan forecast expenditure does not exceed the resources made available. Any recovery plan extending beyond in year will require approval of the Local Authority and the Health Board in addition to the Board.

8.6.4 Where a recovery plan extends beyond the current year any shortfall (the amount recovered in later years) will be charged to reserves held by the Board.

8.6.5. Where such recovery plans are unsuccessful and an overspend occurs at the financial year end, and there are insufficient reserves to meet the overspend, then the partners will be required to make additional payments to the Board. Such arrangements should describe additional recovery plans and a clear formal agreement by the Board and the Parties to break even within a defined timescale.

8.6.6. Subject to there being no outstanding payments due to the partner bodies, the Board will retain any underspend to build up its own reserves and the Chief Finance Officer will update the reserves policy for the Board as and when required.

8.6.7. Redeterminations to payments made by the Local Authority and the Health Board to the Board would apply under the following circumstances:

- Additional one off funding is provided to the Partner bodies by the Scottish Government, or some other body, for expenditure within a service area delegated to the Board. This would include in year allocations for NHS and redeterminations as part of the local government finance settlement. The payments to the Board should be adjusted to reflect the amount of these as they relate to the delegated services.
- The Parties agree that an adjustment to the payment is required to reflect changes to demand and activity levels.
- Where either Party requires to reduce the payment to the Board any proposal requires a justification to be set out and then agreed by both Parties and the Board.

8.6.8. Where payments by the Local Authority and the Health Board are agreed under paragraphs 8.4 to 8.6.7 above they should only be varied as a result of the circumstances set out in paragraph 8.6.7. Any proposal to amend the payments outwith the above, including any proposal to reduce payments as a result of changes in the financial circumstances of either the Local Authority or the Health Board requires a justification to be set out and the agreement of both Parties.

8.7. Financial Reporting to the Board

8.7.1. The responsibility for preparation of the annual accounts of the Board will continue to rest with the Chief Finance Officer of the Board. The reporting requirements for the annual accounts are set out in legislation and regulations and will be prepared following the CIPFA Local Authority Code of Practice.

8.7.2. The Board is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973 (section 13). This will continue to require audited annual accounts to be prepared under the reporting requirements specified in the relevant legislation and regulations (section 12 of the Local Government in Scotland Act 2003 and regulations under section 105 of the Local Government (Scotland) Act 1973). These will be proportionate to the limited number of transactions of the Board whilst complying with the requirements for transparency and true and fair reporting in the public sector.

8.7.3. The Chief Finance Officer of the Board will agree a timetable for the preparation of the annual accounts with the external auditors, Director of Finance of the Health Board and the officer appointed by the Local Authority pursuant to section 95 of the Local Government (Scotland) Act 1973. The timetable for production of the annual accounts of the Board will be set in accordance with guidance from the Scottish Government.

8.7.4. As part of the financial year-end procedures and in order to develop the year-end financial statements, the Chief Finance Officer of the Board will co-ordinate an exercise agreeing the value of balances and transactions with the Local Authority and the Health Board finance teams. Each of the Parties will submit to the Chief Finance Officer of the Board their recorded income, expenditure, receivable and payable balance with the Board. The Local Authority or Health Board respective finance representatives will then work to resolve any differences arising.

8.7.5. As part of the process of preparing the annual accounts of the Board the Chief Finance Officer will be responsible for agreeing balances between the Board, Local Authority and Health Board during the financial year. The Chief Finance Officer will also be responsible for provision of other information required by the Local Authority and the Health Board to complete their annual accounts including group accounts.

8.7.6. The Chief Finance Officer will ensure appropriate systems and processes are in place to:

- Allow execution of financial transactions.
- Ensure an effective internal control environment over such transactions.
- Maintain a record of the income and expenditure of the Board.
- Enable reporting of the financial performance and position of the Board.
- Maintain records of budgets, budget savings, forecast outturns, variances, variance explanations, proposed remedial actions and financial risks.

8.7.7. Recording of all financial information in respect of the integrated services will be in the financial ledger of the Party which is delivering the services on behalf of the Board.

8.7.8. The Parties will provide the required financial administration to enable the transactions for delegated functions (e.g. payment of suppliers, payment of staff, raising of invoices etc.) to be administered and financial reports to be provided to the Chief Finance Officer.

8.7.9. Throughout the financial year the Board will receive comprehensive financial monitoring reports, including for the sum set aside. The format and frequency (on at least a quarterly basis) of the reports will be agreed by the Chief Officer and the Chief Finance Officer in conjunction with the Director of Finance of the Health Board and the officer appointed by the Local Authority pursuant to section 95 of the Local Government (Scotland) Act 1973. The reports will set out information on actual expenditure and budget for the year to date and forecast outturn against annual budget together with explanations of significant variances and details of any action required. These reports will also set out progress with achievement of any budgetary savings required.

8.7.10. Where any report to the Board has a significant financial implication for either of the Parties agreement of that Party is required before submission of the report to the Board.

8.8. Capital Expenditure and Non-Current Assets

8.8.1. The Board will not receive any capital allocations or grants nor will it own any property or other non-current assets. The Local Authority and the Health Board will:

- Continue to own any property or non-current assets used by the Board.
- Have access to sources of funding for capital expenditure.
- Manage and deliver any capital expenditure on behalf of the Board.

8.8.2. The Strategic Plan will inform the financial strategy of the Board and will provide the basis for the Board to present proposals to the Local Authority and the Health Board to influence the Parties' financial five year Plans.

8.8.3. The Chief Officer will work with the relevant officers in the Local Authority and the Health Board to prepare a bid for capital funding for property and other non-current assets used by the Board. This will be approved by the Board.

8.9. VAT

8.9.1 The Board will not be required to be registered for VAT, on the basis that it is not delivering any supplies that fall within the scope of VAT. The actual delivery of functions delegated to the Board will continue to be the responsibility of the Local Authority and the Health Board.

9. Participation and Engagement

9.1. The review of the Scheme has involved consultation with the 'standard consultees' set out in the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014, which apply to preparing an integration scheme or revised integration schemes. These consultees are set out below:

- Health professionals.

- Users of health care.
- Carers of users of health care.
- Commercial providers of health care (if operating within the area to which the Scheme applies).
- Non-commercial providers of health care.
- Social care professionals.
- Users of social care.
- Commercial providers of social care (if operating within the area to which the Scheme applies).
- Non-commercial of social care.
- Staff of the Health Board and Local Authority who are not health professionals or social care professionals.
- Non-commercial providers of social housing.
- Third sector bodies carrying out activities to health or social care.

9.2. In the support that the Parties provide to the Board they will ensure they adhere to a person centred approach, ensuring compassion, respect, equality and fairness. Community and staff involvement and engagement remain crucial to supporting the Board in planning and implementing effective service change and service development, as well as supporting the Board in its commitment to realising continuous improvement in quality, effectiveness and efficiency in service delivery and outcomes.

9.3. The Parties will build on their existing solid foundations, to support the Board's approach to participation and engagement. Further, the Parties will support the Board by taking a coproduction approach within communities and localities.

9.4. To inform this, the Parties will take account of current Statutory Guidance CEL 4 (2010) Informing, Engaging and Consulting with People in Developing Health and Community Care Services and the 'National Standards for Community Engagement' as incorporated in the Orkney Community Planning Partnership's Consultation and Engagement Guidelines as adopted by the Local Authority and the Health Board.

9.5. The Parties, in supporting the Board, will establish a communications and engagement group. The group will be responsible for the development, implementation and monitoring of the communications and engagement strategy. The Group will be in place by September 2015 and the Strategy will be approved by March 2016. Feedback from communities and staff on their experiences of the Board's services will help inform the development of the Strategy.

9.6. Whilst formal arrangements are essential for the Board, they need not be constraining. There is a history in Orkney of involving community representatives on review and project groups and using the co-chair model to advantage. The aim is to maintain this inclusive approach, keeping communities at the heart of the process, within the framework of robust organisational arrangements. Ongoing positive relationships with Voluntary Action Orkney, Orkney's community councils, specialist organisations, care groups, independent care providers, and other health and social

care related community and voluntary groups will add richness to this inclusive approach.

10. Information Sharing and Confidentiality

10.1. The Chief Officer will ensure that the Information Sharing Protocol ('ISP') remains in place, and that the Scottish Accord on the Sharing of Personal Information ('SASPI') continues to be adopted. Information will continue to be shared in accordance with the Data Protection Act (2018) and Information Commissioner's Code of Practice on Data Sharing. The ISP will include procedures for the sharing of information and will be agreed with the Parties.

10.2. The ISP will remain focused on the purposes underlying the sharing of specific sets of information. It is intended for operational management and staff. It provides details of:

- The processes for sharing information.
- The specific purposes served.
- The people it impacts upon.
- The relevant legislative powers.
- What data is to be shared.
- The consent processes involved.
- Any required operational procedures and processes for review.

10.3. The ISP will be formally reviewed on a rolling three year basis unless changes in legislation or national policy indicate that this should be reviewed earlier.

10.4. The Chief Officer will ensure appropriate arrangements are in place in respect of information governance and the requirements of the Scottish Information Commissioner's Office.

10.5. All staff managed within Integrated Services are required to comply with the data protection policies of their employing organisations and the requirements of the ISP.

11. Complaints and compliments

11.1. Complaints provide valuable information which can be used to improve service provision and customer satisfaction. The set of applicable complaints handling procedures enable the Board and the delegated services to address a customer's dissatisfaction and may help to prevent the same problem from happening again, contributing to the continuous improvement of services. The three complaints procedures are: the Board's Complaint Handling Procedure 2021 which is for complaints about the Board as a governance body; the Social Work Complaints Handling Procedure, which is for service users and carers who receive social work and social care services; and the Health Board's Complaints Handling Procedure, which is for service users who receive health care services. The requirement for separate policies reflect distinct statutory requirements, although all three procedures are based on the Scottish Public Services Ombudsman's Model Complaints Handling Procedure. There will remain a single administrative point of

contact for complainants for each Party to co-ordinate complaints specific to the delegated functions to ensure that the requirements of existing prescribed elements of health and social work complaints processes are met. In the event that complaints are received by the Board or the Chief Officer, the Parties will work together to achieve, where possible a joint response identifying the lead Party in the process and confirming this to the individual raising the complaint.

11.2. All complaints procedures will be clearly explained, well publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services. The person making the complaint will always be informed which policies are being applied to their complaint. Both Parties are committed to ensuring that anyone making a complaint has a positive experience that takes account of the integrated arrangements. If the complaint remains unresolved by internal processes, the complainant may refer the matter to the Scottish Public Services Ombudsman through the relevant complaints handling procedure.

11.3. Compliments will also be recorded in line with the Parties' existing policies and processes.

11.4. Complaints management will be a standing item on the agenda of the Clinical and Care Governance Committee (referred to at 5.), the remit of which will include identifying learning from upheld complaints across all delegated functions. With the support of the Parties' complaints officers, the Chief Officer will report statistics on complaint outcomes and compliments to the Board and ensure information briefings are provided to staff so that integrated services are made aware of complaint findings and the learning for services.

12. Claims, Handling Liability and Indemnity

12.1. The Parties and the Board recognise that they could receive a claim arising from, or which relates to, the work undertaken on behalf of the Board.

12.2. The Parties agree to ensure that any such claims are progressed quickly and in a manner which is agreeable between them.

12.3. So far as reasonably practicable, the normal common law and statutory rules relating to liability will apply.

12.4. Each Party will assume responsibility for progressing claims which relate to any act or omission on the part of one of their employees.

12.5. Each Party will assume responsibility for progressing claims which relate to any building which is owned or occupied by them.

12.6. In the event of any claim against the Board or in respect of which it is not clear which party should assume responsibility, the Chief Officer will liaise with the Chief Executives of the Parties (or their representatives) and determine which party should assume responsibility for progressing the claim.

13. Risk Management

13.1. A shared risk management strategy will remain in place and will include risk monitoring and a reporting process for the Parties and the Board. In maintaining, reviewing and monitoring this shared risk management strategy the Chief Officer will review the corporate/strategic risk registers of the Parties and the Board which will provide a list of risks to be incorporated into the Partnership's risk register and service risk registers. The Chief Officer will utilise the system of one of the Parties to avoid duplication.

13.2. The Chief Officer will lead the review of risk management arrangements of the Board with support from the risk management functions of the Parties. The Board will be required to regularly update and agree its approach to risk management and how it communicates strategic risks to the Parties by the Chief Officer. The Board in this regard will pay due regard to the corporate risks of the Parties.

13.3. Any agreement on the sharing of risk management across the Parties and the Board for significant risks that impact on integrated service provision will be set out in the risk management strategy and Board risk register.

14. Dispute Resolution Mechanism

14.1. In the event of any dispute between the Parties in relation to any matter provided for in this Scheme or any of the duties, obligations, rights or powers imposed or conferred upon them by the Act ('Dispute'), the provision of this section 14 will apply.

14.2. Either Party will give to the other written notice of the Dispute, setting out its nature and full particulars (a Dispute Notice), together with relevant supporting documents. The party giving the Dispute Notice will provide a copy to the Chair of the Board. On service of the Dispute Notice, the Chief Executives of the Parties will meet and attempt in good faith to resolve the Dispute.

14.3. Where the matter remains unresolved within 21 days of the service of the Dispute Notice the Parties will inform the Chair of the Board and may proceed to mediation with a view to resolving the issues. Any mediator will be external to the Parties and will be identified and appointed with the agreement of the Chair of the Health Board and Leader of the Local Authority - costs will be met equally. The timeframe to resolve the issue will be agreed prior to the start of the mediation process by the Leader of the Local Authority and Chair of the Health Board and notified to the Chair of the Board. If agreement cannot be reached a referral will be made to the President of The Law Society of Scotland inviting the President to appoint a mediator.

14.4. The Chair of the Board will inform Scottish Ministers in writing of the Dispute and agreed timetable to conclude the mediation process. During this time both Parties will cooperate with each other to mitigate any adverse effect on service delivery pending resolution of the Dispute.

14.5. If the issue remains unresolved after following the steps outlined above, the Chair of the Board will inform Scottish Ministers in writing. Scottish Ministers may then advise the Parties how to proceed.

14.6. Nothing in the Scheme will prevent either Party from seeking legal remedy or from commencing or continuing court proceedings in relation to a Dispute.

Annex 1. (Part 1). Functions that are to be delegated by the Health Board to the Board.

Functions delegated under section 1(6) of the Act

The National Health Service (Scotland) Act 1978(a).	
All functions of Health Boards conferred by, virtue of, the National Health Service (Scotland) Act 1978.	Except functions conferred by or by virtue of: • Section 2(7) (Health Boards). • Section 9 (local consultative committees). • Section 17A (NHS contracts). • Section 17C (personal medical or dental services). • Section 17J (Health Boards' power to enter into general medical services contracts). • Section 28A (remuneration for Part II services). • Section 48 (residential and practice accommodation). • Section 57 (accommodation and services for private patients). • Section 64 (permission for use of facilities in private practice). • Section 79 (purchase of land and moveable property). • Section 86 (accounts of Health Boards and the Agency). • Section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services). • Paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act(Health Boards). And functions conferred by — • The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000. • The Health Boards (Membership and Procedure) (Scotland) Regulations 2001.

	- The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004. - The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 . - The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006. - The National Health Service (Discipline Committees) (Scotland) Regulations 2006. - The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009. - The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009. and - The National Health Service (General Dental Services) (Scotland) Regulations 2010.

Disabled Persons (Services, Consultation and Representation) Act 1986.

Section 7 (persons discharged from hospital).

Community Care and Health (Scotland) Act 2002.

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.

Mental Health (Care and Treatment) (Scotland) Act 2003.

All functions of Health Boards conferred by, or by virtue Except functions conferred by section 22 (approved of, the Mental Health (Care and Treatment) (Scotland) medical practitioners) Act 2003.

Education (Additional Support for Learning) (Scotland) Act 2004.

Section 23 (other agencies etc. to help in exercise of functions under this Act).

Public Health, etc. (Scotland) Act 2008.

Section 2 (duty of Health Boards to protect public health); Section 7 (joint public health protection plans).

Public Services Reform (Scotland) Act 2010.

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010; Except functions conferred by — section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).

| **Patient Rights (Scotland) Act 2011.** |
| All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011. |
| **Children and Young People (Scotland) Act 2014** |
| All functions of Health Boards conferred by, or by virtue of, Part 4 (provision of named persons) and Part 5 (child's plan) of the Children and Young People (Scotland) Act 2014. |
| **Carers (Scotland) Act 2016.** |
| Section 12 (Duty to prepare young carer statement); Section 31 (Duty to prepare local carer strategy). |

Functions delegated under section 1(8) of the Act

The National Health Service (Scotland) Act 1978	
	Except functions conferred by or by virtue of— • section 2(7) (Health Boards); • section 2CB1 (functions of Health Boards outside Scotland); • section 9 (local consultative committees); • section 17A (NHS contracts); • section 17C (personal medical or dental services); • section 17I (use of accommodation); • section 17J (Health Boards' power to enter into general medical services contracts); • section 28A (remuneration for Part II services); • section 38 (care of mothers and young children); • section 38A (breastfeeding); • section 39 (medical and dental inspection, supervision and treatment of pupils and young persons); • section 48 (residential and practice accommodation); • section 55 (hospital accommodation on part payment); • section 57 (accommodation and services for private patients);

	- section 64 (permission for use of facilities in private practice); - section 75A (remission and repayment of charges and payment of travelling expenses); - section 75B (reimbursement of the cost of services provided in another EEA state); - section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013); - section 79 (purchase of land and moveable property); - section 82 use and administration of certain endowments and other property held by Health Boards); - section 83 (power of Health Boards and local health councils to hold property on trust); - section 84A (power to raise money, etc., by appeals, collections etc.); - section 86 (accounts of Health Boards and the Agency); - section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); - section 98 (charges in respect of nonresidents); and - paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);
	and functions conferred by— - The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; - The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302; - The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000;

	- The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; - The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018; - The National Health Service (Discipline Committees) (Scotland) Regulations 2006; - The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006; - The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; - The National Health Service (General Dental Services) (Scotland) Regulations 2010; and - The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011.

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7 (Persons discharged from hospital)

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— - section 22 (approved medical practitioners); - section 34 (inquiries under section 33: co-operation); - section 38 (duties on hospital managers: examination, notification etc.); - section 46 (hospital managers' duties: notification); - section 124 (transfer to other hospital); - section 228 (request for assessment of needs: duty on

	- local authorities and Health Boards); - section 230 (appointment of patient's responsible medical officer); - section 260 (provision of information to patient); - section 264 (detention in conditions of excessive security: state hospitals); - section 267 (orders under sections 264 to 266: recall); - section 281 (correspondence of certain persons detained in hospital);
	and functions conferred by— - The Mental Health (Safety and Security) (Scotland) Regulations 2005; - The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005; - The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and - The Mental Health (England and Wales Crossborder transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.
Education (Additional Support for Learning) (Scotland) Act 2004 Section 23 (other agencies etc to help in exercise of functions under this Act.	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— - section 31 (public functions: duties to provide information on certain expenditure etc.); and - section 32 (public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011	

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by The Patient Rights (complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/3623.

Annex 1 (Part 2). Services currently provided by Health Board which are to be integrated.

- Accident and emergency services provided in the Balfour Hospital for planning and operational oversight purposes with the Chief Officer working closely with Board staff responsible for operational management of hospital services.
- Inpatient hospital services/budgets provided within the Balfour Hospital and capacity in the delegated specialties used in other hospitals located in other Health Boards will form the set aside portion of the hospital budget.
- Macmillan palliative care services provided in the Balfour Hospital also includes cancer chemotherapy. It is proposed that the service is not split into hospital palliative and cancer care, however it is proposed to allocate a number of bed days (corresponding budget).
- Mental health services provided in a hospital – transfer bed budget to the IJB.
- Community mental health teams/service.
- Clinical Psychology Service.
- Substance misuse services (ADP budget).
- District nursing services.
- Health visiting.
- School nursing.
- Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978.
- General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978.
- Public Dental Services.
- Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978.
- Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978.
- Services providing primary medical services to patients during the out-of-hours period.
- Palliative care services provided outwith a hospital.
- Community learning disability services.
- Continence services.
- Services provided by health professionals that aim to promote public health.
- Community Physiotherapy, speech and language, dietetic and OT services.
- Intermediate Care services.
- Family Health Service Prescribing.

- Resource Transfer, including Voluntary services.

Annex 2 (Part 1). Functions delegated by the Local Authority to the Board.

Set out below is the list of functions that must be delegated by the Local Authority to the Board, as set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions, etc.) (Scotland) Regulations 2014. Following this, a second list of additional local authority functions is set out which are to be delegated by choice. These fall within the relevant sections of the Acts set out in the Schedule to the Public Bodies (Joint Working) (Scotland) Act 2014.

Part 1.

Functions which must be delegated by the Local Authority to the Board for the purposes of section 1(7) of the Act.

Enactment conferring function.	Limitation.
National Assistance Act 1948.	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc).	
The Disabled Persons (Employment) Act 1958.	
Section 3 (Provision of sheltered employment by local authorities).	
The Social Work (Scotland) Act 1968	
Section 1 (Local authorities for the administration of the Act).	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities).	So far as it is exercisable in relation to another integration function.
Section 8 (Research).	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc for social work).	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities).	Except insofar as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs).	So far as it is exercisable in relation to another integration function.
Section 28 (Burial or cremation of the dead).	So far as it is exercisable in relation to persons cared for or assisted under another integration function.

Enactment conferring function.	Limitation.
Section 29 (power of local authority to defray expenses of parent, etc., visiting persons or attending funerals).	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision).	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly).	
Disabled Persons (Services, Consultation and Representation) Act 1986(5).	
Section 2 (Rights of authorised representatives of disabled persons).	
Section 3 (Assessment by local authorities of needs of disabled persons).	
Section 7 (Persons discharged from hospital).	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer).	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000.	
Section 10 (Functions of local authorities).	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed).	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed).	Only in relation to residents of establishments which are managed under integration functions.

Enactment conferring function.	Limitation.
Section 41 (Duties and functions of managers of authorised establishment).	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account).	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (Statement of resident's affairs).	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment).	Only in relation to residents of establishments which are managed under integration functions.
Section 45 (Appeal, revocation, etc.).	Only in relation to residents of establishments which are managed under integration functions.
The Housing (Scotland) Act 2001.	
Section 92 (Assistance for housing purposes).	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002.	
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland).	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions).	
The Mental Health (Care and Treatment) (Scotland) Act 2003.	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission).	
Section 25 (Care and support services, etc.).	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development).	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel).	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire).	

Enactment conferring function.	Limitation.
Section 34 (Inquiries under section 33: Co-operation).	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards).	
Section 259 (Advocacy).	
The Housing (Scotland) Act 2006.	
Section 71(1)(b) (Assistance for housing purposes).	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007.	
Section 4 (Council's duty to make inquiries).	
Section 5 (Co-operation).	
Section 6 (Duty to consider importance of providing advocacy and other).	
Section 11 (Assessment Orders).	
Section 14 (Removal orders).	
Section 18 (Protection of moved person's property).	
Section 22 (Right to apply for a banning order).	
Section 40 (Urgent cases).	
Section 42 (Adult Protection Committees).	
Section 43 (Membership).	
Social Care (Self-directed Support) (Scotland) Act 2013.	
Section 5 (Choice of options: adults).	
Section 6 (Choice of options under section 5: assistances).	
Section 7 (Choice of options: adult carers).	
Section 9 (Provision of information about self-directed support).	
Section 11 (Local authority functions).	
Section 12 (Eligibility for direct payment: review).	

Enactment conferring function.	Limitation.
Section 13 (Further choice of options on material change of circumstances).	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery).	
Section 19 (Promotion of options for self-directed support).	
Carers (Scotland) Act 2016.	
Section 6 (Duty to prepare adult carer support plan).	
Section 21 (Duty to set local eligibility criteria).	
Section 24 (Duty to provide support).	
Section 25 (Provisions of support to carers: breaks from caring).	
Section 31 (Duty to prepare local carer strategy).	
Section 34 (Information and advice services for carers).	
Section 35 (Short breaks services statements).	

Part 2

Functions which are conferred by an enactment and are delegated by the Local Authority to the Board pursuant to section 1(5)(a) of the Act.

Enactment conferring function.	Limitation.
National Assistance Act 1948.	
Section 45 (Recovery in cases of misrepresentation or non-disclosure).	
Matrimonial Proceedings (Children) Act 1958.	
Section 11(Reports as to arrangements for future care and upbringing of children).	
The Social Work (Scotland) Act 1968.	
Section 5 (Powers of Secretary of State).	

Enactment conferring function.	Limitation.
Section 6B (Local authority inquiries into matters affecting children.).	
Section 27 (Supervision and care of persons put on probation or released from prisons, etc.).	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence deferred).	
Section 78A (Recovery of contributions).	
Section 80 (Enforcement of duty to make contributions).	
Section 81 (Provisions as to decrees for ailment).	
Section 83 (Variation of trusts).	
Section 86 (Adjustment between authority providing accommodation, etc. and authority of area of residence).	
The Children Act 1975.	
Section 34 (Access and maintenance).	
Section 39 (Reports by local authorities and probation officers).	
Section 40 (Notice of application to be given to local authority).	
Section 50 (Payments towards maintenance of children).	
Health and Social Services and Social Security Adjudications Act 1983.	
Section 21 (Recovery of sums due to local authority where persons in residential accommodation have disposed of assets).	
Section 22 (Arrears of contributions charged on interest in land in England and Wales).	
Section 23 (Arrears of contributions secured over interest in land in Scotland).	
Foster Children (Scotland) Act 1984.	
Section 3 (Local authorities to ensure well-being of and to visit foster children).	

Enactment conferring function.	Limitation.
Section 5 (Notification by persons maintaining or proposing to maintain foster children).	
Section 6 Notification by persons ceasing to maintain foster children).	
Section 8 (Power to inspect premises).	
Section 9 (Power to impose requirements as to the keeping of foster children).	
Section 10 (Power to prohibit the keeping of foster children).	
The Children (Scotland) Act 1995.	
Section 17 (Duty of local authority to child looked after by them).	
Section 20 (Publication of information about services for children).	
Section 21 (Co-operation between authorities).	
Section 22. (Promotion of welfare of children in need).	
Section 23 (Children affected by disability).	
Section 25 (Provision of accommodation for children, etc.).	
Section 26 (Manner of provision of accommodation to child looked after by local authority).	
Section 26A (Provision of continuing care: looked after children).	
Section 27 (Day care for pre-school and other children).	
Section 29 (Aftercare).	
Section 30 (Financial assistance towards expenses of education or training and removal of power to guarantee indentures, etc.).	
Section 31 Review of case of child looked after by local authority).	

Enactment conferring function.	Limitation.
Section 32 (Removal of child from residential establishment).	
Section 36 (Welfare of certain children in hospitals and nursing homes, etc.).	
Section 38 (Short term refuges for children at risk of harm).	
Section 76 (Exclusion orders).	
Criminal Procedure (Scotland) Act 1995.	
Section 51 (Remand and committal of children and young persons).	
Section 203 (Reports).	
Section 234B (Drug treatment and testing order).	
Section 245A (Restriction of liberty orders).	
The Adults with Incapacity (Scotland) Act 2000.	
Section 40 (Supervisory bodies).	
The Community Care and Health (Scotland) Act 2002.	
Section 6 (Deferred payment of accommodation costs).	
Management of Offenders, etc. (Scotland) Act 2005.	
Sections 10 (Arrangements for assessing and managing risks posed by certain offenders).	
Section 11 (Review of arrangements).	
Adoption and Children (Scotland) Act 2007.	
Section 1 (Duty of local authority to provide adoption service).	
Section 5 (Guidance).	
Section 6 (Assistance in carrying out functions under sections 1 and 4).	
Section 9 (Assessment of needs for adoption support services).	
Section 10 (Provision of services).	
Section 11 (Urgent provision).	

Enactment conferring function.	Limitation.
Section 12 (Power to provide payment to person entitled to adoption support service).	
Section 19 (Notice under Section 18 local authorities duties).	
Section 26 (looked after children - adoption is not proceeding).	
Section 45 (Adoption support plans).	
Section 47 (Family member's right to require review of plan).	
Section 48 (Other cases where authority under duty to review plan).	
Section 49 (Re-assessment of needs for adoption support services).	
Section 51 (Guidance).	
Section 71 (Adoption allowance schemes).	
Section 80 (Permanence Orders).	
Section 90 (Precedence of certain other orders).	
Section 99 (Duty of local authority to apply for variation or revocation).	
Section 101 (Local authority to give notice of certain matters).	
Section 105 (Notification of proposed application for order.)	
The Adult Support and Protection (Scotland) Act 2007.	
Section 7 (Visits).	
Section 8 (Interviews).	
Section 9 (Medical examinations).	
Section 10 (Examination of records, etc.).	
Section 16 (Right to remove adult at risk)	
Children's Hearings (Scotland) Act 2011.	
Section 35 (Child assessment orders).	
Section 37 (Child protection orders).	

Enactment conferring function.	Limitation.
Section 42 (Parental responsibilities and rights directions).	
Section 44 (Obligations of local authority).	
Section 48 (Application for variation or termination).	
Section 49 (Notice of an application for variation or termination).	
Section 60 (Local authorities duty to provide information to Principal Reporter).	
Section 131 (Duty of implementation authority to require review).	
Section 144 (Implementation of a compulsory supervision order; general duties of implementation authority).	
Section 145 (Duty where order requires child to reside in a certain place).	
Section 166 (Review of requirement imposed on local authority).	
Section167 (Appeal to Sheriff Principal: section 166).	
Section 180 (Sharing of information: panel members).	
Section 183 (Mutual Assistance).	
Section 184 (Enforcement of obligations of health board under section 183).	
Social Care (Self-directed Support) (Scotland) Act 2013.	
Section 8 (Choice of options; children and family members).	
Section 10 (Provision of information; children under 16).	
Carers (Scotland) Act 2016.	
Section 12 (duty to prepare a young carer statement).	

Part 2.

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(5)(b) of the Act.

Enactment conferring function	Limitation
The Community Care and Health (Scotland) Act 2002.	
Section 4 The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002.	
The Children's Hearings (Scotland) Act 2011	
Section 153 (Secure accommodation: regulations).	

Annex 2 (Part 2). Services currently provided by Orkney Islands Council which are to be integrated

The functions listed in part 1 of this annex relate to the following services:

- Social work services for adults and older people.
- Services and support for adults with physical disabilities and learning disabilities.
- Mental health services.
- Drug and alcohol services.
- Adult protection and domestic abuse.
- Carers and support services.
- Community care assessment teams.
- Support services.
- Care home services.
- Adult placement services.
- Aspects of housing support, including aids and adaptions.
- Day services.
- Local area co-ordination.
- Respite provision.
- Occupational therapy services.
- Re-ablement services, equipment and telecare.

Additional services, delegated by choice:

- Social work services for children and young people.
- Child Care Assessment and Care Management.
- Looked After and Accommodated Children.
- Child Protection.
- Adoption and Fostering.
- Special Needs/Additional Support.
- Early Intervention.
- Through-care Services.
- Youth Justice Services.
- Social Work Criminal Justice Services.
- Services to Courts and Parole Board.
- Assessment of offenders.
- Diversions from Prosecution and Fiscal Work Orders.
- Supervision of offenders subject to a community based order.
- Through care and supervision of released prisoners.
- Multi Agency Public Protection Arrangements.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**NHS Orkney Preparedness Plan – Island Games 2025**
Responsible Executive/Non-Executive:	**Sam Thomas, Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services**
Report Author:	**Sam Thomas, Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services**

1   Purpose

This paper is presented to the Board for a Decision.

Members are asked to.

- **Approve** the NHS Orkney Preparedness Plan and Tactical Operating Model.

This report relates to a:

- Corporate Strategy 2024-2028 – Potential, Performance, People, Patient Safety, Quality and Experience, Place strategic objectives
- Annual Delivery Plan 2024-2025 (ADP)
- Annual Financial Plan
- Financial Sustainability

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Quality

2   Report summary

2.1   Situation

The Island Games 2025, the largest event ever to come to Orkney, is expected to attract around 2,000 attendees, including competitors, officials, VIPs, media, and visitors. This event necessitates a comprehensive preparedness plan to ensure the continuity of essential health services and effective incident management. The games are scheduled to be held from July 12 to July 18, 2025, which is approximately 8 weeks from now.

The event will be hosted across various locations in Orkney, with the Pickaquoy Centre in Kirkwall serving as the main hub for several sports, including archery, athletics, badminton, swimming, squash, and mountain biking. Other events will be spread across different venues, such as Stromness Academy for gymnastics and various locations for football, presenting significant logistical challenges. The anticipated influx of visitors will temporarily increase Orkney's population by approximately 9%, necessitating robust planning to manage the increased demand on local services and protect critical healthcare services for island communities.

Anticipated demand for healthcare services is not anticipated to adversely affect normal service provision within NHS Orkney. The majority of the visitors will be competitors, and therefore generally healthy adults. However, given the nature of the Games, some injuries and illness are inevitable with most likely presentations as follows:

- Sports related injuries during training and events
- Minor injuries or illness among spectators
- Alcohol related problems

The risk of severe sports related injury is generally very low for most events in these Games. Cycling and gymnastics are potentially the most hazardous, with the risk of serious multiple injuries, but such serious injury is generally rare even in these events. For all the events, soft tissue injuries will probably be the most common and the majority of these will be dealt with by the team physiotherapists and doctors.

A tactical operating model (TOM) has been developed to support a planned response to increased demand. The TOM includes tactical escalation arrangements and builds on well-developed and effective processes already in place in the hospital setting.

2.2   Background

The Island Games, initiated in 1985 in the Isle of Man, is a biennial event designed to bring together small islands from around the world for friendly sporting competition. The event was originally part of the Isle of Man Year of Sport and has since grown into a major international event. The 2025 Games mark the 40th anniversary and will be hosted in Orkney, involving 24 member islands from 8 nations (Denmark, Estonia, Finland, Malta, Norway, Spain, Sweden, and the United Kingdom). The games will feature up to 14 sports, making it the largest multi-sport event in Europe for 2025.

Hosting the Island Games presents a unique opportunity for Orkney to showcase its community spirit and hospitality on an international stage. Significant investments have been made by Orkney Islands Council, Event Scotland, Sport Scotland, and other stakeholders to ensure the success of the event. Community engagement is also a key component, with a target of 700 volunteers set to support the running of the games. The event will not only highlight Orkney's capabilities in hosting large-scale events but also aims to leave a lasting legacy for the local community.

Despite this, the Island Games has the potential to increase demand on local healthcare services and a robust preparedness plan is required to ensure continued healthcare provision for the population of Orkney, emergency care provision for non-residents, and effective communication with and guidance for staff.

Whilst differences between previous host islands makes direct extrapolation of injury risk and impact on healthcare services difficult, data and experience from the 2005 and 2023 games has provided helpful insights which have informed our planning and preparedness to date.

2.3 Assessment

2.3.1 Quality/Patient Care

The preparedness plan aims to ensure that essential health services continue to operate without disruption, maintaining high standards of patient care. The Tactical Operating Model has been designed to support a planned response to any increase in demand. Frequent and effective communication with patients before and during the Games will also aim to minimise any impact on healthcare provision.

2.3.2 Workforce

There are potential risks relating to staff availability / pressure due to leave annual leave where colleagues wish to volunteer. The event lands on 'peak holiday season' so release of staff is already well monitored at this time of year. A communication schedule has supported messaging of this to colleagues.

2.3.3 Financial

Improving our financial performance and delivering our financial plan is one of our priorities for the year, as part of the Performance strategic objective. The financial implications include costs associated with additional staffing and medical supplies. No additional costs in relation to staff numbers are expected. Costs associated with treatment and admission to the Balfour will be reclaimed under the visitors policy in line with current practice.

2.3.4 Risk Assessment/Management

The preparedness plan identifies a number of risks including increased demand on healthcare services, public health incidents, and the impact of cruise ship visitors. The preparedness plan includes strategies for risk mitigation including daily SITREPs and a major incident table top exercise undertaken on 16 June 2025.

2.3.5 Equality and Diversity, including health inequalities.

The preparedness plan aims to ensure that healthcare services are protected for our Orkney population whilst providing emergency healthcare provision for all participants, including those from different nationalities. It addresses the need for interpreters and the provision of information on reciprocal healthcare agreements.

2.3.6 Climate Change Sustainability

The preparedness plan is cognisant of metrics and objectives in relation to climate change and achieving our net zero targets are included in our corporate strategy under the Place strategic objective.

2.3.7 Communication, involvement, engagement, and consultation

The preparedness plan emphasises the need for effective, multi-agency communication strategies to be outlined to inform staff, patients, and the public. A communication and engagement plan is in development as a critical component of preparedness.

2.3.8 Route to the meeting

The draft preparedness plan has been developed through the NHS Orkney Games Preparedness Group and informed by professional advisors. The plan in draft was considered in full by SLT and F&P in May 2025 and approved for onwards governance and Board approval.

2.4   Recommendation (s)

The Board is asked to:

i.   **Approve** the NHS Orkney Preparedness Plan and Tactical Operating Model.

2.3   Appendices

The following appendix is included with this report:

Appendix 1, NHS Orkney Island Games Preparedness Plan v3 Final

NHS Orkney

Orkney 2025 International Island Games Preparedness Plan

Version: FINAL v3 May 2025

Document Type: Governance

Contents

1. **Background**

The Island Games started in 1985 in the Isle of Man. The plan then was to bring together a number of small islands from across the world in a friendly sporting competition as part of the Isle of Man Year of Sport. The event was such a success that it was agreed to continue with a regular games event every two years.

The Orkney 2025 International Island Games will take place from 12th to 18th July 2025. It is the largest event ever to come to Orkney and marks the 40th anniversary of the Island Games. Around 2,000 attendees are anticipated to attend. This includes competitors, officials, VIPs, media, and some visitors.

The International Island Games Association is made up of 24 member islands from 8 nations (Denmark, Estonia, Finland, Malta, Norway, Spain, Sweden and the United Kingdom) who come together to compete in friendly competition in up to fourteen sports. It is also the largest multi-sport event in Europe in 2025.

2. **Objectives**

The following objectives will guide the development and implementation of this preparedness plan:

- **Protect Services**: Ensure that essential health services continue to operate. This involves maintaining critical functions and minimising disruptions to patient care.
- **Readiness to Respond**: Develop and maintain plans to respond effectively to various incidents, including major incidents, critical incidents, and business continuity incidents. This includes regular risk assessments, training, and exercises to ensure organisational preparedness.
- **Recover Well**: Implement strategies for recovery to restore normal operations as quickly as possible after an incident. This involves learning from incidents through debriefing and incorporating lessons learned into future planning.
- **Governance**: Ensure clear roles and responsibilities for emergency preparedness within the organisation.
- **Communication**: Ensure effective communication strategies are in place to inform staff, patients, and the public of key messages before, and after the Island Games.
- **Cooperation**: Work collaboratively with partner organizations and agencies to ensure a coordinated approach to preparedness and response to incidents.

3. Orkney as Host Island

Although Kirkwall is the main base for events and activities, events are due to be held at various locations across Orkney (see figure 1 below).

Figure 1. Island Games 2025 Sports Venues

Main Event Summary

The Pickaquoy Centre is hosting Archery, Athletics, Badminton, Swimming, Squash and Mountain biking. Football will be at 10 separate locations across mainland and southern connected isles – presenting a transport challenge. Stromness Academy is hosting gymnastics. The triathlon will be around the streets of Stromness with the venue for golf will also being Stromness.

There will be two significant cycling events on West Mainland with significant road closures.

The competition schedule has been received and confirmed. The schedule has informed our preparedness activity.

Anticipated Number and Location of Visitors

The Games organisers have set a target of 700 volunteers to support the running of the event. Visitor number estimates are unknown at this stage but expected to be minimal due to limited additional holiday accommodation in Orkney during the event. Nirvana Europe is running the accommodation on behalf of the Games organisers. All venues involved in the event that are modified or set up for the purposes of the event need to go via Planning Approval by the Orkney Islands Council. As part of this process, Environmental Health and the NHS Orkney Health Protection Team will undertake an assessment to ensure appropriate washing / toilet facilities, ventilation, consider the provision and management of catering, and ensure provision is sufficient for the potential need to isolate for outbreak management (e.g. separate toilet facilities for GI cases). These details have been included

in the plans for each of the venues and discussed at the Games Safety Advisory Group. The location and number of visitors residing at each is available in the table below.

Table 1. Accommodation Provision

Property	Number
OIC School Dorms (KGS, Stromness Academy, Papdale Primary)	600
Papdale Halls of Residence	152
Army Reserve	60
Hotels / B&Bs / Self Catering (Nirvana)	600 (estimate)
Accommodation Buses (for media?)	74
	1,486

4. Healthcare Requirements and Responsibilities

All partners in the Island Games require a plan which outlines responsibilities and arrangements for healthcare and incident management during the Island Games.

Island Games Organisers

The games organisers are responsible for:

1. A pathway for first aid and anticipated general health issues amongst competitors.
2. First line management of potential sporting injuries suffered in the sports represented.
3. Medical cover for a varied range of events including football athletics and sailing. Sports bodies will often specify levels of provision. A clinical team will be required at venues with sufficient expertise to triage any casualties or injuries to either be treated at the venue or transferred to the polyclinic or Emergency Department.
4. Liaison with NHS Orkney and Scottish Ambulance Service to consider potential transfer to NHS care.
5. Informing competitors about local healthcare arrangements, including the need for appropriate health insurance and to bring enough medication for their stay in Orkney. Visiting teams should have arrangements in place to ensure eligibility for NHS care – being UK residents, EIHC card holders or holding suitable travel / health insurance.

NHS Orkney

NHS Orkney is responsible for:

1. Ensuring continued healthcare service provision for the population of Orkney.
2. Ensuring consistent and effective guidance to our staff regarding their contributions, including in a volunteering capacity,
3. Providing emergency and unscheduled care.
4. People who are 'not ordinarily resident' in the UK can access GP, pharmacy and other services but charges may apply.

5. Planning Process

Groups and Governance

The following groups and associated governance are in place to oversee the planning of the Island Games 2025:

```
┌──────────────────────────────┐   ┌──────────────────────────────────────────────────┐
│ Finance and                  │   │                        Safety Advisory Group       │
│ Performance                  │   │                        (OIC Led)                    │
│ Committee                    │   │                        - NHSO Membership: David     │
│                              │   │                        Miller, Sam Thomas, Elvira   │
│          │                   │   │                        Garcia, Louise Wilson        │
│ NHS Orkney Senior            │   │                        O25 Dormitories              │
│ Leadership Team              │   │                        (O25 Association-Led)         │
│                              │   │                        - NHSO membership: Kirsti     │
│          │                   │   │  Orkney 2025           Jones                        │
│ NHS Orkney - Games           │   │  Planning              O25 Roads & Transport        │
│ Preparedness Group           │   │  Committee             (O25 Association-Led)         │
│ Chair: Sam Thomas            │   │                        O25 Strategy Group           │
│                              │   │                        (O25 Association-Led)         │
│ Resilience Planning          │   │                        - NHSO Membership: Laura      │
│ Group                        │   │                        Skaife-Knight, Alan Cooper    │
│ Chair: David Miller          │   │                        O25 Medical Sub Group        │
│                              │   │                        (O25 Association-Led)         │
└──────────────────────────────┘   │                        - NHSO Membership: John      │
                                    │                        Daniels, Kirsty Cole, Pippa  │
                                    │                        Easener, Bobby Krier, Ruth   │
                                    │                        Flett                        │
                                    └──────────────────────────────────────────────────┘
```

Orkney 2025 Planning Committee

- Chair: Gordon Deans, Chair
- Run by the International Island Games Association which is a company limited by guarantee.

NHS Orkney - Games Preparedness Group

- Chair: Executive Director of NMAHPs & Chief Officer of Acute Services
- Purpose: To coordinate appropriate actions to ensure that NHS Orkney is prepared to continue to carry out their health and care responsibilities before, during and after the Orkney Island 2025 Games. Communication with key partners including NHS Highland, NHS Grampian, NHS 24 and SAS/SCAA is informed by and coordinated via this group. Governance is via chair's assurance report to SLT and Finance and Performance Committee. The NHS Orkney Island Games Preparedness Group is the main planning forum to ensure that NHS Orkney is prepared for any additional demand on resource or incident during the Games.

NHS Orkney Resilience Planning Group

- Chair: NHSO Resilience Officer
- Purpose: Responsible for the planning of resilience exercising and preparedness. This group reports to the preparedness group.

A number of NHS Orkney colleagues are members of the Games sub-groups on a voluntary basis and not formally representing NHS Orkney. However, it is expected that colleagues will feedback to their local departments as appropriate.

Anticipated Demand for Health Services

The Island Games has the potential to increase demand on local healthcare services due to both visitor numbers to Orkney and the nature of the event.

There will be a temporary increase in the Orkney population of at least 2,000 visitors (approximately 9% increase in the population).

As the majority of the visitors will be competitors, and therefore generally healthy adults, there should not be the same level of increased demand for services as seen with Cruise Ships. However, given the nature of the Games, some injuries and illness are inevitable. The most likely problems will be:

- Sports related injuries during training and events
- Minor injuries or illness among spectators
- Alcohol related problems

The risk of severe sports related injury is generally very low for most events in these Games. Cycling and gymnastics are potentially the most hazardous, with the risk of serious multiple injuries, but such serious injury is generally rare even in these events. For all the events, soft tissue injuries will probably be the most common and the majority of these will be dealt with by the team physiotherapists and doctors.

Most spectator injuries and illness are likely to be minor and related to being outside or being in a crowd, for example heatstroke, insect bites and stings, and minor bumps and bruises.

Alcohol related problems such as injuries, intoxication and dehydration may affect competitors, spectators and the local population throughout the week and particularly on the last night. At this stage licensing arrangements for extending opening times of local pubs and bars have yet to be confirmed.

Potential Healthcare Impact

It is anticipated that any additional workload created by the Island Games should not adversely affect normal service provision within NHS Orkney.

The increased demand for travel to and from Orkney at the beginning and end of the Games has the potential to affect patients and staff to and from Aberdeen and Edinburgh. We have taken action to ensure ringfenced travel provision with Loganair and we will continue to monitor the situation.

Cruise ships may continue to visit Orkney over the Games period. This will have an additional impact on local service provision. Whilst this may not directly impact on the Games Medical provision, it emphasises the need to maximise our ability to resolve clinical contacts and minimise burdening local services. Cruise Ships may also provide a significant number of spectators which must be included in risk assessment planning through the Games Safety Group. There are two cruise ships confirmed for the week commencing 14 July 2025 – 16 July 2025 1000 passengers, 18 July 2025 1000 passengers, with a smaller cruise vessel due into Orkney on the 13 July 2025 with 250 passengers.

Differences between host islands makes direct extrapolation of injury risk and impact on healthcare services difficult. However, data and experience from the 2005 and 2023 games provides insights which can inform our planning and preparedness.

Guernsey Games 2023

The Princess Elizabeth Hospital in Guernsey has 104 beds across 12 wards, including 7 ICU beds, 9 paediatric beds plus a private ward comprising 19 beds. Whilst not directly comparable to healthcare provision in Orkney, the Guernsey Games in 2023 gives an estimate of injury burden and healthcare impact to inform our planning.

Polyclinic Service

Healthcare was lead from a 'polyclinic' staffed by physiotherapists (from a range of disciplines), doctors and nurses, underpinned by administrative support. Guernsey Games organisers aimed to have 1 doctor, 1 nurse and 3 therapists on duty at the clinic daily between 8am and 6pm. Paper notes were used to record interactions.

The polyclinic managed 371 patients with 880 patient contacts. Many of these were for physiotherapy, strapping or massage (e.g. one competitor having 8 treatments) and uptake by sport varied considerably with 100 badminton player treatments to 2 sailor treatments.

First Aid

There was an extensive first aid presence at events. This was led by St John's ambulance with 67 contacts over the event – 70% of these were competitors with the remaining 30% spectators or games officials. Presentations included 41 cuts, 10 instances of bruises/swelling and 6 people with hydration needs.

Higher Grade Injuries

Health service impact was considered modest with 7 emergency ambulances required from venues to hospital. These were associated with neck injury (triathlon), ruptured Achillies and a knee injury (badminton), concussion with facial injuries and a knee injury (football), and a non-sport related allergic reaction.

There were 41 ED attendances during the Games. 36 of these were competitors, 2 spectators and 3 support staff). Of these, 2 patients were admitted (one a tibial fracture requiring internal fixation and the other a cervical spine fracture). Other injuries included various soft tissue injuries, a dislocated shoulder, ruptured Achillies and a ruptured quadriceps tendon. Nine patients attended appointments at a fracture clinic for follow up.

More Serious Events

There were no significant incidents or outbreaks reported.

The full report is available here: Final Report Guernsey 2023 (iiga.org)

Shetland Games 2005

Despite being almost 20 years ago, the Shetland Games in 2005 also gives insight from the perspective of a Scottish Island operating in a similar context to inform our planning:

NHS Shetland prepared for the Games on the assumption that the Games would lead to a temporary increase in the population of approximately 13% (2,800). A medical centre operated from 9am to 9pm each day, staffed by Red Cross volunteers and / or paramedics.

During the Games there were 67 contacts with either Scottish Ambulance Service or the Red Cross for sprains, strains, muscular aches, cuts, bruises and scrapes. 4 of these contacts were transferred to the Emergency Department.

During the Games there were 41 Emergency Department attendances (age range between 3 and 76 years old). 5 of these patients were admitted. The most common complaint was injury to leg, foot and ankle. Other problems included head injury, asthma, chest pain and convulsions.

There we no significant incidents or outbreaks reported.

Public Health Issues

The number of visitors and the nature of the event will also increase the risk of a major incident occurring. Potential incidents include:

- An outbreak of gastrointestinal or respiratory illness
- A major incident during an event (such as crowd problems, multiple casualties in a cycling or sailing incident)
- Importing of High Consequence Infectious Diseases (HCIDs) or Viral Haemorrhagic Fevers (VHFs) into Orkney

International Nature of Event

The Games will be conducted in English and many of the competitors will speak some English. Although every team will have at least one English speaking official or local attaché, access to the following interpreters may be required via the language line:

- Danish
- Estonian
- Finnish
- Maltese
- Norwegian
- Spanish
- Swedish

Payment for Medical Care

Most countries represented at the Island Games have reciprocal arrangements for provision of medical care in the UK. For those that do not, the patient's insurance should pay for any medical care provided. An up-to-date list of those countries will be distributed to ED and primary care. Staff will be advised to record details of the nationality / residence of all visitors so that the appropriate measures can be taken to reclaim costs where applicable.

6. Provision of Healthcare and Health Related Services

Island Games Healthcare Arrangements

The Islands Games organisers have produced a medical plan (appendix A) which sets out their responsibilities, proposed arrangements and working assumptions. It is a stated aim of the Games Medical Service to minimise any disruption to existing Island healthcare services.

The main healthcare provision planned by the games organisers is a clinic set up at Glaitness Primary School. This will be staffed by volunteer doctors, nurses, physical therapists and other healthcare and administrative staff. On top of sports related soft tissue strains, bruises and cuts, presentations can be anticipated be those illnesses typically experienced by holidaymakers (coughs, colds, GI upsets, sunburn), sexual health concerns or problems such as forgotten or mislaid medication.

The clinic will be led by the Games Medical Director. Liaison with NHS Orkney will be through a daily morning SITREP and with other designated contacts as necessary.

The clinic will be open 0800 – 1730 from Fri 11 to Fri 18 July 2025. After 1730, a clinician will be available on an on-call basis for acute cases only until one hour after the final event of the day finishes. Calls to the on-call clinician will be made by the on-site clinician or First Aider at each event.

The clinic will provide clinical care from a doctor (or other qualified health professional). Clinicians not qualified to practice independently will be supported by a senior clinician on-call.

Additional planning assumptions:

- First aid cover at venues, opening and closing events, and cover at competition venues is the responsibility of the Games Medical Director and should be detailed in the event medical plan and safety plan.
- Prior to entry all participants (athletes and support staff) will provide a completed medical questionnaire detailing current and previous medical conditions, medications and allergies. Participants must ensure they bring supplies of any current medication with them to last them the duration of their visit until they return home and are able to pick up their next prescription.
- All participants must make themselves aware of their home nation's reciprocal agreements with the NHS and familiarise themselves with what provision they will be entitled to as visitors.
- All participants must ensure they have medical insurance and travel insurance to cover all levels of illness or injury incurred by their sport or any other cause. They must ensure their insurance will cover them for medical repatriation.
- It is anticipated that some Island teams will also bring their own medical teams including doctors, physiotherapists and other AHPs. Details of these teams will be provided in advance.
- A medical leaflet will be produced by the organisers and distributed to all participants detailing available healthcare services and how to access them.
- The medical plan clearly states that if at any point insufficient medical provision is available for an event, it must be paused and must not recommence until sufficient medical provision is available.
- There is a requirement to ensure all participating teams are aware of what organisms and diseases are notifiable within Scotland (noting that this varies between countries). This should be provided to each of the islands' medical teams in advance by the HPT (health protection team), through the Games Medical Director, but can also be found online at: Public Health etc. (Scotland) Act 2008.

<u>Primary Care</u>

It is anticipated that the number of people attending primary care services as temporary residents should not be significantly higher than usual for the peak tourist season.

During the daytime visitors will be expected to attend the Games Medical Centre or ED at Balfour if directed to do so by NHS 24. Out of hours, visitors would be expected to use NHS 24 / the OOH service as appropriate.

Supported communications will be developed to promote 'right care, right place'. Visitors should be encouraged by Games organisers to consider NHS Inform to promote self-management and access appropriate health services e.g. community pharmacy.

Detailed preparedness planning for Primary Care is being undertaken by Orkney Health and Care and will be coordinated and aligned with this plan via the NHS Orkney Games Preparedness Group and NHS Orkney Senior Leadership Team.

NHS 24

Engagement with NHS 24 has commenced to ensure awareness and preparedness for the provision of appropriate advice and guidance including use of NHS Inform. The NHSInform Remote, Rural and Island communities leaflet below is under consideration for adaption for the purposes of the Island Games.

Scottish Ambulance Service

Scottish Ambulance Service has confirmed emergency and response vehicles will be available for the duration of the games with an increase in conveying vehicles and personnel present on island.

The Island Games Committee has a working document outlining a plan of every road closure to accommodate scheduled games which has been shared will all parties.

Balfour Hospital

Patients may be brought to ED by paramedics or may self-present. Additional Emergency Department staff for the duration of the event is in place provided by the resident medical team and Consultant Physicians. Provision of ambulatory care clinic appointments and pull from the Emergency Department will be delivered by the Consultant Physician. A hospital tactical operating model has been developed to support a planned response to increased demand and can be found in appendix 2.

It is expected that as a minimum the following Executive Directors will be in work and on island during the period of the Games:

- CEO
- Executive Director of Nursing, Midwifery, AHPs and Chief Officer of Acute Services
- Medical Director
- Director of Public Health
- Chief Officer – IJB

In addition, the Resilience Officer will be in work and on island and Public Health (specifically the Health Protection Team) will operate a daytime and out of hours rota with an additional colleague available during the period of the Games.

Where there has been a significant incident which requires a heightened response but the information at the time suggests that the resources of the Balfour will not immediately be overloaded, a Major Incident Standby will be declared. This will involve senior hospital staff assessing the state of preparedness in the Emergency Department, and where appropriate health services outwith the hospital.

Moving from Standby to Declared Major Incident will be incremental as additional information becomes available.

The requirement for Major Incident to be declared will normally be obvious and can be declared by Police or Scottish Ambulance Service. The authority to declare a Major Incident Standby or Declared Major Incident is as follows:

- CEO
- Director of Nursing, Midwifery, AHPs and Chief Officer of Acute Services
- Medical Director
- Director of Public Health
- Director of People and Culture
- Director of Finance

As per the NHS Orkney Major Incident Policy, the Director of Nursing, Midwifery, AHPs and Acute Services must be informed of any report of a significant incident received by the switchboard or the Emergency Department during normal working hours. If not available, the CEO, Director of Public Health, Medical Director, Director of People and Culture or Director of Finance must be contacted in turn until contact has been established and Senior Leadership briefed. Out of hours, the Senior Manager on Call must be contacted. A formal back-up Senior Manager on Call rota will be in operation for the duration of the Games. If the primary Senior Manager on Call cannot be reached after 2 attempts the default position should be to call the back-up Senior Manager on Call.

Additional details are available in the NHS Orkney Major Incident Major Emergency Plan which was reviewed and approved by the Finance and Performance Committee in February 2024.

<u>Workforce</u>

We know many colleagues will be competing at the games and many will want to volunteer. Whilst we are incredibly proud to have such willing and eager colleagues who want to give up their time, it is critical that we ensuring protect our healthcare capacity in order run health services for our communities and visitors.

There are potential risks relating to staff availability / pressure due to leave annual leave where colleagues wish to volunteer. The event also lands on 'peak holiday season' so release of staff is already well monitored at this time of year.

We will ensure regular communication with staff to ensure we collectively work together to manage annual leave effectively. The first formal communication is scheduled w/c 12th November to mark the 8-month countdown. This will remind colleagues that during the period of the Games, annual leave entitlements remain the same as normal to ensure we maintain safe staffing in all areas across the organisation. This means we need to work collectively to balance leave requests fairly so that as many colleagues as possible can experience the games during that time.

Road closures during the games have been shared with teams across Orkney to ensure provision is made for getting staff to and from work and to and from patients in the community/residential facilities and access to NHS/OIC owned properties is not impeded.

7. Coordination of Healthcare Provision

Multi-agency Daily SITREPs

A silver / tactical control is proposed during the Games supported by daily morning SITREPs. This is crucial for maintaining situational awareness and coordinated responses. The SITREPs will share intelligence about presentations at the clinic, incidents at competitions and ED or other NHS Orkney attendances to detect any trends and identify any issues requiring escalation. Specifically, these will consider:

- Current Situation: A summary of what has happened so far.
- Actions Taken: Details of the actions that have been completed.
- Planned Actions: What will be done next.
- Issues: Any problems or challenges that need to be addressed.
- Resources: Information about the resources available and any additional needs.

SITREPs should comprise the Games Medical Director, NHS Orkney Senior Manager, NHS Orkney operational representative, Primary Care representative, Public Health representative (CPHM or AHPNS), OIC representative, SAS representative.

A Joint Agency Control Centre is proposed by the Games organisers with an operation centre based within the Saint Magnus suite in the Pickaquoy Centre. This aims to provide a strategic overview of what is happening and where and will operate during any incident or any particular event such as the opening and closing ceremonies.

NHS Orkney Daily Huddle

NHS Orkney will operate a twice-daily huddle to brief and debrief each day to maintain situational awareness, effective communication, coordinate any response, and share intelligence. These huddles will be led by the Senior Manager on Call.

Outbreaks or Incidents

A games environment presents potential for clusters or outbreaks of GI (such as food poisoning and Norovirus), flu-like illnesses associated with shared communal accommodation / events. Risk can be reduced by providing high standard accommodation and excellent catering and hygiene at events. Orkney Islands Council (OIC) Environmental Health will be devising an Environmental Health intervention plan and associated audit, assisted by Public Health.

The NHS Orkney Health Protection Team will be fully staffed and proactively monitoring for cases of infection or GI illness throughout the period of the Games. Protocols will be in place for the management of outbreaks of infectious diseases involving OIC Environmental Health as part of the Joint Health Protection Plan.

Should there be any unusual incidence of infectious disease, there may be a need to isolate individuals / groups within their accommodation. OIC Environmental Health will ensure accommodation is suitable and the Health Protection Team will offer advice as appropriate.

The Health Protection Team will have a clear route of communication with the Games Medical Team so that any concerns about illness or outbreaks of infection can be notified and managed appropriately. A Problem Assessment Group (PAG) or Incident Management Team (IMT) may be called by the Consultant in Public Health Medicine in the case of any significant outbreak. The Games Medical Director will be included within the membership of these groups.

Due to the breadth of nationalities and countries involved in the Games, there is a risk of import of HCIDs or VHFs into Orkney. It is therefore essential that clinical teams are current in their knowledge of management and local preparedness. The High Consequence Infectious Diseases policy requires to be approved and fully implemented (including training of staff in the use of PPE and ensuring adequate supply of PPE) as a priority.

Business Continuity

 There are currently Business Continuity Plans (BCP's) in place for all services, these plans are regularly updated. Exercise Digital Defender is a Business Continuity exercise that is regularly undertaken testing the plans. The revised Business Continuity Policy is planned to be fully introduced to all areas across NHS Orkney by end of June 2025.

The extant NHS Orkney Business Continuity Management Policy has been approved by internal governance arrangements and is in accordance with CCA 2004 Category 1 and 2 responsibilities and other guidance. This outlines what Business Continuity is, its cycle and the roles and responsibilities of staff members about Business Continuity at all levels of the organisation.

NHS Orkney and Orkney Islands Council have Business Continuity Plans (BCPs) in place with clear links to the pandemic plan including provision for an escalation plan. In addition, Primary Health Care contractors have individual plans. All BCPs are subject to review and lessons learned are fed through the Orkney Local Emergency Coordinating Group (OLECG) as well as across internal service areas as appropriate. The NHS Orkney Blog also contains information on Business Continuity for staff.

The focus for NHS Orkney with its partners is to sustain the delivery of core services during worst case scenario within the following areas: Maternity Unit, High Dependency Unit, Emergency Department, Inpatients 1, Inpatients 2 including Macmillan area, Theatre, Radiology, Laboratory, Pharmacy and Renal Unit. Mutual Aid arrangements are fully documented within the updated version of the Major Incident and Major Emergency Plan. The plan was redrafted to support the organisational move and multi-occupancy nature of the new healthcare facility and reflect current arrangements within NHS Scotland Major Incident with Mass Casualties National Plan 2019.

The Resilience Officer will be fully involved in all aspects of preparedness to ensure that business continuity management principles are embedded as part of both planning and service continuity with specific consideration for all critical activities across the Board and

HSPC. This should include analysis of the risks of disruption and the actual effects, and that planning is based upon the likelihood and impact of worst-case scenarios.

Protected Persons Plan

With confirmation that HRH The Princess Royal will be attending the opening ceremony, the resilience officer and Executive Director of Nursing, Midwifery, AHP's and Chief Officer for Acute Services have reviewed and updated the NHSO Protected Persons Plan. Due to the sensitive nature of this plan it has not been shared within this document.

Major Incident

The Orkney Emergency Plan is continuously kept under review and a multi-agency live exercise is planned for June 2025 to test systems and identify areas for improvement in the run up to the Games.

In the event of a more serious 'major incident' at a higher tier, the Orkney Emergency Plan under the Orkney Local Emergency Coordination Group (OLECG) will be activated. This is a multi-agency response including Police Scotland, Scottish Ambulance Service Orkney Islands Council and NHS Orkney. The NHS Orkney Major Incident Major Emergency Plan will be activated. This plan was reviewed and approved in February 2024.

Testing the Plan

A major incident table top exercise will be held in June 2025 with a live exercise also planned in June 2025. This will be a multi-agency live exercise with casualties arriving at ED to test the major incident plan.

Communications and Engagement – Staff and Public

The NHS Orkney blog, website and all other available mediums will be used to distribute relevant, accurate and consistent information to both the public, patients and staff ahead of, during and after the Island Games. A communication and engagement plan is in development in partnership with partner organisations and led by Muckle Media on behalf of the Island Games organisers.

8. **Risks of Note**

Orthopaedics provision

Current service delivery model for orthopaedics is an elective model which provides an element of trauma / orthopaedics with limited capacity to provide surgical intervention. Those requiring surgical intervention beyond the capabilities of the Balfour are transferred via the Trauma Network.

Consultant Orthopaedic advice will be available on an on call basis during the games with capacity for Trauma/Ortho lists secured in theatre for the week of the games, many of the clinical procedures required as a result of injuries sustained in previous games would require referral off island as per agreed pathways of care.

Cruise ships

Cruise ships may continue to visit Orkney over the Games period. This will have an additional impact on local service provision. Whilst this may not directly impact on the Games Medical provision, it emphasises the need to maximise our ability to resolve clinical contacts and minimise burdening local services. Cruise Ships may also provide a significant number of spectators which must be included in risk assessment planning through the Games Safety Group.

From an outbreak / incident perspective, during the period 12th to 18th July 2024 cruise liners brought a total of 18,285 persons into Orkney (12,326 guests and 5,959 crew). During this time only 18 cases of infection onboard were noted (less than 0.1%). During this time, there were 174 ED attendances.

Cruise Ships confirmed for the time period are as follows 250passengers 13th July, 1000 passengers 16th July and 1000 passengers on 19th July.

<u>Increased presentation to core services</u>

Increased presentation is expected to be modest and likely to be of a similar scale to one of the regular cruise ship arrivals in Orkney over the summer. Although there is no data to support this, we have been told anecdotally that several ED attendances and a small number of people seeking medication from pharmacies is typical.

<u>Games Medical Centre</u>

Glaitness Primary School clinic failing would see an increase in primary care, minor injury and ED presentations. Medical Centre provision will be scrutinised through the organising committee and any concerns about effectiveness / sustainability of the planned provision will be raised with early communication to NHSO.

<u>First Aid</u>

First Aid services being unavailable or inadequate would also mean more primary care, minor injury and ED presentations. Unavailability of first aid services would have a substantial impact on the effectiveness and capabilities of the Games Medical Centre. NHS Orkney has full assurance from Games organisers regarding provision of first aid for the duration of the Games.

<u>Workforce</u>

There are potential risks relating to staff availability / pressure due to leave annual leave where colleagues wish to volunteer. The event lands on 'peak holiday season' so release of staff is already well monitored at this time of year. A communication schedule will support messaging of this to colleagues.

There are potential complications due to games attendees being non-EU / foreign nationals with regards to medical insurance cover and payment for provision of healthcare services.

There is a risk that non-UK registered practitioners will seek to practice on Orkney during the Games and they may seek to use NHS Orkney facilities. NHS Orkney will work with the Games organisers to ensure effective communication with non-UK practitioners before and during the event.

<u>Finance</u>

The provision of additional staffing for the duration of the event is agreed with minimal impact on finance from sourcing Orthopaedic consultant advice. Games Organisers have confirmed that partners including Police Scotland have agreed to provide services to the Island Games at no cost.

<u>Outbreaks</u>

There is moderate risk of Covid or flu like illness / GI upsets affecting a team or group in shared accommodation. This will be managed through the Public Health Incident Management Plan and the Games Medical Director involved in incident management teams.

If this escalates to a more serious 'major incident' at a higher tier the Orkney Emergency Plan under Joint Resilience Partnership is activated.

<u>Road Closures</u>

The impact from road closures has been reviewed and NHSO is working closely with the Transport Group to alleviate any concerns from staff or patients and ensure that service delivery is not affected. Main risk is staff getting too and from work and too and from vulnerable patients. Alternative transport is being sought for both staff and patient groups affected which will be minimal due to realignment of rosters and only inviting patients to clinics, for treatment on days which do not affect their postcode area.

All patients attending clinics on the affected road closure days have been advised and appointments rearranged where necessary. Clinical and non clinical rosters have been reviewed to allow safe staffing levels and limit impact from staff being unable to travel.

CONFIDENTIAL: NOT FOR ONWARD CIRCULATION

Scope

The Orkney Island Games Committee will oversee the provision of medical care for athletes, support staff, and spectators attending the games. These services will be delivered by the Orkney Island Games Medical Service (hereby referred to as "IGMS") and will be based at the Orkney Island Games Polyclinic (hereby referred to as the "Polyclinic").

Location

The Polyclinic will be based at Glaitness Primary School.

Address: Pickaquoy Road, Kirkwall KW15 1RP

What3words: prestige. baths. blubber

Opening Times

The Polyclinic will operate a daytime service from 08:30 to 17:30 daily (hereby referred to as "daytime hours"). An on-call service will be available after 17:30 until the final event of the day has concluded (hereby referred to as the "on-call period").

Physiotherapy and massage therapy services will be available after 17.30 until the end of the final event of the day subject to the availability of volunteers

Services

The Polyclinic will be staffed by:

· One senior doctor (GP, Consultant, or SAS equivalent grade)

· One resident doctor or Advanced Nurse Practitioner (ANP)

· One nurse

· One non-clinical receptionist/secretary

· One or more physiotherapists and massage therapists, depending on availability

The Polyclinic will provide medical services equivalent to primary care, urgent care, and minor injuries. Care will be provided for acute medical issues only, excluding ongoing chronic conditions unless an acute exacerbation occurs.

Appointments and Walk-ins

Patient contacts will primarily be by prior appointment.

Walk-in patients will be accepted, with priority given to acute cases and pre-booked appointments.

Standard appointments will last 15 minutes.

Emergency Care

The Polyclinic will not provide emergency care.

Medical emergencies should be directed to Balfour Hospital Emergency Department via 999 ambulance or self-presentation.

Additional Services

· Physiotherapy clinics will be available for athletes, subject to physiotherapist availability.

· Massage therapy and taping will be provided by volunteers from the University of Central Lancashire (UCLAN)

· Space will be available for visiting medical teams to treat their athletes.

· A non-surgical orthopaedic clinic will be available each morning, staffed by an SAS-level orthopaedic surgeon.

· Radiology services, including plain film radiography, are being arranged in conjunction with NHS Orkney Radiology Department.

Booking

· The Polyclinic will have a widely circulated landline telephone number.

· Athletes and support staff may self-refer.

· Event-side clinicians and first aiders may refer patients to the Polyclinic.

· Appointments will be available between 08:30-12:30 and 13:30-17:30.

· The receptionist will collect demographic details and the presenting complaint.

· Patients may choose between face-to-face or telephone consultations.

Spectator Referrals

· Spectators may be referred only if assessed at an event by a first aider or clinician and deemed to have an acute medical issue suitable for Polyclinic assessment.

· Self-referrals from spectators will not be accepted.

· Spectators presenting directly to the Polyclinic will be provided with an information leaflet on accessing appropriate NHS services.

Walk-in Appointments

· Walk-ins will be accepted for athletes and support staff with non-emergency presentations.

· Clinical priority will be given to acute cases and pre-booked appointments.

· Patients will be encouraged to book an appointment where appropriate.

· Emergency walk-ins will trigger an immediate clinical assessment and 999 ambulance call if appropriate.

· Walk-ins from non-athletes and non-support staff will not be accepted and will be redirected to appropriate NHS services.

On-Call Service

· A clinician will be available on-call from 17:30 until the final event concludes.

· The first aider or clinician at the final event of the day must contact the on-call clinician and on-call pharmacist to stand down through a dedicated IGMS Whatsapp group

· The on-call service will only accept referrals from event first aiders or clinicians.

· Non-emergency medical concerns should be directed to NHS24 (111). These details will be included in participant medical packs.

· The on-call clinician will have full access to Polyclinic facilities.

Medical Records

· Clinical notes will be contemporaneous and securely recorded in an online system.

· A discharge letter will be provided for each patient contact.

· Medical records will only be accessible to clinicians.

Orthopaedic Cover

· A SAS-grade orthopaedic doctor will run an orthopaedic clinic daily from 08:30-12:30.

· They will remain on call until the end of the on-call period.

· Patients requiring orthopaedic assessment will be referred after obtaining X-ray imaging where appropriate.

· The clinic will handle soft tissue injuries and fractures suitable for temporary immobilisation (e.g. sling/splint).

Radiology

· Mobile radiology facilities are being provided on site at the polyclinic by NHS Orkney staffed by volunteer radiographers.

· Plain film X ray imaging will be available from 08.30 until the end of the on call period.

· Images will be requested and viewable by polyclinic clinicians.

· After final reporting of images reports will be sent to Alex Hillman, Medical director for further actioning if required.

Prescriptions

· A limited formulary of stat-dose medications will be available on-site in a locked pharmacy cupboard.

· Take-home (TTO) medications will not be dispensed at the Polyclinic.

· Patients requiring TTO medication will be given a prescription for collection at a local pharmacy.

· Sutherlands Pharmacy will provide an on-call dispensing service after hours.

· The on-call pharmacist will be available for consultation and will stand down alongside the on-call physician after the final event of the day.

Resuscitation Equipment and Emergency Protocols

· The Polyclinic will have a defibrillator and resuscitation equipment on-site.

· All Polyclinic staff will be made aware of the location of the defibrillator and resuscitation equipment on induction.

· All clinical staff will be trained to a minimum of Basic Life Support (BLS).

Dental Services

· Acute dental care will be available through the Public Dental Service (PDS).

· Appointments may be available at The Balfour Dental Department or Garson Dental Clinic, Stromness.

· Referrals can be made by clinicians or via self-referral by calling 01856 888 258.

Eye Care

· Minor eye care will be provided by Clark Optometrist.

· Referrals can be made by clinicians or via self-referral by calling Clark Optometrist.

Visiting Medical Teams

· Consultation space will be available for visiting medical practitioners and physiotherapists during daytime hours and the on-call period.

· Visiting clinicians must hold a valid UK medical license.

· Booking for consultation space can be arranged via the Polyclinic telephone line.

· Walk-in requests for consultation space will be accommodated where possible, but priority will be given to pre-booked slots.

Infection Prevention & Control

· Measures will be consistent with NHS best-practices and the requirements of the NIPCM throughout.

Orkney 2025 International Island Games Medical Plan: Medical stats from Guernsey 2023

St John Ambulance: 67

Back Pain	1	1%
Bite/Sting	1	1%
Bruising	3	4%
Chest Pain	1	1%
Exhaustion	1	1%
Foreign Body	1	1%
Fracture/Dislocation	1	1%
Hydration	6	9%
Ice Pack	2	3%
Splinter/Thorn	2	3%
Swelling	7	10%
Wound	41	61%

Cycling - Mountain	6	9%
Cycling - Time Trial	3	4%
Cycling - Criterium	13	19%
Football	1	1%
Friday Seafront	1	1%
Half Marathon	3	4%
Opening Ceremony	6	9%
Triathlon	7	10%
Triathlon Relay	9	13%
Participant	47	70%
Public	16	24%
SJA	1	1%
Staff/Contractor	3	4%

Athletics	18	27%

Emergency Ambulance: 7

Triathlon Neck injury
Badminton Ruptured Achilles
Badminton Knee injury
Football Knocked unconscious and facial injuries
Football Knee injury
Non sport Allergic reaction
Non sport Heartburn (this patient was treated at the scene)

A&E: 41 (inc 7 ambulance)

Football 11
Basketball 5
Badminton 3
Cycling 3
Triathlon 2
Javelin 1
Archery 1*
Swimming 1
* This was not sport related

Polyclinic attendance

Sport	Attendance
Athletics	90
Badminton	100
Basketball	49
Cycling	17
Football	17
Sailing	2

Sport	Attendance
Shooting	1
Swimming	9
Table Tennis	1
Tennis	56
Triathlon	18
Official	9

Appendix B NHS Orkney Island Games Tactical Operating Model v1

INTRODUCTION

This tactical operating model (TOM) has been adapted from NHS Orkney's Winter Preparedness Plan. This plan forms part of the NHS Orkney response to increased demand, recognising that the hospital operates as part of the local and regional health and care system.

Whilst the impact may be different for each service within the local system, there is an inherent co-dependence between services that requires a coordinated approach to ensure that actions are designed to work cohesively and don't intentionally or unintentionally destabilise any of the component parts.

Our plan includes tactical escalation arrangements and builds on well-developed and effective processes we already have in place. Through our TOM we will:

- Be informed by real-time data and analysis that tells us the nature and location of the problem and monitors the effectiveness of our response.
- Ensure action through rapid implementation by the right people at the right time to contain any incidents.
- Be enabled by clear engagement and communication to help protect our staff and communities.

CORE FUNCTIONS

The following core functions will be prioritised pending further actions required:

- Critical and protected activity is to be maintained as far as possible.
- Routine inpatient and day case elective and outpatient activity maintained – predominantly Orthopaedics, General Surgery and Gynaecology
- Emergency attendances, referrals and patient flows In the Emergency Department will be managed in line with the redesign of urgent care principles.
- The Balfour senior leadership team (SLT) will join daily multi-agency SITREPs to ensure system awareness of current and emerging issues.
- Twice daily Balfour site safety huddles will be the key touch points to review safe staffing, capacity, placement plans and for escalation of any other safety concerns.

BED CONFIGURATION AND SURGE PLAN

The following principles have informed the development of this TOM:

- Minimum safe staffing levels exist in all areas and wards / areas are functioning safely as per proposed bed configuration plan.
- All Balfour site surge options have been considered and implemented where safe to do so before the request to Stabilise and Transfer outwith Board area for capacity purposes.
- Ambulance cohorting will not be possible at the Balfour due to lack of suitable space in proximity to ED. Surge options detailed in this paper will support whole site flow and minimise waiting times for SAS handover to ED.

HOSPITAL ACTIVITY

Bed occupancy and availability from July 2022, 2023 and 2024 is provided in figures 1, 2, 3 and 4 below. There is variation from year to year (in part as a result of the variable schedule of visiting services delivered in Orkney by staff from other Boards).

Figure 1. Bed Occupancy (IP1, IP2 and HDU – July 2022, 2023, 2024)

IP1, IP2, HDU Beds Occupied
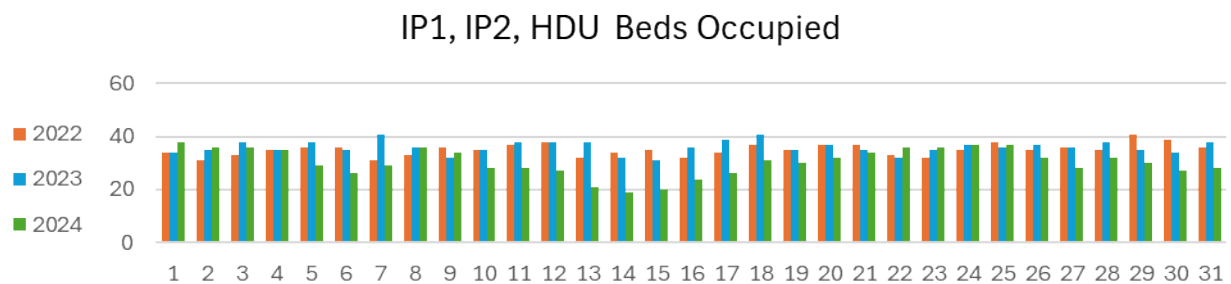
Figure 2. Beds Unoccupied (IP1, IP2 and HDU – July 2022, 2023, 2024)

IP1, IP2, HDU Beds Empty
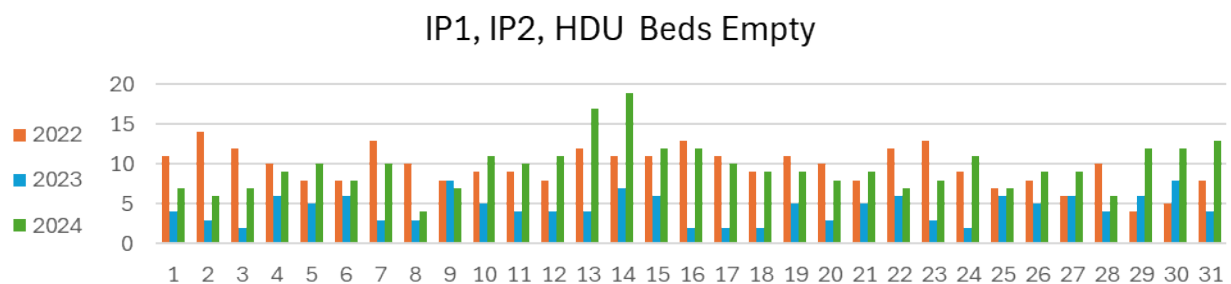
Table 1. Daily Average Bed Position (IP1, IP2, and HDU) – July 2022, 2023, 2024

	Daily Average Occupancy	Daily Average Empty	Daily Average Unavailable
July 2022	35.1 (79% of available)	9.6 (21% of available)	7.3
July 2023	36.0 (89% of available)	4.5 (11% of available)	11.5
July 2024	30.3 (76% of available)	9.7 (24% of available)	12.0

Figure 3. Bed Occupancy (Maternity) – July 2022, 2023, 2024

Maternity Beds Occupied
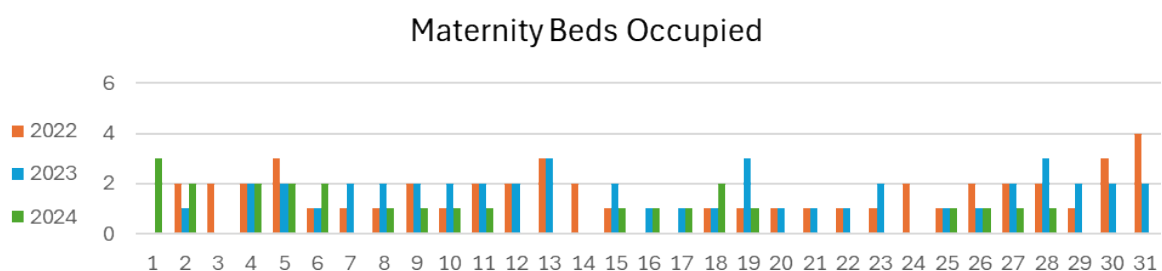
Figure 4. Beds Unoccupied (Maternity) – July 2022, 2023, 2024

Maternity Beds Empty
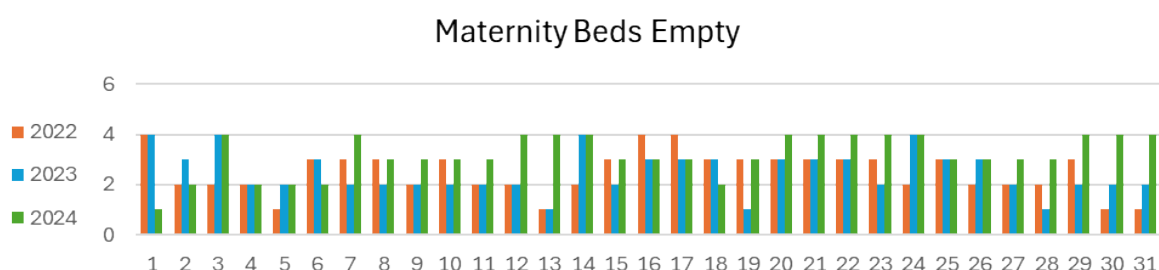
Table 2. Daily Average Bed Position (Maternity) – July 2022, 2023, 2024

	Daily Average Occupancy	Daily Average Empty	Daily Average Unavailable
July 2022	1.5 (38% of available)	2.5 (62% of available)	0
July 2023	1.5 (38% of available)	2.5 (62% of available)	0
July 2024	0.8 (20% of available)	3.2 (80% of available)	0

Figures 5 and 6 provide an overview of Emergency Department attendances and compliance with the 4 hour standard in July over the period 2022 to 2024.

Figure 5. ED Attendance and Compliance – July 2022, 2023, 2024

	Daily Average Attendances (All)	Daily Average Attendances (Standard)	Daily Average Attendances (Urgent)	Total 4Hr Breaches	Total Number Admitted	Average Admitted per Day
July 2022	19.71	18.26	5.7	43	121	3.9
July 2023	21.55	16.87	6.4	76	111	3.6
July 2024	23.35	13.97	9.2	63	130	4.2

Figure 6. ED Attendances by Day of Week and Hour of Day (July 2022, 2023, 2024)

Figure 7. ED Attendances by Hour of Day (July 2022, 2023, 2024)
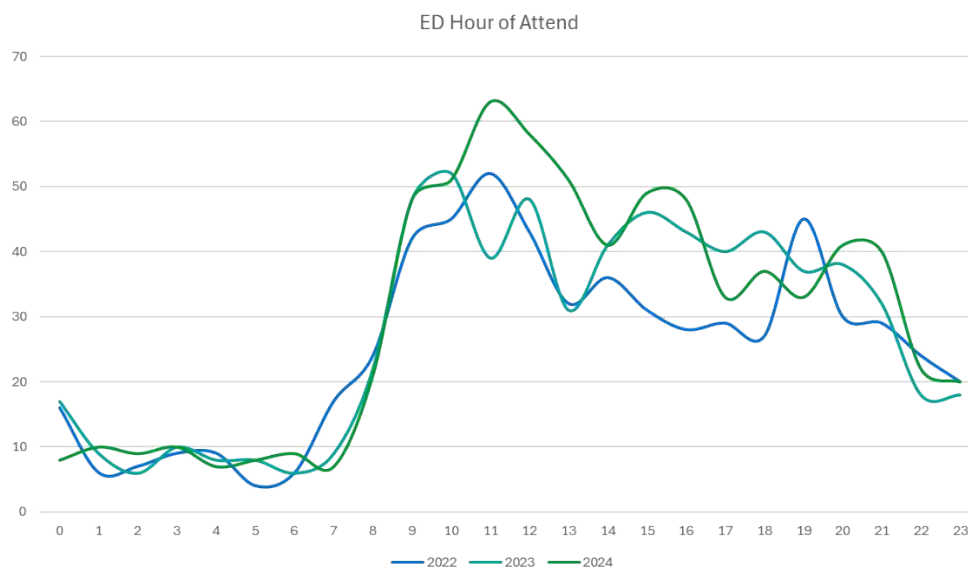
Figure 8. NHS Orkney All Attendances January 2008 – January 2024 (PHS)
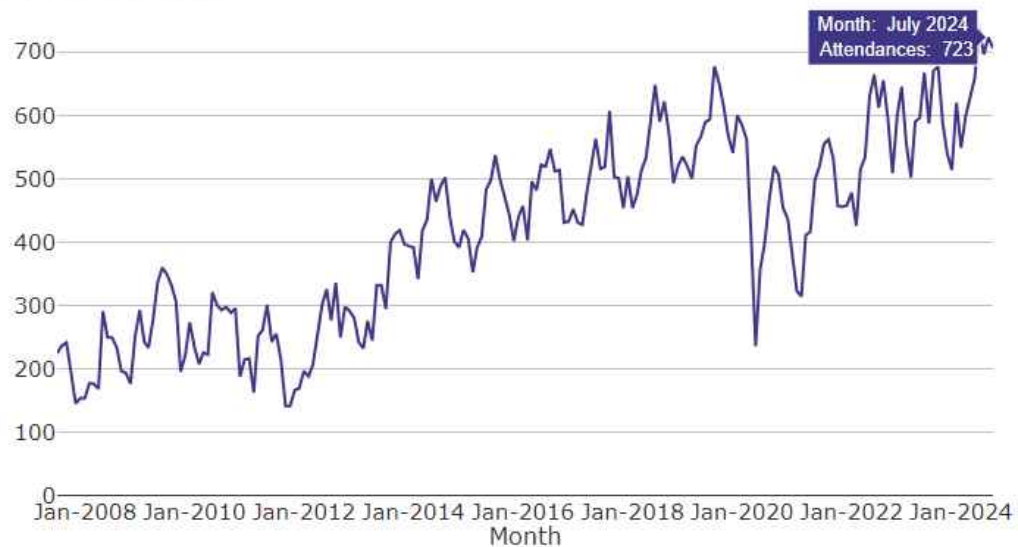
CAPACITY AND SURGE PLAN

The Balfour Hospital adult inpatient bed configuration is:

Ward	Specialty	Staffed in-Patient Capacity (Beds)	Maximum In-Patient Capacity with Surge
Inpatient 1	Acute Medicine, Surgery and Orthopaedics	20	22
Inpatient 2	Assessment and Rehabilitation	12	16
High Dependency Unit	High Dependency Level 2 Care	2	2
Macmillan / Palliative Care	Symptom Control / EoL Care	4	4
Day Case Unit	Day Cases	/	8
Maternity	Obstetrics	/	2
TOTAL		**38**	**54**

The Balfour has individual patient rooms with en-suite, allowing a higher degree of flexibility within the system at times of high occupancy and demand.

Location	Key considerations / Risks	Indicative order of surge
Inpatient 1	• Staff to patient ratio (considering numbers, speciality mix and acuity)	1st
Inpatient 2	• Staff to patient ratio (considering numbers, speciality mix and acuity)	2nd
Macmillan beds	• Staff to patient ratio (considering numbers, speciality mix and acuity) • Impact on Macmillan services	3rd
Maternity surge beds	• Staff to patient ratio (considering numbers, speciality mix and acuity • Impact on Maternity services	4th
ED Care	• Staff to patient ratio (considering numbers, speciality mix and acuity) • Impact on SAS turnaround times and response times • Impact on ED flow and capacity	5th
Conversion of DCU to inpatient beds	• Staff to patient ratio (considering numbers, speciality mix and acuity) • Cancellation of elective procedures and theatre activity • Increased waiting times	6th
Stabilise and Transfer- SG and regional request for support	• Impact on SAS turnaround times and response times • Poor patient journey with risk of deterioration during transfer	7th

Staff ratios – Inpatient 1

Ward ratios are as follows: Day shift 4 RN, 3 HCSW
                                               Night shift 3 RN, 2 HCSW

To increase from 20 to 22 in-patients: NO additional staffing required.
To increase from 22 in-patients and utilise
the 2 surge beds on Maternity: 1 RN per day and night shift will be required.

Staff ratios – Inpatient 2

Ward ratios are as follows: Day shift 2 RN, 2 HCSW
                                               Night shift 2 RN, 2 HCSW

To increase from 12 to 16 inpatients: NO additional staffing required.

Staff ratios – Emergency Department

ED ratios are as follows: Day shift 1 ENP, 2 RN, 1 HCSW
                                               Night shift 1 ENP, 1 RN

To accommodate patients overnight as
in-patients: Day shift 1 RN
                                               Night shift 1 RN

Staff ratios – Day Case Unit

To enable in patient capacity on the DCU: Day shift 2 RN and 1 HCSW per day
                                               Night shift 2 RN and 1 HCSW per day
                                               (These staff will be a cohort of staff from both IP1
                                               and DCU requiring skill mix review and oversight
                                               from the Clinical Nurse Managers)

Maternity will **NOT** be considered as a surge capacity option past the 2 beds on the basis that:
- midwives are not dual trained to care for adult speciality in-patients
- this would derogate the privacy, dignity and security of the maternity service at The Balfour beyond an acceptable level.

Alternative considerations in line with business continuity would be considered in the case of Major Incident declaration.

KEY RISKS

- Utilising surge areas requires comprehensive risk assessment to minimise IPC and other safety risks.
- Loss of any assessment function will have a detrimental impact on hospital flow.
- Availability of multi-professional staff to support the bed surge plan is currently not assured – this applies across all disciplines Nursing, Medical staffing, Physiotherapy, Occupational Therapy, Domestics, Pharmacy.

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 26 June 2025
Title:	Programme for Government 2025-26
Responsible Executive/Non-Executive:	Tammy Sharp, Director of Performance and Transformation (and Deputy CEO)
Report Author:	Alan Cooper, Interim Head of Strategy
	Carrie Somerville, Head of Planning, Performance and Information

1 Purpose

This report is presented to the Board for **Assurance:**

Members are asked to:

   i.   **Note** that NHS Orkney's 2025/26 Year 2 Corporate Strategy objectives largely align with the Programme for Government priorities.
   ii. **Receive** potential opportunities to align with the Programme for Government priorities and leverage opportunities for local implementation to enhance performance and efficiency.

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Annual Delivery Plan 2024/25
- Emerging issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Sustainability

2 Report summary

2.1 Situation

This paper provides an assessment of NHS Orkney's strategic alignment with the Scottish Government's Programme for Government (PfG) 2025-26, announced in May 2025. The full PfG is available at: https://www.gov.scot/publications/programme-government-2025-26/

This paper is intended to support strategic oversight by the Senior Leadership Team and onward assurance to the Finance & Performance Committee. The paper draws on NHS Orkney's 2025/26 Annual Delivery Plan (ADP) and Year 2 Corporate Strategy priorities. A detailed thematic mapping is provided in the appendix.

2.2 Background

The PfG is structured around 4 key priorities:

- Growing the Economy
- Eradicating Child Poverty
- Tackling the Climate Emergency
- High Quality and Sustainable Public Services

Not every aspect of the PfG is directly applicable or within the remit of NHS Orkney, therefore each has been examined for relevance and mapped to corresponding NHS Orkney activity, drawing on our stated priorities where appropriate.

2.3 Assessment

A review of the key Programme for Government commitments against NHS Orkney's stated 2025/26 priorities demonstrates strong alignment, particularly in terms of reducing waiting times, enabling local access to care, and embedding a prevention-first approach. This is summarised in Appendix 1.

However, while the direction is aligned, the PfG also presents areas where NHS Orkney must interpret the national policy intent through a local lens, especially around the operationalisation of island-based care models and digital transformation.

Furthermore, our corporate strategy pillars - Place, People, Patient Safety and Experience, Performance, and Potential – are all reinforced by the PfG. Our work is not only aligned but delivery is already underway against many of the expected outcomes through our Year 2 Corporate Strategy. Key areas are summarised below:

Place

We are progressing work to become a population health system, with prevention, inequalities, and community wellbeing embedded in our ADP. Our contribution to the Local Outcome Improvement Plan (LOIP), focus on screening and vaccination uptake, and early work on the national Population Health Framework all align strongly with national direction.

People

The PfG emphasis on sustainability and locally led change supports our Improving Together workstreams, workforce redesign and leadership development efforts. Our continued focus on recruitment, retention, and role diversification remains critical.

Patient Safety and Experience

The national focus on improving culture, learning, and openness mirrors our governance refresh, new approach to clinical engagement, and quality improvement efforts across the system.

Performance

Addressing long waits and delivering on our financial plan are key priorities in our Year 2 Corporate Strategy. Our targeted Planned Care Submission supports national objectives to reduce 52+ week waits, and we await confirmation of funding for our proposed initiatives

Potential

Digital innovation remains a key enabler. While national digital tools (e.g. dermatology, diabetes pathways) are promising, our implementation pace will depend on infrastructure, training, and support. Our progress on TrakCare optimisation, Near Me, and digital maturity plans is foundational to delivering transformation in our context.

2.3.1 Patient Safety and Quality

The national focus on improving culture, learning, and openness mirrors our governance refresh, new approach to clinical engagement, and quality improvement efforts across the system.

2.3.2 Workforce

The Workforce improvement workstream within the Improving Together Programme is well developed with 8 areas of focus. These include sickness management, mandatory training and appraisals. Corporate Leads have been identified for each area to drive delivery.

2.3.3 Financial

The Board remains at level 3 of the Scottish Government's NHS Finance and Escalation Framework. Workforce transformation accounts for around one third of projected savings for this Financial Year.

2.3.4 Risk Assessment/Management

Effective risk management is essential to ensuring the delivery of safe and high-quality patient care. Failure to proactively identify and address risks may compromise the Board's ability to deliver timely care, with potential adverse effects on patient outcomes and overall experience.

2.3.5 Equality and Diversity, including health inequalities.

Reducing health inequalities is a key priority as part of the Place strategic objective. Equality, diversity and inclusion are also central to the delivery of our People priorities and our Corporate Strategy takes into consideration local, regional, and national policy. The Equality and Diversity Monitoring Report for 2024/25 was approved by the Senior Leadership Team on 1 May 2025.

2.3.6 Communication, involvement, engagement, and consultation

Discussions have taken place with Heads of Service, in the development of this paper.

2.3.7 Route to the Meeting

- Paper presented for discussion and approval at Senior Leadership Team Meeting – Patient Safety, Quality & Experience, Performance and Place on 3rd June.

Assurance - The Board is asked to:

i.   **Note** that NHS Orkney's 2025/26 Year 2 Corporate Strategy objectives largely align with the Programme for Government priorities.
ii. **Receive** potential opportunities to align with the Programme for Government priorities and leverage opportunities for local implementation to enhance performance and efficiency.

4. List of appendices

The following appendices are included with this report:

- **Appendix 1**, Programme for Government 2025 - 26 – Assessment Against NHSO 2025/26 Priorities

Appendix A: Programme for Government – Review Against NHSO 2025/26 Priorities

This appendix provides a structured assessment of NHS Orkney's alignment with the Scottish Government's Programme for Government (PfG) 2025–26. It follows the four PfG strategic priorities and associated sub-headings, assessing each against NHS Orkney's Corporate Strategy and Annual Delivery Plan.

1. Growing the Economy

PfG Commitments:

- Support innovation, including investment in research, digital transformation, and scaling new technologies across sectors.
- Invest in rural economies, protect rural services, and support local infrastructure and resilience.
- Promote Scotland internationally as a destination for investment, sustainability, innovation, and culture.
- Support stronger local communities through place-based working, community empowerment, and local decision-making.

NHS Orkney Response:

NHS Orkney contributes to economic recovery through its role as an anchor institution. Our anchor plan, led by the Public Health team, includes actions on procurement, workforce development, and community wealth building. We are a key partner in the Community Planning Partnership (CPP) and contribute to local economic goals, including support for the Orkney Employability Pathway. Our Anchor Institution Plan supports community wealth building through local procurement, workforce training, and reduction of inequalities. We play an active role in LOIP delivery, supporting shared goals on poverty, wellbeing, and local resilience. Our procurement team work closely with us and other local partners to support the community benefits gateway set up to encourage the local community to submit requests for funding as part of the supplier requirement to provide community benefits as per the regulated procurement contracts.

NHS Orkney is progressing several digital transformation programmes, including TrakCare Inpatient EPR, Near Me expansion, deployment of MORSE in community services, introduction of the national theatre scheduling tool, digital diabetes and digital dermatology pilots. These innovations support more integrated, efficient, and accessible care and align with the 'Potential' and 'Performance' pillars of our corporate strategy. The ADP also highlights alignment with national digital maturity ambitions.

NHS Orkney's role as a key partner in the 2025 Island Games contributes to Orkney's profile as a healthy, sustainable island community. The Island Games is a significant opportunity to showcase Orkney to a global audience.

NHS Orkney's strategy and ADP are grounded in place-based approaches. We deliver community-based care through primary care, mental health, and community nursing, often in collaboration with the third sector.

Opportunities:

There is further opportunity to strengthen our contribution by further quantifying our economic impact and reporting more consistently through the CPP and Board structures. We should continue to build Board and public visibility of our role in place-based improvement.

Use upcoming opportunities - such as the single authority model - to shape NHS Orkney's leadership in public service reform and community development.

2. Eradicating Child Poverty

PfG Commitments:

- Take a whole-government approach to eradicating child poverty and meet the statutory child poverty targets.
- Mitigate cost-of-living pressures through support services, benefits advice, and improved access to essential services.
- Expand holistic family support through integrated local services and early intervention.
- Support parents and carers to enter or sustain employment.
- Improve energy efficiency and reduce fuel poverty.
- Improve early years outcomes, including speech, language, nutrition, and social development.
- Support care-experienced children and deliver on Promise implementation.
- Reduce structural inequalities and embed human rights and inclusion.

NHS Orkney Response:

NHS Orkney supports the Local Outcomes Improvement Plan (LOIP) and contributes to Local Child Poverty Action Reporting through active CPP membership and public health leadership. Our delivery plan includes actions around prevention, health inequalities, and targeted services for families and children. Our public health and prevention work seeks to tackle child poverty through strengthening the pathways between NHS Orkney services who have contact with children and the local community-based partners who offer support relating to accessing benefits, crisis support and fuel poverty. This includes established referral routes, including through midwives, to Orkney Money Matters to give financial support and identify opportunities for income maximisation.

As an anchor institution, NHS Orkney offers local employment, apprenticeships, and support for digital inclusion. Our partnership working through the CPP includes shared work on food security and transport. NHS Orkney participates in the Orkney Employability Pathway and supports flexible working, career pathways, and local recruitment initiatives. NHS Orkney supports signposting for housing and energy advice and works in partnership with local agencies on fuel poverty initiatives. Delivery of the Child Health Programme and early intervention services support this agenda, alongside public health input to HENRY (Healthy Families: Right from the Start) parents and carers programme and breastfeeding support led by maternity services. Maternity and Health Visiting Teams are proactive in promoting and supporting breast feeding and have retained UNICEF Gold Accreditation. We have a thriving and active Peer Support service with each woman offered a Peer contact antenatally. Opportunities to review skill mix are under consideration with a view to increasing our focus on maternal nutrition.

Opportunities:

While NHS Orkney contributes to the Local Child Poverty Action Report, tackling child poverty is not explicitly mentioned in our Corporate Strategy Year 2 priorities, meaning there is no dedicated Board-level statement on tackling child poverty. Greater clarity on our distinct NHS role, including resourcing and impact and opportunities to strengthen a cross-department approach, would strengthen alignment.

3. Tackling the Climate Emergency

PfG Commitments:

- Deliver a just, long-term transition to net zero.
- Create new green jobs and build low-carbon infrastructure.
- Reduce emissions from public, commercial, and personal transport.
- Increase energy efficiency and reduce emissions from buildings, with co-benefits for households experiencing fuel poverty.
- Strengthen community resilience to climate-related risks.
- Protect and restore biodiversity and natural habitats.
- Champion equitable global climate responses and support international leadership.

NHS Orkney Response:

Our delivery plan includes several initiatives that reduce carbon emissions or support sustainability, such as e-bike fleet use, estates decarbonisation planning, and digital consultation platforms.

NHS Orkney has recently decarbonised its estate by removing fossil fuels use across all its owned properties and implemented energy efficient heat pumps. It has also supported travel reduction via digital access (Near Me), and promoted local sustainability initiatives such as the introduction of a fleet of e-bikes. We contribute to wider net zero aims through procurement, public health advocacy, and infrastructure planning. Fleet upgrades, promotion of active travel, and investment in virtual consultation have helped reduce travel emissions. The ADP references sustainable transport solutions for staff and patients.

Our Anchor Institution Strategy supports the local green economy through procurement reform, digital delivery, and remote workforce development. We partner with OIC and UHI on skills and innovation.

Opportunities:

Consider more active promotion of NHS Orkney's green jobs potential and alignment with Orkney's renewable and innovation agenda.

4. High Quality and Sustainable Public Services

PfG Commitments:

- Renew the NHS by improving access, reducing waiting times, strengthening primary and community care, and investing in mental health and diagnostics.
- Strengthen public safety and resilience across justice, emergency services, and public health.
- Improve connectivity, reduce transport emissions, and ensure equitable access to sustainable transport.
- Modernise public services through reform, digital transformation, and stronger collaboration.

NHS Orkney Response:

NHS Orkney has committed to delivering improvements in planned care and has plans to enhance ENT, ophthalmology, orthopaedics, and diagnostics, supported by our planned care funding submissions.

A Primary Care Review is underway, focused on local access, multidisciplinary teams, and sustainability. Digital delivery is embedded across services through TrakCare, Near Me, GP IT and remote monitoring pilots. GIRFE is being used to inform pathway redesign.

NHS Orkney Response: Our health protection, emergency planning and resilience functions support multi-agency planning across infectious disease control, severe weather response, and resilience scenarios. We actively engage with Orkney's Local Resilience Partnership and emergency planning groups.

While NHS Orkney does not directly deliver transport services, we contribute through reduced staff and patient travel (e.g. Near Me), use of e-bikes and low-emission vehicles, and partnership working on active travel and transport access.

Our Corporate Strategy emphasises transformation through digital innovation, collaboration, partnership working, and staff empowerment. Participation in the single authority model is a key strategic opportunity. As a first step, it has been agreed that an initial session with the NHS Orkney CEO and Chair, and OIC CEO and Leader with SG, Govt officials and the proposed facilitators to discuss principles and parameters will take place ahead of a wider discussion with the NHS Orkney full Board and OIC elected members and senior colleagues early Summer 2025.

Opportunities:

There is limited public-facing data on local primary care access. These should be developed to support assurance and national alignment.

Ensure that learning from exercises and emergencies is embedded in local service improvement and clearly reported to the Board. Consider how this aligns with wider health inequalities and security risks.

Align strategic planning and governance with national reform expectations. The single island authority model discussions are an opportunity to enhance integration and explore:

- How we can further optimise public service delivery
- How we improve the effectiveness of the IJB/Community Planning Partnership – so we further improve outcomes and services for our community
- Maximising local accountability
- How we can reduce bureaucracy and duplication

NHS Orkney

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 26 June 2025
Title:	Infection Prevention HAIRT Report
Responsible Executive/Non-Executive:	Sam Thomas, Executive Director of Nursing Midwifery and AHPs & Chief Officer Acute
Report Author:	Sarah Walker Head of Infection Prevention

1   Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board

This aligns to the following NHS Scotland quality ambition(s):

- Safe

2   Report summary

2.1   Situation

This report is presented to the Board for assurance of patient safety for Infection prevention and control and to highlight NHS Orkneys compliance against the IP&C Standards.

The team undertake surveillance and monitoring of infections within NHS Orkney and support the IJB and Third Sector with infection prevention advice.

The Healthcare Associated Infections (HCAI) Local Delivery Plan (LDP) Standards have been issued with a DL (2025) 05. These are interim standards until such a time as the national surveillance review has been completed. This is expected to complete and an options appraisal to go to Scottish Government by November 2025, for review. Currently, the LDP standards have been confirmed for this year as:

> "No increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) by March 2026 from the 2023/2024 baseline".

The baseline figures (cases) were confirmed by ARHAI Scotland earlier this month.

For more information: [Protocol for National Enhanced Surveillance of Bacteraemia](#)

More information on specific pathogens can be found in the National Infection Prevention & Control Manual -[A-Z pathogens](#)

IPC involvement within the Healthcare Built Environment is relatively new to IPC Teams and is an area that is increasing in resource requirements, reducing IPC capacity to manage the core work of an IPC team.

2.2 Background

Infection prevention Team undertakes surveillance and monitoring of infections across Primary and Secondary Care with support for prevention of infection across the IJB and 3rd sector.

The Healthcare Associated Infection Reporting Template (HAIRT) was implemented in 2005 for Board assurance purposes and presented on a bi-monthly basis.

2.3 Assessment

Baseline data for LDP standards are set quite low and will be difficult to maintain/achieve, such as baseline rates of:

SAB – zero

CDI – 1

ECB – five

The important element is that each case is investigated and all preventable HCAIs have any learning and shared with clinicians. The data provided in the HAIRT follows the LDP Standard year. Some cases are yet to be validated with ARHAI so may change once finalised.

2.3.1 Quality/ Patient Care

The team aim to provide any learning from all cases investigations or incidents that would impact/improve patient care. There is clinician, and Infection Prevention Doctor input into all bacteraemia's and CDI cases.

2.3.2 Workforce

The Infection Prevention Workforce Strategic Plan 2022-24 has been implemented and roles and responsibilities have now been worked through locally.

2.3.3 Financial

N/A.

2.3.4 Risk Assessment/Management

Risk assessment is core to the IP&C service and risks raised around some elements of Chapter 4 – Water - within the National Infection Prevention & Control Manual.

2.3.5 Equality and Diversity, including health inequalities
N/A.

2.3.6 Climate Change Sustainability
N/A

2.3.7 Other impacts
N/A

2.3.8 Communication, involvement, engagement, and consultation
The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- Submission through the Infection Prevention and Control Committee – 4/6/25
- Joint Clinical and Care Governance through Chairs assurance papers

2.3.9 Route to the Meeting
This report has been prepared and submitted for acceptance through the route above.

2.4 Recommendation
- **Awareness** – For Members' information only.

3 List of appendices
The following appendices are included with this report:
- None

NHS Orkney
Infection Prevention & Control HAIRT Report
July 2025

Created by:
Sarah Walker
Infection Control Manager

Contents

2 Report Summary

2.1 Situation

This report is presented to the Board for assurance of patient safety for Infection prevention and control and to highlight NHS Orkneys compliance against the IP&C Standards.

The team undertake surveillance and monitoring of infections within NHS Orkney and support the IJB and Third Sector with infection prevention advice.

The Healthcare Associated Infections (HCAI) Local Delivery Plan (LDP) Standards have been issued with a DL (2025) 05. These are interim standards until such a time as the national surveillance review has been completed. This is expected to complete and an options appraisal to go to Scottish Government by November 2025, for review. Currently, the LDP standards have been confirmed for this year as:

"No increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) by March 2026 from the 2023/2024 baseline".

The baseline figures (cases) were confirmed by ARHAI Scotland earlier this month.

For more information: Protocol for National Enhanced Surveillance of Bacteraemia

More information on specific pathogens can be found in the National Infection Prevention & Control Manual -A-Z pathogens

IPC involvement within the Healthcare Built Environment is relatively new to IPC Teams and is an area that is increasing in resource requirements, reducing IPC capacity to manage the core work of an IPC team.

2.2 Background

Infection prevention Team undertakes surveillance and monitoring of infections across Primary and Secondary Care with support for prevention of infection across the IJB and 3rd sector.

The Healthcare Associated Infection Reporting Template (HAIRT) was implemented in 2005 for Board assurance purposes and presented on a bi-monthly basis.

2.3 Assessment

Baseline data for LDP standards are set quite low and will be difficult to maintain/achieve, such as baseline rates of:

SAB – zero

CDI – one

ECB – five

The important element is that each case is investigated and all preventable HCAIs have any learning and shared with clinicians. The data provided in the HAIRT follows the LDP Standard year. Some cases are yet to be validated with ARHAI so may change once finalised.

2.4 Recommendations

The Board is asked to note the report, and the Infection Prevention Team continue to support and facilitate improvement daily, updating staff and changes in the evidence bases; providing information and rationale for areas where improvement can be made. The team also ensure that feedback is given in real time.

![NHS Orkney logo]

Staphylococcus aureus bacteraemia (SAB)

Surveillance is in combination with the Leading Clinician to identify the underlying cause and any risk factors. The LDP standard to March 2026, has been confirmed as no increase in incidence (number of cases) of Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

 LDP Standard baseline using baseline data for 2023-24 – zero HCAI to date; Validation is yet to be confirmed with ARHAI Scotland.

<u>Dashboard</u>

LDP Standard Target Quarters for LDP standard year 2025-26	Total number of cases for *Staphylococcus aureus* bacteraemia (SAB)	HAI Related Cases based on LDP standard
Q1 – Apr - Jun	2	0
Q2 – Jul - Sep		
Q3 – Oct - Dec		
Q4 – Jan - Mar		

Clostridioides difficile Infection

Clostridioides difficile Infection surveillance is undertaken routinely along with the Leading Clinician or GP to identify cause and any risk factors.

The LDP standard to March 2026, has been confirmed as no Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

Zero HCAI cases to date, data yet to be validated with ARHAI.

Escherichia Coli (ECB) Bacteraemia

The LDP standard to March 2026, has been confirmed as no Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

2 under investigation for quarter 4, therefore not included in the data.

Clostridioides difficile Infection – LDP Standard Quarters for 2025-26

	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1	1	0	0
Q2			
Q3			
Q4			

Escherichia Coli (ECB) Bacteraemia – LDP Standard Quarters for 2025-26

	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1	0	0	0
Q2			
Q3			
Q4			

	Cases by Source
Respiratory	
Unknown	
Intra-abdominal	
Hepatobiliary	
Renal Tract Infection	

![NHS Orkney logo]

Multi Drug Resistant Organism (MDRO) Clinical Risk Assessment National Screening

This reported in calendar year quarters by ARHAI. **Target is set at 90%**

The data reflects that a documented formal risk assessment at time of patient admission was carried out to assess whether a patient would be considered to fall

into a **higher risk category for Meticillin Resistant *Staphylococcus aureus* (MRSA) or Carbapenemase-producing *Enterobacteriaceae* (CPE)**

colonisation and does not reflect MRSA or CPE colonisation rates. The criteria for clinical risk assessment is below.

Meticillin Resistant *Staphylococcus aureus* (MRSA)	Carbapenemase-producing *Entrobacteriaceae* (CPE)
The patient has been admitted with a chronic wound/ulcer, or an invasive device which was present prior to admission.	Has the patient been an inpatient in a hospital outside of Scotland in the previous 12 months?
Resident in a Care Home or transferred from another inpatient ward or another hospital	Has the patient had holiday dialysis outside of Scotland in the previous 12 months?
Is admitted to a higher risk speciality (HDU)	Does patient share a bedroom with a colonised /infected CPE case?
Expected to undergo invasive orthopaedic surgery (other than day care)	

Clinical Risk Assessment KPI by Quarter – Local and National Data

Nationally Produced Data →

Quarters by calendar year as reported by ARHAI Scotland	Local MRSA Screening % Scores	Local CPE Screening % Scores	National MRSA Screening % Scores For Benchmarking only	National CPE Screening % Scores For Benchmarking only
Q2Apr-Jun 2024	76%	100%	81%	81%
Q3 Jul-Sept 2024	67%	100%	81%	80%
Q4 Oct-Dec-2024	93%	100%	81%	83%
Q1 Jan-Mar 2025	83%	100%	81%	84%
National Set Target	**90%**	**90%**	**90%**	**90%**

![NHS Orkney logo]

Hand Hygiene

The hand hygiene score for April to May 2025 is now **90%** against the **95% target.**

Missed opportunities through inappropriate personal protective equipment use, poor hand hygiene technique and dress code compliance are the main issues recorded.

Local Domestic and Estates Environmental Scores

The environment is crucial to prevention/transmission of infection; the domestic score continues to sit above the Scottish target of 93%.

No audits were undertaken for January or March due to a glitch with the National Monitoring tool.

The score for April and May has fallen below target, this is reported to be staffing pressures, supervision has been minimised as the supervisors are covering gaps/vacancies in service. The Facilities Team are hoping that most of these issues will be resolved in the forthcoming weeks.

	Domestics % score	Estates % score
Apr-24	96%	99%
May-24	98%	100%
Jun-24	95%	99%
Jul-24	Unavailable	Unavailable
Aug-24	94%	100%
Sep-24	92%	100%
Oct-24	97%	100%
Nov-24	97%	100%
Dec-24	94%	100%
Jan-25	Unavailable	Unavailable
Feb-25	95%	99%
Mar-25	Unavailable	Unavailable
Apr- 25	90%	100%
May-25	91%	100%

Infection Prevention Team Updates

The Primary Care Infection Prevention & Control (IPC) Quality assurance audits are currently in progress with eight out of fifteen practices completed to date. The current practice audit tool has been adapted to include the latest published guidance on water safety from the National Infection Prevention & Control Manual (NIPCM) – Chapter 4 -water, which was issued alongside a DL (2024) 17 and further supported by DL (2024) 24, which highlights the expectation of Board compliance and monitoring against all aspects of the NIPCM. The requirements have also been duplicated in the secondary care IPC audits to ensure that compliance is being monitored on an ongoing basis.

The work on Chapter 4 has been undertaken by a small, short life working group to ensure NHSO is compliant with the Chapter as soon as possible, a gap analysis and action plan has been formulated to measure where improvements can be made. Risks have been raised for some aspects of Chapter 4, where the short life working group continue to work on aspects of the water guidance, and for areas where a derogation is required.

The Built environment work is becoming vast and ongoing and impacting on the daily IPC work, the role on an IPC practitioner has changed dramatically in recent years and the capacity for everyday IPC workload is being impacted, a risk will be raised at the next Risk Management Group to capture staff capacity, at this time.

Care Home Support

IPC Practitioner has supported one Care Home following the recent outbreak there, undertaking a question-and-answer session for staff there. 26 staff members presented for update training and discussions were held around room cleaning, when caring for residents with infections, as well as personal protective equipment refresher and general outbreak management, such as criteria for declaring cases.

The Collaborative Care Home Support Group continue to meet on an as required basis and the team have met to discuss learning from recent outbreak incidents.

Exception Reporting to Scottish Government

No exception reports submitted.

NHS Orkney

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 26 June 2025
Title:	Infection Prevention HAIRT Report
Responsible Executive/Non-Executive:	Sam Thomas, Executive Director of Nursing Midwifery and AHPs & Chief Officer Acute
Report Author:	Sarah Walker Head of Infection Prevention

1   Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board

This aligns to the following NHS Scotland quality ambition(s):

- Safe

2   Report summary

2.1   Situation

This report is presented to the Board for assurance of patient safety for Infection prevention and control and to highlight NHS Orkneys compliance against the IP&C Standards.

The team undertake surveillance and monitoring of infections within NHS Orkney and support the IJB and Third Sector with infection prevention advice.

The Healthcare Associated Infections (HCAI) Local Delivery Plan (LDP) Standards have been issued with a DL (2025) 05. These are interim standards until such a time as the national surveillance review has been completed. This is expected to complete and an options appraisal to go to Scottish Government by November 2025, for review. Currently, the LDP standards have been confirmed for this year as:

"No increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) by March 2026 from the 2023/2024 baseline".

The baseline figures (cases) were confirmed by ARHAI Scotland earlier this month.

For more information: [Protocol for National Enhanced Surveillance of Bacteraemia](#)

More information on specific pathogens can be found in the National Infection Prevention & Control Manual -[A-Z pathogens](#)

IPC involvement within the Healthcare Built Environment is relatively new to IPC Teams and is an area that is increasing in resource requirements, reducing IPC capacity to manage the core work of an IPC team.

2.2 Background

Infection prevention Team undertakes surveillance and monitoring of infections across Primary and Secondary Care with support for prevention of infection across the IJB and 3rd sector.

The Healthcare Associated Infection Reporting Template (HAIRT) was implemented in 2005 for Board assurance purposes and presented on a bi-monthly basis.

2.3 Assessment

Baseline data for LDP standards are set quite low and will be difficult to maintain/achieve, such as baseline rates of:

SAB – Zero

CDI – One

ECB – Five

The important element is that each case is investigated and all preventable HCAIs have any learning and shared with clinicians. The data provided in the HAIRT follows the LDP Standard year. Some cases are yet to be validated with ARHAI so may change once finalised.

2.3.1 Quality/ Patient Care

The team aim to provide any learning from all cases investigations or incidents that would impact/improve patient care. There is clinician, and Infection Prevention Doctor input into all bacteraemia's and CDI cases.

2.3.2 Workforce

The Infection Prevention Workforce Strategic Plan 2022-24 has been implemented, and roles and responsibilities have now been worked through locally.

2.3.3 Financial

N/A.

2.3.4 Risk Assessment/Management

Risk assessment is core to the IP&C service and risks raised around some elements of Chapter 4 – Water - within the National Infection Prevention & Control Manual.

2.3.5 Equality and Diversity, including health inequalities
N/A.

2.3.6 Climate Change Sustainability
N/A

2.3.7 Other impacts
N/A

2.3.8 Communication, involvement, engagement, and consultation
The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- Submission through the Infection Prevention and Control Committee – 040/6/2025
- Joint Clinical and Care Governance through Chairs assurance papers

2.3.9 Route to the Meeting
This report has been prepared and submitted for acceptance through the route above.

2.4 Recommendation
- **Awareness** – For Members' information only.

3 List of appendices
The following appendices are included with this report:
- None

NHS Orkney
Infection Prevention & Control HAIRT Report
June 2025

Created by:
Sarah Walker
Infection Control Manager

Contents

2   Report Summary

2.1   Situation

This report is presented to the Board for assurance of patient safety for Infection prevention and control and to highlight NHS Orkneys compliance against the IP&C Standards.

The team undertake surveillance and monitoring of infections within NHS Orkney and support the IJB and Third Sector with infection prevention advice.

The Healthcare Associated Infections (HCAI) Local Delivery Plan (LDP) Standards have been issued with a DL (2025) 05. These are interim standards until such a time as the national surveillance review has been completed. This is expected to complete and an options appraisal to go to Scottish Government by November 2025, for review. Currently, the LDP standards have been confirmed for this year as:

"No increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) by March 2026 from the 2023/2024 baseline".

The baseline figures (cases) were confirmed by ARHAI Scotland earlier this month.

For more information: [Protocol for National Enhanced Surveillance of Bacteraemia](#)

More information on specific pathogens can be found in the National Infection Prevention & Control Manual -[A-Z pathogens](#)

IPC involvement within the Healthcare Built Environment is relatively new to IPC Teams and is an area that is increasing in resource requirements, reducing IPC capacity to manage the core work of an IPC team.

2.2   Background

Infection prevention Team undertakes surveillance and monitoring of infections across Primary and Secondary Care with support for prevention of infection across the IJB and 3rd sector.

The Healthcare Associated Infection Reporting Template (HAIRT) was implemented in 2005 for Board assurance purposes and presented on a bi-monthly basis.

2.3 Assessment

Baseline data for LDP standards are set quite low and will be difficult to maintain/achieve, such as baseline rates of:

SAB – zero

CDI – one

ECB – five

The important element is that each case is investigated and all preventable HCAIs have any learning and shared with clinicians. The data provided in the HAIRT follows the LDP Standard year. Some cases are yet to be validated with ARHAI so may change once finalised.

2.4 Recommendations

The Board is asked to note the report, and the Infection Prevention Team continue to support and facilitate improvement daily, updating staff and changes in the evidence bases; providing information and rationale for areas where improvement can be made. The team also ensure that feedback is given in real time.

Staphylococcus aureus bacteraemia (SAB)

Surveillance is in combination with the Leading Clinician to identify the underlying cause and any risk factors. The LDP standard to March 2026, has been confirmed as no increase in incidence (number of cases) of Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

 LDP Standard baseline using baseline data for 2023-24 – zero HCAI to date.

Dashboard

LDP Standard Target Quarters for LDP standard year 2025-26	Total number of cases for *Staphylococcus aureus* bacteraemia (SAB)	HCAI Cases based on LDP standard
Q1 – Apr - Jun	2	0
Q2 – Jul - Sep		
Q3 – Oct - Dec		
Q4 – Jan - Mar		

![NHS Orkney logo]

Clostridioides difficile Infection

Clostridioides difficile Infection surveillance is undertaken routinely along with the Leading Clinician or GP to identify cause and any risk factors.

The LDP standard to March 2026, has been confirmed as no Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

Zero HCAI cases to date, data yet to be validated with ARHAI.

Escherichia Coli (ECB) Bacteraemia

The LDP standard to March 2026, has been confirmed as no Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

Zero cases for Q1 of 2025

Clostridioides difficile Infection – LDP Standard Quarters for 2025-26

	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1	0	0	0
Q2			
Q3			
Q4			

Escherichia Coli (ECB) Bacteraemia – LDP Standard Quarters for 2025-26

	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1	0	0	0
Q2			
Q3			
Q4			

	Cases by Source
Respiratory	
Unknown	
Intra-abdominal	
Hepatobiliary	
Renal Tract Infection	

Multi Drug Resistant Organism (MDRO) Clinical Risk Assessment National Screening

This reported in calendar year quarters by ARHAI. **Target is set at 90%**

The data reflects that a documented formal risk assessment at time of patient admission was carried out to assess whether a patient would be considered to fall into a **higher risk category for Meticillin Resistant *Staphylococcus aureus* (MRSA) or Carbapenemase-producing *Enterobacteriaceae* (CPE) colonisation** and does not reflect MRSA or CPE colonisation rates. The criteria for clinical risk assessment is below.

Meticillin Resistant *Staphylococcus aureus* (MRSA)	Carbapenemase-producing *Entrobacteriaceae* (CPE)
The patient has been admitted with a chronic wound/ulcer, or an invasive device which was present prior to admission.	Has the patient been an inpatient in a hospital outside of Scotland in the previous 12 months?
Resident in a Care Home or transferred from another inpatient ward or another hospital	Has the patient had holiday dialysis outside of Scotland in the previous 12 months?
Is admitted to a higher risk speciality (HDU)	Does patient share a bedroom with a colonised /infected CPE case?
Expected to undergo invasive orthopaedic surgery (other than day care)	

Clinical Risk Assessment KPI by Quarter – Local and National Data

Nationally Produced Data	Quarters by calendar year as reported by ARHAI Scotland	Local MRSA Screening % Scores	Local CPE Screening % Scores	National MRSA Screening % Scores For Benchmarking only	National CPE Screening % Scores For Benchmarking only
	Q2Apr-Jun 2024	76%	100%	81%	81%
	Q3 Jul-Sept 2024	67%	100%	81%	80%
	Q4 Oct-Dec-2024	93%	100%	81%	83%
	Q1 Jan-Mar 2025	83%	100%	81%	84%
	National Set Target	**90%**	**90%**	**90%**	**90%**

Hand Hygiene

The hand hygiene score for April to May 2025 is now **90%** against the **95% target.**

Missed opportunities through inappropriate personal protective equipment use, poor hand hygiene technique and dress code compliance are the main issues recorded.

Hand Hygiene -2025

Hand hygiene Apr- May 2025 by Staff Group

Local Domestic and Estates Environmental Scores

The environment is crucial to prevention/transmission of infection; the domestic score continues to sit above the Scottish target of 93%.

No audits were undertaken for January or March due to a glitch with the National Monitoring tool.

The score for April and May has fallen below target, this is reported to be staffing pressures, supervision has been minimised as the supervisors are covering gaps/vacancies in service. The Facilities Team are hoping that most of these issues will be resolved in the forthcoming weeks.

	Domestics % score	Estates % score
Apr-24	96%	99%
May-24	98%	100%
Jun-24	95%	99%
Jul-24	Unavailable	Unavailable
Aug-24	94%	100%
Sep-24	92%	100%
Oct-24	97%	100%
Nov-24	97%	100%
Dec-24	94%	100%
Jan-25	Unavailable	Unavailable
Feb-25	95%	99%
Mar-25	Unavailable	Unavailable
Apr- 25	90%	100%
May-25	91%	100%

Infection Prevention Team Updates

The Primary Care Infection Prevention & Control (IPC) Quality assurance audits are currently in progress with eight out of fifteen practices completed to date. The current practice audit tool has been adapted to include the latest published guidance on water safety from the National Infection Prevention & Control Manual (NIPCM) – Chapter 4 -water, which was issued alongside a DL (2024) 17 and further supported by DL (2024) 24, which highlights the expectation of Board compliance and monitoring against all aspects of the NIPCM. The requirements have also been duplicated in the secondary care IPC audits to ensure that compliance is being monitored on an ongoing basis.

The work on Chapter 4 has been undertaken by a small, short life working group to ensure NHSO is compliant with the Chapter as soon as possible, a gap analysis and action plan has been formulated to measure where improvements can be made. Risks have been raised for some aspects of Chapter 4, where the short life working group continue to work on aspects of the water guidance, and for areas where a derogation is required.

The Built environment work is becoming vast and ongoing and impacting on the daily IPC work, the role on an IPC practitioner has changed dramatically in recent years and the capacity for everyday IPC workload is being impacted, a risk will be raised at the next Risk Management Group to capture staff capacity, at this time.

Care Home Support

IPC Practitioner has supported one Care Home following the recent outbreak there, undertaking a question-and-answer session for staff there. 26 staff members presented for update training and discussions were held around room cleaning, when caring for residents with infections, as well as personal protective equipment refresher and general outbreak management, such as criteria for declaring cases.

The Collaborative Care Home Support Group continue to meet on an as required basis and the team have met to discuss learning from recent outbreak incidents.

Exception Reporting to Scottish Government

No exception reports submitted.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Clinical Services Review Methodology and next steps**
Responsible Executive/Non-Executive:	**Dr Anna Lamont – Medical Director, Sam Thomas – Executive Director Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services, Dr Louise Wilson – Director of Public Health**
Report Author:	**Dr Anna Lamont – Medical Director** **Sam Thomas - Executive Director Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services** **Stephen Brown – Chief Officer Integration Joint Board**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:
- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Clinical Services Review (CSR) was commissioned to identify opportunities for improving outcomes, efficiency, and sustainability in healthcare delivery across NHS Orkney. This paper presents an interim assessment of progress to date and outlines the governance arrangements for the forthcoming prioritisation and implementation of final recommendations. The Board is asked to note the update and the next phase of governance and decision-making.

2.2   Background

The CSR has followed a two-phase methodology: Phase 1 focused on service review and mapping; Phase 2 develops future service proposals. The CSR aimed to align with the Renewal and Reform Framework, Operational Improvement Plan, and Population Health Framework based on information on the frameworks available at the time of the review. Engagement has been broad, involving clinicians, partner boards, and national centres, and has yielded thematic insights to guide service redesign.

2.3   Assessment

2.3.1   Quality/ Patient Care

The CSR identifies opportunities to improve care integration, streamline pathways, and enhance digital infrastructure. Anticipated positive impacts include enhanced continuity of care, reduced duplication, and improved patient outcomes. Risks include disruption during change processes and unmet expectations if implementation is under-resourced

2.3.2   Workforce

Recommendations aim to mitigate existing workforce pressures through better integration, operational support, and skill mix innovation. However, successful delivery will depend on staff engagement and realistic expectations, especially given current capacity constraints in project and change management.

2.3.3   Financial

Whilst several recommendations aim to drive efficiency, implementation will in some cases require upfront investment in areas such as IT infrastructure, workforce development, and change support. A detailed delivery plan and impact analysis will be necessary to support financial governance for those recommendations that are taken forward.

2.3.4   Risk Assessment/Management

Governance risks include disruption to operational delivery, insufficient stakeholder engagement, and failure to deliver against strategic objectives. Risks will be addressed through use of existing programme boards and quality impact assessments, with oversight from the Improving Together Programme Board. The recommendations will be prioritised, noting some have dependencies outside of NHS Orkney, and some require financial investment for transformation.

2.3.5   Equality and Diversity, including health inequalities

The CSR incorporates consideration of island health inequalities and service access across Orkney, including ferry-linked islands. Further impact assessments will be completed alongside the implementation planning.

2.3.6 Climate Change Sustainability

Digital transformation proposals, such as virtual care, support carbon reduction by reducing patient travel. Further environmental impacts will be assessed in the delivery planning phase.

2.3.7 Other impacts

Closer alignment with national and regional initiatives (e.g. North of Scotland collaboration) may generate additional benefits in resilience and shared service delivery.

2.3.8 Communication, involvement, engagement and consultation

Engagement to date includes interviews with 90 clinicians and three workshops with over 80 participants. Ongoing involvement of Clinical Advisory Groups and transparent communication with stakeholders will continue. National and regional stakeholders, including Scottish Government and NHS partner boards, are being actively engaged through established groups.

2.4 Recommendation

- **Awareness** – Note the interim assessment of the Clinical Services Review.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1**, CSR Methodology and Next Steps (8 June 2025)

NHS Orkney Clinical Services Review

Interim Assessment and Governance Next Steps

- Dr Anna Lamont – Medical Director
- Sam Thomas – Executive Director Nursing, Midwifery, Allied Health Professionals and Chief Office Acute Services
- Stephen Brown – Chief Officer Integration Joint Board

8th June 2025

Situation

The Clinical Services Review (CSR) has been commissioned by NHS Orkney, with support from the Scottish Government (SG), to evaluate current services and identify opportunities to optimise and sustainably deliver healthcare. The primary objectives are improving patient outcomes, enhancing service efficiency, and adapting proactively to anticipated future healthcare demands.

This interim report summarises the CSR's current status, the engagement activities undertaken, and outlines the governance considerations necessary to assess and implement the final recommendations.

Background

The CSR adopts a structured two-phase methodology. Phase one concentrates on reviewing and mapping existing services, identifying current operational strengths, challenges, and opportunities. Phase two focuses on developing forward-looking proposals to ensure sustainable, high-quality healthcare provision aligned with both local and national policy objectives.

This robust review aligns with national policy drivers such as the Renewal and Reform Framework, Operational Improvement Plan, and Population Health Framework, alongside local strategic directives encapsulated in NHS Orkney's Corporate Strategy and the 2023/24 Annual Delivery Plan.

Engagement to Date

Clinical and stakeholder engagement has significantly informed the CSR, including input from clinicians in North of Scotland NHS partner boards and National Treatment Centres. Approximately 90 clinicians have participated in detailed interviews, providing insights into service performance and opportunities, which have been integrated into service templates. Additionally, three feedback workshops were held over May and early June, engaging around 80 clinicians to discuss preliminary findings and inform proposals for future healthcare delivery in Orkney.

Scope and Themes Covered by the CSR

The CSR encompasses several broad areas:

1) **Hospital Services**: Including the Emergency Department, High Dependency Unit, Obstetrics and Gynaecology, and specialised services such as Diabetes and Dermatology.
2) **Primary Care and Community Services**: Addressing GP workload, integration with specialist services, mental health support, and innovations in community nursing and allied health professions (AHP).
3) **Digital Healthcare**: Promoting future digital transformation initiatives such as virtual wards, patient self-management tools, and advanced predictive healthcare capabilities.

Key themes include promoting healthy living, enhancing self-management, embracing digital innovation, and achieving sustainable healthcare resource utilisation. Integration across primary and secondary health services and clear clinical pathways have been identified as critical enablers.

Governance Next Steps

Recommendations arising from the final CSR report are anticipated to be available for presentation at the first available Board meeting after the completion of the Report. Assessment of feasibility, and a delivery plan will be required to determine how the recommendations are to be implemented. To facilitate this, the following governance steps are highlighted:

a) Governance Considerations

- Recommendations will be evaluated against established governance criteria, including clinical safety, financial sustainability, service quality impact, regulatory compliance, and alignment with strategic goals.
- Our existing Quality Impact Assessment panel and templates will be utilised from the established improving together programme.
- Clear delineation of accountability and reporting mechanisms for implementation will be essential.
- The CSR outcomes will inform additions to existing governance frameworks to incorporate necessary oversight and assurance measures, utilising existing governance structures including the Improving Together Programme Board for oversight of transformation programmes, and the Planned Care Programme Board for oversight of performance.
- The NHS Board and the Integration Joint Board (as appropriate) will be required to approve any changes in models of delivery that have implications beyond operational improvement.
- Clinical advisory groups will be an essential part of clinical staff engagement and the existing operational clinical governance groups will review and approve clinical policy changes where these arise from the recommendations.

b) Methodology for Recommendation Prioritisation

- Recommendations will be categorised based on urgency, potential impact on service quality, feasibility of implementation, and resource requirements.

- A structured prioritisation framework, incorporating risk assessment and cost-benefit analyses, will guide decision-making.
- Prioritisation will also consider dependencies between recommendations, ensuring coherent sequencing of actions.

Examples of recommendations from the CSR to be considered include:

- Strengthening Emergency Department services by developing a single front-door model integrating flexible teams such as Out of Hours clinicians, SAS paramedics and first responders.
- Optimising clinical pathways for frailty, ambulatory care, and pre-operative assessments.
- Enhancing digital infrastructure by implementing consistent Electronic Patient Records (EPR) - specifically reviewing underutilised functionality of Trakcare.
- Creating an operational management team at the Balfour Hospital to focus on performance, staffing, and service delivery.
- Implementing nurse-led mental health liaison services to support primary care.

Detailed case studies like Dermatology, which successfully utilises specialist GPSI (GP with Special Interest) and NHS Tayside support, and Diabetes care featuring joint clinics and advanced IT support, demonstrate how targeted improvements can be effectively implemented.

c) Clinical and Stakeholder Engagement

- Engagement activities primarily through the Clinical Advisory Groups will ensure clinical staff and stakeholders are actively engaged in refining recommendations, fostering collective ownership and commitment to implementation.
- Transparent communication will be essential to ensure all stakeholders remain informed throughout decision-making for prioritisation and implementation.

d) Scottish Government and Wider Partner Engagement

- Dialogue will be maintained with the Scottish Government to align recommendations with national healthcare priorities and secure necessary funding or policy support, particularly considering Island Communities Impact.
- Engagement with wider NHS Scotland entities, regional NHS boards, and community services will be required to ensure cohesive delivery across health and social care boundaries.
- Regional collaboration opportunities, such as the Virtual North of Scotland (NoS) initiative are part of existing programmes of regional development, and the relevant parts of the recommendations will be shared with regional NoS boards.
- Ongoing engagement with regional and national innovation partners will leverage external expertise, particularly in digital health and sustainable healthcare delivery models.

e) Oversight of Progress

- Robust project management will be essential to oversee the implementation of approved recommendations, including clear milestones and performance indicators.
- Recognising the significant limitations of project and change management resources within NHS Orkney, prioritisation and feasibility assessments will be critical. This will involve detailed engagement with Clinical Advisory Groups and the Extended Senior Leadership Team (ESLT).
- Outcomes from this process will inform updates to the clinical strategy, acknowledging identified high-resource areas such as out-of-hours services, shared service models, and Isles model of care.
- Explicit identification and management of governance risks such as operational disruptions, insufficient staff engagement, and resource inadequacy will be integral, with proactive mitigation strategies developed.

Summary

The CSR represents a significant opportunity to inform our clinical strategy and future of care in NHS Orkney, enhancing quality, sustainability, and patient experience. This interim report underscores the comprehensive preparatory work undertaken and the critical governance steps required to ensure robust evaluation and effective implementation of recommendations.

Further detailed recommendations and the implementation plan will be presented for consideration following production of the final report.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**NHS Orkney Medical Device Policy**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Anna Lamont**

1   Purpose

This is presented to the Board for:

- Approval

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Sustainable

2   Report summary

- NHS Orkney is required to have a Board-level Medical Equipment Policy in place by 31 March 2025 as per SGHD/CMO(2024)17 and CEL 35 (2010).
- The policy presented meets the national checklist for Medical Devices Policies and supports compliance with future Medical Device Regulation (MDR) requirements.
- The policy ensures safe, effective lifecycle management of medical equipment and defines responsibilities across all departments.

The document was submitted to the Scottish Government Medical Devices Policy Unit for review on 15 April 2025 and was approved at SLT on 3rd June 2025.

2.1   Situation

Scottish Government guidance (SGHD/CMO(2024)17) requires each Health Board to adopt and publish a Board Medical Equipment Policy to support regulatory compliance, safe practice and governance. This paper presents the final version of the NHS Orkney policy for approval.

2.2   Background

Following CEL 35 (2010), Boards must demonstrate safe and structured medical equipment management. The CMO's 2024 letter reiterates the importance of policy-led governance as a foundation for MDR readiness. NHS Orkney's draft was submitted to SG in April 2025 for review by IRIC.

2.3   Assessment

The policy covers the full lifecycle of medical devices including governance, risk, training, procurement, and disposal. Specific local structures (e.g. Estates lead replacing Medical Physics) are clearly defined. Risks around implementation delays in sub-procedures have been recognised and will be addressed through the Medical Devices Group.

2.4   Recommendation

Decision – The Board is requested to approve the NHS Orkney Medical Equipment Policy.

3   List of appendices

The following appendix is included with this report:

Appendix 1: NHS Orkney Devices Policy v1.3

Medical Devices Policy

NHS Orkney

Document Number	1.3
Name	Medical Devices Policy
Summary	To ensure safe effective lifecycle management of all medical equipment
Associated documents	
Target audience	All staff who are involved in any aspect of the medical equipment lifecycle (selection, procurement, use, training, support & disposal)
Version number	
Date of this version	March 2025
Review date	
Date of fairness test summary	
Name of Board	NHS Orkney
Approving committee/group	Medical Device Group
Document author	Anna Lamont. Medical Director

CONTENTS

Medical Devices Policy

1. Introduction

Medical equipment and devices are key to the delivery of healthcare services across NHS Orkney. Effective management of these resources minimises risk, ensuring all equipment is:

- Suitable for its intended purpose
- Properly understood by the user
- Appropriately maintained
- Used only for its intended purpose
- Procured in a controlled, co-ordinated way demonstrating best value for the Board taking into account whole-life costs

Specific guidance published by the Medicines and Healthcare products Regulatory Agency (MHRA) and the Scottish Government are fundamental to the formation of this policy:

MHRA Managing Medical Devices (2014)

Scottish Government CEL 35 (2010) A policy for Property and Asset management in Scotland

The Board carries out a range of equipment intensive clinical specialities, each requiring highly complex specialist medical devices. This policy outlines the organisations systematic approach to complete medical equipment lifecycle management. It aims to ensure that recommended safety standards and applicable legislation is adhered to at all times.

2. Medical equipment definition

For the purposes of this policy, the terms medical device and medical equipment are inter-changeable. The term 'medical device' encompasses medical devices as legally defined in the Medical Devices Directive 93/42/EEC. The Regulations define a medical device as:

> *'any instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for human beings for the purpose of: diagnosis, prevention, monitoring, treatment or alleviation of disease diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap investigation, replacement or modification of the anatomy or of a physiological process control of conception and which does not achieve its principle intended action in or on the human body by pharmacological, immunological or metabolic means but may be assisted in its function by such means.'*

2.1. Differentiating between re-usable and single use devices

Medical devices can be broadly split into two main categories:

- re-usable
- single use and limited usage devices

Table 1 provides examples of medical devices in each category and details the associated organisational roles and responsibilities.

Description	Re-usable medical devices/equipment	Single use & limited use medical devices
Examples	Ventilators	Syringes
	Infusion Devices	Bandages
	Patient Monitoring	Gloves
	Hospital Beds	Walking sticks
	Patient Trolleys	
	Portering Wheelchairs	
	Patient Hoists	
	Pressure Mattresses	
	Theatre tables	
Oversight	Medical Devices Group	Practice Development / Procurement
Management	Medical Physics	Practice Development / Procurement

Table 1

The broad definitions above cover most medical devices. However, there are a small range of devices where organisational management responsibility lies with heads of department or specialist service provider groups.

Audiology	Hearing Aids
Physiotherapy	Physiotherapy equipment
Estates	Hi-Lo Baths
Rehabilitation	Walking aids

Table 2

Organisational responsibility for managing medical equipment safety (Hazard) alerts and ensuring the appropriate external reporting of equipment related incidents lies with the Equipment Coordinator, regardless of category, ownership or management.

2.2. Software as a Medical Device

Under the Medical Devices Directive (MDD) 93/42/EEC, software can be considered a 'medical device' if it is intended by the manufacturer to be used specifically for diagnostic or therapeutic purposes. This includes stand-alone applications, mobile health apps, AI-based

tools, and any software integrated into a larger device that significantly contributes to the device's medical function.

Key Regulatory Considerations
- Intended Purpose: The software's stated purpose determines whether it qualifies as a medical device. Software that drives or influences a device's medical performance must be assessed accordingly.
- Lifecycle Management: Software requires ongoing updates, patches, and version control. Each new release or upgrade must be documented and reviewed to ensure ongoing compliance with Essential Requirements.
- Data Integrity and Cybersecurity: As part of the risk assessment, any vulnerability that could affect clinical safety or patient data confidentiality must be identified and mitigated.
- Manufacturer's Instructions: In addition to standard user instructions, software must include clear guidance on required hardware, operating systems, version updates, and security recommendations.

Organisational Responsibilities
- Medical Physics & IT Collaboration: The Medical Physics department, in liaison with IT, must confirm whether software is classed as a medical device and ensure alignment with the Board's existing cybersecurity policies.
- Heads of Department / Service: Ensure end-users are trained on new software features, updates, and limitations. Report any anomalies, bugs, or performance issues through the established incident-reporting routes.

3. Responsibilities

3.1. Chief Executive

The Chief Executive has overall accountability for ensuring the Board has effective systems and controls in place to meet regulatory standards for the management of medical equipment. This includes ensuring that procedures exist to manage risks relating to medical equipment, the reporting of adverse events and the dissemination of safety (Hazard) notifications.

3.2. Medical Director

Executive responsibility for medical equipment management lies with the Medical Director. Responsibilities include:

- Ensuring efficient and effective medical equipment procurement planning is in place
- Ensuring operational lifecycle management of medical equipment is appropriately monitored and controlled
- Chairing the Medical Device Group

Responsibilities for re-usable medical equipment are included within appropriate schemes of delegation to the Head of Medical Physics with ongoing assurance, monitoring and validation of equipment planning and strategy being performed by the Director of Facilities and Infrastructure.

3.3. Head of Estates

The Head of Estates in NHSO manages the role for Medical Devices that is managed by the Head of Medical Physics in mainland NHS Scotland boards. The Head of Estates is the operational and strategic lead for medical equipment lifecycle management. Responsibilities include:

- Production of medical equipment strategy
- Production of medical equipment management operational policies procedures and systems of work
- Production of long term, medium term and short term equipment procurement plans
- Continual quality improvement of all aspects of medical equipment lifecycle management
- Co-chair and administrate the Medical Device Group
- Provide medical equipment expert advice to organisational committees
- Contract management
- Linking with national groups relating to Medical Equipment Lifecycle Management

3.4. Director of Nursing, Associate Medical Directors and Service Managers

The Director of Nursing, Associate Medical Directors and General Managers are accountable to the Medical Director for ensuring that this policy is implemented within their respective Service Units and Directorates. In addition, Service Managers will:

- Verify all equipment plans to ensure compatibility with ongoing strategies

- Verify all equipment purchases within their respective directorates ensuring that that all lifecycle running costs (consumables, maintenance) are identified and appropriately aligned to budgets

3.5. Equipment Coordinator

The role of Equipment Coordinator as laid out in CEL 43 (2009) is formally held by the Head of Health and Safety. The Equipment Coordinator supports the designated Executive Director (Head of Estates and Facilities) in achieving the aims of the CEL. The Equipment Coordinator acts as a single point of contact between the Board, Health Facilities Scotland and the MHRA for all safety issues relating to medical equipment and is responsible for:

- Ensuring managers and staff are aware of the procedures for reporting equipment related adverse incidents for implementing safety advice
- Monitoring all equipment related adverse incidents reports from within the Board
- Receiving emails from Health Facilities Scotland (HFS) and the MHRA notifying of alerts and bulletin, and cascading within own organisation
- Monitoring relevant websites for information on equipment safety and management issues
- Discussing equipment safety issues with HFS and the MHRA
- Promoting equipment safety by staff education and training
- Building and maintaining communication links with HFS
- Attending Equipment Coordinators conferences and seminars
- Monitoring internal cascade systems to ensure alerts are received, assessed and acted on

The role of the Equipment Coordinator is broadly comparable with the role of the MHRA Medical Devices Safety Officer in NHS England.

3.6. Head of Procurement

The Head of Procurement is responsible for:

- Negotiating competitive purchasing arrangements
- The prevention of rogue medical equipment purchases
- Oversight and expert adviser role in all equipment procurement
- Ensuring appropriate policies, systems and controls are in place to ensure all medical equipment procurement is carried out in accordance with the Board's Standing Financial Instructions and all applicable regulation & legislation

3.7. Heads of Department / Service

Heads of Department / Service have a managerial responsibility to ensure that medical equipment is used in a safe manner. This includes:

- Having appropriate processes in place to ensure manufacturers instructions are adhered to
- Identifying and addressing training needs
- Ensuring operators are adequately trained, competent and confident to use the equipment

- Identifying, assessing and addressing risks associated with medical equipment within their departments & operational areas of responsibility
- Ensuring the equipment is looked after in day to day use
- Ensuring Hazard notices are responded to promptly

Heads of department also play an important role in identifying equipment requirements and advising the procurement process as a senior user.

3.8. All staff

The Board requires that all staff are competent and trained in the confident use of any medical equipment that they are required to use. All equipment users must ensure that medical equipment is only used for its intended purpose. Equipment users have primary responsibility for treating the equipment in a careful manner that is consistent with its importance and cost. Responsibilities also include pre-use checks and routine user maintenance and decontamination where required.

- All staff are required to ensure that equipment is within its planned maintenance date prior to use.

3.9. Committee responsibilities

The Medical Device Group

The Medical Device Group (MDG) is the key medical equipment governance group. It has as multidisciplinary membership comprising of clinical leads from all specialities and heads of department from all user areas. The MDG has the following key functions:

- Enables robust input to medical equipment planning and acquisitions, allowing appropriately governed prioritisation and approval of purchases in the context of ongoing clinical strategies
- Allows Executive Director to delegate responsibility to Head of Medical Physics in an appropriate, controlled and monitored manner
- To approve funding for medical equipment purchase in line with equipment plans and other ongoing capital plans
- To ensure all lifecycle running costs (consumables, maintenance) are identified and appropriately aligned to budgets
- To ensure all medical equipment purchases receive formal approval from Medical Physics, Infection Control, Procurement, estates and IT.

Specialist equipment groups

As required the Head of Medical Physics will establish Specialist Equipment Groups to support the evaluation, purchase and implementation of specialist medical equipment.

Examples of when Specialist Equipment Groups may be required include:

- Replacement of Infusion Devices
- Replacement of ECG recorders
- Replacement of Patient Monitors

4. Essential Requirements

All medical equipment procured, commissioned, and used within NHS Orkney must demonstrate compliance with the 'Essential Requirements' as defined in Medical Devices Directive (MDD) 93/42/EEC. These requirements ensure that devices do not compromise the safety or health of patients, users, or other persons when properly installed, maintained, and used in accordance with their intended purpose.

This section applies to any equipment, software or device classified as a medical device under the MDD, including active and non-active devices. It covers re-usable and single-use devices across all clinical areas.

4.1. Compliance Assurance

Safety
Each device must undergo a clinical and technical risk assessment prior to procurement. The assessment confirms that the design, materials, and manufacturing standards align with relevant British Standards (BS) or international equivalents (ISO, IEC).

Performance
Before clinical use, evidence must be provided—preferably from the manufacturer—to confirm that the equipment meets its claimed performance specifications, including accuracy and reliability.

Labelling and Instructions for Use
All devices must have clear, legible labelling in English. Instructions for use must be checked for completeness. Copies are retained in the central library maintained by Medical Physics.

Validation and Testing
During commissioning, devices are validated against the manufacturer's stated performance specifications. Electrical safety testing and functional checks are documented on the Medical Physics Database.

Ongoing Monitoring
Post-market surveillance data (including incident reports and field safety notices) are regularly reviewed by the Medical Device Group. Any device failing to meet Essential Requirements in practice will be quarantined, investigated, and, if necessary, removed from service.

Software Validation and Testing
All software-based devices (including stand-alone software or embedded software within larger systems) must be validated prior to clinical use to ensure they meet safety and performance criteria under normal and reasonably foreseeable conditions

5. Classification of Medical Devices

5.1. Purpose of Classification

Under MDD 93/42/EEC, medical devices are grouped into different classes (I, IIa, IIb, and III) based on their risk to patients and users. Correct classification ensures the device undergoes the level of scrutiny and conformity assessment proportionate to its potential risks.

Software meeting the definition of a medical device under MDD 93/42/EEC follows the same risk-based classification (Class I, IIa, IIb, or III). Determination is made by the intended purpose, level of invasiveness, and potential impact on patient management.

Classification Categories

- Class I: Low-risk devices such as simple dressings or non-invasive items.
- Class IIa: Moderate-risk devices often used invasively or for diagnostic monitoring (e.g., infusion pumps).
- Class IIb: Higher-risk devices used for sustained invasive support or critical monitoring (e.g., anaesthesia machines).
- Class III: High-risk implantable or life-supporting devices (e.g., pacemakers), subject to the most rigorous conformity assessment.
- Simple Data Logging or non-clinical administrative software generally falls outside MDD scope unless it directly influences diagnosis or treatment

5.2. Identification and Confirmation

Verification Role

The Medical Physics, in collaboration with the Head of Procurement, confirms the manufacturer-stated classification. This involves reviewing any available Certificates of Conformity from Notified Bodies, Declarations of Conformity, and technical dossiers.

MHRA Guidance

Classification decisions must align with current MHRA guidelines, which detail classification rules and application examples.

Accountability

The Medical Director holds executive oversight of classification compliance. Any doubt over a device's classification must be escalated to the Medical Device Group before procurement.

Record-Keeping

All classification data, including certificates and relevant regulatory correspondence, are stored centrally in the Medical Physics Database. This allows the Board to evidence the required compliance with classification rules during external audits or inspections.

Implications for Procurement

The class of the device determines the level of review and testing during selection. Higher-risk (Class IIb or III) devices require a more detailed due diligence process, including more stringent supplier evaluations, technical documentation, and post-market surveillance plans.

6. Medical equipment lifecycle management

Medical equipment lifecycle management of re-usable medical equipment can be effectively summarised in the following diagram.
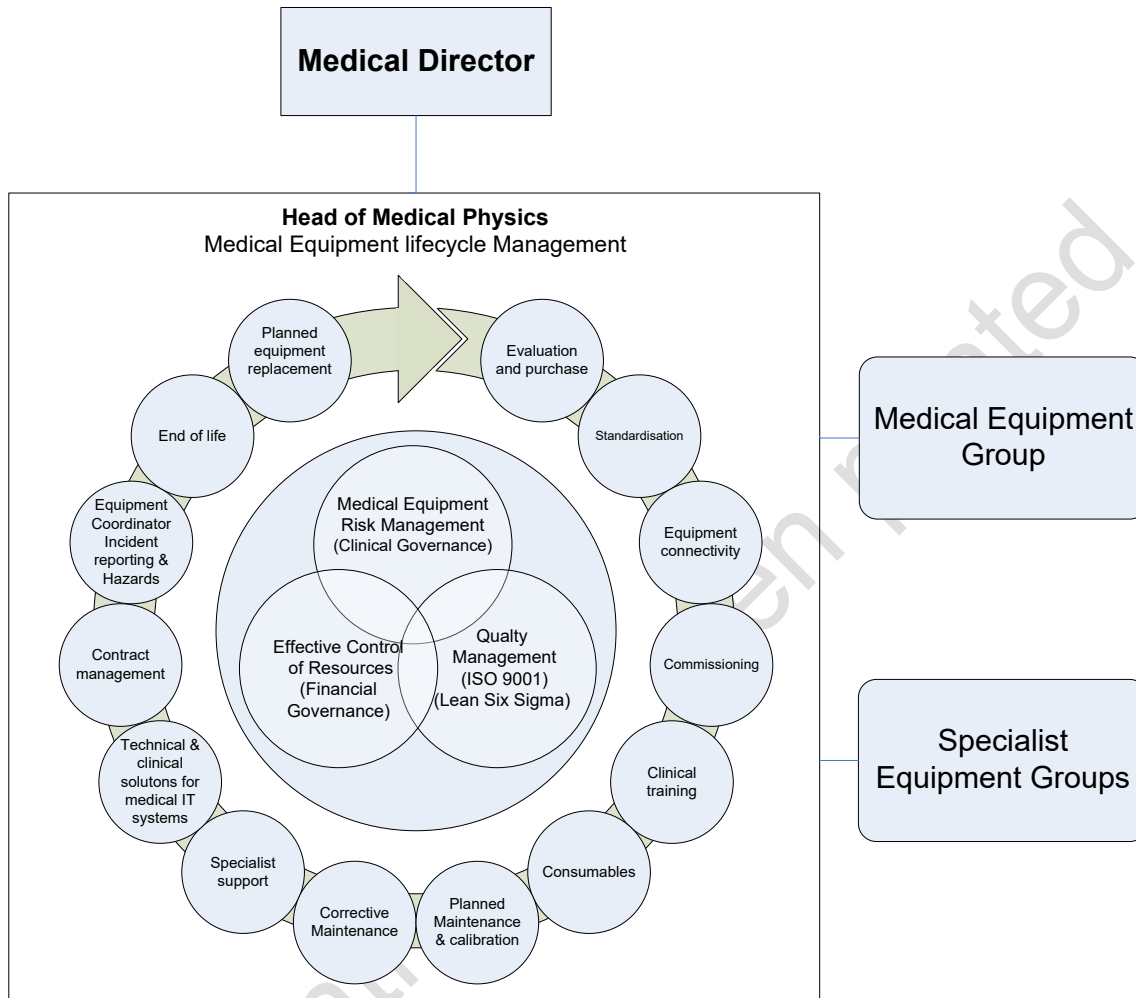
Figure 1: Medical Equipment Lifecycle Management

6.1. Selection and procurement

The selection and procurement of reusable medical equipment is overseen by Medical Physics with Procurement support. It is designed to eliminate rogue purchases and ensure appropriate stakeholder involvement. The process ensures Infection Control input to all medical Equipment purchases. Tenders for high value procurements include assessment of environmental and sustainability credentials of equipment suppliers and the medical equipment under consideration.

6.2. Standardisation & connectivity

The procurement process ensures that consideration is given to equipment standardisation and connectivity. The main driving force for equipment standardisation is the management of risks associated with equipment usage (training, familiarity, reducing variation). It also minimises maintenance and consumable costs, reducing overall lifecycle spend. Standardisation also enables a high level of connectivity and integration between devices to be effectively implemented.

6.3. Commissioning

It is essential that all new equipment is checked against specification and receives safety checks before being placed into clinical use. Commissioning of equipment should include:

- Delivery checks
- Pre-use checks
- Electrical Safety checks
- Storage during commissioning
- Record keeping
- Documentation management
- Clinical and service training

6.4. Electronic inventory

The commissioning process requires important equipment management information relating to medical equipment to be stored on an electronic inventory. Good record keeping underpins the safe and effective management of medical devices. The Medical Physics Database is a centralised equipment management database designed to allow the Board to appropriately administer its medical devices. The database meets all the requirements and minimum datasets set out in guidance by the MHRA and the Scottish Government. Functions of the database include:

- Electronic inventory
- Planned preventative maintenance management
- Corrective maintenance management
- Customer request management
- Contract management
- Planned equipment replacement
- Engineer dashboards
- Supplier administration
- KPI and customer metric generation
- Finance – asset register verification

A second parallel inventory of capital medical equipment exists in the Finance Asset Register. Both are supported by the boards RFID tracking system allowing regular and accurate inventories to be taken and databases updated.

6.5. Documentation (Instructions for use)

Good clear instructions for use have a crucial role in the continued safe and effective use of medical equipment. The lack of adequate instructions for use is recognised by the MHRA as a key equipment safety consideration and a root cause of adverse events.

When a new equipment type is first introduced to a department, a copy of the instructions for use is provided by Medical Physics. In addition to this, a central library of all instructions for use documents is held and maintained by the Medical Physics department. All users have access to the documents on request. Additional copies can also be made available.

6.6. Training

Clinical user training
All healthcare professionals working with medical equipment have a professional duty to ensure their own skills and training remain up to date. Training is a key element in device safety. The quality of training in the appropriate use of medical devices is a recognised root cause in the occurrence adverse incidents. All professional groups within the Board with a responsibility for the safe use of medical devices must have their own medical equipment training policies. The policies must define the requirement and process for adequate record keeping.

Technical training
Members of the Medical Physics department directly responsible for the repair and maintenance of medical equipment must be trained qualified and have the necessary levels of competency to meet the operational requirements of the department.

6.7. Maintenance and repair
Medical device maintenance and repair falls into two distinct categories, corrective maintenance and planned preventative maintenance. Corrective maintenance occurs when a device fails unexpectedly. All faults with medical equipment should be reported immediately and equipment removed from service if required.

Planned Preventative Maintenance (PPM) is managed routine maintenance, scheduled to take place at defined intervals and intended to prevent failures from occurring in the first place.

Decontamination of medical equipment
Decontamination of medical equipment is covered thoroughly by the Board's infection control policies. All staff have a responsibility to ensure equipment is decontaminated before it is received by Medical Physics. All requests for corrective maintenance should be accompanied by a clearance certificate.

Tracking
All maintenance operations are tracked by the call log system within the Medical Physics Database. All equipment undergoing repair is accompanied by a status label to indicate the equipment fault.

Storage (control of product)
Robust control of product is essential to the safe application of the maintenance process. It is common for equipment to be in varying states of repair when stored in Medical Physics labs. It is essential that entry to the labs is controlled to ensure equipment is not disturbed or returned to use before repair is complete.

Specialist support
The Medical Physics Department operates a single department structure across multiple clinical/technical specialities. This differs from the common model of operating multiple specialist departments (anaesthesia, cardiology, renal etc). The range of equipment covered is supported by Specialist Engineers in key specialities. These Specialist Clinical Technologists require more in-depth training and knowledge to address the specific requirements of this equipment and its clinical application.

6.8. Device manufacture and modification by Medical Physics

The in-house manufacture of medical devices is not included within the Medical Physics quality management system.

6.9. Planned equipment replacement

The information held on the Medical Physics and estates database is used to drive the planned equipment replacement programme. The programme generates a ten year outline financial projection which is used to inform medium to long term capital planning.

One of the core remits of the Medical Devices Group (MDG) is to oversee all medical equipment purchases in the context of clinical strategies. The group has strong clinical representation across all directorates and clinical specialities. Annual replacement lists derived from the planned equipment replacement plan are verified by the group before going on to form part of the Board's annual capital plan.

The replacement programme also allows additional individual factors to be considered out with the planned element of replacement. These are laid out in the 'medical equipment purchase process' and include whether the item is:

- Worn out beyond economic repair
- Damaged beyond economic repair
- Unreliable (based on service history)
- Clinically or technically obsolete
- Spare parts are no longer available
- Superseded by a more cost effective or clinically effective device
- Unable to be cleaned or decontaminated effectively

6.10. End of life (decommissioning and disposal)

A process for the removal from service and disposal of medical equipment is essential element of medical equipment lifecycle management. Equipment is regularly removed from use for a verity of reasons including:

- Equipment replaced as part of the planned equipment replacement programme
- Damaged or worn out beyond economic repair
- Clinical or technical obsolescence
- Disposal due to contamination, e.g. Creutzfeldt-Jakob (CJD) etc.
- Changes in local policies for device use
- Absence of manufacturer/supplier support
- Non-availability of correct replacement parts
- Non-availability of specialist repair knowledge

All equipment must be decommissioned via Medical Physics to ensure that it is disposed of correctly, removed from Equipment Management Database and any patient identifiable data is removed appropriately.

6.11. Accreditation

All medical equipment lifecycle management functions carried out by the Medical Physics department are performed to the ISO 9001 Quality Management Standard. This is certified by an independent body.

The ISO 9000 family of standards represents an international consensus on good quality management practices. It consists of standards and guidelines relating to quality management systems and related supporting standards. The application ISO 9001 standards in its self ensure that all internal processes are efficient.

6.12. Audit and monitoring

Monitoring the organisation's medical device management performance is essential to minimise or eliminate risks to patients and staff. Patient safety is enhanced by the use of systemic activities that prevent or reduce the risk of harm to patients. The Board assesses the efficacy of these arrangements through the following mechanisms:

- Annual Internal audit of all equipment management processes
- Annual independent audit of the quality management system to the ISO 9001 standard
- Feedback from service users is gathered via a customer satisfaction survey
- Review of medical device incidents

7. Governance

7.1. Hazard notifications

For the purposes of this policy, the terms Hazard Notification. Safety Notice and Medical Device Alert are interchangeable.

Hazard notifications can originate from the MHRA, HFS, equipment suppliers, and equipment manufacturers or can be internally generated by Medical Physics. Distribution and tracking of hazard notifications is the responsibility of the Equipment Co-ordinator.

7.2. Medical equipment incidents

All incidents or near misses relating to medical equipment must be processed in line with the Board's standard incident reporting policy.

Incidents involving medical equipment must also be reported to Medical Physics immediately to ensure prompt investigation. Where possible, all material evidence relating to adverse events must be preserved, labelled and kept secure. This includes the medical device, consumables, packaging and any other means of batch identification. Equipment involved in serious incidents must not be tampered with and if necessary, will be quarantined by Medical Physics.

7.3. Evaluations

Equipment evaluation is a standard part of selection and procurement, and is encompassed by Medical Physics, Procurement and where required Specialist Equipment Groups.

7.4. Clinical research

The process for controlling equipment required for clinical research is managed by the NHSO Clinical Governance Group.

7.5. Non CE marked devices

All medical devices placed on the market in the European Union must bear the CE Marking to demonstrate they meet the essential requirements of the Medical Device Directive. This helps ensure that they do not compromise the safety and health of patients, users and other persons when properly installed, maintained and used in accordance with their intended purpose.

The use of non CE marked devices is prohibited within NHS Orkney unless carried out under a formal research programme, managed by Research and Development. It is a legal requirement that the UK competent authority (the MHRA) is informed of any clinical investigation involving a non-CE-marked medical device within the UK. These requirements are managed by the Research & Development Department and include:

- MHRA Notification and confirmation letter of no objection
- Clinical Investigation Plan
- Research Ethics Committee approval
- Adequate training for equipment users
- Systems for control and segregation of non CE marked equipment limiting usage to named clinical investigators
- Signed informed patient consent
- Criteria for stopping or curtailing use

8. Off label usage of medical equipment & user modifications

Use of a medical device for anything other than its manufacturer-defined intended purpose is referred to as 'off-label' use. User modifications that alter a device from its original design or function also fall under this definition.

8.1. No Off-Label Use or Modifications as Standard

NHS Orkney does not support off-label use or user modifications of medical devices. Such usage is outside the manufacturer's liability and may carry significant legal and clinical risks under the Medical Devices Directive (MDD) 93/42/EEC.

8.2. Exceptions

Risk-Assessed and Time-Limited Off-Label Use

In exceptional situations where no suitable alternative device is available, an off-label use may be authorised provided:

- A formal risk assessment is completed in line with NHS Scotland guidance, clearly documenting potential hazards, mitigations, and the rationale for using the device off-label.
- Mitigation measures are put in place to reduce identified risks (e.g. extra monitoring, specific user training).
- A defined timeframe for off-label use is agreed and documented, ensuring usage is discontinued or reviewed by the end of the approved period.
- Relevant approvals are obtained (from the Medical Director and Medical Device Group), and the decision is fully recorded in the Board's risk management systems.
- Full disclosure and consent procedures are followed, including informing the patient (where applicable) that the device is not being used per its original labelling.

- Off-label use or modification of a medical device should only proceed if strict controls and safeguards are in place to minimise clinical, legal, and organisational risk. NHS Orkney's default position remains that devices must be used according to their intended purpose, with any deviations subject to formal review and explicit sign-off.

9. Prescribing medical equipment

Any professional user who prescribes medical equipment for use by a patient must be qualified to do so. Non-qualified staff who issue equipment must have the necessary written authority from a professional user before releasing the equipment or have been deemed competent to release it themselves.

Managers must ensure that medical equipment is not issued to patients or carers without the issue of the appropriate instructions and training and having ensured that facilities for maintenance and repair have been clarified.

10. Outsourcing

All aspects of the medical equipment lifecycle management process are managed by the Board. No processes are directly outsourced. Service contracts exist for some medical equipment and co-operative agreements with suppliers are sometimes utilised. In all instances management of the equipment is coordinated directly by Medical Physics and estates.

11. Equipment financing

Arrangements concerning equipment financing are included within the Board's strategic finance plan and Property and Asset Management Strategy (PAMS).

Appendix A: Schedule of Documentation and Delegation

Changes or additions to this schedule will be made in accordance with protocol for changes to the overall policy. The list below is not exhaustive and represents a transitional workplan for areas of protocol and procedure that are recognised as requiring documentation.

Controlled Document	Reviewer / Owner Group(s)	Ratification Group	Status (at time of this Policy version)
Policy			
NHSO Medical Devices Policy (this document)	MDG	SLT	New document
Protocol and Procedure			
Medical Equipment: Acquisition, Introduction or Procurement	MP	MDG	To be Authored – 2024 Legacy version is within Policy for Medical Equipment, 2008.
Loan Medical Equipment Policy	MP	MDG	2021 version
Medical Equipment: Replacement and Disposal	MP	MDG	To be Authored – 2024 Legacy version is within Policy for Medical Equipment, 2008.
Medical Equipment Maintenance	MP	MDG	To be Authored – 2025 Legacy version is within Policy for Medical Equipment, 2008.
Patient-issued medical devices (Issue, Maintenance / Checks / Retrieval)	MDG with Primary Care	MDG	To be Authored – 2025
Novel, research, "in-house" or "modified" devices	Not supported under policy		

Key:
MP = Medical Physics
MDG = Medical Devices Group
SLT = Senior Leadership Team

Appendix B Contacts for NHS Orkney Medical Device Policy

Correct to 31st March 2025

Head of Estates	Alan.Scott3@nhs.scot	Alan Scott
Medical Director	Anna.Lamont@nhs.scot	Anna Lamont
Head of Procurement	kirsty.francis@nhs.scot	Kirsty Francis
Lead Medical Physics Technician	graham.shearer@nhs.scot	Graham Shearer
Head of Health & Safety	lawrence.green@nhs.scot	Lawrence Green
Health and Safety Incidents & Alerts Safety Officer	willem.venter@nhs.scot	Willem Venter

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Cultural Development, Governance and Senior Leadership External Review – Action Plan progress update**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive**
Report Author:	**Laura Skaife-Knight, Chief Executive**

1 Purpose

This is presented to the Board for:

- Assurance on progress against the Action Plan and the highest priorities agreed by the Board.

2 Report summary

2.1 Situation

Mid-2024, our Chief Executive commissioned an external review of Cultural Development, Governance and Senior Leadership at NHS Orkney to help to identify good practice and recommendations for areas of focus to support our continuous improvement.

At its February 2025 meeting, the Board received the Report and approved an Action Plan with a set of highest priorities, all of which have been incorporated into our Year 2 Corporate Strategy (2025/26), to ensure alignment.

It was agreed that progress against the Action Plan was of such significance to the Board's progress that an update would be brought to every public Board meeting commencing April 2025, so that this could be tracked and for transparency. This is the second such update to the Board which summarises the further progress that has been made between April and June 2025 and provides assurance that momentum continues to ensure delivery against the highest priorities that the Board have identified in response to the External Review recommendations.

2.2 Background

Scottish Government (SG) supported NHS Orkney to commission this review as part of a wider package of work we are doing to inform future progress and priorities as the organisation considers what is needed to de-escalate from Level 3 of the NHS Scotland Support and Intervention Framework.

Professor Tracy Myhill led this work as an experienced HR Professional and CEO and prior to her retirement was the Chief Executive of Swansea Bay University Health Board. Previously she was CEO of the Welsh Ambulance Service.

There were 33 recommendations in total in the report, made up of work already underway/started and a small number of new actions.

The highest priorities agreed by the Board, which also feature in our Year 2 (2025/26) Corporate Strategy, are:

1. Executive Team cohesion
2. Clinical Executive Director leadership and engagement
3. Behavioural standards
4. Leadership development programme
5. Appraisals, training and sickness
6. Respecting governance

The remaining actions feature in a standalone Action Plan (see Appendix 1). This paper is a progress update against this Action Plan, which will feature on every public Board agenda until there is assurance and confidence that appropriate progress has been made and sustained.

Progress summary against Action Plan (for the period April–June 2025)

Bringing values to life
- Board, Senior Leadership Team (SLT) and Extended Senior Leadership Team sessions have been held re: behavioural standards development. Wider staff engagement is now commencing (July-September 2025) to develop the new behavioural standards that will underpin our values with a view to launching these in Autumn 2025

Appraisals, mandatory training and sickness absence
- There is early evidence that the different intervention and support we have put in place is having an impact on compliance

Leadership development
- Following a discussion at Extended Senior Leadership Team on 15 April 2025, the Leadership Development Programme was approved at Senior leadership Team meeting on 20 May 2025
- A tender process is now under development for the main Leadership Development Programme which will return to SLT in due course

Executive Clinical Leadership engagement
- Clinical Service Review underway, led by the Clinical Executive Directors, presenting an opportunity for strong clinical engagement in the organisation, with the final report to be produced to deadline by the end of June 2025 for the Clinical Executives to lead and take forward with support from the Chief Officer for the IJB
- A review of clinical engagement is underway, including our approach to clinical advisory groups, to ensure we maximise the clinical voice in change/improvement work. The

outputs of this work are on track to come through our governance system early Autumn 2025

Cultural development and values and behaviours (Executive Team)
- All Executive Directors have completed the 360 degree appraisal process as part of 2024/25 year-end appraisal process and this feedback is informing 2025/26 Personal Development Plans as will be shared with Remuneration Committee in June 2025

Commitment to consistent priorities
- Year 2 Corporate Strategy (2025/26) includes significantly fewer priorities and fixed priorities for the year in response to staff feedback

Respecting governance
- Review of operational governance is underway with 121 meetings with all Executive Directors nearing completion
- Specific improvements relating to respecting our governance included in shared Executive Team objectives for 2025/26 which are coming to Remuneration Committee for approval in June 2025
- Updated paper on package of respecting governance changes to return to June 2025 Board meeting for approval following initial discussion at March 2025's meeting

Support for the Chief Executive
- Whistleblowing has transferred to the Medical Director from the Chief Executive
- Line management of the Communications Team has transferred from the Chief Executive to the Head of Improvement (May 2025)
- The Director of Performance and Transformation (and Deputy Chief Executive) commenced in post in May 2025 – performance, planning, improvement and internal audit have transferred to the Deputy Chief Executive, further bolstering support for the Chief Executive

Proportionate external demands
- Suggestions shared formally with Scottish Government at the May 2025 Quarter 4 Financial Review Meeting

Staffing resource analysis
- Is part of the workforce workstream (Improving Together Programme) and where this work will be picked up, reporting to the Improving Together Board

Narrative balance
Balancing celebrating and recognising our progress with focusing on the areas in which improvements are necessary is central to our approach to internal communications and engagement.

A number of actions have moved to 'closed' status since the last Board meeting, as below:
- Listening to history with fascination and interest
- Balancing the narrative
- Visible leadership and flexible/hybrid working
- Support for the Chief Executive

One action – 'Organisational Development' capacity and expertise – has been paused.

2.3   Assessment

The Board is asked to take:

- Assurance on progress against the Action Plan and the highest priorities agreed by the Board (this update details progress made between April and June 2025).

2.3.1   Quality/ Patient Care

There are a number of recommendations in this report, notably the role of our Clinical Executive Directors and requirement for closer working, in driving improvements to patient safety, experience and quality of care through greater cohesion, along with strengthened team working from our Executive Team.

2.3.2   Equality and Diversity, including health inequalities

NA

2.3.3   Route to the Meeting
This progress update has come direct to the Board.

2.4 Recommendation

- The Board is asked to take assurance on progress against the Action Plan and the highest priorities agreed by the Board (this update details progress made between April and June 2025).

2.5 Appendices

Appendix 1 – Action Plan.

NHS Orkney

Meeting:	**NHS Orkney Public Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**2025 iMatter Results**
Responsible Executive/Non-Executive:	**Jarrard O'Brien, Director of People and Culture**
Report Author:	**Steven Phillips, Head of People and Culture**

1   Purpose

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:
- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred

2   Report summary

2.1   Situation

The iMatter survey was open from Monday 12th May to Monday 2nd June 2025. During this period, colleagues were encouraged to take part in the annual survey through multiple communication channels. The Board, directorates, and teams have now received their results and are required to engage in the action planning phase. NHS Orkney should support managers to convert local outputs into meaningful actions by Tuesday 29th July, by doing the following:

- Conduct manager iMatter sessions to support the process.
- The iMatter lead provides assistance to managers and teams, including a toolbox for managers to use in creating action plans and following up with the team.
- Focus on areas where one or two key actions that will make a difference.
- Provide the organisation with regular updates on iMatter action planning and plan

2.2 Background

The iMatter questionnaire allows colleagues to share their personal experiences, provide feedback on team dynamics, and offer input about the organisation in real time. The results are reported at various levels - team, directorate, and organisation. Once the team receives the results, they work together to create an action plan within 8 weeks. Progress is monitored throughout the year. Teams gather to review the results, exchange ideas, and develop and implement action plans. The process is documented by sharing team stories, making it an integral part of the iMatter process. The iMatter program is monitored nationally and a benchmarking report will be released later in the year.

2.3 Assessment

The paper attached details the Board's outcome in relation to iMatter.

2.3.1 Quality/ Patient Care
iMatter is a valuable tool for continuous improvement that enhances patient care and improves colleagues experience when used appropriately.

2.3.2 Workforce
The iMatter tool is a national development utilised by all NHS Scotland Boards. Its purpose is to assist individuals, teams, Directorates, and Boards in understanding and improving colleague experience.

2.3.3 Financial
None Identified

2.3.4 Risk Assessment/Management
No process-related issues have been identified. However, failing to engage in action planning may have negative consequences for colleagues in terms of a lack of positive change and disengagement if feedback is not seen to proactively drive change. National benchmarking may also generate risk and opportunities for NHS Orkney.

2.3.5 Equality and Diversity, including health inequalities
None identified – this is a nationally procured took that has been impact assessed.

2.3.6 Climate Change Sustainability
None Identified

2.3.7 Other impacts
None Identified

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Area Partnership Forum Tuesday 17 June 2025
- Senior Leadership Team (People) Tuesday 24 June 2025

2.4 Recommendation

- **Awareness** – For Members' information only.

- **Discussion** – Examine and consider the implications of a matter.

2 List of appendices

The following appendices are included with this report:
- **Appendix 1**, iMatter 2025 overview.
- **Appendix 2,** Board Report 2025
- **Appendix 3,** Board Yearly Components Reports
- **Appendix 4**, Raising Concerns Report
- **Appendix 5,** Yearly response rates
- **Appendix 6**, Yearly EEI

iMatter 2025

The iMatter survey was circulated to NHS Orkney staff throughout May and closed on June 2nd. The overarching Board report is attached at (Appendix 2). The response rate for 2025 has remained the same as 2024 at 69%.

There are a number of positives to take from the outputs:

- The employee engagement score has, for the fourth year in a row, increased; 72 (2022), 74 (2023) and 75 (2024) and 76 (2025) (Figure 1)
- Across all the strand scores, aligned to the five pillars of Staff Governance, our weighted index value has remained the same or increased by up to 1 point (Appendix 2)
- Out of the 28 questions asked of staff, we continue to see 24 of the responses are in Strive and Celebrate. In addition, 19 questions showed an increase of 1 to 2 points.
- Our overall experience score increased to 6.7 out of 10. (Figure 2)

Figure 1

Yearly EEI

NHS Orkney

EEI numbers and improvements from last year

Organisation	2021	Improvement	2022	Improvement	2023	Improvement	2024	Improvement	2025
HSCP NHS Orkney (Chief Officer)	-		72	↑	73		-		-
NHS Orkney (Chief Executive Directorate)	70	↑	72	↑	74	↑	75	→	75
NHS Orkney (SMT Directorate)	70		-		-		-		-
NHS Orkney Board Members	86	↓	83	↑	84	→	84	↓	83
NHS Orkney	**70**	↑	**72**	↑	**74**	↑	**75**	↑	**76**

67 - 100	Strive & Celebrate	51 - 66	Monitor to Further Improve	34 - 50	Improve to Monitor	0 - 33	Focus to Improve

Figure 2
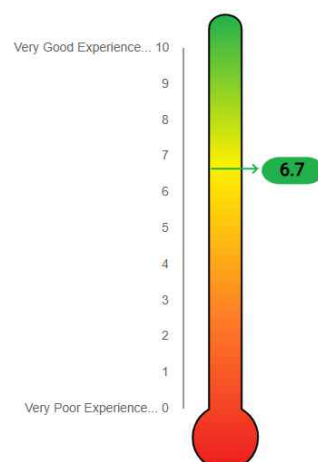
19 of the iMatter staff experience components have increased this year. However, 8 saw no change to the response, and 1 saw a reduction of 1 point.

Although there were slight fluctuations in scores, the areas highlighted from the organisation's feedback to 'monitor to further improve' remain the same as last year:

1. I am confident performance is managed well within my organisation (+1).
2. I have confidence and trust in Board members who are responsible for my organisation (+1).
3. I feel sufficiently involved in decisions relating to my organisation (-1).
4. I feel that board members who are responsible for my organisation are sufficiently visible (no change)

There were no 'improve to monitor' or 'focus to improve areas' at the Board level. However, there were a number of teams within the 'monitor to further improve' area that will be offered support and assistance from the iMatter team where necessary. (See Figure 3)

Figure 3

EEI number for teams within the same Board

EEI Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	67	10	0	0	9	86
Percentage of Teams	77.9%	11.6%	0.0%	0.0%	10%	100%

Raising Concerns

This year, we have observed an improvement in one score, while another remained unchanged compared to last year.

- I am confident that can safely raise concerns about issues in my workplace – 74 (no change)
- I am confident that my concerns will be followed up and responded to – 67 (+2)

Action Planning:

The action planning window opened on June 3rd and will remain open until July 29th. The Scottish government has set this 8-week timeframe to allow managers to upload their plans into the system. The organisation has shared training sessions a Turas Learn module is available to assist managers.

Action planning data will be available from July 30th.

Summary

The iMatter Report has highlighted several areas of achievement to celebrate and some areas that present opportunities for improvement. This year, the EEI score has increased by 1 point, and 24 out of 28 questions remain within the strive and celebrate parameters.

The upward movement in scores is demonstrating an encouraging shift in a positive direction.

To keep the up the positive momentum, it is essential for teams to complete their action-planning process to fully benefit from the iMatter outcomes.

i Matter

Board Report 2025

NHS Orkney

Total number of respondents: 594

Response rate

69%

Respondents: 594
Recipients : 859

EEI

76

Employee Engagement Index

Staff Governance Standards - Strand Score Index

	Strive & Celebrate	Monitor	Improve	Focus	Weighted Index Value
Well Informed	70%	16%		8%	79
Appropriately Trained & Developed	62%	19%	8%	11%	75
Involved in Decisions	50%	24%	11%	15%	71
Treated Fairly & Consistently, with Dignity & Respect, in an Environment where Diversity is Valued	63%	18%	9%	10%	77
Provided with a Continuously Improving & Safe Working Environment, Promoting the Health & Wellbeing of Staff, Patients & the Wider Community	63%	21%		10%	77

● Strive & Celebrate (67 - 100) ● Monitor to Further Improve (51 - 66) ● Improve to Monitor (34 - 50) ● Focus to Improve (0 - 33)

Calculating the Average Score

The number of responses for each point on the scale (Strongly Agree – Strongly Disagree) is multiplied by its number value (6-1) (see right). These scores are then added together and divided by the overall number of responses to the question.

6	Strongly Agree
5	Agree
4	Slightly Agree
3	Slightly Disagree
2	Disagree
1	Strongly Disagree

Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements:

Number of respondents: 594

Statement	Average score
I am clear about my duties and responsibilities	85
I get the information I need to do my job well	80
I am given the time and resources to support my learning growth	72
I have sufficient support to do my job well	77
I am confident my ideas and suggestions are listened to	75
I am confident my ideas and suggestion are acted upon	71
I feel involved in decisions relating to my job	71
I am treated with dignity and respect as an individual	83
I am treated fairly and consistently	81
I get enough helpful feedback on how well I do my work	76
I feel appreciated for the work I do	77
My work gives me a sense of achievement	81

● Strive & Celebrate (67 - 100) ● Monitor to Further Improve (51 - 66) ● Improve to Monitor (34 - 50) ● Focus to Improve (0 - 33)

Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements relating to your team and direct line manager:

Number of respondents: 594

Statement	Average score
I feel my direct line manager cares about my health and well-being	86
My direct line manager is sufficiently approachable	87
I have confidence and trust in my direct line manager	84
I feel involved in decisions relating to my team	77
I am confident performance is managed well within my team	77
My team works well together	82
I would recommend my team as a good one to be a part of	83

● Strive & Celebrate (67 - 100) ● Monitor to Further Improve (51 - 66) ● Improve to Monitor (34 - 50) ● Focus to Improve (0 - 33)

Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements relating to your Organisation:

Number of respondents: 594

Statement	Average score
I understand how my role contributes to the goals of my organisation	81
I feel my organisation cares about my health and wellbeing	71
I feel that board members who are responsible for my organisation are sufficiently visible	61
I have confidence and trust in Board members who are responsible for my organisation	62
I feel sufficiently involved in decisions relating to my organisation	57
I am confident performance is managed well within my organisation	60
I get the help and support I need from other teams and services within the organisation to do my job	70
I would recommend my organisation as a Good place to work	72
I would be happy for a friend or relative to access services within my organisation	76

● Strive & Celebrate (67 - 100) ● Monitor to Further Improve (51 - 66) ● Improve to Monitor (34 - 50) ● Focus to Improve (0 - 33)

Please tell us how you feel about your overall experience of working for your organisation from a scale of 0 to 10 (where 0 = very poor and 10 = very good):

Number of respondents: 594
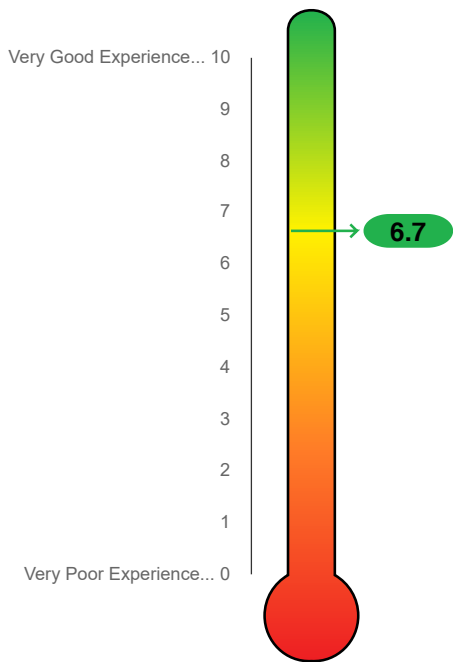
Very Good Experience... 10
9
8
7
6.7
6
5
4
3
2
1
Very Poor Experience... 0

EEI number for teams within the same Board

7.2

EEI Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	67	10	0	0	9	86
Percentage of Teams	77.9%	11.6%	0.0%	0.0%	10%	100%

EEI number for teams within the same Board

EEI Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	67	10	0	0	9	86
Percentage of Teams	77.9%	11.6%	0.0%	0.0%	10%	100%

Board Yearly Components Report

NHS Orkney

7.3

Total number of respondents: 594

iMatter Components

iMatter Questions	Staff Experience Employee Engagement Components	Average Response				
		2021	2022	2023	2024	2025
My direct line manager is sufficiently approachable	Visible and consistent leadership	82	83	84	86	87
I feel my direct line manager cares about my health and well-being	Assessing risk and monitoring work stress and workload	81	81	82	85	86
I am clear about my duties and responsibilities	Role Clarity	81	84	85	85	85
I have confidence and trust in my direct line manager	Confidence and trust in management	78	80	80	83	84
I would recommend my team as a good one to be a part of	Additional Question	78	80	81	82	83
I am treated with dignity and respect as an individual	Valued as an individual	79	80	82	83	83
My team works well together	Effective team working	78	80	80	82	82
I am treated fairly and consistently	Consistent application of employment policies and procedures	76	77	80	81	81
My work gives me a sense of achievement	Job satisfaction	77	81	82	81	81
I understand how my role contributes to the goals of my organisation	Sense of vision, purpose and values	77	80	81	80	81
I get the information I need to do my job well	Clear, appropriate and timeously communication	73	76	78	79	80
I have sufficient support to do my job well	Access to time and resources	71	74	76	76	77
I feel involved in decisions relating to my team	Empowered to influence	70	73	75	75	77
I am confident performance is managed well within my team	Performance management	69	72	74	76	77
I feel appreciated for the work I do	Recognition and reward	71	72	75	75	77
I would be happy for a friend or relative to access services within my organisation	Additional Question	72	73	72	74	76
I get enough helpful feedback on how well I do my work	Performance development and review	69	71	74	74	76
I am confident my ideas and suggestions are listened to	Listened to and acted upon	70	73	75	74	75
I would recommend my organisation as a Good place to work	Additional Question	67	69	70	71	72
I am given the time and resources to support my learning growth	Learning & growth	68	71	72	72	72
I feel involved in decisions relating to my job	Empowered to influence	66	68	71	70	71
I feel my organisation cares about my health and wellbeing	Health and wellbeing support	66	67	69	70	71
I am confident my ideas and suggestion are acted upon	Listened to and acted upon	66	68	71	69	71
I get the help and support I need from other teams and services within the organisation to do my job	Appropriate behaviours and supportive relationships	67	67	69	70	70
I have confidence and trust in Board members who are responsible for my organisation	Confidence and trust in management	57	57	57	61	62
I feel that board members who are responsible for my organisation are sufficiently visible	Visible and consistent leadership	52	52	53	61	61
I am confident performance is managed well within my organisation	Performance management	53	57	58	59	60
I feel sufficiently involved in decisions relating to my organisation	Partnership working	50	53	54	58	57

67 - 100	Strive & Celebrate	51 - 66	Monitor to Further Improve	34 - 50	Improve to Monitor	0 - 33	Focus to Improve

i Matter

Raising Concerns Report

NHS Orkney

Total number of respondents: 594

Thinking of your experience in the last 12 months please tell us if you agree or disagree with the following statements:

Number of respondents: 584

		Average score
I am confident that I can safely raise concerns about issues in my workplace.	61% · 19% · 9% · 11%	74
I am confident that my concerns will be followed up and responded to.	42% · 28% · 13% · 17%	67

● Strongly Agree / Agree   ● Slightly Agree   ● Slightly Disagree   ● Disagree / Strongly Disagree
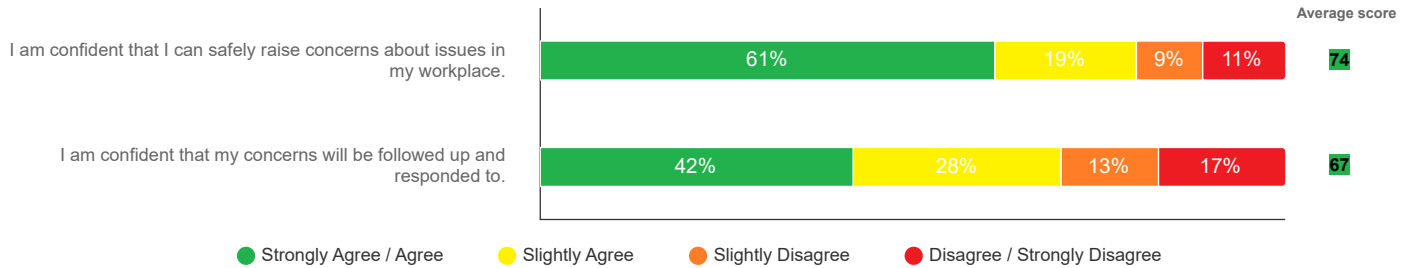
Yearly Response Rates

NHS Orkney

Organisation	Response rate 2021	Improvement	Response rate 2022	Improvement	Response rate 2023	Improvement	Response rate 2024	Improvement	Response rate 2025
HSCP NHS Orkney (Chief Officer)	-		47%	→	47%		-		-
NHS Orkney (Chief Executive Directorate)	65%	↑	66%	↑	70%	↓	69%	→	69%
NHS Orkney (SMT Directorate)	100%		-		-		-		-
NHS Orkney Board Members	77%	↑	82%	↑	89%	↑	93%	↓	87%
NHS Orkney	**65%**	↓	**58%**	↑	**59%**	↑	**69%**	→	**69%**

Yearly EEI

NHS Orkney

EEI numbers and improvements from last year

Organisation	2021	Improvement	2022	Improvement	2023	Improvement	2024	Improvement	2025
HSCP NHS Orkney (Chief Officer)	-		72	↑	73		-		-
NHS Orkney (Chief Executive Directorate)	70	↑	72	↑	74	↑	75	→	75
NHS Orkney (SMT Directorate)	70		-		-		-		-
NHS Orkney Board Members	86	↓	83	↑	84	→	84	↓	83
NHS Orkney	**70**	↑	**72**	↑	**74**	↑	**75**	↑	**76**

| 67 - 100 | Strive & Celebrate | 51 - 66 | Monitor to Further Improve | 34 - 50 | Improve to Monitor | 0 - 33 | Focus to Improve |

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Themes from Board walkarounds**
Responsible Executive/Non-Executive:	**Meghan McEwen, Board Chair and Laura Skaife-Knight**
Report Author:	**Laura Skaife-Knight, Chief Executive**

1 Purpose

This is presented to the Board for Discussion.

- Members are asked to discuss the key themes and improvement actions from latest Board walkaround.

2 Report summary

This paper summarises the main themes from the 1 Board walkaround in May 2025. The visit to the Occupational Health service has been re-scheduled and will take place in July 2025.

2.1 Situation

Board walkarounds are one of the ways in which we ensure the visibility of Board members and ensure staff across the organisation feel heard.

There has been one Board walkaround in May - Primary Care Vaccinations Team.

2.2 Background

Board walkarounds involve a blend of Executive Directors and a Non-Executives visiting different teams and departments across NHS Orkney and listening to how it feels working here.

They are an opportunity to listen, for Board members to get to know staff and build relationships and hear firsthand what staff are proud of and any challenges they face, leading to how Board members can support to resolve and help to unblock issues.

The areas we cover in our conversations with staff are:

1) What is going well in your team/service at the moment?
   - What are you most proud of working in this area?

2) What do you consider to be the main challenges you face on a daily basis?

- o What feedback do people using this service give you?
- o If you could change one thing, what would it be?
- o what do you wish you had more time to do?

3) How can the Board help?

- o Is there anything that you would find helpful to raise to the Board?

4) What does patient safety look like in your area?

- o Do you feel confident in reporting incidents or near misses?
- o Do you get enough feedback when you report incidents/near misses?
- o Do you feel there is enough support for you if you are involved in a patient safety incident?

5) Staff wellbeing: are colleagues aware of support available and have they been able to access that for staff as necessary?

There have been 39 Board walkarounds between May 2023 - June2025, spanning The Balfour, our community and our ferry-linked isles.

Below is a summary of the main feedback received from the walkaround which took place since the Board meeting in April 2025.

Main themes from the visit

Positive:
- Team working, keen to emphasise how well they work together as well as how supportive, kind and respectful they are of one another
- Team recognises diversity with members coming from different backgrounds and with them each bringing a different set of skills and knowledge.
- Staff are passionate and dedicated to the work that they do as well as further developing services.

Areas for improvement:
- Ensuring appropriate clinical space is available to deliver the vaccination service
- Supporting staff to explore a number of 'Bright Ideas' that they had to maximise skills and expertise and collaborate with other services to deliver improved patient care and experience.

2.3   Recommendation

Board walkabouts continue to be a useful and successful engagement tool between Board members and staff/teams.

Members are asked to:

- discuss the key themes and improvement actions from latest Board walkarounds

NHS Orkney

Meeting:	NHS Orkney Board
Meeting date:	**Thursday, 26 June 2025**
Title:	**NHS Orkney Equality and Diversity Reporting**
Responsible Executive/Non-Executive:	**Jay O'Brien, Director of People and Culture**
Report Author:	**Steven Phillips, Head of People and Culture**

1   Purpose

This is presented to the Committee for:

- Decision - Approve the reports submitted to the NHS Orkney Board for final publication

This report relates to a:

- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Effective

2   Report summary

2.1   Situation

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 came into force in May 2012. These specific duties are designed to help public sector organisations effectively meet the general duty.

The key legal duties are:

- Report on mainstreaming the equality duty
- Publish equality outcomes and report progress
- Assess and review policies and practices
- Gather and use employee information

- Publish gender pay gap information
- Publish statements on equal pay
- Consider award criteria and conditions in relation to public procurement

The Equal Pay Statement has been developed by the NHS Scotland Equality and Diversity Leads Group to promote a consistent approach across NHS Scotland, as we are all governed by the same terms and conditions. This Pay Statement has received formal approval from the Director of Human Resources for use.

2.2   Background

These are Statutory Reports which, after Health Board approval, by law, must be posted on the NHS Orkney website to allow public scrutiny. It must also be made widely available to NHS Orkney staff. The main Regulatory body in this field is the Equality and Human Rights Commission for Scotland.

2.3   Assessment

The report ensures compliance with equality legislation and the underlying work aims to reduce health inequalities and related discrimination and foster good relations between people with different characteristics.

2.3.1 Quality/ Patient Care

NHS Orkney relies on its excellent reputation as a fair and equitable employer to attract and retain the staff required to provide the highest standards of healthcare. The Monitoring Report is an important tool for the Board to monitor if this reputation is being maintained and enhanced. It is also available to potential applicants for posts through the NHS Orkney website.

2.3.2 Workforce

The Report also gives the NHS Orkney workforce reassurance that they are working in an environment free from prejudice and discrimination.

2.3.3 Financial

High staff turnover creates costs and requires an increased expenditure on locum staff. Retaining a skilled and settled workforce enhances the quality of patient care and also helps to avoid unnecessary expenditures.

2.3.4 Risk Assessment/Management

The report highlights actions planned for 2024/25 to support good practices in equality and diversity and help ensure NHS Orkney is a good place to work.

2.3.5 Equality and Diversity, including health inequalities

This is a Statutory Report produced under the terms of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

2.3.6 Other impacts

None.

2.3.7 Communication, involvement, engagement and consultation

These reports are fact-based and do not require public involvement prior to production.

2.3.8 Route to the Meeting

Approved at Area Partnership Forum April 2025, Senior Leadership Team May 2025, Staff Governance May 2025

2.4 Recommendation

Decision - Approve the reports submitted to the NHS Orkney Board for final publication

- **Appendix 1,** NHS Orkney Equality and Diversity Workforce Monitoring Report 2024/25
- **Appendix 2**, NHS Orkney Equal Pay Statement and Pay Gap Report 2025.

EQUALITY AND DIVERSITY MONITORING REPORT

2024-25

Contents

Introduction

NHS Orkney is committed to eliminating discrimination and improving equality of opportunity. This means improving the way we deliver our services and the way we employ our colleagues. We want to be amongst Scotland's best NHS Boards in our work to address health inequalities and recognised as a welcoming, caring employer.

All data contained within this report covers the period of 01/03/2024 – 28/02/2025 and as at February 2025, 1,096 employees and bank workers were covered by the equality monitoring process in some capacity. In line with the Scottish Specific Equality Duties Regulations, listed public sector bodies, such as NHS Orkney, are required to gather information on the following:

   a) the composition of the authority's employees (if any); and
   b) the recruitment, development and retention of persons as employees of the authority, with respect to, in each year, the number and relevant protected characteristics of such persons.

This report, therefore, includes sections on ethnicity, disability, sex, sexual orientation, religion and age of the workforce and provides a similar breakdown for new employees within the year, promotions/regrades and leavers. Staff Bank data is included within the main tables in the report. The figures given are in headcount.

While equality monitoring for all new colleagues recruited to the organisation is in place, there remains a proportion of the workforce for which no such record exists because they have been employed by NHS Orkney for many years and prior to this data being collected on a routine basis. Also, only partial information is held on some colleagues; for example, we may hold data on ethnicity but not sexual orientation. Therefore, colleagues have been included where data is available, but the number of colleagues covered within different sections may vary depending on the metric. Finally, the report highlights some of the actions we will undertake within the organisation in 2025/26 to ensure equal opportunity for our colleagues and eliminate discrimination.

Section 1: Ethnic Profile

The following table illustrates the breakdown, by Job Family, of those employees covered by the ethnic monitoring process to date. It shows that of those covered by the process, just over 93% of colleagues' ethnicity status has been completed. Incomplete status includes 'Don't Know' and 'Unknown'.

Table 1.1 Responses to ethnic monitoring by Job Family

	ADMINISTRATIVE SERVICES	ALLIED HEALTH PROFESSION	DENTAL SUPPORT	HEALTHCARE SCIENCES	MEDICAL AND DENTAL	MEDICAL SUPPORT	NURSING MIDWIFERY	OTHER THERAPEUTIC	PERSONAL AND SOCIAL CARE	SENIOR MANAGERS	SUPPORT SERVICES	Grand Total
Incomplete	6	4			14		29	2	1	2	12	70
Incomplete %	3.14%	5.71%	0.00%	0.00%	8.75%	0.00%	6.62%	7.41%	8.33%	12.50%	9.45%	6.39%
Complete	185	66	19	18	146	18	409	25	11	14	115	1026
Complete %	96.86%	94.29%	100.00%	100.00%	91.25%	100.00%	93.38%	92.59%	91.67%	87.50%	90.55%	93.61%

The above table shows the headcount of all employees and bank workers. A total of 1,026 of NHS Orkney's colleagues have completed ethnicity status to date. The following chart shows the percentage of complete/incomplete ethnic status by Job Family

Chart 1: Overall Response rate by Job Family

The lowest completed ethnicity status responses are in Senior Managers, Medical and Dental and Personal and Social Care, and the highest response levels are within Healthcare Sciences, Medical Support and Dental Support.

Breakdown of Ethnic Responses by Job Family
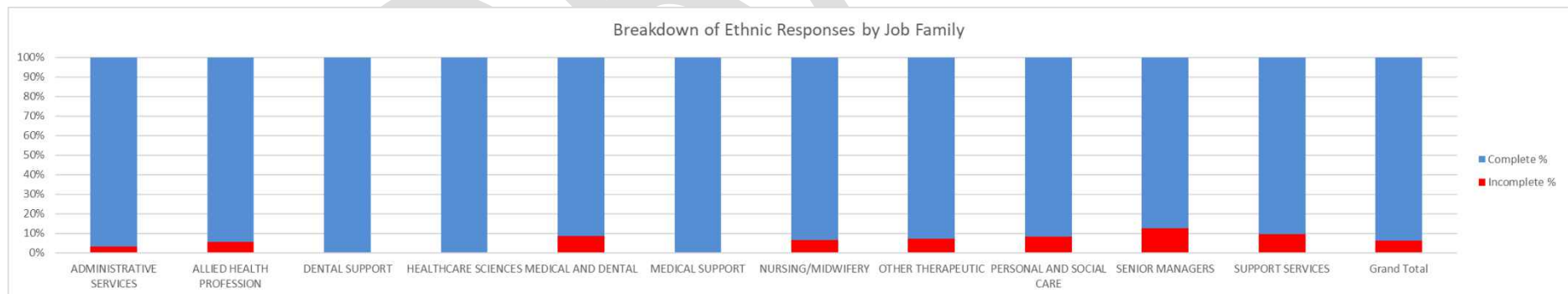
Section 2: Job Family

The tables in this section are broken down using the National Census categories.

The following tables map the ethnicity within individual job family groups split into the census groupings within 'White', Black and Minority Ethnic ('BME') and the numbers recorded as 'Incomplete' with a comparison between all three groups.

Table 2.1 Job Family by BME Ethnic Group Category

	African - African, African Scottish or African British	African - Other	Asian - Chinese, Chinese Scottish or Chinese British	Asian - Indian, Indian Scottish or Indian British	Asian - Other	Asian - Pakistani, Pakistani Scottish or Pakistani British	Mixed or Multiple Ethnic Group	Other Ethnic Group - Arab, Arab Scottish or Arab British	Other Ethnic Group - Other	BME Total
ADMINISTRATIVE SERVICES	1	1			3		2			7
ALLIED HEALTH PROFESSION	2	1		1						4
DENTAL SUPPORT										0
HEALTHCARE SCIENCES		1								1
MEDICAL AND DENTAL	5	1	1	7		7		1	3	25
MEDICAL SUPPORT		1								1
NURSING/MIDWIFERY		9			2					11
OTHER THERAPEUTIC										0
PERSONAL AND SOCIAL CARE										0
SENIOR MANAGERS										0
SUPPORT SERVICES							1			1
Grand Total	8	14	1	8	5	7	3	1	3	50
% of Total Employments	0.73%	1.28%	0.09%	0.73%	0.46%	0.64%	0.27%	0.09%	0.27%	4.56%

Table 2.2 Job Family by White Ethnic Group Category

	White - Irish	White - Other	White - Other British	White - Polish	White - Scottish	Grand Total
ADMINISTRATIVE SERVICES	2	11	34		122	169
ALLIED HEALTH PROFESSION		2	12		45	59
DENTAL SUPPORT		1	3		13	17
HEALTHCARE SCIENCES			4		13	17
MEDICAL AND DENTAL	5	14	47	1	40	107
MEDICAL SUPPORT			3		14	17
NURSING/MIDWIFERY	3	19	63		295	380
OTHER THERAPEUTIC	1	2	4		17	24
PERSONAL AND SOCIAL CARE			3		8	11
SENIOR MANAGERS	2	1	3		7	13
SUPPORT SERVICES		10	16		82	108
Grand Total	**13**	**60**	**192**	**1**	**656**	**922**
% of Total Employments	**1.19%**	**5.47%**	**17.52%**	**0.09%**	**59.85%**	**84.12%**

Table 2.3 Job Family by Incomplete Ethnic Group Category

	Don't Know	Prefer not to say	Incomplete
ADMINISTRATIVE SERVICES	6	9	15
ALLIED HEALTH PROFESSION	4	3	7
DENTAL SUPPORT		2	2
HEALTHCARE SCIENCES			0
MEDICAL AND DENTAL	14	14	28
MEDICAL SUPPORT			0
NURSING/MIDWIFERY	29	18	47
OTHER THERAPEUTIC	2	1	3
PERSONAL AND SOCIAL CARE	1		1
SENIOR MANAGERS	2	1	3
SUPPORT SERVICES	12	6	18
Grand Total	**70**	**54**	124
% of Total Employments	**6.39%**	**4.93%**	**11.31%**

Table 2.4 Job Family by Total Ethnic Group Category

	BME Total	% BME Total	White Total	% White Total	Incomplete Total	% Incomplete	Grand Total
ADMINISTRATIVE SERVICES	7	14.00%	169	18.33%	15	12.10%	191
ALLIED HEALTH PROFESSION	4	8.00%	59	6.40%	7	5.65%	70
DENTAL SUPPORT	0	0.00%	17	1.84%	2	1.61%	19
HEALTHCARE SCIENCES	1	2.00%	17	1.84%	0	0.00%	18
MEDICAL AND DENTAL	25	50.00%	107	11.61%	28	22.58%	160
MEDICAL SUPPORT	1	2.00%	17	1.84%	0	0.00%	18
NURSING/MIDWIFERY	11	22.00%	380	41.21%	47	37.90%	438
OTHER THERAPEUTIC	0	0.00%	24	2.60%	3	2.42%	27
PERSONAL AND SOCIAL CARE	0	0.00%	11	1.19%	1	0.81%	12
SENIOR MANAGERS	0	0.00%	13	1.41%	3	2.42%	16
SUPPORT SERVICES	1	2.00%	108	11.71%	18	14.52%	127
Grand Total	**50**	**4.56%**	**922**	**84.12%**	**124**	**11.31%**	**1096**

In the last Census (SuperWEB2(tm) - Table View, 2022), White total in the Orkney Health Board area was 98.38% and Scotland-wide it was 92.86%. The total equivalent figures for BME were 0.94% in the Orkney Health Board area and 6.01% Scotland-wide. Based on the completed ethnic status within NHS Orkney, the percentage for White total is 84.12% and 4.56% for BME. Work will continue to be undertaken during 2025/26 to eradicate as far as possible the 11.31% incomplete recordings to allow a true comparison to be made between the ethnic status of the NHS Orkney workforce and the census figures for the Orkney area.

Table 2.5 Grade by Ethnicity Group Category - Nursing/Midwifery and Medical Support

Nursing/Midwifery and Medical Support by Banding	African - Other	Asian - Other	Don't Know	Prefer not to say	White - Irish	White - Other	White - Other British	White - Scottish	BME Total	White Total	Incomplete	Grand Total
Band 2	1		6	2	1	2	5	23	1	31	8	40
Band 3		2	11	4		2	8	76	2	86	15	103
Band 4								1	0	1	0	1
Band 5	8		7	8	2	8	24	110	8	144	15	167
Band 6			2	4		5	12	58	0	75	6	81
Band 7			3			1	16	37	0	54	3	57
Band 8A						1	1	3	0	5	0	5
Band 8B	1							1	1	1	0	2
Grand Total	10	2	29	18	3	19	66	309	12	397	47	456
% of Nursing/Midwifery and	2.19%	0.44%	6.36%	3.95%	0.66%	4.17%	14.47%	67.76%	2.63%	87.06%	10.31%	100.00%

The table above, whilst accepting that we have 10.31% of the nursing workforce showing as incomplete, demonstrates that further work needs to be done in terms of Ethnicity data gathering.

Table 2.6 Job Family by Religion

The table below shows a breakdown of religion by Job Family. The largest completed religion status (40.88%) is from those who declare no religion, followed by Church of Scotland (19.34%) and Christian Other (11.95%).

	Buddhist	Christian - Other	Church of Scotland	Hindu	Jewish	Muslim	No Religion	None	Other	Prefer not to say	Roman Catholic	Incomplete	Grand Total
ADMINISTRATIVE SERVICES	1	25	40	1			97	1	1	16	2	7	191
ALLIED HEALTH PROFESSION		8	16	1			26		1	7	3	8	70
DENTAL SUPPORT		2	6				7		1	1		2	19
HEALTHCARE SCIENCES		5	1				11			1			18
MEDICAL AND DENTAL	4	26	7	6	2	8	44	2	2	25	13	21	160
MEDICAL SUPPORT		2	6				8			1	1		18
NURSING/MIDWIFERY	1	43	108	2	2		170	1	2	32	22	55	438
OTHER THERAPEUTIC	1	3	6				13			2		2	27
PERSONAL AND SOCIAL CARE		4	2				5		1				12
SENIOR MANAGERS		1	3				7		1	1	1	2	16
SUPPORT SERVICES	1	12	17				60	3	4	9	2	19	127
Grand Total	8	131	212	10	4	8	448	7	13	95	44	116	1096

Note: 'Don't know' and 'Unknown' are included under 'Incomplete'.

Table 2.7 Job Family by Sexual Orientation

The table below shows the breakdown of sexual orientation by Job Family. Currently, there are 904 records with completed sexual orientation status out of a total headcount of 1,096. The largest completed response (71.08%) is from those who have declared heterosexual, followed by gay/lesbian (1.82%)

	Bisexual	Gay/Lesbian	Heterosexual	Other	Prefer not to say	Don't Know	Grand Total
ADMINISTRATIVE SERVICES	2	5	146	2	15	21	191
ALLIED HEALTH PROFESSION		2	49		6	13	70
DENTAL SUPPORT			15		1	3	19
HEALTHCARE SCIENCES	1		13		1	3	18
MEDICAL AND DENTAL	1	1	115		24	19	160
MEDICAL SUPPORT	1		16		1		18
NURSING/MIDWIFERY	7	9	304	4	25	89	438
OTHER THERAPEUTIC	1		21		2	3	27
PERSONAL AND SOCIAL CARE			11			1	12
SENIOR MANAGERS		2	8		3	3	16
SUPPORT SERVICES		1	81	1	7	37	127
Grand Total	**13**	**20**	**779**	**7**	**85**	**192**	**1096**

According to the Office of National Statistics (ONS) Annual Population Survey for 2022, the estimated percentage of people who identify as lesbian, gay or bisexual (LGB) has increased in the UK between 2020 and 2022. The proportion climbed from 3.1% to 3.3% in England, 3.0% to 3.4% in Scotland, 1.4% to 1.8% in Northern Ireland, and 2.9% to 4.3% in Wales. Within NHS Orkney, the number of colleagues identifying as LGB has increased from 3.6% to 3.65% over the previous year, which is higher than the Scottish average of 3.4% reported by the ONS Annual Population Survey. However, 25.27% of colleagues have not disclosed their status. In 2025/26, the organisation will work with colleagues to understand the reasons behind the high rate of non-disclosure to support efforts to create an inclusive environment for everyone. (Source: ons.gov.uk)

Table 2.8 Job Family by Sex

Job Family	Female	% Female	Male	% Male	Grand Total
ADMINISTRATIVE SERVICES	153	13.96%	38	3.47%	191
ALLIED HEALTH PROFESSION	63	5.75%	7	0.64%	70
DENTAL SUPPORT	18	1.64%	1	0.09%	19
HEALTHCARE SCIENCES	12	1.09%	6	0.55%	18
MEDICAL AND DENTAL	72	6.57%	88	8.03%	160
MEDICAL SUPPORT	16	1.46%	2	0.18%	18
NURSING/MIDWIFERY	401	36.59%	37	3.38%	438
OTHER THERAPEUTIC	22	2.01%	5	0.46%	27
PERSONAL AND SOCIAL CARE	11	1.00%	1	0.09%	12
SENIOR MANAGERS	10	0.91%	6	0.55%	16
SUPPORT SERVICES	84	7.66%	43	3.92%	127
Grand Total	862	78.65%	234	21.35%	1096

The above table shows a predominantly female workforce of 78.65% compared with a male workforce of 21.35%. The greatest numbers of females are found within Nursing & Midwifery, with high numbers also in Administrative Services and Support Services. The Medical and Dental Job Family is the only category where there are more male (8.03%) than female employees (6.57%).

Table 2.9 Grade by Sex - Nursing & Midwifery and Medical Support

Band	Female	% Female	Male	% Male	Total
Band 2	34	7.46%	6	1.32%	40
Band 3	93	20.39%	10	2.19%	103
Band 4	1	0.22%		0.00%	1
Band 5	155	33.99%	12	2.63%	167
Band 6	77	16.89%	4	0.88%	81
Band 7	50	10.96%	7	1.54%	57
Band 8A	5	1.10%		0.00%	5
Band 8B	2	0.44%		0.00%	2
Grand Total	417	91.45%	39	8.55%	456

Section 3: Sex Profile

The tables below show the split of Sex across the characteristics of ethnicity, religion and sexual orientation.

Table 3.1: Gender by BME Ethnic Group Category

	African Scottish or	African - Other	Chinese Scottish or	Indian Scottish or	Asian - Other	Pakistani Scottish or	Ethnic Group	Arab, Arab Scottish	Other	BME Total
Female	5	7	1	2	4	1				20
Male	3	7		6	1	6	3	1	3	30
Grand Total	**8**	**14**	**1**	**8**	**5**	**7**	**3**	**1**	**3**	**50**

Table 3.2: Sex by White Ethnic Group Category

	White - Irish	White - Other	White - Other British	White - Polish	White - Scottish	White - Total
Female	4	49	137	1	556	747
Male	9	11	55		100	175
Grand Total	**13**	**60**	**192**	**1**	**656**	**922**

Table 3.3: Sex by Incomplete Ethnic Group Category

	Don't Know	Prefer not to say	Incomplete Total
Female	53	42	95
Male	17	12	29
Grand Total	**70**	**54**	**124**

Table 3.4: Sex by Total Ethnic Group Category

	BME Total	% BME Total	White - Total	% White - Total	Incomplete Total	% Incomplete Total	Grand Total
Female	20	2.32%	747	86.66%	95	11.02%	862
Male	30	12.82%	175	74.79%	29	12.39%	234
Grand Total	**50**	**4.56%**	**922**	**84.12%**	**124**	**11.31%**	**1096**

Table 3.5: Sex by Religion

	Buddhist	Christian - Other	Church of Scotland	Don't Know	Hindu	Jewish	Muslim	No Religion	None	Other	Prefer not to say	Roman Catholic	Grand Total
Female	2	94	200	95	4	2	1	346	5	11	74	28	862
Male	6	37	12	21	6	2	7	102	2	2	21	16	234
Grand Total	**8**	**131**	**212**	**116**	**10**	**4**	**8**	**448**	**7**	**13**	**95**	**44**	**1096**

Table 3.6: Sex by Sexual Orientation

	Bisexual	Gay/Lesbian	Heterosexual	Other	Prefer not to say	Incomplete	Grand Total
Female	7	11	615	7	66	156	862
Male	6	9	164		19	36	234
Grand Total	**13**	**20**	**779**	**7**	**85**	**192**	**1096**

Note: 'Don't know' and 'Unknown' are included under 'Incomplete'.

Section 4: Demographic Profile

Table 4.1: Age Distribution by Job Family

The table below shows that 41.06% of the workforce is over the age of 50. The proportion of our workforce over 50 is significant and considered in our workforce and service planning activity due to the need to respond to an ageing workforce.

	Under 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 +	Grand Total
ADMINISTRATIVE SERVICES		7	19	26	21	26	21	21	28	19	3	191
ALLIED HEALTH PROFESSION		1	6	8	10	8	10	13	8	3	3	70
DENTAL SUPPORT				1	1	3	2	2	4	5	1	19
HEALTHCARE SCIENCES		1	3	2	1	3	2	4	2			18
MEDICAL AND DENTAL			11	7	15	13	18	17	27	28	24	160
MEDICAL SUPPORT		2	2	3	4	3	1	2	1			18
NURSING/MIDWIFERY	2	31	35	53	63	44	53	54	60	34	9	438
OTHER THERAPEUTIC		1	2	7	5	3	2	2	1	3	1	27
PERSONAL AND SOCIAL CARE		1	1	1	3		2	2		2		12
SENIOR MANAGERS				2	1	4	1	2	1	1	4	16
SUPPORT SERVICES	4	5	14	14	14	6	11	16	18	18	7	127
Grand Total	**6**	**49**	**93**	**124**	**138**	**113**	**123**	**135**	**150**	**113**	**52**	**1096**

The NHSScotland Workforce Policies allow us to offer flexibility for those colleagues who wish to retire and return. The Retirement Policy is promoted throughout the organisation to help us retain expertise and support the transfer of knowledge and expertise to others.

Table 4.2: Age Distribution by Sexual Orientation

Sexual Orientation	Under 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 +	Grand Total
Bisexual		1	1	1	2	2		3		2	1	13
Don't Know	1	6	6	21	31	16	25	23	26	26	11	192
Gay/Lesbian			1	5	6	4			4			20
Heterosexual	2	40	82	95	89	78	90	95	104	73	31	779
Other		1			1	2	1		2			7
Prefer not to say	3	1	3	2	9	11	7	14	14	12	9	85
Grand Total	6	49	93	124	138	113	123	135	150	113	52	1096

Table 4.3: Age Distribution by Religion

	Under 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 +	Grand Total
Buddhist			2	1	1		1		1		2	8
Christian - Other		3	9	8	12	17	19	14	17	19	13	131
Church of Scotland	1	6	8	19	27	27	26	20	37	33	8	212
Don't Know		5	1	14	12	9	16	13	21	18	7	116
Hindu			1		1		5	3				10
Jewish									4			4
Muslim			3			1			1	2	1	8
No Religion	4	32	61	68	55	49	43	54	46	26	10	448
None				3	2			1		1		7
Other			1	1		2	2	1	4	2		13
Prefer not to say	1	3	4	6	19	5	7	21	14	9	6	95
Roman Catholic			3	4	9	3	4	8	5	3	5	44
Grand Total	6	49	93	124	138	113	123	135	150	113	52	1096

Section 5: Disability Profile

The table below shows those colleagues who, during the recruitment process or when updating their record, have declared themselves as having a disability when asked *"Do you have a physical or mental health disability that has a substantial effect on your ability to carry out day to day activities and has lasted or is expected to last 12 months or more?"*

Table 5.1 shows that a total of 16 individuals declared themselves as having a disability. The two areas having the largest workforce with a declared disability are Support Services and Administrative Services. In terms of the wider Orkney population, 23.9% of adults reported a limiting long term physical or mental health problem in 2019 and 25.9% in Scotland (Source: Statistics.Gov.Scot).

Table 5.1: Employees who have declared themselves as having a Disability by Job Family

Job Family	Yes	No	Prefer not to say	Incomplete	Grand Total
ADMINISTRATIVE SERVICES	4	137	8	42	191
ALLIED HEALTH PROFESSION		44	3	23	70
DENTAL SUPPORT		9		10	19
HEALTHCARE SCIENCES		12		6	18
MEDICAL AND DENTAL	1	132	8	19	160
MEDICAL SUPPORT		15		3	18
NURSING/MIDWIFERY	3	299	18	118	438
OTHER THERAPEUTIC	1	22	1	3	27
PERSONAL AND SOCIAL CARE	1	9		2	12
SENIOR MANAGERS	1	12	1	2	16
SUPPORT SERVICES	5	84	4	34	127
Grand Total	**16**	**775**	**43**	**262**	**1096**

Table 5.2: Employees who have declared themselves as having a Disability by Sexual Orientation and Age Category

Sexual Orientation	25 - 29	40 - 44	50 - 54	55 - 59	60 - 64	65 +	Grand Total
Bisexual					1		1
Don't Know			1	1		1	3
Gay/Lesbian				1			1
Heterosexual	3	1	3	4			11
Grand Total	3	1	4	6	1	1	16

Note: 'Don't know', 'Prefer not to say' and 'Unknown' are included under 'Incomplete'.

Table 5.3: Employees who have declared themselves as having a Disability by Religion and Age Category

Religion	25 - 29	40 - 44	50 - 54	55 - 59	60 - 64	65 +	Grand Total
Christian - Other				1			1
Church of Scotland				2			2
No Religion	2	1	3	3		1	10
None			1				1
Other					1		1
Roman Catholic	1						1
Grand Total	3	1	4	6	1	1	16

Section 6: New Starts Profile

There was a total of 134 new starts during 2024/25, of which 38 were bank workers.

Table 6.1: Age Category for New Starts by Job Family

Job Family	Under 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 +	Grand Total
ADMINISTRATIVE SERVICES			3	1	2	2	4	2	3	4		21
ALLIED HEALTH PROFESSION				1		1	1	1		1		5
HEALTHCARE SCIENCES						1		1				2
MEDICAL AND DENTAL			11	3	2	3	2	2	3	7	4	37
MEDICAL SUPPORT		1	1						1			3
NURSING/MIDWIFERY		2	6	9	5	2	2	4	6	1		37
OTHER THERAPEUTIC		2	1	3								6
PERSONAL AND SOCIAL CARE		1						1		1		3
SENIOR MANAGERS					1	1						2
SUPPORT SERVICES	1		3	3	4	2	1	1	2	1		18
Grand Total	**1**	**6**	**25**	**20**	**14**	**12**	**10**	**12**	**15**	**15**	**4**	**134**

The highest proportion of new starts are within the 25-29, 30-34, 55-59 and 60-64 age categories but with variances across the Job Families.

Table 6.2: New Starts by Sex and Age

	Under 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 +	Grand Total
Female	1	5	14	16	11	6	8	10	10	10	1	92
Male		1	11	4	3	6	2	2	5	5	3	42
Grand Total	**1**	**6**	**25**	**20**	**14**	**12**	**10**	**12**	**15**	**15**	**4**	**134**

NEW STARTS BY SEX %

Male, 31.34%

Female, 68.66%
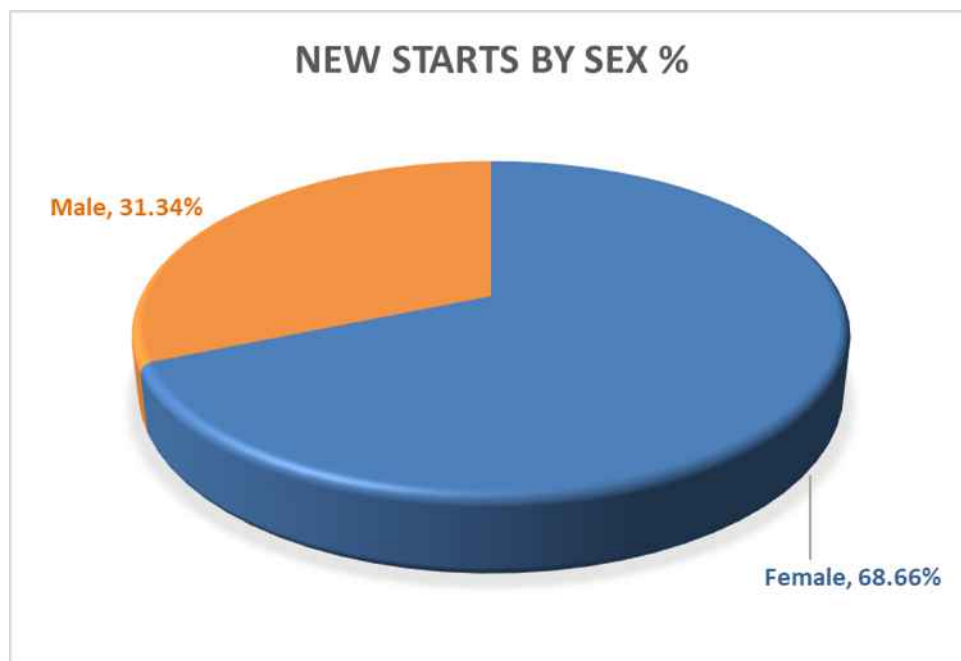
The Sex Ratio within new starts is approximately 69:31 female to male; this compares to the 79:21 ratio for the existing workforce.

Table 6.3 New Start by Sex & Grade - Nursing/Midwifery and Medical Support

Band	Female	Male	Grand Total
Band 3	7	3	10
Band 4	3	4	7
Band 5	15		15
Band 6	3		3
Band 7	4	1	5
Grand Total	32	8	40

Table 6.4: New Starts by Religion

Religion	Headcount
Buddhist	3
Christian - Other	28
Church of Scotland	7
Don't Know	17
Jewish	1
Muslim	3
No Religion	51
None	2
Other	1
Prefer not to say	11
Roman Catholic	10
Grand Total	134

Table 6.5: New Starts by Sexual Orientation

Sexual Orientation	Headcount
Bisexual	4
Gay/Lesbian	4
Heterosexual	100
Incomplete	20
Other	1
Prefer not to say	5
Grand Total	134

Note: 'Don't know' and 'Unknown' are included under 'Incomplete'.

Table 6.6: BME Ethnic Group Category of New Starts by Job Family

Job Family	African - African, African Scottish or African British	African - Other	Asian - Chinese, Chinese Scottish or Chinese British	Asian - Other	Asian - Pakistani, Pakistani Scottish or Pakistani British	Other Ethnic Group - Other	BME Total
ADMINISTRATIVE SERVICES	1						1
ALLIED HEALTH PROFESSION	1	1					2
HEALTHCARE SCIENCES							0
MEDICAL AND DENTAL	1	1	1		2	2	7
MEDICAL SUPPORT		1					1
NURSING/MIDWIFERY		4		1			5
OTHER THERAPEUTIC							0
PERSONAL AND SOCIAL CARE							0
SENIOR MANAGERS							0
SUPPORT SERVICES							0
Grand Total	3	7	1	1	2	2	16

Table 6.7: White Ethnic Group Category of New Starts by Job Family

Job Family	White - Irish	White - Other	White - Other British	White - Polish	White - Scottish	White Total
ADMINISTRATIVE SERVICES		2	6		9	17
ALLIED HEALTH PROFESSION			1		1	2
HEALTHCARE SCIENCES			2			2
MEDICAL AND DENTAL	1	2	14	1	8	26
MEDICAL SUPPORT					2	2
NURSING/MIDWIFERY		1	8		18	27
OTHER THERAPEUTIC	1				3	4
PERSONAL AND SOCIAL CARE					3	3
SENIOR MANAGERS	1				1	2
SUPPORT SERVICES		2	4		10	16
Grand Total	3	7	35	1	55	101

Table 6.8: Incomplete Ethnic Group Category of New Starts by Job Family

Job Family	Incomplete
ADMINISTRATIVE SERVICES	3
ALLIED HEALTH PROFESSION	1
HEALTHCARE SCIENCES	
MEDICAL AND DENTAL	4
MEDICAL SUPPORT	
NURSING/MIDWIFERY	5
OTHER THERAPEUTIC	2
PERSONAL AND SOCIAL CARE	
SENIOR MANAGERS	
SUPPORT SERVICES	2
Grand Total	17

Table 6.9: Total Ethnic Group Category of New Starts by Job Family

Job Family	BME Total	% BME Total	White Total	% White Total	Incomplete Total	% Incomplete Total	Grand Total
ADMINISTRATIVE SERVICES	1	6.25%	17	16.83%	3	17.65%	21
ALLIED HEALTH PROFESSION	2	12.50%	2	1.98%	1	5.88%	5
HEALTHCARE SCIENCES	0	0.00%	2	1.98%	0	0.00%	2
MEDICAL AND DENTAL	7	43.75%	26	25.74%	4	23.53%	37
MEDICAL SUPPORT	1	6.25%	2	1.98%	0	0.00%	3
NURSING/MIDWIFERY	5	31.25%	27	26.73%	5	29.41%	37
OTHER THERAPEUTIC	0	0.00%	4	3.96%	2	11.76%	6
PERSONAL AND SOCIAL CARE	0	0.00%	3	2.97%	0	0.00%	3
SENIOR MANAGERS	0	0.00%	2	1.98%	0	0.00%	2
SUPPORT SERVICES	0	0.00%	16	15.84%	2	11.76%	18
Grand Total	16	11.94%	101	75.37%	17	12.69%	134

In the year, ethnicity for 12.69% of new starts was unspecified. However, 41.04% were identified as 'White Scottish'. The second highest group was' White—Other British', which accounted for 26.12% of new starts. BME individuals made up 11.94% of the new starts.

Section 7: Promotion/ Regrade

The following table identifies those colleagues who have been promoted or regraded (including temporary upgrades) in the year.

Table 7.1: Promotion/ Regrade Profile by Job Family and BME Ethnic Group Category

Job Family	Asian - Other	BME Total
ADMINISTRATIVE SERVICES	1	1
ALLIED HEALTH PROFESSION		
HEALTHCARE SCIENCES		
MEDICAL SUPPORT		
NURSING/MIDWIFERY		
SUPPORT SERVICES		
Grand Total	1	1

Table 7.2: Promotion/ Regrade Profile by Job Family and White Ethnic Group Category

Job Family	White - Other	White - Other British	White - Scottish	White Total
ADMINISTRATIVE SERVICES			5	5
ALLIED HEALTH PROFESSION			2	2
HEALTHCARE SCIENCES			2	2
MEDICAL SUPPORT			1	1
NURSING/MIDWIFERY	1	1	8	10
SUPPORT SERVICES			1	1
Grand Total	1	1	19	21

Table 7.3: Promotion/ Regrade Profile by Job Family and Incomplete Ethnic Group Category,

Job Family	Prefer not to say	Incomplete Total
ADMINISTRATIVE SERVICES	1	1
ALLIED HEALTH PROFESSION		
HEALTHCARE SCIENCES		
MEDICAL SUPPORT		
NURSING/MIDWIFERY		
SUPPORT SERVICES		
Grand Total	1	1

Table 7.4: Promotion/ Regrade Profile by Job Family and Total Ethnic Group Category

Job Family	BME Total	% BME Total	White Total	% White Total	Incomplete Total	% Incomplete Total	Grand Total
ADMINISTRATIVE SERVICES	1	100.00%	5	23.81%	1	100.00%	7
ALLIED HEALTH PROFESSION	0	0.00%	2	9.52%	0	0.00%	2
HEALTHCARE SCIENCES	0	0.00%	2	9.52%	0	0.00%	2
MEDICAL SUPPORT	0	0.00%	1	4.76%	0	0.00%	1
NURSING/MIDWIFERY	0	0.00%	10	47.62%	0	0.00%	10
SUPPORT SERVICES	0	0.00%	1	4.76%	0	0.00%	1
Grand Total	1	4.35%	21	91.30%	1	4.35%	23

The total number of colleagues promoted or regraded in the last year was 23. Ethnic status was known for 22 colleagues. Based on the table above 91.30% of colleagues promoted/regraded were 'White Scottish'; BME were represented by 4.35% and incomplete were represented by 4.35%.

Table 7.5: Promotion/ Regrade Profile by Job Family and Religion

Job Family	Buddhist	Church of Scotland	Incomplete	No Religion	Prefer not to say	Grand Total
ADMINISTRATIVE SERVICES	1	2		3	1	7
ALLIED HEALTH PROFESSION				2		2
HEALTHCARE SCIENCES		1		1		2
MEDICAL SUPPORT				1		1
NURSING/MIDWIFERY		5	1	4		10
SUPPORT SERVICES				1		1
Grand Total	1	8	1	12	1	23

Note: 'Don't know' and 'Unknown' are included under 'Incomplete'.

Table 7.6: Promotion/ Regrade Profile by Job Family and Sexual Orientation

Job Family	Bisexual	Heterosexual	Prefer not to say	Grand Total
ADMINISTRATIVE SERVICES		6	1	7
ALLIED HEALTH PROFESSION		2		2
HEALTHCARE SCIENCES		2		2
MEDICAL SUPPORT		1		1
NURSING/MIDWIFERY	1	9		10
SUPPORT SERVICES		1		1
Grand Total	1	21	1	23

Section 8: Leavers

The following tables show the leavers' profiles. During the year, there were 128 leavers compared to 255 leavers in the same time period last year.

Table 8.1: Leavers by Job Family and BME Ethnic Group Category – March 2024 to February 2025

	African - African, African Scottish or African British	Asian - Indian, Indian Scottish or Indian British	Asian - Pakistani, Pakistani Scottish or Pakistani British	BME Total
ADMINISTRATIVE SERVICES				0
ALLIED HEALTH PROFESSION				0
DENTAL SUPPORT				0
HEALTHCARE SCIENCES				0
MEDICAL AND DENTAL	1	1	1	3
MEDICAL SUPPORT				0
NURSING/MIDWIFERY	1			1
OTHER THERAPEUTIC				0
PERSONAL AND SOCIAL CARE				0
SENIOR MANAGERS	1			1
SUPPORT SERVICES				0
Grand Total	**3**	**1**	**1**	**5**

Table 8.2: Leavers by Job Family and White Ethnic Group Category – March 2024 to February 2025

	White - Irish	White - Other	White - Other British	White - Scottish	White Total
ADMINISTRATIVE SERVICES	1	1	6	18	26
ALLIED HEALTH PROFESSION			3	6	9
DENTAL SUPPORT				1	1
HEALTHCARE SCIENCES				1	1
MEDICAL AND DENTAL		3	11	1	15
MEDICAL SUPPORT				1	1
NURSING/MIDWIFERY		1	12	23	36
OTHER THERAPEUTIC			2	3	5
PERSONAL AND SOCIAL CARE				1	1
SENIOR MANAGERS					0
SUPPORT SERVICES			3	8	11
Grand Total	**1**	**5**	**37**	**63**	**106**

Table 8.3: Leavers by Job Family, Incomplete Ethnic Category and Census Category

	Don't Know	Prefer not to say	Incomplete Total
ADMINISTRATIVE SERVICES	3	1	4
ALLIED HEALTH PROFESSION			0
DENTAL SUPPORT	1	1	2
HEALTHCARE SCIENCES			0
MEDICAL AND DENTAL	4	1	5
MEDICAL SUPPORT	1		1
NURSING/MIDWIFERY	2	2	4
OTHER THERAPEUTIC			0
PERSONAL AND SOCIAL CARE			0
SENIOR MANAGERS	1		1
SUPPORT SERVICES			0
Grand Total	**12**	**5**	**17**

Table 8.4: Leavers by Job Family, Total Ethnic Category and Census Category

Job Family	BME Total	% BME Total	White Total	% White Total	Incomplete Total	% Incomplete Total	Grand Total
ADMINISTRATIVE SERVICES	0	0.00%	26	24.53%	4	23.53%	30
ALLIED HEALTH PROFESSION	0	0.00%	9	8.49%	0	0.00%	9
DENTAL SUPPORT	0	0.00%	1	0.94%	2	11.76%	3
HEALTHCARE SCIENCES	0	0.00%	1	0.94%	0	0.00%	1
MEDICAL AND DENTAL	3	60.00%	15	14.15%	5	29.41%	23
MEDICAL SUPPORT	0	0.00%	1	0.94%	1	5.88%	2
NURSING/MIDWIFERY	1	20.00%	36	33.96%	4	23.53%	41
OTHER THERAPEUTIC	0	0.00%	5	4.72%	0	0.00%	5
PERSONAL AND SOCIAL CARE	0	0.00%	1	0.94%	0	0.00%	1
SENIOR MANAGERS	1	20.00%	0	0.00%	1	5.88%	2
SUPPORT SERVICES	0	0.00%	11	10.38%	0	0.00%	11
Grand Total	**5**	**3.91%**	**106**	**82.81%**	**17**	**13.28%**	**128**

Among all leavers, 87.84% had a recorded ethnic status. Of these, 86.72% were classified as 'White', while 'BME' leavers represented 3.91%. The remaining 13.28% of leavers were categorised as Incomplete.

Table 8.5: Leavers by Job Family and Religion

	Christian - Other	Church of Scotland	Don't Know	Jewish	Muslim	No Religion	Other	Prefer not to say	Roman Catholic	Grand Total
ADMINISTRATIVE SERVICES	6	7	3			10	1	2	1	30
ALLIED HEALTH PROFESSION	1	2				6				9
DENTAL SUPPORT		1	1		1					3
HEALTHCARE SCIENCES		1								1
MEDICAL AND DENTAL	2		5		1	9	1	4	1	23
MEDICAL SUPPORT		1	1							2
NURSING/MIDWIFERY	9	11	1	1		16		3		41
OTHER THERAPEUTIC		2				2		1		5
PERSONAL AND SOCIAL CARE						1				1
SENIOR MANAGERS			1			1				2
SUPPORT SERVICES	1	2				8				11
Grand Total	**19**	**27**	**12**	**1**	**2**	**53**	**2**	**10**	**2**	**128**

Table 8.6: Leavers by Job Family and Sexual Orientation

	Bisexual	Gay/Lesbian	Heterosexual	Prefer not to say	Incomplete	Grand Total
ADMINISTRATIVE SERVICES		1	22	3	4	30
ALLIED HEALTH PROFESSION			9			9
DENTAL SUPPORT			2		1	3
HEALTHCARE SCIENCES			1			1
MEDICAL AND DENTAL	1		14	2	6	23
MEDICAL SUPPORT			1		1	2
NURSING/MIDWIFERY	3		27	3	8	41
OTHER THERAPEUTIC			4		1	5
PERSONAL AND SOCIAL CARE			1			1
SENIOR MANAGERS			1		1	2
SUPPORT SERVICES	1		9		1	11
Grand Total	**5**	**1**	**91**	**8**	**23**	**128**

Note: 'Don't know' and 'Unknown' are included under 'Incomplete'.

Section 9: Job Train Equal Opportunity (Applications)

The information below is collected from our Job Train system and includes all advertisements (both permanent and bank) from 1 March 2024 to 28 February 2025. Job Family categories differentiate from other sections as they are set by Job Train and can't be broken down further. Unknown figures predominantly will include colleagues for whom ethnicity information was not captured as part of the process.

There has been a 1% reduction in applications for the 2024/25 period compared to 2023/24. However, applications from individuals identifying with one of the BME groups have increased by 2.4% compared to the previous year. The use of Artificial Intelligence (AI) in the application process appears to have contributed to this increase, along with a significant rise in international applications. Additionally, it is noted that some individuals may have applied for more than one role, which may also explain the overall increase in applications.

Table 9.1: Job Train Applications by Job Family and BME Ethnic Group Category

	BME												BME Total
	African - African, African Scottish or African British	African - Other	Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian - Chinese, Chinese Scottish or Chinese British	Asian - Indian, Indian Scottish or Indian British	Asian - Other	Asian - Pakistani, Pakistani Scottish or Pakistani British	Caribbean or Black	Caribbean or Black - Black, Black Scottish or Black British	Mixed or Multiple Ethnic Group	Other Ethnic Group - Arab, Arab Scottish or Arab British	Other Ethnic Group - Other	
Administrative Services	179	33	2	0	82	5	18	4	1	4	3	18	349
Allied Health Professions	28	5	1	0	28	2	11	2	0	1	2	4	84
Dental Support	2	0	0	0	13	0	7	0	0	0	2	1	25
Executive Level	2	0	0	0	4	0	2	0	0	0	1	1	10
Healthcare Sciences	33	9	1	2	11	1	3	0	0	1	1	2	64
Medical and Dental	158	23	29	5	190	50	373	5	2	18	52	58	963
Nursing and Midwifery	1394	609	1	7	82	14	23	49	8	12	0	61	2260
Other Therapeutic	101	3	0	0	26	1	1	1	0	1	0	4	138
Personal and Social Care	1	0	0	1	1	0	2	0	0	0	0	0	5
Senior Managers	5	0	0	1	2	0	1	0	0	0	0	0	9
Support Services	93	27	1	0	26	0	6	0	0	0	0	6	159
Grant Total	**1996**	**709**	**35**	**16**	**465**	**73**	**447**	**61**	**11**	**37**	**61**	**155**	**4066**
% of Total Applications	**42.4%**	**15.0%**	**0.7%**	**0.3%**	**9.9%**	**1.5%**	**9.5%**	**1.3%**	**0.2%**	**0.8%**	**1.3%**	**3.3%**	**86.3%**

Table 9.2: Job Train Applications by Job Family and White Ethnic Group Category

	White							White Total
	White - Irish	White - Other	White - Other British	White - Polish	White - Roma	White - Scottish	British - Irish	
Administrative Services	1	10	37	0	1	55	0	104
Allied Health Professions	0	5	5	0	0	9	0	19
Dental Support	0	0	1	0	0	1	0	2
Executive Level	0	0	2	0	0	4	0	6
Healthcare Sciences	0	3	1	0	0	15	0	19
Medical and Dental	1	42	29	3	0	14	0	89
Nursing and Midwifery	4	31	64	1	0	120	2	222
Other Therapeutic	0	3	9	0	0	16	0	28
Personal and Social Care	0	1	2	0	0	4	0	7
Senior Managers	0	2	11	0	0	8	0	21
Support Services	2	13	17	4	1	57	0	94
Grant Total	8	110	178	8	2	303	2	611
% of Total Applications	0.2%	2.3%	3.8%	0.2%	0.0%	6.4%	0.0%	13.0%

Table 9.3: Job Train Applications by Job Family, Prefer not to say (Ethnic Group) Category

	Prefer not to say	Prefer not to say Total
Administrative Services	4	4
Allied Health Professions	1	1
Dental Support	1	1
Executive Level	3	3
Healthcare Sciences	3	3
Medical and Dental	11	11
Nursing and Midwifery	4	4
Other Therapeutic	3	3
Personal and Social Care	1	1
Senior Managers	4	4
Support Services	1	1
Grant Total	36	36
% of Total Applications	0.8%	0.8%

Table 9.4: Job Train Applications by Job Family and Total Ethnic Group Category

	BME Total	BME Total %	White Total	White Total %	Prefer not to say Total	Prefer not to say Total %	Grant Total
Administrative Services	349	76.4%	104	22.8%	4	0.9%	457
Allied Health Professions	84	80.8%	19	18.3%	1	1.0%	104
Dental Support	25	89.3%	2	7.1%	1	3.6%	28
Executive Level	10	52.6%	6	31.6%	3	15.8%	19
Healthcare Sciences	64	74.4%	19	22.1%	3	3.5%	86
Medical and Dental	963	90.6%	89	8.4%	11	1.0%	1063
Nursing and Midwifery	2260	90.9%	222	8.9%	4	0.2%	2486
Other Therapeutic	138	81.7%	28	16.6%	3	1.8%	169
Personal and Social Care	5	38.5%	7	53.8%	1	7.7%	13
Senior Managers	9	26.5%	21	61.8%	4	11.8%	34
Support Services	159	62.6%	94	37.0%	1	0.4%	254
Grant Total	**4066**	**86.3%**	**611**	**13.0%**	**36**	**0.8%**	**4713**

Section 10: Action Planning

In line with the General Duty of the Equality Act 2010, NHS Orkney's objectives are to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between different groups (i.e. people who share a protected characteristic and those who do not).
- foster good relations between different groups.

The purpose of gathering and publishing the information in this report is to support better performance of this duty. Beyond that, good practice in equality and diversity is vital in making NHS Orkney a good place to work.

Actions Planned for 2025-26

Working with the Area Partnership Forum, the key actions that will be undertaken during 2025/26 will include the following:

Equality and Diversity Data

- Continue to encourage colleagues to update their protected characteristics with a particular focus on "Don't Know" responses
- Continue to publish the Equal Pay Monitoring Report and Equal Pay Statement.

Training and Education

- Revise and enhance recruitment training resources, focusing on bias awareness, and ensure that all hiring managers complete the training.
- Collaborate with the Occupational Health team to raise awareness of Access to Work grants provided by the Department for Work and Pensions.
- Initiate our new leadership development programme and succession planning approach for the Executive Team, Senior Leadership Team, and the Board.

Communication

- Promote Once for Scotland work-life balance policies to assist colleagues who care for dependants, and continue promoting and training managers on reasonable adjustments.

Workforce of the Future

- Develop a comprehensive medium-term workforce plan to support the attraction, retention, and development of our colleagues in line with our Corporate Strategy deliverables for 2025/26.

NHS Orkney
Equal Pay Statement and Pay Gap Report 2025

Contents

1. Introduction

NHS Orkney is committed to the principles of equality, diversity and human rights in employment. Staff should receive equal pay for the same or broadly similar work, for work rated as equivalent and for work of equal value (regardless of age, disability, ethnicity or race, gender, marital or civil partnership status, pregnancy, political beliefs, religion or belief, sex or sexual orientation).

NHS Orkney is committed to mainstreaming equality in the workplace and one way of ensuring this is to carry out a pay gap audit. Pay rates within NHS Orkney are in line with national pay arrangements which are determined by the Scottish Government. Staff are appointed to Agenda for Change (AfC) bands and Executive and Senior Manager grades through a recognised national job evaluation process. Progression through the AfC pay bands is then through incremental progression, so those staff with longer service will therefore be paid at the upper end of a pay scale compared to those new into post. Appointment to a Medical and Dental grade is based on the definitions in the Terms and Conditions of service and then progress through the scale is again through incremental progression, with length of service influencing the rate of pay.

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 came into force on 27th May 2012. The Regulations included several measures to monitor how well public bodies are meeting their equality duties. The equal pay monitoring measures include:

- A requirement for public bodies to publish every two years information on any Gender Pay Gap. This information should be shown as any difference:
    - "… between the men's average hourly pay (excluding overtime) and women's average hourly pay (excluding overtime)."
- The information published must be based on the most recent data available.
- Public bodies must publish every four years a statement on Equal Pay.
- From 2017 onwards, every second Report, i.e. every fourth year, the Equal Pay Report must be expanded to include pay information for:
    - persons who are disabled and persons who are not
    - persons who fall into a minority racial group and persons who do not
- The Report must also include information on any occupational segregation amongst its employees: "being the concentration of –
    - men and women;
    - persons who are disabled and persons who are not, and
    - persons who fall into a minority racial group and persons who do not in particular grades and in particular occupations.

This report provides pay gap information for NHS Orkney, based on workforce and payroll data, as at 31st December 2024.

2. The NHS Orkney Equal Pay Statement

This policy has been agreed in partnership and will be reviewed on a regular basis by the NHS Orkney Area Partnership Forum and the Staff Governance Committee.

NHS Orkney is committed to the principles of equality of opportunity in employment and believes that staff should receive equal pay for the same or broadly similar work, or work rated as equivalent and for work of equal value, regardless of their age, disability, ethnicity or race, gender reassignment, marital or civil partnership status, pregnancy and maternity, religion or belief, sex or sexual orientation.

NHS Orkney understands that workers have a right to equal pay between women and men. In addition, the Equality Act 2010 (Specific Duties) (Scotland) Regulations require NHS Orkney to take the following steps:

- Publish gender pay gap information by 30 April 2025, and every two years thereafter, using the specific calculation set out in the Regulations;
- Publish a statement on equal pay between men and women; people who are disabled and who are not; and people who fall into a minority racial group and who do not, to be updated every four years; and
- Publish information on occupational segregation among its employees, being the concentration of men and women; people who are disabled and who are not; and people who fall into a minority racial group and who do not, to be updated every four years.

NHS Orkney also recognises underlying drivers of pay inequality, including occupational segregation, inequality of unpaid care between men and women, lack of flexible working opportunities, and traditional social attitudes. NHS Orkney will take steps within its remit to address these factors in ways that achieve the aims of the NHS Scotland Staff Governance Standard and the Equality Duty.

2.1. National Context

Equal pay is a legal requirement. Women and men performing work of the same value must be paid at the same rate. In contrast, the Gender Pay Gap is a comparison of the average rate of pay for all female staff compared to the average rate of pay for all male staff, regardless of their role.

[Close the Gap](#) produces information on the gender pay gap in Scotland. The purpose of this is to outline and analyse the key trends in the gender pay gap across various measures to show how it has changed over time.

Recent data from the ONS's Annual Survey of Hours and Earnings (ASHE) indicates that both the median and mean gender pay gaps have decreased between 2022 and 2023 across all measures.

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 require listed authorities to publish information about the mean gender pay gap which is the percentage difference between men and women's average hourly pay (excluding overtime). The mean pay gaps have had a slightly larger reduction compared to median pay gaps, where falls have been more varied. The mean pay gaps have all seen significant decreases by around 4 percentage points, with the combined pay gap now sitting at 6.3%, the full-time gap at 3.5%, and the part-time at 22.1%.

Given that the mean pay gap is calculated from the basic hourly rates of all individual employees, it therefore includes the highest and lowest rates and provides an overall indication of the size of the pay gap. The median basic hourly rate, on the other hand, is calculated by taking the mid-point from a list of all employees' basic hourly rates of pay and provides a more accurate representation of the 'typical' difference in pay that is not skewed by the highest or lowest rates. It is possible however that the median pay gap can obscure pay differences that may be associated with gender, ethnicity or disability.

The gender pay gap is a key indicator of the inequalities and differences that still exist in men and women's working lives.

However, women are not all the same, and their experiences of the work are shaped by their different identities, and this contributes to the inequalities they may face. For example, disabled women and women from particular ethnic groups are more likely to be underemployed in terms of skills and face higher pay gaps.

There is a clear business case for organisations to consider gender equality key to enhancing profitability and corporate performance. Research data indicates that considering gender equality enabled organisations to:

- Recruit from the widest talent pool
- Improve staff retention
- Improve decision making and governance

2.2. National Terms and Conditions

NHS Orkney employs staff on nationally negotiated and agreed NHS contracts of employment which includes provisions on pay, pay progression and terms and conditions of employment. These include NHS Agenda for Change (A4C) Contract and Terms & Conditions of employment, NHS Medical and Dental (including General Practitioners) and NHS Scotland Executive and Senior Managers contracts of employment.

NHS Orkney recognises that in order to achieve equal pay for employees doing the same or broadly similar work, work rated as equivalent, or work of equal value, it should implement pay systems which are transparent, based on objective criteria and free from unlawful discrimination.

NHS Scotland is a Living Wage employer and, as such, the lowest available salary of £24,518 translates into an hourly rate of £12.71 per hour, which is above the Scottish Living Wage rate of £12.60 per hour.

2.3. Legislative Framework

The Equality Act 2010 protects people from unlawful discrimination and harassment in employment, when seeking employment, or when engaged in occupations or activities related to work. It also gives women and men a right to equal pay for equal work. It requires that women and men and paid on equally favourable terms where they are employed in 'like work', 'work related as equivalent' or 'work of equal value'.

In line with the Public Sector Equality Duty of the Equality Act 2010, objectives are to ensure we have due regards to the need to:

- Eliminate unfair, unjust or unlawful practices and other discrimination that impact on pay equality;
- Promote equality of opportunity and the principles of equal pay throughout the workforce; and
- Promote good relations between people sharing different protected characteristics in the implementation of equal pay

2.4. Staff Governance Standard

NHS Boards work within a Staff Governance Standard which is underpinned by statute. The Staff Governance Standard sets out what each NHS Scotland employer must achieve in order to continuously improve in relation to the fair and effective management of staff.

The Standard requires all NHS Boards to demonstrate that staff are:
- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where

- Diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

Delivering equal pay is integrally linked to the aims of the Staff Governance Standard.

2.5. Equal Pay and The Gender Pay Gap

Equal pay is a legal requirement. Women and men performing work of the same value must be paid at the same rate.

In contrast, the Gender Pay Gap is a comparison of the average rate of pay for all female staff compared to the average rate of pay for all male staff, regardless of their role.

2.6. Equal Pay Actions

It is good practice and reflects the values of NHS Orkney that pay is awarded fairly and equitably.

We will:

- Review this statement and action points with trade unions, staff networks and professional organisations as appropriate, every 2 years and provide a formal report within 4 years;
- Inform employees how pay practices work and how their own pay is determined;
- Provide training and guidance for managers and for those involved in making decisions about pay and benefits and grading decisions to ensure fair, non-discriminatory and consistent practice;
- Examine our existing and future pay practices for all our employees, including part-time workers, those on fixed term contracts or contracts of unspecified duration, and those on pregnancy, maternity or other authorised leave;
- Undertake regular monitoring of our practices in line with the requirements of the Equality Act 2010; including carrying out and using the results of equality impact assessments.
- Consider, and where appropriate, contribute to equal pay reviews in line with guidance to be developed in partnership with the workforce and Trade Union representatives.
- The Community Planning Partnership in Orkney have committed in 25/26 to an Orkney-wide piece of work re: gender pay. The Director of People and Culture is taking the lead on this for NHS Orkney

Responsibility for implementing this policy is held by the NHS Orkney Chief Executive with the Director of People and Culture having lead responsibility for the delivery of the policy.

If a member of staff wishes to raise a concern at a formal level within NHS Orkney relating to equal pay, the NHS Scotland Grievance Policy is available for their use.

3. NHS Orkney Current Workforce

The data constraints within this report are representative of the payroll/workforce data as at 31 December 2024. NHS Orkney has a total workforce of 1,056 (employees and bank workers) with 833 (78.88%) women and 223 (21.12%) men.

Appendices 1-3 show the distribution of male and female employees across three contract groupings.

- Agenda for Change
- Medical and Dental
- Senior Managers

4. Gender Pay Analysis

This report provides gender pay gap information for NHS Orkney, based on workforce and payroll data, as at 31 December 2024.

The report provides the average hourly basic rate pay gap data calculated as:

The average hourly basic rate is the sum of hourly rates divided by the total workforce (number of employees and bank workers). The average (mean) includes the lowest and highest rates of pay, giving a good overall indication of the gender pay gap.

The percentage pay gap is the difference in the hourly rate of pay, expressed as a percentage of the hourly rate for male employees (A = mean or median hourly rate of pay for male employees, B = mean or median rate of pay for female employees).

$$\textit{Average \% Pay Gap} = \frac{A - B}{A} \times 100$$

A positive % Pay Gap (Monetary Variance M to F) means male employees have a higher average rate of pay compared to female employees.

A summary of the Gender Pay Analysis for NHS Orkney is shown on Table 1.

Table 1. Gender Pay Gap Analysis for NHS Orkney as at 31 December 2024.

	Gender Pay Gap analysis - hourly rate comparison - NHS Orkney staff - 2025									
	Female			Male			Total			
Job Family	Gender Count	Gender Count % of Job Family	Average Basic Hourly Rate	Count of Gender	Gender Count % of Job Family	Average Basic Hourly Rate	Monetary Variance M to F £	Monetary Variance M to F %	Total Gender Count	Total Average Basic Hourly Rate
Agenda for Change	764	84.79%	£19.61	137	15.21%	£20.38	£0.77	3.78%	901	£19.72
Medical and Dental	68	44.44%	£63.10	85	55.56%	£71.35	£8.25	11.57%	153	£67.68
Senior Managers	1	50.00%	£63.86	1	50.00%	£50.79	-£13.07	-25.74%	2	£57.32
NHS Orkney Total	**833**	**78.88%**	**£23.21**	**223**	**21.12%**	**£39.94**	**£16.73**	**41.89%**	**1056**	**£26.74**

Agenda for Change

As at 31 December 2024, NHS Orkney had a workforce of 901(employees and bank workers) in the Agenda for Change category. This is 85.3% of NHS Orkney's total workforce.

Table 2. Summary of Agenda for Change Gender Pay Gap Analysis as at 31 December 2024

Agenda for Change	Female	Male	Difference	% Pay Gap
	N = 764	N = 137		
Average hourly basic rate	£19.61	£20.38	£0.77	3.78%

Table 2 shows the distribution of female and male staff in the Agenda for Change category. Female staff represent more than three-quarters of the workforce within the NHS Orkney Agenda of Change category at 84.79%. Female staff in the Agenda for Change category receive £0.77 less on an average hourly rate than male staff.

Data shows (Table 3) that the average basic hourly rate of male staff is higher than female staff in the following job families: Administrative Services (21.69%), Allied Health Profession (14.42%), Other Therapeutic (11.37%), and Support Services (15.10%) with a monetary variance of £2.46 to £5.28 on average basic hourly rate.

Female staff in the following job families receive higher average basic hourly rate than male staff: Healthcare Sciences (4.03%), Medical Support (4.01%), Personal

and Social Care (49.64%) and Nursing/Midwifery (4.30%). Female staff represent 91.31% of Nursing/Midwifery staff and have a higher average hourly basic rate of £0.82 compared to male staff.

Table 3. Summary gender pay gap analysis of Agenda for Change staff.

Gender Pay Gap analysis - hourly rate comparison - Agenda for Change staff - 2025									
	Female			Male			Total			
Job Family	Count of Gender	Gender Count % of Job Family	Average Hourly Rate	Count of Gender	Gender Count % of Job Family	Average Hourly Rate	Monetary Variance M to F £	Monetary Variance M to F %	Total Count of Gender	Total Average Hourly Rate
ADMINISTRATIVE SERVICES	148	79.57%	£19.05	38	20.43%	£24.32	£5.28	21.69%	186	£20.13
ALLIED HEALTH PROFESSION	63	90.00%	£23.93	7	10.00%	£27.96	£4.03	14.42%	70	£24.33
DENTAL SUPPORT	18	94.74%	£17.89	1	5.26%	£13.93	-£3.96	-28.46%	19	£17.68
HEALTHCARE SCIENCES	12	66.67%	£20.89	6	33.33%	£20.08	-£0.81	-4.03%	18	£20.62
MEDICAL SUPPORT	17	89.47%	£19.31	2	10.53%	£18.56	-£0.74	-4.01%	19	£19.23
NURSING/ MIDWIFERY	389	91.31%	£19.99	37	8.69%	£19.17	-£0.82	-4.30%	426	£19.92
OTHER THERAPEUTIC	19	86.36%	£27.68	3	13.64%	£31.23	£3.55	11.37%	22	£28.16
PERSONAL AND SOCIAL CARE	11	91.67%	£22.58	1	8.33%	£15.09	-£7.49	-49.64%	12	£21.96
SUPPORT SERVICES	87	67.44%	£13.80	42	32.56%	£16.26	£2.46	15.10%	129	£14.60
Grand Total	**764**	**84.79%**	**£19.61**	**137**	**15.21%**	**£20.38**	**£0.77**	**3.78%**	**901**	**£19.72**

Appendix 1 shows the distribution of the Female and Male workforce (employees and bank workers) in the Agenda for Change category.

Medical and Dental

As at 31 December 2024, NHS Orkney had a workforce of 153 (employees and bank workers) in the Medical and Dental Category. This is 14.5% of NHS Orkney's total workforce.

Table 4. Summary of Medical and Dental Gender Pay Gap Analysis as at 31 December 2024

Medical and Dental	Female	Male	Difference	% Pay Gap
	N = 68	N = 85		
Average hourly basic rate	£63.10	£71.35	£8.25	11.57%

Medical and dental staff show a gender pay gap in favour of male staff.

Table 5. Consultant Pay Gap Analysis as at 31 December 2024

Consultant	Female	Male	Difference	% Pay Gap
	N = 11	N = 11		
Average hourly basic rate	£75.93	£80.368	£4.44	5.52%

Consultants show a gender pay gap in favour of male staff, by an average hourly rate of £4.44 more than female Consultants.

Table 6. GP's Pay Gap Analysis as at 31 December 2024

GP's	Female	Male	Difference	% Pay Gap
	N = 16	N = 16		
Average hourly basic rate	£62.80	£68.09	£5.28	-0.72%

GP's show a gender pay gap in favour of male staff, by an average hourly rate of £5.28 more than female GP's.

Appendix 2 shows the distribution of the Female and Male workforce contracted in the Medical and Dental category.

Senior Managers

As at 31 December 2024, NHS Orkney employ two employees in the Executive Management Category and represents 0.2% of NHS Orkney's workforce. Female staff receive £13.07 more than male staff on average, with a 25.74% pay gap in favour of Female staff.

Table 7. Executive Management Pay Gap Analysis as at 31 December 2024

Senior **Managers**	Female	Male	Difference	% Pay Gap
	N = 1	N = 1		
Average hourly basic rate	£63.86	£50.79	-£13.07	-25.74%

N.B. Executive and Senior managers within NHS Orkney are reported under the relevant category in accordance with pay.

Appendix III shows the distribution of the Female and Male workforce contracted in the Executive Management Category.

Overall Gender Pay Gap

Table 8. Overall Gender Pay Gap Analysis as at 31 December 2024 (employees and bank workers)

NHS Orkney	Female	Male	Difference	% Pay Gap
	N = 833 (78.9%)	N = 223 (21.1%)		
Average hourly basic rate	£23.21	£39.94	£16.73	41.89%

The average pay gap is calculated from the hourly rates of all individual employees. It, therefore, includes the lowest and highest rates across the organisation and provides an overall indication of the size of the pay gap.

Whilst the gender pay gap is small for Agenda for Change (average gap of 3.78%) and positive for Senior Managers (average gap -25.74%), the size of the overall pay gap is driven by the larger disparity between male and female pay for the Medical and Dental workforce. This difference is largely due to the higher number of male bank workers compared to female bank workers engaged at NHS Orkney as they are employed with enhanced rates.

Staff employed under Agenda for Change Pay, Terms and Conditions are recruited into a post with a confirmed Agenda for Change pay band, assigned through the application of the NHS Job Evaluation Scheme. The evaluation is undertaken by a trained panel of matchers and is based on the skills and responsibility demands of the post. As such, all employees aligned to the same post/job description will be paid, regardless of their sex, according to the evaluated band outcome for the post.

It is also important to note that each Agenda for Change pay band consists of a number of incremental points. In line with Agenda for Change terms and conditions, each employee will generally either commence in post at the minimum of the pay scale or, in the case of promotion, commence on the first available point on the scale that will afford the employee a salary increase. Thereafter, incremental progression through the scale applies on an annual basis. This means that commencing salary, length of service in the band and timing of each employee's yearly incremental date will have a direct influence on the pay gap within this contract group.

The Medical and Dental staff progress incrementally on their pay scales in a similar way to AFC staff. As such, commencing salary, length of service in grade and timing of each employee's annual incremental date are strong contributory factors to this pay gap.

There are only 2 employees within the Executive Management Category. Given the small numbers involved, it is not possible to draw any firm conclusions from pay in this category.

5. Disability Pay Analysis

This report provides the Disability pay information for NHS Orkney, based on workforce and payroll data, as at 31 December 2024.

Within NHS Orkney, 14 (1.33%) have identified themselves as having a disability whilst 740 (70.08%) have not. Of the remaining 302, 41 (3.88%) answered 'Prefer not to say' and 261 (24.72%) have not answered 'Don't know'.

A summary of the Disability Pay Analysis is shown in the Appendix list. The detailed information from which the summary is compiled is shown at:

- Appendix 4 for Agenda for Change
- Appendix 5 for Medical and Dental
- Appendix 5 for Senior Managers

There is a pay difference of £7.39 between employees who have identified themselves as having a disability and those who have identified as not having a disability. However, 28% of employees (302 individuals) chose the options "Don't know" or "Prefer not to say." This significant portion impacts the analysis, highlighting the need to gather more data from staff to conduct a comprehensive evaluation.

Table 9. Disability Analysis for NHS Orkney as at 31 December 2024.

Occupational Segregation by Disability - NHS Orkney Staff Summary 2025

Medical Condition/Disability in the Last 12 Months	Total No. of Employments	Average Basic Hourly Rate
Don't Know	261	£24.62
No	740	£27.46
Prefer not to say	41	£29.65
Yes	14	£20.07
Grand Total	**1056**	**£26.74**

6. Ethnicity Pay Analysis

Within NHS Orkney, 928 (87.87%) have provided data on their ethnic group whilst 128 (12.12%) have not. A summary of the Ethnicity Pay Analysis is shown below. The detailed information from which the Summary is contained is shown at:

- Appendix 7 for Agenda for Change
- Appendix 8 for Medical and Dental
- Appendix 9 for Senior Managers

The Ethnic Pay Summary is shown below:

Table 9. Ethnicity Pay Analysis for NHS Orkney as at 31 December 2024.

Occupational Segregation by Ethnicity - NHS Orkney Staff Summary 2025

Ethnic Category	Total No. of Employments	Average Basic Hourly Rate
African - African, African Scottish or African British	8	£52.21
African - Other	13	£18.61
Asian - Chinese, Chinese Scottish or Chinese British	1	£23.15
Asian - Indian, Indian Scottish or Indian British	8	£66.95
Asian - Other	5	£16.91
Asian - Pakistani, Pakistani Scottish or Pakistani British	7	£55.66
Don't Know	74	£31.62
Mixed or Multiple Ethnic Group	3	£16.52
Other Ethnic Group - Arab, Arab Scottish or Arab British	1	£55.16
Other Ethnic Group - Other	2	£64.43
Prefer not to say	54	£32.02
White - Irish	10	£46.48
White - Other	59	£31.82
White - Other British	184	£32.82
White - Scottish	627	£22.11
Grand Total	**1056**	**£26.74**

Excluding the "Prefer not to say" and "Don't know" categories whose ethnicity is unknown and using the "White Scottish" category average pay rate of £16.93 as the benchmark, this gives:

- Staff in 11 ethnic categories earned <u>more</u> on average than White Scottish Staff.
- Staff in 3 ethnic categories earned <u>less</u> on average than White Scottish Staff

In numerical terms, this is:

- 408 staff earned MORE on average than White Scottish Staff
- 21 staff earned LESS on average than White Scottish Staff

The figures show that there is no ethnicity pay gap in NHS Orkney pay.

7. Conclusion

The report on the pay gap assists NHS Orkney in understanding the scope and causes of pay disparities and identifying any issues that need to be addressed to reduce these gaps. It's important to note that having a pay gap does not necessarily imply that unlawful discrimination is occurring. Monitoring pay gaps will enable NHS Orkney to explore the reasons behind any disparities and determine whether there is a need to develop action plans to tackle the underlying causes. By consistently publishing and monitoring the gender pay gap in accordance with regulations, NHS Orkney will be able to assess the effectiveness of its efforts to reduce the gap.

8. Recommendations

The Gender Pay Gap Report and Equal Pay Statement is a publication designed to promote better decision-making based on evidence, while also enhancing transparency and accountability. This approach aims to drive meaningful change. The NHS Orkney Staff Governance Committee will be asked to endorse the report's content.

9. Publishing the report

The Gender Pay Gap Report and the Equality Pay Statement will be submitted for approval to the NHS Orkney Area Partnership Forum and the NHS Orkney Staff Governance Committee. Once approved, the report will be accessible on the NHS Orkney website.

10. Comments and feedback

Comments and feedback on this Report will be warmly welcomed. Please send your comments by:

Email: ORK.feedback@nhs.scot

By phone: 01856 888000

By post: Feedback Service
                    Balfour Hospital
                    Foreland Road
                    Kirkwall
                    Orkney, KW15 1NZ

Appendix 1. Gender Pay Gap Analysis for Agenda for Change Staff

Gender Pay Gap analysis - hourly rate comparison - Agenda for Change staff - 2025												
		Female			Male			Total				
Job Family	Band	Count of Gender	Gender Count % of Job Family	Average Hourly Rate	Count of Gender	Gender Count % of Job Family	Average Hourly Rate	Monetary Variance M to F £	Monetary Variance M to F %	Total Count of Gender	Total Average Hourly Rate
ADMINISTRATIVE SERVICES	Band 2	23	12.37%	£13.54	3	1.61%	£13.51	-£0.03	-0.24%	26	£13.53
ADMINISTRATIVE SERVICES	Band 3	40	21.51%	£14.81	3	1.61%	£14.66	-£0.15	-1.00%	43	£14.80
ADMINISTRATIVE SERVICES	Band 4	37	19.89%	£15.91	5	2.69%	£15.89	-£0.03	-0.18%	42	£15.91
ADMINISTRATIVE SERVICES	Band 5	21	11.29%	£20.12	11	5.91%	£18.95	-£1.17	-6.17%	32	£19.72
ADMINISTRATIVE SERVICES	Band 6	3	1.61%	£24.01	8	4.30%	£24.31	£0.30	1.24%	11	£24.22
ADMINISTRATIVE SERVICES	Band 7	10	5.38%	£27.32	2	1.08%	£25.77	-£1.55	-6.03%	12	£27.07
ADMINISTRATIVE SERVICES	Band 8A	6	3.23%	£32.82						6	£32.82
ADMINISTRATIVE SERVICES	Band 8B	3	1.61%	£36.79	2	1.08%	£36.79	£0.00	0.00%	5	£36.79
ADMINISTRATIVE SERVICES	Band 8C	3	1.61%	£45.54	1	0.54%	£46.58	£1.04	2.24%	4	£45.80
ADMINISTRATIVE SERVICES	Band 8D	1	0.54%	£53.80						1	£53.80

ADMINISTRATIVE SERVICES	Band 9	1	0.54%	£61.02	3	1.61%	£61.90	£0.88	1.42%	4	£61.68
ADMINISTRATIVE SERVICES Total		**148**	**79.57%**	**£19.05**	**38**	**20.43%**	**£24.32**	**£5.28**	**21.69%**	**186**	**£20.13**
ALLIED HEALTH PROFESSION	Band 3	5	7.14%	£14.81						5	£14.81
ALLIED HEALTH PROFESSION	Band 4	5	7.14%	£15.62	1	1.43%	£16.42	£0.79	4.84%	6	£15.75
ALLIED HEALTH PROFESSION	Band 5	5	7.14%	£20.01						5	£20.01
ALLIED HEALTH PROFESSION	Band 6	27	38.57%	£23.80						27	£23.80
ALLIED HEALTH PROFESSION	Band 7	19	27.14%	£28.70	4	5.71%	£28.62	-£0.07	-0.26%	23	£28.68
ALLIED HEALTH PROFESSION	Band 8A	2	2.86%	£33.64	2	2.86%	£32.40	-£1.24	-3.82%	4	£33.02
ALLIED HEALTH PROFESSION Total		**63**	**90.00%**	**£23.93**	**7**	**10.00%**	**£27.96**	**£4.03**	**14.42%**	**70**	**£24.33**
DENTAL SUPPORT	Band 3	2	10.53%	£15.03	1	5.26%	£13.93			3	£14.66
DENTAL SUPPORT	Band 4	12	63.16%	£16.31						12	£16.31
DENTAL SUPPORT	Band 6	4	21.05%	£24.08						4	£24.08
DENTAL SUPPORT Total		**18**	**94.74%**	**£17.89**	**1**	**5.26%**	**£13.93**	**-£3.96**	**-28.46%**	**19**	**£17.68**
HEALTHCARE SCIENCES	Band 3	4	22.22%	£15.03	2	11.11%	£15.03	£0.00	0.00%	6	£15.03
HEALTHCARE SCIENCES	Band 4	2	11.11%	£15.75	1	5.56%	£15.09	-£0.66	-4.39%	3	£15.53
HEALTHCARE SCIENCES	Band 5	2	11.11%	£18.56						2	£18.56

Staff Group	Band	Count	%	Rate	Count	%	Rate	Diff £	Diff %	Total Count	Total Rate
HEALTHCARE SCIENCES	Band 6				2	11.11%	£22.95			2	£22.95
HEALTHCARE SCIENCES	Band 7	3	16.67%	£28.36	1	5.56%	£29.41	£1.05	3.58%	4	£28.62
HEALTHCARE SCIENCES	Band 8B	1	5.56%	£36.79						1	£36.79
HEALTHCARE SCIENCES Total		**12**	**66.67%**	**£20.89**	**6**	**33.33%**	**£20.08**	**-£0.81**	**-4.03%**	**18**	**£20.62**
MEDICAL SUPPORT	Band 3	3	15.79%	£14.66						3	£14.66
MEDICAL SUPPORT	Band 5	9	47.37%	£18.26	2	10.53%	£18.56	£0.30	1.62%	11	£18.32
MEDICAL SUPPORT	Band 6	4	21.05%	£23.40						4	£23.40
MEDICAL SUPPORT	Band 7	1	5.26%	£26.25						1	£26.25
MEDICAL SUPPORT Total		**17**	**89.47%**	**£19.31**	**2**	**10.53%**	**£18.56**	**-£0.74**	**-4.01%**	**19**	**£19.23**
NURSING/MIDWIFERY	Band 2	36	8.45%	£13.23	6	1.41%	£13.14	-£0.09	-0.70%	42	£13.22
NURSING/MIDWIFERY	Band 3	84	19.72%	£14.75	9	2.11%	£14.66	-£0.09	-0.63%	93	£14.75
NURSING/MIDWIFERY	Band 4	2	0.47%	£15.09						2	£15.09
NURSING/MIDWIFERY	Band 5	142	33.33%	£19.87	11	2.58%	£18.75	-£1.12	-5.96%	153	£19.79
NURSING/MIDWIFERY	Band 6	72	16.90%	£23.62	4	0.94%	£25.21	£1.59	6.32%	76	£23.70
NURSING/MIDWIFERY	Band 7	46	10.80%	£27.83	7	1.64%	£27.33	-£0.50	-1.82%	53	£27.76
NURSING/MIDWIFERY	Band 8A	5	1.17%	£31.16						5	£31.16

NURSING/MIDWIFERY	Band 8B	2	0.47%	£36.79						2	£36.79
NURSING/MIDWIFERY Total		**389**	**91.31%**	**£19.99**	**37**	**8.69%**	**£19.17**	**-£0.82**	**-4.30%**	**426**	**£19.92**
OTHER THERAPEUTIC	Band 3	1	4.55%	£15.03						1	£15.03
OTHER THERAPEUTIC	Band 4	3	13.64%	£14.33						3	£14.33
OTHER THERAPEUTIC	Band 5	3	13.64%	£19.62						3	£19.62
OTHER THERAPEUTIC	Band 6	1	4.55%	£25.21	1	4.55%	£20.69	-£4.52	-21.86%	2	£22.95
OTHER THERAPEUTIC	Band 7	4	18.18%	£28.38						4	£28.38
OTHER THERAPEUTIC	Band 8A	3	13.64%	£31.99	1	4.55%	£33.64	£1.65	4.91%	4	£32.40
OTHER THERAPEUTIC	Band 8B	2	9.09%	£38.08	1	4.55%	£39.36	£1.28	3.26%	3	£38.50
OTHER THERAPEUTIC	Band 8C	1	4.55%	£46.58						1	£46.58
OTHER THERAPEUTIC	Band 8D	1	4.55%	£51.59						1	£51.59
OTHER THERAPEUTIC Total		**19**	**86.36%**	**£27.68**	**3**	**13.64%**	**£31.23**	**£3.55**	**11.37%**	**22**	**£28.16**
PERSONAL AND SOCIAL CARE	Band 4	2	16.67%	£15.75	1	8.33%	£15.09	-£0.66	-4.39%	3	£15.53
PERSONAL AND SOCIAL CARE	Band 5	2	16.67%	£19.13						2	£19.13
PERSONAL AND SOCIAL CARE	Band 6	3	25.00%	£22.50						3	£22.50
PERSONAL AND SOCIAL CARE	Band 7	3	25.00%	£26.66						3	£26.66

Category	Band										
PERSONAL AND SOCIAL CARE	Band 8A	1	8.33%	£31.16						1	£31.16
PERSONAL AND SOCIAL CARE Total		**11**	**91.67%**	**£22.58**	**1**	**8.33%**	**£15.09**	**-£7.49**	**-49.64%**	**12**	**£21.96**
SUPPORT SERVICES	Band 2	73	56.59%	£13.47	12	9.30%	£13.51	£0.04	0.30%	85	£13.47
SUPPORT SERVICES	Band 3	10	7.75%	£14.92	19	14.73%	£14.91	-£0.01	-0.04%	29	£14.92
SUPPORT SERVICES	Band 4	3	2.33%	£15.97	4	3.10%	£16.42	£0.44	2.69%	7	£16.23
SUPPORT SERVICES	Band 5	1	0.78%	£20.60	2	1.55%	£18.56	-£2.03	-10.95%	3	£19.24
SUPPORT SERVICES	Band 6				3	2.33%	£25.21			3	£25.21
SUPPORT SERVICES	Band 7				1	0.78%	£25.29			1	£25.29
SUPPORT SERVICES	Band 8A				1	0.78%	£33.64			1	£33.64
SUPPORT SERVICES Total		**87**	**67.44%**	**£13.80**	**42**	**32.56%**	**£16.26**	**£2.46**	**15.10%**	**129**	**£14.60**
Grand Total		**764**	**84.79%**	**£19.61**	**137**	**15.21%**	**£20.38**	**£0.77**	**3.78%**	**901**	**£19.72**

Appendix 2. Gender Pay Gap Analysis for Medical and Dental Staff.

Gender Pay Gap analysis hourly rate comparison - Hospital Medical & Dental staff - 2025										
	Female			Male			Total			
Job Family	Gender Count	Gender Count % of Job Family	Average of Basic Hourly Rate	Gender Count	Gender Count % of Job Family	Average of Basic Hourly Rate	Monetary Variance M to F £	Monetary Variance M to F %	Total Gender Count	Total Average Basic Hourly Rate
CONSULTANT	25	37.31%	£75.93	42	62.69%	£80.36	£4.44	5.52%	67	£78.71
DENTAL	3	30.00%	£49.45	7	70.00%	£53.71	£4.26	7.92%	10	£52.43
GP	30	47.62%	£62.80	33	52.38%	£68.09	£5.28	7.76%	63	£65.57
MEDICAL DIRECTOR	1	100.00%	£68.26						1	£68.26
SPECIALITY DOCTOR	2	100.00%	£39.14						2	£39.14
SPECIALTY REGISTRAR	7	70.00%	£30.49	3	30.00%	£22.26	-£8.23	-36.95%	10	£28.02
Grand Total	**68**	**44.44%**	**£63.10**	**85**	**55.56%**	**£71.35**	**£8.25**	**11.57%**	**153**	**£67.68**

Appendix 3. Gender Pay Gap Analysis for Senior Managers

	Female			Male			Total			
Gender Pay Gap analysis hourly rate comparison - Senior Managers - 2025										
Job Family	Gender Count	Gender Count % of Job Family	Average of Basic Hourly Rate	Gender Count	Gender Count % of Job Family	Average of Basic Hourly Rate	Monetary Variance M to F £	Monetary Variance M to F %	Total Gender Count	Total Average Basic Hourly Rate
SENIOR MANAGER GRADE C				1	50.00%	£50.79			1	£50.79
SENIOR MANAGER GRADE E	1	50.00%	£63.86						1	£63.86
Grand Total	**1**	**50.00%**	**£63.86**	**1**	**50.00%**	**£50.79**			**2**	**£57.32**

Appendix 4. Disability Analysis for Agenda for Change Staff

	Occupational Segregation by Disability - AFC Staff 2025		
Job Family	**Medical Condition/Disability in the Last 12 Months**	**Total No. of Employments**	**Average Basic Hourly Rate**
ADMINISTRATIVE SERVICES	Don't Know	41	£20.99
	No	133	£19.83
	Prefer not to say	8	£20.19
	Yes	4	£20.90
ADMINISTRATIVE SERVICES Total		**186**	**£20.13**
ALLIED HEALTH PROFESSION	Don't Know	23	£26.59
	No	44	£23.23
	Prefer not to say	3	£23.12
ALLIED HEALTH PROFESSION Total		**70**	**£24.33**
DENTAL SUPPORT	Don't Know	10	£17.29
	No	9	£18.11
DENTAL SUPPORT Total		**19**	**£17.68**
HEALTHCARE SCIENCES	Don't Know	6	£23.45
	No	12	£19.20
HEALTHCARE SCIENCES Total		**18**	**£20.62**
MEDICAL SUPPORT	Don't Know	4	£21.02
	No	15	£18.75
MEDICAL SUPPORT Total		**19**	**£19.23**
NURSING/MIDWIFERY	Don't Know	116	£20.93

	No	290	£19.54
	Prefer not to say	17	£20.10
	Yes	3	£16.83
NURSING/MIDWIFERY Total		**426**	**£19.92**
OTHER THERAPEUTIC	Don't Know	2	£28.69
	No	18	£27.01
	Prefer not to say	1	£46.58
	Yes	1	£29.41
OTHER THERAPEUTIC Total		**22**	**£28.16**
PERSONAL AND SOCIAL CARE	Don't Know	2	£22.91
	No	9	£21.90
	Yes	1	£20.60
PERSONAL AND SOCIAL CARE Total		**12**	**£21.96**
SUPPORT SERVICES	Don't Know	36	£15.78
	No	85	£14.05
	Prefer not to say	4	£16.19
	Yes	4	£14.25
SUPPORT SERVICES Total		**129**	**£14.60**
Grand Total		**901**	**£19.72**

Appendix 5. Disability Analysis for Medical and Dental Staff

Occupational Segregation by Disability - Medical & Dental staff - 2025		
Medical Condition/Disability in the Last 12 Months	**Total No. of Employments**	**Average Basic Hourly Rate**
Don't Know	21	£69.45
No	123	£67.69
Prefer not to say	8	£66.45
Yes	1	£39.92
Grand Total	**153**	**£67.68**

Appendix 6. Disability Analysis for Senior Managers

Occupational Segregation by Disability - Senior Managers - 2025		
Medical Condition/Disability in the Last 12 Months	**Total No. of Employments**	**Average Basic Hourly Rate**
No	2	£57.32
Grand Total	**2**	**£57.32**

Appendix 7. Ethnicity Analysis for Agenda for Change

Job Family	Ethnic Category	Total No. of Employments	Average Basic Hourly Rate
Occupational Segregation by Ethnicity - AFC Staff 2025			
ADMINISTRATIVE SERVICES	African - African, African Scottish or African British	1	£13.93
	African - Other	1	£17.66
	Asian - Other	3	£18.90
	Don't Know	6	£28.91
	Mixed or Multiple Ethnic Group	2	£17.84
	Prefer not to say	9	£17.96
	White - Irish	2	£22.91
	White - Other	11	£22.55
	White - Other British	33	£23.82
	White - Scottish	118	£18.68
ADMINISTRATIVE SERVICES Total		**186**	**£20.13**
ALLIED HEALTH PROFESSION	African - African, African Scottish or African British	2	£23.47
	African - Other	1	£20.69
	Asian - Indian, Indian Scottish or Indian British	1	£33.64
	Don't Know	4	£24.67
	Prefer not to say	3	£20.31
	White - Other	2	£27.31
	White - Other British	12	£26.23
	White - Scottish	45	£23.84

ALLIED HEALTH PROFESSION Total		**70**	**£24.33**
DENTAL SUPPORT	Prefer not to say	2	£15.72
	White - Other	1	£16.42
	White - Other British	3	£18.52
	White - Scottish	13	£17.89
DENTAL SUPPORT Total		**19**	**£17.68**
HEALTHCARE SCIENCES	African - Other	1	£20.69
	White - Other British	4	£22.91
	White - Scottish	13	£19.91
HEALTHCARE SCIENCES Total		**18**	**£20.62**
MEDICAL SUPPORT	African - Other	1	£16.53
	White - Other British	3	£19.27
	White - Scottish	15	£19.40
MEDICAL SUPPORT Total		**19**	**£19.23**
NURSING/MIDWIFERY	African - Other	9	£18.49
	Asian - Other	2	£13.93
	Don't Know	32	£18.06
	Prefer not to say	19	£19.18
	White - Irish	3	£16.03
	White - Other	19	£20.99
	White - Other British	63	£21.44
	White - Scottish	279	£19.90
NURSING/MIDWIFERY Total		**426**	**£19.92**
OTHER THERAPEUTIC	Don't Know	1	£36.79
	Prefer not to say	1	£46.58
	White - Other	2	£30.29
	White - Other British	3	£27.09
	White - Scottish	15	£26.29
OTHER THERAPEUTIC Total		**22**	**£28.16**

PERSONAL AND SOCIAL CARE	Don't Know	1	£25.21
	White - Other British	3	£22.49
	White - Scottish	8	£21.35
PERSONAL AND SOCIAL CARE Total		**12**	**£21.96**
SUPPORT SERVICES	Don't Know	13	£14.87
	Mixed or Multiple Ethnic Group	1	£13.87
	Prefer not to say	6	£15.43
	White - Other	10	£13.91
	White - Other British	15	£13.44
	White - Scottish	84	£14.80
SUPPORT SERVICES Total		**129**	**£14.60**
Grand Total		**901**	**£19.72**

Appendix 8. Ethnicity Analysis for Medical & Dental Staff

Occupational Segregation by Ethnicity - Medical & Dental staff - 2025		
Ethnic Category	**Total No. of Employments**	**Average Basic Hourly Rate**
African - African, African Scottish or African British	5	£71.36
Asian - Chinese, Chinese Scottish or Chinese British	1	£23.15
Asian - Indian, Indian Scottish or Indian British	7	£71.71
Asian - Pakistani, Pakistani Scottish or Pakistani British	7	£55.66
Don't Know	17	£72.64

Other Ethnic Group - Arab, Arab Scottish or Arab British	1	£55.16
Other Ethnic Group - Other	2	£64.43
Prefer not to say	14	£69.39
White - Irish	5	£74.16
White - Other	14	£68.57
White - Other British	44	£67.46
White - Scottish	36	£66.52
Grand Total	**153**	**£67.68**

Appendix 9. Ethnicity Analysis for Senior Managers

Occupational Segregation by Ethnicity - Senior Managers 2025		
Ethnic Category	**Total No. of Employments**	**Average Basic Hourly Rate**
White - Other British	1	£63.86
White - Scottish	1	£50.79
Grand Total	**2**	**£57.32**

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 26 June 2025
Title:	NHS Scotland Operational Improvement Plan – Implications for NHS Orkney
Responsible Executive/Non-Executive:	Tammy Sharp, Director of Performance and Transformation (and Deputy CEO)
Report Author:	Alan Cooper, Interim Head of Strategy
	Carrie Somerville, Head of Planning, Performance and Information

1   Purpose

This report is presented to the Board for **Assurance:**

Members are asked to:

I.   **Note** that the ADP feedback will be shared with SLT when received from Scottish Government, ahead of formal Board sign off.
II.   **Note** that the Planned Care Programme Board will monitor the outcome of our Planned Care Submission, particularly the extent to which national funding will support our local plans to reduce long waits and improve access to diagnostics.
III. **Discuss** the opportunities and risks that the Operational Improvement Plan presents to NHS Orkney.
IV. **Consider** opportunities for early alignment with the forthcoming Population Health Framework and Health and Social Care Renewal Framework, to support and align to our Clinical Services Review.

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Annual Delivery Plan 2024/25
- Emerging issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Sustainability

2   Report summary

2.1   Situation

The Operational Improvement Plan (OIP) (Appendix 1), published in March 2025, sets out immediate national priorities to relieve system pressures and improve outcomes across NHS Scotland.

The OIP is positioned as the first of three Scottish Government strategic documents to be followed by a Population Health Framework and a Health and Social Care Renewal Framework by June 2025 and is underpinned by Board Annual Delivery Plans (ADP), meaning NHS Orkney's strategic direction is reflected in its development.

NHS Orkney must assess the implications of the OIP and determine how national expectations align with our Corporate Strategy 2024-28 strategic objectives, ADP and current position, particularly in relation to access, balance of care, workforce and digital transformation.

2.2 Background

The OIP builds on all 2025/26 ADP's submitted by NHS Boards and reflects key national commitments to:

- Reducing waiting times, with no one waiting more than 52 weeks by March 2026.
- Shift the balance of care from acute settings into communities.
- Expand digital access and innovation in service delivery.
- Focus on prevention and early intervention to improve population health.

NHS Orkney's Year 2 Corporate Strategy and ADP are already closely aligned with these ambitions. However, the application of national models (such as specialist community pathways) requires local interpretation given our island geography, workforce profile and service configuration. Feedback from our ADP submission is outstanding and our supporting planned care submission is under review by Scottish Government, and we await confirmation of funding to support local delivery of access and treatment priorities.

2.3 Assessment

A review of the key national commitments against NHS Orkney's stated 2025/26 priorities demonstrates clear alignment, particularly in terms of reducing waiting times, enabling local access to care, and embedding a prevention-first approach. This is summarised in appendix 2.

However, while the direction is aligned, the OIP also presents areas where NHS Orkney must interpret the national intent through a local lens, especially around the operationalisation of community-based care models and digital transformation, examples of this include:

- We are not currently delivering Hospital at Home and some specialist models described in the OIP are not transferable to our geography or scale. Our model for shifting the balance of care is built on primary care redesign, local prescribing, virtual access, and close integration with social care.
- We are progressing digital transformation, but our local infrastructure and workforce capacity means we have to carefully balance this across local and national digital priorities.

Our corporate strategy pillars — Place, People, Patient Safety and Experience, Performance, and Potential — are all reinforced by the national OIP. Our work is not only aligned but already delivering many of the expected outcomes through our Year 2 Corporate Strategy:

Place

We are progressing work to become a population health system, with prevention, inequalities, and community wellbeing embedded in our ADP. Our contribution to the Local Outcome Improvement Plan (LOIP), focus on screening and vaccination uptake, and early work on the national Population Health Framework all align strongly with national direction.

People

The OIP emphasis on workforce sustainability and locally led change supports our Improving Together workstreams, workforce redesign and leadership development efforts. Our continued focus on recruitment, retention, and role diversification remains critical.

Patient Safety and Experience

The national focus on improving culture, learning, and openness mirrors our governance refresh, new approach to clinical engagement, and quality improvement efforts across the system.

Performance

Addressing long waits and delivering on our financial plan are key priorities in our Year 2 Corporate Strategy. Our targeted Planned Care Submission supports national objectives to reduce 52+ week waits, and we await confirmation of funding for our proposed initiatives.

Potential

Digital innovation remains a key enabler. While national digital tools (e.g. dermatology, diabetes pathways) are promising, our implementation pace will depend on infrastructure, training, and support. Our progress on TrakCare optimisation, Near Me, and digital maturity plans is foundational to delivering transformation in our context.

2.3.1 Patient Safety and Quality

The national focus on improving culture, learning, and openness mirrors our governance refresh, new approach to clinical engagement, and quality improvement efforts across the system.

2.3.2 Workforce

The Workforce improvement workstream within the Improving Together Programme is well developed with 8 areas of focus. These include sickness management, mandatory training and appraisals. Corporate Leads have been identified for each area to drive delivery.

2.3.3 Financial

The Board remains at level 3 of the Scottish Government's NHS Finance and Escalation Framework. Workforce transformation accounts for around one third of projected savings for this Financial Year.

2.3.4 Risk Assessment/Management

Effective risk management is essential to ensuring the delivery of safe and high-quality patient care. Failure to proactively identify and address risks may compromise the Board's ability to deliver timely care, with potential adverse effects on patient outcomes and overall experience.

2.3.5 Equality and Diversity, including health inequalities.

Reducing health inequalities is a key priority as part of the Place strategic objective. Equality, diversity and inclusion are also central to the delivery of our People priorities and our Corporate Strategy takes into consideration local, regional, and national policy. The Equality and Diversity Monitoring Report for 2024/25 was approved by the Senior Leadership Team on 1 May 2025.

2.3.6 Communication, involvement, engagement, and consultation

Discussions have taken place with Heads of Service, in the development of this paper.

2.3.7 Route to the Meeting

- Paper presented for discussion and approval at Senior Leadership Team Meeting – Patient Safety, Quality & Experience, Performance and Place on 1 May 2025.

Assurance - The Board is asked to:

I. **Note** that the ADP feedback will be shared with SLT when received from Scottish Government, ahead of formal Board sign off.
II. **Note** that the Planned Care Programme Board will monitor the outcome of our Planned Care Submission, particularly the extent to which national funding will support our local plans to reduce long waits and improve access to diagnostics.
III. **Discuss** the opportunities and risks that the Operational Improvement Plan presents to NHS Orkney.
IV. **Consider** opportunities for early alignment with the forthcoming Population Health Framework and Health and Social Care Renewal Framework, to support and align to our Clinical Services Review.

4. List of appendices

The following appendices are included with this report:

- **Appendix 1**, NHS Scotland Operational Improvement Plan
- **Appendix 2,** Programme for Government 2025 - 26 – Assessment Against NHSO 2025/26 Priorities

NHS Scotland Operational Improvement Plan

Contents

Foreword

The First Minister set out this Government's ambition for renewing our NHS in a [speech](#) on 27 January. To deliver against that ambition and ensure a more accessible, more person-centred NHS we must reduce the immediate pressures across the NHS, shift the balance of care from acute services to the community, and use digital and technological innovation to improve access to care.

This will require a process of reform and renewal delivered in partnership with others that reduces immediate pressures across the NHS, addresses waiting times, moves to a 'digital front door' approach, and intervenes earlier and prevents illnesses. It follows years of Westminster austerity, the effects of the pandemic and rising costs due to inflation.

In setting out the next phase of renewal and reform, it is important for me to emphasise the fundamental value of our NHS and its staff – and I will continue to do so as we proceed. We committed to setting out more detail in three documents – firstly in this Operational Improvement Plan, then in a population health framework later in the spring, and lastly in a medium-term approach to health and social care reform before Parliament's summer recess.

Accordingly, this Operational Improvement Plan is focused on the short term. Realistic as well as ambitious, it describes how the specific commitments outlined in January will be delivered and builds on health boards' own delivery planning to improve delivery across NHS Scotland. For all these commitments, the workforce must be supported and enabled with staff involved where possible in local discussions on planning and delivery.

I should stress that this is not a stand-alone plan for the NHS. Instead it builds on the delivery plans of the 22 health boards, prioritising how services will be improved across NHS Scotland.

The relentless focus on delivery through this plan typifies the 'coordinated action and strategic investment' which the First Minister highlighted in his speech. I thank all those involved in supporting these commitments and delivering quality care across our NHS.

Neil Gray
Cabinet Secretary for Health and Social Care

Overview

The NHS requires significant renewal and reform to ensure that we have a sustainable health service, given the scale of growing demand it faces. On 4 June 2024 the Cabinet Secretary for Health and Social Care set out a new vision for health and social care services in Scotland to address this challenge and give focus to the reform work. In summary, this vision is to 'enable people to live longer, healthier and more fulfilling lives', and it requires a focus on prevention, early intervention and quality services.

On 27 January 2025, the First Minister described plans to renew our health service and deliver the change that people in Scotland need. This Operational Improvement Plan is the first component, to be followed by publication of a population health framework and a health and social care service renewal framework. Together these plans will progress reform to ensure long-term sustainability, reduce health inequalities, further harness the benefits of digital technology, and improve population health outcomes in Scotland. They will set out how we will plan our services for our whole population over the short, medium and longer term.

We are co-developing the population health framework with COSLA and in collaboration with Public Health Scotland, NHS Directors of Public Health and other local, regional and national partners. We will publish it in spring 2025. The framework will detail a long-term, cross-government and cross-sector approach to primary prevention of ill health, i.e. how we support people to live healthy and fulfilling lives and stopping health problems arising in the first place.

We will publish our health and social care service renewal framework in late June 2025. It will build on the vision for reform and set out the strategic policy intent for health and social care in Scotland for the medium to longer term.

The Operational Improvement Plan

This Operational Improvement Plan builds on health boards' own delivery planning for 2025-26. It describes a number of commitments and actions across NHS Scotland that are needed to improve the experience of patients.

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
- shifting the balance of care
- improving access to health and social care services through digital and technological innovation
- prevention – ensuring we work with people to prevent illness and more proactively meet their needs

The NHS Recovery Plan 2021-26, published in August 2021, set out ambitions and actions over five years to address the backlog in care and drive the recovery and renewal of NHS services. We will align our reporting on this Operational Improvement Plan with the final reporting for the NHS Recovery Plan.

NHS workforce support

As with any operational improvements across the NHS, staff are at the heart of delivery and first and foremost recognition is required of the heightened pressures with which staff are dealing every day. Support for staff and enabling their voice in the planning of these improvements as well as their delivery is therefore critical.

The Government has engaged staff-side and professional bodies in finalising this plan and have welcomed the constructive input. We will of course build on that engagement as we move into implementation.

This plan continues our increased investment in the workforce. As well as the increases to boards' core budgets for 2025-26, much of the additional investment, such as the £100 million for waiting times, is targeted for extra recruitment, with assurance also provided to boards on recurring funding.

We will work closely with staff-side and professional bodies at a national level and with individual boards to support the right conversations, strategically and locally, to empower and engage the workforce as we move into implementation.

Improving access to treatment

Increasing capacity

We will reduce waiting times ensuring that by March 2026 no one is waiting longer than a year for their new outpatient appointment or inpatient/day-case procedure.

Together with committing an additional £100 million in 2025-26 to target long waits, we will increase overall capacity in the NHS by optimising national and regional working across health board boundaries. This will help to ensure that patients will be able to access the treatment they need more quickly. It will also mean that pressure is eased on local health boards, allowing them to focus on the longest waiting patients or patients with complex health needs.

The additional investment will result in more than 150,000 extra appointments and procedures in 2025-26, such as for surgeries and diagnostic tests, compared with 2024-25. Building on the first instalment of £30 million in 2024-25, which has delivered in excess of targets, this investment will also target cancer pathways to tackle backlogs against the 62-day referral to treatment standard.

The Government has been working closely in new ways with NHS health boards to target this extra investment and coordinate delivery. This includes expanding regional and national delivery by identifying key sites around the country to scale up activity, building on the additional capacity that individual health boards are able to generate using the extra investment to address their own waiting lists.

This enhanced focus is not just about the extra investment, it is about making the best use of the whole £21.7 billion that the Government has committed to health and social care for the coming year. Accordingly Health boards are also maximising their planned annual activity through their 'core' budgets, in dialogue with the Government via the 2025-26 delivery planning process. This includes increasing productivity gains across specialties year on year, which are underpinned by the improvement evidence and support mobilised through clinical networks by the Centre for Sustainable Delivery.

This collaborative work enables the Government to take a coordinated approach to addressing each health board's waiting lists, broken down by specialty for outpatient appointments and for inpatient and day case procedures. All these different trajectories are quantified, modelled and tested for deliverability to project how backlogs will be cleared. That enables the additional investment to be targeted to ensure the longest waits are fully addressed.

Specifically, optimising the use of our network of National Treatment Centres (NTCs) located across Scotland, we will support additional procedures which will see their total planned activity for 2025-26 increasing to well over 30,000 procedures from around 20,000 in 2024-25.

- NHS Golden Jubilee Eye Centre and Surgical Centre - cataract procedures, general and orthopaedic surgery, colorectal procedures, diagnostic procedures and endoscopy

- NTC Forth Valley - during its phased opening, the initial focus is on a variety of procedures, including orthopaedic
- NTC Fife - orthopaedic procedures
- NTC Highland - ophthalmology and orthopaedic procedures

In addition to the National Treatment Centres, we have been working with health boards to identify what additional capacity we can introduce to support the specialties with the longest waiting patients. For example, we have worked with NHS Greater Glasgow and Clyde to establish additional surgical sites, which provide an opportunity to develop dedicated high-volume elective capacity supporting orthopaedics. By investing in such sites, including Gartnavel General Hospital in Glasgow, Inverclyde Royal Hospital in Greenock, Stracathro Hospital in Angus, Perth Royal Infirmary, and Queen Margaret Hospital in Dunfermline, we will deliver extra cataract procedures and additional orthopaedic appointments and procedures.

Health boards working collaboratively over the coming year to invest the additional £100 million will also result in additional appointments and procedures to target any waits over one year wherever they are located across other specialties including ENT, general surgery, gynaecology and urology.

As is current practice, patients may be given the option to travel beyond their local health board area in order to receive treatment more quickly. We know from the latest survey of the Citizens' Panel for health and social care that 84% of respondents agreed they were willing to travel further for specialist services such as surgery if it resulted in better outcomes for them.

We will continue to provide financial support for travel to hospital for patients and authorised escorts, according to eligibility criteria and medical requirements. This includes people in receipt of certain benefits and residents of the Highlands and Islands. On top of that, health boards can also choose to provide support for those who would not otherwise qualify, where it is deemed clinically necessary.

Diagnostics – reducing the backlog

A formal diagnosis is often the first stage of ensuring someone has the right treatment plan and pathway for their individual needs. No matter how serious or benign the condition may be, swift diagnosis is a vital step in a patient's care.

Our ambition is to provide equitable, timely access across NHS Scotland to safe, efficient and effective, patient-centred, diagnostic imaging services.

Drawing from the additional £100 million investment we will deliver additional MRI, CT, ultrasound and endoscopy procedures to target the backlogs. This will support delivery of 95% of referrals to radiology being seen within six weeks by March 2026. This will be done through seven-day services, recruitment, and the use of mobile scanning units.

Expand the Rapid Cancer Diagnostic Services

Rapid Cancer Diagnostic Services (RCDS) are a useful addition to how cancer can be diagnosed in Scotland. They provide primary care services, such as GPs, with access to a new fast-track diagnostic pathway. This will mean that patients across NHS Scotland with non-specific symptoms suspicious of cancer, such as unexplained weight loss and fatigue, have a fast-track referral route to secondary care and continue to be prioritised for diagnostic tests.

The introduction of RCDS in five health board areas to date has shown the benefit for patients and we are committed to continuing to work with health boards to widen access to this service as part of expanding non-specific cancer symptoms referral pathways. The sixth RCDS will open in NHS Forth Valley this spring. We are reviewing the current non-specific symptoms pathways in other boards and gauging where next to expand the model.

Clear Child and Adolescent Mental Health Services (CAMHS) backlogs, and meet the 18-week standard nationally by December 2025, ensuring children and their families get the support they need

In the quarter ending December 2024, for the first time ever, national performance against the CAMHS waiting times standard was met, with 90.6% of children and young people starting treatment within 18 weeks of referral. This was a massive achievement by CAMHS teams who have worked to clear backlogs, in the face of continued high pressure on services. National performance may fluctuate in future quarters as we continue to support NHS health boards to reduce their backlogs. We know that clearing waiting list backlogs will mean that people can access treatment in a more timely way and that earlier interventions lead to better outcomes.

We have provided £123 million recurring additional funding for health boards and Integrated Joint Boards (IJBs) to support improvements across a range of mental health and psychological services and care for all age ranges, including CAMHS, the delivery of psychological therapies and eating disorder care.

We continue to provide enhanced support to those health boards and IJBs not on track to meet the waiting times standard. A formal review of the support will take place for CAMHS in spring 2025, and for psychological therapies in autumn 2025. This includes providing access to professional advice, ensuring improvement plans are in place and monitoring the implementation of these plans. We will request trajectories from health boards to map the route towards meeting the December 2025 target and we will monitor progress against those trajectories monthly, providing additional support where appropriate. We will continue our regular engagement with all health boards and IJBs to ensure risks are identified quickly and mitigations put in place.

Shifting the balance of care

We will work to ensure people receive the right care in the right place, recognising that acute hospitals are not always best for patients or their families. This will include making it easier to see a first point of contact with the NHS, for example a general practice team member, a dentist, optometrist or community pharmacist. It will also mean that, increasingly, assessments and specialist care will be delivered in new and innovative ways and settings, including at home.

Reducing the pressure in our hospitals

We will improve flow throughout the system, reducing delays into the hospital and lengths of stay across all areas of a hospital. This will be done through, for example, optimising alternatives to hospital admission, reducing avoidable admissions, ensuring discharge planning takes place from the point of admission, reducing delays to inpatient investigation and developing remote investigation services. This work will also support acute hospitals to move towards an optimal level, for quality and patient flow, of 85% occupancy at a national level. Measurements of admissions and attendances will assist in monitoring performance.

Work to anticipate and address demand will include early identification of individuals who will need significant healthcare services or interventions in the future, maximising the health and wellbeing of people living in care homes and optimising vaccination for vulnerable groups. In addition, embedding the Getting It Right For Everyone practice model and toolkit nationally, across health and social care services, will provide a multi-agency and person-led approach to care planning.

Our actions will support people to access the right healthcare setting for their care needs, first time, and where possible avoid unnecessary attendance at an Emergency Department. For example, we will increase the number of clinical supervisors at NHS 24 to support signposting and reduce call answering times. We will also optimise the use of Flow Navigation Centres (FNCs) to increase virtual access to Emergency Department teams, involving professionals such as those working in a care home or ambulance who need advice to prevent an unnecessary move of a person to hospital. Those working in FNCs will have more options to refer patients away from the Emergency Department with access to a range of services such as diagnostics, Same Day Emergency Care or Hospital at Home. This will also mean fewer people need to wait in an Emergency Department, thus reducing pressure on these services.

We will support local systems to improve community capacity by increasing responsive community home care support, optimising community rehabilitation and reablement services, expanding Hospital at Home, and increasing step down facilities that provide rehabilitation and prolonged periods of assessment. These interventions will support people to maintain their functional ability, reduce the escalation of their care needs and improve health and wellbeing in their own environment.

As part of on-going delivery planning we are working with all territorial health boards and their health and social care partners to strengthen plans by spring 2025 that set out how they will improve flow in acute hospitals. One of the aims is for each acute setting

to improve resilience and to use its capacity to best respond to increases in demand throughout the year.

Hospital at Home

Hospital at Home provides equivalent care to that provided in a hospital in a person's own home. The service is led by a hospital team who have access to hospital level diagnostics and treatment. For patients, this type of care offers additional benefits, such as reducing the risk of losing physical abilities in the hospital, preventing confusion (delirium) and lowering the chances of getting an infection. In addition, patients seen via Hospital at Home services have reduced risk of becoming dependent or facing delay because they can keep any care package they have in place while they receive their Hospital at Home care.

There is now some form of Hospital at Home pathway in every territorial NHS health board in Scotland. Currently we have 555 Hospital at Home beds for the older people's pathway. We will build on this and expand the number of Hospital at Home beds across a range of pathways to at least 2,000 by December 2026.

To deliver this expansion, we are working with health boards to ensure plans are in place by April 2025 to increase Hospital at Home capacity in line with demand and to support services to work collaboratively. These pathways could include older acute adults, outpatient parenteral antibiotic therapy, respiratory, heart failure and paediatrics. We will work with national boards to ensure that appropriate training and quality improvement expertise is in place to support the development of existing staff and improve the standard of services.

We will look to develop national benchmarking of Hospital at Home services and by summer 2025 key performance indicators of Hospital at Home services will be co-produced with clinical leads. We will work with partners to establish pathways that provide direct referrals from the ambulance service, flow navigation centres, emergency departments, and frailty units to Hospital at Home services by March 2026.

"I was very impressed with the care giving to me at home, I cannot express enough how well I were cared for, I was able to stay in the comfort of my own home with the confidence of home hospital looking after me with the greatest respect. They reassured me at all times and explained everything of their intentions to my care plan."

Patient supported by NHS Forth Valley **hospital at home** team.

Specialist frailty services

As our population ages, the prevalence of frailty is increasing. It is clear based on the evidence that, to improve patient outcomes and deliver high-performing healthcare systems and minimise delays, we must address the issue of frailty.

We will reduce the time that frail people spend in hospitals through prevention, admission avoidance, increased use of short-stay pathways and supporting people to live independently in their communities.

We will achieve this by prioritising care at home, or as close to home as possible, where clinically appropriate. Interventions that can help to do this include using technology that supports 24/7 remote monitoring, and additional preventative and 'home first' services with national and local partners working with providers and service users to develop alternative approaches based on local need and choice.

Frailty at the front door of the Emergency Department

The HIS standards for the care of older people demonstrate ways to optimise outcomes and reduce harm in hospital by identifying and addressing frailty at the earliest opportunity.

By putting in place processes to identify frailty early we can significantly improve a person's quality of life. Early detection means teams can quickly put in place preventative measures which reduce the risk of falls, long periods in the hospital and other complications associated with frailty. We will ensure there are local systems in place to identify people living with frailty at the earliest opportunity.

For patients being admitted to hospital, access to frailty services has been shown to shorten their length of stay and result in better functional outcomes, including reducing the likelihood of being admitted to a care home. Frailty Units are specialist beds to which people can be admitted directly from the Emergency Department or by arrangement. Those units provide intense assessment, specialist skills and early discharge, thereby reducing delays and length of stay.

Providing quick access to Same Day Emergency Care services and creating access for GPs and the Scottish Ambulance Service to get advice from specialists can help reduce the number of people who attend or are admitted to hospital. People can also avoid being admitted or have shorter waiting times if there is better access to assessments and care plans. For example, Frailty Multidisciplinary Teams working alongside emergency departments can help manage people living with frailty and its effects by providing early access to assessment. These teams will have strong relationships with community services which will allow rapid discharge where appropriate to Hospital at Home or enhanced community support.

We will work with health boards to ensure that local plans are in place by April 2025 to develop new frailty services and expand existing services. We will publish guidance by May 2025 which sets out 'what good looks like for a 'front door' frailty service' based on evidence-based practice, to support health boards. By summer 2025 we will have direct access to specialised staff in frailty teams in every core Emergency Department in

Scotland. This will mean that frail, often older patients with complex needs, will receive the wrap-around care they need supporting them to return home or into a care setting as soon as possible ensuring better outcomes. It will mean better care for these most vulnerable patients.

Access to GPs and other primary and community care clinicians

General Practice is at the heart of our healthcare system. Annual investment in General Medical Services now sits above £1 billion and there has been an additional investment of £73.2 million in 2024-25 to uplift core GP services and £190 million for multidisciplinary team members to support general practices.

In 2025-26 we will continue to increase capacity in General Practice. A 20-point action plan on General Practitioner (GP) recruitment and retention, published November 2024, builds on previous work to support the GP workforce. It includes new GP early career fellowships and an enhanced GP Retainer Scheme. We will deliver this action plan by the end of 2026 and GP workforce data will be monitored to measure progress. We will also scope a new quality framework in 2025 to make GP services more consistent across Scotland, so everyone can rely on getting the care they need, no matter where they live.

Pharmacy First Service

We have already widened the range of common clinical conditions, such as shingles, skin infections, urinary tract infections and impetigo, that can be treated by a community pharmacist as part of the NHS Scotland Pharmacy First Service.

We will further expand our Pharmacy First Service, enabling community pharmacists to treat a greater number of clinical conditions and prevent the need for a GP visit – with the first expansion by November 2025. We have already started work with health boards, including NHS 24, GPs and community pharmacists, to scope out further conditions that can be appropriately treated in a community pharmacy. From there we will develop patient group directions (PGDs), which allow community pharmacists to provide a prescription-only medicine without the need to see a GP or other qualified prescriber. We will also work with NHS Education for Scotland to provide any training required to support community pharmacists in treating these further conditions.

In addition from August 2026 all newly registered pharmacists will be able, like doctors and dentists, to practise as prescribers from the point of registration, with newly qualified optometrists also being able to do so from 2029. We will also continue to invest in prescribing training for pharmacists already working in community pharmacy. Between April 2025 and March 2026 there will be investment in a further 240 places. As more pharmacists qualify or train as prescribers this will reduce the requirement to use PGDs when expanding the Pharmacy First service.

Dentistry

We will further strengthen primary care dental services through targeted investment in the workforce to improve capacity and patient access across Scotland.

We have already begun work to improve access to NHS dentistry and provide long-term sustainability of services through the introduction of payment reform in 2023. This has led to clearer and fairer payments to dentists and increasing clinical freedom within our NHS offer, allowing for more personalised care for patients. We recognise, however, that we now need to look urgently at our dental workforce to ensure there is

continued capacity to meet demand into the future and support equitable access to services across Scotland. Our targeted investment programme from 2025 will therefore work holistically to deliver workforce improvements now and into the future.

Existing financial incentives and eligibility will be refreshed and targeted following completion of work with the Board Chief Executives' Dental Services Reference Group by the end of December 2025. This will bring benefit and greater sustainability to communities in accessing NHS dental care.

We are working with NHS Education for Scotland to develop and deliver an innovative training package for General Dental Council (GDC) registered dental therapists – who have qualified overseas – to articulate to full dentist registration status. This will allow them to establish their own practices, if they wish, as well as to deliver care directly to patients in existing practices.

We will also deliver a 7% increase in domestic student numbers from September 2025 – the first regular increase in student numbers in ten years – to ensure an expanded pipeline of new dentists entering the workforce from 2029.

Primary care optometry

We are committed to move optometry services into the community, bringing eye care closer to patients' homes and away from centralised hospital settings.

From summer 2029, optometrists in Scotland, like doctors, dentists and pharmacists, will graduate as independent prescribers - the only UK nation where this will be the case. This will promote a greater contribution of professionals working in the community, supporting wider workforce sustainability.

Building on the success of the Community Glaucoma Service, we will further extend the care delivered by some of our independent prescribing community optometrists in 2025. There will be a new acute anterior eye condition service. There will be changes made to the Statement of Remuneration to enable complex acute anterior eye condition care to be delivered by approved independent prescribing optometrists as part of General Ophthalmic Services, by August 2025. Patients with any one of ten acute anterior eye conditions (e.g. anterior uveitis) will be seen and treated nearer to where they live. The services will be fully operational in most health boards by the end of March 2026, with the opportunity to free up around 40,000 hospital appointments per year. The increased capacity within our hospital eye services will allow people waiting for care to be seen more quickly.

"My Dad was one of the first patients to use the **Community Glaucoma Service** in Glasgow. He no longer has to go on the bus to the Queen Elizabeth Hospital every 3 months. The optometrist who is now managing his glaucoma is actually his own optician who knows him well and he can walk from his home in less than 10 minutes. He is delighted with the service. Thank you"

Improving access to health and social care services through digital and technological innovation

The deployment of digital technologies will help to modernise services and improve efficiency, as noted in the Programme for Government 2024-25. A stronger 'digital first' approach will support the provision of tools that enable personalised patient experiences, tailored health recommendations, and proactive health and care management. Implementation of, for example, remote monitoring of long-term conditions, digital mental health treatments and enhanced use of video access to care and support, alongside existing national digital services such as NHS inform and Care Information Scotland, will allow us to accelerate our 'digital first' approach. Fundamentally, we want it to be easier for people to navigate their way around the health and care system and, for example, manage their appointments in a more flexible, person-centred way. It is about accessing the right care and support, in the right way, and at the right time.

Digital access for your health and social care

Working with NHS Education for Scotland (NES), we will accelerate delivery of our 'Digital Front Door' service to commence roll-out of an app for health and social care by the end of 2025. This is part of our Programme for Government commitment to launch a new national personalised digital health and care service, which will be developed and enhanced over the next five years.

This app will mean people can securely access their hospital appointments online, receive communications, find local services and access and update their personal information. We will start with an initial release (known as a 'Minimum Viable Product') in December 2025 for a limited cohort of people in Lanarkshire, in partnership with NHS Lanarkshire. This will be supported by a plan for roll-out to the whole country. Over time the functionality of the app will be extended to include social care and community health and will be continuously developed, enhanced and extended in scope and scale.

To help with this, and in conjunction with COSLA, the Digital Office for Local Government and Public Health Scotland, we will start the work required to use the Community Health Index (CHI) within local government, beginning with social work and social care. This is to allow the matching of people's records across health and social care and to make it easier to access information and local social care services through the national 'Digital Front Door' service and its associated app.

Longer term, the use of the CHI in local government will support the appropriate sharing of information across health, social work and social care settings by expanding the use of a common identifier for verification and data matching. In practice, for people in Scotland this means a better integrated health and social care system that will streamline citizen access to systems, reduce the need to repeat information multiple times and deliver better outcomes by creating much needed capacity in the health and care system.

Digital Dermatology Pathway

We will roll out a new Digital Dermatology Pathway to all General Practitioners across Scotland and to all NHS health boards by the end of spring 2025.

The procurement of a new digital service has been completed which enables GPs to take photographs of a patient's skin issues and attach those images to a dermatology referral. This was launched in December 2024 and is already available in six territorial health boards and to over 400 GP practices.

For patients, evidence suggests that this will allow around 50% to be returned to the GP, with advice or reassurance, without having an in-person appointment with a consultant. Some patients are also likely to be fast-tracked to further diagnostics or treatment based on assessment at this digital triage stage.

Impact will be tracked by measuring the number of territorial health boards and GP practices using this pathway, the number of referrals containing an image and outcomes from the digital triage process.

National digital type 2 diabetes remission programme

A new national digital intensive weight management programme will be used to support 3,000 people newly diagnosed with type 2 diabetes over the next three years, with the first patients recruited in January 2026.

We anticipate that around 35 to 40% will achieve remission from type 2 diabetes at the end of their first year on the programme, with a majority of patients benefiting from a clinically significant average weight loss of 10% and reductions in blood pressure, all contributing to reduced cardiovascular disease risk and reduction in polypharmacy.

We will measure impact by the number of patients recruited into this programme, their NHS health board, the number who achieve remission and the number with clinically significant weight loss.

Genetic testing to deliver improved clinical outcomes and target medications

Pharmacogenetics is concerned with how an individual's genetic variation affects their response to specific drugs. Identifying these genetic variations allows healthcare providers to choose the most appropriate drug treatment and dose for a patient to improve their treatment outcomes, minimise side effects and reduce adverse drug reactions.

We will start using genetic testing to target medications and deliver improved clinical outcomes for recent stroke patients and newborn babies with bacterial infections. The aim will be to prevent debilitating recurrent strokes and severe adverse reactions to antibiotics.

Genetic testing for recent stroke patients

There will be a pathway established across Scotland for new stroke patients to receive a lab-based genetic test to inform what drug they are given to reduce the risk of a secondary stroke. This programme will begin in October 2025 and be rolled out to all territorial health boards within 12 months.

Once fully implemented, we anticipate over the first year that around 20,000 recent stroke patients would be tested and around 30% moved to a drug that will be more effective in preventing a secondary stroke.

We will measure impact by the number of NHS health boards applying this pathway, the number of patients tested, and the number moved to an alternative drug.

Genetic testing for newborn babies with bacterial infections

A pathway will be established across Scotland for newborn babies to receive a genetic test via a point-of-care device to inform what drug they are given to manage an infection. This programme will begin in October 2025 and be rolled out to all territorial health boards within 18 months.

Once fully implemented, we anticipate over the first year that around 3,000 newborn babies would be tested and those with the relevant genetic variation moved onto an alternative antibiotic as appropriate.

We will measure impact by the number of NHS health boards applying this pathway, the number of patients tested, and the number moved to an alternative drug.

An operating theatre scheduling tool

We are rolling out a theatre scheduling tool that has been shown to increase operating theatre productivity by up to 20% for some specialties. The tool supports health boards to optimise the use of available theatre slots and find patients or procedures that best fill gaps, based on waiting list priority. Improving scheduling will mean better use of our facilities and will make it easier for people to get their treatment quicker. All territorial health boards will have been scheduled into the rollout plan for the theatre scheduling tool by the end of June 2025.

Prevention - working with people to prevent illness and more proactively meet their needs

We want to do more to detect and prevent ill health before it happens - improving health for people and reducing demand on our health and care services.

The Population Health Framework, due to be published in spring 2025, will set out our long-term collective approach to improving Scotland's health and reducing health inequalities. Improving Scotland's health and reducing health inequalities are fundamental contributors to and enablers of each of this Government's four key priorities. The Framework will stimulate and drive improvements – requiring the support of the whole of government and public services, the voluntary sector and private sector and communities – to the key building blocks of what makes for good health. It will take a long-term approach, starting now but with action across the coming decade on primary prevention – actions that support people to live healthy and fulfilling lives and stop problems arising in the first instance[1].

The Health and Social Care Service Renewal Framework will also then focus on the key reform areas that will drive our model of service to be more preventative, to find risk factors sooner and raise the level of early intervention and proactive care. This will help to detect and prevent ill-health. This Framework is due to be published late June 2025.

Proactive prevention

Taking preventative action at any point of a person's health or care needs can make a significant difference. Detecting modifiable risk factors sooner can lead to working with the person to reduce those risk factors through a combination of lifestyle or healthcare interventions. This can also make a difference when a person's health or care needs have become more advanced. For older people, being aware of the risks of frailty and being proactive in maintaining a person's ability to be as active and connected as possible can prevent health deteriorating.

A further £10.5 million will be invested in 2025-26 to expand targeted interventions for cardiovascular disease and frailty prevention. We will agree an Enhanced Service with the BMA in spring 2025 that will increase the number of proactive interventions to prevent cardiovascular disease having a significant impact on patients' long-term health outlook. We will offer by spring 2026 a Frailty Enhanced Service to General Practices, enabling each practice to identify a Frailty Lead. This lead will help drive improvements in frailty care through training, data optimisation, and cross-sector collaboration.

Cardiovascular disease (CVD)

We will invest in a General Practice enhanced service for CVD risk factors (including high blood pressure, high cholesterol, high blood sugar, obesity and smoking). This

---

[1] Public health approach to prevention and the role of NHSScotland - Publications - Public Health Scotland

enhanced service is part of a wider national CVD risk factor suite of improvements. This enhanced service will commence in spring 2025.

This enhanced service will focus on identifying people who may have higher CVD risk and do not currently have that identified. By focusing on people with the highest unmet need, and finding risk factors soon and commencing early interventions, the risks to people's health will be reduced. We know this can make a real difference, for instance lowering a high blood pressure by 10 mm Hg reduces major CVD events by 20%.

Frailty prevention

With an ageing population in Scotland, there is a growing need to identify and manage frailty earlier to reduce avoidable hospital admissions and support people to live well for longer. We will offer a Frailty Enhanced Service to General Practices, enabling each practice to identify a Frailty Lead. This lead will help drive improvements in frailty care through training, data optimisation, and cross-sector collaboration. The terms of the frailty programme will be issued to GPs in April 2025.

Conclusion

This is a plan to improve delivery in a number of specific areas which are key to wider delivery across NHS Scotland.

Assurance around delivery and impact is critical, and accordingly enhanced monitoring arrangements are being put in place to support implementation of this plan. The Government will be closely tracking and managing progress together with health boards, supported by the improvement capability within the Centre for Sustainable Delivery, based on regular reporting from health boards including weekly data returns across key metrics.

The Government will report against this plan publicly and to Parliament within 2025-26, aligned with its next annual update on the NHS Recovery Plan 2021-26, recognising that Public Health Scotland's official statistics on waiting times for the final quarter to March 2026 are not scheduled for publication until May 2026.

This plan will continue to be built on over time. For example, the Government has previously committed to additional annual investment of £100 million for three years, subject to the Scottish Budget process, to clear planned care backlogs to a sustainable position, with 2025-26 being the first full year of that investment.

The Government is grateful for the engagement and input of stakeholders in finalising this plan and looks forward to continuing engagement and collaboration through its implementation.

Scottish Government
Riaghaltas na h-Alba

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-83691-455-6 (web only)

Appendix 2 - Operational Improvement Plan – Review Against NHSO 2025/26 Priorities

This appendix outlines NHS Orkney's commitments within our 2025/26 Annual Delivery Plan and how they align with the national priorities set out in the NHS Scotland Operational Improvement Plan (OIP).

1. Improving Access to Treatment

OIP Commitments:

- Improve CAMHS performance (meet 18-week standard)
- Expand Rapid Cancer Diagnostic Services (RCDS)
- Reduce long waits (especially >52 weeks)
- Increase diagnostics and elective activity
- Support regional collaboration and National Treatment Centres

NHS Orkney Response:

- NHS Orkney regularly meets the CAMHS 18-week waiting time standard and is committed to maintaining this performance in 2025/26. Work is ongoing to improve data quality through implementation of the CAPTND dataset.
- The Board is aligned with the North of Scotland Cancer Network to ensure timely access to Rapid Cancer Diagnostic Pathways via NHS Grampian. We are committed to meeting cancer waiting times standards and improving earlier triage and communication with patients.
- Our ADP commits to reducing waiting times across priority areas including orthopaedics, ophthalmology and diagnostics. These efforts include redesign initiatives, utilisation of national treatment centre allocation and targeted waiting times initiatives. A number of these improvements are subject to confirmation of national funding through planned care monies.

2. Shifting the Balance of Care

OIP Commitment:

- Expand Hospital at Home, optimise community-based models, prevent avoidable admissions, and reduce delayed discharge.

NHS Orkney Response:

- NHS Orkney does not deliver Hospital at Home. Instead, our model reflects a rural and island-appropriate approach.
- Our priorities are focused on primary care transformation, local prescribing, virtual access, and integration with social care to enable people to remain safely at home.
- The Delivery Plan includes commitments to reduce inpatient stays, improve discharge processes (particularly for ferry-linked islands), and continue engagement with GIRFE to enhance anticipatory care and multi-agency working.

3. Digital and Technological Innovation

OIP Commitment:

- Expand virtual access to care, implement national digital pathways (e.g. dermatology, diabetes), improve cyber resilience, and build digital workforce capability.

NHS Orkney Response:

- NHS Orkney is progressing in digital maturity through the implementation of TrakCare Inpatient EPR, MORSE for community services, and cyber resilience measures.
- We are preparing to roll out Digital Dermatology and theatre utilisation tools by Quarter 4 2025/26.
- We are committed to embedding Near Me across specialties to reduce the need for patient travel, including engagement with NHS Grampian to reduce patient travel wherever clinically appropriate.
- Our developing leadership programme and quality improvement programme will build internal capacity and readiness for innovation and transformation.

4. Prevention and Population Health

OIP Commitment:

- Launch the Population Health Framework, shift focus to early intervention and reduce health inequalities.

NHS Orkney Response:

- We are actively preparing to implement the Population Health Framework in collaboration with our Community Planning Partnership (CPP).
- We have prioritised smoking cessation, weight management, screening equity (e.g. breast cancer screening), and immunisation uptake in our ADP.
- We continue to lead work on tackling the cost of living and promoting equity through our public health and strategic planning functions.

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 26 June 2025
Title:	Planned Care – 52-week update
Responsible Executive/Non-Executive:	Tammy Sharp, Director of Performance and Transformation (and Deputy CEO)
Report Author:	Tammy Sharp, Director of Performance and Transformation (and Deputy CEO)

1   Purpose

This report is presented to the Board for **Assurance:**

Members are asked to:

i.   **Receive** the Planned Care – 52-week update
ii. **Note** the actions in place for NHS Orkney to ensure delivery of 0 patients waiting more than 52 weeks by the end of Mar'26

This report relates to a:

- Corporate Strategy 2024/2028 - Performance
- Annual Delivery Plan 2024/25
- Emerging issue
- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred
- Sustainability

2   Report summary

2.1   Situation

In late May'25 following a meeting between Scotland's Board Chief Executives (BCEs) and the First Minister (FM), the FM is seeking further assurance by Boards both individually and collectively regarding the delivery of eliminating all patients waiting more than 52 weeks by the end of March 2026. BCEs responded to this meeting with a collective letter to the FM setting out how they will address his current lack of assurance around Boards ability to deliver the 52-week position. This includes:

- Referral clarity – ensuring clear criteria for urgent and routine referrals are in place, ensuring consistency and clinical decision making / risk management across all Boards
- Plan Revision – revising agreed delivering plans to include funded additionality to prioritise patients waiting over 52 weeks

- Scheduling consistency – implementing a nationally consistent approach to managing urgent and routine scheduling, ensure equity and transparency in access to care
- Validation – working locally with the Centre for Sustainable Delivery (CfSD) to validate waiting lists and to ensure effective demand management prior to scheduling
- Accountability – BCEs are committed to ensuring robust monitoring and action to sustain optimal performance within their Boards against local trajectories. A weekly BCE meeting has been established to discuss individual and collective performance.
- Performance Oversight – in parallel, individual performance and accountability meetings with the Scottish Government Chief Operating Officer to be help weekly to maintain momentum and address local challenges
- Cross-Board Commissioning – actively commissioning waiting list appointments across Boards to optimise the use of available capacity and reduce regional variation
- Data and Transparency – close working with Scottish Government, the CfSD and Public Health Scotland to ensure that the existing Whole System Pressures Dashboard is utilised by every Board providing weekly data by specialty. This will support real-time performance management and targeted interventions.

2.2   Background

The Programme for Government 25/26 was published on the 6th May 2025 setting out a clear vision for supporting patients and reducing the length of wait for Inpatient / Day Care, Outpatient and Imaging Treatment. The PfG builds on the ambitions outlined in the NHS Scotland Operational Improvement Plan published in March 2025, and an additional £100 million has been committed to targeting long waits by increasing overall capacity in the NHS by optimising national and regional working across Health Board boundaries.

To date, Boards in conjunction with the National Planned Care Policy Team have undertaken detailed analyses of planned care activity and developed supporting trajectories for 25/26 with NTC allocations incorporated. Further additionality made possible by the availability of additional funding to support NOP activity has subsequently been built into trajectories. Further work is being undertaken across Boards to look at opportunities to increase productivity to support Health Boards to deliver zero patients waiting more than 52 weeks by Mar'26.

2.3   Assessment

To support the actions set out by BCEs to the FM the following actions have been put in place locally in NHS Orkney:

- Revised trajectories to reflect additionality with confirmed funding by specialty submitted to Scottish Government
- Weekly performance update prepared for NHS Orkney Chief Executive and Chair providing most up to date position on patients waiting more than 52 weeks, detailing key actions and any emerging risks, further reporting to weekly Exec team Meeting and monthly at SLT to ensure senior visibility of the 52-week position
- Stand-alone 52-week report to be provided to Board updating on the latest position and highlighting any emerging risks or concerns going forwards
- Director of Performance and Transformation (and Deputy CEO) chairing NHS Orkney's weekly Waiting Times meeting to ensure sufficient senior level scrutiny at patient level; this includes monitoring of the delivery of visiting service capacity by NHS-Highland and NHS-Grampian as supported by current Service Level Agreements
- Review of internal booking processes to ensure consistent scheduling
- Alignment of actions with the Improving Together Outpatient workstream to ensure opportunities for process efficiencies are recognised and actioned

- Development of a plan to support the use of the National Elective Co-ordination Unit (NECU)[1] offer to support administrative validation of all patients awaiting a NOP and FUP appointment before the end of the financial year
- Work has started reviewing the opportunity for productivity gains across the Planned Care portfolio to ensure the maximum use of available resources

The current 52-week position for NHS Orkney is as follows:

NOP Over 52 weeks as at 16/06/2025

Specialty	Appointment Booked	Not booked	Unavailable	Grand Total
Ear, Nose & Throat	97		1	98
Ophthalmology	93			93
Oral Surgery	3			3
Trauma and Orthopaedic	2		1	3
Grand Total	**195**		**2**	**197**

TTG Over 52 weeks as at 16/06/2025

Specialty	Booked	Not booked	Unavailable	Total
Ophthalmology	1		1	2
Trauma and Orthopaedic		4		4
Grand Total	**1**	**4**	**1**	**6**

It is important to note that there will be patients during this year at risk of tipping into waiting more than 52 weeks for either a NOP or against the TTG standard. Therefore, work is underway to confirm capacity for the remainder of the financial year across all specialties and to ensure that all patients waiting more than 26 weeks are also booked into clinics accordingly.

2.3.1 Patient Safety and Quality

Performance data on patient safety, quality, and experience are reported through the Joint Clinical and Care Governance Committee. While the process for collecting these metrics is well-established and consistently applied, further work is required to expand the dataset and to ensure that there are clear plans for improvement where necessary. This is essential to provide the Board with adequate assurance, as some key performance indicators (KPIs) currently lack defined targets, and improvement plans at both local and national levels.

The Director of People and Culture is currently leading the development of a Patient Experience Programme, which will be taken to the Senior Leadership Team for discussion and approval in July 2025. It is proposed that the programme will be underpinned by the principles of Realistic Medicine, which are:

- Shared Decision Making
- Personalised Approach to Care
- Reduce Harm and Waste
- Reduce Unwarranted Variation
- Managing Risk Better

---

[1] The National Elective Coordination Unit was established by the Scottish Government to support national waiting time recovery and supports local NHS Boards to address the current planned care waiting list backlog by providing: a consistent approach to national capacity, assessment and allocation and waiting list validation at both a local and national level.

- Become Improvers and Innovators

The initial priorities proposed for the programme include:

- Engagement aligned with Year 3 Corporate Strategy Priorities, commencing January 2026
- Launch of patient experience videos for the Board in July 2025
- Expansion of Care Opinion to all Acute Services by March 2026
- Ensuring patient experience is an explicit focus and metric within the quality improvement training which will commence in September 2025

Additional initiatives under consideration include:

- Partnering with Voluntary Action Orkney to involve volunteers in collecting patient feedback
- Involving patients in quality audits and reviewing quality display boards
- Exploring the use of Care Opinion for Integration Joint Board (IJB) services
- Investigating other team-based feedback mechanisms

2.3.2 Workforce

Clinical sessions for all specialties for the remainder of the financial year are currently being finalised.

A preferred candidate has been identified for the Obstetrics and Gynaecology rota. Recruitment processes are currently underway for a consultant anaesthetist and locum consultants.

2.3.3 Financial

NHS Orkney have received additional funding from Scottish Government (against the national £100M investment to support waiting times) to support the following:

- ENT - £92,759 to support 401 NOP and clear the backlog
- Ophthalmology - £72,904 to support 429 NOP and clear the backlog

A weekly return to Scottish Government to report to confirm the use of this funding and activity delivered is in place from 20th June.

Funding requests were also submitted for T&O and Endoscopy:
- T&O – a request of £122,642 was made to support 561 NOP and clear the backlog. This funding request was declined and subsequently appealed. It is likely that NHS Orkney will receive funding to support NOP appointments for patients who without the additional funding will be waiting greater than 45 weeks at the end of Mar'26.
- Endoscopy – a request of £50,454 was made to support 233 NOP and clear the backlog. The outcome of this funding request is still unknown.

It is anticipated that further funding will be made available to support long waits for inpatient treatment.

2.3.4 Risk Assessment/Management

Effective risk management is essential to ensuring the delivery of safe and high-quality patient care. Failure to proactively identify and address risks may compromise the Board's ability to deliver timely care, with potential adverse effects on patient outcomes and overall experience

2.3.5 Equality and Diversity, including health inequalities.

Reducing health inequalities is a key priority as part of the Place strategic objective. Equality, diversity and inclusion are also central to the delivery of our People priorities and our Corporate Strategy takes into consideration local, regional, and national policy. The Equality and Diversity Monitoring Report for 2024/25 was approved by the Senior Leadership Team on 1 May 2025.

2.3.6 Communication, involvement, engagement, and consultation

Discussions have taken place with Planned Care Team, Executive leads and Health Intelligence Team, in the development of this paper.

2.3.7 Route to the Meeting

- Planned Care update provided to SLT on the 24/06 detailing the 52-week position

3. Recommendation(s)

Assurance - The Board is asked to:

i.   **Receive** the Planned Care – 52-week update
ii.   **Note** the actions in place for NHS Orkney to ensure delivery of 0 patients waiting more than 52 weeks by the end of Mar'26

4. List of appendices

None.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Final Improving Together Programme Plan 2025/26**
Responsible Executive/Non-Executive:	**Tammy Sharp, Director of Performance and Transformation (Deputy CEO)**
Report Author:	**Harmony Bourn, Project Manager / Keren Somerville, Head of Finance**

1.0 Purpose

This is presented to the NHS Orkney Board to:

Decision: This paper provides the updated final Improving Together Programme for 2025-26 for approval.

This report relates to:

- Corporate Strategy 2024 – 2028 – Potential, Performance, People, Patient Safety, Quality and Experience, Place
- Annual Financial Plan
- Financial Sustainability

This aligns to the following NHS Scotland quality ambition(s):

- Effective
- Person-centred

2.0 Situation

NHS Orkney has set itself an ambitious financial savings target for 2025-26 of £3.8m in-year (4.5%) with a £2.8m (74%) recurrent contribution. This target has increased from £3.5m as described in the financial plan approved by the Board to include the effect of the acceptance of the transitional funding from Scottish Government. The acceptance of the transitional funding has committed NHS Orkney to returning to financial balance by 2028/29. This results in additional recurring cost savings of £1m required over the next 4 years.

Savings of £2.7m have already been identified for 2025/26 and there are a number of pipeline opportunities currently being assessed to close the remaining gap and further build mitigation resilience.

This paper incorporates the final Improving Together Programme Plan for 2025/26 for approval by the Finance and Performance Committee and then onwards to the NHS Orkney Board in June.

NHS Orkney Board is asked to:

(a) scrutinise and approve the final version of the plan.

(b) note the progress of the programme and the contents of this plan to provide assurance both internally and externally that NHS Orkney have a well-structured programme embedded and a strong focus from the executive to continue to identify and deliver efficiency and productivity opportunities.

3.0 Background

NHS Orkney is currently at Level 3 of the NHS Scotland Support and Intervention Framework and delivering financial efficiencies is a required component of de-escalation. The Board recognise their responsibility to establish a timetable and pathway to achieve financial balance and move toward long-term financial sustainability.

In addition, the Board has accepted the terms and conditions associated with the receipt of transitional funding over the next 4 years. These conditions include delivery of all savings targets in each year and a return to financial balance by 2028/29 at the latest.

4.0 Assessment
The 2025/26 Efficiency Programme

The attached report sets out the one-year financial efficiency plan to enhance quality of care, patient safety and experience and improve operational performance leading to an improvement in NHS Orkney's financial position. The plan sets out confirmed and indicative savings for 2025-2026 based on work currently underway. This report was recommended for approval by the Board by the Finance and Performance Committee in May.

The report (please refer to Appendix 1) is broken down into eight sections and provides a full accounting of the programme as of 12 May 2025 and includes:

- Key Messages
- Background
- Financial Baseline
- Cost Improvement Plan (CIP)
- Efficiency Plan Governance
- Next Steps
- Key Messages
- Appendices
      Workstream Summaries
      Glossary

Key messages for highlighting to members:

▪ We have worked up 78 schemes across 12 workstreams totalling £2.750m as signed off and pending or approved by the Quality Impact Assessment (QIA) Panel.

▪ Against the £5.559m, we have risk assessed this amount with £1.332m (48%) rated as green for delivery, £0.670m (24%) rated as amber rated for delivery, and £0.748m (24%) as red rated for delivery.

- In scenario planning, and considering risk, we have set a downside scenario of £2.057m and an upside scenario of £3.878m.

- There are a range of pipeline schemes currently being worked through, totalling a minimum of £1.050m to bridge the gap to £3.8m although we expect this number to increase as schemes are finalised through Q1 2025/26.

Quality/Patient Care

Successful transformation delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. The benefits of having a safe and effective Improvement function will be realised at an individual, Board, and whole system level.

Substantial medium to long-term benefits can only be achieved and sustained with organisational change that goes beyond quick fixes and technology upgrades.

Risk Assessment/Management

The Improvement programme's risk register reconciles to departmental and corporate risk registers. This will be regularly updated throughout the course of the programme. The key risks identified at this stage include:

- Financial capacity and understanding around validating opportunities and evidencing delivery will delay scheme implementation and lead to underperformance against the planned savings profile.
- There is a risk without the appropriate resources in place for the Improvement Hub, we will be unable to implement the necessary changes to support our Improvement Plan and achieve the efficiencies required by the Scottish Government.
- There is a risk that NHS Orkney will not realise the £3.8m savings nor achieve £2.8m recurrent savings which could impact financial sustainability and the delivery of the 3-year financial plan.
- There is a risk that the scale of workforce change required (equivalent to 20WTE this year and circa £1.25m in-year savings) cannot be realised within a 12-month period due to low attrition rates and reliance on medical agency, and that there is a risk that achievement of these targets will destabilise clinical and support service delivery.

Equality and Diversity, including health inequalities

Central to our work is developing a culture of continuous improvement which has fairness and equity at its heart. Evidence that satisfies each of the six elements regarding Diversity and Inclusion as listed in the QIA guidance document:

- Alignment with The National Plan for Scotland's Islands 2019 and Islands (Scotland) Act 2018

Climate Change Sustainability

Incorporated in the Efficiency Improvement Programme, are schemes to review the number of journeys both to and from the Island for both patients and staff. An additional scheme, The Green Theatres Programme enables environmentally sustainable care by reducing the environmental impact in Theatres and contributing towards Scotland's net zero target.

- Consideration has been given to the NHS Scotland Climate Emergency and Sustainability Strategy

Route to the Meeting

The draft version of this plan has been shared with the relevant groups and committees, as outlined below:

- NHS Orkney Board, 24 April 2025
- Senior Leadership Team, 01 May 2025
- Improving Together Delivery Group, 01 May 2025
- Improving Together Programme Board, 09 May 2025

The final plan, as presented today was recommended for approval by the Board at the following meeting

- The Finance and Performance Committee, 27 May 2025

5.0 Recommendation

NHS Orkney Board is asked to:
  (a) scrutinise and approve the final version of the Improving Together Programme for 2025/26.
  (b) note the progress of the programme and the contents of this plan to provide assurance both internally and externally that NHS Orkney have a well-structured programme embedded and a strong focus from the executive to continue to identify and deliver efficiency and productivity opportunities.

6.0 Appendices

Appendix 1: Final Improving Together Programme Plan 2025-26

Improving Together Programme Efficiency Plan 2025/26

Final Plan

Table of contents

Key Messages

Our Commitment

- This is a one-year financial efficiency plan to enhance quality of care, patient safety and experience and improve operational performance leading to an improvement in NHS Orkney's financial position. The plan sets out confirmed and indicative savings for 2025-2026 based on work currently underway; and a set of sound and rationale assumptions. This is the final plan for 2025/26 for approval by the Finance and Performance Committee and then onwards to the NHS Orkney Board in June.

- This is an ambitious and realistic plan which, at its heart, is developed with and agreed by clinical, operational and corporate teams across the organisation and with the endorsement of the NHS Orkney Board. Through this plan, the organisation reaffirms it commitment to offering high quality clinical care in line with its 5-year corporate strategy 2024- 2028.

- The Board accepts any return to financial balance requires a mix of driving short-term internal efficiencies (transactional change) and longer-term benefits (transformational change) through a reconfiguration of the local health economy, embracing digital improvements and an optimisation of the current estate. These changes are reliant on working with external partners including Scottish Government and partner health boards to realise sustainable whole system benefits through improved productivity and the adoption of new and innovative ways of working.

- Our staff are key to the delivery of the plan and their collaboration, engagement and buy-in has been a cornerstone of the plan's development. NHS Orkney has a well embedded communications strategy to continue to optimise engagement and a well-embedded governance framework to monitor and assure delivery. These are critical precursors to delivery.

- This plan represents a shift from transaction to transformation as part of the Board's three-year financial plan to move closer towards financial balance.

- The 2024/25 financial plan was to deliver a deficit position of £5.778m which has been achieved, with a draft deficit prior to brokerage support of £3.874m, the improvement in the year end outturn was mainly as a result of additional benefits derived from changes in national funding related to Distance Islands Allowance and Agenda for Change (AfC).

- NHS Orkney will be retained at Level 3 of the NHS Scotland Support and Intervention Framework for 2025/26 and will continue to receive support from Scottish Government as it reaffirms it full commitment to moving towards a financially balanced position in the near to medium term. Our current forecast will see us returning to financial balance in 2028/29.

- NHS Orkney has put in place a well-defined programme structure to monitor, report and assure the 12 workstreams and deliver the associated quality and efficiency benefits set out in the plan.

Background

Summary

- Established in 1927, the Old Balfour hospital was replaced by the new Balfour hospital in June 2019. Located in the heart of Kirkwall, it provides a comprehensive range of primary, community-based, and acute services to a population of over 22,000, spread across twenty inhabited islands. The hospital employs circa 800 staff.

- NHS Orkney is the smallest territorial health board in Scotland, covering 70 islands, 20 of which are inhabited. Approximately 75% of the population lives on the Orkney mainland, with the remaining 25% residing on the ferry-linked isles. Despite its size, NHS Orkney has the potential to lead the way in delivering high-quality remote and rural healthcare, offering a comprehensive range of primary, community-based and acute services.

- In 2024/25 there were:
  - 8,948 A&E attendances
  - 1,847 inpatient admissions
  - 3,259 day cases
  - 35,522 outpatient attendances

- The Board operates predominantly from The Balfour, where most acute services are delivered. Additional services are provided in several community settings across the Orkney mainland and isles.

- The organisations vision is to be an outstanding organisation, looking after our community and providing excellent care and is driven by the values of open and honest, respect and kindness.

- NHS Orkney operates with expenditure of c£85m and successfully delivered against the forecast deficit of £5.778m as set out in the 2024/25 financial plan.

- The three-year financial plan reflects the Board's commitment to continue to provide high quality care for patients and improve the resilience and sustainability of services within a challenging financial envelope both locally and nationally.

- This one-year efficiency plan has been developed with executive and operational and clinical staff and the final plan will be signed-off by the Board of Directors in June in accordance with internal governance processes.

- Delivery of this plan and its component 12 workstreams will require a Board-wide effort and an engagement strategy to support implementation is being developed to ensure continued visibility of and buy-in to this programme – one of the Board's key strategic priorities.

- Following the update and the acceptance of the Transitional Funding from the Scottish Government, the Board has a savings target of £3.8m for 2025/26 to achieve its agreed deficit control position of no more than 1% of RRL. The development of the plan has been on sustainable improvement with 72% to be identified as recurrent. The savings to date can be described as 'transactional' in nature. However, significant work is underway to deliver system-wide transformational savings through 2025/26.

Background
Approach to developing and delivering the efficiency programme

- NHS Orkney is currently at Level 3 of the NHS Scotland Support and Intervention Framework and delivering financial efficiencies is a required component of de-escalation. The Board recognise their responsibility to establish a timetable and pathway to achieve financial balance and move toward long-term financial sustainability. To this end, a continuation of the Improving Together programme is underway with the development of a plan for 2025/26.

- At this stage, we have worked up 78 schemes across 12 workstreams totalling £2.750m as signed-off and pending or approved by the Quality Impact Assessment (QIA) Panel. There are a range of pipeline schemes currently being worked through, totalling a minimum of £1.5m to bridge the gap to £3.8m. The Board has a continual cycle of ideas development as teams aim to meet their individual saving targets.

- With a strong track record of savings delivery in 2024/25, the Board recognises that continued delivery becomes more challenging and system-wide transformation is required to unlock significant efficiencies over the next three-year period.

- Each workstream has a named Senior Responsible Officer, Delivery Lead, Clinical Lead, Finance Lead, and People Lead. They are required to deliver a full, robust, and credible plan supported by detailed milestones and subject to quality impact assessments. A named Project Manager from the Improvement Team has been assigned to each workstream.

- We will continue to investigate the key efficiency metrics in to determine the extent to which we can deliver increased efficiencies – in particular in medical agency expenditure where we know substantive staff provide greater continuity of care to our patients and enable better staff satisfaction and morale. will replicate these to measure our progress on an ongoing basis.

- All workstreams will be subject to a quality impact assessment where there is a change to clinical service provision or a change to workforce. Performance indicators for each QIA will be monitored by the Joint Clinical and Care Governance Committee to assure that patient safety and quality of care are not reduced.

- A rigorous and transparent governance framework has been put in place to monitor, report and assure delivery of the efficiency programme against the plan.

- Maintaining momentum for the programme over multiple years is vital to continuous staff engagement and ownership as well as engendering confidence with Scottish Government in NHS Orkney's capability to deliver similar savings in each year over the next three-year period. Success in 2024/25 has positioned the organisation well on both fronts and it is incumbent on the senior leadership team to retain strong financial stewardship and control to realise this agreed priority, as set out in the Corporate Strategy 2024 – 2028

Background
Opportunity Analysis

- The Board recognise that a return to financial balance will be reliant on both driving internal efficiencies as well as real system transformation to how care is offered and provided across the whole health system.

- In the development of this plan, we have worked with the Scottish Government Financial Delivery Unit (SG-FDU) to review a mix of NHS benchmarking to national comparators, regional island health boards with select peers of NHS Shetland and NHS Western Isles and NHS best practice standards to identify the gap to top quartile or better performance.

- Central to our analysis has been the national 15-box grid which we report quarterly to Scottish Government and has been instrumental in informing where NHS Orkney excels (pharmacy, procurement, off-framework nurse agency compliance) and where there is a strong evidence base for improvement (administrative staff (table below), medical agency spend and increase virtual outpatient appointments both for Orkney residents at NHS Orkney (see graph overleaf) and with visiting partner health boards.

- Benchmarking has been shared with workstreams and local analysis is underway to have a succinct narrative to either substantiate the pay variance to norm or to develop plans to bring NHS Orkney in line with good practice.

Sum of 31 December 2023 Row Labels	Administrative Services Vs. Total WTE	Support Services VS. Total WTE	Admin & Support Services Total
NHS Greater Glasgow & Clyde	15%	9%	23%
NHS Lothian	16%	9%	26%
NHS Grampian	16%	11%	27%
NHS Lanarkshire	17%	7%	24%
NHS Tayside	17%	10%	27%
NHS Ayrshire & Arran	16%	9%	25%
NHS Highland	19%	10%	29%
NHS Fife	17%	9%	26%
NHS Forth Valley	17%	3%	20%
NHS Dumfries & Galloway	17%	9%	26%
NHS Borders	20%	11%	31%
National Waiting Times Centre	21%	11%	32%
NHS Western Isles	21%	13%	34%
NHS Shetland	26%	10%	36%
NHS Orkney	25%	12%	37%

Remote Outpatient Appointments

Board Names	%
NHS Highland	18.4%
NHS Lanarkshire	16.7%
NHS Grampian	16.2%
NHS Ayrshire & Arran	15.0%
NHS Greater Glasgow...	11.0%
NHS Tayside	10.8%
NHS Borders	9.0%
NHS Dumfries & Gall...	8.7%
NHS Fife	7.5%
NHS Lothian	5.6%
NHS Forth Valley	5.4%
NHS Western Isles	4.1%
NHS Shetland	4.0%
NHS Orkney	3.3%

Upper Quartile: 14.0%

Background

The Leadership Team

- NHS Orkney has materially strengthened its executive team under the leadership of Laura Skaife-Knight, Chief Executive Officer, appointed in April 2023. The combined executive bring considered experience recently bolstered by the appointment of a Director of Performance and Transformation (and Deputy CEO) to commence from May 2025 and an interim Director of Finance.

- NHS Orkney has benefitted from external resource over the previous 18-months as part of its inclusion in the NHS Scotland Support and Intervention Framework and this was pivotal in delivering productivity efficiencies to achieve its financial plan in 2024/25. The external resource will cease from May 2025 as the Board continues to embrace and drive its own path to sustainability.

- A new governance framework was introduced across the health board in 2024 with improvements made in how all levels conduct business and receive assurance. This included the establishment of an integrated performance report (IPR) and Performance Review Meetings (PRMs) that focus on holding clinical and operational colleagues to account for performance against national and local key performance indicators and act as a barometer for the overall health of healthcare provision in Orkney.

- The new corporate strategy 2024-28 was also launched with good progress in meeting Year 1 objectives and a review and launch of Year 2 objectives has taken place with a continued focus on delivery.

- All Board members undertook a leadership development programme with a similar programme proposed in 2025/26 for senior leaders across the organisation. Quality Improvement (QI) training will be offered from September reflecting investing in our staff to deliver transformational change is imperative to building a sustainable future for the patients, families and communities we serve.

Chair and Chief Executive

Meghan McEwen
Chair

Laura Skaife-Knight
Chief Executive

Non-Executive Directors

Kirsty Cole
Area Clinical Forum Chair

Davie Campbell
Non-Executive Director

Joanna Kenny
Non-Executive Director

Jean Stevenson
Non-Executive Director

Ryan McLaughlin
Employee Director

Izzy Grieve
Non-Executive Director

Jason Taylor
Non-Executive Director

Rona Gold
Non-Executive Director

Executive Directors

Tammy Sharp
Director of Performance & Transformation (& Deputy CEO)

Anna Lamont
Medical Director

Samantha Thomas
Director of Nursing, Midwifery, AHPs & Chief Officer Acute

Melanie Barnes
Interim Director of Finance

Louise Wilson
Director of Public Health

Jarrard O'Brien
Director of People and Culture

Stephen Brown
Chief Officer IJB

Background

Communication and Engagement Plan

- The level of organisational change required to deliver the Improving Together Programme will not materialise without clear communication and engagement across all areas of the organisation. NHS Orkney has a well-developed approach to communicating with all staff through a variety of means including:

  - CEO briefings (monthly) – presented by the CEO to all staff on the financial position and other key strategic issues

  - CEO Fortnightly Blog for all staff (fortnightly) – email to share key messages with all staff.

  - NHS Orkney internal staff bulletin (weekly) – email to all staff with key information.

  - NHS Orkney website & social media – provides news and access to information to the public on all aspects of the Health Board.

- The Bright Ideas Campaign, which launched in 2024 is continuing and provides opportunities for all staff to submit ideas to increase productivity, drive efficiency and improve the work environment.

- Updates to other forums take place through the programme regularly featuring on meeting agendas including Senior Leadership (SLT) and Extended Senior Leadership Team (ESLT), Area Partnership Forum and Hospital sub-committee.

Financial Baseline

Financial Performance to 31 March 2025

2024/25 Summary

- NHS Orkney is currently in Level 3 of the NHS Scotland Support and Intervention Framework, with brokerage of £5.156m required in 2023/24.

- For 2024/25, NHS Orkney has delivered a draft outturn deficit of £3.874m, a significantly improved position against the forecast deficit of £5.778m as set out in the financial plan, mainly due to additional funding received in year for Distant Island Allowance cost pressure and Agenda for Change Reform.

- The forecast deficit of £5.778m was the highest percentage of core resource revenue limit (RRL) at 6% across NHS Scotland.

- Brokerage support of £3.874m was required in 2024/25, total cumulative amount of repayable brokerage will now be £9m which will need to be repaid once the Board returns to financial balance.

- The Board delivered £4m efficiency savings in 2024/25 as set out in the financial plan.

- Maintaining and stabilising the financial position in 2024/25 has been achieved through a more singular focus on transactional opportunities and a reliance on grip and control measures across all elements of substantive and supplementary pay, and non-pay.

- The predominant divers of the Board's underlying deficit relate to an increased establishment (£3.2m) and ongoing reliance on clinical agency (£3.1m), as well as historic non-recurrent efficiency savings delivery.

Financial Baseline
2025/26 Financial Plan & Overview

2025/26 Plan

- Prior to the acceptance of the Transitional Funding Support from the Scottish Government, the 3-year Financial Plan forecast a deficit of £3.106m for 2025/26 reducing to £1.7m in 2027/28.

- The Financial Plan assumes no payment of brokerage over the 3-year period outlined.

The Financial Plan aims to:

- Significantly reduce the underlying deficit and return to a recurring financial balance in as short a timescale as possible whilst ensuring that the improvements required to deliver are sustainable.

- Reduce the dependence on non-recurring efficiency savings to reduce the in-year deficit.

- Develop and implement a clinical transformation programme that will review the current models of care and how they are being delivered and redesign services, taking account of the balance between activity and financial performance

Summary RRL Position	2025/26	2026/27	2027/28
	£m	£m	£m
Deficit brought forward	5.800	3.106	2.964
Add: Non-Recurring Savings	1.199	1.000	1.000
Pressures – Pay	1.400	1.442	1.485
Pressures – non-pay	3.457	2.757	2.869
Baseline Funding Uplift	(2.181)	(2.312)	(2.382)
Additional Non-Recurring Funding	(3.269)	1.221	
Net Gap	6.406	7.214	5.936
CIPs - Recurring	(2.500)	(3.250)	(3.250)
CIPs – Non-recurring	(1.000)	(1.000)	(1.000)
Net Deficit after CIPs	2.906	2.964	1.686
Service Development Commitments	0.200	0.000	0.000
Total deficit including service development commitments	**3.106**	**2.964**	**1.686**

Cost Improvement Plan
Scenario planning

- Each of the workstreams will undergo a rigorous planning process from the identification of the initial opportunity supported by benchmarked data, bottom-up analysis; and where applicable, clinical review and sign-off.

Upside scenario
- The Improvement Team has reviewed potential upside opportunities and assumed additional savings of £1m based on its current assessment and informed by:

    - Increased number of patients receiving diagnostic tests in Orkney and a reduction in travel
    - Improved medical recruitment trajectory of the current 6.3 WTE consultant vacancies now out for recruitment.
    - Procurement savings more reflective of 2024/25 performance.
    - Delivery of the full workforce savings programme

Downside scenario
- A similar assessment was conducted to inform the downside scenario with sensitivities applied totalling £0.69m and informed by:
    - Inability to realise workforce redesign savings at pace due to lower than anticipated vacancy rates.
    - Inability to sell or secure agreement to sell the King Street Old Dental Practice.
    - Inability to realise reduced travel savings at pace.

- Continued efforts to identify additional schemes will form a core part of the on-going engagement strategy and Bright Ideas Campaign. The Improvement Team remain focused on converting those schemes in the 'pipeline' to close the remaining gap to target and build in mitigation resilience.

Workstream	Downside Scenario	Base Case Scenario	Upside Scenario
Corporate	0	176	176
Diagnostics	397	486	530
Estates	15	34	34
Facilities	31	48	48
Medical Recruitment	175	273	375
Outpatient Productivity	TBC	TBC	200
Pharmacy	139	139	180
Procurement	250	300	350
Social Care & Community (IJB)	317	365	435
Theatre Utilisation	TBC	TBC	50
Workforce	733	928	1,500
Clinical Service Review	TBC	TBC	TBC
Total	**2,057**	**2,749**	**3,878**

Indicative forecasts as of 12 May with further development of schemes to be completed through Q1 2025/26

Cost Improvement Plan
Scheme Breakdown

- The profile of savings for 2025/26 is weighted towards pay and non pay with only 8% through income schemes of agreed and transacted and in-development schemes.

- Given the majority of expenditure is across pay, the Board recognises the need to right-size its workforce with 49% of savings currently attributed to pay schemes.

- Non-pay savings currently represent 43% of the total savings.

- The table presents provides a breakdown of the 12 workstreams, categorised by pay, non-pay, and income for 2025/26.

- Total recurrent savings amount to £2.109m, with a further £641k classified as non-recurrent although we expect all future savings to be mostly recurrent.

Workstream	Income	Non-Pay	Pay	Total
Corporate	176	0	0	176
Diagnostics	0	486	0	486
Estates	17	17	0	34
Facilities	17	0	31	48
Medical Recruitment	0	0	273	273
Outpatient Productivity	0	0	0	0
Pharmacy	0	139	0	139
Procurement	0	300	0	300
Social Care & Community (IJB)	0	200	165	365
Theatre Utilisation	0	0	0	0
Workforce	0	53	875	928
Clinical Service Review	0	0	0	0
Total	**210**	**1,195**	**1,344**	**2,749**
Percentage of total	**8%**	**43%**	**49%**	

Cost Improvement Plan
Workstream phasing by month – near-confirmed

- The table below sets out the monthly phasing of the workstreams across the 2025/26 financial year. The appendix to this report contains a summary plan for each of these workstreams. Detailed plans have also been developed and are available through the Improvement Team.

Workstream	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	25/26 IY Savings Total	Full Year Effect
Corporate	£0	£0	£0	£0	£0	£0	£0	£0	£176,000	£0	£0	£0	£176,000	£176,000
Diagnostics	£0	£0	£52,900	£45,400	£45,400	£45,400	£49,567	£49,567	£49,567	£49,567	£49,567	£49,567	£486,500	£464,000
Estates	£0	£5,000	£4,000	£0	£0	£17,000	£0	£0	£6,500	£0	£0	£1,500	£34,000	£46,000
Facilities	£2,593	£2,593	£3,693	£4,360	£4,360	£4,360	£4,360	£4,360	£4,360	£4,360	£4,360	£4,360	£48,119	£48,119
Medical Recruitment	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£43,617	£43,617	£43,617	£43,617	£43,616	£43,616	£273,400	£523,400
Outpatient Productivity	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Pharmacy	£5,792	£5,792	£5,792	£10,903	£10,903	£10,903	£14,853	£14,853	£14,853	£14,853	£14,853	£14,853	£139,200	£139,200
Procurement	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£300,000	£300,000
Social Care & Community (IJB)	£21,235	£21,235	£21,235	£27,902	£77,902	£27,902	£27,902	£27,902	£27,902	£27,902	£27,902	£27,902	£364,821	£364,821
Theatre Utilisation	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Workforce	£49,600	£49,600	£49,600	£49,933	£63,308	£97,239	£66,641	£66,641	£134,503	£66,641	£66,641	£168,434	£928,780	£936,311
Clinical Service Review	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total	**£106,169**	**£111,169**	**£164,169**	**£165,447**	**£228,822**	**£229,753**	**£231,939**	**£231,939**	**£482,301**	**£231,939**	**£231,938**	**£335,231**	**£2,750,820**	**£2,997,851**

Cost Improvement Plan

Closing the Gap

- Work continues to identify additional opportunities. This table sets out the material opportunities that are being assessed and developed with £1.5m indicative savings identified as of 12 May 2025.
- There is a clear expectation that confirmed savings and approved plans will be in place for June 2025.

Workstream	Scheme	Description	Risk Status	Recurrent / Non-recurrent	Indicative Value (£000)
Clinical Service Review	Transformation of clinical services following the Clinical Service Review	A review of opportunities to transform and innovate how services are currently delivered across Orkney	**Amber**	Recurrent	TBC
Facilities	Revised Inpatient Menu	Reducing inpatient meals from 3 to 2	**Amber**	Recurrent	TBC
Outpatients Productivity	Near-Me Virtual Appointments	Increase the uptake of Near-Me virtual appointments and enhance patient experience by reducing the need for patient travel	**Amber**	Recurrent	200
Pharmacy	Expansion of community dressings initiative	Expand the community dressings initiative project to other GP Practices	**Amber**	Recurrent	25
Theatre Productivity	Increased throughput and reduced cancellations	To identify opportunities to improve theatre utilisation and increase overall productivity	**Red**	Recurrent	50
Workforce	Wider workforce redesign opportunities	Includes Band 6 reform opportunities and other workforce opportunities	**Red**	Recurrent	500
Workforce	Additional Grip and Control measures	Consider additional grip and control measures to close the gap to the £3.8m savings target	**Red**	Recurrent / Non-recurrent	275
Total					**1,050**

Cost Improvement Plan

Confidence in delivery

- We expect to complete analysis and develop the remaining schemes through Quarter 1 and therefore will see an increase in savings through the second half of the year. This is customary when organisations implement redesign opportunities as the time to engage staff and see benefits realised take time and careful planning.

- A delivery risk assessment has been completed by the Improvement Team for all schemes with a view that 48% is rated green for delivery with confidence the full savings amount will be achieved, 24% is rated amber with some risk to delivery (around estate disposal and medical recruitment given historic challenge to address agency reliance), 27% has been rated red for delivery, attributed to pay-related schemes. The risk-rating of schemes will be continually monitored and updated monthly to reflect the current position.

Overall Programme		Green	Amber	Red
Assessment at 12 May 2025		1,332	670	748
Percentage of total		48%	24%	27%

Efficiency Plan Governance
Introduction

- NHS Orkney has taken steps to strengthen existing governance arrangements to support delivery of the efficiency programme. A dedicated Improvement Team of 4.2 WTE has been re-established to support its delivery.

- The establishment of the Improvement Team reinforces the Board's commitment to deliver transformational programmes and support its working with external partners across the wider health economy.

- The governance arrangements reflect a matrix management approach with dedicated workstream leads in the more transformational change workstreams of workforce, medical productivity, pharmacy and procurement. This ensures leaders are accountable for implementing the changes at a local level, while the workstream lead is responsible for overall implementation

- Significant steps have been taken to strengthen accountability of the programme within the corporate leadership team. Increased clinical engagement and ownership form a core part of the development of the plan, including clinical sign-off by each workstreams respective clinical lead, where relevant.

- Reporting progress against plans continues through the monthly Improving Together Delivery Group (Chaired by the Head of Finance); and monthly Improving Together Programme Board (Chaired by the Chief Executive). Updates to the Senior Leadership Team, Finance and Performance Committee, and the NHS Orkney Board ensure Executive and Board oversight to maintain focus and ensure cost improvement is championed as one of the Board's key priorities.

- This approach ensures it remains part of the Board's usual business rhythm.

- The Improvement Team will ensure a continued focus on embedding a robust reporting and assurance framework for the whole programme.

The remit of the Improvement Team is to:
- Provide and co-ordinate dedicated resource to support delivery of the turnaround programme, underpinning workstream teams.
- Begin to embed in the organisation a strong programme management culture and an accountability and governance framework to assure delivery of the programme
- Provide independent challenge and support workstream leads to manage execution and delivery risk
- Monitor the delivery of individual plans, manage programme level risks and interdependencies through standardised reporting tools and escalate issues that hinder delivery through a structured reporting framework
- Be the central repository in the organisation and co-ordinating function for all its recovery and turnaround plan documentation
- Engage the organisation in the generation of new ideas through engagement events and other forums to solicit ideas across the whole organisation
- Provide timely evidenced based assurance of progress and variance against plan to the Board

Efficiency Plan Governance
Resourcing and Ownership

- Individuals have been identified to deliver each work stream. Defined role descriptions set up expectations for each of the work stream lead, clinical lead and senior responsible officer roles. Lead clinicians have been engaged through-out the programme and are responsible for sign-off of plans in their respective areas, and accountable for delivery. NHS Orkney recognises the importance of strong clinical engagement though the implementation phase and has taken steps to ensure this continuity from the development phase of the plan.

Core Workstreams

Workstream	SRO	Delivery Lead/s	Clinical Lead/s	Finance Lead	HR Lead	Improvement Team Lead	Staff Side Rep
Corporate	Laura-Skaife Knight	Melanie Barnes	N/A	Mareeya Montero	Steven Phillips	Harmony Bourn	Karen Spence
Diagnostics	Dr Anna Lamont	Nick Crohn	Lorna Wilson	Andrew Grassom	Steven Phillips	Harmony Bourn	N/A
Estates	Laura Skaife-Knight	Alan Scott	Nick Crohn	Mareeya Montero	Steven Phillips	Harmony Bourn	Tony Miller
Facilities	Laura Skaife-Knight	Sharon Keyes	Sarah Walker	Mareeya Montero	Steven Phillips	Lauren Johnstone	Tony Miller
Pharmacy	Dr Anna Lamont	Wendy Lycett	Lyndsay Steel / Russell Mackay	Mareeya Montero	Steven Phillips	Harmony Bourn	N/A
Procurement	Melanie Barnes	Kirsty Francis	Various	Mareeya Montero	Steven Phillips	Lauren Johnstone	N/A
Social Care & Community (IJB)	Stephen Brown	John Daniels	AHP Leads	Bruce Young	Steven Phillips	Harmony Bourn	N/A
Workforce	Jarrard O'Brien	Steven Phillips	Sam Thomas / Dr Anna Lamont	Mareeya Montero	Steven Phillips	Emma West / Lauren Johnstone	Ryan McLaughlin

Transformation Workstreams

Workstream	SRO	Delivery Lead/s	Clinical Lead/s	Finance Lead	HR Lead	Improvement Team Lead	Staff Side Rep
Theatre Utilisation	Samantha Thomas	Nancy Faulkner	Specialty Leads	Andrew Grassom	N/A	Kyran Taylor	N/A
Outpatient Productivity	Dr Anna Lamont	John Daniels	N/A	Andrew Grassom	N/A	Lauren Johnstone	Amanda Manson / Fiona MacKellar
Medical Recruitment	Dr Anna Lamont	Dr Anna Lamont	Specialty Leads	Andrew Grassom	Hannah Kerr	Lauren Johnstone	N/A
Clinical Service Review	Anna Lamont	Jennifer Armstrong / Fiona Mackay	Speciality Leads	Bruce Young	Jarrard O'Brien	Harmony Bourn	Ryan McLaughlin

Efficiency Plan Governance

Reporting Structure and Accountability

- The Improvement Team provide reports into the relevant committees to meet good governance standards The key point to note is the fortnightly workstream meetings and the monthly Delivery Group and Programme Board meetings support an effective rhythm of pace and focus. This diagram depicts the governance and accountability arrangements for the efficiency programme. The standardised reporting framework introduced in 2024/25 will continue to further embed good practice.

Diagram: NHS Orkney Health Board ← Finance & Performance Committee ← Improving Together Programme Board (monthly) ← Improving Together Delivery Group (monthly) ← Improvement Team – Programme Support ← Fortnightly workstream meetings.

Planned Care Programme Board → Improving Together Programme Board (monthly). Planned Care Programme Board includes: Theatre utilisation, Outpatients.

Improving Together Programme Board → Area Partnership Forum, Senior Leadership Team.

Improvement Team – Programme Support → QIA Panel.

Fortnightly workstream meetings:
- Corporate
- Diagnostics
- Digital Transformation
- Estates & Facilities
- Pharmacy
- Procurement
- Social Care & Community (IJB)
- Workforce

Wider organisation / leadership involvement & validation of cross-cutting workstreams

Meeting	Description	Frequency	Chair
Programme Board	Accountable for development and delivery of overall programme, resource and risk management.	Monthly	Chief Executive Officer
Delivery Group	Responsible for operational development of ideas into robust, credible plans.	Monthly	Head of Finance
QIA Panel	To assess the impact of schemes against the six domains set by the Scottish Government to safeguard clinical outcomes, patient care and staff well-being.	Ad hoc	Medical Director / Executive Director of Nursing, Midwifery, AHPs & Chief Officer Acute
Workstreams	Clinical and operational leads with wider staff engagement to identify opportunities and to define and agree opportunities for improvement.	Fortnightly	As defined by workstream

Efficiency Plan Governance

Reporting Documentation

- A suite of standardised documents has been refreshed to support effective monitoring of the programme. These include:

  - CIP documentation (Plan on a Page / Quality Impact Assessment)

  - Programme risk register

  - Efficiency programme tracker

  - Monthly reporting documents for committees and bords.

- Standardised CIP documentation for each scheme 'in implementation' will capture all necessary information through a Plan on a Page and Quality Impact Assessment to support a robust narrative and evidence based for all identified savings.

- A programme risk register has been established to capture current and new risks within the programme. Monitoring of risks occur as part of the Improving Together Delivery and Improving Together Programme Board.

- Individual scheme risks are captured within the Plan on a Page and Quality Impact Assessment.

- An efficiency programme tracker has been established to track and monitor savings. Reporting against performance and milestones for each workstream will take place monthly through the Improving Together Delivery Group and Improving Together Programme Board. Early detection of failed milestones or KPIs will ensure swift action to put mitigating actions in place and return delayed schemes back to original plan, or a revised and approved new trajectory.

Efficiency Savings Plan on a Page

Efficiency Plan Governance
Quality Impact Assessments

- Maintaining the safety and quality of services alongside the delivery of cost improvement plans (CIPs) is a core requirement of the programme.

- Ultimately the Board must determine how to deploy its resources and is responsible for preparing a plan which is deliverable and not detrimental to the quality of patient care.

- The QIA process follows a three-stage approach:

Stage 1 – QIA Screening Tool: An initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. If all quality measures have a low impact score the initial assessment can be approved and no further action is required

Stage 2 – Full QIA: Where there is moderate or higher potential impact on quality in any area a full QIA must be completed and considered against six domains:

    (a) safe
    (b) effective
    (c) person-centred
    (d) the NHS Scotland Realistic Medicine principles
    (e) the NHS Scotland Climate Emergency and Sustainability Strategy
    (f) the National Plan for Scotland's Islands 2019 and Islands (Scotland) Act 2018

Stage 3 – Review and Approval: Once the QIA has been approved by the Clinical Lead and Executive Sponsor they will be passed to the Clinical Panel for formal review and approval. At this stage they can be either Approved, Recommend Amendments or Rejected.

- No scheme can be moved into implementation without the approval of the QIA clinical panel to ensure patient safety, quality of care and staff well-being are effectively safeguarded.

Monitoring
- The monitoring of the quality impact of the schemes will be maintained throughout the year as part of the general quality performance framework. The impact of schemes will be reviewed bi-annually by the Joint Clinical and Care Governance Committee.

- A final paper will be written by the panel for presentation to the Joint Clinical and Care Governance Committee in June with quarterly updates on the impact of implementation on a quarterly basis.

Efficiency Plan Governance
Resourcing

- NHS Orkney are clear that to deliver the change required in 2025/26 and beyond, dedicated resource will be required both in terms of direct delivery of the cross-cutting operational workstreams and infrastructure support through corporate divisions. Inclusive of the Programme Management Office, a total of 4.2 WTE are being deployed to support direct delivery of this programme. This does not include workstream team resource.

2025/26 Direct Programme Support	WTE
Improvement Team	3.0
Workforce workstream Lead	0.5
Service Level Agreements	0.2
Head of Finance	0.5
Total	**4.2**

Indirect Programme Support	Resource
Operational and Clinical Teams	To develop ideas and drive implementation of workstream opportunities through their respective remits.
Information and Performance	To provide analytical support to validate new schemes and confirm delivery of existing schemes against operational KPI's
People & Culture	To support delivery of workforce redesign, pay controls, skill mix changes
Finance	To provide financial monitoring of the programme
Communications Team	To facilitate communication of the programme to stakeholders

Efficiency Plan Governance

Key risks in 2025/26 and mitigations

- Key risks to each of the work streams have been identified in the individual plans and will be monitored on a regular basis. Mitigating actions are also clearly defined in the plans. The key themes emerging are presented in the table below. These will be monitored and managed by the Improvement Team reporting through the relevant committees up to the Improving Together Programme Board.

ID#	Risk	Mitigation
1.1	There is a risk that NHS Orkney will not realise the £3.8m savings nor achieve £2.5m recurrent savings which could impact financial sustainability and the delivery of the 3-year financial plan.	Monthly Delivery Group and Programme Board will be retained to continue scrutiny and assurance. NHS Orkney Board will continue to seek assurance. The Financial Escalation Board has been stood up with the inaugural meeting scheduled for 30 April with Scottish Government attendance. £2.75m indicative savings have been identified so far. Pipeline schemes totalling £0.75m is being progressed. The Clinical Services Review to conclude end-June and any quick-win opportunities will be implemented pending approval.
1.2	There is a risk that the scale of workforce change required (equivalent to 20WTE this year and circa £1.25m in-year savings) cannot be realised within a 12-month period due to low attrition rates and reliance on medical agency, and that there is a risk that achievement of these targets will destabilise clinical and support service delivery.	Director of People and Culture leading work. Scope of work already agreed. Indicative plan on track to be completed by end of March. Input from executive team and senior leadership team (people meeting) to collectively identify mitigations to under delivery. Bright ideas campaign ongoing to ensure engagement.
1.3	There is a risk that transformational schemes may take longer to develop and implement, with savings not being realised within 2025/26. There is a further risk that the organisation does not have the transformational skill set to a sufficient level to identify and develop opportunities nor the level needed to drive the change required, thereby leading to non-delivery of real transformative benefits.	Limited transformational programmes identified for 2025/26 with a focus on high-value material opportunities. External funding secured to contract independent reviewers to undertake a clinical services review to determine future innovative models of care.

Efficiency Plan Governance

Key risks in 2025/26 and mitigations

- Key risks to each of the work streams have been identified in the individual plans and will be monitored on a regular basis. Mitigating actions are also clearly defined in the plans. The key themes emerging are presented in the table below. These will be monitored and managed by the Improvement Team reporting through the relevant committees up to the Improving Together Programme Board.

ID#	Risk	Mitigation
1.4	There is a risk that limited awareness and engagement among all staff could lead to disengagement from the efficiency programme and hinder successful implementation of change.	Regular programme communications in NHS Orkney comms forums. Included as part of monthly CEO briefings. Engagement through bright ideas programme. Improvement team actively reaching out to all teams across NHSO and IJB.
1.5	There is a risk to the deliverability of the workforce workstream due to the upcoming departure of the Director of People and Culture later this year, which may result in a leadership gap for this critical area of work.	Recruitment for the next Director of People and Culture is due to commence in May 2025 to minimise the gap between postholders. The Director of Performance and Transformation commenced on 12 May 2025 and will have oversight of the Improving Together Programme overall and the Head of People and Culture is on the Improving Together Programme Delivery Group as well as attending the fortnightly huddles.

Next Steps

Continuing our commitment to delivery of the efficiency plan

NHS Orkney is clear this efficiency plan represents a continuation of its journey to enhance quality of care, patient safety and experience and improve overall operational performance. A series of further actions have been identified to move to a sustainable improvement in the Health Boards financial positon.

- Progress at pace the development and implementation of 'pipeline' and 'in development' schemes to at least achieve the Board's efficiency target of £3.8m in-year savings.

- Focus on continued enforcement of existing pay and non-pay controls to manage the organisations wider financial position.

- Final authorisation of the quality impact assessment (QIA) for outstanding schemes and on-going monitoring through the Joint Clinical Care Governance Committee.

- Continue development of the communications and engagement effort including on-going promotion of the Bright Ideas Campaign.

- Receive feedback on this draft plan in readiness for the final plan to be submitted to the Board in June 2025.

- Review and management of risk to take account of the changes reflected in this efficiency plan and the move to clinical and non-clinical transformation.

Key Messages

Our Commitment

- This is a one-year financial efficiency plan to enhance quality of care, patient safety and experience and improve operational performance leading to an improvement in NHS Orkney's financial position. The plan sets out confirmed and indicative savings for 2025-2026 based on work currently underway; and a set of sound and rationale assumptions. A final plan will be presented to Finance and Performance Committee in June and then to the NHS Orkney Board.

- This is an ambitious and realistic plan which, at its heart, is developed with and agreed by clinical, operational and corporate teams across the organisation and with the endorsement of the NHS Orkney Board. Through this plan, the organisation reaffirms it commitment to offering high quality clinical care in line with its 5-year corporate strategy 2024- 2028.

- The Board accepts any return to financial balance requires a mix of driving short-term internal efficiencies (transactional change) and longer-term benefits (transformational change) through a reconfiguration of the local health economy, embracing digital improvements and an optimisation of the current estate. These changes are reliant on working with external partners including Scottish Government and partner health boards to realise sustainable whole system benefits through improved productivity and the adoption of new and innovative ways of working.

- Our staff are key to the delivery of the plan and their collaboration, engagement and buy-in has been a cornerstone of the plan's development. NHS Orkney has a well embedded communications strategy to continue to optimise engagement and a well-embedded governance framework to monitor and assure delivery. These are critical precursors to delivery.

- This plan represents a shift from transaction to transformation as part of the Board's three-year financial plan to move closer towards financial balance.

- The 2024/25 financial plan was to deliver a deficit position of £5.778m which has been achieved, with a draft deficit prior to brokerage support of £3.874m, the improvement in the year end outturn was mainly as a result of additional benefits derived from changes in national funding related to Distance Islands Allowance and Agenda for Change (AfC).

- NHS Orkney will be retained at Level 3 of the NHS Scotland Support and Intervention Framework for 2025/26 and will continue to receive support from Scottish Government as it reaffirms it full commitment to moving towards a financially balanced position in the near to medium term. Our current forecast will see us returning to financial balance in 2028/29.

- NHS Orkney has put in place a well-defined programme structure to monitor, report and assure the 12 workstreams and deliver the associated quality and efficiency benefits set out in the plan.

Corporate Workstream

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Laura-Skaife Knight	Melanie Barnes	N/A	Mareeya Montero	Steven Phillips	Harmony Bourn	Karen Spence

Scheme	Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Sale of King Street	Sale of King Street Old Dental Practice	£0	£0	£0	£0	£0	£0	£0	£0	£176,000	£0	£0	£0	£176,000
	Total	£0	£0	£0	£0	£0	£0	£0	£0	**£176,000**	£0	£0	£0	**£176,000**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
The net benefits from this scheme are lower than expected thereby requiring additional savings to be sought from elsewhere	2	2	4	Green	Valuation report has set £176k as a reasonable sale price.	2
There is a risk that the property may not be sold within the financial year or that the Board may not approve the sale	4	4	16	Red	Ensure the proposal for selling the property is progressed through the Strategic Estates and Property Group and onto the Board for approval at pace. Savings have been phased at M12.	9

Diagnostics

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Dr Anna Lamont	Nick Crohn	Lorna Wilson	Andrew Grassom	Steven Phillips	Harmony Bourn	N/A

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Repatriation of MRI patients and other MRI services	Repatriation of MRI patients, savings on travel / increase of mobile unit on site	£0	£0	£37,400	£37,400	£37,400	£37,400	£37,400	£37,400	£37,400	£37,400	£37,400	£37,400	**£374,000**
Repatriation of Elastography Service	Repatriation of Elastography & Ultrasound	£0	£0	£4,250	£4,250	£4,250	£4,250	£4,250	£4,250	£4,250	£4,250	£4,250	£4,250	**£42,500**
Nurse-led Capsule Sponge Endoscopy Service	Introduce a nurse-led capsule sponge endoscopy service to reduce reliance on medically led OGD service	£0	£0	£11,250	£3,750	£3,750	£3,750	£3,750	£3,750	£3,750	£3,750	£3,750	£3,750	**£45,000**
Expansion of Echocardiogram Service - Echocardiology	Expansion of Echocardiogram service on Orkney	£0	£0	£0	£0	£0	£0	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	**£25,000**
	Total	£0	£0	£52,900	£45,400	£45,400	£45,400	£49,567	£49,567	£49,567	£49,567	£49,567	£49,567	**£486,500**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
MRI Repatriation: ▪ Patient travel spend may increase in 2026/27 as funding may not be allocated from the Scottish Government on a recurring basis.	3	3	9	Amber	Savings will be monitored regularly, and a business case will be considered throughout the year to support the establishment of a permanent on-island service if it proves to be cost-effective.	2
MRI Repatriation: ▪ Patients may expect to receive the MRI scanning service on an ongoing basis and patient expectations therefore need to be managed.	3	3	9	Amber	Comms and engagement will be undertaken to ensure that patients and staff understand the MRI scanning service will be in place for 10 months only during 2025/26.	2

Clinical Services Review – underway to conclude from June 2025

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Dr Anna Lamont	Jennifer Armstrong / Fiona Mackay	Speciality Leads	Bruce Young	N/A	Harmony Bourn	Ryan McLaughlin

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score

Estates

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Laura-Skaife Knight	Alan Scott	Nick Crohn	Mareeya Montero	Steven Phillips	Harmony Bourn	James Robertson

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Fleet Cars Review	Review of Leased / Owned Vehicles, incl. usage, servicing & vehicle recalls for all primary & secondary care cars	£0	£0	£2,500	£0	£0	£2,500	£0	£0	£5,000	£0	£0	£0	**£10,000**
Waste Collection	Charge external providers/private companies for waste collection	£0	£0	£1,500	£0	£0	£1,500	£0	£0	£1,500	£0	£0	£1,500	**£6,000**
Grass cutting (grounds and garden)	Cease the grass cutting external contract for the Balfour. Porters to take on grass cutting duties	£0	£5,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£5,000**
Primary Care Equipment Maintenance SLA	Charge primary care GP practices for equipment maintenance. Skerryvore Practice to be piloted first	£0	£0	£0	£0	£0	£1,000	£0	£0	£0	£0	£0	£0	**£1,000**
Invest in Engineer Training (To be compliant with SHTM0101)	Invest in Engineer Training (To be compliant with SHTM0101)	£0	£0	£0	£0	£0	£12,000	£0	£0	£0	£0	£0	£0	**£12,000**
Total		£0	£5,000	£4,000	£0	£0	£17,000	£0	£0	£6,500	£0	£0	£1,500	**£34,000**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
Fleet Cars Review: There is a risk that the surplus vehicles may not be sold or may be sold at a lower price than anticipated, which could impact the savings target.	2	3	**6**	Green	The first list of vehicles for sale were advertise on 02 May, with the second scheduled to be advertised by the end of May. Advertising these vehicles early in the financial year will increase the chances of sale.	2
Staffing constraints and recruitment delays due to recent staff departures may impact the deliverability of investing in engineer training and regular maintenance of the SLA equipment.	3	4	**12**	Amber	The vacant posts are currently undergoing job evaluation, with the aim of advertising them by M04.	6

Facilities

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Laura-Skaife Knight	Sharon Keyes	Sarah Walker	Mareeya Montero	Steven Phillips	Lauren Johnstone	James Robertson

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Electric Vehicle Charges Review - Income	Generate income from the public car charging points	£0	£0	£0	£667	£667	£667	£667	£667	£667	£667	£667	£667	**£6,000**
Internal Staffing Review (Backfill of Facilities Support Officer)	Internal Staffing Review (Backfill of Facilities Support Officer)	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	£2,593	**£31,119**
Catering Food Increase 5%	Increase canteen food prices by 5%	£0	£0	£1,100	£1,100	£1,100	£1,100	£1,100	£1,100	£1,100	£1,100	£1,100	£1,100	**£11,000**
	Total	**£2,593**	**£2,593**	**£3,693**	**£4,360**	**£4,360**	**£4,360**	**£4,360**	**£4,360**	**£4,360**	**£4,360**	**£4,360**	**£4,360**	**£48,119**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
The savings from the electric vehicle will be less than expected if the assumptions in the business case around usage are higher than actuals	2	3	6	Amber	Monitoring of savings will occur from implementation.	4
Internal staffing review determines resource must be re-instated to maintain core service delivery resulting in savings not being realised	2	3	6	Amber	Minimal risk as modelling of workforce has taken place. Management confident in ability to deliver core functions.	4

Medical Recruitment

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Dr Anna Lamont	Dr Anna Lamont	Speciality Leads	Andrew Grassom	Hannah Kerr	Lauren Johnstone	N/A

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Renegotiated Medical Rates	Renegotiating medical rates for agency doctors	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	**£23,400**
Sustainable Medical Model and Agency Reduction & Recruitment (Recruitment to 1WTE current agency post)	Move towards a more sustainable medical model by recruitment substantive staff and replacing agency	£0	£0	£0	£0	£0	£0	£20,833	£20,833	£20,833	£20,833	£20,833	£20,833	**£125,000**
Sustainable Medical Model and Agency Reduction & Recruitment (Recruitment to 1WTE current agency post)	Move towards a more sustainable medical model by recruitment substantive staff and replacing agency	£0	£0	£0	£0	£0	£0	£20,833	£20,833	£20,833	£20,833	£20,833	£20,833	**£125,000**
	Total	£1,950	£1,950	£1,950	£1,950	£1,950	£1,950	£43,617	£43,617	£43,617	£43,617	£43,616	£43,616	£273,400

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
There is a risk that we will not be able to successfully recruit to the posts advertised in March and that we will not be able to meet the recruitment trajectories set thereby delaying the savings set out from this scheme and continuing our reliance on high-cost agency.	3	3	9	Amber	Strengthened recruitment efforts. Retain current agency solution to secure service delivery.	6
Additional vacancies occur resulting in an increase in overall medical expenditure.	2	3	6	Amber	Awareness of expected leavers to inform rapid approach to job description and early recruitment efforts	4

Outpatients Productivity – underway to conclude from June 2025

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Dr Anna Lamont	John Daniels	N/A	Andrew Grassom	N/A	Lauren Johnstone	Amanda Manson / Fiona Mackellar

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Increase uptake of Near Me	Increase uptake of Near Me on the outer-isles and in NHS Grampian / Golden Jubilee													
	Total													

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score

Pharmacy

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Dr Anna Lamont	Wendy Lycett	Lyndsay Steel / Russell Mackay	Mareeya Montero	Steven Phillips	Harmony Bourn	N/A

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Polypharmacy Review	Increase number of Polypharmacy reviews to 7 per week for 42 weeks of the year	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	£2,458	**£29,500**
ScriptSwitch	Ensure scriptswitch up-take is maximised and remains above 40% acceptance rate	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	£3,333	**£40,000**
Medicines of low and limited clinical value	Minimise prescribing of MLCV to appropriate indications only and discontinue prescribing of medicines which are deemed to be of no clinical value	£0	£0	£0	£2,500	£2,500	£2,500	£2,500	£2,500	£2,500	£2,500	£2,500	£2,500	**£22,500**
Medicine switch (proprietary to generic) - Abitarone	Procurement of new generic	£0	£0	£0	£778	£778	£778	£778	£778	£778	£778	£778	£778	**£7,000**
Medicine switch (proprietary to generic) - Cytokine Modulators	Proprietary to Generic	£0	£0	£0	£0	£0	£0	£450	£450	£450	£450	£450	£450	**£2,700**
Medicine switch - Immunoglobin and Albumin	National contract switch	£0	£0	£0	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	**£9,000**
Medicine switch - Ustekinumab	Remaining switch to Biosimilar	£0	£0	£0	£833	£833	£833	£833	£833	£833	£833	£833	£833	**£7,500**
Medicine switch - Omalizumab	Switch to Biosimilar	£0	£0	£0	£0	£0	£0	£3,500	£3,500	£3,500	£3,500	£3,500	£3,500	**£21,000**
Total		**£5,792**	**£5,792**	**£5,792**	**£10,903**	**£10,903**	**£10,903**	**£14,853**	**£14,853**	**£14,853**	**£14,853**	**£14,853**	**£14,853**	**£139,200**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
There is a risk associated with Non-recurring funding element of New Medicines Fund continues	2	5	10	Amber	Maintain regular communication and updates with the Scottish Government	4
Recruitment delays resulted in a significant under spend in the staff budget for 2024(25) which off-set medicines costs. These posts are now being filled; While the staff budget for pharmacy will not incur an overspend for 2025(26), the under-spend will not continue into 2025(26)	2	4	8	Amber	Close monitoring of staffing costs and medicines spend will be maintained throughout 2025/26.	4

Procurement

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Melanie Barnes	Kirsty Francis	Various	Mareeya Montero	Steven Phillips	Lauren Johnstone	N/A

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Standardisation and rationalisation of supplies	Standardisation and rationalisation of supplies	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	**£50,000**
Budget Checker	Reducing stock levels by introducing the budget checker in PECOS	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	**£50,000**
No Pay No PO	No PO no Pay savings will be supported through communications from the interim Director of Finance. The communications around this is currently being developed and will be added as a supporting evidence tab to this document when finalised and produced.	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	**£25,000**
Buyers Guide	The Buyers Guide will be informed through advice received from Scottish Government as is current practice.	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	**£25,000**
Review of procurement contracts	The scope of contracts, leases and SLAs are set out in the tabs 'Full contract list'; 'Full leases list' and 'Full SLA list'.	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	**£150,000**
	Total	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£25,000**	**£300,000**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
There is a risk that orders will be approved and the target savings attributed to PECOS will not be achieved due to a sufficient lack of opportunity or scrutiny.	2	2	**4**	**Green**	Strong engagement and well-established team with clear processes in place.	**2**
There is a risk that the savings attributed to contract review is unachievable.	2	2	**4**	**Green**	Buy in from the clinical nurse managers, executive team and budget holders through highlight report risks.	**2**

Social Care & IJB

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Stephen Brown	John Daniels	AHP Leads	Bruce Young	Steven Phillips	Harmony Bourn	N/A

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
IJB Agency Spend Reduction	Replace agency staff with substantive and reduce agency spend	£0	£0	£0	£6,667	£6,667	£6,667	£6,667	£6,667	£6,667	£6,667	£6,667	£6,667	**£60,000**
Allocations and Contributions	Non-recurrent allocations and contributions	£0	£0	£0	£0	£50,000	£0	£0	£0	£0	£0	£0	£0	**£50,000**
Review of Head of Strategic Planning & Performance vacant post	Remove the Head of Strategic Planning & Performance vacant post from the system on a permanent recurring basis	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	£8,735	**£104,821**
Connect Autism		£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	£12,500	**£150,000**
Total		**£21,235**	**£21,235**	**£21,235**	**£27,902**	**£77,902**	**£27,902**	**£27,902**	**£27,902**	**£27,902**	**£27,902**	**£27,902**	**£27,902**	**£364,821**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
The reduction of agency staff for nursing cannot be achieved due to lack of recruitment. Nurse agency spend has been a chronic challenge for the IJB.	3	3	9	Amber	On-going recruitment efforts supported by the People & Culture Team.	6
The savings associated with the Autism contract cannot be realised as the new model cannot be implemented due to recruitment challenges.	3	3	9	Amber	Close monitoring by management. Improved access criteria.	6

Theatre Utilisation – underway to conclude from June 2025

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Dr Anna Lamont	Nancy Faulkner	Ellen Kesterton	Andrew Grassom	N/A	Kyran Taylor	Karen Spence

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score

Workforce

Senior Responsible Officer	Delivery Lead	Clinical Lead	Finance Lead	People Lead	Improvement Lead	Staff Side Rep
Jarrard O'Brien	Steven Phillips	Sam Thomas / Dr Anna Lamont	Mareeya Montero	Steven Phillips	Lauren Johnstone	Ryan McLaughlin

Scheme	Scheme Description	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Sickness absence reduction	Improve long-term sickness absence across the organisation	£0	£0	£0	£0	£0	£33,931	£0	£0	£67,862	£0	£0	£101,793	£203,586
e-Payslips	Implement e-Payslips across the organisation and move away from paper payslips	£0	£0	£0	£333	£333	£333	£333	£333	£333	£333	£333	£333	£3,000
Staff Travel Reduction	Reduce staff travel spend through vacancy control panel	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£4,167	£50,000
Non-medical Agency Reduction - Acute Healthcare Science	Agency reduction savings in Healthcare Science	£0	£0	£0	£0	£8,375	£8,375	£8,375	£8,375	£8,375	£8,375	£8,375	£8,375	£67,000
Non-medical Agency Reduction - Acute Nursing	Agency reduction savings in Acute Nursing	£0	£0	£0	£0	£5,000	£5,000	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£60,000
Excess Hours and Overtime Reduction	Reduce excess hours and overtime through vacancy control panel	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£8,333	£100,000
Vacant post savings	Includes the 10WTE posts identified as part of the Band 7 and above review	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£37,100	£445,194
Total		**£49,600**	**£49,600**	**£49,600**	**£49,933**	**£63,308**	**£97,239**	**£66,641**	**£66,641**	**£134,503**	**£66,641**	**£66,641**	**£168,434**	**£928,780**

Risk Description	Likelihood	Impact	Score	Rating	Mitigations	Residual Score
There is a risk that the scale of workforce change required (equivalent to 20WTE this year and circa £1.25m in-year savings) cannot be realised within a 12-month period due to low attrition rates and reliance on medical agency, and that there is a risk that achievement of these targets will destabilise clinical and support service delivery.	4	4	16	Red	£672k savings already identified for 2025/26 through Band 7 and above vacancy review with 10WTE posts already identified. Band 6 and below review to commence from 01 May. Preliminary work completed on sickness absence. Fortnightly workforce workstream established and being chaired by Director of People & Culture.	10
The removal of posts and changes to workforce lead to the need to review and reinstate some posts to safeguard patient care and staff well-being	3	3	9	Amber	QIA panel to review all post changes. On-going discussions with line managers to understand local impact. Pre-implementation assessment to ensure all risks considered.	6
Agency savings cannot be achieved due to a lack of suitable candidates or a lack of candidates applying.	3	3	9	Amber	People and Culture developing recruitment efforts to support. Nursing recruitment as a good exemplar approach.	6

Glossary

Acronym	Meaning
APF	Area Partnership Forum
AfC	Agenda for Change
CEO	Chief Executive Officer
CIP	Cost Improvement Plan
ESLT	Extended Senior Leadership Team
FY	Full Year
IJB	Integration Joint Board
IPR	Integrated Performance Report
IY	In Year
KPI	Key Performance Indicator
MRI	Magnetic Resonance Imaging
NHS	National Health Service
NHSO	NHS Orkney
PRM	Performance Review Meeting

Acronym	Meaning
QI	Quality Improvement
QIA	Quality Impact Assessment
RAG	Red Amber Green (rating)
RRL	Revenue Resource Limit
SG-FDU	Scottish Government -Financial Delivery Unit
SLT	Senior Leadership Team
WTE	Whole Time Equivalent

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Month 2 Financial Position Update**
Responsible Executive/Non-Executive:	**Melanie Barnes, Interim Director of Finance**
Report Author:	**Melanie Barnes, Interim Director of Finance**

1   Purpose

This is presented to the Committee for:

- Awareness
- Discussion

This report relates to a:

- Annual Operation Plan
- Government policy
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Effective

2.   Report Summary

2.1   Situation

It is important to continue to fully recognise that NHS Orkney remains escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance and to note the related increased scrutiny and risks that come with this status. Following agreement for the Board to accept the Transitional Funding Support offered by the Scottish Government, the Board submitted a financial plan for the 2025/26 financial period which forecast a full year deficit of £2.176m against the Boards revenue resource limit prior to the Transitional Funding limit of £2m for the year.

2.2 Background

At the end of Month 2, the reported financial position is slightly adverse against the financial plan trajectory. Despite this, the Board remains committed to achieving the forecasted £2.176 million deficit in the final version of the financial plan prior to application of the Transitional Funding Support. To do so, it is essential that the Board reduces its expenditure run rate over the remainder of the financial year, aligning with the original plan profile as the efficiency programme continues to develop.

The reported revenue position after 2 months of the 2025/26 reporting period reflects an overspend of **£1.006m,** slightly above the planned year-to-date overspend of £0.996m. This position includes £0.111m of savings delivery that was not anticipated within the financial plan trajectory. As a result, the overall variance is £0.121m adverse to the original plan at month 2.

In the first two months of the 2025/26 financial year, medical staffing costs have increased by £282k compared to the 2024/25 run rate. Medical staffing recruitment remains a high-risk area within the Improvement Programme, but it is also a key focus for cost reduction over the remainder of the year to realign with the financial plan.

Agency spend in nursing has also continued to remain at a higher level than anticipated to month 2. The 2025/26 Improvement Programme includes targeted actions to reduce non-medical agency costs across both nursing and healthcare sciences. These areas will be closely monitored, with plans to reduce reliance on high-cost agency staffing wherever possible.

Primary care prescribing costs have increased in April and May by £130k (accrued) compared to February and March (actuals). Given the volatility of this area, it will be subject to close scrutiny as more up-to-date information becomes available.

The most significant factor affecting the Board's overall financial position at this stage is the unachieved savings target. Addressing this gap must be a key organisational priority to ensure the financial plan outturn is achieved and to meet the conditions of the Transitional Funding Support agreement.

The key points to note:

- The year to date is based on a run rate which includes a high level of vacancies, any recruitment to these posts (that are not currently being backfilled), will place further pressure on the run rate and increase the need for further savings delivery.

- There remain a few known unknowns where we have no alternative but to use best estimates at this time i.e.
  - Activity volumes delivered through the SLA's with NHS Grampian and Highland and any potential uplift on SLA that may result in a further cost pressure.
  - Agenda for change reform funding and the potential number of band 5 to 6 review submissions, it is possible that the anticipated funding in 2025/26 will not cover the full liability as claims progress.

Volatility across many pay and non pay expenditure headings and reliance run rate reductions over Q2 to Q4 in order to deliver the financial plan outturn.

Full Year Forecast

There are a number of risks which may affect the year end outturn position. At month 2 we have provided a range of potential outcomes that will continue to be worked through as more information becomes available.

To date we are aware of a reduction in an anticipated allocation of £39k from the Scottish Government for 2025/26, the likely case forecast has been updated to take account of this, the Board will therefore be required to identify additional saving schemes of £215k in order to deliver a break even position at the end of 2025/26.

The worst case scenario is adjusted for potential increased cost pressures that were not identified during financial planning and a reduction in the savings delivery for the year, if this outturn was to occur, the Board would not meet the conditions of the transitional funding support and would result in a significant overspend position for the financial year.

Forecast Summary	Financial Plan	Updated Forecast at Month 2		
		Best Case	**Likely Case**	**Worst Case**
	£'000	£'000	£'000	£'000
Brought Foreward Deficit Including B/F non recurring savings	5,060	5,060	5,060	5,060
Funding Uplift	-2,181	-2,181	-2,142	-2,000
Pressures – Pay	1,400	1,400	1,400	1,540
Pressures – Non Pay	3,457	3,457	3,457	3,803
Any Emerging Pressures	1,309	1,309	1,309	1,500
Any New Funding	-3,269	-3,269	-3,269	-3,269
Net Gap	5,776	5,776	5,815	6,634
CIPs - Recurring	-2,800	-2,800	-2,800	-2,700
CIPs – Non Recurring	-1,000	-1,176	-1,000	-700
Service Development Commitments	200	200	200	200
25/26 Out-Turn	2,176	2,000	2,215	3,434
Transitional Funding	-2,000	-2,000	-2,000	0
2025/26 Out-Turn	176	0	215	3,434

List of appendices

The following appendix is included with this report:

- **Appendix 1** - NHS Orkney Month 2 Financial Position

NHS Orkney

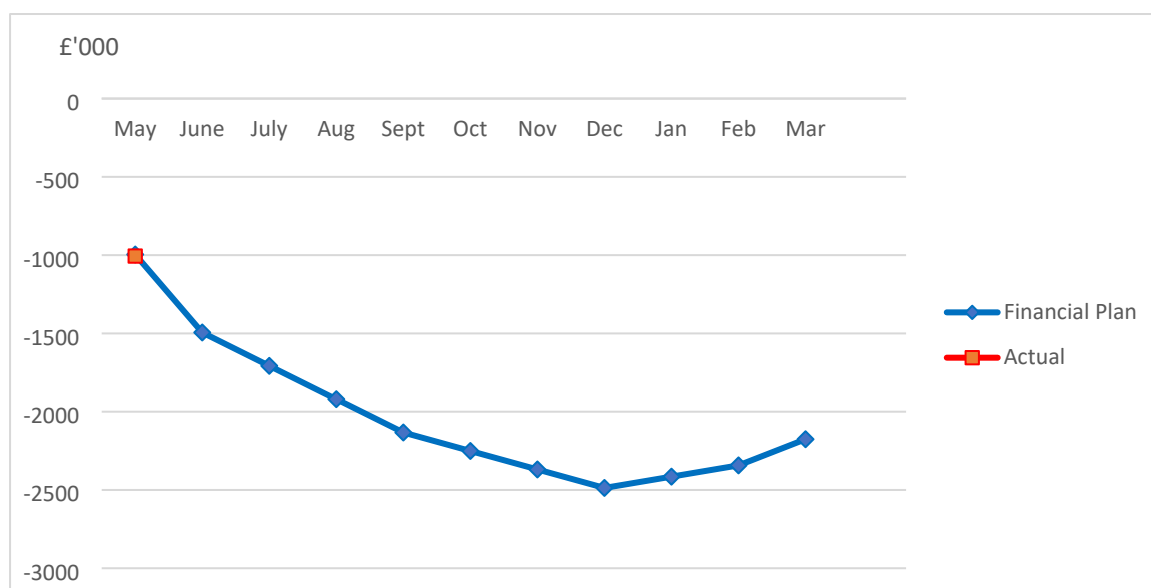**Financial Position – Month 02 2025/26**

Introduction

NHS Orkney remains escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance. The Board has submitted its financial plan for 2025/26, projecting a full-year deficit of £2.176 million against its revenue resource limit, prior to the application of £2 million in Transitional Funding Support agreed with the Scottish Government.

At the end of Month 2, the reported financial position is slightly adverse against the financial plan trajectory. Despite this, the Board remains committed to achieving the forecasted £2.176 million deficit in the final version of the financial plan prior to application of the Transitional Funding Support. To do so, it is essential that the Board reduces its expenditure run rate over the remainder of the financial year, aligning with the original plan profile as the efficiency programme continues to develop.

Year to Date Financial Position

The reported revenue position after 2 months of the 2025/26 reporting period reflects an overspend of **£1.006m,** slightly above the planned year-to-date overspend of £0.996m. This position includes £0.111m of savings delivery that was not anticipated within the financial plan trajectory. As a result, the overall variance is £0.121m adverse to the original plan at month 2. Graph 1 illustrates the financial plan trajectory compared to the actual monthly results after two months of the 2025/26 financial year.

Graph 1: Year to Date Run Rate vs Planned Run Rate

In the first two months of the 2025/26 financial year, medical staffing costs have increased by £282k compared to the 2024/25 run rate. Medical staffing recruitment remains a high-risk area within the Improvement Programme, but it is also a key focus for cost reduction over the remainder of the year to realign with the financial plan.

Agency spend in nursing has also continued to remain at a higher level than anticipated to month 2. The 2025/26 Improvement Programme includes targeted actions to reduce non-medical agency costs across both nursing and healthcare sciences. These areas will be closely monitored, with plans to reduce reliance on high-cost agency staffing wherever possible.

Primary care prescribing costs have increased in April and May by £130k (accrued) compared to February and March (actuals). Given the volatility of this area, it will be subject to close scrutiny as more up-to-date information becomes available.

There are a number of underspends across the Board at Month 2, largely driven by current vacancies. However, as recruitment progresses throughout the year, this will place additional pressure on the run rate and increase the need for further savings delivery.

The most significant factor affecting the Board's overall financial position at this stage is the unachieved savings target. Addressing this gap must be a key organisational priority to ensure the financial plan outturn is achieved and to meet the conditions of the Transitional Funding Support agreement.

The budget setting exercise for 2025/26 has taken place. Several previously identified cost pressures are now funded, which has resulted in an increase to the Board's overall unachieved savings target. While some areas continue to experience over or under-spending, the breakdown by directorate is summarised in the table below and further detail provided later in the report**.**

Area	Variance	Reason
Nursing and Acute Services	£0.551m	Supplementary staffing including nursing and medical agency and high cost locums.
Unachieved Savings Target (Including IJB)	£1.879m	Savings includes the amount required to break even as well as the £3.5m of actual anticipated savings in 25/26.
Estates and Facilities	£0.111m	Various over and underspending areas within Estates and Facilities, the overall underspend is mainly due to vacancies across the directorate, in particular Domestics and Catering posts.

Medical Director	£0.187m	Pharmacy is currently underspending, a number of vacancies in the directorate are impacting the underspend position. Patient travel is currently overspending which is reducing the overall underspend position.
Director of Human Resources	£0.096m	Carrying a number of vacancies with recruitment costs and relocation costs being low in the first two months.
Chief Executive	£0.141m	Vacancies across a number of services and IT service contract spend low in first two months.
Public Health	£0.035m	Vacancies in Health Improvement Services are impacting the month 2 position
Reserves	£0.779m	This includes unallocated reserves from anticipated funding for 2025/26
Integration Joint Board (operational areas)	£0.063m	Vacancies across a number of services has resulted in lower exp
Finance	£0.005m	
Performance & Transformation	£0.007m	
Total Month 02 overspend	**£1.006m**	

Directorate Overview: Month 2 Financial Position

The directorate overview at month 2 is summarised in the below table, with further detail provided.

	Annual Budget	Budget YTD	Spend YTD	Variance YTD
Core RRL	**£000**	**£000**	**£000**	**£000**
Nursing & Acute Services	19,040	3,173	3,724	(551)
Medical Director	19,465	3,244	3,057	187
Integration Joint Board	33,769	5,628	5,565	63
Finance Directorate	1,035	172	168	5
Estates, Facilities & NPD Contracts	10,486	1,748	1,636	111
Chief Executive	4,893	920	779	141
Public Health	1,230	205	170	35
Director of Human Resources	1,753	292	196	96
Performance and Transformation	1,711	285	278	7
Reserves	5,990	998	220	778
Savings Targets (Board)	**(8,872)**	**(1,479)**	**0**	**(1,479)**
Savings Achieved (Board)	**0**	**0**	**0**	**0**
Savings Targets (IJB)	**(2,400)**	**(400)**	**0**	**(400)**
Savings Achieved (IJB)	*0*	*0*	*0*	*0*

Total Core RRL	**88,100**	**14,787**	**15,793**	**(1,006)**
Non Cash Limited				
Dental NCL	767	115	115	(0)
Ophthalmic Services NCL	316	61	61	(0)
Dental and Pharmacy NCL - IJB	907	153	153	(0)
Total Non Cash Ltd	**1,989**	**329**	**329**	**(0)**
Non-Core				
Capital Grants	0	0	0	0
Non-cash Del	0	0	0	0
Annually Managed Expenditure	(0)	0	0	0
Donated Assets Income	0	0	0	0
Capital Charges	3,383	503	503	(0)
Total Non-Core	**3,383**	**503**	**503**	**(0)**
Total for Board	**93,472**	**15,620**	**16,625**	**(1,006)**

Nursing and Acute Services - £0.551m overspend

- *Hospital Medical Staff, £0.596m overspend*

Spend within Hospital Medical Staffing remains high, in the main this is due to locum and agency spend to cover vacant posts in anaesthesia, obstetrics, medicine and surgery. This remains an area of focus for the Improvement team.

- *Ambulatory Nurse Manager, £0.010m overspend*

Small underspends in Dialysis and Theatres are offset by OPD which is currently overspent by £11k, this is in the main due to unregistered bank usage and band 6 bank usage.

- *Clinical Nurse Manager, £22k overspend*

Inpatients 1 (£69k overspend), Inpatients 2 (£19k overspend), Macmillan Specialist Nursing (£32k overspend) are all reporting overspends at month 2 which are being offset by underspends in HDU (£49k underspend), the Emergency Department (£29k underspend) and Macmillan Inpatient (£28k underspend). Agency nursing continues to be utilised in Inpatients 1 and Inpatients 2. It was anticipated that the additional agency workers contracted in Q4 of 2024/25 would be removed in Q1 however, we have seen continued increased spend in the first two months of this financial year.

- *Laboratories, £34k underspend*

Laboratories are reporting an overspend at month 2 due non-pay costs being down, this is offset slightly by an overspend in pays due to agency usage to cover current vacancies.

Medical Director - £0.187m underspend

- *Pharmacy, £190k underspend*

Acute drugs and New Medicines are currently underspent at month 2. Pharmacy are also carrying a number of vacancies which are impacting their overall position for 2025/26.

- *External Commissioning, £24k overspend*

External Commissioning including SLAs and visiting specialist has a combination of over and underspending areas. The Grampian Acute Services SLA is the largest single element within the commissioning budget at £6.7m.

- *Unplanned Activity £58k overspend*

Unplanned Activity is overspent to month 2 but it's variable by nature and is subject to significant potential movement throughout the year and at year end.

- *Patient Travel, £42k overspend*

Patient travel out with Orkney continues to overspend, spend relating to patients travelling to Aberdeen is showing the highest overspend of £40k at month 2.

IJB – Delegated Services - £0.337m overspend

The Delegated Services budgets report a net overspend of £0.337m (including £0.400m of unachieved savings and £0.063m operational underspend).

- *Children's Services, £11k underspend*

The underspend in Children's services is in the main related to vacancies in Health Visiting and School Nurses.

- *Primary Care, £14k underspend*

Primary Care General Medical Services is currently overspending (£100k overspend at month 2) due in the main to locum and agency spend within this area. There are offsetting underspends in Primary Care Administration (£18k underspend), Community Nurses (£67k) and Specialist Nurses (£17k underspend).

- *Primary Care – Dental £15k underspend*

The dental underspends relate in the main to Senior Dental and Dental Nursing, the underspend is reduced due to locum cover charges to month 2.

- *Health and Community Care, £43k underspend*

Mental Health Services are reporting a small underspend of £8k at month 2, this in the main is due to vacancies within this area. There are also underspends within the Health and Community Care Management Team (£23k underspend and Intermediate Care Team (£13k underspend).

- *Primary Care Prescribing, £30k overspend*

The Prescribing Unified budget is currently showing an overspend of £54k. This volatile cost area will continue to be closely monitored along with the accrual assumptions which are based on payments made 2-months in arrears. Vaccination and Immunisation budget is currently underspent by £23k at month 2).

Finance Directorate - £0.005m underspend

The Finance Directorate is currently reporting an underspend of £0.005m, with spend broadly in line with the plan at month 2.

Estates and Facilities - £0.111m underspend

The directorate is reporting an underspend of £111k to date, in the main, the underspend is as a result of vacancies across a number of services and underspending non pay budgets in property maintenance and switchboard - IT.

Chief Executive - £0.141m underspend

There are a number of vacancies across the directorate impacting the month 2 position. Non-pay budgets in IT are currently underspending further impacting the year-to-date position.

Public Health - £0.035m underspend

Currently reporting an underspend of £36k. There are various over and underspending services in this area.

Human Resources - £0.096m underspend

There are a number of underspending areas within the Directorate impacting on the overall underspend, this includes vacancies across a number of areas. With spend on recruitment and relocation expenses being underspent at month 2.

Key Costs - Spend

Pay

High-cost agency continue to be a significant area of concern for the Board, with some reductions being seen in 2024/25 and into 2025/26 in AHPs and Healthcare Sciences, Nursing and Senior Medical continue to rely on high cost agency:

Registered Nursing Agency
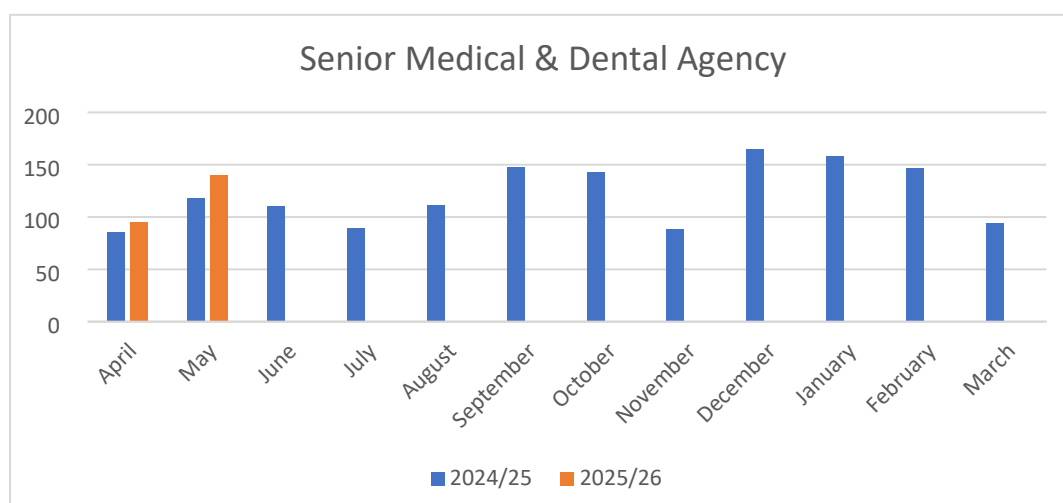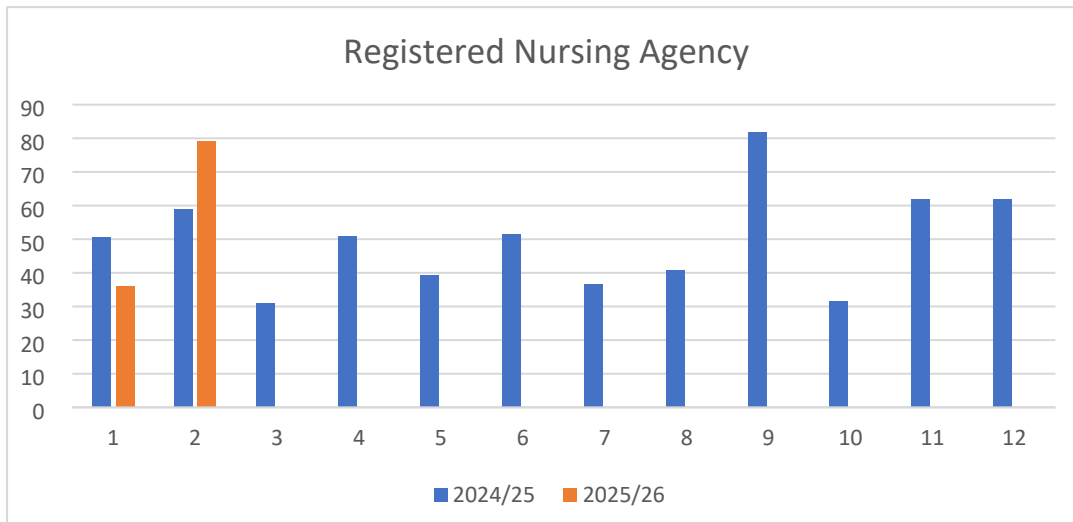
Non-Pay

There are a number of high spending non-pay areas that are monitored through the Improvement Programme for 2025/26 with targeted work via the Procurement, Diagnostics, Outpatient and Pharmacy Workstreams. To month 2 there have been some small reductions in spend across Acute Drugs, Travel (including patient travel) and clinical supplies. The financial plan trajectory anticipates significant reductions in spend in non-pay areas in the final half of the year. These will continue to be closely monitored with deviations identified and corrective action taken as early as possible.

Acute - Drugs

Travel - Including Patient Travel

Legend: 2024/25, 2025/26

Clinical Supplies

Legend: 2024/25, 2025/26
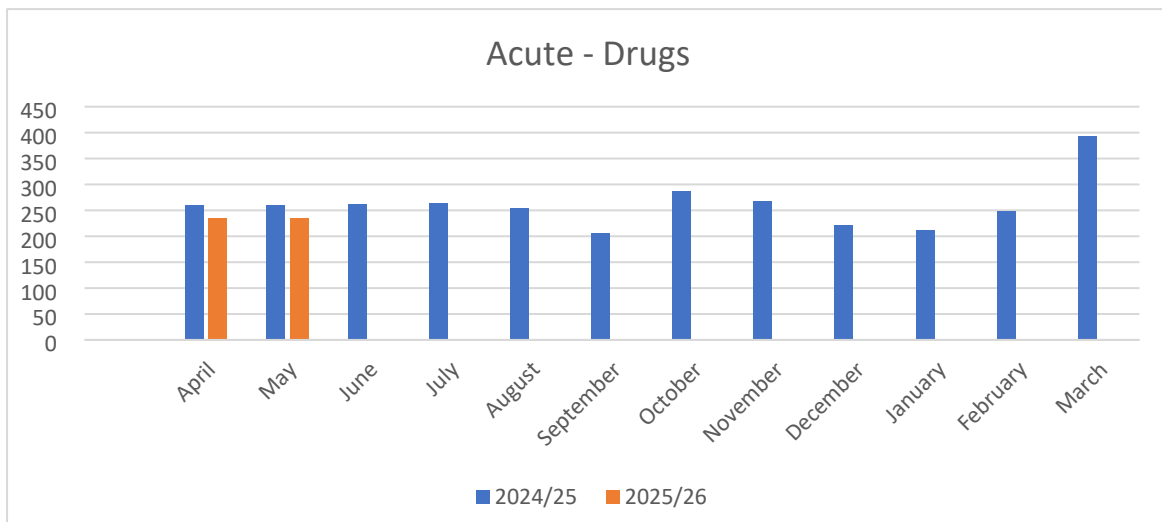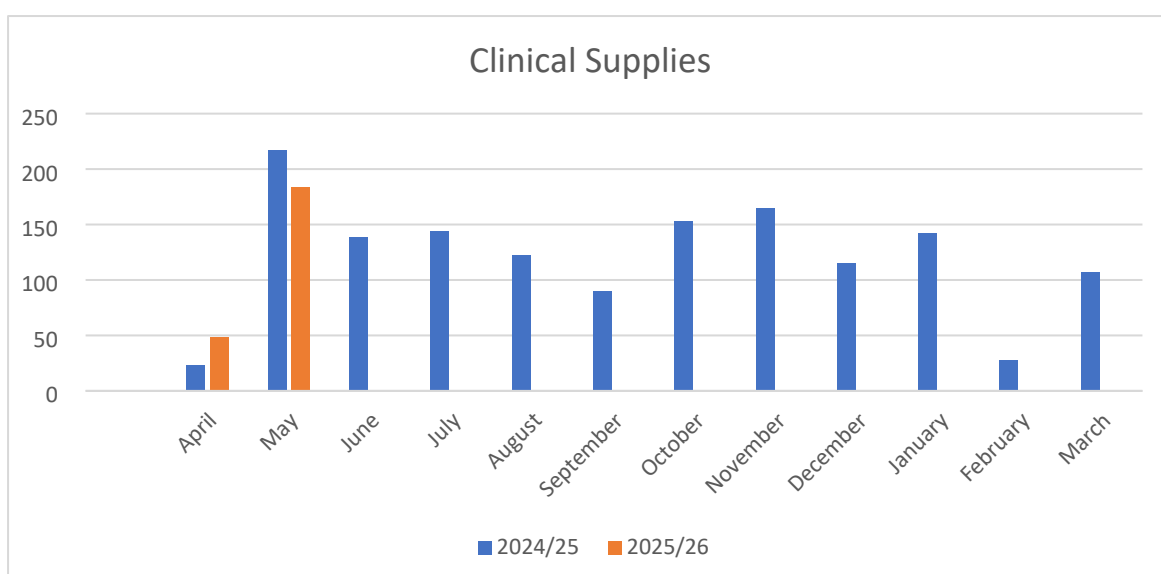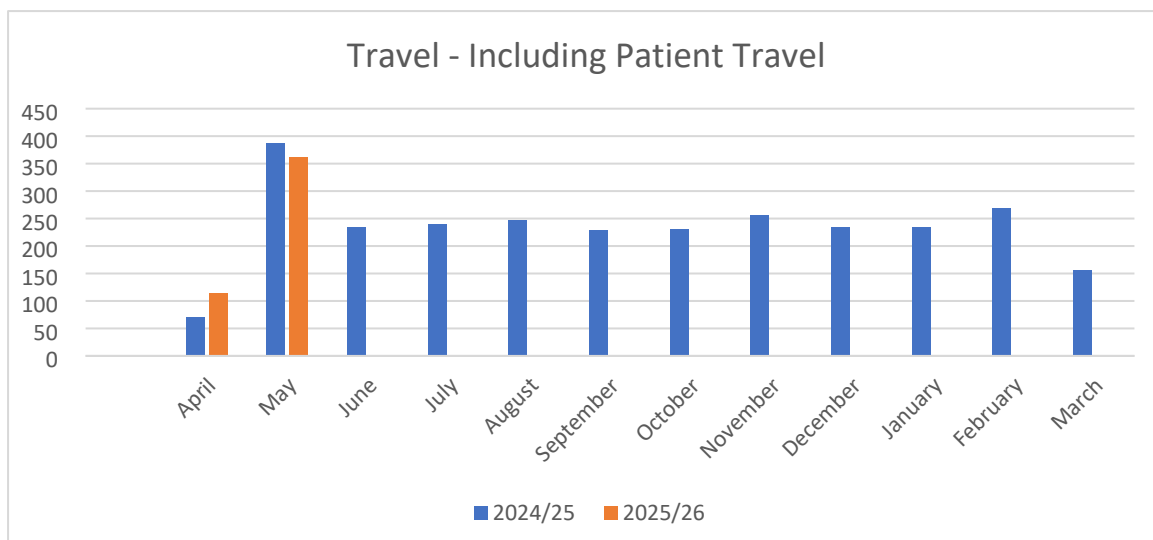
Improvement Programme

NHS Orkney has an integrated improvement function which is responsible for driving savings within the organisation. £3.800m of savings are required to be achieved during 2025/26 to deliver the £2.176m deficit plan (before Transitional Funding Support £2m).

The Board has achieved £0.111m after 2 months to 31 May 2025, with the current programmes in implementation forecast to deliver £3.4m with an additional pipeline schemes being scoped and progressed to implementation stage. Of the £3.4m identified schemes £2.7m have been classified as recurring. A status update is provided for each scheme below:

Efficiency Scheme	In-Year Savings Plan (£)	YTD Actual Savings (£)	In-year Forecast Savings (£)	Progress Update
Sale of King Street	£176,000	£0	£176,000	**Under review with savings planned at M12.** Scheme is under review. £176k relates to sale of property.
Expansion of Echocardiogram Service	£25,000	£0	£25,000	**On track with savings phased from M07.** POAP/QIA in draft. Echo physiologist is in post and agency will be phased out once physiologist is fully trained.
Repatriation of MRI Service	£374,000	£0	£374,000	**On track with savings phased from M04.** Scanner successfully calibrated and protocols established. Initial delays due to support and staffing, with scans due to be scheduled by the end of June.
Repatriation of Elastography Service	£42,500	£0	£42,500	**On track with savings phased from M03.** Software has been installed to scanning equipment, and staff training is scheduled for w/c 16 June, with scans to commence following training.
GP-led Capsule Sponge Endoscopy Service	£36,450	£0	£36,450	**On track with savings phased from M04 although dependent on approval at GP Sub-committee in July.** Pilot training clinics commenced with staff trained. Discussions ongoing around scheduling clinics with consultant oversight until GP-led service is in place.
Fleet Cars Review	£15,000	£11,614	£15,000	**On track with savings phased from M02 and partially delivered.** First batch of cars sold and second batch advertised.
Clinical Waste Collection	£6,000	£0	£6,000	**On track with savings expected from M04.** Individual SLAs developed and will be issued to private providers once Finance confirm SLA uplift.
Primary Care Equipment Maintenance SLA	£1,000	£0	£1,000	**On track with savings expected from M04.** SLA has been signed and finalised.
Invest in Engineer Training (To be compliant with SHTM0101)	£12,000	£0	£12,000	**Progress dependent on recruitment with savings expected from M08.** Scheme is dependent on recruitment, with posts currently awaiting job evaluation with savings expected from M08 subject to successful recruitment and availability of training funding.
Repatriate Water Risk Assessment In-house	£4,520	£0	£4,520	**POAP/QIA to be drafted.** Training scheduled for September to enable water risk assessments to be undertaken internally with savings expected at M08.

Electric Vehicle Charges Review	£6,000	£0	£6,000	**POAP/QIA to be developed following further scoping.** Savings phased from M04 but more likely to materialise from M07, subject to meter installation and approvals via Strategic Estates & Property Group and Area Partnership Forum.
Internal Staffing Review (Backfill of NPD Contract Administrator)	£31,119	£4,534	£31,119	**Net benefit currently being realised through vacancy underspend.** Scheme was initially proposed as a savings scheme. However, a vacancy request has since been submitted to VCP, with the outcome pending.
Catering Food Increase 5%	£11,000	£0	£11,000	**POAP/QIA in progress, pending finance confirmation of proposed uplift.** Savings phased from M03 but more likely to materialise in M06, subject to approval at the Area Partnership Forum in July.
Taxi Usage (Grip and Control)	£2,400	£0	£2,400	**Full data analysis being undertaken with potential for savings to increase.**
Sustainable Medical Model (Recruit to 1WTE current agency)	£125,000	£0	£125,000	**Off track – savings phased from M07, but may be delayed due to unsuccessful appointments in the last recruitment round.** Obs & Gynae consultant appointed with estimated start date of September.
Sustainable Medical Model (Recruit to 1WTE current agency)	£125,000	£0	£125,000	**Off track – savings phased from M07, but may be delayed due to unsuccessful appointments in the last recruitment round.** Posts have been re-advertised for anaesthetists, with medical and surgical re-advertisements to follow
Near-Me Virtual Appointments	£200,000	£0	£106,662	**POAP/QIA in progress and awaiting financial validation, with estimated savings from M07.** Savings were initially projected at £200k, but due to implementation timing and phasing from M07, in-year savings are now estimated at £106k
Withdrawal of liquid nitrogen services	£800	£0	£800	**POAP/QIA to be drafted.** Recently identified pipeline scheme.
PolyPharmacy Review	£29,500	£0	£29,500	**On track, with savings phased from M01.** Reporting delayed due to the pharmacy system's quarterly reporting cycle
ScriptSwitch	£40,000	£0	£40,000	**On track, with savings phased from M01.** Reporting delayed due to the pharmacy system's quarterly reporting cycle
Medicines of low and limited clinical value	£22,500	£0	£22,500	**On track, with savings phased from M04.**
Medicine switch (proprietary to generic) - Abitarone	£7,000	£0	£7,000	**On track, with savings phased from M04.**
Medicine switch (proprietary to generic) - Cytokine Modulators	£2,700	£0	£2,700	**On track, with savings phased from M07.**

Medicine switch (proprietary to generic) - Immunoglobin and Albumin	£9,000	£0	£9,000	**On track, with savings phased from M04.**
Medicine switch (proprietary to generic) - Ustekinumab	£7,500	£0	£7,500	**On track, with savings phased from M04.**
Medicine switch (proprietary to generic) - Omalizumab	£21,000	£0	£21,000	**On track, with savings phased from M07.**
Expansion of community dressings initiative	£25,000	£0	£25,000	**POAP/QIA to be drafted and phasing of savings to be agreed.** This is a recently identified scheme, with implementation delayed until 01 September due to limited Stores support capacity. There is potential to implement sooner if Stores increase capacity or prioritise the scheme.
Standardisation and rationalisation of supplies	£50,000	£0	£50,000	
Budget Checker	£50,000	£0	£50,000	
No PO No Pay	£25,000	£0	£25,000	
Buyers Guide	£25,000	£0	£25,000	
Review of procurement contracts	£150,000	£0	£150,000	
IJB Agency Spend Reduction	£60,000	£0	£60,000	**On track, with savings phased from M04.**
Allocations and Contributions	£50,000	£0	£50,000	**On track, with savings expected from M04.** Non-recurring allocations and contributions have been identified and earmarked as savings.
Review of Head of Strategic Planning & Performance Vacant Post	£104,821	£0	£104,821	**On track, with net benefit realised from vacancy underspend at M01.** Post to be removed following approval at IJB Board in September.
Connect To Autism	£150,000	£25,000	£150,000	**On track, with savings realised from M01.** Autism and ADHD referral assessment have been reduced to a maximum of five per month.
Sickness Absence Reduction	£203,586	£0	£203,586	**On track, with savings phased from M06.** Agreement in place to merge this savings target with the excess, overtime, and bank hours scheme to avoid duplication. A report on sickness absence reduction will be provided to evidence improvements in the targeted areas
e-Payslips	£2,000	£0	£2,000	**POAP/QIA drafted and awaiting financial validaton, with savings phased from M05.**
Staff Travel Reduction	£50,000	£0	£50,000	
Non-medical Agency Reduction - Acute Healthcare Science	£67,000	£0	£67,000	**On track, with savings phased from M05.**
Non-medical Agency Reduction - Acute Nursing	£60,000	£0	£60,000	**On track, with savings phased from M05.**

Excess, Overtime and Bank Hours	£100,000	£0	£100,000	
Vacant Post Review	£445,194	£74,199	£445,194	**On track, with savings delivered from M02 reporting.** Identified posts have been disestablished from budgets, and the Area Partnership Forum was cited on 17 June
Vacancy Control Panel (Band 7+ above review)	£234,448	£0	£234,448	**On track, although savings are dependent on posts becoming vacant.** The Band 7 and above review exercise has been completed, and a process is in place to ensure the Vacancy Control Panel is informed of the exercise's recommendations when posts are submitted.
Vacancy Control Panel (Band 6+ below review)	£250,000	£0	£250,000	The band 6 and below review is at early stages
Total	**£3,435,038**	**£115,347**	**£3,341,700**	

Savings delivery is a key focus, led through the Board's Improving Together Programme, with collaborative working relationships with Scottish Government colleagues, aligned to national improvement programme initiatives including the 15 Box Grid.

Year-End Forecast

There are several risks that could impact the year-end financial position. As of Month 2, we have outlined a range of potential outcomes, which will be refined as more information becomes available.

We are currently aware of a £39k reduction in the anticipated 2025/26 allocation from the Scottish Government. This has been reflected in the updated likely case forecast. As a result, the Board will need to identify additional savings of £215k to achieve a break-even position by the end of the financial year.

In the worst-case scenario, further cost pressures — unaccounted for during initial financial planning — and reduced savings delivery could lead to a significant overspend. Should this occur, the Board would fail to meet the conditions for transitional funding support.

Forecast Summary	Financial Plan	Updated Forecast at Month 2		
		Best Case	**Likely Case**	**Worst Case**
	£'000	£'000	£'000	£'000
Brought Foreward Deficit Including B/F non recurring savings	**5,060**	**5,060**	**5,060**	**5,060**

Funding Uplift	**-2,181**	**-2,181**	**-2,142**	**-2,000**
Pressures – Pay	**1,400**	**1,400**	**1,400**	**1,540**
Pressures – Non Pay	**3,457**	**3,457**	**3,457**	**3,803**
Any Emerging Pressures	**1,309**	**1,309**	**1,309**	**1,500**
Any New Funding	**-3,269**	**-3,269**	**-3,269**	**-3,269**
Net Gap	**5,776**	**5,776**	**5,815**	**6,634**
CIPs - Recurring	**-2,800**	**-2,800**	**-2,800**	**-2,700**
CIPs – Non Recurring	**-1,000**	**-1,176**	**-1,000**	**-700**
Service Development Commitments	**200**	**200**	**200**	**200**
25/26 Out-Turn	**2,176**	**2,000**	**2,215**	**3,434**
Transitional Funding	**-2,000**	**-2,000**	**-2,000**	**0**
2025/26 Out-Turn	**176**	**0**	**215**	**3,434**

Capital

The anticipated Capital formula allocation for 2025/26 is £1.078m, there are a number of earmarked allocations anticipated in year for National Infrastructure Board (£202k), Decontamination (£282k) and Fleet Funding (£4k). Bids for unallocated capital budgets are reviewed and approved through the monthly Capital and Property Strategy Group. There is £613k of unallocated capital funding at the end of month 2.

Capital Projects		Total Approved Budget	YTD Actual	Forecast Remaining Expenditure	Variance	Notes
		£'000	£'000	£'000	£'000	
Formula Capital Projects		265		265	0	Approved Estates Projects 25/26
Earmarked Allocations	NIB Funding	202		202	0	Replacement of medical equipment 25/26
	Decontamination Funding	282		282	0	Replacement of CDU equipment 25/26
	Fleet Funding	4		4	0	Replacement Electric Vehicle Charging points 25/26
Unallocated Budget		813		200	613	£200k for survey works for demolition of the old Balfour
Capital Receipts						
Total		1,566	0	953	613	

Transitional Funding

In April 2024, the Board accepted the offer from the Scottish Government for Transitional Funding Support totalling £5m of additional, non repayable funding from 2025/26 to 2028/29:

2025/26	2026/27	2027/28	2028/29	Total
£2 million	£1.5 million	£1 million	£0.5 million	£5 million

The Board accepted the funding support and a number of key conditions that are required to be met in order to receive the funding, these are:

1. An outturn of under 1% deficit against core RRL must be delivered in 2025/26 (if this condition is not met, this transitional funding arrangement will be removed).

2. Financial balance must be reached by 2028/29 at the latest.

3. The savings programme as detailed in our Financial Plan must be delivered in full across all years.

4. External support funding will be kept under very careful review (aligned to delivery and impact), with a view to this ceasing entirely by 2027/28.

In addition, Scottish Government will require evidence through regular reporting of the impact of our improvement work, including via NHS Orkney's Financial Escalation Board.

Specifically, they expect the following workstreams delivered by 31 March 2026:

5. Workforce reductions of at least 20 WTE in 2025/26 and fully developed plans to further reduce workforce in 2026/27 to a similar level.

6. Evidence of banding reductions where opportunities have presented.

7. The final report from the Clinical Service Review to be presented to Scottish Government in Quarter 3 of 2025/26 outlining the scale of transformation opportunities.

8. Improve productivity and efficiency including increasing Near Me virtual appointments by at least 10% and demonstrating efforts to increase theatre utilisation.

9. Address substantive medical recruitment gaps by reducing the long-standing reliance on locum spend.

Where these conditions are not met, future years' payments will be paused, and further discussions will be held regarding NHS Orkney's position on the NHS Scotland Support and Intervention Framework.

Transitional funding will not be allocated against the year to date position and progress against the conditions will be closely monitored throughout the year.

NHS Scotland Support and Intervention Framework

The Board is required to report the level of cumulative brokerage received from Scottish Government as a proportion of the Boards total revenue resource limit. This is a key assessment criteria moving forward under the NHS Scotland Support and Intervention Framework. The Board received £5.156m of brokerage in the 2023/24 financial year (6.6% relative to the Boards core revenue resource limit (RRL)) and a further £3.874m in the 2024/25 financial year (4.5% of the Boards core RRL).

The total repayable brokerage received by the Board is £9.030m or 10.6% of core RRL. The cumulative position indicates that the Board remains at level 3 of the Support and Intervention Framework as outlined in the table below.

Board Financial Position	Indicative level
10% of core RRL in year brokerage in two consecutive years AND cumulative brokerage of over 25% core RRL	5
6% of core RRL in year brokerage in two consecutive years AND cumulative brokerage of over 15% core RRL	4
4% of core RRL in year brokerage AND cumulative brokerage of over 8% core RRL	3
2% of core RRL in year brokerage OR cumulative brokerage of over 4% core RRL	2
No brokerage or below criteria above	1

The Scottish Government have stated that there will be no brokerage available to Boards in 2025/26. Should financial balance not be achieved, this will be shown as an overspend in the financial statements, leading to potential qualification of accounts.

Conclusion and Next Steps

The year-to-date financial position after the first two months of the 2025/26 financial year shows a slight adverse variance to plan, with a reported deficit of £1.006m compared to the planned deficit of £0.996m. This indicates that corrective action will be needed in the coming months to bring performance back in line with the financial plan.

The Board remains focused on advancing the Improvement Programme and pursuing pipeline opportunities. Targeting areas of high expenditure to reduce the

run rate will be essential to achieving the planned year-end deficit of £2.176m, before Transitional Funding Support.

This report will continue to evolve as we develop new reporting formats aimed at delivering deeper insights.

![NHS Orkney logo]

Financial Escalation Board Chair's Assurance Report

Title of Report:	Chair's Assurance report from the Financial Escalation Board	Date of Meeting: 30 April 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Meghan McEwen, Chair Financial Escalation Board	
Presented By:	Meghan McEwen, Chair Financial Escalation Board	

Purpose
The report summarises the assurances received, approvals, recommendations and decisions made by the Financial Escalation Board at its meeting on the **30 April 2025.**

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
1. No matters of concern or key risks to escalate.	1. Terms of References to be reviewed and brought back to the Financial Escalation Board 28 May 2025 for approval. 2. Deep dives on the Improving Together Workforce Workstream are planned for the Senior Leadership Team (SLT) and Area Partnership Forum (APF).

Positive Assurances to Provide	**Decisions Made**
1. The first meeting of the Financial Escalation Board has taken place 2. This is the first year the Board has made recurring savings. Improving Together Programme, embedding within the organisation and the work undertaken by the Finance team. 3. Budget setting work has resulted in budgets being re-aligned to individuals in posts recognising that this is not the end of the process 4. Excellent engagement in the development of our 2025/26 Improving Together (efficiency) programme 5. Scottish Government will continue to provide support to the Board with our Financial plans and to ensure alignment with the 15-box grid assessment, bench marking against other Boards and sharing of best practice and lessons learned. 6. Opportunities identified for digital savings and efficiencies.	1. No decisions made

Comments on Effectiveness of the Meeting
• Concerns raised regarding the number of apologies received due to a meeting clash with the Integration Joint Board – dates for the rest of the year have been reviewed to avoid this happening in the future.

Financial Escalation Board Chair's Assurance Report

Title of Report:	Chair's Assurance report from the Financial Escalation Board	Date of Meeting: 28 May 2025
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Meghan McEwen, Chair Financial Escalation Board	
Presented By:	Meghan McEwen, Chair Financial Escalation Board	

Purpose
The report summarises the assurances received, approvals, recommendations and decisions made by the Financial Escalation Board at its meeting on the **28 May 2025**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Relative assurance provided on achieving £2 million savings in 2025/26 - cost pressures to brought to the Financial Escalation Board at the earliest opportunity. 2. Capacity and capability within the Improvement Team to support implementation and delivery of the Clinical Services Review recommendations.	1. Terms of References to be updated, with job titles on front cover, Chair of Finance & Performance Committee as Vice-chair and Chief Finance Officer IJB added to Membership. 2. Mitigating actions to be included in the risk section of the Improving Together (efficiency) Programme update to ensure recovery actions are put in place and monitored. 3. Simple tracker and reporting cycle to be put in place to monitor risks of not meeting the Scottish Government Transitional Funding Terms and Conditions. 4. Proposed methodology, process for assessment of Clinical Service Review recommendations to be brought to 25 June 2025 meeting.

Positive Assurances to Provide	Decisions Made
1. Extended Senior Leadership Team are bought into and engaging well with the Improving Together (efficiency) Programme. 2. J Gillespie provided a reflection on the Board compared to 2 years ago, congratulating the Board on progress made to date in relation to financial recovery over the past 2 years	3. Financial Escalation Board Terms of Reference approved with amendments listed above. 4. Financial Plan Addendum showing the impact of the Transitional Funding and our 2024/25 Out-turn approved for onward submission to the Board 26 June 2025.

Comments on Effectiveness of the Meeting
• Members agreed that meetings will be reduced to 1 hour 30 minutes going forward.

NHS Orkney

Financial Escalation Board

Terms of Reference (Approved 28 May 2025)

Version	Action/Amend	Author/Editor	Date
V0.1	Draft Terms of Reference	Interim Director of Finance	05/03/2024
V0.2	Amendments to V0.1	Director of Improvement	05/03/2024
V0.3	Amendments to V0.2	Director of Improvement	05/03/2024
V0.4	Appendix 1 – Meeting dates added for 2025/26	Head of Improvement	14/03/2025
V0.5	Amendments made following Financial Escalation Board 30 April 2025	Head of Improvement	30/04/2025
V0.6	Amendments made following Financial Escalation Board 28 May 2025	Head of Improvement	28/05/2025

Purpose

The Financial Escalation Board has been established to provide Non-Executive and Executive-level oversight, scrutiny, assurance and responsibility for delivery of a financial position for NHS Orkney that is in line or better than the financial year-end deficit position for 2025/26 as agreed with the Scottish Government.

Authority

The Financial Escalation Board has delegated authority from the NHS Orkney Health Board to investigate any activity within its terms of reference.

Governance

The Financial Escalation Board will report into the NHS Orkney Health Board.

Remit

The Board will:

- Provide enhanced oversight of NHS Orkney's financial position monthly.

- To monitor progress and delivery of Scottish Government Transitional funding and provide assurance to the NHS Orkney Health Board via a Chairs Assurance Report.

- Request and receive financial information on all areas of the organisation with a specific focus where expenditure is adverse to plan at service level or similar level of granularity.

- Receive detailed information on key areas of expenditure that present a material opportunity for potential cost reduction, both within NHS Orkney, across the Orkney Health and Social Care system and regionally or nationally. To consider engagement and make a recommendation to Scottish Government for guidance including up to ministerial support.

- Request and receive information on the impact of potential interventions through scenario analysis to determine the impact of said interventions.

- Consider and make determinations on additional interventions to be implemented to curb expenditure or mitigate arising issues.

- Examine actions undertaken by other Health Boards in escalation under the NHS Scotland Support and Intervention Framework to satisfy that all viable cost restrictions are being implemented.

- Receive the outputs of the Clinical Service Review and assess immediate opportunities for financial improvement and transformation.

- Review and consider all guidance from NHS Scotland in relation to the NHS Scotland Support and Intervention Framework and wider financial messaging from Scottish Government.

- Seek assurance that all elements of the national 15-box grid and other published benchmarking data has been implemented or included within the Improving Together Programme forecast.

- Assess the level of risk of opportunities available to this Board and consider the impact on clinical safety, clinical effectiveness and staff.

- Approve communications on any decisions from this Board to the organisation or set delegated authority for this function to an agreed body.

Guiding Principles

The Financial Escalation Board is committed to:

- Working collaboratively with stakeholders
- Ensuring alignment with the Corporate Strategy
- Operating in an open, honest, and transparent manner, consistent with NHS Orkney values
- Delivery that is data driven and evidence-based
- Making decisions that deliver the greatest positive impact to our patients and population

Membership

Core membership of the Financial Escalation Board is as follows:

Name	Job Title	Role
Meghan McEwen	Health Board Chair	Chair
Laura Skaife-Knight	Chief Executive Officer	Member
Jason Taylor	Chair, Audit & Risk Committee	Member
Davie Campbell	Chair, Finance & Performance Committee	Vice Chair
Joanna Kenny	Integration Joint Board Non-Executive Director (Chair from April 2025)	Member
Rona Gold	Chair, Joint Clinical and Care Governance Committee	Member
Tammy Sharp	Director of Performance and Transformation (and Deputy CEO)	Member
Melanie Barnes	Interim Director of Finance	Member
Deborah Langdon	Chief Finance Officer – IJB	Member
Fiona Bennett	Scottish Government Deputy Director Health Finance Directorate	External Advisor
Jay O'Brien	Director of People and Culture	Member
Stephen Brown	Chief Officer Integration Joint Board	Member
Anna Lamont	Medical Director	Member
Sam Thomas	Director of Nursing, Midwifery, AHPs and Chief Officer Acute	Member
Ryan McLaughlin	Employee Director	Member

Invites will be extended by the Chair to additional individuals as and when required for specific agenda items.

Quoracy

Quorum for meetings shall be not less than four full members and must include the following:

- Chair (or Vice-Chair)
- Two non-executive members (including one clinical Executive Director) of the NHS Orkney Health Board

Commented [DC1]: Meghan to review

- Three Executive members of the Board one of whom must be the Chief Executive or Deputy Chief Executive, Director of Finance, and a Clinical Executive Director

If a quorum has not been reached, then the meeting may proceed if those attending agree but no formal decisions may be taken.

Frequency

Meetings will take place monthly. The dates and times are set out in Appendix A.

Meeting arrangements

The Chair will set the agenda. The meeting will be supported administratively by the Corporate Governance Team and will include:

- Co-ordination of meetings
- Collation and dissemination of papers
- Working with the Chair to agree the agenda
- Updating and circulating of the action log and risk register
- Keeping a record of matters arising and issues to be carried forward

Meeting papers will be circulated no later than **five working days** before the scheduled date of the meeting. Papers for the meeting must be submitted to the Corporate Governance Team by 12:00 noon no later than six working days before the scheduled date of the meeting.

All meetings will be summarised in the form of an action Log and a record kept of all reports/documents considered. The action log will be circulated within two working days after each meeting.

Reporting arrangements

This Board will submit minutes and a Chairs Assurance Report into the NHS Orkney Health Board.

Confidentiality

All members are expected to adhere to the NHS Scotland Standards of Business Conduct and Conflicts of Interest Arrangements.

Appendix A: Financial Escalation Board meeting dates and times

Date	Time	Meeting Type
30 April 2025	10.00am – 12pm	Hybrid
28 May 2025	10.00am – 12pm	Hybrid
25 June 2025	10.00am – 12pm	Hybrid
30 July 2025	10.00am – 12pm	Hybrid
27 August 2025	10.00am – 12pm	Hybrid
25 September 2025	10.00am – 12pm	Hybrid
29 October 2025	10.00am – 12pm	Hybrid
26 November 2025	10.00am – 12pm	Hybrid
17 December 2025	10.00am – 12pm	Hybrid
28 January 2026	10.00am – 12pm	Hybrid
25 February 2026	10.00am – 12pm	Hybrid
25 March 2026	10.00am – 12pm	Hybrid

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Respecting our Governance – Changes from 1 October 2025**
Responsible Executive/Non-Executive:	**Laura Skaife-Knight, Chief Executive** **Meghan McEwen, Board Chair**
Report Author:	**Debs Crohn, Head of Improvement**

1   Purpose

This report is presented for: **Decision**. The Board is asked to

- **Discuss** and **approve** the proposed governance changes from 1 October 2025.

This report relates to a:

- Corporate Strategy 2024/28
- Emerging Issue
- Government policy/directive
- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Quality

2   Report summary

2.1   Situation

As set out in the Blueprint for good governance, effective and robust governance is essential in providing high-quality, safe, and sustainable health and social care services. NHS Boards across Scotland continue to operate in an increasingly demanding and complex environment. Regular assessment of the effectiveness of governance arrangements within NHS Boards is a fundamental building block for continuous improvement.

Following the external review commissioned by the Chief Executive, which provided a series of recommendations regarding governance, this report outlines proposed improvements to our governance processes. These steps will build on the success of improvements already made, including the chair's Assurance Reports, the approach to the Integrated Performance Report, and strong relationships within the Board.

The board is asked to **<u>discuss</u>** and **<u>approve</u>** the proposed changes to our governance processes from 1 October 2025.

2.2   Background

NHS Boards are expected to work towards the Blueprint for Good Governance and to regularly assess the effectiveness of their governance arrangements. NHS Orkney has been on Level 3 of the Support and Intervention Framework since October 2023, and the need to focus on transformation and efficiency requires that our governance system to continue to adapt and improve.

The Blueprint for Good Governance states: 'The role of Board members is to provide governance i.e., setting the direction for the organisation and overseeing the delivery of services.' (4.121).

The Blueprint further explains that NHS Board's should develop and implement improvement plans based on external reviews, Board level self-assessment and individual performance reviews (4.205). The recommendations in this paper, and proposed changes are the result of that process including the External Review of Culture, Leadership and Governance which was approved and accepted by The Board in October 2024.

2.3   Assessment

Clear and consistent expectations for all governance committees will ensure we are able to run a joined up, fair, and proportionate governance system that allows Board and committee members the time to discharge their responsibilities as set out in the Blueprint for Good Governance. These guidelines will apply to all governance committees, from October 1, 2025.

As set out in our Corporate Code of Governance, papers must be submitted to the Corporate Governance team 9 days before Board Committee meetings, papers will be published 1 week before meetings take place. Verbal updates should be kept to a minimum. Late papers will not be accepted – papers not received within the timelines outlined above will be recorded on the agenda as 'No paper received'

Proposed changes from 1 October 2025

Updated Governance Committee Cover Sheet

 The Cover Sheet will now include:

- o   Contribution to Strategic Objective
- o   The priorities delegated to each governance committee for assurance on behalf of the Board
- o   Key points for consideration

A model meeting paper template and guidance has been produced (see appendix 1) to ensure consistency across all Committees.

Report Authors will indicate on the cover sheet the purpose of the report as follows:

- **Awareness** – For Members' information (noting) only – papers of this nature should be kept to a minimum.
- **Assurance** – To provide assurance to Committee on progress.
- **Decision** – Reaching a conclusion after the consideration of options and recommendations.
- **Discussion** – To examine and consider the implications as set out in the report

Report authors are required to ensure the title of the report matches that agreed upon by the Committee Chair for inclusion on the agenda.

Executive Directors are required to confirm approval of the report prior to submission to the Corporate Governance Team.

Agenda Setting and Updating

The committee Chair, Lead Executive, and corporate governance team will set the agendas for meetings a week after the committee meeting. Changes to the agenda, including the purpose, format, and structure of papers required, should be discussed with the Committee Chair as soon as possible.

Meeting attendance

Board and committee members are asked to submit apologies at the earliest opportunity to all Board and committee meetings to the Corporate Governance team via email. Executive Board members are asked, wherever possible, to nominate a deputy for Board and governance committee meetings. Non-Executives are asked, wherever possible, to nominate a deputy for governance committees to ensure quoracy, and a good degree of scrutiny can take place in meetings.

Chair's briefings

To ensure our meetings run smoothly and Committee Chairs briefing will be implemented for Board and all Board committees. A template is included at appendix 2 for reference.

The purpose of Chairs briefings is to ensure Committee Chairs are aware of meeting apologies, guest speakers, and the timing and rhythm of their respective committees. Briefings should be light touch and iterated to meet the needs of each committee, whilst also ensuring a degree of consistency across our governance system. These briefings will also support a resilient governance system, should Vice Chairs or deputies be required.

Post Meeting circulation of Chairs Assurance Reports and Actions Logs

Following Committee meetings, the Corporate Governance Team will produce a draft Chair's Assurance Report (appendix 3) and action log for review and approval by the Committee Chair and Vice Chair within 2 days. Committee Chairs are asked to confirm with the Executive Lead that they are content with the CAR and Action Log; these should be returned to the Corporate Governance Team by the Committee Chair/Vice Chair within 5 days.

The Chair's Assurance Reports have been successfully implemented across our governance committee structure. Board members will continue to share learning and suggestions for continually improving how CARs are produced and presented within our governance committees. From October further elaboration and context from committee meetings shall be offered, to allow Board members greater opportunity to triangulate information and context.

The Corporate Governance Team will circulate action logs to action owners once the Committee Chair or vice Chair has approved them. In accordance with the paper deadline, action owners are asked to provide updates to the Corporate Governance Team nine days before the next Committee meeting.

Minutes will be produced by the Corporate Governance Team within 7 working days of Committee Meetings. These should be reviewed and signed off by Committee Chair/Vice Chair and confirmed with Corporate Governance at the earliest opportunity they have been reviewed.

Board Walkaround Standard Operating Procedure

Board walkarounds are one of the many ways we ensure the visibility of Board members and ensure staff across the organisation feel heard. They are an opportunity to listen to teams, for Board members to get to know staff, build relationships, and hear firsthand what staff are proud of and any challenges they face. This enables Board members to offer support in resolving and unblocking issues.

They are also about ensuring feedback is acted on – both the quick wins and the broader themes that emerge from walkarounds, which must feed into our broader staff experience feedback. To support Board Members in conducting Board Workarounds, a draft Standard Operating Procedure is offered for consideration in Appendix 4.

Further Strengthening Assurance Information

The model meeting papers include headings beneath 'Section 2' which enable effective discussion, and for Board members to meet their key requirements within the Blueprint for Good Governance: Setting the Direction, Holding to Account, Assessing Risk, Influencing Culture, Engaging Stakeholders.

From 1 October 2025, paper authors will be asked to pay due care and attention to the headings contained in Section 2 of the model meeting papers. The sections relating to service quality, risk assessment, and equalities are priority areas of scrutiny and assurance for Board members.

A new heading in section 2 has been added, 'Route to the Meeting'. This will show the meetings where information, papers, and reports have been shared and any key information that emerged. This should enable a deeper understanding of the journey of information, the changes that have been proposed and further offer an opportunity for our governance system to demonstrate listening and responding where possible to feedback and challenge.

2.3.1 Quality/ Patient Care

An engaged workforce operating within a culture that promotes psychological safety and staff wellbeing will make better decisions leading to improved outcomes for those receiving our services and their families.

2.3.2 Workforce
There are no direct workforce consequences of this paper. A briefing session will be held for report authors to ensure they are aware of the proposed changes head of implementation.

2.3.3 Financial
There are no direct financial consequences of this paper. Good governance contributes to the efficient and effective use of resources within the Committee's control.

2.3.4 Risk Assessment/Management
Effective governance will ensure we are better placed to identify risks and opportunities and scrutinise proposed mitigating action by management.

2.3.5 Equality and Diversity, including health inequalities
No immediate impacts identified

2.3.6   Climate Change Sustainability
No immediate impacts identified

2.3.7   Other impacts
No immediate impacts identified

2.3.9   Route to the Meeting
A description of the places where a paper, report, or information has been taken along with a summary of the discussions that took place will now be included in our cover papers in section 2.3.9

2.4 Recommendation

The Board is asked to

- **Discuss** and **approve** the proposed governance changes from 1 October 2025,

3.   List of appendices

The following appendices are included with this report:

- **Appendix 1**, Example Updated Committee Cover Page
- **Appendix 2,** Example Committee Chairs Briefing paper
- **Appendix 3**, Example Chairs Assurance Reports
- **Appendix 4,** Board Walkaround Standard Operating Procedure

Joint Clinical and Care Governance (JCCGC) Committee

Our **Values**, aligned to those of NHS Scotland, are:

- Open and honest
- Respect
- Kindness

Our **Strategic Objectives** are:

- **Place** - Be a key partner in leading the delivery of place-based care which improves health outcomes and reduces health inequalities for our community
- **Patient safety, quality and experience -** Consistently deliver safe and high-quality care to our community
- **People -** Ensure NHS Orkney is a great place to work
- **Performance -** Within our budget, ensure our patients receive timely and equitable access to care and services and use our resources effectively
- **Potential** - Ensure innovation, transformation, education and learning are at the forefront of our continuous improvement

Joint Clinical and Care Governance Committee's Purpose

The Joint Clinical and Care Governance Committee (JCCGC) ('the Committee') provides assurance through oversight of NHS Orkney's delegated services delivered by the Integrated Joint Board. The scope of the Committee's oversight fulfils the purposes of:

- the function of the Non-Executive members of NHS Orkney and advisors providing the Board of NHS Orkney with the assurance that robust clinical governance controls and management systems are in place and effective in NHS Orkney, in relation to delegated and non-delegated services it delivers.

- the function of providing the Integration Joint Board with assurance that robust clinical and care governance controls and management systems are in place and effective for the functions that NHS Orkney and Orkney Islands Council have delegated to it.

- MEL (1998)75, MEL (2000)29 and HDL (2001)74 which sets the Boards requirements on the implementation of Clinical Governance in the NHS in Scotland.

> ## Quorum:
>
> Meetings of the Committee will be quorate when at least four members are present and at least two of whom should be Non-Executive Members of NHS Orkney, one of whom must be the Chair or Vice Chair, and two Orkney Island Council voting members of the Integration Joint Board.
>
> Meetings will not take place unless at least one Clinical Executive Director of NHS Orkney and the Chief Social Work Officer, or nominated depute, is present.

Corporate Strategy 2025/26 Strategic Objective	Priorities for 2025/26	What we will deliver in 2025/26	Source of Assurance (examples)
Place	Improve people's physical, mental health and wellbeing by prioritising prevention and early intervention for smoking, obesity, and wellbeing	• Improve our weight management pathways and increase smoking cessation referrals by 5% from 98 in 2023/24 • Launch a new sexual health and bloodborne virus network to drive activity to improve sexual health care, reduce sexually transmitted infections and help achieve viral hepatitis and HIV transmission elimination goals • Introduce the new childhood vaccination schedule with a new routine appointment for children aged 18 months to improve protection from preventable illness	Progress against the Local Outcomes Improvement Plan metrics and progress reports Integrated Performance Report (IPR)
	Progress our ambition to become a Population Health organisation and system by putting prevention and early intervention at the core of what we do	• Work with our partners to implement the new population health framework which will help streamline and co-ordinate system-wide activity • As new models of care are identified prevention will be integrated by embedding referral pathways and social prescribing opportunities to support individuals to improve their health • Contribute to the legacy of the Island Games, including by promoting recruitment opportunities and further improving people's health and wellbeing	Anchor Plan progress updates Integrated Performance Report (IPR)
Patient Safety, Quality and Experience	Launch a new overarching experience programme which includes new behavioural standards to bring our values to life and ensures patient, staff and community feedback drives continuous improvement	• Develop a new approach to how we listen and respond to patient, community and staff feedback to inform service improvements throughout the year	Integrated Performance Report (IPR)

| Performance | Further improve the discharge experience for our patients particularly those living on our ferry-linked isles | • Further reduce complaints related to discharge experience, particularly for patients living on our ferry-linked isles
• Build on the work delivered in 2024/25 to further improve the number of people who are discharged before 12-noon to more than 25%, 7-days a week

• Reduce the number of Delayed Transfers of Care per week to below 6 | Integrated Performance Report (IPR)

Patient complaints |

Appendix 3:

Committee Chairs Briefing: Example

A Committee: October 1, 2025

Meeting Start time: 10:00am

Meeting finish: 12:00pm

*A reminder to feature short breaks every hour

	At the start of all meetings the Chair should:	Running Time
	Ask that all people attending online ensure their camera is on and their microphone is muted. Ask that all people physically attending have Team open on their laptops, their camera is switched on, and that they have selected 'Room Audio' when joining the meeting. Speakers should be muted. All meeting attendees are asked to use the Raise Hand function via Teams A reminder that all meeting chat records are subject to FOI legislation	5 minutes
	Apologies (to be confirmed in the meeting) - Name, role, deputy if named	
	Minutes Presented by Committee Chair for accuracy and approval	
	Matters Arising Presented by Committee Chair by exception	
	Action Log Presented by Lead Executive and items to be updated by exception only. It is expected that updates will take place out with meetings.	
	Corporate Risk Register Presented by Lead Executive	
	Integrated Performance Report	

	Presented by Lead Executive	
	Chairs Assurance Reports	
	Example item *Tim Jones will be joining by link to be invited in by a corporate governance colleague at the request of the chair	15 minutes
	::5 minute break::	

NHS Orkney

JOINT CLINICAL CARE GOVERNANCE COMMITTEE CHAIR'S ASSURANCE REPORT	Date of Meeting	20 February 2025
Board Leads Chair - Rona Gold (Non-executive Director) Vice chair – Issy Grieve (Non-executive Director)	Director of Nursing, Midwifery, AHP and Chief Officer Acute – Sam Thomas, Stephen Brown, Chief Officer Integration Joint Board	
Prepared By:		
Approved By:		
Presented By:		
Corporate Strategy Priorities	• Improve people's physical, mental health and wellbeing by prioritising prevention and early intervention for smoking, obesity and wellbeing • Progress our ambition to become a Population Health organisation and system by putting prevention and early intervention at the core of what we do • Launch a new overarching experience programme which includes new behavioural standards to bring our values to life and ensures patient, staff and community feedback drives continuous improvement • Further improve the discharge experience for our patients particularly those living on our ferry-linked isles	
Purpose	The report summarises assurances received, approvals, recommendations, matters of concerns or key risks and decisions made by the Joint Clinical Care Governance Committee at its meeting on **20 February 2025.**	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. 2.	1. 2.

Positive Assurances to Provide	Decisions Made
1.	1.

Comments on Effectiveness of the Meeting

-

Congruence with our Values - Open, Respect, Kindness

-

1

Board Walkarounds Standard Operating Procedure

Purpose of Board Walkarounds

Board walkarounds are one of the many ways in which we ensure the visibility of Board members and ensure staff across the organisation feel heard. They are an opportunity to listen, for Board members to get to know staff, build relationships and hear firsthand what staff are proud of and any challenges they face to enable Board members to offer support in resolving and unblocking issues.

They are also about ensuring feedback is acted on – both the quick wins and the broader themes that emerge from walkarounds – which must feed into our broader staff experience feedback.

Board walkarounds are undertaken by Executive Directors and Non-Executives visiting different teams and departments across NHS Orkney and listening to how it feels working here. Whilst the majority of Board walkarounds will be face to face in Departments, we recognise that sometimes it may be necessary to undertake conversations virtually, recognising the hybrid nature of our Board given our unique geography.

	Standard Operating Procedure	Responsibility	Timeline
1.	Board member 6-month walkarounds schedule developed including confirmation of department lead contact	Corporate Governance Team	1st April 2025
2.	Meeting invites sent to Departments	Corporate Governance Team	1st April 2025
3.	Board members to identify lead notetaker ahead of the walkaround.	Executive Director/Non-Executive Director	Prior to walkaround
4.	Walkaround takes place following the 'Talk to Us' Walk rounds Information and Guide for Board members (Appendix 1).	Executive Director/Non-Executive Director	NA
5.	At the end of the walkaround, key messages/what Board members have heard should be summarised verbally and shared with the team before the write-up is sent to the Corporate Governance Team	Executive Director/Non-Executive Director	Same day as walkaround

6.	Following the walkaround, a summary email should be sent to the meeting attendee saying, 'thank you'. This should include: • What was heard? (the positives and the areas for improvement/where support is needed) (Appendix 2 – sample of email to send)	Executive Director	Within 2 days of the walkaround
7.	The summary, as agreed by the team, using the template we have agreed (Appendix 3 is a sample of good practice), will be sent to the meeting attendees, Board members who attended, the Executive Director lead for service area and the Team Lead/Head of Service, and cc to the Corporate Governance Team. Via a separate email, the template will be shared with the People and Culture team so this can be built into wider staff experience feedback.	Lead Executive Corporate Governance Team	Within 5 days of the walkaround
8.	The Executive Lead and Team Lead/Head of Service will speak after the walkabout and summary has been shared to agree who will take forward the actions/respond to the feedback received.	Executive Director lead & Team Lead/Head of Service	Within 2 weeks of the walkaround
9.	The Corporate Governance Team will draft the public Board Report for the Chair and CEO summarising the themes from the walkarounds and learning/feedback	Corporate Governance Team	2 weeks before the Board paper deadline

Appendix 1 – 'Talk to Us' Board Walkarounds Information and Guide for Board members.

Teams will be informed at least 2 weeks prior to their Walk rounds and given information to display in their area to inform staff.

Those Board members attending the Walk rounds should take every opportunity to speak to all (or as many as possible) staff colleagues available at the time of the visit.

Helpful to reiterate to the area of visit that the purpose of these visits is not inspection but to be more visible as Board members as this is what the organisations imatter survey is telling us and that as Board members we would find it helpful to gain an insight/deeper understanding into that particular team/area of work.

We should be up for sharing some information about ourselves as Board members (Exec and Non-Executives) why the role, how long we've been in post, areas of interest etc. and that we as a Board are interested in them and what they do.

What we want is to have good conversations, where staff colleagues feel that they are our focus and that we are keen to engage and learn about that particular area – it should be more about the staff on the ground and how it feels. It would be helpful to understand from colleagues the system in which they work in, and any challenges faced as well as providing an important opportunity for sharing success.

Questions		Response
1.	What is going well in your team/service at the moment?	
2.	What are you most proud of working in this area?	
3.	What do you consider to be the main challenges you face on a daily basis?	

	What feedback do people using this service give you? • If you could change one thing, what would it be? • what do you wish you had more time to do?	
4.	How can the Board help? • Is there anything that you would find helpful to raise to the Board?	
5.	What does patient safety look like in your area? (new question added in 2024/25 in Year 2 of our Board walkarounds) • Do you feel confident in reporting incidents or near misses? • Do you get enough feedback when you report incidents/near misses? • Do you feel there is enough support for you if you are involved in a patient safety incident?	
5.	Staff wellbeing: are colleagues aware of support available and have they been able to access that for staff as necessary?	

Appendix 2 – Example summary email to the meeting attendee saying, 'thank you'

Dear Suzanne

On behalf of us both, thank you to you and your team for your time today and for the superb presentations.

Meghan and I enjoyed our time with you all and to learning more about the innovative and exciting improvement work you are leading.

It is clear there is much to be proud of, not least the experience of trainees, 18-week performance, digital developments as evidenced by the Near Me pilot and digital therapies, clinical supervision arrangements, the SLA you have in place with other island Boards, patient outcomes work and the health psychology post – to give just a few examples.

We also heard about the strong relationships you and your team have developed with a range of partners and stakeholders, including Scottish Government as well as the superb work you wanted us to raise with our Board about how remote working in your service has enhanced the digital therapies you can deliver to patients and team working for you all.

Please know we also heard the challenges you described today – including those relating to clinical space, the impact of not having electronic notes and the challenges of working in a small team when it comes to resilience.

We will send a fuller summary of our discussion in the days to come.

For now – thank you for your excellent leadership and to your team for all they do for our patients and communities. It was a pleasure to spend time with you all today (sorry we were not there in person).

Best wishes

Appendix 3 - Board Walkaround reflections

NHS Orkney

Board walkaround reflection
1. What were the strengths highlighted by the people you spoke with? What were you most impressed by?
2, What did you learn about the area/service/people you spoke to?
3. What challenges were highlighted?
4. What 2-3 things do you feel need to be followed up and how will these be taken forward?'

Audit and Risk Committee Minutes 6 May 2025

Attendance

Mel Barnes (Interim Director of Finance), Debs Crohn (Head of Improvement), Suzanne Gray (Senior Financial Accountant), Kat Jenkin (Head of Patient Safety, Quality and Risk), Rashpal Khangura (KPMG), Rachel King (Azets), Dr Anna Lamont (Medical Director), Ryan McLaughlin (Non-Executive Director - Employee Director), Keren Somerville (Head of Finance), Jean Stevenson (Non-Executive Director), Jason Taylor (Chair - Non-Executive Director)

Guests: Iain Gray (Data Protection Officer)

1. ## Cover page

   ### Audit and Risk Committees Purpose

   To support the Board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge

   The Committee will be quorate when there are three members present, one of whom must be the chair or vice-chair.

2. ## Apologies (Presenter: Chair)

   The Chair opened the meeting at 09:30 am and welcomed members to the meeting.

   Apologies received from L Skaife-Knight (Chief Executive Officer).

3. ## Declaration of Interest (Presenter: Chair)

   There were no declarations of interest raised.

4. ## Minute of meeting held on 4 March 2025 (Presenter: Chair)

   The minutes of the Audit and Risk Committee meeting held on 4 March 2025 were approved as an accurate record of the meeting.

5. ## Chairs Assurance Report Audit and Risk Committee 4 March 2025 (Presenter: Chair)

   The Chair's Assurance report of the Audit and Risk Committee meeting held on 4 March 2025 was approved as an accurate record of the meeting.

6. ## Action Log (Presenter: Chair)

   The action log was reviewed, and corrective action agreed on outstanding issues (see action log for details).

7.   **CHAIRS ASSURANCE REPORTS**

8.   **Corporate Risk Register ARC2526-01 (Presenter: Medical Director)**

The Medical Director presented the Corporate Risk Register report providing an overview and update on risk management across NHS Orkney.

There are currently 2 risks aligned to the Audit and Risk Committee.

The Medical Director advised of a change to the presentation of the Risk Register. As actions are now being updated more frequently, the Senior Leadership Team (SLT) have agreed that actions from the previous 6 months will be presented to the Committee so actions can be viewed easily.

The Chair asked that each Committee's requirements are discussed at the Risk Management workshop on the 29 May 2025.

The Head of Patient Safety, Quality and Risk advised that Risk 1211 (Patient waiting times) has been reduced as the target score has been met - risk to be closed at the next SLT meeting.

All risks have been reviewed within the agreed timescales.

The Head of Patient Safety, Quality and Risk advised that we are seeing improvements in relation to completing risk jotters. A test of change in Children's services on managing operational risk is now complete, this has proved successful, the service is now managing operational risks effectively.

J Stevenson asked for confirmation on the mitigation in place for Risk 233 (major incidents) and asked if the major incident test had been undertaken, given the forthcoming Island Games (July). The Medical Director reassured members that the Organisation is in a good position re preparedness for the Island Games.

Decision / Conclusion

The committee reviewed and discussed the risks aligned to the committee and agreed that the committees requirements in relation to the risk register and cover paper should be discussed in the forthcoming risk workshop.

9.   **Risk Management Group Chairs Assurance Report and minutes ARC2526-02 (Presenter: Head of Patient Safety, Quality and Risk)**

The Head of Patient Safety, Quality and Risk presented the Risk Management Group (RMG) Chair's assurance reports from the meetings held on 12 February and 16 April 2025 highlighting:

- **Risk Management Process** - Implementation plan to be presented to the Committee in September 2025 for approval.
- **Serious Adverse Event Review** (SAER's) – Limited capacity to complete SAER's due to lack of reviewers. A risk jotter is being completed and will be brought through our internal governance process.

- **Risk Jotters** - Improvements are being seen across the Organisation in relation to completing risk jotters. A test of change in Children's services on managing operational risk is now complete - the service is now managing operational risks effectively.

J Stevenson asked for clarity on the risk jotter in relation to the absence policy. Head of Patient Safety, Risk Quality and Risk advised that the risk was not sufficient to be able to review and agree what mitigations are required. Risk Owner has been asked to review the risk and to provide further information at the next meeting.

The Chair reminded members where minutes of the Risk Management Group can be accessed.

Decision / Conclusion

The committee welcomed the in-depth discussions held at the Risk Management Group and took assurance from the reports.

10. SLT Chair's Assurance Report ARC2526-03 (Presenter: Chair)

The Chair asked the Committee to note the SLT Chair's Assurance Reports from the meetings held in April and May 2025.

J Stevenson asked for clarity on why the digital maturity risk had been included in the CAR if the risk score has been reduced. The Medical Director advised that it was to ensure the Committee and Board are aware of the change to the scoring, this was not a matter of concern, risk, or escalation.

The Chair reminded members where minutes of the Senior Leadership Team can be accessed.

Decision / Conclusion

The committee welcomed the discussions held at SLT in relation to risk, and took assurance from the reports.

11. Governance Committee Annual Reports 2024/25

11.1. Audit and Risk Committee Annual Report 2024/25 ARC2526-04 (Presenter: Chair)

The Chair presented the Audit and Risk Committee Annual Report 2024/25.

The Interim Director of Finance asked that Brian Stevens (previous Interim Director of Finance) be added to the attendance record for December 2024 and Melanie Barnes (Interim Director of Finance) be added to the March 2025 meeting.

Decision / Conclusion

The committee welcomed and approved the report with the amendment outlined above.

11.2. Committee Annual Reports 2024/25 - ARC2526-05 (Presenter: Chair)

The Chair presented the following Committee Annual Report 2024/25

- Joint Clinical and Care Governance Committee – Annual Report 2024/25
- Finance and Performance Committee Annual Report 2024/25
- Remuneration Committee Annual Report 2024/25
- Staff Governance Committee Annual Report 2024/25
- Senior Leadership Team (SLT) Annual Report 2024/25
- Area Clinical Forum (ACF) Annual Report 2024/25

The chair asked that internal audit planning be added to the Senior Leadership Team Terms of reference for clarity.

The Medical Director advised that whilst there is no Area Medical Committee (AMC) as outlined in the Area Clinical Forum, there are other mechanisms used by clinicians to feed into our Clinical Governance processes.

Decision / Conclusion

The committee welcomed and took assurance on performance as part of the Boards Annual Report 2024/25.

12. PLACE - No items at this meeting

No papers presented at this meeting.

13. PEOPLE

13.1. Statutory and Mandatory Training Requirements for Non-Executives ARC2526-06 (Presenter: Board Chair)

The Head of Improvement presented a proposal from the Board Chair to reduce statutory/mandatory training for Non-executive Directors in line with best practice from other Boards.

J Stevenson and the Employee Director asked that Violence and Aggression be included in the statutory and mandatory training.

Head of Patient Safety, Quality and Risk asked if risk management should be included in the training - the Chair confirmed that the training being proposed is for statutory/mandatory training - risk management will be picked up as a Board Development Session on the 29 May 2025.

Decision/Conclusion

Members approved the proposal for statutory and mandatory training for Non-Executive Directors with the inclusion of Violence and Aggression training.

14.   PERFORMANCE

14.1.   Board Assurance Framework Quarter 4 2024/25 update and Board Assurance Framework Performance Scorecard 2025/26 ARC2526-07 (Presenter: Head of Improvement)

The Head of Improvement provided a Quarter 4 update on the Board Assurance Framework for 2024/25 and the proposed Performance Scorecard for 2025/26.

The Board approved its first Board Assurance Framework in December 2024, a mechanism for assurance on the delivery of its strategic objectives (as set out in our Corporate Strategy) monitored throughout the year and the risks associated with the delivery of each objective. The BAF has been built into the Risk Management Board Development session taking place on the 29 May 2025.

J Stevenson asked that the colour coding be made clearer on the Board Assurance Framework going forward.

Decision/conclusion

Members received and took assurance on the Board Assurance Framework 2024/25 and approved the Performance Scorecard for 2025/26.

15.   POTENTIAL - No items at this meeting

No papers presented at this meeting.

15.1.   Internal Audit

15.1.1.   Internal Audit progress report - ARC2526 -08 (Presenter: Internal Auditor)

Rachel King (Azets) (Internal Auditor) presented an update on progress of the Internal Audit plan since the last Committee meeting.

R King advised that since the Audit and Risk Committee in March 2025, the Annual Report has been completed which concludes Azets work for 2024/25.

The 2025/26 audit cycle comprises five audits. The Financial Management and Reporting and Waiting Times audit reports are currently in the planning stage and will be brought to the Committee in September 2025.

Decision/conclusion

Members received the update and noted progress of the plan.

15.1.2.   Internal Audit Reports (Presenter: Internal Audit)

There are no reports due.

15.1.3. Internal Audit Recommendations ARC2526-09 (Guest: Iain Gray - Data Protection Officer)

The Chair welcomed Iain Gray to the Committee meeting.

I Gray (Data Protection Officer) presented an update on Internal Audit Recommendations for 2023/24 and 2024/25.

In 2024/25, seven internal audits were completed, three of which were presented to the Audit and Risk Committee in September 2024 and four presented to the Audit and Risk Committee in February 2025.

A total of 28 management actions were due for completion up until 06 May 2025. The committee noted the following:

- 2023/24 Internal Audit Recommendations - 14 management actions evidenced as closed 3 have revised dates.
- 2024/25 Internal Audit Recommendations - 21 management actions evidenced as closed, 7 have revised dates.

The Chair asked if the revised timelines were realistic. The Data Protection Officer advised that building on earlier work, conversations had taken place with audit leads to ensure the revised dates were realistic, and reported positive engagement from leads in that process.

The Chair advised that the Internal Audit tracker, to be presented to committee from the next meeting, would assist members in being able to monitor progress as an extra layer of assurance.

J Stevenson asked for clarity on the recruitment and selection policy not being approved and asked for reassurance on when the survey will be completed. The Employee Director was unclear on the request.

The Interim Director of Finance confirmed the adoption of realistic timelines for external audit recommendations.

Decision/conclusion

Members noted the status and update of the actions.

15.1.4. Draft Internal Audit Annual Report 2024/25 ARC2526-10 (Presenter: Internal Audit)

The Internal Auditor presented the draft annual report (audit opinion) for 2024/25 based on the internal audit recommendations. Key themes for 2024/25 include.

- Requirement to update processes, procedures, and outdated documents.
- Staff knowledge and expertise

- Health and Safety risk assessment and inconsistency in how these were being recorded.
- Budget Holder training

The Internal Auditor confirmed that the Audit Opinion for 2024/25 is one of reasonable assurance.

Decision/conclusion

Members agreed that a level of reasonable assurance is a fair and accurate representation given the internal audit work undertaken over the past 12 months.

15.2. External Audit

15.3. External Audit Recommendations ARC2526-12 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the External Audit Recommendations tracker and provided an update on progress. She confirmed actions were in place to address outstanding recommendations, and were on track to be closed as part of the annual account cycle subject to review by external audit.

Decision/conclusion

Members noted the status and update of the actions.

16. ANNUAL ACCOUNTS

16.1. Annual Accounts progress assurance report (Verbal Update (Presenter: Interim Director of Finance)

The Interim Director of Finance provided a verbal update on the Annual Accounts process for 2024/25. The final allocation letter was received 5 May 2025. Information has been shared with external auditors.

Progress remains on track for meeting accounts timelines.

Decision/conclusion

Members received reassurance on the progress with the annual accounts.

17. Finance and Performance Committee Chair's Assurance Report ARC2526-13 (Presenter: Chair)

The Chair presented the Finance and Performance Committee Chair's Assurance Report.

Decision/conclusion

Members noted the report and discussed items escalated to the committee.

18.   Fraud Services Quarterly Report ARC2526-14 (Presenter: Head of Finance)

The Head of Finance presented the Fraud Services Quarterly Report. Head of Finance brought to Committee attention of a recent national fraud case, and advised that the Head of Finance is leading a piece of work to enhance our fraud prevention strategy.

The Chair welcomed the summary and contents of the refreshed cover paper.

Decision/conclusion

Members noted the quarterly report.

19.   Items to be included on the Chair's Assurance Report (Presenter: Chair)

Agreed the following items were to be included in Chairs Assurance Report

- Triangulation on risks by the Senior Leadership Team and Risk Management Group.
- Test of Change Children's services management of operational risk register.
- Minutes and Chair's Assurance Report from the meeting held on 4 March 2025 approved.
- Risk Management workshop scheduled for 29 May 2025
- Audit and Risk Committee Annual Report 2024/25 approved
- Assurance received on Governance Committees performance via Annual Reports 2024/25.
- Mandatory training for Non-executive Directors approved, subject to amendment.
- Board Assurance Framework Quarter 4 2024/25 update and Performance Scorecard 2025/26 approved.
- Summary of internal and external audit recommendations
- Annual Accounts update

20.   Any Other Competent Business (Presenter: Chair)

No AOCB raised.

21.   Items for Information and Noting Only

No items for nothing.

22.   Reflections on the meeting

- Meeting was split to reduce the number of papers coming to the Annual Accounts meeting in 27th May 2025, this was welcomed.

NHS Orkney

Meeting:	**NHSO Board Meeting**
Meeting date:	**Thursday, 26 June 2025**
Title:	**Podiatry Waiting List Performance and Improvement Plan**
Responsible Executive/Non-Executive:	**Sam Thomas, Executive Director of Nursing, Midwifery and AHP's and Chief Officer Acute Services**
Report Author:	**Heather Louttit - Clinical Lead Podiatry**

1   Purpose

This is presented to the Board/Committee for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2   Report summary

2.1   Situation

NHS Orkney Podiatry has been failing to meet the Government Target of, *'at least 90% of 'New' musculoskeletal patients should wait no longer than four weeks to be seen from receipt of referral'* and recovery of musculoskeletal activity.

2.2   Background

The Scottish Government has determined that at least 90% of 'New' musculoskeletal patients should wait no longer than four weeks to be seen from receipt of referral as set out in guidance on waiting times 'NHS Scotland Waiting Time Guidance, July 2012'.

This target is designed to enable appropriate and timely intervention to these individuals, and 'self-referral' aims to enable earlier intervention from an appropriate clinician, patient empowerment, and free up General Practitioner time and capacity. This target also enables

timely triage and referral to Trauma and Orthopaedics in attempt to receive more specialist input and investigation and reduce some cases from becoming chronic and increasingly complex, while increasing satisfactory outcomes and patient experience, as well as reducing the consumption of clinical capacity.

2.3   Assessment

PODIATRY SERVICE SPECIFICATION and PRIORITY ACTIVITY

It is important to take into consideration the overall activities and priorities of NHS Podiatry Clinics. As highlighted at the start of the COVID-19 Pandemic, when all services were suspended in Podiatry apart from the treatment of patients with Active Foot Disease, and those recognised at being of particular risk of developing active foot disease, the critical service in Podiatry, and priority, is that of managing' active foot disease'- Patients with suspected or actual Active Foot Disease do not sit on waiting lists, they are always appointed with immediate effect. These individuals require intensive input from the Department and wider multidisciplinary team, perhaps with 1, 2 or even 3 appointments per week.

If someone develops Active Foot Disease, their management often requires a multidisciplinary approach with much more emphasis on investigation such as radiology and microbiology, specialist input such as from Diabetologists, dieticians and other members of the Diabetic team, General Surgeons, Vascular specialists, Paediatric teams, Nurses, Physiotherapists, OTs; the individual may require Inpatient and high dependency unit admission and possibly patient transfer and travel to Aberdeen Royal Infirmary. This puts an increasing strain on multiple services at advanced financial cost and determent to clinical capacity.

Patients at high risk of Active foot disease are instructed to look daily for any 'danger signs'. These individuals know about their priority in the Department, and if any of these signs are present, they are instructed to seek immediate help- time is of the essence. A 'foot attack' is a clinical emergency. Up to 80% of people with diabetes die within 5 years of having an amputation or a foot ulceration These individuals are appointed as urgent appointments through the' Diabetes or Active Foot Disease Pathway'. Following that first ulceration the affected area of tissue has reduced its tensile strength by 70%, and from that point, these individuals require intensive 'foot protection', consuming clinical capacity, and often live in the cycle, and pattern, of ' remission and reoccurrence' for the remainder of their lives.

Podiatry also has a pool of 'foot protection' patients that require ongoing, timely and appropriate interventions. These are individuals that have been recognised as being at 'high risk' of developing active foot disease- (individuals with 'high risk in remission' or 'high risk' are people with diabetes, advanced peripheral arterial disease, people with complicated rheumatoid arthritis, advanced kidney disease, advanced neuropathy or immunosuppressed or compromised patients).

 A recent audit in May 2024 calculated that, to timely and appropriately attend the current recognised 'foot protection' pool, it would require 2.1 WTE Podiatrists. It is always impetrative to continue to monitor and revise how to use our time and capacity for the most effective management of this cohort of individuals.

NHS Orkney

MUSCULOSKELETAL ACTIVITY

COVID-19 hit the small Podiatry team hard- MSK services were nationally suspended for a prolonged period of time with only 'active foot disease' and 'very high-risk foot protection' services continued. The Orkney team also lost half their staff members, and with a legacy of under establishment, and ongoing chronic staff shortage, recovery of MSK activity struggled.

The limited resilience in small Allied Health Professional teams was highlighted during and after the Pandemic. Overwhelming Waiting lists, created overnight by the pandemic, swamped clinical capacity and activity productivity. There was no additional clinical capacity/ staffing input to deal effectively with back logs, and the Pandemic challenges added chronicity or complexity to cases. Severe staff shortage, in fact, just further limited the resource of clinical time and capacity.

The narrative for the MSK 'New' figures between May 2023 and May 2024 in the Podiatry Department captured and recorded the issues in detail.

'INTERPRETATION of COMMUNITY AHP MUSCULOSKELETAL 4 WEEK COMPLIANCE GRAPH for PODIATRY

The target of, **'at least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for the first outpatient appointment at AHP led Podiatry MSK service'** *was never met by the NHS Orkney Podiatry service during the window of time between May 2023 and May 2024. The reasons for this, from a Podiatry prospective, are because the team were under established; chronic and at times severe staff shortage;* there is no annual leave, sickness or other leave cover in the Department and the team have to prioritise and revert to critical care; stretched specialism needs; *staff prioritising critical and acute care to those individuals with active foot disease; attempts to appoint face-to-face appointments to 'foot protected high risk patients' in a timely and appropriate manner so that they do not develop 'active foot disease'; clinical capacity pressures on triaging of Podiatry lists following suspension of all activity except critical and high risk care provision; historic lengthy waiting lists of 'new' MSK from MSK services being suspended long-term during the pandemic; an increase in MSK referrals; MSK appointments given to patients who have been on the ' New MSK' list the longest rather than those within target window of the last month; attempts, not only, to give 'MSK' patients one 'new ' appointment but to give timely and appropriate follow up ('return')appointments to ' fix' problems and increase patient satisfaction, improve outcomes and be able to discharge patients satisfactorily from the Department and reduce re referrals as ' New MSK' patients again; did not attend rates; room availability; increasing bureaucracy; Orthotist provision issues which affected patients in our 'foot protection', 'Active Foot Disease' and 'MSK' pool of patients; alterations in population demographics and lifestyle; lack of screening during COVID and the Pandemics, other well documented effects on individuals and patient cases presenting increasingly acute, chronic and complex requiring multidisciplinary and specialised clinical input'.*

The exception to meeting the month 'New' MSK target was children who were prioritised and appointed to a face-to-face MSK appointment on referral arrival.

As services have slowly mobilised, it has required substantial, additional clinical capacity, and time, to even triage lists of individuals, who are all requiring help and clinical input, from the small Department.

The use of telephone appointments was utilised where possible to maximise use of clinical time, and clinical contact, and lists available in IT systems such as SCI Diabetes were invaluable for triage, and maximising effect of targeting of clinical capacity and resource.

During the Pandemic, any recovery endeavour was made more difficult with severe staff shortage and small establishment, and any progress has been at the expense of other activity, good will to fit in extra patients and use every moment, and additional unpaid hours. The team have had several big 'pushes' to reduce the numbers towards the territory of nearing targets in the future.

The Department did not focus mainly on seeing 'New' MSK appointments to meet targets. Emphasis is strongly highlighted on the initial 'New' MSK appointment, but clinicians also realise the importance of timely and appropriately follow up appointments and duty of care. 'Return' MSK patients were appointed in attempt to 'fix' problems, with aim to increase patient satisfaction, improve outcomes, be able to discharge patients satisfactorily from the Department, and reduce re referrals as 'New MSK' patients again.

MSK Podiatry specialism is stretched in the Department and activity is dependent on availability of key staff members- the Clinical Lead and our 'Acting up 'Band 6 Podiatrist who are the only members who undertake these appointments. There was no suitable Locum MSK Podiatrist available at any point.

The staff shortage element of not meeting targets is difficult to address. There is a National and local staff shortage with reduction in staff qualifying and an increase in Podiatrists choosing Private practice option. There is further concern as 75% of Podiatry staff working for NHS Orkney is now 55 years old or over.

The current establishment is 4WTE, but our current working establishment is 3.6WTE, which includes an 18-month fixed-term Band 5 Podiatrist post from 9th Dec 2024 until the 6th of June 2026. This has not helped with the MSK activity but has indirectly eased 'foot protection' lists. This was a full- time post, but the Staff member works 22.5 hours 0.6 WTE each week, so there is a 0.4WTE gap.

As in last January 2024, there has been a concerted effort and push to reduce 'New' MSK lists by forgoing admin time, and other activity, and by seeing extra patients in clinics, working extra hours, to reduce the overall number of 'New' MSK patients waiting to be appointed so that we are nearer to being able to appoint patients within the target window, and planning to consistently hit our target. This has also meant reducing the number of 'Return' MSK patients.

March and April 2025 saw another difficult period for the Department due to accumulation of annual leave with over 30 days planned annual leave, and eventual 12 days sickness leave and 5 days bereavement. There were also an unusually high number of referrals at the end of December and January coinciding with the 'push'. There is no cover for these periods of adversity.

However, in May 2025, we have been able to reduce the 'New' MSK waiting list to a level where we are hoping to start to consistently meeting our MSK 'New' National target of, 'at least 90% of 'New' musculoskeletal patients should wait no longer than four weeks to be seen from receipt of referral'. We are now down to much smaller numbers on our lists, and the numbers are the current referrals that can be appointed prior to the target deadline. With the advantages of Trak care the Clinical Admin, 'Acting up' Band 6 Podiatrist and the Clinical Lead will be able to

anticipate and estimate the expected referral numbers and forward plan clinics, with some flexibility and adaptation to cope with high referral months to avoid breach. We should be able to meet the 90% target consistently unless further adversity affects the Department.

There is still little resilience in this activity, as one significant event such as sickness leave or the end of the Band 5 fixed- term contract, will be enough to force the Department to revert to management of critical services as priority. However, the team are in a much better situation and look forward to meeting the target.

Table of Numbers on Podiatry MSK Waiting Lists recorded in the Department

Date	'New' MSKs	'Return' MSKs
20 February 2020	36	35
30 April 2020	65	211
14 August 2020	76	213
27 November 2020	89	196
14 Sep 2021	119	243
26 May 2022	105	294
18 July 2023	109	76
23 April 2024	42	3
15 May 2024	45	61
15 July 2024	60	10
25 September 2024	60	10
19 November 2024	54	18
3 December 2024	15	0
13 January 2025	17	6
11 April 2025	3	13
2 May 2025	0 due today	0 due today(There will be a few on vetting list today)

Recommendations/Improvement Plan

• Now, that the backlog of 'New' waiting list is down, we are able to use Trak care to calculate and estimate the number of expected 'New' referrals and organise appropriate clinics to accommodate these individuals, so that they do not breach the 1-month target. We are also putting in some time, which can be opened up, and flexed into MSK time, in case of unexpected increase in referrals for the month

• Clinical Admin is aware of this process and will be actively involved in monitoring, preventing and escalating potential breach. She will work closely with the Clinical Lead and 'Acting up' band 6 to ensure appropriate and timely appointment and escalating issues as they arrive to the Clinical Lead.

• Efforts need to address the recruitment and retain issues in NHS Podiatry on a local and National level.

• Staff establishment, aging demographics of the staff and succession planning options should be addressed.

- Banding should be appropriate for staff activity and 'Acting up' Podiatrist needs to be resolved.
- There should be a recognised budget and pathway to access mandatory and Department training to enable training plans to be delivered in Departments and there should be a National Identifiable focal point to access available training, where, how and who with appropriate forward advance for rural areas to forward plan, especially with mandatory courses.
- Stretched specialism is on the Podiatry Risk Register
- Robust Training and course pathways in Orkney especially in regard to expenses would benefit up skilling and training staff to improve resilience. This would also benefit patients with increasing patient experience, satisfaction and improved outcomes and effective treatment, as well as staff pride and satisfaction.
- Even with mandatory training, it is difficult to access suitable courses, costs and advance notice of National courses, and there would be benefit if these were available at a singular and known access site for proper planning and delivery.
- Explore and improve patient resource to self-help on NHS Web Site pages.

2.4   Recommendation

Members are asked to

- Note the improvement plan and current challenges being addressed

3   List of appendices

The following appendix is included with this report:

Appendix 1, Podiatry Health Intelligence dashboard data

Population Split: Orkney Mainland vs Ferry-Connected Isles

Anna Lamont 16/6/2025

Update for June 2025

Action: 'Medical Director to confirm the percentage of individuals living on ferry linked isles ahead of the final plan coming to Board in June 2025'

Population Figures (2022 Census)

According to Scotland's 2022 Census, Orkney had a total population of 22,020 residents (National Records of Scotland [NRS], 2023). Dividing this into two groups: Mainland (including the causeway-linked South Isles of Burray and South Ronaldsay) with the outer islands serviced by ferries (the "ferry-linked isles"). The ferry-connected isles collectively accounted for roughly 2,700–2,713 people in 2022, which is about 12% of Orkney's population (Orkney Partnership, 2025). Correspondingly, about 88% (≈19,200 people) resided on Mainland Orkney (plus the linked isles). For context, the 2011 Census had recorded 18,487 people on the mainland plus linked isles versus 2,862 across the non-linked isles (Environment and Forestry, 2024). By 2022, the mainland group saw modest growth while the ferry-access islands' share declined slightly.

Combined population on the outlying isles fell ~5% between the 2011 and 2022 censuses (Orkney Partnership, 2025). In absolute terms, the ferry-served islands went from about 2,862 people in 2011 down to approximately 2,700 in 2022. This drop offset some of the mainland's population gain, resulting in Orkney's overall growth slowing. Orkney's total population grew about 3% from 2011 to 2022, after an 11% increase in the previous decade (Orkney Partnership, 2025).

National Records of Scotland data confirm that from 2010 to 2021 many of Orkney's outer islands saw population decline even as Orkney aggregate population rose (NRS, 2023a). The census data also highlights an aging demographic most evident on the ferry-linked isles. Orkney-wide, 49% of residents are age 50 or above, but on the linked isles approximately 60% of residents are 50+ (Orkney Partnership, 2025).

Consistency and Completeness of Data

Overall, the sources show a consistent change. The 2022 census and NRS estimates agree on Orkney's total (~22k). The Orkney Council's breakdown (Mainland ~19.2k vs ferry isles ~2.7k) is backed by the census (2011 and 2022) and aligns with known ward populations (Orkney Partnership, 2025). The proportions (about 87–88% on Mainland, ~12–13% on outer isles) match earlier observations that roughly three-quarters or more of Orcadians live on the main island (Audit Scotland, 2017).

There are some limitations in the data publicly available from the 2022 census. It provides totals and some high-level breakdowns (e.g. by ward or large island group), but a detailed island-by-island census breakdown is not yet available. The NRS is expected to release detailed island population tables later this year 2025.

References

Audit Scotland (2017) *Local government in Scotland: performance and challenges 2017*. Available at: https://www.audit-scotland.gov.uk/report/local-government-in-scotland-performance-and-challenges-2017

Environment and Forestry (2024) *Scottish Islands Typology: overview 2024.* Available at: https://www.gov.scot/publications/scottish-islands-typology-overview-2024/

National Records of Scotland (2023) *Scotland's Census 2022*. Edinburgh: NRS.

National Records of Scotland (2023a) *Mid-2023 population estimates*. Edinburgh: NRS. https://www.nrscotland.gov.uk/publications/mid-2023-population-estimates/

Orkney Islands Council (2015) *Orkney Locality Plan: Population Baseline Data Appendix*. Kirkwall: OIC. https://www.orkney.gov.uk/media/rtghixo5/i08_app1_locality_plan_non-linked_isles_appendix_2.pdf

Orkney Partnership (2025) *Orkney Community Plan 2025–2030,* Kirkwall: Orkney Islands Council. https://www.orkney.gov.uk/media/euvnuakj/item-21-orkney-community-plan-incorporating-local-outcomes-improvement-plan-ia.pdf

Chair & Chief Executive

NHS Orkney

Dear Caroline

We hope you are well.

At our Board meeting yesterday, we discussed in full the Health Board Collaboration and Leadership paper that all Boards are discussing in their meetings in this latest cycle.

We write to inform you that our Board had an extensive and productive discussion about the importance of strengthened collaboration and cross boundary working, system leadership and optimising relationships between Boards and Health and Social Care Partnerships to further improve care, services and outcomes for our patients and the communities we serve.

Our Board noted and endorsed – and fully supported – each of these actions as set out in the paper:

- The commitment set out by the First Minister to progress the renewal and reform of the NHS in Scotland, and the associated requirement for the Board to seek assurance on the delivery of these commitments – at NHS Orkney we are doing this via our Year 2 (2025/26) Corporate Strategy which our Board approved yesterday, our Annual Delivery Plan and our 2025/26 Efficiency Programme
- The evolution of the new governance arrangements via the NHS Scotland Executive Group which are intended to enable and foster stronger collective accountability whilst underpinning the strength of local accountability mechanisms – Laura has committed to sharing agendas and a summary paper at each In Committee Board meeting for NHS Orkney on the decisions and key discussion points from the NHS Scotland Executive Group meetings, to keep our Board fully briefed and sighted as part of these new governance arrangements
- The duality of our role for the population/Board we serve as well as our contribution to population planning that will cross traditional Board

boundaries and approves local implementation of this approach, consistent with DL(2024)31 and 12 (J) of the 1978 NHS Scotland Act – all NHS Orkney Board members understand the dual nature of our roles and the need to balance our local leadership with that for the benefit of the NHS in Scotland and the greater good

- The anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months as there is requirement to deliver the principles set out by the First Minister in his speech on 27 January, to deliver efficiencies and savings and to put into action the commitments set out in the three reform documents – NHS Orkney's Board is committed to working and contributing to delivering improvement, transformation and increased efficiency at the pace now required, including contributing to strengthened collaboration and cross boundary working in the North of Scotland, with the other Island Boards and fulsome engagement in the Single Authority Model discussions here in Orkney to explore the opportunities for further improving outcomes for our community, efficiency and productivity and reducing unnecessary duplication/ bureaucracy. We have recently started Executive-to-Executive meetings with NHS Orkney and NHS Grampian and NHS Highland, and these meetings will continue on a quarterly basis to foster strengthened relationships and to explore opportunities for greater collaborative working

We hope this update is helpful and provides the necessary assurance that NHS Orkney's Board has discussed this important paper in full and sign up to its contents and recommendations.

We also welcome the revised approach of the same paper coming to all Health Boards for greater consistency and coherence of messaging across the NHS in Scotland, signalling a new way of working and another positive step forward.

Best wishes

Laura and Meghan

Laura Skaife-Knight
Chief Executive

Meghan McEwen
Board Chair

NHS Orkney Governance Meetings 2025/26.

Board — 10:00am

24 April 2025
26 June 2025 (Annual Accounts)
28 August 2025
30 October 2025
11 December 2025
26 February 2026

Remuneration Committee — 2:00pm

6 May 2025
5 August 2025
6 November 2025
9 October 2025 (Annual Review)
3 February 2026
12 March 2026 (Development Session)
(+Ad hoc as required)

Audit and Risk Committee — 09:30am

6 May 2025
27 May 2025
26 June 2025 (Annual Accounts)
2 September 2025
7 October 2025 (Annual Review)
2 December 2025
3 March 2026
17 March 2026 (Development Session)

Board Development Sessions — 9:30am

29 May 2025
24 July 2025
24 September 2025
27 November 2025
29 January 2026
19 March 2026

Finance and Performance Committee — 9:30am

22 May 2025
31 July 2025
23 September 2025
21 October 2025 (Annual Review)
20 November 2025
22 January 2026
5 March 2026 (Development Session)
26 March 2026

Endowment Fund Subcommittee — 9:30am

8 May 2025
7 August 2025
6 November 2025
5 February 2026

Endowment Trustees — 9:30am

5 June 2025
4 December 2025

Joint Clinical and Care Governance Committee — 2:00pm

2 April 2025
3 July 2025
1 October 2025
4 November 2025 (Annual Review)
4 February 2026
25 March 2026 (Development Session)

Integration Joint Board — 9:30am

30 April 2025
2 July 2025
3 September 2025
5 November 2025

Staff Governance Committee — 9.30am

15 May 2025
13 August 2025
16 October 2025 (Annual Review)
13 November 2025
12 February 2026
18 March 2026 (Development Session)

Senior Leadership Team	
• **Patient Safety Quality & Experience** • **Performance** • **Place**	🕐 **1:30pm**
1 April 2025 1 May 2025 3 June 2025 10 July 2025 5 August 2025 11 September 2025 7 October 2025 14 November 2025 8 December 2026 (joint session) 7 January 2026 13 February 2026 13 March 2026	

Senior Leadership Team	
• **Potential** • **People**	🕐 **9:30am**
22 April 2025 20 May 2025 24 June 2025 29 July 2025 26 August 2025 30 September 2025 28 October 2025 25 November 2025 8 December 2025 (joint session) 27 January 2026 24 February 2026 31 March 2026	

Extended SLT Meeting	🕐 **1:30pm**
15 April 2025 17 July 2025 14 October 2025 12 January 2026	

Joint Board and SLT Meeting	🕐 **9:30am**
13 February 2025 14 August 2025 3 February 2026	

Area Partnership Forum	🕐
15 April 2025 20 May 2025 (Development Session) 17 June 2025 15 July 2025 19 August 2025 (Development Session) 16 September 2025 21 October 2025 18 November 2025 (Development Session) 16 December 2025 20 January 2026 17 February 2026 (Development Session) 17 March 2026	

Area Clinical Forum	🕐
4 April 2025 1 May 2025 (Development session) 3 June 2025 1 July 2025 (Development session) 1 August 2025 4 September 2025 (Development session) 7 October 2025 4 November 2025 (Development session) 5 December 2025 3 February 2026 4 March 2026 (Development session)	

NHS Orkney Board - Attendance Record - 1 April 2025 – 31 March 2026

Name:	Position:	24 Apr 25	26-Jun-25	05-Aug-25	30-Oct-25	26-Feb-26
Non- Executive Members						
Meghan McEwen	Chair	Attended				
Davie Campbell	Vice Chair	Attended				
Issy Grieve	Non-Executive Board Member	Attended				
Rona Gold	Non-Executive Board Member	Attended				
Kirsty Cole	Area Clinical Forum Chair	Attended				
Joanna Kenny	Non-Executive Board member	Attended				
Ryan McLaughlin	Employee Director	Attended				
Jason Taylor	Non-Executive Board member	Attended				
Executive Board Members						
Anna Lamont	Medical Director	Attended				
Laura Skaife-Knight	Chief Executive	Attended				
Sam Thomas	Director of Nursing, Midwifery, AHP and Chief Officer Acute Services	Attended				
Loiuse Wilson	Director of Public Health	Absent				
In attendance						
Phil Tydeman	Director of Improvement	Attended				
Stephen Brown	Chief Officer – IJB	Apologies				
Jarrod O'Brien	Director of People and Culture	Apologies				
John Daniels	Head of Primary Care	Attended				
Michelle Mackie	Deputy Director of Nursing					
Steven Phillips	Head of People and Culture	Attended				
Hannah Casey	Public Health Manager	Attended				
Elvira Garcia	Consultant in Public Health					
Debs Crohn	Head of Improvement	Attended				
Attended for specific item:						
Lynn Adam	Clinical Lead - Workforce	Attended				