

NHS Orkney Board 26 February 2026

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



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Minute Public Board Meeting

Thursday 11 December 2025

Present

Dr Kirsty Cole (Chair, Area Clinical Forum), Issy Grieve (Non-Executive Board Member), Joanna Kenny (Non-Executive Board Member), Dr Anna Lamont (Medical Director), James Goodyear (Interim Chief Executive Officer (CEO), Jean Stevenson (Non-Executive Board Member), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services EDoNMAHP), Davie Campbell (Interim Board Chair), Fiona MacKay (Non-Executive Board Member), Ryan McLaughlin (Employee Director – Non-Executive Board Member), Rona Gold (Non-Executive Board Member).

In attendance

Suzanne Gray (Senior Management Accountant), Debs Crohn (Head of Corporate Governance), Tammy Sharp (Director of Performance, Transformation), Shona Lawrence (NHS Orkney Corporate Communications Officer).

1. Cover page

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2. Welcome and Apologies (Presenter: Chair)

The Interim Board Chair opened the meeting at 09.30 am and welcomed Dave Harris (Director of People and Culture) to their first Board Meeting.

Apologies received from Melanie Barnes (Interim Director of Finance), Head of Corporate Governance advised that Suzanne Gray (Senior Financial Accountant) would be attending to present agenda item 15.1 on behalf of the Interim Director of Finance.

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

3. Declarations of Interest (Presenter: Chair)

No declaration of Interest to be recorded.

4. Minutes of Previous Meeting 30 October 2025 (Presenter: Chair)

Minutes of the meeting held on 30 October 2025 were accepted and approved as an accurate record of the meeting.

5. Matters Arising (Presenter: Chair)

No matters arising were raised.

6. Action Log (Presenter: Chair)

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

7. Board Chair and Chief Executive Report to the Board – December 2025 (Presenters: Interim Chair, Interim CEO)

The Interim CEO presented the Board Chair and Chief Executive Report providing an update on key events and activities in November and December 2025.

Substantial work is ongoing in relation to the Public Sector Reform with our partners OIC, IJB and our regional NHS partners due to the establishment of East and West sub regional planning forums. Both partnerships provide excellent opportunities to improve services for our patients in Orkney. These items were discussed in more detail later in the agenda.

The Board continues to make progress on SG's target of no patients waiting more than 52 weeks for an outpatient appointment. The Interim CEO re-iterated that this is a welcomed achievement recognising that no patients should wait this length of time for an appointment.

We continue to be one of the top performing Health Boards for our Emergency Department performance.

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The Board continues to be challenged in relation to our financial position and social care capacity in the Community.

The Interim CEO has continued to meet with staff and this week met with our Central Decontamination Unit. Thanks were expressed to our CDU who have supported NHS Grampian with a recent incident, given food for thought to NHS Assure on how mutual aid and support could be provided should incidents of this nature occur in the future,

The interim Board Chair re-iterated that their focus has been on positive conversations in relation to Public Sector Reform and sub-regional planning.

Decision / Conclusion

The Board noted the update provided

8. A Summary of Ministerial Annual Review 6 October 2025 (Presenter: Interim Board Chair)

The Interim Board Chair provided a summary of the Ministerial Annual Review which took place on 6 October 2025. Ms Maree Todd and Caroline Lamb attended the Board who met with the Area Partnership Forum, Area Clinical Forum, patients followed by a public session.

The Interim CEO re-iterated that the Annual Review is a great way for us to communicate with our community and demonstrates our accountability as a public sector organisation.

The Employee Director advised that the meeting was a moment in time, positive work has taken place since the meeting.

F Mackay asked for clarity on the feelings from Scottish Government following the review. The Interim Board Chair advised that SG were mindful of the work achieved in 2024/25, recognising our current challenges.

The Medical Director confirmed that feedback from Ms Todd and Ms Lamb was very complimentary about our position in terms of innovation and sustainability.

I Greive felt that the conversations were fruitful, Ms. Lamb and Ms. Todd were well prepared and feedback from the public was positive.

Decision / Conclusion

The Board noted the update.

9. Corporate Risk and Assurance Report (Presenter: Medical Director)

The Medical Director presented the Corporate Risk and Assurance report, updating the Board on current risks, recent changes to risk ratings, and any new or closed risks from the last reporting period.

There are several changes being made to how the Risk Register is being presented as part of our commitment to continuous improvement. One of the changes being

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implemented is change to how the risk scores are presented, the cover paper now details the Board's top 4 risks.

J Kenny asked for clarity on the risk being reduced in relation to the financial sustainability score, The Medical Director advised that risk scores are reviewed by risk owners. The financial sustainability risk score has been reduced following the recent financial governance review and our better understanding of our financial position.

The interim Board Chair asked for confirmation of how staff can input into risk management. The Medical Director advised that the Risk Management Group is the place risk owners monitor and review risks, which are then reviewed by the Senior Leadership Team noting that risks are reviewed ahead of the timescales outlined in our risk management framework.

The Interim CEO advised that the change to the financial risk score relates to a review undertaken in May and confirmed that additional controls are now in place to mitigate the risk. The Board is on a continuous improvement journey in relation to risk management recognising that more work is required to embed operational risk management through the Risk Management Group.

J Taylor reflected that there is more evidence through committee minutes that risks are being reviewed, which is welcomed. Audit and Risk Committee recognise that a more proactive approach is required by risk owners. The Interim CEO advised that this requires cultural change, risk owners will be asked to present updates at the Risk Management Group going forward recognising that risk management underpins how we manage our business.

The Medical Director asked the Board and Audit and Risk Committee to recognise the work that has been delivered over the past 12 months, there is alignment with our sub-committees providing a greater level of scrutiny by the Board.

J Stevenson asked for an update on the lack of senior leadership capacity and capability. The Medical Director advised that the update presented is from August 2025, noting that the risk is still live and challenges in relation to interim positions and vacancies. The Director of People and Culture advised that all risks in relation to People are being reviewed, this is a key priority noting that the leadership development programme delivery model needs to be reviewed.

The Employee Director asked for a timeline for when the Leadership Development programme proposal will be in place. The Director of People and Culture advised that this will be a priority in Quarter 4 2025/26, recognising this is not just about leadership development but about capacity across the organisation.

Dr K Cole noted that clinical risks only reference the impact in secondary care, there is no mention of the risk within primary and community care services. The Chief Officer IJB recognised that primary and community care risks are reflected in the IJB risk register, recognising the need for cross-referencing of risks on multiple risk registers. I Greive advised that this will be raised at the Audit and Risk Committee in February 2026.

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The Employee Director asked for clarity on the risk score in relation to Mental Health Team capacity. The Chief Officer IJB advised that the introduction of all age psychiatric team will assist at points when people are in crisis, recognising that recruitment is still underway it will be in the new year before the team is fully staffed. Business continuity plans are in place to support over the Christmas period should this be required.

Decision / Conclusion

The Board noted the progress made to update and the current mitigation of risks highlighted

10. Integrated Performance Report (IPR) December 2025 (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation reminded members of the areas covered within the Integrated Performance Report up till the end of September 2025.

Areas of good performance

Sickness absence remains below the national average.

Diagnostics and imaging services have shown marked improvement, particularly in cardiology and local MRI provision, resulting in enhanced patient access and reduced reliance on external providers and the resulting travel out with Orkney for patients. The Medical Director asked the Board recognising the improvements. The number of people being seen on island is higher than anticipated, this is currently 150 per month. business plan is being developed for the next 12 months, the current provision will expire in June 2026.

Cancer standards reporting 100% compliance with the 31-day treatment standard.

Mental Health and Psychological Therapies continue to exceed national targets

The number of patients waiting over 52 weeks for new outpatient appointments has reduced significantly, demonstrating the impact of targeted capacity increases. J Taylor asked for confirmation on the impact it will make when this piece of work is complete. The Director of Performance and Transformation advised that work is underway to look at patients who are 26 weeks, this is part of our commitment to look at capacity and demand across all specialties.

Areas for improvement

Serious Adverse Event Review capacity - Completion rates are below target due to limited reviewer capacity. Outstanding reviews are expected to be closed next quarter.

Complaints management due to staffing challenges - Stage One complaints response compliance is below target, affected by staffing pressures. Targeted workshops are planned to address this.

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Ongoing challenges in relation to DTOC and social care capacity - Performance is significantly below target, with ongoing challenges in social care recruitment and residential places for those waiting.

Efficiency savings plan is behind where we expect to be at this point in the year - The Board is currently £508k adverse to trajectory, with key drivers including medical recruitment costs, agency nursing, and prescribing.

The Executive Leadership Team presented the Integrated Performance Report by chapter.

Patient Safety, Quality and Experience

The Medical Director advised that most areas are rated green, an explanation was offered in relation to there being no national definition of what is meant by falls with harm. Manual audit work is underway, noting that the number of falls recorded has fallen, the small number of falls presented should be viewed as limited assurance.

Assurance provided that SAER compliance has improved noting that suicide reviews are reliant on external partners.

Patient safety, quality and experience reports are now being presented to clinical advisory groups, a mobility and morbidity group is now in place noting that external organisations cannot complete reviews on behalf of the board.

The Employee Director asked if data could be shared on falls with harm in the IPR. The EDoNMAHP advised that the definition is a national definition, the IPR presented to Board in February 2026 will include additional information noting this will be a manual task.

The Interim Board Chair asked for clarity on the PEWs score being required as zero. The EDoNMAHP advised that the Board has very few paediatric presentations through our Emergency Department. One of the indicators for PEWs is the recording of blood pressure, which can be challenging for children. Challenges have been noted in relation to compliance; work is underway with staff to improve compliance noting that recording is challenging for PEWs.

Operational standards

The EDoNMAHP confirmed there have been challenges in relation to patient flow. The 12-hour standard remains at amber due to retrieval times.

The Interim Board Chair asked for clarity on how we are utilising our assets to reduce the number of Delayed Transfers of Care. The Chief Officer IJB advised that multi-disciplinary teamwork has commenced, recognising that more work is required on our frailty pathway. Other areas have looked at reducing the number of secondary care beds, which would not be an option for Orkney, recognising that this has resulted in overspends on social care due. Scottish Government are aware of the challenges; a paper has been submitted to Ministers in relation to bolstering our social care workforce. There are currently significant vacancies within our social care workforce, whilst numbers remain high, the team are committed to ensuring patients are transferred.

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J Stevenson reflected that DTOC's are impacted by guardianship. The Chief Officer IJB advised that a campaign to raise awareness of Power of Attorney will commence in the New Year.

The Medical Director advised that there are improvements in all outpatient specialties except for ophthalmology, plans are in place to bring this in line in Quarter 4 2025.

There has been a sustained fall in the number of new patients waiting for an outpatient appointment.

Dr K Cole asked for clarity on the SAS turn around times and the bottlenecks referred to too in the Corporate Risk Register. The EDoNMAHP advised that the IPR is correct in terms of turnaround times, this is captured on the risk register in relation to no flow within the hospital should this be the case. Dr K Cole asked that the impact column on the risk register be reviewed for consistency. The Interim CEO confirmed that our Corporate Risk Register does contain anticipatory

Community and Mental Health Services

The Chief Officer IJB advised that the Phio app is now live recognising more timely data is required.

There has been a reduction in waiting times for podiatry – this is now below 12 weeks.

Greater detail around community indicators will be brought to Board going forward noting that data is currently a manual process.

J Kenny asked for clarity on the issues in relation to up to date management data being available to managers and the Board. The Chief Officer IJB advised that this work is underway and will be resolved when MORSE

Population Health

The Medical Director recognised that maternity, childhood immunization and smoking cessation remains above the national target, which is testament to the work of our Public Health Team.

J Stevenson asked for clarity on the uptake of the MMR immunization and asked if a public campaign is required. The Medical Director recognised the need for greater public awareness; this is a national issue noting that the decline in Orkney is less than the national average.

Workforce

The Director of People and Culture is currently looking at the Key Performance Indicators to ensure Board receives assurance on our workforce performance.

There is a recognition that sickness absence due to anxiety needs further analysis to understand the reasons behind this. The Interim Board Chair asked for greater assurance and what is being undertaken to manage sickness absence. The Director of People and

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Culture advised that further work is needed to ensure processes are in place to support both managers and staff, having robust data on Occupational Health and Return to Work interviews. The introduction of regular staff pulse surveys will also support our approach to staff wellbeing.

The Interim Board Chair asked for confirmation on what data would be presented to Board on Workforce planning. This work will be brought to Board in February 2026.

J Taylor asked for confirmation of our vacancy rates and a timeline for when this will be presented to Board. The Director of

Staff appraisals rates remain below target; work is ongoing with managers to improve compliance.

A workshop will take place in Quarter 4 2025/26 to look at what more could be done in terms of substantive recruitment.

Finance

I Grieve welcomed the introduction of the first section of the IPR and the comments in relation to the areas for improvements. I Grieve asked if arrows be re-instated on the IPR. The Medical Director advised that the use of Statistical Control Targets will be challenging, but this will be reviewed ahead of the next IPR being brought to Board in February 2026. A board development session will be scheduled in Quarter 4 on Statistical Control Targets.

Decision/conclusion

The Board received the Integrated Performance Report (IPR) update, noting where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

11. ASSURANCE REPORTS

11.1. Finance and Performance Committee Chair's Assurance Report 26 November 2025 - (Presenter: Fiona Mackay - Chair Finance & Performance Committee)

The Chair of Finance and Performance Committee presented the Finance and Performance Committee Chair's Assurance Report from 26 November 2025 meeting.

Positive assurance provided on the IPR noting progress is being made against several KPIs.

Concerns raised in relation to our financial position and the Robertsons contract.

Work underway to review medical staffing costs and looking at the strategic actions which will deliver financial benefits in 2026/27.

Committee approved changes to Standing Financial Instructions, Committee Terms of Reference, Work Plan and timetables for meetings 2026/27.

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R Gold noted the positive progress in KPI's and strategic actions and asked for clarity on the timescales to bring the deficit back inline this financial year. Interim CEO advised that actions have been identified to bring the deficit back on track, however it is like that our year-end position will be a deficit of £3.8 million and not the required £2million position required by Scottish Government.

Decision / Conclusion

The Board noted the update and took assurance on the report.

11.2. Senior Leadership Team Chair's Assurance Reports 25 November 2025 (Presenter: Interim CEO - Chair of Senior Leadership Team)

The Chair of the Senior Leadership Team (SLT) presented the Chair's Assurance Reports from the 25 November 2025 meeting summarising the main points as follows

Financial position was discussed and the actions needed by the team to address the challenges.

Conversation took place in relation to workforce challenges.

Decisions were taken to streamline the process for risk assessments; senior leadership team has now moved to monthly meetings.

I Grieve noted the risks in relation to Month 6 financial position and noted that there are no actions commissioned in the report. The Interim CEO advised that lengthy conversations took place with SLT in relation to the Vacancy Control Process and reducing the number of agency staffing.

Decision / Conclusion

The Board noted the update and took assurance on the report.

11.3. Area Partnership Forum 18 November 2025 (Presenter: R McLaughlin, Employee Director)

The Chair of the Area Partnership Forum (APF) presented the Chair's Assurance Report from its meeting on 18 November 2025.

Concerns were raised in relation to clinical and staff side engagement in relation to sub-regional planning from a national perspective.

The lack of workforce planning remains an area of concern noting this is progressed.

We have yet to fully implement the Distance Island Allowance requirements

Concerns raised in relation to staff alarms and staff being aware of how to respond to issues, this has been raised with Robertsons Facilities Management. J Kenny asked for clarity on the actions being taken to resolve these issues, noting the risks

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associated with this. The Interim CEO advised that a paper is being taken to Finance and Performance Committee 17 December 2025

The roll out of phase 3 Once for Scotland policies have not yet been implemented due to clarity being required from the National team.

I Grieve thanked the Employee Director and asked for clarity on where actions are being captured and monitored. The Head of Corporate Governance advised that action logs could be shared with Board Members if required.

Decision / Conclusion

The Board noted the update provided.

12. STRATEGIC OBJECTIVE - PLACE

12.1. Public Sector Reform – Orkney’s Routemap to Reform (Presenter: Chief Officer - IJB)

The Chief Officer IJB presented the Public Sector Reform – Orkney’s Routemap to Reform paper for approval following the ask from Scottish Government for transitional arrangements to be put in place for Public Sector Reform.

A local working group made up of the CEOs and Chairs from the Board, IJB and Orkney Islands Council to look at what the opportunities are locally for service resilience recognising the financial challenges across all Organizations.

Over the past few months, a routemap to reform has been developed, discussed and agreed by OIC 9 December and IJB 10 December and is presented to Board for consideration.

Feedback from Ministers is that they are supportive of the proposed approach, if changes are made this will be brought back to all 3 organisations for agreement.

The principles set out in the paper outline an approach to shared services and reducing duplication.

The Interim Board Chair recognised a productive partnership is now in place, the approach has been discussed with the Area Partnership Forum. The Interim CEO confirmed the approach has been productive and this work will be taken forward together with our partners.

R Gold thanked the individuals involved in pulling the proposal together, supportive of the approach and asked how the community would be brought into the conversations going forward. The Chief Officer IJB advised that this will form part of the planning following approval by Scottish Government recognising that one of the principles is ensuring benefit for the people of Orkney this will include meaningful engagement. The Interim CEO advised that the Community Planning Partnership will be a key partner in developing our approach, noting the need for public engagement going forward/

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F MacKay offered her support for the proposal, noting that the Clinical Services Review Recommended exploring opportunities for shared services.

J Kenny advised as Chair of the IJB they are content to support the proposal.

I Grieve asked that communications be put in place with our community to ensure clear and consistent messages are in place.

Decision/Conclusion

The Board approved the Orkney's Routemap to Reform paper for onward submission to Scottish Government.

13. STRATEGIC OBJECTIVE - PATIENT SAFETY, QUALITY AND EXPERIENCE

13.1 Healthcare Associated Infection Reporting Template (HIART) Report (Presenter:EDoNMAHP)

The EDoNMAHP presented the Healthcare Associated Infection Reporting Template Report advising of a drop in compliance in hand hygiene from 93% to **92%**, however this still fails to meet the 95% target. The main issues during this data collection period, is staff wearing nail polish/varnish and failure to undertake hand hygiene before entering a patient room.

The Interim Board Chair asked for confirmation on hand hygiene audits, The EDoNMAHP advised that work has been undertaken with all staff in relation to hand hygiene, staff are advised why audits have been failed, this is also discussed at the nursing and medical huddles. Hand Hygiene is monitored by the Infection Prevention Committee

Board members noted the Infection Prevention and Control week report and advised that the team have been undertaking infection prevention visits to the new Kirkwall Care Home "Kirkjuvar". The visit was followed up with written recommendations and advice with links to the current guidance to the Orkney Islands Council team to support any offered advice.

I Grieve asked the Board to recognise the work undertaken by our IPC team, including additional work in the Community in relation to the new Care Home facility.

J Taylor asked for confirmation of the national targets in relation to *Staphylococcus aureus* bacteraemia (SAB) and *Escherichia coli* bacteraemia (ECB). The EDoNMAHP advised that challenges in relation to the Local Delivery Standard for *Staphylococcus aureus* bacteraemia, as the target was set at zero. NHS Orkney is unlikely to meet its *E. Coli* Bacteraemia target of no more than five cases due to current validated number.

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13.2 Six-monthly whistleblowing reports Quarter 1 and Quarter 2 (Presenter: Medical Director)

The Medical Director advised that no whistleblowing cases have been reported in the first 6 months of the year. Whistleblowing is not included in our mandatory training, recruitment is underway to raise the number of confidential contacts. Activities during speak up week were well received by the organisation.

The Interim Board Chair asked if we have enough capacity within the organisation to deal with whistleblowing. The Medical Director advised that there is a much greater awareness of whistleblowing across the organisation recognising that where a whistleblowing concern is taken forward this will require substantial support from the organisation.

J Taylor (Board Whistleblowing Champion) acknowledged that processes are in place, numbers remain low. Work has been undertaken to raise awareness of whistleblowing with independent contractors.

J Stevenson asked for clarity on how staff morale being low was identified and what is being done to improve staff morale. The Medical Director advised that this information was received by the confidential contacts. The Interim CEO advised that this was discussed at Staff Governance Committee, this needs to be triangulated with the information from the iMatter staff survey and regular pulse surveys with staff.

The Interim CEO asked the Board to reflect on the pro-active approach we take to encouraging staff to speak-up, this will be re-iterated at the next All staff briefing and Senior Leadership Team Meeting.

The Director of People and Culture advised that there is a need to create a culture of people raising issues in the moment.

The Medical Director asked the Board to recognising that the staff morale comment was in relation to the first 2 quarters of this year.

14. STRATEGIC OBJECTIVE - PEOPLE

14.1.1. iMatter 2025 National Report (Presenter: Director of People & Culture)

The Director of People & Culture presented the iMatter 2025 National Report noting that the Board is not an outlier but our engagement score may decrease as we start to look at changes to the ways we deliver services.

The key thing is that the people operations group is taking this piece of work forward particularly around speaking up.

Decision / Conclusion

The Board noted the update provided.

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15. STRATEGIC OBJECTIVE - PERFORMANCE

15.1. Month 7 Finance & Improving Together (efficiency programme) progress report (Presenter: Senior Financial Accountant)

The Senior Financial Accountant presented the Month 7 finance and Improving Together (efficiency) Programme progress report.

At month 7 revenue position shows an overspend of £2.759m, which is £0.508m higher than the planned year-to-date overspend of £2.251m.

Achieved savings at Month 7 is £0.194m adverse to the year to date target of £1.235m. The trajectory of savings was geared towards the final quarters of the financial year with 67.5% due to be delivered in the final 5 months of the year. Following a full review of each of the workstreams, only £1.3m of cash-releasing savings will be delivered (34% of the total target of £3.8m).

A refreshed approach to financial monitoring is now being adopted, financial control targets are now in place. Scottish Government require the Board to deliver a £2 million pound deficit at the year-end.

The Interim CEO advised that financial control target meetings have been undertaken with all Executive Directors, a process of monthly forecasting will be introduced in January 2026 as a standard process.

J Taylor reminded members that a presentation by the previous Director of Finance 12 months ago stated that the Board has posts over establishment and advised that there appears to be an understanding by our community and staff of the need to address the deficit.

The Interim CEO advised that the external financial review highlighted overspends due to staffing establishments – the introduction of financial control targets will the vacancy control panel will mitigate the risk as well as having in place a robust workforce plan noting policy constraint and the pressure which exist across all public sector services.

The Interim Board Chair asked for reassurance that the Vacancy Control Panel is working effectively. The Interim CEO provided assurance that all posts going through the panel are considered in line with the Health and Care Staffing Act, logged and available.

R Gold welcomed the introduction of financial control targets and asked what information will be provided to Board that has not been presented to date recognising the positive leadership changes and the time this takes to embed needs to be reflected to Scottish Government.

R Gold asked for clarity on the £1.3 million cash releasing savings. The Interim CEO advised that this figure relates to the original cash releasing savings plan identified by the Improving Together Programme Board. Following the financial review, turnaround actions equate to £1.75 million this in addition to the £1.3million cash releasing savings.

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Monthly Finance and Performance Committee meetings will provide assurance for the Board going forward.

Decision/conclusion

The Board discussed and noted Month 7 (November 2025) Financial Performance.

15.2. Operational Improvement Plan progress Update (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the Operational Improvement Plan progress update. Two actions remain off track

- **Digital Dermatology** – The Medical Director advised that the technology for Digital Dermatology in Primary Care was put in place in January 2025 and is now being tested by the Skerryvore Practice. The action is now rated amber/green.
- **Frailty service at the Front Door** – The EDoNMAHP advised that a locum consultant geriatrician is now in place, this action will be picked up as part of the Clinical Services Review, noting that the date cannot be revised as the target date has been set by Scottish Government

R Gold thanked the Director of Performance and Transformation for the presentation of the report and asked what the costs of actions rated amber are. The Director of Performance and Transformation advised that this work has not yet been completed by this and will be re-visited with the Interim Director of Finance.

F Mackay noted that there are several plans across the Organisation, there is a need to review all plans in their totality.

The Interim CEO advised that the actions within the OIP will not result in cost savings, noting these will be cost pressures and the nature of delivering remote and rural healthcare service delivery.

Decision/conclusion

The Board discussed and welcomed the update.

15.3. National Planning - Direction Letter Scottish Government (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the Direction Letter from Scottish Government in relation to sub-regional national planning published 13 November 2025.

The new model is designed to strengthen accountability for population-based planning, improve equity of access, and support the long-term transformation and sustainability of Scotland's health and care system.

Current national and place-based planning arrangements remain in place, with no changes to statutory functions or the Scottish Public Finance Model.

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The direction introduces two new collaborative sub-national structures to replace the previous three-region model, East and West, NHS Orkney will be part of the East Sub Regional Delivery Committee chaired by the CEO of NHS Lothian.

The structures will focus on four shared priorities including MyCare.scot, orthopaedic TTG delivery, emergency healthcare services, and a Once for Scotland approach to business systems. Both sub-national groups are required to produce consolidated financial planning for 2026/27 and provide quarterly performance reporting to Ministers.

Implementation is effective immediately, with further operational detail to be developed collaboratively as the new sub-national arrangements mature.

Each area will be required to produce an integrated financial plan.

The Interim Board Chair re-iterated the need for everyone to be part of shaping the planning going forward, there should be no difference to the way services are delivered to patients.

I Grieve raised concerns in relation to services being strengthened but remains skeptical of the changes being proposed.

R Gold asked for clarity on the short-term financial pressure referenced in the workforce section of the report. The Interim CEO advised that this is in relation to leadership capacity and the need to put forward plans for the 4 priority areas and the significant amount of work required to produce integrated plans.

The Interim Board Chair advised that feedback has been provided on the concerns raised by the Board.

Decision/conclusion

The Board discussed and noted the update recognising that the changes need to be reflected to Scottish Government.

15.4. Health and Social Care Surge Plan 2025/26 (Presenter: EDoNMAHP)

The EDoNMAHP presented the Health and Social Care Surge plan 2025/26. There are 5 core priorities

- Prioritise care for those most at risk.
- Utilise effective prevention.
- Ensure the right care, in the right place, at the right time.
- Maximise system capacity and capability.
- Support the mental health and wellbeing of the workforce.

A Target Operating Model for the Acute Setting was offered to the Board, recognising winter pressures are felt all year round.

The Chief Officer IJB discussed the challenges in relation to social care staffing and the inability to flex.

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R Gold thanked EDoNMAHP and Chief Officer IJB for the paper and asked if the Board were being asked to approve an overspend. The EDoNMAHP confirmed that the underspend will be used to deliver our surge plan. The Chief Officer IJB confirmed that additional funding has been identified to support the plan and will not make any material changes to our project spend this financial year.

J Stevenson asked for clarity on staffing levels if the bed base is increased and the impact this would have on safe staffing levels. The EDoNMAHP explained to the Board that an increase from 12 to 16 beds does not require any additional staff. If any patient is in our ED for more than 4 hours, they will be transferred to a bed.

Decision/conclusion

The Board discussed and approved the Health and Social Care Surge plan 2025/26.

16. STRATEGIC OBJECTIVE – POTENTIAL

No papers were presented.

17. ANY OTHER COMPETENT BUSINESS (AOCB)

No other competent business raised.

18. APPROVED MINUTES FROM GOVERNANCE COMMITTEE MEETINGS

19. Staff Governance Committee 15 May 2025

Members noted the minutes of the Staff Governance Committee 15 May 2025.

20. Audit and Risk Committee – 26 June 2025

Members noted the minutes of the Audit and Risk Governance Committee 26 June 2025.

21. Joint Clinical Care Governance Committee – 3 July and 20 August 2025

Members noted the minutes of the Joint Clinical Care Governance Committees 3 July and 20 August 2025.

22. Area Clinical Forum

No minutes received as the Area Clinical Forum has not met since the last Board Meeting.

23. Finance and Performance Committee 31 July 2025

Members noted the minutes of the Finance and Performance Committee 31 July 2025.

24. ITEMS FOR INFORMATION

- 24.1 a - Public Protection and Community Safety Information Sharing Protocol
- 24.2 b - Reduced Working Week Final Approved Implementation Plan NHSO
- 24.3 c - NHS Orkney - Climate Recognition - 23 September 2025

24.1. Board Meeting Schedule 2025/26 (Presenter: Chair)

Members noted the meeting schedule 2025/26.

Item 4

24.2. Record of Attendance 2025/26 (Presenter: Chair)

Members noted the meeting schedule 2025/26.

24.3. Questions from the public

No questions were raised.

The Interim Board Chair closed the meeting at 12.43

Board Chair and Chief Executive Report to the Board

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> • James Goodyear, Interim Chief Executive • Davie Campbell, Interim Board Chair
Report Author(s)	<ul style="list-style-type: none"> • James Goodyear, Interim Chief Executive • Davie Campbell, Interim Board Chair
Purpose of report	<ul style="list-style-type: none"> • Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Corporate Strategy 2024-2028 – Place, Patient Safety, Quality and Experience, People, Performance and Potential strategic objectives • Operational Improvement Plan • Integrated Joint Board Strategic Plan • Annual Delivery Plan 2024-2025 (ADP) • Financial Sustainability
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	<ul style="list-style-type: none"> • This report has been provided to update the Board on our performance, operational standards, key external/internal events and activities from January-February 2026, including meetings with external stakeholders and partners.
Route to meeting	<ul style="list-style-type: none"> • Prepared for NHS Orkney Board – 26 February 2026
Recommendation(s)	<ul style="list-style-type: none"> • Assurance - For members assurance only

Board Chair and Chief Executive Report to the Board

James Goodyear, Interim Chief Executive

Davie Campbell, Interim Board Chair

13/02/2026

1. Situation

- 1.1 This report has been provided to update the Board on our performance, operational standards, key external/internal events and activities from January-February 2026, including meetings with external stakeholders and partners.

2. Assessment

2.1 A summary of our overall performance

What's going well

Reducing our Waiting Lists

Performance remains on track to deliver no >52-week waits across all specialties by March 2026. Targeted Waiting List funding to increase new outpatient activity in Ophthalmology and Ear, Nose and Throat is contributing to this trajectory, and we continue to work closely with the Golden Jubilee to ensure optimal use of capacity for our longest-waiting Orthopaedic patients.

Children, Adolescent Mental Health Service (CAMHS) & Psychological Therapies

Our CAMHS and Psychological Therapies Services continue to exceed national targets for timely access.

Diagnostics

There has been sustained improvement across diagnostics and imaging services, notably in endoscopy, cardiology and local MRI provision. These developments have strengthened local access for patients and reduced dependence on external providers, thereby minimising the requirement for travel away from Orkney.

Emergency Department (ED)

Our 4-hour standard is at 94.75% against a target of 95% due to higher patient acuity and system flow pressures. Weekly reviews of data undertaken.

Cancer Standards

We continue to remain 100% compliant against the national 31-day treatment standard for Cancer.

Item 7

Population Health

Orkney's stop smoking services, run by Quit Your Way Orkney and local pharmacies, were ranked second in Scotland according to the NHS Stop Smoking Services Annual Report (April 2024 – March 2025).

Over half (53.2%) of those supported by Quit Your Way Orkney remained smoke-free after 12 weeks, well above the national average of 29.2%.

Maternity services

In February, we conducted a Maternity peer review and received highly positive feedback regarding the quality of our services. Staff particularly commented on feeling safe to raise concerns, the positive culture within our maternity services, and effective pathways with other Health Boards. Peer reviewers highlighted opportunities for enhancement, specifically recommending more proactive engagement with our risk management and clinical governance team. We will now develop an improvement plan to address these recommendations and note that a future review of our Maternity Services by Healthcare Improvement Scotland is anticipated.

People & Culture

The Workforce workstream of our 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. Mandatory training is discussed with Heads of Department at the Operational People Group and Directors will be held to account at the Performance Review Meetings and, where relevant, expected to provide improvement actions.

Areas for Improvement

Finance

Our financial position at Month 8 remains challenging, the Board is currently £782k adverse to trajectory, with key drivers including medical recruitment costs, agency nursing, and Primary Care prescribing along with legal and settlement fees.

Patient Safety, Quality & Experience

Current capacity challenges continue to affect the timely progression of SAERs. While recent reviews have appropriately triggered additional investigation, this has extended closure times. These delays are expected to reduce over the next quarter as the remaining open reviews are completed.

Two Stage One complaints were logged this month. The team is working proactively with responding teams to resolve these within expected timeframes. Although trends show some improvement, compliance has recently fallen outside control limits, likely linked to staffing pressures within senior nursing. A series of targeted workshops is planned for the coming quarter to support recovery.

New Outpatients

New Outpatient standard remains challenged with performance 58.68% against a target of 95%, with consultant workforce shortages and reliance on external support constraining recovery. The number of patients waiting more than 52 weeks has fallen but is now appearing to be stable. This indicates that recent additional capacity has been used effectively to tackle the longest waits and stabilise overall performance.

Item 7

Treatment Time Guarantee

Treatment Time Guarantee 12-week compliance remains challenged with performance currently 47.98% against a target of 100%, downstream capacity remains a constraint. The initial rise in people waiting in the year was in part due to additional capacity to see new patients leading to more on the waiting lists.

Delayed Transfers of Care

January has been an exceptionally busy month for inpatient services at the Balfour. Thank you to all our teams across the hospital and community for helping to care for patients and keep flow moving so that we can continue to meet the needs of patients attending the emergency department.

2.2 Interim CEO and Chair updates from local, regional and national stakeholder engagement

2.2.1 Interim Board Chair - Davie Campbell

I have attended meetings with the Board Chairs Group to discuss how we, as strategic leaders, advance the principles in the Service Renewal Framework and Population Health Framework. This includes ensuring that prevention is a topic of more conversation across our organisations and communities.

In December 2025, we submitted our Routemap to Reform proposal to the Scottish Government, representing a joint effort by NHS Orkney, Orkney Islands Council, and the Integration Joint Board to tackle financial and demographic challenges. Facing a combined annual deficit of around £26 million, our aim is to deliver sustainable, efficient public services through collaboration. The Scottish Government has backed our plans with £300,000 from the Invest to Save Fund to support transformation.

During December 2025, leaders from all three organisations worked together to develop and refine the Routemap, which received formal endorsement before submission. A Memorandum of Understanding is being developed to outline joint working principles via the Public Sector Reform Leadership Group, focusing on shared services, streamlined governance, cultural change, and digital transformation.

Two full day facilitated sessions are planned in February and March to align leadership and progress the next stage of reform.

Work is well underway on the recruitment of 2 Non-Executive Board Members, 2 very well attended information sessions have taken place, and we are confident we will be successful in appointing.

2.2.2 Interim Chief Executive – James Goodyear

National Priorities

I met with Caroline Lamb and other representatives of the Scottish Government along with NHS Board Chief Executives where we discussed progress against the Operational Improvement Plan (OIP) as well as planning for reducing the working week for agenda for change staff to 36 hours from April 2026.

I have worked closely with Chief Executives of partner health boards in the NHS Scotland East region as we step up work in response to DL(2025)25 Implementation of sub-national planning co-operation and planning directions 2025.

Item 7

Local engagement

Since the last Board Meeting, I have continued to meet with colleagues across the Organisation and our wider stakeholders.

Stephen Brown, Linda Bradford and I were pleased to meet Tom Arthur Minister for Mental Wellbeing and Social Care to discuss our mental health services. Mr Arthur commended Orkney on our CAMHS waiting times which consistently achieve the 18-week standard. We were also able to discuss some of our challenges including caring for people detained under the mental health act who are awaiting transfer to the mainland and to ask Mr Arthur for his support.

Congratulations to colleagues who have contributed to the Scottish Hip Fracture Audit including Rita Mildner care of the elderly consultant, and Diane Smith clinical governance and risk facilitator. NHS Orkney has been named as the health board with the most improved set of results. Participation in clinical audit is a key enabler to improving care for our patients and our results reflect the work done to establish comprehensive assessment for older people.

I've also been reflecting on the progress we are making to bring down the longest planned care waits; this is so important! Each week I hear from patients on the impact that long waits have on their lives. We expect to end the financial year with no one waiting for more than a year for either a new outpatient appointment, or planned procedure. Clearly, we must continue to bring down waits further, but I am encouraged by our progress.

Our interim Director of Finance Melanie Barnes will come to the end of her secondment with NHS Orkney in April 2026. Melanie has worked in NHSO since January 2025 initially as Deputy Director of Finance and then Interim Director of Finance. She has overseen financial management, planning and reporting Mel has also been the Executive lead for Digital and Estates and Facilities since August 2026. Mel has played a key role in supporting us to respond to our pressing financial challenge and I'm grateful to her for the leadership she has shown as a member of the executive team. We wish her well in returning to her substantive employer Scottish Ambulance Service.

Following advice from the Scottish Government I am taking steps to secure our finance leadership and will provide a further update in due course.

Corporate Risk and Assurance Report

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> • Dr Anna Lamont, Medical Director
Report Author(s)	<ul style="list-style-type: none"> • Diane Smith, Clinical Governance and Risk Facilitator
Purpose of report	<ul style="list-style-type: none"> • Discussion
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Annual Operational Plan • Emerging Issue • Local policy
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective
Key points for consideration	<ul style="list-style-type: none"> • Risk C-2026-01, Delivery of mandated digital projects, has been added to the Corporate Risk Register • Risk C-2024-02, Lack of organisational digital maturity, has increased the score from 10 to 15.
Route to meeting	<ul style="list-style-type: none"> • This is presented to this meeting only
Recommendation(s)	<ul style="list-style-type: none"> • Discussion - Consider the implications of a matter

Corporate Risk and Assurance Report

Diane Smith

13/02/2026

1. Situation

1.1 The Corporate Risk Register Report is presented to the Board to provide clarity, oversight, and strengthen organisational scrutiny. This report offers a concise view of changes over the past two months and illustrates how risks are distributed across governance committees.

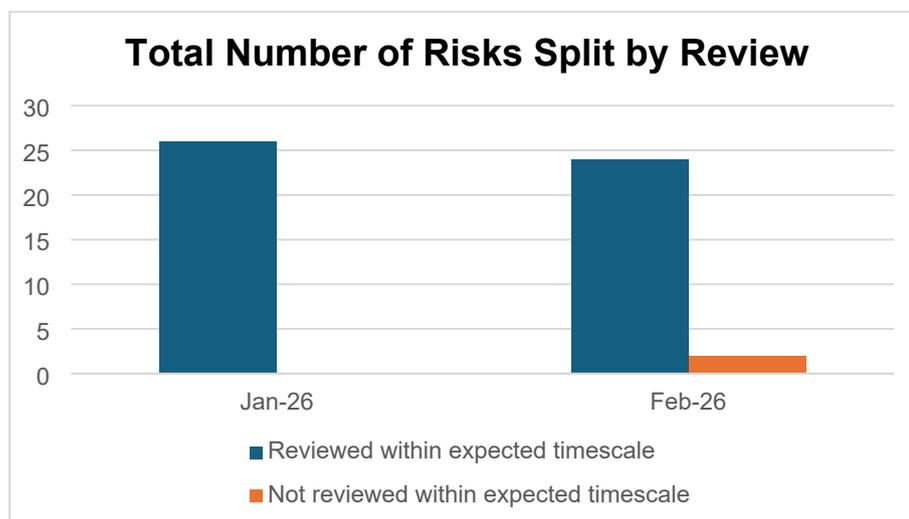
2. Background

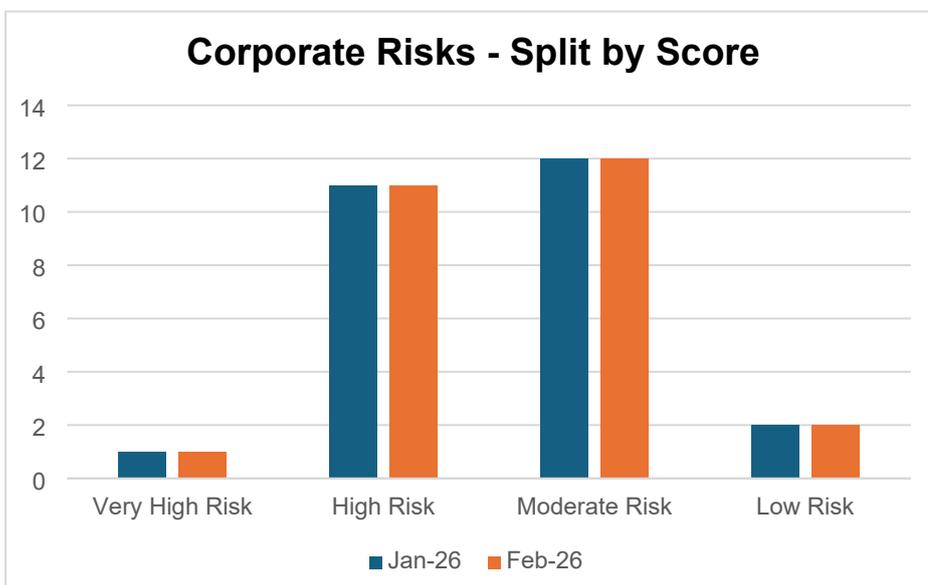
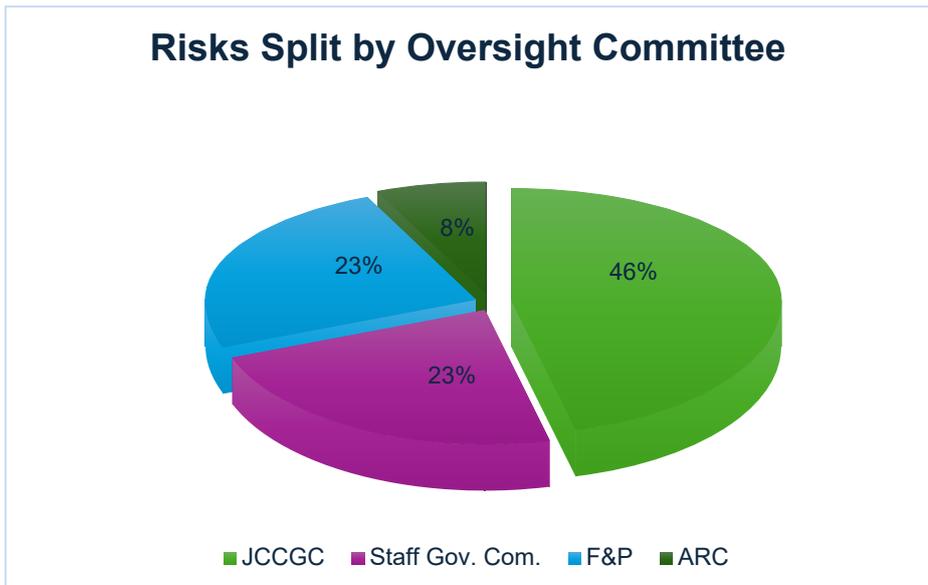
2.1 This report provides an at a glance view of what has changed over two months, and how the risks are shared across committees.

3. Assessment

3.1 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.

3.2 There are no risks put forward for addition or closure this month.





3.3 Normally, the top three corporate risks would be displayed below, but the second highest score is 16 and there are three scored at this, so the top four risks are displayed below.

Top Four Corporate Risks							
ID	Risk Title	Current Impact	Current likelihood	Current Risk Level	Target Risk Level	Mitigating Actions	Actions
510	Corporate Financial sustainability	5	4	20	10	<p>3.2m of efficiency programmes currently in implementation, 2.5m recurrent (above 3% target)</p> <p>in excess of 1m in cost reduction schemes</p> <p>Strengthened governance arrangements - scheme of delegation, performance review meetings, streamlines investment approval process</p> <p>Additional grip and control measures - vacancy control panel, discretionary spend, budget trackers, workforce establishments</p> <p>Plan currently on track to be delivered, expectation is brokerage support to this value will be received.</p> <p>Financial Escalation Board to be stood up.</p>	<p>Update 06/01/2026 - Year-end forecast continues to be £4.2m which is £2.0m higher than the approved financial plan. SG informed of the deteriorated position and details are awaited on the implication for the receipt of the transitional funding. Revised approach to budget management is now implemented and Directors have an expenditure control target for the remainder of the year. Risk score to remain the same at this time.</p> <p>Update 02/12/2025 - Year-end forecast has been revised to and estimate of £4.2m which includes delivery of the turnaround actions of £1.746m. This has been reported to SG and discussed at the Q2 review. Ongoing scrutiny of control targets and expenditure remains in place. Communication sent out confirming no discretionary spend should be incurred. Risk score to remain the same at this time.</p> <p>Update 10/11/2025 - Year-end forecast has been revised to estimate a £6.2m deficit at 31 March 2026. This is £4.2m higher than the approved financial plan. Turnaround actions estimated at £1.746m have been identified, leaving circa £2.45m gap. A revised approach to budget management is being implemented with Directors being given an expenditure control target for the remainder of the year and monthly financial performance meetings with CEO and DoF. SG informed of the deteriorated position.</p> <p>Update 17/10/2025 - Month 6 financial results continue to be off track. A full review of the expenditure forecast and the savings programme has been undertaken in Month 6. This has identified that £4.9m of savings will not be delivered (£2.5m of the £3.8m Improving Together Programme and £2.4m of the £2.4m IJB Savings)</p> <p>An action plan has been received which shows the best, mid and worst case for delivering expenditure reduction for the remaining of the financial year. This is being assessed by the Executive Team and recommendations will be presented to the</p>

						<p>Board.</p> <p>Risk score to remain the same at this time</p> <p>Update 19/08/2025 Month four financial results remain off track for cost savings and delivery of the financial plan. Significant risks around delivery of several of the efficiency programmes remain. Initial measures agreed by SLT have not yet had an effect on reducing costs. Further measures discussed by SLT are being scoped out. Risk scores to remain the same.</p> <p>Update 21/07/2025 Q1 off track for expected cost savings. Q2 forecast showing unlikely to meet expected cost savings. Initial measures agreed by SLT to be implemented immediately these will have a limited effect on reducing costs, further plans are to be brought back to SLT in August to reduce costs over the remainder of the year. Risk likelihood increased to 4, increasing risk score to 20. Score now High risk.</p>
C-2024-01	Lack of senior leadership capacity and capability	4	4	16	4	<p>8a – d leadership development programme and PDPs for all senior leaders</p> <p>SLT formal development programme</p> <p>8c and d personal objectives set and agreed by Remuneration committee</p> <p>Interim Director of Finance commenced in post in September 2024 for 6 months</p> <p>Interviews for substantive Director of Finance are at the end of October</p> <p>Interim Head of Strategy in post on secondment for 6-month period</p> <p>Update 19/01/2026 - Interim Director of Finance appointed and substantive Chair and CEO recruitment being progressed with Scottish Government.</p> <p>Update 21/11/25 - Substantive Director of People and Culture has joined the organisation and will lead on the review of the leadership and development programme.</p> <p>Update 18/08/25 - SLT approved the management training programme in July 2025 and draft papers are in development for the senior leadership programme, which will come to SLT for approval in August. The Interim Chief Executive will start on 15 September and that process is being finalised in collaboration with the Scottish Government. The Interim Director of Finance has agreed to extend her secondment until 31 March 2026, and the next Director of People and Culture will start on 17 November 2025. An Interim Director of People and Culture will be in place part-time between 1 September and 30 November.</p> <p>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.</p> <p>Update 3 Feb 2025 – Interim Director of Finance has been appointed from SAS on a 6-month secondment. Successfully</p>

							appointed the Director of Performance and Transformation (Deputy Chief Executive) start date to be confirmed.
C-2025-06	Strategic Clinical Leadership and Engagement Capacity	4	4	16	8	<p>Clinical Advisory Group Improvement Plan By 30 September 2025, complete and implement the improvement plan for clinical advisory groups, aligned with the review of operational governance. This will include:</p> <ul style="list-style-type: none"> • Defined administrative support and resource commitments to support clinical advisory groups, noting that Copilot is now available to help minimise admin burden for notetaking at least. • Monthly Executive attendance rota established and monitored. • Formalised escalation process for advisory groups via Chair's Assurance Reports, with documented feedback loops to confirm action and closure. <p>By 31 December 2025 - implement the CSR Recommendations relevant to the risk:</p> <ul style="list-style-type: none"> • Ensure project management support via the Improvement Team is in place to support clinical and operational redesign work. This will be complemented by the quality improvement training commencing with cohort 1 in September 2025. • Clinical lead workstream team meetings to be scheduled from Q3, using CSR templates for service redesign. Outcomes to be reported to the Improving together Programme board. • Substantive consultants engaged in national planning meetings, for example, pharmacogenetics project, thrombectomy for stroke management, and senior mental health representation. <p>By 30 September 2025 review Workforce Models and Experience</p>	<p>Update 04/11/2025 Following three workshops earlier in the year, improvements and resource necessary to support the CAGs agreed. All groups now have administrative support for actions and compiling papers/agendas. Exec attendance consistent and has been reviewed as part of ACF agenda. Clinical governance escalation pathway prev agreed and feedback given to groups - template for escalation and return yet to be developed if required. Consultant recruitment now on rolling recurring advert if unsuccessful. Clinical leadership vacancies remain unchanged.</p> <p>Update 11/09/2025 - Agreed for addition to Corporate Risk Register at SLT.</p>

						<ul style="list-style-type: none"> • Commence the exploration of innovative workforce models and regional collaboration to attract and retain senior clinicians in key service leadership positions, recognising the challenges of remote and rural recruitment. • Explore opportunities to improve experience across the employee journey, particularly recruitment, experience for existing clinical staff, and succession planning. Including ensuring all clinical vacancies are advertised promptly, training and development of existing staff, and a named support contact for new senior staff. • Use the iMatter action planning process to co-design improvements in experience for consultants. 	
1225	Insufficient capacity in the social care system	4	4	16	4	<p>Daily safety and site huddles to review site capacity and flow. Twice weekly RMM held to actively discuss DToC.</p> <p>All patients nearing 4 hrs in ED escalated through operational management for agreement to plan.</p> <p>Site surge and capacity plan in place. Daily review of PDD.</p> <p>Active conversations with patients in regard to discharge and early discharge planning.</p>	<p>Update 24/12/2025 - Score reviewed remains at 16. Currently 13 DTOC on site. Current system wide pressures preventing transfer of care to appropriate placement. Older persons pathway and frailty remain key workstreams linked with strategic priorities. Agreement to review risk description following discussion at NHS Orkney Board, new risk description will be complete prior to next Board.</p> <p>30/09/2025 - Current score increased to 16 due to increased DTOC. Currently 17 DTOC, this has been the situation since the first week in July 2025. Current system wide pressures preventing discharge to appropriate placement leading to cancellations of elective procedures. System pressures paper discussed at IJB in July 2025 work streams underway to address reasons for DTOC.</p> <p>Update 14/05/2025 - Business as usual and business continuity plans effective. No services compromised, therefore score reduced to 8.</p> <p>Update 25/02/25 - Mitigating actions remain in place current DToC 12. Risk highlighted at formal executive meeting, SLT and IJB.</p>

3.1 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The robust management of risk provides a safe environment and improves patient safety, quality of care and experience
People	Workforce	No	
Performance	Finance	No	
Potential	Risk Management	Yes	Effective risk management processes are required to underpin the Board's corporate objectives. Risk identification, assessment and management is supported through the presentation and review of the Corporate Risk Register
	Digital	No	
Place	Equality and Diversity including health inequalities	No	
	Climate Change Sustainability	<i>No</i>	

4. Recommendation(s)

4.1 It is asked that the Board discuss the current risks, scores and mitigations of the Corporate Risk Register.

- i **Discussion** – Consider the implications of a matter

5. List of appendices

5.1 The following appendices are included with this report:

- i **Appendix 1**, Corporate Risk Register

Integrated Performance Report (IPR) February 2026 – NHS Orkney Board

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> Tammy Sharp, Director of Performance and Transformation
Report Author(s)	<ul style="list-style-type: none"> Carrie Somerville, Head of Planning, Performance, and Information
Purpose of report	<ul style="list-style-type: none"> Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> Corporate Strategy 2024/28 Annual Operational Plan Emerging Issue Government policy/directive Legal requirement Local policy NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> Safe Effective Quality
Key points for consideration	<ul style="list-style-type: none"> Operational and Workforce Resilience - Sustained service delivery continues to be challenged by workforce gaps, sickness absence, appraisal compliance, and high reliance on temporary staffing. Strengthened accountability, focused People & Culture interventions, and safe-staffing governance remain essential to stabilise performance and reduce operational strain. Financial Sustainability and Performance Variance - The Month 8 financial position shows a material adverse variance driven by unplanned cost pressures, undelivered savings, and a late tariff adjustment. Continued cost control, delivery of savings plans, and reducing reliance on locum and bank staffing are critical to restoring financial grip and improving sustainability. Quality, Safety and Access to Care - While some areas (e.g., childhood immunisations) are performing strongly, key quality and access standards—including Waiting Times, diagnostic sustainability, complaint response times, MEWS compliance, and screening coverage—are off track. Targeted improvement activity, diagnostic capacity stabilisation, and consistent

	oversight through groups like the Screening Oversight Group are required to strengthen quality and patient safety.
Route to meeting	<ul style="list-style-type: none"> • Finance, Community and Operational Chapters - Finance and Performance Committee • People and Culture Chapters – Staff Governance • Patient Safety, Quality and Experience and Population Health – Joint Clinical Care and Governance Committee
Recommendation(s)	<ul style="list-style-type: none"> • Decision - Reaching a conclusion considering the options

Integrated Performance Report (IPR) February 2026 – NHS Orkney Board

Report Author – Carrie Somerville

09/02/2026

1. Situation

- 1.1 The Integrated Performance Report (IPR) – NHS Orkney Board February 2026 (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 2025/26, Financial Recovery Plan and our Improving Together (efficiency) Programme.
- 1.2 Members are asked to receive and approve the Integrated Performance Report (IPR) – NHS Orkney Board February 2026. Noting where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

2. Background

- 2.1 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).

3. Assessment

3.1 Analysis

The report provides an overview of organisational performance across patient safety, operational standards, workforce, community services, and finance. The period covered by the performance data is generally up to the end of December 2025. However, there are some measures with a data time lag either due to their nature or when the information is published by Public Health Scotland.

3.2 Current Position

A summary of key performance highlights and challenges for consideration are included. The following bullet points outline areas of strong performance, as well as ongoing challenges and actions in progress, to support informed discussion.

Key Performance Highlights

- The Month 8 financial position is again adverse against the planned trajectory. The reporting position is £0.782m higher than the planned overspend of £2.369m.
- The Board remains at Level 3 under the national Support and Intervention Framework for Finance, reflecting ongoing financial risk.
- Waiting Times for new outpatients and elective procedures continue to miss NOP and TTG standards, with weekly waiting times meeting providing oversight for patient waits.
 - New Outpatients performance is monitored weekly against all those patients waiting over 20 weeks.
 - TTG performance is monitored weekly against all those patients waiting over 10 weeks
- Diagnostic resilience has improved significantly, with performance now approaching the six-week standard, supported by increased local capacity.
- Successful recruitment into critical posts is enhancing neurodiversity assessment capacity and strengthening mental health liaison functions.
- Community and Acute teams continue to demonstrate strong collaboration to maintain safe, coordinated care for patients.
- Continued improvements within PHIO are contributing to shorter waits for AHP-led MSK services.
- Uptake for both MMR and 6-in-1 vaccinations remains above the 95% target and national averages, maintaining strong population coverage.
- Twelve-week successful quit rates have risen to 53.2%, significantly above the Scottish mean (29.2%), placing NHS Orkney as the second-highest performing board in Scotland.
- A continued downward trend in Stage 1 complaints indicates effective early resolution and strengthened engagement with service users.
- Governance and risk groups now benefit from stronger multidisciplinary and medical representation, improving scrutiny and alignment of actions with learning.

3.3 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 – 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	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.
People	Workforce	Yes	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.
Performance	Finance	Yes	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.
Potential	Risk Management	Yes	There are six risks on the Corporate Risk Register that relate to Finance, Operational Standards or Community these include, Corporate Financial sustainability, Waiting Times data and Lack of organisational digital maturity.
	Digital	Yes	There is a significant risk that the lack of digital maturity, leadership, governance, and a digital strategy which is understood across the organisation will impact on the delivery of our corporate strategy, the delivery of safe patient care and the implementation of our improvement programme across health and social care.
Place	Equality and Diversity including health inequalities	Yes	Reducing health inequalities is a key priority as part of the Place strategic objective. Our Corporate Strategy takes into consideration local, regional, and national policy.
	Climate Change Sustainability	Yes	Specific 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.

4. Recommendations

- **Receive** and **approve** the Integrated Performance Report (IPR) – NHS Orkney Board - February 2026 ahead of it going onward to the public Board Meeting in February 2026
- **Note** where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

4.1 Decision - Reaching a conclusion considering options

5. List of Appendices

5.1 The following appendices are included with this report

- Appendix 1**, the Integrated Performance Report (IPR) – NHS Orkney Board – February 2026.



Integrated Performance Report

Interim Chief Executive:
James Goodyear

February 2026



HEALTH Intelligence

ORK.healthintelligence@nhs.scot

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, green or amber 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.

RAG Status Values	
RED	Key performance indicator not achieved, and performance below average.
AMBER	Key performance indicator not achieved, but performance above average.
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.

The Integrated Performance Report forms the summary view of performance against the organisation's six key domains; Operational Standards (Acute and Community), Population Health, Workforce, Patient Safety, Quality, and Experience, and Finance. Whilst the previous section details how we monitor compliance with national or local standards, we also need to ensure that any significant variance in any given area is monitored, and if necessary, appropriate actions generated. To do this we use Statistical Process Control to assess performance.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action. Our Integrated Performance Report incorporates the use of SPC Charts to identify common cause and special cause variations and uses NHS Improvement SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor. The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 25 data points are needed for a statistical process control chart to have meaningful insight. Data is monitored using the empirical rule which states that 95% of data should fall within 2 standard deviations from the mean, and 99.7% should fall within 3 standard deviations. Values extending beyond these ranges would be considered outliers, identifying them as areas for further review. Trends would be considered under two types of variation: Special Cause (**Concerns** or **Improvement**) and Common Cause (i.e. no significant change). Examples of the symbols that will be used throughout this report have been shown to the right of this page.

Statistical Process Controls may not be applicable to all KPIs featured in the Integrated Performance Report. Where this is the case, these KPIs will use the previously established format.

Variance

Icon	Description
	Common Cause Variation which indicates that there is no significant change in the process
	Special cause variation of concerning nature due to (H)igher values.
	Special cause variation of concerning nature due to (L)ower values.
	Special cause variation of improving nature due to (L)ower values
	Special cause variation of improving nature due to (H)igher values.

Variation Icons: **Orange** indicates concerning special cause variation requiring action; **blue** indicates where improvement appears to lie, and grey indicates no significant change (common cause variation).

Assurance

Icon	Description
	Variation indicates consistently (F)alling short of the target.
	Variation indicates consistently (P)assing the target.
	Variation indicates inconsistently hitting, passing and falling short of the target. This means that the target may sometimes be met and sometimes missed due to random variation.

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation.

NHS Orkney Performance Scorecard

Key Performance Indicators

Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG
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	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	23	Red
4 Patient Safety, Quality, and Experience	Complaints	Number of complaints received.	Medical Director	0	4	Grey
5 Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 1 5 Working Day Response Compliance	Medical Director	100%	50.0%	Red
6 Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 2 20 Working Day Response Compliance	Medical Director	100%	100%	Green
7 Patient Safety, Quality, and Experience	Complaints	Complaints upheld and partially upheld by SPSO	Medical Director	0	0	Green
8 Patient Safety, Quality, and Experience	Incident Reporting	Incident Reporting and 7 Working Day Review Compliance	Medical Director	100%	100%	Green
9 Patient Safety, Quality, and Experience	Significant Adverse Event Reviews	Significant Adverse Event Review Compliance (closed within target date)	Medical Director	100%	50.00%	Red
11 Patient Safety, Quality, and Experience	Women and Children	Maternal Early Warning Score Observations	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	75.0%	Red
12 Patient Safety, Quality, and Experience	Women and Children	Maternal Early Warning Score Escalation	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%	75.0%	Red
13 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	95%	90.0%	Red
14 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	95%	50.0%	Red
15 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%	47.98%	Red
16 Operational Standards	Planned Care	10% reduction in waiting times for Treatment Time Guarantee patients	Medical Director	-10%	6.11%	Red
18 Operational Standards	Planned Care	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%	Medical Director	95%	58.68%	Red
19 Operational Standards	Planned Care	90% of planned/elective patients to commence treatment within 18 weeks of referral	Medical Director	90%	79.8%	Red
20 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%	77.27%	Amber
21 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%	89.88%	Amber
22 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%	94.44%	Amber
23 Operational Standards	Planned Care	0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	Director of Performance and Transformation & Deputy Chief Executive	0	15	Amber
24 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
25 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
28 Operational Standards	Inpatients	Pre-noon discharges	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	25.0%	23.13%	Amber
29 Operational Standards	Unscheduled Care	95% of patients wait no longer 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%	94.75%	Amber
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%	99.85%	Amber
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	00:40:29	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%	37.50%	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	16	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	409	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%	100%	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%	66.67%	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%	58.5%	Amber
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%	25%	Amber
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%	70.09%	Amber
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%	87.5%	Amber
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%	75.28%	Amber
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%	8.33%	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%	91.7%	Green
48 Population Health	Promoting health and wellbeing outcomes	Increase smoking cessation active clients year-on-year	Medical Director	21	17	Red
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)	Medical Director	16	11	Red
50 Population Health	Prevention of Disease	Immunisation uptake rate 6-in-1 primary Course by 12 months	Medical Director	95.0%	96.90%	Green
51 Population Health	Prevention of Disease	Immunisation uptake rate MMR2 by 6 years of age	Medical Director	95.0%	95.30%	Green
52 Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	Medical Director	100.0%	93.8%	Red
53 Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	Medical Director	100.0%	100%	Green
54 Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	Medical Director	100.0%	100%	Green
55 Population Health	Promoting health and wellbeing outcomes	Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	Medical Director	100.0%	84.60%	Red
56 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%	Medical Director	98%	100%	Green
57 Workforce	Sickness Absence	Sickness rates consistently below the national average of <6%	Director of People and Culture	6.71%	6.90%	Red
58 Workforce	Sickness Absence	Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	Director of People and Culture	6.37%	6.11%	Green
59 Workforce	Appraisals	Appraisal compliance rate over the previous 12 months	Director of People and Culture	85.00%	44.44%	Red
60 Workforce	Hours Utilised	Agency hours used vs. average.	Director of People and Culture		1520	Grey
61 Workforce	Hours Utilised	Bank hours used vs. average.	Director of People and Culture		6658	Grey
62 Workforce	Hours Utilised	Overtime hours used vs. average.	Director of People and Culture		519	Grey
63 Workforce	Hours Utilised	Excess hours used vs. average.	Director of People and Culture		996	Grey
64 Finance	Finance	Financial performance against plan - YTD.	Director of Finance	£2,369,000	£3,151,000	Red
65 Finance	Finance	Financial performance against plan - Forecast.	Director of Finance	£2,176,000	£4,200,000	Red
66 Finance	Finance	Efficiency performance against plan - YTD.	Director of Finance	£1,615,000	£1,291,000	Red
67 Finance	Finance	Efficiency performance against plan - Forecast.	Director of Finance	£3,800,000	£2,224,000	Red
68 Finance	Finance	Efficiency programme recurrent savings against plan.	Director of Finance	£1,190,000	£928,000	Red
69 Finance	Finance	Capital performance against plan - YTD.	Director of Finance	£977,000	£12,000	Green
70 Finance	Finance	Capital performance against plan - Forecast.	Director of Finance	£1,675,000	£1,675,000	Green
71 Finance	Finance	75% of invoices to be paid within 10 days of receipt - local target	Director of Finance	75%	62.68%	Red
72 Finance	Finance	90% of invoices to be paid within 30 days of receipt - local target	Director of Finance	90%	85.02%	Red

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 February 2026.

Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG
26 Operational Standards	Theatre	Theatre Utilisation	Medical Director	N/A	43%	
27 Operational Standards	Inpatients	Ensure that acute receiving occupancy is 95% or less.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%		
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%		
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%		

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. The number of stage one complaints continues to reduce, and is recognised as staff undertaking to resolve more issues as a concern raised at a ward level.

Broad and consistent representation at clinical governance groups and risk management groups is now well established, and recently welcomed increased medical representation. These groups are robustly challenging reports and risks to ensure actions arising are consistent with the learning identified.

The updated Significant Adverse Event Review (SAER) process had been ensuring compliance within target time frames however this has fallen below target. All outstanding SAERs are expected to be closed within the next quarter.

RAG Status Values

RED	Key performance indicator not achieved, and performance below average.
AMBER	Key performance indicator not achieved, but performance above average.
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 or amber status will be accompanied with improvement actions, and a timeline for recovery of the position.

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. The updated control chart methodology now better shows where changes over time are significant.

The number of reviewers available for SAERs is a limiting factor for completion to target time frame.

PEWS bundle charting remains non-compliant with national target, though there is good compliance with identifying at risk observations.

The increased number of inpatient falls (without harm) seen in the last month. This is in part due to the nature of patient acuity and frailty across all inpatient areas and high levels of occupancy.

Patient Safety, Quality, and Experience

Number of Complaints Received

Data Source

Patient Experience Officer

Latest Data

31/12/2025

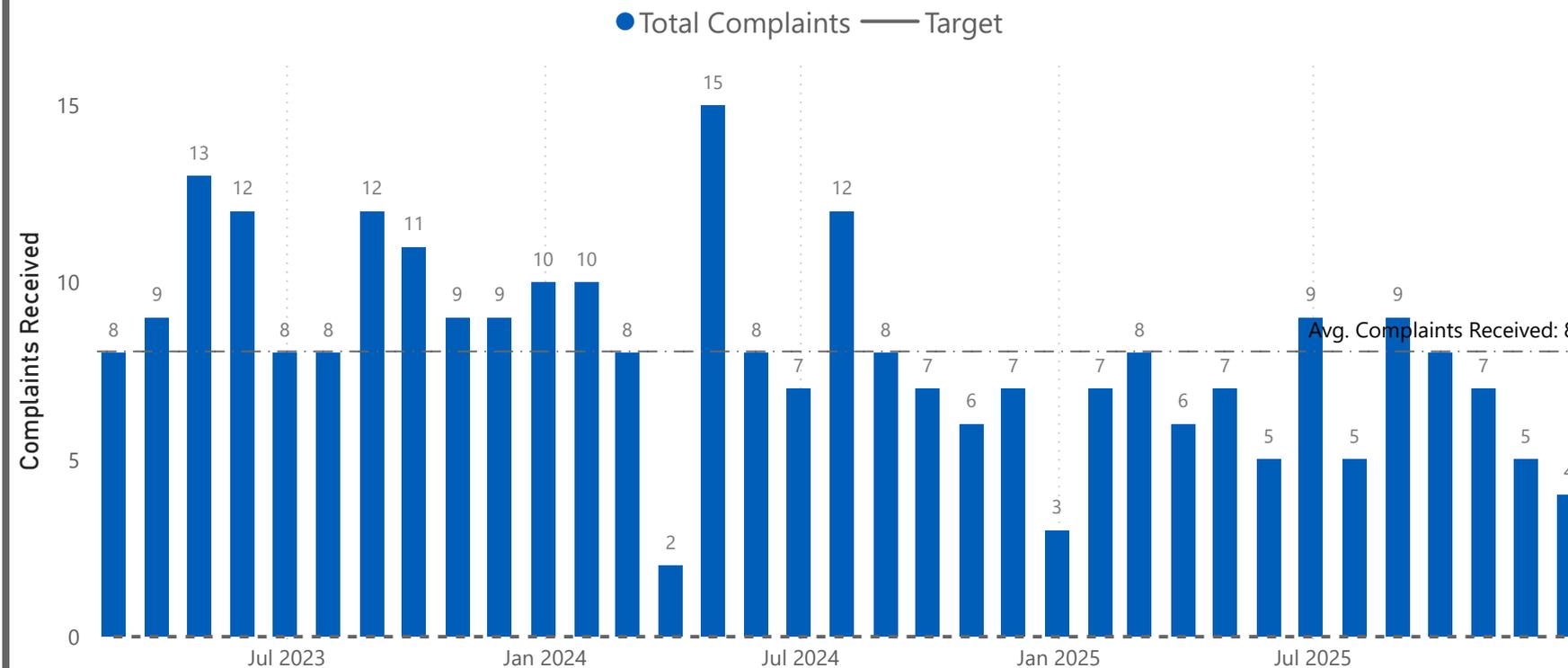
Compliance

KPI	Target	Actual	RAG Value
Number of complaints received.	0	4	Grey

Action	Target Date	Owner	Status
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No target set, actions and target to be updated.

Total Complaints Received



Comments From Executive Lead

There is currently no nationally recognised metric for benchmarking complaints and the organisation welcomes all feedback as this helps to identify areas of excellence as well as areas for improvement.

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Stage One Complaints

Data Source
Patient Experience Officer

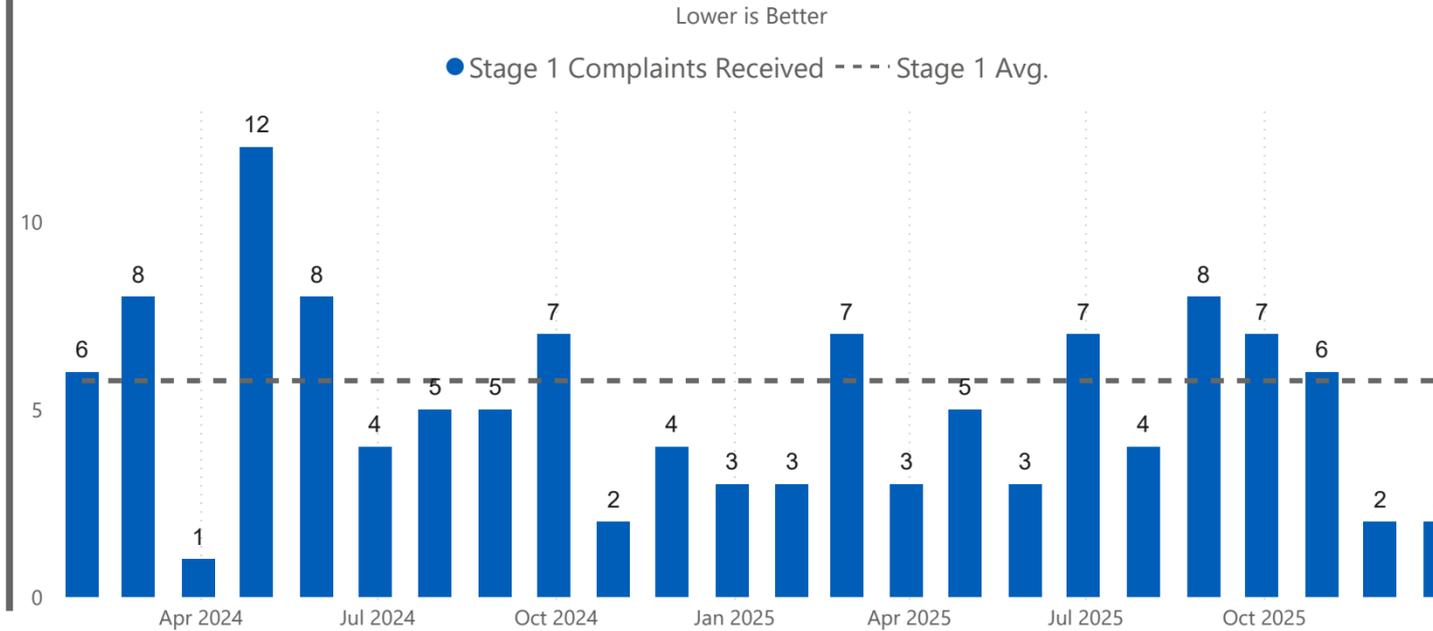
Latest Data
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Complaints Received - Stage 1 5 Working Day Response Compliance	100%	50.0%	Red

Action	Target Date	Owner	Status
Targeted workshops on complaints management to be held	31/12/2025	A Lamont	Off Track

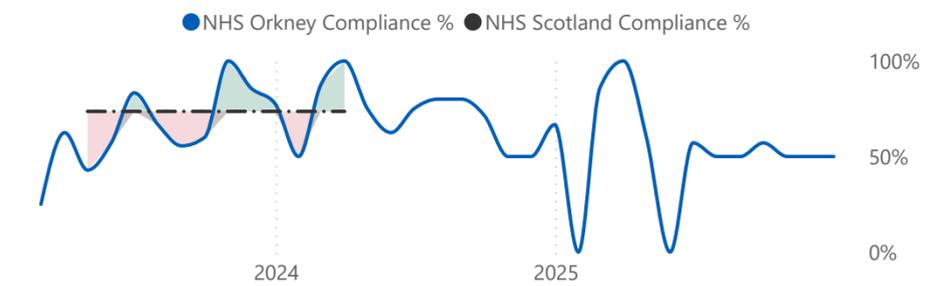
Stage One Complaints Received



Stage One Complaints Received



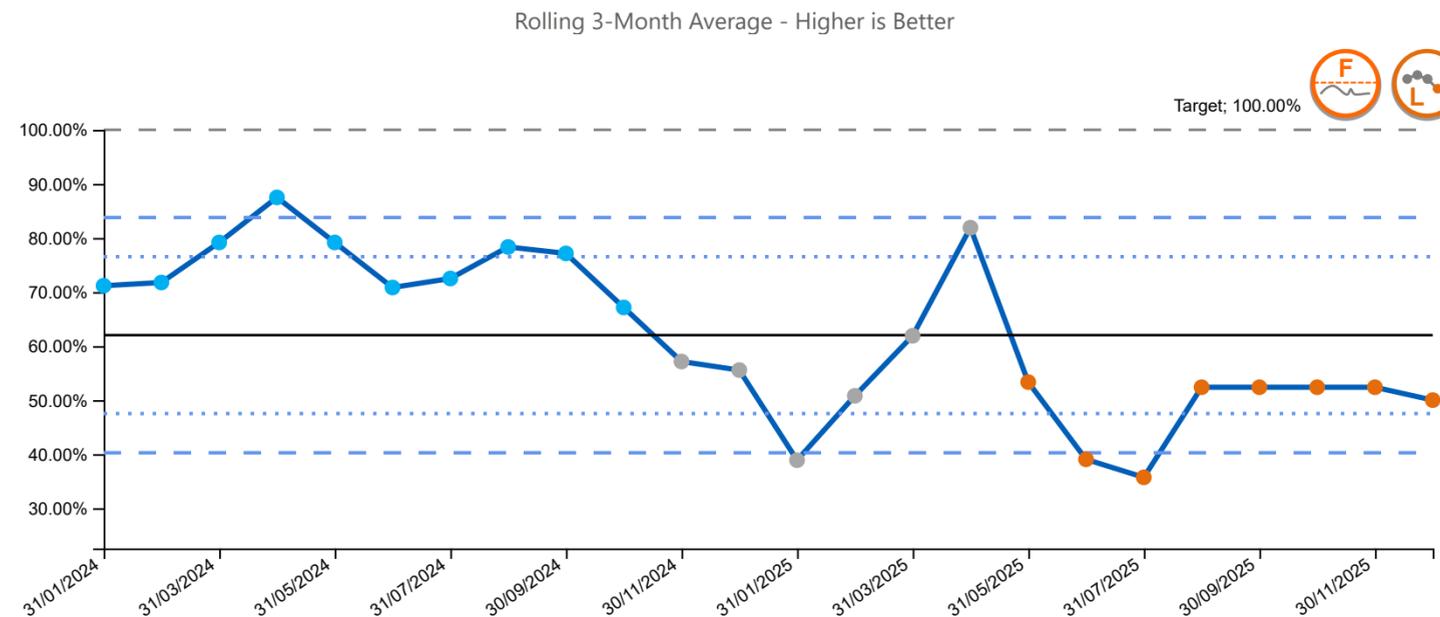
Stage One 5 Working Day Compliance vs. NHS Scotland



Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/01/2024	71.16	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
29/02/2024	71.76	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
31/03/2024	79.17	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
30/04/2024	87.50	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
31/05/2024	79.17	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
30/06/2024	70.83	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
31/07/2024	72.50	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
31/08/2024	78.33	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
30/09/2024	77.14	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
31/10/2024	67.14	62.02	40.26	83.78	47.51	76.53	IMPROVEMENT
30/11/2024	57.14	62.02	40.26	83.78	47.51	76.53	NONE
31/12/2024	55.56	62.02	40.26	83.78	47.51	76.53	NONE
31/01/2025	38.89	62.02	40.26	83.78	47.51	76.53	NONE
28/02/2025	50.79	62.02	40.26	83.78	47.51	76.53	NONE
31/03/2025	61.90	62.02	40.26	83.78	47.51	76.53	NONE
30/04/2025	81.90	62.02	40.26	83.78	47.51	76.53	NONE
31/05/2025	53.33	62.02	40.26	83.78	47.51	76.53	DETERIORATION
30/06/2025	39.05	62.02	40.26	83.78	47.51	76.53	DETERIORATION
31/07/2025	35.71	62.02	40.26	83.78	47.51	76.53	DETERIORATION
31/08/2025	52.38	62.02	40.26	83.78	47.51	76.53	DETERIORATION
30/09/2025	52.38	62.02	40.26	83.78	47.51	76.53	DETERIORATION
31/10/2025	52.38	62.02	40.26	83.78	47.51	76.53	DETERIORATION
30/11/2025	52.38	62.02	40.26	83.78	47.51	76.53	DETERIORATION
31/12/2025	50.00	62.02	40.26	83.78	47.51	76.53	DETERIORATION

Stage One Complaints - 5 Working Day Response Compliance



Comments From Executive Lead

There were two Stage One complaints recorded in the last month. The PSQE team continues to collaborate closely with the relevant responding teams to ensure timely and effective resolution. While there has been improvement compliance has been outside of control limits in recent months considered likely to relate to staffing changes and pressures for senior nursing. Improvement target for next quarter based on targeted workshops on complaint management.

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Stage Two Complaints

Data Source
Patient Experience Officer

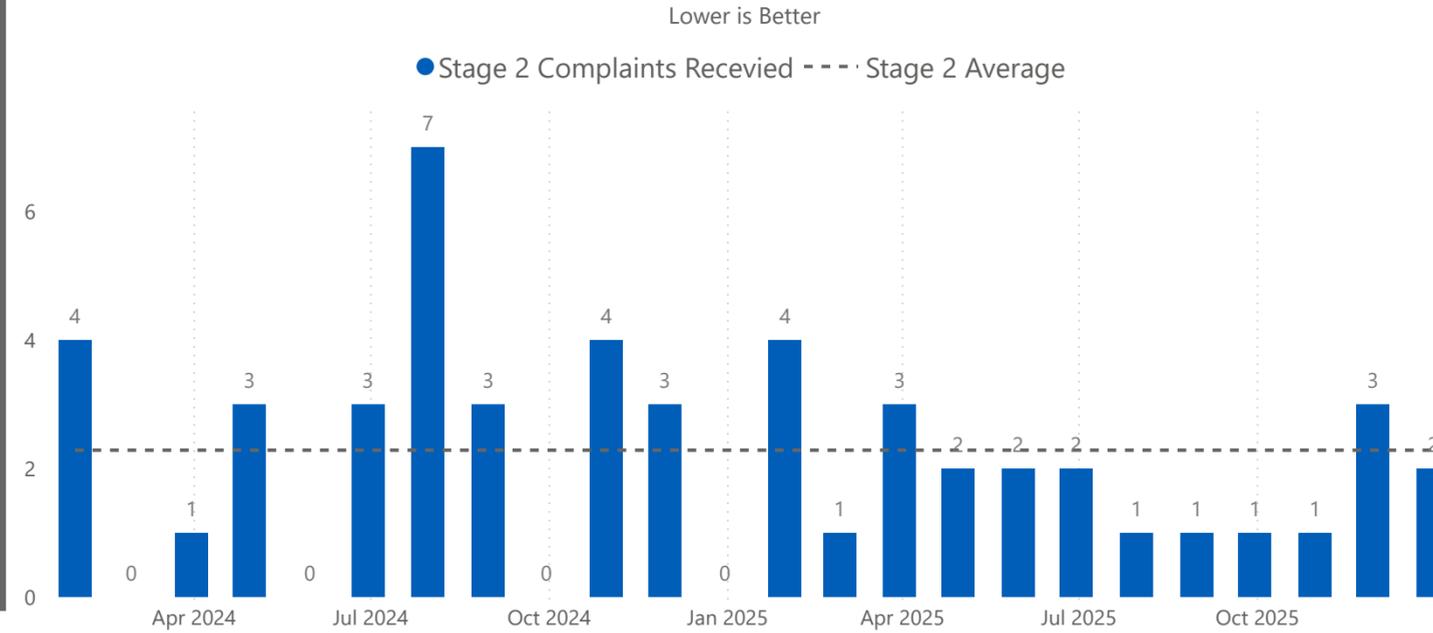
Latest Data
31/12/2025

Compliance

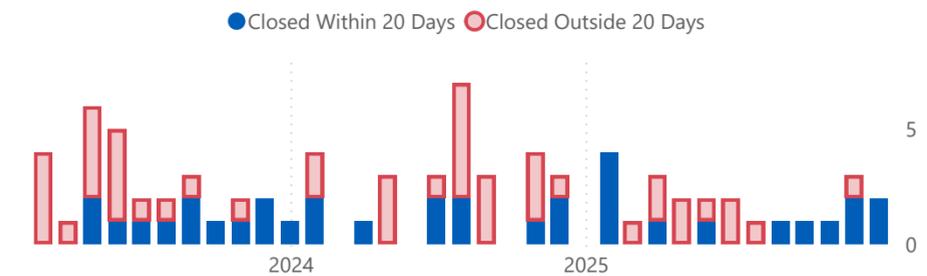
KPI	Target	Actual	RAG Value
Complaints Received - Stage 2 20 Working Day Response Compliance	100%	100%	Green

Action	Target Date	Owner	Status
Targeted workshops on complaints management to be held		A Lamont	In Progress

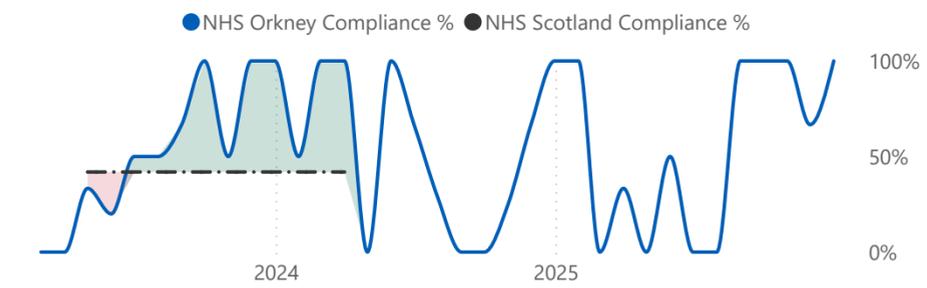
Stage Two Complaints Received



Stage Two Complaints Received



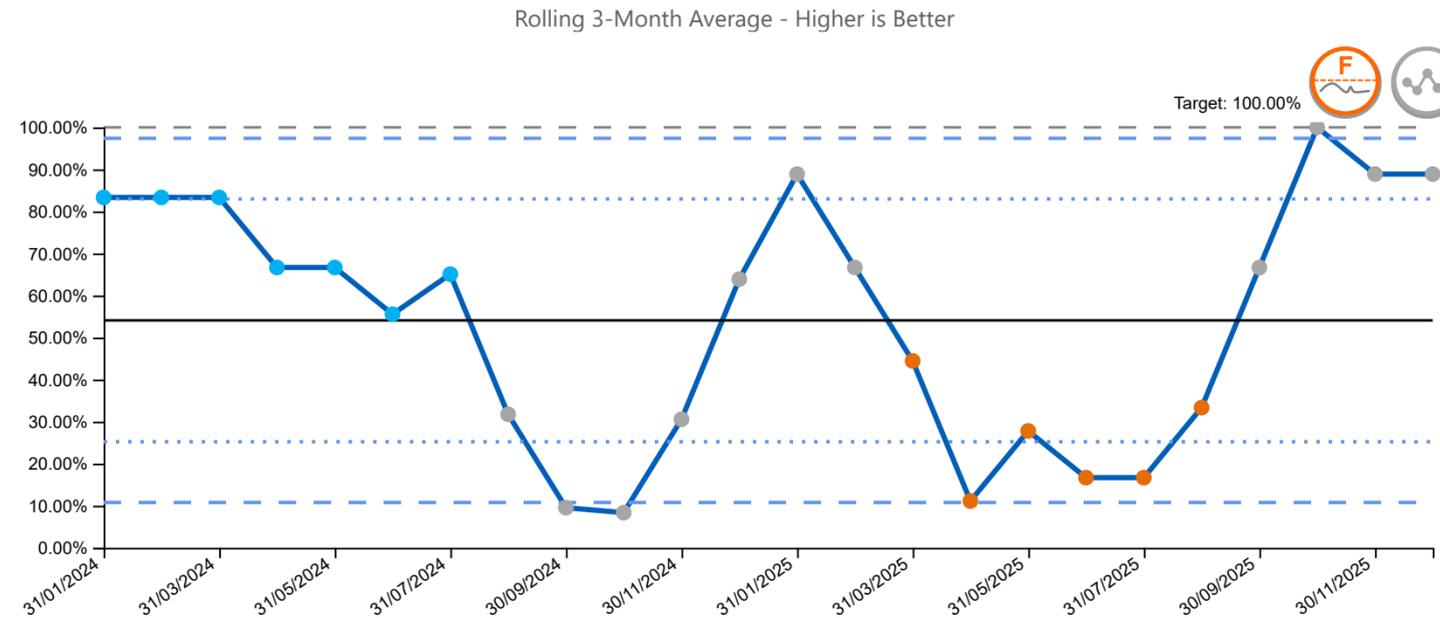
Stage Two 20 Working Day Compliance vs. NHS Scotland



Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/01/2024	83.33	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
29/02/2024	83.33	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
31/03/2024	83.33	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
30/04/2024	66.67	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
31/05/2024	66.67	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
30/06/2024	55.56	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
31/07/2024	65.08	54.08	10.77	97.40	25.21	82.96	IMPROVEMENT
31/08/2024	31.75	54.08	10.77	97.40	25.21	82.96	NONE
30/09/2024	9.52	54.08	10.77	97.40	25.21	82.96	NONE
31/10/2024	8.33	54.08	10.77	97.40	25.21	82.96	NONE
30/11/2024	30.56	54.08	10.77	97.40	25.21	82.96	NONE
31/12/2024	63.89	54.08	10.77	97.40	25.21	82.96	NONE
31/01/2025	88.89	54.08	10.77	97.40	25.21	82.96	NONE
28/02/2025	66.67	54.08	10.77	97.40	25.21	82.96	NONE
31/03/2025	44.44	54.08	10.77	97.40	25.21	82.96	DETERIORATION
30/04/2025	11.11	54.08	10.77	97.40	25.21	82.96	DETERIORATION
31/05/2025	27.78	54.08	10.77	97.40	25.21	82.96	DETERIORATION
30/06/2025	16.67	54.08	10.77	97.40	25.21	82.96	DETERIORATION
31/07/2025	16.67	54.08	10.77	97.40	25.21	82.96	DETERIORATION
31/08/2025	33.33	54.08	10.77	97.40	25.21	82.96	DETERIORATION
30/09/2025	66.67	54.08	10.77	97.40	25.21	82.96	NONE
31/10/2025	100.00	54.08	10.77	97.40	25.21	82.96	NONE
30/11/2025	88.89	54.08	10.77	97.40	25.21	82.96	NONE
31/12/2025	88.89	54.08	10.77	97.40	25.21	82.96	NONE

Stage Two Complaints - 20 Working Day Response Compliance



Comments From Executive Lead

The number of Stage Two complaints remains low, with a slight increase seen in the past two months. These cases are often complex and may require more time to investigate than initially anticipated. Improvement will be targeted through the same workshops for stage one complaints, however given the specific nature of these complaints, an improvement date is not specified.

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Inpatient Falls

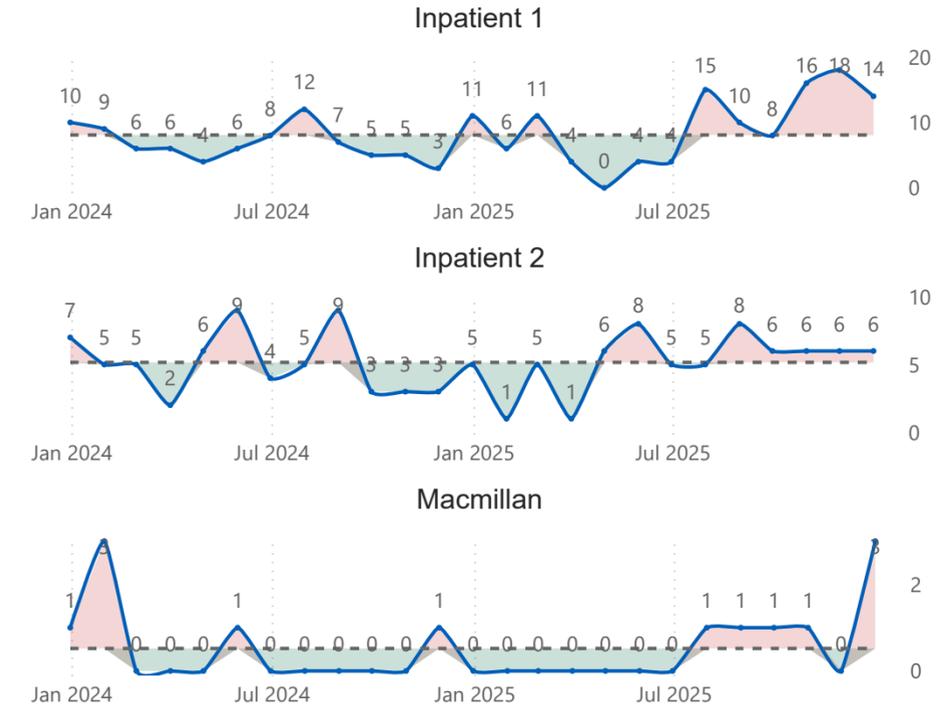
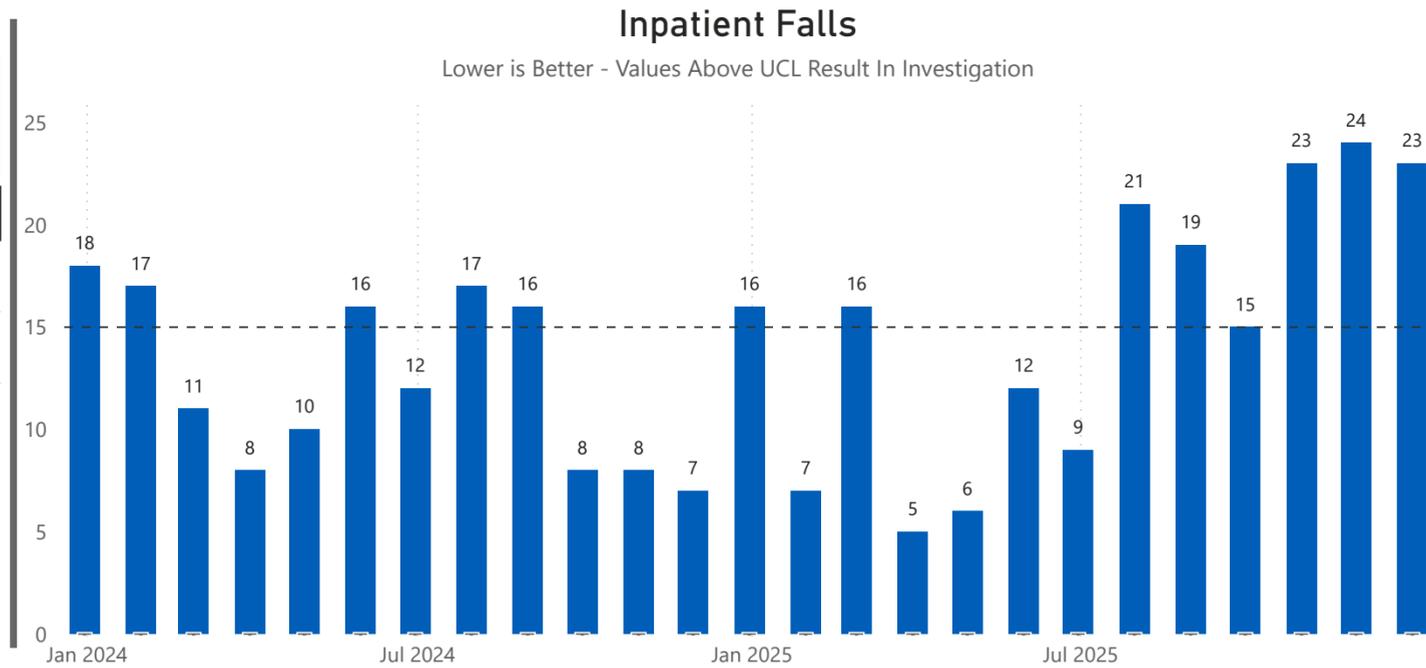
Data Source
Datix, Ward Documentation

Latest Data
31/12/2025

Compliance

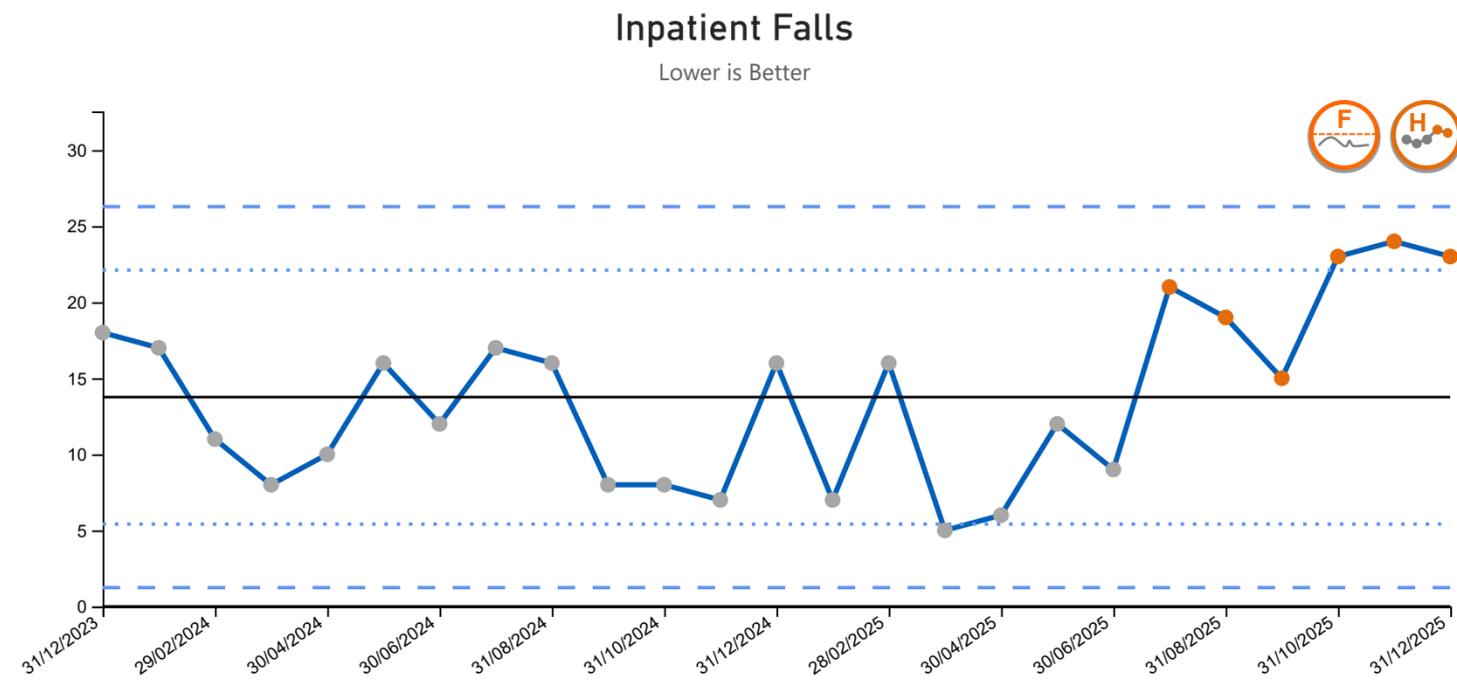
KPI	Target	Actual	RAG Value
Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level)	0	23	Red

Action	Target Date	Owner	Status
Review of data presentation in the IPR for next Board meeting	31/01/2026	S Thomas	In Progress
Deep dive data review of falls in the last 12 months	31/03/2026	S Thomas	In Progress
Improvement work continues with close links with the Scottish Patient Safety Programme (SPSP) falls initiative.	31/03/2026	S Thomas	In Progress



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	18.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/01/2024	17.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
29/02/2024	11.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/03/2024	8.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
30/04/2024	10.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/05/2024	16.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
30/06/2024	12.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/07/2024	17.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/08/2024	16.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
30/09/2024	8.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/10/2024	8.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
30/11/2024	7.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/12/2024	16.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/01/2025	7.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
28/02/2025	16.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/03/2025	5.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
30/04/2025	6.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/05/2025	12.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
30/06/2025	9.00	13.76	0.00	1.24	26.28	5.41	22.11	NONE
31/07/2025	21.00	13.76	0.00	1.24	26.28	5.41	22.11	DETERIORATION
31/08/2025	19.00	13.76	0.00	1.24	26.28	5.41	22.11	DETERIORATION
30/09/2025	15.00	13.76	0.00	1.24	26.28	5.41	22.11	DETERIORATION
31/10/2025	23.00	13.76	0.00	1.24	26.28	5.41	22.11	DETERIORATION
30/11/2025	24.00	13.76	0.00	1.24	26.28	5.41	22.11	DETERIORATION
31/12/2025	23.00	13.76	0.00	1.24	26.28	5.41	22.11	DETERIORATION



Comments From Executive Lead

Although improvement actions supported a decrease to 15 falls across inpatient areas in September. Fall numbers have risen and remained ≥ 23 . A high proportion of these falls recorded are due to single patients with known falls risks who have multiple falls despite increased observation and safety measures.

Safety huddles and identification of those at risk of falls including patient placement in visible bed spaces and enhanced observations are in place. Each fall is reviewed by the multi-disciplinary team and support measures instigated as required.

Work continues under the Scottish Patient Safety Programme national initiative on prevention and management of falls, led by the Excellence in Care lead and Senior Charge Nurses.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Patient Safety, Quality, and Experience

Pressure Ulcers

Data Source

Datix, Ward Documentation

Latest Data

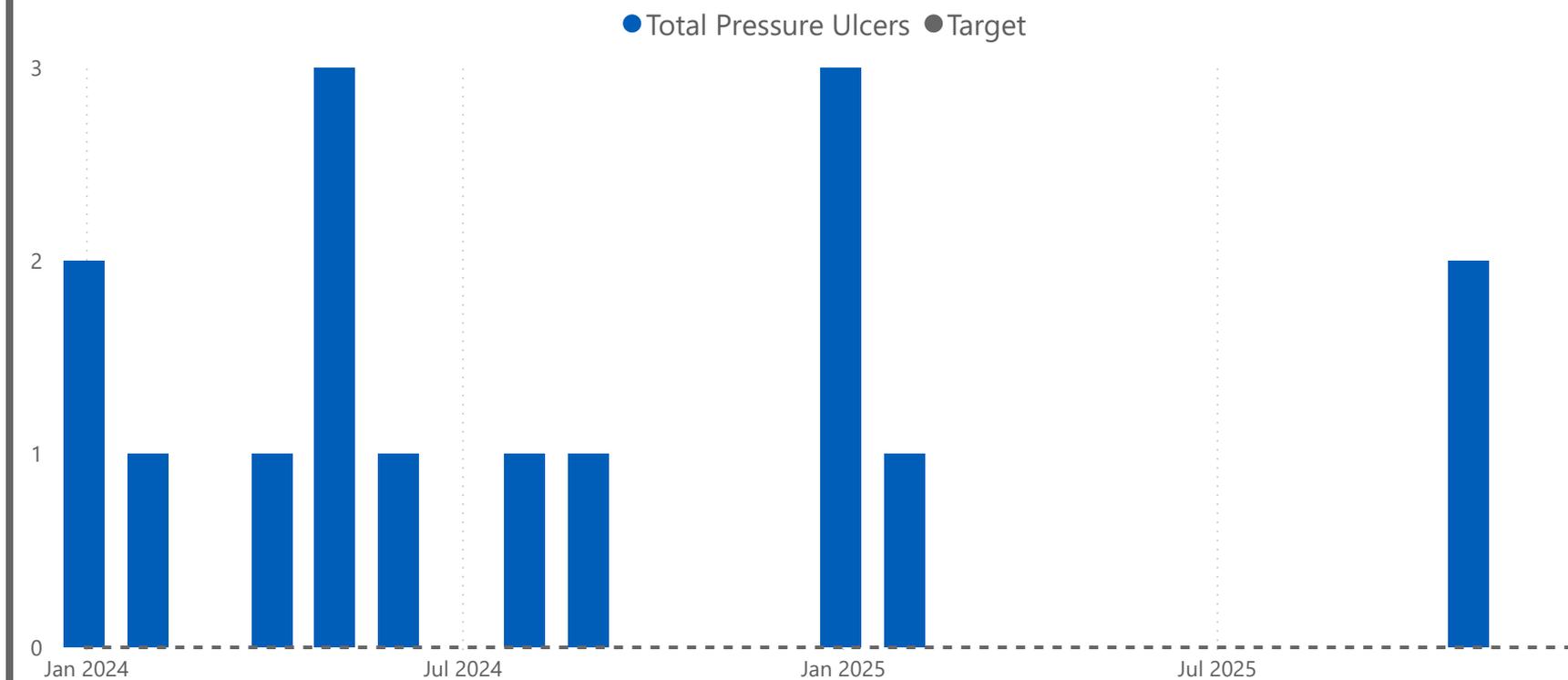
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Number of inpatient acquired pressure ulcers this month	0	0	Green

Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

Inpatient Acquired Pressure Ulcers



Comments From Executive Lead

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Patient Safety, Quality, and Experience

Incident Reporting and Review

Data Source

Datix

Latest Month

31/12/2025

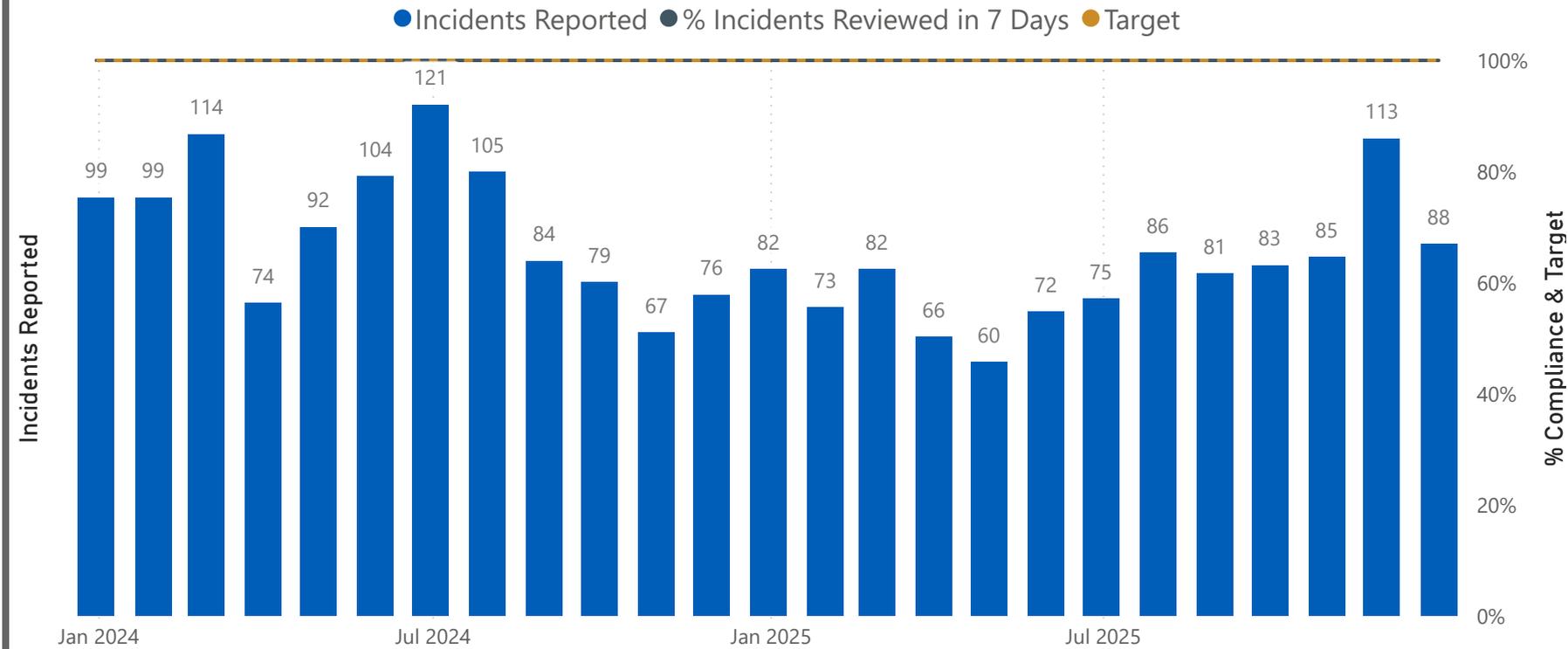
Compliance

KPI	Target	Actual	RAG Value
Incident Reporting and 7 Working Day Review Compliance	100%	100%	Green

Action	Target Date	Owner	Status
--------	-------------	-------	--------

KPI on target, no actions required at this time.

Incident Reporting - 7 Day Review Compliance



Comments From Executive Lead

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Significant Adverse Event Reviews (SAERs)

Data Source

Datix

Latest Data

31/12/2025

Compliance

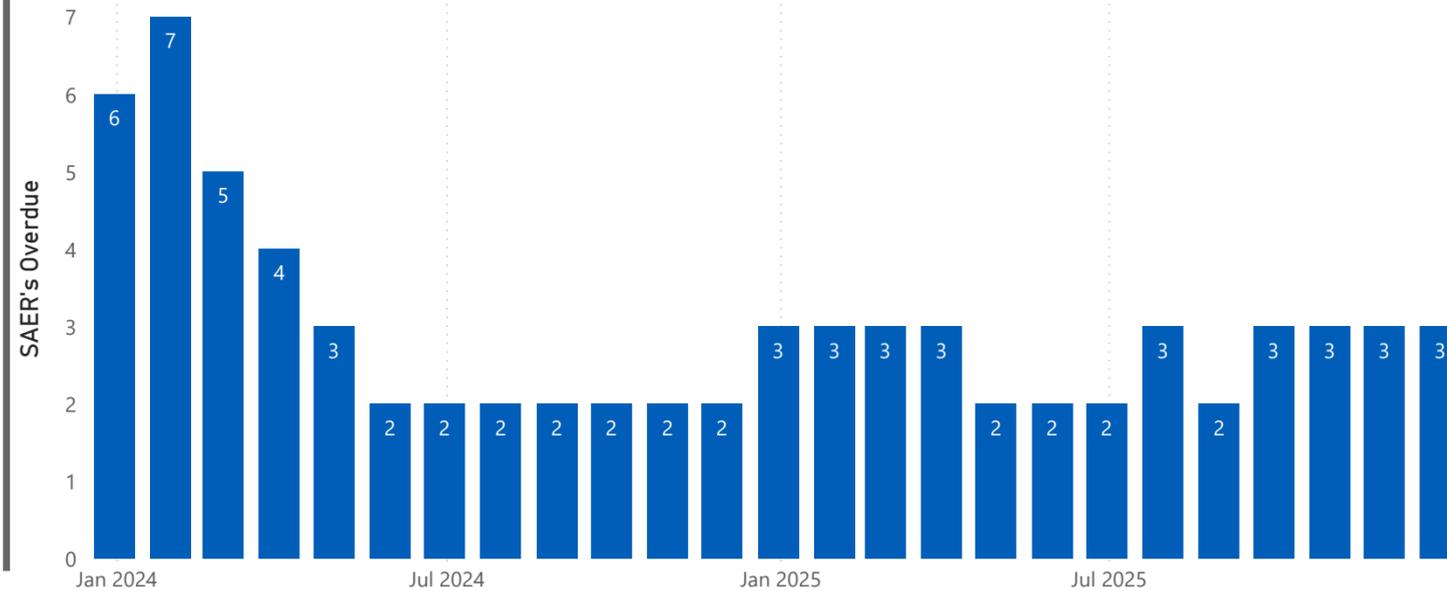
KPI	Target	Actual	RAG Value
Significant Adverse Event Review Compliance (closed within target date)	100%	50.00%	Red

Action	Target Date	Owner	Status
Monitor and support the timely closure of currently open SAERs via the Clinical Governance Group	31/12/2025	A Lamont	Off Track

Monitor and support the timely closure of currently open SAERs via the Clinical Governance Group

31/12/2025 A Lamont Off Track

Significant Adverse Events - SAERs Overdue

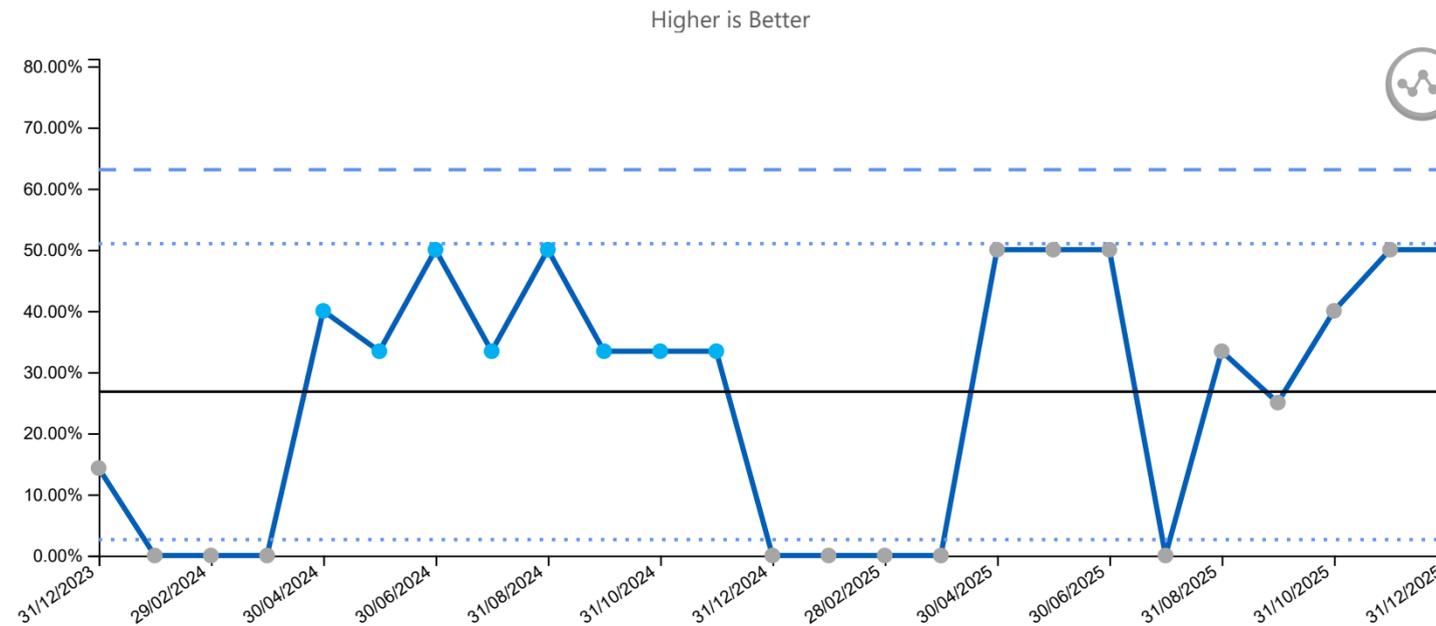


Month	SAER's commissioned	SAER's overdue	% SAER Compliance	Target
30/09/2024	0	2	33.40%	100.00%
31/10/2024	0	2	33.40%	100.00%
30/11/2024	0	2	33.40%	100.00%
31/12/2024	0	3	0.00%	100.00%
31/01/2025	0	3	0.00%	100.00%
28/02/2025	0	3	0.00%	100.00%
31/03/2025	0	3	0.00%	100.00%
30/04/2025	2	2	50.00%	100.00%
31/05/2025	0	2	50.00%	100.00%
30/06/2025	0	2	50.00%	100.00%
31/07/2025	0	3	0.00%	100.00%
31/08/2025	0	2	33.40%	100.00%
30/09/2025	1	3	25.00%	100.00%
31/10/2025	1	3	40.00%	100.00%
30/11/2025	1	3	50.00%	100.00%
31/12/2025	0	3	50.00%	100.00%

Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	14.30	26.79	-9.50	63.08	2.59	50.98	NONE
31/01/2024	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
29/02/2024	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/03/2024	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
30/04/2024	40.00	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
31/05/2024	33.40	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
30/06/2024	50.00	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
31/07/2024	33.40	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
31/08/2024	50.00	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
30/09/2024	33.40	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
31/10/2024	33.40	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
30/11/2024	33.40	26.79	-9.50	63.08	2.59	50.98	IMPROVEMENT
31/12/2024	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/01/2025	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
28/02/2025	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/03/2025	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
30/04/2025	50.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/05/2025	50.00	26.79	-9.50	63.08	2.59	50.98	NONE
30/06/2025	50.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/07/2025	0.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/08/2025	33.40	26.79	-9.50	63.08	2.59	50.98	NONE
30/09/2025	25.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/10/2025	40.00	26.79	-9.50	63.08	2.59	50.98	NONE
30/11/2025	50.00	26.79	-9.50	63.08	2.59	50.98	NONE
31/12/2025	50.00	26.79	-9.50	63.08	2.59	50.98	NONE

Significant Adverse Events - Review Compliance



Comments From Executive Lead

It has been acknowledged that current capacity constraints are impacting the ability to conduct timely reviews. SAERs are reviewed at the Clinical Governance Group and while recent reviews have led to new questions requiring further investigation. While this demonstrates robust scrutiny, it is acknowledged this requires further time for the reports to be closed. This is anticipated to improve over the next quarter as the SAERs currently open are expected to be closed.

Dr Anna Lamont, Medical Director



Patient Safety, Quality, and Experience

Maternal Early Warning Score Escalation

Data Source

Clinical Records

Latest Data

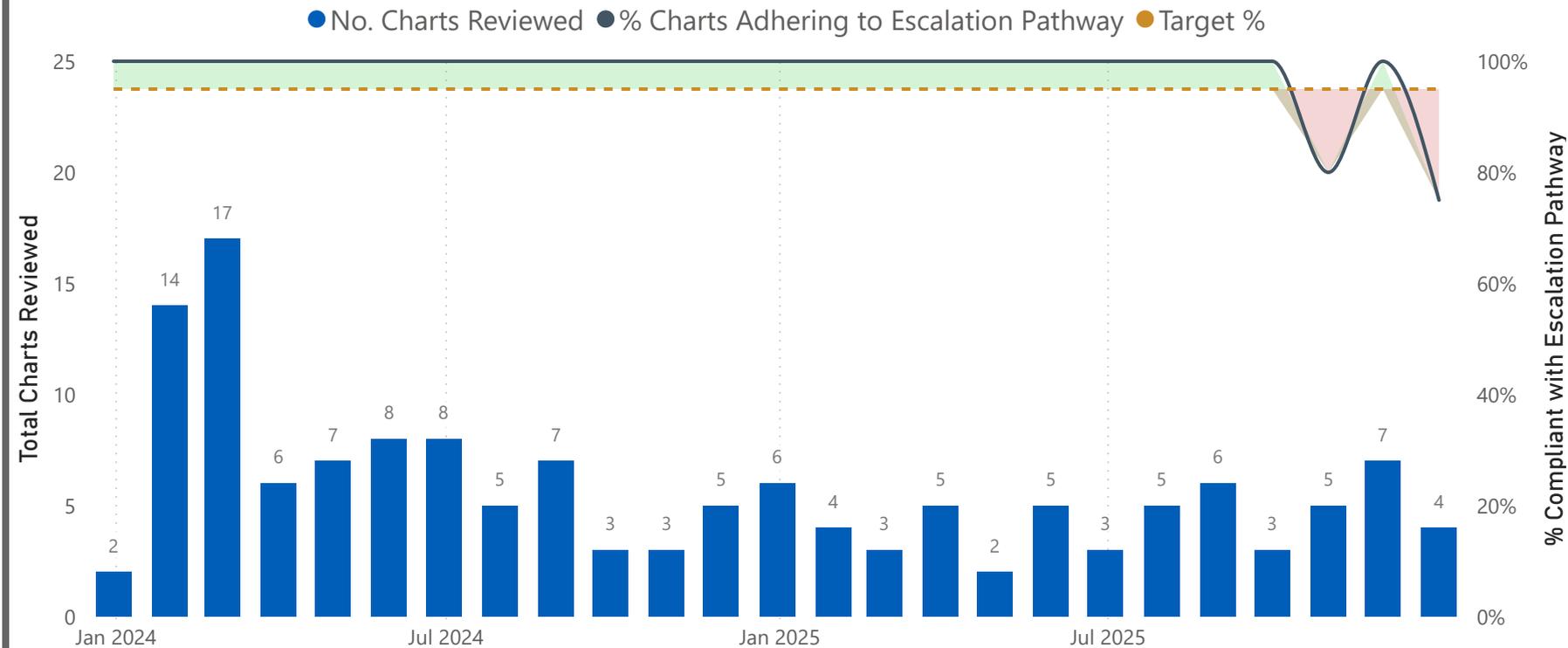
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Maternal Early Warning Score Escalation	95%	75.0%	Red

Action	Target Date	Owner	Status
Deep dive and review of MEWS process to be undertaken.	31/03/2026	L Flett	In Progress

Maternal Early Warning Score Observations



Comments From Executive Lead

Maternal Early Warning Score metrics are currently showing a decrease in performance. As a result, the Senior Charge Midwife is currently undertaking a deep dive and review to understand any reasons for any non-compliance.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Patient Safety, Quality, and Experience

Maternal Early Warning Score Observations

Data Source
Clinical Records

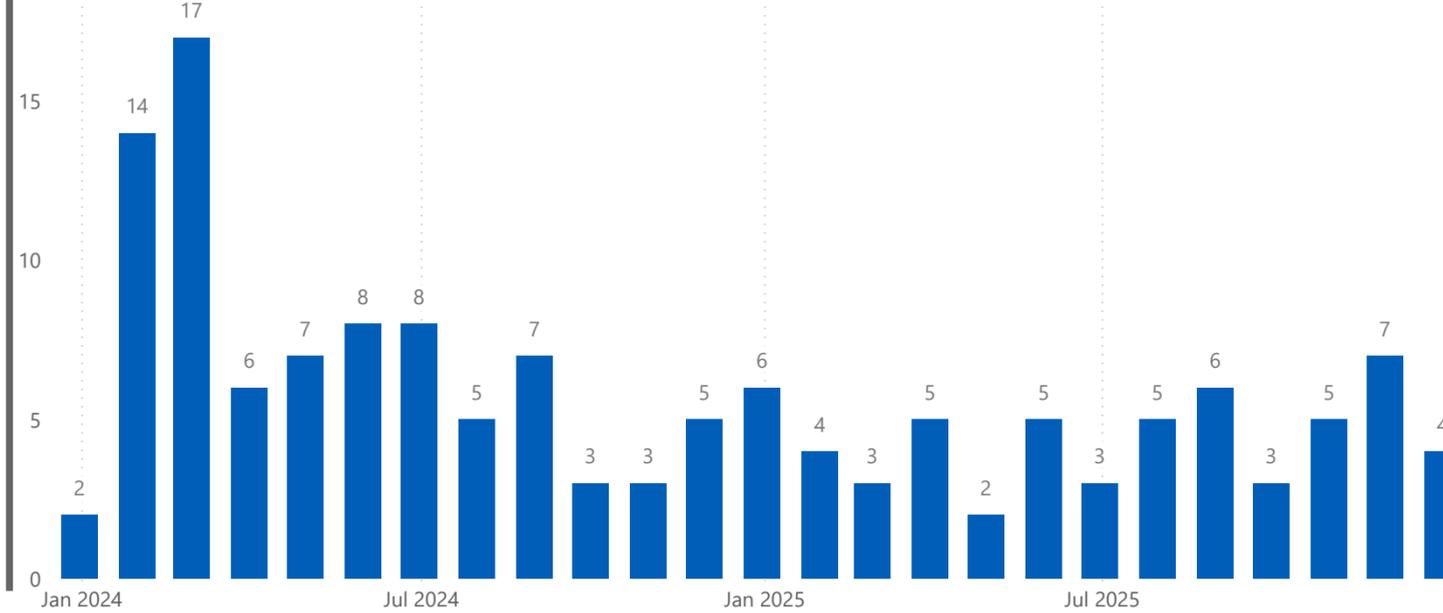
Latest Data
31/12/2025

Compliance

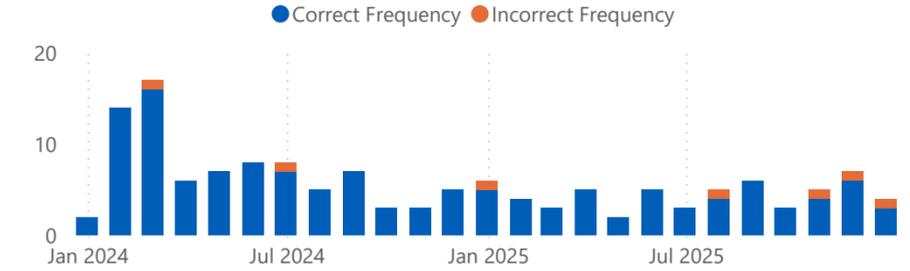
KPI	Target	Actual	RAG Value
Maternal Early Warning Score Observations	95%	75.0%	Red

Action	Target Date	Owner	Status
Deep dive and review of MEWS process to be undertaken.	31/03/2026	L Flett	In Progress

Maternal Early Warning Scores - Charts Reviewed



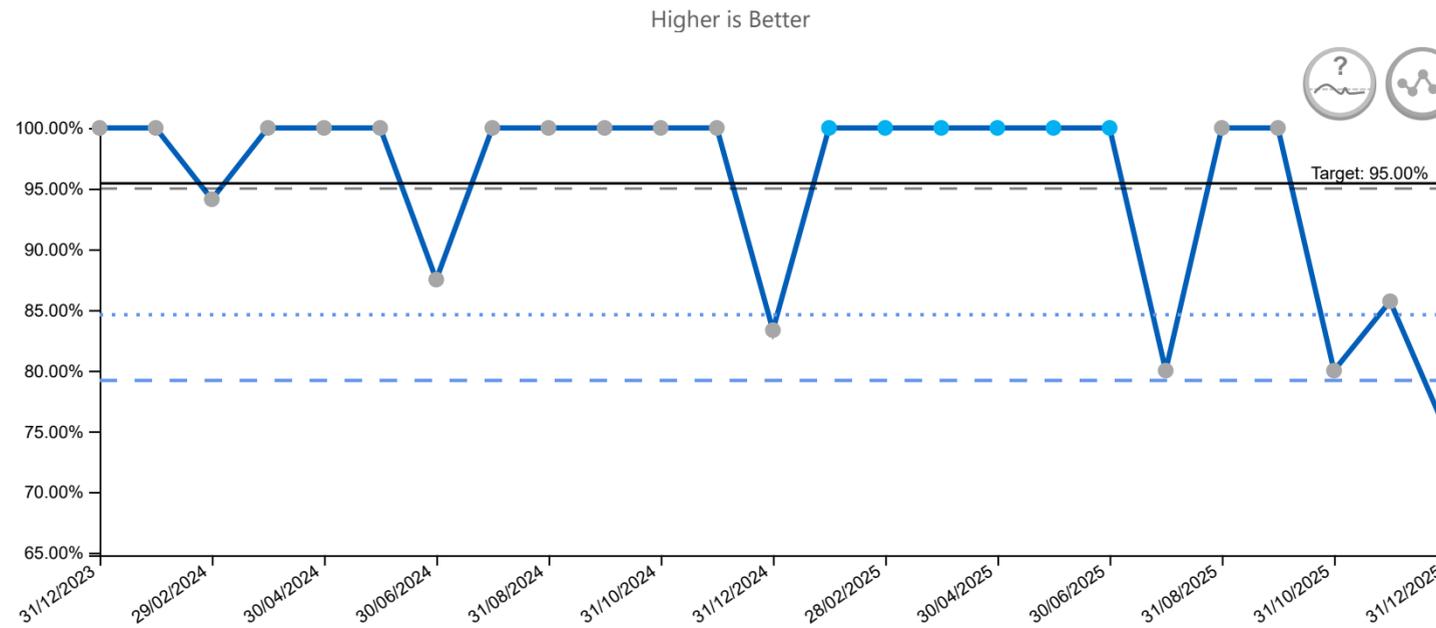
Maternal Early Warning Scores - Frequencies



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/01/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
29/02/2024	94.12	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/03/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
30/04/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/05/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
30/06/2024	87.50	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/07/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/08/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
30/09/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/10/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
30/11/2024	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/12/2024	83.33	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/01/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	IMPROVEMENT
28/02/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	IMPROVEMENT
31/03/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	IMPROVEMENT
30/04/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	IMPROVEMENT
31/05/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	IMPROVEMENT
30/06/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	IMPROVEMENT
31/07/2025	80.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/08/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
30/09/2025	100.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/10/2025	80.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE
30/11/2025	85.71	95.43	95.00	84.47	106.38	88.12	102.73	NONE
31/12/2025	75.00	95.43	95.00	84.47	106.38	88.12	102.73	NONE

Maternal Early Warning Scores - Observation Compliance



Comments From Executive Lead

Maternal Early Warning Score metrics are currently showing a decrease in performance. As a result, the Senior Charge Midwife is currently undertaking a deep dive and review to understand any reasons for any non-compliance.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Patient Safety, Quality, and Experience

Paediatric Early Warning Score (PEWS) Bundle Compliance

Data Source

Clinical Records

Latest Data

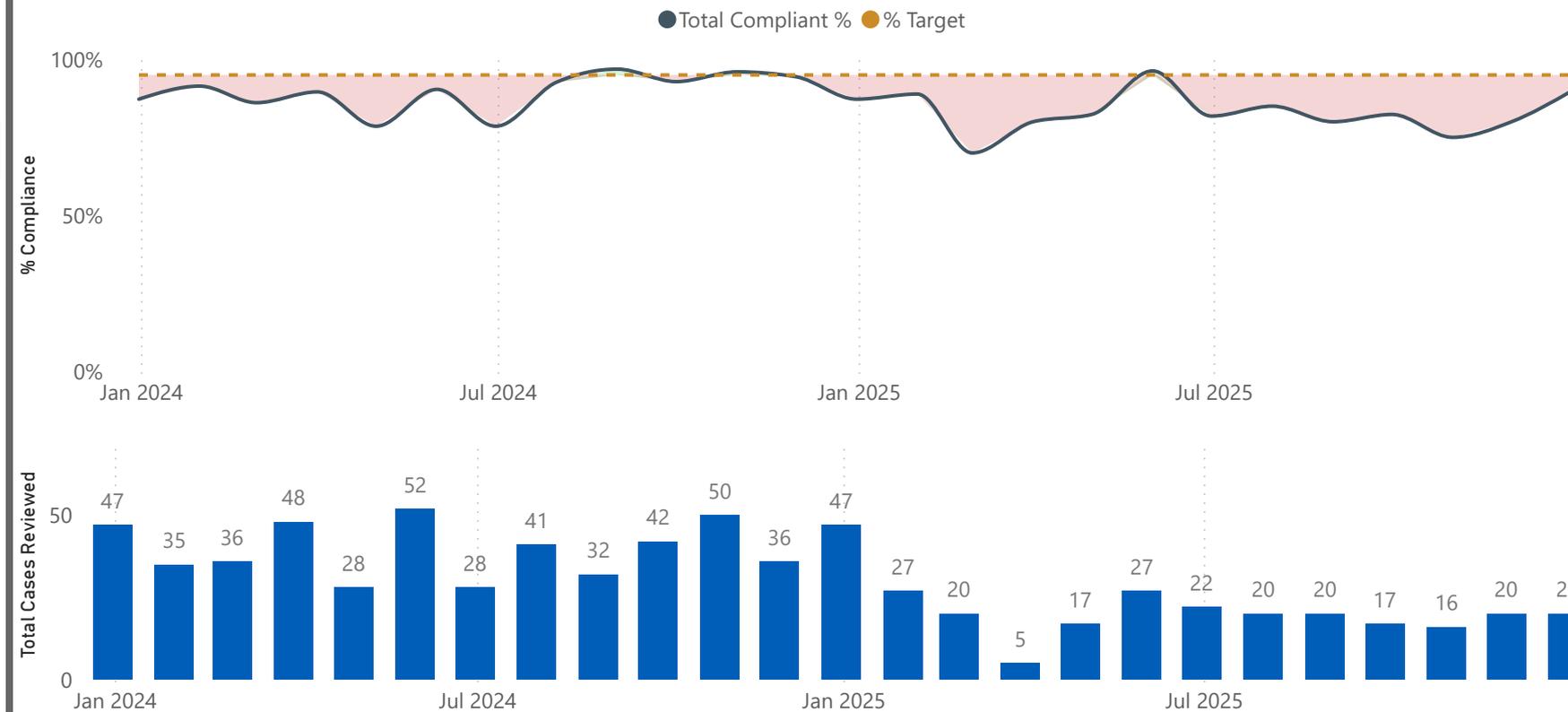
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % Compliance with PEWS Bundle	95%	90.0%	Red

Action	Target Date	Owner	Status
A deep dive on the recording processes around PEWS to be carried out by the Practice Education and Excellence in Care teams.	31/12/2025	S Thomas	Completed
Educational programme to be delivered on processes around completion of PEWS	31/03/2026	S Thomas	In Progress

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



Comments From Executive Lead

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.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Patient Safety, Quality, and Experience

Paediatric Early Warning Score (PEWS) 'At-Risk' Compliance

Data Source

Clinical Records

Latest Data

31/12/2025

Compliance

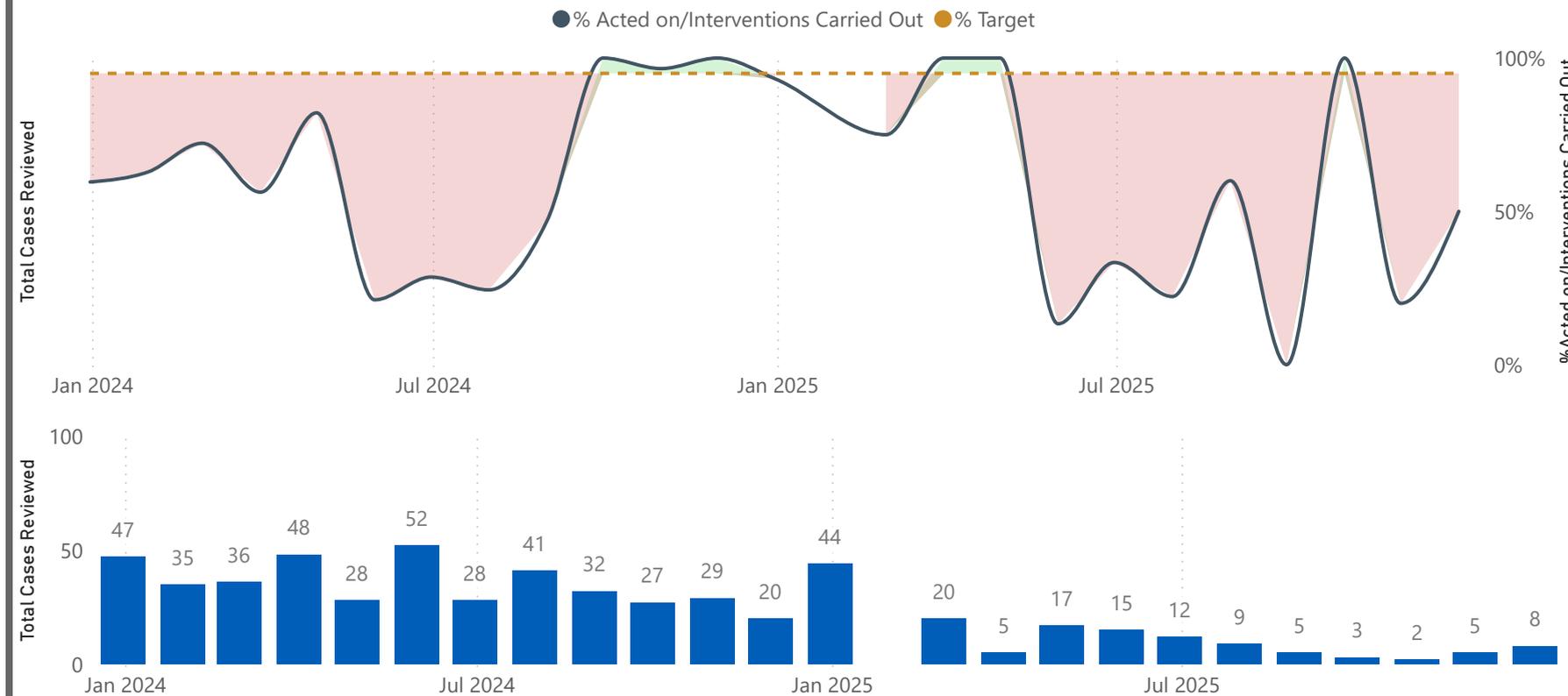
KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % 'at-risk' observations identified and acted upon	95%	50.0%	Red

Action	Target Date	Owner	Status
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A deep dive on the recording processes around PEWS to be carried out by the Practice Education and Excellence in Care teams.

Educational programme to be delivered on processes around completion of PEWS

Paediatric Early Warning Score 'At-Risk' Compliance



Comments From Executive Lead

On review of those charted PEWS measures, there are valid reasons for not escalating or completing required information. A deep dive into utilisation and recording of PEWS will be undertaken by Practice Education and Excellence in Care team.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards Acute

Section Lead(s):

Medical Director

Executive Director of Nursing, Midwifery, Allied Health Professionals & Chief Officer Acute

What's Going Well?

Diagnostic cardiology performance has improved significantly and is now close to the six-week standard, reflecting the impact of substantive staffing and improved local resilience, with reduced reliance on locums and patient travel.

Diagnostic imaging performance has recovered following the transfer of MRI waiting lists from NHS Grampian and continues to improve, supported by the development of local MRI provision which is reducing travel and pathway times.

New Outpatients performance, while below target, shows sustained improvement, with a marked reduction in very long waits, demonstrating effective targeting of additional capacity.

Cancer waiting times remain within standard overall, with strong performance against the 31-day measure.

RAG Status Values

RED	Key performance indicator not achieved, and performance below lower threshold.
AMBER	Key performance indicator not achieved, but performance above lower threshold.
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 or amber status will be accompanied with improvement actions, and a timeline for recovery of the position.

Areas of Concern

New Outpatients remain materially off track against the 12-week standard, and progress remains fragile due to ongoing consultant workforce shortages and reliance on short-term external capacity.

Treatment Time Guarantee performance remains well below standard, with downstream constraints in theatres and access to National Treatment Centres limiting recovery, particularly as increased outpatient activity adds to treatment demand.

Diagnostic endoscopy performance is variable and below target due to reliance on visiting locum provision, with sustainability remaining a concern.

Cancer pathway compliance, particularly for the 62-day standard, is highly sensitive to small numbers, requiring continued case-level scrutiny and escalation.

Operational Standards Accident & Emergency 4-Hour Compliance

Data Source
PHS A&E Publication, TrakCare

Latest Data
31/12/2025

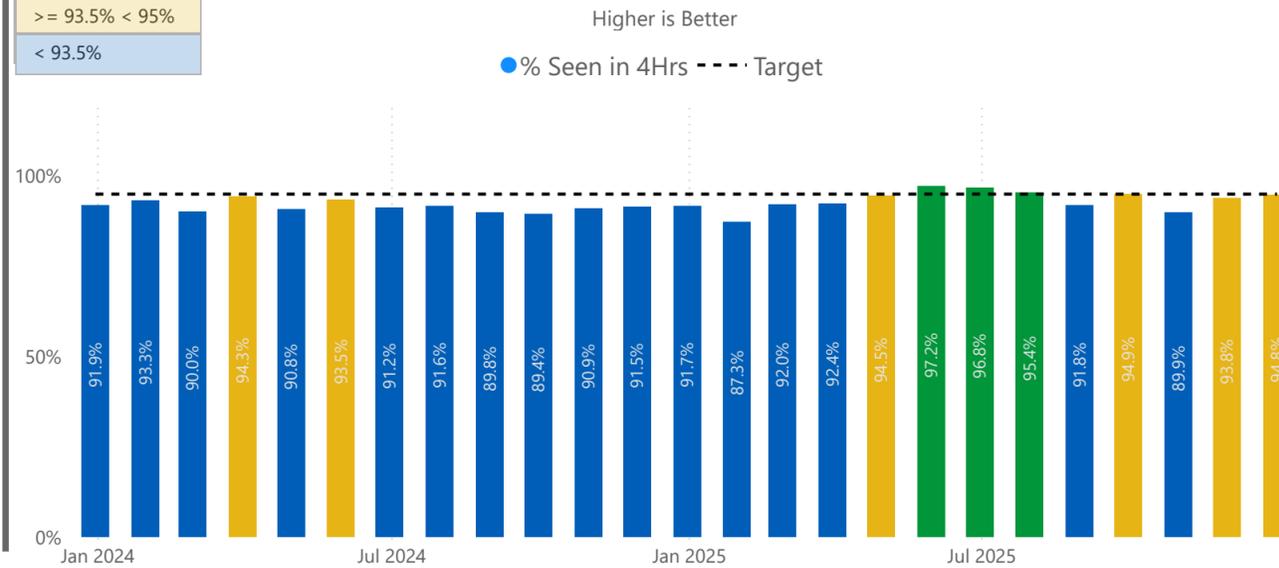
Compliance

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%	94.75%	Amber

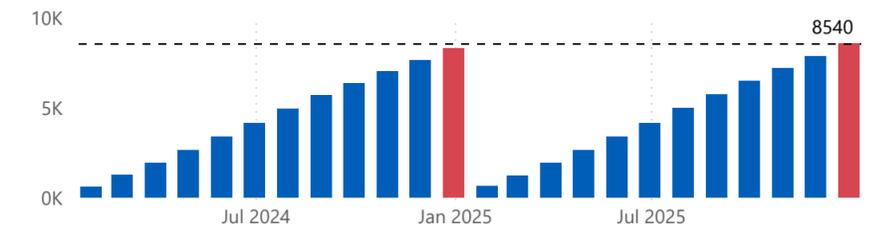
Action	Target Date	Owner	Status
Review of Flow Navigation Centre throughput and redirection of pathways.	31/10/2025	S Thomas	Completed
Continued focus on redirection and other avenues of care.	31/12/2025	S Thomas	Completed

Thresholds
>=95%
>= 93.5% < 95%
< 93.5%

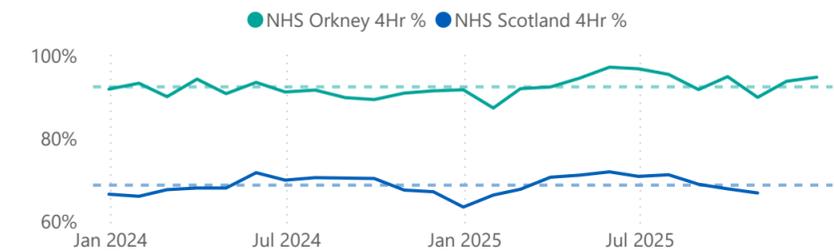
Accident & Emergency 4-Hour Standard Compliance



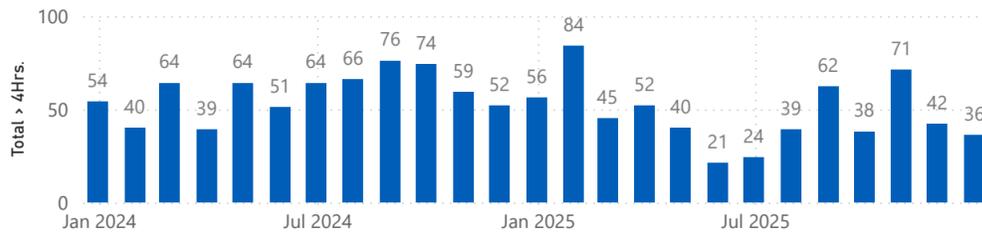
Accident & Emergency Attendances Yearly Comparison



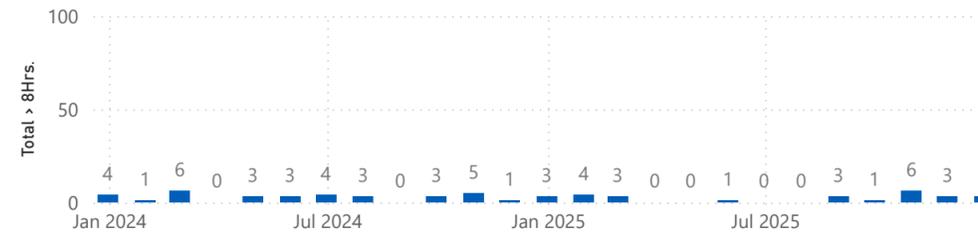
4Hr Standard Compliance vs. National



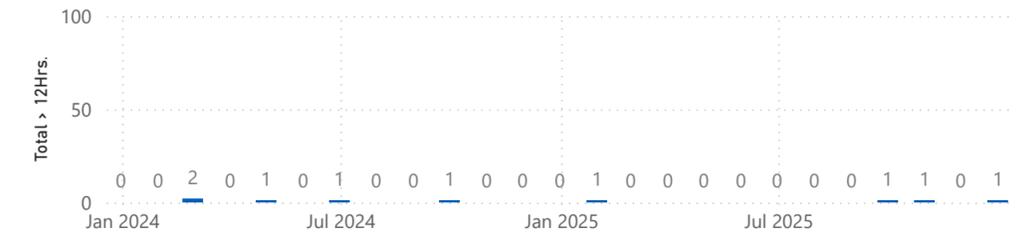
No. of Attendances > 4 Hours



No. of Attendances > 8 Hours



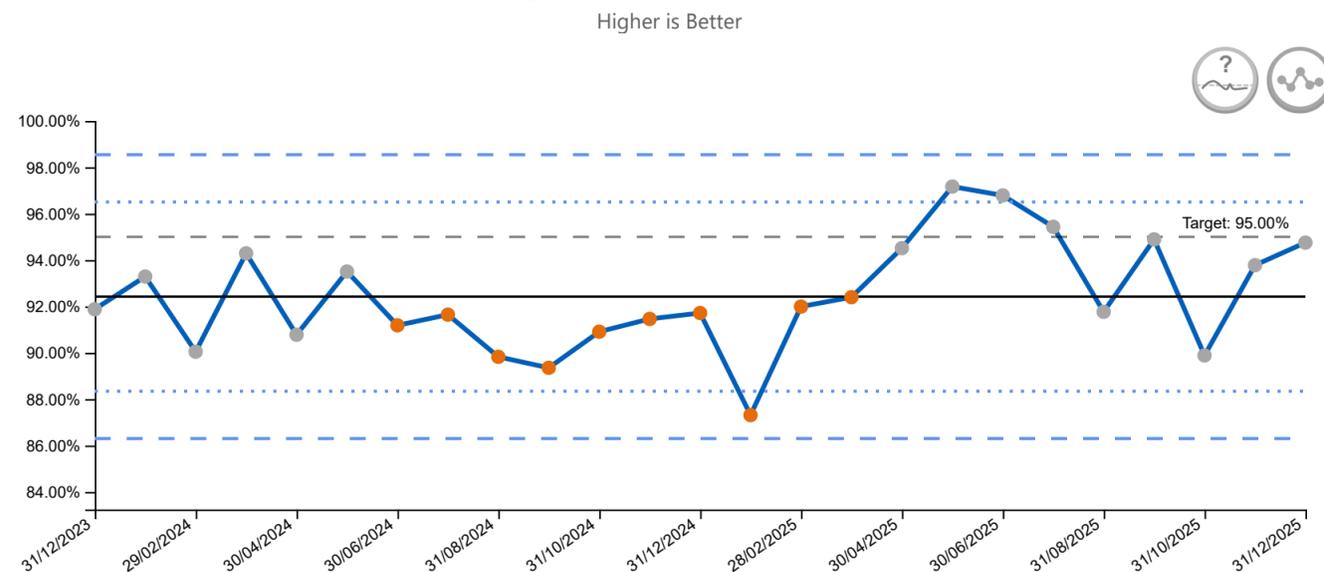
No. of Attendances > 12 Hours



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	91.88	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/01/2024	93.29	92.42	95.00	86.30	98.54	88.34	96.50	NONE
29/02/2024	90.05	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/03/2024	94.29	92.42	95.00	86.30	98.54	88.34	96.50	NONE
30/04/2024	90.78	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/05/2024	93.50	92.42	95.00	86.30	98.54	88.34	96.50	NONE
30/06/2024	91.18	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
31/07/2024	91.65	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
31/08/2024	89.83	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
30/09/2024	89.35	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
31/10/2024	90.91	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
30/11/2024	91.46	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
31/12/2024	91.72	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
31/01/2025	87.31	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
28/02/2025	91.99	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
31/03/2025	92.40	92.42	95.00	86.30	98.54	88.34	96.50	DETERIORATION
30/04/2025	94.51	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/05/2025	97.17	92.42	95.00	86.30	98.54	88.34	96.50	NONE
30/06/2025	96.79	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/07/2025	95.43	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/08/2025	91.77	92.42	95.00	86.30	98.54	88.34	96.50	NONE
30/09/2025	94.89	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/10/2025	89.89	92.42	95.00	86.30	98.54	88.34	96.50	NONE
30/11/2025	93.78	92.42	95.00	86.30	98.54	88.34	96.50	NONE
31/12/2025	94.75	92.42	95.00	86.30	98.54	88.34	96.50	NONE

Accident & Emergency 4-Hour Standard Compliance



Comments From Executive Lead

Current ED performance has dipped below 95%. This has been due to the increased acuity of patients attending and system flow pressures secondary to increase DTOC numbers. Weekly review of data undertaken.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

Accident & Emergency 12-Hour Compliance

Data Source

PHS A&E Publication, TrakCare

Latest Data

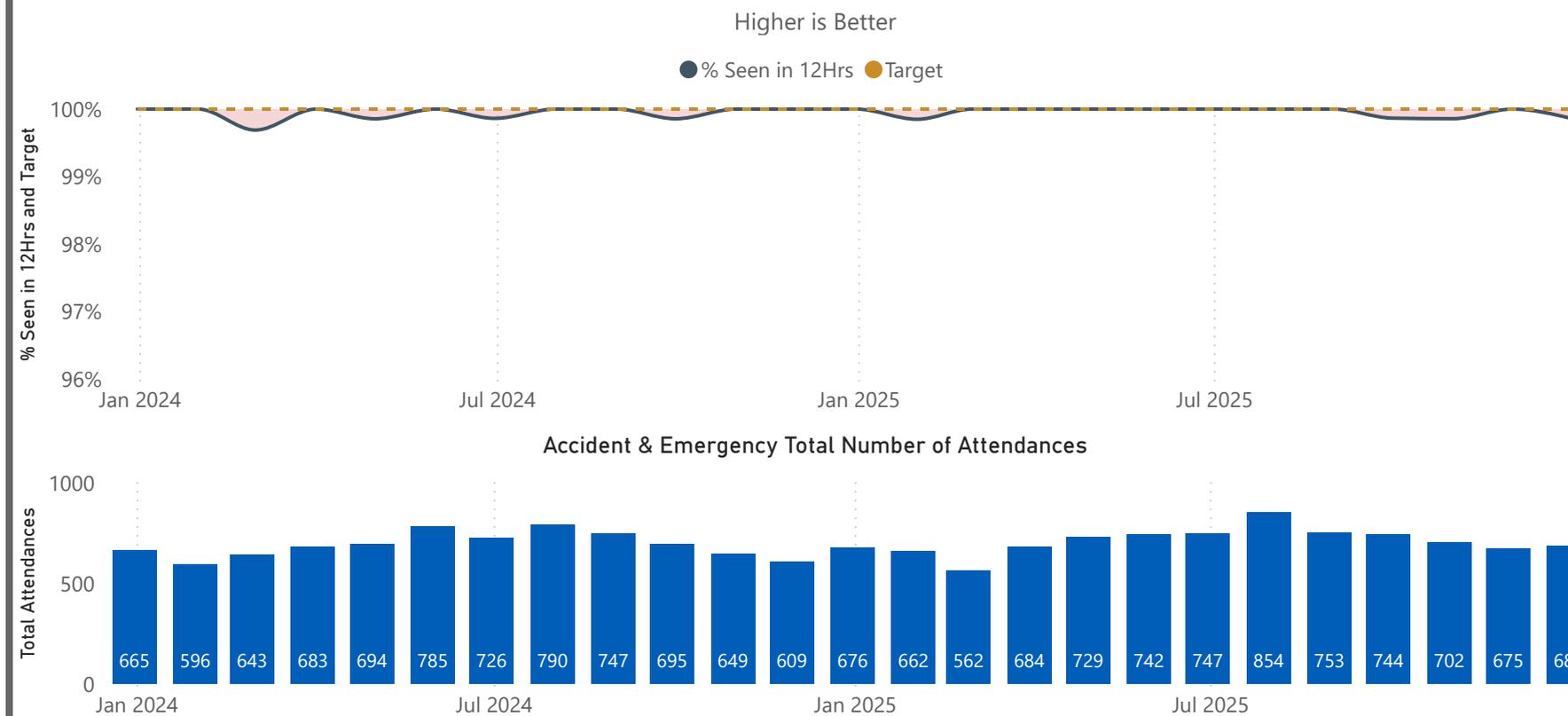
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Patients wait less than 12 hours to admission, discharge, or transfer from A&E	100%	99.85%	Amber

Action	Target Date	Owner	Status
Review 12-hour waits and reasons leading to breach.	01/11/2025	S Thomas	Completed

Accident & Emergency 12-Hour Standard Compliance



Comments From Executive Lead

It is unusual for NHS Orkney to have a patient wait over 12 hours, this case was due to retrieval by specialist services.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

Scottish Ambulance Service Turnaround Times

Data Source

SAS Weekly Operational Statistics

Latest Data

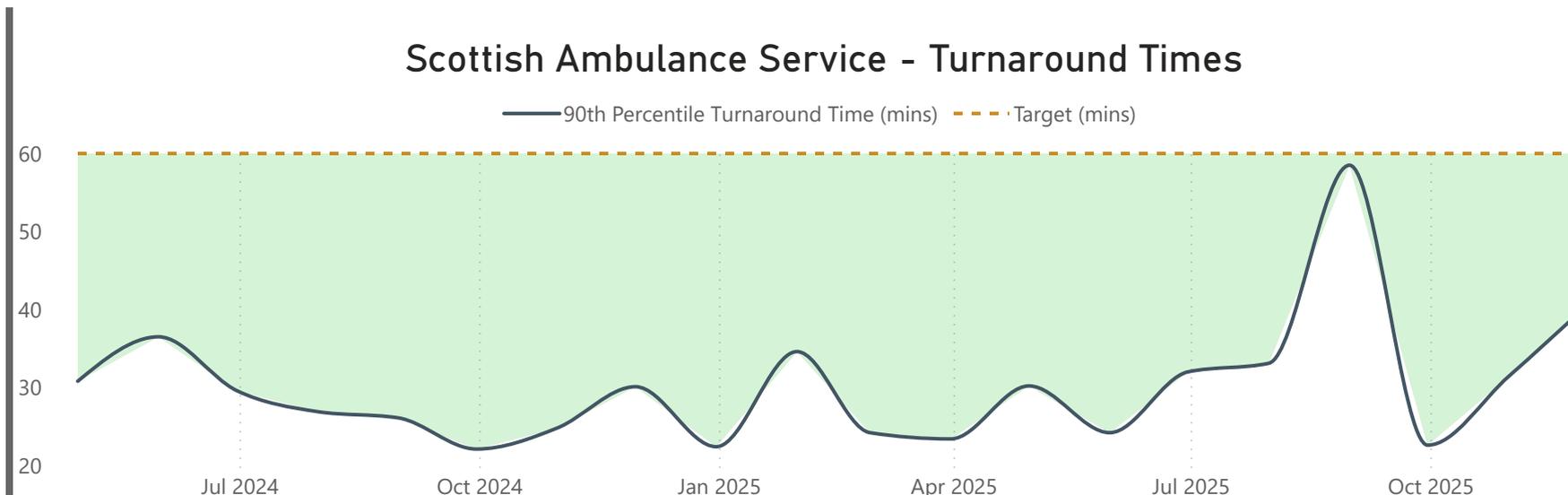
24/11/2025

Compliance

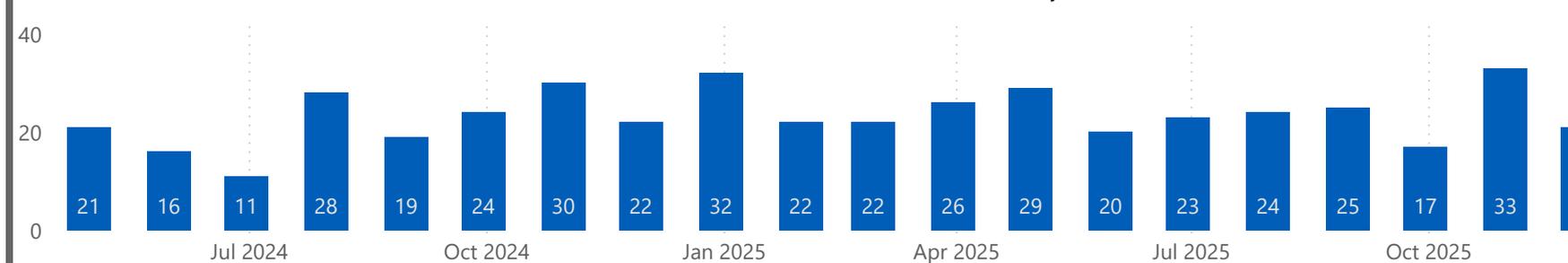
KPI	Target	Actual	RAG Value
Scottish Ambulance Service Turnaround Times - 90th percentile within 60 minutes	60:00	00:40:29	Green

Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

Scottish Ambulance Service - Turnaround Times



Scottish Ambulance Service - Incidents Conveyed



Comments From Executive Lead

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

52-Week Waits Summary (NOP & TTG)

Data Source
OP Recovery Weekly Return, TrakCare

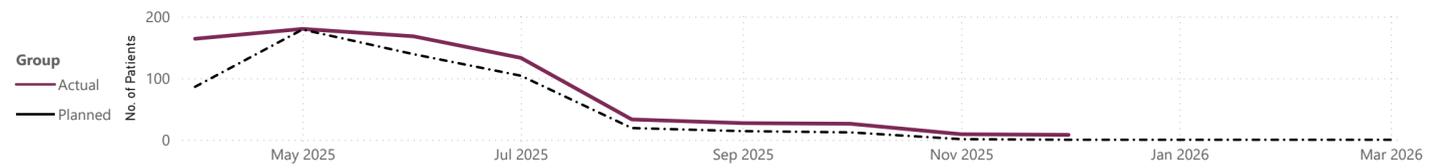
Latest Data
December 2025

Compliance

KPI	Target	Actual	RAG Value
0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	0	15	Amber

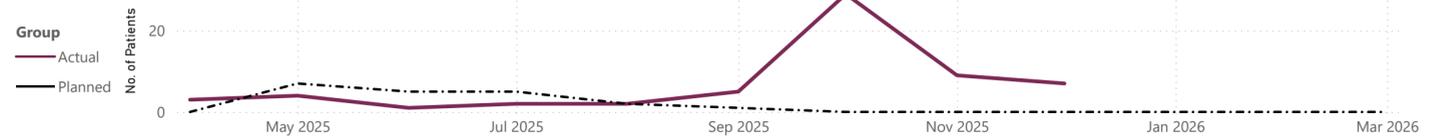
Action	Target Date	Owner	Status
External Capacity Review – Service Level Agreements being reviewed to ensure they meet demand and reduce delays	31/03/2026	C Somerville	In Progress
Internal Capacity Review – Theatre and Outpatient capacity reviews to ensure clinic/theatre utilisation maximised – consider additional or change to schedules	31/03/2026	C Somerville	In Progress
NECU Validation – results from validation to be clinical reviewed and acted on	31/03/2026	C Somerville	In Progress
Waiting Times meeting - review long waits, escalate and track progress	31/03/2026	C Somerville	In Progress

New Outpatients



Specialty	Area	Category	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
All Specialties	New Outpatients	> 52 Weeks	Planned	86	179	139	104	19	14	12	1	0	0	0	0
			Actual	164	180	168	133	33	27	26	9	8			
			+/-	78	1	29	29	14	13	14	8	8	0	0	0

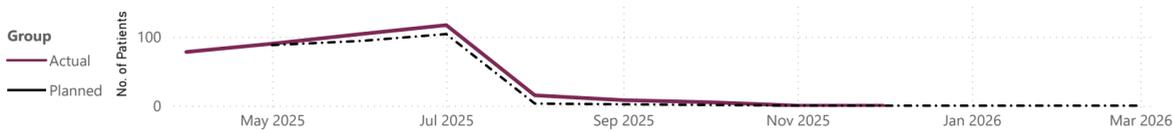
Treatment Time Guarantee



Specialty	Area	Category	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
All Specialties	Treatment Time Guarantee	> 52 Weeks	Planned	0	7	5	5	2	1	0	0	0	0	0	0
			Actual	3	4	1	2	2	5	29	9	7			
			+/-	3	-3	-4	-3	0	4	29	9	7	0	0	0

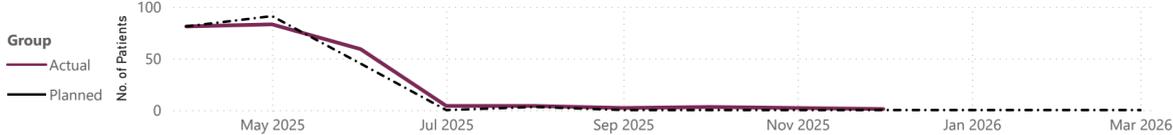
New Outpatients

Ear, Nose, and Throat 52-Week Waits



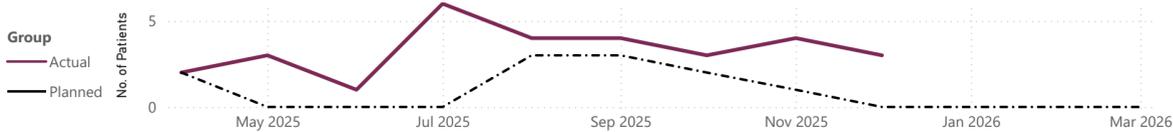
Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ear, Nose, and Throat	Planned		88	94	104	3	2	1	0	0	0	0	0
	Actual	78	90	104	117	15	8	5	0	0			
	+/-	78	2	10	13	12	6	4	0	0			

Ophthalmology 52-Week Waits



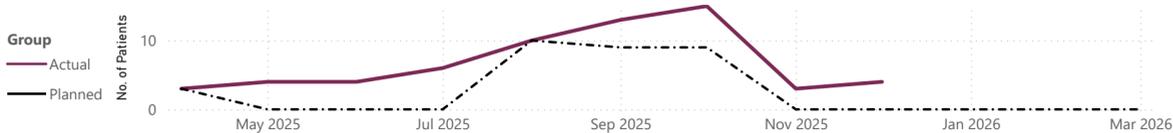
Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ophthalmology	Planned	81	91	45	0	3	0	0	0	0	0	0	0
	Actual	81	83	59	4	4	2	3	2	1			
	+/-	0	-8	14	4	1	2	3	2	1			

Oral Surgery 52-Week Waits



Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Oral Surgery	Planned	2	0	0	0	3	3	2	1	0	0	0	0
	Actual	2	3	1	6	4	4	3	4	3			
	+/-	0	3	1	6	1	1	1	3	3			

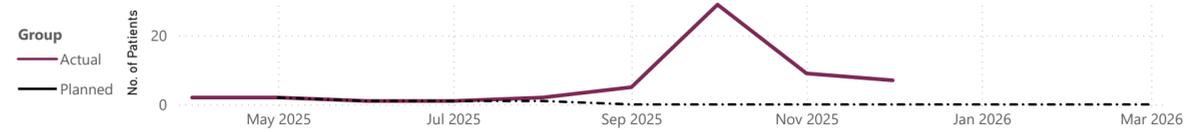
Trauma & Orthopaedic 52-Week Waits



Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Trauma & Orthopaedic	Planned	3	0	0	0	10	9	9	0	0	0	0	0
	Actual	3	4	4	6	10	13	15	3	4			
	+/-	0	4	4	6	0	4	6	3	4			

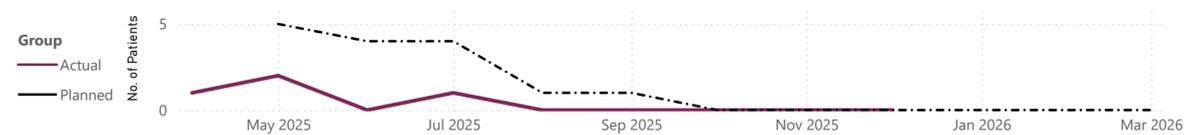
Treatment Time Guarantee

Ophthalmology 52-Week Waits



Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ophthalmology	Planned		2	1	1	1	0	0	0	0	0	0	0
	Actual	2	2	1	1	2	5	29	9	7			
	+/-	2	0	0	0	1	5	29	9	7			

Trauma & Orthopaedic 52-Week Waits



Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Trauma & Orthopaedic	Planned		5	4	4	1	1	0	0	0	0	0	0
	Actual	1	2	0	1	0	0	0	0	0			
	+/-	1	-3	-4	-3	-1	-1	0	0	0			

Comments From Executive Lead

In line with the national commitment, we remain on track to achieve zero patients waiting more than 52 weeks across all specialties by the end of March 2026. Additional funding to support new outpatient activity in Ophthalmology and Ear, Nose and Throat continue to contribute positively to this position. The team is also working closely with the Golden Jubilee to maximise utilisation of our allocation for the longest waiting Trauma and Orthopaedic TTG patients, resulting in a reduction to one patient currently unavailable and awaiting appointment.

As at the end of January 2026, Ophthalmology TTG patients continue to represent the largest proportion of those waiting more than 52 weeks. There are currently five patients, a significant reduction from 29 at the end of October 2025. Of these five patients, one has an appointment booked and one is currently unavailable with a TCI date of 18 February. The remaining three patients are not yet booked, although two have a TCI date of 18 February and one has a TCI date of 25 March.

Tammy Sharp, Director of Performance and Transformation & Deputy Chief Executive Officer



Operational Standards

New Outpatients (NOP) 12 Week Compliance

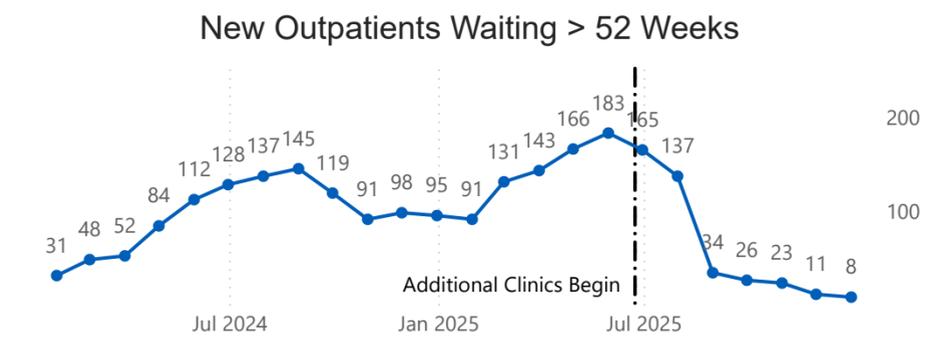
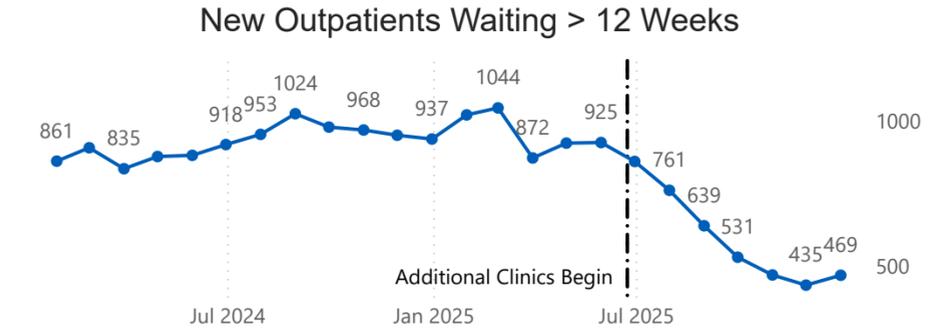
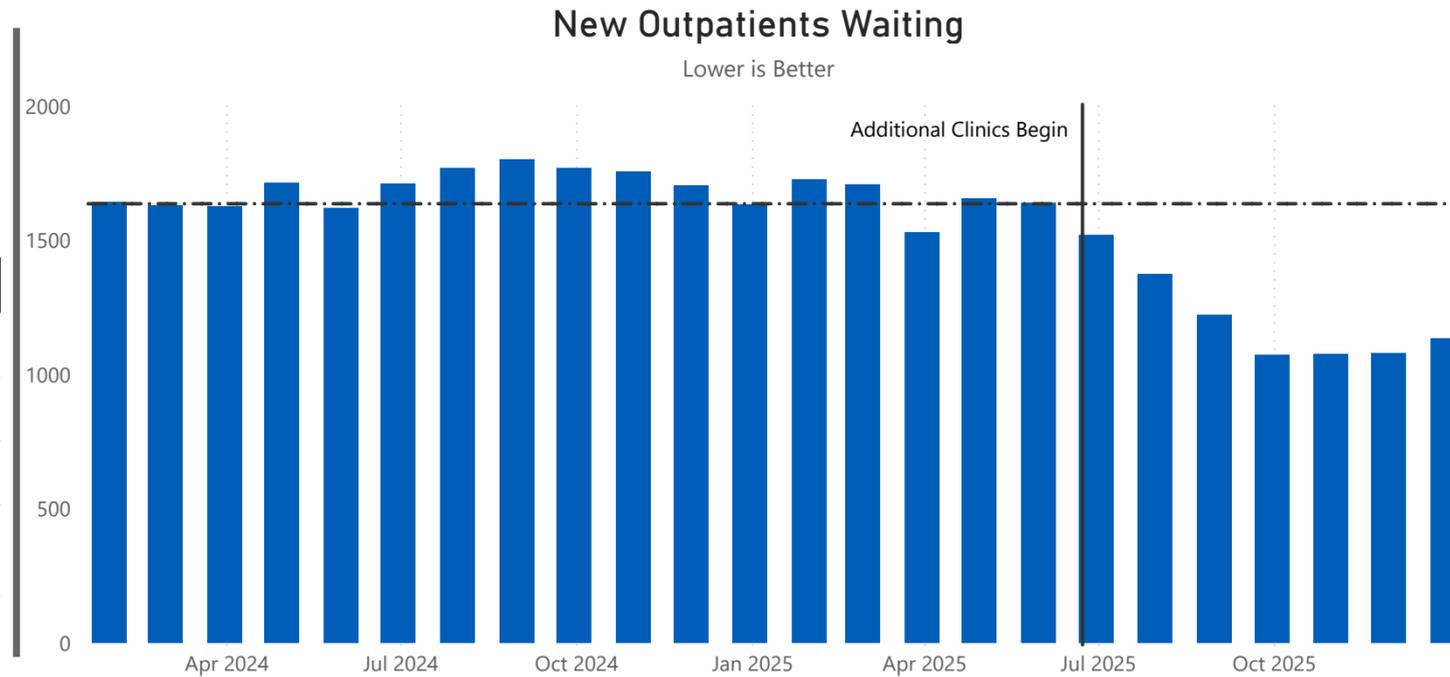
Data Source
OP Recovery Weekly Return

Latest Data
31/12/2025

Compliance

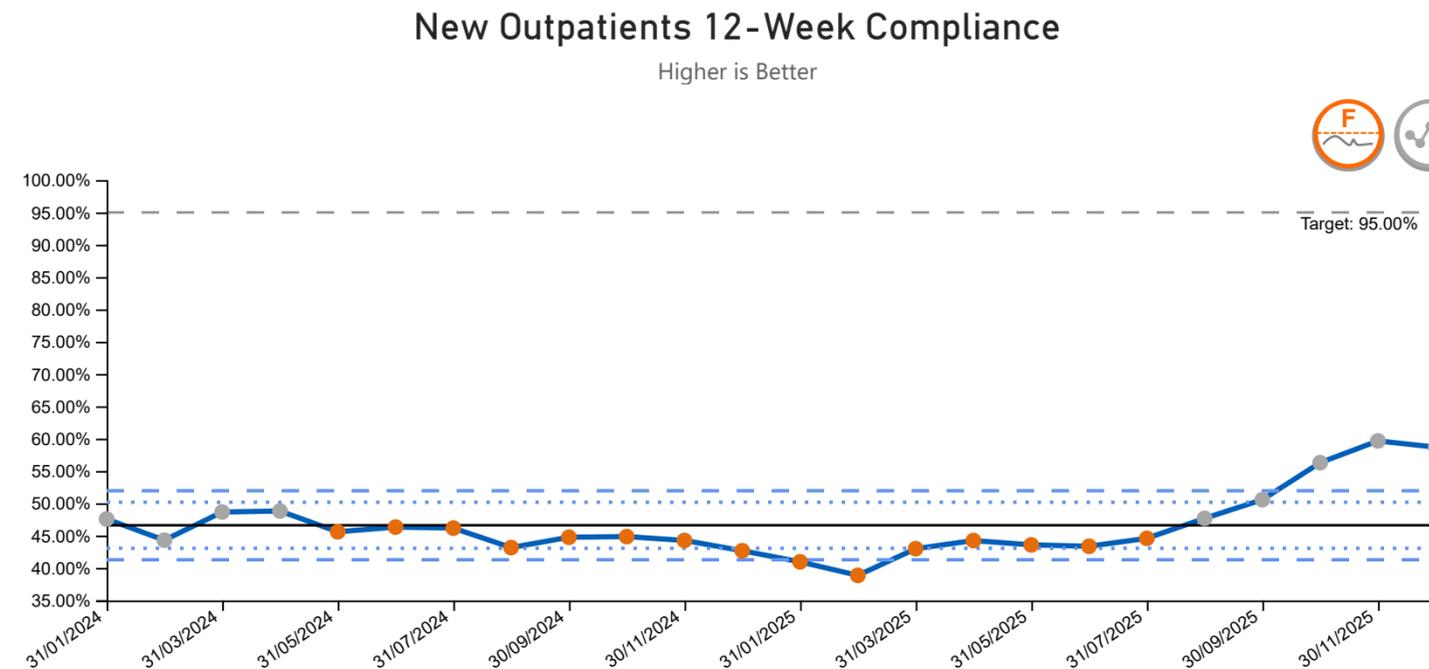
KPI	Target	Actual	RAG Value
95 per cent of patients wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100%	95%	58.68%	Red

Action	Target Date	Owner	Status
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 16 – 19 September 2025	21/10/2025	C Somerville	Completed
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 20 – 24 October 2025	02/12/2025	C Somerville	Completed
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 15 – 18 December 2025	26/02/2026	C Somerville	Completed
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	26/02/2026	C Somerville	In Progress
Demand and Capacity Planning templates to be agreed and reviewed by speciality for 2026/27 activity.	31/03/2026	C Somerville	In Progress



Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/01/2024	48	47	41	52	43	50	NONE
29/02/2024	44	47	41	52	43	50	NONE
31/03/2024	49	47	41	52	43	50	NONE
30/04/2024	49	47	41	52	43	50	NONE
31/05/2024	46	47	41	52	43	50	DETERIORATION
30/06/2024	46	47	41	52	43	50	DETERIORATION
31/07/2024	46	47	41	52	43	50	DETERIORATION
31/08/2024	43	47	41	52	43	50	DETERIORATION
30/09/2024	45	47	41	52	43	50	DETERIORATION
31/10/2024	45	47	41	52	43	50	DETERIORATION
30/11/2024	44	47	41	52	43	50	DETERIORATION
31/12/2024	43	47	41	52	43	50	DETERIORATION
31/01/2025	41	47	41	52	43	50	DETERIORATION
28/02/2025	39	47	41	52	43	50	DETERIORATION
31/03/2025	43	47	41	52	43	50	DETERIORATION
30/04/2025	44	47	41	52	43	50	DETERIORATION
31/05/2025	44	47	41	52	43	50	DETERIORATION
30/06/2025	43	47	41	52	43	50	DETERIORATION
31/07/2025	45	47	41	52	43	50	DETERIORATION
31/08/2025	48	47	41	52	43	50	NONE
30/09/2025	51	47	41	52	43	50	NONE
31/10/2025	56	47	41	52	43	50	NONE
30/11/2025	60	47	41	52	43	50	NONE
31/12/2025	59	47	41	52	43	50	NONE



Comments From Executive Lead

New Outpatient performance against the 12-week standard remains well below the 95% target but has shown progressive improvement, dipping over festive. Additional clinics over the last year have led to marked improvement over the year, and performance challenges are being escalated as needed. The number of patients waiting more than 52 weeks has fallen but is now appearing to be stable. This indicates that recent additional capacity has been used effectively to tackle the longest waits and stabilise overall performance.

Progress, remains modest and fragile. Consultant workforce shortages, particularly in visiting services, continue to constrain capacity, and recovery remains dependent on external support and short-term contracts. Sustained improvement will require ongoing investment and collaboration with partner boards to deliver consistent outpatient activity and consolidate the gains made.

Dr Anna Lamont, Medical Director



Operational Standards

New Outpatients (NOP) Local Improvement Target

Data Source

OP Recovery Weekly Return

Latest Data

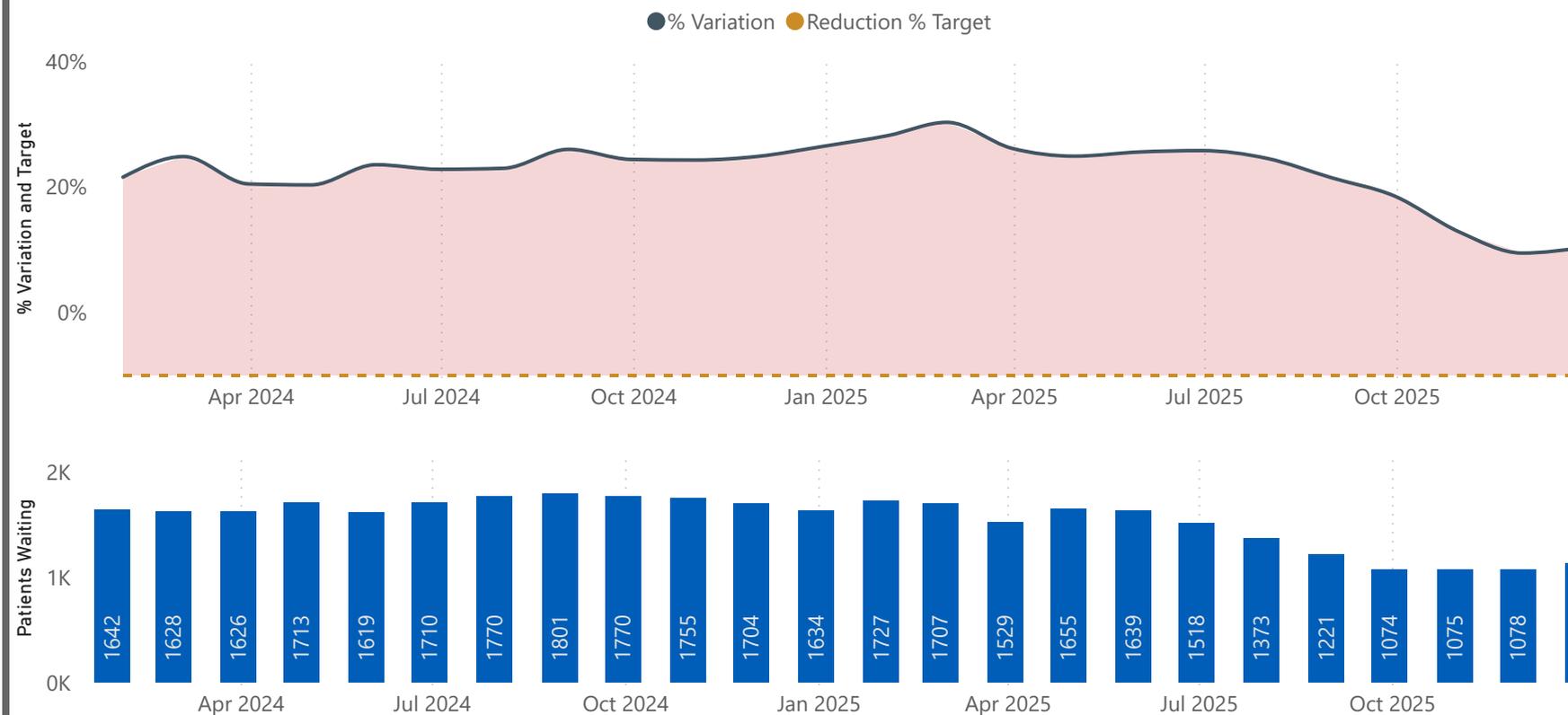
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for New Outpatients	-10%	10.45%	Red

Action	Target Date	Owner	Status
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 16 – 19 September 2025	21/10/2025	C Somerville	Completed
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 20 – 24 October 2025	02/12/2025	C Somerville	Completed
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 15 – 18 December 2025	26/02/2026	C Somerville	In Progress
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	26/02/2026	C Somerville	In Progress

New Outpatients - Local 10% Waiting Times Reduction Compliance



Comments From Executive Lead

Month-on-month improvements in the number of people waiting from earlier in the year, however waiting times for new outpatients are limited by capacity. Approaches nationally to reduce demand including advice on procedures of low clinical value, and redirection at referral triage, are yet to make much of an impact.

Dr Anna Lamont, Medical Director



Operational Standards

Treatment Time Guarantee (TTG) 12 Week Compliance

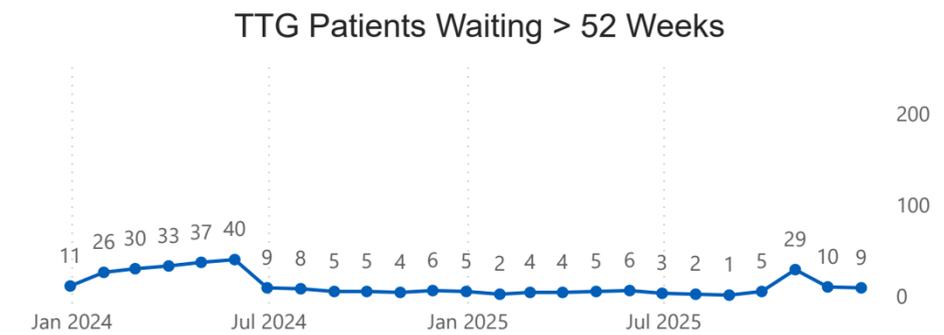
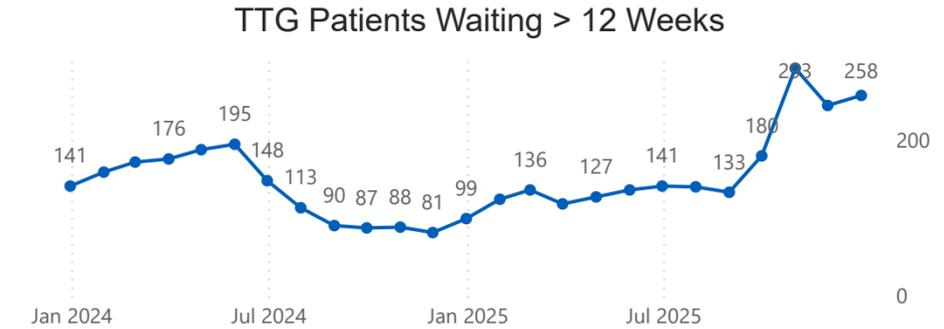
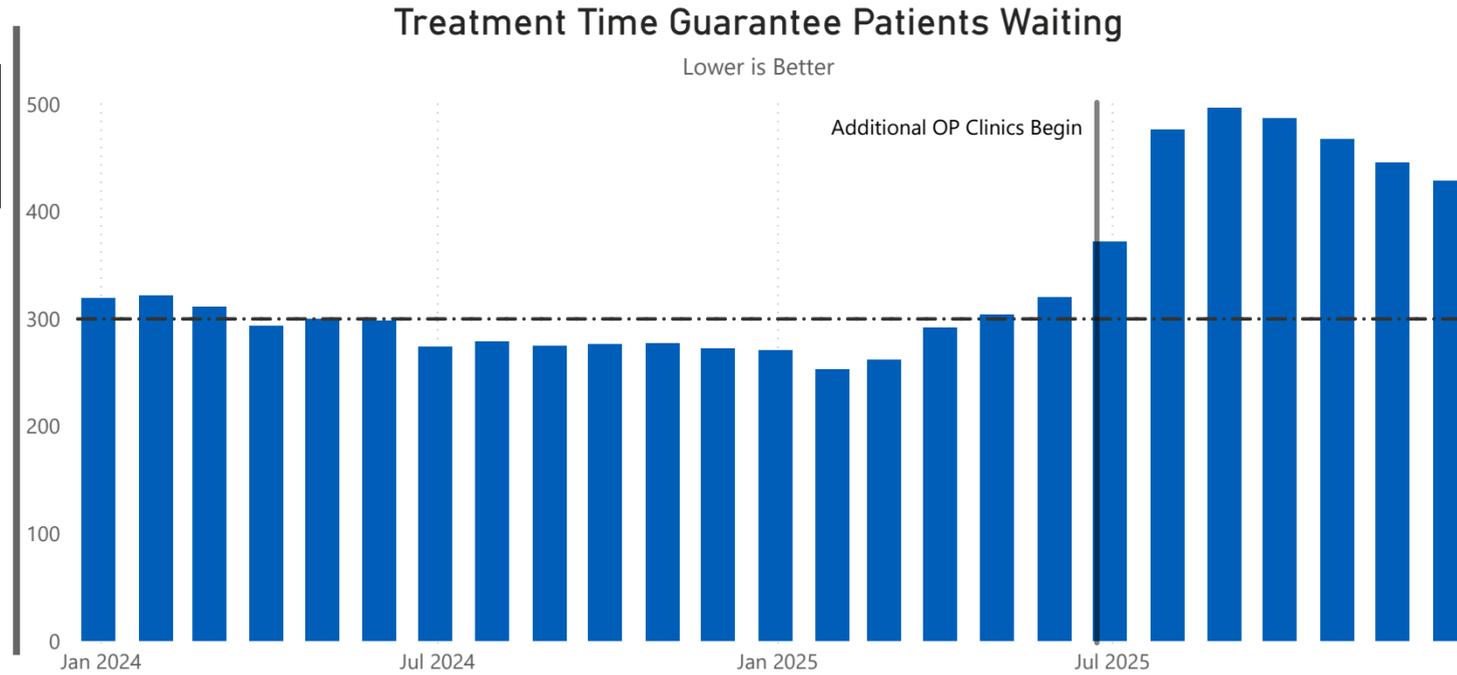
Data Source
TTG Weekly Return

Latest Data
31/12/2025

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%	47.98%	Red

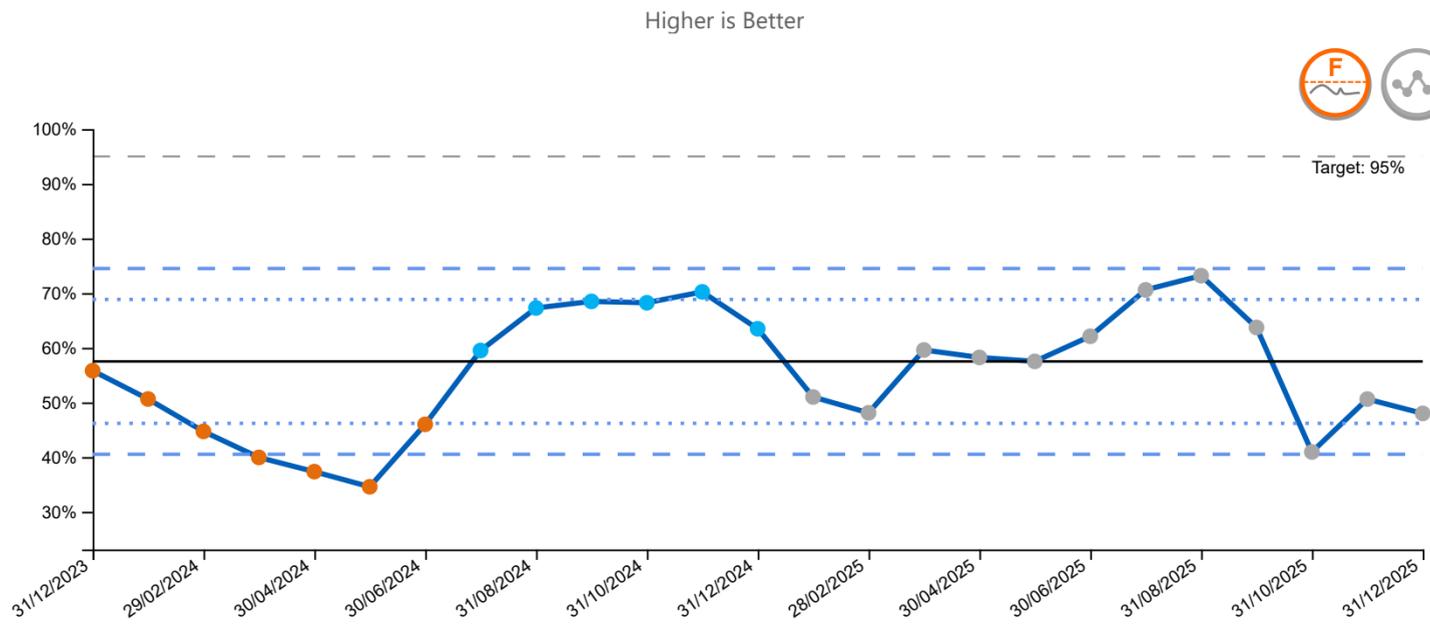
Action	Target Date	Owner	Status
Demand and Capacity Planning templates to be agreed and reviewed by speciality for 2026/27 activity.	31/03/2026	C Somerville	In Progress
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	26/02/2026	C Somerville	In Progress



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	56	57	95	41	74	46	69	DETERIORATION
31/01/2024	51	57	95	41	74	46	69	DETERIORATION
29/02/2024	45	57	95	41	74	46	69	DETERIORATION
31/03/2024	40	57	95	41	74	46	69	DETERIORATION
30/04/2024	37	57	95	41	74	46	69	DETERIORATION
31/05/2024	35	57	95	41	74	46	69	DETERIORATION
30/06/2024	46	57	95	41	74	46	69	DETERIORATION
31/07/2024	59	57	95	41	74	46	69	IMPROVEMENT
31/08/2024	67	57	95	41	74	46	69	IMPROVEMENT
30/09/2024	68	57	95	41	74	46	69	IMPROVEMENT
31/10/2024	68	57	95	41	74	46	69	IMPROVEMENT
30/11/2024	70	57	95	41	74	46	69	IMPROVEMENT
31/12/2024	63	57	95	41	74	46	69	IMPROVEMENT
31/01/2025	51	57	95	41	74	46	69	NONE
28/02/2025	48	57	95	41	74	46	69	NONE
30/03/2025	60	57	95	41	74	46	69	NONE
30/04/2025	58	57	95	41	74	46	69	NONE
31/05/2025	57	57	95	41	74	46	69	NONE
30/06/2025	62	57	95	41	74	46	69	NONE
31/07/2025	71	57	95	41	74	46	69	NONE
31/08/2025	73	57	95	41	74	46	69	NONE
30/09/2025	64	57	95	41	74	46	69	NONE
31/10/2025	41	57	95	41	74	46	69	NONE
30/11/2025	51	57	95	41	74	46	69	NONE
31/12/2025	48	57	95	41	74	46	69	NONE

Treatment Time Guarantee 12-Week Compliance



Target: 95%

Comments From Executive Lead

The initial rise in people waiting in the year was in part due to additional capacity to see new patients leading to more on the waiting lists. As this has stabilised there is a slower recovery in reducing those waiting. This illustrates the challenge of increasing waiting list for interventions when more new patients are seen. We will continue to use this improvement to review and refine pathways and optimise performance to deliver the best patient experience possible. The focus has been on ensuring those waiting the longest are prioritised.

Dr Anna Lamont, Medical Director



Operational Standards

Treatment Time Guarantee (TTG) Local Improvement Target

Data Source

TTG Weekly Return

Latest Data

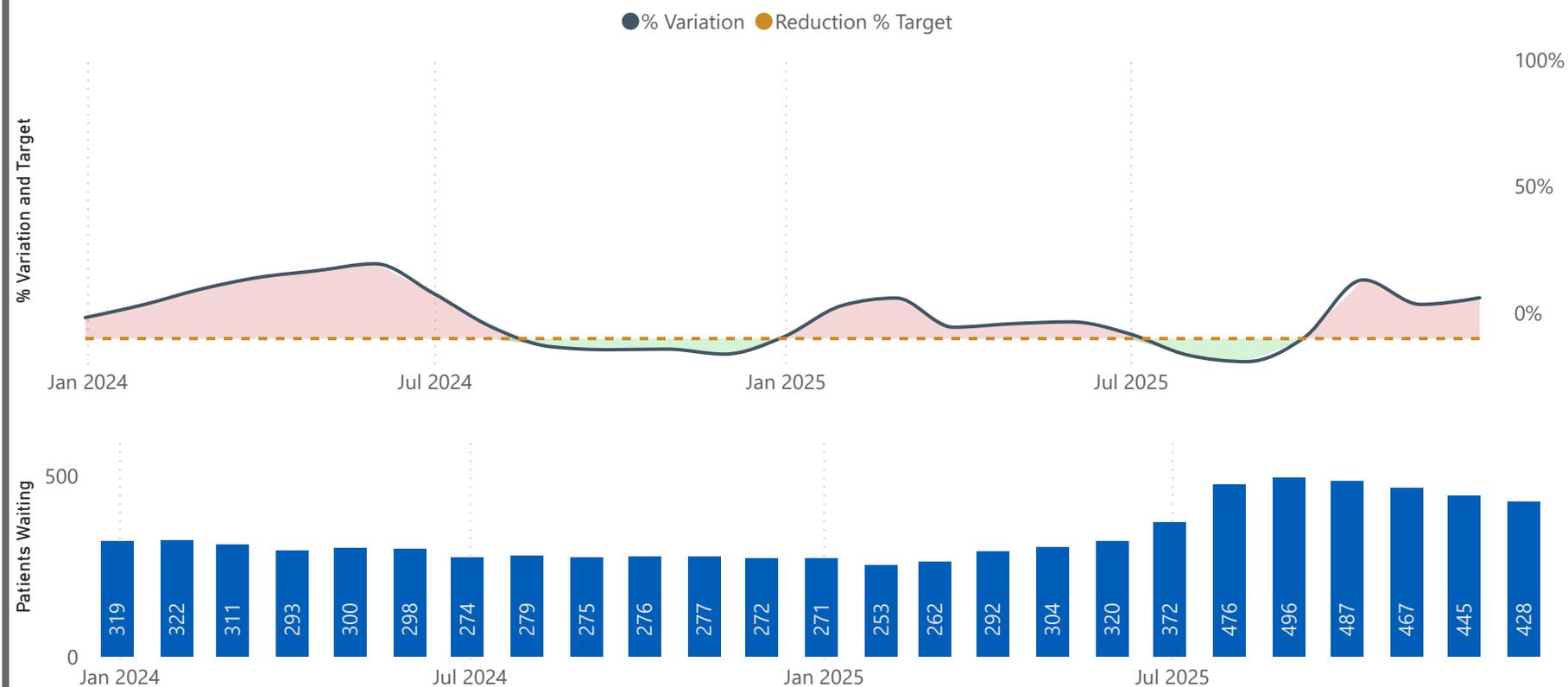
26/12/2025

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for Treatment Time Guarantee patients	-10%	6.11%	Red

Action	Target Date	Owner	Status
Weekly Waiting Times meeting to capture performance and address challenges, escalating where necessary to Planned Care Programme Board	26/02/2026	C Somerville	In Progress
Weekly Waiting Times to review ongoing inpatient demand following additional outpatient clinics, to address gaps in capacity	31/03/2026	C Somerville	In Progress

Treatment Time Guarantee - Local 10% Waiting Times Reduction Compliance



Comments From Executive Lead

After reductions in the number of people waiting earlier in the year, Funding to address long waits for new outpatient activity for ENT, Ophthalmology and some T&O activity is demonstrated as achieving impact through this KPI.

Dr Anna Lamont, Medical Director



Operational Standards

Diagnostic Endoscopy 6 Week Compliance

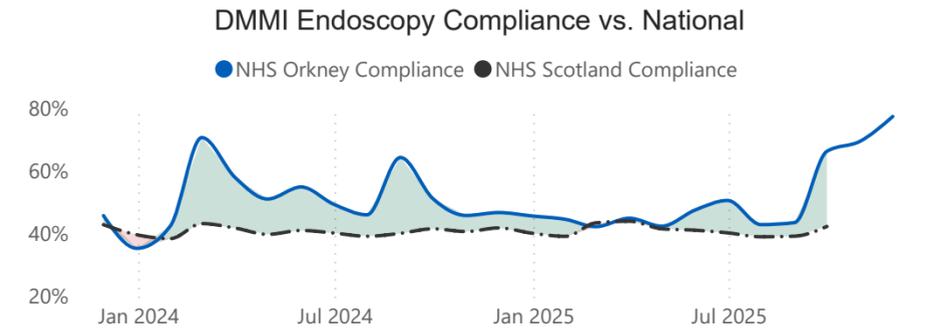
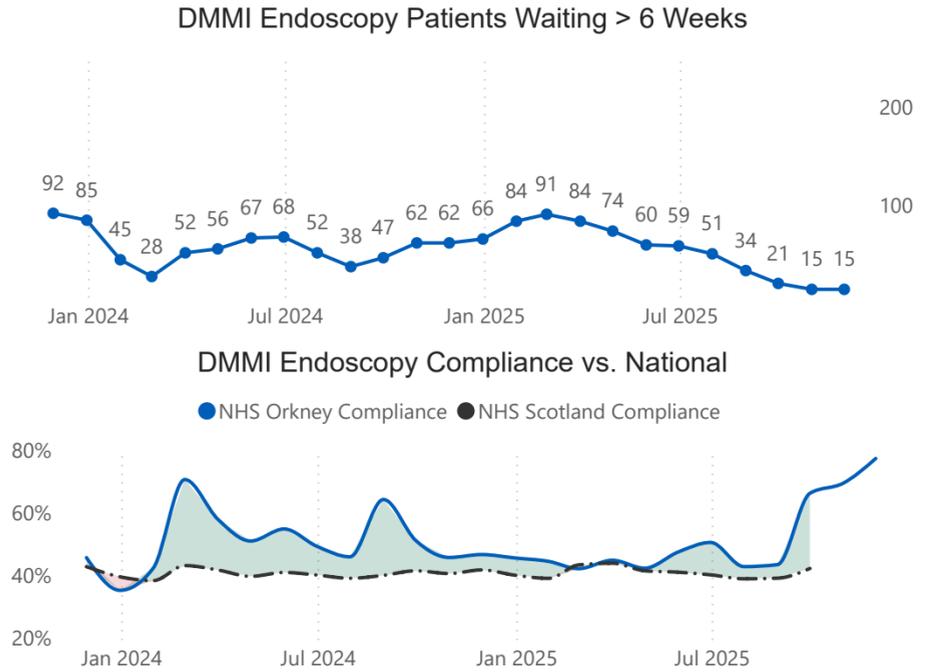
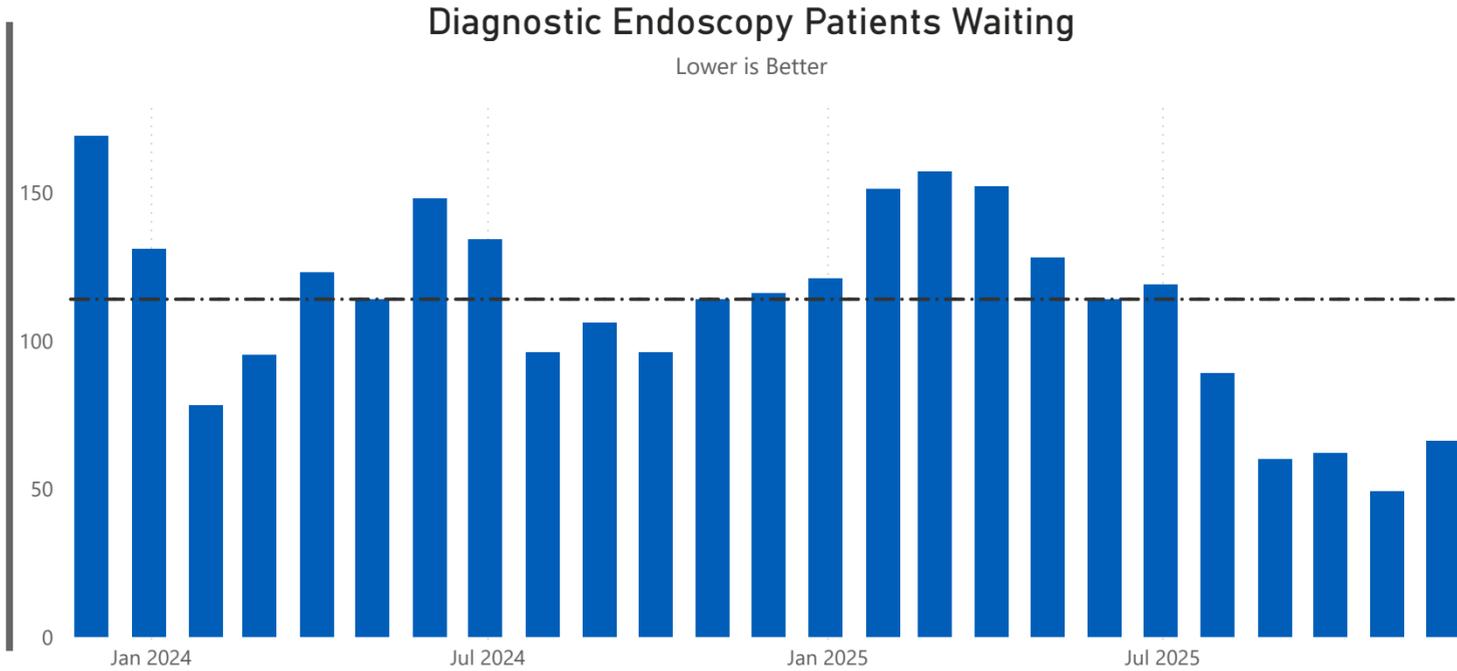
Data Source
DMMI Monthly Return

Latest Data
30/11/2025

Compliance

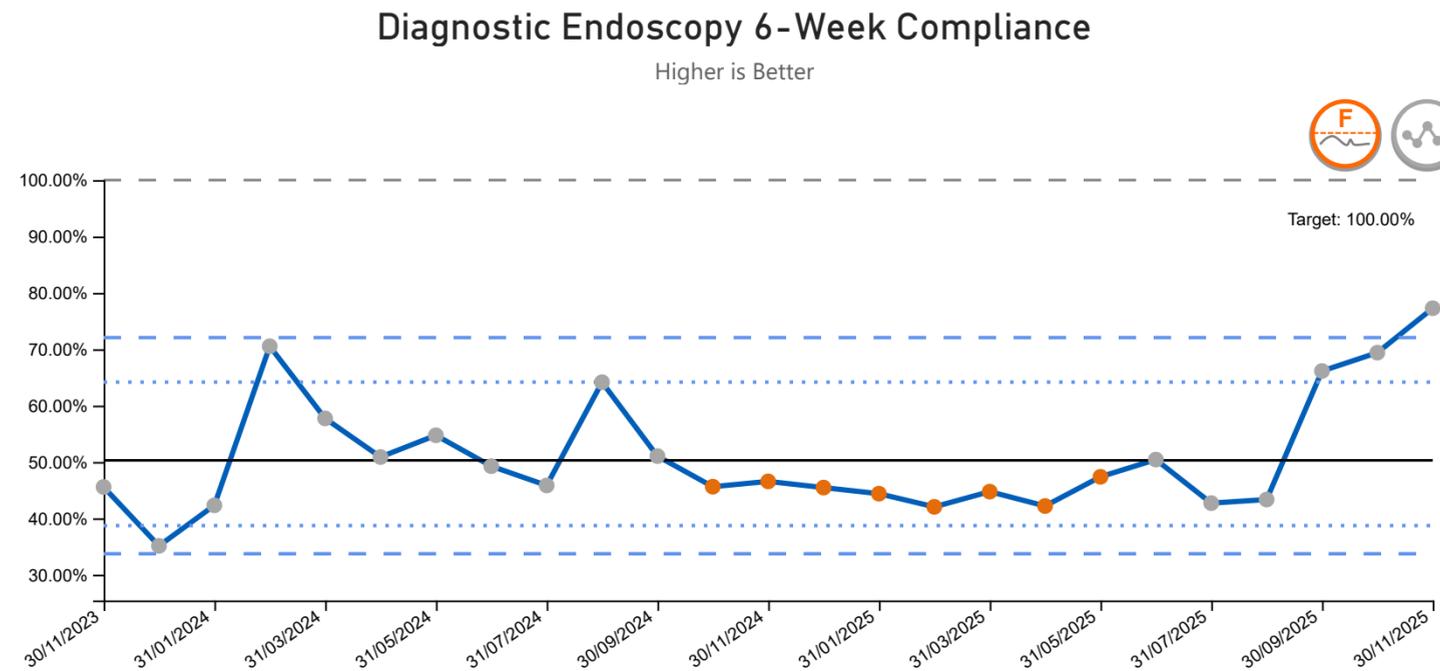
KPI	Target	Actual	RAG Value
100% of patients waiting for key endoscopy diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	77.27%	Amber

Action	Target Date	Owner	Status
Endoscopy short life Focus Group which is chaired by Medical Director meet and identify then address recommendations from 2024 CfSD peer review.	30/10/2025	A Lamont	Completed
Endoscopy Waits will be captured through weekly Waiting Times meeting and challenges address or escalated as required	25/11/2025	C Somerville	Completed



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
30/11/2023	45.56	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/12/2023	35.11	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/01/2024	42.31	50.28	100.00	33.72	72.05	38.71	64.16	NONE
29/02/2024	70.53	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/03/2024	57.72	50.28	100.00	33.72	72.05	38.71	64.16	NONE
30/04/2024	50.88	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/05/2024	54.73	50.28	100.00	33.72	72.05	38.71	64.16	NONE
30/06/2024	49.25	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/07/2024	45.83	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/08/2024	64.15	50.28	100.00	33.72	72.05	38.71	64.16	NONE
30/09/2024	51.04	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/10/2024	45.61	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
30/11/2024	46.55	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
31/12/2024	45.45	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
31/01/2025	44.37	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
28/02/2025	42.04	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
31/03/2025	44.74	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
30/04/2025	42.19	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
31/05/2025	47.37	50.28	100.00	33.72	72.05	38.71	64.16	DETERIORATION
30/06/2025	50.42	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/07/2025	42.70	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/08/2025	43.33	50.28	100.00	33.72	72.05	38.71	64.16	NONE
30/09/2025	66.13	50.28	100.00	33.72	72.05	38.71	64.16	NONE
31/10/2025	69.39	50.28	100.00	33.72	72.05	38.71	64.16	NONE
30/11/2025	77.27	50.28	100.00	33.72	72.05	38.71	64.16	NONE



Comments From Executive Lead

Compliance has shown a marked improvement this year with additional sessions, and the new sponge capsule clinic, with reduction in those waiting. It remains the case that we are below target though since the target is 100%.

Dr Anna Lamont, Medical Director



Operational Standards

Diagnostic Imaging 6 Week Compliance

Data Source
DMMI Monthly Return

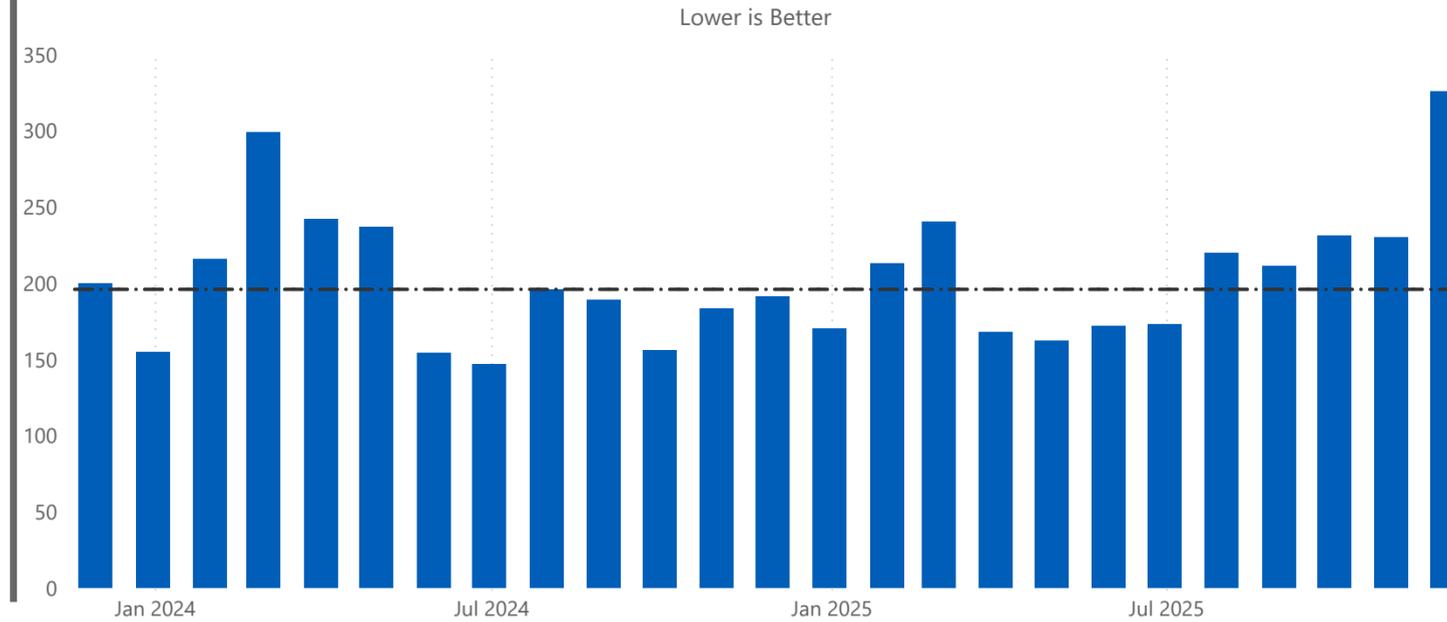
Latest Data
30/11/2025

Compliance

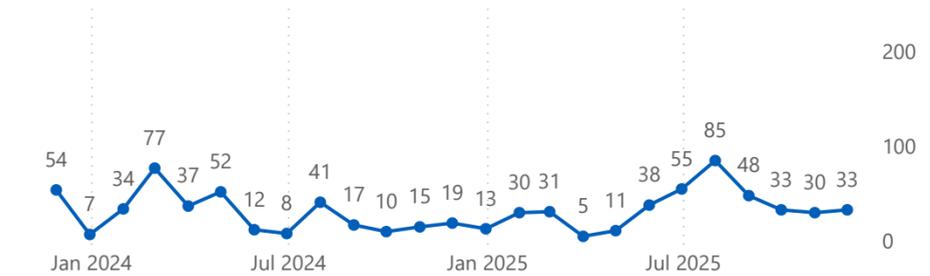
KPI	Target	Actual	RAG Value
100% of patients waiting for key imaging diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	89.88%	Amber

Action	Target Date	Owner	Status
Local prostate MRI scanning to be validated by NHS Grampian to allow patients to be repatriated to Orkney for diagnostics.	14/11/2025	A Lamont	Completed

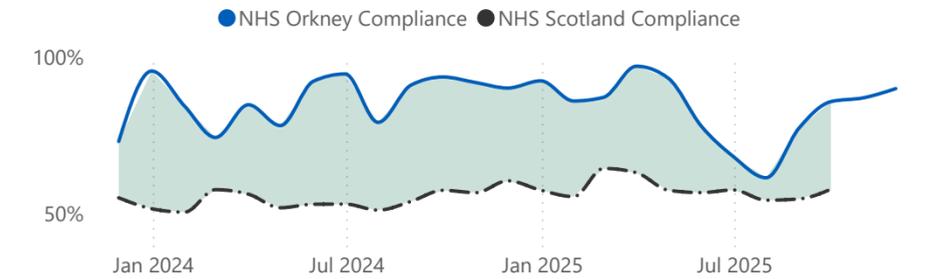
Diagnostic Imaging Patients Waiting



DMMI Imaging Patients Waiting > 6 Weeks



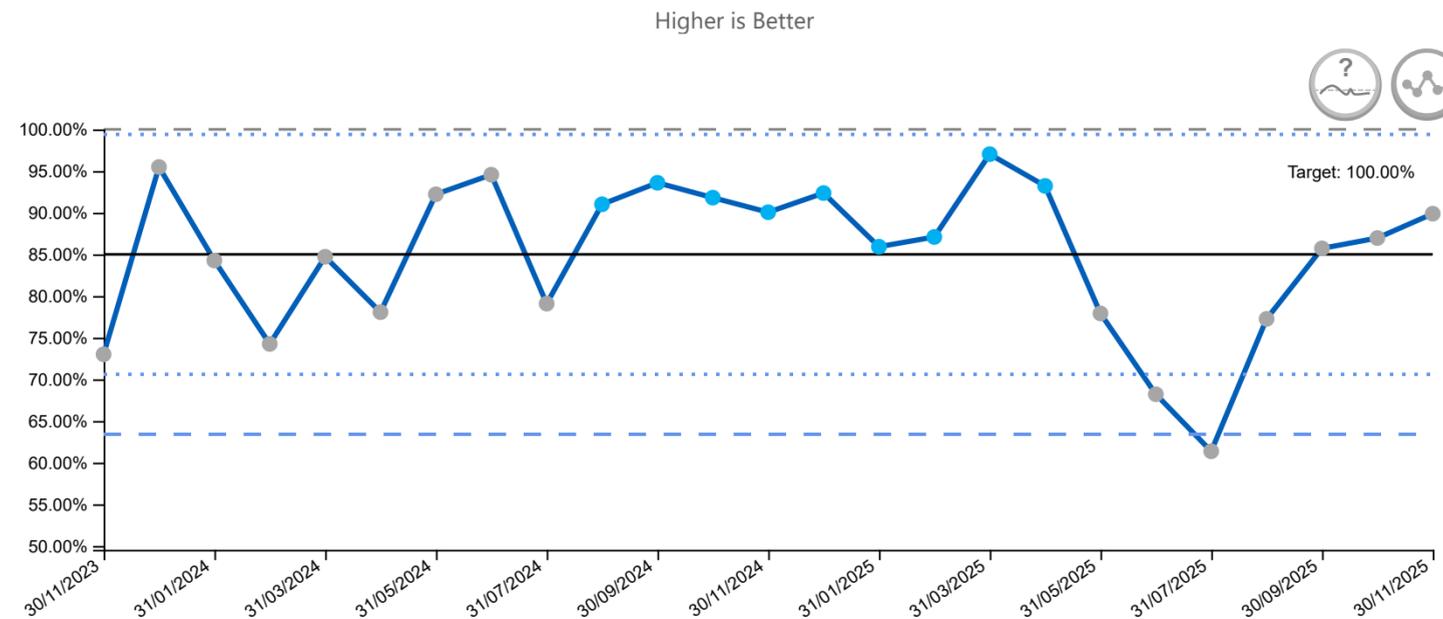
DMMI Imaging Compliance vs. National



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
30/11/2023	73.00	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/12/2023	95.48	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/01/2024	84.26	85.00	100.00	63.40	106.59	70.60	99.39	NONE
29/02/2024	74.25	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/03/2024	84.71	85.00	100.00	63.40	106.59	70.60	99.39	NONE
30/04/2024	78.06	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/05/2024	92.21	85.00	100.00	63.40	106.59	70.60	99.39	NONE
30/06/2024	94.56	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/07/2024	79.08	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/08/2024	91.01	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
30/09/2024	93.59	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
31/10/2024	91.80	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
30/11/2024	90.05	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
31/12/2024	92.35	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
31/01/2025	85.92	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
28/02/2025	87.08	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
31/03/2025	97.02	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
30/04/2025	93.21	85.00	100.00	63.40	106.59	70.60	99.39	IMPROVEMENT
31/05/2025	77.91	85.00	100.00	63.40	106.59	70.60	99.39	NONE
30/06/2025	68.21	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/07/2025	61.36	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/08/2025	77.25	85.00	100.00	63.40	106.59	70.60	99.39	NONE
30/09/2025	85.71	85.00	100.00	63.40	106.59	70.60	99.39	NONE
31/10/2025	86.96	85.00	100.00	63.40	106.59	70.60	99.39	NONE
30/11/2025	89.88	85.00	100.00	63.40	106.59	70.60	99.39	NONE

Diagnostic Imaging 6-Week Compliance



Comments From Executive Lead

Compliance dipped earlier in the year due to the transfer of MRI waiting lists from NHS Grampian but has now recovered. Pressures remain on ultrasound investigations which will limit further improvement over the next quarter.

Dr Anna Lamont, Medical Director



Operational Standards

Diagnostic Cardiology 6 Week Compliance

Data Source
DMMI Monthly Return

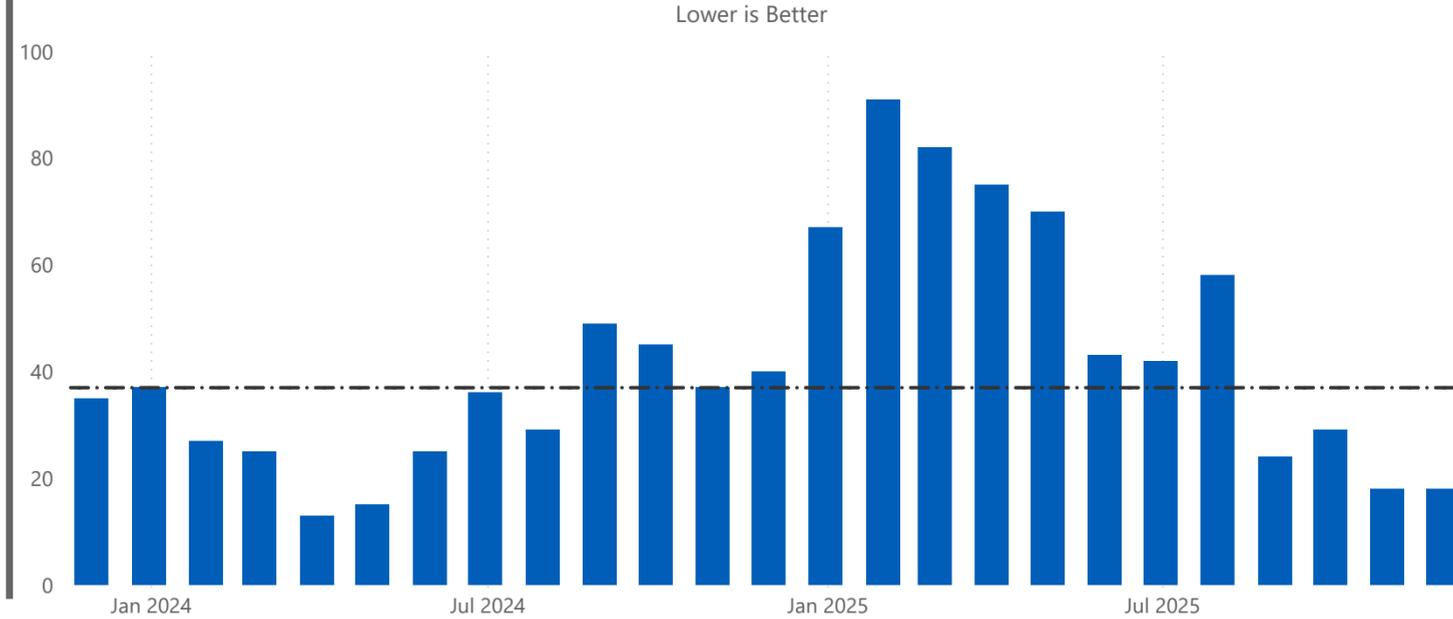
Latest Data
30/11/2025

Compliance

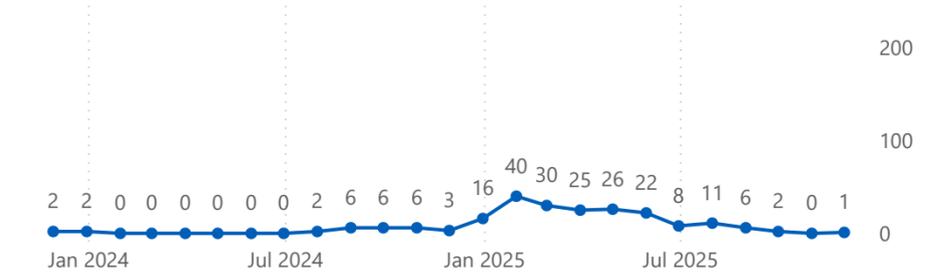
KPI	Target	Actual	RAG Value
100% of patients waiting for key cardiology diagnostic tests and investigations should wait no longer than six weeks (42 days).	100%	94.44%	Amber

Action	Target Date	Owner	Status
Complete induction and supervision for the new physiologist, enabling independent practice by September–October 2025.	01/10/2025	A Lamont	Completed
Continue proactive monitoring of waiting lists and rapid adjustment of locum support to avoid future backlog.	01/10/2025	A Lamont	Off Track
Integrate cardiology planning within the Clinical Services Review (CSR) to develop a sustainable long-term workforce and service model.	01/10/2025	A Lamont	Completed
Maintain close liaison between operational managers and clinical leads to anticipate and respond to any capacity constraints	01/10/2025	A Lamont	Off Track

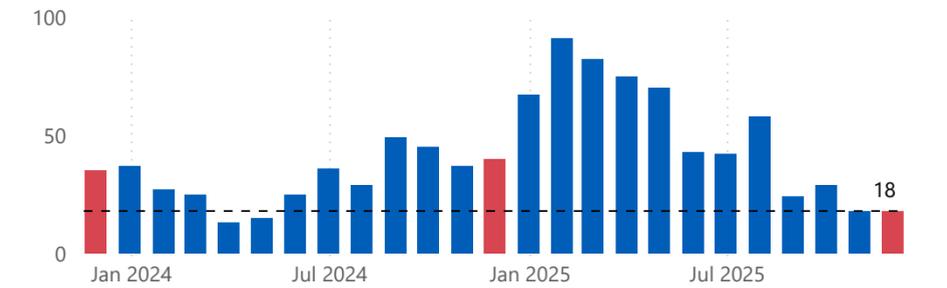
Diagnostic Cardiology Patients Waiting



DMMI Cardiology Patients Waiting > 6 Weeks



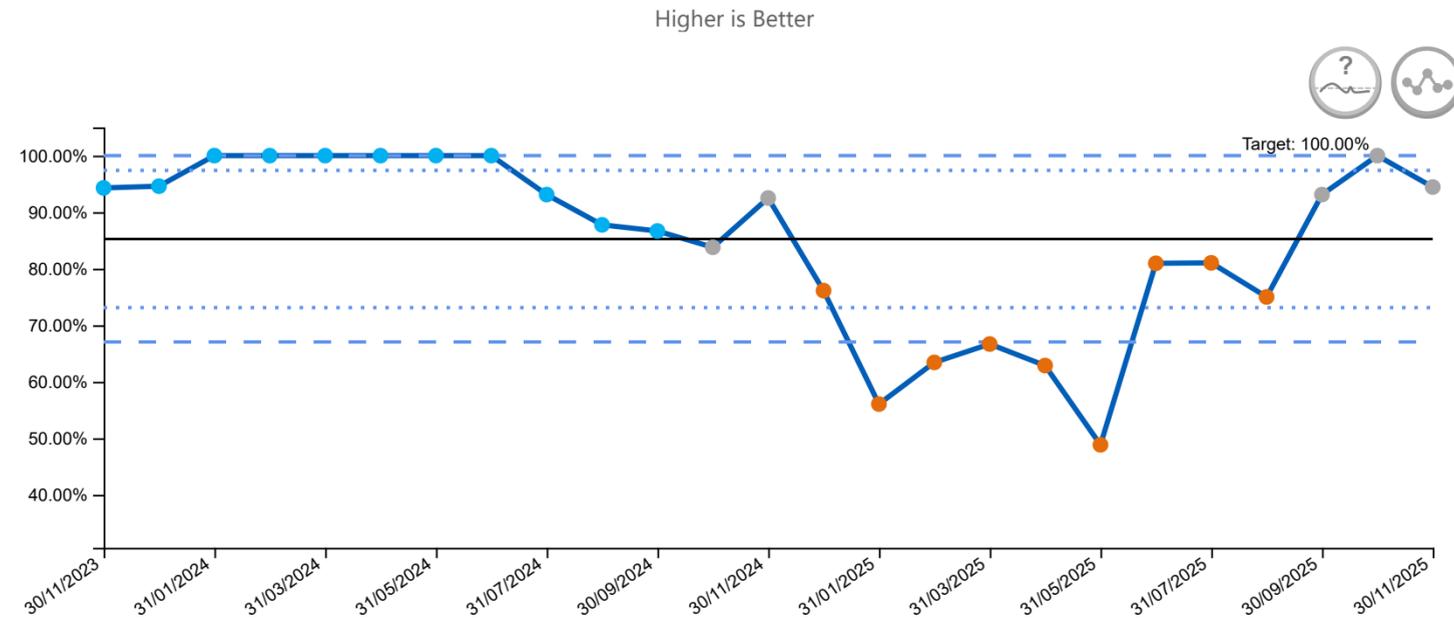
DMMI Cardiology Patients Waiting vs. Previous Year



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
30/11/2023	94.29	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/12/2023	94.59	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/01/2024	100.00	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
29/02/2024	100.00	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/03/2024	100.00	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
30/04/2024	100.00	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/05/2024	100.00	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
30/06/2024	100.00	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/07/2024	93.10	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/08/2024	87.76	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
30/09/2024	86.67	85.25	100.00	67.03	103.46	73.11	97.39	IMPROVEMENT
31/10/2024	83.78	85.25	100.00	67.03	103.46	73.11	97.39	NONE
30/11/2024	92.50	85.25	100.00	67.03	103.46	73.11	97.39	NONE
31/12/2024	76.12	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
31/01/2025	56.04	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
28/02/2025	63.41	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
31/03/2025	66.67	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
30/04/2025	62.86	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
31/05/2025	48.84	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
30/06/2025	80.95	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
31/07/2025	81.03	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
31/08/2025	75.00	85.25	100.00	67.03	103.46	73.11	97.39	DETERIORATION
30/09/2025	93.10	85.25	100.00	67.03	103.46	73.11	97.39	NONE
31/10/2025	100.00	85.25	100.00	67.03	103.46	73.11	97.39	NONE
30/11/2025	94.44	85.25	100.00	67.03	103.46	73.11	97.39	NONE

Diagnostic Cardiology 6-Week Compliance



Comments From Executive Lead

Compliance with the six-week diagnostic cardiology standard has improved significantly, and remains close to the 100% target.

Substantive staffing appointments have helped to deliver greater resilience locally and reduce dependence on locum support and patients travelling to Grampian.

Dr Anna Lamont, Medical Director



Operational Standards

Cancer Waiting Times 31-Day Standard

Data Source

Discovery

Latest Data

30/09/2025

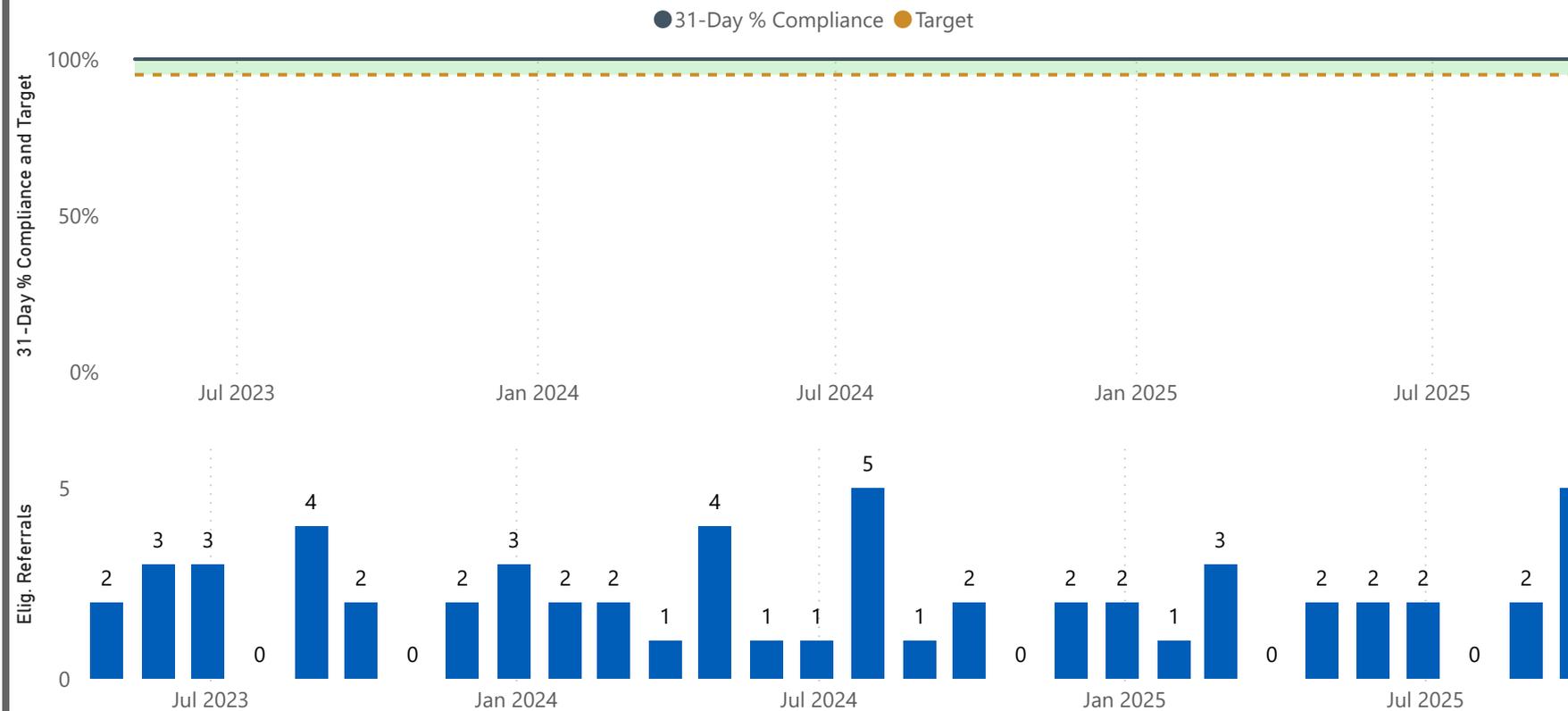
Compliance

KPI	Target	Actual	RAG Value
95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	95%	100%	Green

Action	Target Date	Owner	Status
--------	-------------	-------	--------

KPI on target, no actions required at this time.

Cancer Waiting Times - 31 Day Standard



Comments From Executive Lead

For the most recent quarterly reporting period all patients treated within the standard. Compliance was 100% against a target of 95%.

Dr Anna Lamont, Medical Director



Operational Standards

Cancer Waiting Times 62-Day Standard

Data Source

Discovery

Latest Data

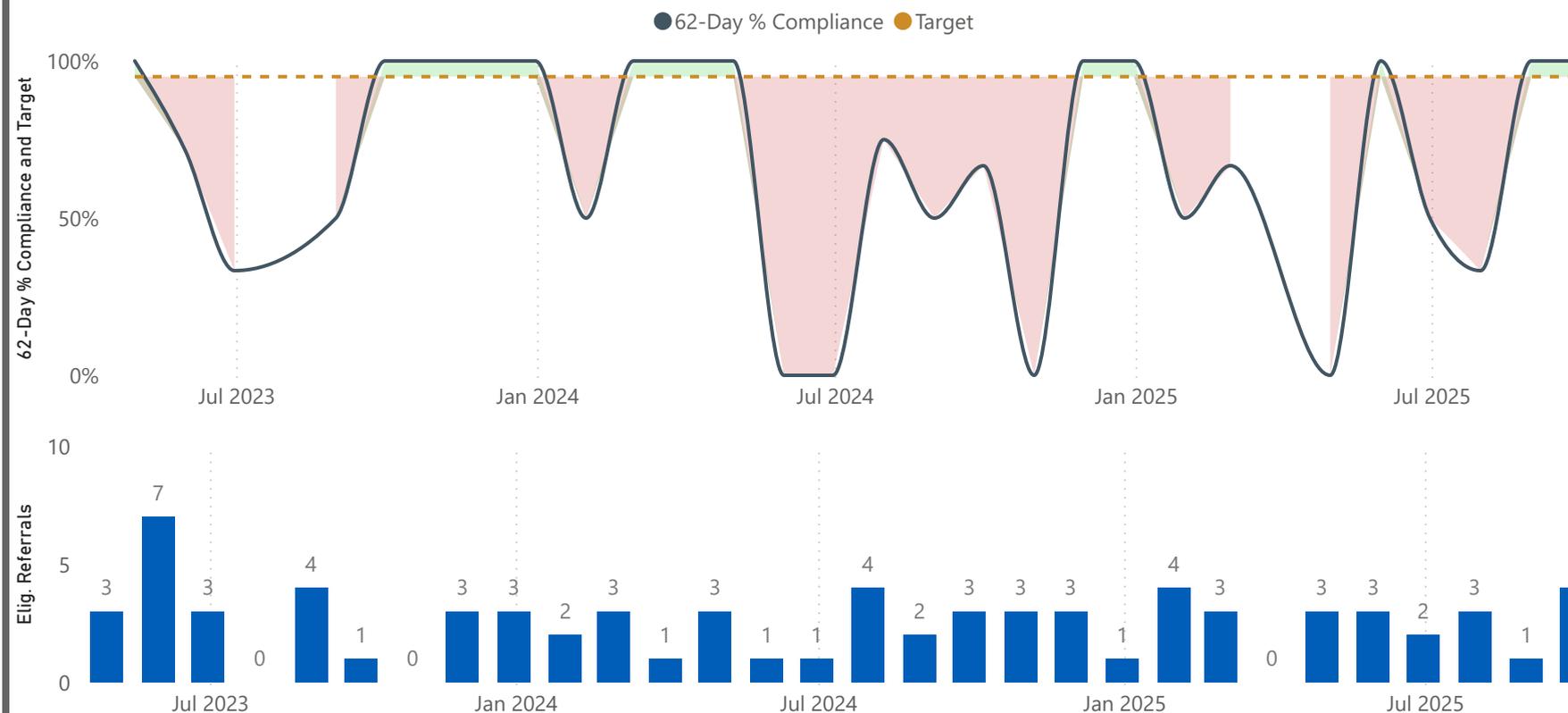
30/09/2025

Compliance

KPI	Target	Actual	RAG Value
90% of those referred urgently with a suspicion of cancer are to begin treatment within 62 days of receipt of referral	90%	100%	Green

Action	Target Date	Owner	Status
Timeline to be reviewed for those patients who breached during the reporting period to understand opportunities to address challenge.	15/12/2025	C Somerville	Completed

Cancer Waiting Times - 62 Day Standard



Comments From Executive Lead

For the most recent quarterly reporting period all patients treated within the standard. Compliance was 100% against a target of 95%.

Dr Anna Lamont, Medical Director



Operational Standards

Inpatient Pre-Noon Discharges

Data Source

TrakCare

Latest Data

31/12/2025

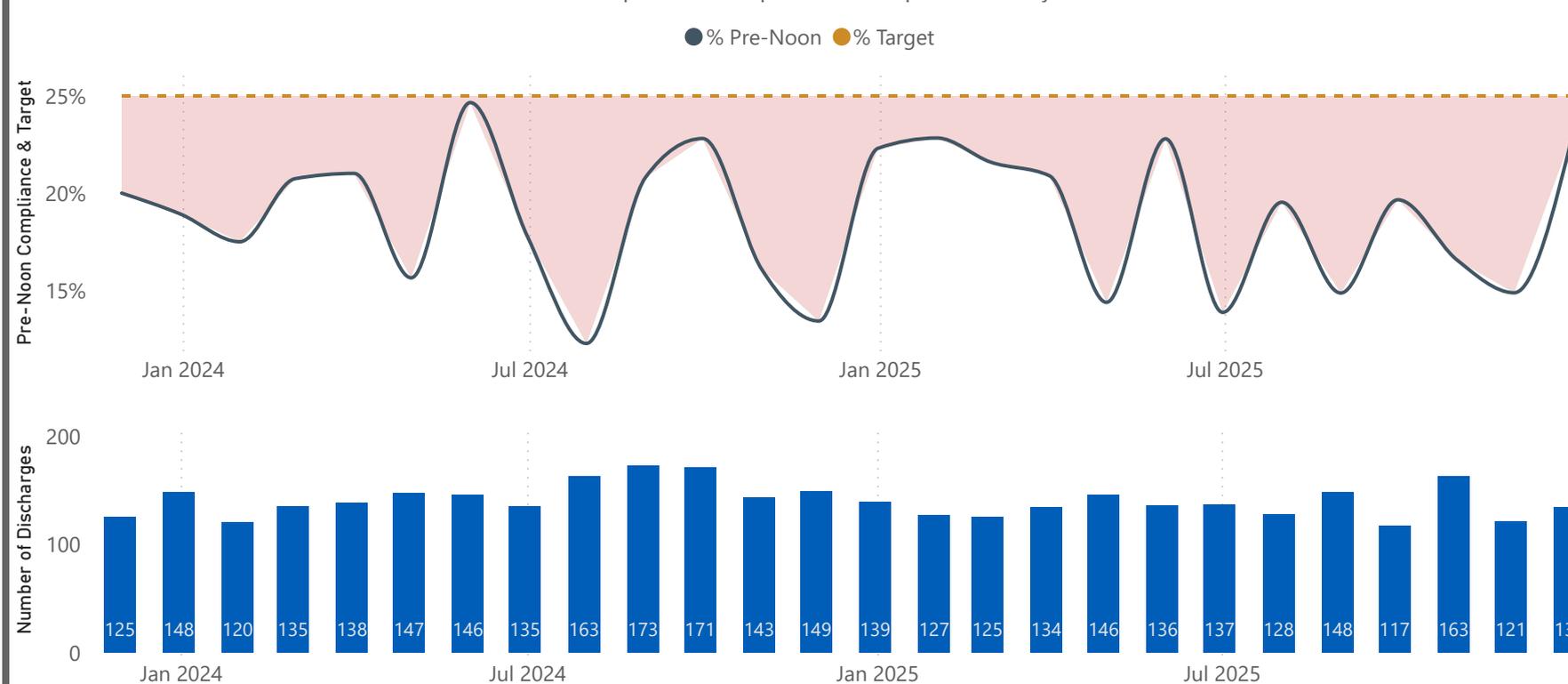
Compliance

KPI	Target	Actual	RAG Value
Pre-noon discharges	25.0%	23.13%	Amber

Action	Target Date	Owner	Status
KPI off-target, actions to be updated.			

Inpatient Discharges - Pre-Noon Compliance

Compliance for Inpatient 1 & Inpatient 2 Only



Comments From Executive Lead

Discharge planning remains a key focus over the next quarter with PDD setting and compliance with red, amber, green pathways.

Utilisation and review of those patients suitable for the collection lounge is underway.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

Delayed Transfers of Care Discharge Compliance

Data Source

Delayed Discharges Monthly Return

Latest Data

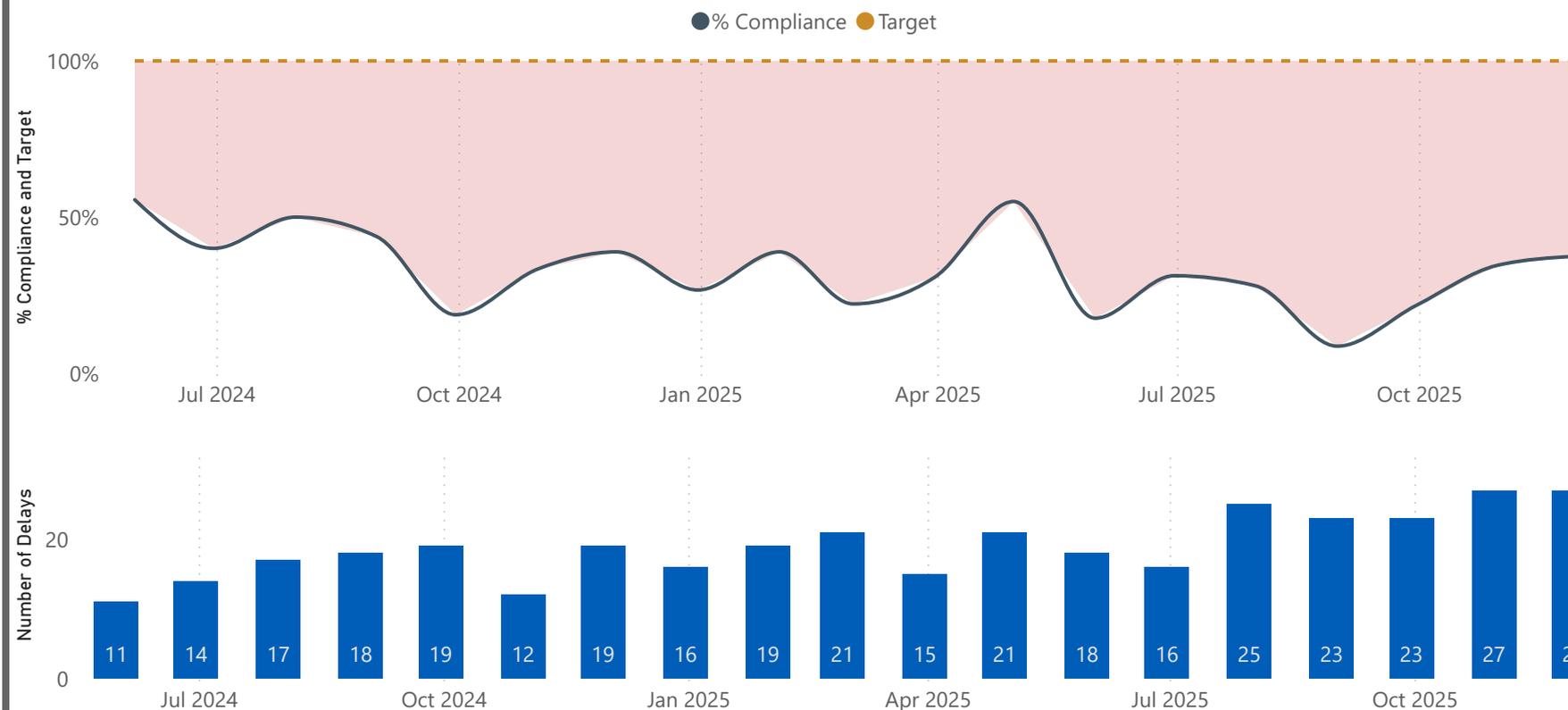
30/11/2025

Compliance

KPI	Target	Actual	RAG Value
Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	100%	37.50%	Red

Action	Target Date	Owner	Status
Review of package of care need to ascertain packages that could be delivered with less hours or in a different way.	31/12/2025	S Thomas	Completed
Discharge planning, setting predicted date of discharge.	31/01/2026	S Thomas	In Progress
Recruitment to social care vacancies. Recruitment date extended due to availability of suitable substantive candidates and agency recruitment.	28/02/2026	S Thomas	In Progress

Delayed Transfers of Care - Discharge Within 14 Days Compliance (excl. Code 9)



Comments From Executive Lead

Current performance update as at 15/01/2026 is 16 delayed transfers of care. Of these 16, 5 are awaiting residential home placement.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

Delayed Transfers of Care at Census Date

Data Source

Delayed Discharges Monthly Return

Latest Data

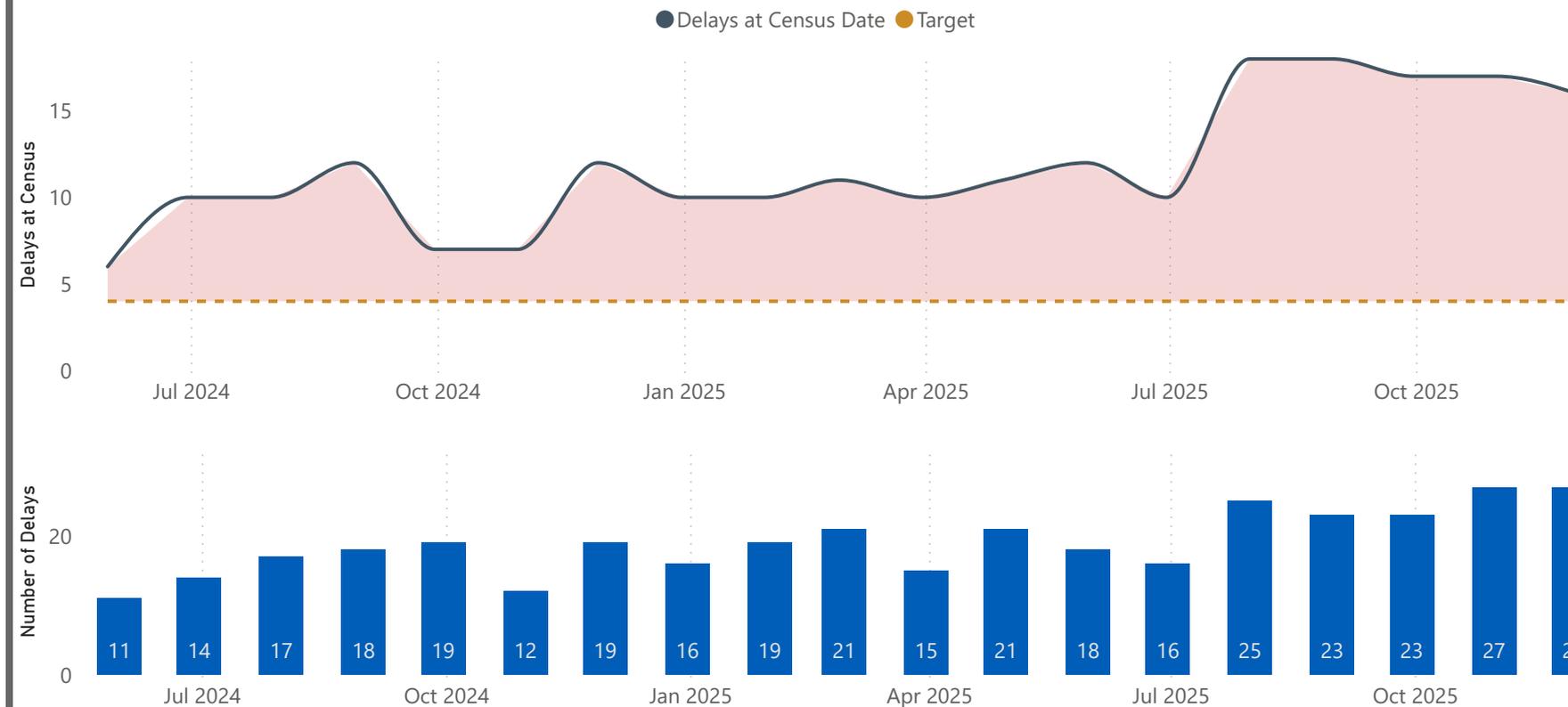
30/11/2025

Compliance

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	16	Red

Action	Target Date	Owner	Status
Discharge planning, setting predicted date of discharge.	31/01/2026	S Thomas	In Progress
Recruitment to social care vacancies. Recruitment date extended due to availability of suitable substantive candidates and agency recruitment.	28/02/2026	S Thomas	In Progress
Review of package of care need to ascertain packages that could be delivered with less hours or in a different way.	31/12/2025	S Thomas	Completed

Delayed Transfers of Care - Delays at Census Date



Comments From Executive Lead

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 15/01/2026 is 16 delayed transfers of care. Of these 16, 5 are awaiting residential home placement.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

Delayed Transfers of Care Bed Days Occupied

Data Source
Delayed Discharges Monthly Return

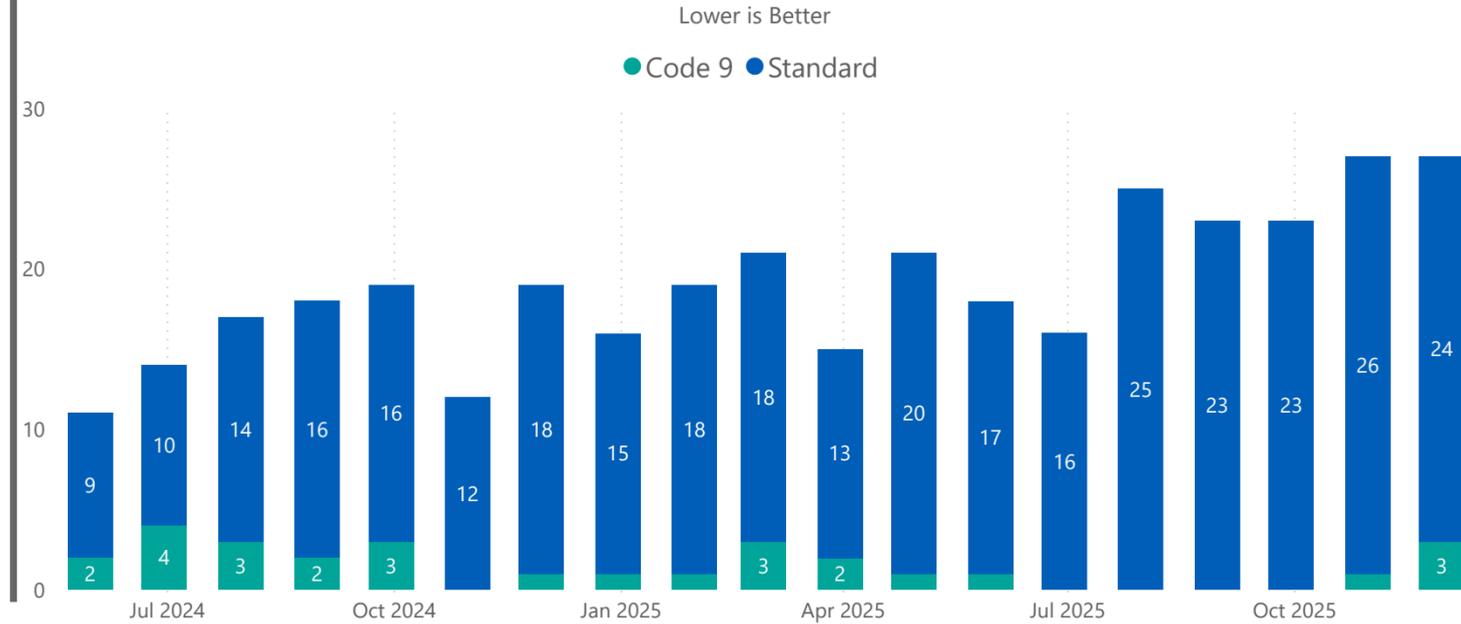
Latest Data
30/11/2025

Compliance

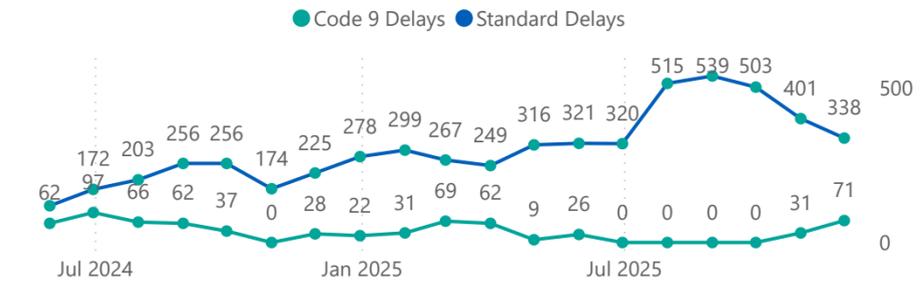
KPI	Target	Actual	RAG Value
Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	56	409	Red

Action	Target Date	Owner	Status
Discharge planning, setting predicted date of discharge.	31/01/2026	S Thomas	In Progress
Recruitment to social care vacancies. Recruitment date extended due to availability of suitable substantive candidates and agency recruitment.	28/02/2026	S Thomas	In Progress
Review of package of care need to ascertain packages that could be delivered with less hours or in a different way.	31/12/2025	S Thomas	Completed

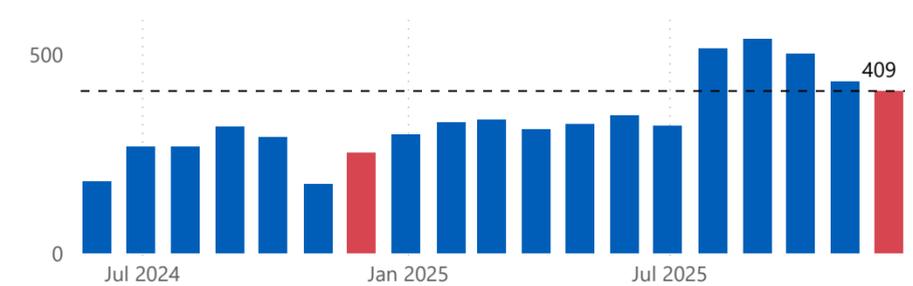
Delayed Transfers of Care - Delays by Type & Month



DToC Bed Days By Delay Type



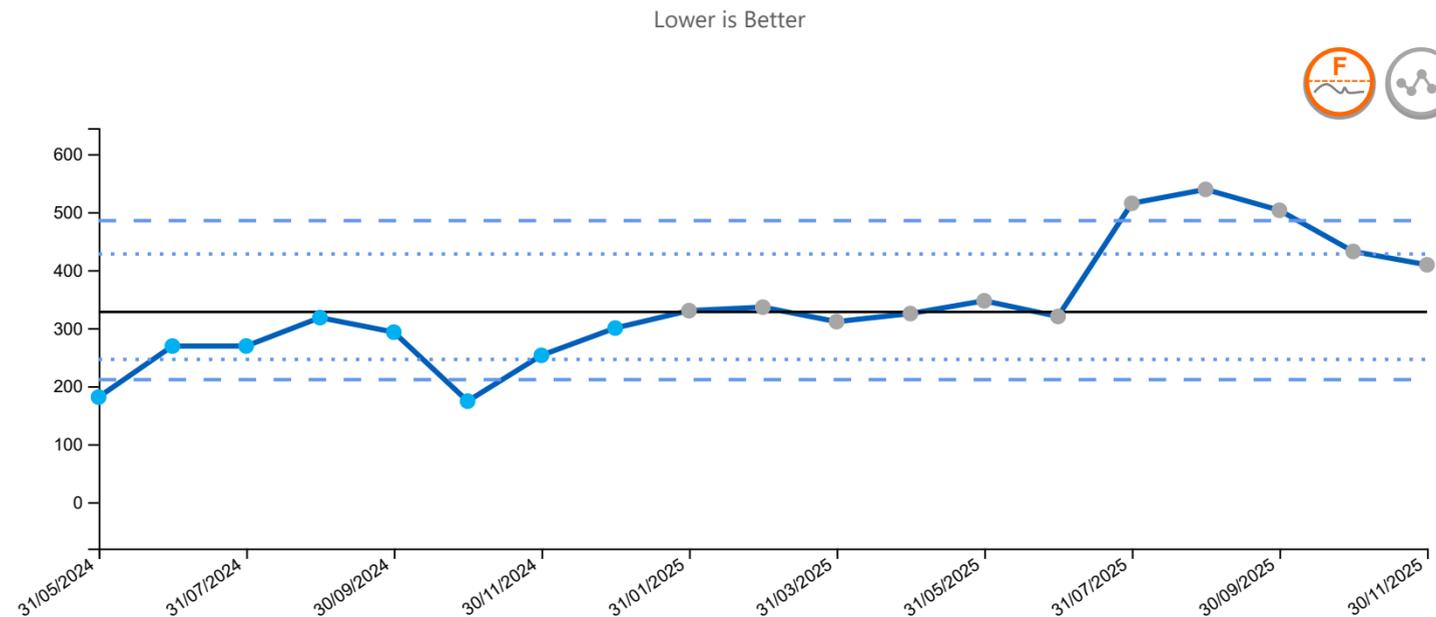
DToC Occupied Bed Days vs. Previous Year



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/05/2024	181	328	56	211	485	246	428	IMPROVEMENT
30/06/2024	269	328	56	211	485	246	428	IMPROVEMENT
31/07/2024	269	328	56	211	485	246	428	IMPROVEMENT
31/08/2024	318	328	56	211	485	246	428	IMPROVEMENT
30/09/2024	293	328	56	211	485	246	428	IMPROVEMENT
31/10/2024	174	328	56	211	485	246	428	IMPROVEMENT
30/11/2024	253	328	56	211	485	246	428	IMPROVEMENT
31/12/2024	300	328	56	211	485	246	428	IMPROVEMENT
31/01/2025	330	328	56	211	485	246	428	NONE
28/02/2025	336	328	56	211	485	246	428	NONE
31/03/2025	311	328	56	211	485	246	428	NONE
30/04/2025	325	328	56	211	485	246	428	NONE
31/05/2025	347	328	56	211	485	246	428	NONE
30/06/2025	320	328	56	211	485	246	428	NONE
31/07/2025	515	328	56	211	485	246	428	NONE
31/08/2025	539	328	56	211	485	246	428	NONE
30/09/2025	503	328	56	211	485	246	428	NONE
31/10/2025	432	328	56	211	485	246	428	NONE
30/11/2025	409	328	56	211	485	246	428	NONE

Delayed Transfers of Care - Occupied Bed Days



Comments From Executive Lead

Current performance update as at 15/01/2026 is 16 delayed transfers of care. Of these 16, 5 are awaiting residential home placement.

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards In Vitro Fertilisation (IVF) 52 Week Screening Compliance

Data Source

IVF Waiting Times Publication

Latest Data

30/09/2025

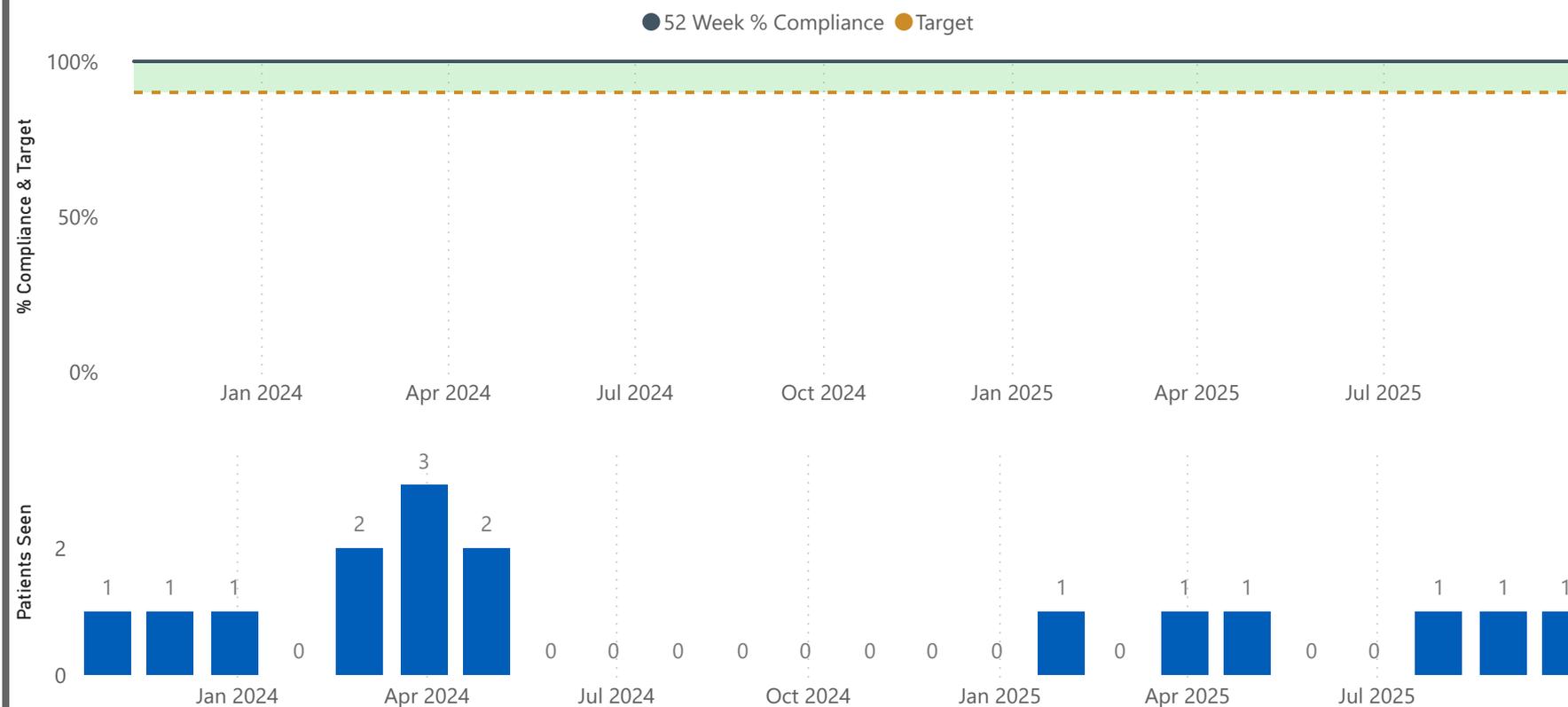
Compliance

KPI	Target	Actual	RAG Value
90% of eligible patients to commence IVF treatment within 12 months of referral	90%	100%	Green

Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

KPI on target, no actions required at this time.

In Vitro Fertilisation (IVF) 52 Week Screening Compliance



Comments From Executive Lead

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Operational Standards

Women Booked to Named Midwife

Data Source

Maternity Staff

Latest Data

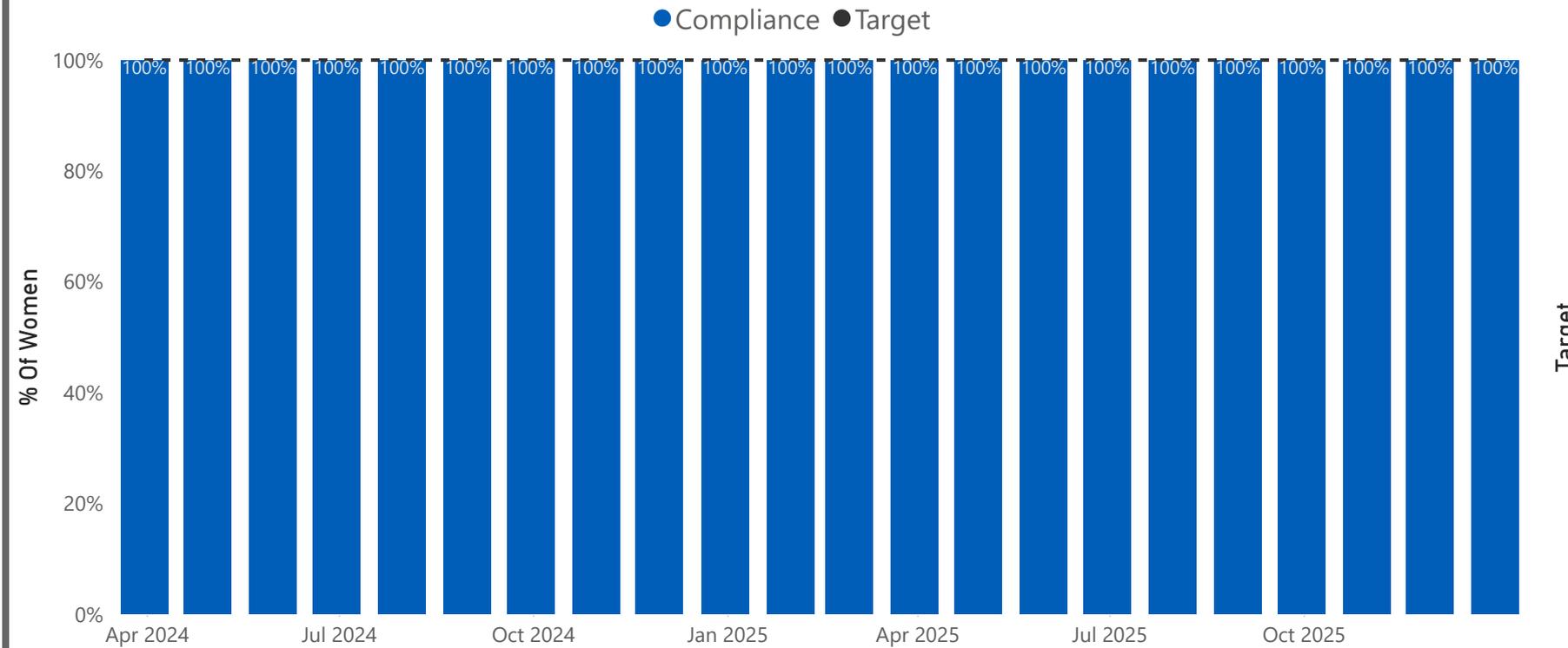
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
100% of women booking in a Board allocated to a primary midwife	100%	100%	Green

Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

Antenatal Care Appointment Delivery - Primary/Buddy Midwife %



Comments From Executive Lead

Sam Thomas, Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services



Community

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

What's Going Well?

The part time Associate Specialist Doctor post recruited to work on Neurodiversity diagnosis for children will commence in January 2026.

The Band 7 Lead for the All Age Nurse Led Psychiatric Liaison Team commenced on 3 November 2025 with other posts in that service now out to advert. CAMHS and Psychological Therapies continue to exceed the national target.

There continues to be good collaboration amongst both Community, and Acute, teams to ensure the best support for patients to best meet their needs as safely as possible.

Progress with PHIO and reduction in waiting times for the AHP led MSK services.

RAG Status Values

RED	Key performance indicator not achieved, and performance below lower threshold.
AMBER	Key performance indicator not achieved, but performance above lower threshold.
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 or amber status will be accompanied with improvement actions, and a timeline for recovery of the position.

Areas of Concern

Significant whole system pressures for teams across both Community, and Acute persist such that despite a number of delayed patients being discharged during December the overall number of delays has remained stubbornly high as new frail patients are added. This has been exacerbated by the weather in early January requiring some planned discharges to be delayed by a further day.

Significant vacancy/capacity issues within some services continue to prove challenging.

Community Child & Adolescent Mental Health 18 Week Compliance

Data Source
CAMHS Monthly Return

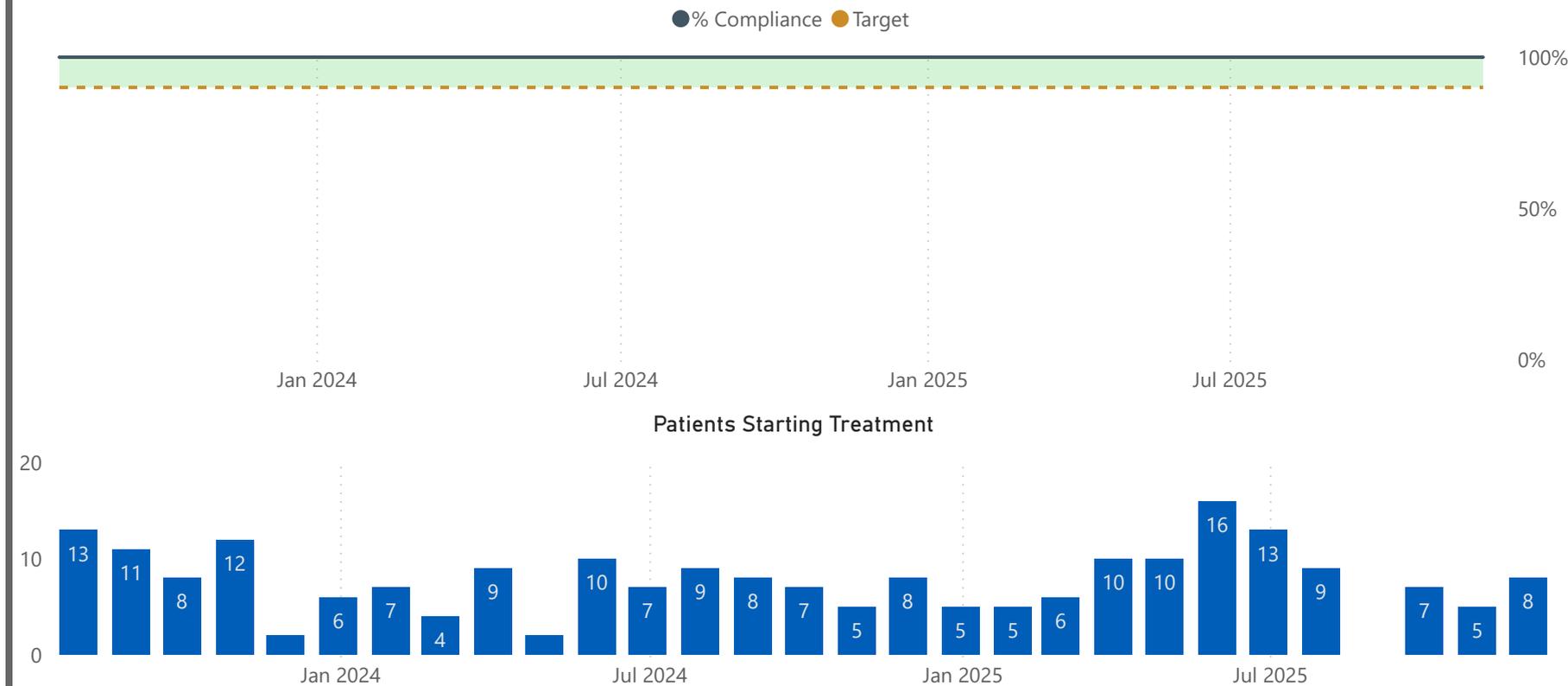
Latest Data
30/11/2025

Compliance

KPI	Target	Actual	RAG Value
90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Compliance rate 98.5%	90%	100%	Green

Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

Child & Adolescent Mental Health - 18 Week Compliance



Comments From Executive Lead

The service continues to exceed this target at the present time, however there are significant gaps, which if recruitment is unsuccessful, will add an additional challenge.

Stephen Brown, Chief Officer of the Integration Joint Board



Community Psychological Therapies 18 Week Compliance

Data Source

PT Monthly Return

Latest Data

30/11/2025

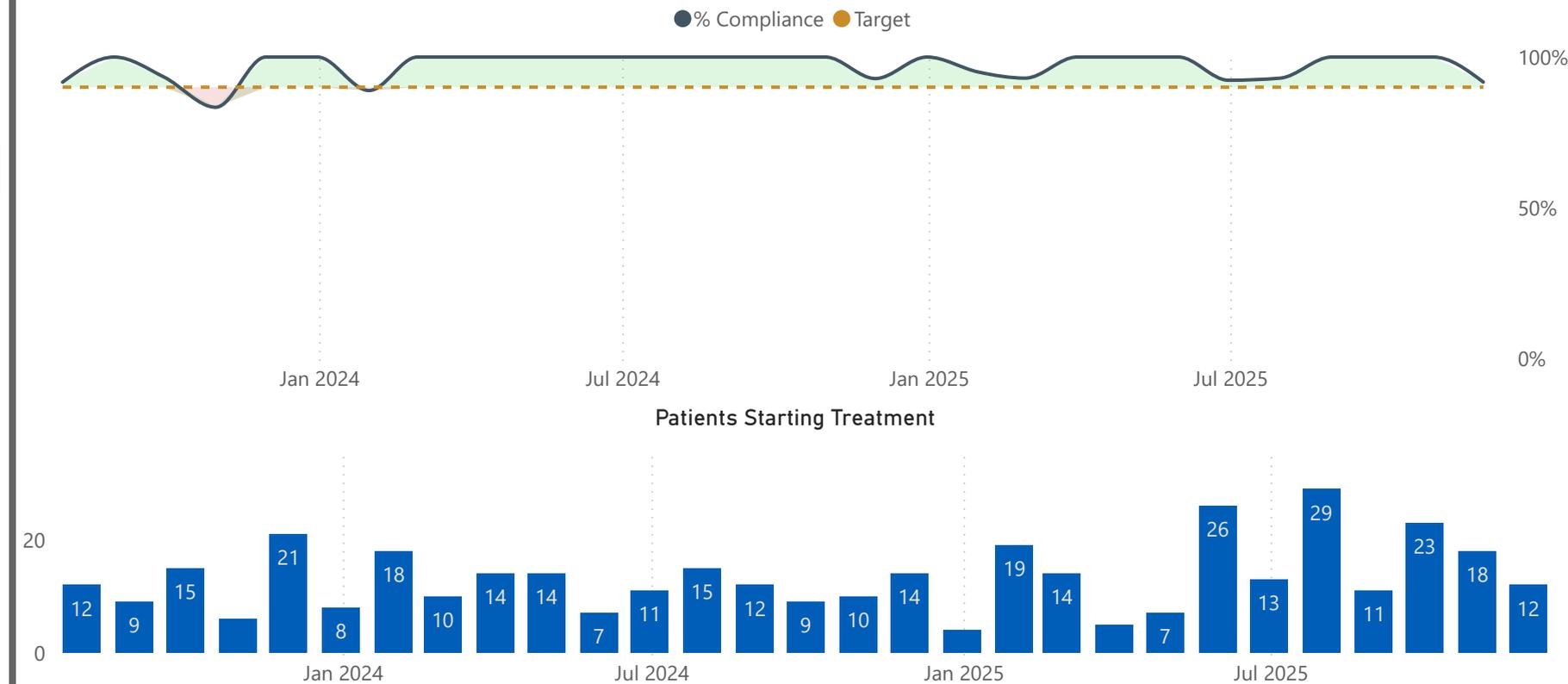
Compliance

KPI	Target	Actual	RAG Value
18 Week Referral to Treatment	90%	91.7%	Green

Action	Target Date	Owner	Status
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KPI on target, no actions required at this time.

Psychological Therapies - 18 Week Compliance



Comments From Executive Lead

Efforts continue to ensure this target is met and further work continues to also reduce waiting times from the national target for patients. Currently Orkney's Psychological Therapies team is in a position to offer some mutual aid to both the Western Isles and Shetland with appropriate SLAs in place.

Stephen Brown, Chief Officer of the Integration Joint Board



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

Data Source

TrakCare

Latest Data

30/09/2025

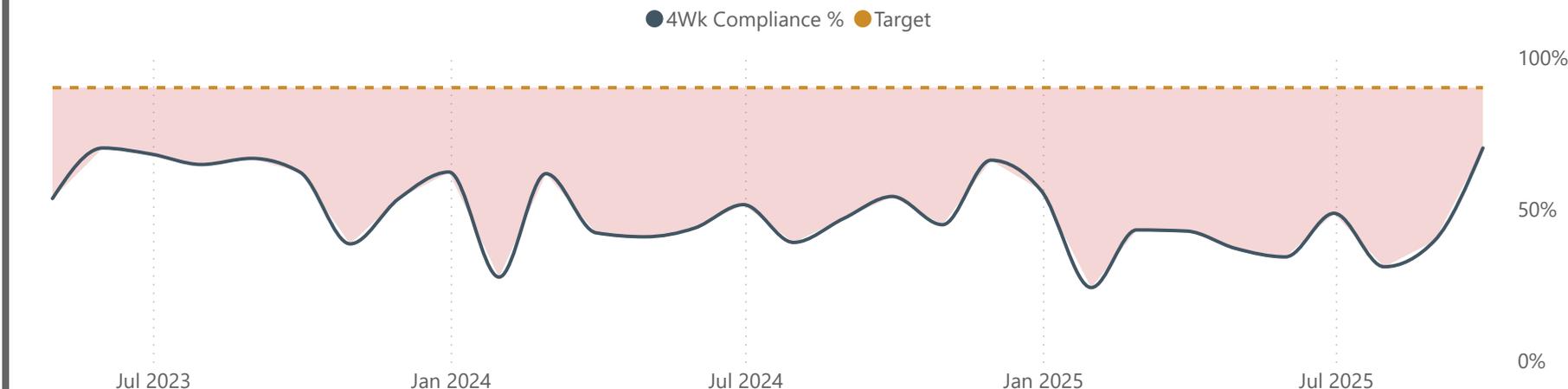
Compliance

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%	70.09%	Amber

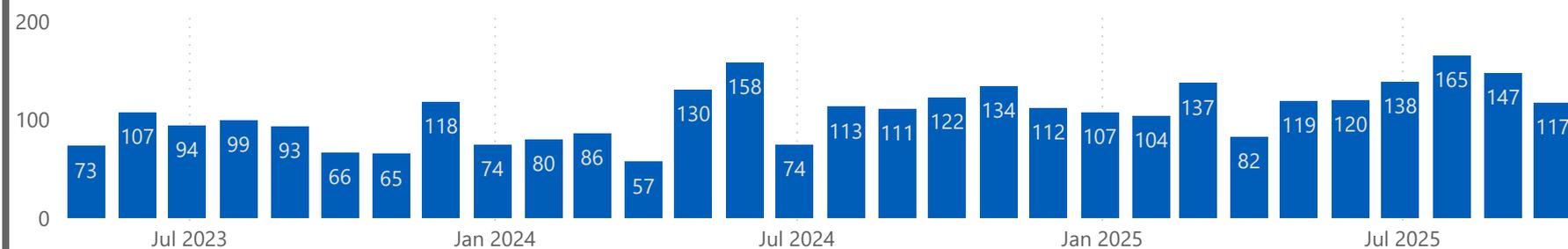
Action	Target Date	Owner	Status
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Specific actions applied to individual service areas in the preceding pages.

AHP MSK All Specialties - 4 Week Compliance



AHP MSK All Specialties - Patients Seen



Comments From Executive Lead

This target is an amalgam of the following three indicators and the actions are detailed by specialty in the following sections.

Stephen Brown, Chief Officer of the Integration Joint Board



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

Data Source

TrakCare

Latest Data

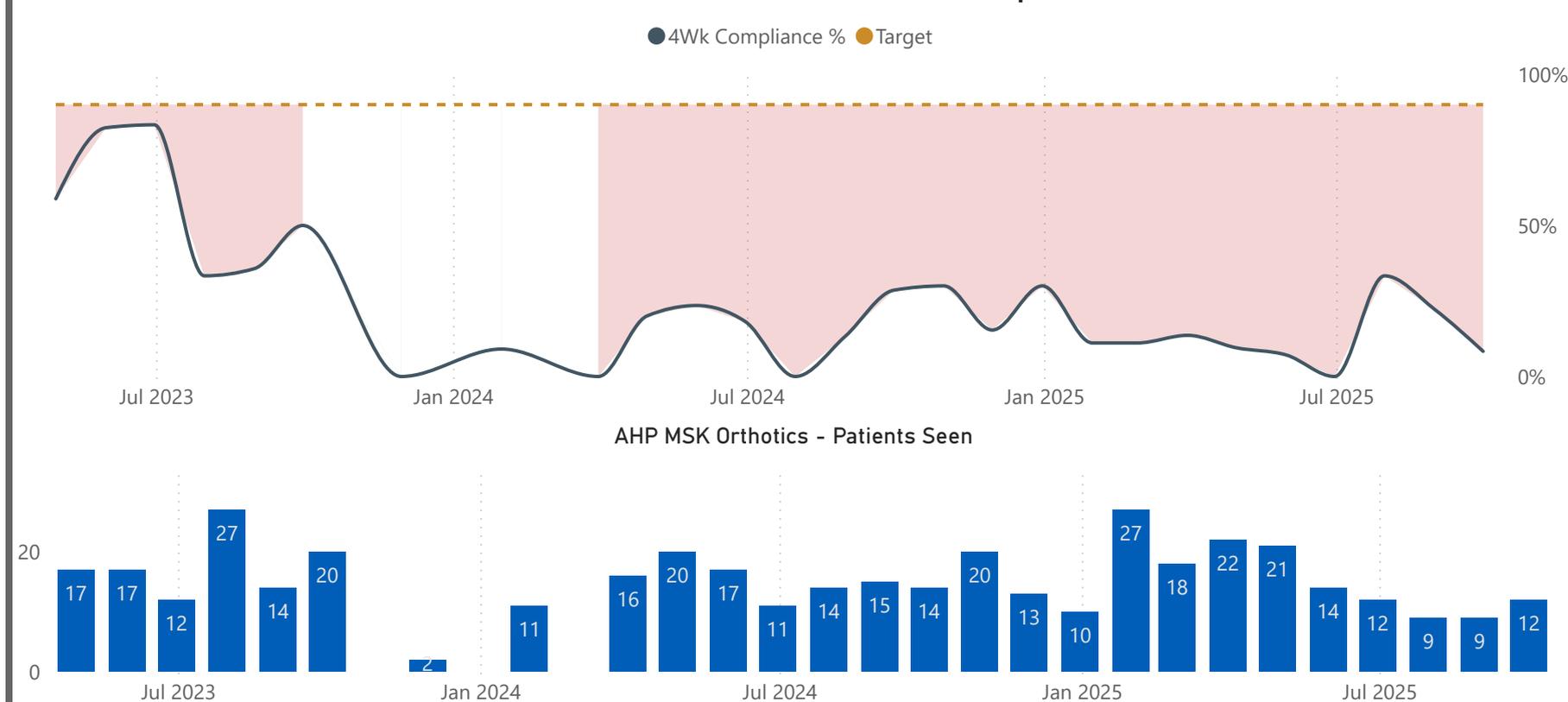
30/09/2025

Compliance

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%	8.33%	Red

Action	Target Date	Owner	Status
Monitor referral numbers and performance	31/12/2025	R Lea	Off Track
Review the current SLA and see what opportunities there are for organising some additional clinics.	31/12/2025	R Lea	Completed
To prepare paper outlining costs of organising additionality to address waiting list	31/01/2026		In Progress

AHP MSK Orthotics - 4 Week Compliance



Comments From Executive Lead

Clinics have reverted to the three days per month outline in the SLA (in the previous year an additional fourth day was paid for). This reduction has seen waiting times increase – the current waiting time for a routine adult appointment is 16 weeks. Paediatric waiting is eight weeks and urgent appointments are appointed within four weeks. Due to how referrals fall and the dates of the clinic in the month this is affecting reporting performance

Stephen Brown, Chief Officer of the Integration Joint Board



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

Data Source

TrakCare

Latest Data

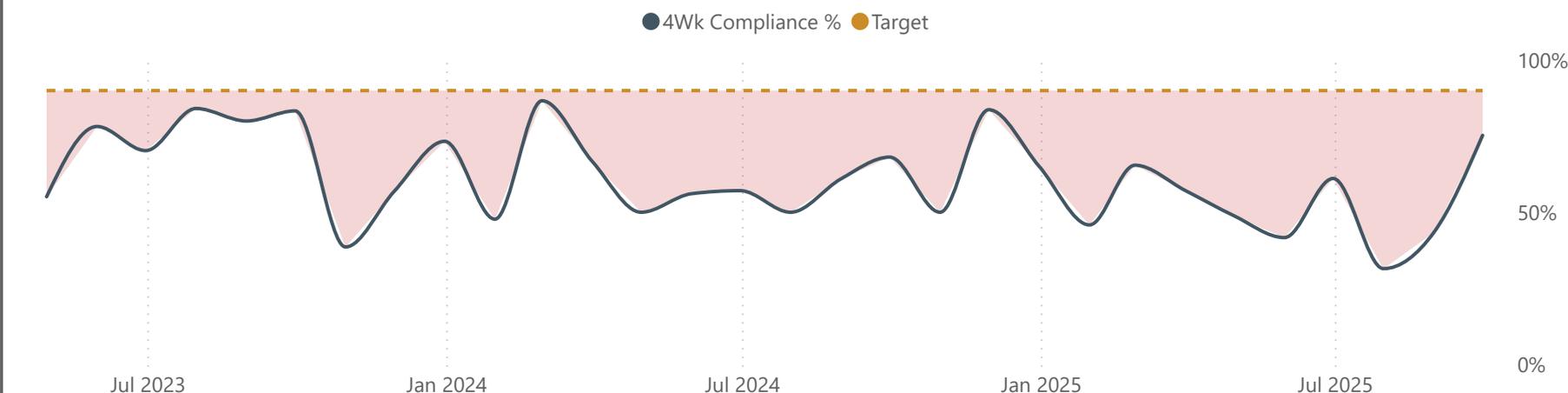
30/09/2025

Compliance

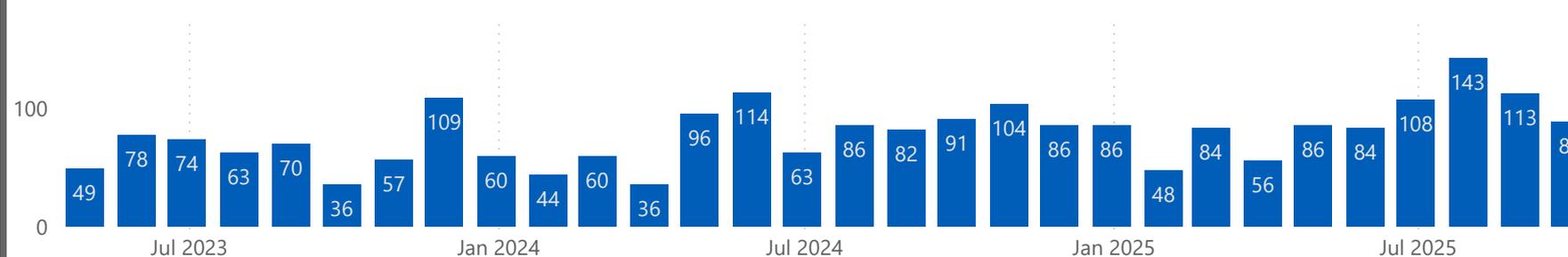
KPI	Target	Actual	RAG Value
At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led physiotherapy musculoskeletal services.	90%	75.28%	Amber

Action	Target Date	Owner	Status
Analyse PHIO data and consider further ways to promote and utilise.	31/01/2026	S Stockan	In Progress
Recruitment to substantive Band 7 role.	31/10/2025	S Stockan	Off Track

AHP MSK Physiotherapy - 4 Week Compliance



AHP MSK Physiotherapy - Patients Seen



Comments From Executive Lead

In the period between July 2025 to September 2025 the MSK Physiotherapy waiting times and patient numbers have continued to reduce with the introduction of the Primary Care component of PHIO. The progress also aligns with the increased activity attributed to a full-time locum in place in May to September, with a reduction in activity in October during the period of recruitment and reduction of staffing to 1.8 WTE, permanent recruitment will see activity increase again in the next quarter. Wait times remain at 22-25 weeks.

Stephen Brown, Chief Officer of the Integration Joint Board



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

Data Source

TrakCare

Latest Data

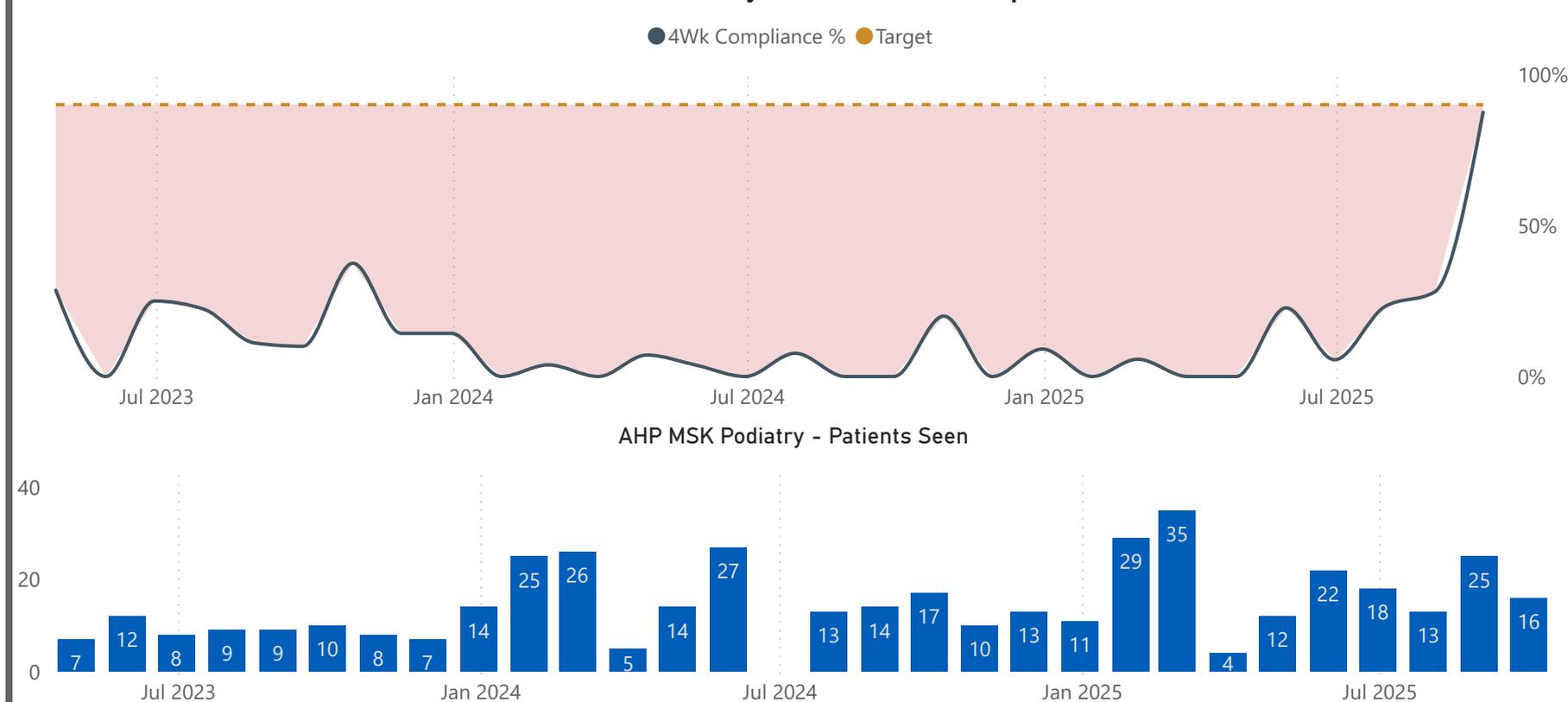
30/09/2025

Compliance

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%	87.5%	Amber

Action	Target Date	Owner	Status
Recruitment to a Podiatry bank post, utilising the spare hours, and explore other opportunities.	31/01/2026	R Lea	In Progress
Work to identify space to deliver 1 additional MSK clinic weekly.	30/09/2025	R Lea	Off Track

AHP MSK Podiatry - 4 Week Compliance



Comments From Executive Lead

In a small team (3.6 WTE) where MSK work is only a small component there are significant impacts when there is annual leave and sickness as there was in this reporting period. The improvement in waiting times considering these challenges is testament to the focus the team has made on this area of work. We have achieved substantive recruitment to the Band 6 role which provides some stability but have a vacancy from 6 January although are hopeful there is interest in that role when it has vacancy approval.

Stephen Brown, Chief Officer of the Integration Joint Board



Population Health

Section Lead (interim):
Medical Director

What's Going Well?

Childhood immunisation uptake remains high, with both MMR and 6-in-1 surpassing the 95% target. Uptake at NHS Orkney over the last quarter is higher than the national average for both metrics.

In 2024/25 Orkney Stop Smoking Services achieved 90.3% of our target (compared to 64.5% of our target in 2023/24). This is testament to the hard work of the team in not only the support provided but all the activities which have promoted the service.

Additionally, in 2024/25 the percentage of Orkney's successful quit attempts at twelve weeks (53.2%) were statistically significantly higher than the Scotland mean (29.2%) and Orkney had second highest 12 week quit rate in Scotland. These statistics reflect the quality of the service that is being provided.

Maternity screening metrics show 100% compliance for most metrics included in the Integrated Performance Report. Trisomy and Bloodspot screening uptake rates were slightly under 100% because of patient circumstances and choice.

RAG Status Values

RED	Key performance indicator not achieved, and performance below average.
AMBER	Key performance indicator not achieved, but performance above average.
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 or amber status will be accompanied with improvement actions, and a timeline for recovery of the position.

Areas of Concern

Childhood immunisation rates in Orkney fluctuate due to small population numbers. Overall, they remain above the Scottish average, though there is a slight downward trend, mirroring the national picture but with less pronounced decline. The Vaccination Management Group is monitoring this closely and is reviewing procedures for children who miss scheduled appointments.

There has been a drop in referrals into the stop smoking service with referrals in September dropping by 50% from the month previously, putting this area off track. The situation will be monitored and the team has been working to address this.

Population Health

Immunisation Uptake Rate MMR by 6 Years of Age

Data Source

PHS Childhood Immunisation Publication

Latest Data

30/09/2025

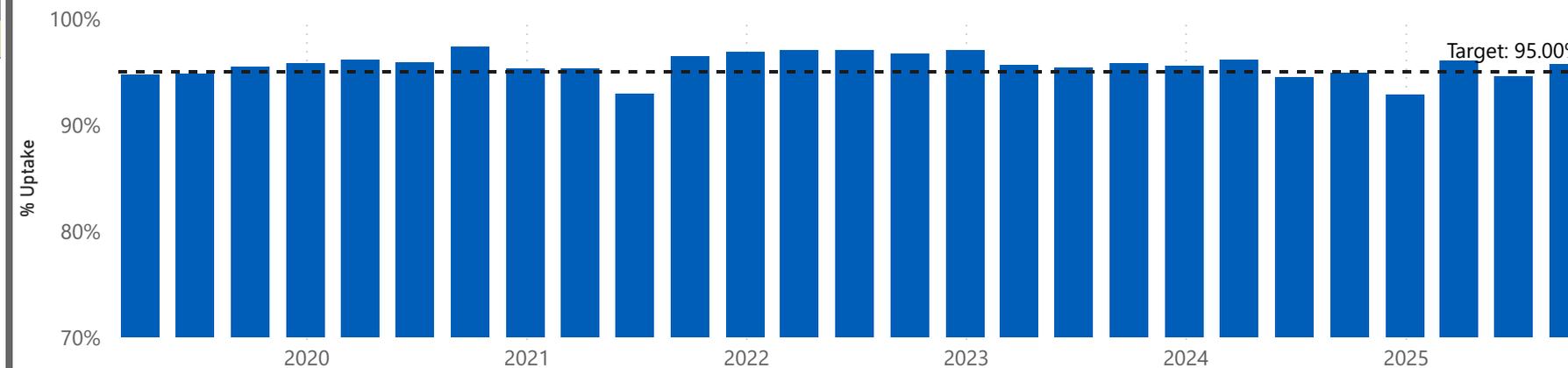
Compliance

KPI	Target	Actual	RAG Value
Immunisation uptake rate MMR2 by 6 years of age	95.0%	95.30%	Green

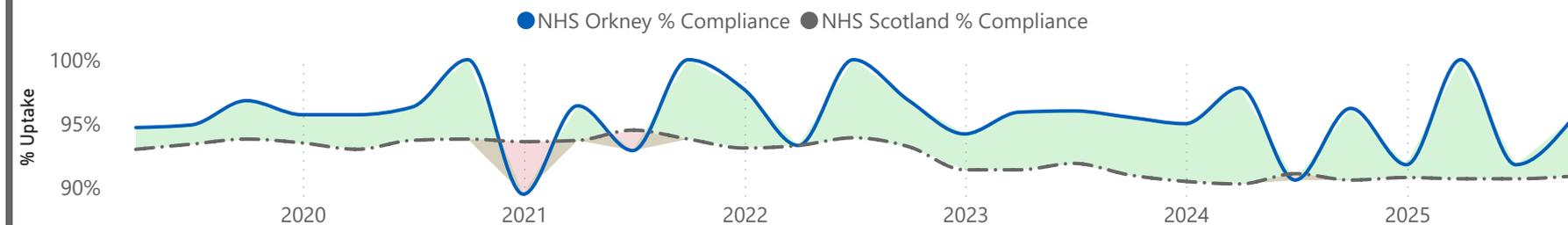
Action	Target Date	Owner	Status
Review of process for children who do not attend vaccination appointments with health visiting team.	31/03/2026	Vaccination Management Group	In Progress

Immunisation Uptake - MMR by 6 Years of Age Compliance

Rolling 3-Quarter Average



Immunisation Uptake - MMR by 6 Years of Age Compliance vs. Scotland



Comments From Executive Lead

Uptake at NHS Orkney over the last quarter is higher than the national average. Childhood immunisation rates in Orkney fluctuate due to small population numbers. Overall, they remain above the Scottish average, though there is a slight downward trend, mirroring the national picture but with less pronounced decline. The Vaccination Management Group is monitoring this closely and is reviewing procedures for children who miss scheduled appointments.

Dr. Anna Lamont, Medical Director (interim section lead)



Population Health

6-in-1 Immunisation Uptake

Data Source

PHS Childhood Immunisation Publication

Latest Data

30/09/2025

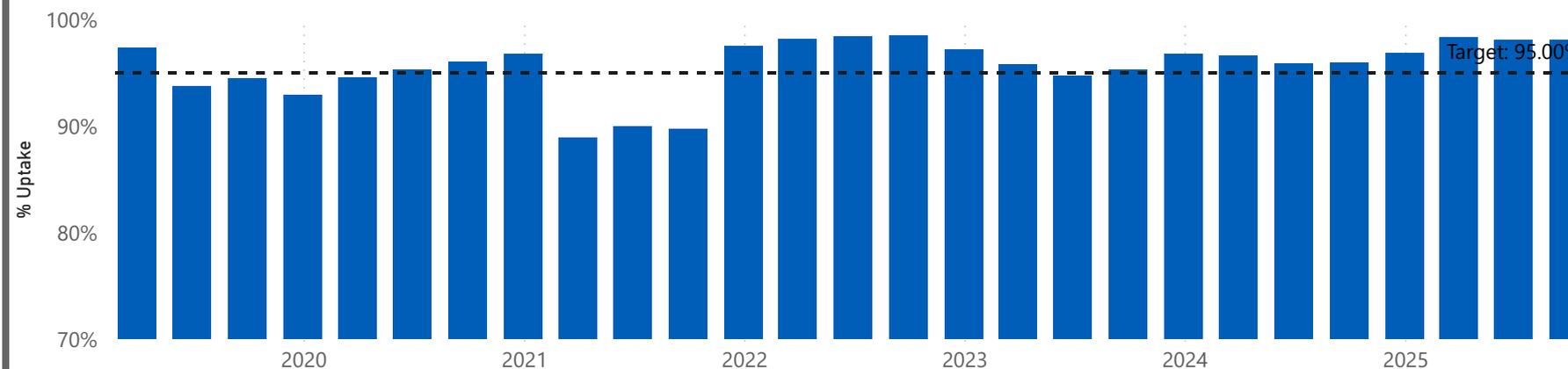
Compliance

KPI	Target	Actual	RAG Value
Immunisation uptake rate 6-in-1 primary Course by 12 months	95.0%	96.90%	Green

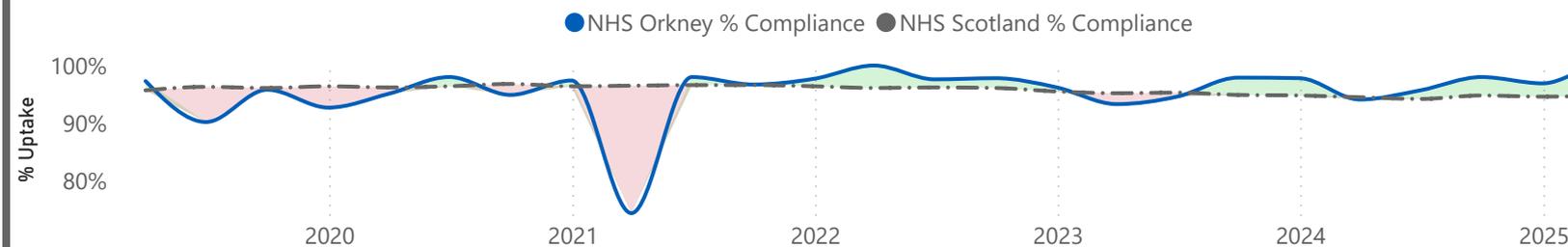
Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

Immunisation Uptake - 6 in 1 by 12 Months Compliance

Rolling 3-Quarter Average



Immunisation Uptake - 6 in 1 by 12 Months Compliance vs. Scotland



Comments From Executive Lead

Dr. Anna Lamont, Medical Director
(interim section lead)



Population Health

Smoking Cessation Active Clients

Data Source
Public Health Team

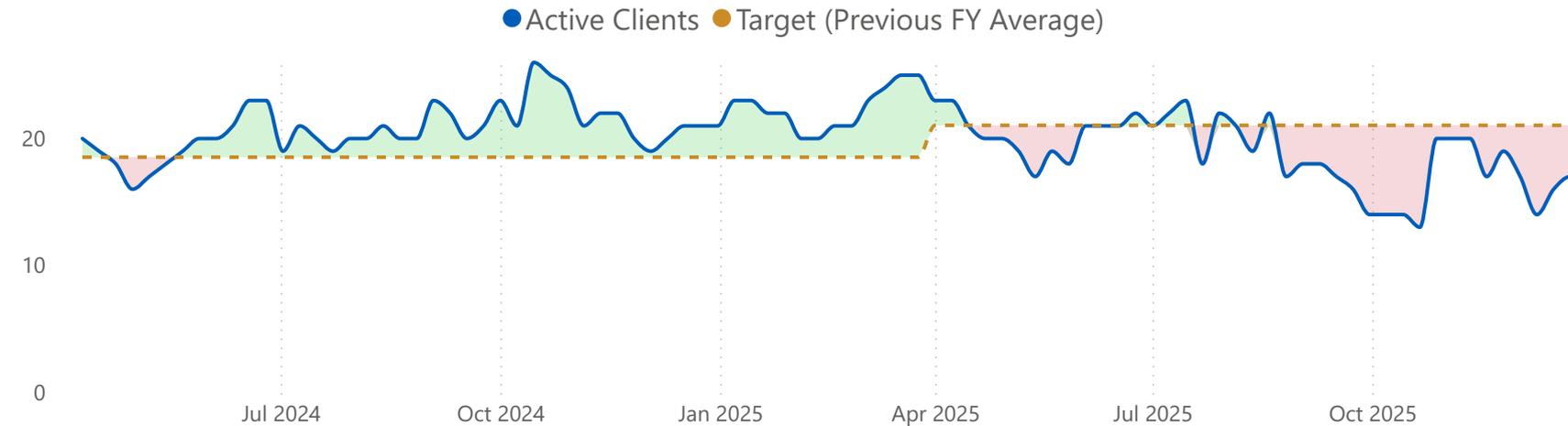
Latest Data
30/12/2025

Compliance

KPI	Target	Actual	RAG Value
Increase smoking cessation active clients year-on-year	21	17	Red

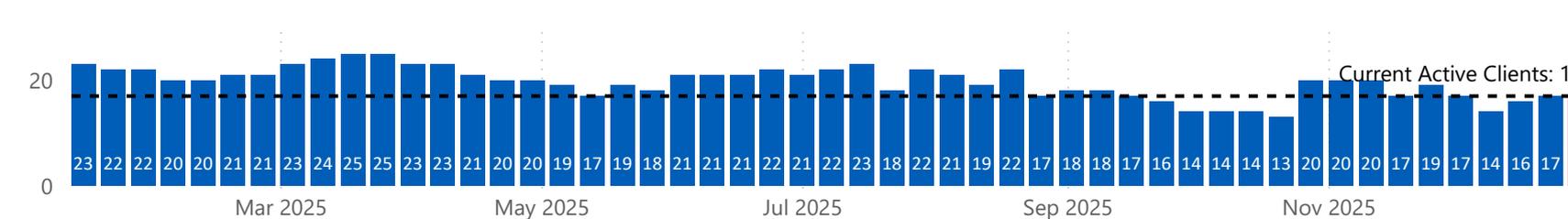
Action	Target Date	Owner	Status
Contacting teams/organisations who work with target groups to attend team meetings or deliver bespoke VBA sessions	31/03/2026	J Strawson	In Progress
Very brief intervention training delivered to staff groups in Orkney	31/03/2026	J Strawson	In Progress

Smoking Cessation - Weekly Active Clients vs. Average



Smoking Cessation - Weekly Active Clients

Red Shows Same Period 12 months Previous



Comments From Executive Lead

Referrals into the smoking cessation service unfortunately dropped again in November, which seems to have accounted for the reduction in active clients, rather than staff capacity. Work is continuing to correct this, and a press release is due to be shared at the end of January to highlight the positive success rates of the service, to drive referrals.

Dr. Anna Lamont, Medical Director
(interim section lead)



Population Health

Smoking Cessation 12-Week Quits

Data Source

Public Health Team

Latest Data

December 2025

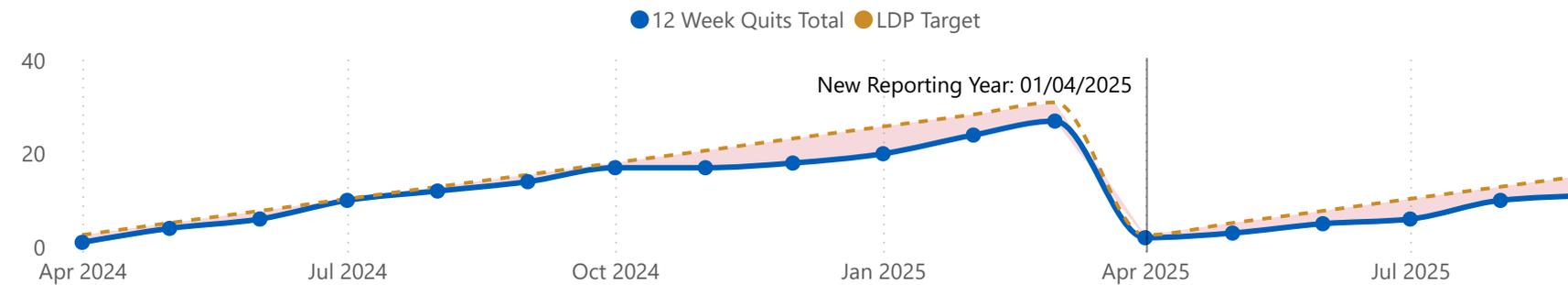
Compliance

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)	16	11	Red

Action	Target Date	Owner	Status
Continued delivery of a sustainable model for specialist stop smoking service (Quit Your Way Orkney)	31/03/2026	J Strawson	In Progress
Very brief intervention training delivered to staff groups in Orkney	31/03/2026	J Strawson	In Progress

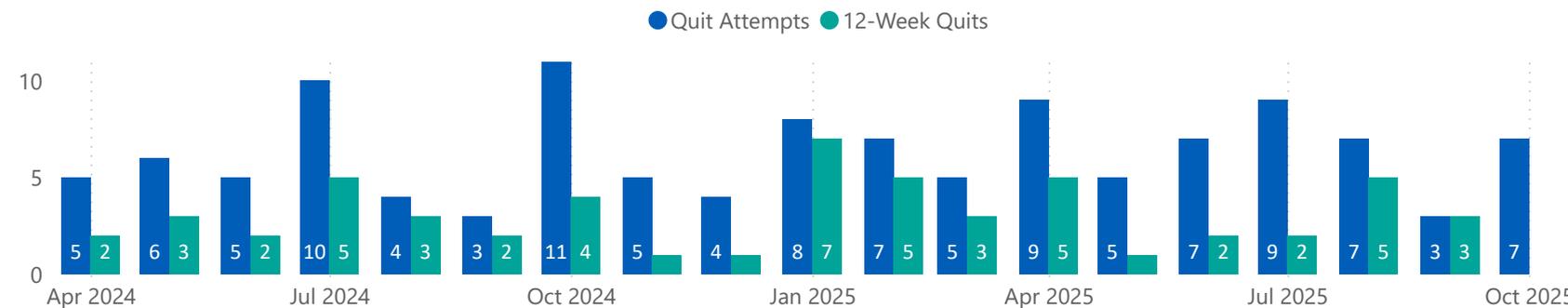
Smoking Cessation - 12-Week Quits vs. Local Delivery Plan (LDP)

Data Relates to SIMD Areas 1, 2 & 3. Data Only Available 12 Weeks After Each Month End.



Smoking Cessation - Total Quit Attempts & 12 Week Quits

Data Only Available 12 Weeks After Each Month End



Comments From Executive Lead

One out of fourteen NHS Boards (NHS Dumfries and Galloway) exceeded their annual LDP Standard target during the financial year 2024/25. NHS Board performances against their annual LDP Standard targets ranged from 18.4% to 125.5%. It is important to note that smoking prevalence informed the LDP target for boards. The LDP target has not been updated since 2019 / 20. Since then, smoking prevalence has declined which has made achieving the LDP target increasingly difficult. That being said, in 2024/25 Orkney Stop Smoking Services achieved 90.3% of our target (compared to 64.5% of our target in 2023/24). This is testament to the hard work of the team in not only the support provided but all the activities which have promoted the service. Additionally, in 2024/25 the percentage of Orkney's successful quit attempts at twelve weeks (53.2%) were statistically significantly higher than the Scotland mean (29.2%) and Orkney had second highest 12 week quit rate in Scotland. These statistics reflect the quality of the service that is being provided.

Dr. Anna Lamont, Medical Director (interim section lead)



Population Health Pregnancy Screening - Haemoglobinopathies

Data Source

Maternity Team

Latest Data

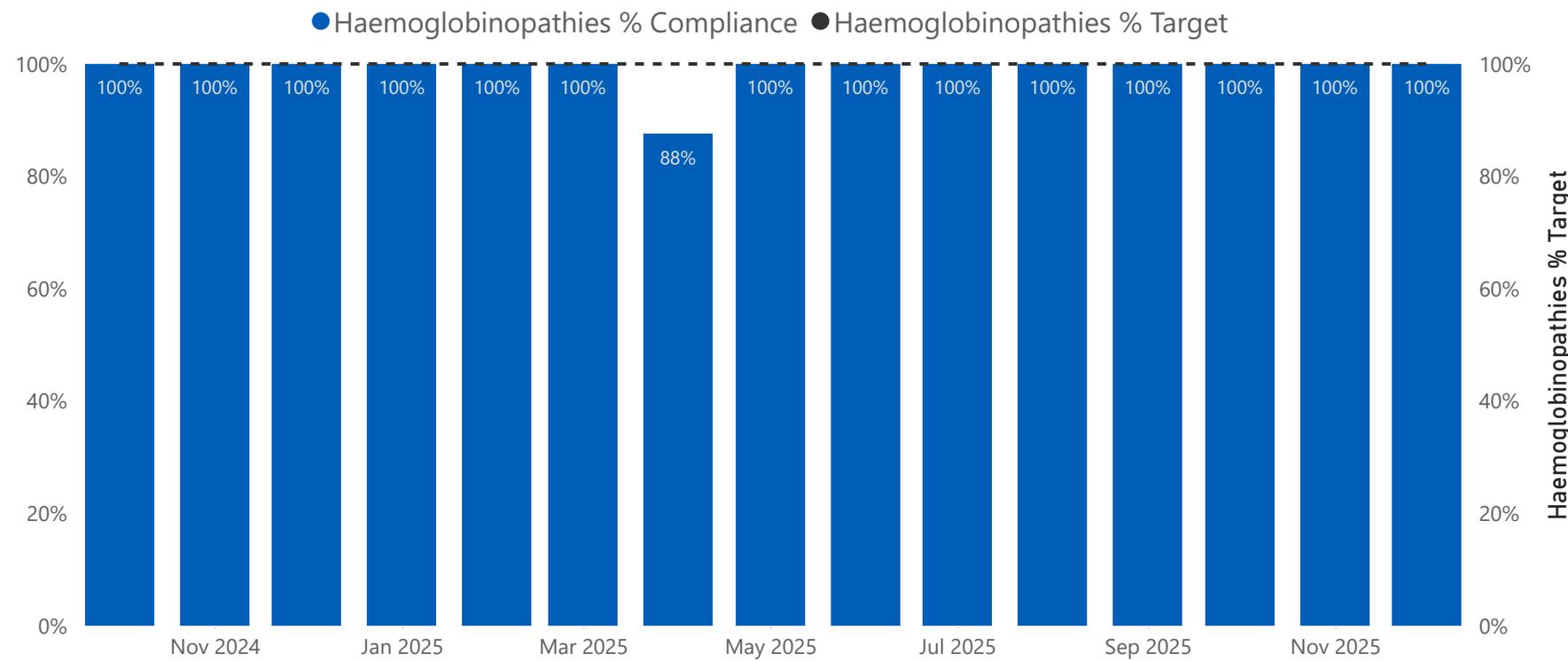
December 2025

Compliance

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	100.0%	100%	Green

Action	Target Date	Owner	Status
KPI on target, no actions required at this time.			

Pregnancy Screening - Haemoglobinopathies Screening Offered



Comments From Executive Lead

**Dr. Anna Lamont, Medical Director
(interim section lead)**



Population Health Pregnancy Screening - Infectious Diseases

Data Source

Maternity Team

Latest Data

December 2025

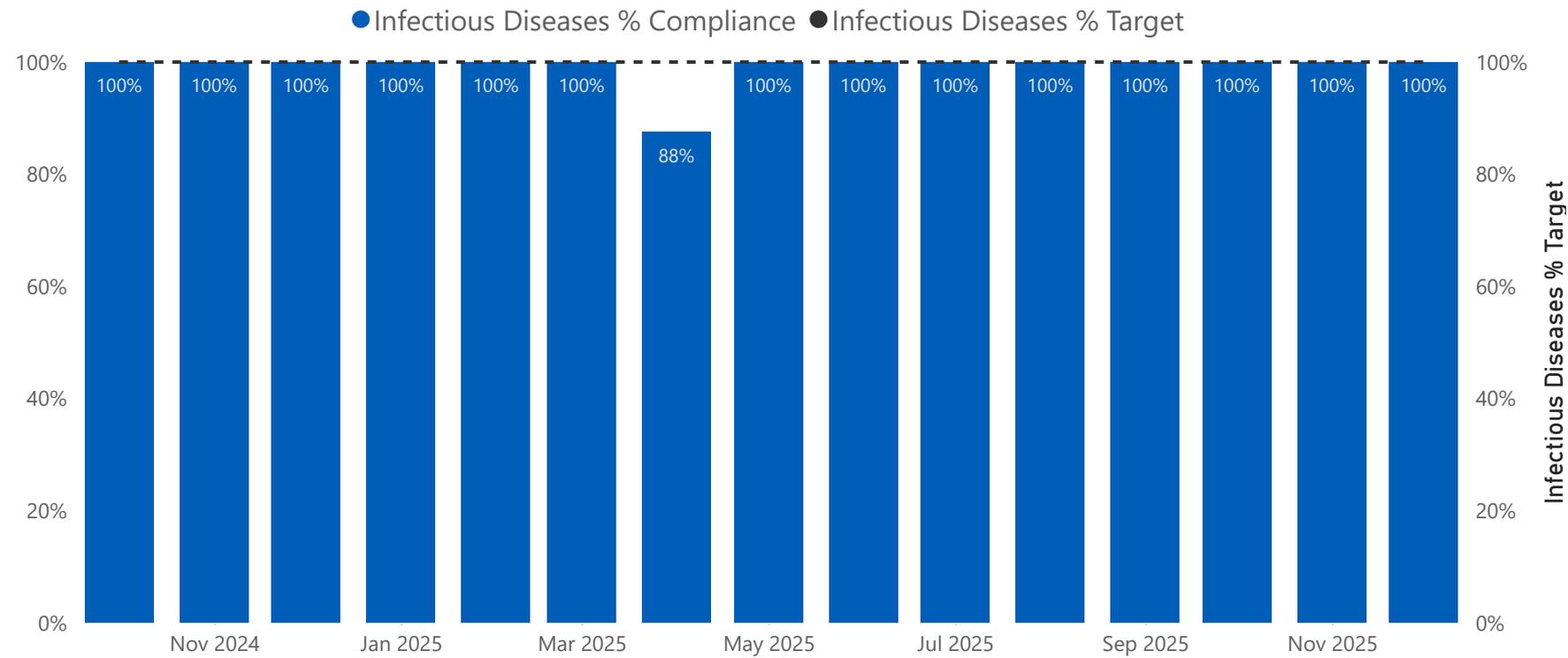
Compliance

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	100.0%	100%	Green

Action	Target Date	Owner	Status
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KPI on target, no actions required at this time.

Pregnancy Screening - Infectious Diseases Screening Offered



Comments From Executive Lead

**Dr. Anna Lamont, Medical Director
(interim section lead)**



Population Health Pregnancy Screening - Trisomy

Data Source

Maternity Team

Latest Data

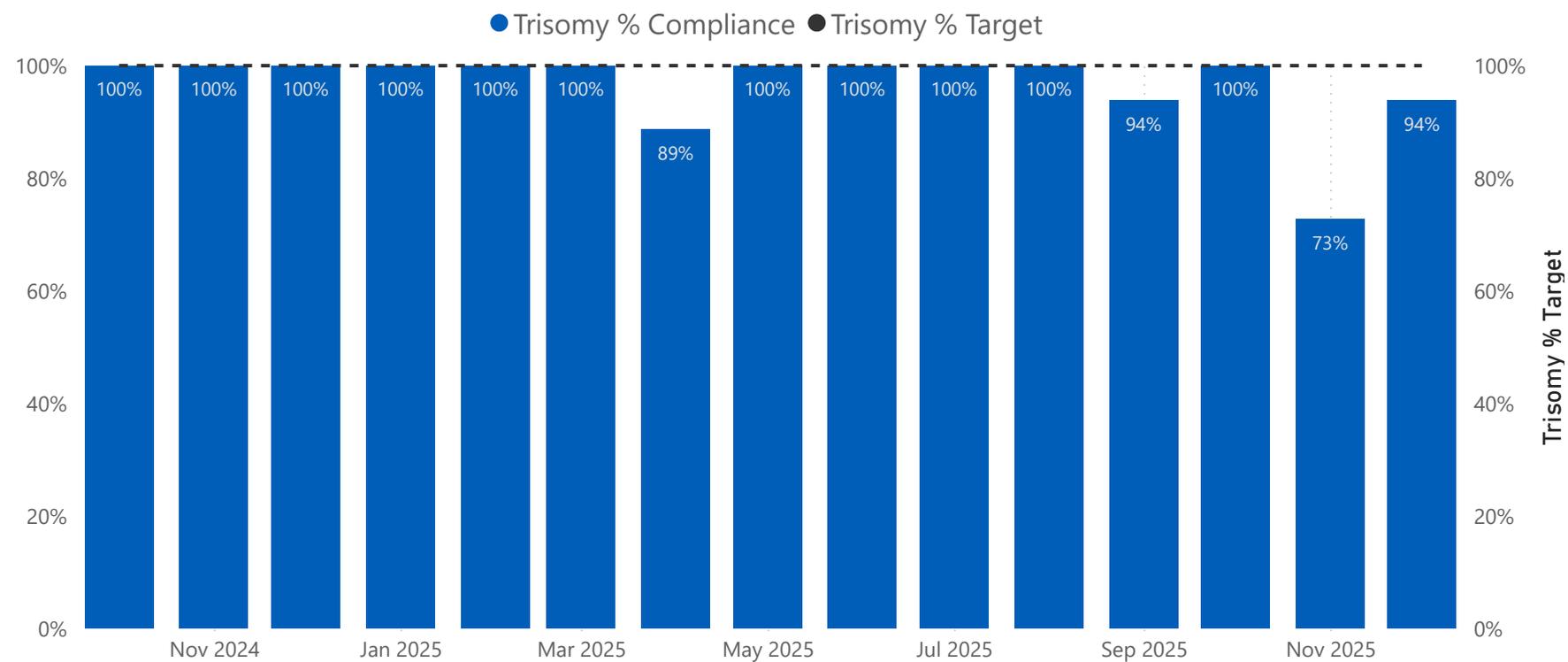
December 2025

Compliance

KPI	Target	Actual	RAG Value
Pregnancy Screening - All eligible pregnant women are offered trisomy screening no later than 20+0 weeks gestation.	100.0%	93.8%	Red

Action	Target Date	Owner	Status
Pregnancy & Newborn Screening Oversight Group to review variance in this KPI and implement actions as appropriate.	31/03/2026		In Progress

Pregnancy Screening - Trisomy Screening Offered Within 20+0 Weeks



Comments From Executive Lead

Trisomy screening uptake rate was slightly under 100% because of patient circumstances and choice. The Pregnancy and Newborn Screening Network is monitoring this closely and will implement actions as appropriate.

**Dr. Anna Lamont, Medical Director
(interim section lead)**



Population Health Blood Spot Screening Compliance

Data Source

Maternity Team

Latest Data

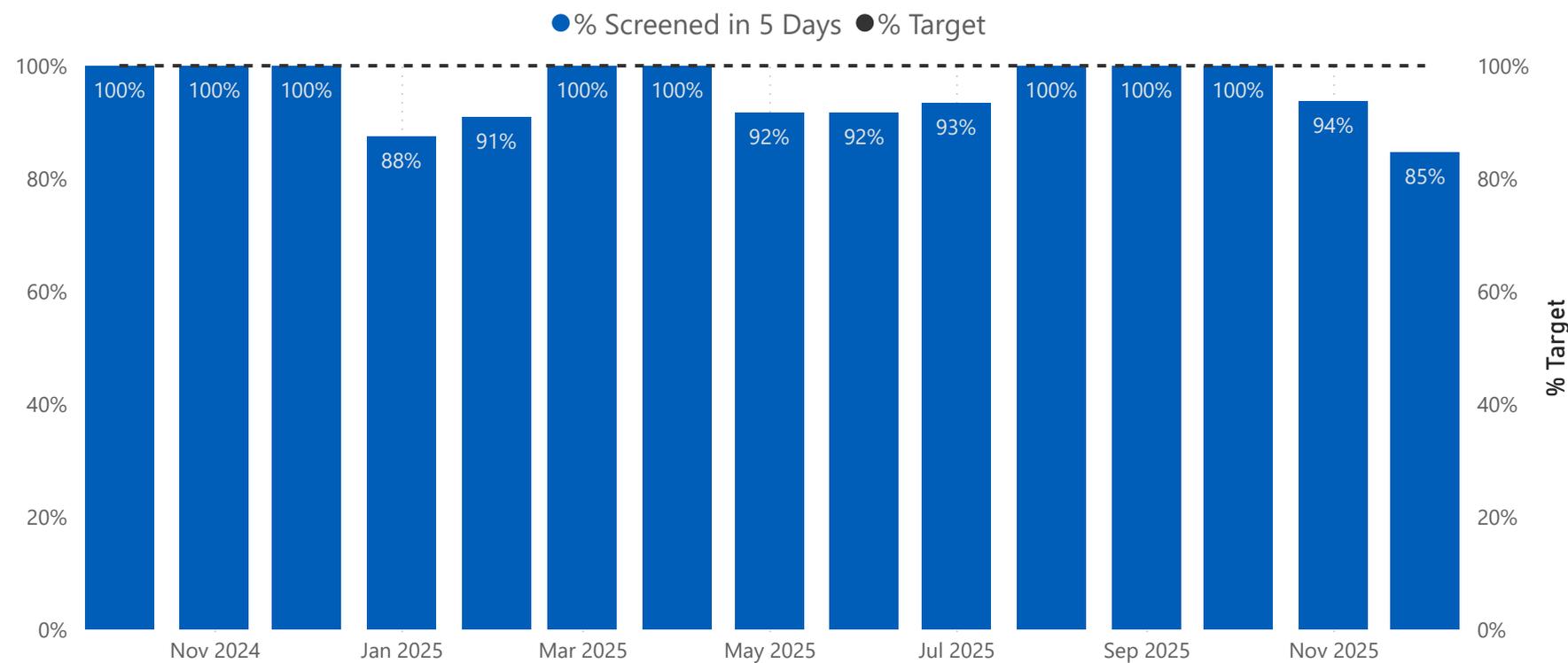
December 2025

Compliance

KPI	Target	Actual	RAG Value
Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	100.0%	84.60%	Red

Action	Target Date	Owner	Status
Pregnancy & Newborn Screening Oversight Group to review variance in this KPI and implement actions as appropriate.	31/03/2026		In Progress

Blood Spot Screening Completed by Day 5



Comments From Executive Lead

Bloodspot screening uptake rate was slightly under 100% because of work capacity. The Pregnancy and Newborn Screening Network is monitoring this closely and will implement actions as appropriate.

**Dr. Anna Lamont, Medical Director
(interim section lead)**



People & Culture

Section Lead(s):
Director of People and Culture

What's Going Well?

The Workforce Improvement Workstream within the Improving Together Programme is well established with eight focus areas, including sickness management, mandatory training, and appraisals. Corporate leads are assigned for each area to oversee delivery, and fortnightly meetings are held to sustain momentum. Early progress can be observed, such as 2-4% increases in training compliance across most Health and Safety courses.

RAG Status Values

RED	Key performance indicator not achieved, and performance below average.
AMBER	Key performance indicator not achieved, but performance above average.
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 or amber status will be accompanied with improvement actions, and a timeline for recovery of the position.

Areas of Concern

Compliance with statutory and mandatory training remains inconsistent, continuing to represent a risk on the Corporate Risk Register. Monthly reports are sent to Executive Directors detailing training compliance within their areas, and a list of all non-compliant individuals will be retrieved from Turas so they can be contacted directly. Mandatory training is discussed with Heads of Department at the Operational People Group and Directors will be held to account at the Performance Review Meetings and, where relevant, expected to provide improvement actions.

People & Culture

NHS Orkney Sickness Absence

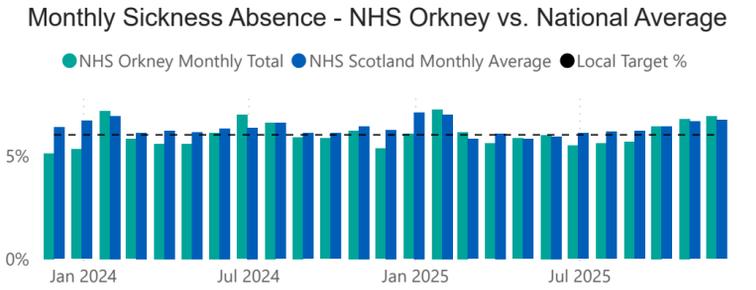
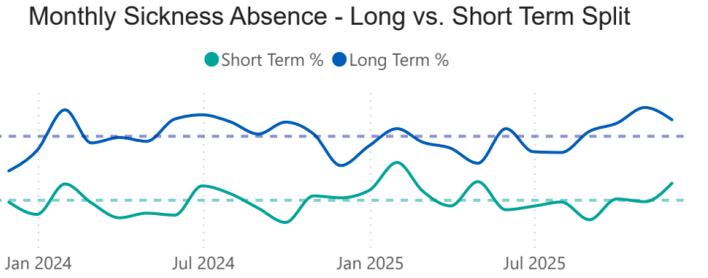
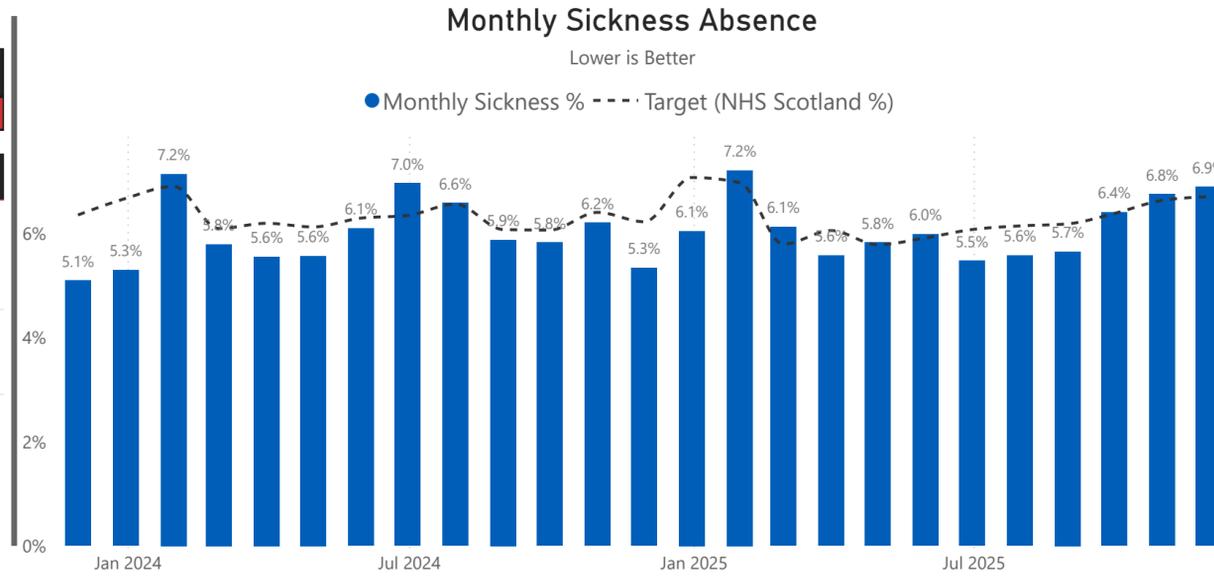
Data Source
SSTS/eESS National

Latest Data
30/11/2025

Compliance

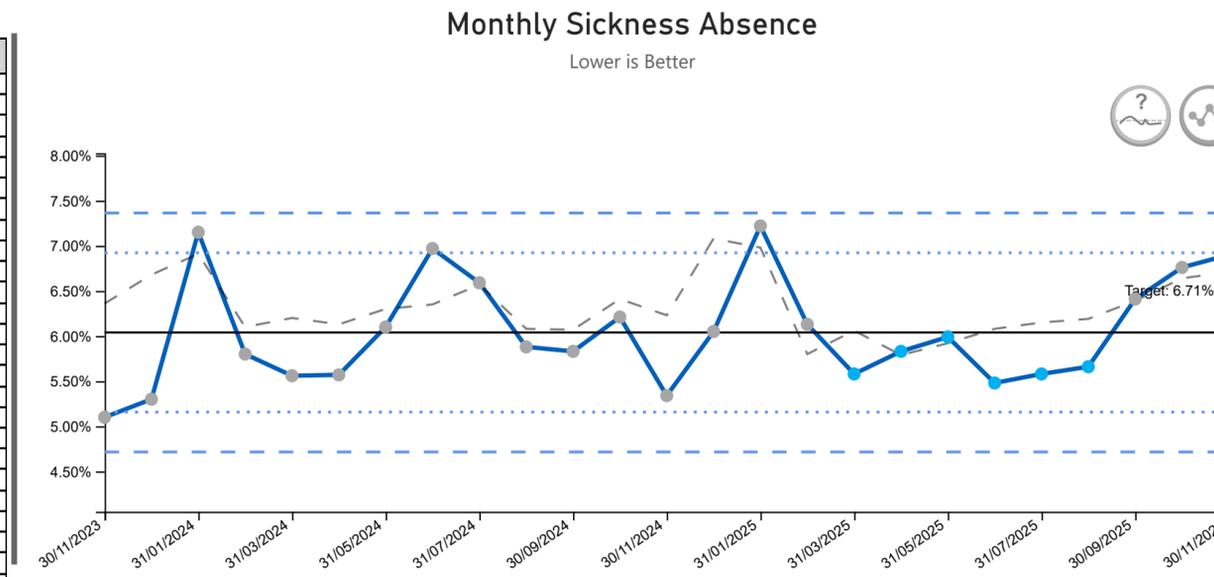
KPI	Target	Actual	RAG Value
Sickness rates consistently below the national average of <6%	6.71%	6.90%	Red

Action	Target Date	Owner	Status
Directors will be held accountable for sickness rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.	31/03/2026		In Progress
Sickness absence is being scrutinised and discussed with Heads of Department at the People Operational People Group.	31/03/2026		In Progress
The People and Culture team continue to support managers across the organisation in sickness management, in line with the Once for Scotland Workforce Policy. The Occupational Health Nurse Manager has been engaging with managers to assist them in helping individuals return to work	31/03/2026		In Progress



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
30/11/2023	5.10	6.04	6.36	4.72	7.36	5.16	6.92	NONE
31/12/2023	5.30	6.04	6.68	4.72	7.36	5.16	6.92	NONE
31/01/2024	7.15	6.04	6.91	4.72	7.36	5.16	6.92	NONE
29/02/2024	5.80	6.04	6.10	4.72	7.36	5.16	6.92	NONE
31/03/2024	5.56	6.04	6.20	4.72	7.36	5.16	6.92	NONE
30/04/2024	5.57	6.04	6.13	4.72	7.36	5.16	6.92	NONE
31/05/2024	6.10	6.04	6.30	4.72	7.36	5.16	6.92	NONE
30/06/2024	6.97	6.04	6.35	4.72	7.36	5.16	6.92	NONE
31/07/2024	6.59	6.04	6.57	4.72	7.36	5.16	6.92	NONE
31/08/2024	5.88	6.04	6.08	4.72	7.36	5.16	6.92	NONE
30/09/2024	5.83	6.04	6.07	4.72	7.36	5.16	6.92	NONE
31/10/2024	6.21	6.04	6.41	4.72	7.36	5.16	6.92	NONE
30/11/2024	5.34	6.04	6.23	4.72	7.36	5.16	6.92	NONE
31/12/2024	6.05	6.04	7.08	4.72	7.36	5.16	6.92	NONE
31/01/2025	7.22	6.04	6.98	4.72	7.36	5.16	6.92	NONE
28/02/2025	6.13	6.04	5.80	4.72	7.36	5.16	6.92	NONE
31/03/2025	5.58	6.04	6.06	4.72	7.36	5.16	6.92	IMPROVEMENT
30/04/2025	5.83	6.04	5.79	4.72	7.36	5.16	6.92	IMPROVEMENT
31/05/2025	5.99	6.04	5.92	4.72	7.36	5.16	6.92	IMPROVEMENT
30/06/2025	5.48	6.04	6.08	4.72	7.36	5.16	6.92	IMPROVEMENT
31/07/2025	5.58	6.04	6.15	4.72	7.36	5.16	6.92	IMPROVEMENT
31/08/2025	5.66	6.04	6.19	4.72	7.36	5.16	6.92	IMPROVEMENT
30/09/2025	6.41	6.04	6.39	4.72	7.36	5.16	6.92	NONE
31/10/2025	6.76	6.04	6.64	4.72	7.36	5.16	6.92	NONE
30/11/2025	6.90	6.04	6.71	4.72	7.36	5.16	6.92	NONE



Comments From Executive Lead

While the monthly absence is rated Red in a RAG rating the overall rate under the Statistical Process Control remains within acceptable limits.

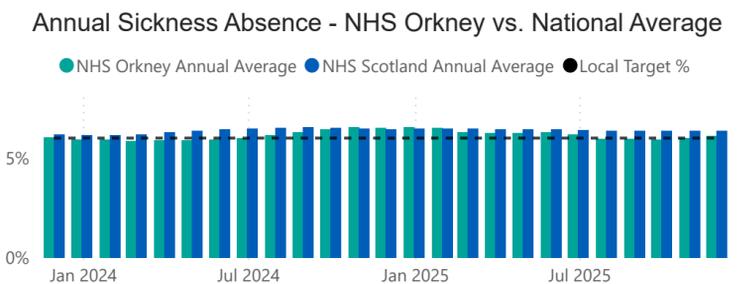
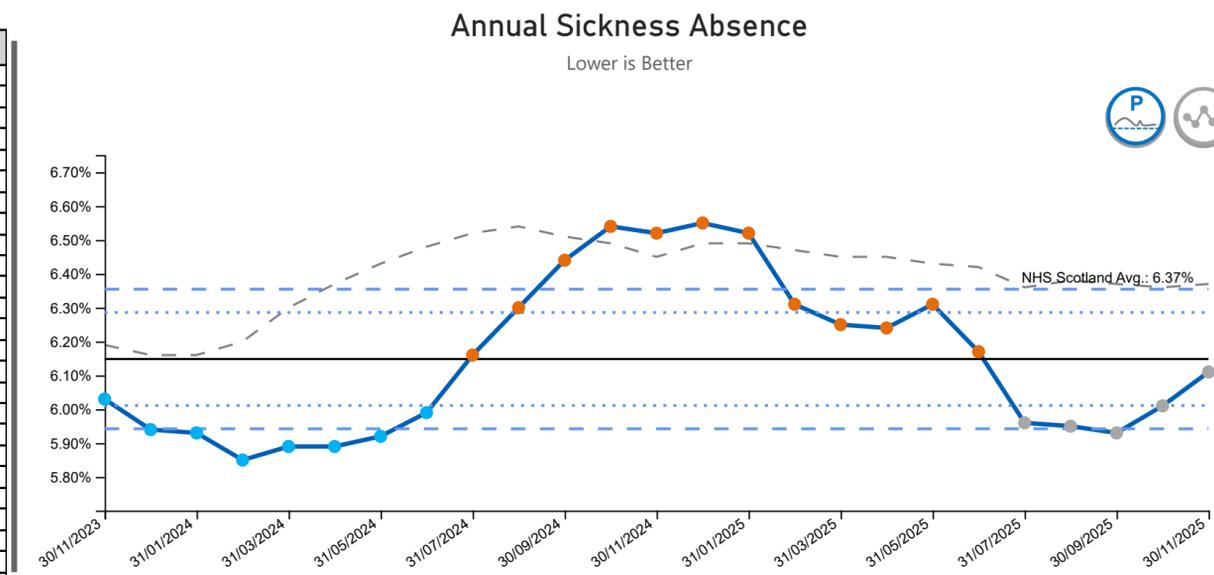
The People and Culture team continue to support managers across the organisation in sickness management, in line with the Once for Scotland Workforce Policy. The Occupational Health Nurse Manager has been engaging with managers to assist them in helping individuals return to work. Sickness absence and the actions managers are taking to support colleagues are discussed at the Operational People Group to share alternative approaches and collectively review possible actions. Directors will be held accountable for sickness rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.

Dave Harris, Director of People and Culture



Statistical Process Control

DATE	VALUE	TARGET	ALT. TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
30/11/2023	6.03	6.15	6.19	5.94	6.35	6.01	6.29	IMPROVEMENT
31/12/2023	5.94	6.15	6.16	5.94	6.35	6.01	6.29	IMPROVEMENT
31/01/2024	5.93	6.15	6.16	5.94	6.35	6.01	6.29	IMPROVEMENT
29/02/2024	5.85	6.15	6.20	5.94	6.35	6.01	6.29	IMPROVEMENT
31/03/2024	5.89	6.15	6.30	5.94	6.35	6.01	6.29	IMPROVEMENT
30/04/2024	5.89	6.15	6.37	5.94	6.35	6.01	6.29	IMPROVEMENT
31/05/2024	5.92	6.15	6.43	5.94	6.35	6.01	6.29	IMPROVEMENT
30/06/2024	5.99	6.15	6.48	5.94	6.35	6.01	6.29	IMPROVEMENT
31/07/2024	6.16	6.15	6.52	5.94	6.35	6.01	6.29	DETERIORATION
31/08/2024	6.30	6.15	6.54	5.94	6.35	6.01	6.29	DETERIORATION
30/09/2024	6.44	6.15	6.51	5.94	6.35	6.01	6.29	DETERIORATION
31/10/2024	6.54	6.15	6.49	5.94	6.35	6.01	6.29	DETERIORATION
30/11/2024	6.52	6.15	6.45	5.94	6.35	6.01	6.29	DETERIORATION
31/12/2024	6.55	6.15	6.49	5.94	6.35	6.01	6.29	DETERIORATION
31/01/2025	6.52	6.15	6.49	5.94	6.35	6.01	6.29	DETERIORATION
28/02/2025	6.31	6.15	6.47	5.94	6.35	6.01	6.29	DETERIORATION
31/03/2025	6.25	6.15	6.45	5.94	6.35	6.01	6.29	DETERIORATION
30/04/2025	6.24	6.15	6.45	5.94	6.35	6.01	6.29	DETERIORATION
31/05/2025	6.31	6.15	6.43	5.94	6.35	6.01	6.29	DETERIORATION
30/06/2025	6.17	6.15	6.42	5.94	6.35	6.01	6.29	DETERIORATION
31/07/2025	5.96	6.15	6.36	5.94	6.35	6.01	6.29	NONE
31/08/2025	5.95	6.15	6.38	5.94	6.35	6.01	6.29	NONE
30/09/2025	5.93	6.15	6.37	5.94	6.35	6.01	6.29	NONE
31/10/2025	6.01	6.15	6.36	5.94	6.35	6.01	6.29	NONE
30/11/2025	6.11	6.15	6.37	5.94	6.35	6.01	6.29	NONE



People & Culture

NHS Orkney Appraisal Rates

Data Source

Workforce Systems

Latest Data

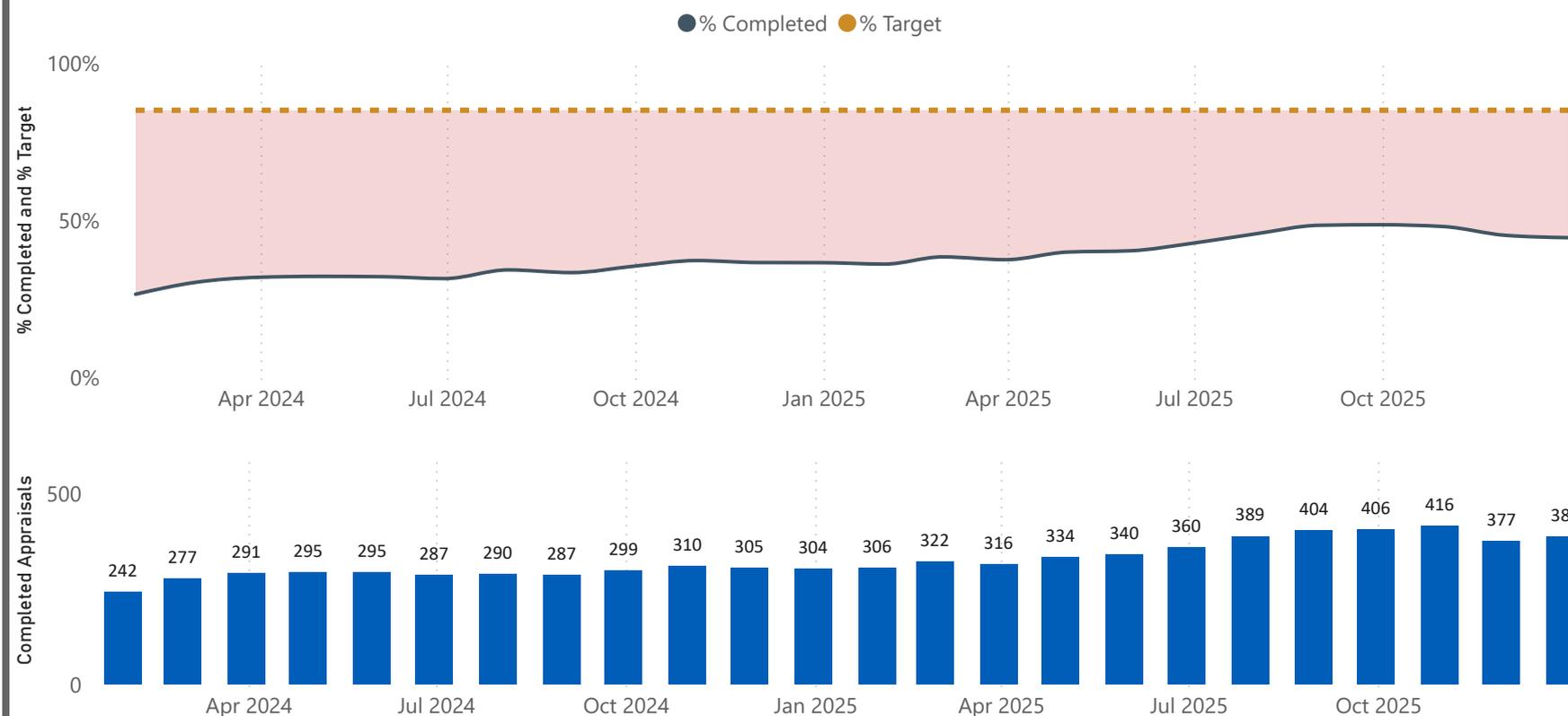
31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Appraisal compliance rate over the previous 12 months	85.00%	44.44%	Red

Action	Target Date	Owner	Status
Directors will be held accountable for appraisal rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.	31/03/2026		In Progress
Other improvement actions being explored included changing to an organisational window for completion rather than individual annual cycles and line managers being given an appraisal objective on being an effective manager, which includes ensuring appraisals are completed.	31/03/2026		In Progress
People & Culture Team to continue assistance in delivery of appraisals via training and support for managers and teams where required.	31/03/2026	K Pyke	In Progress
The Operational People Group is discussing appraisal rates with Heads of Department.	31/03/2026		In Progress

Completed Appraisal Rates



Comments From Executive Lead

The People and Culture team continues to provide training and individual support to managers and teams and the Operational People Group is discussing appraisal rates with Heads of Department.

Directors will be held accountable for appraisal rates at the Performance Review Meetings and, where relevant, asked to provide details on improvement actions.

Other improvement actions being explored included changing to an organisational window for completion rather than individual annual cycles and line managers being given an appraisal objective on being an effective manager, which includes ensuring appraisals are completed.

Dave Harris, Director of People and Culture



People & Culture

Agency Hours Utilised

Data Source

Plus Us MI Report

Latest Data

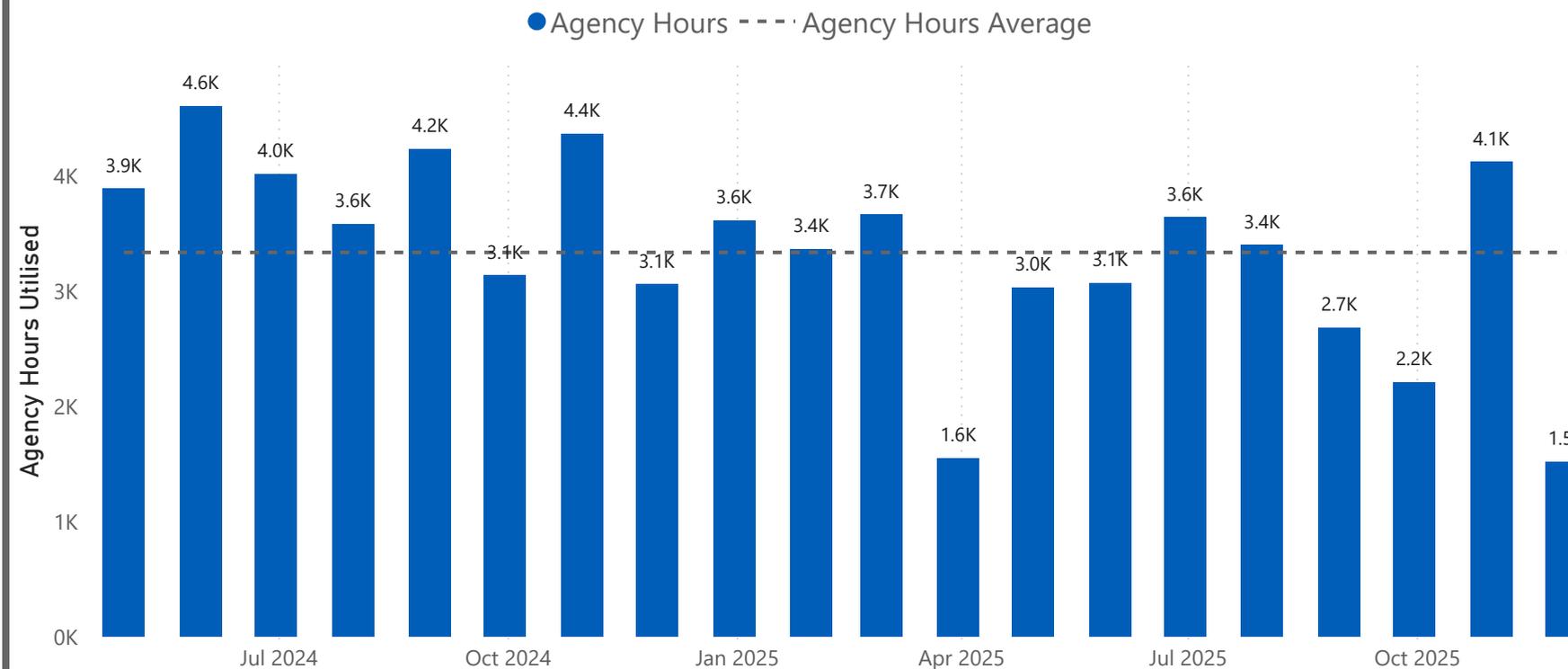
30/11/2025

Compliance

KPI	Target	Actual	RAG Value
Agency hours used vs. average.		1520	Grey

Action	Target Date	Owner	Status
Reduce use of NMAHP agency use, where indicated utilise on framework rates.	31/03/2026	S Thomas	In Progress

Hours Utilised - Agency Hours



Comments From Executive Lead

The use of agency is being managed by the Executive Director of Nursing, Midwifery and Allied Health Professionals, and Chief Officer Acute Services with plans to further reduce utilisation. This includes moving agency consultants onto bank contracts where possible. Medical recruitment is ongoing but remains a significant challenge. There is no agency use across acute NMAHP with some use maintained in hard to recruit to posts in the community and on the isles.

Dave Harris, Director of People and Culture



People & Culture

Bank Hours Utilised

Data Source
Workforce Systems

Latest Data
31/12/2025

Compliance

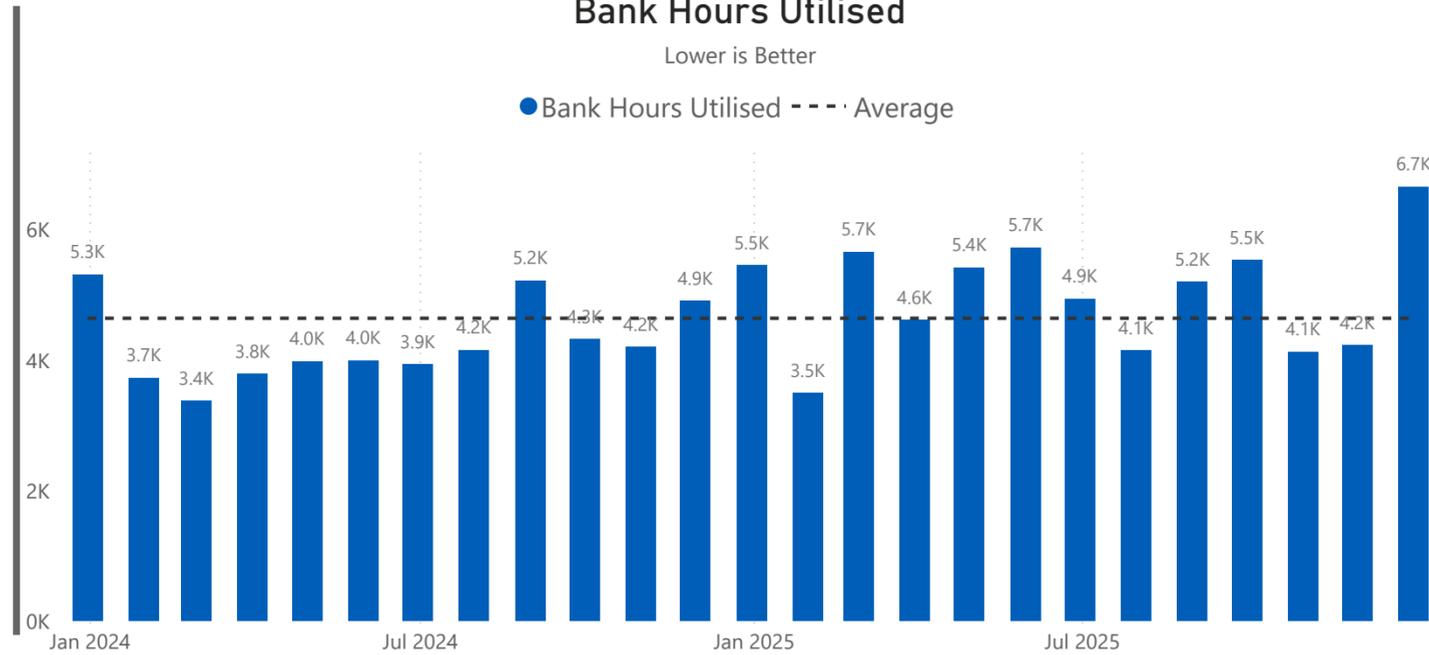
KPI	Target	Actual	RAG Value
Bank hours used vs. average.		6658	Grey

Action	Target Date	Owner	Status
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No target set, actions and target to be updated.

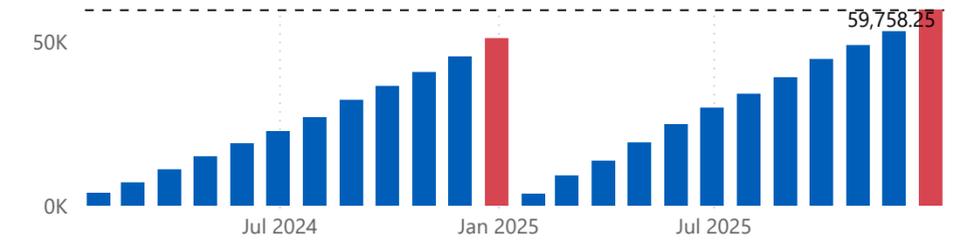
Bank Hours Utilised

Lower is Better



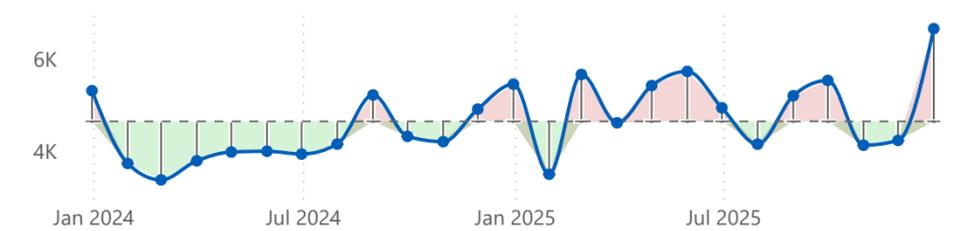
Hours Utilised - Bank Hours vs. Previous Year

Bank Hours Running Total per Year



Hours Utilised - Bank Hours vs. Average

Bank Hours Average Bank Hours Utilised

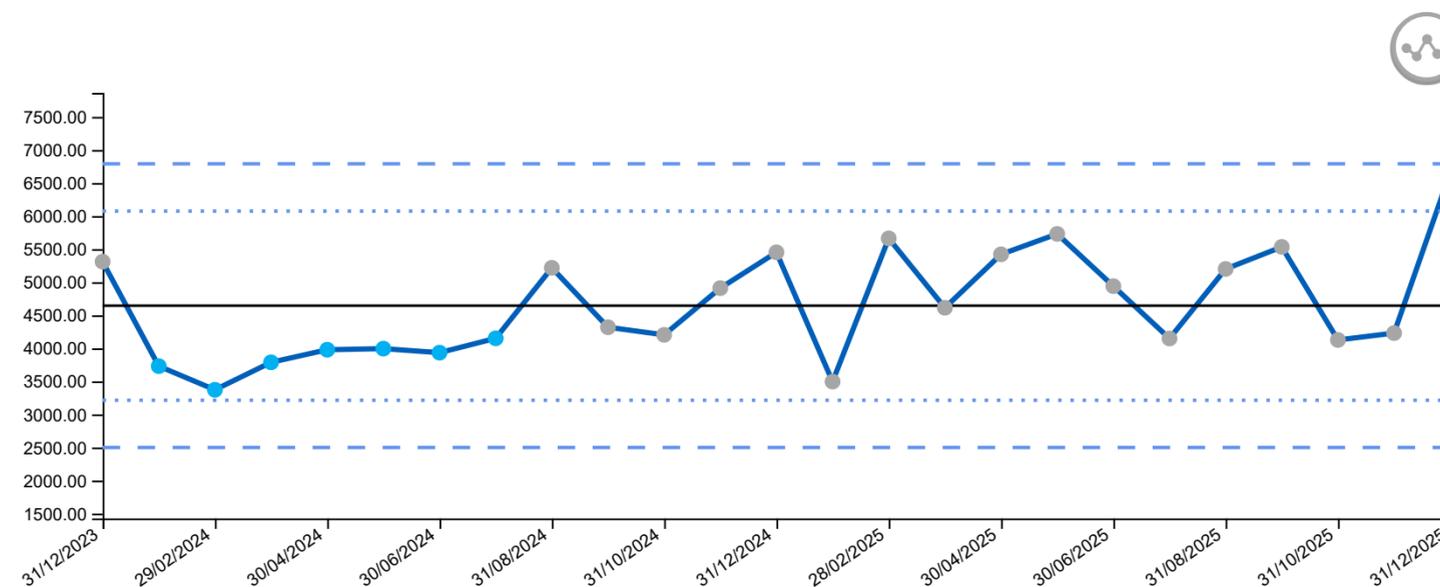


Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	5310.34	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/01/2024	3730.43	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
29/02/2024	3372.92	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
31/03/2024	3787.95	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
30/04/2024	3978.42	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
31/05/2024	3994.97	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
30/06/2024	3934.05	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
31/07/2024	4150.83	4644.77	2499.67	6789.86	3214.70	6074.83	IMPROVEMENT
31/08/2024	5217.01	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
30/09/2024	4318.52	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/10/2024	4203.55	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
30/11/2024	4910.18	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/12/2024	5451.71	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/01/2025	3496.18	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
28/02/2025	5662.32	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/03/2025	4612.93	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
30/04/2025	5421.05	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/05/2025	5729.95	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
30/06/2025	4939.92	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/07/2025	4148.52	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/08/2025	5200.02	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
30/09/2025	5533.22	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/10/2025	4126.30	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
30/11/2025	4230.32	4644.77	2499.67	6789.86	3214.70	6074.83	NONE
31/12/2025	6657.52	4644.77	2499.67	6789.86	3214.70	6074.83	NONE

Bank Hours Utilised

Lower is Better



Comments From Executive Lead

We do not have an organisational target for bank usage but the use of additional hours should not exceed hours vacant or lost to absence. Work is underway through the IPR to look at all additional hours in relation to hours lost to highlight areas for intervention. Approval and oversight of bank usage now forms part of the Vacancy Control Panel Terms of Reference. Work is underway to enhance usage of eRoster across all teams and ensure rota principles are understood and aligned.

Dave Harris, Director of People and Culture



People & Culture

Overtime Hours Utilised

Data Source
Workforce Systems

Latest Data
31/12/2025

Compliance

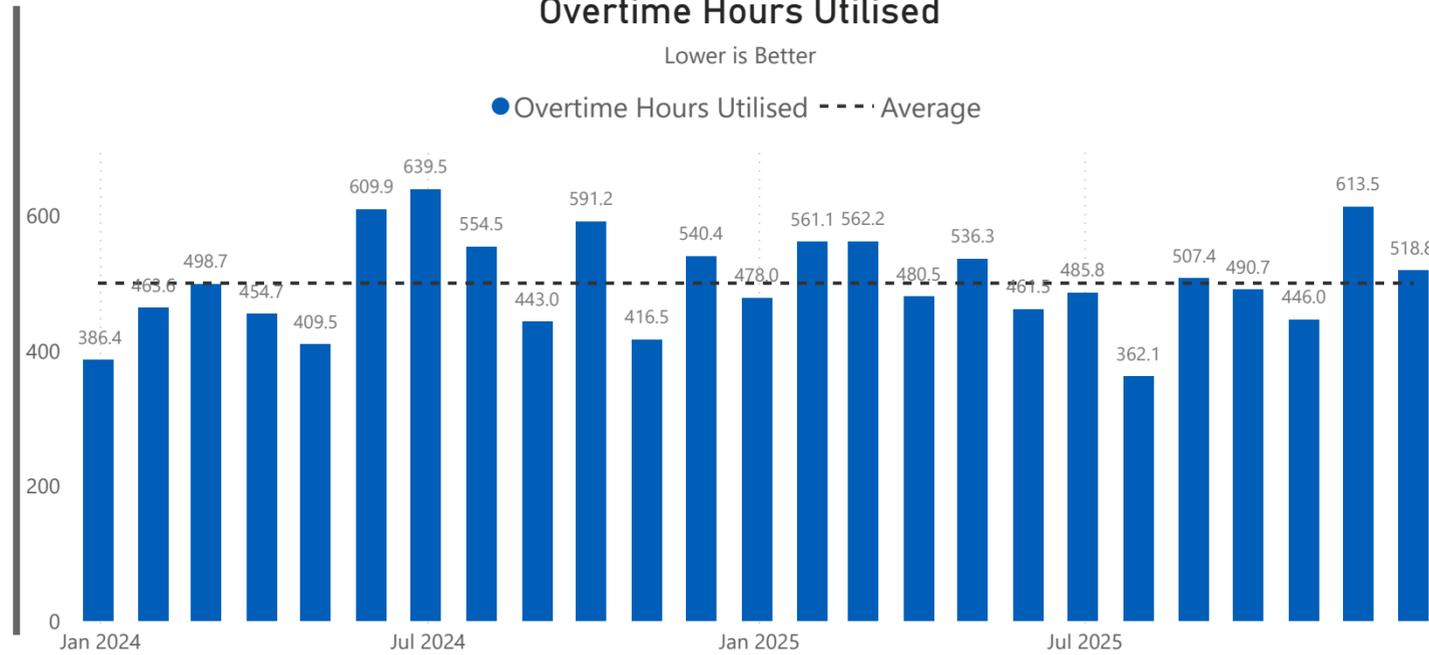
KPI	Target	Actual	RAG Value
Overtime hours used vs. average.		519	Grey

Action	Target Date	Owner	Status
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No target set, actions and target to be updated.

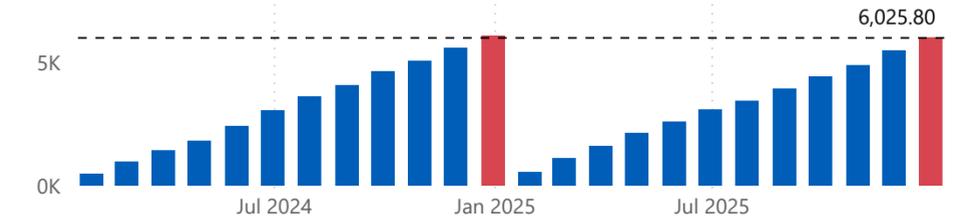
Overtime Hours Utilised

Lower is Better



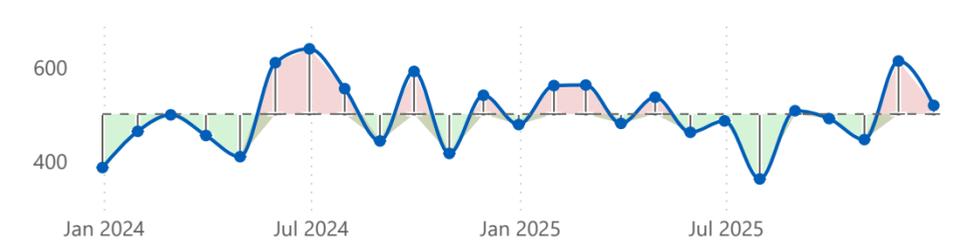
Hours Utilised - Overtime Hours vs. Previous Year

Overtime Hours Running Total per Year



Hours Utilised - Overtime Hours

Overtime Hours vs Average Bank Hours Utilised

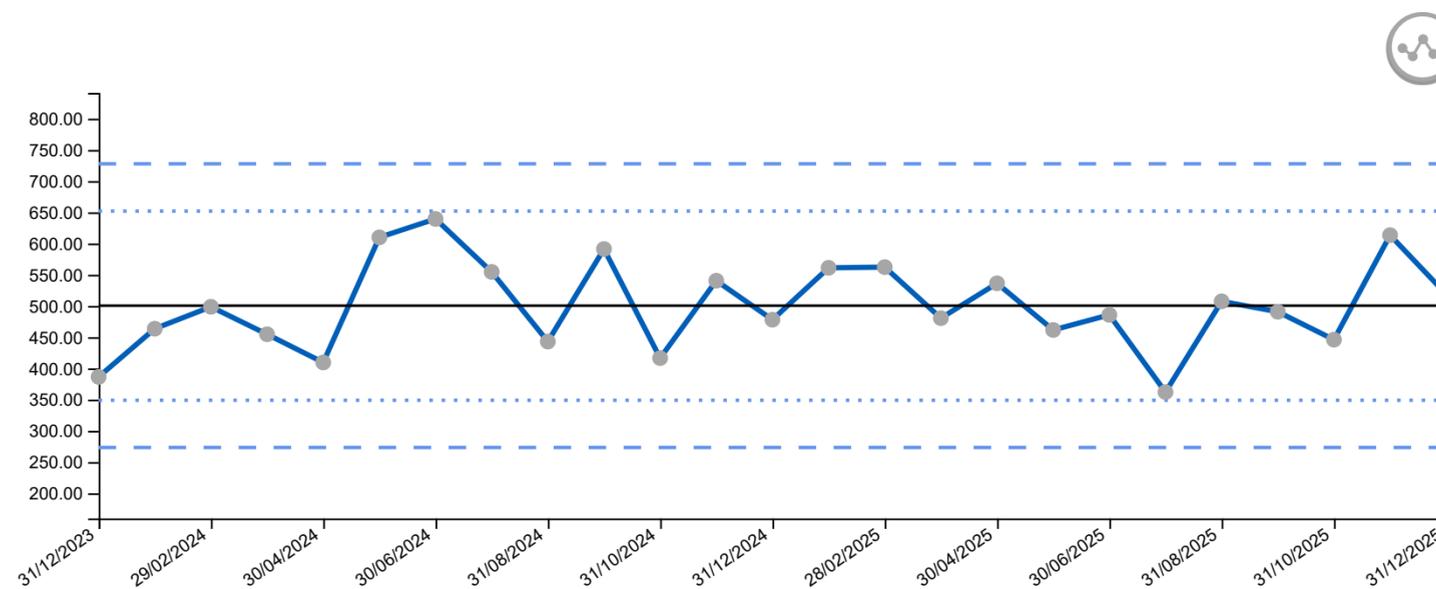


Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	386.42	500.47	273.24	727.70	348.98	651.95	NONE
31/01/2024	463.58	500.47	273.24	727.70	348.98	651.95	NONE
29/02/2024	498.68	500.47	273.24	727.70	348.98	651.95	NONE
31/03/2024	454.67	500.47	273.24	727.70	348.98	651.95	NONE
30/04/2024	409.50	500.47	273.24	727.70	348.98	651.95	NONE
31/05/2024	609.92	500.47	273.24	727.70	348.98	651.95	NONE
30/06/2024	639.45	500.47	273.24	727.70	348.98	651.95	NONE
31/07/2024	554.54	500.47	273.24	727.70	348.98	651.95	NONE
31/08/2024	443.00	500.47	273.24	727.70	348.98	651.95	NONE
30/09/2024	591.23	500.47	273.24	727.70	348.98	651.95	NONE
31/10/2024	416.50	500.47	273.24	727.70	348.98	651.95	NONE
30/11/2024	540.44	500.47	273.24	727.70	348.98	651.95	NONE
31/12/2024	478.00	500.47	273.24	727.70	348.98	651.95	NONE
31/01/2025	561.09	500.47	273.24	727.70	348.98	651.95	NONE
28/02/2025	562.24	500.47	273.24	727.70	348.98	651.95	NONE
31/03/2025	480.50	500.47	273.24	727.70	348.98	651.95	NONE
30/04/2025	536.28	500.47	273.24	727.70	348.98	651.95	NONE
31/05/2025	461.51	500.47	273.24	727.70	348.98	651.95	NONE
30/06/2025	485.75	500.47	273.24	727.70	348.98	651.95	NONE
31/07/2025	362.08	500.47	273.24	727.70	348.98	651.95	NONE
31/08/2025	507.42	500.47	273.24	727.70	348.98	651.95	NONE
30/09/2025	490.67	500.47	273.24	727.70	348.98	651.95	NONE
31/10/2025	446.00	500.47	273.24	727.70	348.98	651.95	NONE
30/11/2025	613.46	500.47	273.24	727.70	348.98	651.95	NONE
31/12/2025	518.80	500.47	273.24	727.70	348.98	651.95	NONE

Overtime Hours Utilised

Lower is Better



Comments From Executive Lead

Overtime has increased over the last quarter due to high occupancy rates, increased utilisation of surge capacity and weather related issues.

Dave Harris, Director of People and Culture



People & Culture

Excess Hours Utilised

Data Source

Workforce Systems

Latest Data

31/12/2025

Compliance

KPI	Target	Actual	RAG Value
Excess hours used vs. average.		996	Grey

Action	Target Date	Owner	Status
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No target set, actions and target to be updated.

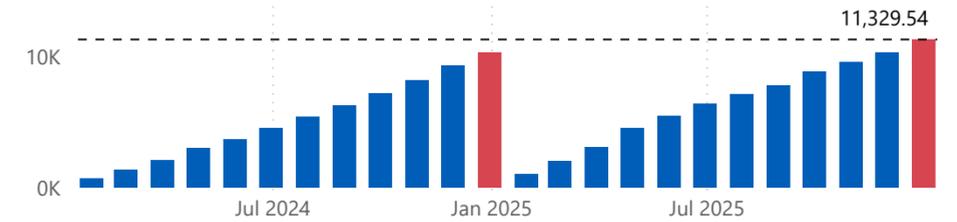
Excess Hours Utilised

Lower is Better



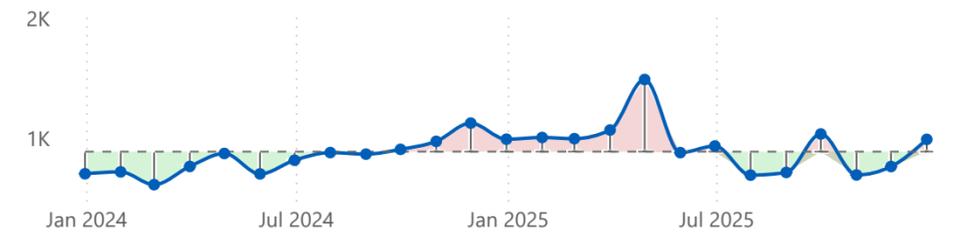
Hours Utilised - Excess Hours vs. Previous Year

Excess Hours Running Total per Year



Hours Utilised - Excess Hours

Excess Hours Average Excess Hours Utilised

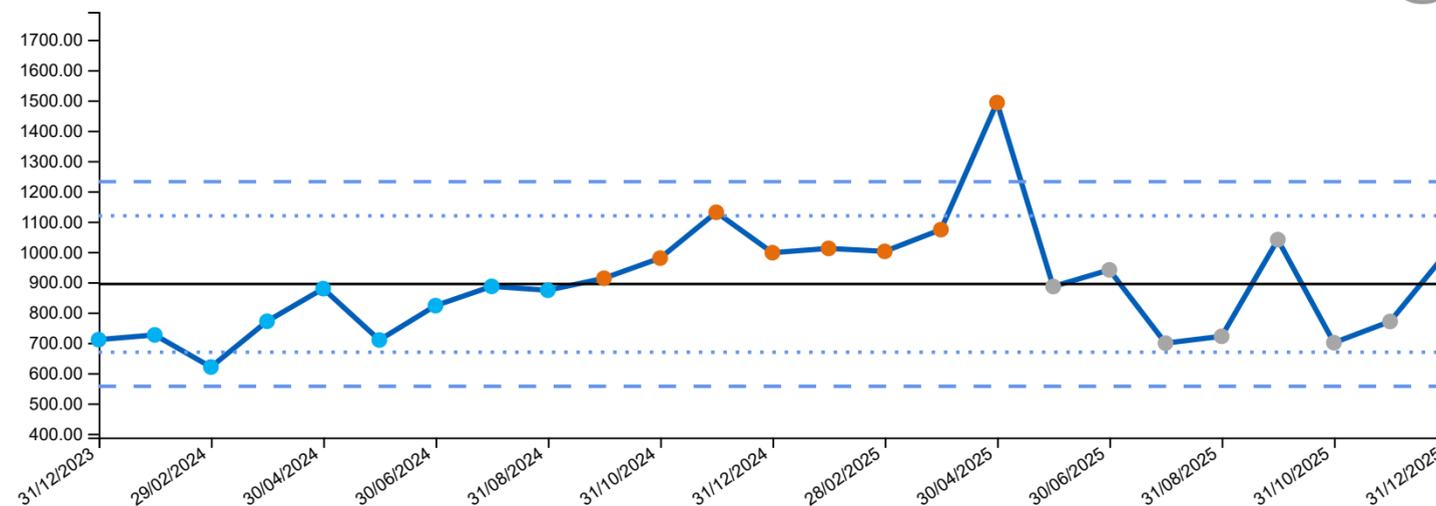


Statistical Process Control

DATE	VALUE	TARGET	LL 99%	UL 99%	LL 95%	UL 95%	SHIFT
31/12/2023	710.09	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
31/01/2024	725.73	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
29/02/2024	619.73	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
31/03/2024	770.74	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
30/04/2024	878.47	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
31/05/2024	708.88	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
30/06/2024	822.30	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
31/07/2024	885.97	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
31/08/2024	873.00	893.75	556.15	1231.35	668.68	1118.82	IMPROVEMENT
30/09/2024	912.73	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
31/10/2024	979.15	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
30/11/2024	1130.39	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
31/12/2024	997.03	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
31/01/2025	1011.16	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
28/02/2025	1001.39	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
31/03/2025	1073.14	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
30/04/2025	1492.39	893.75	556.15	1231.35	668.68	1118.82	DETERIORATION
31/05/2025	885.48	893.75	556.15	1231.35	668.68	1118.82	NONE
30/06/2025	940.41	893.75	556.15	1231.35	668.68	1118.82	NONE
31/07/2025	698.58	893.75	556.15	1231.35	668.68	1118.82	NONE
31/08/2025	721.14	893.75	556.15	1231.35	668.68	1118.82	NONE
30/09/2025	1040.17	893.75	556.15	1231.35	668.68	1118.82	NONE
31/10/2025	700.06	893.75	556.15	1231.35	668.68	1118.82	NONE
30/11/2025	770.10	893.75	556.15	1231.35	668.68	1118.82	NONE
31/12/2025	995.52	893.75	556.15	1231.35	668.68	1118.82	NONE

Excess Hours Utilised

Lower is Better



Comments From Executive Lead

We do not have an organisational target for excess hours usage but the use of additional hours should not exceed hours lost due to vacancies or absence. Work is underway through the IPR to look at all additional hours in relation to hours lost to highlight areas for intervention. Overtime has increased over the last quarter due to high occupancy rates, increased utilisation of surge capacity and weather related issues.

Dave Harris, Director of People and Culture



Finance

Section Lead(s):
Director of Finance

What's Going Well?

The Board approved the 2025/26 Financial Plan with a forecast deficit of £2.176m at 31 March 2026. The efficiency programme has an approved target of £3.8m to deliver in year with £2.8m of that as recurring savings.

RAG Status Values

RED	More than 10% variance from original target.
AMBER	Less than 10% variance from original target.
GREEN	0% variance from original target.

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

Areas of Concern

NHS Orkney continues to be placed on level three of the NHS Scotland Support and Intervention Framework for Finance.

The month 8 position is £782k adverse to trajectory, driven by additional expenditure along with a reduction in allocated funding by SG. The savings programme is also £0.324m adverse to trajectory.

Key drivers of overspend are medical recruitment costs, agency nursing and primary care prescribing along with legal and settlement fees.

A financial governance review has been undertaken during Month 6 which has highlighted the Board may overspend by £6.2m.

Turnaround actions have been quantified at £1.75m which reduces the gap to around £2.4m. Additional measures are being introduced to close the gap.

Finance

Financial Position Summary

Data Source

Finance Performance Report

Latest Data

November 2025

Group	Full Year Budget	Year To Date Budget	Year To Date Actual	Year To Date Variance	Current Month Budget	Current Month Actual	Current Month Variance
Income							
Health Board Income	-1,017	-680	-760	80	-84	-107	23
Other	-491	-327	-828	501	-41	-124	83
Primary Care Patient Charges	-375	-283	-247	-36	-44	-36	-8
Total Income	-1,883	-1,290	-1,835	544	-169	-266	97
Expenditure							
Pay							
Medical & Dental	9,268	6,178	8,316	-2,137	772	1,090	-317
Nursing & Midwifery	16,976	11,303	10,642	661	1,421	1,304	118
Other Staff Costs	27,884	18,650	15,111	3,539	2,336	1,977	359
Total Pay	54,127	36,132	34,069	2,063	4,530	4,370	160
Non Pay							
Drugs - Primary Care	4,902	3,268	3,229	39	408	453	-44
Drugs - Secondary Care	3,558	2,372	2,154	217	296	316	-20
General Dental Services	1,009	729	729	0	87	82	5
General Medical Services	5,251	3,501	3,523	-23	438	311	126
General Ophthalmic Services	316	210	210	0	29	29	0
Medical Supplies	1,594	1,063	1,245	-183	133	185	-52
Other Expenditure	9,305	6,115	11,822	-5,707	785	1,465	-680
Pharmaceutical Services	1,017	702	713	-11	86	76	10
Resource Transfer	2,334	1,556	1,561	-5	195	191	3
SLA's & UNPACs	10,033	6,689	6,775	-86	836	834	3
Total Non-Pay	39,319	26,203	31,962	-5,758	3,293	3,941	-649
Total Expenditure	93,446	62,335	66,031	-3,695	7,823	8,311	-489
Total	91,564	61,045	64,196	-3,151	7,654	8,045	-392

Figures shown in the above table represent £000s

Finance

Financial Performance Against Plan

Data Source

Finance Performance Report

Latest Data

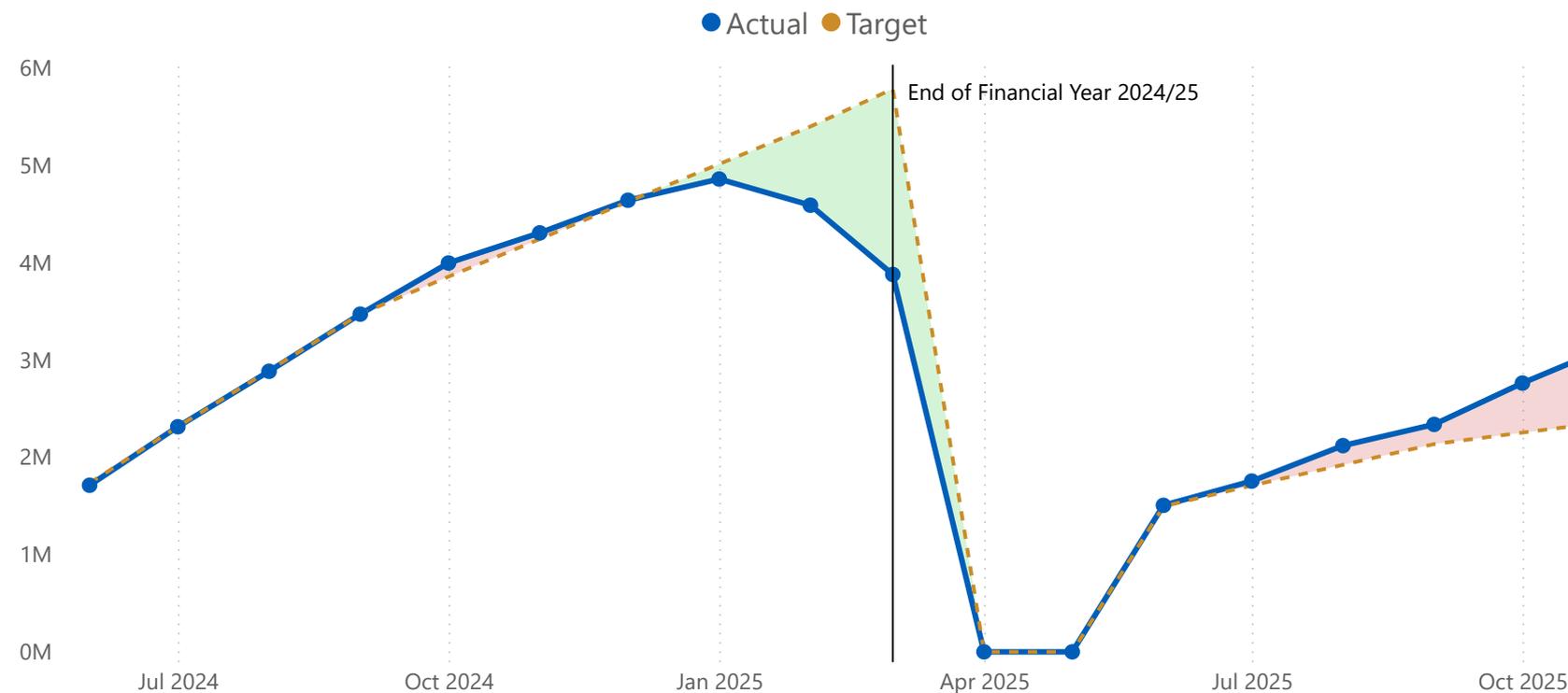
November 2025

Compliance

KPI	Target	Actual	RAG Value
Financial performance against plan - YTD.	£2,369,000	£3,151,000	Red

Action	Target Date	Owner	Status
Review of IJB reserves undertaken to determine whether there is scope for any release	31/01/2026	M Barnes	In Progress
Review of accruals/outstanding income to ensure all assumptions are valid and values within the financial ledger are correct	28/02/2026	M Barnes	In Progress
Ongoing meetings with budget holders to identify cost reduction measures and ensure proper budget control	31/03/2026	M Barnes	In Progress
Ensure all outstanding budget holders undertake training in budget management	31/12/2026	M Barnes	In Progress

Financial Performance Against Plan



Comments From Executive Lead

The Month 8 financial position is again adverse against the planned trajectory. The reporting position is £0.782m higher than the planned overspend of £2.369m. This is a combination of additional expenditure of £458k and unachieved savings of £324k. Funding of £0.079m was removed by SG in Month 5 to fund the tariff transfer to non-discretionary expenditure. This development was not known when the financial plan was approved.

Melanie Barnes, Interim Director of Finance



Finance

Accounts Payable 10-Day Performance

Data Source
AP Performance Report

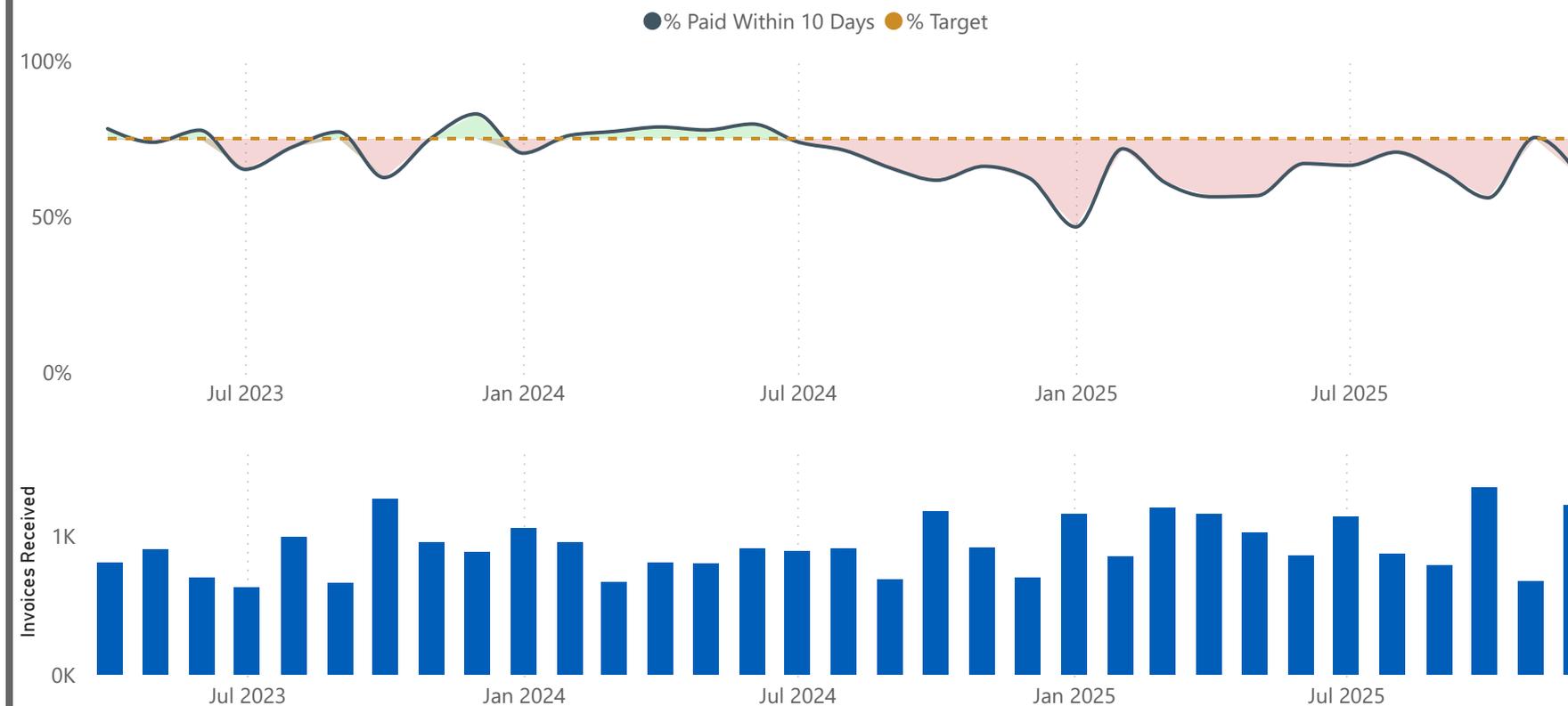
Latest Data
December 2025

Compliance

KPI	Target	Actual	RAG Value
75% of invoices to be paid within 10 days of receipt - local target	75%	62.68%	Red

Action	Target Date	Owner	Status
Continue to escalate issues with receipting of PO's and submission of invoices by departments to DoF	31/03/2026	M Barnes	In Progress
Ensure all outstanding budget holders undertake training in budget management	31/12/2026	M Barnes	In Progress

Accounts Payable - Invoices Paid Within 10 Days of Receipt



Comments From Executive Lead

SG sets an aspirational target for Boards to pay invoices within 10 and 30 days. NHS Orkney continues to strive towards achieving these targets with the limited resources available. The achievement of the targets is dependent on the whole organisation submitting invoices and receipting PO's in a timely manner and the Finance Team continue to engage with the organisation to improve this area. This is demonstrated in the month on month improvement

Melanie Barnes, Interim Director of Finance



Finance

Accounts Payable 30-Day Performance

Data Source
AP Performance Report

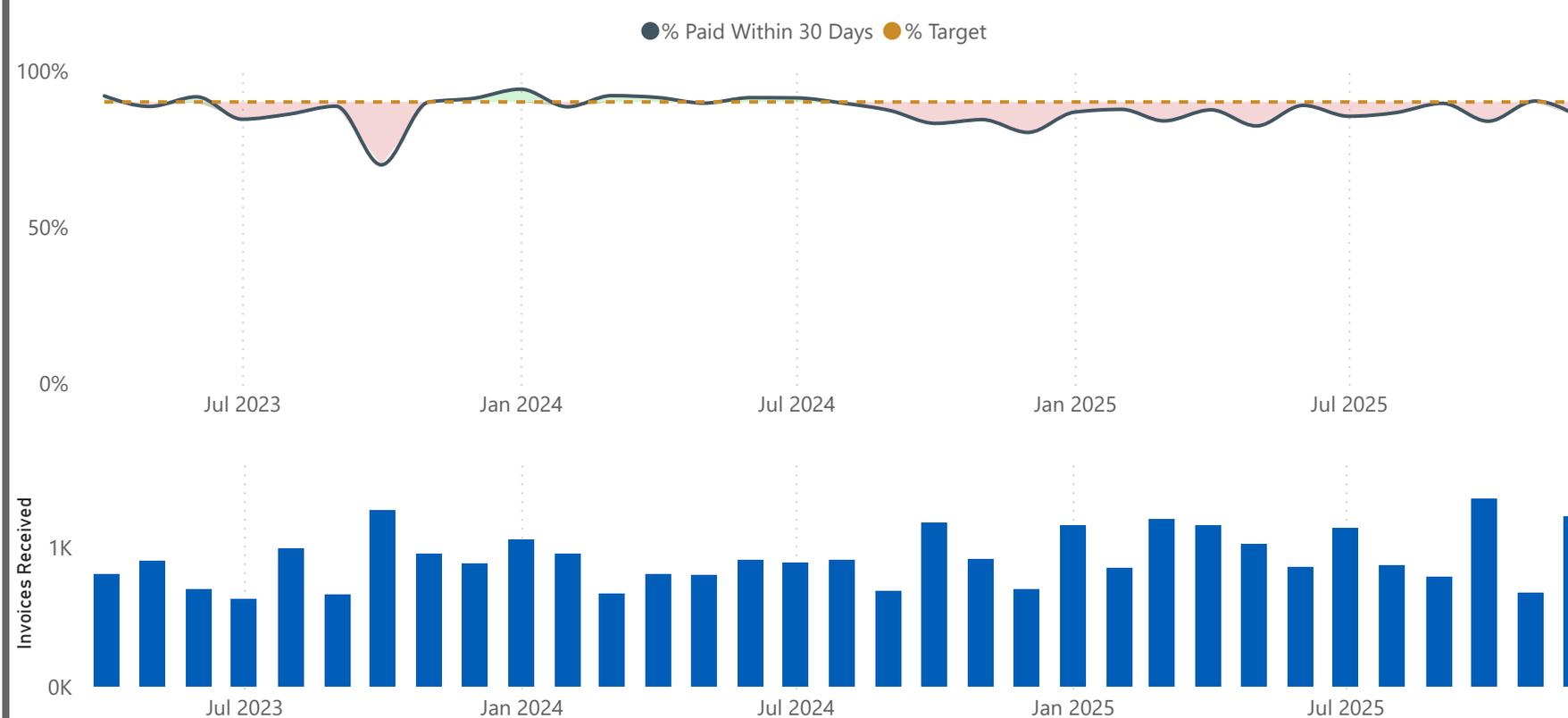
Latest Data
December 2025

Compliance

KPI	Target	Actual	RAG Value
90% of invoices to be paid within 30 days of receipt - local target	90%	85.02%	Red

Action	Target Date	Owner	Status
Continue to escalate issues with receipting of PO's and submission of invoices by departments to DoF	31/03/2026	M Barnes	In Progress
Ensure all outstanding budget holders undertake training in budget management	31/12/2026	M Barnes	In Progress

Accounts Payable - Invoices Paid Within 30 Days of Receipt



Comments From Executive Lead

SG sets an aspirational target for Boards to pay invoices within 10 and 30 days. NHS Orkney continues to strive towards achieving these targets with the limited resources available. The achievement of the targets is dependent on the whole organisation submitting invoices and receipting PO's in a timely manner and the Finance Team continue to engage with the organisation to improve this area. This is demonstrated in the month on month improvement

Melanie Barnes, Interim Director of Finance



Audit and Risk Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Audit and Risk Committee	Date of Meeting: 2 December 2025
Prepared By:	Hazel Aim, Senior Corporate Governance Officer	
Approved By:	Jason Taylor, Chair	
Presented By:	Jason Taylor, Chair	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the <committee> at its meeting on <date>.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> 1. Payroll Controls Audit – significant challenges identified with 21 recommendations made. Cross refer to Staff Governance and Finance & Performance committees. 2. Lack of ownership by action owners in relation to both Risk and Internal Audit recommendations – updates and progress reports have to be actively pursued by administrative staff 	<ol style="list-style-type: none"> 1. Ongoing work around Corporate and Operation risk registers and processes
Positive Assurances to Provide	Decisions Made
<ol style="list-style-type: none"> 1. Operational Risk Registers – significant progress in expanding and standardising with improve governance and accountability 2. Information Governance Audit report reporting good performance 3. Fraud Prevention Strategy – work progressing 4. SNAP update – clinical performance audits brought together under safety, quality and risk banner and standardised. 5. Internal Audit recommendations 23/24 – 4 outstanding, 24/25 – 32 outstanding, 4 closed, 25/26 – 21 outstanding, 3 pending review 6. External Audit recommendations – all complete pending review by External Auditors 	<ol style="list-style-type: none"> 1. Approval of Audit and risk committee core documents 2. Approval of revised Risk Management Group Terms of Reference
Comments on Effectiveness of the Meeting	
<ul style="list-style-type: none"> • Positive comment on the depth and value of internal audit work and how the organisation is using it as an improvement tool. 	

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: 17 December 2025
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Fiona Mackay, Chair, Non-Executive Director	
Presented By:	Fiona MacKay, 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 17 December 2025		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> Robertsons Contract: The Board is experiencing ongoing issues with the Robertsons contract, specifically related to staffing challenges. These concerns have been formally raised with NHS Assure for further review and support and will be invited to Committee. Digital Capacity and capability - There is a clinical risk that current Digital Services Team resources are inadequate for the required business change in 2026/27, potentially causing project delays and impacting strategic goals. The Executive Management Team have been asked to consider further investment, temporary support, shared services, or pausing local priorities to mitigate this and ensure successful delivery. 	<ol style="list-style-type: none"> Financial planning assumptions 2026/27 - in-depth review to identify opportunities for improving and redesigning services to be brought to Committee January 2026.
Positive Assurances to Provide	Decisions Made
<ol style="list-style-type: none"> Assurance taken on the progress and mitigations presented on the latest Corporate Risk Register National Information Security Audit Report received – our compliance has improved year on year. Significant areas of improvement are still required in relation to: Organisational Governance, Information Security Management, System Management, Incident Management, People, Environmental Security, Physical/Building Security 	<ol style="list-style-type: none"> Minutes and Chair's Assurance Report approved from meeting held 18 November 2025.
Comments on Effectiveness of the Meeting	
<ul style="list-style-type: none"> 	

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: 28 January 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Melanie Barnes, Interim Director of Finance	
Presented By:	Fiona MacKay, 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 28 January 2026		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> Delayed Transfers of Care - The number of patients experiencing delayed transfers of care (DTOC) continues to be a significant concern, with high levels now considered 'the norm'. The Chief Officer IJB and the Executive Director of Nursing, Midwifery and Allied Health Professions (EDoNMAHP) have been requested to develop and present a plan to improve system flow in light of our specific demographic challenges. Financial Performance: <p>Month 9: Whilst the forecast out-turn has improved from Month 8, Members acknowledged the ongoing risk of a Section 22 qualification if the financial plan is not delivered and the mitigations in place to manage this risk due to the confirmation from SG that no funding over and above the planned £2m transitional funding will be given.</p> <p>Draft 3 Year Financial Plan: The draft 3-year plan shows a worsening deficit position over the 3 years and a return to financial sustainability is not anticipated over that 3-year period. Members acknowledged the expectation from SG that Boards financial position must improve over the 3 years and this plan does not meet that. Members also acknowledged that even with receipt of the transitional funding there is no break-even position in any of the years and therefore a high risk of a Section 22 Qualification remains</p> Robertsons Contract: The Board is experiencing ongoing issues with the Robertsons contract, specifically related to staffing challenges. These concerns have been formally raised with NHS Assure for further review and support. 	<ol style="list-style-type: none"> Head of Corporate Governance to consolidate the 2 Digital risks to be merged into a single digital risk for inclusion on the Corporate Risk Register In depth deep dive was undertaken on Medical Staffing spend, Executive team to review the recommendations and to bring a plan back to the Finance and Performance Committee 25 February 2026. Head of Estates and NPD Contract to submit a Risk jotter to the next Risk Management Group in relation to the Robertsons contract.

Positive Assurances to Provide	Decisions Made
<ol style="list-style-type: none"> 1. The podiatry service has made notable progress, with the Committee observing clear improvements and a positive outlook for patients. 2. Diagnostic and imaging performance is improving, especially within our endoscopy service. 3. The Board is on track to have no patients waiting over 52 weeks by 31 March 2026. 4. Members endorsed integrated planning, workforce transformation, and efficiency programmes for financial sustainability. They also supported further collaboration with the Scottish Government and Scotland East partners for savings and service redesign. 5. Month 8 and 9 financial performance assurance was noted. 	<ol style="list-style-type: none"> 1. Minutes and Chair's Assurance Report approved from meeting held 17 December 2025. 2. IPR received and approved for onward assurance to Board 26 February 2026 3. Members approved the draft 2026/27 Financial Plan and noted the requirement to deliver £4.173m in savings (approximately 6% of baseline RRL) and the associated high delivery risk.
Comments on Effectiveness of the Meeting	
<ul style="list-style-type: none"> • None noted at the meeting. 	

Senior Leadership Team (SLT) Chair’s Assurance Report to Board

Title of Report:	Chair’s Assurance report from the Senior Leadership Team	Date of Meeting: 12 January 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	James Goodyear, Interim CEO	
Presented By:	James Goodyear, Interim CEO	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on Monday 12 January 2026 .		
Matters of Concern or Key Risks to Escalate		Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> Lack of resources to deliver National Digital Programmes - There is a risk that Insufficient resources in the Digital Services Team risk delaying mandated national digital programmes for 2026/27, potentially impacting delivery of strategic objectives. Financial Position Month 8: There remains a significant variance against trajectory at the end of Month 8. Key actions to mitigate the risk include reinforcing strict financial procedures, promoting staff engagement and opportunities for staff feedback on efficiency and cost-saving ideas for 2026/27. More information to follow in due course. 		<ol style="list-style-type: none"> Sub national (East of Scotland) regional planning – work underway with East of Scotland Health Boards to understand what that means for the Board. A fifth workstream to look at Remote and Rural Healthcare to ensure equity of services including a Strategic Needs Assessment and Islands Impact Assessment. Orkney’s routemap to reform - A proposal for Orkney’s routemap to reform has been submitted to the Scottish Government; opportunity identification is underway. Reduced Working Week implementation – work is underway to understand the impact of implementing all elements of the Agenda for Change reform (protected learning time and time to lead) not just the Reduced Working Week. Financial Planning Waste Reduction (efficiency) 2026/27 – Executive Directors continue to meet with teams to identify efficiency/savings targets 2026/27.
Positive Assurances to provide		Decisions Made
<ol style="list-style-type: none"> The Executive Team expressed their thanks to all staff for their response to the adverse weather during the week commencing 5 January 2026. The Corporate Risk Register has been updated in accordance with our Risk Management Strategy, ensuring the latest information is available to Governance Committees. Constructive discussions took place about fostering a culture where staff feel confident to speak up There has been a marked decrease in the number of active incidents being managed across the Organisation 		<ol style="list-style-type: none"> Minutes and Chair’s Assurance Report approved from meetings held on 25 November 2025. Risk in relation to lack of resources to deliver National Digital Programmes for inclusion on the Corporate Risk Register Safety, Quality, Experience Quarter 2 Report approved for onward assurance to Joint Clinical Care Governance Committee in February 2026.
Feedback about meeting:		
- None recorded.		

Joint Clinical and Care Governance Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Joint Clinical and Care Governance Committee	Date of Meeting 4 February 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Rona Gold, Chair and Non-Executive Director	
Presented By:	Rona Gold, Chair and Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Joint Clinical and Care Governance Committee at its meeting on 04 February 2026 .		
Matters of Concern or Key Risks to Escalate		Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> 1. The Public Health Report was distributed to members after the meeting due to its late arrival. 2. Limited financial resources and storage for Personal Protective Equipment (PPE) could lead to higher costs for the Board. 3. Insufficient clinical engagement in reviews may impact on our ability to deliver Serious Adverse Event Reviews 		<ol style="list-style-type: none"> 1. Social care system capacity risk will be reviewed by the Risk Management Group in February 2026. 2. EDoNMAHP will review how patient fall data is presented to the Committee and shared with members before the next meeting. 3. Consultant in Public Health to provide Weight Management Service update at Committee meeting in April 2026. 4. Port Health Memorandum of Understanding – Members to provide feedback to Consultant in Public Health. Update to be brought to April Meeting.
Positive Assurances to Provide		Decisions Made
<ol style="list-style-type: none"> 1. The corporate risks associated with JCCGC have been reviewed, with the most recent update recorded in November 2025. 2. Members took assurance on the IPR, noting off-track KPIs, and acknowledged plans to restore progress. 3. Assurance provided via the Area Drugs and Therapeutics Committee Chair's Assurance Report 4. Assurance provided from the Infection, Prevention Control Committee Chairs Assurance report 5. Assurance taken on the work of the Social Work and Social Care Governance Board (SWSCGB) 6. Assurance taken in relation to Clinical Governance via the Clinical Governance Group Chairs Assurance Report 7. Committee were assured on the revised Port Health Memorandum of Understanding ensures lawful, consistent port health operations, reducing organisational risk during routine activities or major public health incidents involving vessels or aircraft. 		<ol style="list-style-type: none"> 1. Minutes and Chairs Assurance Report from meeting held 1 October 2025 approved 2. JCCGC Terms of Reference, Workplan and Reporting schedule 2026/27 approved.

8. The number of overdue incidents is now down to its lowest level for several years, progress continues to be made on reducing the backlog of incidents.
9. Assurance provided via the Quarter 2 Safety, Quality and Experience Report.
10. Assurance provided on His Majesty's Inspectorate of Constabulary in Scotland (HMICS) - Draft Custody Inspection Action Report
11. Assurance provided following recent peer review of our maternity services with strong engagement from our maternity team.
12. Members took assurance on the Chief Social Work Officer Annual Report
13. Management of Drug Harms Standard Operating Procedure received and noted
14. Information Sharing Protocol - Public Protection and Community Safety received and noted

Comments on Effectiveness of the Meeting

- None were noted

Staff Governance Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Staff Governance Committee	Date of Meeting: 12 February 2026
Prepared By:	Debs Crohn, Head of Corporate Governance	
Approved By:	Joanna Kenny – Chair	
Presented By:	Joanna Kenny – Chair	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Staff Governance Committee at its meeting on 12 February 2026 .		
Matters of Concern or Key Risks to Escalate		Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> The risk associated with insufficient senior capacity and leadership is being actively managed. An Interim Director of Finance will join the Board on 16 March 2026, and discussions with the Scottish Government regarding the recruitment of a substantive Chief Executive Officer are ongoing. Appraisal rates remain an issue. To address this, the Director of People & Culture is introducing a three-month period (April - June) for managers to complete staff annual appraisals. The number of staff participating in face fit testing has decreased. EDoNMAHP is working with the Infection Control team to improve engagement and increase participation. 		<ol style="list-style-type: none"> Integrated Performance Report – Director of People & Culture and Director of Performance and Transformation are meeting to review workforce indicators presented in the IPR. Update to be brought to the next meeting. Use of Bank/agency staff – an analysis of bank/agency usage and staffing establishments are being undertaken by the Area Partnership Forum - assurance will be provided to Committee 14 May 2026 meeting. Lack of resuscitation training – EDoNMAHP taking this forward with Senior Charge Nurses, assurance to be provided by the Operational People Group. The Director of People and Culture is overseeing the development of a consolidated 'People' Plan that will include the Your Employee Journey Programme. Interim CEO to meet with the Medical Director and EDoNMAHP to discuss concerns about insufficient medical staff involvement in the Board Level Clinicians' Internal Healthcare Staffing Compliance Report for Year 2, Quarter 3. Director of People and Culture is developing a full Business Case for the Education and Improvement focusing on the wider impacts and engagement with all stakeholders.
Positive Assurances to Provide		Decisions Made
<ol style="list-style-type: none"> General Practice now codes veterans when seeing patients, and this information is passed to Secondary Care as part of our commitment to the Armed Forces Veteran Covenant. The Committee completed all actions in the action log before the meeting, showing its growing maturity. Positive assurance provided by the Operational People Group and the Area Partnership Forum Chair's Assurance Reports. Committee acknowledged the Integrated Performance Report noting work underway to review workforce Key Performance Indicators. Positive assurance provided on some improvement on Health and Safety compliance. 		<ol style="list-style-type: none"> Minutes and Chairs Assurance Report from meeting 3 December 2025 approved. Quarter 3 Whistleblowing report approved for submission to the INWO and for publication on the Boards Website. Board Level Clinician(s) Internal Healthcare Staffing Compliance Report Year 2 Quarter 3 approved for onward submission to Healthcare Improvement Scotland Committee Business Cycle and Workplan 2026/27 approved.

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| <ol style="list-style-type: none">6. Committee noted the paper in relation to the Protected Learning Time and changes to the Once for Scotland National Statutory and Mandatory training.7. The Board Level Clinicians' Internal Healthcare Staffing Compliance Report for Year 2, Quarter 3, provided assurance through robust reporting to the Committee, and a review of Corporate Risk is scheduled before the next meeting.8. Committee took assurance that the Reduced Working Week (RWW) plan is being actively progressed with final report being presented to Area Partnership Forum 17 February 2026. | |
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Comments on Effectiveness of the Meeting

- None recorded

Area Clinical Forum Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Area Clinical Forum	Date of Meeting: 12 December 2025
Prepared By:	Frederick Pretorius, Executive Assistant	
Approved By:	Dr Kirsty Cole	
Presented By:	Dr Kirsty Cole	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Clinical Forum at its meeting on 12 December 2025		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> 1. Recruitment challenges linked to accommodation shortages, impacting workforce resilience across multiple clinical areas. 2. High levels of delayed transfers of care, creating significant pressure on acute and community services. 3. Non-delivery of Primary Care Improvement Plan workstreams (pharmacotherapy, Community Treatment and Care, mental health and physiotherapy for example), posing workload and clinical care challenges. 4. Limited clinical representation in Clinical Services Review workstreams noted, risking insufficient clinical input into transformation planning. Members commented that the same limited number of clinicians are on multiple workstream groups. 	<ol style="list-style-type: none"> 1. Development session - see if possible, to revisit and conclude the clinical engagement framework using the "double diamond" approach, with an agreed action plan for embedding clinical engagement in transformation projects. 2. Inclusion of introductions to executive team members and non-executive directors in the development session to strengthen relationships and clarify roles. This process has started and has been well received by ACF members so far. 3. Exploration of an educational component on pharmacogenomics for clinicians, either within the development session or at a future meeting. 4. Commitment to streamline policy review processes, reduce duplication, and involve advisory committees earlier in drafting stages to address delays and improve governance. 5. The Director of Nursing, Midwifery, Allied Health Professions, and Chief Officer of Acute Services to raise concerns regarding lack of general practice and allied health professional representation in Programme Board workstreams to ensure comprehensive clinical input.
Positive Assurances to Provide	Decisions Made
<ol style="list-style-type: none"> 1. Progress on Excellence in Care data reporting, with improved compliance and engagement. 2. Compliance with national safety alerts and medicines governance standards. 3. Increased engagement and attendance within Professional Advisory Committees, supporting collaborative working. 	<ol style="list-style-type: none"> 1. Agreement to request development session in March 2026, focusing on clinical engagement and pharmacogenomics education. 2. Commitment to revisit and conclude the clinical engagement framework initiated earlier in the year.
Comments on Effectiveness of the Meeting	
<ul style="list-style-type: none"> • The meeting was constructive and enabled valuable discussion on strategic priorities, governance, and clinical engagement. • Members agreed that the forum provided a useful platform for collaboration and highlighted the importance of improving governance processes to support timely decision-making and accurate documentation. 	

Area Clinical Forum Chair's Assurance Report to Board

Title of Report:	Chair's Assurance Report from the Area Clinical Forum	Date of Meeting: 04 February 2026
Prepared By:	Frederick Pretorius	
Approved By:	Dr Kirsty Cole, Chair	
Presented By:	Dr Kirsty Cole, Chair	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Clinical Forum at its meeting on 04 February 2026		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> Ongoing absence of the Area Medical Committee, Hospital Sub-Committee, and Area Dental Committee, resulting in a significant governance gap for medical and dental advisory input. NAMAC raised concerns regarding limited eHealth capacity affecting service delivery, including backlogs in uploading cardiology reports and wider digital system constraints. High levels of delayed transfers of care due to limited availability of social care, impacting patient wellbeing and placing sustained pressure on acute, community, and multidisciplinary teams. Concerns from TRADAC teams regarding the reduction in the working week, particularly related to maintaining safe services and leadership capacity within smaller teams. TRADAC highlighted continued issues relating to canteen access, queuing, and access to healthy food choices which had not progressed since December due to operational pressures; this remains a concern for staff wellbeing. ADTC were understood to have progressed plans to explore public facing communication around safe access to private healthcare and medications following concerns raised at a previous ACF meeting. Chair to liaise with ADTC to establish what progress has been made, as committee members have not noted any communication to patients/the public to date. 	<ol style="list-style-type: none"> The Chair and Medical Director will explore options to reinstate or redesign the Area Medical Committee arrangements, including consideration of a quarterly standalone meeting chaired by an external clinician. Medical Director will liaise with Head of Corporate Governance regarding a call for interest in the Hospital Sub Committee Chair position. eHealth colleagues will be invited to a future NAMAC meeting to discuss ongoing capacity issues and system constraints. Governance colleagues and the Committee Support Officer will correct the Terms of Reference appendix and support further revisions once AMC and related structures are clarified. Recruitment activity to support workforce-reduction backfill is underway, with vacancy identification and approval processes progressing. A separate meeting dedicated to strengthening clinical engagement will be convened, including revisiting the earlier advisory-chair development work that was paused. Further development session planning is in progress, including potential inclusion of the CBT evaluation programme previously presented to NAMAC. The Chair will support TRADAC colleagues in their discussions with the catering team around canteen access and availability of healthy food choices for staff and patients.
Positive Assurances to Provide	Decisions Made
<ol style="list-style-type: none"> Community teams reported successful recent recruitment, with new staff expected to begin in post shortly. Staff vaccination uptake has improved since the previous reporting period, with approximately 50% uptake among healthcare staff and rising uptake among social care staff, placing NHS Orkney among the higher-performing boards nationally. 	<ol style="list-style-type: none"> It was agreed to pause scrutiny and review of the Chaperone and Intimate Examination Policy pending national clarification before further local scrutiny. It was agreed that a dedicated meeting on clinical engagement will be convened, with outcomes to be brought back to the ACF.

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| <ol style="list-style-type: none">3. All AHP teams submitted their workforce-reduction plans, which have been reviewed by senior managers and discussed at Executive level.4. Recruitment activity to support workforce-reduction backfill is underway, with vacancy identification and approval processes progressing appropriately.5. Positive assurances were provided regarding the upcoming advertisement of the Lead AHP (Adult) post and the continuation of administrative support from the governance team.6. Continued engagement with the CSB User Group and participation in the Clinical Services Review were noted as positive developments. | <ol style="list-style-type: none">3. Corrections to the Terms of Reference, including removal of the incorrect appendix and further structural review, were agreed to be progressed by governance colleagues and the Committee Support Officer. |
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Comments on Effectiveness of the Meeting

- Members agreed the meeting was effective, with constructive challenge and strong contributions from advisory committees.
- It was noted that time pressures toward the end of the agenda required several items to be handled more briefly than intended.

Area Partnership Forum Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Area Partnership Forum	Date of Meeting: 20 th January 2026
Prepared By:	Jade Rosie, Executive Assistant	
Approved By:	James Goodyear, Interim Chief Executive	
Presented By:	James Goodyear, Interim Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Area Partnership Forum at its meeting on 20 th January 2026.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
<ol style="list-style-type: none"> Assurance was provided that the technical issues around the safety alarms has been solved, however concerns raised on the consistency of staffs understanding of and compliance with safety processes. An increase of approximately 20% in variable staffing was observed between March 2025 and September 2025, alongside substantive workforce growth and stable sickness. The committee explored the potential reasons for this and the possible impact on staff wellbeing. 	<ol style="list-style-type: none"> Audit of staff safety alarm processes underway, with organisational assurance work and staff education to follow. Referred to the Occupational Health, Safety and Wellbeing Committee. OD Advisor preparing a summary of next steps for iMatter, including work on Datix reporting barriers and improving use of Confidential Contacts and Peer Support. Head of People & Culture & Director of Finance reviewing workforce data to understand drivers behind increased variable hours. Review of organisational approaches to managing clock changes to support consistency. Guidance on compensatory rest for on-call AFC staff being drafted for managers. Job Evaluation Lead and Staff Side preparing a paper on sustainable panel arrangements and revised expectations.
Positive Assurances to Provide	Decisions Made
<ol style="list-style-type: none"> National iMatter action plan completion rate has improved from 66% to 74% through additional team submissions. 	<ol style="list-style-type: none"> Organisational Change Business Case for Procurement approved for implementation.
Comments on Effectiveness of the Meeting	
<ul style="list-style-type: none"> The meeting was well-attended, with active participation from members. Agenda was completed efficiently, with clear decisions and actions agreed. 	

Integration Joint Board (IJB) Key Items and Discussions

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> • Stephen Brown, Chief Officer IJB
Report Author(s)	<ul style="list-style-type: none"> • Stephen Brown, Chief Officer IJB.
Purpose of report	<ul style="list-style-type: none"> • Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Government policy/directive • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Person Centred
Key points for consideration	<ul style="list-style-type: none"> • The report gives a brief overview of the agenda and discussion at the Integration Joint Board Meeting on 10 December 2025.
Route to meeting	<ul style="list-style-type: none"> • Not applicable.
Recommendation(s)	<ul style="list-style-type: none"> • Assurance - For members assurance only

Integration Joint Board (IJB) Key Items and Discussions

Stephen Brown, Chief Officer Integration Joint Board (IJB)

26/02/2026

1. Situation

- 1.1 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. Background

- 2.1 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](#).
- 2.2 Since the last report there has been a meeting of the Integration Joint Board on 10 December 2025.

3. Assessment

3.1 Key Points from the December 2025 meeting include:

- i The Integration Joint Board had a report presented on Appointment and Reappointment whereby Members noted the NHS Orkney Non Executive appointments and the recruitment of the Chief Finance Officer for a one year period. The Board also approved the Council's Staffside representative and one of the Carer representatives be appointed to the Performance and Audit Committee.
- ii The Chief Finance Officer presented the Revenue Expenditure Monitoring Report which noted the Integration Joint Board's financial position as at 30 September 2025. This included the position on NHS Orkney commissioned services of an £524k underspend, if the historic £2,400k historic savings target was stripped out. It was noted that including a six month share of the historic savings target would result in NHS Commissioned services having an overspend of £676k. It was also advised that Set Aside services have required an additional £890k budget to match the actual spend.
- iii The Chief Officer presented a report on Public Sector Reform with the Council's Head of Corporate Governance assisting answering Members questions. Following

discussion the Integration Joint Board approved Orkney’s Route Map to Reform and approved the Chief Officer to agree the Memoranda of Understanding with the Scottish Government and other relevant agencies.

- iv Following the Appointment of Chief Internal Auditor report, the Integration Joint Board approved NHS Orkney’s Chief Internal Auditor to be appointed as the Chief Internal Auditor of the Integration Joint Board for a five year period commencing on 1 April 2025.
- v The updated Freedom of Information Policy and Publication Scheme was presented to the Integration Joint Board and was thereafter approved.
- vi The Board approved a discussion in relation to the Primary Care Improvement Plan Regulations in Orkney report to be taken in private. Following discussion, it was agreed to present all options to Members of the GP Sub-committee to agree a clinical recommendation for the Integration Joint Board’s consideration and approval.

3.2 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The Integration Joint Board aims to improve quality of care through joined up provision of services.
People	Workforce	No	There are no workforce implications directly arising as a result of this report.
Performance	Finance	No	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.
Potential	Risk Management	No	There are no risk implications directly arising as a result of this report.
	Digital	No	There are no digital implications directly arising as a result of this report.
Place	Equality and Diversity including health inequalities	No	There are no equality or diversity implications directly arising as a result of this report.
	Climate Change Sustainability	No	There are no climate change implications directly arising as a result of this report.

4. Recommendation

- i **Assurance** – For Members’ assurance only.

Community Planning Partnership Key Items and Discussion

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> • Stephen Brown, Chief Officer IJB
Report Author(s)	<ul style="list-style-type: none"> • Stephen Brown, Chief Officer.
Purpose of report	<ul style="list-style-type: none"> • Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Annual Operational Plan • Legal requirement • Local policy
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Person Centred
Key points for consideration	<ul style="list-style-type: none"> • The report gives a brief overview of the agenda and discussion at the Community Planning Partnership Meeting on 16 December 2025.
Route to meeting	<ul style="list-style-type: none"> • Not applicable.
Recommendation(s)	<ul style="list-style-type: none"> • Assurance - For members assurance only

Community Planning Partnership Key Items and Discussion

Stephen Brown, Chief Officer

26/02/2026

1. Situation

- 1.1 NHS Orkney is a member of the Community Planning Partnership known locally as the Orkney Partnership Board, and this paper aims to provide members with an update of key issues being considered by the Orkney Partnership Board at its last meeting. Since the last report there have been two meetings which were held on 3 July 2025 and on 17 September 2025.

2. Background

- 2.1 As outlined in the Community Empowerment (Scotland) Act (2015) the NHS has a role to facilitate community planning and ensure the partnership carries out its functions efficiently and effectively.

3. Assessment

- 3.1 Key Highlights from the 16 December 2025 meeting include:
 - i There was a Place Director Charter discussion with Ellen Leaver.
 - ii Discussion on Population Health including implementing the population Health Framework, lead by Hannah Casey, Food Resilience and Good Food Plan, led by Hayley Green, and a Discussion on whether to establish a Population Health Delivery Group, led by Garry Burton.
 - iii The Chief Executives of NHS Orkney and Orkney Islands Council provided a draft statement and update on the Public Sector Reform.
 - iv Members received an updated on Orkney Matters 2.
 - v Members were presented with the Community Learning and Development Partnership Annual Report for information.
 - vi The Director of Education, Communities and Housing provided an update on the Local Child Poverty Action Report 2024/25 and the Joint Children's Services Plan and Child Poverty Strategy.
 - vii A discussion was held on the new Scottish Government Islands Plan.

3.2 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Working together with partners should support quality services.
People	Workforce	No	There are no workforce implications directly arising as a result of this report.
Performance	Finance	No	While there are no financial implications directly arising as a result of this report, NHS Orkney has to support resourcing of the Orkney Partnership support.
Potential	Risk Management	No	There are no risk implications directly arising as a result of this report.
	Digital	No	There are no digital implications directly arising as a result of this report.
Place	Equality and Diversity including health inequalities	No	There are no equality or diversity implications directly arising as a result of this report.
	Climate Change Sustainability	No	While there are no climate change implications directly arising as a result of this report, the Orkney Partnership planned work includes work on climate change.

4. Recommendation(s)

- i **Assurance** – For Members’ assurance only.

Public Sector Reform Update

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> • Stephen Brown, Chief Officer IJB
Report Author(s)	<ul style="list-style-type: none"> • Stephen Brown, Chief Officer.
Purpose of report	<ul style="list-style-type: none"> • Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Government policy/directive • Local policy
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	<ul style="list-style-type: none"> • Following Orkney's 'Routemap to Reform' document being approved in December 2025, it was submitted to Scottish Government on 12 December 2025. • Some positive verbal feedback has been received via Scottish Government officials but, as yet, no written feedback has been received from Scottish Ministers. • The Leadership Steering Group (comprising the Chief Executives of NHS Orkney and Orkney Islands Council, the Chair of the NHS Orkney Board, the Leader of Orkney Islands Council, the Chair, Vice Chair and Chief Officer of the Integration Joint Board and the Governance Leads from NHS Orkney and Orkney Islands Council) meets on a three-weekly basis. To further strengthen relationships and begin planning the implementation of the routemap a session with the steering group was helpfully supported by John Sturrock K.C, with a further session planned for early March and a wider engagement session planned for May 2026.
Route to meeting	<ul style="list-style-type: none"> • Not applicable.
Recommendation(s)	<ul style="list-style-type: none"> • Assurance - For members assurance only

Public Sector Reform Update

Stephen Brown, Chief Officer.

26/02/2026

1. Situation

- 1.1 This report is to provide Members with an update on the work being done locally on the Public Sector Reform (PSR).

2. Background

- 2.1 NHS Orkney and Orkney Islands Council are currently addressing a combined annual deficit of approximately £26 million. This represents an unsustainable financial position, which is exacerbated by ongoing demographic changes and public protection pressures, which mean that securing more efficient joined up service provision is the best option for sustaining public services in Orkney.
- 2.2 The Scottish Government's Programme for Government 2025/26 included a pledge, by the end of the current Parliament, to publish: "Preferred models for Single Authority Models in Argyll and Bute, Orkney and Western Isles that have been developed jointly by local government and health and enable a shift towards prevention. This will include a plan and timeline for implementation, with at least one area transitioning to shadow arrangements."
- 2.3 The Scottish Government has offered to support Orkney, through Orkney Islands Council, with £300,000 of funding from its Invest to Save Fund, to support capacity to work with partners on a public service reform model for Orkney.
- 2.4 The Scottish Government had set a number of deadlines for submission of work. The Scottish Government had also intimated that it expected Orkney Islands Council to liaise with the Integration Joint Board and NHS Orkney and submit a detailed reform model by 12 December 2025.
- 2.5 Members will recall that on 11 December 2025, the Board was presented with the Public Sector Reform – Orkney's Routemap to Reform for approval which highlighted the established principles to guide the focus of the work.
- 2.6 These principles are:
 - i There must be benefit to the community. Public Service Reform must deliver clear and measurable benefits to the community.
 - ii Accountability to the Orkney community. The decision-makers of services to the public will be fully and transparently accountable to the people of Orkney.

- iii Understanding of the national situation. Local models of service delivery will relate to and work effectively with regional and national models.
- iv Reduced duplication. Key objectives will be to improve efficiency, pool resources, streamline bureaucracy and improve cohesion across Orkney's public services.

3. Assessment

- 3.1 Following discussion, the Board of NHS Orkney at its meeting on 11 December 2025 approved the Public Sector Reform – Orkney's Routemap to Reform and agreed that the Chief Executive be authorised to agree the Memoranda of Understanding with the Scottish Government and other relevant agencies.
- 3.2 The same paper had been approved at Orkney Islands Council meeting on 9 December and the Integration Joint Board on 10 December.
- 3.3 On 12 December 2025, Orkney's Routemap to Reform was submitted to Scottish Government on behalf of NHS Orkney, Orkney Integration Joint Board and Orkney Islands Council.
- 3.4 The Chief Executives, Chair of NHS Orkney, Leader of Orkney Islands Council, Chair of the Orkney Integration Joint Board and the Chief Officer met with officials from Scottish Government on 12 December 2025.
- 3.5 Three weekly local meetings have been organised which allows the following people to meet:
 - Chief Executive of NHS Orkney.
 - Chief Executive of Orkney Islands Council.
 - Chief Officer of the Orkney Integration Joint Board.
 - Chair of NHS Orkney.
 - Leader of Orkney Islands Council.
 - Chair of the Orkney Integration Joint Board.
 - Vice Chair of the Orkney Integration Joint Board.
 - Head of Corporate Governance, Orkney Islands Council.
 - Head of Corporate Governance, NHS Orkney.
 - Service Manager (Policy and Communications), Orkney Islands Council.
- 3.6 On 9 February 2026, a facilitated all day session with John Sturrock took place with the members identified at 3.5.
- 3.7 A further facilitated session is scheduled on 4 March 2026, which Board Members may recall was a 'hold in the diary' date for a wider engagement

session. It was agreed by the Steering Group, however, that further work is required to plan and shape that session to best make use of Members time It has therefore been agreed that a further facilitated session with those identified in 3.3. is required prior to a wider session with NHS Board, Elected Members and wider Executives of the organisations.

3.8 Following the discussions on 4 March, work will be done to identify a date for the wider session. Given the forthcoming pre-election period, however, it is likely that this wider session will be in the second half of May 2026.

3.9 Updates continue to be provided to NHS Orkney, Orkney Integration Joint Board and Orkney Islands Council Elected Members as work progresses.

3.10 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	No	There are no quality or patient care implications directly arising as a result of this report.
People	Workforce	No	There are no workforce implications directly arising from this report.
Performance	Finance	Yes	<p>In the meantime, and subject to approval by the Scottish Government, the aforementioned funding from the Scottish Government will be applied to progress development of the proposed model of transition in Orkney. This will include the recruitment and employment of a Strategic Project Manager and a Strategic Project Officer to support the project. Their work will include undertaking the scoping and assessment work referred to in sections 7.3. and 8.1. and the design and development of revised operating structures where shared services are assessed as feasible. Resourcing of facilitation sessions between the NHS Orkney, Orkney Islands Council and other key stakeholders will also be necessary, as will be the arrangement of public engagement and consultation activities. There will also be a requirement to commission professional advice from external organisations, which may include legal, financial, communications and other professional advice.</p> <p>On 24 June 2025 the Scottish Government offered an additional £300,000 from its Invest to Save Fund to support with Orkney's public service reform work with the following conditions:</p> <ul style="list-style-type: none"> The funding is to enable the Project/Programme to be carried out.

			<ul style="list-style-type: none"> The funding shall only be used for the purposes of the Project/Programme and for no other purpose whatsoever. Bidders agree to provide 6 monthly updates on progress of the project using a bespoke reporting template. The first report is due on 12 December 2025. Bidders engage, as required, with SG Officials to discuss any specific element of the bid or to provide information as required. The final amount will be subject to the discussion with the local governance review team taking account of what other funding is available already to support some of the work and work already underway at a national level. Any savings from the project can be retained to be reinvested into improving service delivery. <p>Significant analysis would be required to assess the financial impacts of the model of transition and those arising from any operating structures that may be agreed in the future.</p>
Potential	Risk Management	No	There are no other risk implications directly arising as a result of this report.
	Digital	No	There are no digital implications directly arising as a result of this report.
Place	Equality and Diversity including health inequalities	No	There are no equality or diversity implications directly arising as a result of this report.
	Climate Change Sustainability	<i>No</i>	There are no climate change implications directly arising as a result of this report.

4. Recommendation(s)

- i **Assurance** – For Members' assurance only.

Subnational Planning and Delivery Committee (East) update

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> James Goodyear, Interim Chief Executive
Report Author(s)	<ul style="list-style-type: none"> Tammy Sharp, Director Performance and Transformation
Purpose of report	<ul style="list-style-type: none"> Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> Corporate Strategy 2024-2028 – Place, Patient Safety, Quality and Experience, People, Performance and Potential strategic objectives Operational Improvement Plan Financial Sustainability
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> Safe Effective Person Centred
Key points for consideration	<ul style="list-style-type: none"> Paper presented for assurance to the Board on progress made by the Subnational Planning and Delivery Committee East (SPDCE). The Scottish Government issued DL(2025)25 in November 2025. This mandated Health Boards across Scotland to work more closely on 5 key priorities, and to agree joint plans to deliver these by 31st March 2026. DL(2025)25 mandated a focus on this population-level planning on five specific elements, Chairs and Chief Executives of each East Board are members of SPDCE. John Connaghan, Chair of NHS Lothian, chairs SPDCE, and Caroline Hiscox, CEO of NHS Lothian, is the lead officer for this work. The DL is clear that there is no change to the clinical, workforce, and financial governance accountabilities of any Health Board. Ministerial Direction is to bring forward plans by 31st March against the five key priorities above, expectation that SPDCE and SPDCW will continue to work after that date to ensure delivery against plans by 31st March 2029. SPDCE has also commissioned work on Rural and Island healthcare, and terms of reference for orthopaedics, emergency healthcare, digital front door, and Rural and Islands work have been agreed.
Route to meeting	<ul style="list-style-type: none"> Executive Management Team – 23 February 2026 Finance and Performance Committee – 25 February 2026
Recommendation(s)	<ul style="list-style-type: none"> Assurance - For members assurance only

Subnational Planning and Delivery Committee (East) update

19/01/2026

1. Situation

- 1.1 The Scottish Government issued DL(2025)25 in November 2025. This mandated Health Boards across Scotland to work more closely on 5 key priorities, and to agree joint plans to deliver these by 31st March 2026.

2. Background

- 2.1 Health Boards naturally collaborate on the planning and delivery of a range of services across the country. The publication of Scottish Government Strategies such as the *Public Sector Reform Strategy*, the *Service Renewal Framework*, and the *Operational Improvement Plan*, all during 2025, has sharpened ministerial focus on how population-level planning can be mainstreamed within NHS Scotland.
- 2.2 DL(2025)25 mandated a focus on this population-level planning on five specific elements;
- Orthopaedic waiting times
 - Emergency Healthcare services
 - Digital Front Door/MyCare
 - Alignment of Business Systems
 - Consolidated Financial Planning
- 2.3 To support this work, the DL also established two Subnational Planning and Delivery Committees – East and West (SPDCE and SPDCW, respectively). SPDCE comprises the Health Boards for;
- Borders
 - Fife
 - Grampian
 - Lothian
 - Orkney
 - Shetland
 - Tayside
- 2.4 The Chairs and Chief Executives of each of these Boards are members of SPDCE, as are their counterparts from national and special Boards. It is intended to appoint Lead Directors, starting with Strategic Planning, Finance, and Chief Operating Officers, to support this work.

- 2.5 John Connaghan, Chair of NHS Lothian, chairs SPDCE, and Caroline Hiscox, CEO of NHS Lothian, is the lead officer for this work.
- 2.6 As noted, the Ministerial Direction is to bring forward plans by 31st March against the five key priorities above, but the DL is also clear that there is an expectation that SPDCE and SPDCW will continue to work after that date to ensure delivery against these plans by 31st March 2029.
- 2.7 The DL is clear that there is no change to the clinical, workforce, and financial governance accountabilities of any Health Board.

3. Assessment

- 3.1 At time of writing, SPDCE has met twice, with workstreams established on the five key priorities described above. Leadership for these groups is shown at appendix 1, and Board members will note the geographic spread of leaders from across constituent Boards.
- 3.2 Activities undertaken include;
 - Medical Director, Nurse Director, Director of Public Health, Director of Finance, Chief Operating Officer, and Director of Planning input to each work
 - Input from CfSD, PHS, SAS, and NHS24 is being sought and deployed as appropriate
 - 3 Acute Chief Officers assigned to each of Emergency Healthcare and Orthopaedics, and a Nurse Director to each
 - The establishment of weekly Chief Executive, Director of Strategic Planning, and Director of Finance, calls for the East Coast to ensure effective coordination and deployment of skills and resources
 - The commencement of a joint strategic needs assessment process for the East, hand-in-glove with a clear focus on data alignment for Emergency Healthcare and Orthopaedics
 - An outline overarching programme plan has been drafted
 - PHS have commenced work on how best to support a Fairer Scotland Duty assessment process
 - A weekly huddle has been established to bring together the East and West interim leadership teams
 - Interim lead officer capacity is being provided by Colin Briggs (interim Lead Director of Strategic Planning), Jim Crombie (interim Lead Chief Operating Officer), and Craig Marriott (interim Lead Director of Finance).
 - The finance group has identified that the size of the financial challenge is in the order of £330m for 2026-27, and has commenced work on aligning approaches to this across the East Coast
 - Discussions have commenced on transitioning national planning priority arrangements from SGHSCD to SPDCE and SPDCW.
- 3.1 SPDCE has also commissioned work on Rural and Island healthcare.
- 3.2 SPDCE's meeting of 28th January agreed the commissions and terms of reference for orthopaedics, emergency healthcare, digital front door, and Rural and Islands work.

- 3.3 The pace of this work means that a comprehensive accounting of all activities and work is challenging to do but the Chief Executive will be able to provide more up-to-date insight.
- 3.4 Clearly communication across this wide geography and a very significant number of staff and stakeholders is crucial to the success of this project, and efforts such as this paper are a small but representative example of the awareness of the importance of such.
- 3.5 Healthcare Improvement Scotland are part of SPDCE and expertise on public engagement will be sought from their expertise.

3.6 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 – 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The intent of this work is to improve the quality of care for all patients across Scotland. It is too early to comment beyond that headline.
People	Workforce	Yes	The intent of this work is to improve the sustainability of services across Scotland, which will involve workforce considerations, but at this stage it is too early to comment beyond that headline.
Performance	Finance	Yes	As noted above, the current estimated combined deficit is in the region of £330m.
Potential	Risk Management	Yes	At this point the most obvious risk to this project is the very short timescale in which it must be delivered across a highly complex geography and governance. At close of the SPDCE meeting of 28th January there were 43 working days to 31st March. Detailed work has gone into clarifying with the Scottish Government their expectations of “what success looks like”.
	Digital	Yes	SPDCE provides opportunities to address some of our challenges in relation to digital transformation.
Place	Equality and Diversity including health inequalities	Yes	Public Health Scotland are supporting SPDCE on the development of assessment against the Fairer Scotland duty, and from that equality and diversity impact assessment work will flow.
	Climate Change Sustainability	No	None

4. Recommendations

Assurance - For members assurance only

5. List of Appendices

The following appendix is included with this report

Appendix 1, Leadership of workstreams

Agenda for change Reform - Reduced Working Week Implementation Plan

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> • Dave Harris, Director of People and Culture
Report Author(s)	<ul style="list-style-type: none"> • Steven Phillips, Head of People and Culture
Purpose of report	<ul style="list-style-type: none"> • Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Government policy/directive
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Quality • Person Centred
Key points for consideration	<ul style="list-style-type: none"> • Implementation of the Reduction in the Working Week (RWW) is underway across NHS Orkney, with services having plans to transition to the 36-hour week model. • Work continues to be taken forward in partnership with recognised Trade Unions, ensuring staff-side engagement in the process. • Efforts are now focused on ensuring colleagues are supported to retain part-time hours, and recruiting is progressing for backfill, where approved, to ensure service delivery remains.
Route to meeting	<ul style="list-style-type: none"> • Reduction in working week
Recommendation(s)	<ul style="list-style-type: none"> • Assurance - For members assurance only

Agenda for change Reform - Reduced Working Week Implementation Plan

1. Situation

- 1.1 NHS Orkney is progressing the implementation of the national Reduction in the Working Week (RWW) to a 36-hour standard, in line with Scottish Government policy. Work has been underway across the organisation, with local plans in place to support phased implementation. Partnership working with recognised Trade Unions continues to support delivery. Board is asked to take assurance that progress has been made in developing the plan, and that work is underway to support the retention of part-time working hours and to recruit for backfill, where approved.

2. Background

- 2.1 The Scottish Government confirmed the reduction in the standard working week for Agenda for Change (AfC) staff from 37.5 to 36 hours as part of the wider pay review and workforce reform programme. This phased approach began in April 2024 with an initial reduction to 37 hours and will conclude with full implementation by April 2026.
- 2.2 NHS Orkney established a Reduced Working Week (RWW) Oversight Group to ensure robust governance and partnership working throughout the process. The group reports to the Area Partnership Forum (APF) and Staff Governance Committee, with updates provided to the Senior Leadership Team and the Executive Team for assurance and the final approval of the plan.
- 2.3 Directorates submitted detailed assessments of the operational impact of the reduction, including service redesign proposals, retention of part-time hours, and backfill requirements. These assessments highlight significant variance across services, with frontline and 24/7 areas facing the greatest challenges in maintaining safe staffing levels. Financial modelling and workforce planning have been reviewed to ensure compliance with the Health and Care (Staffing) (Scotland) Act 2019.

3. Assessment

3.1 Analysis

Work to implement the national Reduction in the Working Week (RWW) is progressing within NHS Orkney in line with national policy requirements.

Services across the organisation have plans in place to support the transition to a 36-hour working week. Engagement with recognised Trade Unions continues to ensure that the implementation approach is developed in partnership.

3.2 Current Position

Services continue to work through their local arrangements to support the introduction of the reduced working week, and activity is focused on ensuring a consistent and equitable approach across the organisation. The plan received approval from the Executive Directors on Monday 26 January 2026, which has allowed managers to progress their local plans. A meeting also took place with partnership colleagues on Wednesday 4 February 2026 to discuss the plans teams within the organisation have created. The next step in this process is the identification of those part-time workers who will retain their hours to allow system work to be undertaken with payroll teams, and for managers to lead recruitment where approved.

3.3 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 – 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Service Delivery – Risks include reduced patient contact time, delays in treatment, and increased waiting lists.
People	Workforce	Yes	Recruitment backfill remains a critical issue, particularly for one-hour reductions in frontline and 24/7 services. Staff Wellbeing, while supporting work-life balance, risks of stress and workload pressures remain if recruitment and redesign measures are delayed.
Performance	Finance	Yes	Estimated additional cost of £0.680m for part-time retention and backfill; full implementation of AfC change costs projected between £1.7m and £2.0m.
Potential	Risk Management	Yes	Service Delivery – Risks include reduced patient contact time, delays in treatment, and increased waiting lists.
	Digital	No	NA
Place	Equality and Diversity including health inequalities	No	NA
	Climate Change Sustainability	No	NA

4. Recommendations

- 4.1 Note the progress being made in implementing the national Reduction in the Working Week (RWW) across NHS Orkney.

Take assurance that services have plans in place and that they are taking the agreed actions to support delivery of care across the board.

- 4.2 Assurance - For members assurance only

5. List of Appendices

- 5.1 The following appendices are included with this report:
- **Appendix 1, NHS Orkney Approved RWW Plan 2026**

Reduced working Week – Final Plan – NHS Orkney – December 2025

Situation

In line with Scottish Government circular (PCS(AFC)2025/1, Cabinet Secretary's letter dated 18 February 2025), NHS Orkney will reduce the standard full-time working week for Agenda for Change (AfC) staff to 36 hours per week by 1 April 2026. This change supports national ambitions for fair work, staff wellbeing and sustainable service delivery, and is being delivered in partnership with local and national stakeholders.

Background

The Scottish Government published circular PCS(AFC)2024/2 in March 2024 confirming there would be a reduction in the standard working week from 37.5 hours to 36 hours for all AfC staff beginning on 1 April 2024. The process began with an initial reduction to 37 hours from 1 April 2024, with subsequent reductions in the future

The reduction in working hours is part of the wider AfC pay review and workforce reform. NHS Orkney has established a dedicated RWW Oversight Group, reporting to the Area Partnership Forum (APF) and Staff Governance Committee, to ensure robust governance and partnership working throughout the process. The plan is shaped by national circulars and local priorities, with regular updates provided to the Executive Team for assurance.

Assessment

In anticipation for the development of our final plan, managers were asked (through their Executive Directors) to assess what the one hour reduction would look like for them. This pertains to the Staff Governance standard in that staff are directly engaged and involved in decisions relating to them, on how the Reduced Working Week is delivered. Directorates and their departments were asked to complete a proforma with their agreed actions, and proposed service changes and redesigns to accommodate the reduction, while also outlining any implications and backfill requirements.

Strategic Context & Rationale

This initiative aims to –

- Enhance staff wellbeing and work-life balance
- Maintain safe and effective service delivery, in line with the Health and Care (Staffing) (Scotland) Act 2019
- Align NHS Orkney's workforce planning with national reform objectives

Item 12.1.1

Directorate Variance Table

This table summarised departmental returns for RWW, grouped by directorate. It includes the total WTE reduction, part-time hours retained by WTE and recruitment backfill required by WTE.

Directorate	Total WTE Reduction	Part-time hours to be retained (WTE)	Backfill hours to be Recruited (WTE)
Chief Executive	0.09	0.00	0.00
Executive Director of NMAHP and Chief Officer Acute	4.62	2.92	3.73
Medical Director	1.21	0.75	0.00
Director of People and Culture	0.49	0.00	0.00
Performance and Transformation and Deputy CEO	0.74	0.16	0.00
Director of Finance	3.55	1.47	1.82
Chief Officer/Director of Primary Care	4.09	0.99	0.14
Director of Public Health	0.40	0.01	0.00
Totals	15.19	6.30	5.69

The key insights from this data is that the largest WTE reductions are concentrated in frontline and clinical directorates (EDoNMAHP/Chief Officer Acute, Chief Officer/Director of Primary Care and Finance) reflecting both the scale of their workforce and operational complexity of implementing RWW in 24/7 services.

Requests to retain part-time hours are most significant in clinical and support areas, indicating a strong need for flexibility to maintain service continuity.

Backfill requirements are highest in directorates with frontline patient services, such as Acute Care and Pharmacy, where reductions cannot be safely absorbed without additional recruitment.

NHS Orkney is delivering a planned reduction of approximately 15WTE across all directorates.

A full departmental summary of actions to implement RWW, the proposed WTE to be retained part-time workers and recruitment backfill required is detailed in Appendix 2.

Supporting financial analysis from the Finance team has been included as Appendix 1.

Item 12.1.1

Implementation Approach

The RWW Oversight Group leads the process, with membership spanning Finance, People & Culture, Nursing, Primary Care, Communications, Corporate Governance, Performance and Trade Union representatives. Local service plans are being developed in partnership, with guidance and FAQs regularly updated for staff. The plan covers all AfC staff, representing a 4% reduction in working hours (approximately 28WTE across NHS Orkney if all hours/posts require backfill) for the entire reduction from 37.5 to 36 since 2024.

Key Milestones and Timeline

Issues	Who?	Date
Data to be pulled together and clarified as accurate	Bruce Young and Directors for Checking	31 October 2025
Decisions to be taken on part time staff hours and accumulation	RWW Recommendation to APF	31 October 2025
Each Director to consider their own areas for Action Plan	Directors / Senior Managers	30 November 2025
Proposals for each area to be reviewed by RWW Group	RWW	31 December 2025
Executive Director sign off on RWW plan	Executive team	26 January 2026
Approval at APF	RWW to APF	4 February 2026
Assurance to Staff Governance	APF to Staff Governance	12 February 2026
Plan discussed at Senior Leadership Team	SLT	13 February 2026
Final Action Plan for each area	Directors / Senior Managers	February 2026
Introduction of RWW	Health Board	1 April 2026

Item 12.1.1

Key Themes

Service Continuity and Safety

- 24/7 and frontline services (e.g. Macmillan Inpatient, Emergency Department, Porters, Domestic, Pharmacy and Laboratory) report that RWW is constrained by the need to maintain safe staffing and uninterrupted services

Flexible Working and Shift Adjustments

- Many departments are adopting flexible working arrangements by adjusting start and finish times, staggering shifts or spreading reductions across the week; supporting staff wellbeing and maintain service standards

Retention of Part-Time Hours

- Numerous departments have requested to retain their part-time staff existing hours, citing personal circumstances and operational needs

Backfill and Recruitment Needs

- Some departments anticipate the need for backfill to maintain service levels, especially where WTE reductions cannot be absorbed.
- Quantifying total backfill required will be essential for workforce and financial planning

Impact on Patient Care and Waiting Times

- Several clinical areas (e.g. Outpatients, Physiotherapy, Dietetics, Speech and Language Therapy and Dental) report that RWW will reduce patient contact time, increase waiting lists, or require changes to clinic schedules
- Risk and mitigation plans should be clearly flagged
- Medical staff maintain a 40 hour working week, agenda for change staff will be on a 36 hour working week, leading to service delivery gaps

Governance, Assurance and Data Quality

- Returns show a structured approach to sign-off and escalation, but also highlight data inconsistencies and queries (e.g. figures not adding up and narrative mismatches)
- Ongoing data validation with executive directors and managers are essential
- Work continues to progress with the Clinical Lead for Workforce to evidence requirements in line with the Healthcare (Staffing) (Scotland) Act 2019

Minimal Impact Areas

- Some directorates (e.g. People and Culture, Performance and Transformation, Finance and Facilities Management) report that RWW will be absorbed and have identified there will be capacity implications, however the

Item 12.1.1

hours reducing will be managed through flexible hours and no need for backfill or retention

- These are positive examples of adaptability and efficiency

Risks and Issues

- Key risks include: inability and difficulty to implement RWW in some service areas, workload concerns, effect on clinic availability and waiting times, stress, particularly in low-staffed areas
- A RAG summary of risks, with named owners and next steps is recommended

References to National Policy and Guidance

- PCS(AFC)2025/1 Scottish Government Circular
- Cabinet Secretary's letter (18 February 2025)
- Health and Care (Staffing) (Scotland) Act 2019

Conclusion

NHS Orkney is committed to delivering the Reduced Working Week in a way that safeguards patient care, supports staff wellbeing, and aligns with national reform objectives. Partnership working and robust governance will underpin a smooth transition, with ongoing engagement and monitoring to ensure success.

Appendices

- Appendix 1 – Financial Analysis from Finance Team
- Appendix 2 – Directorate plans
- Appendix 3 – NHS Orkney RWW approved implementation plan

Item 12.1.1

Appendix 1

The first table shows the total WTE that managers have said they require, for both part time retained hours and backfill of staff, and the estimated costs. The costs have been estimated using the average cost of each grade by costs centre (where the manager has included a valid cost centre on their return) or the average cost for NHS Orkney (where they haven't). The total requested WTE (11.83wte) is a 2% increase in our AfC establishment (currently 668.23wte) but is less than the 18.56wte that would be required if we replaced every lost hour. The increase in required funding of £0.680m is an increase of 1.6% to our AfC pay budgets of £43.848m

Directorate	Part Time Retention		Backfill	
	WTE	£'000s	WTE	£'000s
Chief Executive	-	-	-	-
Chief Officer/Director of Primary Care	0.99	68.7	0.14	6.5
Director of Finance	1.47	66.5	1.66	76.1
Director of NMAHP and Chief Officer Acute	2.92	172.8	3.73	233.3
Director of People and Culture	-	-	-	-
Director of Performance and Transformation and Deputy CEO	0.16	7.0	-	-
Director of Public Health	0.01	0.5	-	-
Medical Director	0.75	48.1	-	-
	6.30	363.5	5.53	316.0

Item 12.1.1

The second table has the same data as the first but is analysed by the AFC band instead of Directorate

Band	Part Time Retention		Backfill	
	WTE	£'000s	WTE	£'000s
Band 2	0.89	38.3	0.76	32.9
Band 3	1.44	68.3	0.84	40.0
Band 4	0.88	41.2	0.17	7.9
Band 5	1.34	80.3	2.99	179.7
Band 6	1.05	75.6	0.77	55.4
Band 7	0.52	41.1	-	-
Band 8A	0.07	6.6	-	-
Band 8B	0.06	6.3	-	-
Band 8C	0.05	5.8	-	-
Band 8D	-	-	-	-
Band 9	-	-	-	-
	6.30	363.5	5.53	316.0

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PART TIME RETENTION

	WTE										
Directorate	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8 B	Band 8C	Band 8D	Total
Chief Executive	-	-	-	-	-	-	-	-	-	-	-
Chief Officer/Director of Primary Care	-	0.13	0.14	0.16	0.22	0.22	0.03	0.04	0.05	-	0.99
Director of Finance	0.73	0.28	0.46	-	-	-	-	-	-	-	1.47
Director of NMAHP and Chief Officer Acute	0.06	0.98	0.01	1.11	0.52	0.22	-	0.02	-	-	2.92
Director of People and Culture	-	-	-	-	-	-	-	-	-	-	-
Director of Performance and Transformation and Deputy CEO	0.10	0.01	0.03	0.02	-	-	-	-	-	-	0.16
Director of Public Health		0.01	-	-	-	-	-	-	-	-	0.01
Medical Director	-	0.03	0.24	0.05	0.31	0.08	0.04	-	-	-	0.75
	0.89	1.44	0.88	1.34	1.05	0.52	0.07	0.06	0.05	-	6.30

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Directorate	£ 000s										Total	
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8 B	Band 8C	Band 8D		
Chief Executive	-	-	-	-	-	-	-	-	-	-	-	-
Chief Officer/Director of Primary Care	-	6.2	6.5	9.7	15.8	17.7	2.8	4.2	5.8	-	-	68.7
Director of Finance	31.6	13.3	21.5	-	-	-	-	-	-	-	-	66.5
Director of NMAHP and Chief Officer Acute	2.6	46.5	0.5	66.6	37.5	17.1	-	2.1	-	-	-	172.8
Director of People and Culture	-	-	-	-	-	-	-	-	-	-	-	-
Director of Performance and Transformation and Deputy CEO	4.0	0.5	1.5	1.0	-	-	-	-	-	-	-	7.0
Director of Public Health	-	0.5	-	-	-	-	-	-	-	-	-	0.5
Medical Director	-	1.4	11.2	3.0	22.3	6.4	3.7	-	-	-	-	48.1
	38.3	68.3	41.2	80.3	75.6	41.1	6.6	6.3	5.8	-	-	363.5

The above data is cross section of the WTE and £ of part time staff retaining their hours by both directorate and grade of staff

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BACKFILL

Directorate	WTE										Total
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8 B	Band 8C	Band 8D	
Chief Executive	-	-	-	-	-	-	-	-	-	-	-
Chief Officer/Director of Primary Care	-	-	0.14	-	-	-	-	-	-	-	0.14
Director of Finance	0.76	0.84	0.03	0.03	-	-	-	-	-	-	1.66
Director of NMAHP and Chief Officer Acute	-	-	-	2.96	0.77	-	-	-	-	-	3.73
Director of People and Culture	-	-	-	-	-	-	-	-	-	-	-
Director of Performance and Transformation and Deputy CEO	-	-	-	-	-	-	-	-	-	-	-
Director of Public Health	-	-	-	-	-	-	-	-	-	-	-
Medical Director	-	-	-	-	-	-	-	-	-	-	-
	0.76	0.84	0.17	2.99	0.77	-	-	-	-	-	5.53

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Directorate	£ 000s										
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8 B	Band 8C	Band 8D	Total
Chief Executive	-	-	-	-	-	-	-	-	-	-	-
Chief Officer/Director of Primary Care	-	-	6.5	-	-	-	-	-	-	-	6.5
Director of Finance	32.9	40.0	1.4	1.8	-	-	-	-	-	-	76.1
Director of NMAHP and Chief Officer Acute	-	-	-	177.9	55.4	-	-	-	-	-	233.3
Director of People and Culture	-	-	-	-	-	-	-	-	-	-	-
Director of Performance and Transformation and Deputy CEO	-	-	-	-	-	-	-	-	-	-	-
Director of Public Health	-	-	-	-	-	-	-	-	-	-	-
Medical Director	-	-	-	-	-	-	-	-	-	-	-
	32.9	40.0	7.9	179.7	55.4	-	-	-	-	-	316.0

The above data is cross section of the WTE and £ of backfill required (excluding PT staff retaining their hours) by both directorate and grade of staff

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Appendix 2

Directorate – Chief Executive

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (WTE)	Backfill hours required (WTE) – to be recruited by band
Corporate Governance	Flexible working arrangements with working hours managed across the week	0.07		
Information Governance	The team have agreed to adjust start/finish time to accommodate the reduction in the working week.	0.2		

Directorate – Executive Director of Nursing, Midwifery, AHPs and Chief Officer Acute

Department name	Agreed actions for RW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (WTE)	Backfill hours – to be recruited by band	RAG status based on RWW
MacMillan Outpatients	Reducing service available to patients. Changing chemotherapy administration times. Potential for patients to be unable to receive chemo on island, increase in patient travel costs.	0.20	Band 3: 0.02 Band 7: 0.02	Band 5: 0.18	
Macmillan Inpatient	Challenge to alter current work pattern. The ward would be left without and staff on the floor to cover handover times. Potential, that there may not be a member of staff to give handover to staff coming on shift. Poor patient journey and experience, essential service provision - 24/7.	0.30	Band 3: 0.09 Band 5: 0.12	Band 5: 0.28	
NMAHP Practice Education	The current four full-time staff members (CEF/ Clinical skills, Nursing admin x 2) will reduce their combined hours to 36.0. Requirement to ensure we:	0.03			

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	<p>Meet training requirements set by NES and the Scottish Government. Fulfil our Service Level Agreements (SLA) with higher education institutions.</p> <p>Promote and support newly graduated nurses.</p> <p>Provide essential support for international nurses.</p> <p>Promote Allied Health Professional (AHP) careers.</p> <p>The necessary reduction in hours for NHS Scotland while maintaining compliance with key educational and workforce commitments.</p>				
Maternity	<p>We have currently modified the way in which our postnatal clinics are run. We are trialling the use of a postnatal team who have one shift per week floating" to do postnatal visits as and when required. This theory allows for the clinic midwife to be free to see triage patients before or after their antenatal clinic, and should allow a degree of flexibility for shift times to vary in line with RWW. ie one day per week, the "full timers" can either leave 1.5 hours early, or start 1.5 hours later (this hours will be between 1400 & 1530, so should not affect enhancements)</p>	0.46	<p>Band 3: 0.15</p> <p>Band 4: 0.01</p> <p>Band 6: 0.2</p> <p>Band 7: 0.02</p>	Band 6: 0.45	
Outpatient Department B	<p>4 members of staff will need to finish 1 hour earlier a week this could be staggered over a 4 day period. OR Modifying the shifts could be considered. Shorten 2 shifts per week by 30 minutes - 2 days 9 hour shifts and 2 days 9.5 hour shifts for staff. Some staff starting shift at 08.30am to ensure cover until 6pm. Clinics would still be covered either way. Efficiency of staffing clinics also must be considered not all clinics require OPDB assistance.</p>	0.11	<p>Band 3: 0.03</p> <p>Band 5: 0.01</p>		
Infection Prevention	<p>2 P/T staff within the team both keeping their set hours.</p> <p>3 F/T staff members plan to do a flexible working arrangement, which would be 1 Friday or Monday a month</p>	0.1	<p>Band 7: 0.08</p> <p>Band 8b: 0.02</p>		
Inpatient 1	<p>It would be extremely challenging to change work pattern due to the ward environment and handover times, which would impact negatively on patient-contact time and drug administration times. Part-time staff would all like to retain their current hours. Minor adjustments to some start and finish times will be required but this will have minimal impact on the ward.</p> <p>The full time members of staff will reduce their shifts to 3 x 12 hours shifts</p>	0.9	<p>Band 3: 0.35</p> <p>Band 5: 0.22</p> <p>Band 6: 0.03</p>	Band 5: 1.0	

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	The other members of staff would prefer for their hours of work to remain the same shifts lengths as it would cause disruption to the ward handovers as otherwise we would be over 30 hours short per week which would require an additional members of staff to be recruited.		Band 7: 0.02		
HDU	It would be extremely challenging to change work pattern due to the ward environment and handover times, which would impact negatively on patient-contact time and drug administration times. Part-time staff would all like to retain their current hours. Minor adjustments to some start and finish times will be required but this will have minimal impact on the ward.	0.14	Band 5: 0.08 Band 6: 0.02 Band 7: 0.02		
General Management (CNM Flow)	CNM Acute post no backfill required will reduce to 36hrs Flow co-ordinator will reduce to 36hrs - minor impact on service delivery. No backfill or recruitment required.	0.02			
Inpatients 2	All of the part time staff in IP2 want to keep their hours as they are, the same as they did when the hours were reduced originally. If the hours had to be reduced it would be very complicated due to the time of handovers. Shift patterns would need to be changed which many staff would not agree to. Many staff rely on their current shift patten to cover childcare needs etc and we could face losing staff in the shift patterns had to change.	0.65	Band 3: 0.2 Band 5: 0.1		
Day Unit	Can absorb reduction for full time staff. Part time staff all want to keep their hours. If this happens then we will require no adjustments.	0.20	Band 3: 0.03 Band 5: 0.08 Band 6: 0.03		
Renal	Shift will run from 0730-2000 for all staff. Previously to 20.30 for full time members of staff. This can be accommodated. However, handover and safety brief must take place at 0800 for this to happen which can mean staff can't get to huddle in person some days if there is a lot to cover in unit handover/brief.	0.14	Band 6: 0.07 Band 7: 0.02		
Director of Nursing	8B PPN will reduce to 36hrs - no service impact. 8B Lead Midwife (0.85 WTE), 8A posts will both become 36 hours.	0.22			

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Emergency Department	<p>Only 4 team members affected by reduction from 37.5 - 36hours. The remainder of the team have requested to retain their hours. Consideration being made to adjust shift pattern by having a Staggered shift pattern with an RGN on a 09:30 - 22:00 to cover the regular busy period over crew change from day shift to night shift.</p> <p>Regarding organisational change. - Due to shift pattern - staff in ED work top up shift to ensure hours worked, changed may be required due to this hours</p>	0.27	Band 2: 0.06 Band 3: 0.11 Band 5: 0.32 Band 6: 0.13 Band 7: 0.04	Band 6: 0.32	
Theatres	Adjustments to be made only to the full time staff finishing times and shift patterns.	0.54	Band 5: 0.18 Band 6: 0.04	Band 5: 0.5	
Laboratory	<p>The Lab will maintain its current opening hours Mon-Fri 09:00-17:30, Weekends/ Public holidays 08:45-12:30. The on-call service for blood sciences will also remain as Mon-Fri 17:30-09:00 and 12:30-08:45 on weekends/ public holidays.</p> <p>The following decisions have been made by staff on how they will take this time</p> <p style="text-align: center;">Full time staff</p> <p>-Eight staff, including the lab manager, will accrue 1hr 30mins over 5 weeks and take 1 day off. This will be submitted to the lab manager as a day off request for monitoring any conflict. Caveats will have to be made that if there is service pressure the day off may need to be moved to accommodate this.</p> <p>As a frontline service unsocial hours are due to on-call and weekend working and to maintain a 24/7 service these will continue.</p>	0.34		Band 5: 1.0	

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Directorate – Medical Director

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (WTE)	Backfill hours required (WTE) – to be recruited by band
Pharmacy Department	As a core and essential clinical service, including 24/7 business continuity, with an on-call service being introduced to cover the out of hours periods, we would be unable to reduce or adjust departmental opening hours without impacting patient care. The department has a large proportion of part time staff who have all expressed a preference to maintain their existing hours and increase their WTE. I would be strongly supportive of this from a service sustainability point of view. Full time staff have indicated a preference to accrue hours associated with the reduced working week (RWW) and take a scheduled rota day off every 5 weeks. Maintaining services following full implementation of the RWW would require an additional 15.73 hours (0.52WTE) per week of various AFC bands and professional roles. We would be unable to recruit like for like; associated funding would be utilised as part of current workforce and skill mix review.	0.45	Band 3: 0.03 Band 4: 0.04 Band 5: 0.05 Band 6: 0.02 Band 7: 0.03 Band 8a: 0.04	
Radiology	Time is to be taken back by those retaining the time, this will be taken flexibly. Part time staff, with a small reduction in time will, retain their hours and be paid.	0.5	Band 6: 0.03 Band 7: 0.05	
Clinical Physiology	Staff will take time back	0.04		
Audiology	Staff will take time back	0.08		
Safety, Quality and Risk	The department will reduce its working week hours from 09:00 - 17:00 to 09:00 - 16:45 (Mon - Thursday) and 09:00 - 16:30 Friday.	0.11	Band 4: 0.2 Band 6: 0.26	
Medical Education	One team member will reduce from 37 hours to 36 hours with no impact or other changes.	0.03		

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Directorate – Director of People and Culture

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (summary)	Backfill hours required (WTE) – to be recruited by band
People and Culture Directorate	Having reviewed each department within the People and Culture Team I have concluded that there will be no backfill required and no retention of part-time hours. We will manage this largely by reducing people's hours on one day or spread out across multiple days. Consideration has been given to the impact of the reduction in hours across the directorate but I am content that there is no risk to service provision (beyond the existing risk we have across People and Culture team of limited capacity).	0.49		

Directorate – Director of Public Health

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (summary)	Backfill hours required (WTE) – to be recruited by band
Public Health	All staff are discussing start and finish times with managers. The final proposal will be made to senior departmental staff for approval prior to implementation. This is to ensure least disruption to services as possible. However, it should be noted that a reduction in hours of work will necessitate prioritised reduction of activities which will impact on the preventative action of the department. Having already dropped a WTE consultant and having time taken from the department for organisational activities such as trade union activities, this reduction, whilst accommodate, will impact on delivery in the department.	0.4	Band 2: 0.01	

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Directorate – Director of Performance and Transformation and Deputy CEO

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (summary)	Backfill hours required (WTE) – to be recruited by band
Clinical Admin	<p>Turnaround Times: Tasks may take longer during busy periods or when team members are on leave (sickness or annual leave).</p> <p>Hours of Operation: No significant changes to the standard hours the teams operate.</p> <p>Out-of-Hours Resilience as per BCP.</p> <p>Cover Arrangements: Discussed at team level and accommodate individual preferences.</p> <p>Flexi Time: Can be used by exception for urgent or unplanned events.</p> <p>Service Improvements: Review of meeting attendance, streamlining processes with introduction of Waiting Times to Clinical Admin</p>	0.56	Band 2: 0.10 Band 3: 0.01 Band 4: 0.02 Band 5: 0.02	
Health Intelligence and Planning and Performance	<p>Turnaround Times: Tasks may take longer during busy periods or when team members are on leave (sickness or annual leave).</p> <p>Hours of Operation: No significant changes to the standard hours the teams operate.</p> <p>Out-of-Hours Resilience as per BCP.</p> <p>Cover Arrangements: Discussed at team level and accommodate individual preferences.</p> <p>Flexi Time: Can be used by exception for urgent or unplanned events.</p> <p>Service Improvements: Review of meeting attendance, streamlining processes including leadership for Waiting Times to Clinical Admin.</p>	0.15	Band 4: 0.01	
Improvement Team	<p>Turnaround Times: Tasks may take longer during busy periods or when team members are on leave (sickness or annual leave).</p> <p>Hours of Operation: No significant changes to the standard hours the teams operate.</p> <p>Out-of-Hours Resilience as per BCP.</p> <p>Cover Arrangements: Discussed at team level and accommodate</p>	0.03		

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	individual preferences. Flexi Time: Can be used by exception for urgent or unplanned events.			
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Directorate – Director of Finance

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (summary)	Backfill hours required (WTE) – to be recruited by band
Finance	Flexible working arrangements across the team with 36 hours being worked across the week	0.31	Band 3: 0.04 Band 4: 0.05	
Estates & CDU	Reduced hours on a Friday afternoon but estates cover remain as per required levels	0.38		
Central Reception	Switchboard is 24/7 therefore hours to be retained	0.82	Band 3: 0.16	
Porters	Porters are a 24/7 service therefore hours need to be retained	0.24	Band 3: 0.05	Band 3: 0.2
Domestics	Domestics are 24/7 therefore hours to be retained	0.85	Band 2: 0.54	Band 2: 0.76 Band 3: 0.64 Band 4: 0.03 Band 5: 0.03
Laundry	Due to compliance hours need to be maintained	0.05	Band 2: 0.05	
Catering	Due to set times for patient meals, hours need to be retained	0.32	Band 2: 0.14	
Facilities Management	Flexible working across the week to manage hours	0.08		
Information Technology	Each team member has a work from home day per week - this is the day that will see the reduction in time as we found it to be the most effective use of it for the individual and the least impacting on the department.	0.28	Band 4: 0.41	

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Travel Admin	Flexible working across the week to manage hours.	0.15	Band 3: 0.03	
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Directorate – Chief Officer / Director of Primary Care

Department name	Agreed actions for RWW implementation (summary)	Total WTE reduction in department	Part-time hours to be retained – by band (summary)	Backfill hours required (WTE) – to be recruited by band
Physiotherapy	Our team plan to implement these changes in a way that should minimise disruption to service delivery - spread across the working week, however there will still be the unavoidable impact on patient care and a reduction in the number of patients receiving treatment in the working week.	0.31	Band 6: 0.02 Band 7: 0.03	
Podiatry	Reduced working week pattern has been organised to ensure not everyone is off at once. There is impact to patient care including potential clinic cancellation as well as increased stress for staff	0.07		
Dietetics	Shorter working days for all staff with rotation of finishing time early on a Friday afternoon. Potential to change core hours to finish at 3pm on Fridays. Support is needed as already low staffing numbers so will have big impact. This will also mean decrease in patients being seen (1 clinic session a week). Risk of not managing unscheduled care with earlier finishes i.e. tube fed patients' needs to be seen.	0.10		Band 4: 0.14
Intermediate community therapy	Intermediate community therapies operating hours are 0800 - 2000 7 days per week; In recent recruitment we have recruited to 36 hour contracts so have 3 WTE already working that pattern; We will have one WTE to drop one hour and then a further staff member on a 30 hour contract - we are requesting this is retained as otherwise it will be challenging from a rota point of view	0.02	Band 4: 0.02	
Chief Officer	There are three individuals: 1 on a flexible retirement currently doing 33.3 hours (normal role would be 37 hours) and 2 on 37 hours. The RWW will be 0.9 hours (or 1 hour on normal role) and 2 x 1 hours bring the department from a total of 107.30 hours (111 hours on normal role)	0.08		

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	to 104.40 hours (108 hours on a normal role) bringing a reduction of 2.9 hours (3 hours on a normal role). There is sufficient cover amongst the totality of the senior management team and directorate support to support this reduction and have clear escalation.			
Health and Community Care	Agreed that the B8a would reduce hours to 36, however the Band 7 and 8C would retain their hours of 10 and 33.5 hours respectively. Teams are aware of escalation methods and support is available from Council-employed staff.	0.03	Band 7: 0.01 Band 8c: 0.02	
School Nursing	All staff within the team will be reducing their hours but this will be managed by flexible working, change in start or finish times in line with service need.	0.13		
Children's Services (Administration)	For the WTE she will adjust her finish time to reduce hours. One colleague works 15 hours and wishes to retain those hours rather than reduce as it already is a small number of hours in the week	0.04	Band 3: 0.01	
Mental Health Services	There will no change to the operational hours of the majority of services of Monday to Friday, 9am to 5pm. Once the All Age Nurse Led Psychiatric Liaison Team is in place, it will see the hours amend to cover slightly before 9am and after 5pm. Work is progressing with HR/staffside on shifts/hours. There will also be implications to the out of hours cover	0.65		
Speech and Language Therapy	This is both adults and children's speech and language as one service. Both therapists wish to retain their previous hours. All others will reduce in line with RWW. If there is an option to backfill the reduction in hours, this would be a priority consideration as SLT particularly for children have extensive waiting lists that will be impacted by the reduction. A band 4 post with reduction in hours plus a small number of current vacant hours would help support the team to continue the service.	0.2	Band 6: 0.025	
Primary Care Administration	Reduction within team to be split across working week.	0.12		
Administration - Senior Administration Officer	Staggered approach to provide administration support to mitigate gaps to teams.	0.15		

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Primary Care -	Band 7's - ANP's reduced, reduction taken from flexi days they owe NHSO as part of their contract. Band 6's , 1 x CN able to reduce, other band 6's and band 5's unable to reduce as on call 24/7. Band 3 admin already at minimum hours required so unable to reduce.	0.24	Band 3 0.05 Band 5 0.06 Band 6 0.06	
Community Nursing - West	RWW implemented although flexibility required amongst team members selecting early finish days due to workforce gaps. Long term implementation, post recruitment, will not be problematic.	0.081	Band 5: 0.06 Band 6 0.02	
Community Nursing - East	Staggered late starts and early finished now in place within the 5 full time members of staff. Flexibility form team members to accommodate case load needs.	0.135	Band 5: 0.04 Band 6: 0.04	
Long Term Conditions	LTC, with the exception of diabetes, are single handed services. Where the single practitioner is full time, the RWW is now implemented. Part time practitioners are retaining hours	Diabetes 0.027 Dementia 0.027 Parkinsons Nil MS/MND Nil	Diabetes Band 7 0.022 Dementia Nil Parkinsons 0.014 MS/MND 0.02	
Health Visiting	From discussion with the team, 7 staff will have a reduction in the working week to 36 hours and as such we have discussed adjusting start/ finish time or working flexibly to reduce their hours as long as this doesn't leave the service uncovered. There is a string feeling that the majority of the team will still end up working the hours that they were previously as the caseload hasn't reduced and therefore there is still an expectation that all mandatory visits are completed. In Orkney we have a good uptake and have maintained all visits in the home face to face which the team do not want to have to reduce that standard of care to accommodate the RWW. There is a request that consideration is given to backfill the hours with a band 3 post to build in skill mix and continue the high standard set. Colleagues who are on part time hours wish to retain their original part time hours	0.35	Band 7: 0.06	
Peedie Sea Centre	service will readjust times to see patients, part time staff to retain hours. This will impact slightly waiting times.	0.35	Band 4: 0.04	

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(Paediatric Occupational Therapy and Paediatric Physiotherapy)				
Dental	Consultation with nurses to ensure not everyone is off at the same time. consider splitting time off over days. The reduction in hours will impact the clinics dentists can see patients and will be used for admin.	0.35	Band 3: 0.04 Band 4: 0.08 Band 6: 0.02	
Occupational Therapy	discussion with staff to ensure not all staff are off at the same time, there is maintained service resilience and consideration to some light redesign.	0.14	Band 3: 0.03 Band 6: 0.05 Band 7: 0.01	
Vaccination	clinic times will be adjusted to accommodate rww; this will impact winter/spring programmes with limit staff and timescales to ensure vaccinations. This may result in working weekend clinics and excess hours during the week.	0.22		
Children, Families and Justice Service	Escalation process are in place for the sole worker.	0.03		
Primary Care Services	The relevant agenda for change staff will ensure the time taken off is not on the same day and all are aware of the escalation processes	0.11		
Psychological Therapies	The team have request to remain on their current hours to reduce the impact to patient care as all are part time workers and would have to reduce.	0.13	Band 7: 0.04 Band 8a: 0.03 Band 8b: 0.04 Band 8c: 0.03	

Appendix 3

NHS Orkney – Reduced Working Week Implementation Plan

This implementation plan outlines NHS Orkney's approach to reducing the full-time (and pro rata) working week for Agenda for Change (AfC) staff from 37.5 to 36 hours by 1 April 2026. It is based on national guidance including PCS(AFC)2025/1, the Cabinet Secretary's letter dated 18 February 2025, and local governance structures.

1. Governance and Oversight Executive Sponsors and Leads:

Melanie Barnes, Interim Director of Finance
Linda McGovern, Interim Director of People & Culture
Steven Phillips, Head of People & Culture

There is a RWW Oversight Group been established which is a sub-group of the APF. A term of reference has been agreed for this work.

Membership of the Group is as follows:

Linda McGovern	–	Interim Director of People and Culture
Melanie Barnes	–	Interim Director of Finance
Ryan McLaughlin	–	Employee Director
Sam Thomas Acute		Director of Nursing, Midwifery, AHP's and Chief Officer
Debs Crohn	-	Interim Head of Corporate Governance
Steven Phillips	-	Head of People & Culture
Tammy Sharp		Director of Performance, Transformation & Deputy CEO
Michelle Mackie AHP's	-	Lead Midwife Deputy Director of Nursing, Midwifery &
Bruce Young	-	Management Accountant
Fiona MacKellar	-	CSP
John Daniels	-	Head of Primary Care
Karen Spence		UNISON
Lewis Berston		Workforce Systems Manager
Lynn Adam	-	Clinical Lead for Workforce
Margaret Macrae	-	RCN
Shona Lawrence	-	Corporate Communications Officer

Final agreement of this implementation plan will be discussed via the RWW Oversight Group then onwards to Area Partnership Forum and Staff Governance.

To note, regular updates will be given to the Executive Team on the action plans and implementation timings for assurance.

2. Key Milestones

Phase 2 of the Reduced Working Week (RWW), part of the 2023/24 Agenda for Change Pay Review, will progress through NHS Orkney's internal governance processes. This ensures partnership working is in place. Key steps included:

- A paper and draft implementation plan will be presented to the Area Partnership Forum (APF) on for noting and approval.
- The same paper and plan will be presented to the next available Staff Governance Committee. In line with national guidance, the final implementation plan will be submitted to the Scottish Government by 7 October 2025.

3. Scope and Staff Coverage

The RWW applies to all staff employed under Agenda for Change terms and conditions. The total 1.5 hours in the full-time working week represents a 4% decrease in working hours, which equates to approximately 28 WTE across NHS Orkney (assuming that all hours / posts require to be backfilled).

4. Operational Planning

The RWW Oversight Group is leading the implementation, reporting to both the APF and Staff Governance Committee. Local service plans are aligned with national strategy, and staff will be regularly updated through revised guidance and FAQs. Further details will be added to the implementation plan as work progresses.

5. Accumulation of Hours / Payment to Part Time Staff

An interim 4-week accrual model is currently in place for non-rostered staff and for rostered staff this is in line with their ongoing roster period within NHS Orkney for Phase 1 of the reduction in working week (30 mins reduction) in line with Scottish Government guidance. The proposal is to agree this moving forward and the issues arising from this. However the latest guidance leaves this decision to each Health Board in Scotland so this needs to be agreed in partnership moving forward.

In terms of part time staff, currently some staff are being paid for their pro rate reduction in working hours for the 30 minutes. However, moving forward an agreement needs to be reached on whether this will continue for the pro rate reduction of 1.5 hours. There is a potential risk to staff who will reduce hours to below benefits thresholds with subsequent financial disadvantage.

Following the updated Circular PCS(AFC) 2024-25, released in September 2025, it confirms that time can be accumulated and taken from the roster/shift pattern, if

mutually agreed and pre-planned: Note: The 30-minute reduction cannot be accumulated to be taken as extra annual leave. However, where applicable, time can be taken back. The time can be accumulated and taken from the roster/shift pattern where it is mutually agreed and on a pre-planned basis.

It is not within the spirit of the agreement to reduce time in amounts that are so small that the member of staff does not benefit from an improved work-life balance; or to extend unpaid breaks.” This will allow services to plan for Phase 2 and gives an opportunity to discuss accumulation hours over the roster period and will mitigate impact on service delivery, patient safety, and staff wellbeing, especially in 24/7 services where patients often require 1:1 care.

6. Pay Protection

Mark-time pay protection will apply where reduced hours result in lower earnings due to fewer unsocial hours. This will be based on an agreed reference period or actual shifts worked (for staff on set rosters). However, pay protection will be kept to a minimum and only used in exceptional cases.

7. Risks and Mitigations

Key risks include:

Financial sustainability: our current working assumption is that the financial impact of the RWW will be fully funded by the Scottish Government. Provision of recurring funding is essential to ensure safe and sustainable workforce solutions are in place to avoid service disruption and reliance on overtime or bank and agency staff.

Service delivery: Potential delays in assessment, treatment, and discharge; and longer waiting times.

Recruitment: lead in time to recruitment, increased competition for roles (with all NHS Boards likely to be recruiting at the same time) and national shortages in key position, particularly within the nursing and midwifery job family. Various local options need to be considered to address these issues, such as retaining winter pressures staff.

As a Board, NHS Orkney is carefully aligning the implementation of the 36-hour reduced working week with the requirements of the Health and Care (Staffing) (Scotland) Act 2019. The Act places a duty on Boards to always ensure safe and appropriate staffing levels, meaning any reduction in working hours must not compromise patient safety, service delivery or staff wellbeing. To support this, plans are ongoing to recalculate staffing requirements to maintain service coverage with fewer hours per staff member. A robust implementation plan will be developed

internally, outlining how the use of resources such as eRoster, SafeCare¹, and Professional Judgement to monitor staffing, including adequacy, in real time across all services, departments, and professions.

This will help us meet the duty to have a real-time staffing assessment in place. NHS Orkney will also apply Specific Staffing Level Tools as part of the Common Staffing Method for all Nursing and Midwifery teams within scope of the legislation². Work is underway to update the Professional Judgement Tool within SSTS to reflect the reduced hours, which can also support staff groups currently out of scope. Training will be provided to ensure staff understand how these tools align with legislative requirements. These systems will help monitor staffing levels during the transition to a 36-hour week, identify risks early, and implement mitigation strategies. Risks will be monitored continuously, with plans adjusted as needed. NHS Orkney currently report annually to Scottish Ministers on compliance with the legislation, including how staffing decisions are made, risks are managed, and staff concerns are addressed. Workforce planning is being aligned with the Act to support staff wellbeing and ensure long-term service sustainability.

8. Financial and Workforce Implications

Work is underway within individual Directorates to fully assess the financial implications of the RWW on a case-by-case basis. In the meantime, a high-level estimate of the cost of the policy is in the region of £1.7m to £2.0m (depending on backfill requirements). As outlined above, for financial planning purposes we are assuming that this cost will be fully funded by the Scottish Government.

9. National Systems

Another Risk will be the ongoing work required by the national systems including ePayroll, SSTS, and eRostering. These will be updated to reflect changes for all relevant staff. Bulk updates are scheduled for the week beginning 30 March 2026. Significant changes are expected, particularly within the national eRostering system, and internal planning will need to be discussed to manage this transition.

10. Timelines for Completion

Timelines for completion of key pieces of work are attached for information below (Appendix 1).

11. Conclusion

¹ Duties 12IC: real-time staffing assessment in place; 12ID: risk escalation process in place; and 12IE: Arrangements to address severe and recurrent risks; 12IF: Seek clinical advice on staffing; 12IH: Ensure adequate time for clinical leaders

² Duties 12IJ: Follow the common staffing method; 12IK: Common Staffing Method: types of health care; 12IL: Training and consultation of staff

NHS Orkney remains committed to delivering the Reduced Working Week in a manner that safeguards patient care, supports staff wellbeing, and aligns with national reform objectives. We will continue to work in partnership with trade unions, local forums, and national colleagues to ensure a smooth transition

Appendix 1 – Key Implementation Dates

Issues	Who?	Date
Data to be pulled together and clarified as accurate	Bruce Young and Directors for Checking	31 October 2025
Decisions to be taken on part time staff hours and accumulation	RWW Recommendation to APF	31 October 2025
Each Director to consider their own areas for Action Plan	Directors / Senior Managers	30 November 2025
Proposals for each area to be reviewed by RWW Group	RWW	31 December 2025
Approval at APF	RWW to APF	20 January 2026
Proposals discussed at Senior Leadership Group	SLG	13 February 2026
Approval at Staff Governance	APF to Staff Governance	12 February 2026
Final Acton Plan for each area	Directors / Senior Managers	February 2026
Introduction of RWW	Health Board	30 March 2026

Update on Equality Outcomes Report 2026-2029

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> • Dave Harris, Director of People and Culture
Report Author(s)	<ul style="list-style-type: none"> • Dave Harris, Director of People and Culture
Purpose of report	<ul style="list-style-type: none"> • Discussion
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Corporate Strategy 2024/28 • Annual Operational Plan • Emerging Issue • Government policy/directive • Legal requirement • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	<ul style="list-style-type: none"> • Statutory requirement and urgency: NHS Orkney is legally required to publish Equality Outcomes every four years. As outcomes for 2021–2025 have expired and none were published in 2025, there is a pressing need to agree and progress Equality Outcomes for 2026–2029 to ensure compliance and mitigate reputational and governance risk. • Proposed strategic focus: Three draft Equality Outcomes are proposed, focusing on (1) creating a more inclusive, safe, and respectful workplace, (2) improving health outcomes and access for groups experiencing disadvantage within Orkney’s island context, and (3) strengthening NHS Orkney’s approach to antidiscrimination through governance, leadership, and equality impact assessment. • Deliverability, governance, and risk: The draft outcomes aim to balance ambition with realism given limited specialist equality capacity and known data quality challenges.
Route to meeting	<ul style="list-style-type: none"> • Executive Team Meeting 16 February 2026
Recommendation(s)	<ul style="list-style-type: none"> • Discussion - Consider the implications of a matter

Update on Equality Outcomes Report 2026-2029

Dave Harris

26/02/2026

1. Situation

- 1.1 The purpose of this paper is to provide an update on ongoing work to produce NHS Orkney's Equality Outcomes 2026–2029 and to provide Board with some initial draft outcomes for discussion.
- 1.2 This paper does not seek approval at this time. Board feedback is requested to inform finalisation of the Equality Outcomes prior to progression through formal governance and statutory publication.

2. Background

- 2.1 NHS Orkney is required, under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, to publish a set of Equality Outcomes every four years demonstrating how the organisation will meet the Public Sector Equality Duty (PSED).
- 2.2 The last published Equality Outcomes covered the period 2021–2025. Nothing was published in 2025 and so there is now an urgent need to finalise and publish outcomes for 2026-2029.
- 2.3 To progress this work at pace a small group of people from the Public Health and People and Culture teams met to review the previously published outcomes and associated assessments of progress, identify ongoing relevant initiatives and examine examples of good practice Equality Outcomes elsewhere in NHS Scotland.

3. Assessment

- 3.1 Appendix 1 sets out a draft Equality Outcomes report for 2026–2029 that has been developed to:
 - Reflect NHS Orkney's island context and organisational scale.
 - Align with the Corporate Strategy 2024–28
 - Focus on priority areas where meaningful improvement is achievable.
 - Balance ambition with realism in the context of limited specialist equality capacity.

3.2 Proposed Equality Outcomes

The draft report proposes **three Equality Outcomes** for the period 2026–2029:

3.3 Outcome 1 - NHS Orkney becomes a more inclusive, safe, and respectful workplace for all colleagues and patients.

This outcome focuses on staff experience, organisational culture, leadership behaviours, fair work considerations, and improving the quality and completeness of equality data to better support decision-making.

3.4 Outcome 2 - Improved health outcomes and access for groups experiencing disadvantage in Orkney's Island setting.

This outcome addresses population health inequalities, access barriers linked to geography and demographics, and improved use of existing data and engagement activity to inform service planning and improvement.

3.5 Outcome 3 - NHS Orkney continues to make progress in becoming an anti-discrimination organisation.

This outcome focuses on anti-racism, prevention of sexual harassment, equality impact assessment, and embedding equality considerations within planning and governance processes.

3.6 Key Issues for Board Discussion

The Board is invited to discuss and provide feedback on:

- **Strategic focus:** Whether the proposed outcomes reflect the most significant equality priorities for NHS Orkney over the next three years.
- **Ambition and deliverability:** Whether the proposed outcomes and deliverables are realistic within existing capacity and resources.
- **Governance and accountability:** The clarity of proposed executive ownership, performance management, and Board assurance arrangements.
- **Integration:** The extent to which equality outcomes are embedded within existing planning, performance, and improvement frameworks rather than operating as a standalone activity.

3.7 Proposed Next Steps

Following Board discussion, the following next steps are proposed:

- I. Publication of draft outcomes on website for public feedback.
- II. Revised Equality Outcomes to Staff Governance Committee – review and recommend for approval.
- III. NHS Orkney Board – approval for publication (April 2026 deadline).

- IV. Publish Equality Outcomes 2026–2029 and associated evidence summary.
- V. Develop detailed 3-year delivery plan (to be completed by September 2026).
- VI. Annual Progress Reporting integrated into governance cycle.

3.8 General Risk Assessment

Key risks identified within the draft Equality Outcomes report include:

- Insufficient organisational capacity and limited specialist equality expertise.
- Ongoing data quality and completeness issues.
- Risk of non-compliance with statutory duties.
- Reputational risk if progress is not demonstrable.
- Risk of insufficient scrutiny if governance arrangements are unclear.

3.9 Mitigations proposed include clear executive ownership of outcomes, mainstreaming equality within existing governance structures, and proportionate delivery planning.

3.10 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	This would assist NHS Orkney in delivering care that meets the needs of the people of Orkney and addresses health inequalities.
People	Workforce	Yes	The Equality Outcomes place a strong emphasis on workforce experience, inclusion, and culture. Delivery will require sustained leadership commitment, engagement with staff and trade union colleagues, and realistic expectations aligned to organisational capacity.
Performance	Finance	No	There are no direct financial implications arising from this paper. Delivery of the Equality Outcomes will be progressed primarily through existing resources, prioritisation, and integration into core business.
Potential	Risk Management	Yes	Describe relevant risk assessment/mitigations.
	Digital	Yes	No significant impact but there is a link between improving accessibility and increased use of digital solutions
Place	Equality and Diversity including health inequalities	Yes	This paper relates directly to NHS Orkney’s statutory duties under equality and human rights legislation. The draft Equality Outcomes are intended to strengthen compliance and drive meaningful improvement in practice across workforce and service delivery.
	Climate	No	No impact identified.

	Change Sustainability		
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4. Recommendation(s)

4.1 It is recommended that:

- Board notes the action being taken to address this legal requirement.
- Discuss and provide suggestions for improvement on the draft outcomes.

4.2 The action being requested is:

Discussion – Examine and consider the implications of a matter.

5. List of appendices

5.1 The following appendix is included with this report:

- **Appendix 1**, NHS Orkney equality outcomes report 2026-2029 (Draft)

Appendix 1 - NHS ORKNEY – EQUALITY OUTCOMES REPORT 2026–2029 (DRAFT)

1. EXECUTIVE SUMMARY

NHS Orkney is required, under the Equality Act 2010 (Specific Duties) (Scotland), to publish a new set of Equality Outcomes every four years. These outcomes must help the organisation better fulfil the **Public Sector Equality Duty (PSED)**:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Over the last reporting cycle (2021–2025), progress has been mixed. Several statutory workforce-monitoring duties were met, and improvements were made in training coverage across the protected characteristics. However, gaps remain — particularly in **population health inequalities, consultation and involvement, evidence infrastructure, and resourcing capacity**.

This report provides:

- A review of progress and challenges from 2021–2025
- A synthesis of workforce and patient inequality data
- A set of **three Equality Outcomes** for 2026–2029
- Dependencies, risks, and a proposed governance route

The outcomes align with NHS Orkney’s **Corporate Strategy 2024–28**, our island context, national best practice (including NHS Highland’s 2025–2029 approach), and the operational reality acknowledged by colleagues across People & Culture, Public Health, and Corporate Governance.

2. STRATEGIC CONTEXT

2.1 Legislative Framework

- **Equality Act 2010 – Public Sector Equality Duty (PSED)**
- **The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012**

2.2 NHS Orkney Strategic Alignment

Equality and human rights commitments sit across several strategic priorities, including:

- Patient Safety, Quality and Experience
- People
- Performance
- Potential
- Place

2.3 Organisational Capacity & Realism

NHS Orkney lacks specialist dedicated Equality, Diversity and Inclusion (EDI) capacity and so any commitment to equality outcomes must be realistic, focused on key priorities and set within an approach that mainstreams EDI across and within the organisation. It is important to reflect honestly on the challenges of the past and then commit realistically to improvements for the future.

Therefore, outcomes must be **ambitious but deliverable**.

3. REVIEW OF PROGRESS 2021–2025

3.1 Summary of Achievements

Drawing from the **Equality Outcomes Update Report 2021–2025**, progress was evident in:

- Ongoing emphasis on EDI related training (mandatory and otherwise)
- Annual workforce monitoring (ethnicity, sex, disability, age distribution)
- Some improvements in disability and sexual-orientation data completeness for staff
- Enhanced equal pay reporting and occupational segregation data in mainstreaming outputs.

3.2 Areas for Improvement

- Several outcomes remained largely unchanged from 2017 to 2025.
- The importance of supporting staff and decision making with EQIAs and the need to promote this as a core part of planning and evaluation activity. In particular, avoiding this being seen as a “tick box” exercise and ensuring that actions identified in the EQIAs are monitored and delivered.
- The importance of having robust performance management arrangements in place with lead responsible officers identified to deliver activities towards equality outcomes.

- The importance of leadership to cultivate an inclusive workplace culture. For example, the values, behaviours and support for equality, diversity, and inclusion activities in NHS Orkney from the Executive Team and the Board.
 - The need to identify measures to track progress towards equality outcomes.
 - Ensuring effective governance of equality and diversity to ensure it is given the appropriate scrutiny by the Board.
 - The need to provide line managers with the appropriate guidance, tools, and training to support inclusive, diverse and equitable workplace for our people.
 - It is important to avoid assumptions about knowledge and understanding across our people on equality and diversity issues. We need to make sure we meet people where they are and tailor support to make it relevant to roles and responsibilities, whilst setting clear expectations for all.
 - Data quality is important. More work needs to be done to reduce missing ethnicity data and incomplete disability disclosure; gaps in mandatory training records due to system issues; variability in data quality for medical/dental cohorts.
-

4. EVIDENCE BASE FOR 2026–2029

4.1 Workforce Inequalities

Drawing on NHS Orkney workforce reports the following themes have been identified:

- NHS Orkney’s workforce is predominantly White, broadly reflecting the local population, with very small numbers of staff from minority ethnic backgrounds. While this mirrors local demographics, it creates challenges in:
 - Building lived experience of racial inequality within the organisation
 - Developing organisational competence and confidence on race and anti-racism beyond compliance
- This issue is an area requiring active, intentional work rather than passive monitoring.
- Disability declaration rates are lower than desired, with a significant proportion of staff either not disclosing or unsure about disclosure. This limits understanding of reasonable adjustment needs and restricts the organisation’s ability to assess equity in recruitment, development and retention.
- NHS Orkney has an ageing workforce which poses a risk to workforce sustainability, knowledge and skills retention and future recruitment.
- Challenges around staff experience, particularly in the area of “speaking up” and inclusion.

4.2 Patient & Population Health Inequalities

In terms of patient and population health inequalities:

- There is an ageing island population.

- Island-specific barriers (travel, access to specialists, rural isolation) remain key considerations.
 - Limited consultation took place for previous cycles, meaning new outcomes must emphasise evidence gathering and community involvement as well as capturing data from a range of sources.
-

5. PROPOSED EQUALITY OUTCOMES 2026–2029

Below are **three outcomes**, aligned with national good practice and grounded in the reality of NHS Orkney's context.

OUTCOME 1 — NHS Orkney becomes a more inclusive, safe, and respectful workplace for all colleagues and patients.

Deliverables

- Improved quality and comprehensiveness of EDI data by embarking, in partnership with trade union colleagues, on a campaign amongst and with our workforce to ensure positive declarations from employees in all protected characteristics.
 - Reduction in reported incidents linked to harassment or discrimination.
 - Increased participation in EDI training (including anti-racism and cultural humility content).
 - Establishment of a staff network.
 - Provision of access to Mentally Healthy Workplaces training in Orkney
 - Progress living wage considerations on all regulated procurement decisions in NHS Orkney.
 - Provide NHS Orkney data for Gender Pay Gap research progressed in Community Planning Partnership activities.
 - NHS Orkney behavioural framework and values embedded with improvements seen in staff experience in iMatter survey.
 - Improved staff survey results on bullying, speaking up, and team working.
-

OUTCOME 2 — Improved health outcomes and access for groups experiencing disadvantage in Orkney's island setting.

Deliverables

- More effective use of existing engagement channels with the communities of Orkney
- Improved access indicators (waiting times, uptake of screening, digital access, complaints).

- Completion of equality impact assessments on Type 2 Diabetes Mellitus (T2DM) and cardiovascular disease (CVD) care in Orkney to inform future service development.
 - Development of frailty prevention activities which include consideration of the ferry-linked isles.
 - Development of a consistent approach to the follow up of non-attendees within the learning disability and autism populations across Primary Care.
 - Formalisation of reasonable adjustments as standard throughout Orkney screening services.
 - Exploration of the experience and perspective of eligible women living in Orkney of the breast screening service to identify barriers and facilitators to uptake.
-

OUTCOME 3 NHS Orkney continues to make progress in becoming an anti-discrimination organisation.

Deliverables

- Delivery of anti-racism education (staff and leaders).
- Published anti-racism commitments.
- Reporting improvements in race-related staff experience.
- Delivery of sexual harassment in the workplace training.
- Ensuring anti-racism planning is integral to our health care planning through inclusion in Annual Delivery Planning cycle.
- Delivery of the National Framework for the development and delivery of Spiritual Care.
- Examination of the EQIA process and develop a system to identify important issues and monitor progress on key actions.

6. GOVERNANCE, RISKS & MITIGATION

6.1 Key Risks

- Insufficient capacity
- Lack of specialist EDI support
- Data quality issues
- Reputational risk if statutory duties are not met
- Lack of public engagement and involvement

6.2 Mitigation Actions

- Formalise **Exec ownership** of each Equality Outcome and ownership of the associated deliverables.
- Address system issues affecting data integrity.
- Seek regional or national support and collaboration where possible.

7. IMPLEMENTATION & NEXT STEPS

1. **Publish draft outcomes on website** for comment.
2. **Staff Governance Committee** – review and recommend for approval.
3. **NHS Orkney Board** – approval for publication (April 2026 deadline)
4. **Publish Equality Outcomes 2026–2029** and associated evidence summary.
5. **Develop detailed 3-year delivery plan** (to be completed by September 2026)
6. **Annual Progress Reporting** integrated into governance cycle.

Financial Case for MRI provision in NHS Orkney 2026-27

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> • Dr Anna Lamont, Medical Director
Report Author(s)	<ul style="list-style-type: none"> • Dr Anna Lamont • Nick Crohn
Purpose of report	<ul style="list-style-type: none"> • Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Corporate Strategy 2024-2028 – Place, Patient Safety, Quality and Experience, People, Performance and Potential strategic objectives • Operational Improvement Plan • Financial Sustainability
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Quality • Person Centred • Sustainability
Key points for consideration	<ul style="list-style-type: none"> • This paper reviews the current usage of the MRI scanner since locally available from June 2025 • The paper outlines the funding required to continue to provide MRI imaging locally in Orkney based on current usage. • It sets out the governance and monitoring of the service going forwards. • It constitutes the initial submission to the National Imaging Equipment Plan for 2026/27
Route to meeting	<ul style="list-style-type: none"> • Executive Management Team – 9th February 2026
Recommendation(s)	<ul style="list-style-type: none"> • Assurance - For members assurance only

Item 13.1

Financial Case for MRI provision in NHS Orkney 2026-27

1. Executive summary

- 1.1. NHS Orkney is seeking Scottish Government agreement to sustain on-island MRI provision beyond the end of the current time-limited funding period in May 2026. A relocatable MRI scanner has been successfully implemented at The Balfour Hospital, is fully operational, and has been validated for a wide range of examinations including prostate MRI. In practice, the service has repatriated the majority of MRI activity that would otherwise have been referred to NHS Grampian, materially improving access, pathway timeliness, and patient experience.
- 1.2. The original funding was explicitly non-recurrent. Without further support, the service will be withdrawn, and MRI referrals will revert entirely to NHS Grampian. This would reintroduce avoidable patient travel, create significant additional travel cost pressures for NHS Orkney and NHS Grampian. It would increase demand on Grampian radiology capacity, and reverse the clinical and operational benefits achieved during the first year of delivery.
- 1.3. This paper therefore seeks two linked decisions. First, confirmation of funding for at least one further year (2026/27) to allow continuation of the existing relocatable MRI service without disruption. Second, agreement in principle to establish a baselined funding position for MRI provision in Orkney, subject to defined performance measures, governance, and a review point to inform longer-term commissioning arrangements.
- 1.4. Continuation with the current supplier and device represents the lowest-risk and most cost-effective option. The service is proven in situ, staff are trained, and pathways are embedded. A change of supplier would incur significant non-recurrent costs, including approximately £40,000 to remove the existing unit and similar costs to mobilise an alternative, alongside service disruption and delivery risk. NHS Orkney is therefore not proposing a change in supplier.
- 1.5. NHS Orkney continues to demonstrate robust financial and operational oversight, including regular reporting on activity, access, and benefits realisation, that supports longer-term sustainability.

2. Situation

- 2.1. MRI provision in Orkney has historically been constrained by geography and reliance on mainland services. Following the withdrawal of the North Imaging Alliance visiting MRI programme, NHS Orkney implemented a full-time relocatable MRI service at The Balfour Hospital using Scottish Government non-recurrent funding in 2025. The service is now established as part of routine delivery and supports both scheduled and urgent imaging.
- 2.2. Operationally, the service has performed well. Activity has increased steadily since commencement, a broad case mix is being delivered safely on island, and almost all MRI referrals that would previously have required travel to NHS Grampian are now being managed locally. Paediatric scanning remains the exception since acute and inpatient paediatric care is provided only in Aberdeen. The scanner has been validated for prostate MRI and other higher-complexity examinations, further strengthening local diagnostic pathways.

- 2.3. The immediate challenge is sustainability. Current funding arrangements end in May 2026 and there is no baselined allocation beyond that point. Without confirmation of further funding, NHS Orkney will necessarily cease local service and revert MRI referrals to NHS Grampian. This would recreate significant patient travel requirements, generate substantial travel cost pressures, and place additional demand on Grampian radiology services at a time when both Boards remain in financial escalation.
- 2.4. There is also a clear timing constraint. Decisions on continuation funding are required sufficiently in advance of contract notice periods to avoid unplanned service withdrawal. The purpose of this paper is therefore to support timely decision-making that maintains continuity of care, protects system stability, and provides a clear route towards longer-term funding arrangements for MRI provision in Orkney.

3. Updated Cost Analysis Following 2025-26 MRI Provision

- 3.1. The financial position set out below reflects the continuation of the existing relocatable MRI service currently operating at The Balfour Hospital. The model assumes no change in supplier or device, recognising that the current service is operationally stable, clinically validated, and embedded within local pathways.
- 3.2. The estimated total annual cost for continuation of the service in 2026/27 is £789,338, based on current contractual arrangements and updated cost assumptions. The principal cost drivers are:
 - 3.2.1. **Device lease and service contract**, covering provision of the relocatable scanner and associated technical support.
 - 3.2.2. **Staffing**, based on an NHS Orkney-delivered model comprising a Band 7 MRI Lead Radiographer, a Band 6 Radiographer, and a Band 3 Clinical Support Worker. This reflects learning from the first year of operation and provides sufficient resilience to sustain a five-day service and support urgent imaging.
 - 3.2.3. **Electrical power**, which represents a significant but unavoidable cost for MRI provision. Operational experience confirms that the previously modelled power consumption assumptions are realistic for a relocatable MRI unit that must remain energised continuously.
 - 3.2.4. **Reporting and consumables**, reflecting the observed case mix, including an increasing proportion of prostate and other higher-complexity examinations.
- 3.3. Cost assumptions for 2026/27 include a modest inflationary uplift to reflect anticipated pay awards and contractual indexation. These assumptions are stated explicitly within the financial tables and can be refined subject to final contractual negotiation.
- 3.4. No allowance has been made for supplier change or re-procurement within this period. A change in provider would trigger significant non-recurrent costs, including approximately £40,000 to remove the current unit and a similar cost to mobilise and site an alternative device, alongside disruption to a live clinical service. NHS Orkney therefore proposes continuation of the current arrangement as the lowest-risk and best-value option.

Item 13.1

Item	2025-26 £	2026-27- Uprated for inflation £
Compleo 12-month device lease (subject to renegotiation)	438,000	453,768
Consumables	29,520	30,583
MRI Reporting	41,140	41,140
Staffing	178,817	197,593
Electrical power	60,000	62,160
Staff training	4000	4144
Crane shipping and Special Transfer General Order (STGO) for an abnormal load.	Dependent on contract award	Dependent on contract award
Sub Total	£751,477	£789,388

4. Cost Avoidance and Travel Pressure

- 4.1. Based on observed activity and current utilisation, it is estimated that over 1,000 patients per year would require off-island travel for MRI in the absence of local provision. Using current Highlands and Islands Travel Scheme costs, including the proportion of patients requiring escorts, this would generate a gross annual travel cost pressure in the region of £520K based on £520 average cost per patient travelling. This incorporates costs for those requiring escorted travel consistent with previous MRI assessments, and incorporates air fare increases over the last year.
- 4.2. These figures represent avoidable cost pressure rather than cash-releasing or run rate savings. They assume that underlying clinical demand for MRI remains constant and would continue to be met via NHS Grampian if local provision were withdrawn. While actual travel expenditure would depend on individual circumstances and weather-related disruption, the modelling is consistent with historic travel authorisations and recent experience.
- 4.3. In addition to travel costs, withdrawal of the service would transfer in excess of 1,100 MRI examinations per year back to NHS Grampian, increasing pressure on scanning and reporting capacity. NHS Orkney has not sought cost recovery for the repatriated activity delivered locally during the current funding period, recognising that both Boards are in financial escalation and that the primary benefit is system stability rather than inter-Board financial transfer.
- 4.4. Maintaining local MRI provision therefore mitigates a material financial and operational risk, reduces reliance on mainland capacity, and supports more stable diagnostic pathways across the North of Scotland.

5. Demand and utilisation

Table 2, Utilisation of the mobile MRI scanner by scan and referral area for June (installation) to December 2025.

Item 13.1

Month	OP-MRI	OP – MRI Direct Access	ED-MRI	Total - MRI
Jun-25	77	1	3	82
Jul-25	70	0	0	72
Aug-25	96	0	0	100
Sep-25	86	1	1	91
Oct-25	125	0	7	137
Nov-25	102	0	0	109
Dec-25	79	0	0	81
Total	635	2	11	672

Includes appointment status ('Issued', 'Arrived', 'Ex. Done', 'Typed', 'Started', 'Booked', 'Verified'). Note: The data is limited to number of unique referrals, and does not account for multiple scans per patient (average 1.2 per patient)

- 5.1. Activity data from the first year of operation demonstrate sustained and increasing demand for MRI provision in Orkney, with utilisation now exceeding that observed under the previous visiting MRI model.
- 5.2. From service commencement in mid-2025, activity has increased steadily as local pathways have embedded and additional case types have been validated for on-island scanning. In the first five months of operation, 482 MRI examinations were completed. By October 2025, activity had risen to 137 examinations in a single month, equating to 114 patients, reflecting the delivery of multi-sequence studies for some referrals.
- 5.3. Across the initial operating period, throughput has averaged approximately 95–100 examinations per month, equating to an annualised activity level of more than 1,100 examinations if sustained at steady state. This represents a significant increase compared with historic utilisation under the rotational visiting service and reflects both unmet demand and a shift towards MRI being used as the first-line investigation where clinically indicated.
- 5.4. The service is now supporting a broad case mix across medical, surgical, orthopaedic, dementia and cancer pathways. Validation of prostate MRI has further strengthened local diagnostic capability and is expected to contribute to future demand growth. Rather than relying on speculative proportions, NHS Orkney proposes to monitor prostate activity as a defined metric during 2026/27, alongside overall activity and case complexity, to inform longer-term commissioning decisions.
- 5.5. Demand forecasts for 2026/27 therefore assume:
 - Sustained monthly activity at or above current levels.
 - Continued repatriation of the majority of MRI referrals previously sent to NHS Grampian;
 - Moderate growth associated with pathway normalisation and prostate MRI, within existing operating capacity.
 - Activity, utilisation, waiting times and case mix will be reported routinely to provide assurance on performance and value.

6. Report cost and complexity

6.1. Table 3 presents the reporting costs based on the quote from Medica who are delivering reporting for the current scanner.

6.2. 80% of scans were of category 1 complexity (least complex). All category 1 and some category 2 scans are suitable for scanning on the device scoped for NHSO.

Table 3: Reporting costs Medica 2025

Category	Description	2024/25
1	Small Volume CT/MRI; MRI knee, MRI L-spine, MRI IAM	£33.00
2	Intermediate CT/MRI- CT 2-part, CT brain with contrast, MRCP, MRI breast, MRI brain, MRI whole spine, MRI Small Bowel and most other MRI	£55.00
3	Complex CT/MRI- CT 3-part, MRA, CT coronary	£77.00
4	4-part CT/MRI- MRI prostate, MRI liver, MRI whole body	£99.00

6.3. Scans of complexity 3 and 4 will predominantly be reported by NHS Grampian Radiology at their request, especially prostate imaging as part of the local SLA.

6.4. For consistency with observed service delivery, reporting costs have been rebased to reflect a steady-state activity level of approximately 1,100 MRI examinations per annum. Using the same conservative complexity assumptions (80% Category 4, 20% Category 5), this yields an estimated annual reporting cost of £41,140, which is reflected in the updated financial tables.

7. Staffing Model

7.1. The staffing model proposed for 2026/27 reflects learning from the first year of service delivery and the requirement to sustain a safe, resilient MRI service within a small island workforce.

7.2. During initial implementation, a lean staffing model was used to enable rapid mobilisation and minimise cost. While this approach supported service establishment, operational experience has demonstrated that additional resilience is required to safely sustain a five-day service, manage leave and sickness, support urgent imaging, and maintain training and governance standards.

7.3. The proposed staffing model therefore comprises:

- 1 WTE Band 7 MRI Lead Radiographer, providing professional leadership, clinical governance, safety oversight, protocol development, and liaison with clinical teams and reporting services.
- 1 WTE Band 6 Radiographer, with MRI experience, to provide operational resilience, support extended service delivery, and ensure continuity during leave or unplanned absence.

- 1 WTE Band 3 Clinical Support Worker, supporting patient preparation, administration, chaperoning, and workflow efficiency.

7.4. This configuration aligns with staffing levels used for similarly commissioned relocatable MRI services and reflects a proportionate response to observed demand and service complexity. It also enables ongoing skill development within the existing radiography workforce, reducing reliance on agency staffing and supporting recruitment and retention in a nationally constrained profession.

7.5. Importantly, the staffing model is designed to be sustainable rather than minimal. It supports safe delivery of urgent imaging, including spinal and neurological pathways, while maintaining flexibility to adapt operating patterns as demand evolves. Workforce costs included in the financial case reflect this model and are considered necessary to protect service continuity and quality.

Table 6. Staffing requirements MRI NHSO

Staff Role	Banding	Whole-Time Equivalent	Annual Cost (Including On-Costs)
MRI Lead Radiographer/Service Lead	Band 7	1 WTE	£83,685
MRI Radiographer	Band 6	1WTE	£71,569
Clinical Support Worker	Band 3	1 WTE	£42,339
Total Annual Staffing Cost			£197,593

8. Recommendation and Governance

NHS Orkney submitted this case to the Centre for Sustainable Development (CfSD) week ending 10th February, recommending that the National Imaging Plan:

- Approve continuation funding for the existing relocatable MRI service for 2026/27, to ensure continuity of on-island MRI provision and avoid unplanned service withdrawal.
- Agree in principle to establish a baselined funding position for MRI provision in Orkney, subject to defined performance measures, governance, and a structured review to inform longer-term commissioning arrangements.
- Continuation with the current supplier and device is recommended as the lowest-risk and most cost-effective option. A change in supplier would incur significant non-recurrent costs, introduce service disruption, and offer no clinical or operational advantage over the established model.

Governance and Assurance

NHS Orkney will maintain clear governance and oversight arrangements for the service, including:

- Executive accountability through the Medical Director, with operational leadership from Radiology.
- Routine monitoring of activity, utilisation, waiting times, case mix, and reporting turnaround.
- Financial monitoring of spend against agreed budgets.

Item 13.1

- Defined benefits tracking, including patient access, travel avoidance, and system impact.

A formal review point during 2026/27 to assess performance and inform decisions on longer-term funding and commissioning.

These arrangements will provide assurance on value, quality, and sustainability, and support transparent engagement with Scottish Government on future options.

Recommendation

Assurance: For Members' assurance

Healthcare Associated Infection Reporting Template

Meeting	NHS Orkney Board
Meeting date	Thursday, 19 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> Sam Thomas, Executive Director Nursing, Midwifery, AHP's, Chief Officer Acute Services
Report Author(s)	<ul style="list-style-type: none"> Sarah Walker, Head of Infection Prevention
Purpose of report	<ul style="list-style-type: none"> Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> Government policy/directive
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> Safe Effective Quality Person Centred
Key points for consideration	<ul style="list-style-type: none"> Local Delivery Standard Targets are currently within projected levels and one outwith, however this target was also set at zero. Hand Hygiene and MDRO targets have been achieved for this report Additional reporting to Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) Scotland was undertaken as directed by DL (2025) 28, over Christmas and New Year and has now been stepped down.
Route to meeting	<ul style="list-style-type: none"> Nil, this report is a mandatory HCAI Reporting Template (HAIRT), introduced in 2009
Recommendation(s)	<ul style="list-style-type: none"> Assurance - For members assurance only

Healthcare associated Infection Reporting Template

Sarah Walker

06/02/2026

1. Situation

- 1.1 This report is presented to the Board for patient safety assurance in regard to infection prevention and control, and to highlight NHS Orkney's compliance against the Infection Prevention and Control Standards. This is a mandatory report following the Vale of Leven Incident.
- 1.2 The Board should seek to assure that infection prevention and control standards and risks are being managed.

2. Background

- 2.1 For *Staphylococcus aureus* bacteraemia (SAB) and *Escherichia coli* bacteraemia (ECB), the definition of "Healthcare Associated Infection" includes both hospital cases and healthcare cases.

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".

Based on the 2023-24 data, the LDP Standards are set at:

- SAB – Zero
- CDI – One
- ECB – Five

3. Assessment

- 3.1 Surveillance of infection is reported in Local Delivery Plan (LDP) Standard year, which is based on the 2023- 2024 year's Healthcare Associated Infection (HCAI) case numbers. All cases are discussed with Leading Clinicians to ensure that infection sources are correct and any areas for improvement are identified and all preventative actions taken, if identified.

Staphylococcus aureus bacteraemia (SAB)

LDP Standard Target Quarters for LDP standard year 2025-26	HCAI Cases based on LDP standard	Community Case
Q1 – Apr - Jun	2	2
Q2 – Jul - Sep	1	0
Q3 – Oct - Dec	0	0
Q4 – Jan - Mar	1	0

NHS Orkney has **missed** its LDP Standard, as the Standard is set at Zero. However, no cases have been identified as preventable.

Clostridioides difficile Infection (CDI)

LDP Standard Target Quarters for LDP standard year 2025-26	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1 – Apr - Jun	0	0	0
Q2 – Jul - Sep	0	0	0
Q3 – Oct - Dec	0	0	0
Q4 – Jan – Mar	0	1	0

NHS Orkney are currently **on track** to meet the LDP standard which is set at no more than one Healthcare Associated Infection case.

Escherichia Coli Bacteraemia (ECB)

LDP Standard Target Quarters for LDP standard year 2025-26	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1 – Apr - Jun	1	1	0
Q2 – Jul - Sep	2	3	0
Q3 – Oct - Dec	2	0	0
Q4 – Jan – Mar (to date)	0	0	0

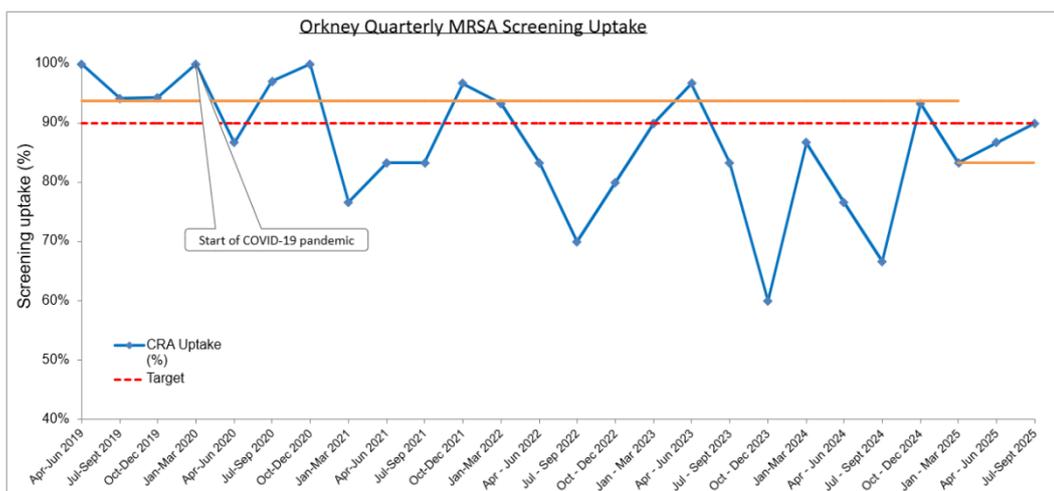
NHS Orkney are currently **on track** to meet the LDP standard which is set to no more than 5 Healthcare associated Infection (HCAI) cases.

3.2 Multi Drug Resistant Organism (MDRO) Clinical Risk Assessment National Screening

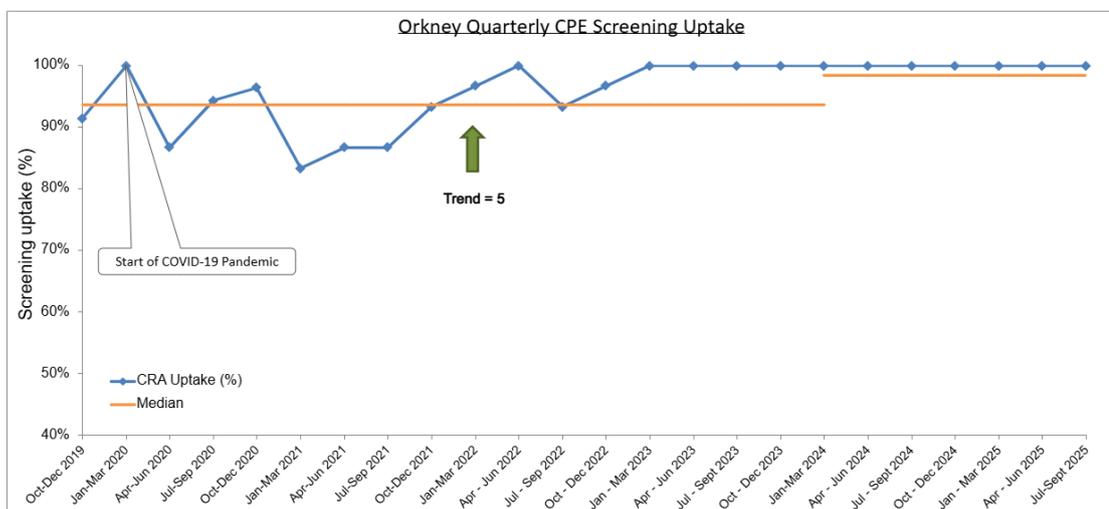
The latest quarters data has been received and shows a gradual improvement in Methicillin Resistant *Staphylococcus Aureus* (MRSA) clinical risk assessment, meeting the 90% target. This a mandatory question set and risk assessment at time of admission. The improvement has been fed back to the teams undertaking this risk assessment. See graph below.

The current Scottish clinical risk assessment for MRSA stands at 84.8% and therefore NHS Orkney is above the Scottish average.

Methicillin Resistant *Staphylococcus Aureus* (MRSA) Clinical Risk Assessment



Carbapenemase Producing *Enterobacteriaceae* (CPE) Clinical Risk Assessment.

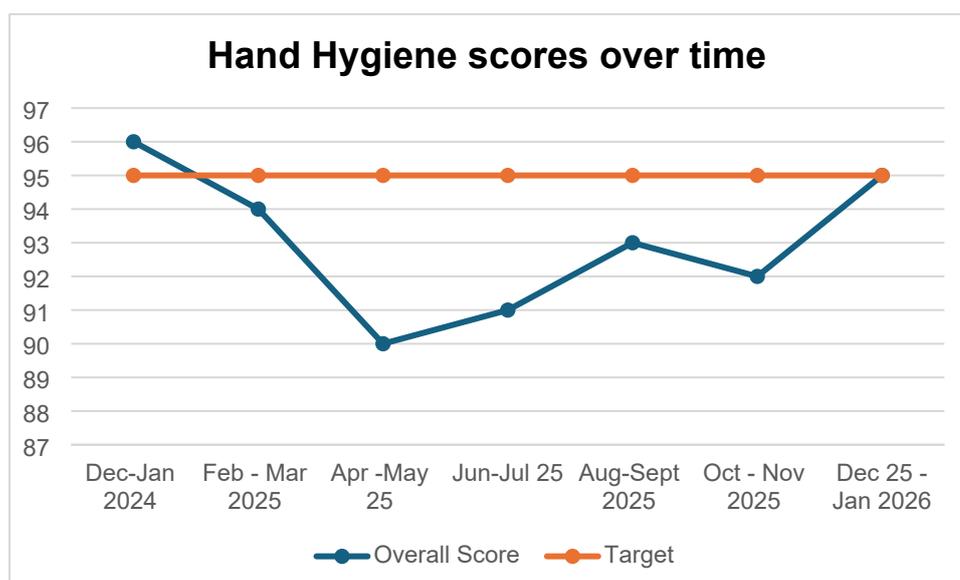


CPE screening remains at 100% this reflects the lack of positive responses to the clinical risk assessment question set, and the low number of patients requiring swab samples obtained, this fluctuates throughout the year with tourist season, as part of the question set is around hospitalisation outwith Scotland.

For benchmarking the Scottish average for this screening is currently 87.2%, so again NHS Orkney are above the Scottish average.

3.3 Hand Hygiene

The hand hygiene score for December to January 2026 is now **95%** which is on target. The main issues during this audit period is dress code and missed opportunities due to not removing personal protective equipment timeously or within the patient environment. All departments continue to complete peer Standard Infection Control Precautions, which include Hand hygiene so will assist improvement over time but is expected to encourage peer reminders using the 'Kind to Remid' process.



3.4 Domestic and Estates Monitoring

Both Domestic and Estates monitoring tool remains above target, however, this does represent a small ad hoc area which is randomly chosen by the tool itself

	Domestics % score	Estates % score
Dec-24	94%	100%
Jan-25	Unavailable	Unavailable
Feb-25	95%	99%
Mar-25	Unavailable	Unavailable
Apr- 25	90%	100%
May-25	91%	100%
Jun-25	92%	100%
Jul-25	95%	100%
Aug-25	96%	100%
Sep-25	95%	100%
Oct-25	97%	100%
Nov-25	97%	100%
Dec- 25	95%	100%
Jan-26	96%	100%

3.5 Community

The Care Home and Community support group has now been re-established with a new Chair of the group and has been widened to incorporate the third sector, which previously had been separate meetings. This a huge step forward again, for information sharing and offering infection prevention support, information and guidance to line managers across all care services.

3.6 Infection Prevention & Control Education

There has been a push to provide water safety training to staff across secondary care consisting of 19 sessions being presented.

Staff attendance: 88 staff members in attendance: broken down into:

- 40 Nurses/Midwives
- 10 HCSW
- 3 ST/N
- 18 Domestic/Facilities staff
- 17 AHP's

Water safety training has been ongoing through the year with the IPC Practitioner undertaking water safety training whilst visiting primary care settings for IPC quality assurance purposes.

3.7 IPC Team Education

Our Infection prevention & control Nurse Kally Laing-Herridge has gained her Post Graduate Diploma in Infection Prevention in December through the University of the Highlands and Islands. Which is fantastic achievement, following her years of study. This also provides a sustainable service for the future.

The IPC Team in collaboration with the Health Protection Nurse Specialist received update training on TB management, which was provided by NHS Grampian TB Specialist Nurse.

3.8 Exception Reporting to ARHAI and Scottish Government.

Following a recent DL issued in December 2025, Boards were requested to utilise the Hospital Infection Incident Outbreak reporting Tool (HIIORT), for any additional and precautionary measure that were being implemented through the winter season.

To meet this request NHS Orkney submitted a HIIORT for enhanced measures for cleaning and staff mask wearing over the Christmas and New Year period when respiratory infections were at their highest within the community.

Application of a fluid resistant mask was also requested of visitors at this time with the premise of protecting our patients from respiratory infections at a time when community transmission was highest. This was stepped down at the beginning of January and the HIIORT has been closed. Using the HIIORT in this way to report changes in business as usual is open, should it be required in the future.

3.9 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	All CDI, SAB and ECB are investigated in collaboration with clinical leads for areas of improvement and to ensure there were no interventions that could have prevented infections. MDRO Clinical risk assessments at time of admission reduce possibility of cross transmission with secondary care.
People	Workforce	No	
Performance	Finance	Yes	Reducing Healthcare associated infections are costly to both patients and the organisation as they result in

			increased treatment stay sand more complex treatment plans often with frequent return visits required.
Potential	Risk Management	Yes	Water Safety Training currently ongoing to reduce possibility of infections transmission from water, which is currently on risk register.
	Digital	No	
Place	Equality and Diversity including health inequalities	No	
	Climate Change Sustainability	No	

4.Recommendation(s)

4.1 To note that two out of the three mandatory reporting surveillane figures are on track to meet the local delivery standard, based on the 2023-24 baseline.

The multi-drug resistant organism (MDRO) national reporting and hand hygiene has improved and is now at target

Domestic and Estates scores are above target.

4.2 **Assurance** – For Members’ assurance only.

5.List of appendices

5.1 The following appendices are included with this report:

None

Safety, Quality and Experience Report, Quarter Two – Quality Extract

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> • Dr Anna Lamont, Medical Director
Report Author(s)	<ul style="list-style-type: none"> • Kat Jenkin, Head of Patient Safety, Quality and Risk
Purpose of report	<ul style="list-style-type: none"> • Discussion
Contribution to Strategic ambition	<ul style="list-style-type: none"> • Annual Operational Plan • Local policy • NHS Board/Integration Joint Board Strategy or Direction
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> • Safe • Effective • Quality
Key points for consideration	<ul style="list-style-type: none"> • Sustained improvement in Excellence in Care (EiC) and quality assurance activity, with data submission rates rising from 15% to 41%, supporting more meaningful analysis and assurance. • Significant progress in service-level improvement projects, including the Community Dressings Pilot, transition of Capsule Sponge Endoscopy to business-as-usual, and ongoing review of cancer pathways to strengthen referral and diagnostic stages. • Strengthened organisational culture and governance, demonstrated through the launch and early embedding of the Values and Behaviours Framework and enhanced focus on learning from incidents and Significant Adverse Events
Route to meeting	<ul style="list-style-type: none"> • The report in whole has been presented to the Clinical Governance Group in December 2025 • The report in whole has been presented to the Senior Leadership Team in January 2026 • The report in whole has been presented to the Joint Clinical and Care Governance Committee in February 2026. <p>The Board is receiving the quality section of the report only.</p>
Recommendation(s)	<ul style="list-style-type: none"> • Discussion - Consider the implications of a matter

Safety, Quality and Experience Report, Quarter Two – Quality Extract

Kat Jenkin, Head of Patient Safety, Quality and Risk

22/01/2026

1. Situation

- 1.1 This extract from the Safety, Quality and Experience report supports the Board's oversight of improvement work ongoing across NHS Orkney. It provides a comprehensive overview of organisational performance in relation to quality improvement activity, outlining progress across clinical and non-clinical domains. Key areas include the Excellence in Care (EiC) programme, the transition of Capsule Sponge Endoscopy to business-as-usual, and the ongoing review of cancer pathways. These initiatives are underpinned by the principles of Realistic Medicine and reflect NHS Scotland's commitment to values-based care.
- 1.2 Quality improvement is approached holistically, recognising that sustainable change requires alignment across systems, behaviours and culture. The work described demonstrates how targeted improvement programmes are being used to enhance diagnostic accuracy, reduce clinical risk, embed learning, strengthen governance, and improve outcomes for patients and staff. Integration of national frameworks such as the Scottish Patient Safety Programme (SPSP) and EiC ensures that improvement activity is both evidence-informed and locally responsive.

2. Background

- 2.1 This extract from the Safety, Quality and Experience report is provided to inform the Board of ongoing improvement work aimed at enhancing patient care and experience. The report consolidates key elements of clinical governance, enabling a system-wide view of quality and safety activity. Its presentation to the Board supports organisational transparency, provides assurance that areas of good practice are being recognised, and confirms that areas requiring improvement are being identified and addressed. This structured reporting approach strengthens accountability and supports continuous improvement aligned with NHS Scotland values and strategic priorities.

3. Assessment

3.1 Quality

We are committed to fostering continuous improvement in quality throughout all aspects of our organisation, encompassing both clinical and non-clinical services. Our approach extends beyond the traditional boundaries of learning from incidents, complaints, and national audits, recognising that meaningful enhancements can arise from focused improvement initiatives as well. The projects undertaken have a direct and positive impact on our service users, ensuring that quality advancements are realised across the entire spectrum of our operations. Below, we provide

examples of such initiatives to illustrate our comprehensive commitment to elevating standards organisation-wide.

3.2 Incidents and SAEs

Efforts remain ongoing to reduce the volume of overdue incidents, with the team continuing to engage directly with individuals and notify handlers regarding their outstanding incidents.

With the new processes in place for clinical governance, there is now an enhanced emphasis on extracting learning from SAEs and ensuring that action plans are both completed, and the resulting lessons disseminated widely. All historic action plans have been thoroughly reviewed, with updates made to reflect the organisation's current position and any progress on actions, ensuring these developments are formally recognised and documented.

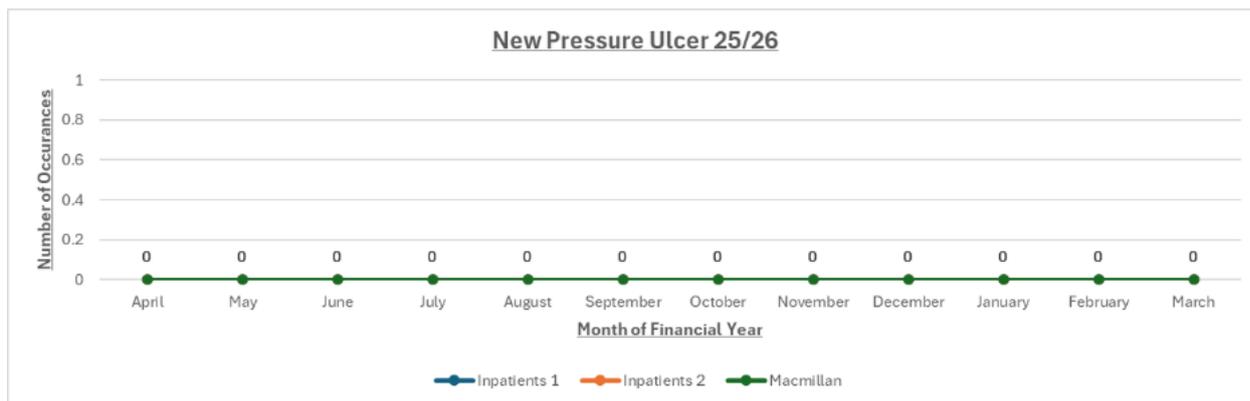
The persistent issue of overdue SAE Reviews remains a concern and is under scrutiny. The organisation is currently dedicating resources to better understand the root causes of these delays and to identify additional support needed to facilitate more timely completion of reviews. This has been highlighted with the recent addition of a risk to the Corporate Risk Register regarding the organisation's capacity to complete timely SAE reviews, a risk driven by limited availability of trained reviewers, an increasing volume of incidents, and competing priorities across the clinical governance team. Addressing these challenges is essential to ensuring that learning is promptly captured and translated into improvements in patient safety and service quality.

3.3 Excellence in Care (EiC).

The bi-annual report for the Chief Nursing Officer (CNO) is scheduled for submission by the end of October 2025. Upon receipt, the CNO will review the document, after which the final report is anticipated to be made available by late December or early January 2026. The findings demonstrate enhanced assurance regarding care quality and further progress in advancing the EiC programme throughout the organisation.

3.4 Pressure Ulcers

Data at the ward level indicate that no pressure ulcers were reported on any inpatient wards.



3.5 Eic Measures and Data Submission

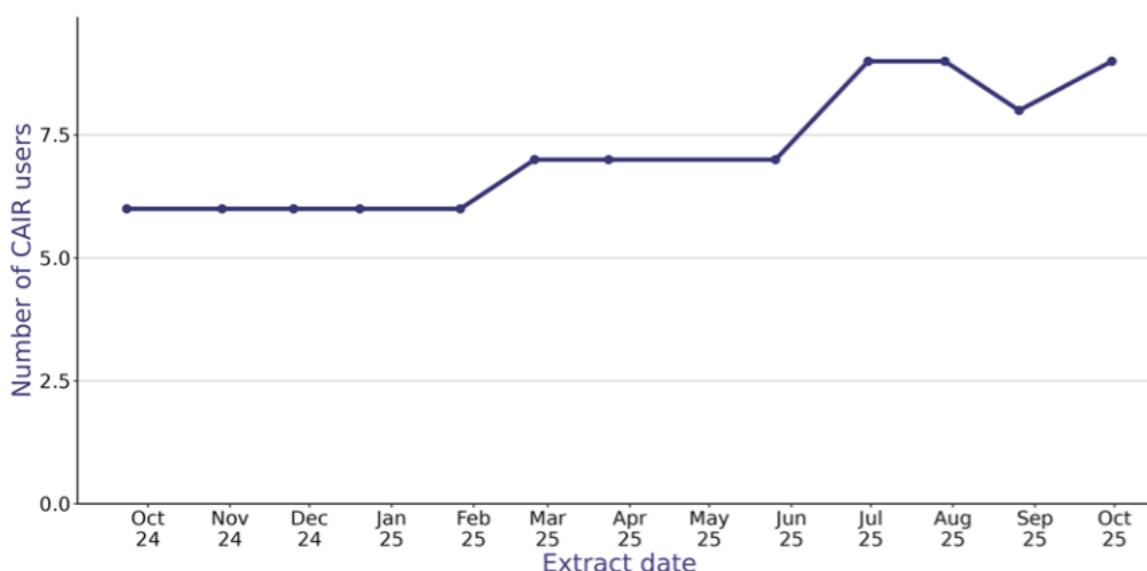
Senior Charge Nurses / Midwife / Operating Department Practitioner are encouraged to use the dashboard to inform staff discussions and team briefs. While data submission has been challenging, rates have improved over the last quarter, and it is anticipated that by January, a full year of data will enable more meaningful analysis through run charts and graphs. There has been an increase from 15% to 41% over the last year in reporting data.

3.6 Overall submission rates

Table 1: Monthly submission rates (%) in NHS Orkney

Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025
15%	15%	19%	23%	33%	37%	40%	30%	37%	37%	37%	41%

Number of Care Assurance and Improvement Resource (CAIR) Users in NHS Orkney. This chart shows the total number of CAIR users in NHS Orkney.



3.7 Quality Improvement Projects

Community Dressings Pilot Project

The Community Dressings Project is progressing well across the West Mainland, with cupboards now implemented in Dounby and Stromness Practices. The first stock order for Dounby Practice has been submitted to the National Distribution Centre, and a process is now in place to ensure all dressings are ordered through the stock system rather than prescribed via Pharmacy. Stromness Practice will follow shortly once their cupboard is fully installed.

This project aims to improve patient experience across the mainland by reducing delays in accessing appropriate dressings and enhancing clinical care and wound healing. Patients will benefit from having the right dressing at the right time, rather than being issued less suitable alternatives whilst waiting for a prescription. Staff will also have greater control over stock levels, immediate access to the full range of dressings, and the ability to select the most appropriate products following their own assessments, rather than relying on prescriptions from practitioners who have not personally assessed the wound. A similar project will be scoped out across the isles over the next year.

3.8 Capsule Sponge Endoscopy

The clinic is now operating as standard practice, and plans are underway to transition to a GP-led referral process. This initiative is currently under review, and additional details are expected to be provided in the next reporting period.

One of the key objectives of moving to a GP triage system is to help decrease the time patients spend on the waiting list for the procedure. By enabling general practitioners to assess and refer patients directly, it is anticipated that access to necessary care will become more efficient and timely. Updates regarding the effectiveness of this approach will be shared as part of future reports.

3.9 Colon Capsule Endoscopy

This innovative project is now being reviewed and scoped out in NHS Orkney to see if this is something we can support going forward. It is still in its infancy, but it is being considered for the future. Further information will be noted in the next reporting period.

3.10 Cancer Workstream

NHS Orkney's cancer pathways, which are aligned with those of NHS Grampian, are presently undergoing a comprehensive and systematic review. This process is primarily centred on strengthening the referral and diagnostic stages of the pathways, as these are managed directly by NHS Orkney and are less dependent on

support from NHS Grampian. The principal objective is to optimise these key stages, thereby improving timeliness, reducing clinical risk, and enhancing the overall patient experience.

To facilitate this work, weekly multidisciplinary meetings have been convened, providing a structured forum for the ongoing evaluation of current pathway performance, identification of areas for improvement, and agreement on targeted actions. The review is progressing satisfactorily, and revised pathways are anticipated to be finalised in the near future. The forthcoming updates are expected to deliver a more streamlined, efficient, and person-centred approach to cancer care within NHS Orkney, ensuring that services remain responsive to patient needs and are in accordance with national standards.

This initiative demonstrates NHS Orkney's ongoing commitment to continuous improvement and the principles of Realistic Medicine, specifically through the delivery of care that is tailored, evidence-based, and focused on what is of greatest importance to patients.

3.11 Realistic Medicine

The six-monthly return to the Scottish Government was completed to review the progress on the Realistic Medicine (RM) action plan for NHS Orkney. This report was commended by the Realistic Medicine Scottish Government team with reference to the extent of the work that is being carried out in Orkney but also the innovation and creativity. This report has been shared with the Senior Leadership Team. Awareness raising of Realistic Medicine is at the forefront of all activity with the opportunity to discuss the principles and impact of RM with the Cabinet Secretary, with the Nursing And Midwifery Advisory Committee, with finance colleagues and exploration of social prescribing.

Further progress has been made around the default Near Me outpatient appointments in collaboration with NHS Grampian. A patient feedback form for patients that do travel for appointments has been compiled with the Realistic Medicine Clinical Lead. This will be used to gather information on the benefits, challenges and value that appointment gave from the patient's perspective. The patient story to illustrate the challenges of travelling from one of Orkney's ferry linked islands to Aberdeen is being created to share with clinicians in Grampian and here at NHS Orkney.

At this half year stage all actions on the plan are progressing well.

3.12 Patient Travel Forms

The primary aim of this project was to enhance the process for collecting patient and escort information required for travel, ensuring that all necessary details are accurately recorded while prioritising patient confidentiality and experience. This initiative was also driven by recent policy changes from SG regarding Highlands & Islands escort requirements, which removed the involvement of GPs and placed responsibility for form completion directly on patients. This shift resulted in numerous challenges, particularly in supporting individuals to provide the required information in a confidential and accessible manner.

To address these challenges, an electronic online form was developed, designed to be user-friendly and to facilitate confidential completion by patients. Recognising that many individuals seek assistance at Central Reception, an iPad has been made available at the front desk to enable patients to complete the forms discreetly, with staff support available if needed. The development process for this project has spanned approximately one year and is now entering the pilot phase. The initial rollout is focused on frequent travellers, allowing for a review period to identify and resolve any issues before the procedure is adopted more broadly.

The outcome of this work is the introduction of a streamlined and secure process for submitting patient travel information, with full implementation anticipated by December, following the successful completion of the pilot phase and any necessary refinements.

3.13 Values and Behaviours Framework

Introduction and Purpose

The launch of NHS Orkney's new organisational Behaviour Framework marks a key milestone in strengthening our culture and leadership. Approved by the Senior Leadership Team and Board, this framework is a top priority in our Year 2 Corporate Strategy and the action plan following an External Review. It brings our values: Open and Honest, Respect, and Kindness, to life through everyday interactions.

The framework responds to findings from the external review into culture, governance, and leadership, which highlighted the need for clearer behavioural expectations across NHS Orkney. It aims to foster a psychologically safe, respectful, and high-performing culture by making our values visible and actionable.

3.14 Engagement Process and Key Themes

The framework was developed from stories and experiences shared by colleagues during engagement sessions. Their voices shaped this work, and consistent feedback helped identify the behaviours that matter most.

Key themes included:

- Promoting open and honest communication
- Demonstrating respect for roles, individuals, and contributions
- Showing kindness through manners, greetings, and valuing others
- Taking accountability and ownership of actions
- Expressing appreciation and acknowledging hard work
- Encouraging positive interactions and respectful challenge of misaligned behaviours

This co-design approach ensured the framework was grounded in real experiences and reflected the lived culture of NHS Orkney.

3.15 Overview of the Framework

Our Behaviour Framework sets out the core behaviours expected of everyone working at NHS Orkney. It defines how we approach our work and interact with others, helping to shape a positive and consistent workplace culture. It outlines the attitudes and behaviours that support us all to live our values more consistently, providing clarity on expectations and supporting a culture of openness, respect, and kindness.

The framework is designed to be practical and accessible, supporting everyday conversations and decision-making. It is designed to complement a variety of systems and development throughout the employee journey.

3.16 Engagement and Launch Activities

The framework was launched internally in early September 2025. Engagement activities have included:

- Continuation of team development sessions
- Drop-in sessions to introduce the framework and explore its relevance to different roles and teams
- Communication to all colleagues to raise awareness and encourage adoption

These activities have supported early adoption and created opportunities for teams to reflect on how the framework applies in their day-to-day work.

3.17 Post Launch Implementation

Since the launch, NHS Orkney has taken steps to embed the framework across the employee journey:

Recruitment and Induction: Values-based interview questions are encouraged, and recruitment and induction materials have been updated to reflect the framework.

Appraisal and Development: A dedicated 1:1 meeting guide zone is being developed within Turas to support values-based conversations.

Team Culture Work: The framework is being used in Organisational Development activities, including iMatter results and within self-awareness and reflective tools.

3.18 Future Plans for Embedding the Framework

We will continue to embed the framework into all aspects of the employee journey, including recruitment, induction, appraisal, and leadership development. Ongoing conversations with teams will support integration and ensure the framework becomes part of our everyday culture.

Evaluation through iMatter results and feedback loops will help us refine our approach and ensure the framework continues to support a positive, values-led working environment. We will continue to monitor uptake and impact, ensuring the framework evolves in response to feedback and organisational learning.

The quality work above demonstrates NHS Orkney's ongoing commitment to continuous improvement in both clinical and non-clinical domains. The organisation is actively addressing overdue incidents and Serious Adverse Event (SAE) reviews, with enhanced processes for extracting learning and disseminating lessons. While challenges remain, these are being recognised and mitigated through targeted actions and inclusion on the Corporate Risk Register.

Quality improvement initiatives, such as the Excellence in Care programme, Community Dressings Pilot, and the transition of Capsule Sponge Endoscopy to business as usual, are delivering measurable benefits for patients and staff. Data submission rates have improved, supporting more robust analysis and assurance. The review of cancer pathways and the adoption of Realistic Medicine principles further evidence a holistic approach to care, focused on safety, effectiveness, and person-centred outcomes.

Workforce achievements are acknowledged, with good practice celebrated and plans in place to support further improvement.

Overall, the organisation is progressing well in its quality improvement journey, with clear evidence of learning, innovation, and alignment to NHS Scotland values. Continued focus on embedding these improvements and addressing outstanding challenges will be essential to sustaining progress and delivering high-quality care across NHS Orkney.

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	The aim of this report is to evidence and provide assurance of areas of excellence supporting quality and good patient care. The report will also highlight areas that are being reviewed and plans to improve the quality and standards of care.
People	Workforce	Yes	The report celebrates where our workforce is demonstrating good practice, supporting positive patient experiences, and also plans to support the teams in improving care where needed.
Performance	Finance	Yes	The report highlights how safety, quality and experience can have a direct financial impact by reducing avoidable harm, streamlining care delivery, and minimising waste. When care is delivered effectively and responsively, it lowers the need for repeat interventions, shortens hospital stays, and optimises resource use, resulting in cost savings and better value for the organisation.
Potential	Risk Management	Yes	Through the identification of themes and trends and review of incidents and complaints, the organisation is enabled to identify areas of increased risk and to formulate mitigating actions to address these.
	Digital	No	
Place	Equality and Diversity including health inequalities	No	
	Climate Change Sustainability	No	

4. Recommendation(s)

It is asked that the Board review and discuss the report and information contained within it.

- i **Discussion** – Examine and consider the implications of a matter.

5. List of appendices

There are no appendices with this paper.

Month 10 Finance & Improving Together (efficiency programme) progress report Cover Paper

Meeting	NHS Orkney Board
Meeting date	Wednesday, 25 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> Melanie Barnes, Interim Director of Finance
Report Author(s)	<ul style="list-style-type: none"> Melanie Barnes, Interim Director of Finance
Purpose of report	<ul style="list-style-type: none"> Discussion
Contribution to Strategic ambition	<ul style="list-style-type: none"> Corporate Strategy 2024/28 Annual Operational Plan Government policy/directive Legal requirement
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> Effective Quality Sustainability
Key points for consideration	<ul style="list-style-type: none"> Improvement in the YTD financial position and year end forecast due to unanticipated income and release of IJB reserves As at Month 10 the reporting position is a deficit of £2.22m and a Year End Forecast of £2.6m. Savings of £2.263m have been achieved as Month 10
Route to meeting	<ul style="list-style-type: none"> Finance and Performance Committee 25 February 2026
Recommendation(s)	<ul style="list-style-type: none"> Discussion - Consider the Implications of a matter

Month 10 Finance & Improving Together (efficiency programme) progress report Cover Paper

Melanie Barnes, Interim Director of Finance

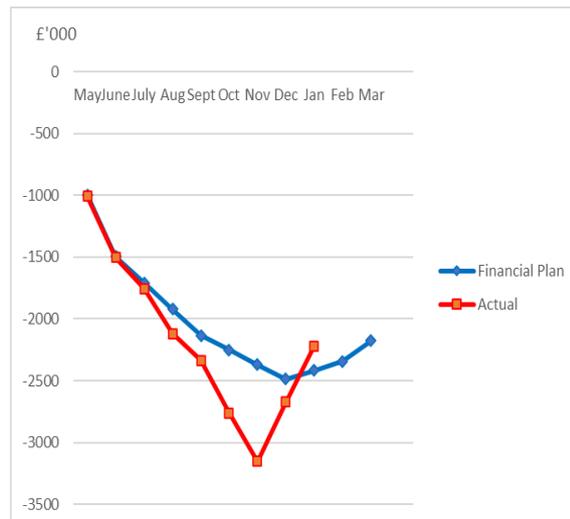
16/02/2026

1. Situation

- 1.1 NHS Orkney remains escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance. The Board has an approved financial plan for 2025/26 which projects a full-year deficit of £2.176 million against its revenue resource limit. This is prior to the application of £2 million in Transitional Funding Support agreed with the Scottish Government.
- 1.2 At the end of Month 10, the reported financial position an overspend of **£2.220m**, which is £44k higher than the planned deficit of £2.176m but £195k lower than the planned trajectory at Month 10.

2. Background

- 2.1 At the end of Month 10, the reported financial position an overspend of **£2.220m**, which is £44k higher than the planned deficit of £2.176m but £195k lower than the planned trajectory at Month 10. The achieved savings at Month 10 is **£0.303m adverse** to the YTD target of £2.565m.
- 2.2 There has been a significant improvement in the YTD position as at Month 10 which is predominantly due to the release of reserves by the IJB. This is a non-recurring benefit for 2025/26 only.



- 2.3 A revised year-end forecast was submitted to SG in Month 8, predicting a deficit of £4.2m at 31 March 2026. Due to the improvements in Month 9, a revised forecast of £3.6m was submitted. With the release of the IJB reserves, the forecast has been further reduced in Month 10 to £2.7m. Scottish Government have confirmed that the transitional funding of £2m will be provided, however any deficit position over £2m will be shown as an overspend in the annual accounts. The risk of a Section 22 qualified accounts being given by External Audit therefore remains.

3. Assessment

3.1 Analysis

Following submission of the revised year-end forecast in Month 8, SG made it clear that they are still expecting NHS Orkney to deliver as close to the approved financial plan as possible. The revised forecast of £2.6m at Month 10 is positive and work is continuing to review expenditure forecasts and savings schemes to identify opportunities for reducing the year end deficit to as close to £2m as possible.

The favourable YTD variance at Month 10 is due to:

- Agreement by the IJB to released utilised reserves of a YTD value of around £580k
- Unanticipated income of around £640k
- Additional unplanned expenditure in the first 10 months which was not included in the financial plan
- a reduction in funding from SG from what was originally anticipated
- YTD savings target underachieved by £0.303m (excluding the unachieved IJB savings target).

3.2 Current Position

At Month 8 a detailed expenditure forecast was undertaken and outlined a range of potential outcomes. This showed that the likely year-end out-turn would be £4.2m. Due to the receipt of income and the release of IJB reserves, this has now been revised to show a likely year end income of £2.7m

3.3 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 – 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Successful delivery of transformation ensures improved clinical outcomes and patient experience. Quality Impact Assessments are a pre-requisite of any identified efficiency/transformation scheme to ensure the best outcomes for patients as part of any scheme pursued in the delivery of the financial plan
People	Workforce	Yes	<p>Delivery of the Board's financial plan is challenging and it is recognised that successful delivery will have an impact on workforce.</p> <p>As part of the financial performance and delivery of the financial plan, changes to WTE, skill mix and role redesign will be necessary, however, these will be subject to Quality Impact Assessments and rigorous engagement with teams prior to implementation and to mitigate adverse concerns.</p>
Performance	Finance	Yes	Failure to deliver against the 2024/25 financial plan outturn will have a significant impact on the Board and the ability to de-escalate from level 3 of the NHS Scotland Support and Intervention Framework. Monthly reporting allows the position to be monitored closely and corrective action to be taken timeously as required.
Potential	Risk Management	Yes	Risk that the Board cannot deliver on its statutory responsibility to deliver a financial balance. Monthly reporting to the Scottish Government to ensure they are aware of the most up to date position/
	Digital	Yes	Investment in digital technology may be required in order to deliver against some of the transformational savings' schemes to ensure the most effective and efficient processes are in place. Additional investment if not captured appropriately during financial planning can have a detrimental impact on delivery of the forecast financial outturn.

Place	Equality and Diversity including health inequalities	Yes	Financial planning and performance along with the ongoing improvement work and savings schemes to ensure delivery against the Board's financial responsibilities has fairness and equality at the heart of ongoing improvement work as captured the QIA and developing a culture of continuous improvement
	Climate Change Sustainability	Yes	A number of the ongoing improvement/ savings schemes in place to deliver against the Board's financial plan incorporate schemes to reduce travel to and from Orkney with a number of additional schemes that look to reduce waste and overall the environmental impact

4. Recommendations

- 4.1 Discuss the Month 10 Financial Position
- 4.2 Discussion - Consider the Implications of a matter

5. List of Appendices

- 5.1 The following appendices are included with this report
 - i. **Appendix No 1**, Month 10 Financial Position

Notes on use of the template

- i. The first page is the cover page, the main body of your report should follow from page 2.
- ii. Where a separate report is attached as the main report, complete the impact assessment and recommendations (sections 3 and 4)
- iii. The markers <...> indicate what should be completed, do not include the <> markers.
- iv. The numbering of each section is automatic, use tab, and shift tab to move ahead and back a numbering level.
- v. Font is Arial 12pt for body text and is set by default
- vi. Do not change the margins

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NHS Orkney

Financial Position – Month 10 2025/26

Introduction

NHS Orkney was escalated to stage 3 of the NHS Scotland Support and Intervention Framework for finance in October 2023 and the Board is focused on reducing its deficit and returning to financial balance in a short a timescale as possible.

The Board has an approved financial plan for 2025/26 which projects a full-year deficit of £2.176 million against its revenue resource limit. This is prior to the application of £2 million in Transitional Funding Support agreed with the Scottish Government.

At the end of Month 10, the reported financial position an overspend of **£2.220m**, which is £44k higher than the planned deficit of £2.176m but £195k lower than the planned trajectory at Month 10.

The Board must reduce its expenditure run rate over the remainder of the financial year to deliver our financial plan.

Year to Date Financial Position

After 10 months of the 2025/26 reporting period, the revenue position shows an **overspend of £2.220m**, which is **£0.044m higher** than the approved deficit in the financial plan of £2.176m but **£0.195m lower** than the planned year-to-date overspend of £2.415m.

The achieved savings at Month 10 is **£0.303m adverse** to the YTD target of £2.565m. The trajectory of savings was geared towards the final quarters of the financial year with 32.5% due to be delivered in the final 2 months of the year. Following a full review of each of the workstreams, only £1.6m of cash-releasing savings will be delivered (42% of the total target of £3.8m).

A review of the expenditure forecast has also been carried out which shows the run-rate is in line with predictions and total expenditure will overspend by £2.66m at year-end following analysis on the reserve position for both the Board and the IJB.

Month 10 Year to Date Financial Position

The favourable YTD variance at Month 10 is due to several events:

- Agreement by the IJB to release unutilised reserves of a YTD value of around £580k
- Unanticipated income of around £640k

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This is offset against:

- Additional unplanned expenditure in the first 10 months which was not included in the financial plan
- a reduction in funding from SG from what was originally anticipated
- YTD savings target underachieved by £0.303m (excluding the unachieved IJB savings target).

Graph 1 illustrates the financial plan trajectory compared to the actual monthly results after 8 months of the 2025/26 financial year.

Graph 1: Year to Date Run Rate vs Planned Run Rate

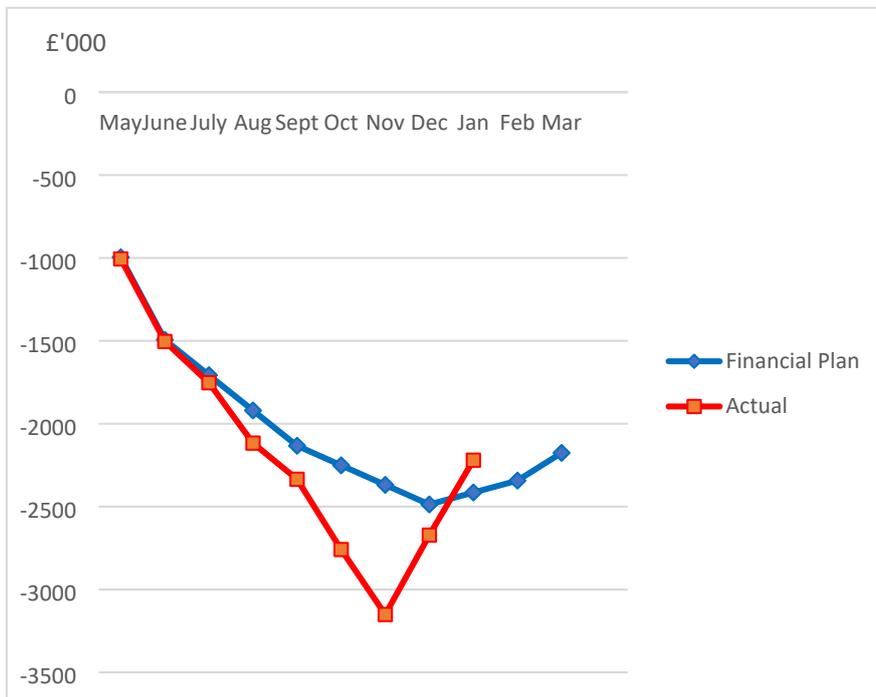


Table 1: Summary Month 10 Position

Level 4 Cost Category	Annual Budget	YTD Period Budget	YTD Actuals	Variance	Period Budget	Actuals	Period Variance
Income							
Health Board Income	-1,017	-848	-1,059	210	-84	-63	-21
Other	-491	-409	-1,051	642	-41	-121	80
Primary Care Patient Charges	-375	-352	-307	-45	-28	-22	-5
Total Income	-1,883	-1,609	-2,417	808	-153	-207	54

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Expenditure							
<u>Pay</u>							
Medical & Dental	9,268	7,723	10,332	-2,609	772	1,030	-258
Nursing & Midwifery	16,979	14,142	13,353	789	1,418	1,312	106
Other Staff Costs	27,918	23,300	19,045	4,256	2,309	1,980	329
Total Pay	54,164	45,165	42,730	2,435	4,500	4,322	177
<u>Non-Pay</u>							
Drugs - Primary Care	4,902	4,085	4,021	63	408	450	-42
Drugs - Secondary Care	3,698	3,081	2,721	360	413	296	117
General Dental Services	1,009	982	982	0	120	120	0
General Medical Services	5,251	4,376	4,366	10	438	411	26
General Ophthalmic Services	316	261	261	-0	22	22	-0
Medical Supplies	1,594	1,328	1,554	-226	133	142	-9
Other Expenditure	10,091	8,303	13,863	-5,560	938	771	166
Pharmaceutical Services	1,017	882	895	-12	89	87	2
Resource Transfer	2,334	1,945	1,940	6	195	187	7
SLA's & UNPACs	10,033	8,361	8,464	-103	836	882	-46
Total Non-Pay	40,244	33,604	39,067	-5,462	3,591	3,370	220
Total Expenditure	94,409	78,770	81,797	-3,027	8,090	7,692	398
Total	92,526	77,161	79,380	-2,220	7,938	7,486	452

Improvement Programme

NHS Orkney has an integrated improvement function which is responsible for driving savings delivery 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 £2.263m after 10 months against a trajectory of £2.565m.

At M5 the Improvement Programme reported a forecast delivery of £3.326m with additional pipeline schemes being scoped and progressed to implementation stage. At Month 5 £1.95m had been highlighted as medium or high risk to deliver.

A further review of all schemes was undertaken during M6 and the savings forecast was updated to reflect progress made to date in the implementation of schemes. As

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part of the process a further exercise has undertaken to focus on schemes that will reduce NHS Orkney's run rate this financial year.

Schemes that do not reduce the run-rate i.e. budget efficiencies, cost avoidance or savings that are caused by increased expenditure have been removed from the savings forecast. Only schemes impacting the run rate will be considered going forwards as part of the forecast. Based on current schemes in place, the Improving Together Programme **will deliver cash releasing savings of £1.654M** of which £1.620M are already in the forecast run rate.

Following the update of the savings forecast in line with these amendments the current savings gap to close for the remainder of 25/26 is £2.2m.

Overview: Month 10 Financial Position (Core RRL)

The overview at Month 10 is summarised in Table 2, with further detail provided in Appendix 1. Estates, Facilities and IT were moved under the Finance Directorate in Month 7.

Table 2 – Core RRL by Area

Directorate		Annual Budget	YTD Period Budget	YTD Actuals	Variance	Period Budget	Actuals	Period Variance
Acute Services Directorate	Income	-235	-196	-312	117	-20	-15	-5
	Pay	17,333	14,444	16,551	-2,107	1,444	1,616	-172
	Non Pay	2,188	1,823	1,805	18	182	140	43
Acute Services Directorate	Total	19,287	16,072	18,044	-1,972	1,607	1,741	-134
Chief Executive Directorate	Income	0	0	-16	16	0	-7	7
	Pay	2,575	2,185	1,925	260	133	190	-57
	Non Pay	167	159	123	36	4	-14	18
Chief Executive Directorate	Total	2,741	2,344	2,032	312	137	169	-32
Chief Officer Integration Board	Income	-528	-440	-547	107	-44	-52	8
	Pay	17,029	14,183	13,127	1,056	1,423	1,344	79
	Non Pay	15,753	13,135	14,741	-1,605	1,348	1,102	247
Chief Officer Integration Board	Total	32,254	26,878	27,321	-442	2,727	2,393	334
Directorate of Human Resources	Income	-43	-35	-74	39	-4	-11	8
	Pay	1,496	1,246	931	316	187	99	88
	Non Pay	333	278	194	83	28	29	-2

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Directorate of Human Resources	Total	1,786	1,489	1,051	438	211	117	94
Finance Directorate	Income	-572	-477	-892	415	-48	-51	3
	Pay	9,385	7,821	5,275	2,547	782	542	240
	Non Pay	2,672	2,193	6,936	-4,743	301	505	-204
Finance Directorate	Total	11,485	9,537	11,319	-1,781	1,035	996	39
Medical Directorate	Income	-196	-165	-249	84	-16	-40	24
	Pay	3,457	2,884	2,685	199	287	302	-15
	Non Pay	16,702	13,819	13,136	684	1,489	1,376	113
Medical Directorate	Total	19,962	16,538	15,572	966	1,760	1,638	122
Performance And Transformation	Income	0	0	-11	11	0	-1	1
	Pay	1,768	1,466	1,322	144	151	141	10
	Non Pay	14	12	40	-28	1	5	-4
Performance And Transformation	Total	1,782	1,478	1,351	127	152	144	8
Public Health Directorate	Income	-66	-55	-74	19	-6	-14	9
	Pay	1,122	935	915	20	93	90	4
	Non Pay	183	153	59	93	15	6	9
Public Health Directorate	Total	1,239	1,032	900	132	103	82	22
	Total	90,537	75,369	77,588	-2,220	7,733	7,281	452

Appendix 1 provides high level performance detail of each area.

Significant Areas of Concern

Medical Staffing Costs

During the first 10 months of the 2025/26 financial year, medical staffing costs have remained high, with costs £1.259m higher than 2024/25, thereby continuing to represent a significant area of financial pressure. This cost category is a key focus within the Board's grip and control measures, with targeted actions being implemented through the Improvement Programme to reduce expenditure over the remainder of the year. Review of locum and agency rates is being undertaken to reduce costs.

Agency Spend

Agency spend in nursing reduced in Q2 (compared to Q1) due to successful recruitment to vacant posts both within Acute and Community services however it rose again in Q3 (to Q1 levels). Community nurse agency costs have remained above what

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was originally planned in the first 10 months of the financial year and rose again in Q3. The agency costs are covering vacancies within community nursing teams and whilst controls are in place to ensure the overall spend does not exceed budget, the continued reliance on agency staffing must be reduced wherever possible.

Primary Care Prescribing

Primary Care prescribing costs continue to be lower than those anticipated during the budget setting process. Funding of £0.079m was removed by SG this year to fund the tariff transfer to non-discretionary expenditure which has had a negative impact on the position. This was not part of the assumptions provided to Boards as part of the financial planning process and was therefore not included in the financial plan.

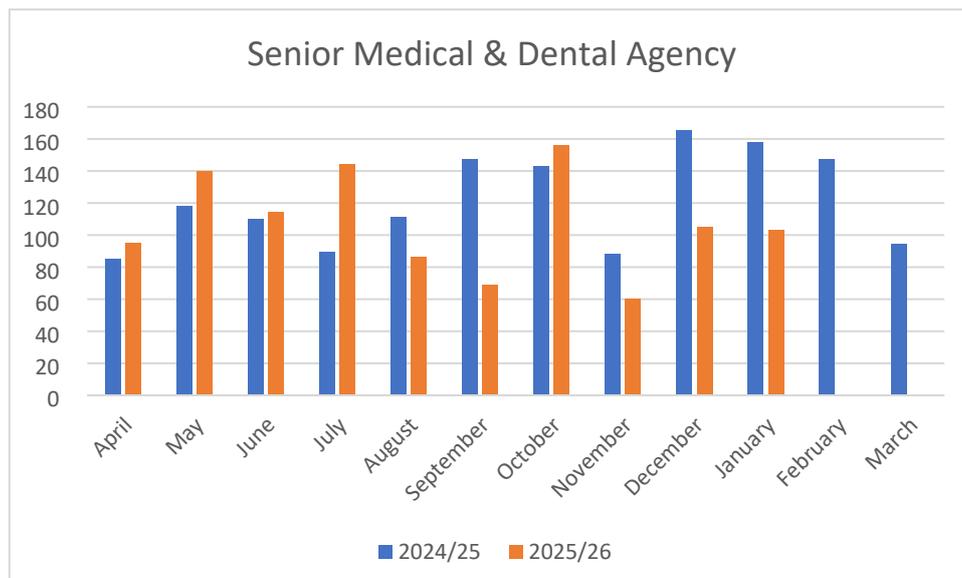
Other areas

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.

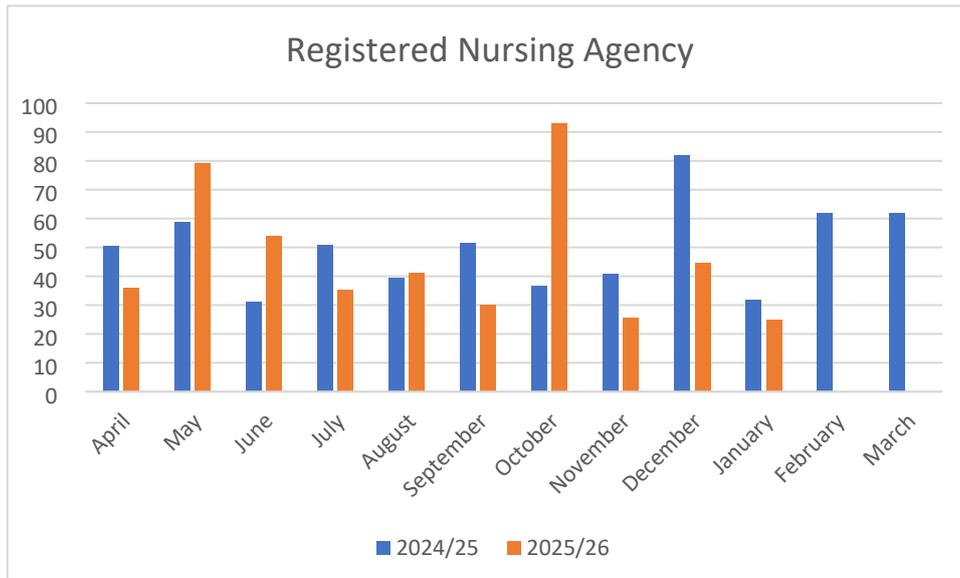
Key Costs - Spend

Pay

Agency costs 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. Community nursing and Senior Medical, however, continue to rely on agency and usage remains at higher levels for the first four month of 2025/26 compared with 2024/25, although there were some improvements in the position at Month 6:



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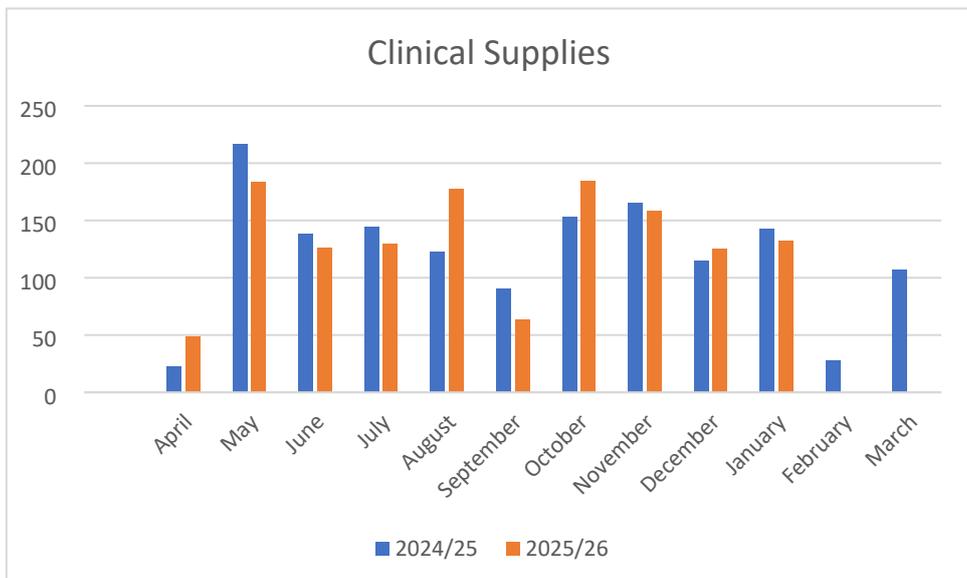
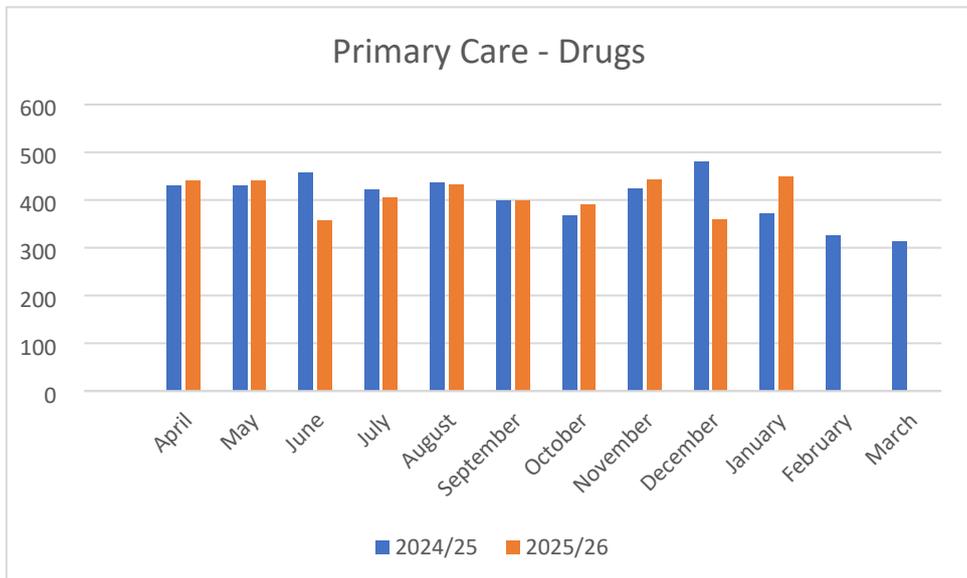
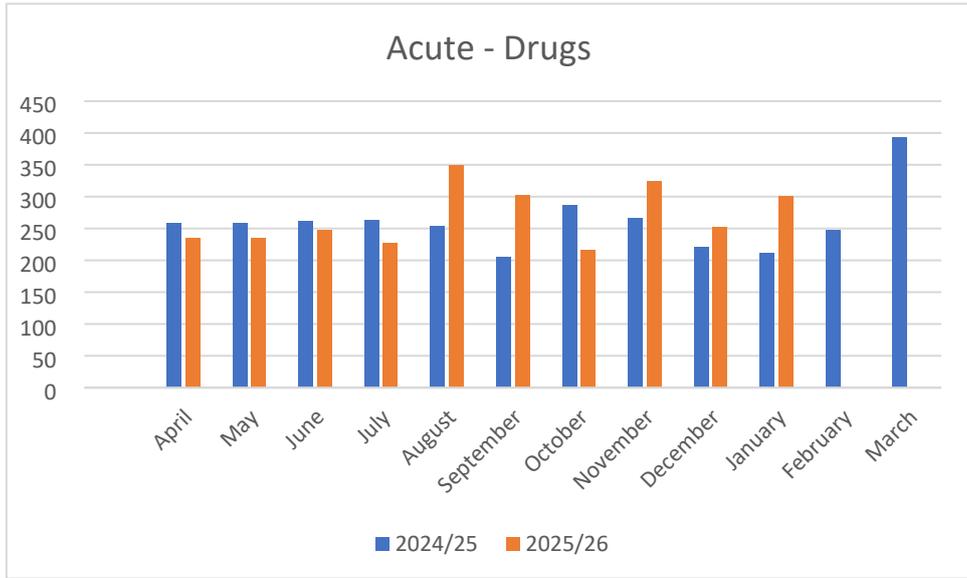


Non-Pay

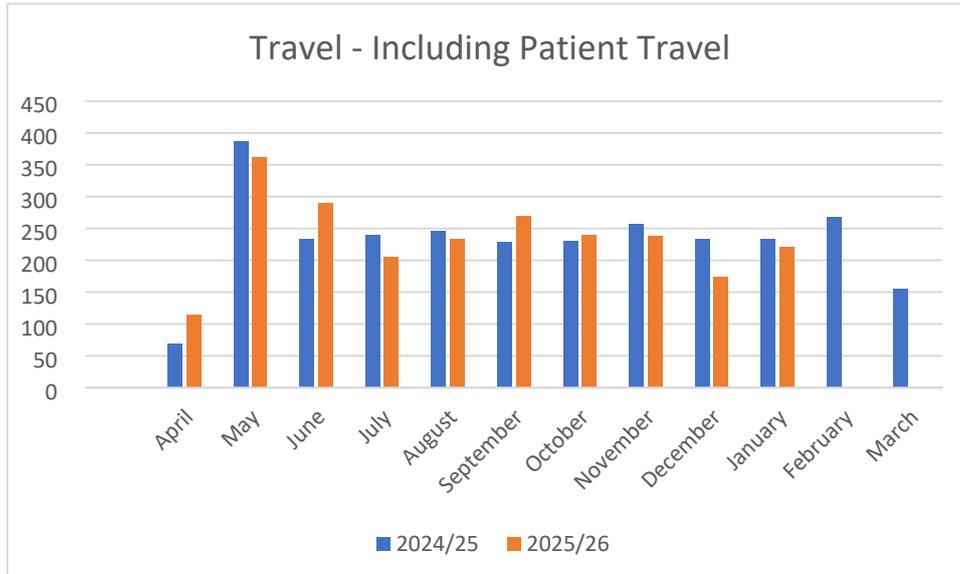
There are several high-spending non-pay areas that are monitored through the Improvement Programme for 2025/26 with targeted work via the Procurement, Diagnostics, Outpatient and Pharmacy Workstreams. As at Month 10 there have been a reduction in spend across Primary Care Drugs compared with the same period last year. These are volatile to changes in price and availability so risks remain that these costs will increase during the remainder of the year.

Travel (including patient and staff travel) saw decrease in Month 10 which is probably a result of fewer patients and staff travelling over the Christmas period. Inflationary increases of 3.8% have been charged from 1 December on flights which will have an impact of the final 4 months of the year. The financial plan assumed a 2.2% increase in the cost of flights.

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Year-End Forecast

As of Month 8, we have undertaken a detailed expenditure forecast and outlined a range of potential outcomes. These will be updated each month.

We are currently aware of a £165k reduction in the 2025/26 allocation from the Scottish Government. This is made up of £79k for Primary Care Drugs, £47k for New Medicines and £39k for Sustainability.

Additional YTD cost pressures for developments not included in the financial plan have also arisen. This is made up of £134k for Windows 11 and £18k for RIS Integration for Radiology.

In addition, there are several cost pressures that have not been quantified yet but will have an impact on the year-end forecast:

- NHS Lothian have confirmed they will move to a 2-year average to calculate activity data for their SLA's. This is likely to result in additional costs to NHSO as the removal of 2021/22 data from the calculation will result in a higher average activity
- The overarching SLA uplift has initially been agreed at 4.33% but that is subject to change in the event of further changes to the pay this year. NHSO internal modelling originally calculated the increase likely to be in the region of 5.5% - 6.0%. The financial plan assumed an increase of 3%, thereby adding an addition 3% cost pressure. The total estimated increase above the plan estimated to be in the region of £400k.
- It is anticipated that there will be a couple of high costs medicines approved this financial year with high patient numbers for NHSO – internal modelling for GLP1-RA suggests a full year cost of around £1m for NHSO
- There are currently 48 submissions through the national portal for the band 5-band 6 review. There is a potential for further impact to the outturn position if

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the settled claims exceed the provision that is currently being made for agenda for change reform costs.

However, over the past 2 months we have seen an increase in non-recurring income and a reduction in expenditure which has improved the forecasted position at year end.

Modelling of the likely year-end scenarios show that in the worst-case scenario the likely overspend is in the region of £3.0m. This is a reduction from previous forecasts due to the increase income and reduced expenditure. Any year-end position over a deficit of £2m will result in reporting an overspend position at year end.

Forecast Summary	Financial Plan	Updated Forecast at Month 6		
		<u>Best Case</u>	<u>Likely Case</u>	<u>Worst Case</u>
	£'000	£'000	£'000	£'000
Net Gap as per Financial Plan	5.776	5.776	5.776	5.776
Any Emerging Pressures		1.500	1.500	1.500
Reduction in Run-Rate		(2.270)	(2.058)	(1.700)
Any New Funding		(0.457)	(0.457)	(0.457)
Reduction in Funding		165	165	165
Net Gap	5,776	4.714	4.926	5.284
CIPs – Recurring	(2,800)	(1.521)	-1.268	(1.268)
CIPs – Non Recurring	(1,000)	(1.193)	-0.994	(0.994)
Service Development Commitments	200	0	0	
25/26 Out-Turn	2,176	2.000	2.664	3.022
Transitional Funding	(2,000)	(2.000)	(2.000)	(2.000)
2025/26 Out-Turn	176	0	0.664	1.022

Capital

The Capital formula allocation for 2025/26 is £1.078m, there are several earmarked allocations anticipated in year for National Infrastructure Board (£202k), Decontamination (£282k), Solar Panels & Batteries (£109k) 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 6 and there is a plan to transfer £500k to Revenue as a result.

Currently there is no risk to any of the projects delivering. A final review of proposals for the unallocated capital funding will be undertaken during Month 7 and thereafter an action plan will be developed to utilise any unallocated budget.

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Capital Projects		Total Approved Budget	YTD Actual	Forecast Remaining Expenditure	Variance	Notes
		£'000	£'000	£'000	£'000	
Formula Capital Projects		265	88	177	0	Approved Estates Projects 25/26
Earmarked Allocations	NIB Funding	202	125	77	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
	Solar Panels & Batteries	109		109	0	Funding agreed for additional solar panels and batteries
Unallocated Budget		813		200	613	£200k for survey works for demolition of the old Balfour
Transfer to Revenue		(500)			(500)	
Capital Receipts						
Total		1,175	213	849	113	

NHS Scotland Support and Intervention Framework

Following the removal of brokerage from 1 April 2025, the NHS Scotland Support and Intervention Framework has been revised to include a two-stage assessment process.

The first stage is to assess the in-year deficit and cumulative level of historic brokerage since 2019/20 as a proportion of the Board's total revenue resource limit.

In 2025/26, the 12-month Core RRL from 2024/25 will be used for this assessment. For NHS Orkney, the 2024/25 Core RRL is £89.019m. NHS Orkney received £5.156m of brokerage in the 2023/24 financial year and a further £3.874m in the 2024/25 financial year. This is a total of 10.1% of the 2024/25 Core RRL and the in-year brokerage of £3.874m for 2024/25 was 4.3%.

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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 second stage is a qualitative assessment of the Board's governance, financial management and internal controls. The assessment will be undertaken by either a senior member from the Scottish Government Health Finance Team or an independent party. The assessment will take account of, but not be limited to, the following factors:

- Quality, timeliness and reliability of financial reporting and engagement between Scottish Government Health Finance and the Board Director of Finance and senior finance team,
- Recommendations from internal audit reports, with a particular focus on governance, internal financial controls and stewardship of financial resources, and progress with implementation thereof,
- Findings and conclusions from external audit reports, and corresponding implementation of recommendations, with a focus on governance, financial controls and financial sustainability,
- Historical financial performance and evidence of delivery of agreed savings plans (including performance in relation to 3% recurring target) and effective mitigation of in year cost pressures whilst balancing performance and quality/safety,
- Proactive engagement with respective IJBs in relation to assessing financial plans, performance and risk share,
- Evidence of effective use of data, benchmarking and external support to drive improvements and the Board's engagement in using this support to develop its own internal delivery plan and
- Evidence of responsibility for improvement actions across the executive team and effectiveness of Board oversight and governance in relation to best use of resources and delivery against agreed plans.

The outcome of the qualitative assessment paired with the first stage assessment will determine the recommendation of any escalation and the level of escalation.

Following this two-stage assessment NHS Orkney remains at Level 3 escalation as confirmed within our Quarter 1 review letter from Scottish Government.

The Scottish Government have reiterated that there will be no brokerage available to Boards in 2025/26. Should financial balance not be achieved, this will be shown as

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an overspend in the financial statements, leading to potential qualification of accounts.

Delivery of the 2025/26 Financial Plan of a deficit of £2.176m and meeting the terms and conditions for the transitional funding should result in NHS Orkney remaining at Level 3 Escalation in this current financial year and should mitigate the financial risk of qualification of our financial statements.

Conclusion and Next Steps

The year-to-date financial position after the first 10 months of the 2025/26 financial year shows an adverse variance to plan, with a reported deficit of **£2.220m**, against the trajectory overspend of £2.415m, giving an overall favourable variance of **£0.195m** at the end of the reporting period.

The Board remains focused delivering its financial plan and returning to financial balance in a short a timescale as possible.

The significant work undertaken to review all schemes within the Improvement Programme and development of a robust expenditure forecast has highlighted that cash releasing savings of £2.5m will not be delivered in this financial year.

Reduction of the run rate will be essential to achieving the planned year-end deficit of £2.176m and the Board is reviewing options to achieve that.

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Appendix 1 –Performance summary

Acute Services - £1.972m overspend

- *Hospital Medical Staff, £2.386m 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, £0.222m overspend*

All services are overspending at the end of month 10. Theatres is overspent by £115k, OPD by £61k and Dialysis by £47k due to unfunded bank usage however Theatres is also overspent on surgical supplies.

- *Clinical Nurse Manager, £196k underspend*

Inpatients 1 (£214k overspend) and Inpatients 2 (£55k overspend) are both reporting overspends at month 10 which are being offset by underspends in HDU (£287k underspend), the Emergency Department (£136k underspend) and Macmillan Inpatient (£148k underspend). It was anticipated that the additional agency workers contracted in Q4 of 2024/25 would be removed in Q1 however, there continues to be some usage so far this year however plans are in place to remove all agency in Acute areas at the earliest opportunity.

- *Women's Health £137k underspend*

All services are underspending at the end of month 10. The main area of underspend is the Maternity Ward (£70k) and most of it can be attributed to vacancies.

- *Laboratories, £113k underspend*

Laboratories are reporting an underspend at month 10 due non-pay costs being down however the adverse movement in this month is due to higher-than-average supplies costs related to the managed service contract. The underspend in non-pay is offset by an overspend in pays due to agency usage to cover current vacancies.

Medical Director - £0.966m underspend

- *Pharmacy, £720k underspend*

New Medicines funding is currently underspent at month 10. Pharmacy are also carrying several vacancies which are impacting their overall position for 2025/26. The favourable movement in M10 is mainly due to additional funding from SG of £0.14m

- *External Commissioning, £49k 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.

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- *Unplanned Activity £73k overspend*

Unplanned Activity is overspent to month 10 but it's variable by nature and is subject to significant potential movement throughout the year and at year end.

- *Patient Travel, £79k overspend*

Patient travel out with Orkney continues to overspend. It is anticipated that spend on patient travel will reduce over the remainder of the year in line with the savings programme related to patient travel.

IJB – Delegated Services - £0.442m overspend

The Delegated Services budgets report a net overspend of £0.442m, £0.975m operational underspend and £1.417m unachieved savings target (Table 1). Further detail on the operational areas is provided below:

- *Children's Services, £30k underspend*

The underspend in Children's services is in the main related to vacancies in Health Visiting and School Nurses.

- *Primary Care, £539k underspend*

Primary Care General Medical Services is currently overspending (£29k overspend at month 10) due in the main to locum and agency spend within this area. There are offsetting underspends in Primary Care Administration (£205k underspend), Community Nurses (£270k) and Specialist Nurses (£69k underspend).

- *Primary Care – Dental £118k underspend*

The dental underspends relate in the main to Senior Dental and Dental Nursing.

- *Health and Community Care, £191k underspend*

Mental Health Services has an overspend of £71k at month 10, this in the main is due to vacancies within this area. There are also underspends within the Health and Community Care Management Team (£117k underspend) and Intermediate Care Team (£37k underspend).

- *Primary Care Prescribing, £38k underspend*

The Prescribing Unified budget is currently showing an underspend of £9k at the end of period 10 while the position includes a reduction in funding from SG for tariff transfer (£79k for 25/26). 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 £21k at month 10.

Finance - £0.245m underspend

Finance is currently reporting an underspend of £0.245m, with spend broadly in line with the position at month 9 however the favourable movement in month 10 is the result of £0.11m of additional funding from SG for risk share arrangements related to compensation payments.

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Estates and Facilities - £0.907m underspend

Estates and Facilities is reporting an underspend of £907k to date, in the main, the underspend is due to vacancies across several services and underspending non pay budgets in hospital maintenance contracts.

Chief Executive - £0.406m underspend

There are several vacancies across the portfolio impacting the month 10 position.

Public Health - £0.132m underspend

Currently reporting an underspend of £132k. There are various over and underspending services in this area.

Human Resources - £0.438m underspend

There are several underspending areas within the service impacting on the overall underspend, this includes vacancies across a number of areas.

Performance and Transformation - £0.127m underspend

There current underspend is mainly related to vacancies with Health Intelligence.

2026/27 Financial Plan for NHS Orkney

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/ Non-Executive	<ul style="list-style-type: none"> Melanie Barnes, Interim Director of Finance
Report Author(s)	<ul style="list-style-type: none"> Melanie Barnes
Purpose of report	<ul style="list-style-type: none"> Decision
Contribution to Strategic ambition	<i>Delete as applicable</i> <ul style="list-style-type: none"> Corporate Strategy 2024/28 Annual Operational Plan Choose an item. Government policy/directive Legal requirement Local policy Choose an item.
Alignment to NHS Scotland quality ambition(s)	<i>Delete as applicable</i> <ul style="list-style-type: none"> Effective Quality Sustainability
Key points for consideration	<ul style="list-style-type: none"> NHS Orkney faces a revised opening deficit of £3.6m for 2026/27, requiring savings of £4.173m to achieve planned position. Scottish Government planning assumptions include a 2% baseline uplift and expectation of 3% recurring savings. Savings of £3.685m, of which £2.964m are recurring, have been identified for 2026/27. Net deficit is forecast to be £1.988m at 31 March 2027. Transitional funding of £1.5m is proposed which leaves around £500k remaining to break-even Delivery risk remains high; transformational change and integrated planning are critical to financial sustainability.
Route to meeting	<i>List all meetings (and dates) the paper has been presented</i> <ul style="list-style-type: none">
Recommendation(s)	<ul style="list-style-type: none"> Decision - Reaching a conclusion considering the options

2026/27 Financial Plan for NHS Orkney

Melanie Barnes, Interim Director of Finance

20/01/2026

1. Situation

- 1.1 NHS Orkney is entering the 2026/27 planning cycle in a highly constrained financial environment. The Board faces a revised opening deficit of **£3.6m**, requiring delivery of **£4.173m in savings** to achieve the planned position. Scottish Government planning assumptions include a **2% baseline uplift** and an expectation of **3% recurring savings**, alongside clear guidance that brokerage is no longer available. Failure to deliver this plan will result in a **Section 22 qualification of the Annual Accounts**, which would be reported to the Scottish Parliament's Public Audit and Post-legislative Scrutiny Committee. The Board is asked to **approve the 2026/27 Financial Plan**, which sets out the actions required to stabilise the financial position and progress towards long-term sustainability.

2. Background

- 2.1 NHS Orkney's financial planning for 2026/27 is set against a challenging strategic and operational context. The organisation operates within the framework of the **Corporate Strategy 2024–28**, the **Annual Operational Plan**, and national policy requirements, including **DL(2025)25 – Implementation of Sub-National Planning**. This directive requires Boards to align local plans with regional structures, ensuring integrated approaches to capacity, workforce, and infrastructure planning across Scotland East.

In March 2025, NHS Orkney's three-year financial plan was approved by Scottish Government, supported by £5m in transitional funding over four years, conditional on achieving financial balance by 2028/29. However, the forecast out-turn for 2025/26 has deteriorated significantly, with a revised deficit of **£3.6m**, meaning the terms of transitional funding have not been met. Brokerage is no longer available, and failure to deliver the 2026/27 plan will result in a **Section 22 qualification** of the Annual Accounts.

Scottish Government planning assumptions for 2026/27 include:

- A **2% baseline funding uplift** (£1.6m) to cover pay and inflationary pressures.
- Full funding for the 2025/26 pay deal and Agenda for Change reform.
- Expectation of **3% recurring savings** on baseline budgets.
- No new recurring commitments without confirmed funding.

The financial plan also reflects the unique challenges of an island health system, including workforce fragility, rising travel costs, and service delivery constraints. Integrated planning—linking finance, activity, workforce, and quality—is essential to ensure sustainability and compliance with statutory duties. Provide pertinent information relating to the situation.

3. Assessment

3.1 Analysis

The financial outlook for 2026/27 remains extremely challenging. NHS Orkney must deliver **£4.173m in savings** to achieve a break-even position, representing approximately **6% of baseline RRL**. This is significantly higher than the 4.8% target set for 2025/26, which was not fully delivered. The deterioration in the 2025/26 out-turn and the removal of brokerage increases the risk profile for 2026/27.

Key drivers include:

- Persistent cost pressures in pay and non-pay areas, including Agenda for Change reform and inflationary impacts.
- Increased travel and procurement costs linked to island geography.
- Workforce fragility, requiring continued reliance on locums and agency staff.
- Limited flexibility for large-scale service redesign due to organisational size and geography

3.2 Three Year Financial Plan

The three-year draft financial plan is as follows:

Summary RRL Position	2025/26	2026/27	2027/28
	£m	£m	£m
Deficit brought forward	3.600	1,988	2,988
Add: Non-Recurring Savings and Funding	2.422	1.582	0.500
Pressures – Pay	1.809	2.979	1.211
Pressures – non-pay	3.713	2.757	3.084
Baseline Funding Uplift	(3.531)	(1.700)	(1.734)
Additional Non-Recurring Funding	(2.340)	(0.500)	(0.300)
Net Gap	5.673	5.533	5.750

CIPs - Recurring	(2.885)	(2.545)	(2.545)
CIPs – Non Recurring	(0.800)	(0)	(0)
Net Deficit after CIPs	1.988	2.988	3.205
Proposed Transitional Funding	(1.500)	(1.000)	(0.500)
Remaining Gap	0.488	1.988	2.705

The three-year plan has worsened from the 2025/26 approved plan, mostly driven by the reduction in planned savings over the 3 year period.

3.3 2026/27 Summary Position

- Opening deficit: **£3.6m**.
- Net gap before savings: **£5.673m**.
- Transitional funding assumed: **£1.5m** (subject to confirmation).
- Savings identified to date:
 - Corporate Schemes **£2.085m risk-adjusted**,
 - Devolved Targets **£1.600m**
 - leaving a gap of **£0.488m**.
- Delivery risk: High, with potential Section 22 qualification if plan is not achieved.

3.4 Impact Assessment

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 - 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	Financial constraints may impact service redesign pace; mitigations include prioritising safety and TTG compliance
People	Workforce	Yes	Workforce fragility persists; plan includes recruitment strategies and wellbeing support to minimise negative impact
Performance	Finance	Yes	Significant financial risk; robust monitoring and efficiency programme in place to manage delivery.
Potential	Risk Management	Yes	High risk of Section 22 qualification; mitigations include strengthened governance and escalation processes
	Digital	Yes	Positive impact through investment in digital programmes (My Care App, Theatre Scheduling) to improve efficiency.

Place	Equality and Diversity including health inequalities	Yes	No adverse impact anticipated; equality duties considered in all redesign proposals.
	Climate Change Sustainability	Yes	Neutral to positive; efficiency measures may reduce carbon footprint, though travel costs remain a challenge.

4. Recommendation(s)

The Board is asked to:

- **Approve** the 2026/27 Financial Plan as set out in this paper.
- Note the requirement to deliver **£4.173m in savings** (approximately 6% of baseline RRL) and the associated high delivery risk.
- Endorse the proposed approach to integrated planning, workforce transformation, and efficiency programmes to achieve financial sustainability.
- Support continued engagement with Scottish Government and Scotland East partners to identify further opportunities for collaborative savings and service redesign.
- Acknowledge the risk of a **Section 22 qualification** if the financial plan is not delivered and the mitigations in place to manage this risk. Describe the recommendations based on the assessment section>

i **Decision** – Reaching a conclusion after the consideration of options.

5. List of appendices

5.1 The following appendices are included with this report:

- **Appendix 1**, NHS Orkney 2026/27 Financial Plan

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NHS Orkney

Financial Plan 2026/27 to 2028/29

Introduction

NHS Orkney is entering the 2026/27 planning cycle in a financially constrained operating environment, with persistent cost-pressures, workforce fragility and ongoing volatility across many areas including cost of travel, procurement and specialist service delivery for an island health system.

This paper sets out the proposed financial planning assumptions for 2026/27 to enable the Board to take a clear, evidence-based position on the scale of the challenge and the parameters required to deliver a balanced and credible plan. The work is anchored in our statutory duties, our Annual Delivery Plan commitments, and the system-wide priorities agreed through the Orkney Partnership, ensuring alignment with national direction, emerging Scottish Government guidance and continued focus on safe, sustainable and value-driven services for our island and ferry-linked communities.

Our financial plan is also aligned with the requirements of the DL(2025)25 – Implementation of Sub-National Planning published in November 2025. This financial plan will form part of the consolidated financial plan for Scotland East to support a shift back to financial balance across all areas and services. The Sub-National Plan will include:

- A description of how capacity, workforce and infrastructure will be deployed across Scotland East
- A set of measurable improvement trajectories and
- Identification of governance and assurance arrangements to monitor delivery and outcomes.

The consolidated plan will be presented to the Finance and Performance Committee and Board in due course, but this document will form the basis of NHS Orkney's submission to the consolidated plan.

NHS Orkney 3-year financial plan 2025/26 to 2027/28 summary

In March 2025, NHS Orkney's Three-Year Financial Plan was approved by Scottish Government following review. The Government confirmed confidence in the organisation's leadership and approved £5m in non-recurring transitional funding over four years, conditional on delivering an out-turn within 1% of core RRL in 2025/26 and achieving full financial balance by 2028/29.

Improved performance in 2024/25 strengthened the opening position for 2025/26, and the plan set out a credible pathway to financial balance by 2028/29. The 2025/26 savings requirement increased to £3.8m, with most plans identified, though some remained medium- or high-risk. Additional cost pressures—particularly new high-cost medicines, inflation risks, and potential AfC reform impacts—continued to require close management.

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The transitional funding mitigated the previously high risk of a Section 22 Qualification, and with the Improving Together Programme embedded, NHS Orkney had a realistic and deliverable route to restoring financial sustainability in line with Scottish Government expectations. The approved deficit for 2025/26 was £2.176m.

The approved four-year financial plan as at 31 March 2025 was:

Table 2 – Revised Financial Plan submission

Summary RRL Position	2025/26	2026/27	2027/28	2028/29
	£m	£m	£m	£m
Deficit brought forward	3.874	2.176	2.034	0.756
Add: Non-Recurring Savings	1.186	1.000	1.000	1.000
Pressures – Pay	1.400	1.442	1.485	1.530
Pressures – non-pay	3.457	2.757	2.869	3.352
Emerging Cost Pressures Identified	1.309			
Baseline Funding Uplift	(2.181)	(2.312)	(2.382)	(2.430)
Additional Non-Recurring Funding	(3.269)	1.221		
Net Gap	5.776	6.284	5.006	4.208
CIPs – Recurring	(2.500)	(3.250)	(3.250)	(3.250)
CIPs – Non Recurring	(1.000)	(1.000)	(1.000)	(0.958)
CIPs – Additional Target	(0.300)			
Net Deficit after CIPs	1.976	2.034	0.756	0.000
Service Development Commitments	0.200	0.000	0.000	0.000
Total deficit including service development commitments	2.176	2.034	0.756	0.000

The transitional funding is not included in these figures as it was to be utilised to show a break-even position in each year. It was recognised that additional savings would be required in 2025/26 and 2026/27 as the level of transitional funding required was not sufficient to break even.

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During 2025/26, however the financial position has been adverse to trajectory throughout the year. In Month 6, a formal review of the forecasted out-turn calculated that without turnaround actions, the Board was heading for a £6.2m deficit. The Board has subsequently implemented several turnaround actions to revise its forecasted year-end deficit to £3.6m. Work is ongoing to review the IJB reserves which may result in the deficit reducing further, however the financial plan within this paper assumes that the closing position for 2025/26 will be a deficit of £3.6m. The receipt of transitional funding does not affect the opening deficit for 2026/27. The Board is committed to improving this position as much as possible and the financial plan will be updated accordingly.

Integrated Planning Approach

Developing an integrated financial plan is critical to ensuring NHS Orkney can make coherent, system-wide decisions that balance finance, activity, workforce and quality. These components are interdependent, and planning them in isolation creates operational blind spots, cost pressures and avoidable variation. An integrated approach provides the Board with a single line of sight across demand, capacity, affordability and clinical impact, enabling informed trade-offs and proactive risk management. It also ensures that any savings, service redesign, or workforce changes are assessed not just for financial viability but for their implications on quality, safety, performance and sustainability. In short, an integrated plan is the mechanism that keeps the organisation open, aligned and strategically disciplined as we navigate a highly constrained environment.

Activity Planning

Effective activity planning is a core requirement for NHS Boards in Scotland, underpinning our ability to deliver safe, person-centred and sustainable care across both elective and unscheduled pathways. By developing a clear view of expected demand, seasonal pressures and local capacity constraints, including the unique challenges of remote, rural and island delivery, Boards can ensure that resources are aligned to need and that clinical risk is proactively managed. For planned care, robust activity planning is essential to meeting national treatment-time guarantees and reducing long waits. For unscheduled care, it supports safe flow, reduces avoidable delays, and strengthens whole-system resilience. Taken together, disciplined activity planning provides the foundation for credible financial planning, workforce deployment and operational performance, ensuring we fulfil our statutory duties and deliver high-quality care for our communities.

Demand, Capacity, Activity and Queue (DCAQ) analysis is a core improvement tool for NHS Boards in Scotland, providing a transparent, data-driven view of how services are performing against current and future demand. By systematically assessing the balance between what is coming in, what we can deliver, and the size and profile of our waiting lists, DCAQ enables clinically credible decision-making and supports the redesign required to deliver national treatment-time guarantees and reduce long waits. It gives Boards a single source of truth on service sustainability, highlights bottlenecks and unwarranted variation, and informs realistic workforce, finance and activity plans. In practice, DCAQ strengthens operational grip, improves forward planning, and ensures that improvement efforts are targeted where they

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deliver the greatest value for patients and staff, particularly in remote, rural and island systems where small changes in demand or capacity have disproportionate impact.

Elective DCAQ Summary – Capacity, Risk and Sustainability

Across new and return outpatient pathways, elective demand continues to outstrip available capacity, with the aggregate position masking significant specialty-level volatility and risk. In 2025/26, total new outpatient demand of 5,983 exceeds planned capacity of 4,930, creating a net gap of +370 despite removal of 1,423 pathways, indicating that current productivity assumptions are insufficient to fully stabilise inflow. While the return outpatient position shows a marginal surplus in capacity in 2026/27 (+172), this improvement is uneven and fragile, heavily reliant on sustained delivery in high-volume specialties such as General Surgery, Ophthalmology and Trauma & Orthopaedics. Several specialties present persistent and material capacity risks across both years, most notably Dermatology, ENT, Pain Management and Oral Surgery, where demand growth and constrained capacity result in recurrent negative gaps, particularly for new patients, increasing the risk of longer waits and pressure on return pathways.

Elective DCAQ – by specialty

Group	Specialty	Waiting List Type	Activity				2025/26				2026/27			
			2023/24	2024/25	2025/26	2026/27	Demand	Capacity	Removed	Gap	Demand	Capacity	Removed	Gap
New Outpatients	Cardiology	New	206	259	246	234	388	246	133	-9	359	234	114	-11
		Return	267	290	308	277	253	308	57	112	300	277	57	34
	Dermatology	New	368	387	355	353	588	355	199	-34	614	353	216	-45
		Return	283	290	260	247	272	260	26	14	267	247	22	2
	Diabetes	New	18	28	13	15	22	13	9	0	24	15	3	-6
		Return	90	87	97	85	134	97	7	-30	83	85	14	16
	Ear, Nose & Throat	New	269	225	514	267	449	514	130	195	476	267	142	-67
		Return	102	172	230	209	363	230	52	-81	191	209	61	79
	General Medicine	New	157	206	193	218	285	193	102	10	362	218	131	-13
		Return	392	415	525	564	650	525	93	-32	701	564	108	-29
	General Surgery	New	1182	1222	1176	1246	1340	1176	164	0	1393	1246	167	20
		Return	1218	850	873	685	1045	873	221	49	800	685	226	111
	Gynaecology	New	459	427	449	438	506	449	86	29	552	438	103	-11
		Return	358	316	375	359	477	375	54	-48	464	359	48	-57
	Ophthalmology	New	465	465	663	455	553	663	98	208	538	455	105	22
		Return	752	1371	1863	1730	2075	1863	207	-5	1946	1730	241	25
	Oral & Maxillofacial Surgery	New	100	296	151	175	174	151	24	1	200	175	23	-2
		Return	74	113	133	106	191	133	21	-37	142	106	23	-13
	Oral Surgery	New	155	173	214	216	336	214	58	-64	298	216	71	-11
		Return	119	68	77	66	97	77	16	-4	83	66	21	4
	Paediatric	New	79	77	79	76	152	79	83	10	159	76	79	-4
		Return	145	135	126	127	194	126	50	-18	198	127	62	-9
	Paediatric Surgery	New	27	17	23	28	30	23	3	-4	31	28	2	-1
		Return	27	34	19	23	19	19	4	4	29	23	3	-3
	Pain Management	New	63	55	53	52	114	53	30	-31	109	52	36	-21
		Return	85	72	84	44	107	84	24	1	64	44	20	0
	Restorative Dentistry	New	0	10	33	24	26	33	5	12	36	24	7	-5
		Return	0	4	9	5	13	9	3	-1	18	5	6	-7
Rheumatology	New	84	64	75	55	146	75	73	2	140	55	79	-6	
	Return	118	89	138	122	168	138	30	0	150	122	24	-4	
Trauma & Orthopaedic	New	626	658	693	695	874	693	226	45	886	695	220	29	
	Return	492	681	563	636	640	563	48	-29	673	636	60	23	
Total New Outpatients	New	4258	4569	4930	4547	5983	4930	1423	370	6177	4547	1498	-132	
	Return	4522	4987	5680	5285	6698	5680	913	-105	6109	5285	996	172	
Treatment Time Guarantee	Dermatology	All	0	18	35	42	42	35	4	-3	44	42	3	1
	Ear, Nose & Throat	All	19	27	32	30	66	32	9	-25	29	30	6	7
	General Surgery	All	305	326	421	432	463	421	56	14	472	432	53	13
	Gynaecology	All	55	72	90	117	92	90	6	4	80	117	4	41
	Ophthalmology	All	145	182	198	202	298	198	16	-84	152	202	7	57
	Oral & Maxillofacial Surgery	All	6	14	20	23	20	20	8	8	38	23	9	-6
	Oral Surgery	All	45	42	53	65	66	53	13	0	77	65	5	-7
	Pain Management	All	62	66	71	62	70	71	3	4	57	62	5	10
	Trauma & Orthopaedic	All	100	65	99	83	188	99	101	12	200	83	103	-14
	Total Treatment Time Guarantee	Total	737	812	1019	1056	1305	1019	216	-70	1149	1056	195	102

From a trajectory perspective, there are marginal improvements between 2025/26 and 2026/27, but this improvement is neither uniform nor resilient. High-volume specialties such as Trauma & Orthopaedics and Ophthalmology demonstrate improving balance for new activity but remain exposed on return pathways, reflecting lengthening follow-up demand and limited flexibility in clinic capacity. The imbalance between new and return activity across

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several services highlights a structural risk within the outpatient model, where short-term focus on new activity risks displacing return capacity and storing future demand rather than resolving it.

The Treatment Time Guarantee (TTG) position reinforces this capacity risk. In 2025/26, total TTG demand exceeds capacity by 70 pathways, with material pressures in Ophthalmology and ENT. While the aggregate TTG position improves in 2026/27 to a positive gap of +102, there is pressure in specific specialties which remains highly sensitive to delivery assumptions, theatre productivity and workforce availability. Overall, the elective DCAQ indicates a system operating with limited headroom, where modest changes in demand, workforce availability or productivity will impact on delivery. However, with clear planning and system and workforce redesign, gaps could be accommodated without creating further financial pressures.

Key Risks

- Persistent demand–capacity imbalance: Total new outpatient demand continues to exceed planned capacity in 2025/26 (+370).
- Specialty-level hotspots: Ongoing capacity gaps in ENT, Pain Management, Oral Surgery and elements of Ophthalmology and Trauma & Orthopaedics present a material risk to NOP and TTG delivery.
- Return pathway pressure: Improvements in new activity are offset by growing return demand in several high-volume specialties, creating the risk that demand is deferred leading to longer waits.
- Winter and workforce sensitivity: The plan is highly exposed to seasonal variation, workforce availability and productivity assumptions, increasing the risk of rapid deterioration during periods of peak pressure.
- Financial risk: Failure to deliver planned activity increases the likelihood of escalation costs, outsourcing and productivity loss, undermining financial sustainability.

Required Actions

- Targeted capacity intervention: Prioritise additional or protected capacity in high-risk specialties, focusing on sustainable solutions rather than short-term mitigation.
- Pathway redesign: Reduce avoidable returns through clinical triage, virtual follow-up, and pathway standardisation to rebalance new and return activity.
- Productivity and flow focus: Strengthen outpatient and theatre productivity assumptions with active monitoring and rapid corrective action where delivery deviates from plan.
- Demand management: Implement tighter referral management and advice-and-guidance models to moderate inflow where clinically appropriate.
- System-wide grip: Maintain clear executive oversight through DCAQ governance, linking elective delivery explicitly to winter planning, workforce plans and financial recovery trajectories.

[Non-elective DCAQ summary – Capacity Risk, Winter Resilience and Financial Sustainability](#)

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ED demand is forecast to continue rising, with attendances increasing from 8,194 in 2022/23 to 9,373 by 2026/27, driving a corresponding increase in emergency admissions and inpatient bed demand. With the ED conversion rate assumed to remain at a steady-state 18.72%, emergency admissions requiring an inpatient bed are forecast to increase to 1,755 by 2026/27, placing sustained pressure on an already constrained bed base. Emergency bed day utilisation is forecast to rise to 12,283 bed days by 2026/27, and when combined with elective activity, total bed days remain persistently high at over 13,300, indicating limited operational headroom. This level of demand materially increases capacity risk, particularly during winter periods, reducing the system's ability to absorb surges in unscheduled care without escalation, cancellation of elective activity. From a financial sustainability perspective, the sustained growth in emergency bed days and constrained capacity heighten the risk of cost pressures associated with premium staffing, extended length of stay, and reduced elective throughput, reinforcing the importance of proactive DCAQ actions focused on flow, length of stay reduction, admission avoidance, and strengthening whole-system winter resilience.

Link to Medical Workforce Sustainability and Cost Pressures

The capacity risks identified through the DCAQ analysis are closely aligned with the workforce and financial pressures set out in the Medical Staffing Deep Dive. Although emergency admissions have reduced from post-pandemic peaks, sustained ED attendance continues to drive downstream demand for acute medical cover, inpatient flow and 24/7 rota resilience across core admitting specialties. To maintain safe service delivery, the organisation has been operating beyond its baseline workforce model, with increased reliance on bank and agency cover in key acute services, reflecting workforce fragility rather than growth in underlying demand. This interplay between sustained front-door pressure and constrained workforce capacity reinforces the need for a more resilient staffing model that secures continuity in the short term while reducing financial risk and escalation. It also underlines the importance of coordinated action across DCAQ planning, flow improvement and workforce stabilisation to support longer-term sustainability.

Non-elective DCAQ

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Data Area	2022/23	2023/24	2024/25	2025/26	2026/27
<p>All ED attendances.</p> <p>The Graph is a condensed version of the weekly chart to better show trends. Highlighted area is forecasted data.</p>					
Total ED Attendances	8194	8502	8769	9214	9373
<p>The number of ED attendances that result in a conversion to IP care.</p> <p>Forecasted data(highlighted area) is based on a base rate of 18.72% conversion. This is the average for the period 01/01/2022 - 14/12/2025.</p> <p>Forecasted Graph shape follows ED attendances due to the figure being a static % of the forecast.</p>					
ED Attends Requiring IP Bed	1578	1491	1685	1559	1755
Admit Rate (%)	19.35	17.62	19.29	18.72	18.72
<p>The total number of bed days attributed to emergency admission types. The forecasting(highlighted area) for this is calculated by the number of emergency admissions through ED * the average bed days per emergency admission. A base rate of 7 average bed days per week per emergency admission has been used here as per historic data.</p>					
Total Bed Days (Through Emergency Adms)	11012	11816	10893	11436	12283
vvg Bed Days Per Emergency Admission	7	8	6	7	7
<p>The total Number of bed days for elective and emergency beds. This was forecasted independently without any consideration to emergency admissions.</p>					
Total Bed Days (Including Elective)	12785	13155	12467	13482	13303

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Financial Forecast and Modelling

Scottish Government Budget 2026/27

Due to the delay of the Westminster Budget, the Scottish Government did not present its budget until 13 January 2026. However, Scottish Government provided several planning assumptions for Boards to base their financial plans on:

- NHS Orkney will receive a 2% uplift on baseline funding in 2026/27. This amounts to £1.6m and is provided to meet the expected costs of the 2025/26 pay deal in line with public sector pay policy. Scottish Government have confirmed that pay will remain fully funded and our plan is consistent with this assumption
- The baseline funding uplift also provides 2% for non-pay to support inflationary pressures
- There will be no change to any other existing allocations but a further NRAC share of £150m will be provided for Agenda For Change Reform.

Scottish Government Planning Expectations

The Scottish Government has set out financial planning principles and considerations to all Boards:

- A clear programme of work and supporting actions to achieve 3% recurring savings on baseline budgets in 2026-27,
- An improved forecast outturn position in 2026-27 compared to 2025-26, on a comparative basis,
- Improvements in the financial position are expected to be shown in years two and three of the plan.
- trajectories for improvement in the financial position supported by detailed narrative plans as to how this will be achieved and the arrangements that will be implemented by the Board to oversee delivery, and
- Final financial plans should be aligned with respective sub-national structures, ensuring read across between local and sub national plans. This should be supplemented by narrative submissions setting out specific delivery and outcomes.

Clear expectations for sub-national planning across Boards was also provided. These expectations are:

- The underlying principle must be that financial deficits across all Boards should be stabilised and where possible reduced in 2026-27.
- Plans must prioritise increasing the level of recurring savings towards the 3% target.
- No new recurring financial commitments should be made without confirmed funding.
- Identify areas of recurring financial pressure where adoption of best practice across the sub-national area can contribute to management of deficits.
- Triangulation with population need, capital infrastructure, workforce planning, and service fragility to identify and inform service plans for sustainable models of care.

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- Alignment with key DL clinical service priorities to ensure that plans to deliver those priorities are affordable.
- Alignment with business systems and digital front door plans as developed and delivered.
- Develop an approach to align capital prioritisation processes and work towards a single capital plan, encapsulating both new capital requests and business continuity processes

This draft plan shows NHS Orkney financial position and 3-year plan only. The final plan will include information on sub-national financial planning for Scotland East.

2026/27 Financial Overview

As confirmed in 2025/26, brokerage is no longer available and all Boards must work towards a break-even position. A deficit position will result in Boards receiving a Section 22 Qualification by External Auditors.

The 2025/26 Financial Plan described an opening deficit of £2.176m for 2026/27. The opening deficit has now been revised to £3.6m in line with our reported position at Month 9. Confirmation has been received from Scottish Government that NHS Orkney will receive its transitional funding of £2m for 2025/26. However, this is non-recurring and will have no impact on the opening position of £3.6m in 2026/27.

NHS Orkney have approved transitional funding of £1.5m for 2026/27, dependent on the outcome of 2025/26. We have developed our 2026/27 Financial Plan on known funding increases and cost pressures and modelled savings delivery targets.

Summary RRL Position	2026/27
	£m
Deficit brought forward	3.600
Add: Non-Recurring Savings/Income	2.422
Pressures – Pay	1.809
Pressures – non-pay	3.713
Baseline Funding Uplift	(3.531)
Additional Non-Recurring Funding	(2.340)
Net Gap before CIPs	5.673
Transitional Funding Agreed	(1.500)
Value of CIPs required	4.173

Based on the assumption that NHS Orkney will receive £1.5m for 2026/27, the level of savings required to achieve that outcome is around £4.2m.

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The Board set its saving target for 2025/26 at £3.8m, however as described in the Improving Together Efficiency Programme Below, only circa £2.0m is forecasted to be delivered. The undelivered savings programme is driving adverse forecast out-turn for 2025/26.

Ongoing pay and non-pay pressures

Uncertainty remains around the volatility of inflation and the latest core CPI figure published by the ONS is 3.4% for the 12 months to December 2025. As described above, Scottish Government planning assumptions have included a 2.2% uplift for non-pay and whilst we have used this rate to forecast our likely cost pressures, there are specific areas we know will have above inflationary rises. The two main areas are the cost of the NPD contract for the new Balfour Hospital and the cost of air travel via LoganAir. We have therefore included an additional £173k within our cost pressures for these areas.

Agenda for Change Reform Costs

From 1 April 2026, the final 1-hour reduction in the working week (RWW) will take effect for all Agenda for Change staff. The implementation plan for NHS Orkney has been finalised and cost of RWW for NHS Orkney is expected to be in the region of £0.7m which is a reduction from the previous estimate of £1.1m.

In addition, as at the beginning of January 2026, 16 Band 5 – 6 submissions have been approved and successfully uplifted. There are 12 submissions awaiting review in the portal and it is estimated that a further 47 could be submitted. If all 75 submissions are successful, the recurring estimated cost will be in the region of £1.1m.

The remaining Agenda for Change reform of implementing protected learning time has not been finalised and costs associated with those have not been fully developed at this time but is anticipated to be around £0.4m.

Funding has been confirmed as £1.5m for RWW, leaving an estimated cost pressure of £0.7m. This has been included in the cost pressures shown in the table above.

National Programmes

There are several national programs, particularly in the digital portfolio, that will incur costs over the period of this financial plan, including the My Care App, Business Systems, Morse and Theatre Scheduling. Where estimates of cost pressures are known these have been included in the table above. However, estimates for additional staffing resources have not been factored in. The key pressure for delivering any National Programme is staffing resources with the relevant skills and experience to implement.

MRI Business Case

Through the successful approval of a Business Case, NHS Orkney has been able to provide MRI services on island during 2025/26 as a test of change. Funding was provided for 1 year to enable the case to be made to retain the MRI service permanently. The updated business case is in its final developments and is due to be submitted to Scottish Government in March

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2026. No additional cost pressure has been included in this plan for the retention of MRI services as it is assumed to be fully funded. The final financial plan due in March 2026 will include the confirmed arrangements.

Challenges and assumptions

As described in the 2025/26 Financial Plan, the size of NHS Orkney and the constraints of being an island Health Board partially limit the scale of change that can be implemented and the pace by which costs can be reduced.

The cost of travel for patients and escorts continues to increase beyond inflationary funding uplifts and as the delivery of services across Scotland East develops it is anticipated that inpatient and outpatient activity will extend beyond NHS Grampian and therefore result in further increases to travel costs.

Recruitment to medical consultants with appropriate skill sets continued to be a challenge in 2025/26 and despite trying new approaches and incentives to recruitment we remain dependent on locums and bank staff.

Resourcing across digital, project management and change management, along with other key skills, is extremely limited within NHS Orkney and the scale of change derived from the implementation of Scotland East delivery plans will require either mutual aid from other Boards or additional resources in NHS Orkney. No additional costs have been assumed within this plan for additional resources as sufficient information is not known at this time of requirements.

Workforce and Service Transformation

Workforce transformation in NHS Orkney is a strategic, ongoing process designed to ensure our workforce is equipped to meet the evolving needs of our population and deliver high-quality, sustainable care. This approach is rooted in national policy and local priorities, aligning with statutory requirements and best practice across NHS Scotland.

Workforce transformation is driven by the need to recruit, retain, deploy, develop, and support staff in ways that respond to demographic changes, service redesign, and financial pressures. Developing progressive roles and career pathways and maximising the contribution of all staff groups will be central.

In NHS Orkney, workforce transformation is embedded within integrated planning, recognising our unique context as an island Health Board. Our workforce plans will focus on building capability—capacity, confidence, and competence—to deliver effective, efficient, and agile services. This means moving beyond traditional roles and considering new career pathways, cross-organisational roles, and flexible models of working.

Key elements include:

- **Alignment with Service Redesign:** Workforce plans will be developed alongside service transformation initiatives, ensuring that staffing models support new ways of working and improved patient outcomes.

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- **Regional Collaboration:** NHS Orkney will collaborate with Orkney Islands Council through the joint “Route Map to Reform” and other NHS Boards across Scotland to deliver regional and national transformation.
- **Risk Management:** Organisational risks associated with workforce planning and development will be actively managed and monitored within the Board’s risk management system.

NHS Orkney will adopt a six steps methodology to integrated workforce planning to underpin our approach. This evidence-based framework will guide managers through defining the plan, mapping service changes, identifying required skills, understanding workforce availability, developing action plans, and implementing, monitoring, and revising strategies.

Workforce Transformation priorities will be:

- **Role Development:** New and advanced practice roles will be developed to meet current and future needs.
- **Recruitment and Retention:** Innovative recruitment strategies and enhanced wellbeing support will be prioritised to attract and retain staff, especially in hard-to-fill roles.
- **Education and Training:** Continuous professional development and statutory training will be supported to ensure staff have the skills required for evolving service models.
- **Efficiency and Agility:** Workforce transformation will be closely linked to financial planning, with efficiency programmes and savings targets supporting sustainable service delivery.

Workforce planning and transformation activities will be overseen by dedicated groups, with regular reporting to the Staff Governance Committee and other forums. Annual workforce projections and compliance reports are produced in line with the Health and Care (Staffing) (Scotland) Act 2019.

In summary, workforce transformation in NHS Orkney is a dynamic, evidence-based process, aligned with national strategy and local needs. It is characterised by integrated planning, regional collaboration, robust methodologies, and a commitment to developing a capable, flexible workforce for the future.

Improving Together Efficiency Programme

2026/27 Efficiency Programme

Within the approval Financial Plan for 2025/26, the Board set a savings target of £3.8m (circa 4.8% of RRL), with £3.3m of identified schemes within the plan and £0.5m of a gap to address during 2025/26. However, the forecast delivery for 2025/26 is £2.0m including budget reduction and run-rate savings, leaving a gap of undelivered savings of £1.8m. The initial £0.5m gap has widened over the course of the year as non-run-rate savings have been removed from the forecast, increasing the scale of the underlying shortfall.

Looking ahead to 2026/27, there is a £4.173m gap to close, as described in the Financial Overview section above. At this stage there are approximately £2.085m of risk adjusted corporate savings schemes identified (see table below). The risk assessment is a worst-case

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scenario assessment of savings delivery to ensure a credible assessment of savings to be achieved.

	(£k) unadjusted risk savings	- Risk Level	(£k) - risk adjusted saving
Schemes 26/27			
Service redesign	1,900	0.33	625
Workforce medical	232	0.93	216
Workforce - nursing	220	0.61	127
Workforce Controls	450	0.63	275
Prescribing - Acute	274	1.00	274
Prescribing - Primary Care	48	1.00	48
Estates & Facilities	270	1.00	258
IJB	250	1.00	250
Income generation	17	0.78	12
Total	3,661		2,085

This leaves around £2.1m of savings to be delivered to meet deliver our planned deficit at 31 March 2027 of £1.5m.

In 2024/25, the Improving Together efficiency programme adopted a bottom-up approach to developing savings schemes. Teams and individuals were supported to generate ideas through a series of facilitated workshops led by the Improvement Team, but they were not required to deliver savings against specific targets — a notable difference from common practice in other NHS organisations. The Bright Ideas programme has operated in parallel, providing an ongoing mechanism to capture additional opportunities as the year progressed. However, the size and values of these schemes remain fairly modest.

Given that around 70% of our cost base is tied up in staff costs, and redundancy is neither affordable nor desirable, a savings target of 1.7% has been devolved to Executive Directors to achieve through their teams. This approach is designed to strengthen collective ownership of NHS Orkney's financial position. While the full delivery of the £1.6m devolved target will not close the full gap, setting teams a realistic (but stretching target) is vital to securing and sustaining engagement throughout the next financial year, particularly as this will be the first time many areas are working to a devolved savings target. A further change in approach this year will be a focus on cash releasing savings and a move away from a focus on budget releasing savings as the organisation works to control totals going forwards.

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Directorate	Value of 1.7% saving to be made
Acute	0.38
CEO	0.05
IJB	0.57
HR	0.02
Finance	0.21
Medical	0.33
Performance	0.03
Public Health	0.02
	<u>1.60</u>

Directors have been asked to provide details of their devolved schemes by end of February 2026 to start delivery as soon into the financial year as possible.

Total savings for 2026/27 are assumed to be £3.685m, leaving a gap of £0.488m. Expectations from SG is that a minimum of 3% recurring savings will be delivered each financial year. For 2026/27, it is assumed that £2.964m will be recurring which is 3.4% of baseline funding.

2027/28 and 2028/29 Efficiency Programme

The organisation will need to progress further transformational change programmes to secure the additional recurring savings required. This will demand dedicated HR capacity, strong programme management discipline, and a more structured approach than in previous years, drawing on lessons learned to ensure deliverability and sustained impact. A key risk is the capacity of teams — particularly the People and Culture Team — to support organisational change, alongside the potential for wider change fatigue across the organisation.

As described in this paper, integrated planning along with workforce and service transformation is required to ensure the organisation is sustainable into the longer term. Opportunities from the developments within the Scotland East programme of work will also drive transformational change within the Board.

For this 3-year plan, a draft efficiency programme has been developed for 2027/28 and 2028/29 building on the corporate schemes planned for 2025/26. It is anticipated these will continue into the 2027/28 and 2028/29 and continue to deliver new recurring savings as they embed into the organisation. These schemes have been risk adjusted by 50% for 2027/28 and 2028/29 to recognise that plans have not been fully developed for these years.

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It is also assumed that devolved targets will continue for Directorates but the value of these has been reduce to 1% of the 2026/27 baseline RRL.

	(£k) unadjusted risk savings	- (£k) unadjusted risk savings
Schemes 27/28		
Service redesign - 26/27 follow on projects	1,500	1,500
Workforce - Medical	300	300
Workforce - Nursing	220	220
Workforce Controls - Variable pay	450	450
Prescribing	325	325
E&F	245	245
IJB	250	250
Income generation	100	100
	3,390	3,390
Assume 50% risk adjustment	1,695	1,695
Adjusted Savings Schemes	1,695	1,695
Devolved Corporate Schemes	850	850
Total Savings	2,545	2,545

Three Year Financial Plan

The three-year draft financial plan is as follows:

Summary RRL Position	2025/26	2026/27	2027/28
	£m	£m	£m
Deficit brought forward	3.600	1.900	2.900
Add: Non-Recurring Savings and Funding	2.422	1.582	0.500
Pressures – Pay	1.809	1.184	1.211
Pressures – non-pay	3.713	2.979	3.084
Baseline Funding Uplift	(3.531)	(1.700)	(1.734)
Additional Non-Recurring Funding	(2.428)	(0.500)	(0.300)
Net Gap	5.585	5.445	5.662
CIPs - Recurring	(2.885)	(2.545)	(2.545)

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CIPs – Non Recurring	(0.800)	(0)	(0)
Net Deficit after CIPs	1.900	2.900	3.117
Proposed Transitional Funding	(1.500)	(1.000)	(0.500)
Remaining Gap	0.400	1.900	2.617

The three-year plan has worsened from the 2025/26 approved plan, mostly driven by the reduction in planned savings over the 3 year period.

The Board is committed to improving its financial position and returning to financial balance in a short a timescale as possible and recognises that to do that, transformational change must be implemented.

Capital Planning

The planning assumption is that our Capital Formula Allocation will remain at £1.078m and the current capital plan is summarized below:

Capital	Financial Year 2026/27
Formula Allocation	£1.078m
Key Schemes:	
Medical Equipment	£0.150
Estates	£0.100
Digital & ICT	£0.420
Other capital projects	£0.408
Total Capital Resource Limit	£1.078

We continue to engage with the Business Continuity and Whole System Planning with Scottish Government. Our expectations is that we will have a nil funding requirement due to the condition of the new Balfour Hospital and the NPD contract terms.

As part of Scotland East, utilisation of Capital Funding across the region will be developed in the coming months and years but this plan assumes 2026/27 will not be affected.

Risks

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There are a number of risks associated with the delivery of the financial plan, particularly in 2025/26 and the risk of delivery of the financial target is currently one of NHS Orkney's highest risks. The table below outlines the risks and the actions in place to mitigate the risk:

Risk Description and consequence	Mitigation Actions	Current Risk Level
<p>Section 22 Qualification of Accounts</p> <p>There is a risk that:</p> <p>Even if the 2026/27 financial plan is delivered, NHS Orkney's 2026/27 Annual Accounts are given a Section 22 qualification due to the deficit position</p> <p>Due to:</p> <p>Scottish Government not providing further brokerage</p> <p>Resulting In: Audit Scotland reporting the Section 22 to Scottish Parliament's Public Audit and Post-legislative Scrutiny Committee</p>	<p>Strong internal controls and monitoring processes of financial position to identify any variance from plan Owner: Director of Finance</p> <p>Ongoing discussions with NHS Orkney Board, Scottish Government and External Auditor to highlight any risk of Section 22 Owner: Director of Finance</p> <p>Complete focus on reducing expenditure and achieving savings targets Owner: Director of Finance and Director of Performance & Transformation</p>	<p>Likelihood 4 Impact 5 Score 20 VERY HIGH</p>
<p>Delivery of CIPs</p> <p>There is a risk that:</p> <p>NHS Orkney cannot deliver the CIPs plans</p> <p>Due to:</p> <p>ongoing operational pressures, reduced capacity or other factors</p> <p>Resulting in:</p>	<p>Clear plans agreed and SROs assigned and actions agreed Owner – Director of Performance & Transformation</p> <p>Improvement Team in place to support SROs and Delivery leads with agreed workstreams Owner – Director of Performance & Transformation</p>	<p>Likelihood 3 Impact 4 Score 12 HIGH</p>

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Implementation plans delayed or not implemented and therefore the financial plan is not delivered		
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Conclusion

This draft Integrated Financial Plan submission describes the challenging position NHS Orkney is facing.

The forecasted adverse position for 2025/26 has increased the challenge going into 2026/27. The level of savings required for 2026/27 to deliver a break-even position is 6% as an overall % of RRL. The Board has not been able to deliver to the level set in 2025/26 of 4.8% of RRL highlighting the incredible challenge. The three-year financial plan has reduced the level of savings in 2027/28 and 2028/29 to circa 3% of its baseline RRL to reflect the challenge it has faced in 2025/26 of delivering savings.

As Scotland East develops and collaborative working across the Boards embeds, it is anticipated further opportunities for change and savings will emerge throughout this 3-year plan.

NHS Orkney recognises that transformational change is required within the organisation and any investment decisions required need to balance financial, clinical and workforce risks.

The overall goal remains to ensure NHS Orkney returns to financial balance in a short a timescale as possible and is financially sustainable in the long term.

Corporate Strategy Year 2 2025/26 Quarter 3 Performance Report

Meeting	NHS Orkney Board
Meeting date	Thursday, 26 February 2026
Responsible Executive/Non-Executive	<ul style="list-style-type: none"> James Goodyear, Interim Chief Executive
Report Author(s)	<ul style="list-style-type: none"> Debs Crohn, Head of Corporate Governance
Purpose of report	<ul style="list-style-type: none"> Assurance
Contribution to Strategic ambition	<ul style="list-style-type: none"> Corporate Strategy 2024-2028 – Place, Patient Safety, Quality and Experience, People, Performance and Potential strategic objectives Operational Improvement Plan Integrated Joint Board Strategic Plan Annual Delivery Plan 2024-2025 (ADP) Financial Sustainability
Alignment to NHS Scotland quality ambition(s)	<ul style="list-style-type: none"> Safe Effective Quality Person Centred Sustainability
Key points for consideration	<ul style="list-style-type: none"> This paper informs the Board about Quarter 3 performance on Year 2 deliverables of Corporate Strategy 2025/26 for assurance purposes. There are 15 deliverables in our Year 2 Corporate Strategy Delivery Plan 2025/26. 3 of the deliverables are RAG rated Red, 4 rated Amber and 8 rated Green. Appendix 1 provides a consolidated scorecard and exception reports for deliverables which are red (significantly off-track) and amber (off-track) in Quarter 3.
Route to meeting	<ul style="list-style-type: none"> Executive Management Team – 2 February 2026 Senior Leadership Team – 12 February 2026 Finance and Performance Committee – 25 February 2026
Recommendation(s)	<ul style="list-style-type: none"> Assurance - For members assurance only

Corporate Strategy Year 2 2025/26 Quarter 3 Performance Report

Debs Crohn, Head of Corporate Governance
19/01/2026

1. Situation

- 1.1 This paper is presented to the NHS Orkney Board for assurance discussion on Quarter 3's performance of the Year 2 deliverables of Corporate Strategy 2025/26.

2. Background

- 2.1 Quarter 3's focus has remained on delivery, performance across all National and Local KPI's, including the Corporate Strategy KPIs/objectives, are now an integral part of our Integrated Performance Report (IPR).
- 2.2 A quarterly performance scorecard has been created for internal reporting, aligning with the Improving Together (efficiency) Programme, Operational Improvement Plan (OIP), 2025/26 Annual Delivery Plan (ADP), Terms and Conditions of Scottish Government funding and our 3-year-financial plan.
- 2.3 Appendix 1 provides a consolidated scorecard and exception reports for deliverables which are red (significantly off-track) and amber (off-track) in Quarter 4.

3. Assessment

3.1 Analysis

Quarter 3 2025/26 performance

Each of the strategic objective deliverables have been given a RAG (Red, Amber, Green) status by the Executive Leads. Table 1 provides a definition for each the Red, Amber Green Status along with the number of deliverables in each category.

There are 15 deliverables in our Year 2 Corporate Strategy Delivery Plan 2025/26. 3 of the deliverables are RAG rated Red, 4 rated Amber and 8 rated Green.

Appendix 1 updates on performance for each Quarter 3 deliverables including exception reports and actions for Red and Amber items. Executive Leads assigned RAG (Red, Amber, Green) statuses to all strategic objectives.

Table 1 defines each status and shows how many deliverables fall into each category.

Table 1 - Red, Amber, Green Status definition and number of deliverables in each category

Category/Status rating	Quarter 1	Quarter 2	Quarter 3
Red - Significantly delayed. <ul style="list-style-type: none"> • Actions not implemented. • Deliverables and improvements not achieved. • Priority will not be delivered within original timescale recurring a minimum of 2 additional quarters to achieve 	4	4	3
Amber - Partially delayed. <ul style="list-style-type: none"> • Some actions implemented. • Progress towards deliverables and improvement evidenced. • A clear plan with mitigations in place to bring the priority back in line with original timescale or delivered within one additional quarter 	1	4	4
Green - Remains on track. <ul style="list-style-type: none"> • Action implemented. • Stated deliverables and improvement evidenced 	9	6	8
Deferred to 2026/27	1	1	0
Total number of deliverables	15	15	15

3.2 Exception Reports by Strategic Objectives

The following section sets out the strategic objectives rated red and amber along with the improvements required to bring the deliverable back on track in Quarter 4.

Strategic Objective – People – Executive Director: Director of People and Culture

RAG Status	KPI(s)	Deliverable(s) at Risk	Actions in place to bring deliverable back on track
Amber	Further improve our overall staff engagement score in the iMatter(staff) survey from 75-77	<p>Communicate across the organisation the priority area update and ensure they are included in your employee journey programme.</p> <p>Teams continue conversations around action plans, updating where appropriate.</p>	<p>No further update - very limited progress due to competing priorities and absences with the People and Culture Team.</p> <p>All priorities within the People strategic objectives are being reviewed alongside requirements to support transformation change programmes and business as usual demands.</p>
Amber	Launch, embed and evaluate new behavioural standards following engagement with our community and staff to underpin our values	We will define the meaning of our values and the behaviours that are associated with them in NHS Orkney.	<p>The Senior Leadership Team at its meeting on the 5 August 2025 agreed the Education and Improvement Centre development will be paused with immediate effect and revisited in Quarter 1 of 2026/27.</p> <p>This decision acknowledges current resource constraints while reaffirming the Centre's status as a Strategic Priority within the Corporate Strategy 2024–2028. All priorities within the People strategic objectives are being reviewed alongside requirements to support transformation change programmes and business as usual demands.</p>
Amber	Develop a new approach to how we listen and respond to patient, community and staff feedback to inform service improvements throughout the year	Develop a patient experience programme that sets out how we will ensure patient feedback drives improvements and how we will engage with our patients and community throughout the year	<p>No further progress on this.</p> <p>All priorities within the People strategic objectives are being reviewed alongside requirements to support transformation change programmes and business as usual demands.</p>
Amber	Develop and implement a medium-term workforce plan to support the attraction, retention and development of our people	No deliverables planned in Quarter 3	No deliverables planned in Quarter 3 but work is ongoing as part of the integrated financial plan to produce a workforce plan.
Amber	Ensure our staff sickness rates are consistently below the national NHS Scotland average of 5.5% and ensure long-term sickness is below 3%	No deliverables planned in Quarter 3	No deliverables planned in Quarter 3, but sick absence rates have reduced and are relatively stable

Amber	Improve compliance with our statutory/mandatory training rates to >80 %	Managers to lead conversations with the data to ensure compliance against target. Managers to embed learning from drop-in sessions and will review TURAS data independently	Some improvements have been made in compliance and local action improvement action plans are being refreshed Of particular focus in Quarter 4 is resuscitation training and the development of more role specific mandatory training,
Amber	Improve appraisal rates from 36% to >60%	Managers to embed learning from intervention support and review appraisal compliance independently and take action as required to ensure compliance	Appraisal rates continue to increase, currently 48.38% against a target of 60%. 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 work with those teams to resolve technical issues. Additional system functionality is available to allow paper uploads and this has been communicated to managers.

Strategic Objective – Performance – Executive Director: Director of Nursing, Midwifery, AHPs and Chief Officer Acute

RAG Status	KPI(s)	Deliverable(s) at Risk	Actions in place to bring deliverable back on track
Red	<p>Continue our path to de-escalation from level 3 of the NHS Scotland Support and Intervention Framework</p> <p>Deliver our 2025/26 financial plan with a year-end deficit of £5.2m</p> <p>Achieve £3.5m savings target</p> <p>Achieve 3% recurrent savings for the second year running</p>	<p>Monitor progress against the approved Financial Plan for 2025/26 through Finance and Performance Committee and Financial Escalation Board and take remedial action to address any deviation from plan. Identify remedial actions to be taken with timelines.</p>	<p>As at Month 8, our financial plan is forecast to be £2m adverse with a year-end out-turn likely to be £4.2m rather than £2.2m. Revised forecast reported to SG and through internal governance. Revised financial controls implemented focussing on control targets and each Director has been given an expenditure control for the remainder of the year to contain the adverse position as far as possible. £1.7m of further mitigations have been identified which is included in the forecast of £4.2m. Our YTD financial position is off track at Month 5 at £200k adverse to trajectory.</p> <p>Additional recovery measures are being put in place, but these are not likely to take effect until Month 6 at the earliest</p> <p>The Financial Escalation Board has been stood down and instead the Finance Performance Committee is being increased to monthly to provide assurance and oversight of the monthly financial position</p> <p>An external financial review has been arranged to provide insight into the run rate and forecast and where there are opportunities for reducing expenditure.</p> <p>Two of the Terms and Conditions of the transitional funding from Scottish Government have been increased to high risk - delivery of an out-turn within 1% of RRL and delivery of the savings plan. This is being monitored through the Finance & Performance Committee, which has moved from bi-monthly to monthly in response to our escalation status.</p> <p>As of Month 5, savings were delivered as per trajectory, however a review of the savings programme has identified that around £1.4m of savings is unlikely to be delivered.</p>
Red	<p>Reduce the number of Delayed Transfers of Care per week to below 6</p>	<p>Embed the principles of Home First by the end of Quarter 3 including</p> <p>Planned Discharge Date setting</p> <p>Discharge setting on admission</p>	<p>Delayed Transfers of Care remains challenging with between 14 and 19 patients onsite.</p> <p>Older persons workstream has commenced, PID approved. In Quarter 4 to bring the deliverable back on track, utilisation of underspend from unscheduled care monies will provide additional agency social care staff to facilitate timely discharge.</p>
Amber	<p>Roll out national theatre scheduling tool by 31 March 2025.</p>	<p>National Once for Scotland procurement exercise completed by SG for Theatre Scheduling tool complete by 31 December 2025 on a once for Scotland basis</p>	<p>Deliverable on track for delivery by 31 March 2025. Local project team established to oversee local implementation of the national theatre scheduling project</p>

Strategic Objective – Potential – Executive Director: Interim Director of Finance

RAG Status	KPI(s)	Deliverable(s) at Risk	Actions in place to bring deliverable back on track
Red	Open our new Education and Improvement Centre	No deliverables planned in Quarter 3 deliverable off-track	No deliverables planned in Quarter 3 deliverable off-track
Red	New model of service delivery for Digital Services	Final report published in November 2025.	Deliverable paused until Quarter 4.

In developing this report, the following areas have been assessed in terms of their impact on delivery of our Corporate Strategy 2024 – 2028

Corporate Strategy Objective	Service Area	Is there an impact Yes/No	Assessment of impact
Patient Safety, Quality and Experience	Quality/Patient Care	Yes	<p>Delivery of the metrics and KPIs set out in the Corporate Strategy will further improve the quality of care (and services) for patients and our community. Patient safety, quality, and experience of one of our strategic objectives. To support our commitment to quality improvement and patient centred care, the Improving Together Programme continues to focus on the following priority areas.</p> <ul style="list-style-type: none"> • Recruitment processes • Outpatients Improvement • Improving access to key services • Improving population health • Achieving Financial plan • Risk Management • Accelerating Digital Transformation
People	Workforce	Yes	<p>We are committed to making NHS Orkney a great place to work, placing the health, wellbeing, and development of our staff at the heart of our strategy. The delivery of our Corporate Strategy metrics and KPIs will support not only high-quality care for patients and the community but also a positive working environment for our workforce. By focusing on staff recruitment, retention, and ongoing professional development, alongside a culture of safety, respect, and kindness, we aim to empower our people to thrive and deliver on our shared strategic objectives.</p>
Performance	Finance	No	<p>Our corporate strategy plays a critical role in accelerating our financial recovery and addressing the current deficit. By implementing clear financial objectives and performance measures, we will ensure resources are targeted efficiently and effectively. This strategic approach not only supports sustainable service delivery and long-term stability but also provides a framework for investment, financial management, and accountability, all of which are essential for recovering NHS Orkney's</p>

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			financial performance and long-term sustainability.
Potential	Risk Management	Yes	Corporate strategic objectives align to the Corporate Risk Register, management and Board Assurance framework. In developing the Corporate Strategy overall objectives for 2025/26, consideration has been given to stress testing reasonability, current resources, and investment implications. Our Corporate strategic objectives align with the Risk Register and updated risk management framework.
	Digital	Yes	Our Year 2 priorities were developed taking into consideration acceleration of digital transformation, which is outlined under the potential strategic objective.
Place	Equality and Diversity including health inequalities	Yes	As part of extensive engagement with our community, we sought the views of those who live on our ferry-linked isles in developing our strategic objectives and priorities for 2025/26. Reducing health inequalities is a key priority for the Board, deliverables have been included in our Place strategic objective with assurance on deliverable being reported to the Board through the Joint Clinical Care Governance Committee. Our Corporate Strategy takes into consideration local, regional, and national policy including delivery of the Population Health Framework.
	Climate Change Sustainability	Yes	Specific metrics and objectives in relation to climate change and achieving our net zero targets are included in our strategy under the Place strategic objective.

4. Recommendations

4.1 Assurance - For members assurance only

4.2 The Board is asked to:

- i. Seek **assurance** on the Corporate Strategy Year 2 2025/25 Quarter 3 report.
- ii. **note** where deliverables are off track and the improvement actions in place to bring deliverables back on track in Quarter 3 (October - December 2025).

5. List of Appendices

5.1 The following appendices are included with this report

Appendix 1, NHS Orkney Corporate Strategy 2025/26 Year 2, Quarter 3 Performance Scorecard, and exception report

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Audit and Risk Committee - 7 October 2025 (Review of Core Documents)

Minute

Attendance

Hazel Aim (Senior Corporate Governance Officer), Melanie Barnes (Interim Director of Finance), Debs Crohn (Interim Head of Corporate Governance), James Goodyear (Interim Chief Executive Officer), Kat Jenkin (Head of Patient Safety, Quality and Risk), Dr Anna Lamont (Medical Director), Ryan McLaughlin (Employee Director, Non-Executive Director), Tammy Sharp (Director of Performance, Transformation and Deputy CEO), Jason Taylor - (Non-Executive Director and Chair).

1. Cover paper

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. Welcome and Apologies (Presenter: Chair)

The Chair opened the meeting at 9.30 am and welcomed members to the meeting.

Apologies were received from J Stevenson (Non-Executive Director) and S Gray (Senior Financial Accountant)

Decision / Conclusion

As this meeting was to review document for ratification at the next meeting, it was agreed that the meeting did not require to be quorate.

3. Review of Core Audit and Risk Committee Documents (Presenter: Chair)

This development session was opportunity for members to consider if any changes are required for 2026/27 in relation to the following core documents

- Terms of Reference
- Membership
- Reporting frequency
- Workplan 2026/27 to ensure it captures both the standard business of the committee and any additional areas of scrutiny and assurance to the Board for the coming year.

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3.1. Audit and Risk Committee Terms of Reference 2026/27 - for review (Presenter: Chair)

Interim Chief Executive questioned whether the committee had sufficient financial skills amongst the Non-executive Directors given that D Campbell was no longer on the committee and whether consideration should be given to co-opting someone with relevant skills Interim Chief Executive to liaise with Interim Head of Corporate Governance to establish financial skill sets of current Non-Executive Members and bring to next meeting.

Senior Financial Accountant to be added to attendance list and the job title for the Head of Quality, Safety and Risk be updated to Head of Patient Safety, Quality and Risk.

Consideration was given to whether 2 meetings in May were still necessary. Members agreed that the 5 May 2026 meeting is to be stood down. Interim Head of Corporate Governance advised that a project plan was devised last year for the annual report and a short life working group met to oversee annual report and annual accounts. Interim Director of Finance reported that they were in conversation with the external auditors to potentially bring next year's audit dates forward to avoid late submission.

Mitigating actions were considered to avoid the impact of extra papers and reading that may occur at 26 May meeting due to dropping the 5 May meeting. The Chair raised concerns about the committee's understanding of pension rules and decisions. Interim Head of Finance clarified the Pension reporting was in alignment with the annual accounts manual.

Head of Patient Safety Quality and Risk questioned the change of whistleblowing reports now moving over to Staff Governance. The Chair will consider whistle blowing arrangements and report to next meeting. Interim Chief Executive to pick up Business Continuity Plan with Lead Executives.

Interim Director of Finance advised that the counter fraud report would be incorporated into the services update

Decision / Conclusion

Members discussed and offered suggestions on the Audit and Risk Committee Terms of Reference.

3.2. Audit and Risk Committee Business Cycle and Workplan 2026/27 (Presenter: Chair)

Some revisions had been made to dates on the workplan and it was felt a new version was required. It was agreed that the Interim Head of Corporate Governance and Medical Director would review the draft workplan for circulating to colleagues.

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The Interim Director of Finance advised that the Counter fraud services quarterly report and fraud liaison officer report will be one document and presented at the 26 May meeting.

Service audit reports from internal audit will be pre circulated for noting only to reduce reading for meetings.

Suggested that the Committee Annual Reports be removed from the Audit and Risk Committee meeting papers at the 26 May 2025 meeting.

SNAP reports will be submitted to June 2026 meeting.

Development session in March 2026 will focus on the key areas Board Members will need to review as part of the sign off process for the Annual Review and Accounts, the annual development session in March will be led by the Interim Director of Finance and cover specific areas, including Pensions, to clarify Annual report and Accounts.

The Chair asked the Interim Head of Corporate Governance to write to committee chairs to request internal audit requirements for 2026/27 and copy in the Director of Performance and Transformation and Board lead for Internal Audit.

Decision / Conclusion

Committee discussed and offered suggestions on the Audit and Risk Committee Workplan 2026/27.

3.3. Timetable for Papers 2026/27 (Presenters: Chair)

Members reviewed the timetable for papers 2026/27.

Decision / Conclusion

The Committee noted the Timetable for papers 2026-27

4. Evaluation of the session (Presenter: Chair)

The Interim Chief Executive and the Chair thanked the Interim Head of Corporate Governance for work done to ensure an efficient and effective meeting.

The Chair closed the meeting at 10:21.

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Orkney NHS Board

Minute of meeting of **Area Clinical Forum of Orkney NHS Board** held on
Friday, 12 December 2025 at 12:15 via MS Teams

Present: Dr. Kirsty Cole – Chair
Nick Crohn – Radiology Manager / Vice Chair ACF
Ellen Kesterton – Quality Improvement Lead / NAMAC Representative
Rona Marcus – Allied Health Professional Lead / TRADAC Chair
Lyndsay Steel – Practice Pharmacist / APC Chair
Samantha Thomas – Executive Director of Nursing, Midwifery, Allied Health Professions, and Chief Officer of Acute Services

In Attendance: Frederick Pretorius – Committee Support

1 Apologies

Apologies were noted from Kirsty Jones – TRADAC Representative, and Lynn Adams – NAMAC Representative

2 Declarations of Interests - Agenda Items

No declarations of interest were raised regarding agenda items.

3 Minute of the Meeting held on 08 October 2025

Members reviewed the document for accuracy and noted minor corrections required:

- References to “I GB” should be amended to “I JB” (Integration Joint Board).
- Acronym “CTAC” should be defined as *Community Treatment and Care* and applied consistently throughout the document.

No further amendments were identified. Members agreed that, subject to these corrections, the minute represented an accurate record of the meeting and was **APPROVED**.

4 Matters Arising

No matters arising were brought to attention at the meeting.

5 Action Log

The Chair noted that the Action Log was not included in the meeting papers due to the absence of administrative support. Members agreed that outstanding actions from previous meetings would be reviewed and updated outside of the meeting to maintain continuity. It was confirmed that any new actions arising during this meeting would be captured and incorporated into the Action Log following transcription.

6 Log of Escalated Items

The log was reviewed by members via the Teams page.

7 Chairs Reports

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7.1 Board

The Chair provided a verbal update on the most recent Board meeting. It was noted that there were no significant items requiring escalation from the Area Clinical Forum to the Board at this time. The Chair confirmed that discussions at the Board had largely focused on the organisation's financial position, which remains challenging but is not unique to NHS Orkney. Members acknowledged that financial pressures continue to influence strategic priorities and service planning and agreed that clinical engagement will be critical in supporting transformation work going forward.

7.2 ACF Chairs Group

The Chair reported that the ACF Chairs Group had met earlier in the year to progress work on clinical engagement using the "double diamond" approach. Members expressed concern that this work had stalled without formal closure and agreed that it should be revisited and concluded. The Chair confirmed that this will be incorporated into the agenda for the upcoming development session in March 2026, ensuring that advisory committees have a clear framework for involvement in transformation projects. Members supported this approach and reiterated the importance of maintaining momentum on clinical engagement.

8 Governance

- 8.1 The Chair opened the discussion by acknowledging the absence of administrative support and the resulting gaps in the meeting papers, including the action log and escalation log. Members agreed that this highlighted the importance of consistent governance processes and reliable administrative arrangements to ensure meetings run smoothly and documentation is accurate.

There was a wider conversation about governance and assurance, particularly around the need for structured support to avoid delays in reporting and escalation. The Chair emphasised that while the committee had managed to progress discussions today, the lack of formal papers and logs was not ideal and should be addressed going forward. Members supported the principle that governance processes must enable timely decision-making and avoid duplication.

9 Policies & Procedures

- 9.1 The Chair invited comments on the current approach to policy development and review. Members expressed concern that policies often arrive late for committee consideration, which can make advisory groups appear reactive rather than proactive. The TRADAC Chair noted that their committee would be meeting with the Information Governance Officer to review outstanding policies and explore ways to involve advisory committees earlier in the drafting process.

In response, the Director of Nursing confirmed that approximately 50 policies were overdue for review and that work was underway to streamline processes. This included reducing duplication, adopting shared policies where appropriate, and ensuring that clinical advisory groups are consulted at an earlier stage. Members agreed that delays in policy approval can pose risks to patient safety and welcomed the commitment to improve the process.

10 Clinical Engagement

The Chair led a detailed discussion on clinical engagement, noting that previous work led by the Medical Director using the "double diamond" approach had stalled without

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formal closure. Members agreed that this work should be revisited and concluded, with a clear plan for embedding clinical engagement in transformation projects.

Concerns were raised about the Clinical Services Review, particularly that current Programme Board workstreams lack representation from general practice and some allied health professionals. The Chair highlighted that general practice is the largest cohort of senior clinicians in NHS Orkney yet appears absent from most workstreams. The Director of Nursing acknowledged this gap and agreed to raise the issue at Programme Board, ensuring that clinical voices are maintained across all workstreams.

Members supported revisiting the clinical engagement framework and incorporating this into the next development session. There was consensus that transformation cannot succeed without meaningful involvement from clinicians across all sectors, and that advisory committees should play a proactive role in shaping service redesign.

11 Development Sessions

11.1 The Chair initiated discussion on the upcoming development session scheduled for March 2026. Members agreed that the session should include a continuation of the previous work on clinical engagement, particularly the “double diamond” approach led by the Medical Director, which had not been formally concluded. It was noted that this work should result in a clear action plan to embed clinical engagement in transformation projects.

The Chair suggested incorporating introductions to new executive team members and non-executive directors as part of the session, similar to the format used previously. Members supported this proposal, recognising the value of strengthening relationships and improving understanding of roles across the organisation.

The APC Chair proposed including an educational component on pharmacogenomics, highlighting its growing relevance and the need for clinicians to understand emerging developments. Members agreed that this topic could either form part of the development session or be presented at a future formal meeting.

The TRADAC Chair emphasised the importance of ensuring that development sessions remain clinically focused and provide practical opportunities for collaboration. Members agreed that the agenda should balance strategic discussion with clinically relevant updates.

The Chair confirmed that January would be skipped due to workload pressures, with the next formal meeting scheduled for February and the development session to follow in March.

- **Clinical Engagement Framework**
 - Complete the “double diamond” approach and agree an action plan for embedding clinical engagement in transformation projects.
- **Introductions to Key Personnel**
 - Include new executive team members and non-executive directors for relationship building and role clarity.
- **Educational Component**

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- Pharmacogenomics overview and implications for clinical practice (suggested by APC Chair).
- **Balance of Content**
 - Ensure a mix of strategic discussion and clinically relevant updates to maintain engagement.

12 Professional Advisory Committees

12.1 Area Dental Committee (ADC)

No submission.

12.2 Area Pharmacy Committee (APC)

The APC Chair reported strong engagement at the recent meeting, with high attendance from community pharmacy colleagues. Discussion focused on non-medical prescribing and the need for ongoing learning opportunities for independent prescribers. Concerns were raised about the lack of structured CPD support in remote and rural settings. The committee also reviewed progress on the new Medication Administration Record (MAR) process for carers, noting improvements but highlighting ongoing challenges with communication and training. Positive assurances were provided regarding compliance with national safety alerts and progress on medicines waste reduction projects.

*The Action Notes and Chairs' Assurance Reports from APC meetings held on **11 June 2025** and **02 December 2025** were **NOTED**.*

12.3 GP Sub Committee

The GP Sub Committee Chair reported that discussions had focused on the challenges surrounding the Primary Care Improvement Plan (PCIP). Members noted that NHS Orkney is currently not delivering three legally mandated workstreams—vaccines, pharmacotherapy, and community treatment and care services—placing additional pressure on GP practices. Concerns were raised about the impact on nursing time and appointment availability, as well as the risk of practices withdrawing from these services. The committee emphasised the need for urgent progress on CTAC implementation and highlighted the importance of maintaining patient safety and service continuity.

*The Action Note and Chair's Assurance Report from the GP Sub Committee meeting held on **17 September 2025** were **NOTED**.*

12.4 Hospital Sub Committee

No Submission.

12.5 NAMAC

The NAMAC representative highlighted concerns around recruitment difficulties linked to accommodation shortages and the impact on service resilience. Governance issues were noted, including the need for improved oversight of staff bank arrangements.

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Positive updates included progress on Excellence in Care data reporting and the expansion of the school nursing team to include continence services, which was recognised as a significant improvement for service users.

*The Action Notes and Chairs' Assurance Reports from NAMAC meetings held on 04 September 2025 were **NOTED**.*

12.6 TRADAC

The TRADAC Chair reported that administrative support had recently improved, which was welcomed by members. Discussion focused on the Clinical Services Review and the need for broader clinical representation in workstreams. Concerns were raised about limited involvement of allied health professionals in transformation planning. The committee also noted ongoing challenges with outpatient space allocation and expressed interest in updates from the Outpatient Improvement Group.

*The Chairs Assurance Report from the meeting held on 25 August 2025 and Action Note from meetings held on 23 June 2025 and were **NOTED**.*

13 **Any Other Competent Business**

The Chair invited members to raise any additional items not covered on the agenda. No further business was raised.

14 **Items to be brought to the attention of the:**

14.1 Board

The Chair confirmed that the following urgent issues will be escalated to the NHS Orkney Board for consideration:

- Recruitment challenges linked to accommodation shortages and their impact on service resilience.
- Risks associated with delayed transfers of care and the resulting pressure on acute and community services.
- Non-delivery of Primary Care Improvement Plan workstreams (vaccines, pharmacotherapy, and Community Treatment and Care), which poses compliance and patient safety risks.
- Financial pressures highlighted during discussions on transformation planning and sustainability.

14.2 Governance Committees

The Chair agreed that the following matters will be referred to relevant governance committees for assurance and oversight:

- Policy review delays and the need for streamlined processes (to Clinical Governance Committee).
- Risks identified in Clinical Services Review workstreams due to limited clinical representation (to Clinical Governance Committee and Finance & Performance Committee).
- Positive assurance on Excellence in Care reporting progress and compliance with national safety alerts (to Clinical Governance Committee).
- Engagement improvements within advisory committees and actions agreed for development sessions (to Staff Governance Committee for workforce engagement context).

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15 Items to be Communicated with the Wider Clinical Community

The Chair agreed that updates from the Professional Advisory Committees would be communicated to the wider clinical community. This will include:

- Progress on Excellence in Care reporting.
- MAR implementation updates.
- Non-medical prescribing developments.
- Clinical engagement priorities and transformation planning.

16 Items to be Escalated

- Matters of Concern or Key Risks to Escalate
 - Recruitment challenges linked to accommodation shortages, impacting workforce resilience.
 - High levels of delayed transfers of care, creating significant pressure on acute and community services.
 - Non-delivery of Primary Care Improvement Plan workstreams (vaccines, pharmacotherapy, and Community Treatment and Care), posing compliance and patient safety risks.
 - Limited clinical representation in Clinical Services Review workstreams, risking insufficient clinical input into transformation planning.
- Positive Assurances to Provide
 - Progress on Excellence in Care data reporting, with improved compliance and engagement.
 - Compliance with national safety alerts and medicines governance standards.
 - Increased engagement and attendance within Professional Advisory Committees, supporting collaborative working.
- Decisions Made
 - Agreement to hold a development session in March 2026, focusing on clinical engagement and pharmacogenomics education.
 - Commitment to revisit and conclude the clinical engagement framework initiated earlier in the year.
 - Confirmation that updates from advisory committees will be communicated to the wider clinical community.
- Comment on Effectiveness of Meeting
 - Members agreed that, despite the absence of administrative support and missing papers, the meeting was constructive and provided valuable discussion on strategic priorities, governance, and clinical engagement.

17 For Information and Noting

17.1 Correspondence

The Chair confirmed that no issues had been raised through correspondence prior to the meeting. Members noted this position.

17.2 Schedule of Meetings 2025/26

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Members reviewed and **NOTED** the attached schedule of meetings for 2025/26. No amendments were proposed.

17.3 **Schedule of Meetings 2026/27**

Members reviewed and **NOTED** the attached schedule of meetings for 2026/27. No amendments were proposed.

The meeting ended at 13:35

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Area Partnership Forum Action Note

Title of meeting: Area Partnership Forum (APF)		Date:	18 November 2025
		Time:	14:00
Chair:	Ryan McLaughlin		
Executive Support:	Jade Rosie		
Members	Present	Apologies	
James Goodyear (JG), Chief Executive (Joint Chair)	X		
Ryan McLaughlin (RM), Employee Director (Joint Chair)	X		
Stephen Brown (SB), Chief Officer IJB			
John Daniels (JD) Head of Primary Care Services	X		
Lauren Flett (LF), RCM			
Tariro Gandiya (TG) – British Medical Association (BMA) representative			
Tony Miller (TM) – UNISON representative	X		
Wilma Brown (WB) – Unison Regional Officer			
Morven Gemmill, Lead AHP			
Hannah Gibson, Human Resources Advisor			
Lawrence Green (LG), Health and Safety Lead	X		
Anna Lamont (AL), Medical Director			
Kath McKinnon, (KM), British Dental Association (BDA)		X	
Caitriana McCallum (CM), British Dietetic Association (BDA)	X		
Fiona MacKellar (FM), Chartered Society of Physiotherapy (CSP)	X		
Margaret MacRae (MM) RCN			
Steven Phillips (SP), Head of People and Culture	X		
Yvonne Stewart, (YS), Society of Radiographers (SOR)			
Sharon Keyes (SK), Head of Facilities & NPD Contract	X		
Keren Somerville, (KS), Head of Finance			
Samantha Thomas, (ST), Director of Nursing & Acute Services	X		
Kate Smith, Lead CT Radiographer			
Amanda Manson, Royal College of Nursing (RCN) Representative	X		
Karen Spence, UNISON Representative		X	

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Dave Harris - Director of People & Culture	X	
Linda McGovern – Interim Director of People & Culture	X	
Lynn Adam, (LA), HCSA Lead	X	
In Attendance		
Kendall Pyke, Organisational Development and Improvement Advisor		
Graeme McCulloch, Learning and Development Adviser		
Michelle Mackie, Deputy Director of Nursing & Midwifery		
Lewis Berston, Workforce Systems Manager		
Debs Crohn – Interim Head of Corporate Governance		
Melanie Barnes – Interim Director of Finance	X	
Katie Harvey – Business Support Officer/Job Evaluation Management Lead		

MEL

No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
1.	Cover Page	Chair	AWARENESS	Members noted the purpose and principles of the Area Partnership Forum (APF).
2.	Welcome	Chair	WELCOME	All members were welcomed to the meeting and NOTED as above. DH was welcomed as the new Director of People and Culture.
3.	Apologies	Chair	AWARENESS	Apologies were received and NOTED as above.
4.	Minutes and CAR of meeting held on 21 October 2025	Chair	DECISION	Members to feedback to Corporate Governance Team any amendments to minutes. Minutes and CAR APPROVED for onward submission to Staff Governance and Board.

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
5.	Matters arising	Chair	DISCUCSSION	No Matters arising.
6.	Area Partnership Forum Action log	Chair	ASSURANCE	The action log was reviewed with updates noted.
CORE BUSINESS				
7.	Equality, Diversity & Inclusion (EDI) Proposals:	Employee Director	DECISION	<p>The Chair introduced the EDI proposals and invited input from members.</p> <p>7.1 the group discussed the benefits of a Staff Equality Network to strengthen engagement and representation. Members agreed this would provide a platform for staff voices and improve inclusivity.</p> <p>AGREED: RM and SP to bring a summary of options for a hybrid model to the next meeting. Action: RM/SP to progress and provide update.</p> <p>7.2 the Adjustment Passport Scheme was explained as a tool to support staff requiring workplace adjustments. Members noted its value for consistency and clarity across departments.</p> <p>AGREED: Approved in principle for future implementation. Action: To be developed and included in future plans.</p>

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
				<p>7.3 the EDI Calendar proposal was reviewed. Members agreed it would help raise awareness of key cultural and diversity dates and support organisational learning. · No objections were raised to any of the proposals.</p> <p>Action: RM and SP to discuss implementation and bring recommendations in Q4.</p>
8.	Chief Executive and Executive Team Updates	Chief Executive	AWARENESS	<p>The Chief Executive gave an update on the Public Service Reform, continuing discussions with the OIC and IJB to explore ways of working together more effectively.</p> <p>Staff Side colleagues expressed concern at the potential impact of the regional planning changes on remote and rural voice, and that this change had been imposed without staff side or clinical input nationally.</p> <p>MB gave an update on the current financial position, The Executive Team agreed to implement expenditure control targets from Month 8, replacing budget variance monitoring. Each director will receive a maximum spend limit for year end, with full accountability starting Month 9. A soft launch was planned in Month 8 to address reporting and calculation issues.</p> <p>The Board would receive Q2 results and an update at the development session next week. Urgent action was required to reduce the deficit and avoid further escalation measures.</p>

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
				<p>Members discussed the frustration at the lack of a multi-year workforce plan to support transformation and improvement work. Assurance was provided that work would begin in this space in the coming months.</p> <p>Action: Updates to be provided at future meetings; multi-year financial/workforce plan to be developed.</p>
9.	Staff Side Updates	Staff Side Leads	DISCUSSION	<p>Safety Alarm Issues: Incorrect alarm addressing identified; engineer to visit next week to correct. Interim measures in place.</p> <p>The Chair noted while it was reassuring that the alarm system issue was being rectified the following week, the significant delay in identifying the problem, and the lack of awareness staff have of the safety alarm system generally, represents a safety risk that needs to be addressed urgently. It was agreed that steps would be taken to ensure departmental inductions included training on safety alarms. Wider concerns were expressed by members about recurrent safety issues being raised and not being addressed, leading to ongoing risk and in some cases preventable accidents.</p> <p>Action: Engineer visit scheduled for Monday 24th November to address alarm location issue; induction guidance to be developed.</p> <p>Interim measure: Porters have printed lists of correct locations for reference.</p> <p>Action: An engineer will visit next week to correct the system</p>

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
				<p>Car Park Safety: Winter maintenance plans in place; Health & Safety and Estates teams leading. Changes are underway to address the lighting issue in the old site car park.</p> <p>Resuscitation Training: Completion rates remain low; concerns for patient safety.</p> <p>Action: Executive team to review and provide update on plans to address training compliance to January APF.</p> <p>Outpatient staff training improving; main concern in Fracture Clinic due to staff changes. JD provided assurances that the fracture clinic issue was in hand.</p>
ITEMS FOR DISCUSSION OR APPROVAL				
10.	Staff Governance Monitoring Exercise – 2024-2025	Chair	DECISION	<p>APPROVED: Staff Governance Monitoring Exercise response for 2024–2025.</p> <p>ACTION: SP to finalise and submit the response to the Staff Governance Committee by the agreed deadline.</p>
11.	Health & Safety Lead – Quarter 2 Update	Chair	DISCUSSION	<p>Violence & Aggression Training compliance increased by 6% overall.</p> <p>Awareness and verbal intervention training reached 89% compliance.</p>

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
				<p>Foundation training at 73%, advanced emergency training showed slight improvement but remained a priority for high-risk groups (IP1, ED, Community Mental Health).</p> <p>Moving & Handling Training rose to 67%, up from 30% last year, due to successful embedding of the passport scheme.</p> <p>Face Fit Testing improved by 1%, but significant challenges remain in attendance.</p> <p>A recent incident highlighted risk: lack of trained staff being face-fit tested on an incoming shift delayed handover until urgent testing was provided by the Health & Safety team.</p>
12.	Photographic and Digital Recording Guidelines for review	EDONMAHP	DISCUSSION	<p>ST presented the updated guidelines for photographic and digital recording within clinical and non-clinical settings.</p> <p>No objections were raised, and members supported the proposed updates</p> <p>The policy was APPROVED by APF</p> <p>ACTION: ST to finalise and circulate updated guidelines to all departments by mid-December</p>

ITEMS FOR NOTING

Item 17.3

No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
13.	Agenda for Change Reform •Reduced Working Week Progress	Director of People and Culture	AWARENESS	<ul style="list-style-type: none"> • The plan was submitted to the Scottish Government last month. • SP had been working on distributing team plans to directors. • Guiding principles for teams were agreed and were being applied consistently, particularly for part-time staff. • The short-life working group remained active, but its meeting clashed with this session and would be rearranged. • Work continued with the aim of having everything agreed by January–February for implementation. • Financial arrangements were still uncertain; an indicative funding plan for next year was in place but was insufficient to cover all Agenda for Change reforms. Final position would depend on the January budget.
14.	Letter from Maree Todd MSP	Chair	AWARENESS	NOTED , no further discussion.
15.	Chair's Assurance Report – Operational People Group	Director of People and Culture	AWARENESS	No update required.
16.	Your Employee Journey	Head of People & Culture	AWARENESS	Update provided, recruitment campaign progress NOTED .
17.	NHS Board Implementation of NHS Scotland	Chair	AWARENESS	No discussion had, to be followed up next month.

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No:	Agenda Item:	Lead person:	Purpose:	Decision/Conclusion/Action: Action by and date (if appropriate)
	Workforce Policies – Phase 3			
18.	AOCB	Chair	DISCUSSION	The paper on Pensions Automatic Re-Enrolment (November 2025) was approved by the APF and will be shared in next week's staff bulletin. Action: Pension Sessions to be set up through either RCM or Unison
19.	Items to be included in the Chairs Assurance Report to Staff Governance Committee week for Agenda for Change staff	Circular	DECISION	
20.	Attendance record 2025/26	Chair	AWARENESS	Attendance record updated as of the 18 November 2025.
21.	Area Partnership Forum Reporting Timetable 2025-26	Chair	AWARENESS	Members noted the Area Partnership Forum Reporting Timetable 2025/26.

** items marked with an asterisk are for noting only and any queries should be raised out with the meeting with the Committee Support, Chair or Lead Director*

Area Partnership Forum Members:

In Attendance / By Invitation:

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Paula Buchan, Regional Officer - UNITE
John Daniels - Head of Primary Care
Samantha Thomas - Director of Nursing,
Midwifery, AHPs and Acute
Lauren Flett – Royal College Midwives (RCM)
Tariro Gandiya – British Medical Association
(BMA)
Morven Gemmill, Associate Director of Allied
Health Professions
Lawrence Green, Health and Safety Lead
Fiona MacKellar – Chartered Society
Physiotherapists (CSR)
Margret MaCrae – Royal College of Nursing
(RCN)
Amanda Manson - Royal College of Nursing
(RCN)
Catriona McCallum, British Dietetics Association
(BDA)
Kath McKinnon, British Dental Association (BDA)
Ryan McLaughlin, Employee Director – Joint
Chair
Tony Miller - Unison
Dave Harris - Director of People and Culture
Steven Phillips - Head of People and Culture
James Robertson - Unison
James Goodyear -Interim Chief Executive – Joint
Chair
Sharon Smith - Head of Facilities & NPD Contract
Kate Smith - Society of Radiographers (SoR)
Karen Spence – Unison
Lynn Adam, (LA), HCSA Lead

Emma Laughton, Internal Comms Officer
Debs Crohn, Interim Head of Corporate
Governance

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Wilma Brown – Unison (papers only)
Karen Davidson - Unison (papers only)
Yvonne Stewart – Society of Radiographers (SoR)
(papers only)
Vacancy, Talent and Culture Manager
Vacancy, Obstetrics & Gynaecology Consultant

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Minute Finance and Performance Committee 17 December 2025

Attendance

Fiona Mackay (Chair – Non-executive Board Member), Melanie Barnes (Interim Director of Finance), Debs Crohn (Head of Corporate Governance), Tammy Sharp (Director of Performance and Transformation), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), James Goodyear (Interim Chief Executive), Ryan Mclaughlin (Non-Executive Director - Employee Director), Jason Taylor (Non-Executive Board Member), Davie Campbell (Non-Executive Board Member – Interim Board Chair), Stephen Brown (Chief Officer IJB), Dave Harris (Director of People and Culture), Sharon Keyes (Head of Facilities and NPD Contract), Dr Anna Lamont (Medical Director), Jean Stevenson (Non-executive Board Member), Isobel Greive (Non-Executive Board Member) and Mohammed Sohail (Chief Finance Officer – IJB)

Kate Doughty (Corporate Records Manager) attended for agenda item 12.2.

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Finance and Performance Committee Purpose

To review the financial and non-financial targets of the Board, to ensure that appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance that the arrangements are working effectively.

Quorum:

Three members present including at least two non-executive Board Members, one of whom must be Chair or Vice-Chair, and one Executive Member.

2. Welcome and Apologies (Presenter: Chair)

The Chair (Fiona Mackay) opened the meeting at 09.30 am and welcomed members.

Apologies received from Dr Louise Wilson (Director of Public Health).

Members agreed the meeting was quorate in accordance with the Boards Code of Corporate Governance.

3. Declarations of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minute of the Finance and Performance Committee held 26 November 2025 (Presenter: Chair)

The Chair asked for comments on the minutes of the meeting on 26 November 2025.

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Decision/conclusion

Minute of the meetings held on 26 November 2025 were accepted as an accurate record of the meeting and approved subject to the ammendment discussed and approved.

5. Matters Arising

The Interim CEO provided an update to Committee on sub-regional planning. Sub national planning structures are being stood up, first meeting East SRPC is Friday this week (add date) with all East Territorial Health Boards and national health boards. An additional remote and rural workstream has been proposed, Lead Director appointments have been delayed, pending national staff side conversations.

East region CEOs met 17 December 2025; regular communications will be issued to East Health Boards. North of Scotland CEO continue to meet to ensure smooth transition into the new structures.

The Chair asked for confirmation on who is representing the Board at the Remote and Rural Workstream. This is being worked through and will be discussed at the meeting 17 December 2025, the Board's Interim CEO has agreed to take a lead role in this space, there is an expectation that Executives leads will be involved and that an Islands Impact Assesment is conducted as well as a Strategic Needs Assesment to ensure a remote model of healthcare is in place to ensure equity for remote and rural communities.

Chief Officer IJB asked that the consultation on the Islands plan which concludes in January 2025 be considered as part of the East of Scotland planning.

The Interim Board Chair asked for an update in relation to Executive financial control targets and the first meetings with Executive Directors. The Interim CEO advised that forecasting work is slightly behind where we want to be, this will be stood up as soon as possible, with an update brought to the next meeting.

Decision/conclusion

Members noted the update on sub-regional planning

6. Action Log (Presenter: Head of Corporate Governance)

The Chair presented the Finance and Performance Committee Action Log 2025/26.

Decision/conclusion

The action log was reviewed, no outstanding issues (see action log for details).

7. CHAIRS ASSURANCE REPORT - Finance and Performance Committee Chair's Assurance Report – 26 November 2025 2025 (Presenter: Chair)

The Committee Chair presented the Chairs Assurance report of the Finance and Performance Committee meeting held on 26 November 2025 for assurance.

Decision/Conclusion

The committee noted the update with the ammendment discussed for onward submission to the Board February 2026.

8. Corporate Risks aligned to the Finance and Performance Committee (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Corporate Risks aligned to the Finance and Performance Committee. All risks have been reviewed in line with our risk management framework.

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Risks in relation to project and change management have been reduced and general safety in the Old Balfour due to mitigating actions.

The Interim Board Chair asked the EDoNMAHP and Chief Officer IJB when the risk score would be reviewed in relation to social care capacity. The EDoNMAHP advised that the risk is reviewed regularly, additional work is required to capture work across the system and not Delayed Transfers of Care (DTC). Whilst there are high levels of DTCs, plans are in place for patients, noting that whilst the indicator is red, monitoring continues in relation to all risks aligned to the Finance and Performance Committee. Chief Officer IJB agreed to review the risk in relation to social care capacity.

J Stevenson asked for clarity on the risk associated with the lack of digital maturity and the implications for the Board. The Interim Director of Finance recognised that a review of the risk. Head of Corporate Governance advised that a risk jotter is being presented to the Risk Management Group on 17 December 2025 in relation to Digital Capacity and Capability.

Decision/Conclusion

Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register

9. DEEP DIVES

The Chair advised that due to scheduling meetings, i.e. the last meeting was 3 weeks ago, no Integrated Performance Report was presented to Committee.

9.1. Financial Planning Assumptions 2026/27

The Interim Director of Finance presented the Financial Planning Assumptions 2026/27 to Committee for discussion.

Developing an integrated financial plan is critical to ensure NHS Orkney can make coherent, system-wide decisions that balance finance, activity, workforce and quality. These components are interdependent, and planning them in isolation creates operational blind spots, cost pressures and avoidable variation.

Our opening deficit has been revised to £4.2m in line with our reported position at Month 7. The £4.2m deficit out-turn for 2025/26 does not meet the terms and conditions of the transitional funding agreement and it is therefore assumed no transitional funding will be received in 2025/26.

NHS Orkney have approved transitional funding of £1.5m for 2026/27, dependent on the outturn of 2025/26. We have developed our 2026/27 Financial Plan on known funding increases and cost pressures and modelled savings delivery targets.

£650K savings scheme has been identified, there is a proposal to give all directorates a target saving. 3 scenarios were presented to committee, each scenario results in a gap in funding.

The Boards financial plan will be integrated into the East of Scotland Plan, although this detail is yet to be agreed.

The Interim Director of Finance advised that the draft financial plan 2026/27 will need to be submitted to Scottish Government by 7 February 2026, will be presented back to Committee in January 2026.

J Taylor asked if transitional funding had been included, noting that £100k was suggested in relation to Isles Network of Care, The Chief Officer IJB advised that work is taking place in the background

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around potential models. The figure presented in the paper is based on a pilot being undertaken on Papa Westray.

J Taylor asked for clarity on the Out of Hours savings being delivered, with a target date of March 2027. The EDoNMAHP advised that this would be the completion date, recognized further work is required.

J Taylor asked if the budget control target of 1.5% is based on pay or non-pay, Interim DOF advised it is based on total budget.

J Taylor asked for confirmation on the target for the reduction in Whole Time Equivalent. Interim Director of Finance advised that no assumptions have been included in the financial plan.

The Interim CEO advised that the planning paper is very much work in progress, guidance shared with Committee as part of the financial review should be used to inform the planning based on best- and worst-case scenario across all our big schemes so a consistent way to understand savings is in place.

The Interim CEO asked for clarity on whether transitional funding would be received if we end the year with a deficit of £4.2M. The Interim Director of Finance confirmed funding would not be received. Recognising our Director of People and Culture joined the Organisation in November there is a piece of work to look at workforce planning, bank and agency controls and activity before the paper returns to Committee in January 2026. In our most recent workforce report (September 2025), our substantive headcount, bank and agency staff costs have increased, whilst sickness absence has remained stable.

J Stevenson asked for clarity in relation to staff redundancy. Director of People and Culture advised that we are constrained in terms of reducing WTE. The Employee Director advised that compulsory redundancy is not an option, voluntary redundancy could be. The Interim Director of Finance advised that voluntary redundancy is an option however agreement would be required by Scottish Government.

The Interim Board Chair asked for case studies/business cases to be included in the financial plan to demonstrate accountability and credibility to Scottish Government rather than presenting high level figures. The Interim CEO advised that the Clinical Services Review Project Initiation Documents provides some of the narrative and advised that the paper presented to Committee is a high-level plan at this stage. In relation to the waste reduction plan, schemes need to be quickly worked up with a 2-3% savings target for all directorates, noting that this may not be achievable. Engagement and conversations with teams will be key to working through the savings targets.

The Medical Director advised that a Business Case for the relocatable MRI scanner is being developed recognising that funding is not available to absorb the service is funding is not secured from Scottish Government.

The EDoNMAHP advised that triangulation of the data is noted important but underpinning this is the consideration which needs to be given to the implications of implementing the Agenda for Change Reduction in Working Week.

The Employee Director asked for confirmation on who will be supporting engagement with staff on savings targets. The Director of Performance and Transformation advised that ongoing work is underway to bolster corporate schemes, Executive Directors will be required to identify savings, once targets are agreed the Improvement Team will be available to facilitate sessions with teams.

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The Interim Director of Finance advised that savings will be identified at directorate level and not at a team level.

The Interim CEO reminded Committee that there is a need to look at service planning commencing in July 2026, this needs to be built into Committee business.

Decision/Conclusion

Committee discussed and noted the report.

10. STRATEGIC OBJECTIVE – PLACE

David Miller (Resilience Officer) joined the meeting at 10.26

10.1. Integrated Emergency Planning update (Presenter: Resilience Lead)

The Resilience Lead presented an Integrated Emergency Planning Update. Members were advised that an emergency planning exercise was undertaken earlier this year following a review of the major incident plan approved 19 January 2024.

The 'Foreland Exercise' was well attended, it was a successful challenging tabletop exercise.

On the 23 June 2025 a live plan exercise was undertaken, there were limitations noting clinical and operational capacity challenges. Lessons learned were presented to the resilience group 2 December 2025, increasing loggist capability, leadership training, improving communications and simplifying tools are being taken forward.

There are financial implications to undertaking live play exercises, recognising the benefits of live play versus desktop exercises.

The Interim CEO thanked the Resilience Officer for the report and lessons learned and asked for more information on when training will be in place for incident management training, particularly for staff who are working on call. The EDoNMAHP advised that HIMS training cannot be delivered on Island, conversations are taking place around alternative methods for delivery of training.

Interim Board Chair asked that actions and timescales for lessons learned be brought back to Committee. The Resilience Officer advised that lessons learned will be presented to Senior Leadership Team. Resilience workplan update to be brought back to Committee in February 2026.

Decision/conclusion

Members noted and took assurance on the report.

11. STRATEGIC OBJECTIVE - PERFORMANCE

11.1 Robertsons Contract Update (Presenter: Head of Facilities and NPD Contract)

The Head of Facilities and NPD contract presented an update to Committee on the Robertsons Contract and concerns raised.

Despite financial penalties being applied, the situation has not improved despite escalation to NHS Assure.

The Interim CEO asked for clarity on how the Robertsons contract is monitored and advice from NHS Assure. The Head of Facilities and NPD contract advised that planned maintenance is managed via

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the service desk. Warning notices are raised with Robertsons Facilities Management, assurance has been given by Directors of Robertsons, however this has not resolved the issues.

The Interim Director of Finance advised that this is a Non-profit distributing contract, governance is a monthly meeting with Robertsons. A quarterly meeting takes place with Robertsons Facilities Management (RFM) Directors, our final point of escalation is NHS Assure, noting that issues with the contract is via NHS Assure.

The Interim CEO asked for confirmation of the financial health of RFM and asked if there is a broader risk of the organisation not putting in place the resources required to deliver the service. The Interim Director of Finance advised that RFM have experienced challenges in relation to recruitment, and there is currently no evidence of financial issues with RFM.

The Head of Facilities and NPD Contract noted that, while financial reporting is ongoing, recruitment remains the main challenge.

J Taylor asked if there are any additional levers that could be used to resolve the issues. The Head of Facilities and NPD advised that the Board needs to continue raising concerns via the service desk.

The Employee Director asked for clarity on internal escalation routes, and if there is an opportunity to utilise NHS Orkney noting our duty of care to staff and patients. The Interim Director of Finance advised that the Board recognises its responsibility for Health and Safety.

The Medical Director advised that the issue with Fire Dampers has been raised as a risk and asked if we could sub-contractor the work and re-charge RFM. The Head of Facilities and NPD advised that sub-contracting would need to be via NHS Assure and Scottish Future Trust.

The Interim CEO asked if the risks are captured on the risk register and asked if NHS Assure would be willing to attend Committee in an advisory capacity. The risk is in the process of being raised with the Risk Management Group.

The Interim Board Chair asked for clarity on the levers available to the Board, Roberstons Contract is a standing agenda item for Committee going forward.

Decision/conclusion

Members noted the update

11.2 Chair's Assurance Report Improving Together Programme Board – 28 November 2025 (Presenter: Interim CEO)

The Interim CEO presented the Chair's Assurance Report from the Improving Together Programme Board 28 November 2025. The Improving Together team have simplified reporting for clarity on actions.

Scottish Government attend the meeting, which has been useful in relation to collaboration with other Health boards.

The Director of Performance and Transformation confirmed that streamlining papers has supported efficiency of meetings.

Decision/conclusion

Members took assurance on the report

11.3 Planned Care Programme Board - Chair's Assurance Report – 11 November 2025

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(Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the Chair's Assurance Report from the Planned Care Programme Board held on 11 November 2025.

The meeting is now running quarterly, with weekly waiting times meeting. Monitoring 52 weeks waiting times position is now via the IPR, members were asked to note that the noting this is not just 52 week waits.

Internal audit has now been undertaken on waiting times.

No items were escalated to Committee.

Decision/conclusion

Members took assurance on the report

11.4 Chairs Assurance Report Strategic Estates and Capital Group 17 November 2025 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Chair's Assurance Report from the Strategic Estates and Capital Group help 17 November 2025.

6 business cases were approved by the Strategic Estates and Capital Group.

20 estates policies were presented for consideration and deferred to the December 2025 meeting to give members time to review the policies.

Robertsons contract and inflationary pressures were escalated to Committee; discussed earlier in the agenda.

The Interim Board Chair asked for an update on the sale of King Street. The Interim DOF advised that the sale is now out to the open market.

Decision/conclusion

Members took assurance from the report

12 POTENTIAL

12.1 Chair's Assurance Report Digital Information Operations Group – 8 December 2025 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Chair's Assurance Reports from the Digital Information Operations Group 8 December 2025.

The Head of Corporate Governance raised the clinical risk that current Digital Services Team resources are inadequate for the required business change in 2026/27, potentially causing project delays and impacting strategic goals. The Executive Management Team should consider further investment, temporary support, shared services, or pausing local priorities to mitigate this and ensure successful delivery. The risk is being escalated to the Risk Management Group for inclusion on the Corporate Risk Register. Mutual aid has been requested from the East of Scotland Digital Leads.

J Stevenson raised concerns in the red rated cyber security risk, Head of Corporate Governance provided assurance that the Board is safe from a cyber security perspective

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Medical Director asked if a business case could be submitted to Capital Group for additional digital resources. The Interim Director of Finance advised that capital funding cannot be used to support revenue costs.

Decision/conclusion

Members took assurance from the reports.

12.2 Network and Information Systems Audit Report 2025 (Presenter: Corporate Records Manager)

The Corporate Records Manager presented an overview of the Network and Information Systems Audit Report 2025.

In Spring 2024 NHS Orkney integrated its reporting for the 'Network and Information Systems Regulations 2018 (NIS), the Records Management Plan (RMP, required under the Public Records Scotland Act), and the Scottish Government (SG) and Convention of Scottish Local Authorities (COSLA) Digital Maturity Assessment.

In November 2025, auditors on behalf of Scottish Government undertook an assessment on progress since the last audit in November 2024, the Board has made significant improvements in compliance across 15 out of 17 areas, with overall compliance status now reaching 56%, from 38% in 2023. Seven categories and 33 sub-categories are rated at 60% compliance or above. 48% of the 427 controls have been achieved.

Members were asked to note progress made in this year's Network and Information Systems (NIS) noting this audit marks the end of the current NIS process, with a new 360 Assurance Maturity Questionnaire and an SC3 Cyber Resilience Assessment to be undertaken by all Board.

J Taylor welcomed the improvement in compliance noting the work that has been undertaken to date, recognising there are areas for development. Head of Corporate Governance to ensure progress is captured via the Digital Information Operations Group (DIOG) Chairs Assurance Report.

The Interim CEO recognised the progress made, noting that the rating isn't clear on what the risk is for the Organisation. Corporate Records Manager advised that areas of improvement noted in the report are: Organisational Governance, Information Security Management, System Management, Incident Management, People, Environmental Security, Physical/Building Security Disaster Recovery and Service Resilience. Head of Corporate Governance to provide Executive Team with an update of areas of vulnerability and actions in place to mitigate any risks.

The Medical Director advised that one of the high-risk areas for the Board is in relation to our reliance on Locums.

Decision/conclusion

Members took assurance from the report.

13 Items agreed for Chairs Assurance Report to Board (Presenter: Chair)

Members agreed on the following items for inclusion in the Chairs Assurance Report to the Board

- Areas of concern
 - Robertsons Contract
 - Digital Capacity

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- Major issues commissioned
 - Service Re-design (4 areas of focus) to be brought to committee January 2026
 - Financial planning assumptions work is underway
- Positive assurance
 - Risk Register
 - Improvement in compliance with national Information Security Audit Report
- Decisions made
 - Minutes and Chairs Assurance Report 18 November 2026 approved

14 AOCB (Presenter: Chair)

No other business raised.

15 Key Items for Noting (Presenter: Chair)

Members noted the Orkney Walk in Centre Proposal

15.1 Attendance Record 2025/26 (Presenter: Chair)

Committee noted the Attendance Record 2025/26

15.2 Timetable for Papers 2025/26 (Presenter: Chair)

Committee noted the Finance and Performance Committee Timetable for Papers 2025/26.

15.3 Evaluation of meeting (Presenter: Chair)

Chair thanked members for their support since taking over as Chair of Committee.

The Chair closed the meeting at 11:27



Item 17.5

Joint Clinical and Care Governance Committee Minutes Wednesday 1 October 2025

Attendance

Stephen Brown (Chief Officer, IJB), Dr Kirsty Cole (Area Clinical Forum Chair), Debs Crohn (Interim Head of Corporate Governance), Kat Jenkin (Head of Patient Safety, Quality and Risk), Dr Anna Lamont (Medical Director), Darren Morrow (Head of Children, Families and Justice Services and Chief Social Work Officer), James Goodyear (Interim Chief Executive), Jean Stevenson (Chair), Councillor Lindsay Hall (Orkney Island Council Elected Representative), Ryan McLaughlin (Employee Director – Non-Executive Director), Fiona Mackay (Non-Executive Director), Michelle Mackie (Deputy Director Nursing/Lead Midwife),

Guests

Elvira Garcia (Consultant in Public Health), Sarah Walker (Head of Infection Prevention), John Daniels (Head of Primary Care), Steven Johnstone (Director of Dentistry), Lynda Bradford (Head of Health and Community Care), Lou Willis (Service Manager Childrens Services).

1. Cover Page

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 and 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.
- the requirements set out in MEL (1998)75, MEL (2000)29 and HDL (2001)74 around the guidance on the implementation of Clinical Governance in the NHS in Scotland.

Quoracy:

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.



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2. Apologies (Presenter: Chair)

J Stevenson (Chair) opened the meeting at 1.00 pm and welcomed members.

Apologies received from Councillor I Taylor, (Orkney Island Council representative) Dr L Wilson (Director of Public Health), M Gemmill (Associate Director of Allied Health Professionals), R Gold (Non-executive Director), S Thomas (EDoNMAHP), Wendy Lycett (Interim Director of Pharmacy), Morven Brooks (CEO, Voluntary Action Orkney), I Grieve (Non-Executive Director)

Elvira Garcia attended the meeting on behalf of Dr Louise Wilson and Michelle Mackie for Sam Thomas.

Members agreed the meeting was quorate in line with the Boards Code of Corporate Governance

3. Declarations of Interests – Agenda Items (Presenter: Chair)

Fiona Mackay (Non-executive Director) declared an interest in agenda item 12.3 Clinical Services Review Progress Report.

4. Minutes of Joint Clinical and Care Governance Committee – 3 July and 20 August 2025 (Presenter: Chair)

Minutes of the Joint Clinical and Care Governance Committee meeting held on 3 July 2025 were accepted as an accurate record of the meeting noting the correction to Cllr Hall's name.

Minutes of the extraordinary Joint Clinical and Care Governance Committee meeting held on 20 August 2025 were accepted as an accurate record of the meeting.

Decision/conclusion

Members approved the minutes of the Joint Clinical Care Governance Committee 3 July and 20 August 2025.

5. Chair's Assurance Report (CAR) from meeting 3 July and 20 August 2025

The Chair presented the Chair's Assurance Reports from the meeting held on the 3 July and 20 August 2025.

Decision/conclusion

Members took assurance on the Chair's Assurance reports from the meetings held on the 3 July and 20 August 2025.

6. Action Log (Presenter: Interim Head of Corporate Governance)

The action log was discussed with corrective action taken and providing updates where required.

Decision/conclusion

Members noted the action log updates.

7. **Corporate Risks aligned to the Joint Clinical and Care Governance Committee - (Presenter: Medical Director)**

The Chair invited questions in relation to the Corporate Risks aligned to the Joint Clinical and Care Governance Committee.

The Medical Director advised that there are 2 additional risks which have been added to the Corporate Risk Register noting that the new risks are not for the JCCGC and are being managed by other governance committees.

Cllr L Hall asked for confirmation on the risk in relation to clinical leadership capacity and engagement and the impact this may have on patient care and asked how the risk would be measured.

The Head of Patient Safety, Quality and Risk advised that the risk was raised in relation to clinicians attending meetings and not in relation to patient safety or care. The Medical Director advised that there is a risk of a risk in relation to clinical leadership capacity and the impact this may have on patient care, however mitigations are in place to ensure patient safety is not impacted by the risk.

The CEO confirmed that there is limited capacity in our clinical teams to engage in our corporate governance, but this will not impact on clinical delivery.

F MacKay asked if risks could be presented to provide more information on the risk rather than just the risk title. The Head of Patient Safety, Quality and Risk advised that full risk is available in Appendix 1, the change to how risks are presented was at the request of Committee.

F MacKay asked if the surveillance colonoscopy backlog risk would be back on track by the end of the financial year. The Medical Director advised that progress has been made in relation to the backlog, whilst there is likely to be a small waiting list by the end of the year, assurance was provided to Committee.

The Medical Director advised Committee that changes within the Quality, Risk and patient experience team will result in capacity challenges within the team.

L Hall asked for confirmation on what is referred to as significant harm. The Medical Director advised that there are 3 categories of harm.

- 1 Significant/permanent harm
- 2 Harm that is reversible
- 3 Harm that could have occurred but hasn't due to mitigations in place.

The Head of Patient Safety, Quality and Risk advised that significant harm referred to in the context of the report is in relation to category 1 significant harm.

The Chair asked if the increase in falls is classed as significant harm. The Head of Patient Safety, Quality and Risk advised that there are no category 1 events related to falls. The Deputy Director of

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Nursing/Lead Midwife advised that the Board has signed up to the Scottish Safety Programme, this is specifically looking at reducing the number of falls.

F MacKay welcomed the changes to the IPR, noting that all the maternity indicators are on track.

The Chair asked for confirmation on the PEWs scores and compliance rates. The Head of Patient Safety, Quality and Risk advised that PEWs scores are for children in paediatric wards. NHS Orkney does not have an inpatient paediatric ward, updates are required to the PEWs paperwork to ensure compliance when documenting observations, training is also underway for all staff.

Decision/conclusion

Members took assurance of progress on the latest Corporate Risk Register

8. Integrated Performance Report (IPR) (Presenter: Medical Director)

The Medical Director invited questions on the Integrated Performance Report drawing members to section 3 of the report. The IPR has a slightly different format from previously shared with members, new information is now provided with an action focused narrative.

The CEO welcomed the format of the report and asked for an update on our complaint response due to the number of complaints not meeting our response rates as set out in our internal framework. The Head of Patient Safety, Quality and Risk advised that there have been significant changes and absences within our nursing teams which have impacted on our ability to meet our timeframes. There has also been an increase in the number of complex stage 2 complaints across multiple organisations increasing our response rates. The Patient Experience team are working on a training package for our nursing teams on how to review and respond to complaints.

The CEO asked if there are any other qualitative measures used on how we respond to complaints. The Head of Patient Safety, Quality and Risk advised that capacity within the team is limited, work has started on the roll-out of Care Opinion across the Organisation.

Decision/conclusion

Members noted the report and took assurance where Key Performance Indicators (KPI's) are off track and the improvement actions in place to bring deliverables back on track.

9. Feedback from National Meetings (Presenters: Medical Director, Chief Officer Integration Joint Board, Executive Director of Nursing Midwifery, AHP and Chief Officer Acute, Consultant in Public Health)

The Deputy Director of Nursing/Lead Midwife invited questions on the Scottish Executive Nurse Directors (SEND) meetings. No questions were raised.

The Chief Officer IJB presented an overview from the national Chief Officers network.

F MacKay asked if there were any updates in relation to the Health and Care Reform agenda. The Chief Officer advised that conversations were focused on opportunities and challenges, early discussions have commenced in Orkney.

Decision/conclusion

Members welcomed and noted the updates from SEND and Chief Officers network noting the following updates were not received: Scottish Association Medical Directors (SAMD) and Directors of Public Health (DPH)

10. CHAIR'S ASSURANCE REPORTS

10.1. Area Drugs and Therapeutics Committee Chair's Assurance Report - (Presenter: Medical Director)

The Medical Director asked members if they had any questions in relation to the report of the meeting held 23 May 2025 advising members that the committee is now well attended and effective.

Decision/Conclusion

Members took assurance from the update.

10.2. Infection, Prevention Control Committee Chair's Assurance Report - (Presenter: Infection Prevention Manager)

The Infection Prevention Manager asked members if they had any questions arising from the Chair's Assurance Report from the meeting held 10 September 2025.

The Chair asked for an update on pest control at The Balfour. The Infection Prevention Manager advised that work is underway to address the issue and will be resolved by the next Committee.

The Employee Director asked for confirmation on the low number of staff undertaking face-fit testing. The Infection Prevention Manager advised that there is a need to ensure clinical areas have staff covered with FP3 masks considering an update to the Infection Prevention Manual. All new staff are face-fit tested as part of the induction process.

Decision/Conclusion

Members received escalated items and took assurance on performance.

10.3. Social Work and Social Care Governance Board (SWSCGB) Chair's Assurance Report - (Presenter: Head of Childrens Services, Criminal Justice and Chief Social Worker)

The Head of Children's Services, Criminal Justice and Chief Social Worker invited questions in relation to the Chair's Assurance Report from the Social Work and Social Care Governance Board 17 June 2025, noting the date of the meeting and the report presented.

A further meeting of the Board took place in September 2025 – Chair's Assurance Report will be presented at the next meeting.

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The investigation at St Rognvalds has now concluded, the outcome of the Care Inspectorate's investigation recognised the improvements that have been made, a phased return of residents to St Rognvald's will now take place.

Whistleblowing concerns have been raised in relation to Enable Orkney – an investigation is underway with the senior management team.

The Chair welcomed the first admissions at St Rognvald's.

Decision/conclusion

Members received escalated items and took assurance on performance.

10.4. Clinical Governance Group Chair's Assurance Report - (Presenter: Medical Director)

The Head of Patient Safety, Quality and Risk received questions from committee members in relation to the report of the Clinical Governance Group meetings held in August and September 2025.

The Head of Patient Safety, Quality and Risk advised that the Clinical Quality Group Chairs Assurance Report was submitted to Committee in error, this should have been included in the resources section on Onboard for information only.

The risk escalated in relation to national and not local capacity in relation to serious adverse event reviews and concerns raised by the advocate general in timeliness of reviews being completed. A piece of work has commenced to identify and source training for SAER's this will be presented at the next CGG meeting.

Positive assurance provided on clinical guidelines being brought to Clinical Governance Group along with quarterly flash reports.

Dr K Cole asked for clarity on GP led triage and allocations being managed by GPs. The Medical Director advised that an ask will be coming out to GPs shortly via the Head of Primary Care for expressions of interest for practices to be involved in the pilot.

L Hall asked for clarity on why there are 2 groups – Clinical Governance Group and Clinical Quality Forum. The Medical Director advised that the difference between the 2 groups is that one is quarterly, one is monthly with different remits.

Decision/Conclusion

Members received escalated items and took assurance on performance.

11. PLACE

11.1. Public Health Annual Report 2024/25 - (Guest: Elvira Garcia – Consultant in Public Health)

Elvira Garcia presented the Public Health Annual Report 2024/25 highlighting the strong partnership working and commitment to reducing health inequalities and prevention focus.

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The Medical Director thanked the Public Health Team for the work on the report.

F MacKay welcomed the annual report and asked that the actions be included within service planning going forward.

The Employee Director thanked the team for the enormous amount of work undertaken by the Public Health Team.

Dr K Cole acknowledged our uptake rates for vaccinations and asked if any further work is required to improve uptake rates for pneumococcal vaccinations.

The Consultant in Public Health advised that this will be discussed at the Vaccination Management Group. The Medical Director asked members to promote the safety of vaccinations recognising the number of missed vaccinations over the past few weeks.

The Chair asked for the number of Abdominal Aortic Aneurysms (AAA) picked up through AAA screening, Consultant in Public Health to share the data with members.

The Head of Patient Safety, Quality and Risk asked for confirmation of the number of births in Orkney during 2023. Consultant in Public Health to confirm if this is in relation to the number of births in Orkney or births for Orkney residents.

Decision/conclusion

Members welcomed and took assurance from the public health annual report 2024/25.

12.

PATIENT SAFETY, QUALITY AND EXPERIENCE

12.1. Annual Social work and Social Care Services Experience Report 2024/25 (Presenter: Head of Childrens Services, Criminal Justice and Chief Social Worker)

The Head of Childrens Services, Criminal Justice and Chief Social Worker presented the Annual Social work and Social Care Services Experience Report 2024/25.

The report was well received noting the positive work that is taking place within our social care teams.

Decision/conclusion

Members welcomed the Annual Social Work and Social Care Services Experience Report 2024/25.

12.2. Safety, Quality and Experience Quarter 1 Report 2025/26 - (Presenter: Head of Patient Safety, Quality and Risk)

The Chair invited questions on the Safety, Quality and Experience Quarter 1 Report 2025/26 The Medical Director highlighted the excellent improvement activity undertaken in realistic medicine and excellence in care projects.

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The Head of Patient Safety, Quality and Risk advised that 2 Serious Adverse Event Reviews are overdue, reports have now been received, the reviews will be completed shortly. There are currently over 300 open incidents, this is a significant reduction from this time last year when there were over 500 open incidents.

Quality improvement projects are taking place across the organisation; this includes Primary Care.

Cllr L Hall asked for confirmation on the compliments received in our Dental Services. The Head of Patient Safety, Quality and Risk advised that the compliment is in relation to in-house dental services.

The Chair was hesitant to accept the phrase “delays in securing community care placements” within the comment on page 10 of the report which states “Falls remain a persistent issue despite mitigation efforts, largely due to patient complexity and delays in securing community care placements.” The Medical Director advised that the number of falls referred to in the report are in relation to patients who are medically fit for discharge and mobile but require longer term care in a care home setting, advising that patients who are fit for discharge are more mobile, this increases the risk of falls (without harm) occurring.

The CEO asked if the data could be split to identify those individuals who are medically fit for discharge. The Head of Patient Safety Quality and Risk advised that our incident management system is not fit for purpose and data would need to be reviewed manually. All falls are reviewed by the patient safety, quality and risk team, assurance provided to Committee that no falls with harm have occurred.

The Employee Director acknowledged that the issue of falls has been raised through the Occupational Health and Safety Wellbeing Group.

F MacKay asked if trajectories have been set for reducing the number of incidents. The Head of Patient Safety, Quality and Risk advised that the aim is to close 100 incidents per month, recognising capacity and vacancies within our nursing teams.

Decision/conclusion

Members received and approved the Safety, Quality and Experience Quarter 1 Report 2025/26.

12.3. Clinical Services Review Progress Update - (Presenter: Medical Director)

The Medical Director presented an update on the Clinical Services Review (CSR) update recognising that Fiona MacKay was part of the review team.

Actions and recommendations from the CSR are being taken forward with Executive and Clinical Leads, project initiation documents are being developed.

The CSR review is being presented at clinical advisory groups.

Cllr L Hall confirmed that they are assured by what is being presented.

Decision/conclusion

Members received, noted, and supported the Clinical Services Review update.

The Head of Health and Community Care joined the meeting at 15:10.

12.4. Mental Health Assurance Report (Presenter: Head of Health and Community Care)

The Head of Health and Community care presented the Mental Health Assurance Report and confirmed that there is 1 WTE psychiatrist in post. Work commenced in August on identifying a psychiatric model for Orkney. We continue to perform well for waiting times across our Mental Health services.

Cllr L Hall asked for confirmation on the number of adults on the waiting lists and the process for accessing the service. Head of Health and Community Care advised that a triage process is in place for those on waiting lists.

The Community Psychiatric Liaison Nurse has been appointed, work continues with MORSE Community Electronic Patient Record, with a go live date of November 2025.

Dr K Cole asked for confirmation on the psychiatric consultant support for older adults and the impact this is having on other areas of the system. Head of Health and Community Care advised that there are a small number of patients which are seen when in crisis, remote support is being considered.

Dr K Cole asked for post diagnostic support for neuro-divergent patients and asked for an update on what patients are being told. A full-time psychology post has been created to support post diagnostics; an early priority will be to review the waiting lists and patient communications.

The Head of Patient Safety Quality and Risk asked for confirmation of how long the longest patient has been waiting for an appointment for the neuro-divergent service, the plan for reducing the backlog and what communications have been issued to patients on the waiting list. The Head of Health and Community Care advised that the longest waits are 2 years, work is in progress to reduce the backlog. All patients have been contacted by the team in relation to waiting times.

Decision/conclusion

Members received and noted the Mental Health Assurance Report.

Director of Dentistry joined the meeting at 15.15.

12.5. Children's Health Assurance Report - (Presenter: Service Manager Children's Health)

The Service Manager Children's Health presented the Children's Health Assurance Report. The therapy team now sits within the Children's services team; challenges remain in the Speech and Language and Occupational Therapy teams due to absences.

The Head of Children's Services, Criminal Justice and Chief Social Worker advised that significant work is underway to support new pathways for neuro-developmental waiting lists, this includes a review of the pathway.

Decision/conclusion

Members received and noted the Children's Health Assurance Report.

F MacKay left the meeting at 15.30.

12.6. Medical Advisor role to Fostering, Adoption, Kinship and Permanency Panel - (Presenter: Head of Childrens Services, Criminal Justice and Chief Social Worker) – paper deferred to next committee meeting.

Head of Primary Care joined the meeting at 15:50.

12.7. Quality Impact Assessment (QIA) Update - (Presenter: Deputy Director Nursing/Lead Midwife)

The Deputy Director Nursing/Lead Midwife presented the Quality Impact Assessment update.

11 of the projects have been assessed, 29 projects are in the pipeline.

Cllr L Hall congratulated the team on the savings achieved to date.

The Medical Director acknowledged that the pre and post QIA has been commended by Scottish Government, this was noted by Committee.

Decision/conclusion

Members received and took assurance on the update.

13. PEOPLE – no papers presented to committee.

14. PERFORMANCE

14.1. Primary Care Services Update (Presenter: Head of Primary Care)

The Head of Primary Care presented the primary care services update. Ongoing transformation work continues within our Community Nursing Teams and Isles Network of Care.

The CEO thanked the Head of Primary Care for the report and asked for confirmation on custody suite. The Head of Primary Care advised that the custody suite is managed by colleagues in Inverness. Recent inspection highlighted nothing that was not already known.

The Chair asked for confirmation on the work underway in relation to care on ferry-linked isles. The Head of Primary Care advised that robust conversations are taking

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place with elected members and Scottish Ambulance Service to ensure we create substantive support and integrated working on the Isles in the future.

Dr K Cole asked for an update on the integration referred to in the out-of-hour GP practice section. The Head of Primary Care advised that the current model does not allow for integration, however as part of the Clinical Services Review, a full review will be undertaken to identify any potential integration opportunities across boundaries and services.

Decision/conclusion

Members welcomed and noted the update.

14.2. Primary Care - 6 Month Dentistry Update (Presenter: Director of Dentistry)

The Director of Dentistry presented a 6-month dentistry update to Committee. An inspection of our public dental services has been completed since the last meeting. Inspectors have indicated no further inspections are required. There have been positive developments in terms of recruitment, however challenges remain in our specialist services.

The CEO noted the improvements and asked if the Board is sighted on demand and capacity models, and how visible this is to the dental community. Management data is available to the Board, data is limited, we are seeing a positive shift in those registering in Orkney.

The Director of Dentistry advised that the Board has no control or visibility on dental practices unless the practice approaches the Board.

The Employee Director asked members to celebrate the work being done within our dental services and specialist services. The Director of Dentistry advised that substantive recruitment is underway for an orthodontic specialist, who will be able to train in-house staff. An additional locum is supporting the reduction of dental backlogs, training has taken place on sedation, conversations have taken place with NHS Grampian to ascertain if they are able to support.

The Head of Primary Care recognised the work undertaken within our dental services under the leadership of the Director of Dentistry. We have seen a 75% reduction in the dental waiting lists.

The relationship between the Board and the Clyde-Munro group has strengthened over the past 12 months, a joint press release will be issued shortly to celebrate the work that has been delivered to improve our dental services.

Decision/conclusion

Members took assurance on the 6 monthly dentistry updates.

15. POTENTIAL – no papers presented

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16. **Emerging issues and Key National Updates (Presenter: Chair)**

The Chief Officer IJB advised that a meeting took place 30 September 2025 in relation to exploring the Public Service Reform agenda which is progressing across Scotland to improve the way services are delivered across Orkney. There is a need for clinical engagement in this space, members will be kept in the loop as this work moves forward.

The Employee Director advised that a North of Scotland (NoS) workshop is taking place on Friday 3 October 2025.

Infection, Prevention Manager left the meeting at 16:01.

17. **Agree items to be included in Chair's Assurance Report to Board (Presenter: Chair)**

Members discussed areas to be included within the Chair's Assurance Report, these include.

Positive assurance

- Positive assurance taken on the reduction in the colonoscopy surveillance backlog.
- Key Performance Indicators in our maternity services on track
- Public Health Report 2024/25
- Annual Social work and Social Care Services Experience Report 2024/25
- Quarter 1 Safety, Quality and Experience Report.
- Mental Health Assurance Report.
- Children's Health Assurance report
- Quality Impact Assessments commended by Scottish Government
- Primary Care Services update and the transformation underway in our Community Nursing and Isles Network of Care service
- Assurance on the work being delivered within our dental and specialist dental services.

18. **AOCB (Presenter: Chair)**

The Medical Director advised that the first Mortality and Morbidity (M&M) Meeting has taken place, an update will be brought to the next meeting via the Clinical Governance Group (CGG) Chair's Assurance Report.

The CEO thanked the Chair for leading the meeting.

The Chair thanked report authors for their papers and the positive work being delivered.

19. **ITEMS FOR INFORMATION AND NOTING ONLY**

Members welcomed and noted the following paper.

19.1. Podiatry Waiting List update (Presenter: Chief Officer IJB)

Members noted the podiatry waiting list update report.

19.2. Members noted the following documents

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- SNBTS TT Annual Update Report 2024/25 NHS Orkney
- Children's Annual Report
- Patient Safety Commissioner - circular to NHS Boards on appointment of first Commissioner - DL (2025)19 - August 2025
- Audiology Quality Management Update - August 2025
- Rehabilitation and Recovery Self-assessment Letter from NHS Scotland Chief Operating Officer
- Rehabilitation and Recovery - Once for Scotland Rehabilitation Approach. Self-assessment guidance
- Rehabilitation - Once for Scotland Rehabilitation Approach - Self Assessment tool - V2 - 2025 (1)
- Maternity and Neonatal Monitoring Cover Letter - NHS Orkney
- Maternity and Neonatal Monitoring Template - Annual - 1 Sept 2024 - 31 Aug 2025
- Acting SPSO letter to CEOs re updated Principles
- 2024 SNAP Scottish hip fracture Audit outliers report and action plan
- 2024 SNAP Scottish Stroke Care Audit outliers report and action plan
- Information Sharing Protocol - Public Protection and Community Safety

19.3. Schedule of Meetings 2025/26 (Presenter: Chair)

Members noted the future meeting dates.

19.4. Record of Attendance 2025/26 (Presenter: Chair)

Members noted the record of attendance 2025/26.

The meeting closed at 16:10



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Minute Staff Governance Committee

3 December 2025

Present

James Goodyear (Interim Chief Executive Officer), Dave Harris (Director People & Culture), , Joanna Kenny (Chair - Non-Executive Board Member), Ryan McLaughlin (Employee Director - Non-Executive Board Member), Karen Spence (Staff Side Representative) and Han Gilles (Staff Side Representative).

In Attendance

Kat Jenkin (Head of Patient Safety, Quality and Risk), Lynn Adam (Clinical Lead for Workforce), Hazel Aim (Senior Corporate Governance Officer), , Lawrence Green (Health and Safety Lead), Willem Venter (Health and Safety Advisor) and Steven Phillips (Head of People and Culture)

1. Cover Page (Presenter: Chair)

Purpose of Staff Governance Committee

- To support and maintain a culture where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the Board and is built upon partnership and collaboration and
- To ensure that robust arrangements to implement the Staff Governance Standards are in place and monitored

Quoracy

Four members including

- Two non-executive members
- One Executive Director or deputy
- One lay representative from Union or Professional body or deputy

2. Welcome and Apologies (Presenter: Chair)

The Chair opened the meeting at 09.30 am and welcomed attendees to the meeting.

Apologies received from Debs Crohn (Head of Corporate Governance), Jean Stevenson (Non-Executive Board Member), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services (EDoNMAHP)), Dr Kirsty Cole (Non-Executive Board Member), Georgie Green (Clinical Education Facilitator), Jason Taylor (Non-Executive Board Member).

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

3. Declarations of Interest - Verbal (Presenter: Chair)

No declaration of Interest to be recorded.

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4. Minute of meeting held on 18 September 2025 (Presenter: Chair)

The Chair presented the draft minute of the meeting held 18 September 2025.

Decision/conclusion

Minute of the meeting held 18 September 2025 were approved as an accurate record of the meeting.

5. Chair's Assurance Report - 18 September 2025 (Presenter: Chair)

The Chair presented the Chair's Assurance Report from the meeting held on 18 September 2025.

Decision / Conclusion

The committee approved the report for onward submission to the Board.

6. Matters Arising - Verbal (Presenter: Chair)

The Interim Chief Executive Officer (CEO) updated Committee on developments regarding staff accommodation. Work has been completed, assurance provided that issues have been resolved. Committee were asked to note that some accommodation leases have been terminated due to poor quality or high costs.

The Head of People and Culture requested clarification regarding the specific assurances required for workforce data. The Chair and Director of People and Culture will discuss with the Head of People and Culture to resolve this matter ahead of the next meeting.

Decision / Conclusion

Committee noted the update.

7. Action Log (Presenter: Chair)

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

8. CHAIR'S ASSURANCE REPORTS

8.1. Occupational Health, Safety and Wellbeing (OHSW) – Chair's Assurance Report (Presenter: Employee Director)

The Employee Director reported that there have been no Occupational Health, Safety and Wellbeing (OHSW) meetings have taken place since the last Staff Governance Committee meeting in October 2025, citing excessive administrative demands on the Chair. The Employee Director and Director of People and Culture agreed to discuss the issue and find a solution ahead of the next meeting in February 2026.

Decision / Conclusion

Committee took assurance on the report.

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8.2. Joint Local Negotiation Committee (JLNC) Chairs Assurance Report - (Presenter: JLNC Chair)

The Joint Local Negotiation Committee (JLNC) has not met since July 2025, and with the previous chair stepping down, the new chair, Tariro Gandiya, has not yet attended the Staff Governance Committee.

The Director of People and Culture, together with the Corporate Governance Team, agreed to reach out to the new chair to encourage them to attend the upcoming Staff Governance Committee meeting.

Decision / Conclusion

Committee took assurance on the report.

8.3. Chairs Assurance Reports Operational People Group (Presenter: Head of People and Culture)

Positive progress is being made by the Operational People Group – Meetings are well attended, Terms of Reference have been updated, noting that there is a gap for clinical representation at the group.

Guidance on Whistleblowing has been shared with the group.

There is a risk additional funding will be required to ensure the ongoing viability of the Employee Assistance Programme (EAP) when the extension of the existing contract comes to an end.

The Interim Chief Executive asked if the Occupational Health, Safety and Wellbeing could be incorporated with this group. The Director of People and Culture raised concerns in relation to losing sight of Health and Safety and that bringing the 2 groups together could result in the meeting being lengthy resulting in the group being less effective. It was agreed that the Director of People and Culture would explore options and provide an update at the next meeting.

Decision / Conclusion

Committee took assurance on the report.

9. CORPORATE RISK REGISTER (Presenter: Director of People and Culture)

The Director of People and Culture presented the Corporate Risks aligned to Committee, highlighting concerns in relation to leadership capacity at all levels emphasising that managers also need support.

The Director of People and Culture suggested that the Leadership Development Programme could be run by staff members already in the organisation, which would help cut costs and minimise dependence on external providers. K Spence supported this idea, noting that there was potential amongst current employees who could benefit from leadership and talent development opportunities. The Chair also acknowledged the range of possibilities that could arise from implementing such programmes across the broader system.

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The Director of People and Culture acknowledged the good work undertaken in project management; however, concerns remain in relation to the lack of change management within the Organisation. The Health and Safety Lead advised that change management is a key element to Health and Safety stress factors.

The Interim Chief Executive informed the group of their recent participation in the launch of the Scottish Approach to Change and emphasised the potential benefits of utilising this framework.

The Clinical Lead for Workforce highlighted gaps in clinical representation, and the Employee Director confirmed that this was seen in almost all meetings. The Interim Chief Executive raised concerns that clinical groups were not represented and were impacted by staffing levels mandated by the Healthcare Staffing Act.

The Director of People and Culture emphasised the importance of risk appetite statements in the Boards decisions making processes.

Decision / Conclusion

Committee noted the content of the risk register, acknowledging improvements made in relation to risk management but agreed further development are still required.

10. INTEGRATED PERFORMANCE REPORT (Presenter: Director of People and Culture)

The Director of People and Culture presented the Workforce chapters of the Integrated Performance Report (IPR) highlighting the challenges with sickness absence rates due to mental health.

Committee noted the progress made in terms of increasing staff appraisal rate recognising that more work is still required and that a cultural change is required to embed meaningful appraisals and regular one to ones as part of our Business as Usual.

H Gillies mentioned a previous workplace where lower-banded staff had their appraisals before more senior staff, providing line managers with a broader perspective. The Head of People and Culture noted that some employees did not recognise the value of these appraisals. The Employee Director added that, while overall compliance rates have increased, there are still considerable differences between directorates.

The Health and Safety Lead stated that earlier notifications of compliance breaches resulted in significant numbers of staff undergoing training simultaneously, causing bottlenecks during renewal periods. Measures are being implemented to resolve this issue, though some staff have expressed reluctance to undertake training before it is due.

Decision / Conclusion

The Committee acknowledged the report and concurred that Executive Directors should maintain accountability for appraisal and training compliance within their respective areas.

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11. APPROVAL OF STAFF GOVERNANCE COMMITTEE CORE DOCUMENTS 2026/27 (Presenter: Chair)

The Chair presented the Staff Governance Committee Core documents 2026/27, advising that minor amendments have been made to the core documents.

The Director of People and Culture has met with the Head of Corporate Governance to align the business cycle with committee priorities. Members noted that further minor changes may be needed, which will be presented to the Committee for approval if necessary.

Decision / Conclusion

Committee approved the Terms of Reference, Business Cycle/Workplan and timetable for papers for 2026/27.

12. PEOPLE

12.1. Agenda for Change Reduced Working Week (RWW) Plan/ Submission to Scottish Government (Presenter: Head of People and Culture)

The Head of People and Culture presented the Reduced Working Week (RWW) implementation plan which had been submitted to the Scottish Government. Committee noted that not all departmental returns have been received, and once received this will be included in the final plan.

The Director of People and Culture acknowledged that discussions have occurred with Executive Directors and provided assurance that the organisation has implemented a pro-active approach to addressing the matter.

Decision / Conclusion

Committee acknowledged the plan and the update and took assurance that the plan is being actively progressed.

12.2. iMatter Health and Social Care Staff Experience Survey 2025 (Presenter: Head of People and Culture)

The Head of People and Culture indicated that, owing to the release date, the iMatter Health and Social Care Staff Experience Survey 2025 has not yet been brought before the Board Committees.

Committee noted the positive trend particularly in whistleblowing and staff raising concerns, however cautioned about next steps, advising that this is yet to be discussed by the Area Partnership Forum.

The Employee Director suggested that survey results could be used to inform Key Performance Indicators (KPIs) to focus on improvements in the less positive areas. The Interim Chief Executive shared his disappointment that the breakdown of data for areas was not available, and that this had been raised with the Scottish Government.

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The Head of People and Culture advised that a national group has been established to look at iMatter scores and advised that they would welcome conversations with directorates regarding their approach to iMatter action planning.

Decision / Conclusion

The Committee noted the contents of the reports and welcomed the update.

12.3. Staff Governance Monitoring Exercise 2024/25 (Presenters: Employee Director, Head of People and Culture)

The Head of People and Culture presented the Staff Governance Monitoring Exercise 2024/25. The report focused on key areas including bullying, harassment, whistleblowing, equality impact assessments, as well as a summary of successes and challenges in delivering the staff governance standards.

The Head of People and Culture confirmed that the report has been presented to the Area Partnership Forum, this will now be presented to the Board for assurance.

Decision / Conclusion

Committee praised the report and were assured by the quality and clarity of the report.

12.4. Scottish Government - Armed Forces and Veterans Recognition Scheme Update (Presenter: Clinical Lead - Workforce)

The Clinical Lead for Workforce presented an update on the Armed Forces and Veterans Recognition Scheme, advising they are the NHS Orkney Champion which is a mandatory role for all Health Boards.

Discussions with veterans revealed gaps in staff awareness of veterans' challenges, prompting a proposed GP recognition scheme. The Board is working with Orkney Islands Council and sharing information through bulletins, newsletters, and a Turas module for staff.

The Clinical Lead for Workforce noted that Orkney has more veterans than the national average. K Spence asked if their issues are similar to those of the general population. The Clinical Lead responded that many are unaware of the armed forces covenant and uncertain about identifying veterans in systems.

The Chair thanked the Clinical Lead for Workforce for her work in promoting the scheme.

Decision / Conclusion

Committee took limited assurance from the report however welcomed the effort to promote training and highlighting issues through various means.

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13. PATIENT SAFETY QUALITY AND EXPERIENCE

13.1. Whistleblowing 6 monthly report (Presenter: Head of Patient Safety, Quality and Risk)

The Head of Patient Safety, Quality and Risk pointed out that the appendices were missing from the quarter 1 and quarter 2 papers. Additionally, the six-monthly reports had been submitted to the Board instead of the Staff Governance Committee. They asked for feedback on the revised format of the report and indicated that it would be sent to the Independent National Whistleblowing Office before being published on NHS Orkney's website.

The Head of Patient Safety, Quality and Risk reported that no whistleblowing concerns were raised in Quarter 2, and all recommendations from Quarter 1 have been implemented. Collaborative work with independent contractors, including general practitioners, opticians, and pharmacies, has taken place to ensure comprehensive understanding of whistleblowing procedures. Updated guidance on whistleblowing has been distributed organisation wide.

During the meeting, the Interim Chief Executive queried the basis for reports of low organisational morale, noting a discrepancy with the Board's iMatter scores. The Head of Patient Safety, Quality and Risk clarified that this feedback was derived from confidential staff contacts at various touchpoints but also confirmed that such feedback is only referenced within this report.

Decision / Conclusion

The Committee noted the contents of the reports.

Head of Patient Safety, Quality and Risk left the meeting at 11:14.

14. PERFORMANCE

14.1. Internal Audit Planning - Verbal (Presenter: Chair)

The Chair confirmed next year's Internal Audit plan had been presented to the Audit and Risk Committee, with five areas scheduled for audit in 2026/27 and additional requests deferred to 2027/28.

J Taylor, as Chair of Audit and Risk Committee, will contact internal auditors about cross-committee assurance, concerns were noted about duplicating previous audits.

Decision / Conclusion

The Committee took assurance on the internal audit plan in principle, pending the outcome of conversations with Interim Chief Executive Chair of Audit and Risk Committee and Director of Performance and Transformation.

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14.2. Health Care Staffing Act Quarter 2 Submission to Scottish Government (Presenter: Clinical Lead - Workforce)

The Clinical Lead for Workforce delivered the board-level compliance report for the second quarter. The Board is still at a level of limited assurance, as indicated by self-assessments from professional leads—six reports were submitted, but three are still pending.

There has been progress in statutory and mandatory training, along with improvements in role-specific training. However, ongoing issues include fully implementing real-time staffing, identifying and mitigating risks, enhancing staff engagement, and applying the common staffing method effectively.

Before submitting the final Quarter 2 report to the Scottish Government, the committee asked for a roadmap outlining percentage targets, quarterly milestones and asked the performance is managed by the Operational People Group.

Decision / Conclusion

The Committee approved the submission of the Quarter 2 report noting continued limited assurance.

15. POTENTIAL

15.1. Health and Safety Update Report (Presenter: Health and Safety Lead)

The Health and Safety Advisor reported on the rollout of digital health and safety control books.

All SharePoint sites are complete, risk assessments have been updated, and staff training is happening.

Violence and aggression training compliance rose by 6%, moving and handling by 12%, and face fitting compliance stands at 63%.

Previous concerns about data accuracy are mostly resolved, though some non-compliance remains.

A health and safety induction pack has gone to the organisational development team. Managers responsible for risk assessment sign-off will receive guidance and are encouraged to ask questions if unclear.

The Chair commended the report and the update for its excellent content.

Decision / Conclusion

Committee took assurance from the reports.

16. ANY OTHER COMPETENT BUSINESS (Presenter: Chair)

The Employee Director noted the absence of clinical representation in the meeting.

Item 17.6

17. Items to be included on the Chair's Assurance Report - Verbal (Presenter: All)

Agreed that the following items would be included in the Chair's Assurance Report

Decisions made

- Minutes and Chairs Assurance Report 18 September 2025 approved
- Staff Governance Committee Terms of Reference, Business Cycle/Workplan and timetable for papers for 2026/27 approved

Risks to be escalated to the Board

- The Joint Local Negotiation Committee (JLNC) has not met since July 2025
- Limited clinical representation at the meeting due to several apologies being received.
- Lack of leadership and change management capacity and capability
- Limited assurance on Health Care Staffing Act compliance

Positive assurance

- Operational People Group is well attended
- Improvements are being seen in relation to improving appraisal rates and managing sickness absence
- Assurance that the RWW plan is being actively progressed
- Positive trend in relation to staff feeling confident to raise concerns
- Staff Governance Monitoring Exercise 2024/25
- Health and Safety improvements
- Armed Forces and Veterans Recognition Scheme

Work underway

- Leadership Development Programme
- iMatter Health and Care Survey 2025
- Streamlining Your Employee Journey

18. ITEMS FOR INFORMATION AND NOTING

18.1. Key documentation for information

The following key documentation was made available to the Committee:

- Director Letter - Consolidated Agency Controls - October 2025
- Your Employee Journey Update
- Reduction of the Full-Time Working Week For Agenda For Change Staff
- BCE Chair & Vice Chair Letter to C Lamb re AfC Reduced Working Week
- CMO Letter - Armed Forces and Veterans Recognition Scheme
- Area Partnership Forum Chairs Assurance Report 21 October 2025
- Area Partnership Forum Chair's Assurance Report 18 November 2025

Item 17.6

The Chair recognised the value of the 'Your Employee Journey' document but suggested further development to include Key Performance Indicators and clearer alignment with Staff Governance standards.

Decision / Conclusion

Committee noted the contents of the documentation.

18.2. Schedule of Meetings for 2025/26 (Presenter: Chair)

Decision / Conclusion

The Committee noted the schedule of Meeting for 2025/26

18.3. Record of Attendance 2025/26 (Presenter: Chair)

Decision / Conclusion

Committee noted the Record of Attendance 2025/26

The Chair closed the meeting at 12:47

Timetable for Submitting Agenda Items and Papers 2026/27

Initial Agenda Planning Meeting ¹	Final Agenda Setting Meeting	Papers in final form ²	Agenda & Papers	Meeting held virtually via MS Teams
with Chair, Lead Executive and Corporate Governance ³ < day of or 1 day after previous meeting >	with Chair, Lead Executive and Corporate Governance 21 days before date of meeting	to be with Corporate Governance < 9 days before Date of Meeting >	to be issued no later than < 7 days before Date of Meeting >	(unless otherwise notified) < Day of Meeting >
26 February 2026	26 March 2026	21 April 2026	23 April 2026	30 April 2026
30 April 2026	4 June 2026	16 June 2026	18 June 2026	25 June 2026
25 June 2026	6 August 2026	18 August 2026	20 August 2026	27 August 2026
27 August 2026	8 October 2026	20 October 2026	22 October 2026	29 October 2026
29 October 2026	19 November 2026	1 December 2026	3 December 2026	10 December 2026
10 December 2026	4 February 2027	16 February 2027	18 February 2027	25 February 2027

¹ Draft minute of previous meeting, action log and business programme to be available

² Any late papers will be placed on the agenda of the following meeting unless the Chair determines that they are urgent

³ Draft agenda, minute and action log issued to Directors following meeting

Chair	Davie Campbell
Vice Chair	Joanna Kenny
Lead Executive	CEO
Corporate Governance Lead	Head of Corporate Governance