Public Board Meeting - 30 October 2025

2025-10-30 09:30 - 12:30 GMT

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NHS Orkney Board
30 October 2025

Purpose of Orkney NHS Board

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

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

- Open and honest
- Respect
- Kindness

Our **Strategic Objectives** are:

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

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

People Ensure NHS Orkney is a great place to work

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

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

Quorum:

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

Public Board Meeting
Minutes
28 August 2025

Present

Melanie Barnes (Interim Director of Finance), Kirsty Cole (Chair, Area Clinical Forum), Issy Grieve (Non-Executive Director), Joanna Kenny (Non-Executive Director), Dr Anna Lamont (Medical Director), Laura Skaife-Knight (Chief Executive Officer), Jean Stevenson (Non-Executive Director), Jason Taylor (Non-Executive Director), Sam Thomas (Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Davie Campbell (Interim Board Chair), Fiona MacKay (Non-Executive Board Member),

In attendance

Debs Crohn (Interim Head of Corporate Governance), Stephen Brown (Chief Officer – Integration Joint Board), Tammy Sharp (Director of Performance,Transformation), Shona Lawrence (NHS Orkney Corporate Communications Officer), Ian Grant (The Orcadian), (BBC Radio Orkney), Andew Stewart, Kendall Pyke (Organisational Development Lead).

1. Cover page

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2. Patient Story

Ken Amer attended the Board to share his personal reflection of the care from NHS Orkney following his diagnosis and treatment for Prostate Cancer. Key points to note:

Patient experience of services in Orkney

- Care was fantastic.
- Staff were very understanding of Ken being self-employed.
- Extended family were very well supported.
- 12 weeks after referral Ken got a call to say a theatre slot was available.

What mattered most to the patient:

- Staff have your health at heart and want to do the best they can for you.
- Medical staff were clear on what was going to happen and when.

Areas for improvement

- Patient wrote to NHS Grampian to ask if they could be moved up the list.
- Patient first presented to ED rather than GP (however circumstances were unclear on the specifics)

I Grieve acknowledged the work Ken has led around men's health, Ken is a real ambassador for men's wellbeing on the mainland and the outer isles.

The Executive Director of Nursing, Midwifery and Allied Health Professionals, and Chief Officer Acute Services (EDoNMAHP) thanked Ken for the presentation on behalf of the Board.

Decision/conclusion
Members welcomed the patient story.

3. Welcome and Apologies (Presenter: Chair)

The Interim Board Chair opened the meeting at 09.30 am and welcomed the attendees.

The Interim Board Chair welcomed Fiona MacKay (Non-executive Board Member) to their first Board.

The Interim Board Chair acknowledged that today was the last meeting for the Director of People and Culture and the Chief Executive Officer (CEO) and thanked them both for their contributions to the Board and their part in our improvement journey. The Interim Board Chair wished them well for the future.

Apologies received from Rona Gold (Non-executive Board Member).

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

4. Declarations of Interest (Presenter: Chair)

Fiona MacKay declared an interest in item 14.1 Clinical Services Review as they had been part of the reviewing team.

5. Minutes of Previous Meeting 26 June 2025 (Presenter: Chair)

Minutes of the meeting held on 26 June 2025 were accepted and approved as an accurate record of the meeting.

6. Matters Arising (Presenter: Chair)

Item 8.2 - I Grieve asked for an update on Hamnavoe House at the July IJB, and asked when an update would be received by the Board. The Chief Officer IJB advised that a meeting of the strategic planning group is scheduled for Tuesday 2 September 2025, to discuss how the fourth wing of Hamnavoe House could be used. Within 4 – 6 weeks recommendations will be presented to the IJB. Delayed Transfers Of Care (DToC) remain a challenge across the system in relation to care home closures and recruitment. As part of the development of the Older People's Strategy this will include longer term solutions for DTOC's. A paper will be brought to the IJB in December 2025.

Item 8.5 – Dr K Cole asked if office bearers are now invited to the Senior Leadership Team. The CEO advised that confirmation will be prodived to the ACF Chair by the Interim Head of Corporate Governance.

In the absence of a Chair's Assurance Report for the Staff Governance Committee, J Kenny asked the Director of People and Culture for an udpate on work underway in relation to statutory/mandatory training, appraisals managing sickness attendnace.

The Director of People and Culture advised that a focused session took place with the Extended Senior Leadership Team (ESLT) in July 2025 focusing on statutory/mandatory training. All members of ESLT were asked to provide an improvement plan for discussion with the CEO and Director of Performance and Transformation (Deputy CEO) to ensure mandatory training was brought up to date by December 2025.

The CEO advised that meetings with managers have now taken place, assurance has been recieved in relation to shifting the dial and improving statutory/mandatoring training compliance.. The Deputy CEO confirmed they are confident that plans are in place to bring the Board back on track.

The Employee Director confirmed that there is a significnat increase in attendance for violence and aggression training, recognising its good to see the improvements and asked that protective learning time is built in to all staff rotas.

7. Action Log (Presenter: Chair)

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

8. Board Chair and Chief Executive Report to the Board – August 2025 (Presenters: Chair, Chief Executive)

The Chief Executive presented the Board Chair and Chief Executive Report to the Board providing an update on key events and activities in July and August 2025. Highlights included:

An update from the Board Chief Executives meeting with the First Minister. Areas discussed included.

- 52 Week waits
- Unscheduled care
- System Flow
- Reducing Delayed Transfers of Care
- 62-day Cancer performance

We are pleased to have hosted 2 Cabinet Secretary visits over the summer to showcase the innovations we continue to deliver here in Orkney. The latest visit was to showcase innovations with Ms Robison in relation to The Balfour being the first Hospital in the country to achieve net zero status.

The CEO thanked everyone at NHS Orkney and wider system partners for the efforts that went into the planning for the Island Games, which made sure the Games ran smoothly. People's dedication, professionalism and teamwork were the backbone of this record-breaking success. The CEO thanked EDoNMAHP for their support in leading the Board's response to the Island Games.

J Taylor asked for confirmation that text message reminders were included in the update. The Interim Head of Corporate Governance advised that as part of the roll out of the Digital Front Door (DFD), which is a national Programme for Government commitment, text messages and electronic letters will be made available to all Health Boards.

9. CHAIR'S ASSURANCE REPORTS

9.1. Joint Clinical and Care Governance Committee (JCCGC) Chair's Assurance Report 3 July and 20 August 2025 (Presenter: Rona Gold - Chair of Joint Clinical and Care Governance Committee)

The Vice-Chair presented the Joint Clinical and Care Governance Committee Chair's Assurance Report 3 July and 20 August 2025.

Key points 3 July 2025 Meeting

Matters of concern in relation to joint strategies e.g. weight loss and physical health. The population health framework will provide an opportunity to bring this together.

Limited assurance provided on the Public Protection Framework – update to be brought to JCCGC December 2025.

Work underway
Primary Care Improvement Plan will be presented to GP Sub Committee September 2025.

Extraordinary Meeting 20 August 2025

Committee considered financial risks in relation to the Clinical Services Review (CSR). The Board was asked to note that some recommendations will require additional investment.

Decision / Conclusion
The Board noted the update.

9.2. Finance and Performance Committee Chair's Assurance Report 31 July 2025 - (Presenter: Davie Campbell - Vice Chair Finance & Performance Committee)

The Chair of Finance and Performance Committee presented the Finance and Performance Committee Chair's Assurance Report from 31 July 2025 meeting.

Points to note

- Adverse financial position at Month 3
- Unscheduled care funding – The paper was not brought to Board in August 2025. Conversations continue with Scottish Government with assurance being brought to Board in October 2025 so traction can be made ahead of winter.
- The CEO updated that a few obstacles have been encountered in relation to deployment of the MORSE community Electronic Patient Record. Further work required around ownership, leadership and governance. This will be taken through our internal governance and brought back to the Finance and Performance Committee.
- Successful delivery of our Island Games Preparedness plan -, whilst Emergency Department attendances increased during the Island Games, our performance remained at 95%.

Decision / Conclusion
The Board noted the update.

9.2.1 Financial Escalation Board Chair's Assurance Report 25 June 2025 (Presenter: Davie Campbell - Vice Chair Finance & Performance Committee)

The Interim Board Chair presented the Financial Escalation Board Chair's Assurance Report 25 June 2025. Points to note

Medical Staffing recruitment remains high risk, deep dive on 27 August 2025. J Taylor advised that the deep dive took place 27 August 2025, a review of our financial position will be undertaken at 6 months, this will be presented back to Board in October 2025.

The Medical Director advised that there are 2 main staffing issues; recruitment of vacant posts – agreed to progress at pace with recruitment. Future staffing model and relationships outlined in the Clinical Services Review. The Medical Director advised that there is a need to recruit permanent substantive medical staff if we are to improve our financial position and savings achieved.

The Director of Performance and Transformation advised that an initial conversation has taken place with Orkney Island Council (OIC) in relation to sharing project management support, we are awaiting confirmation from OIC on whether this will be feasible.

Decision / Conclusion
The Board noted the update.

9.3. Senior Leadership Team Chair's Assurance Reports – July and August 2025 (Presenter: Chief Executive - Chair of Senior Leadership Team)

The Chair of the Senior Leadership Team (SLT) presented the report highlighting the following items which had been discussed at their meetings in July and August 2025 highlighting the following areas of escalation. There have been 6 meetings since the last Board.

The CEO summarised the main points as follows

- Financial position – recovery plans in place to improve performance.
- Concerns were escalated due to an increase in sickness absence in April and May due to stress and anxiety – deep dive has taken place, remains under review.
- Assurance provided that the staff Health and Wellbeing programme will not be affected by changes in staffing.
- Health and Care Staffing Act – this is being monitored by the People's Operational Group. Chair's Assurance Reports are provided from the People's Operational Group.
- Education Improvement Centre – this has been paused due to capacity not being available to take this forward.
- Endoscopy Peer Review – to be covered at In Committee.

J Taylor asked for an update on individuals who require accommodation in late stages of pregnancy. The Medical Director provided an update on the current situation. Conversations are taking place with the Central Legal Office in relation to options moving forward.

Decision / Conclusion
The Board noted the update provided.

9.4. Area Clinical Forum 1 August 2025 (Presenter: Dr Kirsty Cole, Chair of the Area Clinical Forum)

The Chair of the Area Clinical Forum presented the report highlighting the following items which had been discussed at their meeting on 1 August 2025, highlighting the following

- Discussions took place with Balfour based colleagues in relation to record keeping not being electronic – the Clinical Services Review (CSR) will address some of these concerns.
- Private medical intervention, i.e. weight loss medication, is proving challenging for the system. This is being reviewed by the Area Drugs Therapeutics Committee.
- Workshops are planned for colleagues from primary and secondary care to look at interface working across the whole system. Non-clinical colleagues are welcome to attend the workshops.

Decision / Conclusion
The Board noted the update provided.

9.5. Staff Governance Committee - 15 May 2025 (Presenter: Joanna Kenny - Chair of Staff Governance Committee)

No meetings have taken place since the last Board meeting. The next meeting will take place on 18 September 2025.

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

The Medical Director presented the Corporate Risk and Assurance report providing an update on active risks, changes to risk ratings, any newly added risks and any risks that had been closed or made inactive within the last reporting period. Since the last Board meeting, the Risk Management Group are validating operational risk registers moving from a test of change into Business As usual. Good attendance and evidence from clinical colleagues at the Clinical Governance Group and Risk Management Group.

J Taylor asked for an update on risk 1225 (social care capacity) in relation to Delayed Transfers of Care (DToC) as the risk is scored as a medium risk. Confirmation was sought on whether as a Board, there is anything more that could be undertaken to mitigate the risk. The EDoNMAHP advised that when the risk was

last updated it was scored at medium, work is underway with clinical teams to set the planned discharge date at admissions using the first home principal. Paperwork is being reviewed to include a whole system approach to discharge planning. Funding available through Public Sector Reform (PSR) will support the move to prevention.

J Taylor acknowledged that the use of Hamnavoe House in 2020 did make a significant difference.

J Taylor asked for assurance on risk 2025-04 (capacity to under Serious Adverse Event Reviews – SAER's) that the mitigations in place are sufficient to manage the risk. The Medical Director advised that staffing levels are in place to deal with the current staffing establishment recognising the number of SAER's has now reduced.

Lack of senior leadership capacity and capability – R McLaughlin welcomed the work underway on the leadership and management development programme and asked for mitigating actions to be included in the risk register narrative going forward. The CEO advised that Quality Improvement (QI) training is now underway, the leadership and development programme will return to the Senior Leadership Team (SLT) in September 2025 for approval.

J Stevenson asked when the expected outcomes and results of the manager/leadership programme will be seen. The Director of People and Culture advised that this will be next financial year. Quality Improvement training has commenced; the manager training programme will focus on people management skills, finance and sickness absence which will start in Quarter 4. The Leadership programme is likely to see outcomes by the end of 2026.

R McLaughlin asked for an update on the risk in relation to managing sickness absence and mitigating actions in place. The Director of People and Culture advised that the way sickness is managed has improved but further work is required to manage people back to work. R McLaughlin asked if a risk is required in relation to staff sickness due to stress and anxiety. The Director of People and Culture advised that stress absence is also related to causes of stress outside the workplace but recognised that some of the workplace stressors are occurring in relation to capacity and change.

The Medical Director asked the Board to note the changes presented to the Board and asked for the Board to support the changes presented now we have moved to Business as Usual.

Decision / Conclusion
The Board noted the update provided and the current mitigation of risks highlighted

11. Integrated Performance Report (IPR) (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the Integrated Performance Report (IPR).

The Board was reminded that the IPR is under review, the first 3 sections have been updated and circulated for comments. A refreshed IPR will be presented to the Board October 2025.

The Board remains in the top 3 boards nationally for performance against the 4-hour Emergency Department target.

The Board continues to see a reduction in the number of long-term waits (52 week waits). The Board is on track to achieve the trajectory of no patients waiting longer than 52 weeks by March 2026.

The EDoNMAHP advised that maternity data is being carried out with the team, this will be included in the October 2025 update.

Chief Officer IJB updated that the data presented is from March 2025 noting this is due to national reporting. The introduction of the Phio app has made some significant improvements in reducing waiting times in the podiatry service.

Finance
The Interim Director of Finance advised that additional SLT meetings have taken place, and the Board is off-track at the end of Quarter 1.

I Grieve thanked the team for the changes in the IPR and asked for an update on dental waiting lists. The Chief Officer IJB advised that successful recruitment has taken place in the dental service, we continue to work with the dental community with the aim that by the summer of 2026 all those waiting for a dentist will have received an appointment.

F MacKay asked for a dashboard to be included at the front of the IPR and consideration to be given to introducing the Amber status for tracking performance. The Director of Performance and Transformation advised that the amber status will be included in the refreshed version available from October 2025.

The CEO apologised to the Board that 2 chapters of the IPR are not included in the paper (Population Health and Patient Safety, Quality and Experience) and this will be shared with the Board for good governance.

The Medical Director reminded the Board that small numbers being reported in relation to 62-day waits for cancer need to be viewed with caution.

R McLaughlin asked for an update on statistical outliers in relation to workforce data. The Director of People and Culture advised that targeted work is being undertaken with managers around best practice and quality appraisals and how these can be scheduled throughout the year.

The EDoNMAHP advised that some of the teams are 100% noting that areas with high demands are being supported to schedule appraisals, no additional training will be authorised if statutory/mandatory training is not up to date.

The Interim Director of Finance advised that the team are at 90% compliance with statutory/mandatory training and are on track for all appraisals to be completed.

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. Limited assurance provided at the Workforce and Patient Safety, Quality and Experience sections were not included in the report.

12. STRATEGIC OBJECTIVE - PLACE

12.1. Integration Joint Board (IJB) Strategic Plan 2025-2028 - what this means for NHS Orkney (Presenter: Chief Officer - Integration Joint Board)

No papers received. The Chief Officer IJB provided assurance that papers will be provided going forward.

12.2. Integration Joint Board (IJB) Key Messages from Meeting 30 April 2025 (Presenter: Chief Officer - Integration Joint Board)

No papers received. The Chief Officer IJB provided assurance that papers will be provided going forward.

13. STRATEGIC OBJECTIVE - PEOPLE

13.1. External Review - culture governance and senior leadership - August 2025 progress update (Chief Executive)

The Chief Executive provided an udpate following a commitment to Board to bring progress

Completed actions:

- Cultural development and Values and Behaviours Framework
- Non-Executive Development

Actions now mostly complete/progress are being made:

- Respect for our governance
- CEO portfolio redistributed, and role review underway
- Appraisal and statutory training – strengthened actions in place,

- Leadership Development programme

Overdue

- Clinical engagement – including the refresh and relaunch of Clinical Advisory Groups and what clinical engagement looks like at NHS Orkney.
- Staff engagement - Introducing quarterly pulse surveys for staff.
- Restate role of Chair and Vice Chair responsibilities via clear communication to all Board members.

Decision / Conclusion
The Board noted the update provided received assurance.

13.2. Behavioural Standards Framework - Defining the culture we want (Presenter: Director of People and Culture)

Kendall Pyke – Organisational Development Advisor joined the meeting at 10.55.

The Director of People and Culture provided an overview of the engagement work undertaken in the development of the Behavioural Standards Framework which offers people a common language and to respectfully challlenge behviours where required. The standards have been developed with and by staff and the Board.

The Organisaitonal Development Advisor advised that further sessions are still planned but feedback from staff has been positive and consistent. The framework includes a section on how leaders should model behaviours.

An implementation plan pending approval by the Board will be included in values based recruitment, appraisals and staff induction, work will continue with teams to embed the standards. The Board were asked for their commitment sign up to and agree to role model the behavioural standards.

The Director of People and Culture confirmed that the behaviours will be shared with our Community as part of our approach to patient and staff experience.

R McLaughlin welcomed the behavoural standards framework and asked for clarity on how it will be measured. The Director of People and Culture advised that a piece of work needs to be undertaken to map standards to staff and patient feedback so data can be shared to show how we are living the standards. Measuring success of the behavioural framework needs to be tracked against the staff governance standards to reduce duplication.

The EDoNMAHP thanked the People and Culture team for their work and acknowledged clincial engagement in the process.

Decision/conclusion
The Board approved the Behavioural Standards Framework.

K Pyke left the meeting at 11.04.

13.3. Executive Team portfolios - September 2025 (Presenter: Chief Executive)

The CEO presented an update to the Board on changes to the Executive Team portfolios from 1 September 2025.

Decsion/conclusion

The Board noted the Executive Team portfolio updates.

13.4 12 month review of themes from Board walkarounds and next steps

The CEO presented the 12 month review of the themes for Board walkarounds. 19 walkarounds have now taken place, there is a need for the feedback to be locked into our staff experience team.

There have been 6 walkarounds in July and August 2025, members noted the themes.

J Taylor asked for an update to address concerns in relation to clincial space. The CEO advised that asks for clinical space should be made through the Capital and Strategic Estates Group. The Interim Director of Finance advised that communications will be issued to staff, however no requests have been received to date.

I Grieve welcomed the link being made with the staff experience programme and asked that Non-executive Directors and Directors continue to meet with staff. The CEO confirmed that there will be no changes to the current process.

F MacKay noted that one of the areas of improvement was in relation to resiliance of small teams and educaiton, this could be linked with the CSR recommendations, improvement journey and Corporate Strategy. This is a great opportunity to use the ‘you said, we did’ method to provide updates to staff. The CEO confirmed that the themes from the paper will be shared with staff starting this week.

R McLaughlin if walkaround could be targetted in areas that did not score high for lack of visiblity in iMatter survey as well as walkarounds on the outer isles.

Decsion/conclusion

Board noted the update.

14. STRATEGIC OBJECTIVE - PATIENT SAFETY, QUALITY AND EXPERIENCE

14.1. Clincial Services Review Implementation Plan (Presenter: Medical Director)

The Medical Director advised that the CSR recommendations and implementation plan has been shared with staff and clinical advisory groups. Whilst there is a focus

on the implementation review, we have complex services delivered nationally, NHS Grampian and NHS Highland, this requires engagement with our clinical colleagues.

Feedback has been received from staff that not all services have been provided, recognising that the scope of the review was made clear at the outset.

The recommendations presented include engagement, consultation, listening to those working and being involved in the systems. The CSR is a cross-executive delivery programme providing a real opportunity for transformation, recognising resources (financial and people) are required to embed the change required.

A prioritisation exercise has been undertaken on the recommendations, whilst there are significant savings to be made, most of the recommendations are cost neutral or will come at a cost.

I Grieve recognised that there is substantial information to digest and welcomed the 6 workstreams identified. In relation to the implementation plan what is the process around the challenges outlined in the paper, and how will the multiple themes be prioritised and timescales identified, SMART targets and ownership by delivery leads.

The Medical Director acknowledged the questions raised by I Grieve, SMART targets and timescales will follow once agreement has been reached.

DOPT agreed that there are 6 workstreams and executive leads identified. Workshops are taking place with those involved, this will take a couple of months to complete. Project Initiation Documents and SMART targets.

Clinical and community engagement still needs to be worked through recognising that the corporate strategy and improvement programme need to dovetail together.

F MacKay reminded colleagues that she has an interest in this piece of work and asked that consideration be given to not viewing the workstreams in isolation, there should be a clear read across to all recommendations. Whilst clinical engagement is important, this extends to the whole workforce. In section 9.4 there are areas of significant savings which can be realised to support financial recovery.

J Taylor asked for confirmation that staff were bought into the changes recognising that there are considerable savings to be made.

The Director of Performance and Transformation advised that digital will be a cross-cutting theme, the Improving Together Programme Board will be refreshed to oversee the CSR recommendations.

Dr K Cole asked for sight of the mapping exercises undertaken which underpinned the CSR. The Medical Director advised that this will be shared with Board Members in-committee.

The Medical Director stressed that the CSR was and continues to be clinically focused and not financially led.

Decision / Conclusion
The Board took assurance on the Clinical Services Review Implementation Plan.

14.2. Healthcare Associated Infection Reporting Template (HIART) Report (Presenter: Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services)

The EDoNMAHP acknowledged changes to the report, feedback welcomed on the report.

Hand hygiene remains a challenge, Board noted that all other standards are being met. The Infection Prevention Control Team continue to work with staff to raise awareness of hand hygiene, further work is required but this remains a key focus for the Board.

The EDoNMAHP thanked the Infection Prevention and Control Team and our facilities team for keeping our patient safe.

Decision/conclusion
The Board discussed and took assurance on the Healthcare Associated Infection Reporting Template report.

14.3. Safe Delivery of Care (SDoC) inspection programme 2025/2026 - what this means for NHS Orkney (Presenters: EDoNMAHP)

The Interim Board Chair asked what risk SDoC poses to the Board. The Interim Directof of Finance advised that this will result in additional cost pressures to the Board if actions are required, this may require dis-investment in other areas.

The EDoNMAHP advised that regular walkabouts should mitigate the risk of additional cost pressures.

Decision/conclusion
The Board received and noted the update.

14.4. Patient Experience Framework 2025/26 (Presenter: Director of People and Culture)

The Diirector of People and Culture advised that the patient experience framework is the principles we will work to in terms of how we engage with our patients.The framework has been developed based on the realstic medicine principles.

It was proposed that patient journeys for planned and unschdeduled care be developed as we part of the implemenation of the Patient Experience Framework.

Decision/conclusion

The Board approved the Patient Experience Framework 2025/26

14.5. Duty of Candour and Significant Adverse Events Annual Report 2024/25

The Medical Director presented the Duty of Candour and Significant Adverse Events Annual Report 2024/25 which is a requirement for all Health Boards in Scotland.

The Board noted that there has been more SAER's closed than opened this financial year.

J Taylor asked for evidence of how learning has been embedded when staff changes occur. The Medical Director advised that all SAER's are now presented to the Clinical Governance Group. Recommendations are scrutinised and embedded in processes with named contacts identified to ensure communications are in place.

J Taylor asked if there is a role for Clinical Audits to be undertaken to ensure learning from SAER's is embedded. The Medical Director agreed to consider the role of Clincial Audits as part of learning from Duty of Candour SAER's.

J Kenny asked for clarity on how people who have been involved in compassionate conversation training has been embedded in SAER's as a success story. Medical Director acknowledged the need share success stories.

Decision/conclusion
The Board received and approved the Duty of Candour and Significant Adverse Events Annual Report 2024/25

14.6. NHS Orkney Patient Feedback (Complaints) Annual Report - 2024/25

The Medical Director presented the NHS Orkney Patient Feedback (Complaints) Annual Report 2024/25 recognising the number of complaints received is decreasing and that the report covers both primary and secondary care. The roll out of Care Opinion has commenced for secondary care but not primary care.

The Board welcomed the compliments section of the report.

J Stevenson provided positive feedback from a patient receiving support in our Intermediate Care Team.

J Taylor asked for an update on incident management and assurance that the Board has sufficient staff trained to undertake SAER's. The Medical Director advised that investigating incidents is different to managing SAER's and that there is sufficient staff to undertake reviews.

Decision/conclusion
The Board received and approved the Orkney Patient Feedback (Complaints) Annual Report - 2024/25

14.7 Infection Prevention Annual Report 2024/25

The EDoNMAHP presented the Infection Prevention Annual Report 2024/25 for approval by the Board.

I Grieve congratulated the team for being proactive in promoting good hygiene across the community and secondary care noting all premises were visited on the outer isles.

Decision/conclusion
The Board received and approved the Infection Prevention Annual Report 2024/25

15. STRATEGIC OBJECTIVE - PERFORMANCE

15.1. Corporate Strategy 2025/26 Delivery Plan and Quarter 1 update (Presenter: CEO)

The CEO presented the Quarter 1 2025/26 Corporate Strategy update. There are 15 deliverables in our Year 2 Corporate Strategy Delivery Plan 2025/26. 4 of the deliverables are RAG rated Red, 1 rated Amber, 9 Green and 1 deferred to 2026/27.

The 4 deliverables off track – statutory/mandatory training, appraisls, Delayed Transfers of Care and pausing of the Education and improvement Hub were discused earlier in the agenda.

The CEO advised that the Board level lead for the potential strategic objective will transfer to the Interim Director of Finance from 1 September 2025.

Decision/conclusion
The Board noted the update.

15.2. Operational Improvement Plan (Presenter: Director of Performance & Transformation)

The Director of Performance and Transformation provided an overview of the NHS Scotland Operational Improvement Plan. The Board has undertaken a self-assessment against the plan, and this was shared with the Board. The Board's self-assessment is on track and rated green overall, progress will be monitored through our Annual Delivery Plan. The amber action in relation to implementing a frailty model as the front door will be taken forward as part of the CSR recommendations.

The CEO thanked the Director of Performance and Transformation for the self-assesment and asked that an additional column be added so a narrative could be included for actions which are off-track.

Decision/conclusion
The Board noted the update.

15.3. Planned Care - 52-week waits update (Presenter: Director of Performance & Transformation)

The Director of Performance and Transformation confirmed that the planned care 52 week wait trajectory remains on track to meet the target of having no patients waiting longer than 52 week waits by 31 March 2026.

J Taylor asked for reassurance that those patients requiring urgent appointments are not impacted by focusing on patients waiting 52-week waits. Performance is being managed at the weekly meetings, all Boards have been asked how they can support other Boards with reducing waiting times.

Decision/conclusion
The Board noted the update.

15.4. Financial Performance Report August 2025/26 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented Month 4 financial performance. £245k savings have been achieved, however the plan remains £46k off track due to staffing costs. Unquantified cost pressures include Service Level Agreement increase of 6% resulting in an additional £400k cost pressure.

Band 5 reviews continue but are unquantifiable at this stage.

IT costs pressures have been identified which will need to be included in Month 5 position.

The Board is predicting a £3.4 million deficit at year-end, which is out with our tolerance levels set out in the transitional funding terms and conditions. The Interim Director of Finance advised that this would result in the Board being issued a section 22 notice as the tolerance level is 1% of our RLL which equates to £1 million.

The Board has a £3.8 million savings plan for this financial year, 7% has been achieved to date. The Board noted that savings are planned to be realised towards the end of this financial year.

Additional schemes are being identified by the improvement team, recovery actions were identified by SLT, and benefits are planned to be realized in Month 6. A full review of the financial position will be undertaken at the end of Quarter 2.

I Grieve was heartened by the position on Month 4 in comparison to Month 3. The Interim Director of Finance advised that the position will be clearer at Month 6, and this will provide a good indication for our year-end position.

Dr K Cole asked for clarity on cost pressures for dental and medical staffing and asked what was being done differently to encourage applicants to move to Orkney.

The Medical Director advised that the approach to recruiting substantive medical staff has been changed, one of the challenges has been people withdrawing from posts when they have been shortlisted and several Board recruiting at the same

time. BMJ, Facebook and Linkedin have not proved to be successful, golden helloes and other mechanisms for advertising posts are being looked at following feedback from clinicians. The Medical Director advised that transport links are a selling point for applicants. Vacancies will be advertised as they occur being cognisant of the time of year. International recruitment and Physician Associates have been considered, assurance provided that we are taking a different approach to recruitment. Members were asked to forward ideas to the Medical Director.

Decision/conclusion
The Board discussed and noted Month 4 (August 2025) Financial Performance.

15.5. Improving Together (efficiency) Programme Update - August 2025 (Presenter: Director of Performance & Transformation)

The Director of Performance and Transformation presented the Improving Together (efficiency) Programme update. A key piece of work is underway to validate the cost schemes and asked the Board if the financial update and Improving Together Programme Udpate being combined.

Decision/conclusion
The Board noted the update and agreed that the Improving Together (efficiency) programme and financial performance report be combined.

15.6. Proposal for King Street and the Old Balfour site (Presenter: Chair)

The Interim Director of Finance provided an update on work underway on the Old Balfour Site. Tenders will go out in the next couple of weeks for the survey work required, for demolotion in 2027.

The Interim Director of Finance provided an overview of the options avaialbe for the disposal of King Street.

J Taylor acknowledged that the paper sets out long term accommodation needs, and asked for clarity around short term accommodation at St Rognvalds House. The Interim Director of Finance advised that work is underway to scope options, this work is being led by OIC. J Stevenson advised that there are no plans for St Rognvalds House, options are being considered by officers.

J Taylor stated that he was not opposed to the sale of King Street and this had originally been ear marked for short term accommodation needs. There is a concern that selling the property will not address the issues of accommodation for staff. The Interim Director of Finance advised that investment in King Street may not be a viable option for the Board and the Board should avoid influencing market forces. Our responsbility as a Board is that anyone on the open market can purchase the property.

The Interim Director of Finance advsied that the sale will be handled by the Central Legal Office on behalf of the Board.

The Medical Director advised that a wider piece of work is underway to look at staff accommodation.

I Grieve fully supported the sale of King Street on the open market, acknowledging that opportunities will arise to address the challenges being faced in terms of staff accommodation.

Decision/conclusion
The Board noted the Old Balfour Site update and approved the disposal of King Street.

16. STRATEGIC OBJECTIVE – POTENTIAL

No papers were presented.

17. ANY OTHER COMPETENT BUSINESS (AOCB)

No other competent business was raised.

18. APPROVED MINUTES FROM GOVERNANCE COMMITTEE MEETINGS

19. Joint Clinical Care Governance Committee - 2 April 2025

Members noted the minutes of the Audit and Risk Committee 6 May 2025.

20. Finance and Performance Committee 22 May 2025

Members noted the minutes of the Audit and Risk Committee 6 May 2025.

21. ITEMS FOR INFORMATION – none presented

21.1. ITEMS FOR AWARENESS

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

Members noted the meeting schedule 2025/26.

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

Members noted the meeting schedule 2025/26.

21.4. Questions from the public

No questions were raised by the public.

The meeting closed at 12.22

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Board Chair and Chief Executive Report**
Responsible Executive/Non-Executive:	**Davie Campbell, Interim Board Chair and James Goodyear, Interim Chief Executive**
Report Author:	**Davie Campbell, Interim Board Chair and James Goodyear, Interim Chief Executive**

1 Purpose

This report is presented to the Board for:

- Awareness

2 Report summary

2.1 Situation

This report has been provided to update the Board on our performance, operational standards, key external/internal events and activities from September-October 2025, including meetings with external stakeholders and partners.

2.2 A summary of our overall performance

What's going well

Reducing our Waiting Lists

We remain on target to achieve the Scottish Government target of zero patients waiting no longer than 52-weeks for treatment in hospital and the community. All patients waiting more than 52 weeks for New Outpatients Appointments (NOP) under the Treatment Time Guarantee (TTG) have been appointed except those patients who are unavailable. Plans are in place for patients currently unavailable to support appointing when they become available (i.e. shadow booking).

Behavioural Standards Framework

Following extensive engagement with staff and the Board our Behavioural Standards Framework was launched in early September following approval by the Senior Leadership Team and Board.

Patient Safety, Quality & Experience

The Trust has reported zero acquired pressure ulcers during the last period however has seen an increase in patient falls.

CAMHS & Psychological Therapies

100% of young people and 93% of adults are seen within 18 weeks, both exceeding targets.

Population Health

Most standards are being met, including high immunisation uptake, but 12-week smoking cessation targets are not being achieved. Additional support and training have been implemented.

Diagnostics

Cardiology compliance improved significantly following locum support and new staff. Local MRI provision is reducing wait times.

Emergency Department (ED)

Our 4-hour standard is at 91.76% due to higher patient acuity and delayed transfers. Weekly reviews and a new frailty workstream are in place.

Women & Children's Services

IVF access and midwife continuity are at 100%; intrapartum continuity remains above target.

Areas for Improvement

Finance

The position remains challenging, with a £197k adverse variance due to increased costs and reduced funding. Recovery measures are agreed but not yet reflected in results. As at 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. Other opportunities are being actively explored

People & Culture

Workforce improvements are underway with rising training and appraisal rates; further work is required to improve our compliance rates.

Treatment Time Guarantee

Whilst 12-week compliance has improved to 73.19%, downstream capacity remains a constraint.

New Outpatients

Compliance is at 47.67%. Service tracking, recruitment, and short-term contracts are being used to address this. Working with NHS Grampian, in Quarter 3 we will roll-out digital first for all outpatient appointments. NHS Orkney and NHS Grampian have been working together to enable more Orkney residents to see consultants in Aberdeen via Near Me, rather than travelling for in-person appointments where clinically safe to do so.

Delayed Transfers of Care

Discharge delays remain a major issue, impacting hospital flow and overall performance.

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

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.

I attended the Community Planning Partnership meeting in September, where we discussed Public Sector Reform, service resilience in small communities, and the opportunity to give relevant updates from NHSO to the partnership. I have volunteered to Chair the Equality Delivery Group and look forward to working on this important work.

I was delighted to welcome the Cabinet Secretary for Finance and Local Government 19 August 2025 where we showcased the work we are doing in relation to climate change and sustainability.

We were pleased to welcome Ms Maree Todd, Minister for Drugs and Alcohol and Caroline Lamb, Chief Executive NHS Scotland and Director General Health and Care Directorates Scottish Government for our Ministerial Annual Review which took place Monday 6 October 2025 where we shared our journey of improvement, our challenges and responses to these and our future plans.

I have met with various teams across the organisation and learn more around the challenges they face but also the great work that is being done on a dailly basis to care for our community.
As we face these difficult challenges together, I am heartened and energised by the passion our staff have to deliver quality care to our patients.

Interim Chief Executive – James Goodyear

Since my appointment in September 2025, I have engaged with staff, teams, and key stakeholders across all levels of the health and social care system. Notably, I attended a joint meeting with NHS Highland to explore regional collaboration and held constructive discussions with Orkney Island Council regarding Public Sector Reform.

With our Interim Board Chair, I had the opportunity to attend the Community Planning Partnership for Orkney where I met with a range of partners from across the wider public and third sectors.
I had the privilege of attending my inaugural in-person meeting in Edinburgh with the NHS Scotland Executive Group. During this session, the principal focus for Board Chief Executives and representatives from the Scottish Government centred on advancing the delivery of the Operational Improvement Plan.

Regular weekly meetings are being maintained with Board Chief Executives. The primary objective of these meetings is to ensure the effective delivery of planned care, with a particular emphasis on achieving the target of eliminating all patients waiting 52 weeks or longer for care and treatment by March 2026. This commitment aligns with the First Minister’s stated priorities, and all Boards are required to demonstrate enhanced focus and clear evidence of progress in this area.

I had the privilege of representing the Board at the North of Scotland Chief Executives’ meetings, where discussions were centred on identifying and advancing regional opportunities. A particular emphasis was placed on the implementation of both the Service Renewal Framework and Population Health Framework. In addition, collaborative efforts to accelerate digital transformation across the region were rigorously explored. With our Board Chair and our executive team, I participated in the 'Re-imagining the North' workshop, during which we engaged in substantive discussions on key strategic issues relevant to our

region. These engagements continue to reinforce our commitment to strategic alignment and innovation at a regional level.

Formal media engagements have been undertaken, including interviews with BBC Radio Orkney and The Orcadian. Additionally, I published my first ‘Check in with the Chief' column in The Orcadian. I also had the privilege of co-chairing my first Area Partnership Meeting on 21 October 2025.

It has been a genuine privilege to visit our staff and engage with them directly across a range of teams and services. To date, I have had the opportunity to meet with colleagues in person, which has provided valuable insights into the dedication and professionalism demonstrated throughout our organisation.

During my recent visit to the Rousay GP Surgery, I gained valuable insights into the pivotal roles undertaken by the Advanced Nurse Practitioner and Emergency First Responders. These professionals deliver essential emergency response services within the community to which they also belong, fostering a strong sense of local engagement and resilience. The experience of travelling by ferry to the island further underscored for me the critical importance of reliable transport links for our island communities. I was also encouraged to learn of the highly effective collaboration between the Rousay team and Dounby Surgery, who provide regular clinics on the island several times each week. This partnership exemplifies our commitment to integrated, accessible care for our patients.

I had the opportunity to engage directly with one of our patients during my visit to the Dialysis Unit, who shared their perspective on the exemplary standard of care consistently delivered by our dedicated team. Our discussions included the increasing demand for renal dialysis services and the proactive measures being undertaken to address future requirements. I was briefed on the collaborative efforts between our Dialysis Unit and Emergency Department teams, which are instrumental in ensuring patients requiring urgent attention for broader health concerns receive timely and appropriate care.

I was pleased to have the opportunity to tour our facilities at The Balfour alongside Sharon Keyes, Head of Facilities and NPD Contract, as well as members of the Robertsons team. This visit enabled me to gain a deeper understanding of the sustainability initiatives currently underway and our engagement with the local community. It also provided valuable insight into the ways in which our infrastructure underpins the delivery of high-quality care. The greenspace poly tunnels: the allotment plots were of particular interest as they reflect our commitment to fostering a positive and resilient environment for both staff and patients.

I have spent time engaging with colleagues from our community mental health services. I am pleased to report notable progress in reducing patient waiting times across a range of services, attributable in large part to the successful recruitment of substantive staff. Our discussions also encompassed the ongoing challenges presented by changes in leadership, the implementation of new systems, and the increasing demand for services, particularly with respect to dementia care, which is linked to our ageing population. We further explored the critical importance of ensuring that individuals with learning disabilities receive appropriate physical health checks.

I have participated in meetings with service managers and lead managers representing community care, primary care, dentistry, and social work teams. I am encouraged to note several positive developments, including the recruitment of substantive staff, a reduction in the number of looked after children, and the exceptional commitment demonstrated by colleagues across agencies in supporting older people to remain in their homes.

I attended the Orkney Suicide Prevention Event on 25 September 2025. I am acutely aware that many individuals within our community, including members of our organisation, may have been affected by suicide in some capacity. I welcomed the opportunity to demonstrate my support for this important initiative and to gain a deeper understanding of the extensive range of practical and emotional support services available to people across Orkney. The event provided valuable insight into the collaborative efforts being

undertaken locally to address this critical issue, and I wish to acknowledge the dedication of those involved in delivering these essential services.

I had the opportunity to meet with Jenny Fraser and Tariro Gandiya, who serve as Chairs of the British Medical Association Local Negotiating Committee. Our discussions were both constructive and insightful, focusing on the experiences of doctors working within NHS Orkney. This engagement provided valuable perspectives on the challenges and opportunities faced by our medical staff and will inform our ongoing commitment to supporting our clinical workforce.

I was very interested to learn about Realistic Medicine in Orkney. The six Realistic Medicine principles can help us improve patient care and use our resources wisely by supporting shared decision making with patients and a personalised approach to care. In doing so we can reduce harm, waste, and unwarranted variation, manage risk better, innovate and improve. It was great to hear about how we are empowering young patients to ask questions about their care and feel confident to be involved in decisions about their health.

I also received a progress update on the Clinical Service Review including the work to redesign our operational structures, improve our care for older people, improve planned care pathways and redesign access for patients at the front door. This work is crucial if we are to develop health services that are clinically and financially sustainable to meet the needs of our communities.

I have now met with all Board Members and attended all Governance and Operational meetings. Through these engagements, I am developing a more comprehensive understanding of the Board's governance framework and have identified areas where enhancements may be introduced to further strengthen our governance arrangements, particularly in response to the recommendations arising from the externally commissioned review into our senior leadership, organisational culture, and governance practices. I have been particularly impressed by the spirit of collaboration demonstrated across teams, which continues to play a vital role in maintaining patient safety under challenging circumstances.

In conclusion, we wish to extend our sincere thanks to the Board for its ongoing support and commitment during this period of change and renewed focus. The dedication and professionalism shown by our staff and partners across all services continue to inspire and drive us forward. As we look to the months ahead, we remain committed to delivering high-quality, person-centred care to the people of Orkney, while embracing innovation and working collaboratively to meet the evolving needs of our communities.

We are confident that, together, we can build on our recent progress and address future challenges with resilience, transparency, and shared purpose.

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Corporate Risk and Assurance Report**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Kat Jenkin, Head of Patient Safety, Quality and Risk; Diane Smith, Clinical Governance and Risk Facilitator**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Annual Operation Plan
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

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

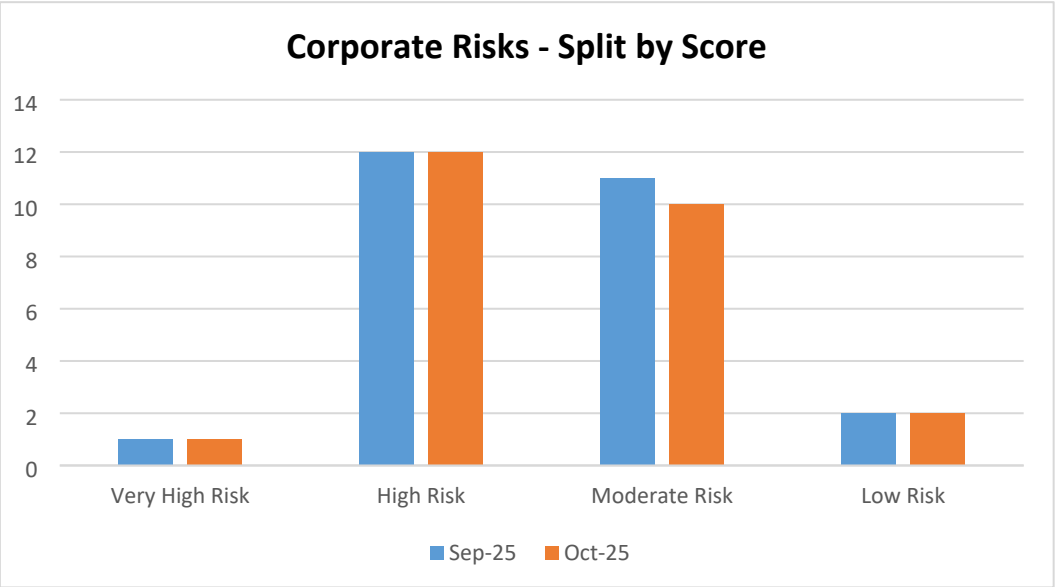
The risk actions are continually added to and to ensure the actions remain relevant, any actions more than six months old will be removed from the current register to aid clarity.

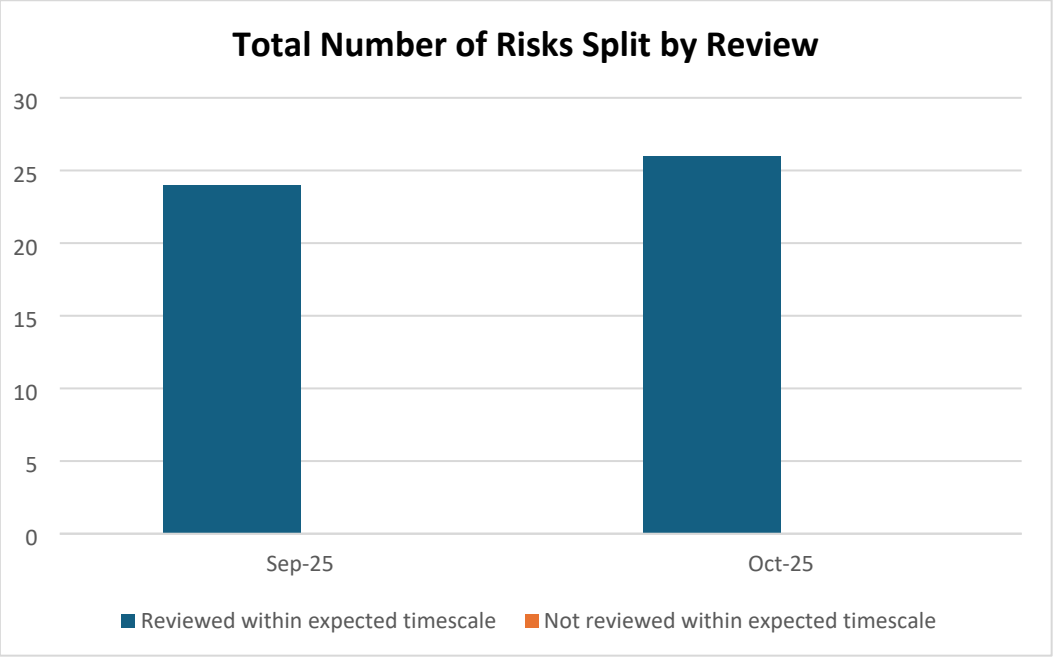
2.2 Background

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

2.3 Assessment

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







There were three risks proposed for addition in September and were discussed at SLT on 11 September 2025. Two risks were accepted and added to the Corporate Risk Register and one risk was rejected:

Risks Proposed for Addition			
Risk Title	Lead Executive	Risk Owner	Oversight Committee
Shortfall in training budget for nurses, midwives and allied health professionals - rejected 11/09/2025	Executive Director of Nursing, Midwifery and Allied Health Professionals	Executive Director of Nursing, Midwifery and Allied Health Professionals	Staff Governance Committee
Project Management - Added 11/09/2025, C-2025-05	Director of Finance	Director of Finance	Finance and Performance Committee
Clinical Leadership - Added 11/09/2025, C-2025-06	Director of People and Culture	Medical Director	Staff Governance Committee

There was one risk proposed for closure and this was closed at SLT on 07 October 2025.

Risks Proposed for Closure		
Risk ID	Risk Title	Reason for Closure
C-2024-09 – closed by SLT 07/10/2025	Island Games 2025	Mitigations completed and Games completed

Normally the top three corporate risks would be highlighted within this report, but the top five risks are scored 20 and 16 and therefore the top five risks are summarised in the table below.

NHS Orkney

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Top Five 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	3.2m of efficiency programmes currently in implementation, 2.5m recurrent (above 3% target) in excess of 1m in cost reduction schemes Strengthened governance arrangements - scheme of delegation, performance review meetings, streamlines investment approval process Additional grip and control measures - vacancy control panel, discretionary spend, budget trackers, workforce establishments Plan currently on track to be delivered, expectation is brokerage support to this value will be received. Financial Escalation Board to be stood up.	**Update 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) 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 Board. Risk score to remain the same at this time **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. **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. **Update 14/05/2025** - Unaudited outcome for 2024/25 is a deficit of 3.874M, significant improvement from forecast plan of 5.778m. The 2025/25 financial plan has been approved by Scottish Government this outlines a forecast deficit of 3.1m 2025/26 reducing to 1.7m 2027/28. In addition Scottish Government have confirmed that NHS O will receive non-repayable, non-recurring funding over the next 4 years to support the return to financial balance by 2028/29 this means that the risk of a section 22 qualification is significantly reduced as this funding should result in a break even position in 2025/26. Risk can therefore be reduced to 15. **Update 13/04/2025** - Final out-turn for 2024/25 is being finalised but is on-track to deliver our revised target of £4.2m. 2025/26 Financial Plan has been submitted to SG with forecast £3m. Conversations are ongoing regarding the plan and we will have a final position from SG at the end of April. Financial Escalation Board first meeting at the end of April to commence scrutiny of the Board's finances. No change to SG position of no brokerage therefore 2025/26 still likely to result in a Section 22 Qualification. No change to the risk level at this stage – continues to be a very high risk
C-2024-01	Lack of senior leadership capacity and capability	4	**4**	16	4	8a – d leadership development programme and PDPs for all senior leaders SLT formal development programme	**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

						8c and d personal objectives set and agreed by Renumeration committee Interim Director of Finance commenced in post in September 2024 for 6 months Interviews for substantive Director of Finance are at the end of October Interim Head of Strategy in post on secondment for 6-month period	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. **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.
C-2025-05	Project Management and Change Management	4	**4**	16	8	Training being provided in Quality Improvement for the staff leading on improvement works – 2 cohorts planned with completion by March 2026 **Action: Director of Performance & Transformation** Upskilling of the two Project Managers in the Team both undertaking MSP/Prince 2 course (Programme Management), completion end of July. **Action: Director of Performance & Transformation** All change and improvement programmes to be planned to ensure capacity within the small team to deliver – ongoing -imbed into BAU process – by August 2025 **Action: Director of Performance & Transformation** Programmes to be developed with a detailed	**Update 11/09/2025** - Agreed for addition to corporate risk register at SLT.

						scope, anticipated benefits, risks, timescales and project management plan – ongoing -imbed into BAU process – by August 2025 **Action: Director of Performance & Transformation** Repatriation of work from the Improvement Team that does not fall within the teams remit and outside of the improvement programmes of work – actively being reviewed with completion by September 2025 **Action: Director of Performance & Transformation** Head of Improvement currently seconded without backfill at present, structure of team to be reviewed and resource to be aligned to meet the needs of the improvement agenda in the organisation. - actively being reviewed with completion by September 2025 **Action: Director of Performance & Transformation**	
C-2025-06	Strategic Clinical Leadership and Engagement Capacity	4	**4**	16	8	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: • 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. By 31 December 2025 - implement the CSR	**Update 11/09/2025** - Agreed for addition to corporate risk register at SLT.

						Recommendations relevant to the risk: • 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. By 30 September 2025 review Workforce Models and Experience • 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	Daily safety and site huddles to review site capacity and flow. Twice weekly RMM held to actively discuss DToC.	**Update 30/09/205 -** 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

						All patients nearing 4 hrs in ED escalated through operational management for agreement to plan. Site surge and capacity plan in place. Daily review of PDD. Active conversations with patients in regard to discharge and early discharge panning.	to cancellations of elective procedures. System pressures paper discussed at IJB in July 2025 work streams underway to address reasons for DTOC. **Update 14/05/2025 -** Business as usual and business continuity plans effective. No services compromised, therefore score reduced to 8. **Update 25/02/25 -** Mitigating actions remain in place current DToC 12. Risk highlighted at formal executive meeting, SLT and IJB.

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

2.3.1 Equality and Diversity, including health inequalities

There are no identified impacts identified through this report.

2.3.2 Climate Change Sustainability

There are no identified impacts identified through this report.

2.3.3 Route to the Meeting

This paper is prepared for this meeting only.

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix one: Corporate Risk Register

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Integrated Performance Report (IPR) - October 2025**
Responsible Executive/Non-Executive:	**Tammy Sharp, Director of Performance and Transformation/Deputy CEO**
Report Author:	**Carrie Somerville – Head of Planning, Performance and Information**

1 Purpose

This report is presented to the Board for Awareness:

Members are asked to:

i. **Receive** the Integrated Performance Report (IPR) October 2025 update.
ii. **Note** where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

This report relates to a:

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

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

- Safe
- Effective
- Person Centred
- Sustainability

2 Report summary

2.1 Situation

The Integrated Performance Report October 2025 (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.

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

2.2 Background

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

2.3 Assessment

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

Key points for consideration

- Performance across Operational Standards continues to present a mixed picture. Notably, there has been improvement for those waiting longest, reflecting ongoing efforts to address areas where performance remains off-track. Cross-team collaboration remains a key driver of progress across key performance indicators. A current example includes the initiative to repatriate prostate MRI scanning to Orkney, which is expected to positively impact waiting times and improve patient experience. Work is ongoing to sustain improvements and ensure targeted action in areas requiring further attention.
- The financial position remains adverse to the planned trajectory, primarily due to additional unplanned expenditure of approximately £200k.
- Performance across Community standards continues to show improvements, this includes for those patients waiting for Physiotherapy, Podiatry and Orthotics appointments. Some areas continue to face vacancy and capacity pressures impacting performance. Recent approval to recruit to enhance neurodevelopment services will help to address capacity challenges.
- Performance across the Patient Safety, Quality & Experience section highlights key developments and areas requiring continued focus, particularly in complaints management, clinical governance, and the Significant Adverse Event Review (SAER) process. Several KPIs are currently on track, including the number of complaints upheld by the Scottish Public Services Ombudsman, the number of inpatient pressure ulcers reported during the period, and incident reporting rates. Where performance is off track— including Stage 1 and Stage 2 complaints and SAER completion— targeted actions have been identified and are being progressed to close the gaps.
- Population Health performance remains strong across many KPIs, with continued delivery against core standards. However, performance is currently off track for the 12-week smoking cessation standard. The Public Health team is actively monitoring this and, in collaboration with a multi-agency group, has implemented a tiered support model tailored to client needs. Additional training has been delivered to improve referral pathways into stop smoking services.

As part of our commitment to continuous improvement, the Director of Performance and Transformation/Deputy CEO has led a comprehensive review of the Integrated Performance Report (IPR). This review was undertaken in collaboration with relevant Executive Directors and has resulted in a refreshed format for each chapter of the report.

Key enhancements include:
Improved Clarity and Usability: We've restructured the format to make it easier to understand and for the reader to review it more effectively. This includes the introduction of amber status indicating where the key performance indicator has not been achieved but performance is above average.
Introduction of SPC Reporting: Statistical Process Control (SPC) charts have been incorporated to support more robust analysis of performance trends, helping to distinguish between normal variation and areas requiring intervention.
Introduction of Actions: All KPIs currently off-track within the IPR will now be accompanied by detailed information on planned remedial actions. This will include the specific action to be taken, the target completion date, the responsible owner, and a status update.

Feedback is actively encouraged to help refine the report to ensure it continues to support informed ove

2.3.1 Patient Safety and Quality

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

There are six risks on the Corporate Risk Register that relate to Fin Finance, Community and Operational Standards these include, Corporate Financial sustainability, Waiting Times data and Lack of organisational digital maturity.

2.3.5 Equality and Diversity, including health inequalities.

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

2.3.6 Communication, involvement, engagement, and consultation

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

2.3.7 Route to the Meeting

The full report was discussed and agreed at the Senior Leadership Team meeting on 7 October 2025, ahead of Board.

Finance, Operational Standards and Community Chapter was discussed at the Finance and Performance Committee meeting on 23 September 2025.

People and Culture Chapter was discussed at the Staff Governance Committee meeting on 16 October 2025.

Patient Safety, Quality and Experience and Population Health Chapter was discussed at the Joint Clinical Care Governance Committee on 1 October 2025

3. Recommendation(s)

Assurance - The Board are asked to:

- **Receive** the Integrated Performance Report (IPR) October 2025 update.
- **Note** where Key Performance Indicators (KPIs) are off track and the improvement actions in place to bring deliverables back on track.

4. List of appendices

The following appendix is included with this report:

- **Appendix 1**, Integrated Performance Report (IPR) – October 2025

NHS Orkney

Integrated Performance Report

Interim Chief Executive:
James Goodyear

October 2025



HEALTH Intelligence

ORK.healthintelligence@nhs

Introduction

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

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

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

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

RAG Status Values	
RED	Key performance indicator not achieved, 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.

Icon	What it shows.
↑	Performance has improved.
↓	Performance has deteriorated.
↔	Performance has remained the same.
X	Insufficient data available to allow comparison.

Statistical Process Control

The Integrated Performance Report forms the summary view of performance against the organisations 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 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels. If data point falls outside these levels, an investigation would be triggered. It contains two types of trend 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 Implemented

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG	Variance
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	19	Red	
4	Patient Safety, Quality, and Experience	Complaints	Number of complaints received.	Medical Director	0	8	Grey	
5	Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 1 5 Working Day Response Compliance	Medical Director	100%	57.14%	Red	
6	Patient Safety, Quality, and Experience	Complaints	Complaints Received - Stage 2 20 Working Day Response Compliance	Medical Director	100%	0%	Red	
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%	33.40%	Amber	
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%	100%	Green	
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%	100%	Green	
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%	80.00%	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%	60.00%	Amber	
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%	73.19%	Amber	
16	Operational Standards	Planned Care	10% reduction in waiting times for Treatment Time Guarantee patients	Medical Director	-10%	-19.10%	Green	
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%	47.67%	Amber	
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%	42.70%	Red	
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%	61.36%	Red	
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%	88.89%	Red	
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	14	27	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%	N/A	Grey	
25	Operational Standards	Cancer	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	Medical Director	95%	N/A	Grey	
28	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%	91.76%	Red	
29	Operational Standards	Unscheduled Care	Patients wait less than 12 hours to admission, discharge, or transfer from A&E	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	100%	100%	Green	
30	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	00:58:27	Green	
31	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%	8.7%	Red	
32	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	18	Red	
33	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	539	Red	
34	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%		Green	
35	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	
36	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%	62.50%	Green	
37	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%	40%	Red	
38	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%	0%	Red	
40	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%	42.68%	Red	
41	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led podiatry musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	0%	Red	
42	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led physiotherapy musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	57.14%	Red	
43	Community	National 4 week MSK target	At least 90% of patients from receipt of referral should wait no longer than four weeks to be seen for a first outpatient appointment at allied health professional led orthotics musculoskeletal services.	Chief Officer (Integration Joint Board)	90%	13.64%	Red	
45	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	
46	Community	Psychological Therapies	18 Week Referral to Treatment	Chief Officer (Integration Joint Board)	90%	93%	Green	
47	Population Health	Promoting health and wellbeing outcomes	Increase smoking cessation active clients year-on-year	Medical Director	21	22	Green	
48	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	33	29	Red	
49	Population Health	Prevention of Disease	Immunisation uptake rate 6-in-1 primary Course by 12 months	Medical Director	95%	100%	Green	
50	Population Health	Prevention of Disease	Immunisation uptake rate MMR2 by 6 years of age	Medical Director	95%	100%	Green	
51	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%	100%	Green	
52	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered haemoglobinopathies screening.	Medical Director	100%	100%	Green	
53	Population Health	Promoting health and wellbeing outcomes	Pregnancy Screening - All eligible pregnant women are offered infectious diseases screening	Medical Director	100%	100%	Green	
54	Population Health	Promoting health and wellbeing outcomes	Bloodspot Screening - 100% of newborn babies have bloodspot Screening completed by day 5	Medical Director	100%	100%	Green	
55	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	
56	Workforce	Sickness Absence	Sickness rates consistently below the national average of <6%	Interim Director of People and Culture	5.92%	5.48%	Green	
57	Workforce	Sickness Absence	Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	Interim Director of People and Culture	6.43%	6.17%	Green	
58	Workforce	Appraisals	Appraisal compliance rate over the previous 12 months	Interim Director of People and Culture	85%	48.38%	Amber	
59	Workforce	Hours Utilised	Agency hours used vs. average.	Interim Director of People and Culture		2680	Grey	
60	Workforce	Hours Utilised	Bank hours used vs. average.	Interim Director of People and Culture		5200.02	Grey	
61	Workforce	Hours Utilised	Overtime hours used vs. average.	Interim Director of People and Culture		507.42	Grey	
62	Workforce	Hours Utilised	Excess hours used vs. average.	Interim Director of People and Culture		721.14	Grey	
63	Finance	Finance	Financial performance against plan - YTD.	Director of Finance	£1,920,000	£2,117,000	Red	
64	Finance	Finance	Financial performance against plan - Forecast.	Director of Finance	£2,176,000	£2,176,000	Green	
65	Finance	Finance	Efficiency performance against plan - YTD.	Director of Finance	£571,000	£571,000	Green	
66	Finance	Finance	Efficiency performance against plan - Forecast.	Director of Finance	£3,800,000	£3,800,000	Green	
67	Finance	Finance	Efficiency programme recurrent savings against plan.	Director of Finance	£472,000	£472,000	Green	
68	Finance	Finance	Capital performance against plan - YTD.	Director of Finance	£0	£0	Green	
69	Finance	Finance	Capital performance against plan - Forecast.	Director of Finance	£1,566,000	£1,566,000	Green	
70	Finance	Finance	75% of invoices to be paid within 10 days of receipt - local target	Director of Finance	75%	70.64%	Amber	
71	Finance	Finance	90% of invoices to be paid within 30 days of receipt - local target	Director of Finance	90%	86.58%	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 December 2025.

	Section	Service Area	NHS Orkney KPI's	Executive Lead	Target	Actual	Latest RAG	Variance
26	Operational Standards	Inpatients	Ensure that acute receiving occupancy is 95% or less.	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute	95%			
27	Operational Standards	Inpatients	Pre-noon discharges	Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute				
39	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%			
44	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 for the second quarter, 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.

Patient Safety, Quality, and Experience
Number of Complaints Received

Data Source
Patient Experience Officer

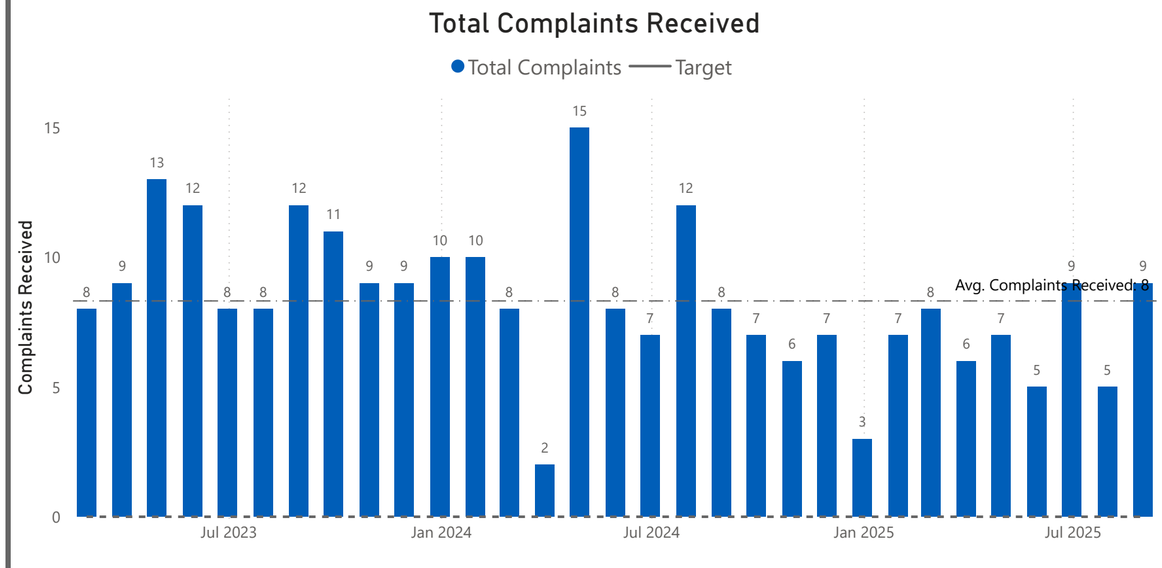
Latest Data
31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Number of complaints received.	0	8	Grey

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.



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 1 Complaints

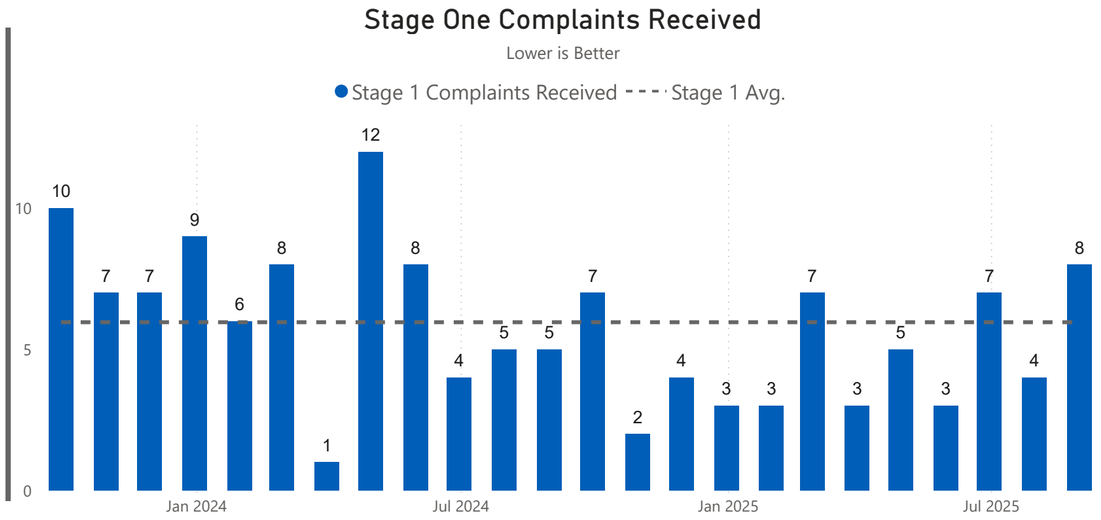
Data Source
Patient Experience Officer

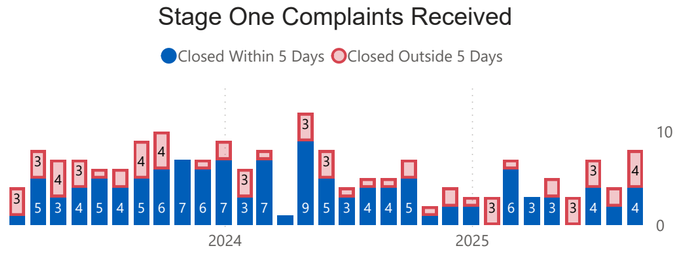
Latest Data
31/08/2025

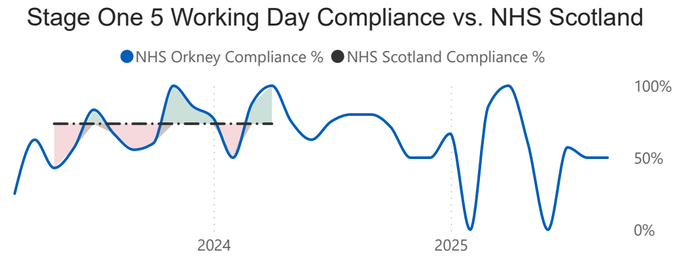
Compliance

KPI	Target	Actual	RAG Value
Complaints Received - Stage 1 5 Working Day Response Compliance	100%	57.14%	Red

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







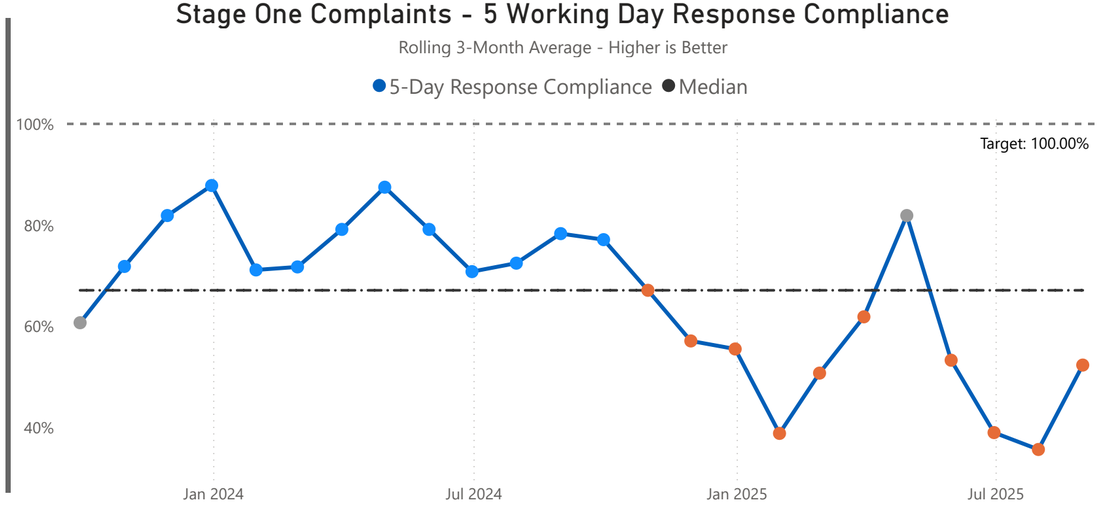
Statistical Process Control

Variance	Description
	Special cause variation of concerning nature due to (L)ower values.

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Stage One - Last 6 Months

Month	Received	Closed < 5 Working Days	%	3-Month Avg. %	Variance
31/03/2025	3	3	100.00%	61.90%	
30/04/2025	5	3	60.00%	81.90%	
31/05/2025	3	0	0.00%	53.33%	
30/06/2025	7	4	57.14%	39.05%	
31/07/2025	4	2	50.00%	35.71%	
31/08/2025	8	4	50.00%	52.38%	



Comments From Executive Lead

There were seven 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

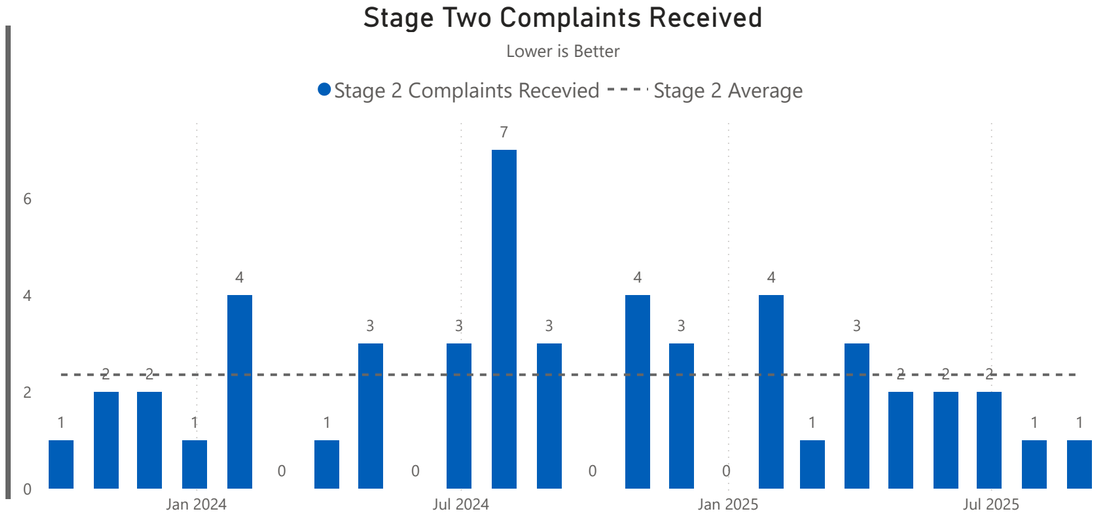
Data Source
Patient Experience Officer

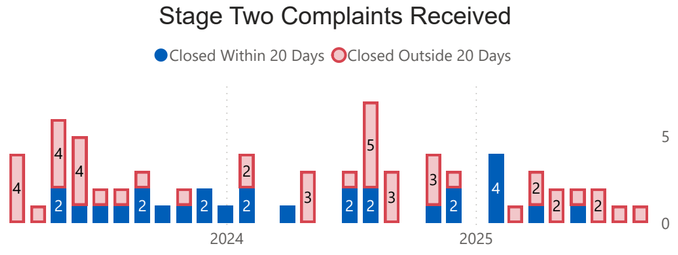
Latest Data
31/08/2025

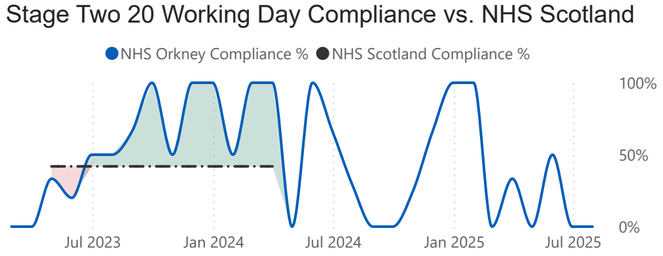
Compliance

KPI	Target	Actual	RAG Value
Complaints Received - Stage 2 20 Working Day Response Compliance	100%	0%	Red

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







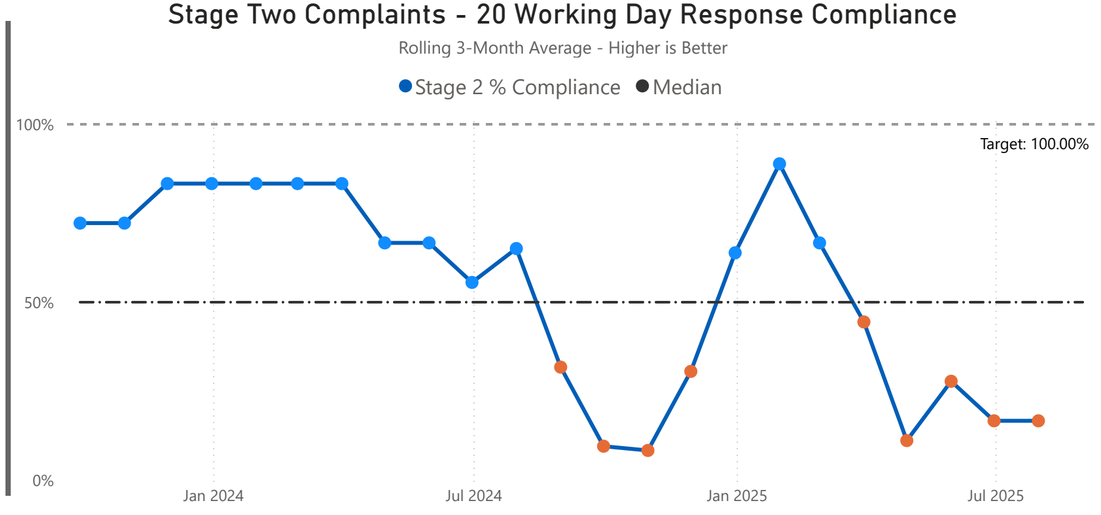
Statistical Process Control

Variance	Description
	Special cause variation of concerning nature due to (L)ower values.

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	Stage 2 Complaints	Closed < 20 Working Days	%	Variance
31/03/2025	3	1	33.33%	
30/04/2025	2	0	0.00%	
31/05/2025	2	1	50.00%	
30/06/2025	2	0	0.00%	
31/07/2025	1	0	0.00%	
31/08/2025	1			



Comments From Executive Lead

The number of Stage Two complaints remains low, with one recorded in each of 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

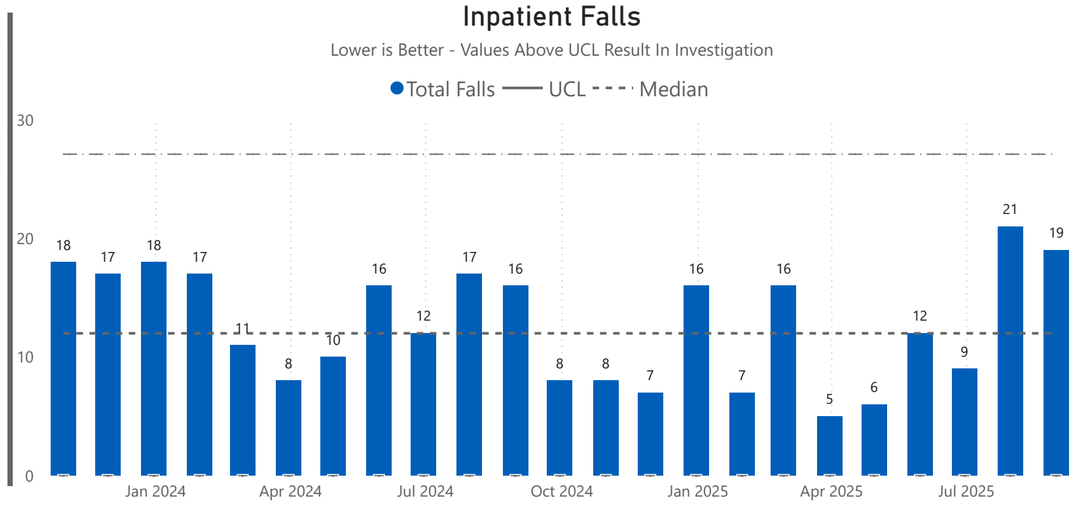
Latest Data
31/08/2025

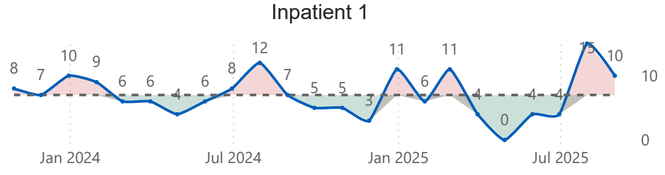
Compliance

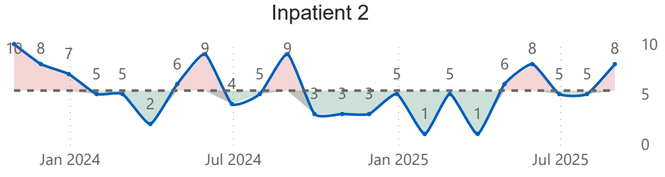
KPI	Target	Actual	RAG Value
Inpatient falls (an event which results in a person coming to rest unintentionally on the ground or floor or other lower level)	0	19	Red

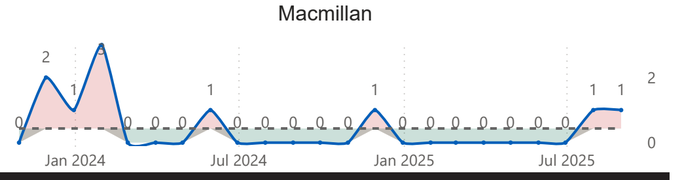
Action	Target Date	Owner	Status

KPI off-target, actions to be updated.









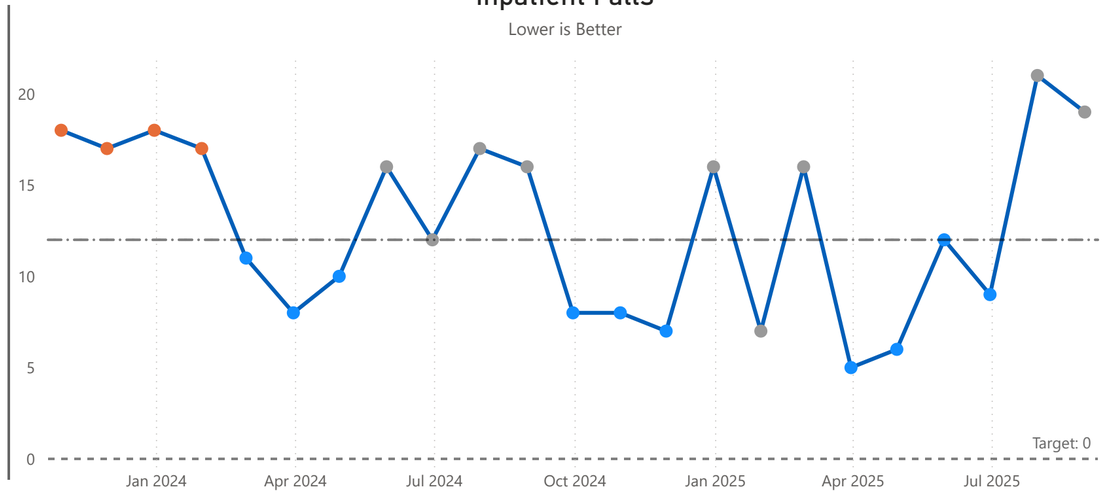
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicators consistently (F)alling short of the target.

Last 6 Months

Month	Inpatients 1	Inpatients 2	MacMillan	Total	Variance
31/03/2025	4	1	0	5	
30/04/2025	0	6	0	6	
31/05/2025	4	8	0	12	
30/06/2025	4	5	0	9	
31/07/2025	15	5	1	21	
31/08/2025	10	8	1	19	



Comments From Executive Lead

An improvement in inpatient falls secondary to measures put in place was seen in quarter 2, with an average of 9 falls against an overall median of 13. As patient acuity and occupied bed days have increased, an increase in falls to a peak of 21 per month was seen in July. August saw this number reduce to 19 but this still remains higher than is typically seen across inpatient areas. Some of the increased number recorded is due to single patients with known falls risks.

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
Significant Adverse Event Reviews (SAERs)

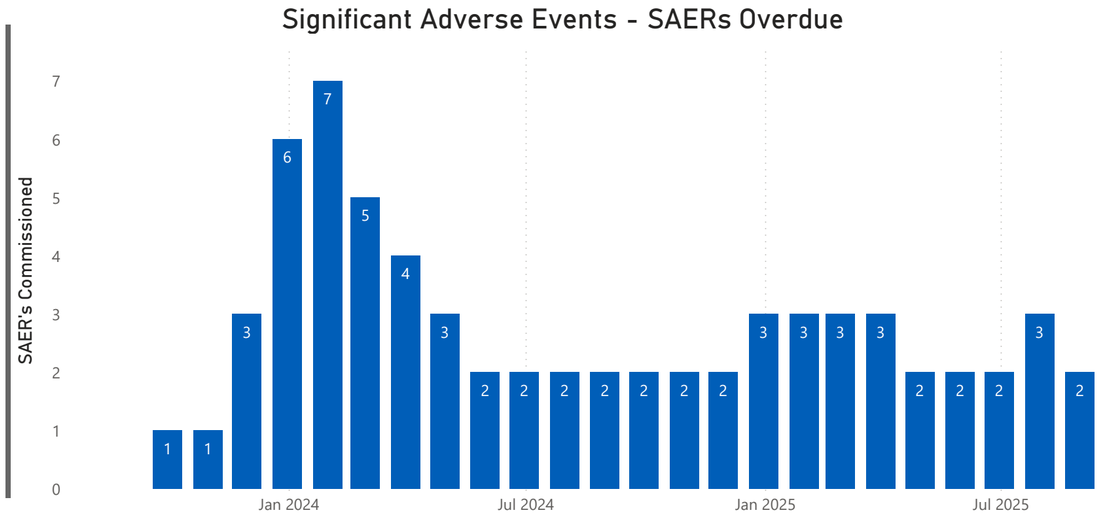
Data Source: Datix

Latest Data: 31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Significant Adverse Event Review Compliance (closed within target date)	100%	33.40%	Amber

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	In Progress



Month	SAER's commissioned	SAER's overdue	% SAER Compliance	Target
31/05/2024	0	2	33.40%	100.00%
30/06/2024	1	2	50.00%	100.00%
31/07/2024	0	2	33.40%	100.00%
31/08/2024	1	2	50.00%	100.00%
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%

Statistical Process Control

Variance — **Description**

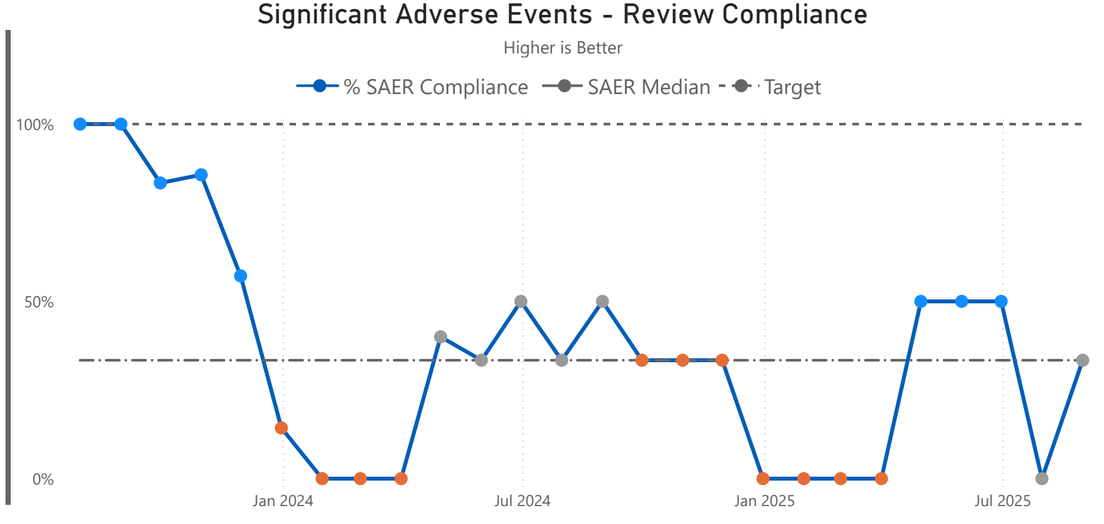
Common Cause Variation which indicates that there is no significant change in the process

Assurance — **Description**

Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	SAER's overdue	% SAER Compliance	Target	Variance
31/03/2025	3	0.00%	100.00%	
30/04/2025	2	50.00%	100.00%	
31/05/2025	2	50.00%	100.00%	
30/06/2025	2	50.00%	100.00%	
31/07/2025	3	0.00%	100.00%	
31/08/2025	2	33.40%	100.00%	



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
Paediatric Early Warning Score (PEWS) Bundle Compliance

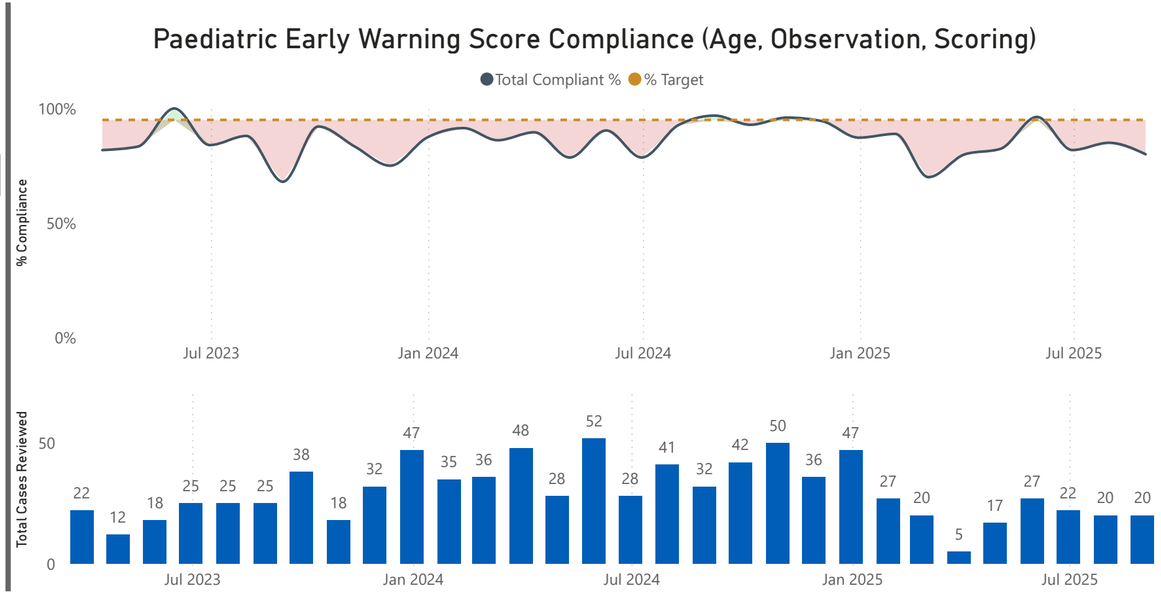
Data Source: Clinical Records

Latest Data: 31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % Compliance with PEWS Bundle	95%	80.00%	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	In Progress



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

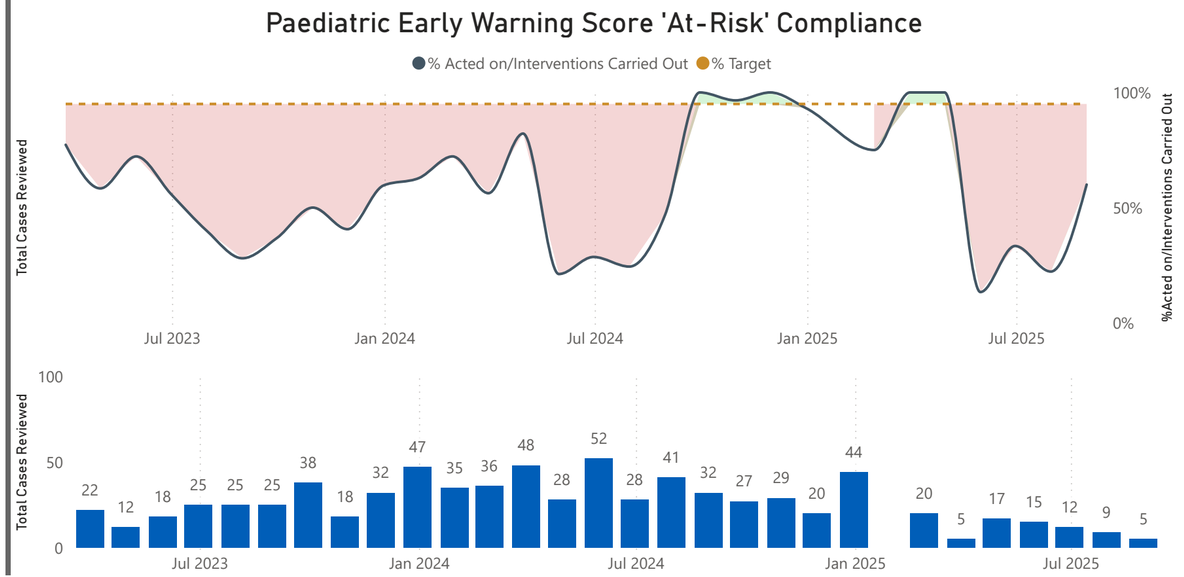
Data Source
Clinical Records

Latest Data
31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Paediatric Early Warning Score (PEWs) - % 'at-risk' observations identified and acted upon	95%	60.00%	Amber

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	In Progress



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?

- Treatment Time Guarantee (TTG) performance continues to improve. Overall 12-week compliance has risen to 73.19% at 31 August 2025. The local improvement metric also evidences impact, with TTG waiting times reduced by 19.1% against the 10% reduction goal. As expected, converting long outpatient waits into treatment plans has increased list additions, but the underlying flow through to treatment is moving in the right direction.

- Diagnostics show encouraging progress in cardiology. Compliance improved from 48.84% (May) to 88.89% (July) as a planned block of locum sessions cleared backlog, and the newly appointed physiologist who joined in June is moving through induction toward independent practice—providing better resilience and reduced reliance on external provision.

- In Women and Children, IVF access is sustained at 100% within 12 months, women are consistently allocated a primary midwife (100%), and intrapartum continuity is above target at 62.5%. These are notable positives for patient experience and continuity of care.

- Finally, although overall imaging compliance has dipped, the local commissioning of MRI is an important service development. The scanner was delivered in late May with first patients through in mid-June, which will progressively reduce travel and should stabilise pathway times as the backlog from the transferred waiting list is worked down.

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

- New Outpatients remain materially off-track against the national 12-week standard: compliance has improved but sits at 47.67% (August). Mitigations include an SLA tracker for visiting services, further recruitment activity, and short-term external contracts, but recovery will take sustained capacity and time.

- TTG, while improving, remains below the 100% standard. The principal constraint is downstream capacity (theatres and off-island specialties). The push to assess and list long-waiting outpatients has a beneficial effect on timeliness but increases the total number awaiting treatment, creating a risk to percentage compliance if supply does not rise commensurately.

- Diagnostic Endoscopy performance is well below target (42.70% compliance in July) and variable due to reliance on visiting locums. Sessions are scheduled through October 2025, with planning underway beyond that point, but sustainability remains a concern without firmer, longer-term capacity and workforce cover.

- Cancer pathways are fragile at low volumes. The current reported position shows 0% against both the 31-day and 62-day standards, reflecting the impact of a small number of breaches on percentage compliance. Each case is reviewed locally and nationally; there is no discernible seasonal or predictive pattern to help target interventions, so continued case-level tracking and escalation are required.

- Flow out of hospital remains a significant constraint. Delayed discharge measures are red across the board: only 8.7% discharged within two weeks (vs 100% target), 18 patients delayed at census (target 4), and 539 delayed bed days (target 56). These pressures risk eroding upstream gains in unscheduled care and planned care throughput.

Operational Standards
Accident & Emergency 4-Hour Compliance

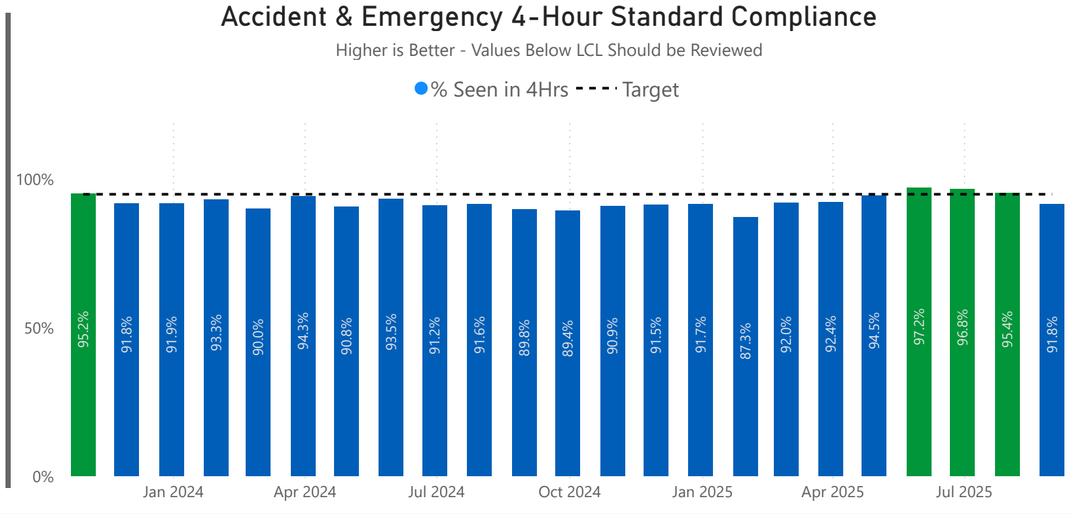
Data Source
PHS A&E Publication, TrakCare

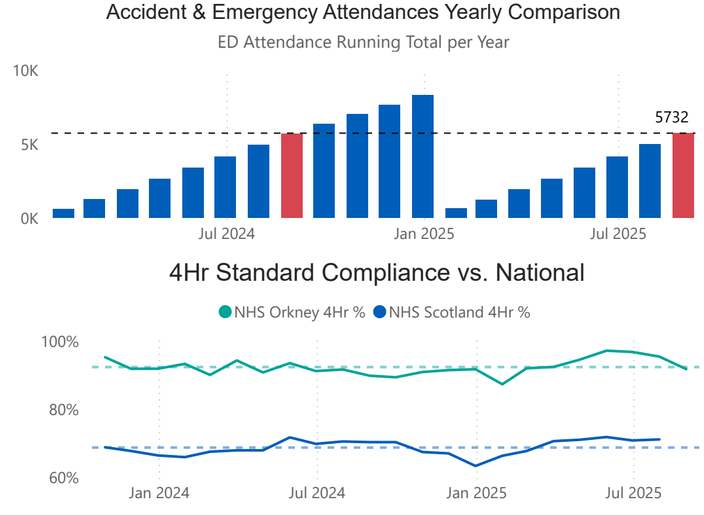
Latest Data
31/08/2025

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%	91.76%	Red

Action	Target Date	Owner	Status
Review of Flow Navigation Centre throughput and redirection of pathways.	31/10/2025	S Thomas	In Progress





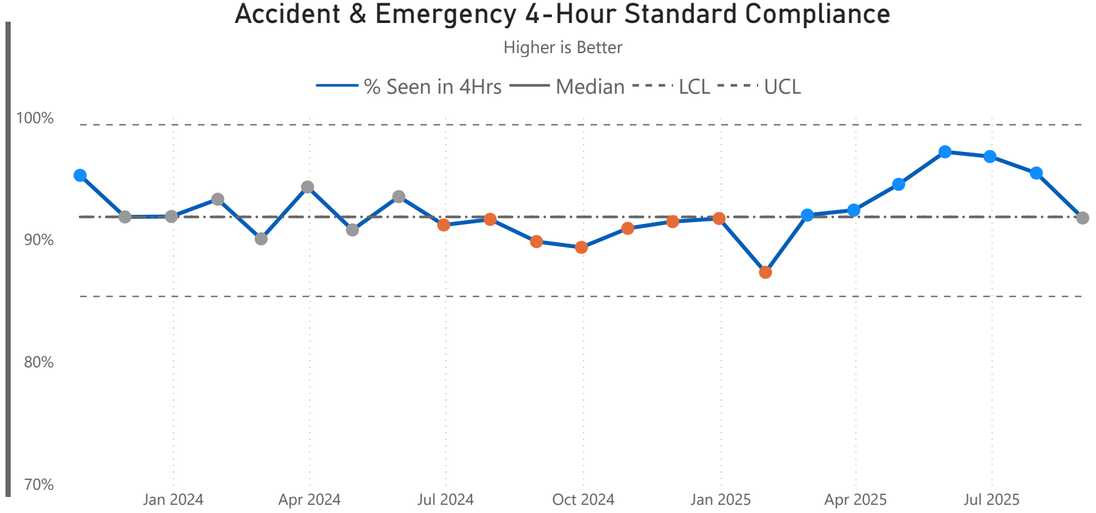
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	Attends	> 12Hrs.	> 8Hrs.	> 4Hrs.	% < 4Hrs	Scotland %	Variance
31/03/2025	684	0	0	52	92.40%	70.60%	
30/04/2025	729	0	0	40	94.51%	71.00%	
31/05/2025	742	0	1	21	97.17%	71.80%	
30/06/2025	747	0	0	24	96.79%	70.80%	
31/07/2025	854	0	0	39	95.43%	71.10%	
31/08/2025	752	0	3	62	91.76%		



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
52-Week Waits Summary (NOP & TTG)

Data Source
OP Recovery Weekly Return, TrakCare

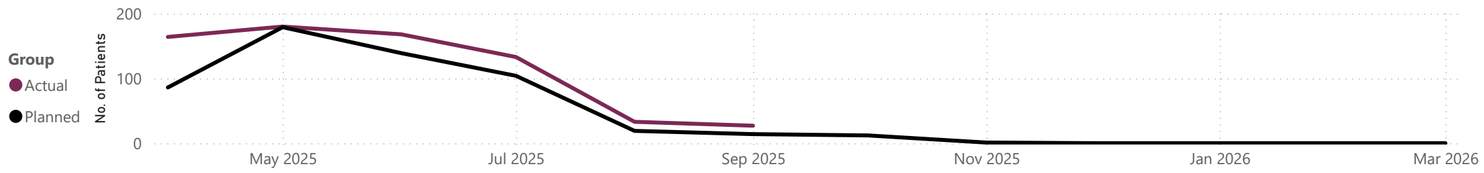
Latest Data
September 2025

Compliance

KPI	Target	Actual	RAG Value
0 patients waiting more than 52 weeks on a New Outpatient or Treatment Time Guarantee waiting list	14	27	Amber

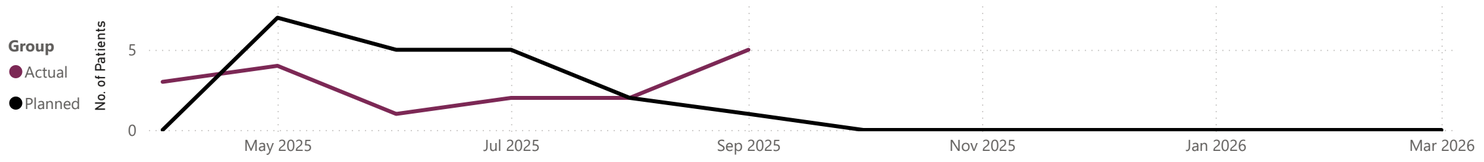
Action	Target Date	Owner	Status
External Capacity Review – Service Level Agreements being reviewed to ensure they meet demand and reduce delays	31/03/2026	C Sommerville	In Progress
Internal Capacity Review – Theatre and Outpatient capacity reviews to ensure clinic/theatre utilisation maximised – consider additional or change to schedules	31/03/2026	C Sommerville	In Progress
NECU Validation – results from validation to be clinical reviewed and acted on	31/03/2026	C Sommerville	In Progress
Waiting Times meeting - review long waits, escalate and track progress	31/03/2026	C Sommerville	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						
			+/-	78	1	29	29	14	13	0	0	0	0	0	0

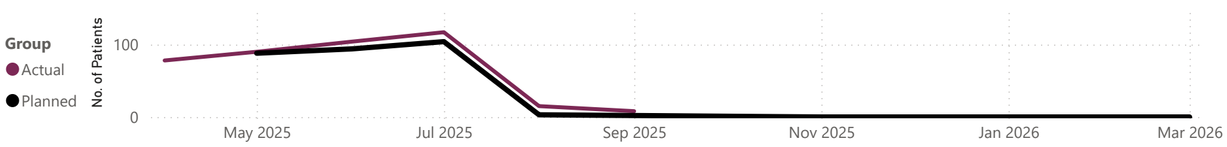
Treatment Time Guarantee



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						
			+/-	3	-3	-4	-3	0	4	0	0	0	0	0	0

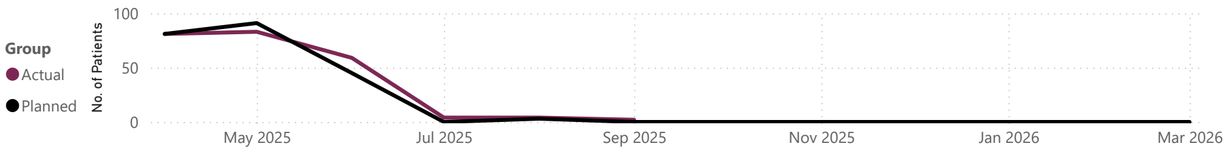
New Outpatients

Ear, Nose, and Throat 52-Week Waits



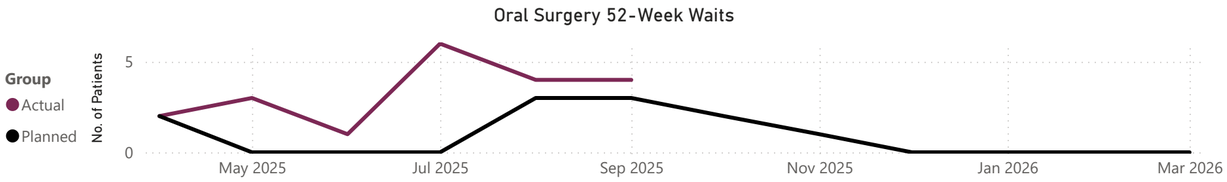
Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ear, Nose, and Throat	Planned		88	94	104	3	2	1	0	0	0	0	0
	Actual	78	90	104	117	15	8						
	+/-	78	2	10	13	12	6						

Ophthalmology 52-Week Waits



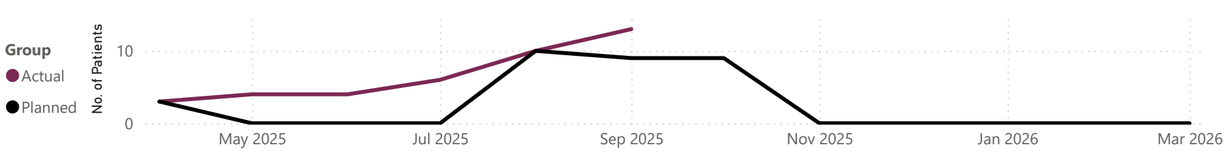
Specialty	Group	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Ophthalmology	Planned	81	91	45	0	3	0	0	0	0	0	0	0
	Actual	81	83	59	4	4	2						
	+/-	0	-8	14	4	1	2						

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						
	+/-	0	3	1	6	1	1						

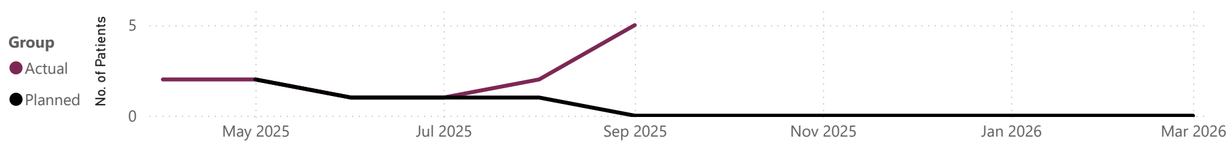
Trauma & Orthopaedic 52-Week Waits



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						
	+/-	0	4	4	6	0	4						

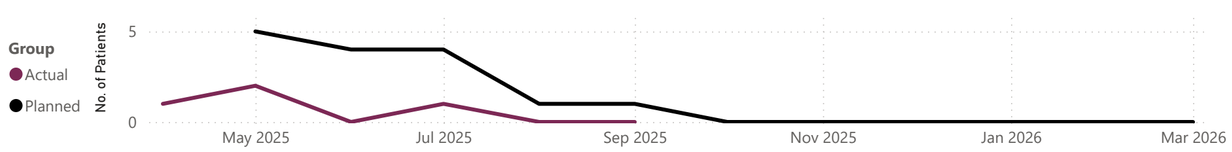
Treatment Time Guarantee

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						
	+/-	2	0	0	0	1	5						

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						
	+/-	1	-3	-4	-3	-1	-1						

Comments From Executive Lead

We are on track to deliver 0 patients waiting more than 52 weeks by the end of March 2026 across all specialties. Additional funding providing to support new outpatient activity in Ophthalmology and Ear, Nose and Throat is supporting the delivery of this position. The team are working closely with the Golden Jubilee to ensure maximum use of our allocation for our longest waiting Trauma and Orthopaedic patients.



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

Operational Standards
New Outpatients (NOP) 12 Week Compliance

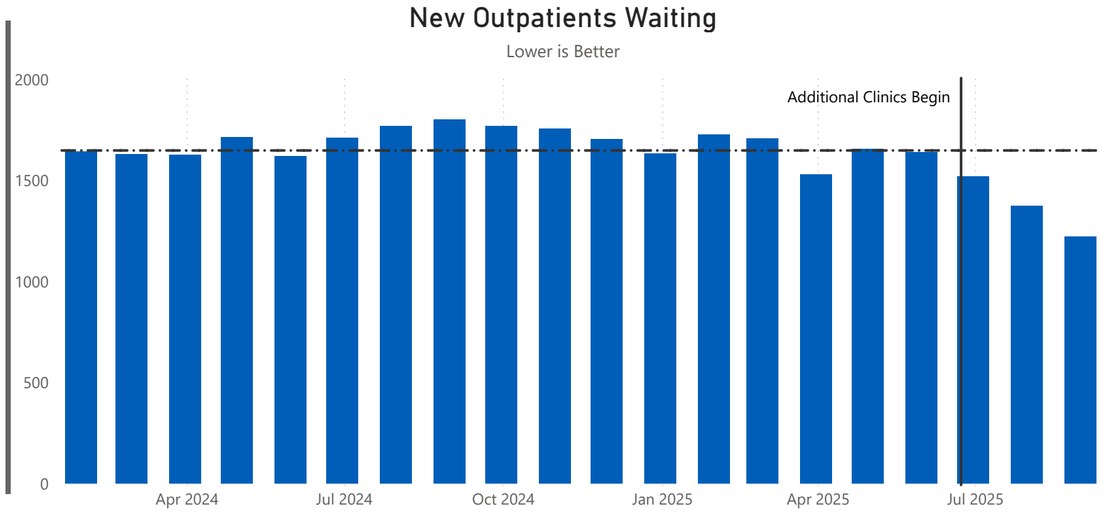
Data Source: OP Recovery Weekly Return

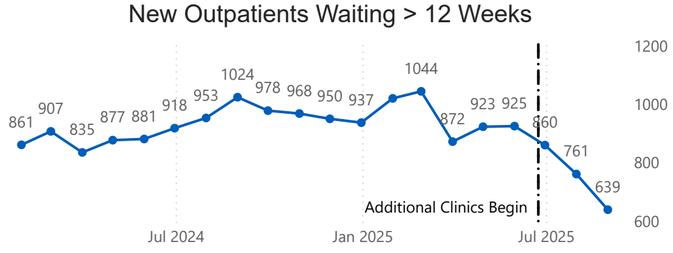
Latest Data: 31/08/2025

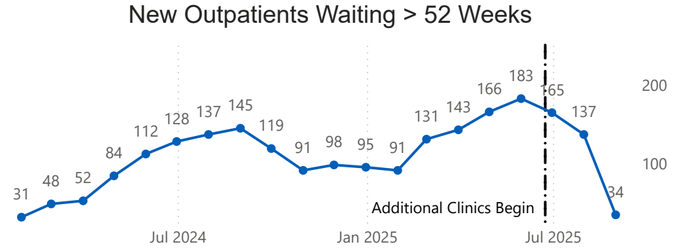
Compliance

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%	47.67%	Amber

Action	Target Date	Owner	Status
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 16 – 19 September 2025	21/10/2025	C Sommerville	In Progress
Identify and address challenges impacting performance during the Weekly Waiting Times meeting, and escalate if required, to the Planned Care Board, and if necessary, to the Finance and Performance Committee or Senior Leadership Team.	30/10/2025	T Sharp	In Progress
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 20 – 24 October 2025	02/12/2025	C Sommerville	In Progress
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 15 – 18 December 2025	26/02/2026	C Sommerville	In Progress







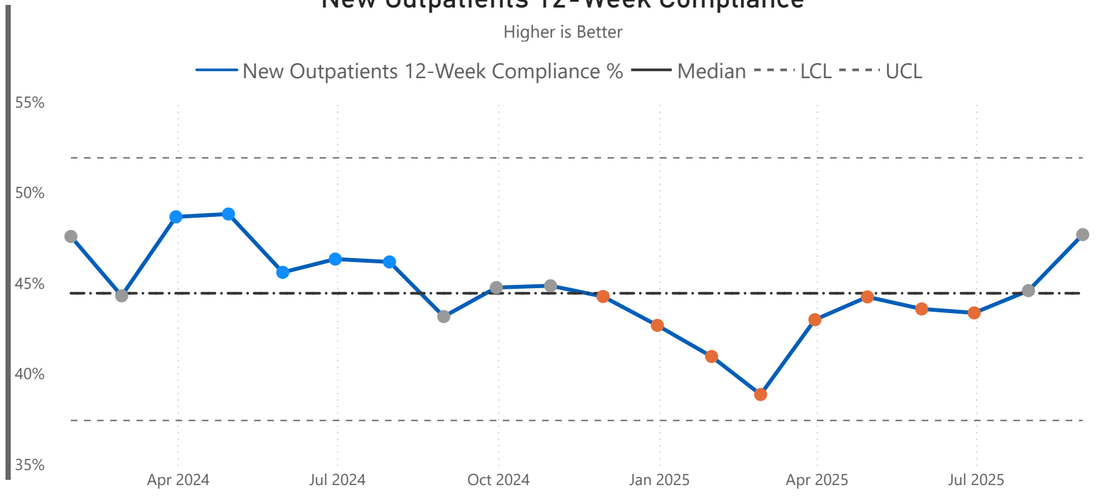
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
F	Variation indicates consistently (F)alling short of the target.

Last 6 Months

Month	Waiting	> 52Wks.	> 26Wks.	> 12Wks.	12Wk Compliance	Variance
31/03/2025	1529	143	571	872	42.97%	
30/04/2025	1655	166	591	923	44.23%	
31/05/2025	1639	183	614	925	43.56%	
30/06/2025	1518	165	532	860	43.35%	
31/07/2025	1373	137	416	761	44.57%	
31/08/2025	1221	34	296	639	47.67%	



Comments From Executive Lead

New Outpatient performance against the 12-week standard remains well below the 95% target but is showing signs of recovery. Compliance improved to 47.67% in August 2025, up from around 43% earlier in the year. The number of patients waiting more than 52 weeks has fallen sharply from 183 in May to 34 in August, and the total outpatient list has reduced from over 1,600 in April to about 1,220. This indicates that recent additional capacity has been used effectively to tackle the longest waits and stabilise overall performance.

Progress, however, is 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

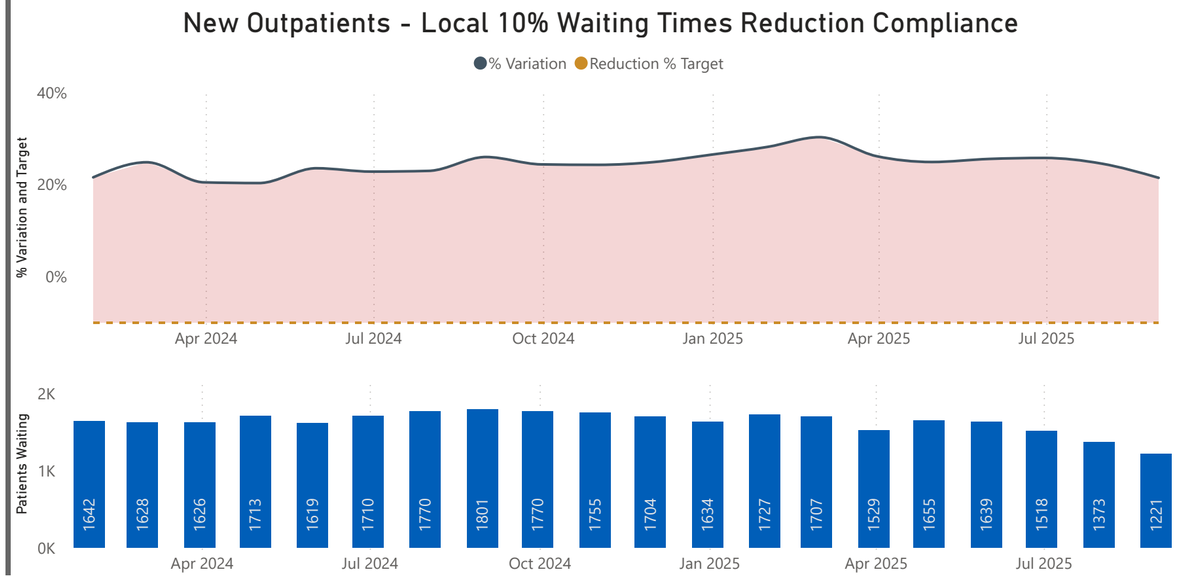
Data Source: OP Recovery Weekly Return

Latest Data: 31/08/2025

Compliance

KPI	Target	Actual	RAG Value
10% reduction in waiting times for New Outpatients	-10%	21.46%	Red

Action	Target Date	Owner	Status
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 16 – 19 September 2025	21/10/2025	C Sommerville	In Progress
Identify and address challenges impacting performance during the Weekly Waiting Times meeting, and escalate if required, to the Planned Care Board, and if necessary, to the Finance and Performance Committee or Senior Leadership Team.	30/10/2025	T Sharp	In Progress
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 20 – 24 October 2025	02/12/2025	C Sommerville	In Progress
Additional Ophthalmology Waiting List Initiative outpatient clinics to take place 15 – 18 December 2025	26/02/2026	C Sommerville	In Progress



Comments From Executive Lead

Month on month improvements in compliance, now at 47.67 in August, The 100% target has not been achieved clearly, but a quarterly 10% reduction has been achieved.

Dr Anna Lamont, Medical Director



Operational Standards
Treatment Time Guarantee (TTG) 12 Week Compliance

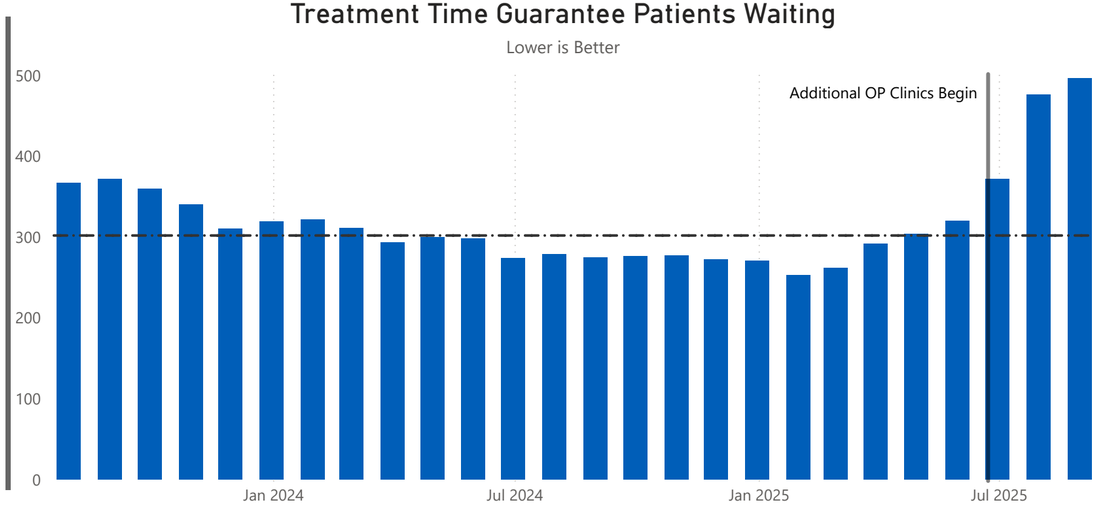
Data Source: TTG Weekly Return

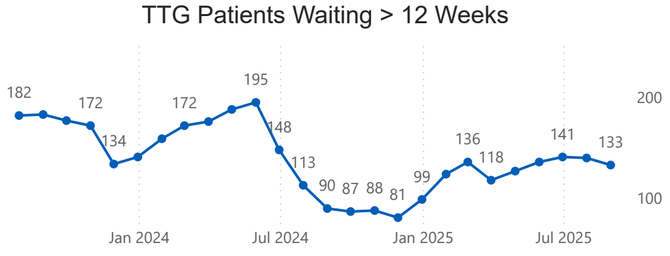
Latest Data: 31/08/2025

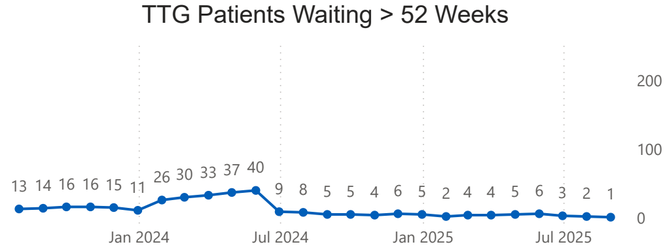
Compliance

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%	73.19%	Amber

Action	Target Date	Owner	Status
Weekly Waiting Times meeting which is chaired by Director of Performance and Transformation/Deputy CEO to meet and identify then address challenges impacting performance. Escalation if required, to the Planned Care Board.	30/10/2025	T Sharp	In Progress







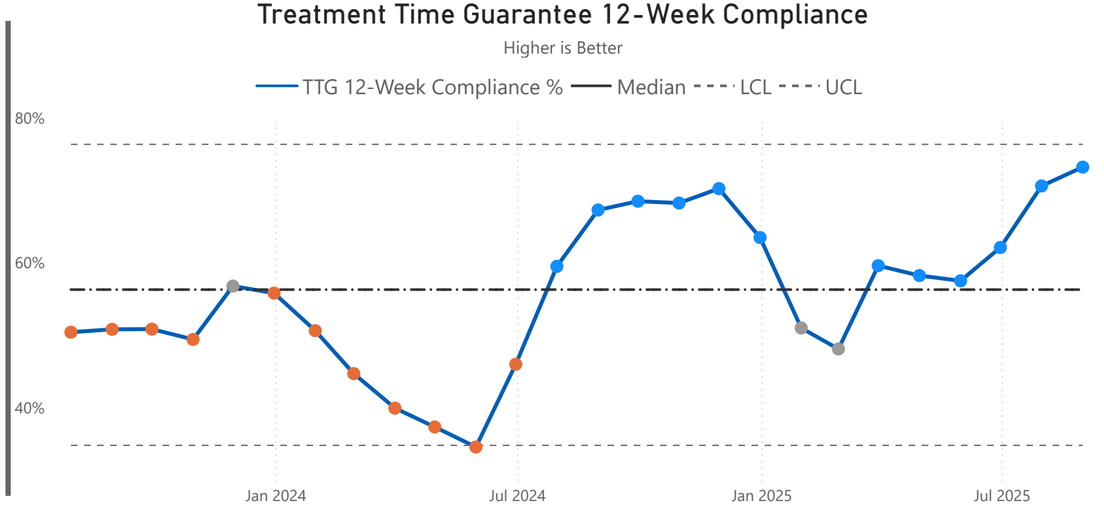
Statistical Process Control

Variance	Description
H	Special cause variation of improving nature due to (H)igher values.

Assurance	Description
F	Variation indicates consistently (F)alling short of the target.

Last 6 Months

Month	Waiting	> 52 Wks.	> 26 Wks.	> 12 Wks.	12Wk. Compliance	Variance
30/03/2025	292	4	52	118	59.59%	
30/04/2025	304	5	78	127	58.22%	
31/05/2025	320	6	82	136	57.50%	
30/06/2025	372	3	72	141	62.10%	
31/07/2025	476	2	61	140	70.59%	
31/08/2025	496	1	57	133	73.19%	



Comments From Executive Lead

Additional outpatient clinics from non recurrent funds from Scottish Government have shown a rapid rise in TTG 12 week compliance now at 73%. However, with more patients being assessed, more patients have agreed to treatment which increases the number of patients on the waiting list.

Performance is limited by capacity in theatres and in other boards requiring referral to. While the data suggests we are on track to be compliant in the next 6 months, the continued increase in outpatient clinics means the number of people waiting will also increase and make achieving target percentage less likely.

Dr Anna Lamont, Medical Director



Operational Standards
Diagnostic Endoscopy 6 Week Compliance

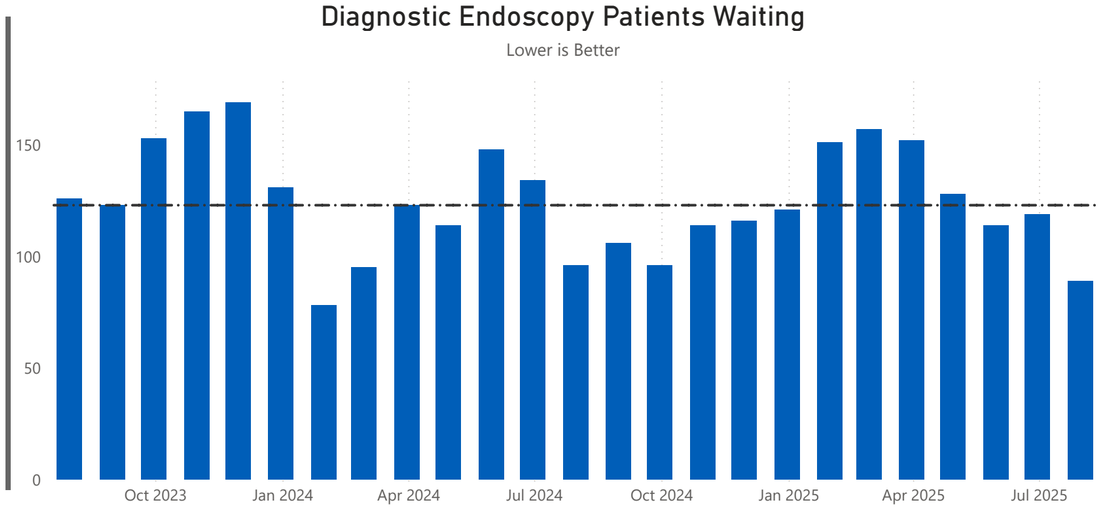
Data Source: DMMI Monthly Return

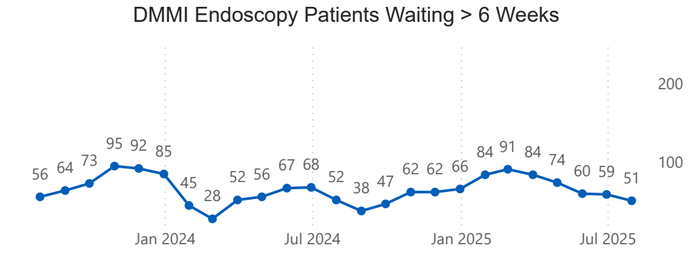
Latest Data: 31/07/2025

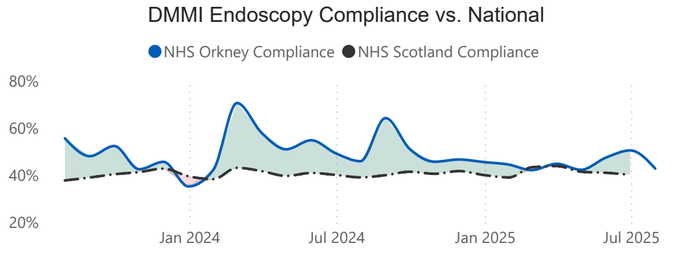
Compliance

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%	42.70%	Red

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	In Progress







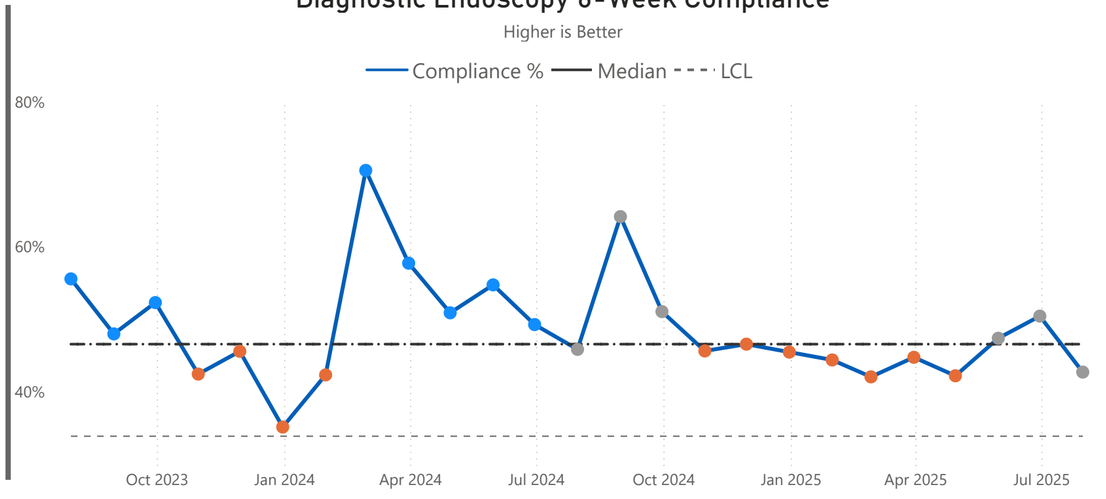
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicates consistently (F)alling short of the target.

Last 6 Months

Month	Waiting	Over 6Wks	% Compliance	Target	Variance
28/02/2025	157	91	42.04%	100.00%	
31/03/2025	152	84	44.74%	100.00%	
30/04/2025	128	74	42.19%	100.00%	
31/05/2025	114	60	47.37%	100.00%	
30/06/2025	119	59	50.42%	100.00%	
31/07/2025	89	51	42.70%	100.00%	



Comments From Executive Lead

Compliance is at 42.7% compared to 50.42% for the last reporting period which is assessed as not a significant change but remains well below the 100% target. The trend has been variable, reflecting reliance on visiting locums and inconsistent service provision. Capacity has been scheduled up until October 2025, with further planning underway to ensure capacity is available beyond this time. Increase in the number of sessions and increased scrutiny of performance data is reflected in reductions in the number of patients waiting for diagnostic endoscopy.

Dr Anna Lamont, Medical Director



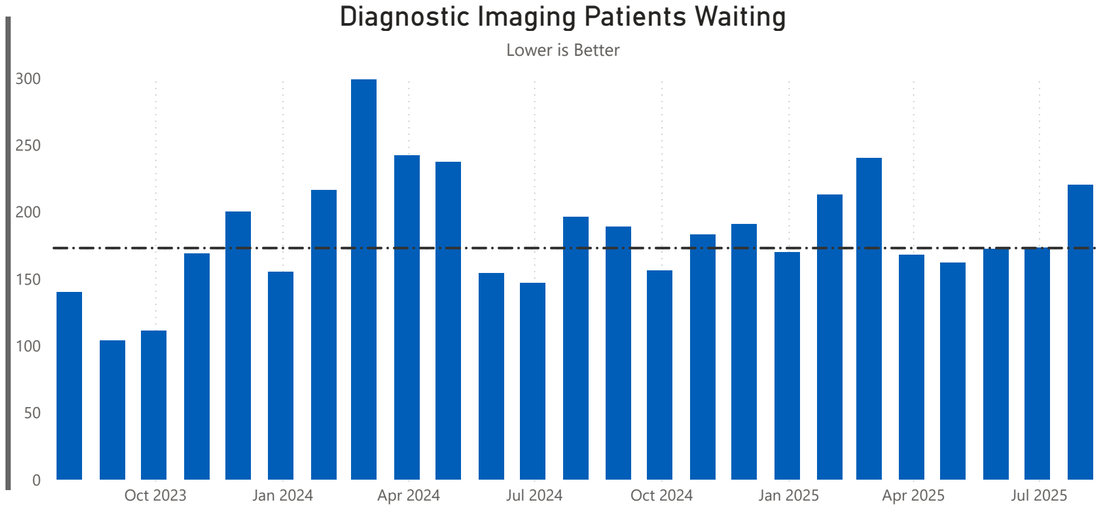
Operational Standards
Diagnostic Imaging 6 Week Compliance

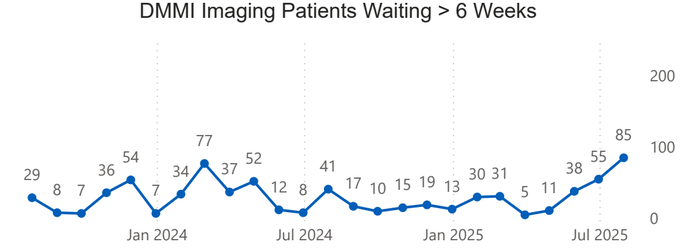
Data Source	Latest Data
DMMI Monthly Return	31/07/2025

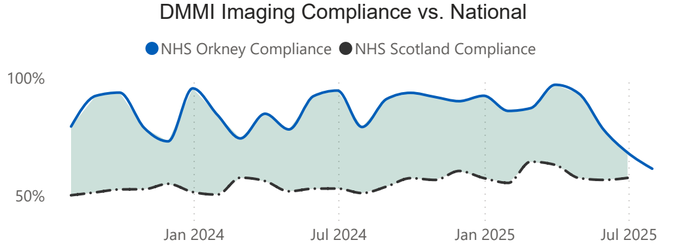
Compliance

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%	61.36%	Red

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	In Progress







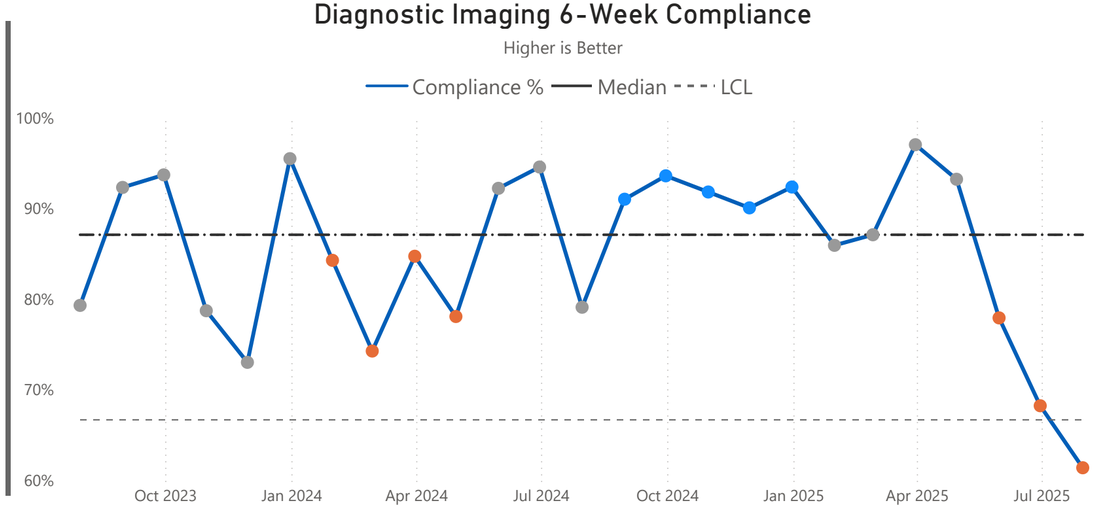
Statistical Process Control

Variance	Description
L	Special cause variation of concerning nature due to (L)ower values.

Assurance	Description
F	Variation indicates consistently (F)alling short of the target.

Last 6 Months

Month	Waiting	Over 6Wks	% Compliance	Target	Variance
28/02/2025	240	31	87.08%	100.00%	
31/03/2025	168	5	97.02%	100.00%	
30/04/2025	162	11	93.21%	100.00%	
31/05/2025	172	38	77.91%	100.00%	
30/06/2025	173	55	68.21%	100.00%	
31/07/2025	220	85	61.36%	100.00%	



Comments From Executive Lead

Diagnostic 6 week compliance has shown a sharp fall in operational compliance. This is due to the waiting list for MRI having been transferred from NHS Grampian to NHSO with the new MRI scanner on site -all patients previously on NHSG's waiting list have moved to NHSO. 35 out of 37 patients breaching target are for MRI.

Dr Anna Lamont, Medical Director



Operational Standards
Diagnostic Cardiology 6 Week Compliance

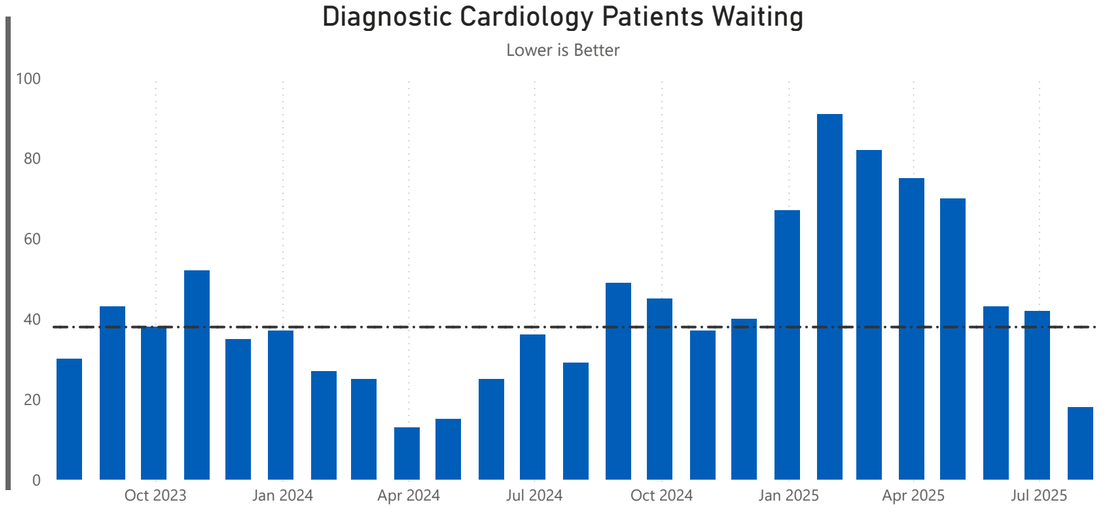
Data Source: DMMI Monthly Return

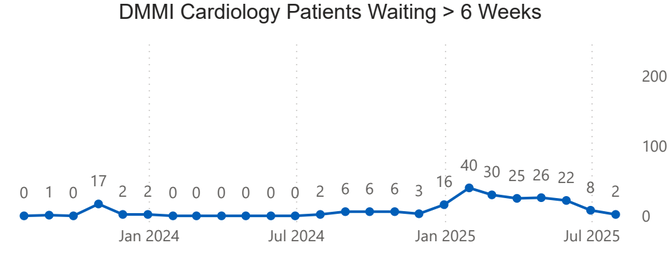
Latest Data: 31/07/2025

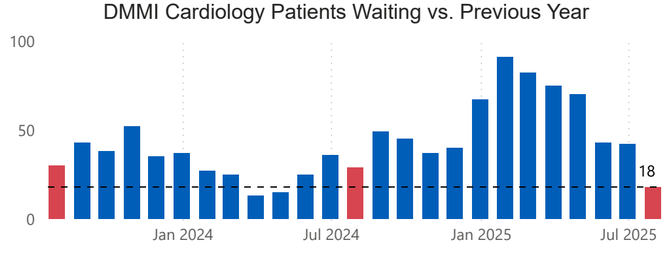
Compliance

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%	88.89%	Red

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	In Progress
Continue proactive monitoring of waiting lists and rapid adjustment of locum support to avoid future backlog.	01/10/2025	A Lamont	In Progress
Integrate cardiology planning within the Clinical Services Review (CSR) to develop a sustainable long-term workforce and service model.	01/10/2025	A Lamont	In Progress
Maintain close liaison between operational managers and clinical leads to anticipate and respond to any capacity constraints	01/10/2025	A Lamont	In Progress







Statistical Process Control

Variance **Description**

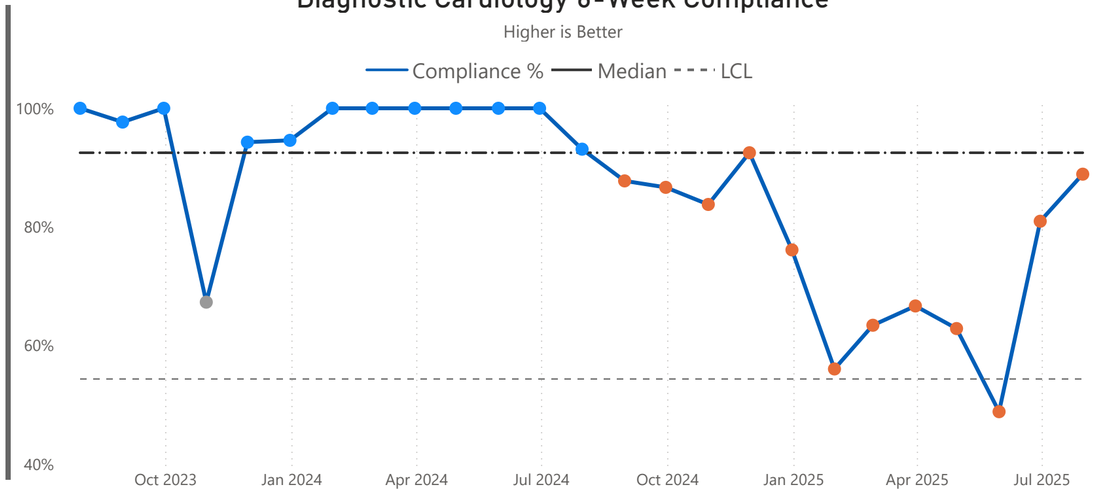
Special cause variation of concerning nature due to (L)ower values.

Assurance **Description**

Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	Waiting	Over 6Wks	% Compliance	Target	Variance
28/02/2025	82	30	63.41%	100.00%	
31/03/2025	75	25	66.67%	100.00%	
30/04/2025	70	26	62.86%	100.00%	
31/05/2025	43	22	48.84%	100.00%	
30/06/2025	42	8	80.95%	100.00%	
31/07/2025	18	2	88.89%	100.00%	



Comments From Executive Lead

Compliance with the six-week diagnostic cardiology standard has improved significantly, rising from 48.84% in May 2025 to 88.89% in July 2025. The earlier dip was related to reduced locum availability around December 2024 and early 2025, which limited service capacity. A recent block of locum sessions has allowed the backlog to be cleared.

NHS Orkney has long maintained on-site echo capacity with external locum and NHSO consultant support, reducing the need for patients to travel to Aberdeen for transthoracic echo. The newly appointed physiologist, who joined in June 2025, is progressing through an induction period, and once fully operational will provide greater resilience and reduce dependence on locum support.

Dr Anna Lamont, Medical Director



Operational Standards
Delayed Transfers of Care Discharge Compliance

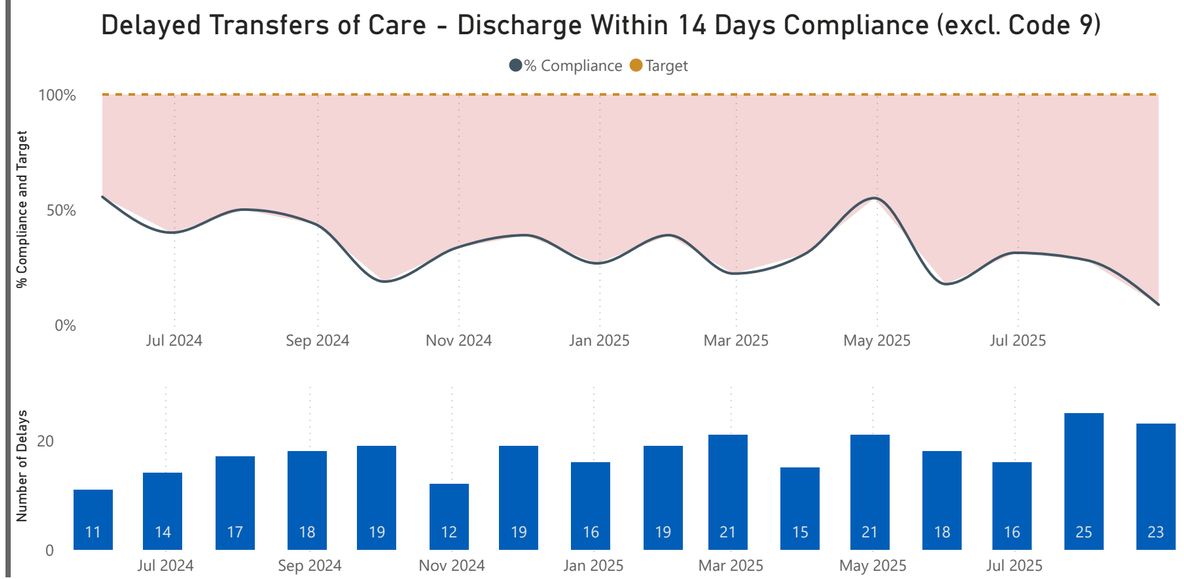
Data Source: Delayed Discharges Monthly Return

Latest Data: 31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Number of people experiencing a delay discharged within 2 weeks (excluding complex code 9 delays)	100%	8.7%	Red

Action	Target Date	Owner	Status
Discharge planning, setting predicted date of discharge.	31/10/2025	S Thomas	In Progress
Recruitment to social care vacancies.	31/10/2025	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.	31/10/2025	S Thomas	In Progress



Comments From Executive Lead

Current performance update as at 11/09/2025 is 17 delayed transfers of care. Of these 17, 7 are awaiting residential home placement.



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

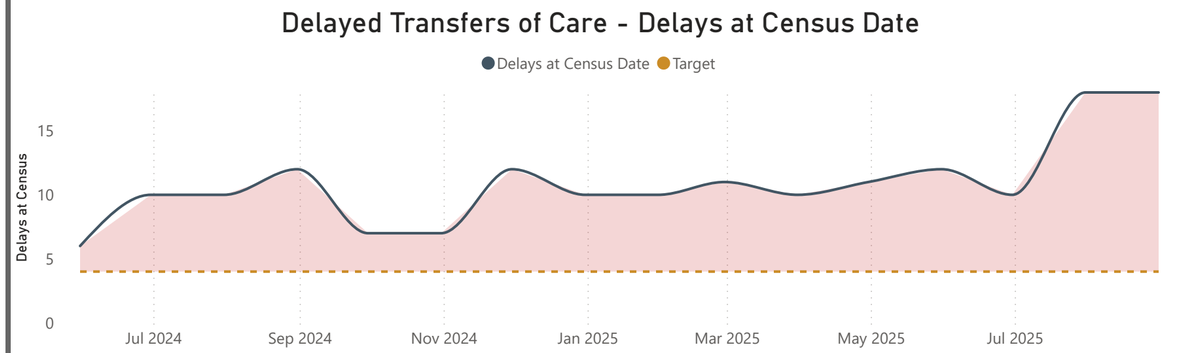
Operational Standards
Delayed Transfers of Care at Census Date

Data Source	Latest Data
Delayed Discharges Monthly Return	31/08/2025

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	18	Red

Action	Target Date	Owner	Status
Discharge planning, setting predicted date of discharge.	31/10/2025	S Thomas	In Progress
Recruitment to social care vacancies.	31/10/2025	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.	31/10/2025	S Thomas	In Progress



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 11/09/2025 is 17 delayed transfers of care. Of these 17, 7 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

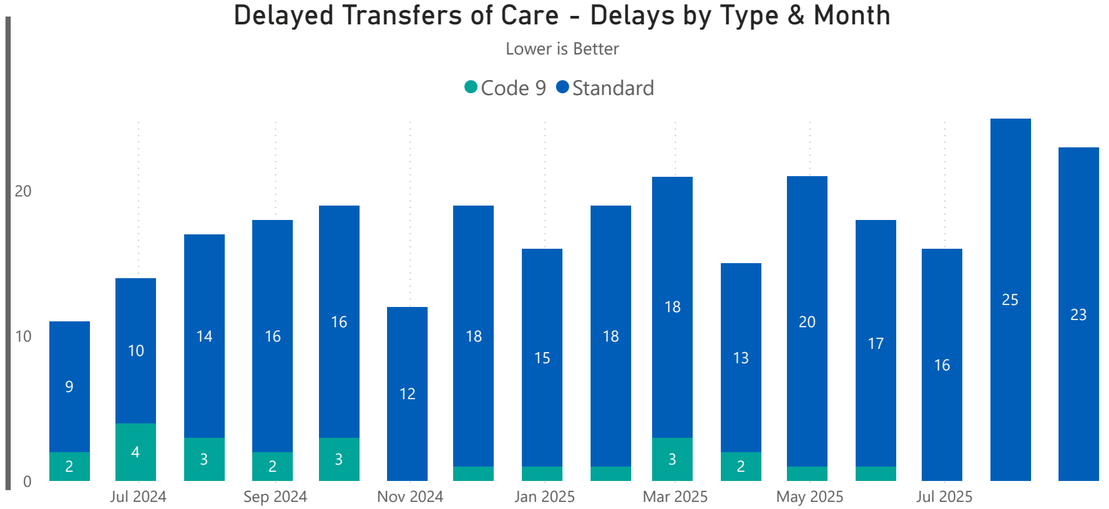
Data Source: Delayed Discharges Monthly Return

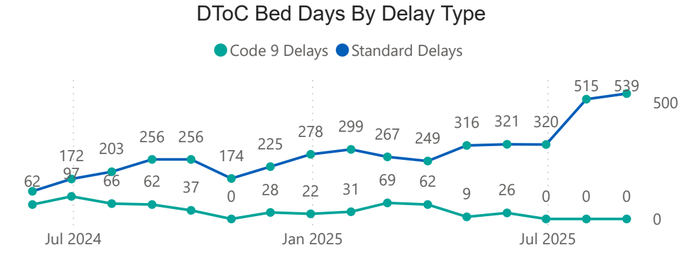
Latest Data: 31/08/2025

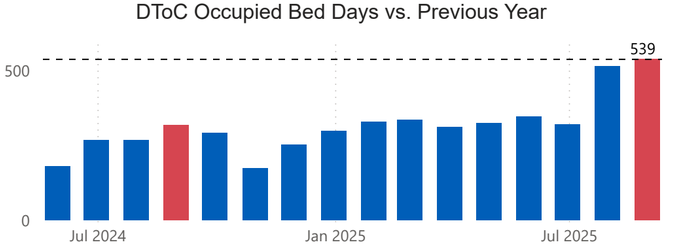
Compliance

KPI	Target	Actual	RAG Value
Number of hospital bed days associated with delayed discharges (any length or reason) in the calendar month.	56	539	Red

Action	Target Date	Owner	Status
Discharge planning, setting predicted date of discharge.	31/10/2025	S Thomas	In Progress
Recruitment to social care vacancies.	31/10/2025	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.	31/10/2025	S Thomas	In Progress







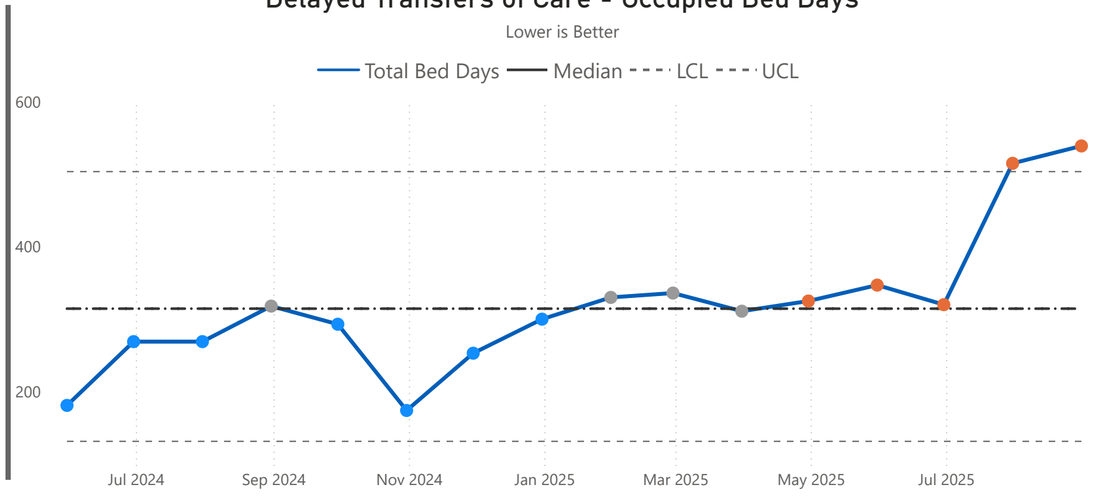
Statistical Process Control

Variance	Description
H	Special cause variation of concerning nature due to (H)igher values.

Assurance	Description
F	Variation indicates consistently (F)alling short of the target.

Last 6 Months

Month	Total Delays	Standard Bed Days	Code 9 Bed Days	Total Bed Days	Variance
31/03/2025	15	249	62	311	
30/04/2025	21	316	9	325	
31/05/2025	18	321	26	347	
30/06/2025	16	320	0	320	
31/07/2025	25	515	0	515	
31/08/2025	23	539	0	539	



Comments From Executive Lead

Current performance update as at 11/09/2025 is 17 delayed transfers of care. Of these 17, 7 are awaiting residential home placement.

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 Integration Joint Board has approved the establishment of an Associate Specialist Doctor for two sessions a week and an additional Band 8b Psychology post to assist with neurodevelopmental provision in Orkney. Some hours of the Psychology post have already commenced in post.

MSK waiting lists across physio, podiatry and orthotics continue to reduce.

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

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

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

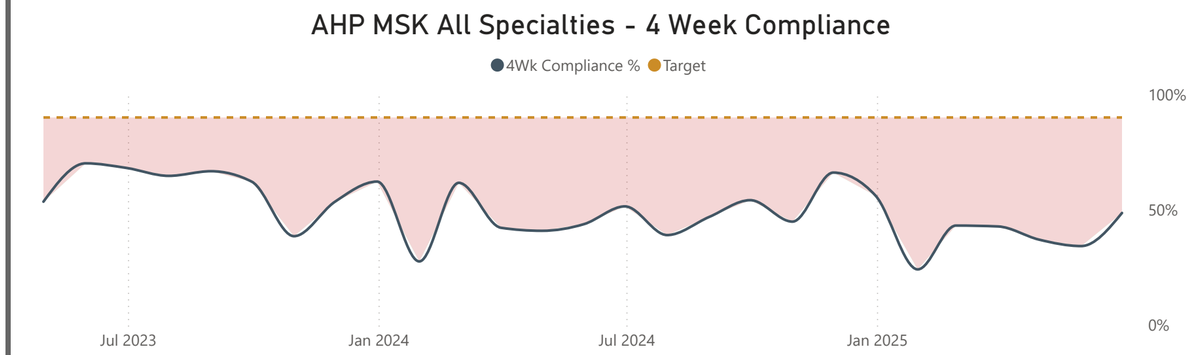
Data Source
MSK Quarterly Publication/TrakCare

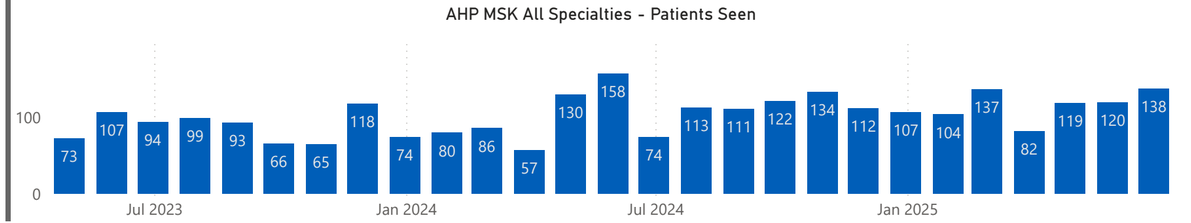
Latest Data
30/06/2025

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%	42.68%	Red

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





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

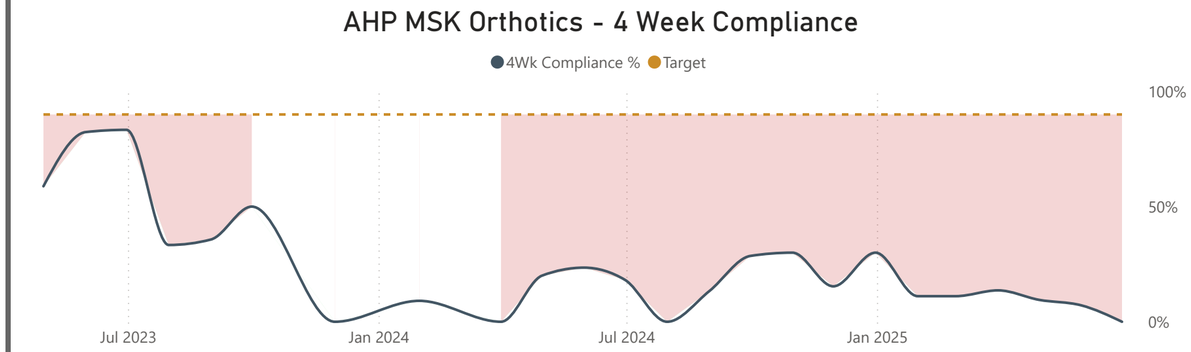
Data Source
MSK Quarterly Publication/TrakCare

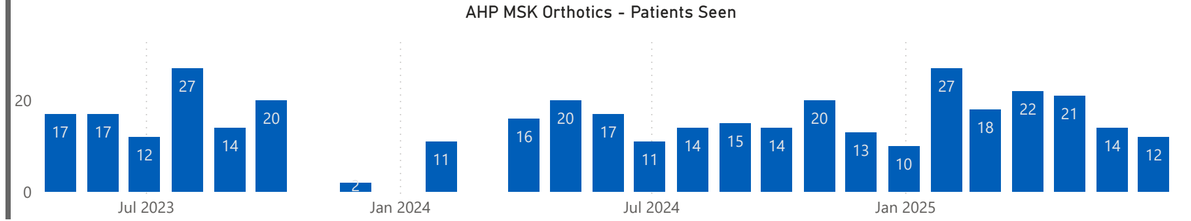
Latest Data
30/06/2025

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%	13.64%	Red

Action	Target Date	Owner	Status
Monitor referral numbers and performance	31/10/2025	R Lea	In Progress





Comments From Executive Lead

Previous reduction in the routine wait has been maintained. The way the clinics are organised will continue to challenge our ability to meet the four week target.

Stephen Brown, Chief Officer of the Integration Joint Board



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

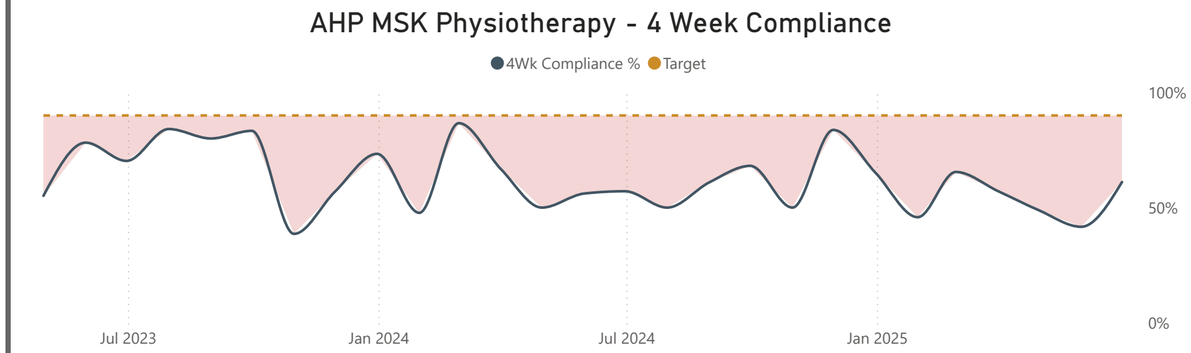
Data Source
MSK Quarterly Publication/TrakCare

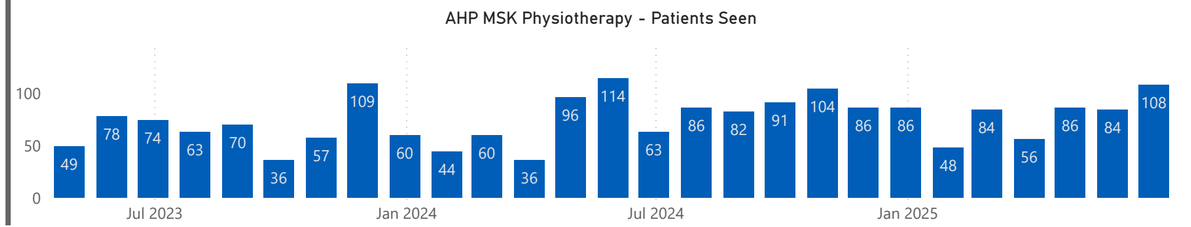
Latest Data
30/06/2025

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%	57.14%	Red

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





Comments From Executive Lead

In this period the MSK Physiotherapy waiting times and patient numbers have continued to reduce as the waiting list improvement initiative nears completion. This progress aligns with increased activity attributed to a full-time locum in place in May to September to support the MSK service whilst vacancy was sitting at 50%. Capacity previously provided via the Primary Care First Point of Contact Practitioners is not currently available. Referral rates have also reduced, demonstrating some of the impact that PHIO, the digital MSK tool, is having on patients requiring face to face physiotherapy. Ongoing data will help assess ongoing impact as awareness grows.

Stephen Brown, Chief Officer of the Integration Joint Board



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

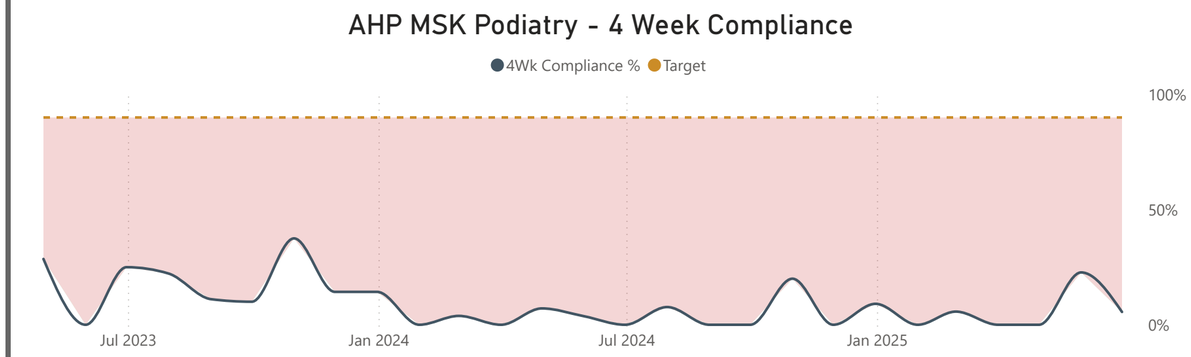
Data Source
MSK Quarterly Publication/TrakCare

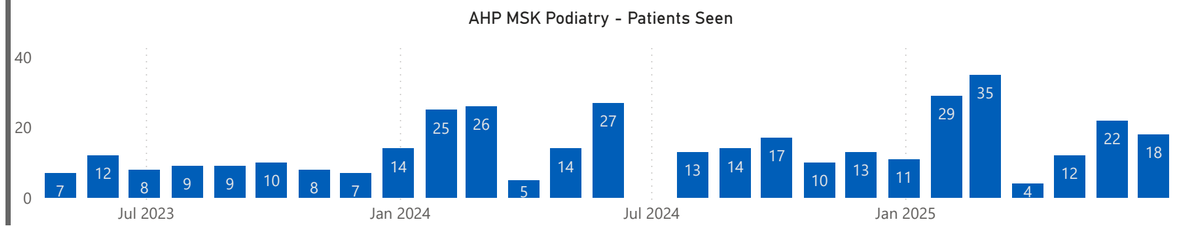
Latest Data
30/06/2025

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%	0%	Red

Action	Target Date	Owner	Status
Advertise bank position to explore local labour market availability.	30/09/2025	R Lea	In Progress
Work to identify space to deliver 1 additional MSK clinic weekly.	30/09/2025	R Lea	In Progress





Comments From Executive Lead

Waiting times continue to improve. Progress is impacted in a small team at times due to annual leave and unplanned absence. Availability of clinic space is also affecting waiting times.

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 programmes.

Maternity screening metrics show strong compliance at the latest position with 100% compliance for all metrics included in the Integrated Performance Report.

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 the smoking cessation 12-week LDP standard remains slightly off track. The Public Health team continue to monitor this and have, via a multi-agency group, developed a tiered approach based on client need. Training has also been provided to support referrals into stop smoking services.

Population Health
Smoking Cessation 12-Week Quits

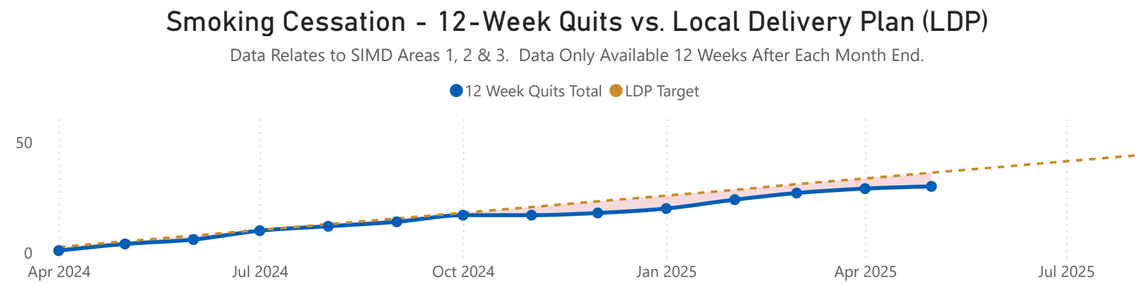
Data Source
Public Health Team

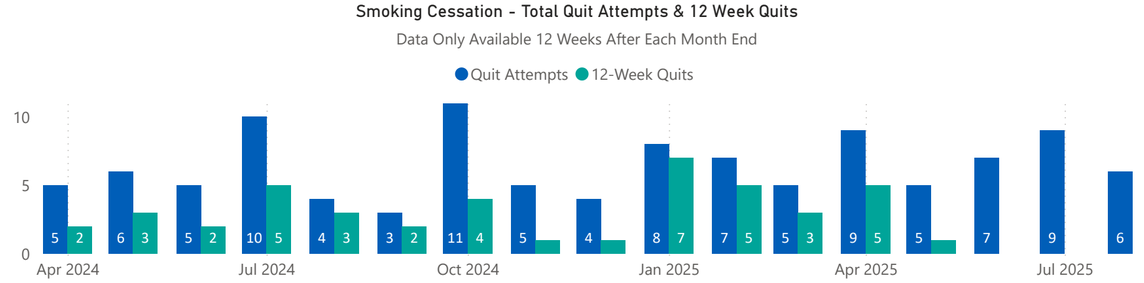
Latest Data
August 2025

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)	33	29	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





Comments From Executive Lead

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

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



People & Culture

Section Lead(s):
Interim Director of People and Culture

What's Going Well?

The Workforce improvement workstream within the Improving Together Programme is well developed with 8 areas of focus, including sickness management, mandatory training and appraisals. Corporate leads are identified for each area to drive delivery and fortnightly meetings take place to maintain momentum. Progress is starting to be seen in training compliance for example, 2-4% increases have been seen across most Health and Safety courses. Appraisal rates have also increased to 48.38%.

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

People & Culture
NHS Orkney Sickness Absence

Data Source
SSTS/eESS National

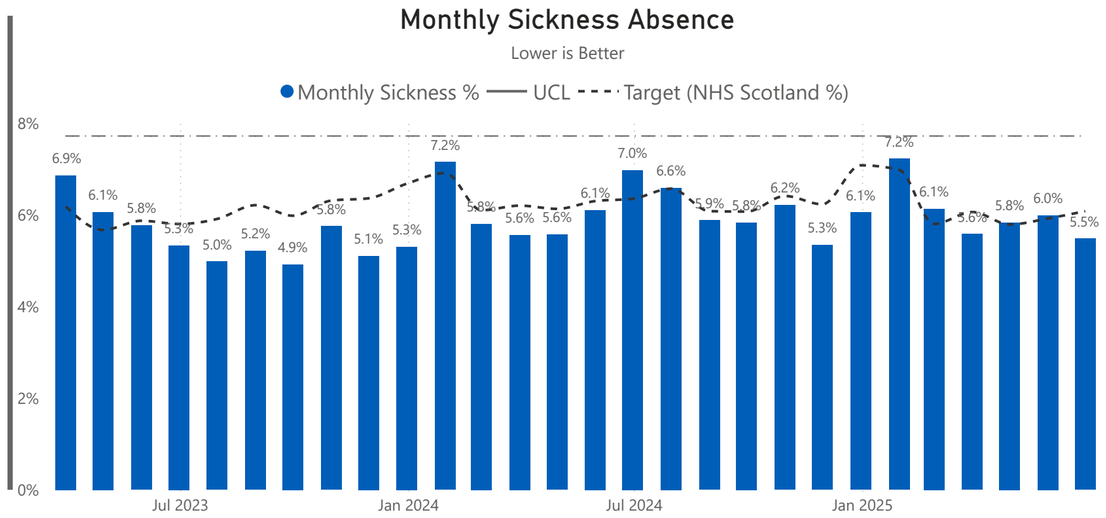
Latest Data
30/06/2025

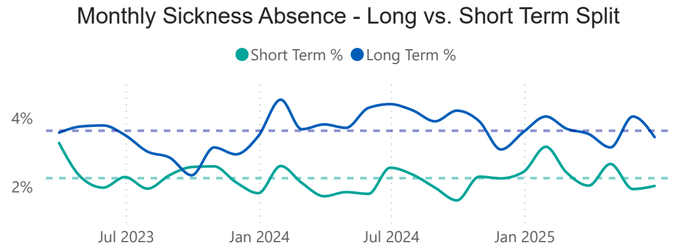
Compliance

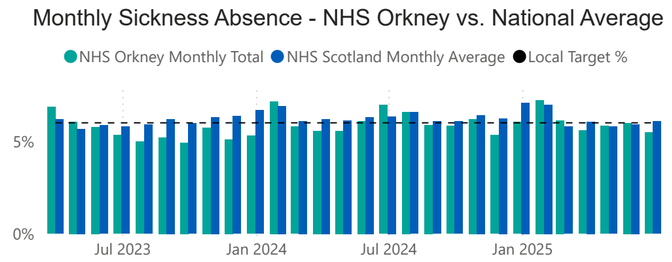
KPI	Target	Actual	RAG Value
Monthly comparison for previous 12 months NHS Scotland and NHS Orkney	6.43%	6.17%	Green

Action	Target Date	Owner	Status

KPI on target, no actions required at this time.







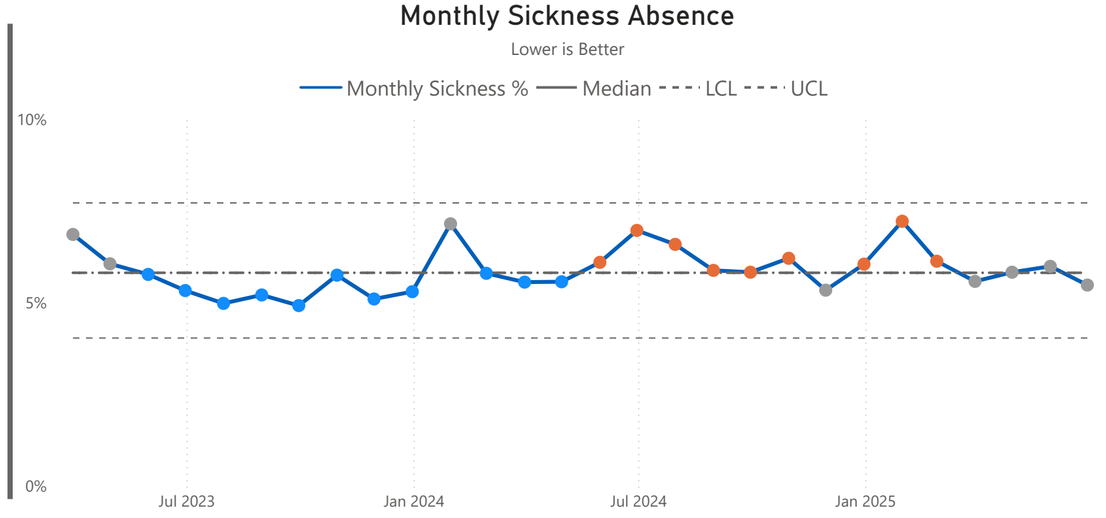
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

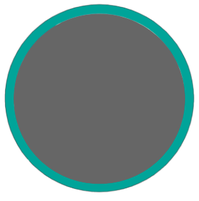
Month	Short Term %	Long Term %	Total %	NHS Scotland %	Variance
31/01/2025	3.17%	4.05%	7.22%	6.98%	
28/02/2025	2.43%	3.70%	6.13%	5.80%	
31/03/2025	2.04%	3.54%	5.58%	6.06%	
30/04/2025	2.67%	3.15%	5.83%	5.79%	
31/05/2025	1.94%	4.05%	5.99%	5.92%	
30/06/2025	2.03%	3.45%	5.48%	6.08%	



Comments From Executive Lead

The People and Culture team continues to work with priority areas (IP2 and Community Mental Health, and now IP1) to support sickness management in line with Once for Scotland Workforce Policy. The Occupational Health Nurse Manager has been engaging with managers to help them support people back to work.

Linda McGovern, Interim Director of People and Culture



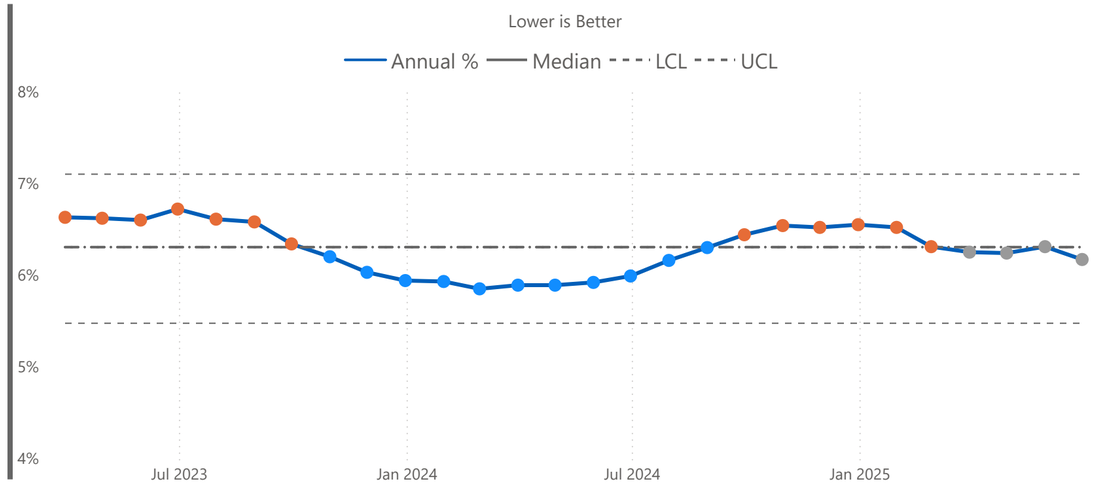
Statistical Process Control

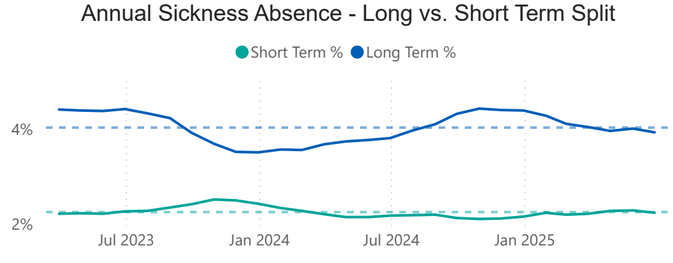
Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

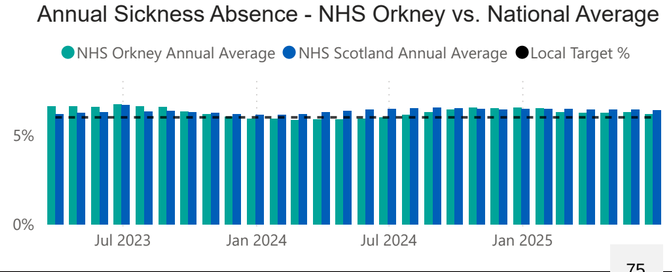
Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	Short Term %	Long Term %	Total %	NHS Scotland %	Variance
31/01/2025	2.24%	4.28%	6.52%	6.49%	
28/02/2025	2.20%	4.11%	6.31%	6.47%	
31/03/2025	2.22%	4.04%	6.25%	6.45%	
30/04/2025	2.28%	3.96%	6.24%	6.45%	
31/05/2025	2.29%	4.01%	6.31%	6.43%	
30/06/2025	2.24%	3.93%	6.17%	6.42%	







People & Culture
NHS Orkney Appraisal Rates

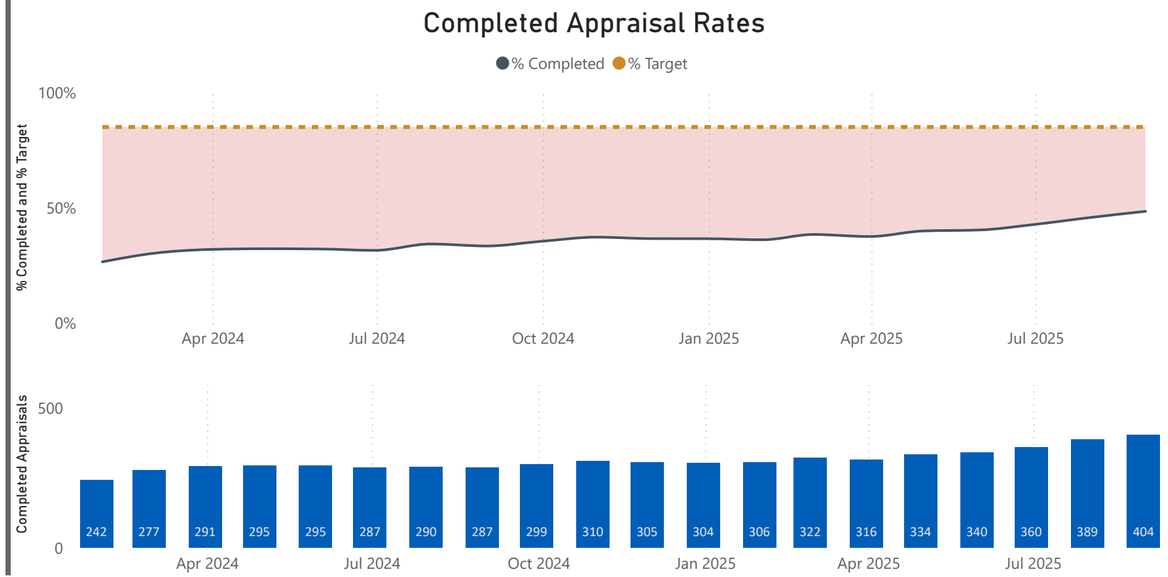
Data Source
Workforce Systems

Latest Data
31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Appraisal compliance rate over the previous 12 months	85%	48.38%	Amber

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



Comments From Executive Lead

Appraisal rates continue to increase, currently 48.38%. 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.

Linda McGovern, Interim Director of People and Culture

People & Culture
Agency Hours Utilised

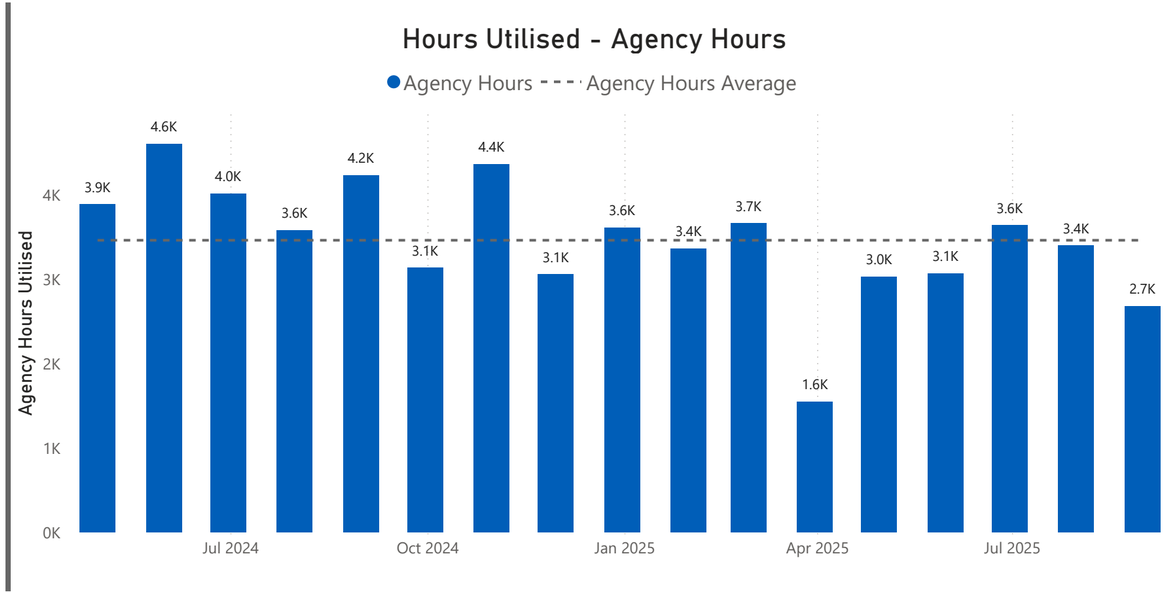
Data Source	Latest Data
Plus Us MI Report	31/08/2025

Compliance

KPI	Target	Actual	RAG Value
Agency hours used vs. average.		2680	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.



Comments From Executive Lead

The use of agency is being managed by the Director of Nursing, Midwifery and Allied Health Professions, and Chief Officer Acute Services with plans to reduce by month 5. This includes moving locum consultants onto bank contracts where possible and reducing reliance on high-cost agency workers. Medical recruitment is ongoing but remains a significant challenge.

Linda McGovern, Interim Director of People and Culture

People & Culture
Bank Hours Utilised

Data Source
Workforce Systems

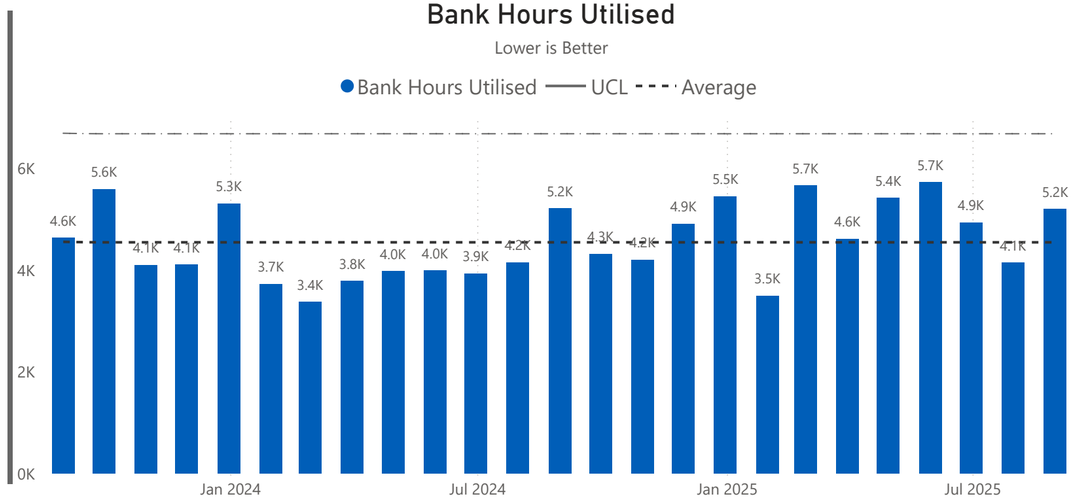
Latest Data
31/08/2025

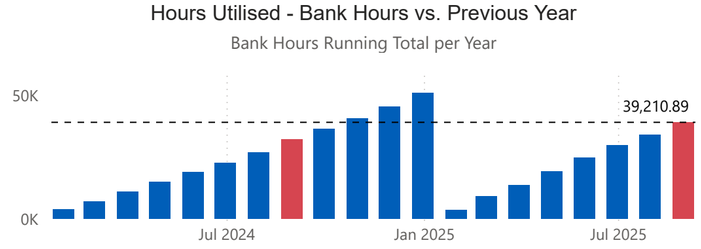
Compliance

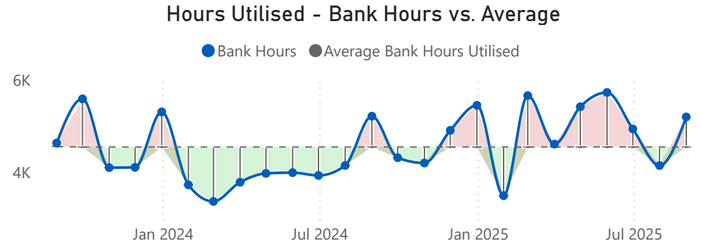
KPI	Target	Actual	RAG Value
Bank hours used vs. average.		5200.02	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.







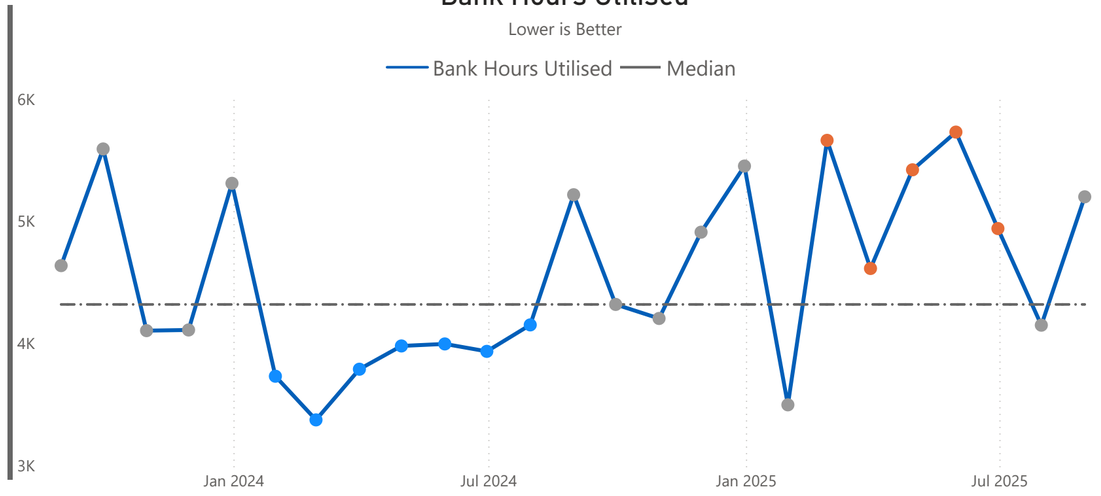
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	Bank Hours Used	Bank Hours Median	UCL	Variance
31/03/2025	4,612.93	4,318.52	6,686.56	
30/04/2025	5,421.05	4,318.52	6,686.56	
31/05/2025	5,729.95	4,318.52	6,686.56	
30/06/2025	4,939.92	4,318.52	6,686.56	
31/07/2025	4,148.52	4,318.52	6,686.56	
31/08/2025	5,200.02	4,318.52	6,686.56	



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.

Linda McGovern, Interim Director of People and Culture

People & Culture
Overtime Hours Utilised

Data Source
Workforce Systems

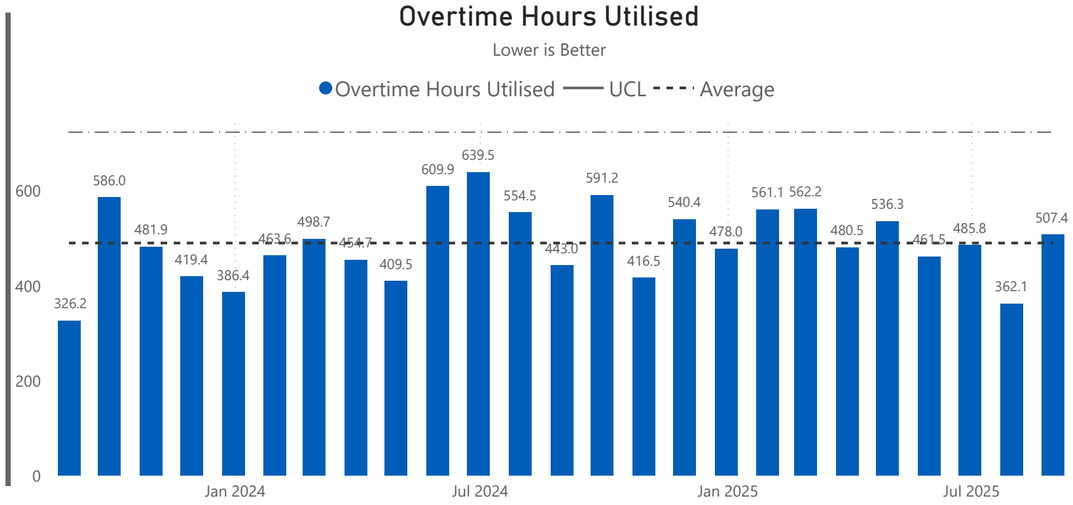
Latest Data
31/08/2025

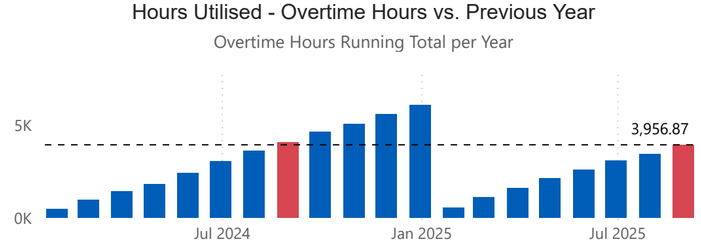
Compliance

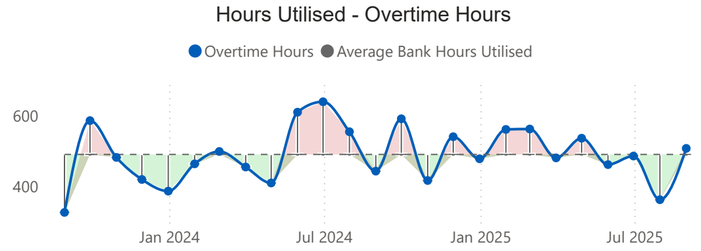
KPI	Target	Actual	RAG Value
Overtime hours used vs. average.		507.42	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.



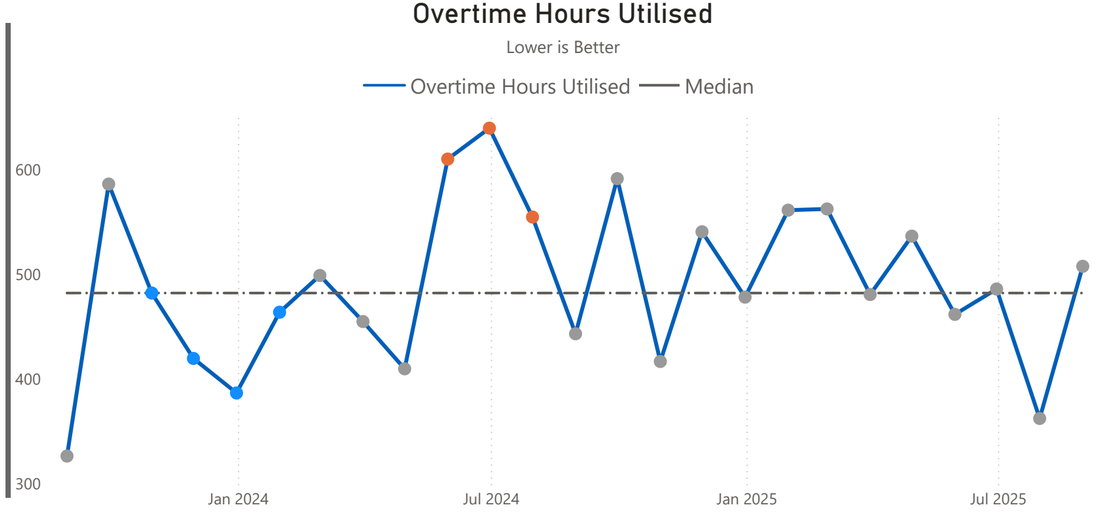




Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.



Last 6 Months

Month	Overtime Hours Used	Overtime Hours Median	UCL	Variance
31/03/2025	480.50	481.92	724.00	
30/04/2025	536.28	481.92	724.00	
31/05/2025	461.51	481.92	724.00	
30/06/2025	485.75	481.92	724.00	
31/07/2025	362.08	481.92	724.00	
31/08/2025	507.42	481.92	724.00	

Comments From Executive Lead

Linda McGovern, Interim Director of People and Culture

People & Culture
Excess Hours Utilised

Data Source
Workforce Systems

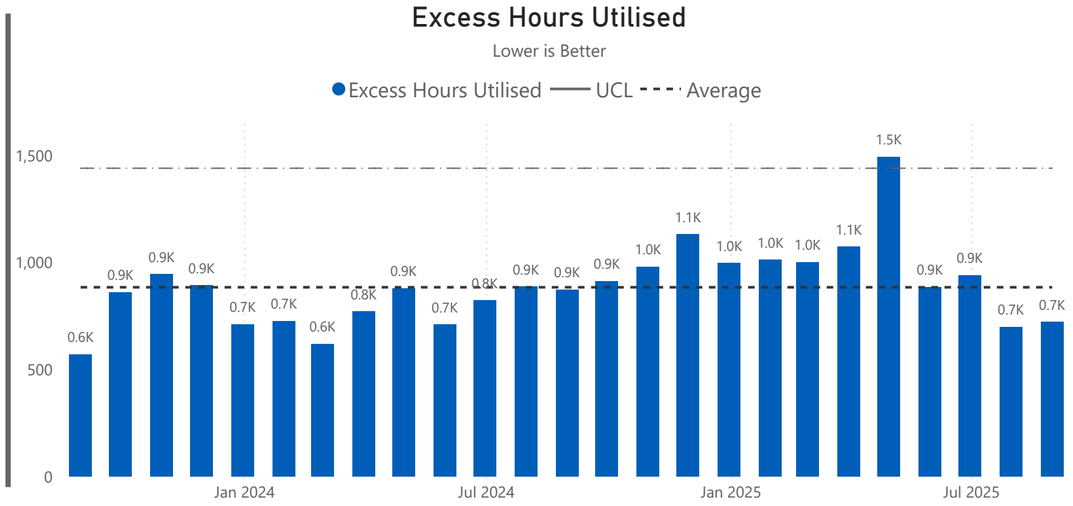
Latest Data
31/08/2025

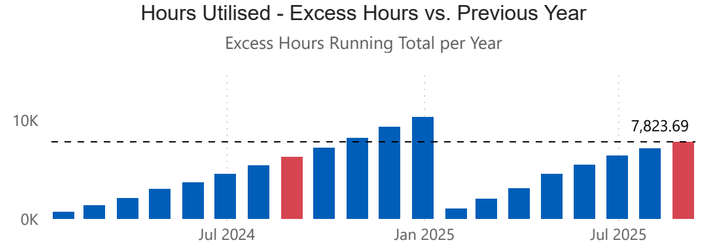
Compliance

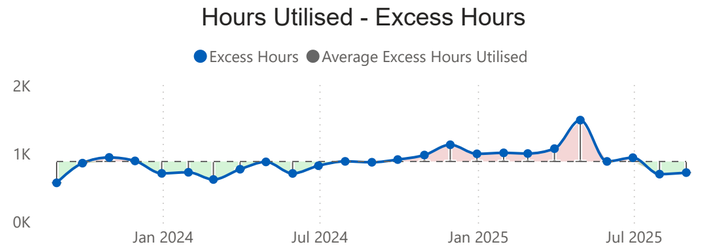
KPI	Target	Actual	RAG Value
Excess hours used vs. average.		721.14	Grey

Action	Target Date	Owner	Status

No target set, actions and target to be updated.







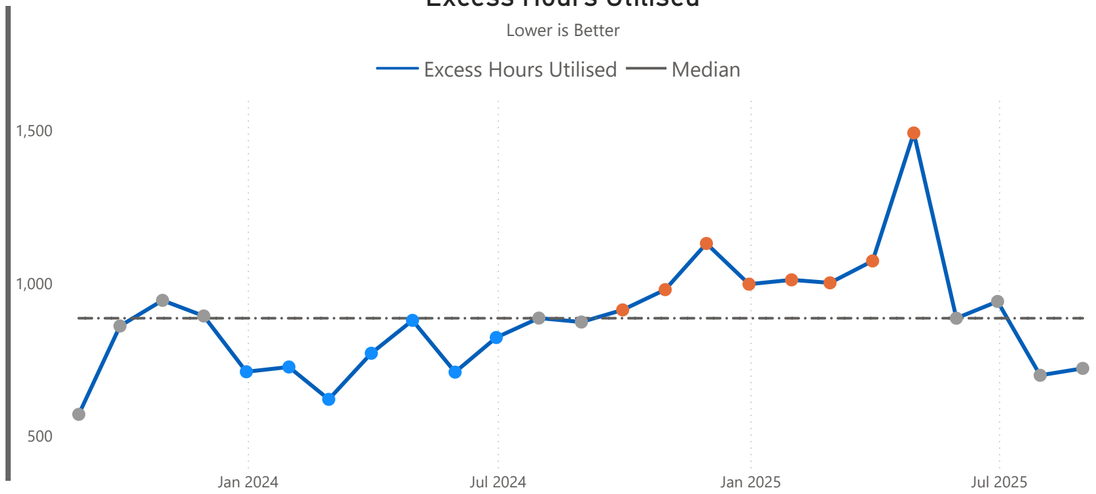
Statistical Process Control

Variance	Description
	Common Cause Variation which indicates that there is no significant change in the process

Assurance	Description
	Variation indicates inconsistently hitting, passing and falling short of the target.

Last 6 Months

Month	Excess Hours Used	Excess Hours Median	UCL	Variance
31/03/2025	1,073.14	885.48	1,440.11	
30/04/2025	1,492.39	885.48	1,440.11	
31/05/2025	885.48	885.48	1,440.11	
30/06/2025	940.41	885.48	1,440.11	
31/07/2025	698.58	885.48	1,440.11	
31/08/2025	721.14	885.48	1,440.11	



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.

Linda McGovern, Interim 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.

At Month 5, savings have been delivered as per the trajectory of £571k, with £471k (83%) recurring savings.

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

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

The month 5 position is £197k adverse to trajectory, driven by additional expenditure along with a reduction in allocated funding by SG.

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

Recovery measures have been agreed by SLT but the benefit of these have not been seen within the Month 5 results. Focus must continue to be on reducing expenditure and identify areas of disinvestment across the organisation.

Finance
Financial Position Summary

Data Source
Finance Performance Report

Latest Data
August 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	-428	-456	28	-84	-72	-12
Patient Charges Primary Care	-375	-177	-151	-26	-45	-41	-4
Other	-491	-205	-540	335	-41	-100	59
Total Income	-1,883	-810	-1,147	337	-170	-213	43
Expenditure							
Pay							
Medical & Dental	9,268	3,862	5,259	-1,397	772	1,063	-291
Nursing & Midwifery	16,909	7,047	6,635	412	1,485	1,289	196
Other Staff Costs	27,570	11,542	9,358	2,184	2,354	1,883	471
Non Pay							
General Medical Services	4,886	2,036	2,181	-145	366	493	-127
Pharmaceutical Services	1,017	446	452	-6	103	97	6
General Dental Services	1,009	472	468	4	124	121	3
General Ophthalmic Services	316	126	126	0	23	23	0
Drugs - Primary Care	4,902	2,042	2,021	21	382	426	-44
Drugs - Secondary Care	3,558	1,482	1,327	155	281	355	-74
SLAs & UNPACs	10,034	4,180	4,176	4	836	786	50
Medical Supplies	1,594	664	757	-93	133	193	-60
Resource Transfer	2,334	973	981	-8	195	193	2
Other Expenditure	14,957	5,806	6,931	-1,125	1,290	1,237	53
Reserves - Board	5,666	1,889	638	1,251	426	62	364
Savings Targets - Board	-8,734	-2,911	0	-2,911	-756	0	-756
Savings Targets - IJB	-2,400	-800	0	-800	-200	0	-200
Total Expenditure	92,886	38,856	41,310	-2,454	7,814	8,221	-407
Total	91,003	38,046	40,163	-2,117	7,644	8,008	-364

Figures shown in the above table represent £000s

Finance
Accounts Payable 10-Day Performance

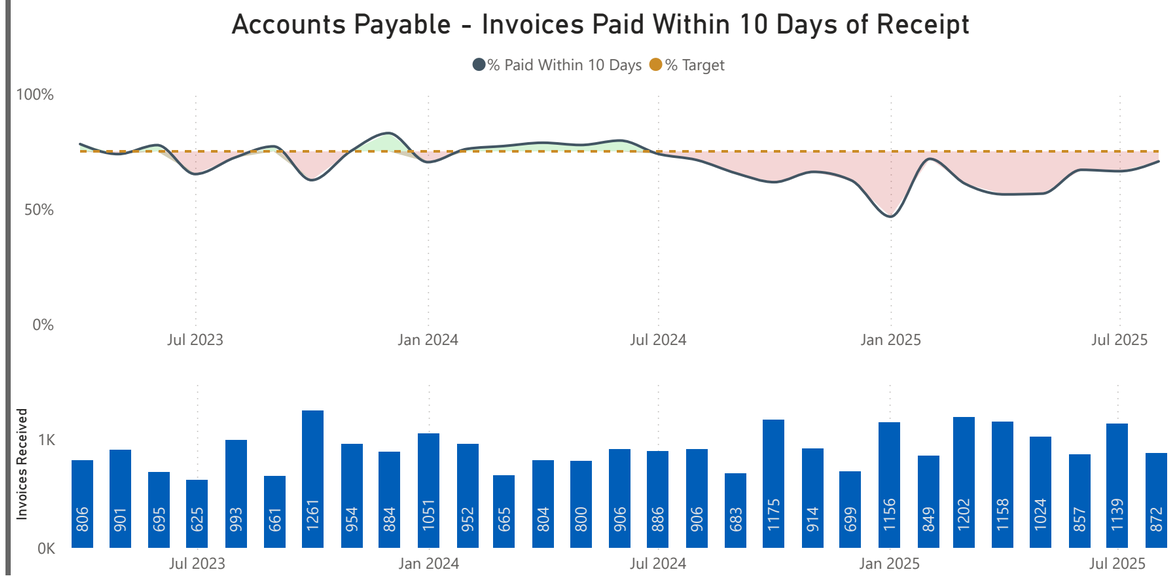
Data Source
AP Performance Report

Latest Data
August 2025

Compliance

KPI	Target	Actual	RAG Value
75% of invoices to be paid within 10 days of receipt - local target	75%	70.64%	Amber

Action	Target Date	Owner	Status
Ensure all outstanding budget holders undertake training in budget management	31/12/2025	M Barnes	In Progress
Continue to escalate issues with receipting of PO's and submission of invoices by departments to DoF	31/03/2026	M Barnes	In Progress



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

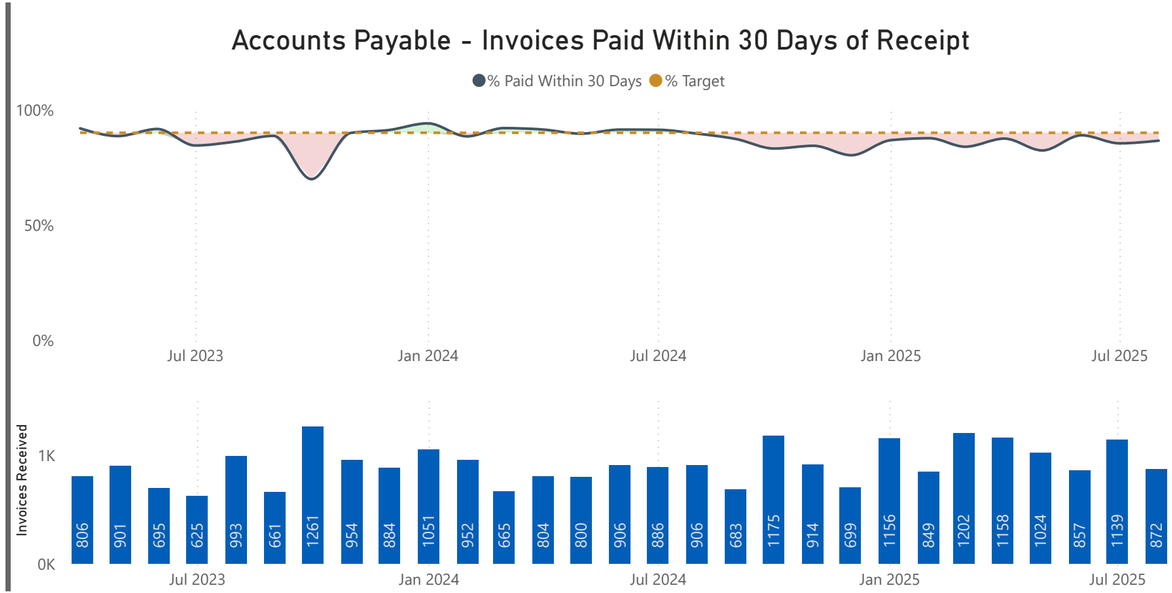
Data Source
AP Performance Report

Latest Data
August 2025

Compliance

KPI	Target	Actual	RAG Value
90% of invoices to be paid within 30 days of receipt - local target	90%	86.58%	Red

Action	Target Date	Owner	Status
Ensure all outstanding budget holders undertake training in budget management	31/12/2025	M Barnes	In Progress
Continue to escalate issues with receipting of PO's and submission of invoices by departments to DoF	31/03/2026	M Barnes	In Progress



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



NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Governance Committee Membership November 2025 – March 2026**
Responsible Executive/Non-Executive:	**Davie Campbell, Interim Board Chair**
Report Author:	**Debs Crohn, Interim Head of Corporate Governance**

1 Purpose

This is presented to the Health Board for a **decision.** The Board is asked to:

- **Approve** the reviewed and updated Governance Committee Membership as set out in Appendix 1.
- **Approve** a 12-month test of change of the Area Partnership Forum (APF) reporting directly to the Board with immediate effect

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Effective governance committees are essential to ensure the Board fulfils its statutory responsibilities and delivers on its strategic objectives.

Following the departure of the Board Chair in August 2025 and appointment of a new Non-executive Board member, a review of Committee Membership has been undertaken, the Board is asked to consider and approve the proposed changes with immediate effect.

The Board is asked to approve a 12-month test of change for the Area Partnership Forum (APF) to report directly to the Board, effective immediately. This approach matches standard practice in other Boards, as shown in Table 1.

2.2 Background

As set out in the blueprint for good governance, robust committee structures enable clear lines of accountability, promote informed decision-making, and support transparency throughout the organisation.

Such committees provide the necessary oversight, scrutiny, and assurance that key risks are managed, performance is monitored, and public resources are used efficiently and responsibly. In this way, they underpin the delivery of safe, effective, and person-centred care, fostering an environment of continuous improvement and public trust.

In determining the membership of Committees, the Board must have due regard to its purpose, role and remit, and accountability requirements, each Governance Committee of the Board must have a minimum number of Non-Executive Members which includes those Non-Executive Members who are members due to the office they hold.

2.3 Assessment

Committee membership November 2025 – March 2027

A review of the Board's membership of its committees to ensure all non-executive members can fulfil their responsibilities within their current time commitments is complete. Appendix 1 details the proposed membership of each committee from November 2025 in accordance with their Terms of Reference, highlighting any specific requirements or mandatory exclusions that must be observed.

These changes have been carefully considered to balance the workload across committees, address risks associated with financial escalation, ensure non-executive directors' skills and experiences are being used effectively in support of the Boards strategic objectives and to support succession planning for key roles, for example the Board Chair and the Integration Joint Board.

Area Partnership Forum reporting

Following a request by the Chair of the Area Partnership, reporting structures for the APF in 7 Health Boards has been undertaken. As set out in Table 1 it is a mixed economy of where the APF reports.

Health Board	APF reporting structure
NHS Lothian	Board
NHS Grampian	Board
NHA Western Isles	Board
NHS Ayrshire and Arran	Board
NHS Shetland	Staff Governance Committee
NHS Orkney	Staff Governance Committee

Consideration should be given to a 12-month test of change of the Area Partnership Forum (APF) reporting directly to the Board, noting that a Chairs Assurance Report will be provided to the Staff Governance Committee for assurance.

Effectiveness of the changes outlined above will form part of the Annual Review of Committee core documents and reflected in Committee effectiveness annual reports.

2.3.1 Financial

There is no additional financial impact to the recommendations.

2.4 Recommendation(s)

The Board is asked to

- **Approve** the reviewed and updated Governance Committee Membership as set out in Appendix 1.
- **Approve** a 12-month test of change of the Area Partnership Forum (APF) reporting directly to the Board with immediate effect

3. Appendices

Appendix 1, Proposed Committee Membership November 2025 – March 2027.

ORKNEY NHS BOARD

Chair: Davie Campell
Vice-Chairperson: Joanna Kenny

PROPOSED GOVERNANCE STANDING COMMITTEES November 2025 – March 2027

Audit and Risk Committee	**Chair**	**Vice Chair**	**Non-executive Board Members**	**Lead Executive**
Four non-executive members including the Employee Director but not the Chair of the Board. Ordinarily the Audit Committee chair cannot chair any Governance Committee of the Board but can be a member of other governance committees	Jason Taylor	Issy Grieve	Ryan McLaughlin Rona Gold	Medical Director
Finance and Performance Committee	**Chair**	**Vice Chair**	**Non-executive Board Members**	**Lead Executive**
Four non-executive members including the Local Authority member	Fiona MacKay	Jason Taylor	Jean Stevenson (Local Authority) Ryan McLaughlin Davie Campbell	Director of Finance
Integration Joint Board	**Chair**	**Non-executive Board Members**	**Deputies**	**Lead Executive**
Three non-executive members	Joanna Kenny	Issy Grieve Rona Gold	Davie Campbell Fiona Mackay	Chief Officer - IJB
Integration Joint Board Audit Committee	**Chair**	**Non-executive Board Members**	**Deputies**	**Lead Executive**
		Issy Grieve Rona Gold		Chief Officer - IJB

Joint Clinical and Care Governance Committee	Chair	Vice Chair	Non-executive Board Members	Lead Executive
Three non-executive members one of whom must be the Area Clinical Forum Chair and a voting member of the Integration Joint Board.	Rona Gold	Fiona MacKay	Dr Kirsty Cole Ryan McLaughlin	Executive Director of Nursing, Midwifery, AHP's and Chief Officer Acute Services
Staff Governance Committee	**Chair**	**Vice Chair**	**Non-executive Board Members**	**Lead Executive**
Four non-executive members including the Employee Director	Joanna Kenny	Jean Stevenson	Ryan McLaughlin Dr Kirsty Cole	Director of People and Culture
Remuneration Committee	**Chair**	**Vice Chair**	**Non-executive Board Members**	**Lead Executive**
Four non-executive members including the Chair of the Board and the Employee Director	Joanna Kenny	TBC	Davie Campbell Ryan McLaughlin Jason Taylor	Director of People and Culture
OTHER COMMITTEES				
Endowment Fund Sub Committee	**Chair**	**Vice Chair**	**Non-executive Board Members**	**Lead Executive(s)**
Five Trustees, one of whom will be the Director of Finance	Issy Grieve		Jean Stevenson (Local Authority) Fiona Mackay All other Trustees to attend in rotation	Executive Director Nursing, Midwifery, AHPs and Chief Officer Acute Services Director of Finance
Orkney Alcohol and Drugs Partnership			**Pharmacy Practices Committee**	
Issy Grieve Deputy – Fiona MacKay			Chair to be appointed as and when required.	
Area Partnership Forum			**Area Clinical Forum**	
Ryan McLaughlin – Chair			Dr Kirsty Cole - Chair	

Orkney Partnership Board		Succession Planning Committee
Davie Campbell		Issie Grieve - Chair

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 20 August 2025**
Prepared By:	Rona Gold, Chair and Non-Executive Director	
Approved By:	Sam Thomas Executive Director of Nursing, Midwifery, Allied Health Profession (AHP's) and Chief Officer Acute Services	
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 **20 August 2025**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. The Board is requested to consider the financial risks associated in implementing the Clinical Services Review (CSR) recommendations. It should be noted that, although some changes may ultimately prove cost-neutral, the majority will entail transitional expenditures that must be carefully prioritised and managed.	1. Medical Director to review and address the referral process for pre-operative assessments to ensure patients referred via Grampian are offered local assessment options where possible with an update brought to 1 October 2025 meeting. 2. Medical Director, EDoNMAHP and Chief Officer IJB to prepare clear public communication to distinguish the Clinical Services Review recommendations from recent media narratives and ensure accurate messaging for the public board. 3. Medical Director, EDoNMAHP and Chief Officer IJB to seek explicit Board support for a phased implementation recommendation, acknowledging current financial and resource constraints.
Positive Assurances to Provide	**Decisions Made**
1. Members discussed and agreed that governance arrangements are in place and that implementation readiness was sufficient for consideration by the Board at its meeting 28 August 2025.	1. None made.

Comments on Effectiveness of the Meeting

- None noted.

Item 11.1.2

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 01 October 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	Jean Stevenson – Vice Chair Joint Clinical Care Governance Committee	
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 **01 October 2025.**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concern or key risks to escalate.	1. No major actions commissioned/work underway.
Positive Assurances to Provide	**Decisions Made**
1. Positive assurance taken on the reduction in the colonoscopy surveillance backlog. 2. Key Performance Indicators in our maternity services remain on track as evidenced in the Integrated Performance Report. 3. The Public Health Report 2024/25 was welcomed highlighting our strong partnership working and commitment to reducing health inequalities. 4. Annual Social work and Social Care Services Experience Report 2024/25 was well received, noting the positive work that is taking place within our social care teams. 5. Assurance taken on the 2024/25 Quarter 1 Safety, Quality and Experience Report. 6. Assurance taken on the Mental Health Assurance Report. 7. Assurance provided on the Children's Health Assurance report and work underway on neuro-developmental pathways. 8. Quality Impact Assessments continue to be embedded within our Improving Together (efficiency) programme, our approach has been commended by Scottish Government. 9. Assurance taken on the Primary Care Services update and the transformation underway in our Community Nursing and Isles Network of Care services. 10. Committee recognised and took assurance on the work being done within our dental and specialist services.	1. No decisions made.

Comments on Effectiveness of the Meeting

- Excellent papers presented at the meeting contributed to positive tone and discussion at the meeting

Item 11.2

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: 23 September 2025**
Prepared By:	Debs Crohn, Interim 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 23 September 2025		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Our financial position at the end of Month 5 remains offtrack against plan – a rapid financial review has been commissioned which will be used to inform conversations with Scottish Government and improvement actions which will need to be put in place to bring our financial plan back on track. 2. It is unlikely that the workforce workstream will meet its savings target this financial year, work is underway to look at how further savings could be met. The Interim Director of Finance and Director of Transformation and performance continue to review all planned savings. 3. There is a risk that the Agenda for Change Reduced Working Week (RWW) may impact on delivery of services, patient quality and safety. A weekly Short Life Working Group has been established to oversee the implementation of the changes. 4. Delayed Transfers of Care (DTOCs) present a significant risk to the delivery of safe, effective, and timely healthcare across the system. Strategic partnership working, action planning and forward planning for winter is in place The Board is asked to note that mitigating risks associated with DTOCs remains a priority, with regular oversight and collaborative initiatives aimed at enhancing patient flow, optimizing resource use, and maintaining high standards of care across the system. 5. NHS Grampian confirmed as a delivery partner for the deployment of MORSE (Community Electronic Patient Record). It remains unclear if any additional costs pressure will be associated with the implementation and there are risks around delivery	1. EDoNMAHP will draft a clear position statement on Unscheduled Care Funding. This document will be prepared for review by the Executive and shared with the committee before the Board Meeting in October 2025, enabling informed discussion and decision-making.

timescales and the availability of NHS Grampian – paper to be presented to DIOG 24 September 2025 setting out the costs and risks.	
Positive Assurances to Provide	**Decisions Made**
1. Assurance provided that robust measures are in place to ensure there will be no patients waiting more than 52 weeks for planned care by 31 March 2026. Our current trajectory remains strong and on track to deliver this commitment, with diligent monitoring through the monthly Planned Care Programme Board and continuous oversight of waiting times for all patients. 2. A refreshed weekly delivery group is now in place focused on actions and putting in place recovery actions for actions which are off track. 3. Improvements to the Integrated Performance Report (IPR) were noted and welcomed as they provide additional assurance to committees and the Board of our financial and operational performance. 4. The NHS Grampian eHealth team continues to provide valuable support to NHS Orkney, both locally and through national engagement.	1. No decisions made.
Comments on Effectiveness of the Meeting	
• Committee welcomed Fiona Mackay as the Committee Chair and James Goodyear Interim CEO. • The Interim Board Chair thanked members for stepping in to cover gaps on the agenda • The Medical Director felt that there had been opportunities for participation and engagement from all attendees. • Committee recognised the need to ensure duplication is reduced across all committees.	

Item 11.2.1

Financial Escalation Board Chair's Assurance Report

Title of Report:	Chair's Assurance report from the Financial Escalation Board	**Date of Meeting: 27 August 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	Jason Taylor – Non-executive Board Member	
Presented By:	Jason Taylor – Non-executive Board Member	

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Financial Escalation Board at its meeting on the **27 August 2025**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. The Month 4 financial position is off plan, with £46k in additional spending. 2. Concerns were raised by the CEO in relation to the Board not behaving as Board who is closer to level 4 escalation than level 3, and that transformational change is now required at pace to ensure the organisation is financially sustainable for the future.	1. Interim Director of Finance and CEO have completed a review of IJB spend, as requested by Scottish Government, paper to be presented to Financial Escalation Board 25 September 2025. 2. Clinical Services Review (CSR) recommendations will go to Board on 28 August 2025.
Positive Assurances to Provide	**Decisions Made**
1. In response to Month 3 overspend, Enhanced controls and compliance with transitional funding terms agreed and in place.	1. Deep dives on equipment service contracts and miscellaneous expenditure will be brought to 25 September Financial Escalation Board. 2. Proposal for Deep dive into elements of IJB expenditure to be brought to 25 September Financial Escalation Board. 3. Members approved the recommendations in the medical staffing deep dive, paper noting these are contained within the CSR. Medical Director to take the recommendations from the deep dive through our internal governance process. 3. To ensure we meet the conditions set out in the transitional funding terms and conditions, a full review of our financial position will be undertaken by the Interim Director of Finance at the end of Quarter 2 (September 2025), returning to Financial Escalation Board 29 October 2025.

Comments on Effectiveness of the Meeting

Item 11.2.2

Financial Escalation Board Chair's Assurance Report

Title of Report:	Chair's Assurance report from the Financial Escalation Board	**Date of Meeting: 25 September 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	Jason Taylor – Non-executive Board Member	
Presented By:	Jason Taylor – Non-executive Board Member	

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Financial Escalation Board at its meeting on the **25 September 2025**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. At the end of Month 5, the reported financial position is adverse against the financial plan trajectory. The underlying driver is additional expenditure in the first quarter of around £200k, which has been partially offset by additional income in Month 4 (neither of which were factored into the financial plan).	1. Interim Head of Corporate Governance to transfer all outstanding actions from the Financial Escalation Board to the Finance and Performance Action log, the Financial Escalation Board Action log to be closed. 2. Interim Director of Finance to bring a deep dive on the Month 6 financial position to the November 2025 Finance and Performance Committee 3. Interim Director of Finance to bring a deep dive on the Integration Joint Board savings target to the December 2025 Finance and Performance Committee
Positive Assurances to Provide	**Decisions Made**
1. Received deep dives relating to Equipment Service Contracts and Miscellaneous expenditure. With the exception of one variance currently being investigated, variances identified have been fully reconciled and / or relevant reasons provided.	1. Financial Escalation Board to be stood down, Finance and Performance Committee to be moved to the last week of each month and include an agenda item for deep dives with an open invite to Scottish Government to attend.

Comments on Effectiveness of the Meeting

- Members said that the meeting was useful at the point it was established but recognised there was duplication with other governance committees, and felt it the appropriate moment to stand down and incorporate the valuable elements into Finance & Performance Committee.

NHS Orkney

Item 11.3

Audit and Risk Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from Audit and Risk Committee	**Date of Meeting: 02 September 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	Jason Taylor, Chair/Non-Executive Director	
Presented By:	Jason Taylor, Chair/Non-Executive Director	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Audit and Risk Committee **02 September 2025**		

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
1. Committee took limited assurance on the mitigations in place for the risk associated with senior leadership stability and resilience noting the risk is not only related to recruitment but on-boarding staff into the organisation. Director of People and culture to ensure this is included in the Employee Journey Programme. 2. Committee raised concerns about potential risks associated with the introduction of Artificial Intelligence (AI). Board is asked to consider the risks associated with the use of AI and organisational awareness.	1. Head of Patient Safety, Quality and Risk and Medical Director to review and update Corporate Risk Register to include links or reference to relevant documentary evidence, and to ensure mitigating actions are SMART, risk / action owners are clearly identified. 2. Counter Fraud Strategy and staff awareness sessions are in development – to return to Committee December 2025.
Positive Assurances to Provide	**Decisions Made**
1. Risk Management Group meetings now have good representation from across the Organisation and are supervising operational risk register – this is a significant change for the Organisation this is reflected in the Chairs Assurance Reports and minutes of meetings. 2. Assurance provided on the Public Health Scotland SNAP Audit – findings to be shared with JCCGC. 3. 2 x Internal Audits received – Waiting Times and Financial Management – audits are more 'in depth' than previous years and 'shining a light' on areas of good practice as well as those requiring improvement. 4. Internal Audit Recommendations 2023/24: 23 actions closed, 1 in progress and 1 not yet due, 2024/25: 22 actions closed, 8 in progress and 5 not yet due.	1. Property Transactions Report 2024/25 approved for submission to Scottish Government. 2. Audit recommendations associated with Business Continuity Plans remain open – Data Protection Officer to bring an evidenced proposal for closure of management actions to Committee December 2025.
Feedback about meeting: - Committee felt that it was focusing on what is important to the organisation and had proposed solutions. - Assurance provided on the risk process with improvements agreed	

Senior Leadership Team (SLT) People and Potential

Title of Report:	Chair's Assurance report from the Senior Leadership Team	**Date of Meeting: 26 August 2025**
Prepared By:	Debs Crohn, Head of Improvement	
Approved By:	Senior Leadership Team People and Potential	
Presented By:	Laura Skaife-Knight, Chief Executive	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **26 August 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No items of concern or key risks to be escalated to the Board.	1. Leadership and Manager Development Programme - Three mandatory modules - Finance, Appraisals, and Attendance Management will launch for managers in Quarter 4 2025/26, pending SLT approval on 11 September 2025. The Leadership Programme proposal and tender will come to the same meeting. 2. Operational People Group: Terms of Reference and financial limits are under review; findings will return to SLT on 30 September 2025. 3. Microsoft Co-Pilot roll-out: Launch scheduled for August 2025, with strong SLT support for leveraging AI to accelerate digital transformation. 4. Statutory/mandatory training uptake has slightly improved following recent action plans, as 121 meetings with CEO and Deputy CEO continue with SLT members. 5. Work to review Terms of Reference for the Operational Workforce Group to ensure decisions are delegated wherever possible and financial limits for operational groups to also be reviewed.
Positive Assurances to Provide	**Decisions Made**
1. Workforce dashboards are now live providing managers with up-to-date data on statutory/mandatory training and staff appraisals. 2. Microsoft Co-Pilot roll-out is on track to enhance efficiency, with progress noted in digital submissions. 3. Whistleblowing guidance is now live, staff are able to report via Datix system.	1. Employee Assistance refreshed Programme proposal approved. 2. The following policies were approved for onward assurance to Staff Governance Committee • NHS Orkney Organisational Change Policy • Recruitment and Selection Policy • Safety-related policies • Manual Handling policy- refresh

	3. Behavioural Standards Framework approved for onward submission to the Board on 28 August 2025 4. Sale of King Street approved for onward approval by the Board on 28 August 2025.
Feedback about meeting: - It was noted that some members were quiet in the meeting and did not contribute. - This was the last meeting the CEO will Chair and asked SLT to keep going, keep supporting each other and continuing to focus on delivery and doing what is right for our community, patients and staff.	

NHS Orkney

Item 11.4.2

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

Title of Report:	Chair's Assurance report from the Senior Leadership Team	**Date of Meeting: 11 September 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	Tammy Sharp, Director of Performance and Transformation	
Presented By:	James Goodyear, CEO	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **11 September 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concerns or key risks to escalate to the Board.	1. Risk Management Group to review the wording related to the risk of insufficient training budget for non-essential training to clarify and define what constitutes "essential training."
Positive Assurances to Provide	**Decisions Made**
1. Positive assurance provided that the process of reviewing and updating all outdated policies and procedures is progressing as planned – completion end of Quarter 3 2025/26.	1. Lack of project management capacity and capability risk approved for adding to the Corporate Risk Register 2. Lack of Strategic Clinical Leadership and Engagement Capacity risk approved for adding to the Corporate Risk Register 3. Public Health Annual Report 2024/25 approved for onward submission to JCCGC and Board in October 2025. 4. Quarter 1 Safety, Quality and Experience report approved for onward assurance to Joint Clinical and Care Governance Committee and October Board 2025. 5. An overspill car park to be created in the area behind the CSB next to the Poly tunnels. 6. Procurement Annual Report 2024/25 approved for onward assurance to Finance and Performance Committee 23 September 2025 for publication.
Feedback about meeting: -	

NHS Orkney

Item 11.4.3

Senior Leadership Team (SLT) People and Potential Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report from the Senior Leadership Team (People and Potential)	**Date of Meeting: 30 September 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	James Goodyear, CEO	
Presented By:	James Goodyear, CEO	

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **30 September 2025**.

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. No matters of concerns or key risks to escalate to the Board.	1. The Senior Leadership Team (SLT) agrees that we need to focus on fewer priorities and make our processes simpler. We now need to set aside time to make these changes, and the SLT will discuss and decide how to move forward. 2. For the MORSE Community Electronic Patient Record project, each team needs to confirm the time and resources required, the costs involved and agree on a timeline with NHS Grampian. These details will be reviewed by the Digital Information Operations Group and reported back to SLT 28 October 2025.
Positive Assurances to Provide	**Decisions Made**
1. We value our excellent staff, and the Senior Leadership Team knows that working closely with them is key to tackling our financial challenges.	1. Social Media policy approved subject to referencing the need for registrants to adhere to professional standards social media policy 2. MORSE (Community Electronic Patient Record) Project Initiation Document approved.

Feedback about meeting:

- The CEO asked members to think about whether one meeting each month should be held in person.
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Item 11.4.4

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

Title of Report:	Chair's Assurance report from the Senior Leadership Team	**Date of Meeting: 7 October 2025**
Prepared By:	Debs Crohn, Interim Head of Corporate Governance	
Approved By:	James Goodyear, CEO	
Presented By:	James Goodyear, CEO	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Senior Leadership Team at its meeting on **7 October 2025**.		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Our month 5 financial position remains £197k adverse to our financial plan. A review of our financial governance is underway this will return to Finance and Performance Committee in November 2025.	1. Staff will receive communications about the Clinical Supervision and Midwifery Framework rollout, highlighting its role in staff wellbeing, available remote supervision options, and its importance for professional registration following approval by the Senior Leadership Team. 2. A workshop will be taking place in the next couple weeks with the Executive team led by the Interim Head of Corporate Governance to look at simplifying our operational governance. A discussion paper will be brought back to SLT in November 2025 for consideration.
Positive Assurances to Provide	**Decisions Made**
1. We are one of the first Board's tin Scotland to use Statistical Process Control charts as part of our Integrated Performance Report. 2. Good progress continues in relation to ensuring that 0 patients are waiting over 52 weeks by 31 March 2026.	1. Risk C2024-09 (Island Games) approved for closure. 2. Integrated Performance Report was approved for onward assurance to the Board. 3. EV Infrastructure charging proposal approved 4. Clinical Supervision for Nursing and Midwifery Framework approved noting we are the first Board in Scotland to implement the framework. 5. Proposal for pharmacy on call rota approved, with further work required to agree how this will be implemented.
Feedback about meeting: -	

Chair's Assurance Report Area Clinical Forum

Title of Report:	**Chair's Assurance report Area Clinical Forum**	**Date of Meeting: 08/10/2025**
Prepared By:	Dr. Kirsty Cole	
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 on 8th October 2025		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Chair reported that the National Area Clinical Forum Chair's group has asked that clarity is provided on the responsibilities of Boards relating to support of their clinical advisory groups. Whilst the Blue Print for Good Governance and the National Health Services (Scotland) Act 1978 make clear reference to this, this is not reflected in practice including in Orkney with variation across the Health Boards. This risks our clinical advisory groups feeling undervalued. • The Dental and Hospital Sub Groups are currently not formally meeting until support arrangements can be agreed with the health board. • Primary Care Improvement Plan proposals have not yet been submitted to the GPSub Committee or the IJB with ongoing gaps in primary care physiotherapy, mental health services, community treatment and care services and pharmacotherapy services having an impact on General Practice across Orkney. The group acknowledged the strain on primary care services and the urgent need for solutions.	• Development session outcomes from 4 September 2025 were noted, highlighting the Forum's commitment to continuous professional development. • Ongoing work to resolve funding and workforce challenges in primary care. • Options for standing up of a discharge planning group to facilitate planning and preparation for patient discharge to the community to be explored by the Executive Director of Nursing, Midwifery, AHP's & Chief Officer Acute Services in collaboration with NAMAC and TRADAC colleagues.
Positive Assurances to Provide	**Decisions Made**
• NHS Orkney's new Whistleblowing Guideline was presented by the Head of Patient Safety Quality and Risk and was well received. • Medical Director presented the recommendations from the Clinical Services Review leading to robust discussion. • Vice Chair provided a verbal report following the ACF Ministerial Annual Review Session with committee members that were present feeling Scottish Government colleagues were interested and listened well.	• Discussion relating to the NHS Orkney Clinical Supervision for Nursing and Midwifery Framework Implementation Policy deferred to next meeting due to absence of presenter. • Attendance of Clinical Executives at Area Clinical Forum meetings agreed whilst allowing a section at the end of the meeting to progress without Executive colleagues present – it was felt that under some circumstances this may encourage more open discussion and sharing, with the Chair agreeing to feed the outcome of any such discussions to Executive colleagues as agreed by committee members.

Comments on Effectiveness of the Meeting

The meeting was conducted in a manner consistent with the Board's values of Openness, Honesty, Respect, and Kindness.

Staff Governance Committee Chair's Assurance Report to Board

Title of Report:	Chair's Assurance report to the Board	**Date of Meeting 18 September 2025**
Prepared By:	Hazel Aim, Senior Corporate Government Officer	
Approved By:	Joanna Kenny, Chair, Staff Governance Committee	
Presented By:	Joanna Kenny, Chair, Staff Governance Committee	
Purpose		
The report summarises the assurances received, approvals, recommendations and decisions made by the Staff Governance Committee at its meeting on **18 September 2025.**		

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. The Board are asked to note that the meeting was re-scheduled from 13 August 2025 due to not being quorate. As a result, papers brought to committee were out of date. 2. There is a risk that the lack of leadership capacity is impacting on operations and staff morale within several teams. There continues to be an increase in the number of staff absent from work due to mental health related sickness – a proactive intervention is now required and sickness absences has led to an increased workload for the Occupational Health Nurse Manager who is a single point of access. 3. Recruitment of consultants remains challenging; this work is being overseen by the Improving Together Programme. 4. Staff accommodation issues persist with some issues dating back several years. Committee asked that a minimum set of standards be put in place for landlords who wish to rent to accommodation to NHS Orkney.	1. Employee Director/Area Partnership Forum to work with People and Culture team to address inaccurate data in relation to Basic Life Support training – updated figures to be brought to next meeting. 2. Director of People and Culture to ensure the full Integrated Performance Report is presented at the next Committee meeting. 3. Committee requested ongoing assurance on the Whistle Blowing action plan progress. Head of Patient Safety, Quality and Risk to bring an update on delivery of the action plan to each committee. 4. Employee Director to identify a replacement staff side representative to sit on the Committee. 5. Executive Director of Nursing, Midwifery and AHP's (EDoNMAHP) to share iMatter report from Nursing and Midwifery/. 6. Leadership capacity and sickness absence management be added to the agenda for the next meeting and clearer mitigations be added to the risk register along with links to supporting documents.
Positive Assurances to Provide	**Decisions Made**
1. Committee welcomed a presentation from Nick Crohn (Radiology Manager) on reducing presentations at the Balfour Hospital during the Island Games. 2. Health and Safety Update report and revised up to date figures showed positive progress with manual handling compliance being notably improved.	1. Year 2 Quarter 1 Health and Care Staffing Act report approved for onward submission to Scottish Government.
Comments on Effectiveness of the Meeting	
• Committee welcomed the staff story at the start of the meeting. • As some papers were deferred due to the meeting being rescheduled, the meeting was planned for two hours instead of the usual three; it overran by 30 minutes	

NHS Orkney

Meeting:	**Board of NHS Orkney**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Community Planning (Orkney Partnership Board) Update.**
Responsible Executive/Non-Executive:	**Stephen Brown, Chief Officer, IJB.**
Report Author:	**Stephen Brown, Chief Officer, IJB**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operation Plan
- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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.

2.2 Background

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.

2.3 Assessment

Key Highlights from the 3 July 2025 meeting include:

Ellen Leaver, Scottish Government Place Director for Orkney, attended the meeting which was held at the Scottish Fire and Rescue Office, as part of her visit in July 2025.

The Board considered the Orkney Community Wealth Building Action Plan to consider the feedback from the consultation and the adoption of the revised Action Plan. Following discussion it was agreed to adopt the revised Action Plan.

The revised Orkney Community Planning Partnership logo and website was presented to the Board for views. Following discussion, it was agreed to adopt the shield logo design and develop a brand back with guidance for logo use.

The Population Health Framework for 2025 to 2035 was provided to Members for information noting that a full discussion would be undertaken at the next Board meeting.

NHS Orkney shared the Scottish Government and COSLA Health and Social Care Renewal Framework which the Board noted and considered next steps. It was noted that the Framework emphasises prevention, community based care and digital solutions. The Board discussed the need for a strategic needs assessment and the challenges of funding the transition.

A verbal updated was provided by the Chief Executive of the Council on the Public Sector Reform. It was noted that work would continue to explore how best to meet the aims of Public Sector Reform in Orkney to get best value for the Orkney community and to ensure involvement from all relevant parties to discussions.

The Board agreed a workshop on Community Safety should be set up later in the year which all relevant stakeholders to be identified and invited to participate.

Key Highlights from the 17 September 2025 meeting include:

A report was presented on Resourcing the CPP which included a Joint Resourcing of Community Planning Support and a verbal update on the Procedure to recruit new Community Planning Manager

NHS Orkney provided an Update on the Scottish Government and COSLA Population Health Framework 2025 – 2035.

A verbal updated was provided by the Chief Executive of the Council and the Interim Chief Executive of NHS Orkney on the Public Sector Reform.

The Board was presented the Orkney Community Planning Partnership's Annual Report for 2024/25 for approval.

The Chief Officer and Director of Education, Communities and Housing provided an update on the Joint Children's Services Plan and Child Poverty Strategy.

2.3.1 Quality/ Patient Care

Working together with partners should support quality services.

2.3.2 Workforce

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

2.3.3 Financial

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.

2.3.4 Risk Assessment/Management

There are no risk implications directly arising as a result of this report.

2.3.5 Equality and Diversity, including health inequalities

There are no equality or diversity implications directly arising as a result of this report.

2.3.6 Climate Change Sustainability

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.

2.3.7 Other impacts

While there are no other implications directly arising as a result of this report, the Orkney Partnership planned work includes work on sustainability.

2.3.7 Communication, involvement, engagement and consultation

NHS Orkney undertakes communication as part of the Orkney Partnership.

2.3.9 Route to the Meeting

This is a summary of the Orkney Partnership Board meeting.

2.4 Recommendation

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

3 List of appendices

Not applicable.

NHS Orkney

Meeting:	**Board of NHS Orkney**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Integration Joint Board Key Items and Discussion.**
Responsible Executive/Non-Executive:	**Stephen Brown, Chief Officer, IJB**
Report Author:	**Stephanie Johnston, Secretary to Chief Officer, IJB**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Orkney receives Directions from the Orkney Integration Joint Board in relation to a range of delegated services. There are three Non-Executive Directors of the NHS Orkney Board who are also voting members of the Integration Joint Board.

2.2 Background

Integration Joint Boards arose from the Public Bodies (Joint Working) (Scotland) Act 2014 which required integration of certain aspects of adult health and social services. As well as

prescribed functions that had to be delegated additional functions could be included and these are captured in the Integration Scheme.

Since the last report there have been four meetings of the Integration Joint Board with Special Meetings on 25 June 2025 and 25 September 2025 and normal meetings on 2 July 2025 and 3 September 2025.

2.3 Assessment

Key points from June 2025 Special meeting:

The June 2025 meeting was a Special one agenda item to approve the Annual Performance Report for submission to Scottish Government by the end of 30 June 2025. There is a requirement for a copy of the Annual Performance Report to be presented to both partner organisations thereafter. The Annual Performance Report is on the agenda for information as a separate agenda item.

Key Points from the July 2025 meeting include:

Members approved the Medium-Term Financial Plan 2025-28, pending some small amendments which have since been made and the Plan is available on the Integration Joint Board Finance webpages.

A paper was presented to the Board on Delayed Transfers of Care – System Pressure detailing the current circumstances and recommending establishing a Short Life Working Group to look to address current challenges. Following discussion, it was agreed that the Terms of Reference of the Group would be amended to reflect comments made.

The Integration Joint Board approved additional service of two posts following the Neurodevelopmental Provision report. A Direction has subsequently been issued to NHS Orkney for some sessions of an Associate Specialist Doctor for Children and Young People and creation of a Band 8B Psychology post.

The Integration Joint Board took assurance from the Orkney Alcohol and Drugs Partnership Annual return, which was submitted to Scottish Government on 4 June 2025.

The first Third Sector Commissioned Services Update was presented to Members which was compiled by the Third Sector Working Group. The report set out the key issues and opportunities and following comments at the Meeting, future reports will evolve to address questions asked.

Key Points from the September 2025 meeting include:

Members noted the appointments of the Chief Finance Officer, the Registered Medical Practitioner who is a GP, the Nurse Representative and the Registered Medical

Practitioner who is not a GP to the Board. Members also approved the Chief Officer to advertise for the vacant service user representative.

The Board scrutinised the Revenue Expenditure Outturn for the financial year 2024/25 noting the overspend position of £4.448 million, with 0.892 million overspend on NHS Orkney commissioned services and £3.556 million on Orkney Islands Council commissioned services. It was noted that the entirety of the NHS Orkney overspend can be attributed to the £2.4 million savings target.

It was agreed to defer the Revenue Expenditure Monitoring Report and Financial Recovery Plan to a Special meeting of the Integration Joint Board.

The Board considered the amended Risk Register which detailed the number of risks which were categorised as 'Very High', 'High', 'Medium' and 'Low' risk. Following discussion, it was agreed that further consideration of ensuring all risks contained in the Register were strategic and where necessary risks were amalgamated.

An update was provided on the Primary Care Improvement Plan which provided an overview of service status for 2024/25 in relation to the Vaccination Transformation Programme, Pharmacotherapy; Community Treatment and Care (CTAC), Community Link Practitioners, First Contact Physiotherapy and Mental Health Practitioners. The Board also noted the mitigation in the absence of service delivery and next steps for Primary Care Services.

Key Points from the September 2025 Special meeting:

The September 2025 Special meeting was a two-item agenda to consider the Revenue Expenditure Monitoring Report and the Financial Recovery Plan which was agreed to defer from the meeting on 3 September.

The Board considered the Revenue Expenditure Monitoring Report noting that the Board is currently showing an overspend position of £815k on delegated budgets and an overspend of £435k on Set Aside services. The Board also approved a Direction to be issued to NHS Orkney to disestablish the post of Head of Strategic Planning and Performance and utilising the recurrent budget to put towards the NHS Orkney savings target.

Following discussion on the Financial Recovery Plan, the Board agreed that further work was required on the Plan particularly in relation to enhancing the financial details of the proposed Plan.

2.3.1 Quality/ Patient Care

The Integration Joint Board aims to improve quality of care through joined up provision of services.

2.3.2 Workforce

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

2.3.3 Financial

There are no financial implications directly arising as a result of this report. There are close links between NHS Orkney's finance department and the Chief Officer and Chief Finance Officer.

2.3.4 Risk Assessment/Management

There are no risk implications directly arising as a result of this report.

2.3.5 Equality and Diversity, including health inequalities

There are no equality or diversity implications directly arising as a result of this report.

2.3.6 Climate Change Sustainability

There are no climate change implications directly arising as a result of this report.

2.3.7 Other impacts

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

2.3.7 Communication, involvement, engagement and consultation

The Integration Joint Board is a public meeting, where members of the public can attend in the viewing gallery at the Council Chamber or can listen to the audio casting of the meeting which is available for one year after the date of the meeting.

2.3.8 Route to the Meeting

This is a summary of the Integration Joint Board meeting key items and discussion.

2.4 Recommendation

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

3 List of appendices

Not Applicable.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**NHS Orkney — Public Health Annual Report 2024/25**
Responsible Executive/Non-Executive:	**Dr Anna Lamont, Medical Director**
Report Author:	**Elvira Garcia, Consultant in Public Health Medicine Hannah Casey, Public Health Manager Kirsti Jones, Advanced Health Protection Nurse Specialist**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Corporate Strategy 2024/28
- Annual Operational Plan
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Orkney Public Health Annual Report 2024/25 summarises key activities undertaken to improve population health and reduce inequalities. It highlights performance across health protection, immunisation, screening, mental wellbeing, and prevention programmes. The report was submitted to the Senior Leadership Team for consideration and endorsement ahead of its presentation to the Joint Clinical and Care Governance Committee and now to NHS Orkney Board.

2.2 Background

The Annual Report is the routine account of Public Health functions and performance across 2024/25. It draws on surveillance, published and service data, local programme activity and partnership work. It is intended for consideration to SLT and the Board and for public transparency. This year's report reflects NHS Orkney's continued commitment to improving health outcomes, addressing inequalities, and delivering high-quality services in a remote and rural context. The full Report is appended for the Board to review.

2.3 Assessment

- **Health inequalities remain a key challenge**: Life expectancy and health outcomes vary significantly across Orkney, with deprivation, geography, and gender contributing to unequal opportunities for good health.
- **Strong performance in immunisation and screening**: Uptake across most vaccination and screening programmes remains high, with Orkney often exceeding national averages. However, some age groups show early signs of decline, requiring targeted action.
- **Progress in prevention and wellbeing initiatives**: Public Health has delivered a wide range of programmes addressing early years, mental wellbeing, tobacco harm, healthy weight, and financial inclusion, with a focus on reducing inequalities.
- **Opportunities and risks**: Continued innovation and partnership working are strengths, but workforce capacity, IT transitions, and sustaining engagement in remote areas present ongoing risks to delivery.

2.3.1 Quality/ Patient Care

The report highlights improvements in vaccination uptake, screening performance, and outbreak management, all contributing positively to patient safety and quality of care. No negative impacts identified.

2.3.2 Workforce

Public Health initiatives support staff wellbeing through training, mental health awareness, and active travel schemes. However, workforce capacity remains a challenge in sustaining service delivery.

2.3.3 Financial

Preventative programmes and early intervention may reduce long-term service demand and associated costs. No significant capital impact: efficiencies are expected through digital systems and service redesign.

2.3.4 Risk Assessment/Management

Risks such as declining vaccine uptake in some groups, IT transitions, and service disruption are identified and mitigated through monitoring, partnership working, and contingency planning.

2.3.5 Equality and Diversity, including health inequalities

The report addresses health inequalities through targeted programmes, including financial inclusion, tobacco harm reduction, and rural access. It supports the Public Sector Equality Duty and Fairer Scotland Duty, with specific consideration of island and ferry-linked communities.

2.3.6 Climate Change Sustainability

Initiatives such as active travel promotion, eBike fleet, and sustainable procurement contribute positively to NHS Orkney's environmental goals and reduce carbon impact.

2.3.7 Digital

Transition to the new Child Health System and use of digital platforms (e.g. MyDesmond, TURAS Learn) support NHS Orkney's digitisation goals and improve service access and efficiency.

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders as set out in the accompanying report.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Senior Leadership Team, 11 September 2025
- Joint Clinical and Care Governance Committee, 1 October 2025.

2.4 Recommendations

- **Assurance –** NHS Orkney is undertaking its duties in relation to Public Health activities

3 List of appendices

The following appendices are included with this report:

- **Appendix 1,** NHS Orkney — Public Health Annual Report 2024/25

NHS Orkney - Public Health Annual Health Report

2024/25

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Supporting the population to maintain a healthy diet and engage in physical activity …….. 56

Engaging in secondary and tertiary ill health prevention …….. 60

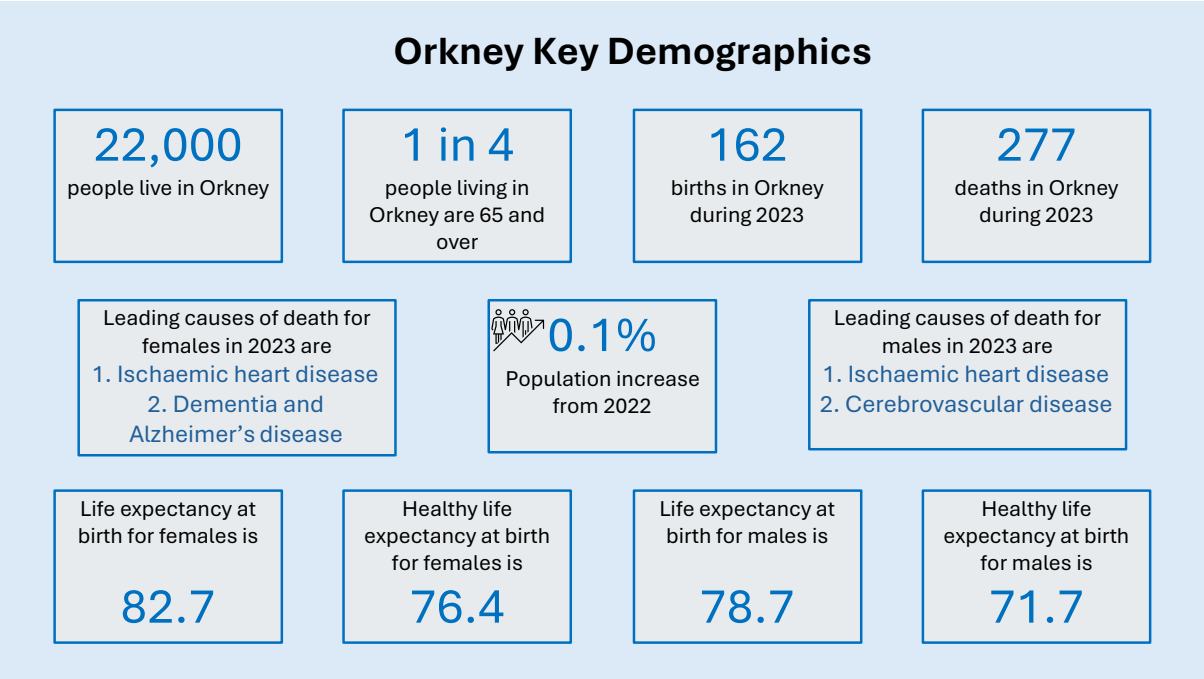
Introduction

The following report outlines some of the activities which the Public Health Team have undertaken during 2024/25 to improve and protect the health of the population and reduce health inequalities in Orkney. These are reported under the following actions:

- Increasing access to health protecting, promoting and sustainable places.
- Working towards every child having the best start in life.
- Promoting positive mental wellbeing.
- Increasing access to smoke free environment and reducing harm from alcohol and drugs.
- Supporting the development of a sustainable, inclusive economy in Orkney which ensures a health standard of living for all.
- Supporting the population to maintain a healthy diet and engage in physical activity.
- Engaging in secondary and tertiary ill health prevention.

Demographics

Orkney is the smallest Territorial Health Board area in Scotland, made up of 70 islands of which 20 are inhabited. In 2023, 22,000 people lived in Orkney. Orkney is mainly classified as a remote and rural location with 33.5% of the population living in areas classified as remote small towns[1]. In 2023, 25.4% of the population were 65 and over, compared to the Scottish average of 20.3%[2]. This increased representation of the older age range does, and will continue to, present challenges to our health and care system.



3, 4

There is a range of factors which impact health, from the physical environment to the social and economic factors affecting life. Health and care services are only one driver of health[5]. Health inequalities are the differences in people's health which can be driven by the opportunities they have to lead healthy lives. Opportunities for health can be influences by a combination of social factors, economic factors and geographical factors[6]. The Scottish Index of Multiple Deprivation (SIMD) can be used as a tool to understand the differences in outcomes, relating to health, between those living in areas with the highest levels of relative deprivation and those living in

[1] Scottish Government (2022) Scottish Government Urban Rural Classification 2020. 5. Classifying Other Geographies and Land Area calculations - Scottish Government Urban Rural Classification 2020 - gov.scot

[2] ScotPHO (2025) Population Profile, NHS Orkney - ScotPHO profiles

[3] NRS (2024) Orkney Islands Council Area Profile https://webarchive.nrscotland.gov.uk/20241128124632/https://www.nrscotland.gov.uk/files//statistics/council-area-data-sheets/orkney-islands-council-profile.html

[4] Health life expectancy – NRS (2022) Healthy life expectancy 2019-2022 https://www.nrscotland.gov.uk/publications/healthy-life-expectancy-2019-2021/#

[5] Scottish Government (2025) Population Health Framework 2025- 2035 Scotland's Population Health Framework 2025-2035

[6] The King's Fund (2022) What are health inequalities. What Are Health Inequalities? | The King's Fund

areas with the lowest relative deprivation, within Scotland, or within Orkney itself. Figure 1 demonstrates the different levels of deaths in under 75-year-olds in Orkney between those living in the areas with the highest levels of relative deprivation and those in the areas with the lowest levels. The difference is potentially attributable to inequality[2].

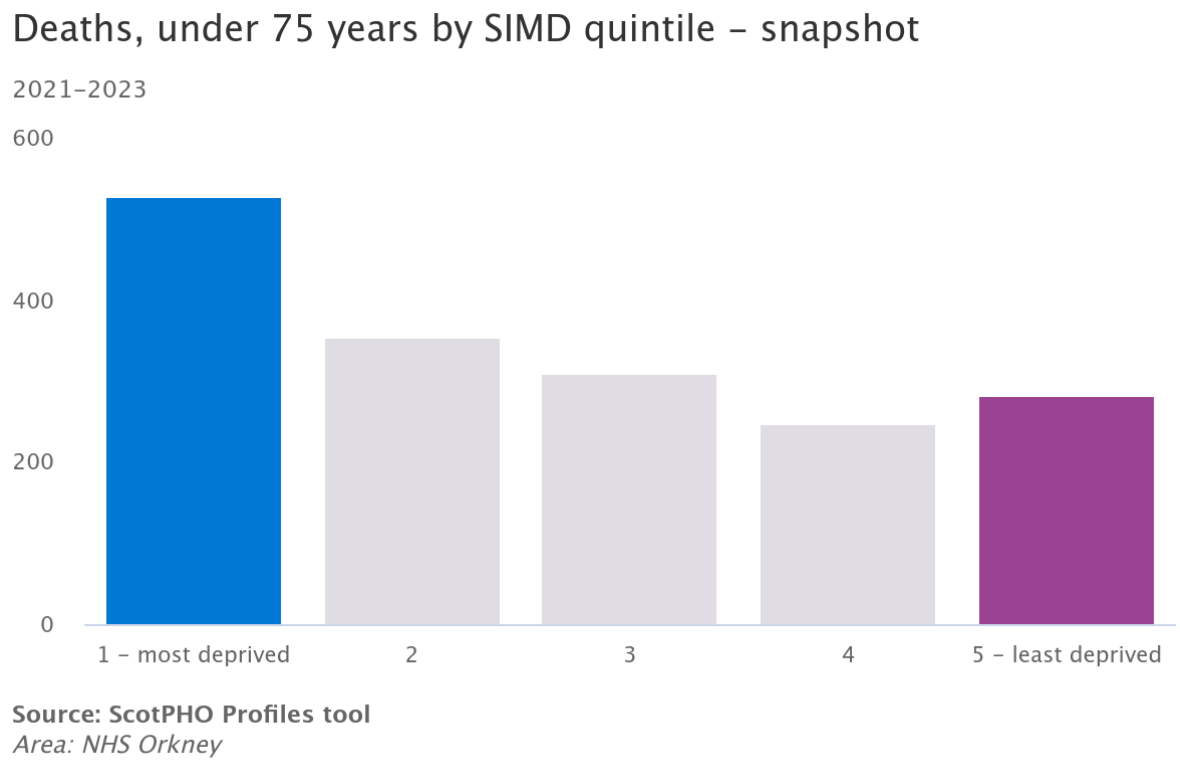


Figure 1: Deaths, under 75 years by SIMD quintile (Orkney)

In Orkney, the life expectancy for females (2021 to 2023) is 82.7 years. However, there is a gap of 4.6 years between the life expectancy for females living in the least deprived areas, and the females living in the most deprived areas (84.5 years and 79.9 years respectively). The life expectancy for males (2021 to 2023) is 78.7 years. However, there is a gap of 3.1 years between the life expectancy for males living in the least deprived areas, and the males living in the most deprived areas (79.7 years and 76.6 years respectively).

Socio-economic differences are not the only factors impacting health inequalities. For example, in Orkney, there are more female adults who are a healthy weight than male adults[2] (figure 2).

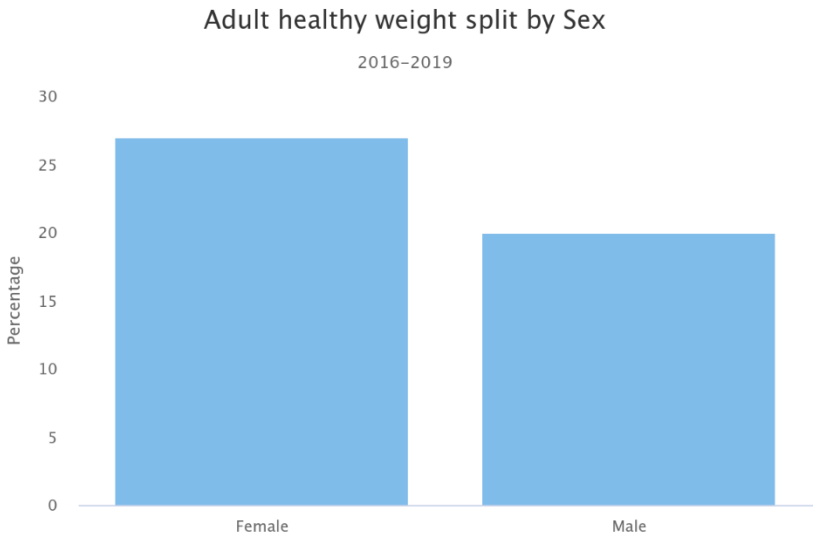


Figure 2: Adult healthy weight by sex (Orkney)

It is clear that, in order to improve the health of the population in Orkney, it is important to consider the health opportunities between groups of the population within Orkney as well as the overall population.

Increasing access to health protecting, promoting and sustainable places

Active Travel

A reduction in greenhouse gas emissions, and therefore improved air quality, can have a positive impact on health in itself. However, the benefits of active travel in relation to health are broad and can include increased levels of physical activity. This can have a particular benefit if there is an increase in physical activity levels for those not already meeting the current physical activity guidelines. The physical activity guidelines for adults are to achieve at least 2 hours and 30 mins of moderate intensity activity a week such as brisk walking or cycling or alternatively to engage in higher intensity physical activity. The advice is to minimise the amount of time spent being sedentary and, where possible, break up periods of not moving with light physical activity[7]. So, increased engagement in active travel can support people to achieve these guidelines or at least break up sedentary periods.

Even a small increase in physical activity can improve a person's health and quality of life. People who do engage in regular physical activity have lower risks of many conditions. This demonstrates the preventative impact that increased physical activity, which can be achieved through engaging in active travel, can have on the risk of developing significant health conditions. Significant health conditions which physical activity can reduce the risk of are arthritis, coronary heart disease and stroke, type 2 diabetes and certain cancers. Active travel can also support mental wellbeing through increasing both formal and informal social interaction as well as improving access to green spaces such as parks and blue spaces such as beaches. As well as improving general mood, regular physical activity can improve self-confidence, sleep quality, energy levels and stress levels[7].

However, the benefits from engaging with active travel may not be able to be realised across the whole population in Orkney particularly if we do not design places with groups who may find it more difficult to engage in active travel in mind.

On the 24th of June 2024, NHS Orkney Public Health Team supported the launch event for the 'Orkney Travel Matters' report published by Sustrans and Orkney Islands Council through presentation of the benefits of active travel in relation to health. This report reveals the result of research as to how residents in Orkney are currently travelling and what would help them to walk, wheel or cycle more. The report also outlines the impact of walking, wheeling and cycling in Orkney, as well as recent infrastructure developments and future plans. The report can be accessed online at Orkney Travel Matters 2023.

[7] Gov.uk (2019) Physical activity guidelines: adults and older adults. Physical activity guidelines: adults and older adults - GOV.UK

The Health Improvement Team at NHS Orkney has been actively involved in the development and implementation of an eBike fleet to support staff engagement with active travel. This initiative aligns with broader goals to promote physical activity and sustainable transport within the workplace. Extensive research was conducted to identify suitable insurance options that would allow staff to use the eBikes for both work-related and leisure purposes. In October 2024, appropriate insurance cover was successfully secured. Although the timing coincided with less favourable weather conditions, the coverage will enable full promotion of the eBike fleet during 2025.

A user guide PowerPoint presentation was developed by the Health Improvement Team to support staff in using the eBikes safely and effectively. Four eBikes were to be distributed to NHS Orkney Island locations, ensuring equitable access to active travel opportunities for staff across both mainland and island sites.

Following the funding received from Cycling UK to purchase the eBikes, a visit from a representative for Rural Connections at Cycling UK was scheduled to observe and support NHS Orkney's active travel initiatives. Due to unforeseen circumstance, the visit was postponed and is now expected to take place in 2025. Cycling UK are keen to support the promotion of physical activity and active travel within the NHS workplace. In 2025/26, the Health Improvement Team will monitor and evaluate staff usage and feedback to inform future developments.

MAP of Health Behaviour Change

The MAP (Motivation, Action, Prompts and Cues) of Health Behaviour Change learning programme was developed by NHS Education for Scotland[8]. MAP is designed to build the knowledge, skills and confidence of practitioners working in any service where a person's health and wellbeing could be enhanced by making changes to their behaviour. This supports our services in Orkney to engage in a health promoting focus within their interactions with the community. The learning programme equips learners with up to date, evidence-based, behaviour change techniques to effectively structure behaviour change conversations in a person-centred manner.

There are currently two MAP training programmes: the CORE MAP and the Healthy Beginnings MAP. CORE MAP is for practitioners working with adults, to support those adults themselves to make behaviour changes. Healthy Beginnings MAP is for practitioners working in Early Years services to develop skills in supporting families to make changes which will lead to positive health and wellbeing outcomes for their children.

[8] Behaviour Change for Health | NHS Education for Scotland

Three members of the Health Improvement Team are currently trained to deliver MAP. In 2024/25 the delivery of MAP in Orkney was focused on CORE MAP rather than Healthy Beginnings, due to the potential overlap with the HENRY programme which is also focused on Early Years. It was decided that retaining focus on engagement with HENRY should be prioritised for this staff group due to the additional benefits the HENRY programme could offer for this patient group. Over the year 2024/25 CORE MAP was delivered three times in Orkney. All three deliveries were arranged directly with specifically targeted participants. A total of 11 participants from roles within the NHS and community development attended CORE MAP in 2024/25.

Health Protection

Health protection is the area of public health that deals with external threats to health, such as infection and environmental issues to reduce the health impacts relating to these. It is vital for protecting the health of the population. It involves:

- Preventing the transmission of communicable diseases.
- Managing outbreaks and other incidents which threaten the public health.
- Ensuring the safety and quality of food, water, air, and the general environment.
- Immunisation Programmes.

To be effective, Health Protection is a multi-disciplinary activity. The NHS Orkney Health Protection Team (HPT) work with teams in Primary Care, Secondary Care Orkney Islands Council, Scottish Water, and other partner agencies to ensure that an integrated approach to the health of the public across Orkney is maintained.

Notifiable Infections

The HPT receive notifications for many notifiable diseases and organisms under the Public Health etc (Scotland) Act 2008. Notifiable diseases are any disease that is required by law to be reported to the health board. Most, but not all, notifiable diseases are infectious diseases. If a registered medical practitioner has a reasonable suspicion that a patient whom they are attending has a notifiable disease, they should not wait until laboratory confirmation of the suspected disease before notifying the health board. If a notifiable organism is identified by a laboratory, then the laboratory should notify the relevant HPT.

Diseases are notified so the health board is aware of where in the community significant diseases are being found. Having this information lets the HPT take steps to control the spread of infectious diseases and to protect the local community.

When compared to the 2023/24 data, increases have been seen in cases of Cryptosporidiosis, Giardiasis, Hepatitis C, Meningococcal Meningitis, Norovirus, Pertussis (Whooping Cough) and Seasonal Influenza (Table 1). When comparing with 2022/23 data, only Cryptosporidiosis, Hepatitis C, Pertussis and Seasonal Influenza show an increase in numbers.

Table 1: Number of notifications of infectious diseases/organisms reported by financial year (Source: NHS Orkney HP Zone clinical system)

Diagnosis	Case Numbers by year		
	2022-2023	2023-2024	2024-2025
Acute Hepatitis E	0	0	*
Campylobacteriosis	34	31	30
Clostridium difficile associated disease (CDAD)	*	7	5
Cryptosporidiosis	*	*	11
E.coli infection (non STEC)	35	33	17
E. coli STEC (Shiga toxin-producing Escherichia coli)	*	*	*
Giardiasis	0	0	*
Hepatitis B	*	*	0
Hepatitis C	0	0	*
iGAS (Invasive Group A Streptococcal Disease)	*	*	*
Legionnaires Disease	0	0	0
Listeriosis	0	0	0
Mpox	*	0	0
Measles	0	0	0
Meningococcal Meningitis	*	0	*
Mumps	0	0	0
Neisseria meningitidis	0	0	0
Norovirus	87	*	54

Mycobacterium (Non Tuberculous)	*	*	0
Pertussis	0	0	17
Respiratory syncytial virus	*	*	10
Salmonellosis	*	*	*
Scabies	0	*	0
Seasonal Influenza	30	16	52
Tuberculosis	*	*	0
Total	**211**	**100**	**196**

** denotes fewer than 5.*

Influenza

The incidence of influenza reported nationally by PHS moved from moderate to high during week 49 of 2024 and reached extraordinary levels in week 50. The case rate was three times that of the same period the previous year, when cases did not rise above moderate levels across the full season. Continuing through the 2024/25 period, levels decreased again sharply, dropping to high in week 2 of 2025 and continued to decrease over the first quarter, being reported as low in week 14 (week ending 6th April 2025). Baseline levels were reached in week 17 (week ending 27 April 2025). Influenza A was the predominant circulating type nationally, and within NHS Orkney.

Across NHS Orkney, 51 cases of Influenza A were noted during the reporting period – this is just over three times the 2023/2024 figures, and comparable with the national case rate increase. All but one (which was reported in September 2024) occurred between week 51 of 2024 and week 7 of 2025, in line with the heightened national levels over the winter period.

COVID-19

Asymptomatic health and social care testing ceased in health and social care settings on 3rd June 2024, with a pause having been in place since the 28th of September 2022. The number of reported positive cases of COVID-19 was low (Table 2). NHS Orkney HPT only monitor reported case numbers in the general population but continued to support care homes in their management of cases.

Table 2: *General population confirmed covid-19 cases reported to NHS Orkney Public Health team for the defined period against (in brackets) those linked to care homes. (Source: NHS Orkney HP Zone clinical system)*

COVID-19 CASES	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023-2024 (care home linked cases)	16 (3)	13 (5)	10 (1)	7 (1)	9 (6)	6 (1)	14	6	4	4	6	1	**96 (17)**
2024-2025 (care home linked cases)	1	0	11*	9 (3)	3	0	0	0	0	1 (1)	0	0	**25 (4)**

**7 of these were linked to a cluster amongst hospital inpatients*

Outbreaks

Since April 2024, there have been six outbreaks of infection in Orkney care homes which have been managed by the HPT. A breakdown can be seen in Table 3, but a summary follows.

Four outbreaks were of a respiratory nature. There was a total of 48 cases and included 5 associated deaths* (included in the table below). The outbreaks lasted between 17 and 48 days. As per current guidance, outbreaks were declared over only once a period of time equivalent to two incubation periods specific to the source pathogen had passed with no further transmission observed. COVID-19 outbreaks within the care homes remained low, with only a single outbreak and 3 associated cases for the 2024/25 reporting period. It is noted that the times of greatest resident cases link to periods when previous vaccination doses may be waning.

There were two gastrointestinal outbreaks over 2024/25, with a total of 46 cases. These lasted nine and 12 days.

Table 3: total care home confirmed case numbers, for 2024/25, by infection (Source: NHS Orkney HP Zone clinical system)

2024/25	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Covid	-	-	-	3	-	-	-	-	-	-	-	-	**-**
RSV	-	-	-	-	-	-	-	-	2	-	-	-	**-**
Influenza A	-	-	-	-	-	-	-	-	-	36*	7	-	**-**
Norovirus	-	-	-	-	-	-	-	-	-	-	11	-	**-**
Gastroenteritis (unconfirmed pathogen)	-	-	-	-	-	-	-	-	-	-	-	35	**-**

The HPT work closely with the Infection Prevention Team (IPT), particularly during periods of outbreak, to ensure all mitigation measures have been correctly applied and appropriate procedures are being followed.

In the reporting period, there have been two recorded outbreaks of gastrointestinal infection in educational settings. Education staff were supported by the HPT to manage these situations appropriately.

The HPT is routinely represented at Collaborative Care Home Support Team (CCHST) meetings, which are scheduled fortnightly, and include representatives from the IPT, individual care homes, local authority, 3rd sector partners, pharmacy, primary care and the Care Inspectorate.

Adult Immunisation Programmes

The COVID-19 vaccination programme commenced at the end of 2020 in line with advice from the Joint Committee on Vaccination and Immunisation (JCVI) focussing on the protection of health and social care staff and systems. The main aim of the COVID-19 Programme remains the prevention of severe illness, hospitalisations and deaths in those most at risk. However, 2024 saw the beginning of a transition from pandemic response to that of routine immunisation.

2024 Spring COVID-19 Booster Vaccination Programme

Following advice from the JCVI, an additional spring booster dose of COVID-19 was offered to certain high-priority groups which were considered at higher risk of serious illness, boosting their protection. The Spring Vaccination COVID-19 Programme ran from 01 April to 30 June 2024. The JCVI advised that a COVID-19 vaccine dose was to be offered to a limited number of individuals.

Appointment letters, emails, or texts were sent to the majority of individuals eligible for vaccination in Orkney, with the exception of residents in care homes for older adults, who received the vaccine in that setting.

The response to the COVID-19 Spring vaccination programme across Orkney in 2023 and 2024 was good, with a slight decrease in 2024 in line with the Scottish population, but resulting generally in uptake higher than in the Scottish population. The percentage uptake of Spring COVID-19 vaccinations in eligible groups in Orkney and Scotland can be seen in Table 4.

*Table 4: COVID-19 Spring vaccination surveillance uptake rates (surveillance view), as a percentage, for Orkney and Scotland. (Source: PHS vaccination annual report and *Discovery 28/08/2025)*

Uptake COVID-19 (Spring)	2023		2024	
	Orkney	Scotland	*Orkney	Scotland
Older People Care Home Residents	93.8	90.9	83.3	81.6
Aged 75+ years	84.1	82.7	75.3	72.9
Severely Weakened Immune System	59.4	60.2	n/a	n/a
Weakened Immune System	59.7	57.7	59.6	45.7
Aged 6 months to 4 years + and weakened immune system	n/a	n/a	25.0	6.9
Total Eligible	**78.4**	**76.6**	**71.2**	**65.2**

**Please note this data is unpublished and therefore is subject to change*

2024/25 Autumn/Winter Vaccination Programme

The Autumn/Winter Vaccination (COVID-19 and Influenza) Programme commenced in Orkney in September 2023. Appointment letters, emails or texts were sent to the majority of individuals eligible for vaccination in Orkney, with the exception of those residents in care homes for the older adults, who received the vaccine in this setting. Drop-in sessions were available until the end of the campaign on 31 March 2024.

In line with the JCVI advice to maximise protection in those most vulnerable to serious illness, COVID-19 vaccines have only been offered to certain priority groups from 25 August 2023.

The response to the COVID-19 vaccination programme across Orkney during the Autumn/Winter Season 2024/25 decreased when compared with the previous season, in line with the trend observed in Scotland. Most COVID-19 uptake rates were above the Scottish average, with NHS Orkney being again the Board with the highest uptake in adults in Scotland.

Table 5 provides data on the COVID-19 Winter vaccination uptake in Orkney and Scotland.

*Table 5: COVID-19 Autumn-Winter vaccination uptake rates (surveillance view), as a percentage, for Orkney and Scotland. (Source: PHS vaccination annual report and *Discovery 28/08/2025)*

Uptake COVID-19 (Autumn-Winter)	2023/24		*2024/25	
	Orkney	Scotland	Orkney	Scotland
Older People Care Home Residents	87.1	85.6	86.3	81.5
Aged 75+ years	84.3	84.1	78.2	76.6
Aged 65+ years	n/a	n/a	n/a	n/a
Aged 65-74 years	78.4	74.7	71.4	63.4
At risk aged 18 to 64 years	n/a	n/a	44.0	27.6
At risk aged 12 to 64 years	52.7	36.8	n/a	n/a
At risk aged 12 to 17 years	n/a	n/a	22.9	7.3
At risk aged 5 to 11 years	8.1	6.9	12.9	6.0
At risk aged 6 months to 4 years	14.3	5.1	19.4	6.3
At risk aged 6 months to 64 years	n/a	n/a	n/a	n/a
Weakened Immune System	70.1	59.4	58.6	47.0
Frontline Health Care Workers	42.3	35.1	28.4	23.5
All Social Care Workers	26.7	20.1	15.6	11.7
Total Eligible	**66.3**	**56.6**	**58.7**	**47.4**

**Please note this data is unpublished and therefore is subject to change*

Seasonal Influenza Immunisation Programme

The influenza immunisation programme in winter is delivered to provide protection for those at risk of infection with seasonal flu viruses, building on the success of the previous year's programme to prevent ill health, and minimise further impact on the NHS and social care services.

From 2013, the childhood influenza vaccination programme has been offered to preschool children, primary school children and children aged 6 months to two years of age in clinical risk groups. From the 2021/22 season, the JCVI recommended to further extend the childhood influenza vaccination programme to include secondary school pupils.

Other groups were offered influenza vaccination during the 2021/22 to 2023/24 seasons, such as frontline staff working in social care, education or custodial institutions.

The response to the influenza vaccination programme across Orkney during the Autumn- Winter Season 2023/24 decreased when compared with the previous

season, in line with the trend observed in Scotland. Most flu uptake rates were above the Scottish average, with NHS Orkney being again the Board with the highest uptake in adults in Scotland. The percentage uptake of flu vaccinations in different eligible groups can be seen in Table 6.

*Table 6: Influenza Autumn-Winter vaccination uptake rates (surveillance view), as a percentage, for Orkney and Scotland. (Source: PHS vaccination annual report and *Discovery 18/11/2024 and 28/08/2025)*

Uptake Influenza Vaccine (Autumn-Winter)	**2023/24**		***2024/25**	
	Orkney	**Scotland**	**Orkney**	**Scotland**
Residents in older adult care homes	88.2	86.3	89.7	83.8
Aged 75+ years	84.1	84.7	82.2	80.6
Aged 65+ years	n/a	n/a	78.3	74.1
Aged 65-74 years	78.9	75.7	74.7	68.7
Aged 50-64 years	58.5	42.7	n/a	n/a
At risk aged 18 to 64 years	58.5	42.2	52.7	34.6
At risk aged 18 to 64 years (flu only)	40.4	26.6	n/a	n/a
Weakened Immune System	73.5	64.1	73.7	61.0
All Health Care Workers	55.3	42.2	44.4	35.9
All Social Care Workers	35.1	25.9	23.7	17.2
Total Adult Flu	**65.0**	**53.7**	**64.2**	**53.2**
At risk aged 6 months to 2 years	50.0	39.8	40.7	37.5
Pre-school (2-5 years)	57.1	48.8	58.6	50.3
Primary School	73.4	69.0	73.7	68.1
Secondary School (under 18 years)	51.6	52.9	52.4	53.1
Total Children Flu	**61.9**	**59.3**	**62.6**	**59.2**

**Please note this data is unpublished and therefore is subject to change*

Pneumococcal Immunisation Programme

The pneumococcal vaccine provides protection against pneumococcal infections which may result in life-threatening invasive disease, such as pneumonia, meningitis,

and septicaemia. The pneumococcal vaccine is recommended for all people aged 65 years and over, and people aged 2 to 64 years old who are at higher risk of developing complications from a pneumococcal infection. A full list of those eligible for the pneumococcal vaccine is available on NHS inform. There is also a routine infant programme for babies from age 12 weeks.

Uptake is the proportion of eligible individuals who received a vaccine during a specific time period, excluding those previously vaccinated. Coverage is the proportion of eligible individuals who have been vaccinated up to a specific date, regardless of when they received the vaccine. This represents a snapshot at a single point in time.

Vaccine uptake and coverage data for pneumococcal vaccination are available in Tables 7 and 8. Uptake is the proportion of eligible individuals who received a vaccine during a specific time period, excluding those previously vaccinated. Coverage is the proportion of eligible individuals who have been vaccinated up to a specific date, regardless of when they received the vaccine (this represents a snapshot at a single point in time). The uptake and coverage in Orkney is generally slightly worse than in Scotland, with the best level of protection seen in adults aged 65 and over.

*Table 7: Pneumococcal Vaccination Uptake, as a percentage, for Orkney and Scotland. (Source: *Discovery 28/08/2025)*

Pneumococcal Vaccination Uptake	**2023/24**		***2024/25**	
	Orkney	**Scotland**	**Orkney**	**Scotland**
At risk aged 2 to 64 years	34.4	15.1	14.5	21.4
Aged 65+ years	13.7	17.2	12.6	16.1
Pneumococcal every 5 years	14.4	16.2	6.8	14.5
TOTAL	**21.0**	**16.3**	**13.2**	**18.3**

**Please note this data is unpublished and therefore is subject to change.*

*Table 8: Pneumococcal Vaccination Coverage, as a percentage, for Orkney and Scotland. (Source: *Discovery 28/08/2025)*

Pneumococcal Vaccination Coverage	**On 31/03/2025**	
	Orkney	**Scotland**
At risk aged 2 to 64 years	54.3	55.5
Aged 65+ years	72.6	77.4
Pneumococcal every 5 years	34.1	31.4
TOTAL	**68.6**	**71.2**

**Please note this data is unpublished and therefore is subject to change.*

Herpes Zoster (Shingles) Immunisation Programme

The Herpes Zoster Immunisation Programme started in 2013. The shingles vaccine can reduce the risk of getting shingles and the risk of complications. The main complication from shingles is post-hepatic neuralgia, a neuropathic pain that can persist for months or years and the risk and severity increase with age.

The shingles vaccination programme runs from 1st September to 31 August. Appointments are being offered to eligible individuals. Referrals from clinicians are also being received.

One dose of Zostavax, a live shingles vaccine, was previously routinely offered to those eligible and not contraindicated. In September 2021, Shingrix, a non-live shingles vaccine, was made available to immunocompromised individuals aged 70 to 79 years, who were contraindicated to receive Zostavax, as part of the NHS shingles vaccination programme.

Since 1 September 2023, all newly eligible individuals have been offered the non-live shingles vaccine Shingrix, which has a two-dose schedule vaccine. Zostavax is no longer being used. The shingles vaccine is now recommended for the following groups:

- People aged 65 on or after 1 September 2023 (those who turned 65 prior to that date will be eligible when they turn 70).
- People aged 70 to 79 who have not previously had the vaccine.
- People aged 50 and over with a severely weakened immune system or about to start immunosuppressive therapy.

The latest Zostavax uptake figures are from the 2021/22 campaign and showed the following rates in Orkney: 51.7% for those age 70 years (Scottish average 45.1%) and 73.3% for the catch-up cohort, aged 71-79 years (Scottish average 63.08%).

Tables 9, 10 and 11, provide uptake and coverage data of Shingrix vaccination. It should be noted that the eligible individuals aged 71-79 years in 2024/25 have been offered shingles vaccination previously, and this is the reason why their uptake is low but their coverage is high. The Orkney uptake rates are generally lower than in Scotland, but the coverage, indicating the percentage of eligible population that is protected, is higher, indicating that a larger proportion of eligible individuals were vaccinated in Orkney in previous years than in Scotland.

*Table 9: Shingrix (Shingles) Vaccination Dose 1 uptake rates, as a percentage, for Orkney and Scotland. (Source: * Discovery 28/08/2025)*

Shingrix (Shingles) Vaccination Dose 1 Uptake	**2024/25**	
	Orkney	**Scotland**
Severely weakened immune system	n/a	n/a
Over 50 severely weakened immune system	31.9	26.1
Aged 65 years	53.4	60.2
Aged 66 years	5.2	13.8
Aged 70 years	56.3	67.8
Aged 71-79 years	8.6	7.9
TOTAL	**29.9**	**35.5**

**Please note this data is unpublished and therefore is subject to change.*

*Table 10: Shingrix (Shingles) Vaccination Dose 2 uptake rates, as a percentage, for Orkney and Scotland. (Source: * Discovery 28/08/2025)*

Shingrix (Shingles) Vaccination Dose 1 Uptake	**2024/25**	
	Orkney	**Scotland**
Severely weakened immune system	n/a	n/a
Over 50 severely weakened immune system	80.0	58.1
Aged 65 years	94.1	76.1
Aged 66 years	59.3	61.9
Aged 70 years	92.2	82.4
Aged 71-79 years	74.7	64.0
TOTAL	**86.5**	**72.7**

**Please note this data is unpublished and therefore is subject to change.*

*Table 11: Shingles Vaccination Coverage, as a percentage, for Orkney and Scotland. (Source: * Discovery 28/08/2025)*

Shingles Vaccination Coverage 31/05/2024	**On 22/08/2025**	
	Orkney	**Scotland**
Severely weakened immune system	n/a	n/a
Over 50 severely weakened immune system	65.4	9.9
Aged 65 years	52.2	47.1
Aged 66 years	61.7	60.2
Aged 70 years	56.3	57.3
Aged 71-79 years	74.8	78.1

TOTAL	**68.3**	**69.0**

**Please note this data is unpublished and therefore is subject to change.*

Respiratory Syncytial Virus vaccine programme

Respiratory syncytial virus (RSV) is a major respiratory virus that is common over the winter period, typically November to February. While the symptoms are mild for many, RSV accounts for around 30,000 hospitalisations of children under 5 in the UK annually, and for 20 to 30 infant deaths.

RSV can also be severe in older adults, causing pneumonia and flare-ups of existing lung disease and other long-term conditions. It causes around 9,000 hospitalisations in those aged over 75 in the UK each year.

RSV vaccine began to be offered in Scotland from August 2024 to those turning 75 between 01/08/24 and 31/07/2025, and those already aged 75 – 79. It is also offered during pregnancy, regardless of age. Table 12 provides uptake of RSV vaccination across Orkney and Scotland.

*Table 12: RSV Vaccination Coverage from 21/08/2024, as a percentage, for Orkney and Scotland. (Source: *Discovery 28/08/2025)*

RSV Vaccination uptake 2024/25	Orkney	Scotland
Older adults total	75.0	70.7
Aged 75 – 79 years	75.1	70.8
Aged 75 – 79 years (resident in care home)	85.7	68.2
Turning age 75	74.4	70.0
Turning age 75 (resident in care home)	n/a	60.7
Pregnancy (delivered and ongoing)	60.3	46.6
TOTAL	**73.5**	**67.2**

**Please note this data is unpublished and therefore is subject to change.*

Vaccinations of individuals in the Sexual Health Nordhaven clinic

The HPV vaccine is available in Scotland for men who have sex with men (MSM) up to and including 45 years of age. The vaccination is offered to men who attend sexual health and HIV clinics. The HPV vaccination will help prevent infections that can cause genital warts and certain types of cancer.

Mpox is caused by a virus similar to the one that causes smallpox, so vaccines designed for smallpox are expected to prevent or reduce the severity of mpox.

The smallpox vaccine started to be offered to certain patients as part of the response to the 2022 outbreak of clade 2 mpox, which mainly affected gay, bisexual or other men who have sex with men (GBMSM). Scotland continues to offer mpox vaccination to those at greatest risk.

The vaccine is recommended for people whose sexual networks mean they are more likely to come into contact with mpox. These include:

- Gay or bisexual men who have sex with men, those who have multiple partners, those who take part in group sex, those who attend sex on premises venues, or those who have had a bacterial sexually transmitted infection such as chlamydia, gonorrhoea or syphilis in the past year.
- some trans and non-binary people who are in similar sexual networks to GBMSM.
- some healthcare workers in high-risk settings where they may care for a patient with mpox.

Gonorrhoea is a sexually transmitted infection caused by bacteria. If untreated, infection can lead to pain in the testicles, prostate and lower belly. It also can increase the risk of infertility and pregnancy complications. In rare cases, gonorrhoea can spread through the blood to cause infections in other parts of the body such as the skin, heart and joints.

Gonorrhoea is caused by bacteria closely related to the ones that cause meningococcal disease. Research has shown that the meningococcal B (MenB) vaccine may also help to protect against gonorrhoea.

From August 2025, the vaccine will be offered opportunistically in Orkney, and across Scotland, to gay, bisexual and other men who have sex with men (GBMSM) who are both:

- attending a sexual health clinic in Scotland
- assessed as being at increased risk of coming into contact with gonorrhoea

Sexual health clinics may also offer the vaccine to others that they assess as being at increased risk of coming into contact with gonorrhoea. This may include those involved in selling or exchanging sex without using condoms.

Sexual Health and Blood Borne Viruses (SH and BBV)

Orkney SH and BBV Network

The Orkney SH and BBV Network, chaired by the Consultant in Public Health Medicine, was established in January 2025. It includes partners such as the Nordhaven SH Clinic, the Orkney Drug and Alcohol Team (ODAT), Obstetrics, the SH Managed Care Network (MCN) Clinical Lead from NHS Grampian, Health Improvement, and the HIV Transmission Elimination (HIVTE) Champion.

The Network aims to ensure that NHS Orkney implements the actions from Scotland´s SH and BBV action plan and HIV Transmission Elimination Delivery Plan. It will expand its membership to include other relevant colleagues from the Orkney Islands Council and the Third Sector.

In 2025/26, the Orkney Sexual Health and Blood-Borne Virus Network will review SH and BBV services through a gap analysis against national standards[9] and the national Sexual Health and Blood-Borne Virus Action Plan (2023-2026)[10].

By the end of Q1 2025/ 26, areas for improvement will have been identified by the network, with a presentation of an Orkney SH and BBV Improvement plan by the end of Q2. This timetable recognises the already exemplary SH service provided by NHS Orkney and a lower prevalence of BBV compared to the rest of Scotland. Progress will be monitored through regular network meetings and reported to the Joint Clinical and Care Governance Committee.

This Improvement Plan will include actions aimed at improving outcomes, decreasing the incidence of sexually transmitted infections and unintended pregnancies. It will also seek to contribute to the reduction of transmission of viral hepatitis and human immunodeficiency virus in Orkney.

Current potential priority areas to be discussed by the Orkney SH and BBV network have been identified as:

- Data & Reporting
- Access & Engagement
- HIV Prevention
- Service Development

[9] Healthcare Improvement Scotland Sexual Health Standards. Available here: https://www.healthcareimprovementscotland.scot/publications/sexual-health-standards/
[10] Sexual health and blood-borne virus action plan: 2023 to 2026. Available here: https://www.gov.scot/publications/sexual-health-blood-borne-virus-action-plan-2023-2026/

Working towards every child having the best start in life

HENRY (Health, Exercise, Nutrition for the Really Young)

In 2024/25, delivery of the HENRY Right from the Start Programme commenced following the provision of Core Training and Facilitator Training in spring of 2024. Two 'Healthy Families Right From the Start' programmes have been delivered to parents and carers with children aged 1-5 years. Right from the Start is an eight-week programme, delivered to groups of up to eight attendees and is held online or in person. The programme has been designed by HENRY to support parents, carers and families of children aged 0-5 years make positive, healthy lifestyle choices. The techniques used also focus on enabling attendees to gain confidence and skills in communicating with both their children and their families to help achieve any adaptions in lifestyle they feel would be appropriate. Nine participants registered for the programme and six completed the full programme.

Four stand-alone HENRY workshops have also been successfully delivered, with 23 participants registering and 15 completing the sessions. The workshops are Fussy Eating, Let's Get Active, Starting Solids and Understanding Children's Behaviour. These stand-alone workshops appeal to parents and carers unable to commit to an eight-week programme and contain elements contained in the core programme. Workshops also serve as an introduction to the broader programme and encourage engagement. The workshops are delivered both online and in-person.

Throughout 2024/25, the Growing up in Orkney Resource continues to be shared with schools, community groups and within health care environments. This continues to support parents and carers concerned around healthy weight. The resource is now available online, through NHSO website, and is available for members of the public and professional services to access.

The HENRY programme is a new service. Therefore, to encourage engagement, reduce the risk of workshop cancellations, to strengthen awareness, and to create wider professional support, the HENRY team have attended eight local wellbeing and school events, in addition to tradition communication routes.

HENRY facilitators have recently completed further training for the HENRY Growing Up Programme that will allow them to support families with children aged 6-12. Delivery of this programme is scheduled to run in the first quarter of 2025/26.

Child Health System

The management of the Child Health System was transferred to Public Health from Primary Care in October 2017. The Child Health System comprises of multiple modules, CHI, SIRS, Pre-School and School. SIRS is the system that schedules and

records all childhood immunisations and where the administrators would record any new births (once registered with a CHI number) and bloodspot results. All Health Visitor records, for example first visit forms and pre-school vision screening clinics, are recorded through the Pre-School system. Finally, all school bases and school immunisation programmes are managed and recorded using the school system.

For many years, the Public Health Admin Team have been heavily involved in the national project transitioning the Child Health System to a new fit-for-purpose system. This project has faced lots of challenges and is due to go live in October 2025. In preparation, throughout 2024/25, the Public Health Administration Team, has attended multiple weekly meetings, carried out user acceptance testing (UAT) and increased internal audits and data testing. Included in this work is a review of working practices to ensure that services are efficient and as accurate as possible. Throughout the year, the team have continued to keep stakeholders updated with the progress. It is expected that there should be little to no impact to services.

Childhood Immunisation Programmes

Vaccination is one of the most cost-effective public health interventions to safeguard present and future health and wellbeing. Immunisation provides both direct individual protection to infectious diseases and indirect protection to the population, including those too young or too ill to be immunised, through herd immunity. The level of uptake at which herd immunity is achieved is the basis for national and international targets.

The high vaccination uptake rates across Scotland and in Orkney correlate with low numbers of outbreaks of vaccine preventable diseases. As uptake improves and vaccine preventable diseases become less common in the population, the need for vaccines appears less obvious and there is a risk that uptake declines and diseases re-emerge.

Vaccine Preventable Diseases

Vaccine-preventable diseases are those which are notifiable for surveillance purposes and for which a vaccine is available. In Orkney and across Scotland the prevalence of vaccine preventable diseases is low (Table 13).

***Table 13**: Vaccine Preventable Diseases (Sources: NHS Orkney HP Zone clinical system and Public Health Scotland)*

Vaccine Preventable Diseases cases	
COVID-19	The first case was seen in Orkney in March 2020. The World Health Organisation (WHO) declared on 5th May 2023 that COVID-19 was

	an established and ongoing health issue which no longer constituted a public health emergency of international concern. Global circulation of this virus continues.
Diphtheria	There have been no cases of confirmed diphtheria infection in Orkney since 2014.
Haemophilus influenzae	There have been no cases of confirmed invasive *H. influenzae* type b infection in Orkney since 2014
Hepatitis B	There have been fewer than 5 cases of confirmed Hepatitis B infection in Orkney since 2014
Human Papilloma Virus (HPV)	Surveillance has shown that the HPV vaccine has reduced the highest grade of cervical pre-cancer at age 20 by almost 90% in Scotland. A study published in January 2024 by Public Health Scotland (PHS), in collaboration with the Universities of Strathclyde and Edinburgh, found that no cervical cancer cases had been detected in fully vaccinated women following the HPV immunisation at age 12-13 since the programme started in Scotland in 2008.
Influenza	During 2022/23, there were high levels of influenza activity which were concentrated in a relatively short period, and relatively early within the typical seasonal range. There was a small reduction of cases in 2023/24. For the 2024/25 reporting period there was a sharp increase in cases, to extraordinary levels, between week 50 2024 and week 2 2025. Cases declined over quarter 1 2025 and were at low level by the end of week 14 2025.
Measles	There have been fewer than 5 confirmed measles cases in Orkney since 2014.
Meningococcal disease	There have been 5 confirmed cases in Orkney since 2014.
Mpox	Smallpox vaccination began being offered to protect individuals at high risk of mpox from 2022. There have been fewer than 5 confirmed cases in Orkney since 2022.
Mumps	There have been 11 cases of laboratory-confirmed mumps in Orkney, mostly in 2019/2020 with none since.
Pertussis (whooping cough)	There have been 25 confirmed cases of whooping cough in Orkney since 2019, with 9 of these in 2024/25.

Pneumococcal disease (13 serotypes)	There have been fewer than 5 cases of confirmed invasive pneumococcal infection in Orkney since 2014.
Poliomyelitis	There have been no cases of confirmed poliomyelitis infection in Orkney since 2014.
Rotavirus	Following the introduction of the immunisation programme in 2013 there has been a reduction in numbers of hospital admissions in children under 5 years, and numbers of GP consultations for gastrointestinal illness in infants under 1 year in Scotland. The number of reports of confirmed rotavirus in Scotland was 1283 in 2012, and 102 in 2021.
RSV (Respiratory Syncytial Virus)	RSV vaccination began being offered to pregnant women and individuals aged 75-79 from August 2024. There have been 10 cases in Orkney since that time – of these seven were not eligible for vaccination, and two eligible individuals had declined vaccination. The status of the tenth individual was not known.
Rubella	The last reported case of laboratory-confirmed rubella in Scotland was in 2017.
Varicella-zoster	Rates of admissions and GP consultations for shingles show higher rates in the more susceptible older age groups. There seems to be a slight decrease in admissions in Scotland since the introduction of shingles vaccine in 2013 in the cohorts of eligible individuals. Vaccination, against chickenpox for children is being considered nationally at the time of writing.
Tetanus	There have been no confirmed cases of tetanus in Orkney since 2014.
Tuberculosis (TB)	Incidence of TB in Orkney is lower than the Scottish average, with fewer than 5 confirmed cases since 2014.

Childhood Immunisation Schedule

The Routine Childhood Immunisation Schedule, in Scotland, is changing from 1st July 2025. Children continue to be protected against the same diseases, just with different timings and combinations than previously. Children born in Scotland can expect to have 10 injections and 2 oral vaccinations in their first year of life. By the time they reach the age of 18 they will have had 15 separate injections. These injections protect children from a number of potentially life-threatening illnesses including diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus*

influenzae type B (Hib), hepatitis B, pneumococcal disease, rotavirus, meningococcal type C (Meningitis C), meningococcal type B (Meningitis B) measles, mumps and rubella.

National consideration is also being given to offering children the varicella vaccination. This would be given at alongside MMR (becoming MMRV) at 12 and 18 months.

In addition to the core immunisation programmes targeted vaccination - Bacillus Calmette-Guérin (BCG) - vaccinations are offered to children in relevant at-risk groups.

The Vaccination Service took over responsibility for vaccinating babies from Heilendi, Skerryvore, Dounby, and Daisy Villa GP Practices in April 2023. Previously, the practices had dealt with appointment-setting, however, since the transfer of responsibility NHS Orkney has moved to using the national Scottish Immunisation and Recall System (SIRS) to make appointments and contact patients and their families.

Uptake rates for childhood immunisation programmes for the last three seasons (years ending 31st March 2023, 2024, and 2025) in Orkney and compared with the Scottish average are available in Table 13. The uptake rates for vaccinations in Orkney by 12 months have returned to a level comparable with that of 2022/23, following a slight decrease in 2023/24. This is a similar pattern to Scottish rates. Uptake rates by 24 months and 5 years tend to be higher than the Scottish average. Uptake rates by 6 years are higher than Scottish average.

***Table 13**: Childhood vaccination uptake rates for NHS Orkney and Scotland, as a percentage, by financial year.* (Source: Public Health Scotland (PHS))

Childhood Immunisations Uptake	**2022/23**		**2023/24**		**2024/25**	
	Orkney	**Scotland**	**Orkney**	**Scotland**	**Orkney**	**Scotland**
Uptake by 12 months						
6-in-1 primary course: diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B (DTaP/IPV/Hib/HepB)	97.7	95.5	95.7	94.8	97.2	94.5

Pneumoccocal (PVC) primary course	95.3	95.5	93.9	95.0	96.1	95.4
Rotavirus primary course	93.6	92.6	90.9	92.6	93.3	92.2
Meningococcal B (MenB) primary course	97.7	94.2	93.9	93.7	96.7	94.0
Uptake by 24 months						
6-in-1 primary course	98.9	96.5	98.3	96.2	95.3	95.8
Measles, mumps & rubella (MMR) 1	97.4	93.4	98.3	92.8	94.7	92.8
Hib/MenC	97.4	93.2	97.8	92.8	94.7	92.9
PCV Booster	96.3	93.0	97.2	92.7	94.1	92.7
MenB booster	96.8	96.6	97.2	92.1	94.7	92.4
Uptake by 5 years						
MMR 1	95.2	95.2	95.7	95.5	97.6	95.3
Hib/MenC	95.2	94.7	93.8	94.8	97.6	94.6
4 in 1 booster: diphtheria, tetanus, pertussis (whooping cough), polio	93.8	90.8	94.7	89.6	94.7	89.7
MMR2	93.3	90.2	93.8	89.2	94.2	89.2

Uptake by 6 years						
MMR 1	97.2	94.8	97.5	94.4	94.7	94.9
4 in 1 booster	95.8	92.5	97.0	91.1	94.2	90.9
MMR2	95.8	91.8	97.0	90.4	93.7	90.3

Further information on childhood immunisations can be found at: https://publichealthscotland.scot/publications/childhood-immunisation-statistics-scotland/childhood-immunisation-statistics-scotland-quarter-and-year-ending-31-march-2025/

In Scotland the annual uptake rates have shown gradual declines over the past 10 years across all routine immunisations. However, throughout this period uptake has remained high. In January-March 2025, uptake for children turning 12 months old by quarter was: Pneumococcal Conjugate Vaccine (95.8%), 6-in-1 (94.7%), MenB (94.5%) and Rotavirus (92.9%). Uptake of these children from 2015 to 2025 by quarter in Scotland is shown in Figure 3:

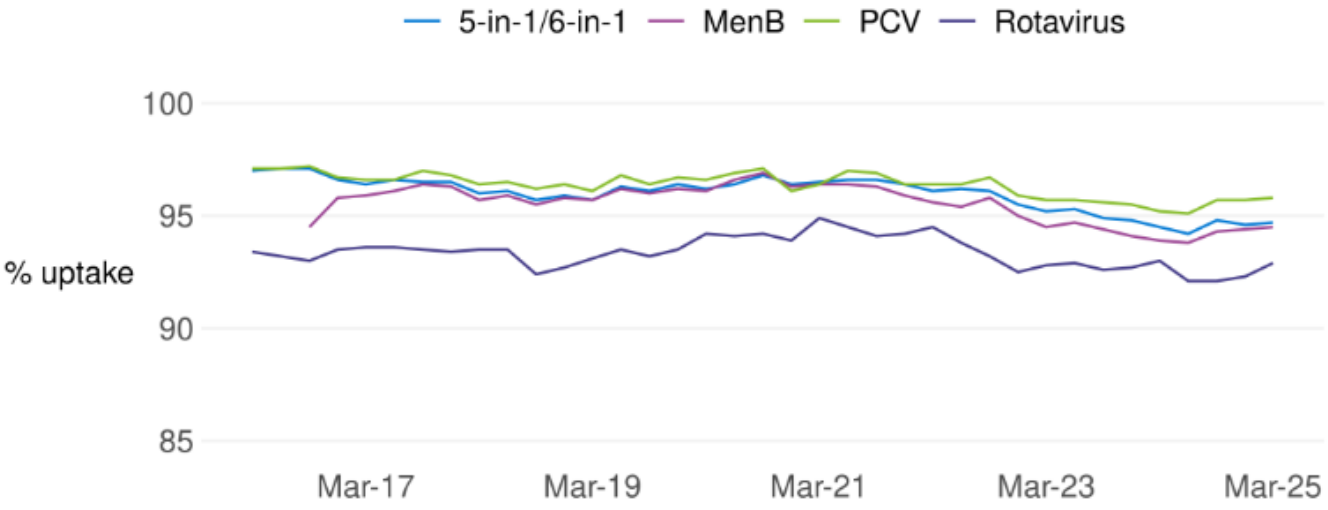


Figure 3: Trend in primary immunisation uptake rates of children in Scotland turning 12 months of age, by quarter, for the period 2015 to 2025. (Source: PHS childhood statistics report)

Data for up to one year of age

Table 14 shows the Orkney immunisation uptake rates by 12 months of age, with Table 15 providing the Scottish data. For local data there were issues with completion in the early 2010s for a number of vaccinations across a range of age groups. Performance in 2023/24 fell across the vaccine groups both nationally and locally compared with previous years. While the 2024/25 figures remained similar for Scotland, locally all vaccinations for this age group saw a rise in uptake.

Table 14: NHS Orkney primary immunisation uptake rate, as a percentage, at 12 months of age by financial year since 2010. (Source: PHS childhood statistics report))

Year	5-in-1/ 6-in-1	PCV	Rotavirus	MenB
2010/11	90.6	88.2	..	..
2011/12	89.5	89.5	..	..
2012/13	94.9	94.4	..	..
2013/14	96.7	95.7	..	..
2014/15	95.3	95.8	..	..
2015/16	88.9	89.4	87.3	..
2016/17	92.3	92.9	86.2	..
2017/18	97.0	97.0	95.0	96.5
2018/19	95.6	95.1	93.4	95.6
2019/20	94.5	94.5	89.9	93.5
2020/21	91.8	92.8	89.7	91.8
2021/22	97.8	97.3	96.8	96.8
2022/23	97.7	95.3	93.6	97.7
2023/24	95.7	93.9	90.9	93.9
2024/25	97.2	96.1	93.3	96.7

Table 15: NHS Scotland primary immunisation uptake rate, as a percentage, at 12 months of age by financial year since 2010. (Source: PHS childhood statistics report))

Year	5-in-1/ 6-in-1	PCV	Rotavirus	MenB
2010/11	97.0	97.0	..	..
2011/12	97.4	97.4	..	..
2012/13	97.4	97.4	..	..
2013/14	97.5	97.5	..	..
2014/15	97.4	97.4	..	..
2015/16	97.2	97.1	92.9	..
2016/17	96.8	96.8	93.1	..
2017/18	96.5	96.8	93.4	95.9
2018/19	95.8	96.3	92.7	95.4
2019/20	96.2	96.6	93.4	95.8
2020/21	96.5	97.1	94.2	96.3
2021/22	96.3	96.4	94.0	95.6
2022/23	95.5	95.5	92.6	94.2
2023/24	94.8	95.0	92.6	93.7
2024/25	94.5	95.4	92.2	94.0

Data for up to 2 years of age

Tables 16 and 17 show NHS Orkney and Scotland primary and booster uptake rates by 2 years of age since 2010. Locally, 2024/25 saw a decline in uptake rates for all vaccinations across age group. However, other than the 5-in-1/6-in-1, all remain higher than the Scottish rates.

Table 16: NHS Orkney primary and booster uptake rates, as a percentage, by 24 months of age by financial year. (Source: PHS childhood statistics report))

Primary course uptake %			Booster uptake %		
Year	5-in-1/ 6-in-1	MMR1	Hib/MenC	PCVB	MenB Booster
2010/11	99.5	94.5	91.7	93.1	..
2011/12	96.1	89.8	89.3	89.8	..

2012/13	95.7	92.8	92.8	92.3	..
2013/14	99.1	92.6	91.7	91.7	..
2014/15	99.1	94.4	93.4	93.4	..
2015/16	97.4	96.9	95.8	96.3	..
2016/17	94.1	90.4	90.4	90.9	..
2017/18	97.0	95.5	95.0	94.5	..
2018/19	97.0	96.5	96.5	93.5	93.0
2019/20	96.9	94.3	93.2	92.7	93.2
2020/21	93.2	92.7	92.7	92.2	92.7
2021/22	98.5	96.4	96.4	95.4	95.9
2022/23	98.9	97.4	97.4	96.3	96.8
2023/24	98.3	98.3	97.8	97.2	97.2
2024/25	95.3	94.7	94.7	94.1	94.7

Table 17: NHS Scotland primary and booster uptake rates, as a percentage, by 24 months of age by financial year. (Source: PHS childhood statistics report))

Year	Primary course uptake %		Booster uptake %		
	5-in-1/ 6-in-1	MMR1	Hib/MenC	PCVB	MenB Booster
2010/11	98.1	93.2	93.9	93.4	..
2011/12	98.1	94.3	95.3	94.5	..
2012/13	98.2	95.1	95.7	95.5	..
2013/14	98.2	95.6	95.7	95.5	..
2014/15	98.1	95.4	95.4	95.4	..
2015/16	97.9	95.4	95.4	95.3	..
2016/17	97.7	94.9	95.0	94.9	..
2017/18	97.6	94.6	94.9	94.8	..
2018/19	97.2	94.0	94.4	94.5	93.6

2019/20	96.9	94.0	94.3	94.4	93.6
2020/21	97.3	94.9	95.0	95.1	94.5
2021/22	97.1	94.4	94.3	94.3	93.9
2022/23	96.5	93.4	93.2	93.0	92.6
2023/24	96.2	92.8	92.8	92.7	92.1
2024/25	95.8	92.8	92.9	92.7	92.4

Data for up to 5 years of age

Tables 18 and 19 show the MMR and booster uptake rates by 5 years of age for NHS Orkney and NHS Scotland since 2014. Locally, all uptake rates for 2024/25 have improved over 2022/23 and 2023/24.

Table 18: NHS Orkney MMR and booster uptake rates, as a percentage, by 5 years of age by financial year. (Source: PHS childhood statistics report))

Year	MMR1	Hib/MenC	4-in-1	MMR2
2014/15	93.9	90.4	92.6	91.3
2015/16	93.7	92.3	88.3	87.4
2016/17	90.7	90.3	88.9	85.8
2017/18	96.3	94.1	95.9	95.4
2018/19	97.2	91.9	96.2	96.7
2019/20	98.0	96.0	96.0	96.0
2020/21	99.1	98.1	97.2	96.8
2021/22	97.6	97.6	96.7	96.2
2022/23	95.2	95.2	93.8	93.3
2023/24	95.7	93.8	94.7	93.8
2024/25	97.6	97.6	94.7	94.2

Table 19: NHS Scotland MMR and booster uptake rates, as a percentage, by 5 years of age by financial year. (Source: PHS childhood statistics report))

Year	MMR1	Hib/MenC	4-in-1	MMR2
2014/15	97.2	95.8	94.1	93.3
2015/16	97.1	96.2	93.7	93.1
2016/17	96.9	96.0	93.4	92.9
2017/18	96.9	96.1	92.7	92.1
2018/19	96.8	95.9	91.9	91.5
2019/20	96.7	95.9	91.9	91.5
2020/21	96.6	96.0	92.8	92.3
2021/22	96.0	95.6	92.7	92.2
2022/23	95.2	94.7	90.8	90.2
2023/24	95.5	94.8	89.6	89.2
2024/25	95.3	94.6	89.7	89.2

Data for up to 6 years of age

Tables 20 and 21 show the MMR and booster uptake rates by 6 years of age for NHS Orkney and Scotland. Local rates have shown a decline since last year in contrast to the national data, however in both 4-in-1 and the MMR booster, rates remain higher than the national figure.

Table 20: Uptake MMR and booster by 6 years of age, as a percentage, by financial year for NHS Orkney. (Source: PHS childhood statistics report))

Year	MMR1	4-in-1	MMR2
2010/11	94.8	..	92.7
2011/12	94.5	..	92.2
2012/13	95.2	..	89.2
2013/14	95.0	..	91.4
2014/15	96.3	92.5	90.5
2015/16	94.0	94.0	92.2

2016/17	94.1	89.6	89.2
2017/18	91.1	91.5	89.3
2018/19	96.9	96.0	95.1
2019/20	95.8	95.3	95.3
2020/21	96.1	94.1	94.1
2021/22	97.7	96.7	96.3
2022/23	97.2	95.8	95.8
2023/24	97.5	97.0	97.0
2024/25	94.7	94.2	93.7

Table 21: Uptake MMR and booster by 6 years of age, as a percentage, by financial year for NHS Scotland. (Source: PHS childhood statistics report))

Year	MMR1	4-in-1	MMR2
2010/11	96.0	..	92.8
2011/12	96.2	..	93.1
2012/13	96.5	..	93.3
2013/14	96.8	..	94.3
2014/15	96.9	95.5	94.6
2015/16	96.7	95.2	94.4
2016/17	96.4	94.9	94.2
2017/18	96.4	94.5	94.0
2018/19	96.4	93.8	93.3
2019/20	96.3	93.5	93.1
2020/21	96.5	93.9	93.4
2021/22	96.2	94.0	93.3
2022/23	94.8	92.5	91.8

2023/24	94.4	91.1	90.4
2024/25	95.0	90.9	90.4

Summary

Overall, the uptake of childhood vaccinations has remained relatively high in Orkney over the past year with a number of age groups showing increased uptake rates of vaccinations. The vaccination rates for those aged 24 months and those aged 6 years have dropped and particular focus should be placed on ensuring uptake for these groups improves.

HPV Vaccination and other Teenage boosters

Cervical cancer is the most common cancer in women under 35 years of age in Scotland and human papillomavirus (HPV) is the main risk factor. The HPV vaccine has been offered to girls in secondary schools since 2008. Following advice from the Joint Committee on Vaccination and Immunisation (JCVI) the programme was extended to adolescent boys during the 2019/20 academic year.

The vaccine helps to protect against the main cause of cervical cancer. Scotland is the only UK nation consistently hitting the 90% HPV vaccination target (in S4 girls), and its success is further demonstrated by research showing that, since HPV vaccination was introduced in 2008, no cervical cancer cases have been detected in Scotland in women who were fully vaccinated at age 12-13. The Scottish Government recently established an Expert Group to advise on how Scotland can work towards cervical cancer elimination.

Since January 2023 the HPV vaccine has been offered to all S1 pupils because it is most effective before they become sexually active. In previous years, two doses of the vaccine were recommended. However, more recent evidence demonstrated that only one dose is needed to give protection unless further doses are clinically required. Therefore, all eligible secondary school-aged children are now be offered one dose. That dose provides them with the same level of protection as the previous two doses.

Several vaccine boosters are offered to teenagers at school. These offer protection against HPV, tetanus, diphtheria, polio and meningococcal types A, C, W and Y. There is also an opportunity to catch up on MMR vaccination. Data is available in Table 22.

Table 22: Teenage booster uptake rates for NHS Orkney and Scotland, as a percentage, by the end of school year (latest available data is 2023/24). (Source: PHS teenage immunisation report).

Teenage boosters Uptake	2021/22		2022/23		2023/24	
	Orkney	Scotland	Orkney	Scotland	Orkney	Scotland
Human papillomavirus (HPV) completed course (S3)	78.9	87.2	84.1	85.2	87.7	81.6
Tetanus, diphtheria and polio (S4)	77.3	74.9	76.6	77.3	75.6	75.5
Meningococcal types ACWY (S4)	77.3	73.8	77.0	77.4	75.6	75.6

The school immunisation programme utilises a mixed model delivery approach with young people being invited to attend primary care for vaccinations in the isles practices and the programme being delivered in schools on the mainland. Those who miss the initial vaccination offer are reoffered throughout their school career.

Pertussis (Whooping Cough) Vaccination for pregnant women

Pertussis is a highly contagious bacterial infection of the lungs and airways. It causes bouts of repeated coughing that can last for two or three months or more and can make babies and young children very ill. Pertussis is spread in the droplets of the coughs and sneezes of someone with the infection. An increase in pertussis cases was seen across the UK and Europe from late 2023, continuing into the first half of 2024. In the 2024/25 reporting period, Orkney had nine confirmed cases (compared to an overall total of 12 confirmed cases in the years prior to that).

A single dose of Pertussis/whooping cough vaccine is offered to all pregnant women by the midwifery team during weeks 16 to 32 of pregnancy to maximise the likelihood that the baby will be protected from birth. Immunisation is timed to boost levels of protective antibodies passing from the pregnant woman to the baby. New mothers who have not been vaccinated against whooping cough during pregnancy are offered the vaccination up to when their child receives their first vaccinations at eight weeks of age.

The uptake rates of the pertussis vaccination programme, available in Table 23, have been excellent and above the Scottish average:

Table 23: Pertussis Vaccination uptake rates, as a percentage, for Orkney and Scotland. (Source: PHS vaccination annual report))

Uptake Pertussis Vaccination	Orkney	Scotland
2021/22	90.4	83.1

2022/23	89.9	82.8
2023/24 (latest available)	89.2	82.3

In summary, the vaccination uptake rates in Orkney are generally very good, and in most cases significantly better than Scotland as a whole. Locally, there has been a slight downward trend in vaccine uptake but rates are still generally good. There has been concern across Scotland and the UK as a whole about resurgence of measles. Although this has not been seen in Orkney, we must continue to encourage parents to get their children vaccinated with MMR. It is expected that from 2026, MMR will be replaced with MMRV vaccine (which will protect against chickenpox, and well as measles, mumps and rubella/German measles). The publicity which will accompany this change will present a good opportunity to stress the importance of this vaccine to local parents.

Pregnancy and Newborn Screening Programme

Pregnancy screening is offered at various stages of pregnancy to all women in Scotland during their routine antenatal appointments. While pregnancy and newborn screening is often considered as a national programme, it comprises a number of individual programmes, which include:

- Antenatal Haemoglobinopathy (sickle cell and thalassaemia) Screening.
- Antenatal Infectious Diseases Screening (Hepatitis B, Syphilis, HIV).
- Antenatal Trisomy (Down's, Edward's and Patau's Syndromes) Screening.
- Foetal Anomaly Screening.
- Newborn Bloodspot Screening (NBS); and
- Universal Neonatal Hearing Screening (UNHS)

The aims of the programmes vary, and include: providing information for women so that they can make informed decisions (including whether to continue with the pregnancy); enabling timeous treatment of mother and baby to support a successful pregnancy; reducing transmission of communicable diseases from mother to baby; reducing the risk of acute/chronic disease in the baby; and providing information to enable early intervention which can improve health and prevent severe disability or even death.

The components of the programme are offered by the midwifery team at an appropriate stage of the antenatal or postnatal period are shown in Tables 24 and 25.

Table 24: Pregnancy screening tests

STAGE OF PREGNANCY WHEN TEST PERFORMED	CONDITION SCREENED FOR	MODE OF TESTING
First Trimester	Haemoglobinopathies (Sickle cell and Thalassaemia)	Blood test
	Infectious diseases (Hepatitis B, Syphilis and HIV)	Blood test
	Down's syndrome Edwards' syndrome Patau's syndrome	Blood test and Ultrasound scan
Second Trimester	Foetal Anomaly Scan	Ultrasound scan
	Down's syndrome[11]	Blood test

Table 25: Newborn screening tests

AGE OF BABY	CONDITION(S) SCREENED FOR	MODE OF TESTING
96 hours after birth	1. Congenital hypothyroidism (CHT) 2. Cystic Fibrosis (CF) 3. Sickle Cell Disorders(SCD) 4. Phenylketonuria (PKU) 5. Medium chain Acyl-CoA Dehydrogenase Deficiency (MCADD) 6. Maple Syrup Urine Disease (MSUD) 7. Isovaleric Acidemia (IVA) 8. Glutaric Aciduria Type 1 (GA1) 9. Homocystinuria (HCU)	Heel prick – drops of blood collected on card and sent via Royal Mail to Scottish Newborn Screening Lab at QEUH, Glasgow
Ideally prior to discharge from hospital after birth but should be done within 4 weeks. Variable	Hearing loss	2 methods used in Scotland: AABR (automated auditory brainstem response) and OAE (otoacoustc emIssIon)[12]

[11] If not able to be carried out in first trimester.

[12] The method used in Orkney is OAE

models across country		

The screening tests are mainly offered as part of routine clinical care, and unlike most of the other national screening programmes, have much less resource in terms of dedicated IT systems and staff (especially at health board level). National resources commissioned by National Services and Screening Division (NSD), NHS National Services Scotland include the three pregnancy screening laboratories (first trimester Trisomy -Down's, Edwards' and Patau's- screening in Lothian, 2nd trimester Down's syndrome screening in Bolton and non-invasive prenatal testing -NIPT- in Dundee) and the Scottish Newborn Screening Laboratory (SNSL) in Glasgow. Blood samples for haemoglobinopathy screening and infectious diseases screening are analysed in local laboratories.

Governance

In NHS Orkney, oversight is provided by the BSPHL and the Lead Midwife through chairmanship of a local group. The BSPHL is the main point of contact with the national programme and attends quarterly national Pregnancy & Newborn Screening Board Coordinator meetings. The BSPHL chairs the NHS Orkney Pregnancy and Newborn Screening Oversight Group, which includes representatives from midwifery, obstetrics and audiology.

Unlike in the other national screening programmes, there have been no national groups for other professionals involved in Pregnancy and Newborn Screening, e.g. midwives, obstetricians, sonographers, although the Programme Board and its sub-groups do include representation from these professions. The Pregnancy & Newborn Screening Board Coordinator group is to become more interactive; the group name is to be changed to Board Coordination Group and membership reviewed so both strategy and delivery elements would be represented.

The Pregnancy and Newborn Screening Programme Board (chaired by a Director of Public Health) is the programme's overarching governance group and reports to the National Screening Oversight Board which in turn reports to the Scottish Screening Committee and Board Chief Executives.

The NHS Orkney Pregnancy and Newborn Screening Oversight Group routinely oversees and manages minor issues and service challenges, assesses the risks

associated with these, and continuously seeks to improve systems and processes to reduce them. Examples of these have included: monitoring numbers of blood samples rejected by the national Down Syndrome Screening lab and putting measures in place to reduce these; monitoring 2nd trimester Down Syndrome Screening rates and taking steps to improve these; and monitoring/ reducing rejection rates of Newborn Blood Spot (NBS) samples and putting safeguarding mechanisms in place to ensure appropriate follow-up.

Quality measures

There is a lack of consistent data collection and monitoring within/across health boards, for (many of the different parts of) each element of Pregnancy and Newborn Screening. Where there is dedicated resource, this can support the collection and collation of data.

The national review of screening programmes and standards for each programme by Healthcare Improvement Scotland (HIS) should clarify governance arrangements for all screening programmes, including the analysis of relevant quantitative and qualitative indicators. A suite of Key Performance Indicators is being produced – this data is not currently routinely collected at local or national level.

The standards for the PNBS programme are to be reviewed and are available here: https://www.healthcareimprovementscotland.scot/publications/pregnancy-and-newborn-screening-standards/

Screening for haemoglobinopathies and infectious diseases

BadgerNet data has been reviewed at the NHS Orkney Pregnancy & Newborn Screening Oversight Group. No issues have been identified.

Information on the NHS England Sickle Cell and Thalassaemia Screening Programme (SCT) training programme has been circulated to maternity services and with an ask to circulate this locally. The training programme is online and can be completed over multiple sessions. The lead midwife has checked that that our provision specifications/ protocols are standardised across the programme.

Trisomy and foetal anomaly Screening

A screening test for Down's syndrome, Edwards' syndrome and Patau's syndrome is available between weeks 10 and 14 of pregnancy (first trimester). It is a combined test because it combines an ultrasound scan with a blood test. The blood test can be carried out at the same time as the 12-week scan.

Blood tests combine with scans which measure the fluid at the back of the baby's neck to determine the "nuchal translucency". The woman's age and the information from the two tests are used to work out the chance of the baby having one of the syndromes.

Obtaining a nuchal translucency measurement depends on the position of the baby and is not always possible. If this is the case a blood test called the quadruple test will be offered between weeks 14 and 20 of pregnancy (second trimester). The first trimester test provides a more accurate screening test result, so the second trimester is to be offered if not able to be carried out in first trimester, for example, due to late presentation. Table 26 shows that Orkney undertakes a lower proportion of second trimester screening. Locally women are booked in early, so testing is not usually required in second trimester.

Table 26: Percentage of Second trimester screening.
(Source: First Trimester Trisomy Screening Lothian Laboratory Annual Data Report 2023/24 and 2024/25)

2nd trimester %	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Scotland	18.0	16.8	16.9	16.2	16.0	15.3	13.7
Orkney	12.9	9.9	5.8	4.2	6.2	3.7	2.2

During the period April 2024 to March 2025 there was only one first trimester trisomy screening samples were taken late in Orkney, and none too early. Of the samples submitted for first trimester screening in Orkney during 2024/25, 98% 98% request forms were completed, meeting the KPI target. Any issues are reviewed at the NHS Orkney Pregnancy & Newborn Screening Oversight Group, and remedial actions taken forward by the Lead midwife.

Newborn Blood Spot Screening

Newborn blood spot screens for nine different rare but potentially serious inherited diseases. It's usually carried out around five days after the baby is born. Performance data for the period 2024/25 is outlined below:

- 143 samples were submitted.
- Declines for screening were 0.
- No babies screened were too old for Cystic Fibrosis (CF) screening, this screen can only be performed until the baby is eight weeks old.

- No samples were submitted from babies who had moved into Orkney, children remain eligible for screening until they reach one year of age.
- 4 (4.9%, above the Scottish average of 4.08%) of the Orkney samples required to be repeated for avoidable reasons; 4 (2.8%) insufficient sample, 1 (0.7%) were under 4 days (which is too young for reliable screening), 1 sample (0.7%) was unsuitable, and in 1 (0.7%, above the Scottish average of 0.86%) the Community Health Index (CHI) was missing.
- In 4 (2.8%, above the Scottish average of 1.5%) of the Orkney samples there was necessary information not recorded on the bloodspot card; 3 (2.1%) had a date of sample missing or incorrect, and in 2 (1.4%) of the day 4 samples the time of birth or the time when the sample was taken was missing.
- 91.2% of initial samples were taken between 4-5 completed days (96-120 hours) of life, above the Scottish average (91.1%) and above the Essential criteria level of ≥90%. There can be a clinical indication for taking samples out with the usual time frame.
- 82.4% of samples were received by the laboratory in Glasgow within the ideal time of no later than three working days after the sample was taken. This was below the Scottish average of 88.8% and the Essential criteria level of ≥95%

Newborn Hearing Screening Programme (NHSP)

Universal Neonatal Hearing Screening consists of a simple test that looks for a clear response from both of a baby's ears. The test is usually done in the first few weeks after the baby is born, often before leaving the maternity unit. The test doesn't hurt and isn't uncomfortable. It's quick and can take place while a baby sleeps. A Scotland wide review of Audiology services for children and adults is being undertaken.

Since 2012/13, half of the Scottish NHS boards have been using a dedicated module (ABR) on the Scottish Birth Record (SBR) for the newborn hearing screening programme. Half of the Boards, including Orkney, use an alternative IT solution (OAE) that is also used in other parts of the UK. The SBR module is becoming increasingly obsolete and will require significant development and maintenance, and it cannot provide the functionality of alternative systems used which is presenting a significant clinical risk to the programme.

To enable national reporting, quality assurance and benchmarking across the whole programme, there is ongoing discussion in relation to the possibility of all Boards adopting the same IT system to support the programme.

Hearing Screening locally available uptake data is available in Table 27.

Table 27: Percentage of Second trimester screening.

Hearing Screening Uptake (Proportion of eligible children for whom the hearing process is finished by 4 weeks of age)	**NHS Orkney**
Apr-Jun 2022	97.3%
Jul-Sep 2022	97.8%
Oct 2022 – March 2025	100%
National target is ≥98% (essential) / > 99.5% (desirable) Scotland uptake was 96.7% between Apr 2022 and March 2023, and <100% between Apr and Sep 2023.	

Promoting positive mental wellbeing

Throughout 2024/25, the Health Improvement Team continues to collaborate with the local Suicide Prevention Task Force led by Orkney Islands Council. As part of the Task Force, Public Health has supported and contributed as part of the final stages of the development of a Suicide Prevention App – SOS Orkney, a free mobile phone App that has been promoted across the community.

Aimed at those both experiencing distress, and those who have concerns about friends and family, Public Health continue to raise awareness of the App by sharing as part of NHS Comms, at Wellbeing events and by using social media.

The Public Health Team continue to focus on the delivery of Save a Life – Suicide Awareness Training – for both NHS and Orkney Islands Council (OIC) staff. Close collaboration with the Community Learning and Development (CLD) team in 23/24 has resulted in the delivery of an equitable standard of training, and access to it, across both internal members of staff and the public. During 2024/25 there were three online training sessions delivered to 23 attendees. The focus of this online training has been to enable access across the remote and rural geography of Orkney, including staff based on the Isles who would otherwise have difficulty in travelling to access training. Regular feedback following each session is used to identify areas of improvement and may relate to either the delivery or the content of these sessions.

During 2024/25, two further members of the Public Health Team have been trained to deliver Mentally Healthy Workplace training. This launch of this training is planned 2025-26 with delivery focused on supporting external partners, providing managers with skills to recognise and support their workforce to manage stress or wider mental health concerns.

Increasing access to a smoke free environment and reducing harm from alcohol and drugs

Tobacco

Smoking rates are highest in the most deprived areas of Scotland. Deprivation in Orkney as a more rural community can be more difficult to identify and may have a complex relationship with behaviour habits. As a child who is born in a more socially deprived area is more likely to grow up around smokers[13], considerations around the impact of deprivation are important relating to smoking behaviours, not only for current smokers but also for the children and young people who may be negatively impacted.

Between 2019/2023, the smoking prevalence in Orkney among adults aged 16 years and over was 14%[14]. This includes 6.7% of women recorded as a current smoker at first booking in Orkney during 2022-2024[15].

The burden of disease due to smoking is unequally spread across society and there are a number of groups of people at higher risk of smoking. These include people with a mental health condition; those who are on lower incomes; and those who have contact with the criminal justice system in addition to many more[16]. Ill health and smoking is an avoidable risk of disease that is unequally distributed toward more vulnerable groups of people in Orkney and therefore it remains a public health concern.

Smoking Cessation Service

Attempts to quit smoking can be made by individual smokers with or without the support of NHS Stop Smoking Services. This report focuses on services including community pharmacy services and the NHS Orkney specialist stop smoking service (non-pharmacy) - Quit your Way Orkney.

In 2023 – 2024, between April and December, 52 quit attempts were made with the help of Orkney Stop Smoking Services. Between April 2024 and March 2025 79 quit attempts were made with the support of Orkney Stop Smoking Services. Of the quit attempts made in 2024 - 2025 54 were LDP quit attempts (against the annual target agreed in the local delivery plan of achieving 31 quits at 12 weeks). By comparison,

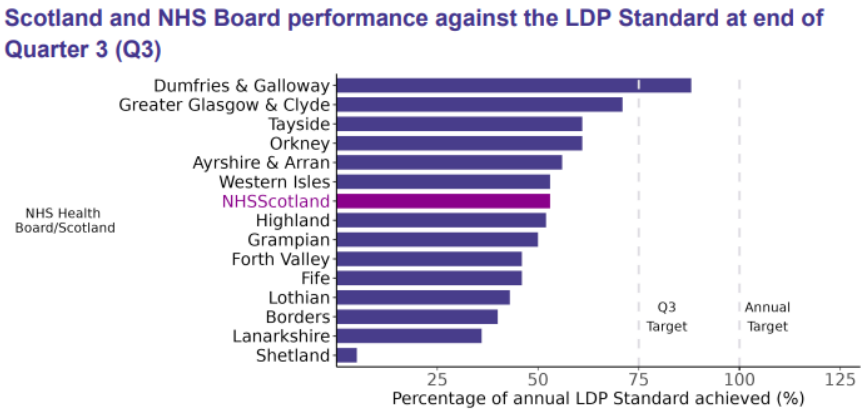
[13] Public Health Scotland (2021) Smoking. Smoking prevention - Smoking - Health topics - Public Health Scotland
[14] The Scottish Household Survey. Scottish Health Survey (shinyapps.io)
[15] ScotPHO Profiles ScotPHO profiles (shinyapps.io)
[16] Ash (2019) Health inequalities and smoking. ASH-Briefing_Health-Inequalities.pdf

in 2023 – 2024 during the same time period, 71 quit attempts were made. 40 of which were LDP quit attempts[17].

Client follow-up at both four and twelve weeks in 2024/2025 was conducted by telephone, video call using Near Me or in-person consultations. Information on successful quits in 2024/2025 were all self-reported and not validated using carbon monoxide (CO) breath testing which detects current smoking.

Of the 54 LDP quit attempts made in 2024/2025 from April to March in Orkney, 28 (51%) resulted in a self-reported successful quit at the twelve-week follow-up stage which is 90% of the annual target of achieving 31 LDP 12 week quits[18] set by the Scottish Government.

Figure 4 (below) shows the percentage of successful LDP quits at twelve weeks in 2024/2025 April to December by NHS board[19]. The percentage of successful LDP quits at twelve weeks for NHS boards ranged from 88% in NHS Dumfries and Galloway to 5% in NHS Shetland**Error! Bookmark not defined.**. The percentage of successful LDP quit attempts at twelve weeks in NHS Orkney was 61% which is higher than the Scottish average of 53%.



Quit Your Way Orkney Communications

The Quit Your Way Orkney 2024 – 2025 Communication Plan focused on maintaining and growing our relationships with community partners to ensure they are aware of the stop smoking support available and confident to raise the issue and refer on to the support services available. The Quit Your Way Orkney service set itself the target to receive 100 referrals in 2024/25. Between 1st April 2024 and 31st March 2025 118 referrals were made to Quit Your Way Orkney. Of these referrals,

[17] Dashboard - NHS stop smoking services Scotland - April 2023 to March 2024 - NHS Stop Smoking Services Scotland - Publications - Public Health Scotland

[18] NHS stop smoking services - Local Delivery Plan Standard, 2024/25 (Quarter 3) - NHS stop smoking services quarterly - Publications - Public Health Scotland

[19] NHS Stop Smoking Services

44% were self-referrals. The activities completed to achieve building and maintaining relationships with community partners were:

- Continuing regular delivery of an education session (Very Brief Advice on Smoking) for professionals / volunteers on how to raise the issue of smoking and the local support available for stopping smoking.
- Ensuring the regular presence of information about local stop smoking support on social media. Informed by the learning from increasing our social media content in 2023 – 2024, the messages of the content are diverse, current, evidence-based and non-stigmatising. Content was also developed for individuals at different stages of behaviour change in relation smoking and that we are targeting different demographics.
- Regular distribution of posters, leaflets and digital displays advertising the stop smoking support available in Orkney to prominent locations in the community, including the ferry-linked isles.
- Regular communication with current referrers to highlight the impact of their efforts raising the issue and making referrals to motivate them to continue making referrals.

Maternity Services

Carbon Monoxide (CO) monitoring should be performed on every pregnant patient, regardless of smoking status, at their first antenatal appointment and the 36-week appointment[20]. To support the achievement of this within NHS Orkney Maternity Services, Public Health purchased a new Carbon Monoxide (CO) Monitor for NHS Orkney Maternity Unit and created a 'CO Monitor and Resources Box' for the Maternity Unit to house all 'Smoking in Pregnancy' resources together, including the CO Monitor, to support their efficient delivery of CO monitoring and associated conversations. A CO Monitoring Pathway informed by the NICE guidance was created to outline the processes to be undertaken by Maternity staff, the criteria for referring patients to specialist stop smoking support and the process for making a referral.

Within the Quit Your Way Orkney service a pathway of care for pregnant patients was created, informed by the NICE recommendations on treating tobacco dependence in pregnancy. This was operationalised in 2024 / 2025 and is delivered by a smoking cessation advisor who has received specialist training on treating tobacco dependence during pregnancy and in the first year after childbirth. This has included establishing a communication link with the Health Visiting service to ensure they are informed for conversations about tobacco during the post-partum period and

[20] NICE (2023) Tobacco: preventing uptake, promoting quitting and treating dependence. NG209. Recommendations on treating tobacco dependence | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE

making it standard procedure for our smoking cessation advisor to deliver a check-in call during the post-partum period.

NHS Orkney Smoke Free Site Policy

The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 came into effect on 5th September 2022 and made it an offence to smoke or knowingly permit smoking within 15 metres of a hospital building in Scotland.

The NHS Orkney Smoke Free Site Policy was published in 2017 prior to the 2022 regulations and therefore the NHS Orkney Smoke Free Site Policy was due for a full review against current guidance and update to incorporate the 2022 regulations. The policy review and update process began in Q3 of 2023/2024 and was coordinated by the Health Improvement Team. The NHS Orkney Smoke Free Site Policy was approved by the NHS Orkney Senior Leadership Team in July 2024. This includes an updated Inpatient Smoking Referral Pathway and recommends that all frontline staff should be trained to provide Very Brief Advice (VBA) on Smoking and make referrals to Quit Your Way Orkney for ongoing support to make and maintain a quit attempt. This recommendation is valuable for encouraging attendance of VBA on Smoking training. A communication plan to ensure awareness of the policy and its implications is being actioned.

In Q2 of 2024/25 a staff member from the Health Improvement Team began attending the monthly NHS Orkney Corporate Induction to introduce the organisation's new staff to the Public Health department with specific focus on ensuring awareness of NHS Orkney Smoke Free Site Policy and expectations of staff in relation to it as well as of the support available for stopping smoking.

Very Brief Advice (VBA) on Smoking

The Quit Your Way Orkney team developed the Orkney Very Brief Advice (VBA) on Smoking training session in 2023/24 and then began delivering it to health, care and third sector staff / volunteers. In 2024/25 delivery continued of the Orkney VBA on Smoking training session. The training session seeks to ensure that all health and social care professionals are confident to deliver Very Brief Advice on Smoking and are aware of the local stop smoking support services available to refer on to.

Six VBA on Smoking training sessions were delivered in 2024/25. Five of the sessions were open to anyone from health, care and the third sector to attend. One of the sessions was organised specifically for NHS Orkney Dental colleagues. Of the 47 people who registered to attend a session 40 people attended a session in 2024/25.

31 people who attended the training sessions were employees of either NHS Orkney or Orkney Islands Council. The other 9 people who attended were employees /

volunteers from local third sector organisations. In all training sessions delivered, the participants self-reported confidence and knowledge scores increased after participation in the training.

A post-attendance survey to gather feedback from participants was completed by 14 people. The feedback received highlights that participants found the session useful and that it provided practical, straightforward advice on delivering VBA on Smoking. All 14 respondents reported that the session increased their confidence to use the Very Brief Advice (VBA) on smoking approach in their practice and all respondents felt they would recommend the training to others.

A 6-month post-attendance survey to gather feedback from participants has been completed by 13 people. Of the 13 respondents, 10 had used the VBA on Smoking approach in their practice since attending the training. Those who haven't used it reported that the barrier to delivering VBA was a lack of opportunity to deliver the intervention. Facilitators to delivering VBA have access to printed materials for using as conversation tools and for individuals to take away with them to consider. The Quit Your Way Orkney team is considering what actions we can take to ensure individuals who have attended VBA training have access to printed materials to support their conversations about smoking.

The system originally established for managing the registrations of participants for training and the necessary administrative steps required was burdensome and inefficient. During 2024/25 options were sought to reduce the administrative burden and streamline the processes involved with managing the registrations to attend training. The result was VBA on Smoking being advertised on TURAS Learn and all training registrations being managed through that system. This change has significantly reduced the time spent on administration of bookings, increased efficiency and removed opportunities for human error to be introduced. The transition to using TURAS Learn has been replicated across all the training delivered by the Health Improvement Team.

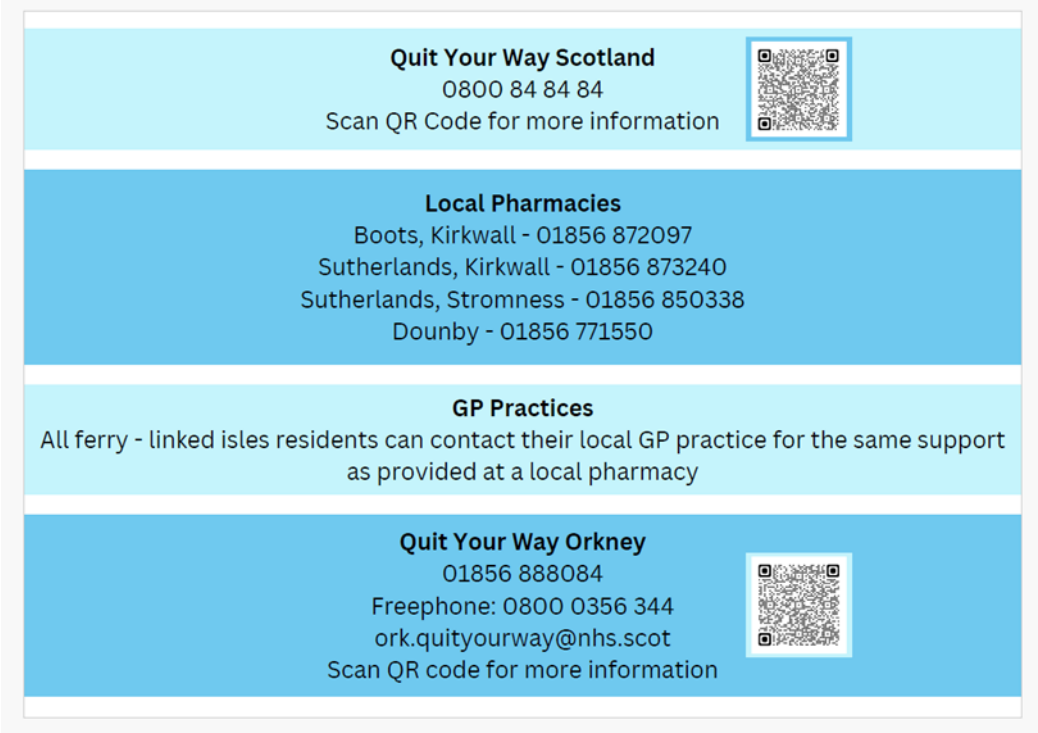
Multi-Agency Group (Orkney Tobacco Action Group)

A multi-agency group focused on reducing the harm of tobacco in our community continued to meet in 2024/25. During this time, the Group has been formalised and an action plan developed for 2025-2028. This includes delivery actions relating to prevention (creating an environment where young people in Orkney do not smoke), protection (protecting people in Orkney from the harms of second-hand smoke) and cessation (helping people to quit smoking in Orkney). The action plan was developed from a self-assessment which the group undertook and completed relating to the NICE guidelines for tobacco related work.

The three-tiered approach to stop smoking support within Orkney has continued to be communicated. The tiered approach increases in intensity of support with Tier 1 being the nationally provided phone and webchat support, Tier 2 is the support

available in community pharmacies and Tier 3 is the specialist stop smoking service (Quit Your Way Orkney).





Alcohol and Drugs Partnership

NHS Orkney is a partner member of the Alcohol and Drugs Partnership which has continued throughout 2023/24. Action relating to alcohol and drugs are completed through this partnership and NHS Orkney's influence with the Alcohol Licensing Board in relation to advising on potential health implications of this Board's activities. The Orkney Alcohol and Drugs Partnership Strategy for 2021-2026 is available here: Orkney ADP Strategy 2021-26 FINAL.pdf (scot.nhs.uk). The Partnership governance structure is through the Integrated Joint Board.

Supporting the development of a sustainable, inclusive economy in Orkney which ensures a healthy standard of living for all

Financial Inclusion Pathway

Deprivation exists in Orkney. A proportion of the population are living in the Scottish Index of Multiple Deprivation quintile 2 (which is the most deprived quintile in Orkney)[21]. It is also recognised that there are households facing poverty but living in rural areas which overall are less deprived areas.

In 2017 Scottish Parliament introduced the Child Poverty Bill which sets out targets to reduce the number of children experiencing the effects from poverty by 2030. In 2023/24, Public Health worked closely with colleagues in Health Visiting to develop and implement the NHS Orkney Financial Inclusion Pathway for Pregnancy and Pre-school. This document is NHS Orkney's response to Scottish Government's call for all Health Boards to take action to address financial inequalities and child poverty. NHS Health Scotland have also introduced a Toolkit to aid Health Boards in their development of Financial Inclusion Referral Pathways between Health, and welfare and finance services. This toolkit and related documents were used in the development of this local pathway.

The pathway was launched in the Autumn of 2024 which included associated communications to all staff and presentations offered to a small number of selected priority staff groups. It was designed to be an operational document which aims to provide day-to-day direction to all staff working within and for NHS Orkney, who come into direct contact with service users who may be experiencing poverty or financial difficulties, including (but not exclusively) food & fuel insecurity. Its purpose is to ensure that all Health Staff are working in a co-ordinated and inclusive manner to support families experiencing financial difficulties.

Healthy Working Lives

Following the results of the previous year's health needs assessment, the Health Improvement Team initiated a workplace health bulletin in 2024/25. This is distributed via email to workplaces and stakeholders across Orkney. The bulletin has provided signposting to a range of workplace health resources, covering topics such as good and fair work, mental health awareness, and musculoskeletal health. Engagement has also taken place with RSABI, a Scottish charity supporting individuals in agriculture. Discussions have been held to explore opportunities for joint working to support the health and wellbeing of the farming community in

[21] Scottish Government (2020) Scottish Index of Multiple Deprivation. SIMD (Scottish Index of Multiple Deprivation)

Orkney. Additionally, collaboration with Learning Link Orkney has enabled the team to gain insight into the courses available, which are now being promoted to workplaces. These courses aim to support staff in improving their numeracy and literacy skills, thereby enhancing job prospects and workplace confidence.

A workplace webinar was facilitated during 2024/25 for NHS Orkney staff in partnership with Home Energy Scotland. The session focused on practical strategies for reducing energy bills and included guidance on accessing financial support for energy efficiency improvements at home. In addition, to prepare for the delivery of Mentally Healthy Workplace training for managers in 2025/26, the Health Improvement Team have been actively engaging with the training content to ensure it is delivered to a high standard, both online and in person.

To mark 'Time to Talk Day' on the 6th of February 2025, the Health Improvement Team carried out promotional activities, distributing resource packs to all team managers within the hospital and external NHS workplaces. These packs included posters and interactive games, aligning with the national social media campaign to encourage open conversations about mental health.

The team is currently in the early stages of a feasibility study for a health improvement roadshow targeting the ferry-linked islands. Meetings have been arranged with island wellbeing coordinators to better understand the unique needs of each community. The roadshow may include sessions on type 2 diabetes management and HENRY workshops, which promote healthy lifestyles for families.

The Health Improvement Team now have a representative on the Orkney Local Employability Partnership. This involvement presents a valuable opportunity to engage with local employers and advocate for good and fair work practices across the Orkney in future.

NHS Orkney as an Anchor Institution

As an 'Anchor Institution', which is large organisation unlikely to relocate from the community, NHS Orkney will redirect wealth back into the Orkney community to help address the wider determinants of health inequalities. This will be achieved through fair work opportunities, local purchasing, purposeful use of land and assets, reducing environmental impact and working with partners.



In 2024/25, the Graduate Apprenticeship opportunities and Foundation

Apprenticeships in NHS Orkney continued, with three colleagues successfully graduating. NHS Orkney has participated in an activity which offered senior pupils at Stromness Academy and Kirkwall Grammar School the opportunity to visit a mobile skills unit which was based at the Balfour and provided pupils with the chance to learn more about careers and participate in a basic life support skills session. NHS Orkney also participated in the Orkney careers fair which was delivered in partnership with Skills Development Scotland and Developing the Young Workforce which was held on Wednesday, 2 October 2024 and attracted 916 young people and adults from across Orkney and Caithness.

The Community Benefits Portal continues to be in place in Orkney. This is an online portal which connects NHS Scotland suppliers with communities in Scotland by matching suppliers to Scottish Third Sector organisations who require assistance or support. In Scotland, the portal related to non-monetary assistance such as the product itself, training, professional advice and work placement opportunities.

In September 2024, a Climate Awareness week was run by NHS Orkney. Various literature was provided by Orkney Islands Council to educate staff on how to reduce waste. In September NHS Orkney started to charge for single use containers in the restaurant which has encouraged staff to bring their own reusable cups and containers and reduced waste. A number of reusable cups and loyalty cards for recycling were handed out free of charge at the Climate Awareness Week.

NHS Orkney Public Health Team, and Estates Team, continue to engage with our partners to work together in our ambition to redirect wealth back into the Orkney community to help address the wider determinants of health inequalities. This is achieved through engagement in sustainability focussed groups, the Local Employability Partnership and the Community Planning Partnership.

Supporting the population to maintain a healthy diet and engage in physical activity

Healthy Weight

In the past five years, healthy weight work within NHS Orkney's Public Health Department has related closely to the implementation of the Type 2 Diabetes Framework. This programme of work specifically began as seed funding to implement 'A Healthier Future: Type 2 Diabetes prevention, early detection and intervention: framework' in early 2019. From the summer of 2019, the programme was developed to include the implementation of the Tier 2 and 3 Child and Adult Weight Management Standards.

This work to implement the Type 2 Diabetes and weight management standards has supported the development of a wider range of sustainable services in Orkney which were not previously available, including access to health psychology. This has allowed service provision to be delivered using a range of options accessible to those in more remote and rural areas. Access remains a challenge for those without access to elements of infrastructure needed for remote consultation or support; however, services continue to adapt and collaborate in an attempt to adapt to reduce health inequalities across the Isles.

Healthy weight is impacted by the environment in which we like and therefore, a preventative approach to healthy weight requires consideration of how the place we live impacts on health. The needs assessments completed relating to both child and adult healthy weight highlighted the need to address the wider influences relating to diet and physical activity through partnership working. This is further strengthened through the recent Population Health Framework published by Scottish Government which identifies improving health weight as an initial priority

Good Food Nation

The Public Health Team continue to meet with Orkney Islands Council Colleagues to discuss best to prepare for the implementation of Good Food Plans by both NHS Orkney and Orkney Islands Council. Throughout 2024/25, Public Health have met with Nourish Scotland for updates on three occasions, a government appointed agency who are supporting Boards in the delivery of these Plans.

The contributions from Public Health to a Good Food Plan are expected to include consideration across a number of health inequalities including both physical and mental wellbeing across Good Food pathways. The contributions of the NHS Orkney Dietetics Team, including the Public Health Dietician, continue to be important to highlight the potential impact of diet-related disease in Orkney.

Initiation of Good Food Plans at a local level have stalled during this period, whist the Scottish Government have been reviewing feedback and analysing the results of the Consultation document. It is expected that the Scottish Government will commence with implementing the Good Food Act in 2025-26, providing both updates and guidance around expectations of content for Good Food Plans. Once the Act is launched, there will be a twelve-month period of completion for Plans to be submitted.

Food Availability Project

Access to healthy, affordable food is important for health and prevention of disease in the population in Orkney as healthy eating, alongside active living and maintaining a healthy weight, are associated with a range of health benefits. The Community Planning Partnership in Orkney has been working for years to improve food security in the wake of the Covid-19 pandemic and the Cost-of-Living Crisis. This has included the commissioning of a Food Dignity Briefing Report which used research, local and national data, gathering of best practice examples and interviews with local stakeholders to identify the prevalence of food poverty in Orkney and potential recommended solutions. The report suggested that one driver of food poverty in the smaller areas and island areas of Orkney could be the high cost of food[22].

In 2024/25, NHS Orkney Public Health Team, in partnership with the University of Glasgow, proposed a research project to quantitatively understand cost and availability of food to support a healthy diet in Orkney. It is recognised that this is dependent on a sustainable and effective food supply chain at all times of the year in Orkney, despite possible weather disruptions and population fluxes through tourism potentially impacting on supply and demand. Therefore, it was proposed that cost and availability of selected food items would be determined across the islands at four intervals throughout a one-year period to provide a greater insight into the cost and availability of a healthy food basket across the areas of Orkney. The initial data collection for this project began in February 2025 and is expected to complete in November 2025.

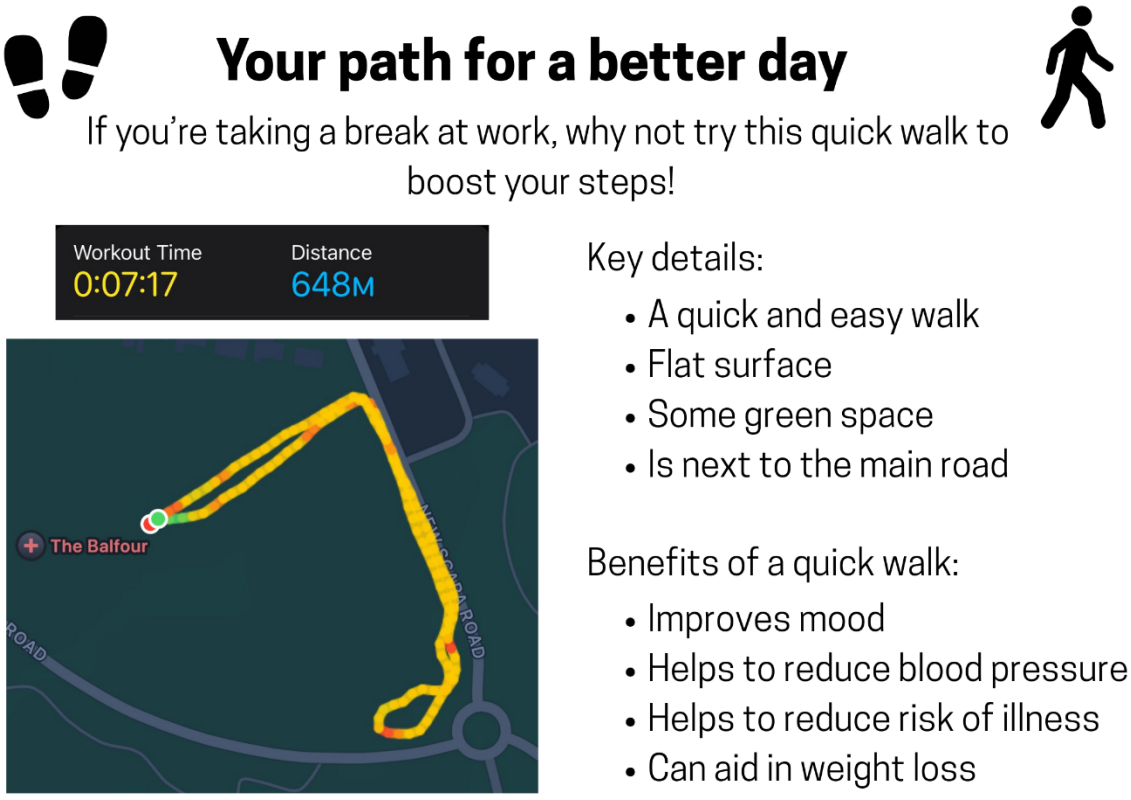
Physical Activity

NHS Orkney Public Health Team have continued to engage in the development of the Orkney Physical Activity and Wellbeing Strategy which is lead by Orkney Islands Council. In addition to this, a physical activity social media communication plan was created for 2025/26, which included posts promoting movement to adults, elderly

[22] Lloyd E. & McEwen M. (2022) ORKNEY FOOD DIGNITY RECOMMENDATION REPORT Briefing document. Orkney-Food-Dignity-Reccomendations-Report.pdf (vaorkney.org.uk)

people, children, pregnant people, and adults with disabilities. The posts aim to motivate these demographics to increase their physical activity levels, and signpost to many opportunities for how to do this. The plan additionally aims to bring attention to the Chief Medical Officers Physical Activity Guidelines. The guidelines have been further promoted to NHS Orkney stall through internal comms, email communications, and posters around the Balfour including within prominent patient areas such as GP or Outpatient waiting rooms.

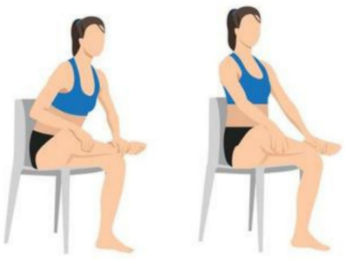
Part of the Physical Activity Strategy in relation to adult physical activity was promoting and increasing activity levels within NHS Orkney staff. To support this, four walking routes were developed and distributed to staff within the Balfour. These routes designed to fit in with staff break or lunch times, or to be utilised during walking meetings. An example of this is shown below:



To compliment to walking routes, exercise sheets were developed and distributed to staff. The light exercises were designed to support staff to move their bodies during their working day during break or lunch. Both walking routes and exercises were distributed through line manager emails, internal comms, screen displays and being printed and distributed around the Balfour. An example of this is shown below:

Small movements make a big difference

This gentle stretch helps release tension in your hips, glutes, and lower back - ideal after long hours of standing or lifting



This stretch can ease tight hips and glutes, helping you stay mobile and comfortable through long shifts

- Sit down comfortably.
- Cross one leg so your foot rests on the opposite knee.
- Gently lean forward toward the crossed leg.
- Hold for 15–30 seconds, then switch sides.
- You'll feel the stretch in your glutes and hips.

Engaging in secondary and tertiary ill health prevention

Screening Programmes

National screening programmes are population level services that identify healthy people who may be at increased risk of a disease or condition. If an increased risk of a disease is identified the individual can then be offered information, further tests, and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. Screening can reduce the risk of developing a condition or its complications, but it cannot offer a guarantee of protection. In any screening programme there is a minimum of false positive results and false negative results.

There are six national screening programmes (Abdominal Aortic Aneurysm (AAA), Bowel, Breast, Cervical, Diabetic Eye (DES) and Pregnancy & Newborn (PNBS).

As national screening programmes, oversight is provided by National Services Scotland (NSS), who are accountable to the Scottish Screening Committee and ultimately Scottish Government, but the 14 territorial health boards are responsible for ensuring that their resident population has appropriate access to screening which meets the standards of the national programme(s). The Board Screening Public Health Lead (BSPHL), previously called Board Screening Coordinator, oversees the delivery, quality, and effectiveness of the screening programme for their resident eligible population and is directly accountable to the Director of Public Health.

Operational oversight and assurance of the programmes are provided by the BSPHL through a number of meeting groups: at a regional level for the Abdominal Aortic Aneurysm (AAA) and Cervical Screening Programmes through the AAA Screening Programme Collaborative and the Cervical Screening Monitoring Group. Local oversight groups have been established for the Diabetic Eye Screening (DES) and Pregnancy and Newborn Screening programmes which in 2023/24 reported by exception to the Quality Forum and through the Public Health report to the Joint Clinical and Care Governance Committee. Further oversight of the cancer Screening programmes and care pathways, including for the Bowel Screening Programme, was through the NHS Orkney Cancer Care Delivery Group.

Screening Standards for the programmes are developed by Health Improvement Scotland (HIS). The standards map the screening programme pathways and apply to all services involved in the delivery of the programme within NHS Scotland.

Key Performance Indicators (KPIs) are a set of measures used to monitor and evaluate programme effectiveness. The KPIs consist of descriptive numbers and percentages that describe key aspects of the performance of the Programme. The purpose of reporting achievement of the KPIs is to give a high-level view of the performance of the screening programmes, act as a driver for continuous

improvement, and to direct specific review of any areas that (from the KPIs) appear to be underperforming. Each KPI has two thresholds (targets):

- Essential - the minimum level of performance that the screening programme is expected to attain.
- Desirable - the screening programme should aspire towards attaining and maintaining performance at this level.

NHS Boards are expected, as a minimum, to meet the essential thresholds for all key performance indicators. Where available some KPIs will be included in this report.

Scottish Abdominal Aortic Aneurysm Screening Programme

An abdominal aortic aneurysm is a swelling of the aorta, the main blood vessel that leads away from the heart to the rest of the body. As a person gets older the wall of the aorta in a person's abdomen can become weak and balloon out. A one-off ultrasound examination to measure the width of the aorta is offered to all men in Orkney in their 65th year. Men are only invited for recall if an aneurysm which requires regular monitoring (measuring between 3.0cms to 5.4cms) is seen.

NHS Orkney is part of an AAA Screening collaborative with NHS Grampian and NHS Shetland. NHS Grampian staff undertake all screening activity.

Standards

The standards for the AAA screening programme[23] cover the following areas:

- Leadership and governance
- Information
- Call–recall
- Attendance and uptake
- Primary screening
- Surveillance
- Quality assurance of AAA image
- Referral to vascular services

[23] AAA Screening standards are available here: https://www.healthcareimprovementscotland.scot/publications/abdominal-aortic-aneurysm-aaa-screening-standards/

- Treatment, and
- Postoperative outcomes.

Key Performance Indicators

The key performance indicators for the Scottish AAA Screening Programme are intended to offer a focus on aspects of the patient journey from invitation, through the delivery of the scan and referral for clinical assessment, to outcome of surgical intervention, if this is required.

The latest publication of KPI data is for the year ending 31st March 2024.

The uptake target for the AAA screening programme, is the percentage of eligible men tested before age 66 years and 3 months and had a screening result of positive, negative, or non-visualisation (KPI 1.2a). Table 28 below shows the uptake in Orkney has been above the Desirable target and Scotland figures since the programme restarted in July 2020.

***Table 28**: AAA Screening uptake rates for 2020/21 to 2023/24 (Sources: PHS[24])*

AAA uptake (percentage)	2020/21	2021/22	2022/23	2023/24
Orkney	83.1	92.0	88.9	91.1
Scotland	78.0	72.6	70.7	77.3
Essential target ≥ 75%. Desirable target ≥ 85%				

Available data indicating the percentage of eligible population in Orkney who are tested before age 66 and 3 months by Scottish Index of Multiple Deprivation (SIMD) using NHS Board level quintiles (KPI 1.3a) demonstrates that in Orkney the rates are consistently higher than in Scotland, and that in 2023/24 the Desirable criteria was met for those men in all quintiles, including men in quintile 2, the quintile with those experiencing the highest level of deprivation in Orkney (Table 29).

***Table 29:** AAA Screening uptake rates for 2020/21 to 2023/24 by SIMD (Sources: PHS)*

AAA uptake by SIMD (percentage)	2020/21		2021/22		2022/23		2023/24	
	Orkney	Scotland	Orkney	Scotland	Orkney	Scotland	Orkney	Scotland

[24] PHS AAA Screening data available here: https://publichealthscotland.scot/publications/scottish-abdominal-aortic-aneurysm-aaa-screening-programme-statistics/

TOTAL	83.1	78.0	92.0	84.6	88..9	84.5	91.1	84.6
1 = most deprived	-	72.1	-	76.4	-	76.1	-	75.8
2	84.4	75.7	89.5	81.3	76.9	81.5	91.3	81.5
3	76.3	75.8	88.0	85.6	93.1	85.3	87.1	86.4
4	85.6	79.9	93.5	88.8	90.7	88.6	92.1	88.7
5 = least deprived	-	86.0	100.0	88.9	100.0	89.9	-	90.4
Unknown	-	-	-	72.4	-	73.7	-	66.7
Essential target ≥ 75%. Desirable target ≥ 85%								

Scottish Bowel (Colorectal) Cancer Screening Programme

Bowel cancer is the third most common cancer and the second most common cause of death due to cancer in Scotland. The national bowel screening programme was introduced into Scotland in 2007. Participants are sent a test kit to their home and return a sample from a bowel motion to the Bowel Screening Laboratory. The test looks for hidden blood in stool. Those with a positive test result are referred to their health board of residence for follow-up, with the majority receiving a colonoscopy.

Bowel screening is offered to men and women aged 50 to 74 years to help find and treat bowel cancer early. Bowel screening can also identify precancerous growths (adenomas) that can be removed, preventing cancer occurring in the first place. People aged 75 years and over can request a screening kit.

People can reduce their risk of developing bowel cancer by:

- Eating a healthy diet
- Limiting foods high in sugar and fat, and avoiding sugary drink
- Avoiding processed meat like bacon and sausages and limiting red meat
- Getting to and keeping a healthy weight
- Being more active in everyday life, this includes walking more and sitting less
- Drinking less alcohol
- Stopping smoking
- Telling their GP if they have any worries about their bowel habits.

Standards

The standards for the Bowel screening programme[25] cover the following areas:

- Screening invitation
- Laboratory service
- Screening test result
- Pre-investigation assessment
- Diagnostic investigation
- Histopathology

Key performance indicators

Key performance indicators for the bowel screening programme include uptake, laboratory, and clinical outcomes of screened individuals. The report is published in two yearly cycles with the latest published data being for the period 1st May 2022 to the 30th of April 2024. No new data has been published since the last iteration of this report, which was released in November 2024.

Previously reported data showed that bowel screening uptake data (KPI 1) for those invited in Orkney during 2021-23 was 69.8%, similar than the previous annual uptake of 70.0%, against a national performance of 65.7%. The data demonstrated that uptake rates for Orkney residents remain above the national target of 60% and have shown an improvement from the 68% reported for 2019-21 (Table 30).

Table 30: *Bowel Screening uptake rates for 2019-21 to 2022-24 (Sources: PHS[26])*

Bowel uptake (percentage)	**2019-21**	**2020-22**	**2021-23**	**2022-24**
Orkney	68.9	70.1	70.0	69.8
Scotland	65.3	67.0	66.1	65.7
Acceptable target ≥ 52%. Achievable target ≥ 60%				

[25] Bowel Screening standards are available here: https://www.healthcareimprovementscotland.scot/publications/bowel-screening-standards/

[26] PHS Bowel Screening data available here: https://www.publichealthscotland.scot/publications/scottish-bowel-screening-programme-statistics/

Previously reported data showed that a similar proportion of individuals received positive results (KPI 3) in 2022-24 in Orkney compared to the previous year, with an increase in test positivity rate from 1.9% in 2017-19 to just over 2.5% in 2022/24. This was on a background of a slight reduction in positive results nationally during the same period (Table 31).

Table 31: *Bowel Screening uptake rates, as a percentage, for 2019-21 to 2022-24 (Sources: PHS[27])*

Bowel Screening Positivity rates	Orkney	Scotland
2017-19	1.9	2.9
2018-20	2.1	2.8
2019-21	2.3	2.8
2020-22	2.5	2.8
2021-23	2.5	2.8
2022-24	2.56	2.79

For the bowel screening programme, the focus of work is on managing colonoscopy capacity across Scotland and improving the quality of screening data. The trends in waiting time from patient referral (due to a positive screening test result) to the first colonoscopy procedure following the referral (KPI 4) are monitored. Within Orkney, colonoscopy capacity is managed through clinical prioritisation. The Senior Charge Nurse for Theatre makes sure those who are most urgent are prioritised and additional lists are held whenever capacity allows to minimise waiting times.

Scottish Breast Screening Programme (SBSP)

Breast screening is a test for breast cancers that are too small to see or feel. Breast cancer is the most common cancer in women. About 1000 women die of breast cancer every year in Scotland. Older women have a higher chance of developing breast cancer, particularly after the menopause. It can also affect younger women. In Scotland women between the ages of 50 and 70 years are invited for breast screening every three years. Women aged over 70 years plus 364 days can continue to be screened if they arrange an appointment with the local screening centre.

[27] PHS Bowel Screening data available here: https://www.publichealthscotland.scot/publications/scottish-bowel-screening-programme-statistics/

There are several factors which increase the chance of developing breast cancer, including:

- Being overweight
- Drinking alcohol
- Taking some forms of Hormone Replacement Therapy (HRT)

Women may also have a higher chance of developing breast cancer if members of their family have had breast cancer, particularly at a young age.

The screening service was paused during the COVID-19 pandemic along with the other national adult screening programmes. A phased approach has been in place since November 2022 for the reintroduction of self-referrals for individuals aged 71 years and over to the programme. From 1st December 2023, the self-referral of all clients aged 71 years and over was reinstated, extending self-referral to clients aged 75 years and over with no previous history of breast cancer.

The screening programme for NHS Orkney residents is provided through the Northeast Scotland Breast Screening Service, which is hosted by NHS Grampian and based in Aberdeen. A mobile unit visits Orkney every three years. The service is supported by the NHS Orkney Surgical team and Breast care Nurses, who see breast screening ladies to pass on results, and to discuss multi-disciplinary team decisions and further treatment. All women recalled for review attend the Breast Screening Centre in Aberdeen.

For those clients requesting an appointment within a location in which the centre is not screening, the client is advised of the approximate timescale and asked to re-contact the centre around the expected screening date. Nearly 3200 Orkney women between the ages of 50-70 years were invited to attend for breast screening between April and July 2024.

Standards

The standards for the Breast screening programme[28] cover the following areas:

- Leadership and governance
- information and support
- call-recall

[28] Breast Screening standards are available here: https://www.healthcareimprovementscotland.scot/publications/breast-screening-services-standards/

- screening process
- recall for assessment
- surgical referral, and
- detection rates.

Key Performance Indicators

The Breast Screening Service visit Orkney in April and July 2024, but no KPI data for 2024/25 has been published yet. No new data has been published since the last iteration of this report, which was released in November 2024.

The latest published figures (previously reported) indicated that the uptake of the breast screening programme between April 2020 and March 2023 was 83.7% in Orkney and 75.9% in Scotland, with a national target of 70%, and it has been over 81.9% since 2013-16.

Scottish Cervical Screening Programme (SCSP)

The aim of the Scottish Cervical Screening Programme is to reduce the number of women who develop invasive cancer (incidence) and the number of women who die from it (mortality) through a population-based screening programme for eligible women. Screening is offered to all with a cervix aged 25-64 years every five years. Participants on non-routine screening (where screening results have shown changes that need further investigation or follow up) will be invited up to 70 years of age. Cervical screening saves around 5,000 lives in the UK every year and prevents 8 out of 10 cervical cancers from developing.

Cervical cancer is the most common cancer in women aged 25 to 34 years in Scotland.

The risk of developing cervical cancer is increased if a woman:

- Is, or has been, sexually active
- Smokes, as this affects the cells in the cervix

The cervical screening test (smear test) checks cells from the cervix for human papillomavirus (HPV). HPV is very common; four out of five people in Scotland will catch it at some point in their lives. As there are usually no symptoms many people have it for months or years without knowing it. The body fights off HPV infections naturally, but one in ten infections are harder to get rid of. Cervical screening looks for the presence of HPV virus, if virus is found then the same sample will be looked at for cell changes. At this stage, any abnormalities can easily be monitored or

treated, and treatment is usually very effective. Without treatment the changes can sometimes develop into cervical cancer in around 10 to 15 years' time.

The diagram below developed by NSS outlines the delivery components and the participant screening pathway for the cervical programme (Figure 5).

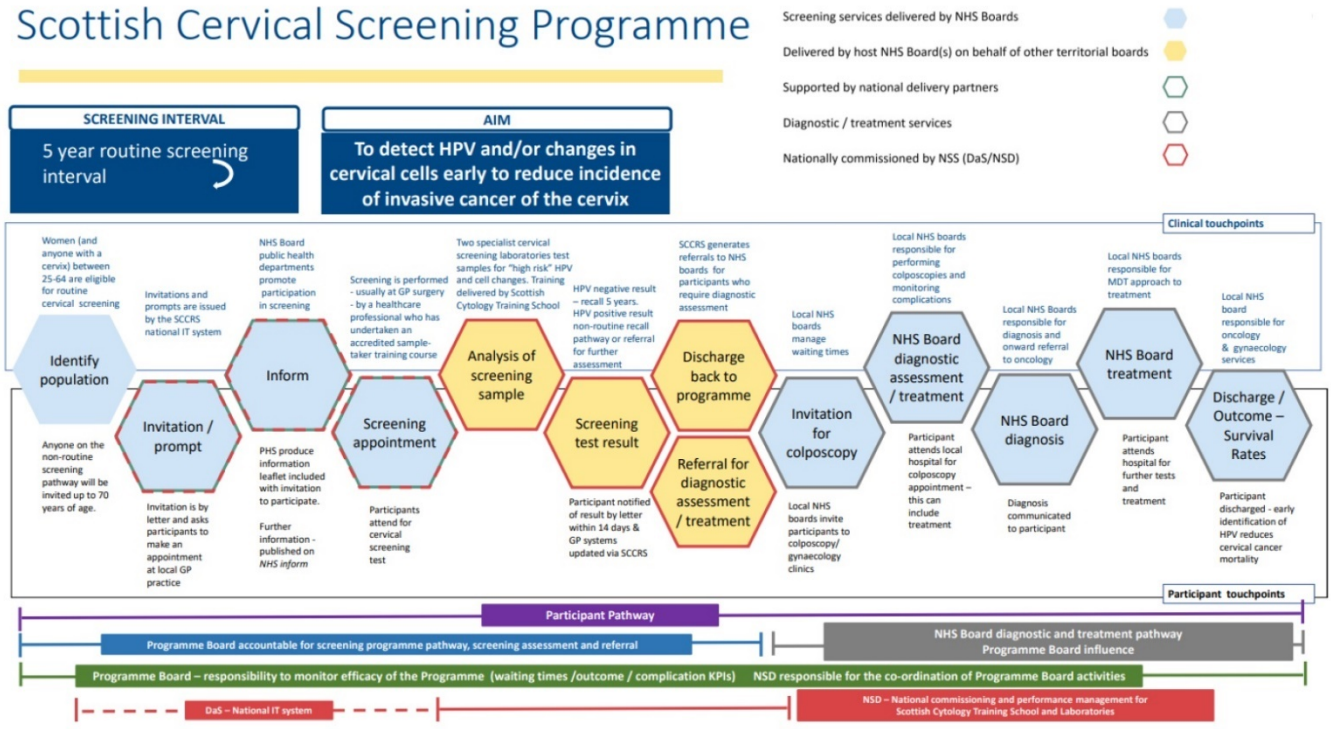


Figure 5: *Scottish Cervical Screening Programme Pathway*

Standards

The standards for the Cervical screening programme[29] cover the following areas:

- leadership and governance
- information and support
- call-recall
- screening process
- recall for assessment

[29] Cervical Screening Standards are available here: https://www.healthcareimprovementscotland.scot/publications/cervical-screening-standards/

- surgical referral, and
- detection rates

Key Performance Indicators

The KPIs for the cervical screening programme cover attendance and uptake, laboratory services, the screening process, effectiveness of the screening programme, colposcopy service and colposcopy treatment. A short life working group has been established to review the KPIs for the programme.

The latest published KPI data available for the programme[30] is for the year up to 31st March 2022. No new data has been published since the last iteration of this report, which was released in November 2024.

Table 30 provides previously reported uptake data, in a three-year rolling period from 2012/15 to 2020/23, showing that Orkney has consistently been above Scotland's figures and above the optimal performance standard of 80%.

***Table 33**: Cervical Screening Uptake (3 year rolling period) from 2012/15 to 2020/23 in Orkney and Scotland. (Source: PHS)*

Cervical Screening uptake %	**2012/15**	**2013/16**	**2014/17**	**2015/18**	**2016/19**	**2017/20**	**2018/21**	**2019/22**	**2020/23**
Orkney	**84.6**	**83.8**	**83.7**	**83.7**	**81.9**	**81.9**	**81.8**	**83.6**	**83.7**
Scotland	**72.5**	**71.9**	**71.7**	**71.2**	**72.3**	**72.2**	**73.2**	**74.5**	**75.9**
Efficiency standard: 75%. Optimal performance standard: 80**%.**									

Scottish Diabetic Eye Screening (DES) Programme

People with type 1 or type 2 diabetes are at higher risk of eye disease due to high blood sugar levels causing damage to the cells in the retina (back of the eye). All people with diabetes aged 12 years and over in Orkney are offered an eye screen. Diabetic Eye Screening (DRS) is a test (photographs of the back of the eyes) to check if the small blood vessels in the retina have leaked or become blocked. When detected early treatment can be provided to reduce or prevent damage to an

[30] PHS Cervical Screening data available here: https://www.publichealthscotland.scot/publications/scottish-breast-screening-programme-statistics/scottish-breast-screening-programme-statistics-annual-update-to-31-march-2023/

individual's eyesight. Left untreated diabetic retinopathy can cause blindness or serious damage.

People at high risk of sight loss are offered screening annually or six-monthly. Those at low risk of sight loss are offered screening every two years. A person's previous screening history is used to determine whether they are deemed low risk of sight loss.

An OCT (optical coherence tomography) scan is sometimes needed to detect macular oedemawhich is the leading cause of moderate sight loss in people with diabetes. OCT is now delivered by the DES team in Orkney, with the scans reviewed by the visiting Ophthalmologist within the following month.

An individual can reduce their chance of developing diabetic retinopathy by:

- Controlling their blood glucose levels
- Getting their blood pressure checked regularly.
- Speaking to their optician if they have a problem with their eyesight.
- Taking medication as prescribed
- Attending DES appointments

NSS commissions the Scottish Diabetic Eye Screening Collaborative which brings together individuals from all NHS boards in Scotland to facilitate the delivery of the DES Screening Programme. It promotes equitable and accessible delivery of care, supporting health professionals. Following the pause in screening during the COVID-19 pandemic, a new database (OPTOMIZE) was implemented to support the DES programme.

Prior to January 2021, patients attending the Diabetic Eye Screening (DES) programme with a retinal grading score indicating Diabetic Retinopathy or Maculopathy (MO) may have been referred to Ophthalmology services. At this point the patient was suspended from the DES programme. Only 10% of these patients were found to have MO and held within a surveillance loop within Ophthalmology. This practice led to unwarranted variation resulting in some patients being reviewed by Consultant Ophthalmologists and undergoing in some cases examinations which were not required. This resulted in unnecessary worry for patients as well as inappropriate use of consultant resource. The associated suspension from the DES programme may also have resulted in variances in practice across Scotland as to how patients' retinopathy was monitored.

To improve the specificity of referrals to Ophthalmology and ensure national consistency, a surveillance cycle based on Optical Coherence Tomography (OCT) was introduced under the auspices of the DES programme in January 2021.

During April 2023 to March 2024, OCT scans were undertaken in the DES clinic, reducing attendance at Ophthalmology clinics. The OCT scans are now reviewed via a virtual assessment clinic taking approximately one hour of consultant time per month.

Standards

The standards for the DES programme[31] cover the following areas:

- leadership and governance
- call-recall
- attendance and uptake
- screening process
- referral, and
- treatment.

Key Performance Indicators

The KPIs for the diabetic eye screening programme cover attendance and uptake, screening performance, screening outcomes, and ophthalmology performance.

The number of encounters where a picture of the back of the eye could not be taken with the digital camera, is increasing due to cataract waiting times. This will increase the numbers of patients needing to attend slit lamp clinics.

In the second half of 2024, the NHS Orkney's DES programme experienced a temporary suspension due to staffing challenges. The pause was managed appropriately, with clear communication to affected patients and a commitment to resume services promptly. Screening activity recommenced in December 2024, with NHS Orkney able to see 200 affected individuals by February 2025. Despite this disruption, provisional key performance indicators data for 2024/25 indicate that the DES service has performed strongly, achieving the highest attendance and successful screening rates in Scotland in Q4, which is a remarkable achievement in the context of this temporary suspension.

[31] The DES standards are available here: https://www.healthcareimprovementscotland.scot/publications/diabetic-retinopathy-screening-standards/

Published performance data will not be available until system verification has been completed, but some data is locally available (Tables 35 to 38).

The recording system (Optomize) is being updated to version 5.4. Until completion, it is known that here are errors in KPI 1 (invitation rate). The data presented below has not been yet validated.

Table 35: *DES Invitation Rate Cumulative Q1 – Q4 2024/25*

DES Invitation Rate Cumulative Q1 – Q4 2024/25	NHS Orkney	Scotland
Apr 24-Jun 24 (target 25%)	24.7%	27.0%
Apr 24-Sep 24 (target 50%)	43.5%	49.4%
Apr 24-Dec 24 (target 75%)	54.4%	69.6%
Apr 24-Mar 25 (target 100%)	89.8%	88.6%

Table 36: *DES Attendance Rate Cumulative Q1 – Q4 2024/25*

DES Attendance Rate Cumulative Q1 – Q4 2024/25	NHS Orkney	Scotland
Apr 24-Jun 24 (target 20%)	22.7%	18.9%
Apr 24-Sep 24 (target 40%)	43.2%	37.3%
Apr 24-Dec 24 (target 60%)	45.4%	54.0%
Apr 24-Mar 25 (target 80%)	83.5%	70.7%

Table 38: *DES Annual Successful Screening Rate 12 months prior*

DES Annual Successful Screening Rate 12 months prior	NHS Orkney	Scotland
Apr 24-Jun 24 (target 80%)	78.9%	66.1%
Apr 24-Sep 24 (target 80%)	77.4%	66.4%
Apr 24-Dec 24 (target 80%)	62.1%	68.0%

Apr 24-Mar 25 (target 80%)	80.8%	69.1%

Table 37: *DES Biennial Successful Screening Rate 24 months prior*

DES Biennial Successful Screening Rate 24 months prior	NHS Orkney	Scotland
Apr 24-Jun 24 (target 80%)	91.7%	80.4%
Apr 24-Sep 24 (target 80%)	88.5%	79.0%
Apr 24-Dec 24 (target 80%)	81.9%	78.6%
Apr 24-Mar 25 (target 80%)	88.5%	78.7%

Pre-Diabetes and Type 2 Diabetes Education

The MyDesmond programmes provides patients an online platform for learning and managing their diabetes in a way that works for them. Within NHS Orkney, three MyDesmond programmes are offered. These are, the Type 2 Diabetes Online Management programme, Let's Prevent for Pre-diabetes and Baby Steps for Gestational diabetes as detailed below:

- **Type 2 Diabetes** – MyDesmond type 2 diabetes online management programme is a free online health education and behavioural change programme that will help you set personal goals around diet, exercise, and wellbeing to support you in making sustainable healthy lifestyle choices. This programme is suitable for anyone with a diagnosis of type 2 diabetes regardless of whether you are newly diagnosed or have been diagnosed for some time.
- **Lets Prevent** – MyDesmond Lets Prevent programme is a free online health education and behavioural change programme that will put you on the path to better health and wellbeing. Lets Prevent will help you set personal goals around diet, exercise, and wellbeing to support you in making sustainable healthy lifestyle choices and reduce the risk of developing type 2 diabetes. Lets Prevent is suitable for individuals that have been diagnosed with pre-diabetes and find themselves at risk of developing type 2 diabetes.

- **Baby Steps** – MyDesmond Baby Steps programme is a free online health education and behaviour change programme that supports and empowers those who have been diagnosed with gestational diabetes during pregnancy. Baby Steps recognises there is no ‘one-size-fits-all’ approach to life after gestational diabetes. This program will inform, inspire, and motivate you as you work towards making small changes that will have a big impact on your long-term health – with the ultimate goal of decreasing your risk of developing type 2 diabetes.

Within 2024/25, 16 patients were referred into and created accounts across the three MyDesmond programmes. The MyDesmond programmes have been promoted through in-person events, social media and liaising with referrers. A self-referral form is currently in development to support in increasing referrals.

Control It is a two hour group session which supported interactive learning and discussion in a relaxed, non-judgemental environment for patients who are newly diagnosed with Type 2 Diabetes or Pre-diabetes, or for patients with Type 2 Diabetes. The session aim to support participants to:

- Understand what Type 2 Diabetes is and the short/long term effects of high blood glucose.
- Understand healthy eating and how diet impacts on health and Type 2 Diabetes.
- Increase skills and knowledge to make realistic changes through setting manageable goals.
- Be aware of the benefits of exercise and keeping active and to explore the challenges related to this.
- Successfully management different factors of their lives that may influence their Type 2 Diabetes including stress and sleep.

Since the Type 2 Diabetes education service restarted after the Covid-19 pandemic, there have been 21 sessions have taken place with 93 people attending. Phone calls have been made to patients that had not opted into the education session, to gather feedback on their choice to not attend for service improvement, to give an opportunity for people to pose any questions to a person delivering the programme, as well as to offer the participant booklet and other useful resources to be sent to them. Through these calls, 98 additional people have received the ‘Control It’ booklet and other useful resources.

Improving the Cancer Journey

The Improving the Cancer Journey (ICJ) service, in partnership with Macmillan Cancer Support, went live in December 2024, with an official launch in January 2025. The ICJ service supports anyone in Orkney affected by cancer with their non-clinical needs. This can include the patient with the diagnosis, or anyone impacted by that diagnosis such as partner, family, friends or carers.

When a person is referred into the ICJ service, they are offered a Holistic Needs Assessment (HNA) which is a 72-point checkbox style questionnaire that identifies that matters most to that person and what their main concerns are. The 5 categories of concern are financial, practical, physical, spiritual and emotional.

Following the completion of the HNA and meaningful conversations with an ICJ Link Worker, and care plan will be created for the patient, to ensure they are receiving all the relevant information and support they require throughout their cancer journey.

From the 17th of December 2024, to 30th of July 2025, the ICJ service has received 58 referrals. The vast majority of referrals were from Macmillan services.

Being a new service, it was important for the ICJ service to be present within the community and engage with potential referrers, while additionally learning about services for patient. To do this, the ICJ team have attended around 30 separate team meetings, including meetings such as the GP Subgroup and Cluster, various NHS Orkney and Orkney Islands Council team meetings, Citizen's Advice Bureau, THAW, Relationship Scotland Orkney, and many more. The ICJ team have additionally attended various local community groups to engage with the public, such as BALL groups, CLAN men's and women's groups, community tea mornings.

To support in becoming a well-known service within the Orkney community, the ICJ service have hosted and taken part in various events, such as an open day for World Cancer Day and an ICJ Introduction Day, multiple stalls in Tesco, and a stall in the Kirkwall Library, at a Social Prescribing event, and at Stromness Shopping Week.

Providing promotional material to key stakeholders and within the community has additionally been a key method of promoting the service. A service promotion poster and leaflet were developed and widely distributed across the community, including in primary care sites, community centres, local councils, shopping and leisure facilities and third sector premises. Further promotional materials developed include bookmarks and a pull up banner.

Improving the Cancer Journey (ICJ)

The Improving the Cancer Journey (ICJ) service is here to support anyone in Orkney that has been affected by cancer, with their non-clinical needs.

It can be difficult to know what services are out there but through caring and non-judgemental support, ICJ is here to help.

How does it work?

Everyone accessing ICJ is offered a simple check box style questionnaire that looks at the needs or concerns someone may have about any area of life, not just cancer. These concerns can be:

- Financial - How will I pay for my food and bills when I'm not working?
- Practical - Who will look after my farm / house when I'm accessing treatment?
- Physical - How will my treatment affect my appearance and energy levels?
- Emotional - I'm worried about my family and friends, and feel anxious and lonely
- Spiritual - How do I deal with past regrets or worries about the future?

Scan the QR code to access the ICJ website and self-referral form

01856 888084 (Public Health Department)

ork.icj@nhs.scot

Additional areas of promotion utilised by the ICJ service have been a NHS Orkney press release, articles in the Orcadian newspaper, interview on Radio Orkney, internal promotion to NHS Orkney staff through newsletters and Teams pages and screen displays, regular posts in various community newsletters including VAO and Island newsletters, regular emails to distribution lists, and social media promotion from the NHS Orkney Public Health Facebook page. All of the above methods of promotion allow us to reach various demographics within the community and support in creating public knowledge and understanding of how the Improving the Cancer Journey service can support them.

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Cultural Development, Governance and Senior Leadership External Review – Action Plan progress update**
Responsible Executive/Non-Executive:	**James Goodyear, Interim Chief Executive**
Report Author:	**James Goodyear, Interim Chief Executive**

1 Purpose

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

The Board is asked to take assurance

- On the continued progress against the Action Plan and the highest priorities agreed by the Board, noting actions which are ow noverdue.

2 Report summary

2.1 Situation

Mid-2024, our previous Chief Executive commissioned an external review of Cultural Development, Governance and Senior Leadership at NHS Orkney to help to identify good practice and recommendations for areas of focus to support our continuous improvement.

At its February 2025 meeting, the Board received the Report and approved an Action Plan with a set of highest priorities, all of which have been incorporated into our Year 2 Corporate Strategy (2025/26) to ensure alignment and delivery this financial year.

It was agreed that progress against the Action Plan was of such significance to the Board's progress that an update would be brought to every public Board meeting commencing April 2025, so that this could be tracked and for transparency.

This is the fourth update to the Board which evidences that we continue to make progress against the recommendations and have taken forward further work between September and October 2025, providing assurance that we are delivering on our commitment to delivery against the highest priorities that the Board agreed.

2.2 Background

Scottish Government (SG) supported NHS Orkney to commission this review as part of a wider package of work we are doing to inform future progress and priorities as the organisation considers

what is needed to de-escalate from Level 3 of the NHS Scotland Support and Intervention Framework.

Professor Tracy Myhill led this work as an experienced HR Professional and CEO and prior to her retirement was the Chief Executive of Swansea Bay University Health Board.

There were 33 recommendations in total in the report, made up of work already underway/started and a small number of new actions.

The highest priorities agreed by the Board, which also feature in our Year 2 (2025/26) Corporate Strategy, are:

1. Executive Team cohesion
2. Clinical Executive Director leadership and engagement
3. Behavioural standards
4. Leadership development programme
5. Appraisals, training and sickness
6. Respecting governance

The remaining actions are outlined in the Action Plan (see Appendix 1 for the latest status update of each individual action).

This report is a progress update against this Action Plan, which will feature on every public Board agenda until the Board is assured and confident that appropriate progress is being made and sustained.

Progress summary against Action Plan (for the period September - October 2025)

Completed actions:

1. Cultural development and Values and Behaviours Framework - Behavioural standards Framework launched September 2025 following extensive engagement with staff and the Board.
2. Distributed leadership – CEO portfolio redistributed following the departure of the Chief Executive in September 2025, and role review underway and near completion.

There are several actions now mostly complete/progress being made:

1. Leadership Development programme/tender process – coming to Senior Leadership Team in October for approval, the managers' programme agreed and to launch in Quarter 3 2025/26.
2. Respect for our governance – operational governance review now concluded, an improvement plan will be developed for consideration by the Senior Leadership Team in November 2025.
3. Restating the role of Chair and Vice Chair responsibilities via clear communication to all Board members – this will be completed by the end of November 2025.
4. Staffing resource analysis - This action is being taken forward as part of the workforce workstream (Improving Together (efficiency) programme) led by the Interim Director of People and Culture.

The following actions are overdue based on the original deadlines agreed (some of which were due for completion at the end of Quarter 1 2025/26):

1. Clinical engagement - the refresh and relaunch of the Clinical Strategy, this will be guided by insights gained from the Clinical Services Review.
2. Staff engagement - Introducing the quarterly pulse survey for staff which will be taken forward when the Director of People and Culture joins the Organisation in November 2025.

2.3 Assessment

The Board is asked to take assurance on progress against the Action Plan and the highest priorities agreed by the Board and noting those actions which are now overdue (this update details progress made between September and October 2025).

2.3.1 Quality/ Patient Care

There are several recommendations in this report, notably the role of our Clinical Executive Directors and requirement for closer working, in driving improvements to patient safety, experience and quality of care through greater cohesion, along with strengthened team working from our Executive Team.

2.3.2 Equality and Diversity, including health inequalities

In relation to equality, diversity, and health inequalities, the Board remains committed to fostering an inclusive environment that addresses the varied needs of both patients and staff. The report highlights several recommendations aimed at reducing health disparities and strengthening diversity initiatives, with an emphasis on collaborative working among Clinical Executive Directors. This approach seeks to ensure equitable access to care and improve patient outcomes through targeted actions and ongoing engagement, reflecting the Organisation's priority to champion fairness and tackle inequalities across all services.

2.3.3 Route to the Meeting

This progress update has come direct to the Board.

2.4 Recommendation

- The Board is asked to take assurance on the continued progress against the Action Plan and the highest priorities agreed by the Board, noting actions which are now overdue.

2.5 Appendices

- **Appendix 1** – Action Plan.

NHS Orkney

Meeting:	**NHS Orkney Board Meeting**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Themes from Board Walkarounds August, September and October 2025**
Responsible Executive/Non-Executive:	**Davie Campbell, Interim Board Chair and James Goodyear, Interim CEO**
Report Author:	**James Goodyear, Interim CEO**

1 Purpose

This report is presented to the Board for **Discussion.**

The Board is asked to.

- **Discuss** the themes from Board Walkarounds held in August, September and October 2025.

This report relates to:

- Corporate Strategy 2024/28 - People
- Operational Improvement Plan
- Annual Delivery Plan
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Board Walkarounds are one of the ways in which we ensure the visibility of Board members and ensure staff across the organisation feel heard.

This report summarises the main themes from the Board Walkarounds in August, September and October 2025 and provides an analysis of the key themes for the Board to consider.

2.2 Background

Board Walkarounds involve a blend of Executive Directors and a Non-Executives visiting different teams and departments across NHS Orkney and listening to how it feels working here.

They are an opportunity for Board members to listen, to get to know staff and build relationships and hear firsthand what staff are proud of and any challenges they face. Following a Board Walkaround, Board members are asked to consider what support they can offer to resolve challenges and, in some cases, unblock issues.

Since the last Board meeting in August 2025, three walkarounds have taken place as follows:

- Information Governance and Freedom of Information (FOI) Team
- Rousay GP Surgery
- Executive Assistant Team

Main themes from reflections of visits in August, September and October 2025

Below is a summary of the main feedback received from the three most recent walkaround reflections.

What's working well:

- Strong teamwork, positive relationships
- Good links within NHS Orkney
- Exceptional external audit into our Information Governance Service
- Teams are flexible to meet the breadth of services being delivered
- Supportive Team Manager makes the team feel valued
- Constructive problem-solving across the team

Areas for improvement:

- Publication of bank and locum costs on our website will reduce will improve visibility and reduce the multiple Freedom of Information requests being received
- The creation of a non-clinical administration team will free up time for senior leaders.
- Improvements are needed to gather feedback from staff which will supplement objective measures set out in our Corporate Strategy
- Communication on discharges from The Balfour to our ferry linked isles.
- A better organisation wide understanding of the importance of response times to and from the executive assistant's team
- An inconsistent approach to ownership leads to duplication.

2.3 Recommendation

The Board is asked to:

- **Discuss** the themes from Board Walkarounds held in August, September and October 2025.

3. Appendices

- No appendices included

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Safety, Quality and Experience Report, Quarter Two – Quality Extract**
Responsible Executive/Non-Executive:	**Anna Lamont, Medical Director**
Report Author:	**Kat Jenkin, Head of Patient Safety, Quality and Risk**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Annual Operation Plan
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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.

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.

2.2 Background

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.

2.3 Assessment

Quality

We strive to continually improve quality across all our services, clinical and non-clinical. The improvement projects that are carried out in non-clinical services impact on our service users and some of these are included below to demonstrate how we are improving quality across the board not just from learning from incidents, complaints and national audit.

Excellence in Care (EiC).

The year end NHS Orkney Board report, reviewed by the Chief Nursing Officer, evidences substantial progress led by the Excellence in Care (EiC) Nurse and supported by the iHealth team. This work has strengthened assurance around care quality and continues to advance the EiC programme across the organisation.

Pressure Ulcers

Inpatient acquired Pressure Ulcers: No new cases on the wards have been reported. Four patients were admitted with pressure ulcers in June in Eir Acute ward, none in the other wards. Work was undertaken in the last financial year to support the staff around tissue viability which is reflected in the numbers (zero) of inpatient acquired pressure ulcers.

EiC Measures and Data Submission

Submission rates for EiC measures have shown steady improvement, with a temporary 6% decline in May attributed to delays in data retrieval, which has since been resolved. Additional measures, including School Nursing and the Maternity Early Warning Score, were introduced in June. Public Health Scotland (PHS) is currently reviewing measures related to Multi Drug Resistant Organisms (MDRO), Mental Health, and Perinatal care, all of which are being actively supported by the EiC Nurse and relevant clinical colleagues within NHS Orkney.

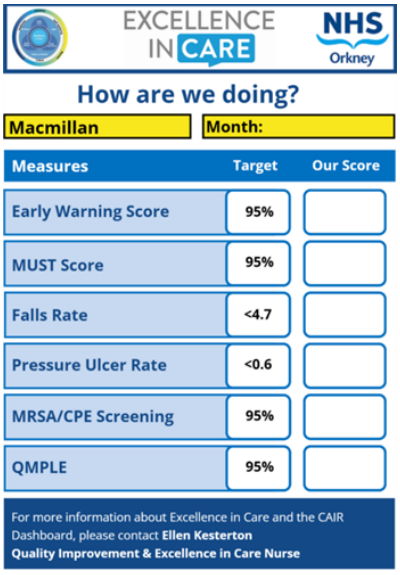
Table 1: Monthly Submission Rates (%) – NHS Orkney

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
19%	19%	19%	19%	19%	19%	19%	28%	31%	34%	28%	34%

The submission report presents data on the nationally agreed Excellence in Care (EiC) measures as captured in the CAIR dashboard, covering the period from June 2024 to June 2025. High levels of data completeness across teams are essential to enable meaningful evaluation of care standards. This report serves as a key resource for the Quality Improvement Board and is displayed in ward areas to support visibility and engagement.

Senior Charge Nurses and Midwives 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.

To support transparency and shared responsibility, ward-level EiC posters, such as the example from Macmillan Ward below, have been developed to display performance against national benchmarks, reinforcing NHS Orkney's values of care, compassion, dignity, respect, quality, and teamwork.


EXCELLENCE IN CARE

NHS Orkney

How are we doing?

Macmillan | Month:

Measures	Target	Our Score
Early Warning Score	95%	
MUST Score	95%	
Falls Rate	<4.7	
Pressure Ulcer Rate	<0.6	
MRSA/CPE Screening	95%	
QMPLE	95%	

For more information about Excellence in Care and the CAIR Dashboard, please contact **Ellen Kesterton**
Quality Improvement & Excellence in Care Nurse

Quality Improvement Projects

Community Dressings Pilot Project

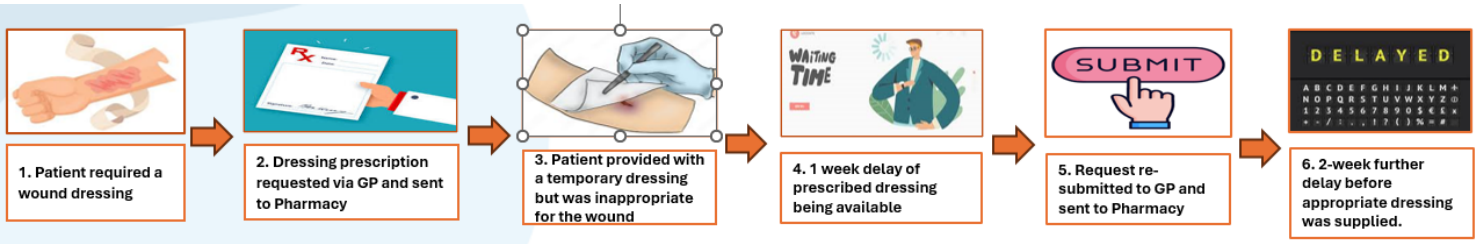
This project aimed to transition from pharmacy-led prescribing of dressings to a top-up stock-based model to minimise waste, improve timely access to appropriate dressings, reduce costs, and standardise stock control.

Before the pilot project, dressings were prescribed through pharmacy. This meant that when a patient required a dressing for a wound, the community nursing team had to request a prescription, wait for the pharmacy to authorise it, and then supply it to the patient.

Due to this delay, patients were often given unsuitable or inappropriate dressings as a temporary measure until the prescribed item became available. In some cases, the prescribed dressing was still not appropriate or did not fit the wound, resulting in further delays while an alternative was prescribed.

When dressings were prescribed but found to be unfit for use, they could not be repurposed for other patients, leading to significant waste.

The following case example illustrates this challenge within the community setting.



A pilot project was introduced within the East Mainland Community Nursing Team to transition from pharmacy-led prescribing of dressings to a top-up stock-based model. The project involved close collaboration between community nursing, pharmacy, the improvement team, finance, estates, and procurement.

As part of the pilot, a cupboard at Skerryvore Practice was identified and refitted to store a standardised supply of dressings. Once this was in place, prescribing of dressings ceased. The implementation of the new dressing supply process has delivered measurable benefits across patient care, staff experience, and organisational sustainability. Patients have experienced improved clinical outcomes, including enhanced wound healing and reduced delays in treatment, with timely access to appropriate dressings contributing to a more efficient and person-centred care pathway. One patient, who previously required multiple home visits per week, now safely receives care once weekly due to improved stock control and access, demonstrating the tangible impact on patient experience and resource use.

For staff, the process has enabled immediate access to suitable dressings, allowing clinical teams to exercise professional judgement based on direct assessment rather than relying on prescriptions issued remotely. This has reduced delays in care delivery and improved autonomy in clinical decision-making. Staff have reported that the new system has significantly enhanced their ability to provide responsive care.

From a financial and sustainability perspective, the project has exceeded expectations, delivering savings of £28,050, more than double the original target. Dressings are now managed as NHS Orkney property rather than being allocated to individual patients, reducing waste and ensuring efficient use of resources. The success of this initiative has also catalysed further process improvements aimed at reducing delays and enhancing financial sustainability across the organisation.

Building on the success of the initial pilot, the next phase will be rolled out across the West Mainland. This includes the refitting of storage cupboards within Dounby and Stromness Practices. Due to location-specific constraints, this phase will operate using a manual Pecos ordering system rather than the previously implemented top-up stock model. However, the operational process will remain consistent, ensuring continuity in access and care delivery.

The expansion is expected to generate further financial savings, reduce product waste, and maintain timely access to appropriate dressings and clinical supplies. These improvements will continue to support both patient outcomes and staff efficiency, reinforcing the benefits already demonstrated in the pilot phase.

Following the West Mainland implementation, the longer-term objective is to extend the model across the isles. This phased approach reflects NHS Orkney's commitment to sustainable service improvement, equitable access, and the delivery of high-quality, person-centred care across all geographic areas.

Capsule Sponge Endoscopy

The Capsule Sponge Endoscopy service is transitioning from a test-of-change model to a Business as Usual (BAU) clinic, following a lesson learned review and approval by the Clinical Quality Group in July 2025. Referral processes, consent protocols, and the Standard Operating Procedure (SOP) will be reviewed and approved accordingly.

A comprehensive documentation package has been developed to support this transition. The SOP was updated post-approval on 15 January 2025. Patient feedback indicates enhanced experience, reduced clinical risk, and improved diagnostic accuracy for oesophageal conditions. The initiative also contributes to shorter waiting times and aligns with the principles of Realistic Medicine, emphasising personalised care, shared decision-making, and continuous improvement.

Cancer Workstream

NHS Orkney's cancer pathways, aligned with those of NHS Grampian, are currently undergoing a structured review. This review is focused on strengthening the entire referral to discharge process, with the aim of improving timeframes and therefore, reducing clinical risk, and enhancing the overall patient experience.

Weekly multidisciplinary meetings have been established to support this work, providing a consistent forum for evaluating current pathway performance, identifying gaps, and agreeing on improvement actions. The review is progressing well, with revised pathways expected to be finalised shortly. These updates will support a more streamlined and person-centred approach to cancer care across NHS Orkney, ensuring that services are responsive to patient needs and aligned with national standards.

This work reflects NHS Orkney's commitment to continuous improvement and the principles of Realistic Medicine, particularly in delivering care that is tailored, evidence-informed, and focused on what matters most to patients.

Realistic Medicine

Funding for the Realistic Medicine Clinical Lead Role was confirmed at the end of 2024/25 with the final year report and action plan for 2025/26 agreed. This year's plan focuses on awareness raising, embedding Realistic Medicine into systems through specific projects. Ongoing collaboration with Grampian's Realistic Medicine team continues with regular meetings and planning.

Awareness Raising

Opportunities to share Values Based Health and Care and Realistic Medicine through meetings and planned presentations have been completed in the following areas: Clinical Education meeting, oral health, radiology, Green Maternity and a staff training session with the Dounby Surgery. These opportunities have allowed the Realistic Medicine principles to be connected to the work in these areas but has also allowed the sharing of good practice and ideas to further develop values - based health and care. In a national context the School Engagement Project has been shared at the NHS Scotland Conference and the Realistic Medicine Conference in a poster format. This poster will be displayed in the foyer. This work has also been published in the Realistic Medicine Case Book which showcases good practice across Scotland.

Embedding Realistic Medicine in our systems

Realistic Medicine principles are being actively embedded within NHS Orkney's approach to patient experience, particularly through the work led by the Director of People and Culture. These principles are shaping how the organisation interprets, evaluates, and reports on patient experience, ensuring that care is person-centred, outcomes-focused, and aligned with individual needs and values.

A key area of application is the outpatient transformation programme, where Realistic Medicine has informed the approach to Near Me appointments, particularly those aligned with NHS Grampian pathways. This supports a personalised model of care by reducing unnecessary travel and improving accessibility.

By integrating Realistic Medicine into strategic planning and operational delivery, NHS Orkney is strengthening its commitment to delivering care that is compassionate, evidence-informed, and responsive to what matters most to patients.

Conclusion

NHS Orkney continues to demonstrate a sustained commitment to improving quality across all services. Progress in incident management, Excellence in Care, and targeted improvement projects reflects a system-wide approach to enhancing patient outcomes, staff experience, and organisational sustainability. The integration of Realistic Medicine principles further supports person-centred care and continuous improvement.

2.3.1 Quality/ Patient Care

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.

2.3.2 Workforce

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.

2.3.3 Financial

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.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

There is no identified impact identified with this paper.

2.3.6 Climate Change Sustainability

There is no identified impact identified with this paper.

2.3.7 Other impacts

There is no identified impact identified with this paper.

2.3.7 Communication, involvement, engagement and consultation

The Safety, Quality and Risk team has engaged with a number of services and areas across the organisation to provide the information within this report.

2.3.9 Route to the Meeting

To ensure that excellence and learning is highlighted and shared across the organisation this report has been shared with the Clinical Quality Group and Senior Leadership Team, prior to being presented at Joint Clinical and Care Governance Committee in its entirety with the quality extract being presented to Board.

2.4 Recommendation

It is asked that the Board review and discuss the report and information contained within it.

- **Discussion** – Examine and consider the implications of a matter.

3 List of appendices

There are no appendices with this paper.

NHS Orkney

Meeting:	NHS Orkney Board
Meeting date:	Thursday, 30 October 2025
Title:	Infection Prevention HAIRT Report
Responsible Executive/Non-Executive:	Sam Thomas, Executive Director of Nursing Midwifery and AHPs & Chief Officer Acute
Report Author:	Sarah Walker Head of Infection Prevention

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board

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

- Safe
- Effective
- Quality
- Person centred

2 Report summary

2.1 Situation

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 IP&C Standards.

- Local Delivery Plan (LDP) Standards to date; surveillance for Quarter 2 (LDP Standard year) has been yet to be validated with Antimicrobial and Healthcare Associated Infection Scotland (ARHAI). However, those being confirmed are included in this report and are based on Healthcare Associated Infections (HCAI) only, as per **DL(2025) 05**.

  To date Healthcare Associated Infection cases:

  SAB – 3
  CDI – 0
  ECB – 4

- SSI surveillance is currently paused, pending review

- Meticillin Resistant *Staphylococcus aureus* (MRSA) and Carbapenemase producing *Enterobacteriaceae* (CPE) national Clinical Risk Assessment, which requires completion at time of admission: for Quarter 2 (calendar year) data has been received from the Antimicrobial and Healthcare Associated Infection Scotland Data team and currently sits at:

  MRSA Clinical Risk Assessment - **87%**, despite this not meeting the 90% target, it remains marginally above the NHS Scotland average of 83%.

  CPE Clinical Risk Assessment remains **100%**

  Changes have been made to the Clinical risk assessment document to reflect the changing picture across Scotland and individuals undergoing treatment abroad.

- Hand Hygiene scores have improved slightly from 91% at the last report to **93%,** however this still fails to meet the 95% target. This reflects colleagues cleaning hands but using the incorrect technique, which could impact on their hand health or alternatively some missed opportunities to undertake hand hygiene by new staff members, discussion at the time of audit with individuals continues but peer "Kind to Remind" messaging within departments needs to become embedded.

- Domestic monitoring scores remain above the national target of 90%:

  August - Domestic: **95.68**% Estates: **100**%

  September - Domestic: **95.09**% Estates: **99.97**%

- Infection Prevention Team Updates:

  Work including ensuring a local voice within national stakeholder groups for developing guidance and plans for future surveillance requirement is ongoing. New High Consequence Infectious Disease guidance has been added as an Addendum to the National Infection Prevention and Control Manual, and this require a huge drive to ensure that the Board can demonstrate preparedness for a case presentation.

  Care home and third Sector education has been delivered and commencement of Standard Infection prevention and Control quality assurance audits, to support and encourage Care Home teams to implement peer auditing for improvement.

  Antimicrobial Resistance and Healthcare Associated Infections Scotland have released their Annual Report – **link here.**

2.2 Background

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

There is a vast category of criteria that would capture cases within healthcare associated including, a timing from admission to obtaining blood culture samples, and further examples would be receiving haemodialysis as an outpatient, overnight admission to hospital in the previous 30 days, resides in a care facility or undergone any medical procedure which broke mucous or skin barrier (list is not exhaustive), therefore, many cases will be considered healthcare associated, due to the demographics of the patient groups in general.

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

2.3 Assessment

The Board has not achieved its Local Delivery Standard for *Staphylococcus aureus* bacteraemia, as the target was set at zero. NHS Orkney are also very unlikely to meet its *E. Coli* Bacteraemia target of no more than five cases. This is in part due to the extremely low level of cases set for achievement and that the criteria for inclusion under the heading of Healthcare Associated Infections includes quite a wide remit, such as admission to hospital in the previous 30 days (including an unrelated admission), having bloods obtained in General Practice or living in a care home.

However, the key factor is that each and every case is investigated.

For more information: Protocol for National Enhanced Surveillance of Bacteraemia

More information on specific pathogens can be found in the National Infection Prevention & Control Manual - A-Z pathogens

2.3.1 Quality/ Patient Care

Each mandatory surveillance case is investigated in collaboration with their clinician and the Infection Prevention & Control Doctor. All infections assessed as preventable when investigated are reported as incidents, through the Incident Reporting System and shared with clinicians and teams supported by any educational needs identified.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A.

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Climate Change Sustainability

N/A

2.3.7 Other impacts

N/A

2.3.8 Communication, involvement, engagement, and consultation

N/A

2.3.9 Route to the Meeting

N/A – Healthcare Associated Infection Reporting Template (HAIRT) is a standard agenda item for Board awareness, as requested by Scottish Government.

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- None



NHS Orkney

Infection Prevention & Control Healthcare Associated Infection Reporting Template (HAIRT)

October 2025

Created by:

Sarah Walker

Head of Infection Prevention



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Executive Summary

Summary of the April 2025 - March 2026 Local Delivery Plan HCAI Standard to date

***Staphylococcus aureus* bacteraemia**

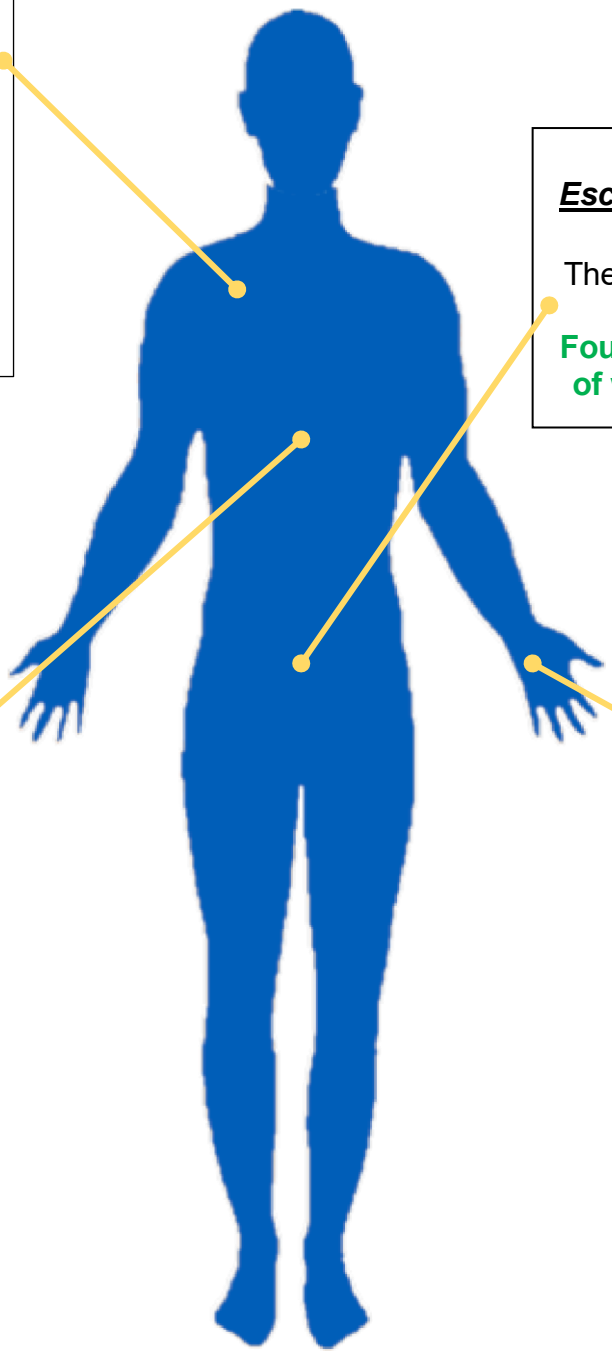
The Standard is set at zero HCAI cases

Three cases to date which includes one yet to validated

***Escherichia Coli* bacteraemia**

The standard is set at 5 HCAIs

Four cases to date with three of which yet to be validated



***Clostridioides difficile* Infection**

The standard is set at one HCAI case

Zero cases to date

Hand hygiene

Currently stands at **93%** for hand hygiene across secondary care for August and September, main issues noted were non-compliance with WHO 5 moments for hand hygiene by new staff and incorrect hand hygiene technique, this requires to be driven within departments by peer support and by Department Leads

Staphylococcus aureus bacteraemia (SAB)

Surveillance is in combination with the Leading Clinician to identify the underlying cause and any risk factors. The LDP standard to March 2026, has been confirmed as no increase in incidence (number of cases) of Healthcare Associated Infection (HCAI) cases, based on the baseline 2023-24 case numbers.

LDP Standard baseline using baseline data for 2023-24, which equates to no more than zero healthcare associated Infection cases.

Status: Two cases confirmed for LDP standard quarter 1, one case not yet validated with the national surveillance team for quarter 2.

Dashboard

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

Clostridioides difficile Infection

Clostridioides difficile Infection surveillance is undertaken routinely along with the Leading Clinician or GP to identify cause and any risk factors.

The LDP standard to March 2026, is set at no more than one Healthcare associated Infection case.

Status: Zero cases for Q2 LDP standard, yet to be validated with the national surveillance team.

Clostridioides difficile Infection – LDP Standard Quarters for 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			
Q4 – Jan - Mar			

Escherichia Coli (ECB) Bacteraemia

The LDP standard to March 2026 is set at which equates to no more than 5 Healthcare associated Infection (HCAI) cases.

HCAI includes admission for any reason within 30 days

Status: three HCAI cases for LDP Standard Q2, yet to be validated with ARHAI

Escherichia Coli (ECB) Bacteraemia – LDP Standard Quarters for 2025-26

	Community Cases	Healthcare Associated Cases (HCAI)	Hospital Cases (HCAI)
Q1	1	1	0
Q2	1	3	0
Q3			
Q4			

LDP standard only included	Cases by Source
Respiratory	
Unknown	
Intra-abdominal	
Hepatobiliary	
Renal Tract Infection	3
Other	1

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

The Clinical Risk Assessment question set is quite fluid and has been updated to capture, where there is a national change to reflect where risks have been recorded through the surveillance program, i.e. cosmetic surgery abroad, and locally hospitalisation in a cruise ship sick bay (changes highlighted in blue for information)

Q2 calendar year received from national data team, reported in calendar year quarters by ARHAI. **Target is set at 90%** and reflects that a documented formal risk assessment at patient admission was carried out to **assess risk of colonisation for Meticillin Resistant *Staphylococcus aureus* (MRSA) or Carbapenemase-producing *Enterobacteriaceae* (CPE) colonisation only.** This does not reflect MRSA or CPE colonisation rates.

Question set below:

Meticillin Resistant *Staphylococcus aureus* (MRSA)	**Carbapenemase-producing *Enterobacteriaceae* (CPE)**
The patient has been admitted with a chronic wound/ulcer, or an invasive device which was present prior to admission.	Has the patient been an inpatient (including cruise ship sick bay/ward), received cosmetic surgery in the previous 12 months?
Care Home resident or Inpatient Hospital transfer (cruise ship sick bay)?	Has the patient had holiday dialysis outside of Scotland in the previous 12 months?
Is admitted to a higher risk speciality (HDU)	Does patient share a bedroom with a colonised /infected CPE case?
Expected to undergo invasive orthopaedic surgery (other than day care)	

Clinical Risk Assessment KPI by Quarter – Local and National Data

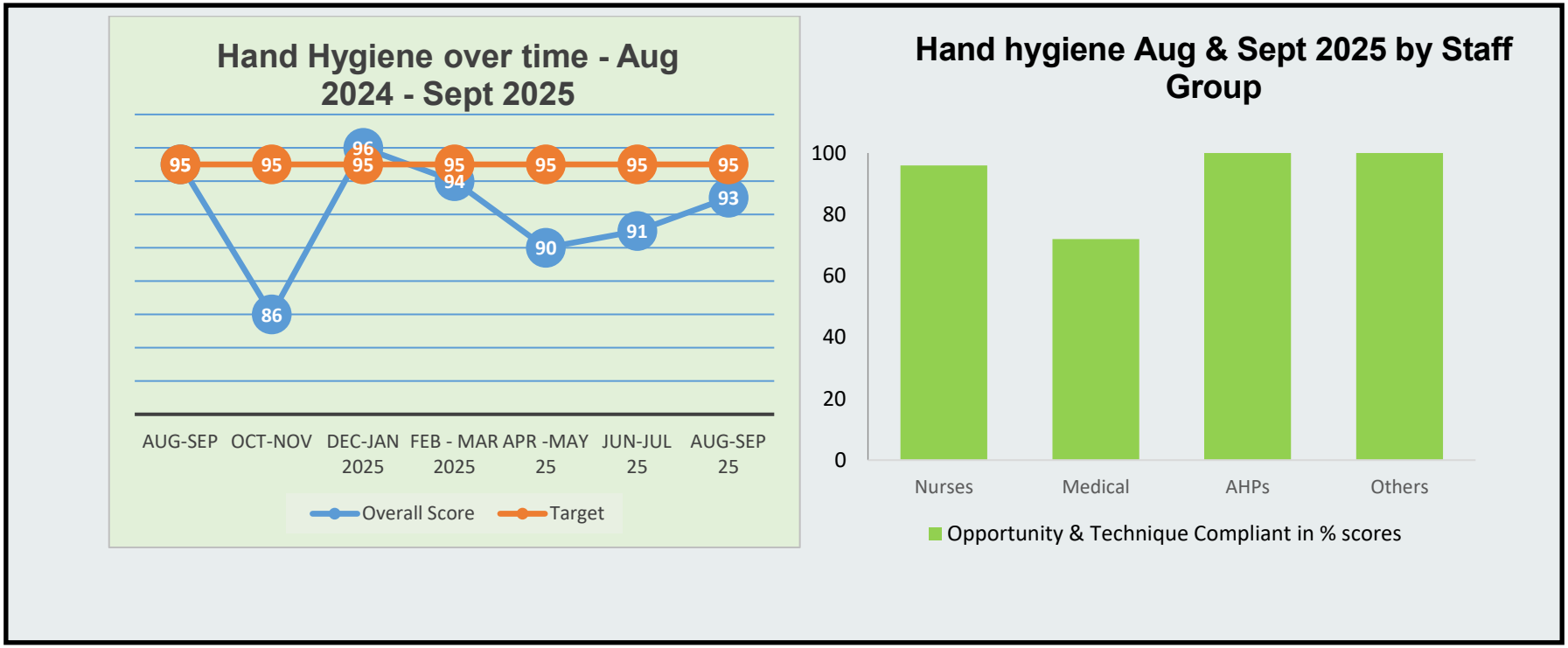
Nationally Produced Data

Quarters by calendar year as reported by ARHAI Scotland	**Local MRSA Screening % Scores**	**Local CPE Screening % Scores**	**National MRSA Screening % Scores For Benchmarking only**	**National CPE Screening % Scores For Benchmarking only**
Q3 Jul-Sept 2024	67%	100%	81%	80%
Q4 Oct-Dec-2024	93%	100%	81%	83%
Q1 Jan-Mar 2025	83%	100%	81%	84%
Q2 Apr-Jun 2025	87%	100%	83%	85%
National Set Target	**90%**	**90%**	**90%**	**90%**

Hand Hygiene

The hand hygiene score for June to July 2025 is now **93%** against the **95% target.**

The main issues are incorrect technique for hand hygiene, and medical staff not following the World Health Organisation “5 moments for Hand hygiene”. Any areas for improvements are discussed with individuals at the time of audit and fed back to department leads for follow up. All departments continue to complete peer Standard Infection Control Precautions, which include Hand hygiene so will assist improvement over time.



Local Domestic and Estates Environmental Scores by month

The environment is crucial to prevention/transmission of infection; the domestic score continues to sit above the Scottish target of 90%.

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

Infection Prevention Team (IPT) Updates

National Workstreams There are number of national workstreams ongoing currently, which are being supported by Board IPTs, most with implementation in 2026, so another busy year ahead, an example is below:

- Future National Surveillance Currently work is ongoing within a national stakeholder group for forward planning and discussion with the Scottish Government on what national surveillance will entail and setting of new Local Delivery Standards from April next year.
- Task and Finish group for High Consequence Infectious Disease Personal Protective Equipment Group has just concluded and an addendum to the National Infection prevention and Control Manual added. The release of the addendum was supported by **a** DL 2025(20) informing Boards of an implementation date of August 2026. Preparedness for a case of high consequence infectious disease is led by Public Health, supported by the Infection Prevention team for staff PPE training and to support secondary care patient pathways. Implementation and embedding will require full support of Primary and Secondary Care to demonstrate Board preparedness across both settings.
- Transmission Based Precautions with NHS Scotland leading the way on these changes, NHSO IPT are fully involved in the stakeholder group. This work has been some time in progress with an expectation of publishing and implementation in April 2026.
- Antimicrobial Resistance and Healthcare Associated Infection Scotland have now published their annual report for 2024, which is accessible here

Secondary Care Updates

- Despite the increased activity within secondary care in recent months the departmental teams continue to complete their Standard Infection Control Precautions peer audits, and this is the best way for teams to understand that SICPs are for all patients every time, so teams need to be congratulated.
- Quality assurance audits continue undertaken by the Infection prevention team to ensure that safety through infection prevention is front and centre of colleague's minds.
- To support this and in preparedness for a Healthcare Improvement Scotland (HIS), HAI and Care inspection, Leadership walkarounds undertaken by the HAI executive Lead, head of Infection prevention, Head of Estates, Domestic Supervisors

and Health & Safety Advisor are near completion, with just one area left to complete, which is scheduled for later this month.

- All recent inspections published by the HIS team are shared on an ongoing basis with Senior Charge Nurses, for benchmarking and improvement plans, where required.

Primary Care.

- Annual quality assurance audits are completed and improvement plans received from most practices. The IP Practitioner continues to meet with practitioners on a regular basis as they wish, to assist with progressing the improvement plans.

Care Home Support

Following all recent education and support offered to Care Home Managers and Seniors, around winter preparedness/outbreak management and following encouragement for Care Home teams to undertake their own Standard Infection Control Precautions, the Infection prevention Practitioner has commenced quality assurance audits with feedback to teams when on site and followed up in writing to the Care Manager, along with links to the national guidance, in the hope that this will offer the motivation to commence their own in house audits.
These audits are a little more challenging, due to the geography of the buildings therefore audits have been adapted to include hypothetical scenarios on what Personal Protective Equipment would be required for tasks and the steps included for compliant Hand hygiene technique.
The audits to date have highlighted that there is some improvements required, and this will be a work in progress.

Third Sector Education

Following discussion through the Care Home and Care at Home Support Group, the IP team offered to support Crossroads Orkney with some Infection prevention education. This was interactive session with the team. There were two main themes, hand hygiene and importance of bare below the elbows – why do we carry out hand hygiene was the main goal of the training. Those who attended where asked to take part in using the lightboxes for awareness of the quality of their hand hygiene and frequently missed areas, and the correct

method for putting on and taking off their personal protective equipment to prevent contamination. This encouraged really good discussion within the team. The feedback and evaluations forms were very positive from the manager and the staff who attended.

Exception Reporting to Scottish Government

No exception reporting required.

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Clinical Services Review Update**
Responsible Executive/Non-Executive:	**Dr Anna Lamont: Medical Director** **Stephen Brown: Chief Officer IJB** **Sam Thomas: EDoNMAHP & Chief Officer Acute Services** **Tammy Sharp: Director of Performance and Transformation (and Deputy CEO)**
Report Author:	**Dr Anna Lamont**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Corporate Strategy 2024/28
- Annual Operational Plan
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Clinical Services Review (CSR) programme has formally transitioned from the review stage into implementation. Dr Anna Lamont has been confirmed as Board Lead, with

Tammy Sharp coordinating overall programme support and delivery. Executive and clinical leads have been assigned across the six priority workstreams, and governance arrangements are being embedded through the Improving Together Programme Board (ITPB), Joint Clinical and Care Governance Committee (JCCGC), Clinical Governance Group, and the Finance & Performance Committee (F&P).

The CSR is now a standing item at ITPB. From October, the ITPB will operate a two-part format, with Part 2 dedicated to CSR outputs and highlight reporting. JCCGC remains the primary Committee for clinical assurance of implementation.

2.2 Background

The CSR was commissioned with Scottish Government support to address the long-term sustainability, quality, and equity of clinical services across NHS Orkney. The final report, authored by Jennifer Armstrong, was received in July 2025. It aligns with NHS Scotland's Renewal and Reform framework and NHS Orkney's Corporate Strategy 2024–28 and sets out a whole-system plan to redesign services around safety, effectiveness, and person-centred care.

The CSR recommendations span hospital services (acute/front door and planned care), primary and community services, older persons' care, Isles care, and digital healthcare. An operational CSR Implementation Group, including the Medical Director, Director of Nursing, Chief Officer IJB, and Director of Performance and Transformation, have been meeting weekly to oversee delivery.

Six workstreams have been established with designated executive and clinical leads:

- **Operational Structure** – Tammy Sharp
- **Acute / Front Door** – Sam Thomas
- **Planned Care** – Anna Lamont
- **Older Persons – Stephen Brown**
- **Isles Care** – Stephen Brown
- **Digital** – Melanie Barnes

Each workstream is responsible for action plans, development of Project Initiation Documents (PIDs), identification of delivery leads, and engagement with clinical staff and system partners.

2.3 Assessment

Workstream Activation

- Initial workshops have been held or scheduled for all workstreams during September.
- The Operational Structure workshop was arranged for early September, facilitated by Fiona Hogg, and focused on embedding a whole-system model to support sustainable service delivery.
- The Digital workstream is a cross-cutting theme and will be the last workshop held to support input from all other workstreams as necessary

Programme Documentation

- Project Initiation Documents (PIDs) and project plans have been written for each workstream following completion of each of the initial workshops
- Each Executive Lead will have a PID and draft project plan available ahead of the October Board meeting, ensuring visibility of milestones, risks, and interdependencies.

Engagement

- A communications and engagement plan to support the workstreams of the Clinical Services Review will be worked up to sit alongside project documentation and plans
- Feedback mechanisms will be designed and implemented to capture staff input before and after sessions, and to ensure feedback loops into programme governance.
- Work is underway to extend engagement to patients and community voices, recognising this was not in the scope of the original CSR but is considered essential for legitimacy of implementation.

- **Resourcing**
  - Recruitment is in progress for two project managers within existing substantive role funding.
  - Interim project management cover has been provided by extension to existing staff roles ensuring continuity.
  - The development of detailed Project Initiation Documents across all workstreams, has highlighted recurring themes of constrained project capacity, reliance on interim roles, and the need for coordinated support across programmes. The Improving Together Programme Board (ITPB) has endorsed the principle of aligning project management capacity across interdependent workstreams to optimise delivery efficiency and to ensure clinical and operational input is not duplicated.

2.3.1 Quality/ Patient Care

Positive impacts are anticipated through improved patient pathways and digital innovation. Risks include delivery pace being constrained by staffing capacity, both clinical and project management.

2.3.2 Workforce

Workforce sustainability is a system-wide risk: many posts critical to delivery are filled by temporary staff, leaving implementation vulnerable to turnover. There is a need for clear succession planning and investment in clinical leadership to mitigate this risk.

2.3.3 Climate Change Sustainability

The CSR implementation supports NHS Orkney's climate commitments, with anticipated benefits through **digital-first approaches**, reduced patient travel, and integrated care closer to home.

2.3.4 Finance

Currently balanced risk assessment for costs. While there are some opportunities for savings, these require transformational organisational change particularly for unscheduled care.

2.3.5 Risk Management

There are potential risks to patient care and service delivery if we transform service delivery models without adequate staffing resource or if that staffing resource is then withdrawn after a period of time resulting in risks to safe patient care delivery. Identified risks include sufficient resource for transformational change and spend to save cost impact.

2.3.6 Digital

- Digital enablement is a cross-cutting dependency for almost every workstream:
- Open Eyes implementation is planned for 2026/27, with NHS Orkney participating in national planning meetings this year.
- Datix renewal and RIS/PACS migration are required to modernise safety and imaging systems.
- Microsoft Co-Pilot rollout and Morse Community Electronic Patient Record (EPR) implementation are critical enablers of service redesign.
- A project manager for the digital workstream has been appointed, strengthening delivery capacity. The Digital and Information Oversight Group (DIOG) will complete a Must, Should, Could, Would (MoSCoW) prioritisation exercise of the CSR digital workstream recommendations on 27 October 2025. This process will align digital investment and staff resource with the needs of each CSR workstream and ensure that system dependencies — including EPR modernisation, imaging platforms, and decision-support tools are addressed coherently across the programme. Outcomes will be reported to the ITPB and JCCGC in November.

2.3.7 Equality and Diversity

Supports Public Sector Equality Duty and acknowledges island-specific healthcare delivery

2.3.8 Route to the Meeting - Governance

Clinical services review approved at NHSO Board August 2025

- The CSR is now formally reporting through ITPB, with Part 2 of the Board from October dedicated to CSR progress and highlight reporting.
- Strategic oversight is via Finance & Performance Committee.
- Operational delivery is through the Clinical Governance Group.
- Clinical assurance rests with JCCGC, which receives this update.

2.4 Recommendation

Assurance JCCGC is asked to:

1. Note the governance arrangements and leadership structure now in place.
2. Support the planned clinical engagement sessions and encourage wide staff participation.
3. Acknowledge the digital dependencies and risks and ensure alignment with the Digital and Information Oversight Group (DIOG).
4. Endorse the shared executive approach to CSR delivery, recognising current capacity constraints and the importance of sustained resourcing.

3 List of appendices

The following appendices are included with this report:

- **None**

Item 15.1

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Corporate Strategy Year 2 2025/26 Quarter 2 Report**
Responsible Executive/Non-Executive:	**James Goodyear, Interim Chief Executive**
Report Author:	**Debs Crohn, Interim Head of Corporate Governance**

1 Purpose

This paper is presented to the NHS Orkney Board for **Assurance**:

Members are asked to.

i. **receive** the Corporate Strategy Year 2 2025/26 Quarter 2 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).

This report relates to a:

- Corporate Strategy 2024-2028 – Place, Patient Safety, Quality and Experience, People, Performance and Potential strategic objectives
- Operational Improvement Plan (OIP)
- Integrated Joint Board Strategic Plan
- Annual Delivery Plan 2025-26 (ADP)
- Financial Sustainability

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

- Safe
- Effective
- Person Centred
- Sustainability

2 Report summary

2.1 Situation

This paper informs the Board about Quarter 2 performance on Year 2 deliverables of Corporate Strategy 2025/25 for assurance purposes.

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.

Appendix 1 provides a consolidated scorecard and exception reports for deliverables which are red (significantly off-track) and amber (off-track) in Quarter 2.

2.2 Background

Quarter 2'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) and Performance Review Meetings (PRMs).

2.3 Assessment

Quarter 2 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. 4 of the deliverables are RAG rated Red, 4 rated Amber, 6 Green and 1 deferred to 2026/27.

Appendix 1 updates on performance for each Quarter 2 deliverable in the Year 2 Corporate Strategy Delivery Plan 2025/26, 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
Red - Significantly delayed. • 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
Amber - Partially delayed. • 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
Green - Remains on track. • Action implemented. • Stated deliverables and improvement evidenced	9	6
Deferred to 2026/27	1	1
Total number of deliverables	15	15

NHS Orkney

Item 15.1

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.

Strategic Objective – Patient Safety, Quality and Experience – Executive Director: Medical Director

RAG Status	KPI	Deliverable at Risk	Actions in place to bring deliverable back on track
Amber	Complete an operational governance review which reduces duplication of papers, information and attendance at meetings and ensure respecting our governance is part of our Board development programme	Revised Operational Governance Structure implemented by 30 September 2025.	Operational governance review is now complete - implementation deferred to Quarter 4 following a 5S's exercise (Sort, Set in order, Shine, Standardise and sustain) by the Executive Team in October 2025.

Strategic Objective – Performance – Executive Director: Director of Nursing, Midwifery, AHPs and Chief Officer Acute

Commented [JO1]: There are a range of actions and KPIs under improving access and reducing waits how have we chosen which to highlight here?

RAG Status	KPI(s)	Deliverable(s) at Risk	Actions in place to bring deliverable back on track
Red	We will deliver our 2025/26 financial plan of achieving a £2.176m deficit as at 31 March 2026 and continue our path to de-escalation from level 3 of the NHS Scotland Support and Intervention Framework and return to financial balance by 31 March 2029. We will comply with all terms and conditions associated with the provision of the Transitional Funding support from the Scottish Government (1% of RRL) for 2025/26 and deliver our 2025/26 financial plan of achieving a £2.176m deficit We will deliver £3.8m savings by 31 March 2026 We will deliver 3% recurrent savings (£2.4m) by 31 March 206, continuing the trend for the second year running	Finalised Improving Together Programme plan monitored through monthly reporting via the Improving Together Delivery Group and Improving Together Programme Board with escalation through the Finance and Performance Committee or the Escalation Board as required. Pipeline schemes developed to ensure the overall savings target for the year is delivered. Validation of savings delivery monthly. Implement pipeline schemes/ remedial actions where savings are off track in the quarter.	Our YTD financial position is off track at Month 5 at £200k adverse to trajectory. Additional recovery measures are being put in place, but these are not likely to take effect until Month 6 at the earliest The Financial Escalation Board is being stood down and instead the Finance Performance Committee is being increased to monthly to provide assurance and oversight of the monthly financial position An external financial review has been arranged to provide insight into the run rate and forecast and where there are opportunities for reducing expenditure. 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. 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. Other opportunities are being actively explored.
Red	Reduce the number of Delayed Transfers of Care per week to below 6	Public communications campaign to encourage people to arrange power of attorney and guardianship.	Resource Management Meeting continue twice weekly to discuss all inpatients who may require social care on discharge. Current delayed transfers of care is 17 patients on average over the Quarter.

			Multi-disciplinary meets weekly to discuss all inpatients who may require social care on discharge. Delayed Transfers of Care paper presented to IJB in July 2025. Surge and capacity plan reviewed and updated where appropriate.
Amber	Act on feedback from patients to further improve access to the following services: • Mental Health • Dentistry • Neurodiversity • Outpatients • Primary Care	Develop a patient experience programme that provides a framework for embedding patient experience and engagement into all we do and includes all of the ways we listen to patients and the community.	Patient experience framework which sets out how we listen to and engage with patients developed and approved by the Board in August 2025 Due to capacity issues within the team and a change in Board level lead for patient experience, the patient experience programme will be developed and approved in Quarter 3 by the Senior Leadership Team for onward assurance to the Board
Amber	Increase the number of patients treated in our theatre by 10%	Theatre slots pre-populated up to the end of Quarter 2 to increase theatre utilisation. Theatre utilisation improvement plan developed and approved by the Planned Care Programme Board by 31 July 2025.	Due to significant staffing absences, work has stalled during Quarter 2. A Senior Charge Nurse has now been appointed - an improvement plan will be put in place to bring deliverables back on track in Quarter 3.

Strategic Objective – People – Executive Director: Interim Director of People and Culture

RAG Status	KPI	Deliverable at Risk	Actions in place to bring deliverable back on track
Red	Improve compliance with our statutory/mandatory training rates to >80 %	Introduce drop-in sessions for line managers to learn how to understand TURAS data for area of responsibility. Extended SLT members to produce improvement plans and present these to CEO/Deputy CEO throughout July/August to see marked improvement by December 2025.	Extended SLT members have produced improvement plans which sets out the actions being taken to increase compliance with statutory/mandatory training. Improvement plans presented to CEO/Deputy CEO throughout July/August to ensure there is a marked improvement by December 2025. Appraisal rates continue to increase, currently 48.38%. 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.
Amber	Improve appraisal rates from 36% to >60%	Continue to monitor appraisal compliance. Move to and identify other priority areas across the organisation.	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 – Potential – Executive Director – Interim Director of Finance

RAG Status	KPI	Deliverable at Risk	Actions in place to bring deliverable back on track
Red	Launch a new Education Strategy for all staff groups. Open our new Education and Improvement Centre	Present a business case to the Senior Leadership Team setting out design, costs and timelines for the development of the Education and Improvement Hub, including relocation solutions for affected teams.	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. This decision acknowledges current resource constraints while reaffirming the Centre's status as a Strategic Priority within the Corporate Strategy 2024–2028.
Amber	New model of service delivery for Digital Services	The outcomes/recommendations presented to the Digital Information Operations Group (DIOG) on 25 August 2025, SLT on 30 September 2025, Board and Finance and Performance Committee in October 2025.	Paper brought to SLT May 2025 outlining the potential options for closer collaboration with North of Scotland Health Boards. Work on the future delivery model for the Boards Digital Services progressed albeit slower than as previously agreed due to key absences within the Digital Services team.

2.3.1 Quality/Patient Care

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.

- Recruitment processes
- Outpatients Improvement
- Improving access to key services
- Improving population health
- Achieving Financial plan
- Risk Management
- Accelerating Digital Transformation

2.3.2 Workforce

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.

2.3.3 Financial

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 financial performance and long-term sustainability.

2.3.4 Risk Assessment/Management

Corporate strategic objectives align to the Corporate Risk Register and new risk management 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.

Our Year 2 priorities were developed taking into consideration resource assessment, and investment considerations.

2.3.5 Equality and Diversity, including health inequalities.

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.

2.3.6 Climate Change Sustainability

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.

2.3.7 Communication, involvement, engagement, and consultation

This paper has been produced for the purposes of NHS Orkney Board. The Board has performed its duties to involve and engage external stakeholders where appropriate.

2.3.8 Route to the Meeting

This paper has been developed following engagement and feedback from the Senior Leadership Team and approved at the Senior Leadership Team Meeting 28 October 2025.

2.4 Recommendation (s)

The NHS Orkney Board is asked to:

i. **receive** the Corporate Strategy Year 2 2025/25 Quarter 2 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).

2.3 Appendices

The following appendix is included with this report:

- **Appendix 1**, NHS Orkney Corporate Strategy 2025/26 Year 2, Quarter 2 Performance Scorecard, and exception report

NHS Orkney

Meeting:	**NHS Orkney Board**
Meeting date:	**Thursday, 30 October 2025**
Title:	**Month 6 Financial Position Update**
Responsible Executive/Non-Executive:	**Melanie Barnes, Interim Director of Finance**
Report Author:	**Melanie Barnes, Interim Director of Finance**

1 Purpose

This is presented to the Committee for:

- Awareness
- Discussion

This report relates to a:

- Annual Operation Plan
- Government policy
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Effective

2. Report Summary

2.1 Situation

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.

2.2 Background

After 6 months of the 2025/26 reporting period, the revenue position shows an **overspend of £2.335m**, which is **£0.159m higher** than the approved deficit in the financial plan of £2.176m and **£0.202m higher** than the planned year-to-date overspend of £2.133m.

The achieved savings at Month 6 is **£0.057m adverse** to the YTD target of £0.855m. The trajectory of savings was geared towards the final quarters of the financial year with 78% due to be delivered in the final 6 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). 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.

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 around £6.2m at year-end. However, this does not consider analysis on the reserve position for both the Board and the IJB.

2.3 Assessment

The adverse variance at Month 6 is mainly due to three issues:

- Additional unplanned expenditure in the first 6 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 £0.057m

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.

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 £0.798m of savings after 6 months against a trajectory of £0.855m.

A review of all schemes has been undertaken during Month 6 and 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 £1.3M** of which £0.9M are already in the forecast run rate.

There are several risks that could impact the year-end financial position. As of Month 4, we have outlined a range of potential outcomes, which will be refined as more information becomes available.

As of Month 6, 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.

In addition, there are several cost pressures that have not been quantified as 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 not yet been agreed. NHSO internal modelling calculates that the increase is likely to be in the region of 5.5% - 6.0%. The financial plan assume an increase of 3%, thereby adding an addition 3% cost pressure
- 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 the settled claims exceed the provision that is currently being made for agenda for change reform costs.
- The year-end forecast assumes that the IJB will deliver its savings target of £2.4m in full. The savings target has been in place since 2020/21 and has not been delivered recurringly. The non-delivery of this is a risk to the year-end out-turn.

The forecast at Month 6 has been updated to reflect the anticipated reduced delivery of savings and estimated additional costs not included in the original financial plan. The worst case scenario could result in the Board failing to meet the conditions for transitional funding support and as a result receiving a qualified external audit opinion.

Forecast Summary	Financial Plan	Updated Forecast at Month 6		
		Best Case	**Likely Case**	**Worst Case**
	£'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		**(4,150)**	**(1,855)**	**(165)**
Any New Funding				
Reduction in Funding		**165**	**165**	**165**

Net Gap	**5,776**	**3.291**	**5.586**	**7,276**
CIPs - Recurring	**-2,800**	**-1,000**	**-1,000**	
CIPs – Non Recurring	**-1,000**	**-300**	**-300**	**-1.300**
Service Development Commitments	**200**	**0**	**0**	**200**
25/26 Out-Turn	**2,176**	**2,000**	**4,286**	**6,176**
Transitional Funding	**-2,000**	**-2,000**	**0**	**0**
2025/26 Out-Turn	**176**	**0**	**4,286**	**6,176**

2.4 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	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	Delivery of the Board's financial plan is challenging and it is recognised that successful delivery will have an impact on workforce. 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.
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

3. Recommendation(s)

- **Discussion** – Discuss the Month 6 financial position

4. List of appendices

The following appendix is included with this report:

- Appendix 1 - NHS Orkney Month 6 Financial Position

NHS Orkney

Financial Position – Month 06 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.

The Transitional Funding Support arrangements compel the Board to deliver on the forecast outturn of £2.176m deficit for 2025/26 along with several additional criteria.

At the end of Month 6, the reported financial position is an overspend of **£2.335m**, which is £159k higher than the planned deficit of £2.176m and £202k higher than the planned trajectory at Month 6.

A full review of the Improving Together Programme has been undertaken which has determined that there will be a **shortfall in delivery of cash releasing savings of £2.5m,** resulting in only £1.3m of savings being delivered. Within the efficiency programme £1.2m is budget reduction, of which some may result in a cash reduction.

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 6 months of the 2025/26 reporting period, the revenue position shows an **overspend of £2.335m**, which is **£0.159m higher** than the approved deficit in the financial plan of £2.176m and **£0.202m higher** than the planned year-to-date overspend of £2.133m.

The achieved savings at Month 6 is **£0.057m adverse** to the YTD target of £0.855m. The trajectory of savings was geared towards the final quarters of the financial year with 78% due to be delivered in the final 6 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 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 around £6.2m at year-end. However, this does not consider analysis on the reserve position for both the Board and the IJB.

Action Plan

During Month 6, the Board has undertaken a full review of its financial forecast and savings plan. Following the internal Senior Leadership Team meetings in August which identified initial turnaround actions, further actions are now being assessed. These include further actions around recruitment and variable pay, strengthening existing Improving Together workstreams, increasing level of income generation and controls over discretionary non-pay spend.

Further recommendations will be made to the Board on actions to be taken and how any resulting service risks will be managed.

Month 6 Year to Date Financial Position

The adverse variance at Month 6 is due to three issues:

- Additional unplanned expenditure in the first 6 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 £0.057m

Graph 1 illustrates the financial plan trajectory compared to the actual monthly results after six months of the 2025/26 financial year.

Graph 1: Year to Date Run Rate vs Planned Run Rate

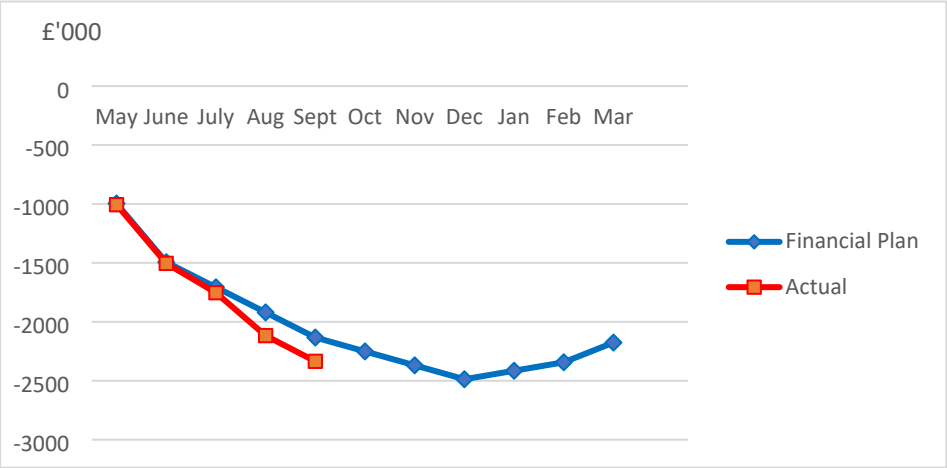


Table 1: Summary Month 6 Position

	Full Year Budget	Year To Date			Current Month		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*
Income							
Health Board Income	(1,017)	(512)	(506)	(6)	(84)	(50)	(34)
Patient Charges Primary Care	(375)	(206)	(177)	(29)	(29)	(26)	(3)
Other	(491)	(245)	(641)	396	(41)	(102)	61
Total Income	**(1,883)**	**(963)**	**(1,324)**	**361**	**(154)**	**(178)**	24
Expenditure							
Pay							
Medical & Dental	9,268	4,634	6,183	(1,549)	772	924	(152)
Nursing & Midwifery	16,965	8,462	7,982	480	1,415	1,347	68
Other Staff Costs	27,729	13,927	11,235	2,692	2,385	1,877	508
Non Pay							
General Medical Services	5,251	2,625	2,756	(131)	590	575	15
Pharmaceutical Services	1,017	538	557	(19)	92	105	(13)
General Dental Services	1,009	536	536	0	65	68	(3)
General Ophthalmic Services	316	154	154	0	29	29	0
Drugs - Primary Care	4,902	2,451	2,381	70	408	360	48
Drugs - Secondary Care	3,558	1,779	1,626	153	296	298	(2)
SLAs & UNPACs	10,034	5,016	5,061	(45)	836	885	(49)
Medical Supplies	1,594	797	840	(43)	133	84	49
Resource Transfer	2,334	1,167	1,175	(8)	195	195	0
Other Expenditure	14,785	7,395	8,083	(688)	1,149	1,272	(123)
Reserves - Board	5,701	2,794	848	1,946	439	110	329
Savings Targets - Board	(8,704)	(4,354)	0	(4,354)	(738)	0	(738)

Savings Targets - IJB	(2,400)	(1,200)	0	(1,200)	(200)	0	(200)
Total Expenditure	**93,359**	**46,721**	**49,417**	**(2,696)**	**7,866**	**8,129**	**(263)**
Total	**91,476**	**45,758**	**48,093**	**(2,335)**	**7,712**	**7,951**	**(239)**

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 £0.798m after 6 months against a trajectory of £0.855m.

At Month 5 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 has been undertaken during Month 6 and the savings forecast has been updated to reflect progress made to date in the implementation of schemes. As 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 £1.3M** of which £0.9M 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 £2.5m.

Overview: Month 6 Financial Position (Core RRL)

The overview at Month 6 is summarised in Table 2, with further detail provided in Appendix 1.

Table 2 – Core RRL by Area

Directorate		Annual Budget	YTD Budget	YTD Actuals	YTD Variance	Period Budget	Actuals	Period Variance
		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute Services Directorate	Income	(235)	(117)	(130)	13	(20)	40	(60)
	Pay	17,315	8,658	9,811	(1,153)	1,458	1,666	(209)
	Non-Pay	2,188	1,094	1,008	86	182	84	98
	Total	**19,269**	**9,634**	**10,688**	**(1,054)**	**1,620**	**1,791**	**(170)**
Medical Directorate	Income	(196)	(102)	(118)	16	(16)	(28)	12
	Pay	3,488	1,731	1,588	143	293	232	60
	Non-Pay	16,562	8,201	7,872	330	1,337	1,394	(57)
	Total	**19,853**	**9,830**	**9,341**	**489**	**1,614**	**1,598**	**16**
Integration Joint Board - Operational Budgets	Income	(528)	(264)	(303)	39	(44)	(47)	3
	Pay	16,956	8,456	7,815	641	1,459	1,221	238
	Non-Pay	18,117	9,080	9,237	(156)	1,625	1,535	91
	Total	**34,545**	**17,272**	**16,748**	**524**	**3,040**	**2,709**	**331**
Chief Executive Officer	Income	(162)	(81)	(306)	225	(14)	(40)	27
	Pay	8,670	4,412	3,862	550	735	643	92
	Non-Pay	7,027	3,573	3,453	120	582	622	(41)
	Total	**15,535**	**7,904**	**7,010**	**894**	**1,304**	**1,225**	**79**
Directorate Of Human Resources	Income	(43)	(21)	(45)	23	(4)	(5)	2
	Pay	1,413	706	555	152	118	89	29
	Non-Pay	333	167	108	58	28	10	18
	Total	**1,704**	**852**	**618**	**233**	**142**	**93**	**49**
Finance Directorate	Income	(410)	(205)	(235)	30	(34)	(73)	39
	Pay	860	430	446	(16)	72	75	(3)
	Non-Pay	585	293	261	31	48	20	29
	Total	**1,035**	**518**	**473**	**45**	**86**	**22**	**64**
Performance And Transformation Directorate	Income	0	0	(7)	7	0	(1)	1
	Pay	1,711	856	779	77	143	131	11

	Non-Pay	(1)	(0)	27	(27)	(0)	3	(3)
	Total	**1,711**	**855**	**798**	**57**	**143**	**133**	**9**
Public Health Directorate	**Income**	(66)	(33)	(40)	7	(6)	(6)	0
	Pay	1,122	561	544	17	93	89	4
	Non-Pay	183	92	31	60	15	7	8
	Total	**1,239**	**619**	**535**	**84**	**103**	**90**	**13**
Reserves	**Pay**	2,425	1,213	0	1,213	202		202
	Non-Pay	3,276	1,581	848	733	237	110	127
	Total	**5,701**	**2,794**	**848**	**1,946**	**439**	**110**	**329**
Unachieved Savings Board	**Non-Pay**	(8,704)	(4,354)	0	(4,354)	(738)		(738)
	Total	**(8,704)**	**(4,354)**	**0**	**(4,354)**	**(738)**	**0**	**(738)**
Unachieved Savings IJB	**Non-Pay**	(2,400)	(1,200)	0	(1,200)	(200)	0	(200)
	Total	**(2,400)**	**(1,200)**	**0**	**(1,200)**	**(200)**	**0**	**(200)**
	Total	**89,487**	**44,725**	**47,060**	**(2,335)**	**7,553**	**7,772**	**(219)**

Appendix 1 provides high level performance detail of each area.

Significant Areas of Concern

Medical Staffing Costs

During the first 6 months of the 2025/26 financial year, medical staffing costs have remained high, with costs £1m 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 has reduced in Q2 (compared to Q1) due to successful recruitment to vacant posts both within Acute and Community services. However, nurse agency costs have however remained above what was planned in the first 6 months of the financial year. These areas will be closely monitored, with plans in place to reduce reliance on high-cost agency staffing 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

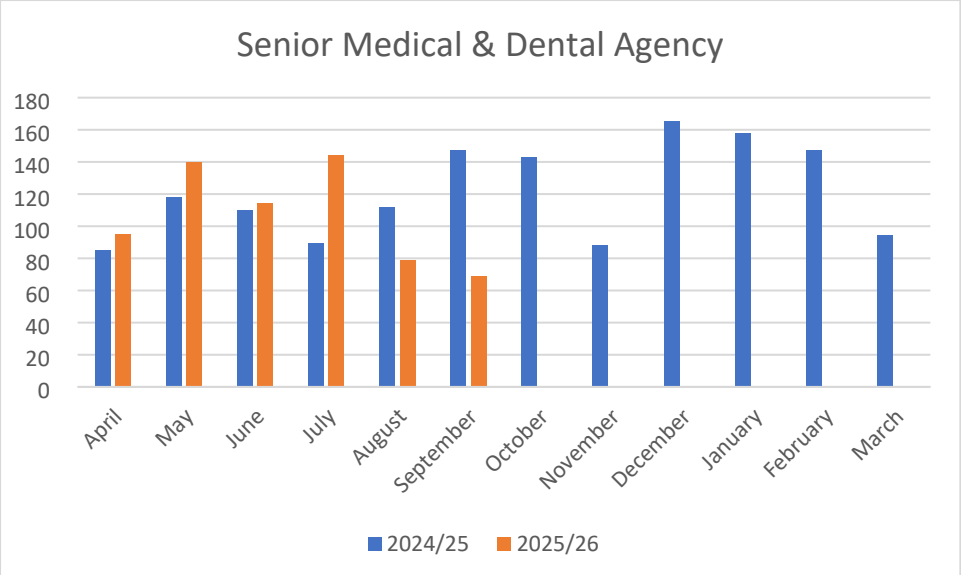
As at the end of Month 6, the Board continues to report underspends across multiple areas, largely attributable to unfilled posts. To mitigate any financial impact from ongoing recruitment activity, the Senior Leadership Team has agreed a series of measures to further control expenditure in this area. These include a review of all currently advertised vacancies, with the intention of withdrawing any deemed non-essential. All new vacancy requests are subject to weekly review by the Executive Team in collaboration with Staff Side representatives.

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

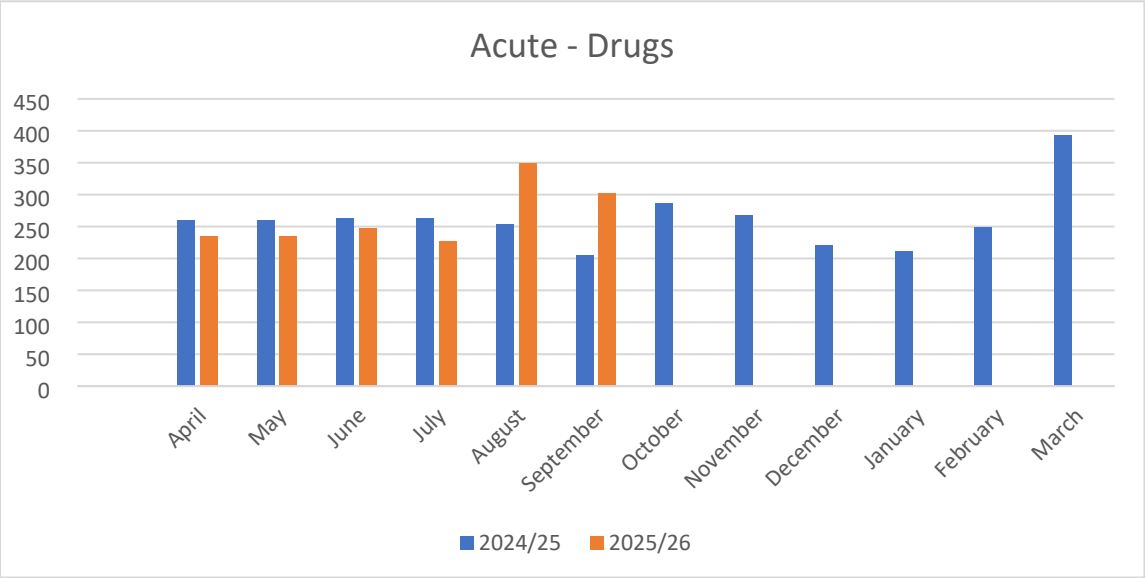
High-cost agency continues to be a significant area of concern for the Board, with some reductions being seen in 2024/25 and into 2025/26 in AHPs and Healthcare Sciences. Nursing and Senior Medical, however, continue to rely on high-cost agency, usage remains at higher levels for the first four month of 2025/26 compared with 2024/25, although there has been some improvement in the position at Month 6:

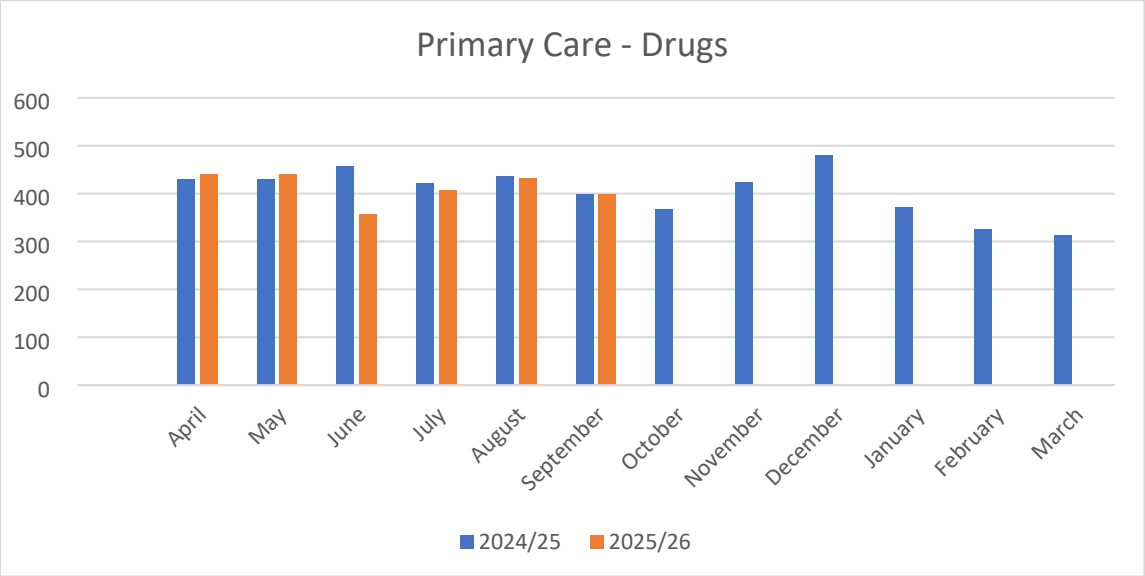


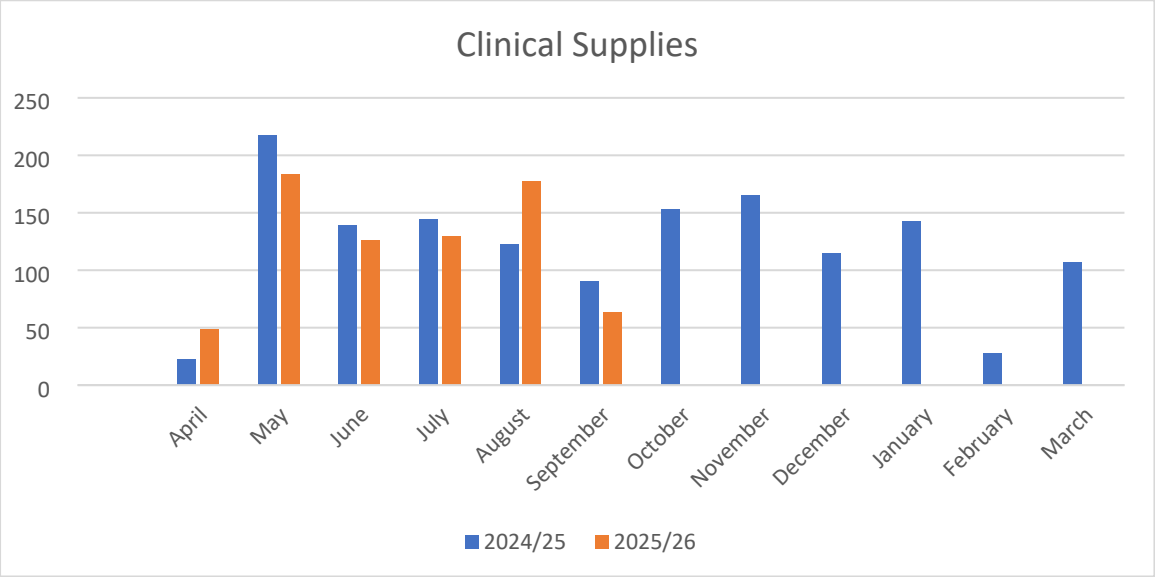
Non-Pay

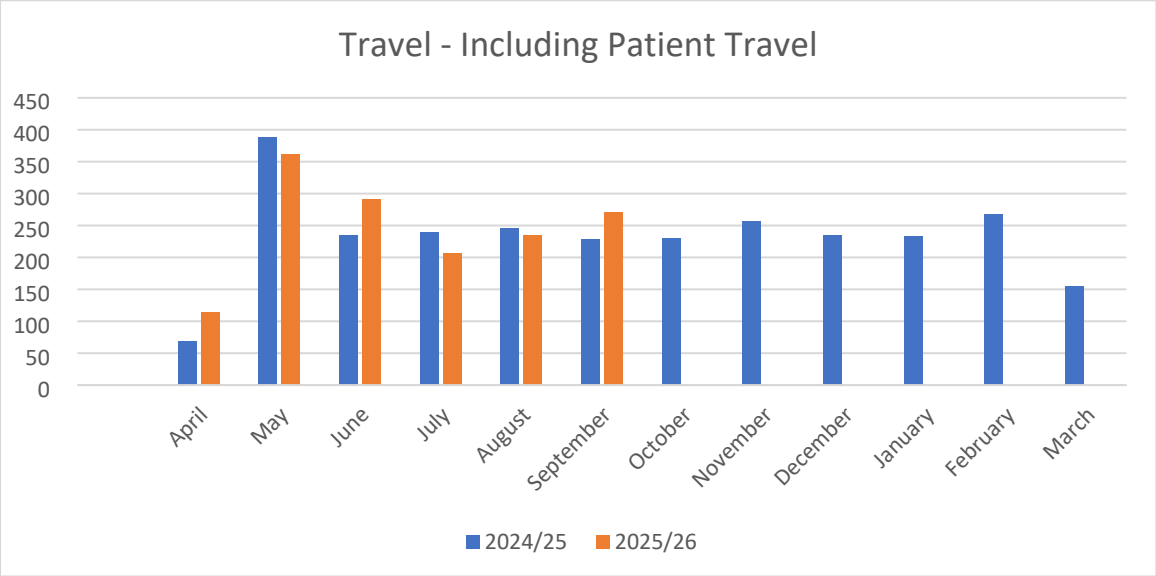
There are several high-spending non-pay areas that are monitored through the Improvement Programme for 2025/26 with targeted work via the Procurement, Diagnostics, Outpatient and Pharmacy Workstreams. As at Month 6 there have been a reduction in spend across Primary Care Drugs compared with the same 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) has seen an increase in Month 6 despite a reduction staff travel, in line with grip and control measures, due to increased patient travel costs. The financial plan trajectory anticipates significant reductions in spend in non-pay areas in the final half of the year. These will continue to be closely monitored with deviations identified and corrective action taken as early as possible.









Year-End Forecast

As of Month 6, 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 not yet been agreed. NHSO internal modelling calculates that the increase is likely to be in the region of 5.5% - 6.0%. The financial plan assume an increase of 3%, thereby adding an addition 3% cost pressure. This is 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 the settled claims exceed the provision that is currently being made for agenda for change reform costs.

In the worst-case scenario, further cost pressures, unaccounted for during initial financial planning, and reduced savings delivery could lead to a significantly increased overspend of between £4.3m and £6.2m at year end. Should this occur, the Board would fail to meet the conditions for transitional funding support. It would result in the Board receiving a qualified external audit opinion.

Forecast Summary	Financial Plan	Updated Forecast at Month 6		
		Best Case	**Likely Case**	**Worst Case**
	£'000	**£'000**	**£'000**	**£'000**
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2025/26 Out-Turn	**176**	**0**	**4,286**	**6,176**

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.

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.

Capital Projects		Total Approved Budget	YTD Actual	Forecast Remaining Expenditure	Variance	Notes
		£'000	£'000	£'000	£'000	
Formula Capital Projects		265		265	0	Approved Estates Projects 25/26
Earmarked Allocations	NIB Funding	202		202	0	Replacement of medical equipment 25/26
	Decontamination Funding	282		282	0	Replacement of CDU equipment 25/26
	Fleet Funding	4		4	0	Replacement Electric Vehicle Charging points 25/26
	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
Capital Receipts						
Total		1,675	0	1,062	613	

Transitional Funding

In April 2024, the Board accepted the offer from the Scottish Government for Transitional Funding Support totalling £5m of additional, non-repayable funding from 2025/26 to 2028/29:

2025/26	2026/27	2027/28	2028/29	Total
£2 million	£1.5 million	£1 million	£0.5 million	£5 million

The Board accepted the funding support and several key conditions that are required to be met to receive the funding, these are:

1. An outturn of under 1% deficit against core RRL must be delivered in 2025/26 (if this condition is not met, this transitional funding arrangement will be removed).
2. Financial balance must be reached by 2028/29 at the latest.
3. The savings programme as detailed in our Financial Plan must be delivered in full across all years.
4. External support funding will be kept under very careful review (aligned to delivery and impact), with a view to this ceasing entirely by 2027/28.

In addition, Scottish Government will require evidence through regular reporting of the impact of our improvement work, including via NHS Orkney's Financial Escalation Board.

Specifically, they expect the following workstreams delivered by 31 March 2026:

5. Workforce reductions of at least 20 WTE in 2025/26 and fully developed plans to further reduce workforce in 2026/27 to a similar level.
6. Evidence of banding reductions where opportunities have presented.
7. The final report from the Clinical Service Review to be presented to Scottish Government in Quarter 3 of 2025/26 outlining the scale of transformation opportunities.
8. Improve productivity and efficiency including increasing Near Me virtual appointments by at least 10% and demonstrating efforts to increase theatre utilisation.
9. Address substantive medical recruitment gaps by reducing the long-standing reliance on locum spend.

Where these conditions are not met, future years' payments will be paused, and further discussions will be held regarding NHS Orkney's position on the NHS Scotland Support and Intervention Framework.

Transitional funding will not be allocated against the year-to-date position and progress against the conditions will be closely monitored throughout the year.

Risks remain around meeting conditions 1, 2,3 and 5. These are being monitored through the Finance and Performance Committee,

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 oof 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%.

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 qualitive 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 qualitive 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 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. However, as outlined in this paper, the Month 6 position is adverse to plan and if this continues the risk of Level 4 or Level 5 Escalation increases, along with the risk of qualified accounts.

Conclusion and Next Steps

The year-to-date financial position after the first six months of the 2025/26 financial year shows an adverse variance to plan, with a reported deficit of **£2.335m,** against the trajectory overspend of £2.133m, giving an overall adverse variance of **£0.202m** 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.

Appendix 1 –Performance summary

Acute Services - £1.054m overspend

- *Hospital Medical Staff, £1.341m 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, £0.098m overspend*

All services are overspending at the end of month 6. Theatres is overspent by £40k, OPD by £38k and Dialysis by £20k to month 6 mainly due to unfunded bank usage however Theatres is also overspent on surgical supplies.

- *Clinical Nurse Manager, £95k underspend*

Inpatients 1 (£138k overspend) and Inpatients 2 (£48k overspend) are both reporting overspends at month 6 which are being offset by underspends in HDU (£170k underspend), the Emergency Department (£88k underspend) and Macmillan Inpatient (£81k 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 in month 6, plans are in place to remove all agency in Acute areas at the earliest opportunity.

- *Laboratories, £124k underspend*

Laboratories are reporting an underspend at month 6 due non-pay costs being down, this is offset by an overspend in pays due to agency usage to cover current vacancies.

Medical Director - £0.489m underspend

- *Pharmacy, £370k underspend*

Acute drugs and New Medicines are currently underspent at month 6. Pharmacy are also carrying a number of vacancies which are impacting their overall position for 2025/26.

- *External Commissioning, £5k overspend*

External Commissioning including SLAs and visiting specialist has a combination of over and underspending areas. The Grampian Acute Services SLA is the largest single element within the commissioning budget at £6.7m.

- *Unplanned Activity £43k overspend*

Unplanned Activity is over spent to month 6 but it's variable by nature and is subject to significant potential movement throughout the year and at year end. The adverse movement in month 6 is mainly due to a single patient being treated at NHS Lanarkshire.

- *Patient Travel, £104k 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 - £0.676m overspend

The Delegated Services budgets report a net overspend of £0.676m, £0.524m operational underspend and £1.200m unachieved savings target (Table 1). Further detail on the operational areas is provided below:

- *Children's Services, £17k underspend*

The underspend in Children's services is in the main related to vacancies in Health Visiting and School Nurses.

- *Primary Care, £143k underspend*

Primary Care General Medical Services is currently overspending (£206k overspend at month 6) due in the main to locum and agency spend within this area. There are offsetting underspends in Primary Care Administration (£102k underspend), Community Nurses (£216k) and Specialist Nurses (£27k underspend). The favourable movement in month 6 is mainly due to an over accrual of locum costs in month 5.

- *Primary Care – Dental £55k underspend*

The dental underspends relate in the main to Senior Dental and Dental Nursing.

- *Health and Community Care, £197k underspend*

Mental Health Services has an underspend of £28k at month 6, this in the main is due to vacancies within this area. There are also underspends within the Health and Community Care Management Team (£56k underspend) and Intermediate Care Team (£16k underspend).

- *Primary Care Prescribing, £61k underspend*

The Prescribing Unified budget is currently showing an underspend of £32k at the end of period 6 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 £34k at month 5.

Finance - £0.045m overspend

Finance is currently reporting an overspend of £0.019m, with spend broadly in line with the plan at month 6, a slight deterioration in the outturn due to reduced income in the period.

Estates and Facilities - £0.654m underspend

Estates and Facilities is reporting an underspend of £654k to date, in the main, the underspend is due to vacancies across a number of services and underspending non pay budgets in hospital maintenance contracts.

Chief Executive - £0.240m underspend

There are several vacancies across the portfolio impacting the month 6 position.

Public Health - £0.084m underspend

Currently reporting an underspend of £84k. There are various over and underspending services in this area.

Human Resources - £0.233m underspend

There are several underspending areas within the service impacting on the overall underspend, this includes vacancies across a number of areas.

Staff Governance Committee Minutes
15 May 2025

Attendance

Members

Kirsty Cole (Chair, Area Clinical Forum), Debs Crohn (Head of Improvement), Jenny Fraser (Chair JLNC), Georgina Green (Practice Education Facilitator), Lawrence Green (Health and Safety Lead), Kat Jenkin (Head of Patient Safety, Quality and Risk), Joanna Kenny (Chair, Non-Executive Director), Ryan McLaughlin (Non-Executive Director - Employee Director), Nikki Milne (Staffside), Jarrard O'Brien (Director of People and Culture), Steven Phillips (Head of People and Culture), Laura Skaife-Knight (CEO), Jason Taylor (Non-Executive Director), Sam Thomas (Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services).

Guests

Lou Willis (Service Manager, Children's Health Services), Lewis Berston (System Workforce Lead)

1. Cover Paper

Staff Governance Committee's Purpose

- 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.

2. Staff Story - Team Orkney Leader of the Year - Overview to follow (Presenters: Director of People and Culture, Guests: Lou Willis - Service Manager, Children's Health Services)

The Chair (J Kenny) opened the meeting at 09.30 am and welcomed G Green and N Milne.

The Chair welcomed Lou Willis - Service Manager, Children's Health Services, to the Committee.

Lou Willis shared with the Committee her experience of what it meant to be awarded the Team Orkney Leader of the Year Award and the importance of compassionate and quiet leadership.

K Cole thanked the Children's Health team for getting the children's incontinence service back up and running for Orkney and noted the impact this had had on young people and their families.

The Chief Executive congratulated L Willis on recognising the need for strong leadership and implementing leadership journeys into our new leadership development programme, recognising that there are leaders at all levels of the Organisation.

Committee Chair acknowledged the need for leadership champions and the need for this to be modelled in a compassionate manner.

L Willis left the meeting at 09.42 am.

3. Apologies (Presenters: Chair)

Apologies received from Karen Spence (Unison), Lynn Adam (Clinical Lead Workforce). Members agreed the meeting was quorate in accordance with the Boards Code of Corporate Governance.

4. Declarations of Interest - Verbal (Presenter: Chair)

There were no declarations of interest raised.

5. Minute of meeting held on 12 February 2025 (Presenters: Chair)

Decision/conclusion
The Minutes of the meetings held on 12 February 2025 were accepted as an accurate record of the meeting and approved.

6. Chair's Assurance Report - 12 February 2025 (Presenter: Chair) SGC25/26-01

Committee Chair presented the Chairs Assurance report of the Staff Governance Committee meeting held on 12 February 2025.

Decision/Conclusion
The committee noted the report and discussed items escalated to the committee.

7. Matters Arising - Verbal

No matters arising were raised.

8. Action Log (Presenter: Chair)

The action log was reviewed, no outstanding issues (see action log for details).

9. Chair's Assurance Reports

9.1. Area Partnership Forum Chair’s Assurance Report 15 April 2025 SGC25/26-02 (Presenter: CEO, Employee Director)

The Employee Director presented the Chairs Assurance report of the Area Partnership Forum meeting held on 15 April 2025. Matters of escalation and concerns are covered later in the agenda.

Concerns regarding staff side not being included in the Improving Together Programme Board - this has now been resolved.

Funding for Band 5/6 reviews has been confirmed it will not be recurrent. DoNMAHP confirmed that the funding was for all Agenda for Change reform implementation not just the Band 5 to Band 6 uplift. Addendum to be added to the APF Chairs Assurance Report.

Decision/Conclusion
The committee noted the report and discussed items escalated to the committee.

9.2. Occupational Health, Safety and Wellbeing (OHSW) Chair's Assurance Report (Presenter: Director of People and Culture) SGC25/26-03

The Director of People and Culture presented the Chairs Assurance report of the Occupational Health, Safety and Wellbeing Committee (OHSWC) held on 8 April 2025 highlighting the concern for training on Personal Protective Equipment (PPE) - work is still required to ensure people are adequately trained. The Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services (DoNMAHP) advised that training is required to support the implementation of the High Consequences Infectious Diseases (HCID) policy and the national PPE policy. DoNMAHP to advise on wording to be added to the Chairs Assurance Report.

Health and Safety Lead provided positive assurance on the use of electric pool car vehicles - several gaps were highlighted in management systems. Improvements have now been put in place for managing electric vehicles - a policy is now being put in place, including finalising where the management sits between the Estates and Facilities teams.

TURAS models have now been introduced for inducting staff on the use of using electric vehicles, pre-inspection checks and legal requirements.

The Employee Director advised that actions are now in place for assurance on reporting of water issues. The Chief Executive advised that a paper is being presented at the Finance and Performance Committee (FPC) on how governance has been strengthened for the Robertsons contract, including additional oversight from our Interim Director of Finance.

Decision/Conclusion
The committee noted the report and discussed items escalated to the committee.

9.3. JLNC Chair's Assurance Report - 24 January 2025 SGC25/26-04 (Presenter: JLNC Chair)

J Fraser presented the Chairs Assurance report of the JLNC held on 24 January 2025. The Committee Chair asked if the JLNC has been meeting since January 2025. Positive assurance provided on work undertaken to improve the IT joiners process for clinicians.

J Fraser advised that she will be stepping down from her position when she retires on the 1 August 2025.

The Chief Executive noted the comments about clinicians not being listened to and asked what more is needed to address the concerns.

J Fraser advised that this has improved since the last meeting, notably attendance at Extended Senior Leadership Team (ESLT). Issues remain around the lack of understanding and progress, noting that clinicians have engaged well in the Clinical Services Review.

K Cole asked if there was a process for Hospital Sub Committee and JLNC to engage with one another, including clarity about what items go to each forum for discussion. She asked if there was a role for the ACF Chair to support. K Cole to arrange a conversation with the Chair of the Hospital Sub-Committee to offer her support.

The Committee Chair thanked J Fraser for their contributions and support as Chair of JLNC.

Decision/Conclusion
The committee noted the report and discussed items escalated to the committee.

9.4. Operational Workforce Group Chair's Assurance Reports (Presenter: Director of People and Culture)

No report presented as no meetings have taken place since the last Committee meeting.

The Director of People and Culture advised that the next meeting would take place on the 27 May 2025 and on a bi-monthly basis according to the current Terms of Reference. The Terms of Reference will be reviewed at the May meeting, and it is likely this will be increased to meet once a month.

10. Corporate Risk Register SGC25/26-05 (Presenter: Director of People and Culture)

The Director of People and Culture presented the Corporate Risks aligned to the Staff Governance Committee. There are 4 risks on the Corporate Risk Register in relation to the workforce.

- **Senior Leadership capacity and capability** – Recruitment to the substantive Director of Finance and Director of People and Culture will commence shortly. Tammy Sharp Director of Performance, Transformation and Deputy CEO Commenced in post 12 May 2025. Leadership and manager development and Quality Improvement (QI) training will be presented to the Senior Leadership Team (SLT) 20 May 2025. First QI cohort will commence in September 2025.
- **Workforce wellbeing** - Your Employee Journey was launched Tuesday 13 May 2025 - this will be a standing agenda item at Committee for monitoring.
- **iMatter** opened this week which will provide the latest moment-in-time review of staff experience. The Director of People and Culture recognised the need to have a rolling programme of staff feedback throughout the year although this needed to be manageable within existing resources.
- **The Health and Care Staffing Act** (HCSA) was discussed later in the agenda.
- **Mandatory training** compliance is included in the workforce report and discussed later in the agenda.

J Taylor raised concerns regarding the risks being mitigated correctly in relation to face to face training and the HCSA as Committee have consistently taken limited assurance in these areas.

Director of People and Culture advised that this will be picked up at the Workforce Operational Group meeting on the 27 May 2025.

DoNMAHP confirmed that additional support from the People and Culture team is having a positive impact on training levels recognising that mitigating actions need to be reviewed and having a substantive workforce in place will support the release of staff to attend training.

The Chief Executive advised that the PRM's last week focused on sickness management, appraisals and statutory/mandatory training, and we are seeing an improvement in ownership from leaders.
J Taylor acknowledged and welcomed the step change

Decision/Conclusion
The committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register.

11. Integrated Performance Report - Workforce Chapter May 2025 SGC25/26-06 (Presenter: Director of People and Culture)

The Director of People and Culture presented the May 2025 workforce chapter of the Integrated Performance Report (IPR) noting this has already been presented to the Board at its public meeting in April 2025.

Good news stories

- Agency hours used are down.
- Increase in training (between 2-4% in most areas) and appraisals rates (39% in May 2025).

Areas of concern

The Board finished the year above the usual national average of 6% (NHS Orkney 6.25%) for staff sickness. The NHS Scotland average at year end, however, was 6.4%.

The People and Culture Team are providing additional support to support areas of high sickness levels and low appraisal rates.

Employee Director advised that there has been a real culture shift in areas of high sickness rates - this was welcomed. A concern was raised regarding appraisal rates not improving in areas which have had additional support from the People and Culture team given the level on intervention.

The Head of People and Culture advised that the Domestics team continue to collaborate with the People and Culture team to schedule appraisals and asked the Committee to note the culture shift seen over the past 12 months. Community Nursing remains an area of concern; hence the level of intervention being provided - this includes training for staff, although it was noted that vacancies are especially high in this team and recruitment is challenging. The new

TURAS appraisal 'zone' has been updated and will be live 16 May 2025 to provide additional information for reviewers, including a one-page summary of how to complete online appraisals.

J Taylor asked if the Integrated Performance Report (IPR) could be split to detail the long-term sickness absence rates and agency, bank, and excess hours - this is being reviewed by the People and Culture Team.

The Director of People and Culture advised that work is underway in the areas outlined above particularly how excess, bank hours and agency are being used in comparison with staff sickness and vacancies. Work had begun through the Workforce Improvement workstream to complete detailed analyses team by team to look at opportunities for improvement.

N Milne reminded members that there is a person behind every statistic.

The Chief Executive acknowledged that the appraisal target needs to reflect what is in our Corporate Strategy (60% by March 2026) and the improvement target date of June 2025 needed review.

The Chief Executive asked for a date when a single workforce report will come to the Committee in the Integrated Performance Report.

Head of Planning, Performance and Information is undertaking a piece of work to look at all metrics within the IPR.

The Chief Executive advised that a piece of work is required by the Executive team in relation to improvement dates in the IPR to ensure collective understanding and realistic target dates for improvement.

L Berston asked for clarity on the 60% appraisals rates and the denominator for how this is calculated. The Head of People and Culture advised that further work is required to confirm how the appraisal target will be calculated going forward. Proposal to be brought to the next Committee meeting.

Decision/conclusion
Committee took assurance on the operational data presented.

12. Update from National Human Resource Directors Meeting SGC25/26-07 (Presenter: Director of People and Culture)

The Director of People and Culture provided an update from National Human Resource Directors Meeting for information. Points to note.

- Executive Director Appraisals are well underway prior to submission to the National Performance Management Committee
- Regional/national collaboration opportunities remain a key focus
- Planning for the roll out of national Business Systems which will replace existing systems in HR, Finance and Payroll
- Workforce planning and service re-design are key given the transformation required of all Boards but formal workforce plans would not be due to the Government until the NHS Renewal Plan was released so that Boards could consider the workforce implications.

Decision/conclusion
The Committee noted and welcomed the update.

13. Staff Governance Committee Annual Report 2024/25 SGC25/26-08 (Presenter: Chair)

The Committee Chair presented the Staff Governance Committee Annual Report 2024/25.

Decision/conclusion
Committee formally approved the annual report for 2024/25.

14. PEOPLE

14.1. Update on the Employee Journey including priorities SGC25/26-09 (Presenter: Head of People and Culture)

The Head of People and Culture presented an update on the Employee Journey including priorities areas.

The Employee Journey programme was launched to the Extended Senior Leadership Team (ESLT) 12 May 2025 and launched to the Organisation on 13 May 2025. Programme documentation is available on the People and Culture Wellbeing site.

Values and Behaviours workshop was undertaken with the ESLT on 12 May 2025, feedback will be categorised with a follow-up session being delivered by the People and Culture team.

The Leadership Development Programme will be presented to SLT 20 May 2025, work is underway to review the TURAS platform regarding management skills.

Automated process is now in place for staff to upload documentation to support completion of PVG checks. Face to face session with Estates and Facilities teams Friday 16 May 2025.

Training needs analysis is underway to look at how professional advisers on the Board can support training.

Feedback has been requested by staff on the Team Orkney Awards.

Full analysis of the Employee Assistance Programme is underway, and a paper is being prepared to show the use and impact of Endowment funds for wellbeing - this will be shared with Endowment Committee on 5 June 2025.

DoNMAHP thanked the team for their support but asked if there was a link into national meetings in relation to mapping role-specific training – recognition this needs to be taken into consideration.

The Employee Director asked for clarity on where this work will be monitored - Director of People and Culture advised that the Operational Workforce Group will oversee and deliver this work recognising this is a whole organisational approach to embedding the programme.

The Employee Director asked for confirmation that resources are in place to deliver the plan and whether there was an implementation roadmap. The Director of People and Culture advised that implementation plans at a project level are included in the report, which is a live document. The front page is the road map for the programme overall, scale and pace of the work will be determined by resources, and clarity on priorities will come from staff feedback.

The Employee Director asked for confirmation on what succession planning is in place for when current funding ceases in December 2025. The Director of People and Culture advised that a paper will be presented to a full meeting of the Endowment Trustees in June 2025 and that this needs to be added to the risk section of the project plan.

The Chief Executive advised that she had asked for external advice and clarity on the rules in relation to Endowment Funding. If the bid for ongoing wellbeing funding is unsuccessful the Board would need to highlight it as a cost pressure noting that the Board committed to supporting and delivering the Employee Journey Programme - key elements of which are value and recognition, and staff wellbeing.

Decision/conclusion
The committee received the update and took assurance on what was presented.

14.2. Agenda for Change Reform Implementation SGC25/26-10 (Presenter: Head of People and Culture)

The Head of People and Culture presented an update on the Agenda for Change Reform Implementation. Work has been undertaken to support the reduction of the Reduced Working Week. Progress has been made on staff retaining part-time hours. The Employee Director asked for confirmation on the costs for staff in relation to overtime. The Director of People and Culture advised that the way this is being recorded is challenging as reporting does not accurately differentiate overtime use for the reduced working week vs general overtime.

DoNMAHP confirmed the issues in relation to reducing the working week, recognising that for some teams this was easier to do than others. As we move into the next phase there is a need to understand the whole-time equivalency which needs to be employed to enable us to release our workforce.

Staff have been involved in reviewing the 9 national mandatory learning modules.

Job evaluation has been undertaken on the Band 5 reviews with the Royal College of Nursing and Unison. The Employee Director advised that the Board is well ahead of other areas and thanked Catherine Siderfin for her support and leadership.

Meetings continue with our staff side representatives to undertake Band 5 job evaluation - a date has not been confirmed for this work to be completed.

We will be reducing the working week by a final hour from the 1 April 2026.

Work on protected learning continues with staff side colleagues.

The Employee Director asked that the data and plan be brought to the Committee in August 2025.

K Cole asked what the plan is for new employees joining the Organisation from 1 April 2026. The Head of People and Culture advised that a national group has been established to look at this and has requested to be part of the working group noting that all Boards are required to work to a Once for Scotland approach.

Meeting to be arranged for the Board to discuss the implications of the Agenda for Change Reform Implementation plan.

Decision/conclusion
The committee received the update and took assurance of what was presented.
Head of Patient Safety, Quality and Risk joined the meeting at 11.20 am.

15. PATIENT SAFETY QUALITY AND EXPERIENCE

15.1. Health and Care (Staffing) (Scotland) Act Annual Report 2024/25 SGC25/26-11 (Presenter: Director of People and Culture)

The Director of People and Culture presented an update on the Health and Care (Staffing) (Scotland) Act Annual Report 2024/25, noting that this had been approved by the Board in April and was subsequently submitted to Scottish Government 30 April 2025. He thanked the Employee Director and Clinical Lead for Workforce for acting promptly on the Board feedback to prepare the final submission.

An improvement plan is in place to address the limited assurance, challenges are as follows.

- Rostering practice
- Releasing time to lead and attend training.
- Recording decision making
- Quick wins, including finalising Standard Operating Procedures and organisational hierarchies for both operational management and professional accountability

The improvement plan will be overseen by the Operational Workforce Group noting there is a significant amount of work required to deliver the plan.

The Committee Chair asked that the Annual Report is presented to the Staff Governance Committee before the Board going forward. The Employee Director noted that there may be a need to look at reviewing Committee's meeting frequency.
Head of Improvement advised that further conversation would be advisable with the Board Chair, noting that changes to meeting cycles for 2025/26 would not be appropriate.

J Taylor asked if all aspects of the Act apply to the Board - DoNMAHP advised that the Board is required to comply with all sections of the Act.

Decision/conclusion

Committee took limited assurance on the Health and Social Care Staffing Act Annual Report 2024/25

15.2. Whistle Blowing Quarter 4 2024/25 Report SGC25/26-12 (Presenter: Head of Patient Safety, Quality and Risk)

The Head of Patient Safety, Quality and Risk presented the Quarter 4 2024/25 Whistle Blowing report. No whistle blowing concerns raised this quarter.

Independent National Whistle Blowing Office have concluded their investigations this has been accepted by the Board and implementation of the recommendations being taken forward.

A workshop has been delivered for senior managers to raise awareness of whistle blowing.

One anonymous whistle blowing has been received and addressed.

Whistleblowing training uptake has been low, SLT agreed that this would not be made mandatory at this time.

Decision/conclusion
Committee discussed and noted the update.

Head of Patient Safety, Quality and Risk left the meeting at 11.40 am.

16. PERFORMANCE

16.1. Workforce Report April - March 2025 SGC25/26-13 (Presenters: Head of People and Culture)

The Systems Workforce Lead presented the Workforce Report April - March 2025 including the full annual year.

The committee noted that Equality and Diversity data was included in the report.

The Committee Chair noted the excellent quality of the report, which has evolved over time.

K Cole noted that the number of staff absent from work from musculo-skeletal, stress and anxiety remains a challenge for our community as well as staff and asked if there is a way the Board could work with our GPs to access our Occupational Health service.

Head of People and Culture thanked our GP colleagues for referring staff to our Employee Assistance Programme - there is an opportunity for staff self-referral forms to be sent to GP's. Promotional material will be circulated to GPs in regard to accessing services through Able Futures shortly.

G Green advised that the clinical restorative supervision policy will be rolled out later this year, this will support staff health and well-being.

Decision/conclusion
Committee discussed and noted the update.

16.2. Area Partnership Forum (APF) Annual Report 2024/25 SGC25/26-14 (Presenters: APF Joint Chair)

The APF Joint Chairs presented the Area Partnership Forum (APF) Annual Report 2024/25 for awareness.

Decision/conclusion
The committee welcomed and noted the annual report.

16.3. Equality and Diversity Annual Report 2024/25 SGC25/26-15 (Presenter: Head of People and Culture)

The Head of People and Culture presented the Equality and Diversity Annual Report 2024/25 as a formal requirement to be approved by the Board.

Committee noted the following.

- The Board is more diverse than the community we serve.
- There is a need to encourage colleagues to declare disability so support can be put in place i.e., access to work grants.
- Equal pay statement agreed in Area Partnership Forum

The Committee Chair thanked the team for the reports and welcomed them.

J Taylor welcomed the data presented but asked for clarity on the number of people applying for nursing roles who are not registered nurses. The DoNMAHP advised that robust checks are in place to mitigate any risks.

Employee Director asked for clarity on any implications of changes in relation to changing facilities - Head of People and Culture advised that communications were being prepared for all staff. The Director of People and Culture confirmed that Boards were taking a collective approach to communicating with staff on this issue and there was a strong need to maintain a nationally united front. The Chief Executive advised that an Accountable Officer meeting will take place shortly in relation to learning from recent challenges in Fife.

Decision/conclusion
The committee discussed and recommended approval of the Equality and Diversity Annual Report 2024/25 by the Board.

N Milne left the meeting at 12.10 pm

16.4. Nursing and Midwifery Taskforce Report: Delivering Together for a Stronger Nursing and Midwifery Workforce Publication (February 2025) SGC25/26-16 (Presenter: DoNMAHP)

The Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services presented the Nursing and Midwifery Taskforce Report: Delivering Together for a Stronger Nursing and Midwifery Workforce Publication (February 2025) for awareness and consideration of local implications.

This is a new item at Staff Governance Committee - points to note.

- workforce shortages across specialties and regions
- declining applications rates for midwifery and nursing
- Attrition rates arising from placements available to students.
- workplace stressors
- Challenging population needs.
- 17 recommendations apply to the Board.

The 17 recommendations will be taken to NAMAC and brought back to the Committee in Quarter 4 2025/26.

J Taylor welcomed the opportunity this report provides for the Board in terms of recruiting nursing and midwives.

G Green advised that the Board is working with Robert Gordon and University of the Highlands and Islands to explore opportunities of Orkney being a satellite centre.

Decision/conclusion
The committee welcomed the report, noting local implications.

16.5. Job Planning Progress Report May 2025 SGC25/26-17 (Presenter: Medical Director)

The Chair suggested that as the Medical Director was not able to attend the paper could be updated for the next Staff Governance Committee meeting, rather than waiting for the next 6 months as per the business cycle.

The Chief Executive agreed and asked that the updated report include confirmation of clinical engagement, a focus on productivity and people versus process noting that this work will not be completed by the end of May 2025.

J Fraser advised that the process has taken too long to get to this point, focusing too much on the IT process. The staff side felt that the numbers on the report are inaccurate in relation to the number of people being ready to sign off job plans.

K Cole asked for clarity on why the process has taken so long given this is for 12 people. Job planning should be about conversations and the need to look forward rather than past job planning, what the individual brings to the Organisation and completed on an annual basis.

The Chief Executive asked that clarity be provided on what the issues are with IT, and if this is a solution to completing the process.

The Employee Director asked the JLNC Chair if the job planning progress could be completed by the August Committee meeting. The Head of People and Culture asked that it should be the ambition to have job planning completed by the next meeting but given individual circumstances, this may not be possible.

Decision/conclusion
The committee noted the report and deferred to the next meeting in August 2025.

17. POTENTIAL

17.1. Health and Safety related policy Updates 2025/26 SGC25/26-18 (Presenter: Health and Safety Lead Update)

The Health and Safety Lead presented an update on Health and Safety related policies 2025/26 noting minor amendments have been made.

Decision/conclusion
The committee approved the updated Manual Handling policy and procedure.

18. Any other competent business - Verbal

No other competent business was raised.

19. Items to be included on the Chair's Assurance Report - Verbal

- Board conversation to take place in relation to Agenda for change Reform Implications
- Job planning update
- IPR - Single Workforce chapter to be developed.

20. ITEMS FOR INFORMATION AND NOTING

20.1. Items for noting

The committee noted the following key documentation.

- Reduced working week compliance.

20.2. Schedule of Meetings for 2025/26 (Presenter: Chair)

Committee noted the Record of Attendance 2025/26

Audit and Risk Committee (Annual Accounts) Minutes
26 June 2025

Attendance

Hazel Aim (Senior Corporate Governance Officer), Melanie Barnes (Interim Director of Finance), Debs Crohn (Head of Improvement), Suzanne Gray (Senior Financial Accountant), Anna Lamont (Medical Director), Laura Skaife-Knight (Chief Executive Officer - CEO), Keren Somerville (Head of Finance), Jean Stevenson (Non-Executive Director), Jason Taylor (Chair, Non-Executive Director), Davie Campbell (Non-Executive Director), Rona Gold (Non-Executive Director), Issy Grieve (Non-Executive Director), Joanna Kenny (Non-Executive Director), Jarrard O'Brien (Director of People and Culture).

Guests

Taimoor Alam (External Audit, KPMG), David Eardley (Azets), Kirsty Cole (Non-Executive Director), Rashpal Khangura (External Audit, KPMG), Meghan McEwen (Board Chair), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services (EDoNMAHP)

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The purpose of the Audit and Risk Committee is to support the Board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge.

The Committee will be quorate when there are three members present, one of whom must be the chair or vice-chair.

2. Apologies (Presenter: Chair)

The Chair opened the meeting at 9.30 am and welcomed members to the meeting.

Apologies received from Kat Jenkin (Head of Patient Safety, Quality and Risk), Stephen Brown (Chief Officer Integration Joint Board), Tammy Sharpe (Director Performance, Transformation Deputy CEO) and Ryan McLaughin (Employee Director, Non-executive Director).

Due to apologies being received from the Employee Director, and to ensure quoracy of the Committee, D Campbell deputised for the Employee Director.

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

3. Declaration of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minute of meeting held on 27 May 2025 (Presenters: Chair)

The Chair presented the minutes of the meeting held on 27 May 2025.

Decision/conclusion
The minutes of the Audit and Risk Committee meeting held on 27 May 2025 were approved as an accurate record of the meeting.

4.1. Chairs Assurance Report from meeting on 27 May 2025 (Presenter: Chair)

The Chair presented the Chairs Assurance Report from the meeting held on 27 May 2025.

Decision/conclusion
The Chair's Assurance report of the Audit and Risk Committee held on 27 May 2025 was approved as an accurate record of the meeting.

5. PERFORMANCE - ANNUAL ACCOUNTS NOT FOR PUBLICATION UNTIL LAID BEFORE PARLIAMENT

5.1. Approval of Orkney Health Board Endowment Fund Annual Accounts 2024/25 (Presenter: Head of Finance)

The Head of Finance presented the annual audited Endowment Fund accounts which had been approved by Endowment Trustees' meeting on 5 June for awareness. Key points to note.

- net assets of £0.98m at year end compared with £1.05M at end of March 2024.
- decrease of £70k is due to a deficit in charitable activities of £49K and a net loss in investments of £21K.
- income was in line with the previous year, reported expenditure was £7k up from the previous year.

Decision/conclusion

Members noted the Endowment Fund accounts for the year ended 31 March 2025 which had been approved by Endowment Fund Trustees at its meeting on 5 June 2025.

5.2. NHS Orkney Annual Report and Accounts for year ended 31 March 2025 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Board's Annual Report and Accounts for year ended 31 March 2025 for a decision. The deadline for submission of Annual Report and Accounts to Scottish Government is 30th June 2025.

Members were reminded that the Annual Report and Accounts will be made public once they are laid before Parliament in September 2025.

The performance report showed a deficit of £3.874M which was an improved position from financial plan. £4.1M savings were delivered, of which £2.9m were recurring. Funding from Scottish Government increased by £11M during 2024/25, primarily due to £3m on annual uplift, £5m on pay related allocations and £1 of financial recovery funding. Payment policy days of credit have been reduced to 18 days, which is a good achievement based on data from across Scotland.

Orkney Health Board Endowment Fund accounts are consolidated within the annual accounts. The Integrated Joint Board deficit of £0.6M was primarily due to increases in pay that were awarded last year.

Accountability report confirmed the action plan against the Blueprint for good governance was completed. It also confirmed no special payments were made by the Board, in line with last year. Losses increased to £6k due to write off's of invoices raised for overseas and out-of-area patients after exhausting ways to recover money.

K Cole asked for confirmation of why the Director of People and Culture is not noted as a Board member. The Board Chair advised that this role is not an Executive appointment by the Cabinet Secretary and therefore is an advisor to the Board.

CEO confirmed that whistleblowing is reported through the Staff Governance Committee and that where there was relevance to safety and quality this would be reported to the Joint Clinical and Care Governance Committee.

I Grieve referred to the £6k loss from overseas patient debt and enquired whether going forward, a request should be made by the Health Board for part of the income from the tourism tax. The Interim Director of Finance agreed it would be useful to have a conversation.

EDoNMAHP is collaborating with finance colleagues regarding island visitors, scoping out additional processes in order that losses are not sustained.

Board Chair asked if names of Directors are redacted in other boards' (endowment) reports, noting that Orkney is a small community and there may need to be a discussion as to what it means and how it would affect individuals. The Interim Director of Finance confirmed there was time to explore this as accounts will not be made public until October 2025 but confirmed submission to Scottish Government cannot include redactions. D Campbell also confirmed submissions to OSCR could not be redacted as this is a legal requirement.

Interim Director of Finance explained notes referring to the financial statement.

Referring to note 4 regarding an increase of £1.8m of operating income, Interim Director of Finance advised that this was in relation to the Integration Joint Board. The Board Chair asked for confirmation of what was commissioned. Interim Director of Finance confirmed that this was in relation to paying for uplifts and commissioned services.

Referring to note 7 regarding the valuation of property, D Campbell advised there was a requirement to revalue property every 5 years and asked what processes were in place to ensure this didn't lapse. Interim Director of Finance reassured committee there were robust processes in place to ensure this didn't happen.

Referring to note 8 regarding stock, Board Chair enquired re progress in stock reduction and specifically to drugs. EDoNMAHP confirmed that work has been undertaken with procurement, transport issues meant that some stock could not be reduced but work was ongoing to ensure stock on site was kept to a minimum. Medical Director noted that pharmacy have recorded a significant saving in stock this financial year.

Referring to note 14 regarding contingent liability, the Board Chair asked if the accounting treatment of the value of re-banding of nurses' pay from band 5 to 6 was consistent across Scotland. Interim Director of Finance confirmed that it was and that the amount was unknown at this time.

Referring to note 15 regarding events after the reporting period, Interim Director of Finance confirmed there were no capital commitments or leases, but changes noted from last year are the addition of the labs contract.

J. Taylor thanked the Interim Director of Finance for the thorough presentation.

Board Chair commented on the marvelous achievement and thanked the Interim Director of Finance and the Finance Team as the annual Governance Statement shows good internal controls are in place with clear evidence of our continuous improvement journey and strengthened approach to grip, control, risk management and assurance.

The CEO thanked the finance team for their fantastic teamwork, good process, co-ordination, and documentation journey of improvement in the development of the Annual Report and Annual Accounts. The Head of Improvement is working with our communications team to provide a summary of the report for the public; this will be available once the report has been laid before parliament in September 2025.

Decision/conclusion

Members received and recommended approval of the Annual Report and Annual Accounts for Year-ended 31 March 2025 to the Board.

5.3. Annual Audit Report from External Auditor 2024/25 (Presenters: External Auditor)

R Khangura (External Auditor) presented the draft Annual Audit Report 2024/25 to Committee prior to signing off.

R Khangura explained the purpose of the report and confirmed that the Board would be notified by Audit Scotland once the report is signed by the Board.

R Khangura advised that he would be providing an unqualified opinion that the accounts are a true and fair view of the financial position and performance. He confirmed the status of the audit was complete and the materiality was unchanged from the audit plan. He reported there was no significant risk to valuation of buildings.

R Khangura presented findings on 4 key areas: financial management, sustainability, vision leadership governance and useful resources to improve outcomes.

R Khangura stressed that there are still concerns regarding the Board's financial sustainability, recognising that meeting targets remains a challenge.

Considerable progress has been made this financial year, particularly in relation to embedding processes which are beginning to show outcomes. Management is asked to consider incorporating completeness checks.

Members noted that there are no new recommendations, and no adjusted audit differences.

R Khangura thanked the Finance team for their support throughout the audit process.

T Alam (External Auditor) presented external audit findings in relation to fraud risk and advised that the target position has been met. There were no unidentified/unrecognised expenditure or liabilities, with sufficient management processes in place to address risk - no recommendations were issued.

Having identified the Valuation of land and buildings as a significant risk in the audit plan, following appraisal of the revaluation undertaken, the risk level had been reduced.

Consolidation schedules were consistent with no reportable finding and confirmation was given that progress is being made regarding the National Fraud Initiative.

The Chair noted the change in dynamics and improved relationships with external audit as this is all part of our journey of improvement. Recognition was given to the significant improvements made and are being embedded within our governance arrangements.

Decision/conclusion
Members welcomed confirmation of an unqualified audit opinion by external auditors and approved the External Audit Report.

5.4. Draft Representation Letter (Presenter: Chief Executive)

The CEO presented the draft representation letter to Committee. Committee considered the draft representation letter noting the corrections required prior to signing off.

Decision/conclusion

Members authorised the Chief Executive to sign the representation letter as Accountable Officer for the Board.

5.5. Nationl Services Scotland (NSS) Audit Reports (Presenters: Interim Director of Finance)

Interim Director of Finance presented the National Services Scotland Audit Reports for 2024/25 for awareness.

Decision/conclusion

Assurance was taken from the National Services Scotland (NSS) Payments to Primary Care Contractors (Practitioner and Counter Fraud Services) and National IT services Audit Reports 2024/25.

6. Items to be included on the Chairs Assurance Report (Presenter: Chair)

Members agreed that the following items would be included in the Chairs Assurance Report

Positive assurance

- Excellent teamwork by the Finance and Corporate Governance team in the production of the Annual Report and Annual Accounts
- Positive relationship improvements and flow of information during the annual accounts process demonstrating commitment to displaying our values of openness.
- Annual governance statement shows clear evidence of continuous improvement
- No unadjusted un-audit differences identified by external auditors.
- Positive assurance from the external audit report
- Assurance taken from the National Services Scotland (NSS) Payments to Primary Care Contractors (Practitioner and Counter Fraud Services) and National IT services Audit Reports 2024/25
- Orkney Health Board Endowment Fund Annual Accounts 2024/25 received.

Decisions made.

- Draft NHS Orkney Annual Report and Accounts for year ended 31 March 2025 reviewed with a recommendation to the Board for approval.
- Authorised Chief Executive to sign representation letter as Accountable Officer for the Board.

7. Any Other Competent Business (Presenter: Chair)

No other competent business was raised.

8. ITEMS FOR INFORMATION OR NOTING (Presenter: Chair)

There were no items for information or noting

The Chair closed the meeting at 10.40am.

Joint Clinical and Care Governance Committee Minutes
Thursday 3 July 2025

Attendance

Members: Stephen Brown (Chief Officer, IJB), Dr Kirsty Cole (Area Clinical Forum Chair), Debs Crohn (Interim Head of Corporate Governance), Rona Gold (Chair), Kat Jenkin (Head of Patient Safety, Quality and Risk), Dr Anna Lamont (Medical Director), Darren Morrow (Head of Children, Families and Justice Services/Chief Social Work Officer), Laura Skaife-Knight (Chief Executive), Jean Stevenson (Vice Chair), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Issy Grieve (Non-Executive Board Member), Wendy Lycett (Interim Director of Pharmacy), Lindsay Hall (Orkney Island Council Elected Representative).

Guests

Hannah Casey (Public Health Manager), Lynsey Harper (Public Protection Lead), Elvira Garcia (Consultant in Public Health), Sarah Walker (Head of Infection, Prevention and Control) and John Daniels (Head of Primary Care).

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 deputy, is present.

2. Apologies (Presenter: Chair)

R Gold opened the meeting at 1.30 pm and welcomed members to the meeting.

Apologies received from I Taylor, (Orkney Island Council representative), Dr L Wilson (Director of Public Health), M Gemmill (Associate Director of Allied Health Professionals).

Elvira Garcia attended the meeting on behalf of Dr Louise Wilson.

Members agreed the meeting was quorate in line with the Boards Code of Corporate Governance.

3. Declarations of Interests – Agenda Items (Presenter: Chair)

No declarations of interest were raised.

4. Minutes of Joint Clinical and Care Governance Committee - 2 April 2025 (Presenter: Chair)

The minutes of the Joint Clinical and Care Governance Committee meeting held on 2 April 2025 were accepted as an accurate record of the meeting.

Dr K Cole asked that minutes were consistent going forward including her job title being correct.

5. Action Log (Presenter: Chair)

The action log was discussed with corrective action taken and updates provided where required.

6. Chair's Assurance Report (CAR) from meeting 2 April 2025

Members noted the Chair's Assurance report from the meeting held on the 2 April 2025.

7. Corporate Risks aligned to the Joint Clinical and Care Governance Committee - JCCGC25/26 (Presenter: Executive Director of Nursing Midwifery, AHP and Chief Officer Acute).

The Chair invited questions from Members in relation to the Corporate Risks aligned to the Joint Clinical and Care Governance Committee.

The Committee noted the report which provided an update and overview of the management of risks related to committee. The top five risks were detailed within the report.

Dr K Cole asked for clarity on the risk of fragile services in relation to the timescales for the ophthalmology peer review timescales. The Medical Director confirmed that the peer review has been shared with members, An Ophthalmology workshop has taken place as part of the Clinical Service Review (CSR) the 3 pathways arising from the review are now in the planning phase. Dr K Cole noted that the risk was last reviewed in January 2025. A further update will be provided as part of the CSR.

The Chair acknowledged that some of the mitigating actions do not state what actions are planned or who is the risk owner making it challenging for Committee to take assurance on risk management.

Dr K Cole asked for timescales on the NHS Highland Service Level Agreement Reviews,

L Hall asked for an update on capacity within Mental Health Services in relation to training for staff. The EDoNMAHP confirmed that training has now taken place. Narrative to be updated in the risk register to reflect on-going recruitment of Band 6 and Band 7 within the service.

The Chair asked for mitigating actions to be added to the risk register, including a link to the overarching Mental Health Plan. The Chief Officer IJB confirmed that the plan will be shared with Committee including mitigating factors. The Chair confirmed that the mitigating actions were not included in the update due to timing of the report being produced.

The Chair asked for clarity on risks that had been downgraded and the criteria for the risk being reduced. The EDoNMAHP advised that the risk in relation to reduced capacity at The Balfour has been downgraded as a result of the risk assessment at that time being low. However, the situation has now changed, and the risk will be reviewed considering the changes.

Decision/conclusion
Members took assurance of progress on the latest Corporate Risk Register.

8. Integrated Performance Report (IPR) (Presenter: Executive Director of Nursing Midwifery, AHP and Chief Officer Acute)

The Chair invited questions on the Integrated Performance Report (IPR).

The Consultant in Public Health advised that the target in relation to smoking cessation is incorrect and confirmed that the target remains off track but is expected to come back on track over the year.

The CEO asked if capacity in relation to undertaking Serious Adverse Event Reviews (SAER's) is due to staffing capacity. The Medical Director advised that there are sufficient people trained to undertake SAER's. The CEO asked for clarity on this position as previously it was stated that not enough people were available to undertake the reviews. The Medical Director confirmed that this was in relation to the backlog of SAER's, however as these are clearing capacity is not as big an issue as it has been previously.

The Head of Patient Safety, Quality and Risk advised that one of the challenges in relation to SAER's is due to the high number of complex SAER's, however assurance was provided on current performance noting that several staff have left the organisation who were trained in SAER's. A risk jotter has been developed by the Clinical Governance Group; this will be brought to the next JCCGC meeting in October 2025.

The CEO asked what the timescale for completing the training for SAER's is noting this has been ongoing for some time.

J Stevenson asked for clarity on the significant risk of the lack of digital maturity and how this will impact on our ability to accelerate digital transformation. The Head of Patient Safety Quality and Riks confirmed that the digital maturity risk has been downgraded due to the amount of work and mitigation actions which have been put in place with a clear focus on the 3 priorities identified in our Corporate Strategy.

The Chair asked for clarity on when the deep dive on the Paediatric Early Warning Scores (PEWs) will be complete. The EDoNMAHP advised that the way the PEWs scores are recorded has changed, our Practice Education Facilitator advised that training will be undertaken for staff to ensure the changes are embedding in custom and practice.

The Chair asked for confirmation on the data referred to for screening and Measles, Mumps, Rubella data in the population health section. The Consultant in Public Health confirmed that the data is correct and is the latest data advising that data is being validated by our local Vaccination team.

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 Chair thanked the EDoNMAHP for the paper, and the CEO for introducing feedback from National Meetings to the JCCGC agenda.

The EDoNMAHP provided an update from the Sottish Executive Nurse Directors (SEND) meeting held in June 2025.

The CEO asked where the Board is in relation to Maternity Peer Review. The EDoNMAHP advised that the Board has agreed the Terms of Reference for the maternity Peer Review, once reviewers are in place a benchmark will be undertaken against the Maternity Review of NHS Tayside. The aim is to have the review complete by the end of Quarter 3 2025/26.

Decision/conclusion

Members welcomed and noted the update from SEND, noting the following updates were not received

- Scottish Association Medical Directors (SAMD)
- Directors of Public Health (DPH)
- Chief Officers Meeting

10. CHAIR'S ASSURANCE REPORTS

10.1. Area Drugs and Therapeutics Committee (ADTC) Chair's Assurance Report (Presenter: Medical Director)

The Medical Director received questions from committee members in relation to the report of the ADTC meeting held 10 February 2025.

The Medical Director advised that the CAR is the report from the February meeting and advised that the meeting in May did not take place but asked members to note the information in relation to prescribing pubity blockers which was an emerging matter - this will be included in the next Chairs Assurance Report.

The Chair asked for confirmation on what is meant by pathways for clinical pathways and policies. The Medical Director advised this relates to decisions made.

Chairs should ensure that dates for actions to be completed are included in Chairs Assurance Reports as well as not using acronyms.

The May 2025 CAR will be brought to the next meeting.

Decision/Conclusion
Members took assurance from the update.

10.2. Infection, Prevention Control Committee (IPCC) Chair's Assurance Report JCCGC25/26 - (Presenter: EDoNMAHP)

The EDoNMAHP received questions from committee members in relation to the report of the IPCC meeting held on 4 June 2025.

The Chair asked if the risk in relation to pest control should be on the corporate risk register. The Infection Prevention and Control Lead advised that an improvement plan is in place with Robertsons who provide facility management at The Balfour.

The Chair asked what the impact is of the removal of the Highly Contagious Infection Disease (HCID) competency framework, The Infection Prevention Control Lead confirmed that there is a national workstream looking at the framework and confirmed the national body has removed the framework. However, local permission has been granted by the IPCC to use the framework in the absence of a national framework which is welcomed by staff.

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) - No paper recieved

No Chairs Assurance Report received due to timing of the meeting.

Verbal assurance provided by the Head of Children's Services, Criminal Justice and Chief Social Worker that the Social Work and Social Care Governance Board continues to meet within its cycle.

Two Chairs Assurance Reports will be brought to Committee in October 2025.

10.4. Clinical Governance Group Chair's Assurance Report and action notes JCCGC25/26 - (Presenter: Medical Director)

The Medical Director received questions from committee members in relation to the report of the Clinical Governance Group (CGG) meeting held 10 June 2025 and action notes from the meeting held 11 March 2025.

Dr K Cole asked for clarity on splash zone and the risk associated with it and the implications of this for Primary Care. The Infection Prevention and Control lead advised that this covers all splash zones across The Balfour. The Head of Patient Safety, Quality and Risk advised that the risk currently is on the acute risk register and not the Orkney Health and Care Risk Register.

J Stevenson asked for confirmation on the governance for research. The Head of Patient Safety, Quality and Risk advised that this is in relation to all research being undertaken across the Organisation this includes ethical consideration. The Medical Director confirmed that a

Service Level Agreement (SLA) is in place with NHS Highland if ethical research is required. The Chief Officer IJB asked that consideration be given to research across the Community Planning Partnership in the context of this decision.

The EDoNMAHP asked for confirmation that the CGG was quorate noting the number of apologies at the meeting and non-attendance from key services. The Head of Patient Safety, Quality and Risk confirmed that the meeting was quorate in line with the Terms of Reference.

Decision/Conclusion
Members received escalated items and took assurance on performance

11. PLACE

11.1. Public Health Burden of Disease Update (Guest: Hannah Casey - Public Health Manager)

Hannah Casey - Public Health Manager, attended the meeting at 14.30

The Public Health Manager took questions on the Public Health Burden of Disease paper.

Interim Director of Pharmacy asked for confirmation on the increase in the number of referrals to the childhood weight management service and asked if these has resulted in increased waiting times. The Public Health Manager advised that capacity is available to meet the number of referrals being received.

J Stevenson thanked the Public Health team for the paper.

CEO asked who is involved in developing the Good Food Nation Plan and was keen to understand the governance route. The Public Health Manager advised that Sharon Keyes is the lead for NHS Orkney working in partnership with Orkney Island Council. Once the act is enacted Orkney has 12 months to implement the recommendations. The Public Health Manager advised that as there is not currently a plan in place governance has not been confirmed.

EDoNMAHP advised that the local food plan and weight management plan should come through JCCGC. Chief Officer IJB advised that 1 plan for Orkney should be delivered advising that once the plan has been approved by the Community Planning Partnership it will come through JCCGC for good governance.

Dr K Cole asked for confirmation on involvement in the physical well-being strategy and where this is being brought through the Board's governance system. The Public Health Manager advised that this work has been ongoing for several years, this is currently being taken through Orkney Island Council governance. Concerns were raised in relation to visibility within the Board on the physical well-being strategy.

Committee raised concerns regarding the lack of visibility on the development of joint strategies like the Physical Well-being Strategy as this is resulting in limited assurance being taken by Committee. The CEO advised that operational governance review has identified that the Place strategic objective is less developed and advised that the Population Health Framework provides an opportunity to bring this work together.

The Chair asked if any of the interventions have measurable data that could be shared with Committee. The Public Health Manager advised that data is shared with the Clinical Governance Group and Public Health Scotland (PHS).

Dr K Cole asked for confirmation of Orkney's position on the delivery of weight loss medication and what the plans are noting our small local services. The Medical Director acknowledged that national guidance has not yet been issued, and bariatric patients in Orkney are referred to NHS Grampian. Information will be shared with Committee once available.

Decision/conclusion
Members welcomed the update and took assurance on the Public Health Burden of Disease Update (Weight Management)

The Public Health Manager left the meeting at 15.07

11.2. Public Health Report - Sexual Health and Blood Borne Viruses (BBV) Report JCCGC25/26 - (Presenter: Consultant in Public Health)

The Consultant in Public Health Manager took questions from members on the Sexual Health and Blood Borne Viruses (BBV) Report.

The Chief Officer IJB asked if there is any more work that could be undertaken to increase the number of people being tested for Hepatitis C. The Consultant in Public Health advised that this was raised with Scottish Government at their last visit. The Alcohol and Drugs Service have tried to raise awareness; work continues with the Alcohol and Drugs Partnership to reach those at risk from injecting opioids.

Dr K Cole declared a clinical conflict of interest in relation to developing a PREPP pathway for Orkney when one is already in place through the Nordhaven Clinic at The Balfour Visit. The Consultant in Public Health suggested that a conversation would be useful at the next Sexual Health Network.

The Chair asked if the Blood Borne Virus Improvement Plan would be shared with Committee. The Consultant in Public Health confirmed that outcomes and a gap analysis from the Scottish Government’s visit will be forwarded to the CEO and Director of Public Health, this will be shared with the Sexual Health Network prior to being presented to Committee.

Decision/conclusion
Members received the update and took assurance

12. PATIENT SAFETY, QUALITY AND EXPERIENCE

12.1. Safety, Quality and Experience Quarter 4 Report 2024/25 (Presenter: Medical Director)

The Chair invited questions on the Safety, Quality and Experience Quarter 4 Report 2024/25.

J Stevenson sought clarity on why falls with and falls without harm could not be provided. The Head of Patient Safety, Quality and Risk advised that there is no national definition of falls with harm. The EDoNMAHP and Head of Patient Safety, Quality and Risk are looking at a local definition of harm, noting that national reporting will not be able to be changed. Training

has taken place with Inpatient (IP) 1 and IP2 staff, this has led to a reduction in the number of falls supported by our Excellence in Care Lead.

J Stevenson asked how visibility issues could be resolved given our wards are built on a curve. The EDoNMAHP advised that patients who are at risk of falls are placed in sight of the nurse's station to mitigate the risks.

Decision/conclusion
Members received and approved the Safety, Quality and Experience Quarter 4 Report 2024/25.

12.2. Duty of Candour and Significant Adverse Events Annual Report 2024/25 (Presenter: Medical Director)

The Head of Patient Safety, Quality and Risk took questions on the Duty of Candour and Significant Adverse Events Annual Report 2024/25 noting the information has been brought to Committee over the past 12 months.

The Medical Director advised that consideration needs to be given to when the Duty of Candour is applied in the Significant Adverse Events process.

Decision/conclusion
Members received and approved the Duty of Candour and Significant Adverse Events Annual Report 2024/25.

12.3. Duty of Candour - Organisational Duty of Candour Procedure Non-statutory Guidance - Revised March 2025 (Presenter: Medical Director)

The Head of Patient Safety, Quality and Risk presented the Organisational Duty of Candour Procedure Non-Statutory Guidance - Revised March 2025. The Chair asked members to review the Duty of Candour Procedure Non-Statutory Guidance - Revised March 2025.

Decision/conclusion
Members received and noted the Organisational Duty of Candour Procedure Non-statutory Guidance - Revised March 2025

12.4. NHS Orkney Patient Feedback (Complaints) Annual Report 2024/25 (Presenter: Medical Director)

The Head of Patient Safety, Quality and Risk presented the NHS Orkney Patient Feedback (Complaints) Annual Report – 2024/25.

Decision/conclusion
Members received and approved of the NHS Orkney Patient Feedback (Complaints) Annual Report – 2024/25.

12.5. Infection Prevention Annual Report 2024/25 (Presenter: Executive Director of Nursing Midwifery, AHP and Chief Officer Acute)

The EDoNMAHP presented the Infection Prevention Annual Report 2024/25.

Decision/conclusion
Members received and approved the Infection Prevention Annual Report 2024/25.

12.6. Primary Care Improvement Plan (PCIP) Annual Update (Presenter: Head of Primary Care)

The Head of Primary Care presented the Primary Care Improvement Plan (PCIP) Annual Update.

Dr K Cole asked for clarity on NHS Orkney's spending allocation of Primary Care Improvement funding. The Chief Officer IJB acknowledged that there had been challenges in relation to posts being filled.

Dr K Cole asked for confirmation on advice taken by the Central Legal Office (CLO) on delivery of the Primary Care Improvement Plan as there is a risk associated with regulated services. Chief Officer IJB advised that no Board in Scotland is fully compliant. GP Sub Committee and Primary Care Management Team will be involved in mapping out what is required, the Integration Joint Board will be required to consider what level of risks would be accepted.

Dr K Cole asked for timescales on defining the risk and when this will be presented to the IJB. The Chief Officer advised that a paper will be taken to the IJB in September 2025.

Head of Primary Care outlined the risks of not delivering regulated services in terms of what wouldn't be delivered. One option would be to agree to a local solution with support from the Central Legal Office noting that the Board is not in a position to deliver everything with the amount of funding the Board receives.

The Interim Director of Pharmacy advised that whilst we are not delivering pharmacotherapy and Community Treatment Assessment Centre (CTAC) work is underway at a national level.

The Chair thanked the Head of Primary Care for the paper and asked for confirmation on relevant stakeholders and requested these be named where possible in future reports. Chief Officer IJB confirmed that the PCIP and utilisation of the funds requires IJB sign off, Committee will be kept updated on progress.

Dr K Cole advised that the report has not yet been taken through the GP Sub-Committee noting that it would be useful to ensure relevant stakeholders are clearly set out in papers going forward.

Decision/conclusion
Members received and took assurance on the Primary Care Improvement Plan (PCIP) Annual Update

12.7. Psychiatric Emergency Plan (Presenter: Head of Health & Community Care)

The Chair invited questions on the Psychiatric Emergency Plan.

The Chair asked that report authors are clear on who is referred to as stakeholders noting that the list of stakeholders is lengthy.

L Hall asked for confirmation on what is being referred to by non-ferry linked isles. Chief Officer IJB advised that clarity is required re ferry linked isles and stakeholders.

Dr K Cole advised that text was missing from flow chart, and reference was made in relation to key workers.

Clarity required on what is meant by Risk Assessment Matrix (RAM) as set out in Page 269.

The Chair asked for clarity on when the review of distress brief interventions would be complete as set out on page 238. The Chief Officer IJB confirmed that the plan will be reviewed on a 12 monthly basis. Paper to come back to Committee in 12 months.

Decision/conclusion
Members received and took assurance on the Psychiatric Emergency Plan.

12.8. Public Protection Assurance Framework Update (Presenter: Public Protection Lead)

The EDoNMAHP presented the Public Protection Assurance Framework Update.

The Chair invited questions from members.

Dr K Cole welcomed the report and asked for the areas that have been partially completed what the plan is for completing the actions. Public Protection Lead advised that further stakeholder engagement is now required to populate the improvement plan with clear timelines.

CEO advised that it was challenging to take assurance on progress are there are gaps in the paper for example timelines and action owners

EDoNMAHP thanked those involved in getting the plan to where it currently is noting that more work is required. Public Protection is on our Corporate Risk Register; there is a role for the Public Protection Committee to support the development and implementation of the PPP Assurance Framework. Included in the paper is who is employed in Public Protection in other Health Boards, noting that the Board is an outlier in terms of delivering Public Protection.

The CEO advised that it is unclear what is required, by who and when.

The Chair asked that additional support be identified to populate the Assurance Framework and structure required to ensure the Board is assured we are meeting our legal requirement.

The Head of Children's Services, Criminal Justice and Chief Social Worker acknowledged that Public Protection must take a multi-agency approach, improved links with the Public Protection Committee are required. Public Protection is one of the areas which will be subject to inspection by Scottish Government.

The Chair asked if there was a mentor that could be identified to support partnership working with the Public Protection Lead.

The CEO asked for confirmation on the touch points to ensure the work is monitored over the next 6 months. EDoNMAHP advised this will be undertaken by the 4 sub-groups of the Public Protection Committee.

EDoNMAHP to bring updated self-assesment taking a multi-agency approach with oversight from the Public Protection Committee sub-groups to be brought to January 2026 Committee.

Decision/conclusion
Members received the update, taking limited assurance on the implementation of the Public Protection Assurance Framework noting this is on our Corporate Risk Register.

L Hall left the meeting at 16.10 - the Committee were no longer quorate.

L Harper left the meeting at 16.15

12.9. Joint Inspection of Adult Support and Protection – Progress Review (Presenter: Head of Health and Community Care)

The Chair invited questions from members on the Joint Inspection of Adult Support and Protection Progress Review noting this has been discussed at the Integration Joint Board.

The Chief Officer IJB asked Committee to recognise that since the adult support and protection inspection, it's important to acknowledge the progress that the multi-agency teams have made over the last few years in this area and the positive output achieved since the inspection.

Decision/conclusion
Members noted the report.

12.10. NHS Greater Glasgow and Clyde Emergency Department Review and NHS Orkney Self-assessment (Presenter: EDoNMAHP)

The EDoNMAHP presented the NHS Greater Glasgow and Clyde Emergency Department Review and NHS Orkney Self-assessment. The self-assessment will be discussed at Senior Leadership Team 10 July 2025.

The Medical Director asked if the risks outlined in the paper will be linked into the Risk Management Group. EDoNMAHP advised that the risks will come through the Risk Jotter process. The QR code for patient feedback requires further work and linkages with patient experience team.

Chief Officer IJB asked if there was anything of specific relevance for Committee which needs to be considered. Whilst there are 41 recommendations, 25 of these relate to NHS Orkney.

EDoNMAHP advised that this exercise has not been undertaken by all Boards.

Dr K Cole asked for confirmation on the action on patient safety feedback - feedback mechanisms are in place Head of Patient Safety Quality and Risk is working with colleagues in the Emergency Department (ED) to reduce duplication of effort.

Dr K Cole asked for confirmation on appraisals rates for staff in the Emergency Department. The EDoNMAHP advised that leaders in ED are ensuring appraisals are undertaken for all staff.

J Stevenson welcomed that the Manchester triage training is taking place.
.
The Chair asked for updates at quarterly meetings to ensure progress is monitored as per the action plan within the report.

The Chair thanked EDoNMAHP for the breadth of the work that's being undertaken. Committee were pleased to see the pro-active approach taken by NHS Orkney on the NHS Orkney Self-assessment against the NHS Greater Glasgow and Clyde Emergency Department Review. This shows a shift in terms of taking a real learning and improvement approach.

Decision/conclusion
Members reviewed the action plan and took assurance of actions being taken.

12.11. Quality Impact Assessments (Presenter: EDoNMAHP)

Committee received an update on Quality Impact Assessments noting that the governance route is from a clinical and patient safety perspective.

Dr K Cole asked for clarity on the autism pathway referenced in Appendix 1. The Chief officer IJB advised that this is a timing issue.

Decision/conclusion
Members received the update.

13. PERFORMANCE

14. Emerging issues and Key National Updates (Presenter: Chair)

No emerging issues or Key National Updates not already covered on the agenda were discussed.

15. 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

Matters of concern

- Lack of visibility on the development of joint strategies like the Physical Well-being and Weight Management strategies resulting in limited assurance being taken by Committee.
- Limited assurance taken on the implementation of the Public Protection Assurance Framework noting this sits on our Corporate Risk Register.

Decisions made

- Safety, Quality and Experience Quarter 4 Report 2024/25 approved.
- Duty of Candour and Significant Adverse Events Annual Report 2024/25 approved.

- NHS Orkney Patient Feedback (Complaints) Annual Report - 2024-25 approved.
- Infection Prevention Annual Report 2024/25 approved.

Positive assurance provided

- Assurance taken
  - Corporate Risk's aligned to Committee
  - Integrated Performance Report
  - Area Drugs and Therapeutics Committee.
  - Infection Prevention Control Committee
- Process for undertaking research
- Sexual Health and Blood Borne Viruses (BBV) Report
- Primary Care Improvement Plan (PCIP) Annual Update
- Psychiatric Emergency Plan.
- NHS Orkney Self-assessment against the NHS Greater Glasgow and Clyde Emergency Department Review.

16. AOCB (Presenter: Chair)

The Medical Director asked for it to be noted that the safety quality and experience report has now been in place for a year. The report contains a lot of positive feedback which has been shared with the organisation.

Having completed a one-year cycle, the report presented was the 4th report.

The Chair thanked the Medical Director for their comments, recognising that sometime papers are skimmed over when assurance is clear from the papers and that there has been lots of positives throughout this committee meeting.

17. ITEMS FOR INFORMATION AND NOTING ONLY

Members welcomed and noted the following paper

17.1. Centre for Sustainable Delivery Endoscopy review report (Presenter: Medical Director)

Members noted the Centre for Sustainable Delivery Endoscopy review report.

17.2. Schedule of Meetings 2025/26 (Presenter: Chair)

Members noted the future meeting dates.

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

Members noted the record of attendance 2025/26.

17.4. Date of next meeting - Wednesday 1 October 2025

Next meeting will take place Wednesday 1 October 2025.

The meeting closed at 17.00.

Extraordinary Joint Clinical and Care Governance Committee Minutes Wednesday 20 August 2025

Attendance

Members

Members: Stephen Brown (Chief Officer, IJB), Kat Jenkin (Head of Patient Safety, Quality and Risk), Dr Anna Lamont (Medical Director), Jean Stevenson (Vice-Chair), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services), Issy Grieve (Non-Executive Board Member), Wendy Lycett (Interim Director of Pharmacy), Lindsay Hall (Orkney Island Council Elected Representative).

1. Welcome and Apologies (Presenter: Chair)

J Stevenson (Vice-Chair) opened the meeting at 2.00 pm and welcomed members to the meeting.

Apologies received from I Taylor, (Orkney Island Council representative) Dr Louise Wilson (Director of Public Health), M Gemmill (Associate Director of Allied Health Professionals), Dr Kirsty Cole (Area Clinical Forum Chair), Laura Skaife-Knight (CEO).

2. Clinical Services Review Implementation Plan (Presenters: Medical Director, Executive Director of Nursing Midwifery, AHP and Chief Officer Acute (EDoNMAHP) and Chief Officer Integration Joint Board).

The Vice Chair confirmed that the meeting's purpose was to take assurance on governance arrangements and implementation plan with the intention to prepare for board-level discussions scheduled for 28 August 2025.

The Medical Director presented the Clinical Services Review (CSR) implementation plan outlining the governance arrangements, financial risks, and readiness for board-level discussion, with the group confirming assurance for moving forward to the public board.

The Medical Director confirmed that the implementation plan is the first formal presentation of the final CSR report to a Board subcommittee, at the request of the Board Chair and Chief Executive, and that the same paper will be presented at the Public Board meeting 28 August 2025 for assurance. The report has been shared with the Senior Leadership Team (SLT), extended SLT (ESLT), clinical engagement groups and will be shared wider following consideration by the Board.

The Medical Director highlighted the importance for ongoing engagement with clinical advisory groups and the importance of maintaining consensus, especially for recommendations with significant organisational transformation, emphasising that public communication would follow Board review and that further engagement would be required for areas lacking consensus.

Members discussed the financial risks associated with the CSR recommendations, clarifying that while some changes may be cost-neutral in the long term, most carry transitional costs require careful prioritisation.

Concerns were raised by I Grieve and J Stevenson in relation to costings and financial pressures. The Medical Director explained that each Horizon 1 recommendation in the CSR has been individually scored for financial and organisational risk, with some changes being easier to implement due to clinical consensus, while others, particularly those with the greatest potential savings carried higher risks and required further engagement.

The Chief Officer IJB described the approach of prioritising recommendations which will yield both improvements and savings, whilst acknowledging that some changes will require upfront investment. Members agreed that transformation would necessitate a spend-to-save approach and that further financial detail would be needed as implementation progressed.

I Grieve asked that any recommendations to the Board should note that, although cost neutrality is possible, there is a significant likelihood of additional expenses. Transformation will require accepting some transitional expenditure.

I Grieve asked for clarity on how the CSR aligns with Government Funding and Policy particularly for unscheduled care and frailty, clarifying the use of non-recurrent funds and the adaptation of national expectations to local context. The EDoNMAHP clarified that whilst there are new monies for planned care, unscheduled care funding is non-recurrent and already committed, and that the CSR recommendations align with the requirements for these funds.

The EDoNMAHP explained that government expectations for a frailty unit in each emergency department were being adapted locally due to organisational size, with funding used for consultant geriatrician support and comprehensive geriatric assessment, as well as supporting outpatient antibiotic therapies to prevent admissions. Orkney's small size necessitates a different approach to initiatives like 'hospital at home,' focusing instead on in-reach and outreach services, and leveraging the expertise of staff to deliver services that meet both local needs and government expectations.

The Chair asked for clarification on the process for pre-operative assessments for patients referred to the Golden Jubilee in Glasgow, confirming that most assessments are conducted locally, with rare exceptions due to referral pathways. The EDoNMAHP confirmed that the majority of patients do not travel to Glasgow for preoperative assessment, as these are conducted on Orkney, with only rare exceptions for specific medical reasons. The team now seeks to arrange local assessments in such cases where possible.

Decision/conclusion

Members discussed and agreed that governance arrangements are in place and that implementation readiness was sufficient for consideration by the Board at its meeting 28 August 2025.

3. AOCB (Presenter: Chair)

No other business was raised.

The meeting closed at 14.30

Finance and Peformance Committee Minutes
31 July 2025

Attendance

Melanie Barnes (Interim Director of Finance), Stephen Brown (Chief Officer - Integration Joint Board (IJB), Davie Campbell (Chair - Non-Executive Director), Debs Crohn (Interim Head of Corporate Governance), Kat Jenkin (Head of Patient Safety, Quality and Risk), Joanna Kenny (Non-Executive Director), Ryan McLaughlin (Non-Executive Director - Employee Director), Alan Scott (Head of Estates), Tammy Sharp (Director of Performance, Transformation), Laura Skaife-Knight (Chief Executive Officer), Keren Somerville (Head of Finance), Sam Thomas (Executive Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services EDoNMAHP), Dr Anna Lamont (Medical Director), Deborah Langan (Chief Finance Officer – IJB).

1. Cover page (Presenter: Chair)

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 the 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 (Davie Campbell) opened the meeting at 09.30 am and welcomed members to the meeting.

Apologies received from Jarrod O Brien (Director of People and Culture), Sharon Keyes (Head of Facilities and NPD Contract), Jean Stevenson (Non-Executive Director) and Meghan McEwen (Chair), Jason Taylor (Non-executive Director).

3. Declarations of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minutes of the Finance and Performance Committee 22 May 2025 (Presenter: Chair)

The Chair presented the minutes of the Finance and Performance Committee held 22 May 2025.

Decision/conclusion
The Minutes of the meetings held on 22 May 2025 were accepted as an accurate record of the meeting and approved.

5. Action Log (Presenter: Chair)

The Interim Head of Corporate Governance presented the Action Log to the Committee.

Decision/conclusion
The action log was reviewed, no outstanding issues (see action log for details).

6. Matters Arising (Presenter: Chair)

No matters arising were raised.

7. Chairs Assurance Report Finance and Performance Committee 22 May 2025 (Presenter: Chair)

The Committee Chair presented the Chairs Assurance report of the Finance and Performance Committee meeting held on 22 May 2025.

Delayed Transfers of Care (DToC) - Workshop has taken place with Care Home Managers to better understand issues and staffing ratios. The follow-up meeting will take place early September 2025, in the meantime interim solutions are being discussed in relation to Hamnavoe House. The DToC report presented to the IJB was well received, a whole system task force is being established recognising.

Capacity for managing change management - A risk has been identified, agreement at the Executive Team to undertake recruitment in the Improvement Team. Work is underway to re-patriate administrative tasks back to the Organisation. These changes will better support the Improving Together (efficiency) programme and Clinical Services Review.

The CEO confirmed that all Boards have received confirmation from Scottish Government that Annual Delivery Plan will form part of reporting on the Operational Improvement Plan.

Options are being explored to mitigate the risk associated with the workforce delivery workstream, this risk continues and is at risk of increasing.

Decision/Conclusion
The committee noted the update.

8. Update from National Directors of Finance Meeting (Presenters: Head of Finance)

The Head of Finance presented an update from the National Directors of Finance Meeting, highlighting the following.

- 4 groups have been established to take forward the chief executive delivery plan.
- Procurement continues on deployment of the National Business Systems

Decision/conclusion
Members noted the update.

9. 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; no new risks have been added in relation to finance and performance.

In relation to degradation from guidance on water, there is no risk to patient safety.

Central Decontamination Unit and waiting times risks are now closed having met their target score.

The Committee Chair asked if the risk in relation to the Island Games would be closed. The Interim Director of Finance advised that risk will be closed ahead of the next meeting.

The CEO asked for confirmation of the issues in relation to the Old Balfour site. Head of Estates confirmed that a walk of the site was undertaken last week on the back of recent vandalism, CCTV cameras have been installed on site. Monitoring the site continues; there is no evidence that opening the car park has increased vandalism at the Old Balfour.

Decision/Conclusion
Committee took assurance on the progress and mitigations presented on the latest Corporate Risk Register

10. PLACE

10.1. Chair's Assurance Report - Sustainability Steering Group (Presenter: Head of Facilities and NPD)

No meeting has taken place since the last update to the Committee due to the timing of the meeting. The next meeting will take place in September, with CAR being presented to the Committee in October 2025.

10.2. Chairs Assurance Report - Capital and Property Strategy Group 9 June 2025 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Chairs Assurance report from the Capital and Strategic Estates Group meeting 9 June 2025.

Capital spend is on track, unallocated spend of £600k remains noting this is still early in the year. Funding has been earmarked for the Old Balfour site, but this is no longer required.

Conversations have taken place with University Highlands and Islands and Orkney Island Council (OIC) re a housing accommodation strategy.

A proposal will be presented to the Committee in January 2026 on the plans for the Old Balfour Site. This item is to be discussed later in the agenda.

Decision/conclusion
Members noted the update.

10.3. Update on the Old Balfour and King Street sites (Presenters: Interim Director of Finance)

The Interim Director of Finance presented an update on the Old Balfour and King Street sites.
Conversations have taken place with Scottish Government and funding confirmed for surveys and demolition of the Old Balfour Site. Procurement will commence in August 2025 including identification of contaminants. Timescales to be confirmed.

A strategic housing accommodation proposal is being developed in partnership with Hub North, this will be returned to the Committee in January 2026.

Conversations have taken place with OIC in relation to King Street, a formal proposal to dispose of King Street will be presented to the Board shortly.

Chief Officer IJB asked for confirmation of income from King Street as this was included in our financial plan for 2026/27. The Interim Director of Finance advised that the sale of King Street is likely to be September 2025, however there is a risk that the funding may not materialise this financial year resulting in a £175k cost pressure.

The CEO asked for confirmation on whether a decision in relation to the sale of King Street was made by the Board. Interim Director of Finance to confirm if a decision has been made.

Decision/conclusion
Members welcomed the update on the Old Balfour and King Street sites.

11. PATIENT SAFETY, QUALITY AND EXPERIENCE - No papers presented

12. PERFORMANCE

12.1. Programme for Government - NHS Reform and Renewal Framework - what this means for NHS Orkney - item deferred (Presenters: Head of Planning, Performance and Information)

Item deferred to the next meeting.

The CEO advised that confirmation is required on the Executive Leads for Reform and Renewal agenda.

12.2. Integrated Performance Report (IPR) - Finance and Performance (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the Integrated Performance Report.
Director of Performance and Transformation advised that work is underway to refresh chapters of the Integrated Performance Report, and metrics and format have been updated.

The Refreshed IPR will be circulated to Board Members for comments. Refreshed sections will be included in August 2025 IPR. The refreshed IPR will be in place by October 2025.

Acute/operational services

The EDoNMAHP advised that from an acute performance, ED continues to be in the top 3 performers. During the Island Games performance increased however we remained at 95%.

Work on inpatient falls continues, no pressure sores reported demonstrating our commitment to continuous improvement.

Community services

The Chair asked if the narrative for Community services be updated in the next IPR. The Chief Officer - IJB acknowledged the need for metrics to be featured in the IPR particularly in relation to Alcohol and Drugs Services.

Finance
Status at Month 3 is rated red, driven by the additional £200k increase in spending.

Decision/conclusion
Members noted and took assurance on the IPR.

12.3. Month 3 (June 2025) Financial Results and Improving Together (efficiency) Programme update (Presenters: Interim Director of Finance)

The Interim Director of Finance presented Month 3 (June 2025) Financial Results and Improving Together (efficiency) Programme update. The Board is £200k off track against plan due to increased locum and agency staffing.

To date only 5% of savings have been achieved, significant risk in relation to workforce workstream and sale of King Street. Cost pressures not accounted for are in relation to a 5-6% SLA uplift, the plan was agreed at 3%. High-cost drugs will increase costs, these are currently unknown,

Additional Extended Senior Leadership Team (ESLT), Executive and Senior Leadership Team (SLT) meetings have taken place, however there are substantial risks in relation to not meeting the terms and conditions of transitional funding.

EDoNMAHP advised that agency nurses are being used due to vacancies and long term sickness. We have been successful in our substantive recruitment, new graduate nurses have commenced in IP1, theatres and ED. Once rotations are complete staff will be placed in areas of greatest need. Long term sickness challenges continue, with support from the People and Culture team this is being addressed.

Chief Officer IJB advised that challenges remain in relation to savings within the IJB. Sessions have been scheduled in August 2025 to look at the project plan for the

Clinical Services Review recognising that some of the savings may not be achieved until Quarter 4 2025/26 and 2027/28.

The Director of Performance and Transformation advised that an Executive Grip and Control meeting now takes place weekly.

The CEO confirmed that a review of IJB spend is now complete. All Executive Directors are reviewing all staffing establishments to identify posts which could be removed and opportunities with a reduction quote being confirmed. An additional SLT meeting will take place on 5 August to discuss opportunities.

The Committee Chair asked for confirmation on saving costs against Near Me (virtual consultations) as this has been reduced due to capacity issues. The Interim Director of Finance advised that savings targets were set earlier this year, we are heavily dependent on NHS Grampian and their ability to deliver the service.

Decision/conclusion
Members discussed and took assurance on the update.

12.4. Planned Care - 52 week waits and addressing longest waits (Presenter: Director of Performance and Transformation)

The Director of Performance and Transformation presented the Planned Care 52 weeks waits and addressing the longest waits paper and confirmed that all patients who are available to be booked are now booked recognising that all people are not at 52 week waits.

The key area of risk is the Ears and Nose Throat service and ensuring we meet our Treatment Time Guarantee (TTG) for all services.

Work continues with the National Elective Co-ordination Unit (NECU) to review all waiting lists; this will be completed by the end of this year.

The CEO asked for confirmation on the impact of not receiving funding for Endoscopy services. Director of Performance and Transformation advised that conversations have taken place with NHS Highland; there could be an opportunity for locums from NHS Highland to provide Endoscopy service in Orkney.

Decision/conclusion
Members welcomed and noted the update.

12.5. NHS Renewal – Urgent and Unscheduled Care Funding 2025/26 (Presenters: EDoNMAHP)

The EDoNMAHP presented the NHS Renewal – Urgent and Unscheduled Care Funding 2025/26 for assurance, advising that the First Minister has committed to increasing bed capacity and frailty models at the front door in this current parliament.

Initial conversations took place with the Board earlier this year, the Board were asked to submit a bid for unscheduled care funding. EDoNMAHP and Chief Officer IJB submitted a funding bid to Scottish Government; confirmation has been received that

NHS Orkney has been allocated £746 funding. Funding has been allocated as follows.

- £161k - For unscheduled winter monies
- £400k - Frailty and front door model
- £140k - Hospital at Home

EDoNMAHP advised that we currently do not deliver a Hospital at Home service due to substantive funding not being allocated, however this additional funding provides an opportunity to deliver anti-biotics in the Community which will result in a cost saving in relation to bed days advising that target set by Scottish Government is a reduction of 10 bed days saved per month.

The funding will also be used to enable the Respiratory Advanced Practioner to provide respiratory support in the Community. This was included in our Annual Delivery Plan, Operational Improvement Plan and a recommendation in the Clinical Services Review. The funding proposal included establishing a multi-disciplinary team at the front door to avoid admission and identify frail elderly and set up a virtual ward. Target is the national ED performance standard.

The EDoNMAHP advised that there is a risk that this is not recurrent funding, targets have not yet been confirmed but are likely to be the Getting It Right for Everyone targets. There is a risk that recruiting for fixed term contract is a challenge due to lack of accommodation and travel.

J Kenny asked for confirmation of how much the Hospital at Home service will cost as the Hospital at Home and Frailty work go hand in hand. The EDoNMAHP advised that some of this work is already being delivered, the £140k will fund an additional 2 posts,

The Chair asked for additional details on the benefits and what will be delivered. EDoNMAHP advised that this was not captured in the submission but was discussed with Scottish Government's Policy Team. There is a risk that not understanding the trajectories and metrics we will not deliver the additionality required by Scottish Government.

The Interim Director of Finance raised a concern regarding non-recurrent funding and asked for clarity on what additionally will be delivered and how long will embedding the staffing in our operational model noting this is temporary funding.

The EDoNMAHP advised that delivering the Outpatient Parenteral Antibiotic Therapy (OPAT) service will support re-patriation of patients from Aberdeen and a reduction in bed days. In relation to staffing, some of the staff are already in post or are working as locums, there is currently no capacity to support physiotherapy and occupational therapy at the front door, however there is interest in people relocating to Orkney.

EDoNMAHP confirmed that this funding will not be used for permanent recruitment, however Scottish Government are expecting that staff will be recruited on a permanent basis. The Chief Officer – IJB reminded Committee that all Boards are in the same position in relation to this being non-recurrent funding.

EDoNMAHP advised that engagement with the Nursing and Midwifery Advisory Committee (NAMAC) has taken place, recognising this funding is part of a wider transformation piece of work.

The Employee Director raised a concern that we are adding additional cost pressures to a system which is already experiencing financial challenges.

J Kenny advised that there is a risk that focusing on front door model is rushing to address one issue but may create additional pressures elsewhere in the health and care system and felt unable to commit to accepting the funding due to the risk of non-delivery. System re-design needs to be undertaken with the resources we currently have.

The CEO thanked EDoNMAHP and Chief Officer IJB for their work on submitting the bid recognising links to the CSR and FM priorities. The suggestion of putting substantive posts in the system and the lack of clarity on KPI's creates a high risk for the Board.

J Kenny raised concerns regarding the paper coming to Board in August 2025, and how this will be presented to the Integration Joint Board. EDoNMAHP advised that the issue is in relation to timing, recognising the first submission on KPI's is due 31 July 2025.

Due to the level of risks associated with the funding and the need for further clinical engagement it was agreed that the paper presented to Board 28 August 2025 clearly sets out the benefits, KPI's, wider pieces of work already underway, risks and mitigations.

Decision/conclusion
Members discussed the NHS Renewal – Urgent and Unscheduled Care Funding 2025/26.

12.6. Addendum to 3-year financial plan (Presenter: Interim Director of Finance)

Dr Anna Lamont joined the meeting at 10.50.

The Interim Director of Finance presented the addendum to the 3-year financial plan along with the extension to the 4-year plan to bring the Board back to balance.

The Committee Chair asked for confirmation of increased savings in 2026/27. The Interim Director of Finance advised that operational financial planning would commence in October 2025 to ensure the additional £500k savings are delivered.

Scottish Government have accepted and approved the addendum to the 3-year financial plan. Quarter 1 meeting with Scottish Government will take place next week, there is a need to review Agenda for Change additional pay costs.

Employee Director asked for confirmation that the medical staffing savings will be achieved in year and asked if funding for pay uplifts will be covered by Scottish Government. The Interim Director of Finance advised that all savings plans are being

reviewed. The Medical Director advised that recruitment for medical staffing remains a challenge, several methods of recruitment have been tried, and a further recruitment campaign will take place in the next 2 weeks.

The Committee Chair asked for confirmation of the high-level risk in relation to the Board being issued with a section 22 - this has now been reviewed and updated on the Corporate Risk Register which has been reduced.

Decision/conclusion
Members noted the addendum to the 3-year financial plan and took assurance on what was presented.

12.7. Process for approving Business Cases (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the process for approving Business Cases to the Committee for approval.

Criteria were agreed by SLT in October 2024, the template presented will be used for all pay and non-pay business cases.

Decision/conclusion
Members welcomed and approved the process for approving Business Cases

12.8. Litigation 6-monthly Report (Presenter: Head of Patient Safety, Quality and Risk)

The Head of Patient Safety, Quality and Risk presented the litigation 6-monthly report. Claims are being processed, there are no outstanding claims.

Committee Chair welcomed sight of the report at Committee.

J Kenny asked for confirmation that all staff are required to undertake training on the use of hoists. Head of Patient Safety, Quality and Risk advised that all staff are required to be compliant with the use of hoists as part of manual handling training.

Decision/conclusion
Members welcomed and noted the litigation 6-monthly report.

12.9. Revised Standing Financial Instructions Phase 2 Update (Presenter: Interim Director of Finance)

The Head of Finance presented the revised Standing Financial Instructions Phase 2 update.
Amendments are minor wording changes and do not substantially change context or process.

Decision/conclusion
Members discussed and approved the revised Standing Financial Instructions Phase 2

12.10. Chair's Assurance Report - Improving Together Programme Board 11 July 2025 (Presenter: Chief Executive)

The Chief Executive presented the Improving Together Programme Board Chairs Assurance Report from the meeting held 11 July 2025.

Matters of escalation in relation to project management support, medical staffing and Quarter 1 results were covered earlier in the agenda.

Decision/conclusion
Members noted the update and took assurance on what was presented.

12.11. Planned Care Programme Board - Chair's Assurance Report 17 July 2025 (Presenter: Director of Performance and Transformation)

The Director pf Performance and Transformation presented the Planned Care Programme Board - Chair's Assurance Report 17 July 2025.

No matters of escalation.

Health Intelligence team are supporting the Radiology team to develop trajectories for MRI patients who have been repatriated from NHS Grampian waiting lists.

Work continues to clinically assess patients who have indicated they no longer require an appointment via the NECU validation exercise on ENT, general medicine, general surgery, Ophthalmology and Trauma and Orthopaedics. Plans will be in place to have all assessments completed and patients removed from waiting lists by the end of July 2025.

Decision/conclusion
Members noted the update and took assurance on what was presented.

13. PEOPLE - No papers presented

14. POTENTIAL

14.1. Chair's Assurance Report - Digital and Information Operational Group (DIOG) (Presenter: Interim Head of Corporate Governance)

The Interim Head of Corporate Governance presented the Chair's Assurance Report - Digital and Information Operational Group (DIOG).

Matters of escalation

Transition from OneTrust to GRC Tool – Security to manage our Information Asset registers will result in a cost pressure to the Board – Business Case to be developed.by the end of Quarter 2 once more information on costings is available from National Services Scotland.

Resourcing challenges within our eHealth Team due to staff absences. From Monday 26 May 2025, NHS Grampian will provide short-term support for eHealth tickets – this will be picked up as part of the Digital Services Review currently underway.

The implementation for the roll-out of MORSE (Community EPR) will require a programme to be stood up to roll-out to all Community Services – this will be a cost pressure to the Board. Amendment to the Business Case for hosting MORSE will be considered by the Senior Leadership Team 26 August 2025.

Decision/conclusion
Members noted the update and took assurance on what was presented.

14.2. Digital and Information Services Operational Delivery Plan Quarter 1 2025/26 Update (Presenter: Head of Information Technology)

The Interim Head of Corporate Governance presented the Digital and Information Services Operational Delivery Plan Quarter 1 update. The Interim Head of Corporate Governance presented an overview of the national and local digital deliverables and updated on progress to date on actions in NHS Orkney's Corporate Strategy Delivery Plan 2025/26.

The First Minister has made it clear that NHS renewal and reform must be underpinned by a digital-first approach to ensure sustainable and future-proofed healthcare services.

As set out in NHS Orkney's Year 2 Corporate Strategy, a key priority under the Potential Strategic Objective is to accelerate digital transformation. There are no deliverables rated red or amber in Quarter 1.

Led by the Chief Executive of NHS Shetland, conversations continue at a North of Scotland level to look at how we could potentially share digital resources, noting that all our clinical services are hosted by NHS Grampian.

The Digital Services Delivery Plan 2025/25 will continue to be monitored by the Digital Information Operations Group (DIOG) with quarterly reports and monthly Chair's Assurance Reports presented to the Finance and Performance Committee for Assurance.

The Interim Director of Finance asked if a 2 - 3-year plan could be developed which encompasses all national digital requests.

Head of Finance asked if Electronic Patient Records and Order comms could be included in the Digital Delivery Plan. The Chief Executive advised that until the model of delivery for digital services, staffing and lack of clinical engagement need to be addressed before this can be rolled out.

Committee Chair asked if an additional narrative could be included in Appendix 4 for tracking business as usual deliverables.

Decision/conclusion
Members welcomed the Quarter 1 update and took assurance on delivery of the Digital and Information Services Operational Delivery Plan

14.3. National Business Systems Update - implications for NHS Orkney (Presenter: Interim Director of Finance)

The Interim Director of Finance presented an update on the NHS National Business Systems Update and members discussed the implications for NHS Orkney.

Implementation for NHS Orkney will be substantial and require standardised operating procedures across all Boards likely to be deployed in 2026/27 for full roll out by 2027/28.

A full business case will be developed over the next 6 months; Directors of Finance are looking at how funding will be allocated for the roll-out as this is currently not funded.

EDoNMAHP shared that concerns have been raised by the Scottish Executive Nurse Directors on clinical engagement with the National Business Systems Update. Interim Director of Finance advised that e-roster is out of scope for this piece of work.

Decision/conclusion
Members noted the update.

15. ANY OTHER COMPETENT BUSINESS

EDoNMAHP asked for successful completion of the Island Games to be noted. The Committee Chair said they were looking forward to the lessons learned being brought to the Committee.

16. ITEMS TO BE INCLUDED IN THE CHAIR'S ASSURANCE REPORT TO BOARD

The committee agreed with the following items being included in the Chair's Assurance Report for escalation to the Board

Escalations

- Urgent unscheduled care funding 2025/26
- Improving Together Workforce Workstream
- Quarter 1 financial performance

Positive Assurance

- 52 weeks' wait performance.
- Successful completion of the Island Games

Decisions made.

- Business Case process approved.
- Standing Financial Instructions phase 2 approved

Work Underway

- Balfour King Street
- Refresh of the Integrated Performance Report (IPR)
- National business systems

17. KEY ITEMS FOR NOTING (Presenter: chair)

17.1. Key documentation (Presenter: Chair)

Members noted the following documents.

- Community Glaucoma Service response to MSP - May 2025
- PCS(AFC)2025-5 - Pay and Conditions for NHS Staff Covered by The Agenda for Change Agreement
- CCHST- Collaborative Care Home Support Teams - Funding and objectives letter - 2025-26- draft May 22, 2025, FINAL
- Board Chief Executive Finance Update - July 2025
- NHS Territorial Boards - Annual Delivery Plan 2025-26 - July 2025
- Financial Delivery Unit Annual Report 2024-2025
- Financial Delivery Unit Update - July 2025
- Sustainability Funding Letter - June 2025
- NHS Scotland Employer National Insurance Contributions Increase- June 2025
- Board Chief Executive Finance Update - July 2025
- Letter to NHS July 2025-Scottish Public Finance Manual Guidance

17.2. Finance and Performance Committee - Timetable for Papers - 2025/26 (Presenter: Chair)

Members noted the Finance and Performance Committee - Timetable for Papers - 2025/26

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

Members noted the Record of Attendance 2025/26.

The Chair closed the meeting at 11.30.

PUBLIC PROTECTION AND COMMUNITY SAFETY

A framework for the sharing of information in furtherance of Community Safety and Public Protection across Orkney

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1. PARTIES AND PARTNERS

1.1. Parties

This is an Information Sharing Protocol ("**ISP**") amongst:

- Orkney Islands Council.
- NHS Orkney.
- Police Scotland.
- Orkney Integration Joint Board.

(together the "Parties")

1.2. Community Partners.

2. INFORMATION

The Parties can agree to nominate further organisations to be Community Partners under this ISP.

The duties of the Chief Constable and police officers of Police Scotland include the prevention, detection or investigation of a crime or suspected crime; the prevention of harm or the risk of harm to an individual; and the preservation of community safety.

The Parties and Community Partners work together in the interests of community safety and public protection and are committed to proactive individual and public protection and promoting community and organisational resilience, in order to safeguard the people and communities of Orkney. The Parties and Community Partners will share information in furtherance of this aim. This ISP outlines the terms under which information will be shared and will support the lawful, consistent, accurate, sensitive and effective sharing of information between the Parties and any Community Partners.

It is a fundamental principle of this ISP that relevant information will be shared proportionately and responsibly between the Parties and Community Partners. It is however incumbent on all Parties and Community Partners to recognise that any information must have a lawful basis for being shared under this ISP.

The Orkney Chief Officers Group (COG) provides leadership, governance, and ensures local accountability for all aspects of public protection, and meets regularly to discuss relevant issues and share information on a reasonable and appropriate basis. Other forums for effective information sharing include but are not limited to MARAC / MAPPA processes,

Orkney Public Protection Committee (OPPC) and Highlands and Islands MAPPA Strategic Oversight Group ("HIMSOG").

This ISP can be read alongside any other relevant ISP to ensure that information is shared lawfully and effectively. For the avoidance of doubt, this ISP is designed to cover information sharing between the Parties and Community Partners in furtherance of community safety and public protection. It is not intended to replace specific ISPs which are in place to cover more specific situations or arrangements. Where there is a specific ISP in place for specific circumstances then that should take precedence over this ISP in those circumstances.

3. DEFINITIONS OF RELEVANT GROUPS, STRATEGIES AND PROCESSES

The work of a number of groups, strategies and processes will be covered by this Information Sharing Protocol, the following have the meanings stated:

Confidentiality Statement means at relevant meetings, and in particular where personal information relating to individuals is likely to be discussed or referred to, a relevant confidentiality statement will be read and signed by all participants at the beginning of the meeting and kept as a record of the fact that all participants are aware of their responsibilities in terms of data protection legislation and this ISP.

MARAC means a Multi-Agency Risk Assessment Conference in Orkney to allow all statutory and voluntary agencies to provide a consistent and structured response to managing the risk posed by perpetrators in cases of domestic abuse that are categorised as high risk. MARACs allow all the relevant agencies to share information and decide upon the most appropriate way to reduce or manage the risks around each case of domestic abuse that is subject of a MARAC. The MARAC model fits into the ethos of multi-agency working. No single agency can solve all the related problems but by identifying high risk cases and by sharing information and working together through the MARAC process, the outcomes for the victims/survivors of domestic abuse can be improved.

MAPPA means Multi Agency Public Protection Arrangements, which are a set of statutory arrangements of which the primary purpose is to maintain public protection and the reduction of serious harm. The protection of children, adults at risk and other members of the public are paramount. It is a structure by which registered sex offenders, mentally disordered restricted patients and other offenders who, by reason of their conviction, pose a risk of serious harm to the public are managed through the effective sharing of relevant information, and the assessment and management of that risk.

Personal Data means data which relates to a living individual, who can be identified from that data alone, or from that data and other information, which is in the possession of, or is likely to come into the possession of, the Data Controller (as defined below), and includes any expression of opinion about the individual and any indication of intentions in respect of the individual.

Public Protection Information means any personal data shared under this ISP in furtherance of community safety or public protection.

Referral Process is an agreed process by which issues of concern in relation to the vulnerability of individuals or communities can be referred into appropriate agencies, through and between agencies covered by this ISP.

Special Category Data means personal data that is more sensitive and therefore requires more protection than "regular" personal data. It includes biometric and genetic data and personal information that reveals ethnicity, political opinions, religious or other beliefs or trade union membership, as well as personal data that concerns health, a person's sex life or sexual orientation.

4. DEFINITIONS

- **Data Controller** means the person who determines the purposes for which and the manner in which any Personal Data are, or are to be, processed;

- **Data Protection Laws** means the Data Protection Act 2018 ("**DPA**") and the UK General Data Protection Regulation ("**UK GDPR**"), as such legislation may be amended, updated or replaced with equivalent legislation from time to time

- For the purposes of this ISP, the terms "**Data Controller**", "**Personal Data**", "**Personal Data Breach**" and "**Processing**" (and the expressions "**Process**", "**Processed**" and "**Processes**" shall be construed accordingly) and "Processor" shall have the meanings set out in the Data Protection Laws

- **ISP** means this Information Sharing Protocol.

5. PURPOSE

This ISP is intended to

- allow the sharing of Public Protection Information in accordance with relevant legislation in particular Data Protection Laws.

- Set out the principles which underpin the exchange of information between the Parties and Community Partners.

- Define the specific purposes for which the Parties have agreed to share Public Protection Information.
- Describe the roles and structures which will support the exchange of Public Protection Information between the Parties and Community Partners.
- Describe the arrangements which have been agreed for exchanging Public Protection Information.
- Describe the security procedures necessary to ensure that the confidentiality of Public Protection Information exchanged is maintained.
- Set out the responsibilities of the Parties and Community Partners.
- Provide staff with clear guidelines on the information sharing.

6. KEY LEGISLATION

This ISP aims to satisfy the requirements of the following legislation/regulations:

The Data Protection Act 2018 ("DPA")- sets out the framework for data protection law in the UK. It updates and replaces the Data Protection Act 1998 and came into effect on 25 May 2018.

Human Rights Act 1998 ("HRA") which protects the rights and fundamental freedoms of the individual, and **the Regulation of Investigatory Powers (Scotland) Act 2000 ("RIPSA") and the Regulation of Investigatory Powers Act 2000 ("RIPA")**, which regulate the use of certain investigative powers and the use of information obtained thereby, also have a bearing on the investigation of crime and disorder and the protection of community and public safety. However, they should not be seen as limiting effective and thorough investigation but should act as a constant reminder that all relevant information which is gained, handled and disclosed is done so within these legislative frameworks. For the avoidance of doubt, each Party is responsible for its own compliance with HRA, RIPSA and RIPA.

Housing (Scotland) Act 2001 provides the statutory basis for local authorities and RSLs to take 'eviction' action on the grounds of antisocial behaviour. There are other specific pieces of legislation which govern noise, pollution and general acts of nuisance, some of which are criminal acts. Much of this type of conduct contributes to and is now generally referred to as antisocial behaviour.

Antisocial Behaviour etc. (Scotland) Act 2004 contains a specific information sharing power - section 139 of the Act makes specific provision on the disclosure and sharing

of information between the local authority, the Chief Constable and RSLs where it is necessary or expedient for the purposes of any provision of the Act or any other enactment, the purpose of which is to make provision for or in connection with antisocial behaviour or its effects.

Adults with Incapacity (Scotland) Act 2000 and Adult Support and Protection (Scotland) Act 2007.

Children and Young People (Scotland) Act 2014.

Criminal Procedure (Scotland) Act 1995 and the Criminal Justice (Scotland) Act 2003.

The Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 which establish a coherent framework for emergency planning and response ranging from local to national level. It also specifically places legal obligations for increased co-operation and information sharing between different emergency services and also to non-emergency services that might have a role in an emergency (non-emergency services are defined as "Category 2 responders" under the Schedule 1 of the Act).

The Counter Terrorism and Security Act 2015

UK GDPR - amended the DPA and merged it with the requirements of the EU General Data Protection Regulation (2016/79) to form a UK-specific data protection regime.

Relevant Trading Standards & Licensing legislation and regulations

7. WHAT INFORMATION CAN BE SHARED?

7.1 The Parties and Community Partners may share information, including but not limited to Public Protection Information with each other under this ISP. The sharing of information under this ISP can be, both in response to a direct request under the terms of this ISP and proactively, to seek support and assistance from other Parties in tackling crime and antisocial behaviour, supporting and protecting vulnerable people and protecting community safety where it is desirable to do so, unless there is an overriding legal reason not to do so.

7.2 The Parties and Community Partners recognise that in most cases when Public Protection Information is shared under this ISP, the Parties and Community Partners must ensure there is a lawful basis and a sufficiently robust public interest justification for the sharing of Personal Data without consent. The need for

confidentiality needs to be balanced against the benefit of disclosure in the public interest. Each case must be assessed individually, but the most likely justifications for sharing information without consent will be as follows:

7.2.1 if the information is required for the prevention, detection or investigation of a crime or suspected crime or the apprehension or prosecution of offenders. (This applies to agencies other than Police Scotland and will not necessarily require to result in action being taken by Police Scotland);

7.2.2 if the information is necessary to protect an individual or community;

7.2.3 if the information is required for the purpose of discharging statutory functions; or

7.2.4 if the information is required in connection with legal proceedings or prospective legal proceedings.

7.3 Data protection is not a barrier to effective inter-agency and inter-departmental information sharing. The DPA 2018 sets out a number of grounds for legitimate sharing of information and a number of circumstances where UKGDPR may not apply which will be relied upon for information sharing under this ISP.

7.4 Consent is not the only justification for sharing Personal Data and although Personal Data should only be shared when this is necessary and proportionate, the Parties and Community Partners should be mindful of their responsibilities and need for a lawful basis when sharing Personal Data under this ISP and likewise mindful of the risks of not sharing relevant Personal Data without consent.

8. DATA PROTECTION AND INFORMATION REQUESTS

8.1 Each Party and Community Partner is a Data Controller with individual responsibility for data protection compliance and undertakes to have a valid notification with the Information Commissioner which covers the Processing of the Personal Data shared under this ISP.

8.2 Each Party and Community Partner is responsible for ensuring that relevant staff are given appropriate data protection training.

8.3 Each Party and Community Partner must ensure that data sharing is appropriate in the circumstances of the particular case.

8.4 It is the responsibility of each Party and Community Partner to comply with any Subject Access Request received. The receiver of the Subject Access Request must

give consideration to relevant exemptions under the DPA and, if there is any doubt as to whether the information should be disclosed, advice can be sought from the Party and/or Community Partner who provided the information if considered appropriate in the circumstances. The interpretation of the Party in receipt of the Subject Access Request will be final and conclusive.

8.5 No term of this ISP, whether express or implied, shall preclude any party from disclosing, if required, or considered necessary under the Freedom of Information (Scotland) Act 2002 (the "**2002 Act**"), details of all matters relating to this ISP. The Parties and/or Community Partners will co-operate with the Party in receipt of the request, who will consult the other Parties and/or Community Partners, when their views can help inform the applicability of an exemption. The interpretation of the Party in receipt of the FOI request of the 2002 Act and any exemptions therein will be final and conclusive.

9. ACCESS AND SECURITY PROCEDURES

9.1 Each Party and Community Partner undertakes to comply with the provisions of the DPA and, in particular, undertakes that appropriate technical and organisational measures shall be taken against unlawful or unauthorised processing of Personal Data shared under this ISP and against accidental loss or destruction of, or damage to, this Personal Data.

9.2 Access to Public Protection Information shared under this ISP must be restricted by Parties and Community Partners to their staff on a 'need to know' basis in connection with the purpose of this ISP. If inappropriate access by an individual is suspected by any party, the matter will be reported to the individual's manager for investigation and action as appropriate.

9.3 Where a Party and/or Community Partner to this ISP becomes aware that Public Protection Information, shared amongst the Parties or amongst any of them in consequence of and for the purpose of this ISP (as detailed in section 8.1 above) may, by operation of Law or Court Order or otherwise, be disclosed (either by that Party or another Party to this ISP) to a third party for a purpose and/or use other than intended by the Parties to this ISP, that Party will notify the originator of that information (the "Notified Party") of the same so that the Notified Party may have an opportunity to challenge such disclosure..

9.4 Individuals will only be authorised to access information where they are required to do so in order to perform their role, and only to the extent necessary to carry this

out. All staff that may receive or have access to Personal Data provided under this ISP must be checked to confirm their identity, or any outstanding criminal prosecutions/investigations which would indicate that they should not be permitted access to Public Protection Information shared under to this ISP.

9.5 Each Party and Community Partner must have formal policies and procedures in place to address the physical security of buildings, security awareness and staff training and security management of both manual and electronic systems where identifiable information may be held. Staff who receive, store, process, handle and disseminate information should do so at all times in accordance with individual Party policy and guidance.

9.6 All Public Protection Information shall be updated as required. Updates may be provided by each Party to the other Parties and Community Partners when information or circumstances change and it is considered that the Public Protection Information still requires to be shared. The Parties and Community Partners recognise the importance of good records management, in ensuring that information is regularly validated and refreshed. Inaccurate and out of date data is clearly detrimental to effective information sharing.

9.7 All transfer of Public Protection Information must be secure and in line with best practice guidelines, including any guidance issued by the Cabinet Office or the Information Commissioner's Office.

9.8 Each Party must nominate a designated senior manager to manage any information security incident and liaise with the other relevant Parties and Community Partners during any report of and investigation into a loss, compromise or damage to Public Protection Information shared under this ISP.

9.9 Each Party and Community Partner must notify any other relevant Party of any risks to the Public Protection Information shared under this ISP, or, in the event of a compromise of confidentiality, integrity or availability, within 24 hours of discovering the event

9.10 In relation to serious Data breaches either the data controller or the Party which becomes aware of such serious breach will notify the ICO within seventy-two (72)

hours of becoming aware of such breach. Data subjects will also be notified of such serious breach by that Party without undue delay unless:

(i) that Party has implemented appropriate technical and organisational measures in relation to the data suffering the breach such as encryption measures; or

(ii) that Party has taken subsequent measures to ensure that high risk to the individual is no longer likely; or

(iii) to do so would involve disproportionate effect, in which case a public communication or similar measure should be undertaken.

9.11 In order to determine whether the breach is serious the Parties will at least consider the potential detriment to data subjects, the volume of personal data lost/released/corrupted and the sensitivity of the personal data lost/released/corrupted. Each Party will also inform any other Party who is a data controller in respect of such Personal Data as soon as practicable after becoming aware of such breach.

10. ROLES AND RESPONSIBILITIES

10.1 The Parties named at paragraph 1.1 above are responsible for overseeing this ISP.

10.2 Each Party and Community Partner must designate a single point of contact ("**SPOC**") who will work together in good faith with the other Parties' SPOCs to implement this ISP and jointly resolve matters that arise in relation to this ISP. Signatories are responsible for ensuring there is a named SPOC within their organisation and for providing this information to the Orkney Chief Officers Group.

10.3 The SPOC for each Party is responsible for reviewing the Public Protection Information held to ensure the sharing, use and storage of Public Protection Information complies with the Data Protection Principles under the DPA, and in particular, that the Public Protection Information is:

- **processed lawfully, fairly and in a transparent manner in relation to individuals;**
- **collected and used for specified, explicit and legitimate purposes;**
- **adequate, relevant and not excessive in relation to the purpose for which the Public Protection Information is processed;**

- **accurate and, where necessary, up to date;**
- **not kept longer than necessary; and**
- **handled in a way to ensure appropriate security measures are in place to protect data.**

10.4 Any Public Protection Information which does not comply with the above principles will, where appropriate, be corrected or destroyed.

10.5 Public Protection Information discovered to be inaccurate or inadequate for the specified purpose will be brought to the attention of the originator of the Public Protection Information. The originator will be responsible for correcting it and notifying the recipients of the corrections.

10.6 The SPOCs are responsible for maintaining records of the Public Protection Information shared, including the date of disclosure and who authorised it.

11. REVIEW OF THE ISP

11.1 The ISP will be reviewed one year after the implementation date and annually thereafter, but any Party can request a review at any time, providing that Party has a reasonable justification for reviewing the ISP.

11.2 The review will be carried out by the SPOCs via the Orkney Chief Officers Group. When conducting the review of this ISP the Parties will consider the following, whether the:

11.2.1 ISP is achieving its purpose

11.2.2 Public Protection Information sharing is operating smoothly

11.2.3 contact details require updating

11.3 Any Party should report any general information governance issues or concerns relating to the ISP, to the Orkney Chief Officers Group at any time.

11.4 Any changes identified during the review must be agreed by all Parties to this ISP.

12. DURATION AND TERMINATION

12.1 This ISP shall come into force immediately on being executed by the Parties and shall remain in force unless terminated or superseded in terms hereof.

12.2 The Parties may nominate and agree that further Community Partners may be added to this ISP by completing Community Partner Letter of Adherence, as set out in Appendix 1.

12.3 Notwithstanding the termination of this ISP, any duties of confidentiality imposed on the Parties or in respect of staff or agents hereunder in respect of Public Protection Information shared hereunder, shall subsist indefinitely.

12.4 Any Community Partner may withdraw from this ISP on giving six weeks' written notice to the Parties of their intention to do so.

12.5 This ISP may be varied by the written agreement of all the Parties.

12.6 Any Party may terminate this ISP by notice in writing immediately to the other Parties if:

12.6.1 another Party is in breach of any of the terms of this ISP which, in the case of a breach capable of remedy, shall not have been remedied by that other Party within 21 days of receipt of a written notice specifying the breach and requiring its remedy; or

12.6.2 another Party is incompetent, guilty of gross misconduct and/or any other serious or persistent negligence in the carrying out of its duties hereunder.

12.7 The obligations on the Parties and Community Partners under this ISP shall be continuing and, in particular, shall survive termination of the ISP.

BOILERPLATE CLAUSES

13 DISPUTES

The Parties and Community Partners agree to act in good faith at all times and attempt to resolve any disputes arising as a result of their respective rights and duties hereunder on an amicable basis.

14 ASSIGNATION AND SUB CONTRACTING

The Parties and Community Partners shall not assign or otherwise transfer by any means whatsoever, their rights and obligations under this ISP.

15 NO WAIVER

Failure to exercise, or any delay in exercising, any right or remedy provided under this ISP, or by law, shall not constitute a waiver of that, or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy

16 INDEMNITY

A Party and/or Community Partner who fails to comply with the terms of this ISP will indemnify and keep indemnified each Party from and against all cost, claims, demands, damages, losses and liabilities incurred as a consequence of such failure (including, but not limited to, the imposition of any monetary penalty by the Information Commissioner).

17 GOVERNING LAW

This ISP shall be governed by Scots law and the Parties and Community Partners hereto submit to the exclusive jurisdiction of the Scottish Courts.

SIGNATURE BY THE PARTIES

ORKNEY ISLANDS COUNCIL a Local Authority constituted under the Local Government etc. (Scotland) Act 1994 and having its principal offices at School Place, Kirkwall, Orkney, KW15 1NY;

ORKNEY INTEGRATION JOINT BOARD a separate legal entity constituted under the Public Bodies (Joint Working) (Scotland) Act 2014 and having its principal offices at OHAC, School Place, Kirkwall, Orkney, KW15 1NY; and

CHIEF CONSTABLE OF THE POLICE SERVICE OF SCOTLAND appointed in terms of Section 7 of the Police and Fire Reform (Scotland) act 2012 (hereinafter referred to as "the Chief Constable")

NHS ORKNEY a Health Board constituted under the National Health Services (Scotland) Act 1978 and having its principal offices at Balfour Hospital, Foreland Road, Kirkwall,

Authorised to sign for and on behalf of **Police Scotland**:-

Signature .....

Name SCOTT ROBERTSON

Designation CHIEF INSPECTOR POLICE SERVICE OF SCOTLAND

Date 4/9/2025

Witness:-

Signature .....

Name KAREN SCOTT

Address KIRKWALL POLICE STATION

Date 04/09/2025

KW15 1NZ

We, the undersigned, agree to adopt and adhere to this Information Sharing Protocol:

Authorised to sign for and on behalf of **Orkney Islands Council**:-

Signature .....

Name GAVIN MITCHELL

Designation HEAD OF CORPORATE GOVERNANCE

Date 04/09/2025

Witness:-

Signature .....

Name ANN MUIR

Address C/O OIC, SCHOOL PLACE, KIRKWALL

Date 04/09/2025

Authorised to sign for and on behalf of **Orkney IJB**:-

Signature .....

Name STEPHEN BROWN

Designation CHIEF OFFICER

Date 4/9/25

Witness:-

Signature .....

Name CALLAN HUNTER-CURTIS

Address 9 WALLIWALL ROAD KIRKWALL, ORKNEY

Date 04/09/2025

Authorised to sign for and on behalf of **NHS Orkney**-

Signature .....

Name SAM THOMAS

Designation EXECUTIVE DIRECTOR OF NURSING MIDWIFERY AHPS

Date 4/9/25

Witness:-

Signature .....

Name IAIN GRAY

Address 61 Copland, Stromness

Date 4/9/25

Appendix 1 - Community Partner - Letter of Adherence to ISP

PUBLIC PROTECTION AND COMMUNITY SAFETY
INFORMATION SHARING PROTOCOL

The Parties have agreed that_____ should become a Community Partner under the Public Protection and Community Safety Information Sharing Protocol between Police Scotland, Orkney Islands Council, Orkney Integration Joint Board and NHS Orkney.

We, the undersigned, agree to adopt, adhere and comply with the terms of to the Public Protection and Community Safety Information Sharing Protocol as a Community Partner:

Authorised to sign for and on behalf of _____:-

Signature .....

Name .....

Designation .....

Date .....

Place of Signing .....

Witness:-

Signature.....

Name .....

Address .....

Date .....

Item 11

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	–	Director of Nursing, Midwifery, AHP's and Chief Officer Acute
Debs Crohn	-	Interim Head of Corporate Governance
Steven Phillips	-	Head of People & Culture
Tammy Sharp	-	Director of Performance, Transformation & Deputy CEO
Michelle Mackie	-	Lead Midwife Deputy Director of Nursing, Midwifery & AHP's
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 in 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, SafeCare[1], 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 legislation[2]. 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.

[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

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

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	13 January 2026
Proposals discussed at Senior Leadership Group	SLG	27 January 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	1 April 2026

Cabinet Secretary for Health and Social Care
Rùnaire a' Chaibineit airson Slàinte agus Cùram Sòisealta
Neil Gray MSP
Niall Gray BPA
Cabinet Secretary for Transport
Fiona Hyslop MSP
Cabinet Secretary for Climate Action and Energy
Gillian Martin MSP

Scottish Government
Riaghaltas na h-Alba

Davie Campbell
Interim Chair
NHS Orkney
david.campbell15@nhs.scot

23 September 2025

Dear Davie

We wish to congratulate the staff of NHS Orkney on the excellent work they have carried out to help create a sustainable, low-carbon health service. NHS Orkney is leading the way for NHS Scotland in its actions to reduce its greenhouse gas emissions and we want to highlight the following achievements:

- 100% of NHS Orkney's fleet is now electric, ahead of the target date of December 2025
- The completion in March this year of projects to install renewable heating systems across its whole estate
- Reducing anaesthetic nitrous oxide emissions by 94% compared to 2018/19
- Reducing volatile medical gas emissions by 82% compared to 2018/19
- The completion of the Balfour in 2019, the first net-zero designed hospital in Scotland
- The installation of a clinical waste treatment unit, reducing transport emissions and increasing the islands' resilience
- The creation of polytunnels for therapeutic gardening.

These things could not have been done without the dedication and skill of teams across your organisation. The twin crises of climate change and nature loss are having devastating consequences but the work of your team demonstrates that we can take action to improve the lives of current and future generations.

The Cabinet Secretary for Finance and Local Government, Shona Robison MSP, visited NHS Orkney on 20 August and was very impressed by the approach taken to promote an environment where staff-led innovations result in improved patient experience as well as improved sustainability. Many of the sustainability initiatives at Orkney began as ideas to improve patient experience and wellbeing but have also resulted in environmental benefits. For example, the promotion of services locally or online has reduced inter-island and off-island travel, which has improved the experience of patients as well as reducing travel emissions.

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Ms Robison saw for herself the work at the Balfour hospital, possibly the “greenest” hospital in the UK. This is a hospital running on 100% electricity and heated by heat pumps. Along with the now 100% NHS Orkney electric fleet, this shows that it is possible to decarbonise NHS Scotland and meet our net zero climate emission targets for 2040. We would welcome NHS Orkney sharing its experience of how it has made these changes with other parts of NHS Scotland and showcasing its work more widely.

NHS Scotland is a member of the World Health Organisation’s Alliance for Transformative Action on Climate and Health, which works to realise the ambition set at COP26 of building climate resilient and sustainable health systems. It is also a member of Healthcare Without Harm Europe, which exists to create a sustainable healthcare sector in Europe. The Scottish Government will seek opportunities for NHS Orkney to promote its excellent work through these initiatives and to inspire others outwith Scotland to follow your team’s example.

We appreciate that there is still more work to be done at NHS Orkney to create a sustainable and low-carbon health system. However, it is important to recognise the significant progress that has been made so far and we look forward to hearing about the Health Board’s future successes.

Yours sincerely







NEIL GRAY **GILLIAN MARTIN** **FIONA HYSLOP**

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Timetable for Submitting Agenda Items and Papers 2025/26

Initial Agenda Planning Meeting[1]	Final Agenda Planning Meeting	Papers in final form[2]	Agenda & Papers	Meeting
With Chair, Chief Executive and Corporate Services Manager[3]	with Chair, Chief Executive and Corporate Services Manager	to be with Corporate Services Manager by	to be issued no later than	(unless otherwise notified) **at**
12:00 noon	**12:00 noon**	**17:00**	**16:00**	**09:30**
< 1 week after previous meeting >	*< 4 weeks before Date of Meeting >*	***< 9 days** before Date of Meeting >*	*< 1 week before Date of Meeting >*	*< Day of Meeting >*
	27 March 2025	15 April 2025	17 April 2025	**24 April 2025**
1 May 2025	29 May 2025	17 June 2025	19 June 2025	**26 June 2025 (Annual Accounts)**
3 July 2025	31 July 2025	19 August 2025	21 August 2025	**28 August 2025**
4 September 2025	2 October 2025	21 October 2025	23 October 2025	**30 October 2025**
6 November 2025	13 November 2025	2 December 2025	4 December 2025	**11 December 2025**
18 December 2025	29 January 2026	17 February 2026	19 February 2026	**26 February 2026**

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*